Course Book

HEALTH POLICY AND PLANNING

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HEALTH POLICY AND PLANNING

MASTHEAD

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INTRODUCTION

WELCOME

SIGNPOSTS THROUGHOUT THE COURSE BOOK

This course book contains the core content for this course. Additional learning materials can be found on the learning platform, but this course book should form the basis for your learning.

The content of this course book is divided into units, which are divided further into sections. Each section contains only one new key concept to allow you to quickly and efficiently add new learning material to your existing knowledge.

At the end of each section of the digital course book, you will find self-check questions. These questions are designed to help you check whether you have understood the concepts in each section.

For all modules with a final exam, you must complete the knowledge tests on the learning platform. You will pass the knowledge test for each unit when you answer at least 80% of the questions correctly.

When you have passed the knowledge tests for all the units, the course is considered finished and you will be able to register for the final assessment. Please ensure that you complete the evaluation prior to registering for the assessment.

Good luck!

SUGGESTED READING

GENERAL SUGGESTIONS

Blank, R., Burau, V., & Kuhlmann, E. (2018). *Comparative health policy* (5th ed.). Red Globe Press. http://search.ebscohost.com.pxz.iubh.de:8080/login.aspx?direct=true&db=cat05114a&AN=ihb.49652&site=eds-live&scope=site

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UNIT 5

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REQUIRED READING

UNIT 1

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UNIT 5

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Dollar, D. (2001). Is globalization good for your health? *Bulletin of the World Health Organization, 79*, 827—833. http://search.ebscohost.com.pxz.iubh.de:8080/login.aspx?direct=true&db=asn&AN=5476726&site=eds-live&scope=site

UNIT 6

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LEARNING OBJECTIVES

The health sector plays an important role in the economy of many countries, being seen as a driving force of economies as it encourages innovation, investments in new technologies, and, most importantly, ensures that the population is healthy and therefore economically productive. However, some see the health sector as a liability, absorbing large amounts of national resources. Whether going to a hospital, visiting a clinic for a consultation, or heading to the pharmacy for medication, all citizens will need the health sector at some point in their lives. Given the nature and importance of health, the health sector should be given special status.

Many decisions unrelated to healthcare, e.g., the social determinants of health and nutrition, in addition to environmental factors like pollution, can have a major impact on people's health. Economic policies, such as taxes on cigarettes also play a role in the health of the public. Consequently, it is very important to understand the relationship between public policy, health policy, and health in order to address major contemporary health problems. These can include increased antibiotic resistance, high rates of obesity, the challenge of emerging diseases, and the rising prevalence of chronic disease, to name a few. Therefore, health policy is imperative in order prioritize health problems and guides the allocation of resources in order to ultimately improve the health of the population.

This **Health Policy and Planning** course book provides a comprehensive introduction to health policy and its related "who," "what," "when," and "how" aspects.

UNIT 1

POLICYMAKING AND HEALTH POLICYMAKING

STUDY GOALS

On completion of this unit, you will be able to …

- identify the differences between policy and politics.
- define and differentiate between policy, public policy, and health policy.
- understand roles and responsibilities of different stakeholders in health policy.
- construct a power/interest grid to categorize and manage stakeholders.

1. POLICYMAKING AND HEALTH POLICYMAKING

Introduction

This unit will explain what makes health policy so unique, including the complexity of policymaking and the role of politics in policy. The definitions and differences between policy, public policy, and health policy will also be explored. Since stakeholders are the cornerstone of health policy, this unit will explicitly explain how to identify and categorize them on the power/interest grid, as well as how to manage and engage with them. The role of the private sector in health policy will also be highlighted, followed by a description of the policy process and its steps.

1.1 Making Policy in a Complex World

Policymaking is a complex process involving many participants with different roles, needs, interests, and resources. The study of policy is the study of who gets what, why they get it, and what difference it makes. As policymaking becomes more and more complex, policymakers across the world are increasingly interested in using tools, techniques, and technologies to understand and intervene. Policy formulation and implementation usually involves solving problems in complex systems that include different personnel, institutions, and dynamic environmental factors, along with examining how to create or change specific aspects to achieve the expected results.

The complex nature of policy is also due to the fact that even a relatively simple objective, such as launching a vaccination campaign, requires extensive research, a great deal of information, and a wide range of expertise. Furthermore, this involves the mobilization, cooperation, collaboration, and coordination of a large number of resources, people, and organizations, all of which must act in specific ways during specific time frames (Buse et al., 2012). Furthermore, additional factors, such as corruption, incompetence, political motivations, financial difficulties, insufficient resources, and conflicting interests all come into play. For these reasons, many policies fail. These obvious weaknesses in the policymaking process pose serious problems, but they can, in principle, be dealt with (Buse et al., 2012). Better governance, more concerted effort, goodwill, more evidence-based information, better-qualified experts, and greater transparency can all greatly alleviate the aforementioned problems and improve the entire process of policymaking. Additionally, there are entire disciplines of project management, economics, and public management whose sole aim is to provide theories, ideas, and techniques on how to improve the policymaking process in order to achieve better policy results (Cairney, 2012).

Policymaking and Research

Another aspect that makes policymaking complex is the "complicated" relationship between research produced by researchers or scientists and that produced by policymakers. This relationship is the subject of a permanent paradox—policymakers constantly call for empirical data, evidence, facts, and authoritative explanations to base their policy on. Policy makers involved in almost all steps of the policymaking process try to justify their decisions by basing it on scientific evidence. However, the communication between researchers and policymakers has been limited in most cases to the transmission of evidence by researchers, leaving explanations, interpretation, and judgments related to the policy process to the policymakers. Furthermore, extensive research has highlighted the limits of the use of evidence in policymaking. This "gap" between research and policy/policymakers can be attributed to a gap in both communication and understanding.

Policy and Politics

There has been a constant struggle both to reconcile policy and politics and to differentiate between them, especially as they are highly interrelated. The differences between policy and politics are summarized in the table below. While policy and politics are not one and the same, politics is essential to determine how citizens and policymakers understand and define existing social conditions and policy issues, promote certain types of interventions over others, and generate various challenges in policy implementation (Drèze, 2018).

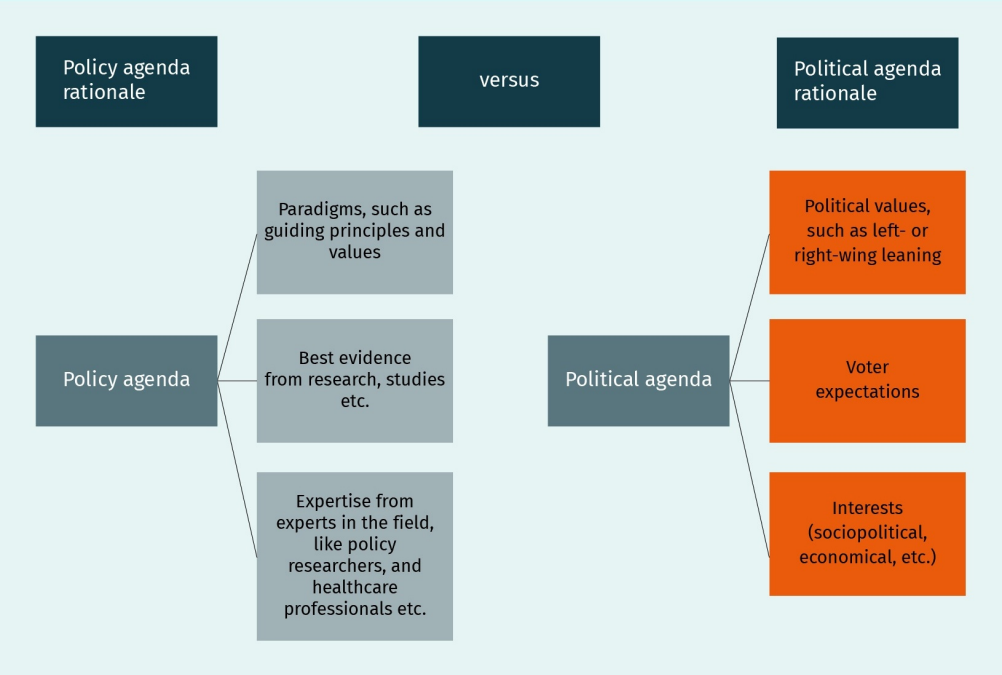
Table 1: The Difference between Policy and Politics

Policy	Politics
Commitment or statement of intent. Guidelines make people, organizations, or parties accountable. Policy is a set of rules or principles that guide decisions (Drèze, 2018).	Refers to authority and is related to public life. Politics generally revolve around government and its activities. "Politics" is a term related to the process of an organization (Drèze, 2018).
Focused on **content**.	Focused on **process**.
A government's, political party's, or corporation's plans, guiding principles, or policies of action designed to influence and make decisions, actions, and other matters (Drèze, 2018).	The science and process of governing, especially by political entities such as the state, managing affairs both internal and external (Drèze, 2018).
Can be termed as a "principle." It can thus be said that policy is "principle-based."	The practice and theory of governance. It can thus be said that policy is "power-based."
Any expert can inform policy in their field.	Politics are carried out by politicians and elected officials.

Source: Mirna Naccache, (2022).

Another way to differentiate between policy and politics is by looking at their rationale, in other words, what factors drive each of them. The figure below presents the factors that influence politics versus the factors that influence policy.

Figure 1: Rationale behind Political Agenda versus Policy Agenda



Source: Mirna Naccache, based on Ammar (2009).

Complexity of Health Policymaking

Health policymaking is much more complex than any other form of policymaking This is primarily attributed to "the enormous complexity of the healthcare system because of its nonlinear, dynamic, and unpredictable nature" (Lipsitz, 2012, p. 243). This complexity also stems from a number of additional reasons: Firstly, as per the World Health Organization's (WHO) constitution, developed in 1964, non-healthcare professionals (i.e., patients) cannot evaluate their own needs in terms of treatment and medication, even those who have moderate to proficient levels of health literacy (Guise et al., 2021). Consequently, health is not a commodity, with health products such as medications that treat diseases like hypertension and diabetes being essential. These are medicines that people must receive in sufficient quantities at all times in order to maintain their health.

Another reason for the complexity of health policy is that health is affected by sectors and decisions that have nothing to do with healthcare, yet often involve matters of life and death. Examples can be environmental factors (e.g., pollution), socioeconomic factors (e.g., poverty), and economic policies (e.g., taxes on alcoholic beverages, or the lack thereof). Health policy is also deemed complex because, even though all citizens will consume healthcare services and products in their lifetime, the need for medication and medical treatment is unpredictable. A good example of this is the COVID-19 pandemic, when the rapid surge in the numbers of people infected around the world led to a sudden, exponential need for ventilators to provide oxygen to COVID-19 patients who could not breathe on their own.

Lastly, the **epidemiologic transition**, also known as the **demographic shift**, has changed the patterns of populations in terms of life expectancy, age distribution, fertility, mortality, and causes of death (Braveman & Gottlieb, 2014). Additionally, the epidemiologic transition has shifted mortality and morbidity largely away from communicable or infectious disease (e.g., hepatitis, measles, and tuberculosis) and towards noncommunicable or chronic diseases (e.g., cancer, heart disease, and diabetes mellitus). These changes, in turn, have given rise to an aging population, as people around the world have started to live longer and thus require more health services. This has led to an increase in the need for and access to quality healthcare (Phillips, 1994). Therefore, the epidemiologic transition has had a pronounced effect on the design of health policies, adding to the complexity of health policymaking.

Epidemiologic transition
This is the process by which the pattern of mortality and disease in a population is transformed from one of high infant mortality and epidemics to one of chronic diseases.

Demographic shift
This is the historical shift from high birth and mortality rates in societies with minimal technology and education (especially in women), towards economic development, low birth and mortality rates, high rates of female education, educational development, and highly skilled societies.

Despite health being a basic human right which should be separated from political interests, health has increasingly become a political issue (World Health Organization, 1946). This is because the health of a society usually involves actions taken by the government in order to reach specific health outcomes unlikely to be achieved by individuals undertaking the same goals. Examples of such actions include programs on injury and disease prevention. Public health is only achieved through collective action, and not through individual efforts. Yet, despite all of this, healthcare policies remain low on the agenda of most political parties, elected officials, and governments around the world. The rising drug prices in many countries, e.g., the United States of America (USA) are an example of this, with no restrictive policies being developed or implemented to improve access to such drugs, even if this would mean reducing corporate profits (Jackson, 2012; Kesselheim et al., 2016).

Nevertheless, politics is increasingly influencing health policy and health has become a political issue. Those who work in health policy, whether they hold a position in the government, an advocacy group, a research organization, or a healthcare institution, must understand the political dimensions of the health problem they are looking at, as well as the proposed solution. This understanding can help them better predict short-term constraints and long-term opportunities for change (Bhattacharya, 2013).

Contextual Factors that Affect Health Policy

Adding to the complexity of health policy are systemic issues related to context, such as economic, social, cultural, and political factors. These "contextual factors" can be national, regional, or international. While there are several ways to categorize these factors, Leichter (1979) provides a useful and straightforward format, as outlined below.

Situational factors

Situational factors are defined as transient, temporary, or special events or conditions that may affect policy, such as natural disasters. These are also called "focus events" (Leichter, 1979). They may be a specific, one-time occurrence or public recognition of a new concern that has been widely disseminated for a long time. For example, the COVID-19 pandemic has led to using new technologies, namely the messenger RNA (mRNA) in COVID-19 vaccines. This has, in turn, expedited the deployment of the same mRNA technology to fight the Human Immunodeficiency Virus (HIV), with clinical trials

starting in October 2021. Accordingly, the "focus event" in this example is the COVID-19 pandemic, which prompted researchers and international pharmaceutical companies to study and develop a novel vaccine technology not used before.

Structural factors

Structural factors are relatively constant factors in a society. They may include political systems, types of economic, sociodemographic characteristics, technological progress, and the degree to which the civil society is given the opportunity to participate in policy discussions and decision-making (Leichter, 1979).

Cultural factors

Cultural factors, such as religious observances, customs (which often accompany religious and other beliefs), values, social organization, material culture, as well as accepted gender roles and occupations may also affect health policy (Leichter, 1979). The status or language differences of ethnic minorities or vulnerable populations, such as refugees, may cause these groups to know little about their rights in accessing healthcare services, which can, in turn, lead to their health needs not being met. For example, in some Middle Eastern societies, women often cannot easily access medical services (one reason may be that they must be accompanied by their husband) or have considerable stigmas surrounding certain diseases (e.g., breast cancer) (Kawar, 2013).

International or exogenous factors

International or exogenous factors can lead to greater interdependence between countries and promote sovereignty and international cooperation in healthcare. Although many health problems are caused by national or local governments, some health problems require cooperation between countries, regions, or multilateral organizations.

A prime example of such cooperation, not to mention one that was resoundingly successful, were the global efforts that led to the eradication of polio. The Global Polio Eradication Initiative (GPEI) began in 1988, and was led by the WHO, the Rotary Foundation, the United Nations Children's Fund (UNICEF), The Gates Foundation, and the United States Center for Disease Control and Prevention (CDC) (Benecke & DeYoung, 2019). By 2018, three serotypes of wild poliovirus were certified as eradicated. By 2020, the annual number of poliovirus cases had decreased by more than 99.9 percent worldwide from the estimated 350,000 cases prior to the launch of the GPEI (Benecke & DeYoung, 2019).

However, efforts are still needed because, even if a country manages to vaccinate all its children against polio, cases can be imported from neighboring countries by unvaccinated people. This happened in a period between 2012 and 2013, when the lack of polio vaccines led to an outbreak of polio cases in war-torn Syria, causing cases to be imported to neighboring countries hosting refugees (Benecke & DeYoung, 2019). The "anti-vaxx" movement can also be seen as a threat to the milestones achieved in vaccination and can lead to outbreaks and the resurgence of otherwise preventable diseases, such as measles. In 2019, measles outbreaks in the USA reached emergency levels, and other countries such as Brazil, France, Italy, Japan, and Ukraine also recorded outbreaks (Benecke & DeYoung,

2019). All these factors are unique to both their settings and time, which contributes to their complexity. In order to understand health problems and formulate policies to address them, all factors related to context must be analyzed and understood.

Theories of Public Policy

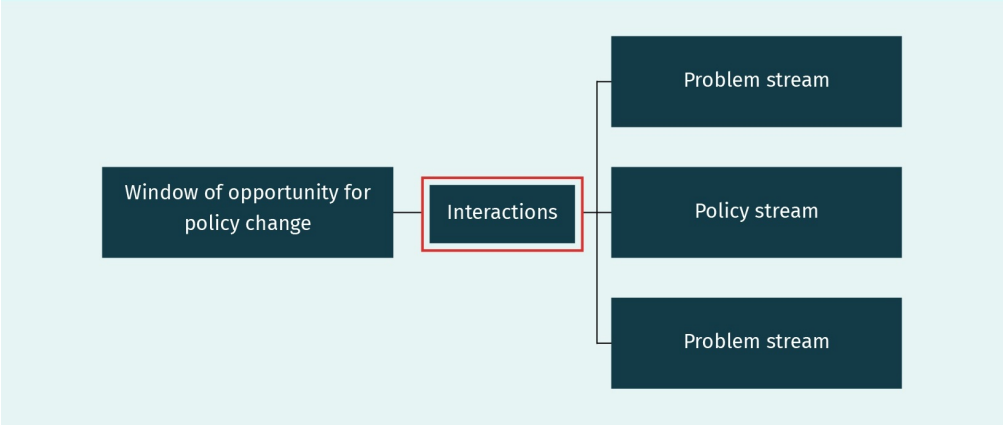
There are three main theoretical approaches to study policymaking, outlined below.

Approach one: Kingdon's multiple streams

In 1984, political scientist John Kingdon created the multiple streams framework. This framework shows that the policy process can be separated into three streams: the problem stream, the policy stream, and the politics stream (Kingdon, 1994; Kingdon 2003). The problem stream is when a problem starts getting the attention of policymakers. Once that happens, there is a probability that the problem will get onto their agenda. The policy stream is when policy proposals for that specific problem are made available. The politics stream is when there is a change in the political mood in favor of solving the problem and when decision makers and politicians become receptive for solutions (Kingdon, 1994; Kingdon 2003). When these three streams meet and interact, this creates a window for policy change (Kingdon, 1994). The multiple streams framework is a powerful tool that helps in understanding policymaking and agenda setting (Kingdon, 1994; Kingdon 2003).

Kingdon's multiple streams framework can be used in various real-world scenarios. For example, a group of researchers in Iran used this framework in order to put the issue of hepatitis C infections (which are prevalent in Iran) on the policy-maker agenda. They were successful in focusing the attention of decision- and policy-makers, who have since started working on policies implementing appropriate programs with the aim to have eliminated the disease from Iran by 2030 (Behzadifar et al., 2019).

Figure 2: Kingdon's Multiple Streams Framework



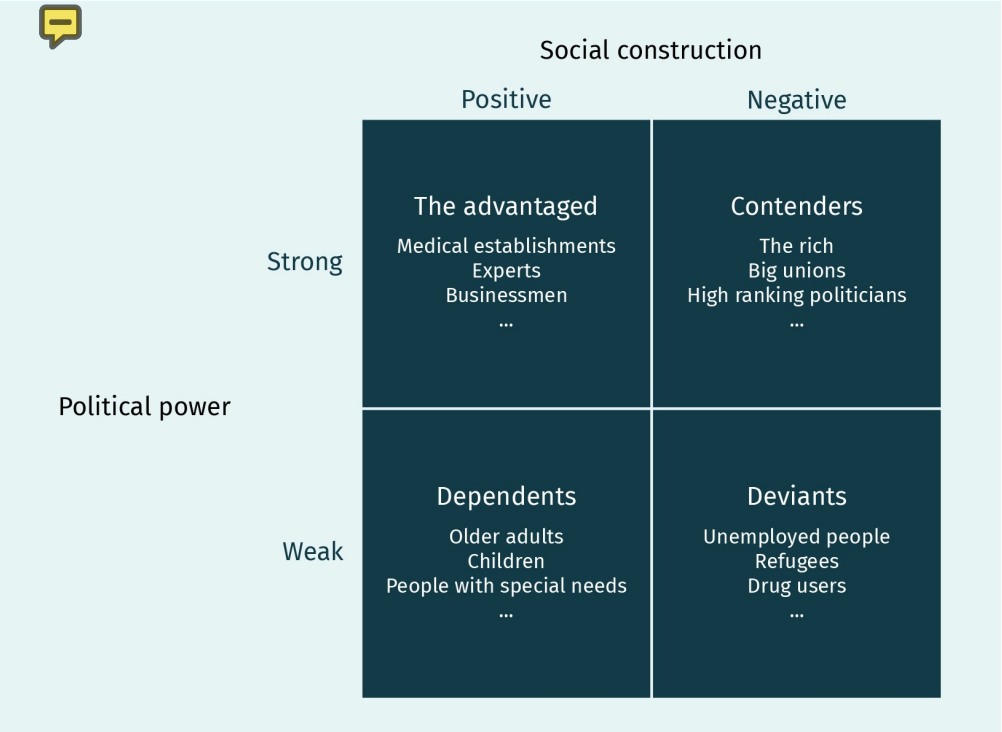
Source: Mirna Naccache, based on Kingdon (1994).

Approach two: Schneider and Ingram's social construction of target populations

A social construction is a stereotype about a specific group of people that is shaped by culture, history, politics, religion, socialization, the media, and literature. Positive constructions comprise positive descriptions such as honest, deserving, clever, humanitarian, etc., while a destructive construction comprises negative descriptions, such as unworthy, egoistic, irresponsible, and insincere (Ingram et al., 2007). Policymakers pass value judgments on social groups in society and on how they should be treated by the government. Simply put, this means "good groups" should be rewarded while "bad groups" should be sanctioned (Ingram et al., 2017). This is due to the fact that policymakers tend to favor providing advantaged groups (~~such as~~ people of higher socioeconomic standing) with supportive policies, since they are constructed positively as both deserving and powerful. In these cases, the group reacts favorably and in turn offers support to the policymakers (Ingram et al., 2007).

Alternately, policymakers are more likely to impose penalties on negatively constructed groups, for example refugees, prisoners, and unemployed individuals (Ingram et al., 2007). Since these groups possess little or no power, there is no fear of democratic revenge from the groups themselves, and the public agrees on penalties for these negatively constructed groups. In Schneider and Ingram's social construction, it all boils down to power (Ingram et al., 2007). For example, a study was done in the USA on the spread of HIV/AIDS and tuberculosis in prisons (Nicholson-Crotty & Nicholson-Crotty, 2004). The researchers behind this study highlighted the fact that this was the result of inadequate funding for treatment and prevention programs for these diseases, and that these low levels of funding are ultimately the result of negative constructions that policymakers have of criminals and potential criminals (Nicholson-Crotty & Nicholson-Crotty, 2004).

Figure 3: Schneider and Ingram's Social Constructivism Model



Source: Mirna Naccache, based on Ingram et al. (2007).

Approach three: Sabatier and Weible's advocacy coalition frameworks

Policymaking happens in a complex manner through many layers in government, with multiple actors and over a long period of time (often a decade). Its key elements are as follows (Sabatier & Weible, 2019):

- coalitions. Groups of actors who share same beliefs around a policy issue. They may include public officials, interest group members, and researchers.
- beliefs. Core or fundamental beliefs (e.g., religious or universal). Policy core is a belief related to a specific field of policy (e.g., the paradigm around the role of private sector etc.) and how these beliefs are linked to implementation.
- policy subsystems. Participants who regularly seek to influence policy within an area or sector.
- policy brokers. Actors who mediate between the coalitions and push for one decision.
- resources. This can be the authority and power to make decisions, public opinion, financial resources, etc.

According to this framework, the policy process creates room for competition between coalitions of actors, who advocate for different policy problems and solutions based on their beliefs and subsystems. For example, this framework was used in Nigeria in order to form coalition groups who worked on making and sustaining maternal and child health in

the country a political priority. This framework and the coalitions formed led to positive shifts in policymakers' attitudes and increased policy support for free and easily accessible maternal and child health programs in Nigeria (Okeke et al., 2021)

1.2 Policy—Public Policy—Health Policy

It is important to define the terms policy, public policy, and health policy in order to be able to distinguish them from one another.

Policy

Policy refers to a set of rules or guidelines that guide decisions to determine a course of action. A policy is also defined as a plan, guiding principle, or course of action taken by a government, political party, business, or organization intended to influence and determine decisions and actions. A policy is usually a goal that is problem-based and solution-oriented. Policy can be a law, regulation, contract, procedure, administrative action, incentive, guiding principle, or voluntary practice (Alla et al., 2017).

Policies are made by both the public and private sectors and may be developed by the government, multinational corporations, small businesses, educational institutions, or healthcare institutions. The private sector usually develops their internal policies to govern their processes and services with an end goal in mind, usually some sort of gain (e.g., profit). However, the private sector must develop their policies while taking into consideration the confines and limits set forth by the public law and government. The private sector also has to take public opinion into consideration, as it would directly impact its profit if they developed a policy viewed unfavorably by the public.

A policymaker has the power to influence and is responsible for formulating policies at a local, national, regional, or international level. Policymakers are not just politicians, as anyone who can influence policy is considered a policymaker.

Public Policy

Public policy usually refers to polices made by the government. Public policy is the sum of activities undertaken by the government, whether acting directly or indirectly through agents, and having an influence on the lives of the citizens (Cairney, 2012). Another definition of public policy is a statement of action, a decision, or a choice made by a government (Cairney, 2012). The focus of public policy is the "public and its problems" (Alla et al., 2017, p. 2). Public policy includes governmental laws, decrees, regulations, court decisions, and local ordinances (Cairney, 2012).

Despite assumptions that all public policies should be made to attain a certain purpose or achieve a certain goal, another definition of policy is what governments decide to do or not to do. This means that a government deciding not to do something, in other words failing to act (explicitly or implicitly), is also considered a policy. For example, the cost of

brand-name prescription drugs in the USA is 3.44 times higher than in other countries. Successive administrations have chosen not to step in and regulate the costs, therefore their inaction can be considered their policy on this issue (Jackson, 2012).

Health Policy

Health is defined as the state of physical, psychological, and social wellbeing, not merely the absence of illness, injury, or disease (World Health Organization, 1984). Health is a basic human right and is central to one's happiness and well-being. It also significantly contributes to prosperity, wealth, and even economic progress. Studies have shown that populations that are healthier tend to be more productive and contribute to economic and social development.

Understanding the relationship between health and health policy allows us to tackle major global health issues, such as antibiotic resistance and obesity, as well as the exponential increase in non-communicable diseases, including diabetes, heart-related diseases, and cancer. Health policy helps in guiding resources and decisions towards prioritizing and addressing health issues such as these.

In order to understand these relationships, it is crucial to define what health policy is. There are various definitions, but according to the WHO, policy in healthcare is "an expression of goals for improving the health situation, the priorities among these goals, and the main direction for attaining them" (World Health Organization, 1986, p. 86). However, health itself can be defined in various ways—for example, some dictionaries define health simply as having no illness or injury (Oleribe et al., 2018). As such, there are several possible definitions of health policy. Health policy is related to the action or inaction by public and private sectors that affect the health of the public, as well as all the components of the healthcare system. This includes, but is not limited to, policies related to the access to and availability of health services, delivery of healthcare services, quality of health services, funding arrangements, healthcare financing, and regulation of healthcare institution.

Social determinants of health

Social determinants of health are non-health related conditions, such as gender, race, socioeconomic status, education level, income level, employment status, occupation, and living conditions, which affect health both directly and indirectly and may lead to numerous health risks (Saunders et al., 2017). Addressing these determinants is crucial for improving health and reducing long-term health disparities. An increasing number of health policies are being developed worldwide with the aim of addressing the social determinants of health both inside and outside the **health system**. Outside the health system, there are many that seek to shape the policies and practices of the non-health sector in ways that promote health and health equity. Nutrition programs and early childhood education programs for low-income communities are examples of these initiatives, which aim to promote health equity and improve the health of underprivileged communities.

Health system
A health system consists of all the organizations, institutions, people, and actions whose primary goal is to protect and improve the health of the public.

Categories of health policies

Global health policy is a branch of health policy that focuses on global and national health systems, including healthcare and public health services. It also focuses on resource allocation across countries and organizations, and the implementation of plans and solutions to achieve health goals. Global health policy governs the global governance structure that formulates public health policy on a global scale. When solving global health problems, global health policy means putting the health needs of people worldwide above the needs and interests of specific countries, namely countries in the global North. The "Global Action Plan on Antimicrobial Resistance" is an example of global health policy. It was developed in order to improve global coordinated action to combat the growing problem worldwide of antimicrobial resistance (AMR) (Munkholm & Rubin, 2020).

Healthcare services policy is a branch of health policy that focuses on improving the provision, access, effectiveness, quality, efficiency, equity, and safety of healthcare services. The current efforts to improve the provision of healthcare services through the primary healthcare system (which is a crucial component of the health system) have been a priority for many low to middle income countries, such as Tanzania. In 2019, Tanzania was able to launch the universal health coverage program which covers general outpatient and inpatient care, optical services, specialized surgery, pharmaceuticals, and orthopedic services for the most underprivileged populations in the country (Wang et al., 2018).

Pharmaceutical policy is a branch of health policy that involves the development, supply, and use of medications in the healthcare system. It includes polices related to drugs (both brand name and generic), biological products (products from biological sources and not chemical ingredients), vaccines, and natural health products. For example, in Canada, the Patent Drug Price Review Board reviews drug pricing and compares Canada's proposed price with those in other countries in order to determine whether the price is "too high," in which case the manufacturer must submit a recommended price to the appropriate regulatory agency (Jackson, 2012).

Public health policy is defined as the laws, regulations, actions, and decisions implemented in society to promote health and ensure that specific health goals are achieved. Public health policy is multidisciplinary in nature and it involves many sectors, including healthcare, education, environment, and agriculture, to name a few. Vaccination policy, tobacco control policy, and breastfeeding promotion policy are some other examples of public health policy (Bhattacharya, 2013).

Mental health policy is a somewhat newer branch of health policy that has emerged in the past decade, quickly gaining momentum and prominence. Accordingly, governments, health departments, and health ministries have been formulating visions and principles, setting goals, and establishing a wide range of action models. General mental health policy objectives include promoting good mental health, reducing the incidence and prevalence of mental disorders (by prevention and treatment), reducing the extent and severity of related disorders (by rehabilitation), developing services for people with health problems, and reducing stigma related to mental health (Pilgrim, 2019). All these goals aim to promote the human rights and dignity of patients with mental illness, to promote the psychological aspects of general medical care, and to reduce mortality associated with men-

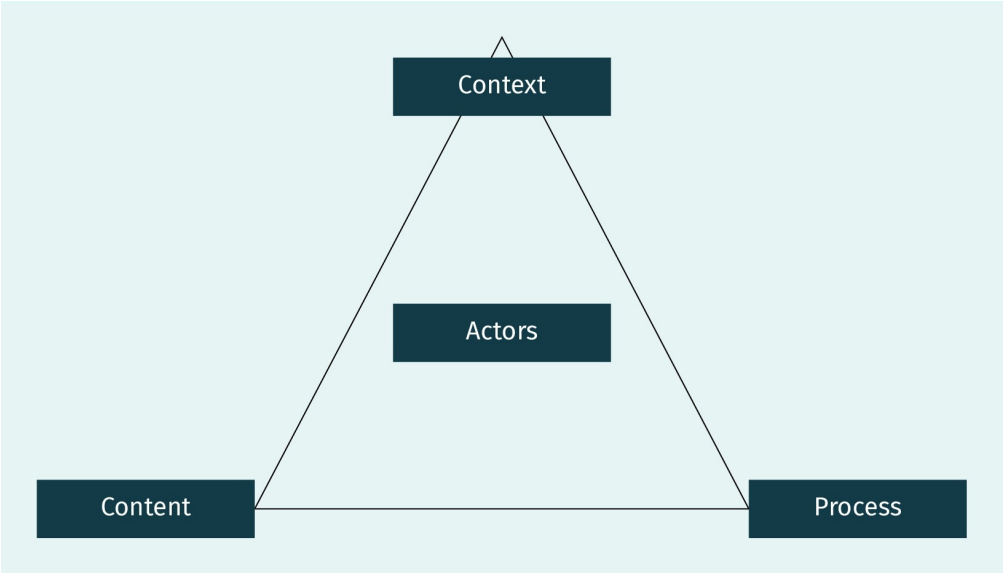
tal illness, including suicide. In the Netherlands, for example, through a comprehensive sick leave policy and progressive attitudes towards mental health, people experiencing mental health problems can take paid days off from work for recovery (Jenkins, 2003).

Health policy triangle

Health policy decisions are not always based on best evidence and are not necessarily the result of a process of rational discussion and evaluation about how to achieve specific goals. The context in which health-related decisions are made is usually highly political. Health policy decisions can also be conditioned on socially implicit value judgments. Therefore, health policy does not always achieve its implementation goals. Likewise, health policies can be adapted based on socially implicit values and judgments. The health policy framework was first developed by Walt and Gilson in 1994 to analyze health policies, although its relevance extends beyond the health sector (Walt et al., 2008).

This framework, as shown in the figure below, highlights the importance of taking power and power dynamic into account throughout the health policy process (Wollmann, 2017; O'Brien et al., 2020). The "content" of the policy denotes the policy objectives, operational policies, regulations, guidelines, legislation, and more, with "context" referring to systemic factors such as social, economic, political, or cultural aspects. "Process" refers to how health policies are initiated, formulated, implemented, and evaluated. In the middle of the triangle lies the "actors" element, referring to influential individuals, groups, and organizations that affect or are affected by the health policy decision.

Figure 4: Walt and Gilson's Policy Triangle Framework



Source: Mirna Naccache, based on Walt & Gilson (1994).

This framework can be used both prospectively and retrospectively. This framework has influenced the health policy research in many countries with varying political and health systems. It has also been used to analyze health problems globally (Wollmann, 2017).

However, this framework is a highly simplified representation of a complex set of interrelationships. Therefore, while this framework is a helpful tool for thinking systematically about all the different factors affecting health policy, the lack of details may lead to confusion or oversimplification of the health problem in question.

Sodi et al. (2021) used this framework to assess mental health policies and legislation enacted in Ghana, Kenya, South Africa, and Zimbabwe to respond to the increased need for mental health services as a result of the COVID-19 pandemic and other health emergencies. By using this framework, Sodi et al. (2021) were able to identify the strengths of and gaps in existing mental health policies and give recommendations on how they could be improved and strengthened in future health emergencies.

Self-reflection/discussion

Think of an example of policy, public policy, and health policy from your own country.

1.3 Stakeholders in Health Policy

"A stakeholder can be defined as any person, group, or organization involved in or affected by a course of action" (Guise et al., 2021, p.1). Each stakeholder has different interests, requirements, and interpretations of health policy. Therefore, all stakeholders should be communicated with at the level that suits them.

Healthcare stakeholders play an important role in the development and direction of the healthcare industry. Their support is very important as it provides funding, support, strategic directions, and solutions for the entire healthcare system. Healthcare professionals can influence public opinion on a medical system and its subsidiaries by providing information and opinions about specific healthcare institutions (Kaur & Victoria, 2017).

In health policy, a "stakeholder" is anyone who is integrally involved in or affected by the healthcare system and would be substantially affected by reforms or changes to the system (Kaur & Victoria, 2017). Stakeholders include healthcare providers (physicians, pharmacists, nurses, nutritionists, midwives, physiotherapists, etc.), patients and their families, governments, and non-governmental organizations. Essentially everyone is a stakeholder when it comes to health policy. The interrelationship between stakeholders in the healthcare system and stakeholders in health policy is quite complex, as different stakeholders have different interests, levels of influence, and levels of power when comes to the specific policy at hand.

Stakeholder Analysis

At its core, health policy is about managing stakeholders, because policy exists to fulfill stakeholder requirements and needs (Eskerod & Jepsen, 2013). Remember that, although stakeholders may be organizations or institutions, policymakers must ultimately communicate with people. Therefore, it is imperative that the correct individual stakeholders within a stakeholder organization or institution are identified. The identification of stake-

holders is an iterative process, meaning that it should be continuously repeated throughout the policy process to make sure that no stakeholder is omitted. This is essential, as the future and success of a policy falls on the stakeholders and their interpretation of it.

The process of identifying stakeholders starts as soon as the idea of the policy is conceived. During this identification process, the information of each stakeholder needs to be recorded in the stakeholders' register, a document describing the stakeholders of a specific policy, their interests, influence, and impact on the policy. Ideally, the stakeholder register should be completed early in the policymaking process to ensure proper stakeholder engagement and management. A stakeholder register usually contains the following information: names, titles, roles, power, interest, type of influence, requirements, expectations, contact information, and communication needs/frequency.

Stakeholders can be identified through a variety of methods, including

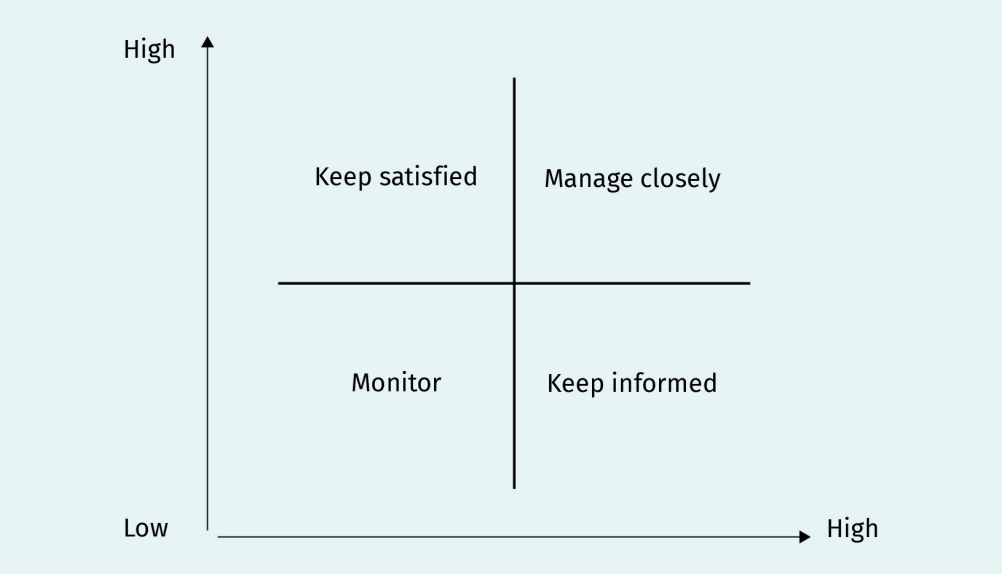
- checking existing documentation. Organizational process assets, previously used stakeholder engagement plans, and existing stakeholder registers can be checked for information on potential stakeholders.
- stakeholder benchmarking. Similar policies are examined in order to determine who the possible stakeholders are.
- interviews with experts. A great deal of information can be gathered from influential stakeholders who are experts on the subject matter of the policy at hand. Open-ended questions are the best type to ask during these interviews.
- brainstorming sessions. Brainstorming with one's team or with experts is a good technique for collecting information and identifying stakeholders. In these sessions, the following questions may be asked: Who is directly or indirectly involved with the project? Who may be affected by the policy? Who gains or loses?

Again, stakeholder identification is a continual process. As the policy process progresses, new stakeholders may be identified and come on board, while some previously identified stakeholders may lose interest. Additionally, the power and interest of stakeholders may change over time, so it is essential to keep track of stakeholders' attributes.

Power/Interest Grid

The most widely used tool in stakeholder management is the power/interest grid. This is a matrix used for categorizing stakeholders during the policymaking process to allow the stakeholders to be effectively managed. Before using this tool, all the stakeholders involved in the policy process should be identified. They are then plotted on the grid in relation to the power and interest they have in regard to the policy being formulated.

Figure 5: Power/ Interest Grid



Source: Mirna Naccache, based on Mendelow (1981).

The figure above illustrates the different approaches that should be taken for the segregation and subsequent prioritization of the identified stakeholders. Stakeholders who have high power and high interest in the policy being formulated, discussed, implemented, or evaluated are usually decision makers and have the biggest impact on the project success. As such, their expectations must be closely managed.

Stakeholders with high power but low interest in the policy should be kept in the loop. Because of the power they yield, these stakeholders need to be kept satisfied, despite their disinterest. However, this type of stakeholder should be treated with caution; if they become unsatisfied, they may use their power to affect the policy in a negative way, such as hindering the formulation or implementation of a policy.

Stakeholders who yield low power but have high interest in the policy should be kept adequately informed and in a timely manner. Regularly communicating with these stakeholders is crucial to ensure that no major issues arise, as they can often be very helpful during the policy process. Finally, stakeholders who yield low power and have low interest in the policy ought to be monitored, avoiding excessive communication.

Once stakeholders have been put into one of the four power/interest categories, it is time to think strategically about how to best engage and earn the ongoing support of each of these stakeholders. Some helpful questions are: What motivates this stakeholder? What priorities will not threaten them? Is this stakeholder likely to have a positive view of this policy? If not, what can be done to change their perception? After the profiles of each stakeholder type have been built, the next phase of the stakeholder management process is to develop a stakeholder communication plan.

Self-reflection/discussion

List the different stakeholders in your countries that might be involved with the health policy on breast cancer in your own country, then classify and plot them on the power/interest grid.

Steps in Management of Stakeholders

The following are the seven sequential steps that should be followed to effectively manage stakeholders:

1. Identify all relevant stakeholders and record their information in the stakeholder register.
2. Analyze the role of each stakeholder in terms of interest in the policy at hand, their power to affect said policy, and whether they pose a potential threat or facilitate the process of policymaking.
3. Plot the stakeholders on the power/interest grid.
4. Classify the relationship with each stakeholder, based on where they are plotted on the power/interest grid.
5. Formulate strategies for the management of each stakeholder, based on where they lie on the power/interest grid.
6. Implement these formulated strategies and develop specific implementation programs for each stakeholder, based on where they lie on the power/interest grid.
7. Evaluate the implications of effectively managing each stakeholder, based on where they lie on the power/interest grid.

1.4 The Private Sector

Role of the State and Public Sector

Before delving into the role of the private sector in public and health policy, one must look at the history and the role of the government, or more accurately the state, in health systems and, in turn, in health policy. In most countries up until the early 1980s, the state led the delivery of healthcare services, ensuring its quality and financing. Additionally, the state played a main role in the allocation of resources in the health system and in setting health priorities (Hancock, 2020). Examples of such policies and regulations include (Hancock, 2020):

- providing licenses to healthcare practitioners
- setting forth requirements for the registration of healthcare facilities
- requiring provision of information for monitoring quality
- setting charges and reimbursement rates
- controlling training curricula and setting requirements for continued education
- introducing accreditation of facilities

In addition to all of the above, states worldwide have also assumed a primary role in public health policy, for example by

- the fluoridation of table salt,
- tobacco control,
- promoting road safety in order to decrease the threat of motor vehicle accidents and injuries,
- ensuring access to safe drinking water, and
- setting standards for food labeling to combat obesity.

In many countries, the state, represented by the government or the Ministry or Department of Health, plays a prominent role in the financing and provision of healthcare to ensure equality and equity and to avoid any potential market failure. If consumers or producers of healthcare services do not consider externalities (in terms on costs and benefits), they will not always produce or consume the best degree of healthcare services. In addition, the market and the private sector will not be able to provide many "public goods" in the form of health services because it lacks the incentive to do so. Here, public goods are defined as those goods/services that are "non-competitive" in terms of consumption (with one person's consumption not affecting others' consumption of the same good) and "non-exclusive" (no barriers to consumer access to goods/services, including payment) (Kapilashrami & Baru, 2018).

Furthermore, if parts of the private sector (like the pharmaceutical industry or a hospital in a specific area) establish a monopoly on a health service or product, this may lead to overcharging (Kapilashrami & Baru, 2018). However, some economists argue that the lack of an effective healthcare market provides a relatively weak incentive for the state to provide healthcare services (with the exception of public and preventive healthcare services), because these can be resolved through regulation. Nevertheless, another argument in favor of the role of a powerful state revolves around the fact that there is an asymmetry of information between consumers and providers (Mackintosh et al., 2016). Consumers are at a disadvantage, while private providers of healthcare services are in an exceptionally advantageous position and can take advantage of this imbalance through over-treatment, leading to higher profits.

Moreover, the demand for medical care is unpredictable, uncertain, and often costly. This provides an argument in support of private insurance. However, experience and data from many countries show that the private insurance market does not work well in terms of health, providing a further reason for state participation (Mackintosh et al., 2016).

Further issues must be considered, regarding the ethical underpinnings of the healthcare system, the debate around equity, and the concern that many individuals are, or may become, too poor to afford healthcare services, requiring the protection and support of the state. This comes under the wider debate regarding healthcare, as some argue that access to healthcare services is a right for all, regardless of their socioeconomic status. However, there are those of the opinion that healthcare services are like any other service or good, whereby access to them should rely on the consumers' capacity, ability, and willingness to pay for these services.

Role of the Private Sector

The private sector refers to the for-profit or commercial sector and is characterized by its market profit-making orientation. It includes associations that aim to make profit for their owners, with profit and return on investment as the core defining characteristics of the private business sector. Even in companies that pursue other goals related to society, environment, or employee concerns, these ideals are secondary and are supportive of the main goal: making profit. This is due to the fact that, in the absence of profits and returns for shareholders, such companies will cease to exist (Mackintosh et al., 2016).

For-profit organizations vary greatly in their characteristics, with the private sector consisting of companies that may be large or small, domestic, multinational, or international. In the health sector, examples of organizations and institutions that make up the private sector include private physician clinics, large group clinics, privately owned community pharmacies, pharmacy chains, generic drug manufacturers, large pharmaceutical companies, medical equipment suppliers, and private hospitals and nursing homes (Mackintosh et al., 2016).

When considering the role of the private sector in health policy, it is usually beneficial to expand the scope of analysis and include registered organizations whose legal status is non-profit organizations (Mackintosh et al., 2016). These may include business associations, trade federations, advocacy groups (such as patient advocacy groups), academic organizations, and research centers, as well as local and international non-governmental organizations (NGOs) that are engaged in the health policy process. For example, Médecins Sans Frontières/Doctors Without Borders, is a humanitarian non-governmental organization that provides medical assistance internationally. Since the early 2000s, it has played a vital role in health policy, specifically related to communicable diseases (namely malaria, in Africa; Mackintosh et al., 2016).

The power of the private sector in health policy

The power of these organizations and companies stem from their resources and their ability to achieve a desired result. They also provide taxes to the government and some are major employers in the economy, allowing them to gain influence over the government. Big pharmaceutical companies (located all over the world, but especially in the USA) with more than 10,000 employees and annual net profits in the billions of dollars hold significant power (Kapilashrami & Baru, 2018). Additionally, companies in many sectors offer specialized knowledge that the government relies on in the making of policy and regulations. For all these reasons, both small and large private companies are health policy stakeholders, often playing a major role in debates. In most countries, the government makes and implements public policy, but the private sector is directly or indirectly involved in the process (Szakonyi, 2021).

Public policy often affects the private sector, and as such the private sector may attempt to influence public policy, steering it towards its own interests (Szakonyi, 2021). This influence can be exerted in many ways, for example through financing. This is when a company

may donate money to politicians, political campaigns, and political parties in the hope that they will be more receptive to the demands of the company in the political process if they come to power (Verma, 2016).

Furthermore, private companies may lobby for or against specific policies that affect their interests. Tobacco control policies have been pushed in many countries over the past two decades (Assunta & Dorotheo, 2016). Tobacco companies recognize the impact of these approaches and have actively fought against them by discrediting proven science, exaggerating the economic importance of the tobacco industry, reinforcing their political ties in order to delay the implementation of regulations, and continuously lobbying for weaker tobacco control policies (O'Brien et al., 2020; Hird et al., 2021).

Self-regulation in the private sector

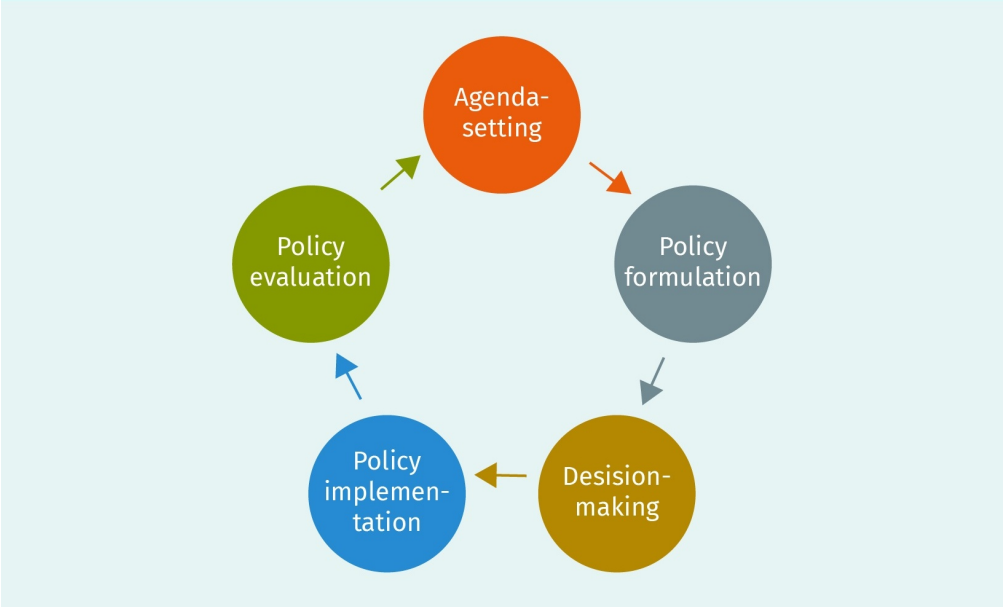
One of the ways that the private sector is involved in health policy is through self-regulation, which refers to private companies establishing their own rules, regulations, and policies for operating within a specific domain. These self-regulatory mechanisms do not contradict the regulations and policies set forth by the government, but rather align with them (Kapilashrami & Baru, 2018).

Private companies and organizations are increasingly adopting self-regulatory mechanisms in areas indirectly affecting health, such as food and beverages. Stakeholders from the private sector are involved in policy formulation, adoption, and implementation, often without reference to governmental stakeholders. Although policy set forth by the private sector may promote health, it can still have negative potential impacts (Kapilashrami & Baru, 2018). Therefore, there is still a need for public supervision, especially as the private sector continues to have a growing stake in public policy.

1.5 The Policy Process

Any policy that is established and carried out by any entity, be it the government, a healthcare organization, or something else, goes through five stages from inception to conclusion. These are agenda-setting, policy formulation, decision-making, policy implementation, and policy evaluation (Mickwitz, 2021), as illustrated below.

Figure 6: The Policy Process



Source: Mirna Naccache, based on Hill & Varone (2021).

Agenda-Setting

The first step in the policy process is agenda setting. Agenda setting is the way in which problems come to a government's attention. Problems or challenges that affect the general public are identified, with potential solutions being proposed by the stakeholders (Hill & Varone, 2021). The role of the government and public sector is to ensure that they respond to the health needs of the public in a timely manner. This step relates to the "why" of the policy.

Policy Formulation

Policy formulation is the second phase in the policy process, in which the different policy options are taken into consideration, examined, and formulated. This step consists of policymakers discussing and suggesting potential solutions to mitigate the problems raised during the agenda setting stage. In some cases, it is necessary to choose from specific aspects of the different suggested policy options (Hill & Varone, 2021). The policy chosen to resolve the issue depends on two factors. The first factor is that the selected policy must be an adequate means of solving the problem in the most viable and efficient way. Effective formulation involves analysis and determination of alternative solutions to the problem. Secondly, policies must be politically feasible, which is usually achieved by establishing a majority consensus through negotiation (Hill & Varone, 2021). For this reason, policy formulation includes analysis to determine the most effective policy and political mandate. **Cost-benefit analysis (CBA)** is one of the most common methods of assessing and comparing the economic efficiency of proposed policies by systematically

Cost-benefit analysis (CBA)
This is the systematic process used to estimate the strengths and weaknesses of alternative options. It is mainly used to determine which options provide the best approach to achieve benefits while preserving resources.

predicting their social costs and benefits. It is crucial that governments and public sectors ensure that any potential policy does not lead to further inequities in access, quality, and affordability of healthcare. This step relates to the "how" of the policy.

Health policy analysis

Health policy analysis is the hardest task in policymaking, defining and outlining the guidelines' purpose. It also identifies similarities and differences in the expected results and estimated costs of competing alternative policies. Health policy analysis helps explain the interactions between institutions, interests, and ideas in the policy process. Health policy analysis can also be used to come to a conclusion or make adjustments by analyzing previous policies (Browne et al., 2019). Conducting health policy analysis ensures that the process to choose the best policy option is systematic and leads to finding the most effective and feasible policy to address the problem.

Decision-making

The third step is decision-making, in which a course of action (or non-action) is adopted for implementation in the future. In order to be implemented, the developed guidelines must be adopted by the responsible body. The same factors that affect agenda setting can also have an influence on policy adoption (Broadnax, 1976). For example, policies that address health issues brought about by crises can often be adopted immediately. At the same time, a strong stakeholder groups can use their political influence to decide which policy to adopt (Mongiello, 2016).

The media (both traditional and social media) can also play an important role in policy adoption. When news, reports, and commentaries are presented objectively and without bias, this can provide a forum to discuss various policy options. If the media shows a positive bias, it may increase the likelihood that policy recommendations will be adopted (Broadnax, 1976). However, unfavorable media bias may undermine policy recommendations. This step relates to the "who" of the policy.

Policy Implementation

Policy implementation is the fourth stage of the policy cycle and is the point at which the adopted policy is put into effect. The implementation of the policy refers to the actual formulation of the proposed solution. The successful implementation of a particular policy depends on three main criteria, as follows (Pekonen, 1985):

1. A policy needs to be clearly communicated by the respective policymakers (for example, local health officials or Health Ministers) to the relevant managing bodies with the authority to make policies within the bureaucracy. For example, policies aimed at enhancing road safety by reducing the frequency of drunk driving will be passed on to

law enforcement officials for their implementation. If existing institutions are unable to implement specific policies, new institutions must be established and subsequently staffed.
2. If policies are to be effectively implemented, they need to be clearly and easily communicated. Too much ambiguity at this stage will lead to the involvement of the judiciary, forcing legislators to clarify the purpose and means of their policy implementation. The judicial authorities can also veto the implementation of such policies.
3. The resources used for implementation must be integrated within existing processes and institutions without causing widespread interference, competition, or conflict.

In addition to the criteria above, when policies are passed on to an institution without sufficient guidance, policy implementation can become more complicated. Policymaking is usually the result a symbolic use of politics in terms of coming to a compromise. As a result, the implementation step often brings confusion to policy management agencies (Pekonen, 1985).

In addition, bureaucratic incompetence and scandals may further complicate the implementation of policy. The problems in the implementation of many health policies have led some scholars to conclude that new policy measures either cannot be initiated or will take a long time to be implemented by the respective agencies (Pekonen, 1985). This makes policy implementation perhaps the most surprising aspect of the policy process.

Policy Evaluation

Policy evaluation is the process of monitoring and evaluating the results after a policy has been implemented. Once in place, a policy must be continuously evaluated, although some policies that have become ingrained over time do not receive any kind of evaluation. Evaluation may be based on many criteria. Informal assessments may simply be based on anecdotes or stories. The pros and cons of a policy can be evaluated in more depth through sincere and honest stakeholder feedback. Formal research can provide empirical evidence of policy effectiveness (Wollmann, 2017). Finally, scientific research provides the most objective data to assess if a policy has produced clear causal outcomes (Wollmann, 2017). Policy evaluation can be conducted at different times. For example, healthcare organization administrators who seek to improve operations can evaluate the policy while it is being implemented. After implementation, it can be further evaluated to understand its overall effectiveness.

Even though there are numerous ways by which policies may be evaluated, more often than not, policies are not evaluated at all. One of the reasons is because the design and implementation of formal and scientific research is time consuming, costly, and complicated. Furthermore, while informal evaluation is much more accessible, it tends to be highly biased and subjective.

Additionally, policies in general (but particularly health policies) can be difficult to assess. Some policies aim to achieve broad conceptual goals that are subject to several different interpretations (Moyson et al., 2017). For example, “healthy air quality” is difficult to define in ways that will be universally accepted by all stakeholders (Moyson et al., 2017). Policies may also contain several objectives that may not be compatible with each other.

Moreover, a policy evaluation focuses on the content of a specific policy, whether the "problem" has been properly addressed by the policy and what its impact is. Based on these considerations a policy can be determined to be "successful." But whose view determines the "problem" and "success?" Process-focused policy evaluations (rather than content-focused) consider the process of the creation of conditions for success, rather than whether it effectively addresses problems through policy action (Hamra et al., 2020). This step relates to the "what" of the policy.

Self-reflection/discussion

Can you think of a successful health policy in your country? Why do you think it succeeded? Alternatively, can you think of an example of a health policy that failed? Did it fail because the original intention was not worthwhile or for other reasons?

SUMMARY

The policymaking process is a complex one, as it involves many participants with different roles, needs, interests, and resources. Factors that make it so complex include corruption, incompetence, political motivations, financial difficulties, insufficient resources, and conflicting interests. While policy and politics are often thought to be interchangeable, they are not. They are, however, becoming increasingly intertwined.

Health policy is a branch of policy that deals with all decisions, actions (or inactions), laws, regulations, and programs related to health. It is important to differentiate between policy, public policy, and health policy. There are different branches of health policy, but they all serve the same goal: to improve the population's health.

At the core of health policy are stakeholders, meaning anyone that is integrally involved in or affected by the healthcare system and would be substantially affected by reforms or any changes to the system. Stakeholder analysis, which includes identifying, prioritizing, and managing, is crucial. One of the gold-standard tools for this process is the power/interest grid.

Every policy that is developed and carried out either by governments, healthcare organizations, or other entities goes through five stages from inception to conclusion. These five stages are agenda setting, policy formulation, decision-making, policy implementation, and policy evaluation. Each of these steps has its own characteristics and challenges.

The state plays the leading role in the delivery of healthcare services, ensuring equitable and affordable access to the high-quality healthcare services. However, the role of the private sector has been growing over the past decades. This can be seen as either positive or negative, as the

private sector sometimes exerts influence in a negative way in order to promote its own interests at the expense of the greater good and the health of the public.

UNIT 2

AGENDA SETTING

STUDY GOALS

On completion of this unit, you will be able to …

- understand the notion of the “right to health.”
- summarize the different factors that influence the policy agenda.
- describe the role of the government in health policy agenda settings.
- analyze the role of mass media in health policy agenda settings.

2. AGENDA SETTING

Introduction

This unit will discuss the different aspects of agenda setting, including the right to health, what guides policy, what "problem definition" is, and who sets the agenda for policy. With all the health-related problems a population can face, proper prioritization is essential. The usefulness of the Hall model of legitimacy, feasibility, and support for such prioritization will be explored. In most countries, the government acts as the main agenda setter, a role which will be examined in detail. The complex relationship between the different branches of government (legislature, executive, and judiciary) and their specific roles in public policymaking will also be highlighted. Lastly, mass media's crucial role in setting the policy agenda will be discussed.

2.1 The "Right to Health"

The "right to health" was first articulated in 1946 in the World Health Organization's (WHO) Constitution. But it was not until 1966 that it became a right set forth by the Universal Declaration of Human Rights. The right to health is the social, cultural, and economic right of all individuals to have access to a minimum universal standard of health (Brown, 2016). Accordingly, this requires a complete governmental and societal approach to set effective health policies that ensure that no one is left behind. That being said, in our modern, globalized context, health-related issues have become both a regional and a global issue. A prime example is the COVID-19 virus, which started as an epidemic in China, but quickly spread and became a global pandemic, requiring global efforts to combat it. However, in most cases policy is guided by many factors and not primarily the "right to health." In the following section the different factors, issues, and principles that can guide policy will be discussed.

What Guides Policy?

Policies are often guided by universal principles, stemming from the notion that all human beings are born free and equal when it comes to dignity and rights. Examples include rights set forth by **international conventions**, such as basic human rights and the right to health for all (United Nations, 1948). Policies may also be guided by ideas and values. Values are enduring, moral beliefs about the way the world ought to be, and tend to guide action, fuel rhetoric, and facilitate or constrain one's receptivity to research evidence and, in turn, policies.

International conventions
These are treaties signed between two or more nations that act as international agreements. Examples of such conventions include the WHO's Right to Health and the Nuremberg Code (1947).

Policies may also be triggered by events and problems, which quickly gain the attention of the policymakers. Additionally, these issues usually involve an interaction between the four factors listed below, which acts as a triggering mechanism or catalyst for policy.

1. Scope. The scope refers to the number of people affected. The higher the scope, the more likely policymakers are to act and to do so swiftly. For example, obesity is prevalent in a number of countries, including the United Kingdom (UK) (with an estimated 28 percent of adults being obese and 36.2 percent overweight) and the United States of America (USA) (with an estimated obesity level of 42.4 percent). This has prompted these respective governments to quickly enact obesity prevention policies (Wang et al., 2020; Robinson et al., 2021).
2. Intensity. This refers to the extent of the effect on the public. The greater the intensity, the greater the problem's effect on the public, which influences a government's reaction. For example, in the early days of the 2020 COVID-19 pandemic, the government of South Korea promptly enacted policies to quarantine, trace, and actively surveil infected people in response to an exponential rise in COVID-19 cases (Cheng et al., 2020).
3. Time. This refers to whether the event is sudden and acute, or gradual and over a longer time period. For example, the response to the abrupt arrival of the COVID-19 pandemic, in which governments around the world had to quickly act in order to protect the public and push for novel and preventative treatments such as vaccines. Conversely, in the 1980s and early 1990s when the **HIV/AIDS epidemic** hit, many governments were very slow to act, which led to the WHO publishing a report in 1999 stating that announced that acquired immunodeficiency syndrome (AIDS) was the fourth leading cause of death worldwide and number one cause of death in Africa (UNAIDS, 2015).
4. Resources. This refers to the availability of resources in terms of money, human resources, time, etc. If the resources to address or mitigate a certain event or problem are readily available, policymakers are more likely to take action. To revisit the example of the HIV/AIDS epidemic, one of the factors that hindered governments from acting swiftly was the lack of resources, namely money and the means to accurately diagnose the disease (Fearon, 2005).

HIV/AIDS epidemic
The human immunodeficiency virus (HIV) targets and weakens the immune system, making individuals susceptible to infections and some types of cancer, with the most advanced stage of an HIV infection being acquired immunodeficiency syndrome (AIDS). The epidemic lasted from the 1980s until the early 2000s, however, due to stigma and discrimination against the LGBTQ+ community and other affected groups, many governments were slow to act.

Policy can be influenced by interests, which can be defined as "sides" on an issue. In the language of politics, interests can be defined as the result of people experiencing (or imagining) the effects of a policy (or a group of policies) and attempting to influence them with their own interests in mind (Greenhalgh, 2021). Another definition of interests is a stake or involvement, usually financial, in something. For example, Coca-Cola has played a huge role in shaping obesity science and, in turn, public health policy, towards its own interests in China, Mexico, and South Africa. Coca-Cola did so by redirecting the obesity science and policy of these countries to focus on physical activity, rather than the regulation of sugary drinks (Greenhalgh, 2021).

Similarly, policy may be influenced by stakeholders. These are usually individuals or institutions whose position may differ from one policy area to another, over time, and by jurisdiction. Accordingly, policy sub-systems and networks, i.e., groups of stakeholders who seek to influence government decisions in a specific policy area, have arisen. These groups focus on the "procedures" for making policies and may ultimately become influential enough to have a say in them. Examples of such policy sub-systems and networks are the tobacco industry, the pharmaceutical industry, and the food and beverage industry (Greenhalgh, 2021). On the positive side, the LGBTQ+ community acted as a policy sub-

system to spearhead efforts in combatting the HIV/AIDs epidemic by addressing the stigma surrounding the disease and protesting governments' muted response to it (UNAIDS, 2015).

Self-reflection/discussion

Which health problems have recently received serious attention from your country's government? Why do you think these particular issues take precedence over others? (Buse et al., 2012)

Problem Definition

Prior to setting the policy agenda, a crucial step is to define the problem that should be addressed through policy. Problem definition is the first stage of the policy cycle and refers to a systematic definition of an issue, alongside a clear and comprehensive understanding of its causes and impact. This stage provides the structure and direction for the entire policy process. Some of the tools that could be used for problem definition include (but are not limited to) **root-cause analysis (RCA)**, problem tree analysis (a tool used to map the cause and effect of a specific problem in order to come with a solution for it), and paradigms.

Root-cause analysis (RCA)
This is the process of discovering the root cause of a problem in order to determine an appropriate solution. RCA systematically prevents and solves potential problems, and it is therefore much more effective than just treating temporary symptoms.

Developing a problem statement

After the problem has been defined, the next course of action is to develop a problem statement. In order to do so, the following steps must be followed (Sidney, 2017):

- Think about the problem
- Delineate the problem's boundaries
- Develop a base with research and evidence-based facts
- List the goals and objectives of possible policy solutions
- Identify the potential key stakeholders
- Review the problem statement

Agenda-Setting

Agenda setting refers to the action of actually getting an issue onto the formal policy agenda of issues to be resolved by the policymakers (such as the president, government, parliament, Health Minister, or other relevant ministries). Naturally, the list of issues being actively considered varies between governmental branches. Important matters, such as economic conditions or relations with other countries are usually considered by the president or prime minister. The Ministry of Health and its respective minister, however, have a more specialized agenda that may include "advanced political issues," such as which drugs should be approved and their subsequent reimbursement schemes (Cogan, 1999). Here, the terms "high politics" and "low politics" refer to the technicality of the issue, as well as its degree of complexity in terms of resources and time commitment.

Stakeholders outside governments can advise policymakers on solving problems, but the policymakers themselves must participate in the process of officially solving problems through policies. Decision-making bodies within governments "can only do so many things within their available time period, and available resources" (Cogan, 1999, p. 390). Therefore, items on the agenda tend to go through a competitive selection process, meaning that not all problems are ultimately resolved. Inevitably, the problems faced by some people will be ignored, which means that some of the constituencies' needs will be rejected.

Sometimes potential agenda items include legacy issues from the previous period or re-examination of implemented policies that may have previously failed. In 2020, Lebanon faced an economic crisis and a rapid devaluation of the local currency, resulting in a need to ration the subsidization of imported medication for chronic illnesses. The then Prime Minister refused to do so, fearing that the medication prices would skyrocket. In 2021, the newly elected Lebanese government had no choice but to completely stop subsidizing all imported medication, as there was no longer enough foreign currency in the national bank to continue subsidization (Dagher & Nehme, 2021).

At any time, national or local policymakers may be paying close attention to a relatively small number of current or potential problems. In a decentralized system, issues are sometimes placed on the agendas of all levels of government at the same time to coordinate decision-making. An example of this is the response to the COVID-19 pandemic at its beginning in 2020, which required all levels of government to work simultaneously and in unison.

Altman and Petkus (1994, p. 42) point out that "as issues become prominent issues, and as individuals or groups begin to take action, legislators put issues on the policy agenda." Since the 1950s, most countries took many years to put their population issues on the policy agenda. Similarly, it took the majority of the world many years to place maternal health and HIV/AIDS on their governmental policy agendas (World Health Organization, 2019; Abdollahpour et al., 2019; Bayer, 1991; Bongaarts & Over, 2010). However, over the past three decades, with a clear problem framework and strong evidence, stakeholders have been able to put key issues on policy agendas. The LGBTQ+ community's success in lobbying to put HIV/AIDS on the policy agenda is a perfect example of this (Hamid & Sule, 2021). Therr are two main types of policy agendas:

1. Systemic or macro agendas, which include the widest range of potential issues that may be considered for action by the government. An example of this type of agenda is when the COVID-19 pandemic started in 2020 and governments began exploring different means to address it.
2. Institutional or micro agendas, which include those issues that are already up for consideration by decision makers, legislatures, or courts. Building on the example above, after governments decided how to address the COVID-19 issue on a national scale, local decision-makers (such as municipalities) also began investigating how best to control the virus on a state or city level.

Who sets the agenda?

In most cases, the main actors in the policy process, the government and the media, are the two entities that place issues on the policy agenda. Moreover, in most circumstances, the primary role of the media in the policymaking process is more likely to be one of contributing to setting the policy agenda rather than to other steps of the process. However, other actors, such as the business community, the medical community, and other interest groups can also play a role in setting the agenda (Kingdon, 1984).

2.2 Legitimacy, Feasibility, and Support

There are a number of theoretical models of agenda setting. The Hall model, one of the most prominent and widely used theories, is described below.

The Hall Model of Legitimacy, Feasibility, and Support

The Hall model suggests that an issue and possible response will be included in a government's agenda if it has high legitimacy, feasibility, and support (Hall et al., 1975). Hall and her colleagues provided a simple and easy-to-apply model to analyze which problems might be prioritized and dealt with by the government. For example, this framework was effectively used in Ethiopia for policy on advancing environmental sanitation through health promotion in communities all over the country (Agide et al., 2019).

Legitimacy

Legitimacy describes the government's belief that they should be concerned about the issue, and that they have the right, and even the obligation, to intervene. Most citizens of most societies, past and present, expect governments to maintain law and order and protect the country from all forms of attack. These are widely accepted as legitimate national activities (Hall et al., 1975).

Feasibility

Feasibility refers to the degree of ease with which a policy could be implemented. It is defined as the existence of the necessary technical and theoretical knowledge, the availability of resources and skilled employees, administrative capabilities, and the necessary government infrastructure. There may be technical, financial, or labor restrictions which indicate that a particular policy cannot be implemented, no matter how legitimate it is considered (Hall et al., 1975).

Support

Lastly, support refers to the important, yet elusive, issue of public support for the government, at least on issues related to policy. Authoritarian regimes are, of course, less dependent on popular support than democratic governments, but even these regimes must ensure that the policies of key groups (such as the armed forces) receive some sup-

port. If there is a lack of support or dissatisfaction with the government as a whole, it may be difficult for the government to put an issue on the agenda and then take action (Hall et al., 1975).

The logic of Hall's 1975 model is that the government will assess whether a problem belongs on the high or low end of each of the three continuums. If an issue has high legitimacy (the government is deemed to have the right to intervene), high feasibility (sufficient resources, personnel, and infrastructure are available), and high support (the most important interest groups are supportive, or at least not obstructive), then an issue's chances of getting onto the policy agenda and proceeding smoothly are greatly increased. However, this does not rule out more "strategic" reasons for putting an issue on the policy agenda. Sometimes, a government will publicly state their position on a particular issue to show that they care about it or in order to appease donors who ask for a response as a condition or in exchange for aid. A government may also do this do to confuse political opponents, even if they do not truly want to implement the policy or the policy has low feasibility or support (Hall et al., 1975).

Self-reflection/discussion

What health-related government policies and programs are generally considered to be legitimate? What measures would you like to introduce into your country's healthcare system, but likely have very low feasibility? (Buse et al., 2012)

2.3 Governments as Agenda Setters

Governments, specifically in high-income, industrialized countries, can be quite influential when it comes to setting the international policy agenda. For example, as the USA had donated the largest sums of money towards combating the HIV/AIDS epidemic, it dictated how these funds were used. At that time, they actively promoted the **"ABC" strategy** as the go-to strategy for HIV/AIDS control and prevention globally and specifically in Sub-Saharan Africa. This was done despite the fact that most public health professionals criticized this strategy, deeming it ineffective (Bayer, 1991).

"ABC" strategy
This approach to HIV/AIDS stands for: abstain, be faithful (or reduce the number of your sex partners), and use a condom. This strategy was highly polarizing and controversial.

In most countries, the government is clearly the main agenda setter. This is due to the fact that most governments control the legislative process and initiate policy changes. In the 1990s, it became common to "preset" the agenda for a term by publicizing detailed platforms, which political parties promise to implement if elected. A political platform or manifesto is a formally approved set of goals created by political parties or individual candidates in order to appeal to the general public and ultimately gain their support and votes. This is one of the most obvious ways governments try to set the agenda (Green-Pedersen & Wilkerson, 2006). However, being included in the election platform will only increase the likelihood of an issue being put on the agenda and acted upon—it does not guarantee it. For example, the politicians who write the manifesto may not pay enough attention to the feasibility of their promises (Green-Pedersen & Wilkerson, 2006).

Except in the pre-election party manifesto, to what extent are governments pursuing proactive problem searching for items that need to be included in their policy agenda? Not many governments do so. Accordingly, Hogwood and Gunn (1984) argue that governments should do so, as being able to anticipate problems in advance can minimize adverse effects and avoid potential crises. This includes assessing potential solutions in the external environment, such as population and technology (Hogwood & Gunn, 1984). "Problem searching" is usually part of the monitoring and evaluation process which could help identify potential issues early on. In almost all countries, when formulating health policies in areas such as payment and reimbursement for services, chronic disease management, long-term care for the ever-increasing elderly population, etc. must be taken into consideration. New solutions can be used to solve old problems, such as electronically linking patient records kept by different institutions (Hogwood & Gunn, 1984).

Consequently, new issues are beginning to show that they will lead to crises down the line. An example is the predicted impact of climate change on the agricultural economy, which would, in turn, lead to public health risks. In addition to the services of the elected government, one of the jobs of responsible officials is to prepare reports, identify future policy issues, and bring them to the attention of relevant ministers. This is especially relevant to problems that are largely inevitable, such as climate change and global warming. However, there is no guarantee that a government will address long-term issues, perhaps preferring to leave these to the next administration (Thesen, 2013).

Policy Change and Agenda-Setting Under Crisis

In some cases, a perceived crisis is one of the main reasons a policy window (as in a window of opportunity for a certain policy) is opened. Policymaking during a crisis period is quite different from "normal" policymaking, for example, making it easier to think more seriously about radical policies than in calmer times (Lee et al., 2020). Generally, when the most important policymakers believe that a crisis exists, then that is when an actual, highly threatening crisis exists. Failure to act in such situations may lead to even more catastrophic consequences. When an event does not have these characteristics, it is unlikely to be considered a crisis. However, if an external entity confirms the severity of the situation and pressures the government, action is more likely to occur (Lee et al., 2020).

Government Non-Decision-Making

Although both policymaking in times of crises and the usual, non-crisis policy model help explain why (or why not) issues appear on the policy agenda, observable actions provide an incomplete guide to how policies are determined. In other words, when considering what to include on the public policy agenda, one must consider the possibility of non-policy or non-decision-making (Bachrach & Baratz, 1963). Those with sufficient power can not only prevent items from being put on the agenda, but they can also influence policymakers' desires to only discuss issues deemed acceptable, without having to think about taking action.

An example of non-decision-making is related to the often radical "market" reforms of many healthcare systems in the 1990s (Lipsman, 2020). Although there are hypotheses on how to organize and direct the healthcare system (such as the privatization of public hospitals and the competition between healthcare providers), these have been hampered by the interests of the dominant group of professionals, such as physicians and hospitals (Cairl & Imershein, 1977). In such a case it is very clear that non-action is itself an action, with the goal of continuing and benefiting the status quo. This often has a negative impact on under-served populations.

2.4 Legislature, Executive, and Judiciary

According to Howlett and Ramesh (2003), there are two characteristics of a government system that have a major impact on a country's ability to formulate and implement policies: autonomy and capacity. Autonomy is the means by which government agencies can resist being influenced by self-interested groups and act objectively as arbiters of social conflicts. The government system may not be neutral in the political sense; different governments serve different ideologies. Ideally though, it should remain autonomous. By remaining autonomous, governments improve the welfare of the entire country, rather than just responding to and protecting the interests of specific societal sectors. "Capacity" refers to the ability of a government to formulate and implement policies. It stems from the expertise, resources, and continuity of government agencies (Howlett & Ramesh, 2003). For example, a government must be able to reliably pay civil servants and control corruption.

Relations between the Legislature, Executive, and Judiciary

On a more complex level, ministries must respect the fact that their decisions and actions can have a significant impact on other parts of the government and therefore avoid self-interested actions. Different forms of government systems have differing impacts on governments' autonomy and ability in policymaking. In particular, the relationship and the dynamics between the legislature, the executive branch, and the judiciary affect the way public policy is made (United Nations Development Program, 2009).

The legislature is the governing body representing the people, enacting legislation that regulates the public and overseeing the executive branch (that is, the leaders of the country, such as the President, Prime Minister, or other ministers). The main responsibility of the judiciary is to ensure that a government acts in a timely manner and within the scope of law (passed by the legislature), and for arbitrating disputes over interpretation the interpretation of law (United Nations Development Program, 2009).

Under the parliamentary system, the chairman of a government is typically elected by and from the members of legislature (because the minister is considered a member of parliament or cabinet) and remains in office as long as they have majority support from the legislature (United Nations Development Program, 2009; Marques & Hoyler, 2021).

In a presidential system such as the USA, the executive branch is typically separated from the legislature and elected independently by the public, without the support of most members of the legislature for governance. These system differences have a major impact on the way in which the respective governments administer policies (Gardbaum, 2017; Wilson, 2017). In a presidential system, the executive branch (the President and senior officials) can propose a policy, but for it to become law, it must be approved by the legislature (whose members come from a variety of political parties). Additionally, members of the legislature can be active in the process of policy formulation and revision. This means that policymaking is more open than in the parliamentary system and that stakeholders are more influential (Marques & Hoyler, 2021).

Conversely, in the parliamentary system (and within its ruling party), there may be some political controversy and negotiation happening behind the scenes. The administration can usually rely on the majority of the legislature to support the desired policy. If the executive branch does not have an absolute majority in the legislature, as is more common in proportional representation countries where a large number of political parties may exist, the executive branch must compromise to conduct politics through the legislature. This makes the policy process slower and more complex, but some argue that it is not as difficult as making a policy under the presidential system. In a parliamentary system, policymaking is ultimately concentrated in the executive branch, which usually allows the government to take quicker and more decisive action. The status of the judiciary also affects the government's policy process (Buse et al., 2012). Additionally, politics can also play a critical role, depending on how the judiciary is chosen.

In federal systems or systems based on written constitutions, human rights declarations are usually included. There is usually an independent judicial body, such as a Supreme Court, that is responsible for arbitrating disputes between different levels of government and ensuring that the government's laws and actions conform to the principles of the constitution (Wilson, 2017; Araya & Valencia, 2020). In countries like the United Kingdom (UK) that have no written constitution, although the government is independent (from external influence), the courts are more limited in restricting the executive branch to protect the rights and freedoms of citizens, and as a result, policymaking is easier (Stephenson, 2021).

Self-reflection/discussion

Suppose you are the Minister of Health in your country and want to introduce fundamental changes to your healthcare system, such as a new reimbursement scheme in public hospitals. List the different considerations that you must consider in order to introduce such a legislation into the presidential system, and then make a separate list for a parliamentary system. (Buse et al., 2012)

Political Parties

As opposed to a one-party nation, in a liberal democracy people are free to establish a party and run for elections without any intervention from the government. A party typically becomes part of larger social entity, falling somewhere between pressure or interest groups and the government, because members of the executive and legislative depart-

ments often come from one of the major political parties. Parties prepare manifests and political documents for campaigning in elections. In this way, political parties can have a direct impact on the outcome of the election and what follows.

However, voters are unlikely to vote for a particular policy and instead are asked to support a broad package of measures designed to maximize the party's appeal. The details of what policies are on the agenda of the government and how they are subsequently developed go beyond the direct control of the party and voters. Of course, the current administration must be careful not to deviate significantly from what it promised during the elections, even if things change. Public officials and ministers may find it much more technically and politically difficult to translate promises into coherent policies than what they had imagined when they were in the position of the opposition. However, failure to keep election promises will endanger future support, even though there is no explicit obligation to follow all the details of the party's policies. If the party does not fulfill its promises, the constituency can hold them accountable by not voting for them in the next election round (Jenke & Huettel, 2016).

Political parties have a modest but direct influence on politics as they can affect the composition of the legislature and the executive (and in some cases judicial) departments. It has a greater indirect effect by affecting the placement. In a one-party system, it is the government that allows political parties to formulate all the policies and find the best way to implement them (Brady, 1980). Overall, one-party elections do not provide voters with real choices or policy options, and criticisms of the ruling party and its government are often silenced or suppressed. The one-party system allows political parties to intervene directly in politics and polities (Wlezien & Soroka, 2016). There is no clear or simple division between a political party and a government or legislature. Both the executive branch and the legislature could be criticized by the party for the dismissal of ministers and lawmakers as well as for not responding with sufficient enthusiasm to the party's views (Baum et al., 2017). Conversely, a government in a liberal democracy is responsible for making political decisions when a political party comes to power in an election. Ministers can coordinate party policies in light of political pressures and changing political frameworks (Brady, 1980).

The Role of the Legislature

In most countries, the legislature's decisions are an expression of the will of the people (popular sovereignty), and the constitution stipulates that the legislature is the highest decision-making body. Most legislatures have three formal features: they represent the people, enact laws, and supervise the government, prime minister, president, and/or minister. Legislators in a democratic system usually consist only of elected representatives such as ministers, senators, as well as members of parliament. Three-fifths of all countries have unicameral parliaments (Buse et al., 2012), while the rest have two rooms (or chambers or houses).

In general, the role of the UK House of Lords or the USA Senate is to review and refine the bill, thereby contributing to better policy and legislation (Waldron, 2016). In the presidential system, the legislature has executive branch autonomy and can participate in politics from time to time, but only in the context of executive powers. In the parliamentary sys-

tem, the role of the legislature is not to initiate politics, but primarily to make the government accountable to the public for its implementation. The legislature can identify legislative issues and request changes (Mainwaring & Shugart, 1997).

In fact, in many different government systems, the legislature is increasingly seen as an institution that is struggling to confirm decisions made elsewhere and hold the administration accountable (Mainwaring & Shugart, 1997). In a review of parliamentary literature, Healey and Robinson (1992) pointed out that elected representatives rarely exceed their limits in the political process. This is due to the fact that, for example, in some countries there is a history of imprisonment without trial when someone voices criticism so elected representatives avoid going out of the political limits. The parliamentary system allows members of parliament to review and postpone the law, but if the government has a majority in parliamentary and appropriate party discipline, it will defeat the opposition. Individual legislatures have the opportunity to form direct policies only if there is no clear majority and the government relies on a small number of small parties, leading to one of the arguments in favor of proportional representation (Healey & Robinson, 1992). This begs the question: If the legislature does not have much power over policymaking, then where does that power lie?

The Role of the Executive

In most multi-party countries, the majority of policymaking power lies with the executive branch, i.e., the administrative body headed by the prime minister or president, and often referred to as a "cabinet." Elected executive committee members are assisted by bureaucrats or officials who advise and direct the minister. The relative impact of elected civil servants and bureaucrats on politics has been the subject of much debate. This depends largely on the country, the duration of the investigation, and the nature of the political issue. However, there are those long-term, un-elected/un-appointed employees whose role is to keep the systems running despite the changes in government.

In contrast to the legislature, the executive branch has far more resources in terms of the constitution, information, finances, and human resources (Knill & Tosun, 2020). This branch has the authority to govern the country and the power to develop and implement policies, with the decisive factor being the ability to choose when to submit a bill to the legislature. In a parliamentary system, there are few administrative restrictions as long as the government has a majority in the legislature (Appleby & Olijnyk, 2020). In a presidential system, when it comes to legislation, the executive branch must persuade the legislature to approve the proposed measures (Knill & Tosun, 2020). However, there is a wide range of policy areas in which the executive branch has discretion, especially with regard to defense, national security, and foreign policy (Appleby & Olijnyk, 2020). In many cases, once the budget is approved by the legislature, the government has extensive control over how the funds are used, yet there are feedback loops for control, such as external audits (Knill & Tosun, 2020).

The Role of the Chief Executive

An important question to consider is that, since the executive branch is considered to be very strong, does its power come from the overall decision-making of the cabinet, or does it come from the power of the president, the prime minister, or both? Additionally, who holds the position comparable to a Chairman of the Board of directors in a private company (Mezey, 2019)? In low-income countries where political leadership is personal (i.e., seeking personal gain), irresponsible, and non-responsible, the constitutional control of the executive branch is rare and most of the major political decisions are in the hands of the Chief Executive Officer (Grindle & Thomas, 1991). An example can be seen in Liberia, where in 2014, inadequacies on the part of the government allowed the Ebola epidemic to spread rapidly (Simen-Kapeu et al., 2021).

Policy execution is so closely aligned with the goals and methods of the Chief Executive that it may be in the hands of a small group of ministers selected by the head of government from the cabinet. The parliamentary system, especially in countries like the UK, is increasingly debating the more authoritative decision-making style of the Prime Minister. For example, in the late 1980s, many found that the administration of the UK's Prime Minister Tony Blair and his direct staff were increasingly gaining more power as key policy-makers, with the rest of the cabinet and civil servants having very little (if any) input.

This culminated in Tony Blair making an important announcement on major changes in the organization and management of the **National Health Service (NHS)** without consulting any of his cabinet colleagues. He announced a plan to raise the UK's spending on publicly funded medical care as a percentage of national income to the average spending of the European Union. This sudden commitment quickly led to a review of the sources and levels of NHS spending and led to the decision to increase spending to unprecedented levels over the course of five years (Wanless, 2002). Other ministers and civil servants faced factual obedience. The NHS's resources and capabilities had to increase significantly, ending the long-standing criticism that many of the UK's problems were simply due to underinvestment (Secretary of State for Health, 2000).

National Health Service (NHS)
This is the government-funded medical and healthcare service that everyone living in the UK (England, Northern Ireland, Scotland, and Wales) can use without being asked to pay the full cost of the service. It a is publicly funded healthcare system whose funding comes out of general taxation.

Individual political leadership is important, even in today's complex landscape which tends to constrain national governments in many ways. One of the prime examples of the impact of conflicting leadership decisions was the HIV/AIDS policy of the South African and Ugandan governments of the late 1990s to early 2000s. The prevalence of HIV/AIDS in both countries was very high. In South Africa, as part of his policy to control information and resistance to Western scientific rule, the then-President Thabo Mbeki denied the relationship between HIV and AIDS (Schneider, 2002). Accordingly, Mbeki's government opted not to support the purchase of antiretroviral drugs for the treatment of AIDS patients in South Africa (Parkhurst, 2001).

In Uganda President Yoweri Museveni opted for a very different policy, which entailed discussing the issue of HIV/AIDS in Uganda openly and transparently. Additionally, he invited all stakeholders, including civil society groups, to support the establishment of a national response to the epidemic. Even though Uganda's broader political environment favored such a response, the President himself played a crucial role in this policy's direction (Parkhurst, 2001).

The contribution of the bureaucracy

Appointed officials who administer the government system are known as civil servants or public servants (Nyadera & Islam, 2020). Although they are called "servants" of the systems in which they are employed, their roles go beyond simply managing the political process in various policy areas (Baekgaard et al., 2018). There are too many executive functions that these servant have to perform and, as such, they have been known to delegate many of these functions to bureaucrats to perform on their behalf (Nyadera & Islam, 2020). Civil servants are also influential, based on their knowledge, expertise, and experience (Rockman, 2020). Most bureaucrats stay to maintain the government's system while ministers and governments come and go when their tenure is over. Even in countries where the highest level of civil servants change when there is a change of power, such as the USA and most Latin American countries, the work of the majority of civil servants is unaffected (Nyadera & Islam, 2020).

Countries such as Australia, New Zealand, and the UK have a strong tradition of civil service independence and neutrality. New governments and ministers rely on officials to assist them until they are familiar with the details of their tasks, but they can also be suspicious. Officials who have stood up for their party or administration in the past are unlikely to serve rival-led governments and accept their views on policy options (Smalskys & Urbanovič, 2017). The power of the bureaucracy over politicians varies from country to country, over time, and between policy areas (Rockman, 2020). For example, countries such as France, Japan, Singapore, and South Korea attach great importance to public service, neutral professional ethics, and a clear mission of providing independent political advice (Peters, 2018). After a long period of training, civil servants form a homogeneous and informed group, seeking a lifelong career in the government (Peters, 2018).

The position of the Ministry of Health

Bureaucracy is not a seamless organization. It is divided into departments or provinces, like other authorities with specific functions. Indeed, specialization is a hallmark of bureaucracy, with each of these organizations having its own interests and ways of working (Dwivedi & Gow, 2019). Of course, the treasury is responsible for allocating resources to different sectors according to government priorities, but ideally an individual ministry such as the Ministry of Health. Which would in turn allow it to respond appropriately to the needs of the health sector. Conflicts are inevitable as ministries insist on a fair distribution of state budgets. In addition, different ministries refer to different "policy communities" or "policy networks" (groups from a particular sector, organized both inside and outside the government, that seek to influence government policy). In addition, individual ministries are often internally structured according to functional, technical, or political aspects (Campos & Reich, 2019).

The Ministry of Health, for example, typically has departments related to the main aspects of the medical system, such as hospitals, primary healthcare, and public health, as well as medical, nursing, and other specialized advisory departments. In addition, depending on the degree of decentralization of the government system, it may have its own federal-, local-, or district-level health authorities that do not play a major role in establishing and developing guidelines, but are important for their implementation (Ettelt et al., 2007).

Consequently, ministries have different statuses. Where is the Ministry of Health usually located in the informal hierarchy of ministries? In low- and middle-income countries, Ministries of Health lag far behind the Ministries of Defense, Economy/Trade, Finance, and Foreign Affairs, despite the relatively large budgets of Ministries of Labor and health organizations. In most middle- and high-income countries, the Ministries of Health are well-funded and given similar priority compared to other ministries (Costa & Rocha, 2018).

Despite these aspects, it should be noted that health issues tend to be the focus of cabinets only in times of health-related crises (Hornung & Bandelow, 2021). However, crises associated with epidemics (such as malaria, tuberculosis, and, more recently, COVID-19) can potentially lead to discussions about how to find funds to purchase expensive medicines or acquire new technologies, even against a backdrop of declining governmental income (Collins et al., 2020). In such cases, it is common to see in-depth discussions of fees for health services during these crises at clinics that otherwise offer health services free of charge. These fees are often unpopular, and more importantly, tend to reduce access for the most vulnerable and underprivileged societal groups (Hornung & Bandelow, 2021).

Self-reflection/discussion

In low- to middle-income countries, why do you think that the Ministry of Health is often relatively low down on the hierarchy of status and attention? (Buse et al., 2012)

Relations with other ministries

In almost every country, not just those with low health ministry status, other ministries with health policies have their own sectoral policy issues, rather than being interested in contributing to the government's overall health system. As a result, departments, especially those in the fields of raw materials, agriculture, and education, need to pursue their own goals and are obligated to achieve them. As a result, they may not prioritize the impact of their choices on human health (Sheikh et al., 2021). Many countries have established interdisciplinary bodies to develop and implement health policy or government-wide bodies in response to increased awareness of potential health-related crises. More recently, many countries have established national committees or task forces to attempt to respond to crises consistently across all relevant government agencies (Thombs et. al.,2017). However, when the national health budget is spread across so many sectors, it can be spread too thinly, with no clear understanding of how to spend it (Organisation for Economic Co-operation and Development, 2013).

Despite these sustainable efforts, most policies are more sector-based, reflecting the general structure of individual government ministries. Generally speaking, Ministries of Agriculture have continued to promote agriculture (e.g., tobacco) with the sole purpose of maximizing profits, without serious consideration of potential adverse health and nutritional consequences (Hawkes & Ruel, 2006). While many governments continue to seek to build more integrated or "group" institutions and processes for policy development and implementation, fragmentation of political processes is much easier to define than

amendments. In many respects, it is underpinned by other goals, such as empowering governments, which may increase the need for more specialized and better coordination systems (Bejaković, 2018).

Self-reflection/discussion (Buse et al. 2012)

In your country, what government policy decisions might have been different if they had taken the health effects into consideration?

Policy versus Politics

There is a constant struggle to reconcile and differentiate between policy and politics, especially as they are highly interrelated. The differences between policy and politics are summarized in the table below. While policy and politics are not one and the same, politics is important for "how citizens and policymakers recognize and define existing social conditions and political issues and promote certain types of intervention" over other types, and generate various challenges in policy implementation (Drèze, 2018, p. 45).

Table 2: The Difference between Policy and Politics

Policy	Politics
Commitment or statement of intent. Guidelines make people, organizations, or parties accountable. Policy is a set of rules or principles that guide decisions (Drèze, 2018).	Refers to authority and is related to public life. Politics generally revolve around government and its activities. "Politics" is a term related to the process of an organization (Drèze, 2018).
Focused on **content**.	Focused on **process**.
A government's, political party's, or corporation's plans, guiding principles, or policies of action designed to influence and make decisions, actions, and other matters (Drèze, 2018).	The science and process of governing, especially by political entities such as the state, managing affairs both internal and external (Drèze, 2018).
Can be termed as a "principle." It can thus be said that policy is "principle-based."	Governance theory and practice It can this be said that policy is "power-based."
Any expert can inform policy in their field.	Politics are carried out by politicians and elected officials.

Source: Mirna Naccache, (2022).

Policy Implementation

Policies are implemented in a variety of methods, but they usually fall under one of the three following categories (Campos & Reich, 2019):

1. Legislation. For example, licensing, control of supply, and intellectual property (e.g., patents)
2. Contracts. For example, contracts between Ministries of Public Health and public hospitals
3. Guidelines. For example, healthcare facility accreditation and codes of ethics for different medical professions

A summary on the characteristics of the different types of policy implementation methods is found in the table below.

Table 3: Different Types of Policy Implementation Methods

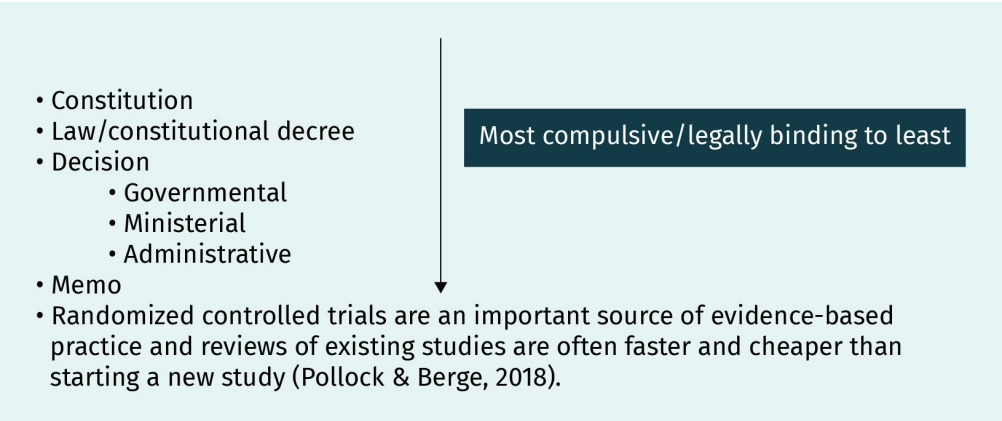
Law	Contract	Guidelines
• Compulsory: highly legally binding • Rigid: clauses cannot be negotiated	• Legal binding: penalty clause • Flexible/light process: negotiated arrangements	• Common agreement • Flexible/heavy process: consensus building
Universal	Particular	General
Enforcement	Agreement	Commitment
Concerns all	Concerns involved parties	Concerns peers
General supervision, attorney-general/police	Monitoring system and/or product evaluation	Retroactive control

Source: Mirna Naccache, (2022).

Policy instruments

Policy instruments are the methods used by a government to implement and promote certain policies with a specific set of goals in mind. They are interventions designed by the government with the intention of successfully implementing a certain policy, all while making sure that stakeholders abide by it (Vedung, 2017; Capano & Lippi, 2017). Policies without a clear objective and a proper means of implementation tend to fail in the long run. Some routinely used policy instruments include constitutional changes, laws, decrees, decisions, and memos. These instruments vary when it comes to their continuum of compulsion and how legally binding they are.

Figure 7: Continuum of Compulsion of Policy Instruments



Source: Mirna Naccache, (2022).

2.5 Mass Media as Agenda Setters

To what extent and under what circumstances does the mass media focus on a particular topic and influence our thinking? How much influence does the media yield over policy-makers when it comes to political interest and action? In the past, the role of the media in policymaking tended to be underestimated. However, mass media has a significant impact on governments' political agendas through its ability to address and shape issues and the public's opinion in a way that affects government response (Hamid & Sule, 2021). The launching of the internet in the 1990s made this process even clearer, as it allowed for the rapid rallying and consequent feedback of public opinion in ways that could not be easily controlled nor predicted by governments, but nevertheless must be addressed (Harrabin et al., 2003).

Print and electronic media (including social media) are the two basic types of media. They perform many important functions, as they are the public's main sources of information, also acting as a promotional mechanism. Additionally, they are agents of socialization, meaning they transmit a society's culture and guide social values and norms. The media "generate[s] beliefs and acceptance of dominant political and economic institutions such as democracy and capitalism by acting on behalf of legitimacy" (Marger, 2019, p. 240). They can also criticize the way society and government work, as well as opening new perspectives to the public (Robinson, 2017).

This influence goes both ways: the mechanics of the media are also influenced by the political system (Robinson, 2017), particularly in more totalitarian systems (Mukhongo & Macharia, 2016). In many countries, newspapers and television stations are completely state-owned and self-censored for fear of government retaliation, which compromises impartiality. In other countries where the media is conceptually independent from the state, editors and journalists still may be threatened, imprisoned, deported, or worse (Graber & Dunaway, 2017).

Governments and individual administrations are not able to easily influence or undermine internet-based media and satellite broadcasts. This is because they are less accessible in lower-income countries than the easy-to-control traditional media represented by television and radio (Donohue et al., 1973). Despite the vast freedoms given to the media in liberal democracies, governments can subtly control mass media (Donohue et al., 1973). Governments have become more and more concerned about its image in the media, offering exclusive news and proactively warning of political announcements in exchange for generally positive coverage. Nevertheless, this poses a dilemma over what should take precedence: careful, critical reporting, or making time-sensitive news available quickly.

In most Western democracies, mass-media organizations are part of large conglomerates with wide media interests. Business tycoons such as Rupert Murdoch own several of the most widely known mass-media outlets (McChesney, 2015). As such, it can be argued that the personal political values and commercial goals of these owners routinely direct what is emphasized by the media outlets they own. Most commercial media outlets also rely on advertising to some extent (McChesney, 2015). The ownership and advertising bias of the majority of newspapers and television networks in most countries are right-wing, capitalist, and political. Similarly, advertisers and commercial interests can directly impact media content. For example, the sponsor of a newspaper could publish an article that appears to be written by a neutral journalist but actually aims to promote the interests of the industry (Hiebert & Gibbons, 2017).

The media is dominated by states and large commercial interests, but still may raise issues on political agendas being promoted by researchers and interest groups unrelated to states and businesses. Occasionally, they act like interest groups by campaigning for issues that have been unfairly ignored. One of the most notable examples is the campaign by The Sunday Times in the UK, which, in the 1970s, advocated for higher compensation for children born with birth defects caused by **thalidomide**. This was done after the newspaper and its researchers succeeded in showing that the risk of congenital malformations was, in fact, predictable (Karpf, 1988). Similarly, in the early 2000s, the Daily Mail launched a clearly populist campaign with the aim of attracting readers. The campaign, focused on the topic of speed cameras, criticized research on injury mitigation as being seriously flawed and instead aimed to outrage readers by focusing on the governmental income gained from speeding tickets (Rosenfeld, 2019).

The thalidomide tragedy
In the late 1950s and early 1960s, thalidomide was marketed as a treatment for nausea in pregnant women, although it soon became apparent that the treatment resulted in severe birth defects in thousands of children, namely missing extremities. This tragedy marked a turning point, as it prompted international regulatory agencies to develop systematic toxicity testing policies (Karpf, 1988).

The media has been called upon to take more responsibility for reporting on public health issues. Still, the extent of the media's impact on policymakers is questionable. Firstly, policymakers have a variety of sources, and the media itself can be used to raise awareness of a particular issue. Often, the content of government press releases is simply quoted verbatim by busy journalists. Secondly, it is difficult to separate the different areas that affect what is on the policy agenda. Both types of media are part of the process itself, as opposed to being outside the process. In most cases, the media emphasizes movements that started elsewhere. In other words, it helps describe the problem, but it does not always highlight the solution. Thirdly, policymakers are less likely to be drawn into action from a single media account. Collaboration between media outlets can make a difference, but in a highly competitive environment, a consistent view on a subject is unlikely, espe-

cially in the news media, which is always looking for novelty. Just as there are examples of political changes brought about by the media, so too are there examples of politicians and their officials resisting the media pressure to change politics (Harrabin et al., 2003).

There is clearly no easy answer to questions such as "to what extent does the mass media influence public opinion?" The content of political issues, the political background, the process by which discussions are developed, and the decisions on political issues all impact how influential the media is. In low-income countries, it is difficult to see the influence of the media on policymakers. Journalists, editors, broadcasters, and social media influencers are all members of the "urban elite" and usually have close ties with government decision-makers. If the media is directly owned by the government, it is unlikely that a critical analysis of government policies will be conducted. In many low-income countries, the political circle is small, and journalists who are seen as a threat to the political system are often the first to be arrested during oppression. This situation is changing, but the independence of the media is still vulnerable to political whims and a weak capital base. For example, consumer advertising revenue in high-income countries does not exist in other countries, making their media financially independent on the government, but not necessarily independent of commercial interests (Karpf, 1988).

The existence of democracy seems to play an important role in influencing the media agenda in low- and middle-income countries. To illustrate this idea, Sen (1983) compares the role of the media in reporting food shortages and famines in China and India by looking at the role of the respective media and its impact on government responses. From 1959 to 1961, China suffered a major famine due to poor crops, however, even with an estimated 14 to 16 million deaths, the media remained silent. On the other hand, while India is generally considered an impoverished country and has had many years of major food insecurity, it has never experienced famine (Sen, 1983).

Sen argues that India, unlike China, is democratic, with more room for press freedom, which Sen attributes as one of the reasons that famine never occurred. Sen argues that the Indian government "cannot afford to fail to take prompt action when large-scale starvation threatens. Newspapers play an important part in this, in making the facts known and forcing the challenge to be faced. So does the pressure of opposition parties" (Sen, 1983, p. 55). Conversely, in China, there are very few ways to urge government action to avoid disasters, enabling even something as momentous as the famine to remain hidden (Deng, 2020). Ironically, at the time of the famine, the Chinese Communist Party was far more interested in distributing food (at the public's expense) to secure food for everyone than India's government was. Therefore, in normal times, widespread malnutrition and non-acute hunger in India can clearly be avoided (Deng, 2020).

Self-reflection/discussion

Think of some mass media campaigns in your country aimed at getting the government to address specific public health issues. What was the health issue? How did the media present it? Was it presented fairly and responsibly? Did the report influence the political debate and help put this issue on the policy agenda? In your opinion, did media coverage have a positive or negative impact on policy? (Buse et al., 2012)

SUMMARY

Policy is guided by several factors such as universal principles, ideas, and values. It may be triggered by events and problems and it can be influenced by interest groups and other stakeholders. The right to health is one of the main guiding principles for health policy.

Agenda-setting refers to the action of putting the "issue" on the formal policy agenda of decision makers. Issues come to the attention of policy-makers and get on the policy agenda through a variety of methods. There are several theoretical models for agenda setting. One of the most prominent is the Hall model of legitimacy, feasibility, and support, which suggests that issues will only be included in a government's agenda when they are high in terms of their legitimacy, feasibility, and support.

In most countries, governments are clearly the main agenda setters, because most governments control the legislative process and often initiate policy changes. Often crises are one of the main reasons that open policy windows and put new issues on the policy agenda. Two characteristics of government systems that have a major impact on the country's ability to formulate and implement policies are autonomy and capacity. Another feature influencing the formation of public order is related to the relationship between the legislature, executive, and judiciary. This relationship is a complex one that depends on the form of government system in the individual country.

Mass media (both print and electronic) has a significant impact on political agendas through its ability to address and shape issues and public opinion. This impact may be a positive one such as when the media sheds light on a specific health crisis but may also have a negative impact due to bias and personal interests.

UNIT 3

EVIDENCE-BASED POLICYMAKING

STUDY GOALS

On completion of this unit, you will be able to:

- define the terms evidence, research, and knowledge translation.
- explain evidence-based policymaking, the different limitations for evidence, and its use in policymaking.
- distinguish between formal and informal sources of evidence.
- understand quantitative research, qualitative research, mixed methods research, and the hierarchy of evidence.
- compare the positivism, interpretivism, and naturalistic paradigms.
- understand health policy analysis and its steps.

3. EVIDENCE-BASED POLICYMAKING

Introduction

This unit will discuss what evidence-based policymaking (EBP) is, detailing the different sources of evidence in terms of formal sources, including quantitative, qualitative, and mixed methods research, as opposed to informal sources such as grey literature. The hierarchy of evidence will also be highlighted, before delving into the paradigms of policy research, in particular the positivism, interpretivism, and naturalistic paradigms. The objectives, aims, importance, and process of health policy analysis will also be examined, ending with a discussion of the limitations of using evidence in the policymaking process.

3.1 Sources of Evidence

Before delving into EBP and the various sources of evidence, it is crucial to define the terms evidence, research, and knowledge translation. Evidence can be defined as knowledge of any form with sufficient quality use to assist in making a decision. Evidence includes but is not limited to research (Davies, 1999). Research can be defined as a "a systematic activity aimed at creating and associating rigorous new knowledge with previously existing knowledge in order to improve understanding of the physical or social world" (Buse et al., 2012, p. 158). Lastly, knowledge translation can be defined as strategies involving various "linking" and "exchange" activities designed to narrow the social, cultural, and technical "gap" between researchers, policymaker and the politics community (Kitson & Harvey, 2016).

Evidence-Based Policymaking

With the move towards evidence-based medicine in the 1980s, the push towards EBP also gained momentum. This momentum culminated in 1997, when Tony Blair, the Prime Minister of the United Kingdom (UK) at the time, and his cabinet went on record saying that it was time to end ideology based policymaking and base policies on concrete and objective evidence (Arthur, 2017).

EBP is an idea that suggests that all policy decisions need to be based on or supported by rigorously established and objective evidence (Cairney, 2016). This is in implicit opposition to the idea that policy decisions must be based on "common sense" or idealism. The use of rigorous, objective, and comprehensive scientific knowledge (as opposed to fragmented, manipulated, or selected knowledge) as the basis for policymaking is believed to be the most useful for achieving social goals (Cairney, 2016; Arthur, 2017).

It should be noted that some policy researchers prefer to use the term "evidence-informed policy" rather than EBP (Mullen, 2016). This shift in language by some policy researchers aims to encourage policy- and decision-makers to think critically about the underlying desire to improve the use of evidence in terms of rigor and quality, while avoiding some of

the important limitations and reductionist ideas sometimes found in evidence-based language. This terminology highlights that this practice is characterized by systematic and transparent access, including the assessment of evidence as an input to the policy and decision-making process. Nevertheless, the term EBP is widespread and can be found in most literature on policy and policymaking (Mullen, 2016). This highlights the systematic desire to have policies based on rigorous and high-quality evidence while shifting away from the use of biased, false, and subjective evidence in policymaking (Cairney & Oliver, 2017).

Use of evidence in health policymaking

Including quality research evidence in the health policy process is considered an important strategy for improving the healthcare system around the world (Global Programme on Evidence for Health Policy, 2003). Therefore, health policymaking in most high-income countries, has been facilitated by the use of evidence, while in low- and middle-income countries the ability of healthcare systems to serve their respective populations remains severely limited due to health policymaking still tending to rely on trial and error, rather than evidence (Okoli, 2002).

However, the policymaking process does not always follow the clear and direct logic of science and some argue that the use of evidence by policymakers is strongly associated with the cognitive and institutional characteristics of the policymaking process. Health policy is a central element in the sustainability of health systems; it involves a complex process of interaction between stakeholders with different perspectives, powers, interests, and agendas. This poses a challenge to the effective use of evidence in health policies and practices, particularly in most low- and middle-income countries (Brownson et al., 2009).

Nevertheless, the use of evidence in health policymaking is imperative as it can improve the health policy process by identifying new issues in the policy agenda, facilitate decision-making about policy content and direction, and improve the process of assessing the impact of policy. The role and use of evidence in policymaking is an area that is still under study. Previous research on EBP has focused on the extent to which evidence is formed. As such there is limited understanding on the relative value of the different types of evidence in making health decisions in different policy areas and situations (Onwujekwe et al., 2015).

Sources of Evidence

Evidence is published by various sources, such as scientific journals, academic journals, books, conference reports, websites, and news reports (Reynolds, 2008). Academic publications are published in scientific journals and typically thought to be of the highest quality, due the independent peer review process they have to go through prior to being published (Reynolds, 2008). However, it should be noted that some peer-reviewed journals do not follow a rigorous revision and evaluation process of manuscripts that are or will be published in them. An important principle in translating evidence is that all evidence should be evaluated critically, regardless of its source.

Formal sources

Formal sources are sources that go through an extensive and rigorous review, assessment, and revision process before they are published. The credentials of each author on the source are evaluated and, when the source details are published, the authors' references are provided in addition to literature references and citations. The most commonly-used formal sources are in academic library collections, as well as scholarly and scientific sources (Dalheim et al., 2012). Formal sources can also be defined as being created in a regulated or legal manner, and are often objective and impersonal (Kaye, 1995).

Quantitative evidence

Quantitative research is the process by which numerical data are collected and analyzed. Quantitative research is generally used to assess patterns, find means, make predictions, test causality, and generate results generalized to a wider population. Quantitative research is widely used in the natural and social sciences such as biology, chemistry, medicine, psychology, economics, sociology, and marketing (Stockemer, 2019).

Quantitative research methods can be used for descriptive, correlated, or experimental research (Stockemer, 2019). The descriptive survey only looks for an overall summary of the survey variables. Correlation studies examine the relationships between research variables. Experimental studies systematically examine whether there is a causal relationship between variables. Both correlation and experimental studies can be used to formally test hypotheses or predictions using statistics. The results can be generalized to a wider population based on the sampling method used. To collect quantitative data, it is necessary to use operational definitions that transform abstract concepts (such as mood) into observable and quantifiable measurements (such as self-assessment of emotions and energy levels) (Stockemer, 2019).

There are four main types of quantitative research: descriptive, correlational, causal-comparative/quasi-experimental, and experimental research (Nardi, 2018).

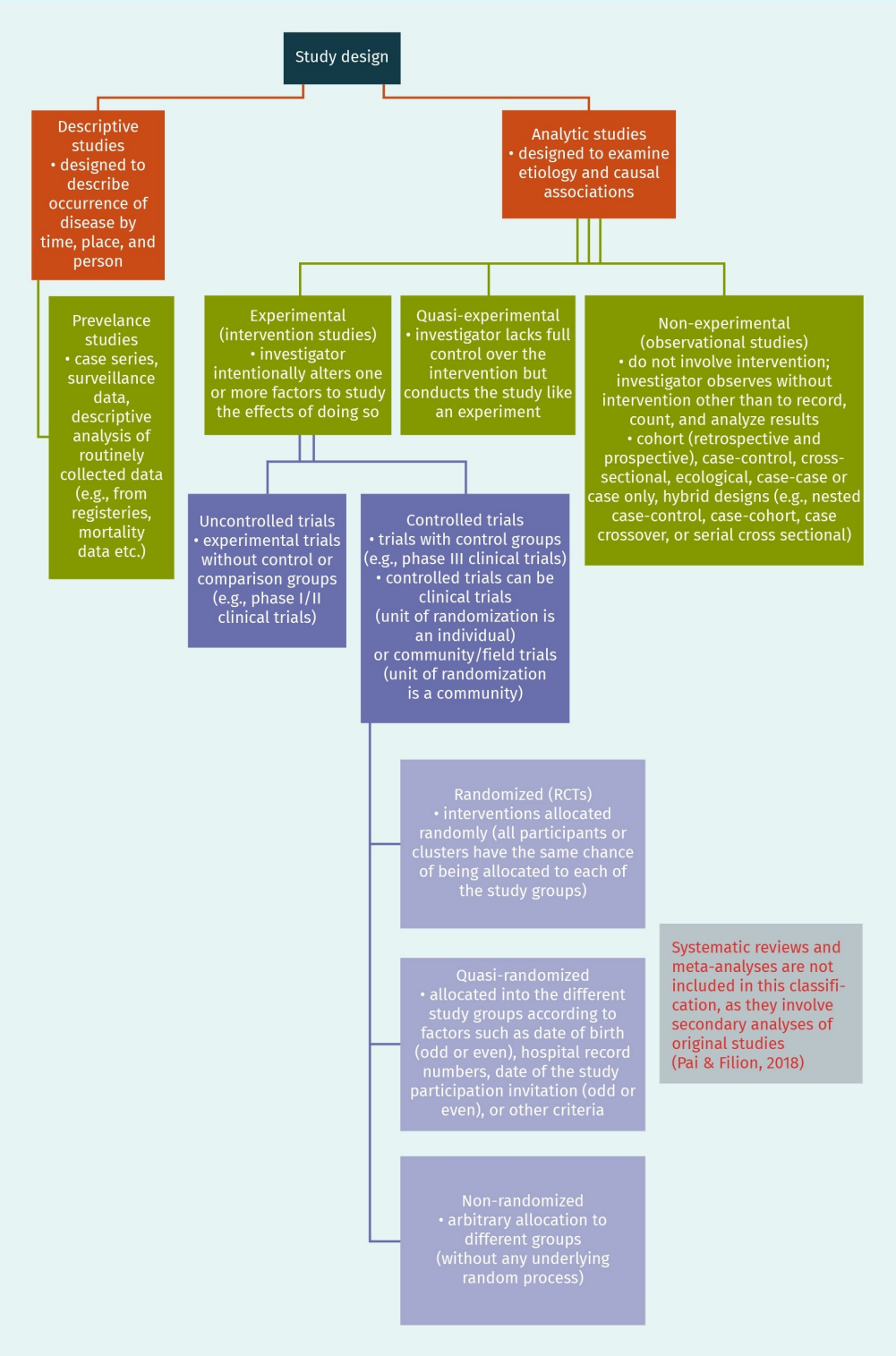
Descriptive studies

Quantitiative studies

The main types of quantitative studies used in policy research are systematic reviews, randomized controlled studies, cohort studies, cross-sectional studies, and case-control studies (Vandenbroucke et al., 2014). Each one of these studies is explained in more detail below:

Cohort studies

Figure 8: Study Design Classifications



Source: Mirna Naccache, based on Pai, M. & Filion, K. (2018).

Table 4: Advantages and Disadvantages of Quantitative Evidence

Advantages	Disadvantages
Standardized data collection protocols and concrete definitions of abstract concepts allow for repeat research (Edmonds & Kennedy, 2016).	Even with accurate and restrictive operational definitions, complex concepts cannot be properly represented. For example, the concept of mood can only be expressed numerically in quantitative studies but can be explained in detail in qualitative studies (Edmonds & Kennedy, 2016).
Studies can be reproduced in different cultural environments, times, or different groups of participants. The results can be compared statistically (Yilmaz, 2013).	Predefined variables and measurement methods may ignore other related observations (Yilmaz, 2013).
Quantitative data analysis allows you to process and analyze data from large samples using reliable and consistent methods (Rahman, 2020).	Despite standardized procedures, structural strain can still affect quantitative research. Missing data, inaccurate measurements, or improper sampling methods are biases that can lead to false conclusions (Rahman, 2020).
Using formalized and established hypothesis testing methods means that research variables, predictions, data collection, and testing methods must be carefully reviewed and reported before reaching results (Gelo et al., 2008).	Quantitative studies often use unnatural environments such as laboratories or do not consider historical and cultural backgrounds that can affect data collection and results (Gelo et al., 2008).

Source: Mirna Naccache, (2022).

Qualitative evidence

Qualitative research is the opposite of quantitative research, in which non-numerical data (such as text, video, and audio) are collected and analyzed with the aim of understanding concepts, opinions, or experiences (Gerring, 2017). Qualitative research is mainly used to gain in-depth insights into the problem or generate new ideas for the research in questions. Qualitative research is the opposite of quantitative research, which collects and analyzes numerical data for statistical analysis. Qualitative research is widely used in fields such as the humanities, social sciences, anthropology, sociology, education, health sciences, and history (Gerring, 2017). Examples of research questions that can be answered through qualitative research include

- How has social media shaped the perception body image in teenagers?
- How is a healthy diet interpreted by children and adults in the United States of America (USA)?
- How is anxiety experienced around the world?

Qualitative research is used to understand how people perceive and experience the world (Smith & Smith, 2018; Hamilton & Finley, 2019). There are many approaches to qualitative research, but they are flexible and tend to focus on gaining rich meaning in the interpretation of the data. Common approaches include grounded theory, ethnography, action research, phenomenological research, and narrative research (Smith & Smith, 2018), which have some things in common but emphasize different goals and perspectives, as detailed below (Tolley et al., 2016):

- grounded theory. Researchers collect extensive data on interesting topics and inductively develop theories.
- ethnography. Researchers immerse themselves in groups and organizations to understand their culture.
- action research. Researchers and participants jointly combine theory and practice to drive social change.
- phenomenological research. Researchers study phenomena or events by explaining and interpreting the life experiences of participants.
- narrative research. Studies how stories are told to understand how participants perceive and understand their experiences.

The most common qualitative methods are (Gill et al., 2008)

- observation. The researcher records what they saw, heard, or encountered in detailed on-site notes.
- interview. The researcher asks people questions in one-on-one conversations. These can be structured, semi-structured, or open-ended interviews.
- **Focus group discussion**. The researcher asks a question, sparking discussion in a group of people.
- Survey. The researcher distributes questionnaires with open-ended questions.
- Secondary research. The researcher collects existing data in the form of text, images, audio, or video records.

Focus group discussions
These involve gathering people of similar backgrounds or experiences to discuss a particular topic of interest, by asking questions about their perceptions, attitudes, beliefs, opinions, ideas etc., with participants free to talk and discuss with other group members. Focus groups generally involve group interviews with small groups of eight to twelve people, with a moderator (interviewer) taking the lead in a loosely-structured discussion.

Since the sources of qualitative data can be in text, photo, video, and audio formats collected from interview records, survey responses, field notes, or records from the natural environment, there are several ways to analyze collected data and come up with results. However, most types of qualitative data analysis share the same five steps, as follows (LeCompte, 2000):

1. Preparation and organization of data. This means copying the interview or entering field notes.
2. Checking and investigation of data. This refers to examining the data for patterns and repetitive ideas that occur.
3. Developing a data coding system. Based on the first idea, the researcher writes a set of code that can be applied to classify the data (Elliott, 2018).
4. Assign a code to the data. For example, in a qualitative research analysis, this means looking at each participant's answers and coding them into a table. While reviewing the data, the researcher can write new code to add to the system as needed (Elliott, 2018).
5. Identification of recurring topics, which are linked with the code to related comprehensive topics (Elliott, 2018).

Consequently, there are several specific approaches to analyzing qualitative data. These methods have a similar process but emphasize different concepts, as outlined below:

- content analysis. This is used to explain and classify common words, phrases, and ideas with qualitative data (Sgier, n.d.). An example of how this can be used is through researchers performing content analysis to find the language used to describe patient experiences during certain treatments, such as chemotherapy.
- thematic analysis. This is used to recognize and interpret qualitative data patterns and themes (Frasso et al., 2018). An example of this in use is how psychologists can apply theme analysis to learn how social media tourism affects mental health.
- text analysis. This kind of analysis examines the content, structure, and design of text (Frasso et al., 2018). Researchers can use text analysis to understand how media coverage of health-related issues has changed over the last decade.
- discourse analysis. Studies communication and how language is used to produce effects in specific situations (Frasso et al., 2018). An example of this is use is political scientists using this type of analysis to find out how politicians build confidence in election campaigns.

Qualitative research can be of great value in policymaking (Green & Thorogood, 2018). Evidence resulting from qualitative research cannot be obtained by any other form of research (specifically quantitative research methods), as it examines the living experiences of stakeholders, providing detailed policy context, and providing subtle insights into the process by which the program is implemented (Murphy & Dingwall, 2017). Additionally, it can provide a bigger picture and useful insights for problems that are difficult to "quantify" (Green & Thorogood, 2018). Despite all the aforementioned benefits, policymakers have repeatedly expressed their preference for quantitative research. This is especially true for randomized controlled trials (RCTs), which are considered to be the "gold standard" of evaluation methods (Murphy & Dingwall, 2017).

Table 5: Advantages and Disadvantages of Qualitative Evidence

Advantages	Disadvantages
The process of collecting and analyzing data can be adjusted as new ideas and patterns emerge. You are not strictly determined in advance (Mays& Pope, 2020).	In the real world, qualitative research is often unreliable due to uncontrolled factors that affect the data (Smith, 2018).
Data collection is done in a real context or in a naturalistic way (Drisko, 2020)	Qualitative research cannot be reproduced due to the researcher's primary role in analyzing and interpreting the data. Interpretations of the same data can be very different, as researchers determine what is important and what is irrelevant in the analysis of the data.
A detailed description of people's experiences, emotions, and perceptions can be used to design, test, or improve a system or product (Mays& Pope, 2020)	Small samples are often used to collect detailed data about a particular context. Despite the rigorous analytical procedure, it is difficult to draw generalizable conclusions because the data may be distorted and do not represent a wider population (Smith, 2018).
Free-form answers mean that researchers can discover new problems and opportunities that were otherwise unthinkable (Drisko, 2020).	Large amounts of text can be managed and recorded in software, but data analysis often requires manual checking or performance (Drisko, 2020).

Source: Mirna Naccache, (2022).

Quantitative versus qualitative research

In data collection and analysis, quantitative research is generally concerned with numbers and statistics, while qualitative research is generally related to words and meanings. However, they are both important for gaining different types of knowledge. Quantitative and qualitative research allow for the collection and analysis of data using different research methods and answer different types of research questions (Cadena-Iñiguez et al., 2017).

The main differences between quantitative and qualitative research are summarized in the following table.

Table 6: Qualitative versus Quantitative Research

Quantitative research	Qualitative research
Main focus is on testing theories and hypotheses	Main focus is on exploring ideas and formulating a theory or hypothesis
Analysis by mathematical and statistical analysis	Analyzed by summary, classification, and interpretation
Mainly expressed in numbers, graphs, and tables	Mainly expressed in words
Requires many respondents and generally larger sample size	Requires fewer respondents and generally smaller sample size
Closed (most cases multiple choice like Likert scale) questions	Open-ended questions
Key terms used testing, measurement, objectivity, replicability	Key terms used understanding, context, complexity, subjectivity

Source: Mirna Naccache, (2022).

Mixed methods research

Mixed methods research is a research approach in which researchers collect and analyze both quantitative and qualitative data within the same study (Schrauf, 2016). The use of mixed methods research in healthcare has been on the rise in the past decade, as a result of the increasing complexity in healthcare delivery. Mixed methods research leverages the potential strengths of both qualitative and quantitative methods. This allows researchers to explore different perspectives and uncover the relationships that exist between the complex layers of multifaceted research questions (Schrauf, 2016). As healthcare providers and policymakers strive to ensure the quality and safety of patients and their families, researchers are using mixed methods to interact with current healthcare trends in an increasingly diversified clinical environment (Wisdom et al., 2011).

Mixed methods research requires a mixture of targeted methods in data collection, data analysis, and interpretation of evidence. The keyword is “mixed.” This is because an important step in the mixed approach is data linkage or integration at the right time for research process phenomena from different perspectives and through different research perspectives (McKim, 2017). For example, a randomized controlled trial that evaluates the

decision-making support of women making decisions about childbirth after caesarean section to assess changes in knowledge, the degree of decision-making conflict, childbirth decisions, and outcomes. Quantitative data were collected, while qualitative narrative data were collected to gain insight into the factors that influenced women's decision-making experience and choice of childbirth mode (Wisdom et al., 2011).

The mixed methods design is suitable for answering research questions that cannot be answered either quantitatively or qualitatively.

The mixed methods approach can be used to better understand the relationships and discrepancies between qualitative and quantitative data (Palinkas et al., 2011; Schrauf, 2016). It can enable participants to have strong opinions, share experiences throughout the research process, enrich evidence, and facilitate a variety of exploratory tools that enable more detailed answers to questions. Various perspectives illuminate the research subject, enriching the researcher's experience. However, the process of mixing methods within a study can complicate the implementation of the study. Interdisciplinary research teams often need more resources (because they need to be familiar with alternative research paradigms and different approaches to sample selection, data collection, data analysis, data synthesis or integration) and additional research training may be required (Palinkas et al., 2011).

The five main features of a well-designed mixed methods study are (Creswell & Plano-Clark, 2011)

1. Collection and analysis of quantitative (closed) and qualitative (open) data
2. Applying rigorous procedures to the collection and analysis of data in the tradition of each method, including ensuring appropriate sample sizes for quantitative and qualitative analyses
3. Integrating data during data collection, analysis, or discussion
4. Using procedures to implement qualitative and quantitative components simultaneously or sequentially in the same sample or different samples
5. Constructing procedures for philosophical/theoretical research models, such as social constructionist models that seek to understand multiple perspectives on a single topic. For example, what patients, nurses, clinicians, and staff consider to be "high quality treatment" in the setting of primary healthcare.

Mixed methods research design can be used for multiple purposes, some of which are outlined below.

Table 7: Advantages and Limitations of the Mixed Methods Approach

Advantages	Limitations
These approaches compare quantitative and qualitative data. The mixing method is especially helpful in understanding the discrepancy between quantitative and qualitative results (AHRQ, 2013).	These approaches increase the complexity of the evaluation. Mixed law research is complex to plan and execute. They require careful planning to explain all aspects of the study, including qualitative and quantitative parts (identical, embedded, or parallel) study samples, timing (a sequence of qualitative and quantitative parts); and planning of data integration. Integrating qualitative and quantitative data during an analysis is often a difficult step for many researchers (AHRQ, 2013).
The approach reflects the perspective of the participants. The mixed methods gives the study participants a say and ensures that the study results are based on the participants' experience (AHRQ, 2013).	An interdisciplinary research team is required. Conducting high-quality mixed law research requires an interdisciplinary team of researchers who must be open to methods that may not be in their area of expertise in larger research services. Finding a qualitative expert who is willing to discuss quantitative analysis, and vice versa, can be a challenge in many environments. As each method must meet its own criteria of rigor, it can be difficult to guarantee the proper quality of each component of a mixed methods study. For example, quantitative analysis is much greater to obtain statistical significance than qualitative analysis, which requires the association to be achieved with saturation goals (doing more interviews and not revealing new information). Sample size required. If the statistical significance is inadequate, an embedded sample in which a qualitative subsample is embedded in a larger quantitative sample is useful (AHRQ, 2013).
Scientific interactions are promoted through mixed methods approaches. Such studies extend interdisciplinary team research by facilitating interactions between quantitative, qualitative, and mixed-method scientists (AHRQ, 2013).	Extensive resources are required. After all, mixed methods research is labor-intensive and requires more resources and time than conducting single methods research (AHRQ, 2013).
Mixed methods approaches provide methodological flexibility. Mixing methods are flexible and adaptable to many study designs such as observational studies and randomized trials, providing more information than quantitative studies alone can provide (AHRQ, 2013).	
Large and extensive data can be collected. The mixed approach also reflects how individuals naturally collect information by integrating quantitative and qualitative data. For example, sports stories often integrate quantitative data (results or error counts) with qualitative data (highlight explanations and photos) to provide a more complete story than either method alone (AHRQ, 2013).	

Source: Mirna Naccache, based on Agency for Healthcare Research and Quality (2013).

Informal Sources

Informal sources published by individuals or organizations may not contain author qualifications or citations, making it difficult to establish authority, and often lack any process or rigor to evaluate the data and findings. Important emerging literature shows the role of informal knowledge in the planning of public health programs, due to the fact that in some cases researchers, public health professional, and policymakers may need to make decisions about issues that are under-researched. In addition, due to the context-dependent nature of community-based health policy interventions, studies on the effectiveness of interventions may not be available (Kothari et al., 2015). There are several types of informal sources, detailed below.

Grey literature

This type of information is produced by organizations outside of commercial, academic, and scientific publishing and distribution channels, and is therefore not normally found in databases. In general, the types of publications considered to be grey literature include government documents/report, newsletters, policy literature, reports by non-governmental agencies and civil society groups, and working papers. Organizations that produce grey literature include nongovernmental organizations, governmental agencies, charities, academic centers, private companies, and consultants (Conn et al., 2003).

Grey literature may be open access or may be distributed privately within an organization or group due to lacking systematic means of dissemination and collection. Its quality, review, and production criteria can vary significantly. Additionally, grey literature can be difficult to find, access, and rate, but this can be addressed by developing an appropriate search strategy (Lawrence et al., 2015).

The relative importance and use of grey literature depends largely on the field of study and topic, the methodological approach, and the sources of information used (Gelfand & Lin, 2013). For example, in some areas, especially life sciences and medicine, only peer-reviewed scientific journals have traditionally been used, but in other areas such as agriculture, aviation, and engineering, grey literary resources are more dominant (Gelfand & Lin, 2013; Lawrence, 2017).

In the past decade, systematic revisions of the literature on health and medicine have highlighted the importance of finding and analyzing grey literature as part of the creating a comprehensive evidence base and as it helps avoid publication bias (Lawrence, 2017).

Grey literature is of particular importance as a means of disseminating scientific and technical information, as well as policy and practice information. Experts have emphasized its importance, due to the detailed research results (such as those published in doctoral dissertations) and its promptness as, in many cases, results are published in grey literature 12 to 18 months before they are published in academic journals and other formal sources of information (Gelfand & Lin, 2013).

In particular, governments, as well as public and industrial laboratories, often produce most of their grey materials for internal use (Lawrence, 2017). The concept of EBP somewhat recognizes the importance of grey literature as part of its evidence repertoire (MacDonald et al., 2015).

Other informal sources

Other informal sources of evidence can include blogs and social media posts, podcasts, letters and emails, and videos on social media platforms.

One of the platforms considered an informal source are open-source websites. These are not considered to be reliable sources of information, yet they are increasingly being used by members of the academic community, from policymakers to students to members of the public as an easily accessible tertiary source of information (Jemielniak & Aibar, 2016; Singer et al., 2017). However, open-source websites are not considered to be trusted or reliable sources of information, so quoting open-source websites in research is generally considered unacceptable (Jemielniak & Aibar, 2016; Sahut & Tricot, 2018). This is especially true given that anyone can edit the information provided at any time. Most errors are fixed quickly, but some are overlooked. However, it should be noted that open-source websites do feature some good and credible articles which are more sophisticated and professional, and generally more reliable (Sahut & Tricot, 2018). These articles are frequently reviewed, edited many times, pass many "tests," and are then confirmed as "good" or "featured," so they can be used for deeper investigations than usual and can act as a starting point for research (Singer et al., 2017; Sahut & Tricot, 2018).

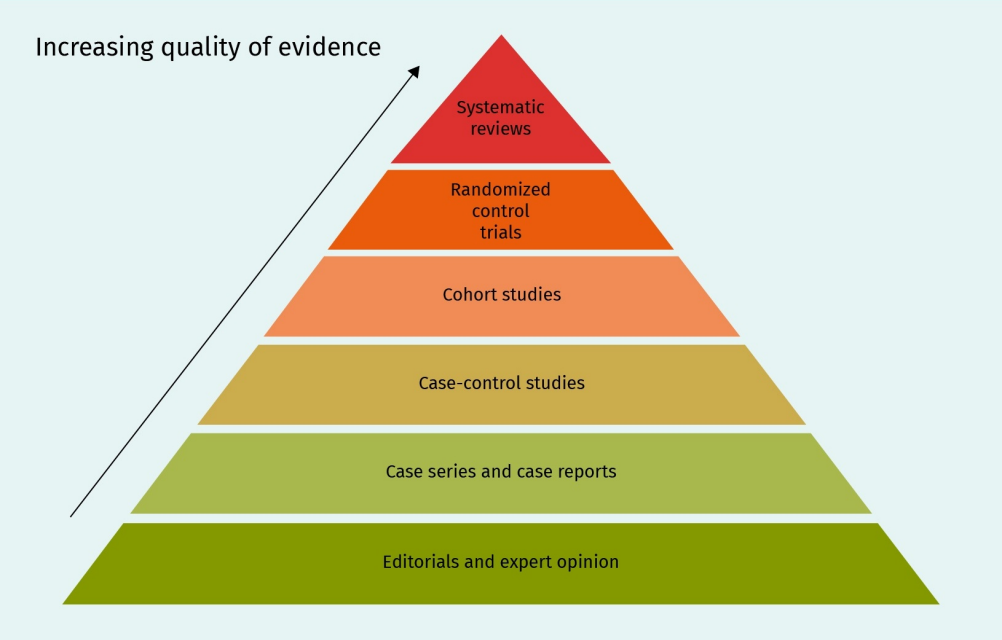
Hierarchy of Evidence

The hierarchy of evidence is a framework for ranking evidence to be used in health policymaking. The hierarchy of evidence (or level of evidence) is a top-down approach used to rank the relative strength of scientific research results (Canadian Task Force on the Periodic Health Examination, 1979). There is broad consensus on the relative strength of large-scale epidemiological studies. Over 80 different hierarchies have been proposed to assess medical evidence (Murad et al., 2016), with study design (such as single patient case reports and blinded randomized controlled trials) and measured endpoints (such as survival and quality of life) influencing the strength of the evidence. In clinical studies, the best evidence of therapeutic effect comes primarily from RCTs (Brighton et al., 2003). Systematic reviews are usually ranked as the highest-quality evidence or as the "gold standard" when it comes to policy research (Doleac, 2019).

Since the late 1970s, there are a number of "hierarchies of evidence" that have been developed to enable different research methods to be ranked according to the validity and reliabilities of their findings (Canadian Task Force on the Periodic Health Examination, 1979). These hierarchies can be used in a variety of methods as a means of "grading" the quality of the research (Murad et al., 2016).

The use of the hierarchy of evidence has been increasingly criticized in the twenty-first century (Tugwell & Knottnerus, 2015). Some of these critiques include the fact that this hierarchy ignores the use and importance of qualitative studies and the fact that the "gold standard" that is systematic reviews is not without limitations and flaws (Bigby, 2008; Tugwell & Knottnerus, 2015).

Figure 9: Hierarchy of Evidence



Source: Mirna Naccache, based on Canadian Task Force on the Periodic Health Examination (1979).

The concept of the "quality" of evidence can be defined as the degree of confidence in the estimation of the effect being sufficient to support a particular recommendation. This definition means two things: Firstly, the research team must make a judgment on the quality of the evidence based on the specific context in which they use it. Secondly, because systematic reviews do not—or at least should not—make recommendations, they require different definitions (Guyatt et al., 2008). In this case, the quality of the evidence reflects the confidence that the effect estimate is correct.

Similarly, research rigor is important to assess. Rigor is, qualitatively speaking, a way to build trust or confidence in the results of research studies. This allows researchers to establish consistency in the methods used over time. It also provides an accurate representation of the population under study. Components related to rigor include credibility, transferability, dependability, and conformability. Credibility refers to the degree to which a research report is reliable and appropriate, especially with respect to the level of consensus between participants and researchers (Polit & Beck, 2012). Transferability denotes the ability to transfer research results or methods from one group to another and is synonymous with external validity. One way to establish transferability is to provide a detailed description of the population under study by explaining the demographic and geographical boundaries of the study. Consequently, dependability refers to the consistency and

reliability of research results and the level of documentation of research procedures that allows non-researchers to follow, review, and criticize the research process. As a quality criterion, dependability is particularly relevant for ecological and nature maintenance applications in the early stages of testing results in multiple contexts to increase the reliability of evidence. Lastly, conformability refers to the objectivity of a study in data collection and analysis. There must be an agreement between two or more independent individuals about the accuracy, relevance, or meaning of the data. Conformability also provides a means of demonstrating quality (Polit & Beck, 2012).

3.2 Paradigms in Policy Research

Paradigms are the basic theoretical methods for observing and understanding the world and are important for defining the methodology that researchers will apply. Traditionally, the two dominant and contrasting paradigms have always been the positivist paradigm and the naturalistic. The positivism or experimental paradigm is related to scientific methods and research, and therefore to quantitative methods. The naturalistic paradigm is usually associated with certain fields of social anthropology and sociology and is consistent with the use of qualitative methods.

Positivism

Positivism relies on hypothetical deduction to verify a priori hypothesis, usually expressed in a quantitative manner, in which causality and the functional relationship between explanatory factors (independent variables) and outcomes (dependent variables) can be derived (Panhwar et al., 2017; Park et al., 2020). However, empirical research does not always rely on quantitative methods. For example, an experimental study that tests the effects of interventions through qualitative analysis also conforms to the positivist paradigm (Park et al., 2020). Positivism relies on often quantitative positivist methods to test a priori hypotheses. This allows the estimation of the functional relationship between the cause and explanation factor (independent variable) and the effect (dependent variable). For example, experimental studies examining the effects of interventions through qualitative analysis fit into the positivist paradigm. The main goal of positivist research is to generate descriptive or causal relationships that ultimately lead to the prediction and control of the phenomenon in question (Park et al., 2020).

Ontology: The nature of reality

The positivist paradigm assumes that there is one concrete reality—one that can be understood, identified, and measured. Thus, causal inference has temporal priority (that is, X must precede Y in time for X to cause Y). These inferences can be complicated by false correlations (i.e., factors other than the identified factors that do not affect the results) and especially undefined confounding factors (i.e., undefined factor V is also a cause of Y in the identified space; Park et al., 2020).

Epistemology: The nature of knowledge

Positivism argues that knowledge can and must be developed objectively without the value of researchers and participants affecting its development. Knowledge is true when properly developed, meaning it is certain, realistic, and accurate. There must be an absolute separation between research participants and researchers in order for the truth to develop "correctly." To achieve this separation, positivists work with both dualism and objectivity. In other words, positivist thinking argues that participants and researchers can actually be separated (dualism). In addition, the two units are separated by adhering to strict protocols to reduce research bias (objectivity; Park et al., 2020).

Axiology: The value of the research process

Positivism relies heavily on objectivity and therefore rejects the meaning of an individual's subjective experience and values, such as the experience and values of research participants and researchers (Park et al., 2020). This requires researchers to remain objective and not interact with participants while collecting data. It also requires the researcher to not be involved in the experiment. In some areas, such objectivity is very easy to implement. For example, imagine an experimental physicist doing research in a vacuum. There, external factors other than the system being studied are not part of the experiment. This objectivity is more difficult to achieve in other areas. For example, empiricism can be applied to social science research because it requires the use of rigorous research protocols that minimize researcher bias (Park et al., 2020).

Positivism methodologies emphasize that research must be conducted in an environment where variables can be controlled and manipulated. In the social sciences, researchers need to create a somewhat artificial environment, in which other external factors other than research variables are minimized (Lindenfeld, 2020). In the purest form of positivism, the sole focus of research is to examine descriptive or causal relationships between research variables, as is done in the natural sciences. Therefore, the experimental design of the positivist paradigm, including the quasi-experimental design, is prioritized. The results of these experiments are used to confirm or improve the theory and can lead to new hypotheses and questions about new research (Lindenfeld, 2020).

The main goal of the positivist experiment is to isolate and control the effects of all factors and examine only the most important variables of interest (for example, only that X may have caused Y). In this regard, positivist researchers are most interested in the internal validity of the study, that is, how well the design and evidence of the study accumulate assertions of causal inference. Internal validity with a focus on causality should not be confused with evaluation validity, which deals with how well a particular component (educational assessment, psychological measurement, etc.) is measured (Lindenfeld, 2020). The rigor of the positive paradigm, especially quantitative social science research, is assessed according to the degree to which researchers have succeeded in minimizing the threat to internal validity. Such threats can include the following (Lindenfeld, 2020; Park et al., 2020):

- maturity and prehistoric. Events that occur during the survey and affect the results

- measurement. How well the composition is measured (i.e., the validity of the assessment)
- statistical regression. Statistical methodology which identifies and characterizes the relationships between variables measured and framed according to central tendencies
- test effects. Test impact on subsequent measurements
- choices. Existing differences in participants
- mortality. Dropout from participants
- differences in interaction selection and maturity. Differences between various groups result in changes to the groups

Studies conducted in the positivist paradigm work to carefully monitor these threats to internal validity and develop study designs that allow control of related confounding factors (Park et al., 2020). According to positivism, ensuring internal validity and accounting for confounding factors are key to guaranteeing the rigor of the research tests. Positivism also stresses the importance of having a sufficient sample size in order to ensure power and a significant effect size. Accordingly, sufficient sample size and, in turn, power and effect size, should be determined through the use of appropriate statistical tests (Park et al., 2020). As opposed to other research paradigms that do not place much importance on having a large study sample, positivist researches believe that having a large enough sample is crucial, as it allows for the use of a statistical principle to choose the right study designs that determine a "priori virtual effect size" (Park et al., 2020, p. 691). In other words, a large sample size allows researchers to determine the actual "potential size of the difference" between the intervention group and the control group (Park et al., 2020 p. 691). The larger the sample size, the less uncertain the statistics and the more reliable the results are (Park et al., 2020).

Interpretivism

Interpretivism involves researchers to interpret the elements of research, allowing interpretivism to integrate human interests into research (Alharahsheh & Pius 2020). Correspondingly, interpretation researchers suspect that access to reality (given or socially constructed) is only through the social constructions of language, consciousness, common meanings, and means (Ryan, 2018). The development of the interpretation philosophy is based on the criticism of empiricism in social sciences (Ryan, 2018). Therefore, this philosophy emphasizes qualitative analysis rather than quantitative analysis (Pulla & Carter, 2018).

Interpretation studies are seen as ideological, related to a philosophical position, and used to summarize various approaches such as social constructions, phenomenology, and interpretation (Alharahsheh & Pius 2020). This rejects the objectivists' view that meaning is independent of world consciousness (Ryan, 2018). According to an interpretivist approach, it is important for researchers as social actors to recognize the differences between people (Alharahsheh & Pius, 2020). In addition, "interpretivist studies" are usually focused on meaning and multiple methods can be used to reflect different aspects of the subject (Alharahsheh & Pius, 2020).

Interpretivism evolved among researchers who were dissatisfied with post-positivism (Alharahsheh & Pius, 2020), feeling that the theory was too general and inadequate to reflect the nuances and variability of human interactions. Interpretivists believe that human research by humans cannot produce objective results, because researchers' values and beliefs cannot be completely removed from research (Pulla & Carter, 2018; Alharahsheh & Pius, 2020). Therefore, instead of looking for an objective perspective, interpretists look for the meaning of the subjective experience of an individual engaged in a social interaction (Pulla & Carter, 2018; Alharahsheh & Pius, 2020). Many interpretivist researchers seek to delve into the social context which they are studying, to internally understand and formulate theories about communities or groups of individuals (Pulla & Carter, 2018). Interpretivism is an inductive practice influenced by philosophical frameworks, such as hermeneutics, phenomenology, and symbolic interactionism (Alharahsheh & Pius, 2020). Methods of interpretation are used in many areas of social science, including history, sociology, political science, anthropology, and many more (Pulla & Carter, 2018).

Naturalistic Paradigm

Naturalistic research is a type of research in which a researcher observes and carefully records behaviors and phenomena, without interfering with the object or phenomenon as much as possible in the natural environment, sometimes for a prolonged period of time (Guba, 1979). In medical research, naturalistic research usually involves observing the normal activities of people, however, obviously, the presence of observers can influence everyday activities (Guba & Lincoln, 1982). The naturalistic paradigm that influences research makes several claims about how researchers understand human interactions. Naturalistic researchers understand that reality is subjective because it is diverse and socially constructed. Context interacts with human experience to create and shape human reality (Guba, 1979; Guba & Lincoln, 1982).

The naturalistic paradigm (or simply naturalism) puts forward specific propositions on epistemology (how a person knows something), ontology (the essence of human existence), and axiology (a person's values) that influence naturalistic inquiry. This paradigm assumes that there are multiple interpretations of reality, and the goal of researchers working in this perspective is to understand how individuals construct their own reality in their social context. However, one of the main criticisms of these paradigms is that they have not really evolved over time (Erlandson et al., 1993).

Health Policy Analysis

Policy analysis "is a generic name for a range of techniques and tools to study the characteristics of established policies, how the policies came to be and what their consequences are" (Collins, 2005, p. 192).

Health policy analysis is an interdisciplinary field based on economics, political science, sociology, epidemiology, and biostatistics. It aims to explain, describe, and understand how health and healthcare-related problems are understood and interpreted, as well as how policies aimed at addressing these problems are initiated, developed, implemented, and evaluated. Accordingly, health policy analysis can be used to achieve the following (Collins, 2005):

- explain how and why policy decisions are taken (or not)
- assess the impacts of these policies on individuals, populations, society, and costs
- inform and enlighten future policy decision-making

Health policy analysis can be undertaken to determine the following (Browne et al., 2019):

- Descriptive. What is happening (the present consequences of the policy), as well as what has happened (the past consequences of the policy)
- Explanatory. Why it happened
- Predictive. What the consequences of policy alternatives will be in the future, including doing nothing
- Valuative. What the value of the consequences of a particular policy is (costs, utilization, satisfaction, health outcomes, etc.)
- Prescriptive/normative. What should happen (looking ahead)

Health policy analysis can be undertaken at the clinical level, for example, to develop, implement, and evaluate clinical guidelines, at the administrative/managerial level, for example, to assess the implementation of policies such as accreditation and at the legislative level, for example, to assess development, implementation, and evaluation of banning smoking in public places (Browne et al., 2019).

A very important question to ask is "who conducts health policy analysis and where?" Health policy analysis can be undertaken through the following (Green & Thorogood, 2017):

- scholarly activity conducted in universities to understand, explain, inform, and influence policy processes
- professional activity within governments and stakeholder organizations to identify problems and develop policy solutions
- stakeholder-oriented activity to develop position statements for the purposes of influencing the policy process

The core questions of health policy analysis are as follows (Walt et al., 2008):

- What is the nature of the problem?
- What is the policy trying to achieve?
- How shall the policy go about addressing it?
- How will we know if the policy has been have been successful or not?

The seven steps to conduct health policy analysis are as follows (Fischer et al., 2017; Morgan, 2017; Weimer & Vining, 2017):

1. Define the context/state the problem
2. Analyze the actors/stakeholders
3. Develop policy options (look at the context—how much does it align with the "rules of the game," public acceptance etc.)
4. Project the outcome and potential impact (cost, benefit, etc.)
5. Apply evaluative criteria

6. Evaluate and weigh the outcome
7. Make decisions based on the evidence

1. Define the context/state problem

In the first step it is important to be specific when defining the nature of the problem and determining who the affected population is (Bacchi, 2016). Then one must look at historical evolution in order to comprehensively study the context, which in turn will make it easier to analyze the causes (Leichter, 1979; Bacchi, 2016), which may be analyzed through root-cause analysis.

2. Analyze the actors/stakeholders

In this step all the possible actors that have a stake in the policy at hand are analyzed. After analysis, their levels of interest and power are identified and plotted on the power/interest grid to determine how best to manage and engage with them (Leichter, 1979).

3. Develop policy options

In this step, best practices and benchmarks are compared and contrasted. At this stage it is important to solicit the input of stakeholders as consensus starts building and gain the support of the stakeholders who would facilitate things going forward (Dunn, 2017). Examples of approaches include incentives, information, and offering new programs.

4. Project the outcome and potential impact

In this step, the outcomes and potential impact of the policy are assessed in terms of the benefits for the population and community (such as health outcomes), cost, ethics and equity, administrative and organizational feasibility, and the perspectives of various stakeholders (El-Jardali et al., 2014; Gilson et al., 2018).

5./6. Apply evaluative criteria/Evaluate and weigh the outcome

In this step a decision matrix is developed based on specific criteria set forth by the researchers. The decision matrix is a table that helps visualize the clear winner between various options. To create a matrix, determine the criteria that are important to the final decision and assign weights to each criterion (Campos & Reich, 2019), as shown in the example below.

Table 8: Decision Matrix

Criteria (relative weight)	Policy option 1 (Score 1—10)	Policy option 2 (Score 1—10)
Population benefit (---)		
Cost (---)		
Ethics/equity (---)		

Criteria (relative weight)	Policy option 1 (Score 1—10)	Policy option 2 (Score 1—10)
Organizational		
Feasibility (----)		
Stakeholders		
Total		

Source: Mirna Naccache, based on Agency for Healthcare Research and Quality (2009).

7. Make decisions based on evidence

In this step, a decision is made based on the best option presented in the decision matrix. After the decision is made, it is shared with the stakeholder. Following this step, the policy must be advocated for, then implement and evaluated (McLaughlin & McLaughlin, 2014).

Table 9: Example of How to Use the Decision Matrix

Scenario: Policymakers want to develop a policy to decrease the prevelance of smoking among youth.		
Criteria (relative weight)	*Policy option 1: Increase taxation on tobacco products (Score 1—10)*	*Policy option 2: Eliminate access of youth to tobacco products through asking for ID etc. (Score 1—10)*
Population benefit	10	10
Cost	5	8
Ethics/equity	6	6
Organizational	7	7
Feasibility	8	6
Stakeholders	8	9
Total	44	46

Source: Mirna Naccache, (2022).

Based on the above matrix, the second policy option may be considered to be the better option.

3.3 Limitations

Despite all the information already mentioned about the importance of the use of the best evidence in policymaking, as well as the various types and sources of evidence, it is important to note that there are limitations.

Unavailability of the Evidence Needed

In some cases, the best evidence needed for the formulation and implementation of a specific policy may not be available. This is especially true when it comes to implementing new management techniques and technologies (Malekinejad et al., 2018). In such cases, scientific knowledge is (as yet) unavailable and often contains too little organizational data to draw credible and valid conclusions, disrupting the policymaking process and reducing the chances of favorable outcomes (Malekinejad et al., 2018). Similarly, another limitation is that the current management environment is changing more rapidly than ever before. This limits the relevance and applicability of scientific and empirical knowledge generated in any policymaking context other than the current day (Pfeffer & Sutton, 2006). In these cases, there is no other choice but to look at the evidence already present and treat the policy at hand as a prototype in terms of what may and may not work (Pfeffer & Sutton, 2006). An example of this limitation can be seen in the early days of the COVID-19 pandemic, when there was little evidence on how to best deal with such a crisis, resulting in governments and policymakers across the world not knowing what to do in order to minimize it (Cairney, 2021).

Knowledge and Skill Gap among Policymakers

Another significant limitation is that many policymakers need to develop new skills to find and evaluate evidence, which takes a lot of time and effort. Without these skills, policymakers tend to be limited due to confirmation bias, meaning they only see evidence to support their personal experiences and judgments. In addition, most policymakers lack the research skills to understand scientific evidence and scientific or pure medical terminology. In general, this is due to fact that scientists and policymakers come from very different backgrounds and work environments/cultures (Cairney & Oliver, 2017).

Biases of the Evidence

Research bias occurs when a researcher, intentionally or unintentionally, biases the entire process towards specific research results by introducing systematic errors in the sample data. In other words, it is the process by which a researcher manipulates systematic research to achieve a particular result (Pannucci & Wilkins, 2010).

Design bias

Conflict of Interest

One of the problems often associated with scientific evidence and its subsequent use in policy or decisions making at any level is conflict of interest. The definition of conflict of interest is not consistently defined, but it relates to concerns that competing interests can affect research methods and the interpretation of data and conclusions. Conflicts of interest in research mainly occur when it is perceived that the obligations and responsibilities of a researcher are prioritized over one's own interests and obligations. Conflicts of interest can be realistic, potential, or perceived and can be related to both monetary and non-monetary interests (Romain, 2015).

In extreme cases, conflicts of interest can contribute to scientific misconduct, hinder the training of scientists, delay the dissemination of research results, impair human health and the environment, and mislead social scientific decisions (Resnik, 2007). Government-sponsored research, whether directly and indirectly, is a major source of government input for policymaking. Nevertheless, a government agency's perceived preference for a particular type of study has a significant impact on how the study is conducted and may lead to biased results. Policy researchers have built research capabilities that enable them to provide results on perceived priority topics for governments. But again, the topics and formats are usually influenced by priorities of the donor (in this case the government; Resnik, 2007).

Correspondingly, when research is funded by private donors, such as pharmaceutical companies, there is further concern regarding potential conflicts of interest and their effects on the evidence produced and its quality. Nevertheless, privately funded and sponsored clinical research is extremely necessary because the involvement of non-governmental, privately owned organizations allows researchers access to resources (money, equipment, technology, etc.) otherwise unavailable through government funding (Resnik, 2007).

There are several ways to mitigate conflicts of interests, including obliging researchers to disclose any conflicts of interest in their publications and implementing effective management strategies to minimize their development (Resnik, 2004). However, conflicts of interest remain a valid concern and a possible limitation in the use of research in policymaking.

Relationship between Researchers and Policymakers

The relationship between researchers/scientists and policymakers has historically been a "complicated" relationship, which is subject to a permanent paradox (Gollust et al., 2017). Policymakers are constantly seeking empirical data, evidence, facts, and authoritative explanations on which to base their policies in order to justify their decisions based on scientific evidence (Gollust et al., 2017). However, the communication between researchers and policymakers is almost always limited to the communication of evidence by researchers, leaving the explanations, interpretations, and judgments associated with the policy process to the policymakers. In addition, the literature clearly highlights that the use of evidence in policymaking is limited (Gollust et al., 2017; Uzochukwu et al., 2016). This "gap" between research and policy/politics can be traced back to the gap of communication and understanding between these two parties, which renders a lot of research pointless and purposeless (Uzochukwu et al., 2016).

SUMMARY

Evidence-based policymaking (EBP) is the notion of all policy decisions being based on or supported by rigorously established and objective evidence. EBP emphasizes the use of rigorous, objective, and comprehen-

sive scientific knowledge as the basis for policymaking and is believed to be most the useful in terms of achieving goals, as opposed to relying on idealism and intuition.

The two main sources of evidence are formal sources and informal. Formal sources encompass all sources that go through an extensive and rigorous review, assessment, and revision process before they are published. These sources are derived from quantitative research methods, such as descriptive, correlated, or experimental research, and qualitative research methods, such as research that focuses on understanding concepts, opinions, or experiences. Mixed methods research utilizes both quantitative and qualitative methods within the same study in order to obtain more comprehensive research results. The other source of evidence is informal sources, whose credibility and authority are difficult to establish. These include grey literature, open-source websites, blogs/social media posts, podcasts, letters/emails, and videos on social media platforms. The credibility and the quality of evidence can be assessed and plotted on the hierarchy of evidence.

A paradigm is the basic theoretical method for observing and understanding the world and is important in defining the methodology adopted by researchers. Traditionally, positivist paradigm and naturalism are the two dominant yet opposite paradigms. Positivism, or experimental paradigm, refers to scientific and thus quantitative research. The naturalistic paradigm is usually associated with specific areas of sociology and social sciences and is consistent with the use of qualitative methods.

There are several limitations to EBP. These include the unavailability of the evidence needed, evidence biases, conflicts of interest, and the complicated relationship between researchers and policymakers.

UNIT 4

THE ROLE OF INTEREST GROUPS

STUDY GOALS

On completion of this unit, you will be able to …

- define the key terms related to interest groups.
- discuss the idea of pluralism.
- describe interest groups, as well as their various types, functions, impacts, and influences.
- summarize the role of civil society in health, health advocacy, and health policy, as well as its relationship to the state.
- understand the role of private sector interest groups and lobbying in the policymaking process.
- discuss public-private health partnerships, their role, how to adopt them, their common features, and their disadvantages.

4. THE ROLE OF INTEREST GROUPS

Introduction 

This unit will discuss interest groups as one of the main stakeholders in the health policy-making process. It will delve into the concept of pluralism and discuss the different types of interest groups and their functions in society. The first section will also cover the relationship between interest groups and government, its impact, and which interest groups are most influential, followed by the role of civil society groups in the health policymaking process, an emphasis on non-governmental organizations. Furthermore, the roles, types, and interests of private sector interest groups will be described, and the concept of lobbying explained, before finally explaining public-private health partnerships, their features, adoption, and disadvantages.

4.1 Types of Interest Groups

In health policy, stakeholders are those who are integrally involved in or influenced by the healthcare system and who will be significantly affected by system reforms or changes (Paprica et al., 2015). Therefore, stakeholders can be healthcare providers (doctors, pharmacists, nurses, nutritionists, midwives, physiotherapists, etc.), patients, patient families, governments, non-governmental organizations, or the private sector (including pharmaceutical companies, privately owned healthcare institutions). Basically, everyone is a stakeholder when it comes to health policy. Interrelationships between actors in the healthcare system, and thus between healthcare policies, are very complex as different actors have different interests and different levels of influence and power in relation to their policies (Paprica et al., 2015).

Even though governments and governmental policymakers are at the heart of the policy-making process, governments often consult with external groups about issues and to gather information. In return, these groups seek to influence ministers and officials. In most countries, an increasing number of pressure groups, more commonly known as interest groups, are trying to influence how governments think about policy and service delivery (Daly et al., 2020).

There is a wide range of interest groups, including community-based, religious, industry, and philanthropic groups, to name a few. These groups use a variety of tactics, such as building relationships with powerful policymakers, media mobilization, establishing formal debates, or providing criticism of government policy to the political opposition (Daly et al., 2020). Some stakeholders are far more influential than others. When it comes to health, medical professionals remain the most significant non-governmental interest group in most countries (Daly et al., 2020). However, the internet age has altered this, as the patient-physician relationship has changed, resulting in physicians having less influence on patient behavior in general (Gerber & Eiser, 2001). However, their influence on health policy continues to be significant (Daly et al., 2020).

Key Definitions

When discussing the topic of stakeholder and interest groups there are several key definitions that needs to be explained, such as interest groups, civil society, and discourse (cognitive) community. The main goal of interest groups is to promote interest or put pressure on the government regarding specific issues and problems. Interest in this case may denote a particular point of view, ideological, social, or political ideals, economic gain, or power. Accordingly, two groups can be active in the same context, but represent different points of view. For example, patient interest groups provide patient-oriented education, advocacy, and support services, working mainly in the context of healthcare organizations, while hospital interest groups work in the same context but have different points of view when it comes to patient care (Rose, 2013).

To start with, civil society is considered a type of interest group and can be defined as a group or organization beyond the family/household and external to the government. Civil society may or may not be involved in public policy (for example, sports clubs are considered a civil society organizations; Buse et al., 2012) and pressure groups are generally not considered a part of civil society (Murphy, 2012). Discourse (cognitive) community is a policy community marked by common political values, and a common understanding of the problem, its definition, and reasons, whereas internal (governmental) groups are interest groups that pursue strategies aimed at gaining and improving their status (Murphy, 2012). They are legal participants in the policy process. Interest (or pressure) groups are a type of civil society group that tries to influence policy (Buse et al., 2012), the process of achieving a specific goal being part of the policy process. Consequently, interest networks are policy communities that are established based on common goals and interests (Kogan, 2018).

Various other interest groups include the following:

- interest networks. These are small, stable, and exclusive policy communities, usually involving administrative staff, institutions, legislative committees, and interest groups (such as defense procurement) (Maloney et al., 1994, as cited in Buse et al., 2012).
- distribution networks. These are considered to be loose, unstable networks composed of a large number of members, usually playing an advisory role in the policymaking process (Maloney, et al., 1994).
- non-governmental organizations (NGOs). Essentially any not-for-profit, non-governmental organization (Buse et al., 2012). The term NGO is now increasingly being used to refer to structured organizations that provide services (Tallberg et al., 2018).
- policy communities (subsystems). These are relatively stable collections of individuals and organizations participating in an identifiable part of broader public policy, including health policy. Each area of health policy contains identifiable subsystems, such as mental health policies, and their own policy communities (Buse et al., 2012).
- sectional groups. These are interest groups whose main goal is to protect and improve the interests of the society/population they represent (Richardson, 2000).
- social movements. These are comprised of groups of people sharing specific points of views. Accordingly, they try to influence the points of views of others, but they have no formal organizational structure. Notable examples of civil rights movements include the American civil rights movement, feminism, the LGBTQ+ rights movement, and environmentalism (Burstein & Linton, 2002).

Stakeholder Management

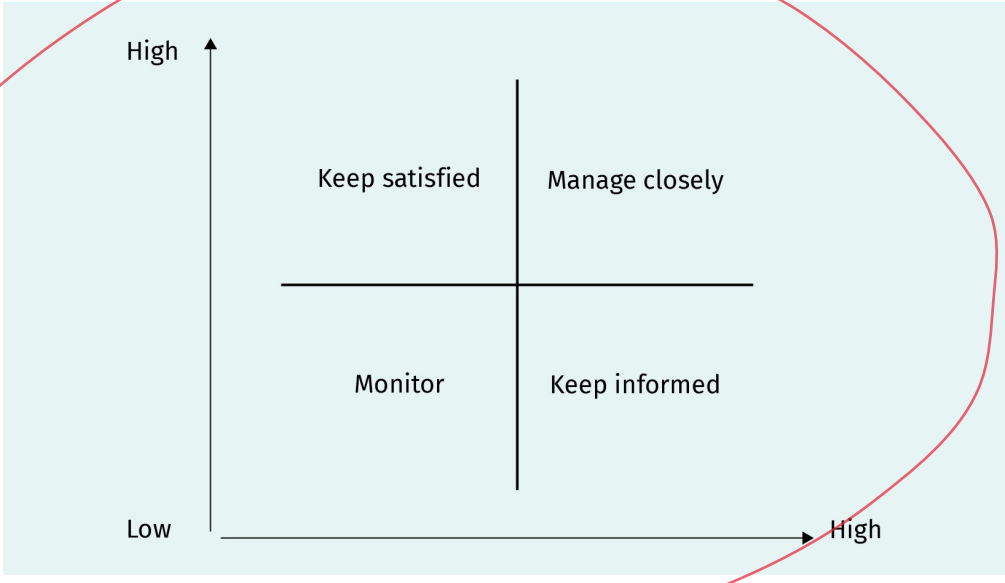
The process of identifying stakeholders begins as soon as the policy process starts. Stakeholder identification is an ongoing process. As the policy process progresses, new stakeholders may be identified and added to the policy, but some previously identified stakeholders may lose interest (Pedrini & Ferri, 2019).

After the identification process has been initiated, a stakeholder register should be created. This is a document describing the stakeholders of a particular policy, their interests, impacts, and impact on the policy (Eskerod & Jepsen, 2013; Pedrini & Ferri, 2019). Ideally, stakeholder registrations should be completed early in the policymaking process to ensure proper stakeholder involvement and control (Pedrini & Ferri, 2019). Stakeholder registrations typically contain the following information: name, title, role, authority, interests, type of impact, requirements, expectations, contact information, and communication needs/frequency. Stakeholders can be identified through looking at existing documents, benchmarking, interviews with experts, and brainstorming sessions (Eskerod & Jepsen, 2013). In addition, it is important to pay attention to stakeholder attributes, as the power and interests of the stakeholders can change over time (Pedrini & Ferri, 2019).

Power/interest grid

The most widely used tool in stakeholder management is the power/interest grid. This is a matrix used to classify stakeholders in the policymaking process to effectively manage them. Before using this tool, all stakeholders involved in the policy process should be identified. Stakeholders draw on the grid based on their power and interest in the policy being developed.

Figure 10: Power/ Interest Grid



Source: Mirna Naccache, based on Mendelow (1981).

The figure above explains the different approaches that should be taken for the isolation and subsequent prioritization of the identified stakeholders. Stakeholders with high power and high interest in the policies being formulated, discussed, implemented, or evaluated are usually decision makers and have the greatest impact on the success of the project, so their expectations must be closely managed.

Stakeholders with high power but low interest in policies should remain in the loop. These stakeholders need to remain satisfied, even if they are not interested, as they generate power. Such stakeholders should be treated with caution, because if they are dissatisfied, they may use their power to influence policies in a negative way, such as hindering the formulation and/or implementation of policies.

Stakeholders who have low influence on policies but are interested in policies should obtain sufficient information in a timely manner. These people are usually very helpful in the policymaking process. Regular communication is essential to ensure that no major issues arise. Finally, stakeholders with both low power and low interest in policies should be monitored.

Once that is done and the stakeholders are categorized into one of the four power/interest categories, it is important to determine how best to get strategically involved and maintain the continued support of each of those stakeholders. Some helpful questions to assist engagement with stakeholders and determine their support include: What motivates these stakeholders? Which priorities do they not endanger? Could this stakeholder be positive about the policy? If not, what can be done to change their perception? After the stakeholder type profile is created, the next step in the stakeholder management process is to create a stakeholder communication plan.

Pluralism

The theory of pluralism is a theory that "power is widely dispersed throughout the society, so that no group has absolute power" (Buse et al., 2012, p.101). Pluralists have been successful in their ability to shed light on national arbitration thinking between competing interests and groups when formulating policies (Eck, 2006). As a result, they have focused on the notion of interest groups in order explain how the policy is formed (Eck, 2006). They believe that, even though there are "elites or elite groups" in such a powerful institution, no "elites or elite groups" dominate at all times (Eck, 2006; Eklund, 2009). Additionally, researchers have emphasized that sources of power, for example money, expertise information, and professional knowledge, are unequally distributed (Eck, 2006; Eklund, 2009). Although this may be generally considered true when it comes to conventional policy issues ("low-level politics"), pluralism has come under criticism for neglecting to pay attention to the fact that major "high-level politics," such as economic decisions, are often dominated by a small, elite group, whose aim is to protect existing economic systems (Hassan, 1986). In this context, pluralism is clearly "limited," as interest groups that wish to replace the capitalist economic system of with a socialist economic system will most likely not be invited to participate in the policy process (Buse et al., 2012).

Pluralists have also been criticized for failing to recognize significant differences between countries, especially in many low-income countries, where until recently there was little evidence of national interest groups putting pressure on governments and opening up the policy process to non-government influence (Hassan, 1986; Buse et al., 2012). Traditionally, in low-income countries, external governmental influence has often come from personal and family relationships, in which ministers and officials are expected to use their positions to improve the situation of certain members of their families or tribes (Hassan, 1986; Eklund, 2009; Buse et al., 2012). However, in the 1980s and 1990s, there was increasing evidence of interest group activity in low-income countries (Hulme & Edward, 1997). When compared to the role of interest groups in high-income countries, one can see that they have been playing a significant role in the policy process for a very long time (Hulme & Edward, 1997).

For example, the number of NGOs has grown exponentially in Africa (Matthews, 2017). South Africa alone is home to more than 100,000 registered NGOs, while in Kenya the number of NGOs between 1997 and 2006 was shown to have increased by more than 400 percent (Matthews, 2017). Part of this growth is due to the lack of authoritarian and elitist government action in many countries, which helps NGOs achieve political and institutional reforms in the provision of services. This is due to donor organizations' growing awareness about their role in encouraging governments to take greater responsibility for their citizens (Hulme & Edward, 1997, as cited in Buse et al., 2012). As a result, donors have made more money available to these organizations in low-income countries (Hulme & Edward, 1997, as cited in Buse et al., 2012). In the AIDS field, for example, in 2004 Nigeria received about 90 million USD from the World Bank (Smith, 2021). Most of this money has gone to NGOs to support them in the provision of AIDS services and put pressure on governments to improve access to anti-retroviral medication for treatment and prophylaxis (Smith, 2021).

Interest Groups

"Interest group" is just another term for "pressure group." Although there are differences in the definition of interest group, most authors would agree with the following three characteristics (Langguth, 2019):

1. Voluntary-individuals or organizations choose to join them
2. Aims to achieve certain expected goals
3. Does not try to infiltrate the decision-making process, but rather is considered a contributor to the formal policymaking and governmental process

Pressure groups do not aim to gain formal political power, unlike political parties which, along with interest groups, people can join voluntarily and are goal–oriented, with the main aim of gaining political power (Langguth, 2019). Yet sometimes pressure groups may evolve into political parties, and then participate in policymaking within the government (Dudley & Richardson, 1996). For example, the German Green Party was originally an environmental pressure group, but most were in organized groups outside the government, even if some had very close relationships with the German government (Langguth, 2019).

Self-reflection/discussion

Regarding health policy, make a list of groups that could be classified as "interest groups."

Different Types of Interest Groups

Interest groups are classified by political scientists into a number of "analytical types" (Buse et al., 2012). Two of note are sectional groups (sometimes referred to as sectoral groups) and cause groups (Hopkins et al., 2019). The protection and promotion of the interests of its members and the social groups they advocate for are the primary aim of sectional groups, while a cause group's primary purpose is the promotion of a specific topic or cause. Cause groups have open membership, whereby anyone who believes in and supports the cause can join, without any goal of personal gain if the cause is successful (Hopkins et al., 2019).

Examples of sectional groups are unions and employees' organizations, as well as professional bodies (Hopkins et al., 2019), while examples of cause groups include human rights and environmental protection groups. Broadly speaking, section groups tend to represent the interests of production and industry. For example, healthcare workers, such as doctors and nurses, increase the likelihood that the group will claim the interests of consumers. A cause group stands for a cause, such as general patients' rights or people with a specific illness like multiple sclerosis, however, this distinction is not always so clear. For example, organizations that represent people with disabilities can be considered both sectional and cause groups, because such groups want to improve the position of people with disabilities, while standing for both their own interests and those of the people with special needs or disabilities. Sometimes members of section groups join the group not for reasons of personal or self-interest in the cause at hand, but rather because they believe in the underlying principles and support the cause. For example, individuals with right-leaning political ideologies wanting to protect the freedom of people who smoke in public may join a sectional group that is working on allowing people to smoke in public, not because they themselves are smokers or want to smoke in public, but rather because they believe that personal freedoms should not be interfered with by anyone, including governments (Hopkins et al., 2019).

Sectional groups

Sectional groups can usually negotiate with the government, as they usually play an important role in the country's economy. Their influence and role within governments is heavily dependent on how important the government considers their role to be. It is worth noting that this influence can be magnified due to their immense resources, allowing them to have more influence or power than expected. Sometimes if these groups do not like a governmental policy, they can challenge it. An example of this is public sector organized unions, which can ask their members to go on strike or withdraw from the their workforce, which would risk harm to both the economy and the government's reputation, as well as the withdrawal of financial support for political parties (mainly left-leaning parties). Clearly, the power of interest groups like unions depends on factors such as economic structure, wage structure, and number of unions. One example of this is the fact that it is more difficult to organize workers that work in small firms (even if there are many

workers), compared to workers in large firms, who are easier to organize in labor unions, even if they only have a small number of workers. This is because unions have less power and influence when negotiating in a decentralized system compared to a centralized one (Grant, 1984).

Media (both mass media and internet-based media) can be seen as a special form of interest group that sets the agenda to maximize profits and plays a particularly important role in selling services. This can be attributed to the close contact that many media outlets have with the government. Such outlets tend to have the greatest impact, while other media outlets and interest groups are generally less impactful and influential, mainly because their importance during the policy implementation is low (Grant, 1984).

In health policy, medical professions have traditionally been regarded as dominant positions, because they manage the delivery of healthcare services and play a major role in formulating health policies. In high-income countries, physicians have long been able to regulate and manage their routine clinical practice. Whereas the roles of other healthcare professionals, particularly nurses (whether registered nurses or practical nurses), have traditionally been dependent on the consent and approval of physicians (Grant, 1984). Furthermore, historically they have never been perceived as acting independently, but rather their role in healthcare organizations has been primarily seen as one offering support to physicians. In the minds of the general public, medical professionals at the individual, local, or national level are highly regarded and considered a reliable source of health advice (Grant, 1984).

The health system has always favored and catered to the preferences and interests of medical professionals. For example, in the United Kingdom (UK), the refund and reimbursement rates for the NHS are closely linked with the contracted payment rates for individual healthcare providers (Allsop, 1995). However, since the 1980s, there have been important multi-layered structural changes that have challenged the privileged status of medical professionals. In the 1980s and 1990s, all these challenges were found in the policies set forth by the conservative UK government. This government not only introduced aggressive policies like the NHS's "single market" policy, which was widely rejected by healthcare organizations, but also succeeded in 1991 in dividing the profession, thereby weakening its abilities. One example was the 1991 internal market reform, wherein general practitioners were given the choice to maintain their budget for patients' voluntary hospital care and drug costs. This became difficult for the union to oppose because a significant number of practitioners wanted this (Allsop, 1995).

It is clear from an examination of policy trends that the interests of medical professions have lost some of their influence in high-income countries due to a loss of clinical autonomy, as well as the loss of a major part of their monopoly on service delivery (medical professions previously had clinical autonomy on how they offered clinical services; Johnson, 1995, as cited in Buse et al., 2012). However, they still have a lot of influence on health policy, as the medical professionals and institutions for which they speak are still considered pillars of health systems and an important resource in their success (Johnson, 1995, as cited in Buse et al., 2012).

Unlike in high-income countries, professional unions and associations do not exert influence when it comes to health policy in many low-income countries (Walt, 1994). This is attributed to the fact that the provision of public and publicly paid healthcare services (including prevention activities) are generally carried out by community health workers and nurses in health community centers, public hospitals, and primary care centers. In these countries, doctors tend to serve the small urban elite (who can pay—either out of pocket or via insurance) primarily through private practice. Accordingly, doctors have influence over the public health policies of these countries, but primarily as civil servants of the Ministry of Health, represented by the Minister of Health, rather than by serving through medical unions and associations (Walt, 1994).

Cause groups

Cause groups are intended to promote topics that are not necessarily specific to their members themselves, but which could be topics of interest to them (Buse et al., 2012). A concrete example of this would be people living with AIDS, who can form interest groups to shape policies related to this disease directly, as it personally affects them. People from a wide of backgrounds and beliefs can unite into an organization, such as Greenpeace, which aims to protect the environment and wildlife conservation (Suciyanto, 2016), Amnesty International, which works to shed light on human rights violations, or Médecins Sans Frontières/Doctors Without Borders, which works around the world in conflict zones to offer humanitarian interventions (Samarasekera, 2021).

Generally, cause groups are thought be formed spontaneously through individuals acting based on their values and beliefs (Petracca, 2018). However, it should be noted that some these cause groups are in fact "front" groups set up by large corporations and enterprises to introduce their points of view into civil society debates in a seemingly more compelling and endearing way (Petracca, 2018). The public relations arms/offices of large companies and corporations believe that their message is much more likely to be heard by the general public when they are clearly represented by a seemingly unconnected group of interests. For example, the Global Climate Coalition fought against the 1997 **UN Framework Treaty Kyoto Protocol Climate**, however it was not immediately apparent to the general public that the funding of this coalition was provided by the automotive and oil industries (van der Gaast, 2017). Another example could be the tobacco industry, because in many countries across the world they actively fund libertarian organizations to stand against government regulations by emphasizing the fight for the rights of smokers to smoke freely wherever they want (Hook & Rose Markus, 2020).

UN Framework Treaty Kyoto Protocol
This was an international treaty to expand the United Nations Framework Convention on Climate Change (UNFCCC) in 1992, based on the scientific consensus of Global warming and requiring countries to reduce greenhouse gas/artificial CO2 emissions.

Similarly, food production and related industries fund what appear to be independent and objective research institutes, such as Sugar Research Organization and the International Life Sciences Institute and the World. This in turn may impact the research generated, leading to biases in the research results, as well as the fact that such institutes have the ability to quash unfavorable research findings, not to mention publish misleading information (Steele et al., 2019).

Over the last 25 years, the number of members of interest groups in Western countries has increased, while political party membership has declined (Gillette, 1983). Political scientists argue that this is due to growing disillusionment with traditional left and right parties

and the apparent distance of elected representatives even in democratic regimes, especially with regards to young people. This is also the result of the fact that many people believe that traditional political parties have mostly ignored large issues that affect them, such as climate change, or deemed them unimportant (Gillette, 1983).

Self-reflection/discussion

What are the key resources that stakeholders need to make a difference? What do they want? Think of as many different stakeholders as you know, then write down their resources and potential attributes (Buse et al., 2012).

Internal and External Interest Groups

It is also possible to analyze interest groups according to the degree of government recognition or legalization related to the group's strategies and goals. Grant (1984) points out that there are two basic categories in this regard—internal and external groups. An internal group refers to a group that has not formally become a part of a governmental agency, but is regarded as legal by the government, and regularly consults and abides by the "rules of the game." For example, if they agree to participate in any governmental committee, they have to abide by the principles of confidentiality and refrain from sharing anything related to the discussions until the ministers say otherwise or give the green light to share information on the policy direction (Grant, 1984). Internal groups therefore participate closely in the development of policy ideas in their respective fields. When it comes to health policy, experts and expert groups like nursing and doctors' associations are usually consulted or sometimes directly involved in political development, even if they do not always get their way (Grant, 1984). For example, in the UK, the Association of the British Pharmaceutical Industry (ABPI) has "insider status" with the Ministry of Health, as the Ministry and, therefore, the government strives to promote the pharmaceutical industry in the country, while ensuring that medications are safe, effective, and made available to patients as soon as possible (Buse et al., 2012; Mulinari & Ozieranski, 2018). The ABPI, senior officials, and ministers hold regular meetings to discuss government regulations related to medication and prices of medication (Mulinari & Ozieranski, 2018).

In contrast, external or outsider groups are either organizations that refuse to participate closely in government processes for strategic reasons, or they are do not have a reputation as legitimate participants in the policymaking process (Grant, 1984).

~~The best~~ An example of an outsider group in contemporary health are anti-abortion groups, ~~due the fact that their views are fierce and they have the reputation to back it up, especially if they~~ who are known to take action against abortion clinics and other related centers and clinics (Grant, 1984). Similarly, one very famous group is Billboard Utilising Graffitists Against Unhealthy Promotions (BUGA UP), which was established in Sydney in 1979 and it is known to take direct action by destroying (albeit illegally) outdoor advertisements of products deemed to be unhealthy, particularly those related to tobacco and alcoholic beverages (Chapman, 1996). Its strategy is to change tobacco and alcohol advertising in order to ultimately reduce harm on the population (Chapman, 1996).

Over time, the strategies followed by interest groups may change (Buse et al., 2012). Greenpeace is one example of this, as at their inception, the organization used direct action to draw attention to environmental protection problems. It famously disrupted and mostly put a stop to the activities of whaling ships (Susanto, 2017). Recently, this has changed, as Greenpeace has adopted a less public and confrontational strategy, choosing instead an advocacy strategy fully based on sound scientific evidence. In this process, the group formed a closer relationship with some governments around the world, although it may not be regarded as a complete internal group (Susanto, 2017). Those groups that change their strategy or position are called a threshold group (Chapman, 1996). Research on the evolution of policies on HIV/AIDS clearly highlights how outsider groups played a major role in bringing attention to the AIDS epidemic in the UK, as well as in the United States of America (USA; Seckinelgin, 2002, as cited in Buse et al., 2012). Additionally, research also shows how they used their expertise and knowledge of the illness to put pressure on governments to take the epidemic seriously (Seckinelgin, 2002, as cited in Buse et al., 2012). As circumstances changed, some of these organizations became more involved in the provision of policies and services and were able to achieve insider status. In many cases, outsider groups become insider groups by being responsible for providing services paid for by governments or international donors. History can repeat itself in low-income countries that emphasize outsider groups, such as with South Africa's therapeutic behavior groups. They continue to talk about how pharmaceutical companies benefit from AIDS medications and are pressing to stop importing cheap, government-licensed generics (Seckinelgin, 2002, as cited in Buse et al., 2012).

Self-reflection/discussion

Look up information about interest groups that operate in the health sector (for example, those that operate in an area of health interests you). Then try to understand their strategies, their activities, and whether or not they are viewed as insiders, outsiders, or threshold groups (Buse et al., 2012).

What Do Interest Groups Do?

In summary, different types of interest groups reflect the range of functions that society can perform. Peterson (1999) states that stakeholders perform seven functions in society, as follows (Peterson, 1999, as cited in Buse et al., 2021):

1. Participation. Elections in democratic countries are a reasonably rare and indirect method of citizen participation in public issues, interest groups provide voters with another way to participate in politics and register their opinions with politicians.
2. Representatives. Policymakers take into consideration the points of view of different interest groups, which usually expands the range of opinions considered when formulating and implementing policy.
3. Political education. Offering members the means to understand politics through providing political education.

4. Motivation. Shedding light on new issues by bringing them to the attention of governments and the public at large. Stakeholders can also share more information with governments to encourage them to look at problems differently. In some cases, interest groups also assist in the formulation of new policy through scientific and political activities.
5. Mobilization. Putting pressure on governments to support and implement new policies (for example, by stimulating media interest in a topic).
6. Monitoring. Through increased evaluation of both the behavior and performance of governments, interest groups can contribute to the public holding leaders accountable, checking whether political commitments have been upheld. Interest groups have also been known to hold private companies and multinational corporations accountable for their actions when governments fail to do so.
7. Provisioning. Using their knowledge to provide services with or without governmental funding support (for example, missionary organizations).

These groups are also increasingly involved in conducting or commissioning scientific research, providing technical advice, and implementing or threatening legal action against governments and multinational corporations (Peterson, 1999, as cited in Buse et al., 2021). For example, in a proceeding against the South African government, local and international civil society organizations played an important role in forcing it to compromise on the principle that anti-retroviral drugs should be widely available (Hoen, 2011).

Relationship between the State and Interest Groups

Researchers note that when it comes to health policymaking, individuals and organizations that have interests, expertise, and knowledge in the respective health field play a major role in putting certain issues on governmental agendas (Paprica et al., 2015). Consequently, in some health policy issues, a wider range of actors/stakeholders may be involved. Who participates, for which reasons, and how their relationship is constructed, have been the subjects of many studies (Paprica et al., 2015). These studies have been called "problem networks," "policy networks," "policy communities," and "policy subsystems" at different times (Peterson, 1999).

The definition and classification of interest groups can be unclear and lead to confusion (Marsh & Rhodes, 1992). A simple way to differentiate between formal and informal relationships, and between government and non-governmental stakeholders, is to identify the different policy subsystems or communities with which they interact. In the simplest case, a policy subsystem or community is an identifiable subsector of public decision-making (Marsh & Rhodes, 1992). For example, in health policy, the formulation of reproductive health policy is completely different from healthcare financing policy, and they both involve different stakeholders and actors (Omar et al., 2010).

Some subsystems are part of what is known as "iron triangles," which are quite stable yet highly exclusive relationships between politicians/policymakers, bureaucratic, and commercial interests (Omar et al., 2010). A good example of this is defense procurement, whereby the military (end users), the government and the suppliers or weaponry form an "iron triangle." Other subsystems are generally larger (more entities are involved), more fluid, and the boundaries are not clear (for example, family policies; Shankardass et al.,

2018). The challenges of the 1980s led to a shift in the British medical profession's role in health policy from a closed policy community to a more open one (Hutchison et al., 2011). The number and space of groups representing users, even consumer groups, are still relatively small compared than the professional groups (Hutchison et al., 2011).

Marsh and Rhodes (1992) distinguish between policy communities, which they consider highly integrated networks characterized by relationship stability, exclusive and narrow interests, and long-term sustainability, and "issue networks," which play an advisory role in policy development and are characterized by unstable networks made up of a big number of participants seeking mutual benefits (Marsh & Rhodes, 1992).

The main point of the policy community is that there is continuous interaction between the formal and informal networks of relationships between participants (Lewis, 2005, as cited in Buse et al., 2012). In relation to health policy, organizations and individuals include practitioners (medical professionals), end users (patients), the general public, researchers (laboratories, academia, social sciences etc.), commentators (journalists and policy analysts), companies (pharmaceutical corporations, medical equipment manufacturers), healthcare organizations (private and public hospitals and clinics), insurance companies, governments, decision makers (politicians), and organizations (both local and international). These groups tend to participate in the policymaking process to varying degrees, depending on the problem participants (Lewis, 2005, as cited in Buse et al., 2012).

The policy community is not necessarily a mutually agreed network between participants. Increasingly, health policy communities in high-income countries are characterized by conflicts between powerful interest groups representing providers and specific communities and governmental participants (Lewis, 2005, as cited in Buse et al., 2012). These groups can also have a comparative advantage in bridging the gap between the general public and policymakers.

Within a policy subsystem or community, the following two motivations guide the actions of those groups that are involved in policy development and formulation (Howlett & Ramesh, 2003):

1. Knowledge and expertise
2. Material interests

Therefore, discourse community membership (also referred to as the "epistemological community") is formed by general politics with a general understanding of values and problems, their definitions, and their causes (Howlett & Ramesh, 2003). This community is usually characterized by disagreements about policy options and responses. "Networks of interest" are based on common and important concerns (Howlett & Ramesh, 2003). Both the discourse community and interest networks operate as part of the health policy subsystem because their interest and ideas play a role in policy formulation (Howlett & Ramesh, 2003). If the discourse community and network of interests are stable, cohesive, and thoroughly linked, policy subsystems have difficulty accessing new policy options. A common understanding of the nature of policy issues and the subsequent range of possible solutions, once established, are difficult to change (Howlett & Ramesh, 2003). An

example of the discourse community is People for the Ethical Treatment of Animals (PETA), an organization committed to ending animal cruelty in business and society and facilitating consideration of animal interests in daily decision-making and general policies and practices (Cherry, 2016). An example of an interest network is the Medicines for Malaria Venture, whose mission is to reduce the burden of malaria in endemic countries through the discovery, development, and supply of new, effective, and affordable antimalarial drugs (Hentschel & Itoh 2003).

Interest Groups and their Influence

In general business interest groups (like big pharmaceutical companies), followed by labor interest groups (like physicians' associations) are considered the most important interest groups in most areas of public and health policy. This is because both capital and labor are crucial to the economic cycle (Fraussen, 2020). In commercial societies, power over the means of production is concentrated in the hands of business rather than the state. Therefore, business yields a lot of power over the government, especially with the current movement towards globalization, wherein large international corporations yield considerable amounts of power as they easily move their products and capital from one country to another fairly easily if they feel that they are being negatively impacted by governmental policies in any way (Fraussen, 2020). Furthermore, it is also worth noting that businesses, almost by definition, have the most resources at their disposal to strategically concentrate on influencing policy.

There is a wide range of artificial and marketable interests in the health policy community (Silva et al., 2018). Indeed, in healthcare systems where services are handed in intimately possessed and managed institutions, there will be expansive links with private sector actors who bring new ideas and practices into the public sector (Silva et al., 2018). However, governments, in addition to healthcare professionals, still have a major influence in health policymaking (Varone et al., 2018). For governments, this is because of the large use of public finances and provisions in most (particularly high-income) countries (Buse et al., 2012). In the case of physicians, this is because of the medical monopoly over a body of knowledge, along with the control that they can yield over the provision of their services (Varone et al., 2018). Unfortunately, consumer feedback and the interests of the general public are heeded and acknowledged less and less (Alford, 1975, as cited in Buse et al., 2012).

Sociologist Robert Alford, in a series of studies on sanatorium reform in New York in the 1960s and early 1970s, stated that there are three structural or innate interests behind the interactions between the varied interests and interest groups in healthcare in high-income countries (Alford, 1975, as cited in Buse et al., 2012), as follows:

1. The professional monopolists. Physicians and (to a lesser degree) other healthcare professionals, whose main interests are served by the current social and political structures of government, as well as the current system governing the healthcare system.
2. The commercial rationalizers. People who challenge professional monopolies by trying to adopt similar strategies, such as the rational planning of facilities, styles of effective medical delivery, and ultra-modern surgical styles (rather than medical judg-

ments). These could be private insurance companies, government payers, health insurance companies, employers who want to consider the cost of insuring workers, a marketable sanatorium chain, etc.
3. The equal health lawyers and community health lawyers. A wide range of relatively oppressed interest groups defending the rights of the patients and trying to ask for more equitable access to healthcare for the poor and marginalized, while demanding that the points of view and feedback of patients be taken into consideration when formulating any policy pertaining to public health.

When Alford published the *Structural Interests Proposal* in 1975, consumers and the general public did not have much of a say in health policy or the design health programs, but rather directors and managers of healthcare organizations were trying to gain control of how to fund and organize the health system. Nevertheless, healthcare professionals, namely doctors, were still very influential (Buse et al., 2012).

Over the last three decades, commercial rationalists and advocates of care and community health have increased their influence in the formation of health policies in high-income countries (Johnson, 1995). Nonetheless, healthcare professionals namely physicians, despite some loss of autonomy in clinical practice are still widely recognized as the single most influential interest group in health policy. The "structuralist" approach is a valuable method to get a macro overview of policy and who or what influences it. However, to comprehend the dynamics of a particular policy decision in a specific situation, it is crucial to examine the connections and relationships within the different networks (Johnson, 1995).

Impact of Interest Groups

Advocacy groups, such as groups that advocate for patient rights, are becoming more and more apparent, even though such groups have traditionally been weak or non-existent in terms of impact. This is even the case in low-income countries, where they now also play a more influential role in health policy. Of course, their level of influence and direct impact of policies varies from one place to another, and from one issue to another (Rose, 2013).

An example of this is the response to the HIV/AIDS epidemic worldwide, showing the impact that interest groups in general and civil society groups in particular had in terms of shedding light on the disease, not to mention mobilization efforts and resources to deal with it. In this regard, Zuniga (2006) states that "civil society organizations, … [defined] as any group of individuals independent of government and business, contribute so much to the fight against the global health crisis with more than 3,000 organizations in approximately 150 countries … [coping] with this disease" (p. 343). Studies also highlight how activism shifted from being just in high-income countries to having activism lead the way to treat and prevent this disease in low-income countries (Zuniga, 2006).

Is Interest Group Participation a Good Thing?

So far, studies on the role of interest groups have not looked at the positive and negative consequences these groups have on policies. However, in democratic societies, the participation of NGOs in the policy process is generally considered to be a very good thing. However, there are always potential drawbacks (Buse et al., 2012). Therefore, it can be argued that this is an area of policy that needs further in-depth research in the future.

Self-reflection/discussion

Write down the positive and negative aspects of having a lot of interest groups involved in the health policymaking process (Buse et al., 2012).

4.2 Civil-Society Groups

Today, people generally think of interest groups as being part of civil society, meaning that they are situated in the social part between private spaces, such as households and families, and the public domain, such as governments (Bennett et al., 2019). Therefore, the term "civil society groups" is sometimes synonymous with interest groups, although public policy issues can be secondary to the identity of some civil society groups (for example, sports clubs generally only occasionally take a stand on an issue that may affect their sporting activities; Bennett et al., 2019). Therefore, it can be said that "civil society organizations represent a wider range of organizations" (Buse et al., 2012, p. 103). It is important to note that not all civil society groups are considered interest groups (Buse et al., 2012).

Interest groups can be easily started by a group of people who care about a specific cause, needing little to no formal organization. If many such groups get together for a common cause or get involved together regarding a specific issue, sociologists label this a "social movement" (Grant, 1984). For example, in 2020, a series of protests erupted in different parts of the USA against racism, discrimination, and inequality experienced by African Americans (Bonilla & Tillery, 2020; Özbilgin & Erbil, 2021). These protests were led by a voluntary coalition of civilians who opposed policing policies against people of color in the USA. The movement had minimal organization and seemed to be largely organized through posts on social media platforms (Bonilla & Tillery, 2020; Özbilgin & Erbil, 2021). Many researchers argue that, had this social movement had a more formal organizational structure, it would have had a larger impact, as it would have led to a number of small groups being formed, with various stakeholders with slightly different goals (Bonilla & Tillery, 2020; Özbilgin & Erbil, 2021).

NGOs

Non-governmental organizations (NGOs) are the most recognizable part of civil society (Buse et al., 2012). Originally the term "non-governmental" referred to any non-profit organization working independently from the government. However, the definition of NGO has changed to cover any structured organization with head offices and paid employees, working in areas such as humanitarian aid or advocacy for vulnerable populations

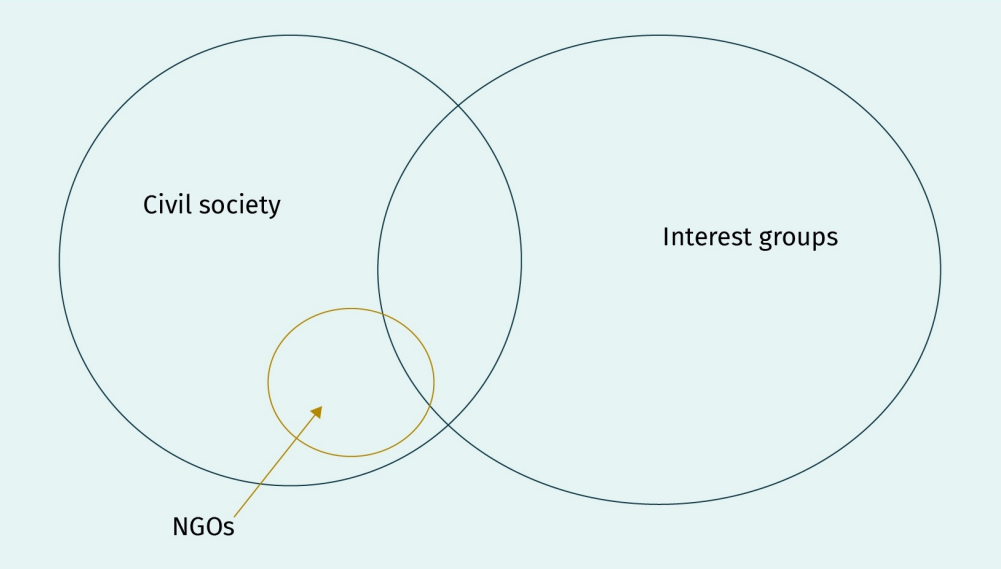
(Jordan, 2005). In many instances, the services provided currently provided by NGOs were previously provided by governments, for example NGOs that work with refugees and provide health services to refugees (Gilson et al., 1994; Torun et al., 2018). However, many NGOs still want to influence public policy and can therefore also act as pressure groups (Shah, 1996; Jordan, 2005).

Generally, "civil society groups" (also called pressure groups) have a very positive connotation, implying that such groups are full of vitality, non-authoritarian, and yet trustworthy to society (Shah, 1996; Jordan, 2005). However, politicians or public officials, may perceive a "pressure group" as illegitimate, having unbalanced views, or even annoying (Shah, 1996).

Yet it can be argued that not all civil society groups are essentially beneficial to society (Buse et al., 2012). For example, organized crime groups are considered to be part of civil society, yet their impact on society is undeniably negative (Giddens, 2001). There is a lot of debate as to whether all civil society groups should be considered interest groups, which has led to further debates on whether or not it is accurate to characterize all interest groups as civil society groups (Giddens, 2001).

Several authors tend to exclude interest groups that deal with market/business activities, such as economic organizations (representing the interest of groups such as business, labor, and professional groups) from being part of civil society (Giddens, 2001). This is due to the argument that civil society is "an area between the state and the market: a strong buffer zone enough to control the country and the market, thereby preventing everyone from becoming too powerful and dominating" (Giddens, 2001, p. 15). Therefore, civil society is probably located in an empty social space that is not otherwise occupied by family/households, the state, or the market (Giddens, 2001).

Figure 11: Civil Society Organizations, Interest Groups, and NGOs



Source: Mirna Naccache, based on Buse et al. (2012).

The Role of Civil Society

Over the past few decades, the role of civil society worldwide has expanded, becoming more prominent, visible, and diversified (Bolleyer & Correa, 2020). One of the factors influencing this growth has been the increasing challenges due to the imbalance of power between the state and civil society. This growth was driven by several factors, including dissatisfaction with state performance in terms of the provision of healthcare services, the growing power of transnational corporations, and the weakening of governmental authority due to globalization (Bolleyer & Correa, 2020).

Civil society networks have been formed within and across countries to promote broader and more "cross-border" support for public interests on global policy issues, such as human rights, the environment, debt, development, and health (Van Rooy, 2020). For example, during the meeting of the World Trade Organization in 2000, the fact that several global civil society groups lobbied to improve the pricing of and access to medication dominated headlines around the world (Van Rooy, 2020). Increased public interest in the right to participate in policies and processes was due to the increasing demand for improving public accountability on issues that impact the lives of people on local, national, and global levels (Bolleyer & Correa, 2020; Van Rooy, 2020). Additionally, the visibility of civil society has also improved as civil society organizations have been increasingly networking and organizing domestically and globally with the support of extensive access to information and increased use of electronic communication through the internet and social media (Bolleyer & Correa, 2020; Van Rooy, 2020).

The growing role of civil society in the policymaking process is not only attributed to political lobbying, but also to a shift in the understanding of the policymaking process. Moreover, the increasing importance and growing presence of civil society at the national and global levels has also led local governments and global institutions to establish formal and regulated mechanisms with civil society organizations in order to listen and respond to their feedback, claims, etc. (Egholm et al., 2020).

Civil society and health

Civil society has long played an important role in public health, which could be seen as early as the 1800s through the provision of health services, among other activities (Zeegers Paget et al., 2017). Yet, over time, the recognition of the contribution that civil societies have had on health has changed. A very important development that helped to shape the role of civil society in health was the Alma Ata Declaration of 1978, which is considered a milestone. It recognized that people's participation in the health system is at the core of **primary healthcare** and that organized social action plays a role in ensuring health benefits. However, the health reforms of the 1990s downplayed the participation of the welfare state and the community and paid more attention to the market (Zeegers Paget et al., 2017).

Compared to the technical, economic, and management factors in the health system, social value has received less attention (Lim et al., 2014). The role of the state has been reduced whether through deliberate policies, like structural adjustment plans, or through reducing public expenditure on health or decreasing the quality of health services paid for

by the government. In low- to middle-income countries, coverage of the poorest individuals has been greatly reduced, meaning many people are unable to obtain effective services and tend to rely on health services offered by civil society organizations. These trends have led many civil society organizations to take on new roles, including health advocacy, service provision, and working on improving access to health (Lim et al., 2014).

Primary healthcare
This is the gateway to the health system and includes health services ranging from prevention to wellness and treatments for common illnesses. Primary care providers often maintain long-term relationships with patients, advising and treating them on a range of health-related issues.

Achieving health goals has been increasingly dependent on politics, trade, employment, social factors, and (most importantly) the involvement of civil society (Obiajulu, 2006; Lim et al., 2014). For example, many youth organizations have become a main contributor to the promotion of reproductive health in adolescents, despite not being originally established to deal with health-related issues. Another example is that many civil society organizations, such as trade unions, have been known to play a crucial role in lobbying for essential drugs in low-income countries (Obiajulu, 2006).

The contributions and functions of civil society in health are summarized in the below table.

Table 10: Role of Civil Society in the Health System

Category	Examples of Function/Contribution of civil society
Health services	• Service provision • Facilitating community interactions with services • Distributing health resources such as condoms, bed nets, or cement for toilets • Building health worker moral and support
Health promotion and information exchange	• Obtaining and disseminating health information • Building informed public choice on health • Implementing and using health research • Helping to shift social attitudes • Mobilizing and organizing for health
Policy setting	• Representing public and community interests in policy • Promoting equity and pro-poor policies • Negotiating public health standards and approaches • Building policy consensus, disseminating policy positions • Enhancing public support for policies
Resource mobilization and allocation	• Financing health services • Raising community preferences in resource allocation • Mobilizing and organising community co-financing of services • Promoting pro-poor and equity concerns in resource allocation • Building public accountability and transparency in raising, allocating and managing resources

Category	Examples of Function/Contribution of civil society
Monitoring quality of care and responsiveness	• Monitoring responsiveness and quality of health services • Giving voice to marginalized groups, promoting equity • Representing patient rights in quality of care issues • Channeling and negotiating patient complaints and claims

Source: Mirna Naccache, based on World Health Organization (2001).

The role of civil society in health advocacy and policy

While civil society plays a prominent role in the provision of healthcare services, it also makes other important contributions to health, such as promoting healthy public choices, encouraging changes in public understanding and attitudes towards health topics, building more effective interactions between medical professionals and the public, and improving community management and involvement in health interventions (Greer et al., 2017).

As has been recently recognized, health is not only the result of biology, but also economy, society, and politics. Civil society input and actions call for a higher number of state and "non-state" actors (Greer et al., 2017). Many development-oriented civil society organizations are active in both the political and policy arena, through the monitoring and evaluation of the impact of global public health agreement, access to and the pricing of essential medications, and international health related treaties on issues like mining, climate change, and tobacco laws. Many global civil society organizations promote and use human rights tools and actions to promote health for all. They monitor health and human rights issues, such as patient rights, maternal health rights, and refugee health (Greer et al., 2017).

The increase in the activities of civil society organizations reflects the public's refusal to accept inequality in access to healthcare or the excessive decline in the coverage of public health services. Activities to address these inequalities could be increasing health promotion or offering private, low cost, or even free services, as a way to decrease healthcare coverage gaps and inequities (Greer et al., 2017). In terms of primary healthcare policy, civil society organizations have also become more compelling and important when emphasizing community participation. These health system processes on the local, national, and global levels show that civil society organizations are important to prompt the public to participate in the health system (Greer et al., 2017). In addition, civil society has been known to bring in technical expertise, highly skilled human resources, and knowledge to the health system, while putting pressure on the government on behalf of the public sector to do more to improve the health of the population (Yúdice, 2018).

The Partnership Between the State and Civil Society

These changes and developments have led to greater demand for more "responsibility" and "stewardship" from the government when it comes to health (Brandsen et al., 2017). This has led to various stakeholders playing a bigger role in healthcare to fill the gaps when the state cannot. Thus, governments have formed relationships with many stakeholders, including civil society. There is still a need for the state to establish stronger connections with civil society public interest groups in order to improve health and balance connections with the private commercial sector (Brandsen et al., 2017). This relationship has many benefits and risks for both parties. Some of the benefits and risks are summarized in the table below.

Table 11: Benefits and Risks of the Partnership Between the State and Civil Society

Benefits for the state (World Health Organization, 2001) • Support national/global values, government regulation of harmful commercial interests, public policy goals, and strengthen the legitimacy of public information and government operations • Introducing informed leadership in new perspectives, technical expertise, competence and talent, networks, and health • Increasing service provision and public program implementation, especially in marginalized communities and remote areas • Increased financial contribution to health programs	**Benefits for civil society (World Health Organization, 2001)** • Increasing health policy influence by integrating civil society concerns into policymaking, including balancing commercial interests and building consensus on health policy priorities • Provide legal capacity for civil participation and strengthen the legitimacy of civil society activities • Improving the connection and transparency of interaction with the state • Improve the prospects for political education, participation and building social capital, thereby strengthening the capacity of civil society • Improved access to medical services • Expand opportunities to increase participation in health programs
Risks for the state (World Health Organization, 2001) • Civil society representativeness cannot be assumed to be objective as they may be a hidden channel for corporate interests and potential conflicts of interests between the state and civil society interests. For the state, it is important to assess the representativeness, authenticity, interests, and capacities of the civil society organizations it works with • Cross-cutting and multiple roles in civil society can lead to different views and numbers and can be difficult to manage. Civil society clearly does not speak in one voice, but there is an asymmetry in ability and number between north and south • Civil society has varying degrees of accountability to the communities it represents. These features may undermine the legitimacy of civil society's position on national and international platforms • The risk of civil servants migrating to join civil society organizations, thereby undermining the state in terms of technical expertise and capabilities	**Risks for civil society (World Health Organization, 2001)** • State links may distort civil society voices and representation by giving privilege to a few interlocutors. If this bias is towards civil society representing more affluent or global north interests, then perspectives and access of more marginal groups can be weakened • Dependence on the state for access or resources may compromise the autonomy, and accountability may make civil society reluctant to criticize the state • Work on government program or funding priorities could distort civil society priorities • Risk of civil society staff leaving to join government units, leaving them weaker in technical expertise and capacity

Source: Mirna Naccache, based on World Health Organization (2001).

4.3 Private-Sector Interest Groups

The private sector has a long history of participating in healthcare. The history of the involvement of the private sector in healthcare, whether as a direct provider of services (doctors, pharmacies, hospitals, etc.) or as a provider or manufacturer of medical equipment, material, and technologies used in healthcare, is long and comprehensive (Sheingold & Hahn, 2014).

There is no one clear concrete definition for the participation of the private sector in health and it appears that related concepts, namely public-private partnerships and privatization, are used inconsistently. Therefore, it is rather challenging to accurately define the exact involvement of the private sector in healthcare (De Wolf & Toebes, 2016). This is further complicated by the healthcare system context and dynamics as well as the role/power dynamics of the private sector in healthcare systems.

This is a de-facto issue and not a passive concept, so it makes more sense to explain what the involvement of the private sector in healthcare means rather than define it (Allen & Bloomfield, 2016; De Wolf & Toebes, 2016). Such involvement is medical and covers a wide range of activities carried out by different non-state actors in healthcare (De Wolf & Toebes, 2016).

These parties include multinational enterprises, NGOs, private institutions (including charities and other non-profit organizations), and individuals, such as general practitioners and consultants (De Wolf & Toebes, 2016). Their roles may include direct healthcare provision, healthcare facility management, production and provision of health products and services (pharmaceuticals, medications, rehabilitation, etc.), and funding of health products and services (De Wolf & Toebes, 2016). These activities and roles can also be performed within a healthcare system that is publicly operated (Palmer, 2002; De Wolf & Toebes, 2016). This is the case in the UK, where private actors play the main role in long-term care facilities for people with disabilities, even within the publicly owned national health system (Palmer, 2002). This involvement can also be done through a public-private partnership or through privatization of parts of the health system (as shown in the table below).

Table 12: Forms of Private Sector Involvement

Type of involvement in healthcare	Respective private sector actors
Financers, funder, or payers	Privately owned health insurance companies Philanthropic organization/charities
Service providers	Privately owned hospitals and clinics Doctors and nurses who work in private practice Civil society organizations

Type of involvement in healthcare	Respective private sector actors
Suppliers of health services	Pharmaceutical companies Medical equipment suppliers

Source: Mirna Naccache, based on De Wolf, A., & Toebes, B. (2016).

Globally, until the 1960s, the number of interest groups in health policy was small and concentrated, with their positions being generally constant and fairly predictable. However, with the rise of worldwide social movements, the number of interest groups in the private sector has greatly increased and diversified (Giaimo, 2014).

Role of Private Sector Interest Groups in Health Policy

It is well known that all types of private sector groups and institutions are interested in health policy and seek a voice in health policymaking (Contandriopoulos, 2011). The relationship between private sector interest groups in health and health policymakers can be described as ranging from confrontational to collaborative (Evans, 2001). However, there is some imprecision in the exact nature of these interrelationships because most, if not all, collaborative arrangements are indistinctly described as taking many forms (Evans, 2001; Contandriopoulos, 2011).

For example, in the healthcare sector, certain forms of associations may be called coalitions, an example of which could be the relationship between the pharmaceutical industry and patient organizations (Herxheimer, 2003). The pharmaceutical industry may share common interests with some patient groups, including the official inclusion of certain drugs in the government's essential drug lists (Herxheimer, 2003). However, these groups often feel that other arrangements provide better benefits to them, rather than forming an open coalition. Companies can help hire, fund, and train staff in a particular patient organization, but avoid visibly promoting a list of drugs. However, patient organizations also participate in lobbying and are well funded and trained to do so (Herxheimer, 2003). Private sector interest groups in healthcare seek to influence policymakers through a number of ways, chief among them being by providing money to finance campaigns (Giaimo, 2014).

Research institutes as an interest group in health policy

Research institutes (commonly known as "think tanks") often serve as sources of political ideas, and act as ships that carry ideas along the policymaking stream (Giaimo, 2014). The separation is not always very clear, though research institutes often play a more significant role than simply communicating policy ideas based on sound scientific evidence. In fact, research institutes are increasingly trying to shape such ideas into legislation that could be passed by parliament and approved by the government. To be successful in this undertaking, they often need to form alliances with each other, as well as with parliamentary and administrative parties (Giaimo, 2014).

Additionally, research institutes provide policy ideas that are taken up by non-governmental stakeholder groups in their efforts to play a role in the policymaking process (Giaimo, 2014). Research institutes also carry out policy analysis of legislation or existing programs,

and their reporting may affect the process and content of the legislation. Some research institutes are independent while promoting policies that are closely related to specific stakeholders and political parties (Giaimo, 2014).

Lobbying

The word "lobby" as a noun historically refers to the area where the citizens are located inside the parliament or congress building to meet and discuss policies and legislations with elected officials (Buse et al., 2012). This term is also used as a verb, meaning making direct contact/communication with policymakers to discuss policies. Lobbies and interest groups have one thing in common and it is that they are both trying to influence policy and decision makers. Lobbyists are hired by a variety of people, and may be privately owned companies that commercially represent their interests and that of their customers (Buse et al., 2012).

Private healthcare organizations and interest groups often lobby lawmakers to influence health policy decisions which affect virtually all aspects of healthcare, including compensation for the provision of goods and services, healthcare financing licensing, research priorities, and oversight (Contandriopoulos, 2011; Buse et al., 2012).

Case study: Lobbying on social determinants of health

As they attempt to enhance health outcomes and lower total healthcare costs in their communities, public health professionals are increasingly investing in social determinants of health (SDOH; Counts et al., 2021). SDOH are significantly influenced by policy, therefore healthcare advocacy on SDOH concerns could have a significant impact through good policy change. In the USA between 2015 and 2019, federal lobbying disclosures from the ten highest-spending health insurance and healthcare provider organizations and related associations were examined to find lobbying on the most important SDOH issues. Only five organizations stated that they lobbied on some SDOH concerns, such as financial strain, employment, food insecurity, and interpersonal safety, but none stated that they lobbied on specific issues, such as non-healthcare related jobs, housing instability, transit, or education. The opportunity to address SDOH through lobbying has largely been squandered. Healthcare organizations have the chance to boost the impact of their SDOH strategy and improve public health by lobbying on upstream SDOH policy concerns (Counts et al., 2021).

4.4 Public-Private Health Partnerships

A public-private partnership in health refers to an agreement between the government and the private sector, with the primary purpose being to provide public health infrastructure, community health facilities, and other health-related products and services. This kind of partnership is characterized by investment, risk, return, and responsibility sharing in order to achieve mutual benefit for both parties (Monaghan et al., 2001).

In 1993, the World Health Assembly appealed to the World Health Organization (WHO) to mobilize and promote the support of all partners in health development, including NGOs, private sector organizations and institutions, and states/governments worldwide to form public-private health partnerships in order to push forward the implementation of national strategies for health. It also encouraged the public sector to expand and deepen its ties with the private sector, citing the necessity of establishing innovative partnerships (Buse & Waxman, 2001).

These partnerships may cross borders and connect at least two parties, businesses (or industry groups), and intergovernmental organizations to achieve the mutually agreed and well-defined division of labor-based health promotion goals. The emergence of these partnerships has been exponentially increasing in the past couple of decades (Visconti et al., 2017). For example, the WHO's initiative on public-private partnerships for health has identified nearly 70 global public-private health partnerships, one of which being the Global Polio Eradication Initiative (Buse & Waxman, 2001). Furthermore, these partnerships have been shown to have the ability to advance public health messages and create industry incentives for the development of innovative healthcare goods (such as medical equipment and medications) and services (Visconti et al., 2017).

The three different types of public-private partnerships are as follows (Joudyian et al., 2021):

1. Introducing private sector ownership into state-owned enterprises, adopting various possible structures, and selling majority or minority shares
2. Private financing initiatives and other arrangements, in which the public sector signs long-term agreements for purchasing quality services to leverage private sector management skills inspired by private financing risks
3. The sale of public services to a bigger market, in which the expertise and funds of the private sector are utilized to develop and improve the commercial potential of governmental assets and services

Adopting Public-Private Health Partnerships

Although the public sector represents the core potential and resource pool for providing important public healthcare services, the private sector is considered vital for its effective use of expertise to realize the substantial value of these resources (Ballantyne & Stewart, 2019). Without the participation of the private sector, the potential of the public sector cannot be fully realized. The participation of the private sector can create more opportunities through offering business incentives, focusing on customer needs, creating innovative methods, and better use of expertise in the fields of management and business (Ballantyne & Stewart, 2019).

This partnership is not just privatization (Monaghan et al., 2001). The main driving factors for improving the efficiency of privatization projects are investment freedom, management skills, and profit motives. Using public-private health partnerships to leverage these forces can provide a long-term and sustainable way to improve social infrastructure, increase the value of publicly owned assets, and the effective utilization of taxpayer money (Monaghan et al., 2001).

Consequently, although the benefits of public-private health partnerships have been proven, the development of public-private health partnerships on a global scale is incomplete, especially because of a lack of understanding on the best way to involve private sector skills in the provision of health services and activities provided by the public sector (Buse & Waxman, 2001).

However, the UK, Western Europe, and Japan have incorporated this notion and recent studies indicate that such partnerships have achieved favorable results (Clarke, 2014). In these examples, the private sector is mainly responsible for the design, construction, operation, and maintenance of hospitals, while the public sector is responsible for providing patient care, recruiting doctors and nurses, and other core medical services (Clarke, 2014). In addition to considering the stability, the business plan, and the certainty of funding, there are three key factors for the success of the partnership (Buse & Waxman, 2001):

1. Risk allocation. Allocate risk to those best positioned to manage risk, i.e. governments haves experience and expertise in delivering clinical services and ensuring the well-being of patients, doctors, and nurses, while non-critical services are private sector transaction offerings. This clear separation of risks enables hospitals to respond quickly and effectively to patient needs (Buse & Waxman, 2001).
2. Project size. In spite of the benefits of these public-private partnerships, the processes involved can be complex and require the input of consultants. Therefore, substantial investment is required to absorb additional costs, such as legal and financial advisory fees (Buse & Waxman, 2001).
3. Evaluation process. Mainly driven by the concept of "value for money," which considers "cost optimization throughout the life cycle." In the long-term, the private sector alternative is more worthwhile than that of the public sector because it takes account of both capital and maintenance costs (Buse & Waxman, 2001).

Strengthening public-private partnerships is key to ensuring sustainable economic and social growth in the health sector (Buse & Waxman, 2001; Visconti et al., 2017).In order to build such a strong relationship the following principles should be taken into consideration (Visconti et al., 2017):

- Draw from past experience. Privatization has been helpful in defining the relationship between the public and private sectors and has led to the creation of thousands of job opportunities, as well as a boost in the economy as a whole. Still, it is regarded with suspicion and skepticism. Governments need to recognize the reasons behind these shortcomings in order to address them.
- Become a better partner. Lessons learned need to be evaluated and applied to make governments better partners and ensure public services are improved and are a clear and effective use of taxpayers' money. This can be achieved by having the government as a long-term shareholder, adding value to the enterprise and using the same guidelines used in the private sector and other areas.
- Protect the public interest. The key to the success of public-private partnerships is whether or not there is added value generated by the partnership that benefits the users of services in the public sector. Governments need to protect the interest of the general public by implementing a clear structure and process that assesses the usefulness and total cost of ownership of services provided by the private sector. Such a moni-

toring and evaluation process should assess if there is better management and use of money and capital. Governments should also have clear, effective, and mandatory regulations that ensure all public services providers are held accountable to their patients, as well as the communities that depend on them. It is crucial to maintain the continued governmental involvement in the elements of public-private partnerships that are of high public interest.

- Recognize employee contributions. Dedicated employees are vital to the short- and long-term success of the partnership, so it is important that their contributions are recognized and their needs addressed.
- Innovative partnerships. Public-private partnerships aim to change the way governments and private sectors do business and interact with one another, in the hopes of using the skills, expertise, experience, and funding of the private sector to develop a wide range of new and innovative services and activities in the public sector.

Features of Common Public-Private Partnership Models in Healthcare

Historically, governments have allowed the private sector to provide services through healthcare public-private partnership to fulfill one or more of the following six functions (Visconti et al., 2017):

1. Financing. Project financing or co-financing
2. Design. The project design, including the design of infrastructure and care delivery models
3. Construction. The construction or modification of facilities in the project
4. Maintenance. The maintenance of the hardware infrastructure (facilities and applicable equipment)
5. Operations. The provision of applicable equipment, information technology (IT), and management/delivery of non-clinical services
6. Delivery. The delivery and management of designated clinical and clinical support services

Disadvantages of Public-Private Health Partnerships

Despite the advantages of public-private health partnerships, there are still several shortcomings, obstacles, and disadvantages to their implementation (Al-Hanawi et al., 2020). These include the high cost of providing goods and services, difficulties in specifying services (for example, due to the innovation of medical equipment), both of which make it difficult to quantify the cost of public-private partnership projects, and interaction with the public and private sectors. The political risk associated with long-term cooperation between the private and public health sector is that there are "unstable and often unpredictable external conditions (such as pandemic risks)" (Al-Hanawi et al., 2020, p. 4). Some of these conditions include "difficult and often inappropriate infrastructure maintenance and service of delivery pricing, lengthy procurement processes, lack of appropriate skills, lack of attraction of powerful financial markets and incomplete risk transfer and higher end-user fees" (Al-Hanawi et al., 2020, p. 4).

Public-private health partnerships in healthcare projects also encounter many other obstacles, as do public-private health partnership investments, including a lack of appropriate skills and experience, lengthy bidding and negotiation processes, lack of a sound legal framework, legal risks, unfavorable economic and commercial conditions, inefficient public procurement frameworks, lack of mature financial engineering technology, public opposition, delays due to political debate, and a lack of competition (Osei-Kyei & Chan, 2015). Both public and private partners in public-private health partnership arrangements should strive to overcome these obstacles and ensure that they do not hinder the progress of the proposed project. For a successful long-term public-private health partnership, one of the most important issues is to determine and ensure a sound contract and relationship governance mechanism (Osei-Kyei & Chan, 2015), which is indirectly related to the type of health public-private partnership model (Zheng et al., 2008). For example, in the long-term, private financing initiative contracts are the least flexible, whereas social capital has no incentive to make any necessary changes, which may have a negative impact on public-private relations (Osei-Kyei & Chan, 2015).

SUMMARY

Interest groups are groups whose main goal is to promote interest or put pressure on the government in specific issues and/or problems. There are several categories of interest groups, which can be divided into either private interest groups or public ones. Interest groups can be classified as either sectional or cause groups, with sectional groups usually being those that are recognized by and negotiate with the government. Cause groups are intended to promote topics that are not necessarily specific to its members themselves but can be topics that are of interest to them. The relationship between interest groups and the state is complex and multifaceted, with some groups being more influential than others in promoting their interests and ideas.

One of the main interest groups in health policy is civil society, which can be defined as a group or organization beyond the family/household and external to the government. Non-governmental organizations (NGOs) are the most familiar part of civil society, although the global role of civil society has expanded and become more prominent, visible, and diversified within the health system, including health policy. The partnership between the state and civil society is generally viewed in a positive light due to its positive impact, yet it has some drawbacks.

Multinational enterprises, private institutions, and individuals, such as general practitioners, are all considered to be private interest groups, serving a variety of roles, including direct healthcare provision and health funding. One of the main activities of private interest groups when it comes to health policy is lobbying.

Public-private partnerships in health refer to arrangements between the government and the private sector, where the main goal is improving the health of the general public through a multitude of activities. Despite the many advantages of these partnerships, they still have several distinct disadvantages.

UNIT 5

COMPARATIVE HEALTH POLICY

STUDY GOALS

On completion of this unit, you will be able to …

- define globalization and its role and effect on health, as well as how it has affected the policymaking process.
- list the different UN agencies that deal with health, while discussing cooperation in global health.
- describe the role of health policies within the health system, including how policies are used to address health inequality.
- discuss public health policies internationally, in terms of global health and international health regulations, as well as the role played by foreign policy in health.
- explain cross-national learning.

5. COMPARATIVE HEALTH POLICY

Introduction

This unit will explain how globalization has influenced health policy and how the health policy process is globalized. It will discuss international cooperation in health policy, as well as listing the different agencies that deal with health and health policy on a global scale. This will be followed by a discussion of the role and importance of health policy within a health system and how health policy attempts to address health inequity. Then it will examine how foreign policy affects health and vice versa, after which the notion of international public health policies will be discussed in terms in diplomacy, international health treaties, and global health (including global health policy). This unit will end with an explanation of cross-national learning when it comes to health policies, with a focus on the challenges faced when dealing with the policy making process and cross-national learning.

5.1 Globalizing the Policy Process

Few health policies (or countries, for that matter) remain unaffected by global factors and influences. Even in high-income countries, health policies, such as those related to obesity, may be subject to pressures and influences from multinational corporations.

National policies may also be affected by international trade rules. For example, when Canada banned the import of asbestos from the European Union on health grounds, this ban was challenged by the World Trade Organization (Gleeson & Labonté, 2020). Both low- and high-income countries are vulnerable to the effects of external factors on their national health policies, even though this is more likely to affect low-income countries (Gleeson & Labonté, 2020). For example, both high- and low-income countries voluntarily coordinate to combat global health threats, for example to control infectious diseases, such as **Severe Acute Respiratory Syndrome (SARS)** and COVID-19 (Jalloh et al., 2021).

Severe Acute Respiratory Syndrome (SARS) This is a coronavirus-related respiratory disease which was first reported in Asia in February 2003. This virus spread to 20 countries across the world but suddenly disappeared in 2004.

As mentioned above, in low-income countries health policies are more likely to be affected by external and global factors. For example, donor organizations can set social, political, and economic conditions in recipient countries (Jalloh et al., 2021). Or sometimes there are pressures on governments in low-income contexts to adopt certain policies, as happened during the AIDS epidemic in the 1980s and 1990s in South Africa, where local social movements pressured the local government to treat those infected with disease (Sabi & Rieker, 2017). Another example is the role played by Global Alliance for Vaccines and Immunization in pushing low-income countries to implement child immunization programs (Bresee et al., 2019).

Even through local policies have always been affected by global factors, globalization has led to an increase in this phenomenon An important issue for health policy analysts is how to assess globalization influences on the policymaking process (Dollar, 2001). These issues can be summarized into three questions:

1. How does globalization facilitate policy and guideline transfer between countries and international organizations?
2. Who or what influences the policy making process?
3. How does globalization shape and affect local and global health policy?

Globalization

Before delving further into the globalization of the health policy process, an overview of globalization background and traditional government cooperation in healthcare is needed. The term globalization has many definitions used in many different ways and perspectives on whether globalization is a good or negative thing remain polarized, while some even dispute the existence of the globalization phenomenon (Steger, 2017).

With this in mind, there are five common ways the term globalization is used to mean, as follows:

1. Internationalization. Globalization is related to the ever-increasing volume, frequency, intensity, and breadth of transactions and movement of goods, human being, ideas, money, and sometimes even infectious diseases across borders and across continents (Laverick, 2016).
2. Liberalization. Elimination of barriers, particularly those related to trade, making movement easier (Scholte, 2000).
3. Universalization. The homogenization of cultures and reduction of cultural differences (Scholte, 2000).
4. **McDonaldization**. Adopting a "Western culture" (i.e., a European or North American culture), more specifically American values and policies (Jeon et al., 2015).
5. Inter-dependence. An increase in collaboration, cooperation, interconnection, and relationships between countries (Tollison & Willett, 1973).

McDonaldization
In his 1993 book "The McDonaldization of Society," sociologist George Ritzer proposed this theory, which states that aspects of American culture are being adopted through the world through the concept of fast-food.

Even though many question whether these globalization trends are new or old, almost everyone agrees that the current scale and intensity of globalization is greater than ever before, as countries are becoming more and more interdependent (Scholte, 2000).

Scholte (2000) posits that the novelty of the modern world revolves around the reconfiguration of "social space," particularly the emergence of super territories or cross-world geography. Even though "territorial" space, which can be defined as cities, countries, and villages, will continue to exist, policy makers, decision makers, and anyone involved in policy should take into consideration that people and organizations have changed, leading to the establishment of more connections and interconnections with others in a way that exceeds boundaries and borders. This means that people can have loyalties, values, identity, beliefs, and interests beyond their nationality (Scholte, 2000).

Moreover, with the technological revolution and the internet, time and space seem to have been compressed, causing people to feel closer and be more inter-connected to one another, regardless of where or how they live (Scholte, 2000). For example, millions of personal computers and laptops around the world may be infected by the same computer virus concurrently, regardless of where they are physically located (Lallie et al., 2021). Likewise, millions of crypto-currency and other monetary transactions take place over the internet globally every day. These examples show the modern aspects of globalization pertaining to technology and cyberspace (Lallie et al., 2021). It is also worth mentioning that technological globalization has provided the promise of democratization of information, which may or may not be a positive thing.

The three aspects of globalization are temporal, spatial, and cognitive (Lee et al., 2002). The temporal aspect refers to how globalization is making the world move at a faster pace than ever before, while the spatial dimension refers to how globalization is increasingly removing boundaries and decreasing spaces between people. Lastly, the cognitive aspect refers to the rapid proliferation of values, beliefs, ideas, identifies, and interests, due to the wide spread of technology facilitating communication (namely, the internet). For many, globalization is removing boundaries and creating a "global village," and everyone is a villager, irrespective of where they live. However, others believe that globalization is only the adoption of Western culture and values, particularly individualism and consumerism (Lee et al., 2002).

Health and Globalization

One of the areas where the impact of globalization is most evident is infectious/communicable diseases. Microorganisms (such as bacteria, viruses, and fungi) can travel very quickly around the world in a matter of days or even hours. In 2003 for example, the SARS epidemic spread quickly from China and other Asian countries to North America in a matter of days. This epidemic not only caused diseases and death, but also led to great economic losses (estimated at $30 billion per day) in the economies of the affected countries (Lam et al., 2003). Another similar example occurred in 1990, when cholera quickly spread all over Latin America from Peru (more specifically, the source of the disease was a ship that docked in one of Peru's ports) and led to thousands of deaths, in addition to significant losses in the economy and trade of the affected countries (Kimball, 2016). A further example can be seen in the Nigerian polio outbreak of 2004, which spread to 12 African countries, which had previously been deemed to have eradicated polio (Kennedy, 2016). A more recent example is, of course, COVID-19, which started in Wuhan, China, but quickly spread all over the world, leading to death, morbidities, and enormous economic losses due to most countries employing lockdowns as a means of containment (Chen et al., 2020). These examples clearly highlight that, as a result of globalization, infectious diseases that are not contained by local health systems are likely to spread and becoming a global health threat.

Infectious diseases are not the only thing spreading quickly due to globalization. Food trade and production, food and beverage marketing, and even eating habits have changed, leading to the spread of unhealthy diets, which tend to pose health risks (Kearney, 2010; Labonté, 2015). Studies also show that behavior has also become globalized, affecting sedentary lifestyles, smoking, and alcohol use (Labonté, 2015). Therefore, it can

be argued that the rise in non-communicable diseases, which are also generally chronic in nature, such as cardiovascular diseases, came about as an indirect result of the globalization of these lifestyle and eating habits. An example of this can be seen following the discovery of oil reserves and subsequent industrial development in the Arabian Gulf, which led to the adoption of many Western values, such as fast food culture, which has been directly attributed to the rapid increase in the prevalence of obesity in those countries, which, in turn, has led to an increase in the incidence and prevalence of chronic non-communicable diseases (Balhareth et al., 2019).

It is important to note that obesity and climate change are linked in many ways. For example, about 25 percent of greenhouse emissions can be attributed to the production of food, and scientists have concluded that avoiding global warming will be difficult unless individuals modify their eating habits dramatically (Godlee, 2012). Simultaneously, climate change has put the world's food supply at risk due to an unprecedented abuse of resources, namely land and water. Therefore, reforming the food system to save the planet necessitates new corporate practices, as well as new national and international laws and regulations. Individual consumer actions, such as cutting down on animal-based food products and reducing food waste, however, are also important (Godlee, 2012).

The way countries' health systems respond to health threats may also be affected by globalization (Labonté, 2015). A pressing example of this is the immigration of healthcare human resources from low-income to high-income countries. High-income countries with a need for healthcare workers tend to hire healthcare workers from low-income countries for many reasons, including the fact that these workers tend to ask for a lower wage (Bludau, 2021). India and the Philippines are the two main countries that are known for "healthcare workers for export," alongside Nigeria and South Africa, who lose a lot of their healthcare workers due to extremely poor working conditions and low wages (Bludau, 2021). As a result of this, there has been an influx of healthcare workers from low-income to high-income countries, leading to shortages in most medical and clinical professionals in more than 50 countries, which has resulted in some countries being unable to provide basic medical services such as emergency reproductive health services (Bludau, 2021).

Self-reflection/discussion

Select a health issue or problem and attempt to identify how globalization affects it positively and negatively (Buse et al., 2012).

International Cooperation in Health

Countries have always been concerned about the spread of cross-border illness (McKee et al., 2005). For example, as early as the fourteenth century, the city-state of Venice forcibly isolated ships suspected of carrying plague-infected rats, a policy which spread to other ports. These pioneering efforts prepared the ground for more formal attempts to follow (Tognotti, 2013). In the nineteenth century, international agreements were made to reduce the spread of infectious diseases through trade restrictions.

One such policy is the International Health Regulations (IHRs) which will be discussed in detail later in this unit. However, despite these breakthroughs, there are a lot of limitations to countries collaborating and cooperating in health issues (Kamradt-Scott, 2016). Specifically, many countries have failed to report to the World Health Organization (WHO) when infectious diseases spread in their country and the WHO is powerless to do anything about the lack of compliance (Kamradt-Scott, 2016). For example, several African countries were late in reporting cases of the Ebola virus, while there were several other countries that did not report any Ebola outbreaks, despite experts believing that they had cases of Ebola (Mboussou et al., 2019). However, it is important to note that, when it comes to health issues, countries can cooperate and collaborate in different ways, through both formal and informal channels (McKee et al., 2005).

UN: United Nations

The United Nations (UN) was established after World War II to ensure the maintenance of global peace and the security of countries (Luard, 1979). Sovereign nation states make up the UN and they are at the core of its system (as members). Members of the UN can choose to also become members of UN sub-organizations such as the WHO, the United Nations High Commissioner for Refugees (UNHCR), and the United Nations Children's Fund (UNICEF), to name a few (Luard, 1979). These sub-organizations were established to promote exchanges and cooperation between the respective member states in order to solve common problems (Cratsley & Mackey, 2018; Murray et al., 2015). However, within the United Nation's system, high-income countries and their respective governments may play a role in influencing health policy internationally, as well as potentially being able to affect national health policies, specifically in low-income countries (Mackey & Liang, 2013).

WHO: World Health Organization

The WHO was founded in 1948, serving as the specialized health agency of the UN, with the main goal of leading and coordinating all health-related initiatives and activities internationally (Cueto et al., 2019). Its headquarters are in Geneva, Switzerland, and it has six regional offices (Global Programme on Evidence for Health Policy, 2003). Currently, 192 countries are associate members of the WHO, along with 193 NGOs (Cueto et al., 2019). None of the NGOs have a right to vote, however, as WHO members, they can have "official relationships" with the WHO member countries, as well as a say in the organizational governance of the WHO (Cueto et al., 2019).

The WHO is managed by the World Health Assembly (WHA), which is composed of representatives from member states, usually represented by the countries' Health Ministers (Kickbusch et al., 2010). The WHA holds annual meetings to approve the organization's plans and budgets, and make international decisions regarding certain health policies (Kickbusch et al., 2010; Buse et al., 2012). The WHO constitution grants the WHA power to adopt conventions or agreements on any matter within the scope of the organization's competence (Global Programme on Evidence for Health Policy, 2003). Each member state has one vote and decisions are made based on general consensus. The decisions made are binding to all members unless they opt out, which they have to do through a written memo (Gostin et al., 2015). However, the constitution of the WHO does not include any sanctions for non-compliance to any WHO regulations or decisions (Gostin et al., 2015).

Most decisions are non-binding recommendations, serving as technical guidelines (Buse et al., 2012; Clift, 2013), which countries can adopt or reject based on their relevance and importance to national policies (Buse et al., 2012; Kimura & Nakamura, 2020). The WHA is guided by an executive committee that promotes the conference's work and puts its decisions and policies into action (Kimura & Nakamura, 2020). In addition to the Director-General (who is elected), approximately 3,500 experts and employees work at the WHA (of all nationalities), who are considered experts in the field of health (Cueto et al., 2019). The WHO has the following six functions (Global Programme on Evidence for Health Policy, 2003; Clift, 2013; Buse et al., 2012):

1. Developing consistent, ethical, and evidence-based policies (Global Programme on Evidence for Health Policy, 2003; Clift, 2013)
2. Managing information by evaluating trends, comparing performance, and setting the international health policy agenda (Global Programme on Evidence for Health Policy, 2003; Clift, 2013)
3. Driving health improvement by resource, technical, and policy support to sustain and support local and intergovernmental capacity (Global Programme on Evidence for Health Policy, 2003; Clift, 2013)
4. Maintaining and sustaining local, regional, and global health partnerships (Global Programme on Evidence for Health Policy, 2003; Clift, 2013)
5. Formulating, verifying, supervising, and promoting the correct implementation of the guidelines, recommendations, and standards that have been agreed upon (Global Programme on Evidence for Health Policy, 2003; Clift, 2013)
6. Encouraging the development and subsequent testing of new technologies, tools, and policies for disease management, risk mitigation, and provision/management of healthcare services (Global Programme on Evidence for Health Policy, 2003; Clift, 2013)

The most important function of the WHO is the development of health standards, recommendations, and guidelines, which are developed by their extensive and global network of health experts (Gostin et al., 2015). Although the WHO may provide countries with technical support and expertise for the development of health policies, it cannot "impose" any of these policies on any of the member states (Gostin et al., 2015).

Other UN agencies that deal with health

Within the UN there are other organizations with responsibilities and activities related to health (World Health Organization, 2019b). These agencies are as follows (World Health Organization, 2019b):

- Food and Agriculture Organization (FAO)
- United Nations Children's Fund (UNICEF)
- United Nations Development Program (UNDP)
- United Nations Drug Abuse and Control Fund (UNODC)
- United Nations HIV/AIDS Program (UNAIDs)
- World Bank
- World Food Program (WFP)

These organizations work together, exchange information, and collaborate to improve global health, however each is an independent organization with its own interests (and the interests of its members), and they frequently compete with each other and pursue differing health policy options (Buse et al., 2012). For example, there was a major conflict between WHO and UNICEF in the 1980s about how to best interpret primary healthcare policies (Druetz, 2018). The WHO's position was that primary care improves health in low-income countries and it should do so through multisectoral preventive approaches aimed at improving the quality of water (for drinking and other uses), sanitation, literacy/education, and nutrition (Druetz, 2018). Alternately, UNICEF's position was that primary healthcare should focus on specific, cost-effective services and activities, such as child immunization (Mosley, 1984). Although the conflict was swiftly resolved, it highlighted the differences between these organizations and how they view health policies (Mosley, 1984).

Even though the World Bank does not directly play a role in health policies, it has a major impact, as the mission of the World Bank is to provide financial and capital assistance (when asked) to member countries in order to help them with development projects (Buse, 1994). Unlike other UN agencies, where decisions are decided on a one-country–one-vote basis, the World Bank's voting rights are tied to its members' capital contributions (Buse, 1994, as cited in Buse et al., 2012). Accordingly, the World Bank is often perceived as an instrument used by high-income countries (Abbasi, 1999; Buse et al., 2012).

The World Bank entered the health sector when it started funding health-related projects in the 1960s, and when it started financing medical services in the 1960s and 1980s, respectively (Ugalde & Jackson, 1995). By the 2000s, the World Bank was the largest foreign financier of health-related initiatives in low- and middle-income countries. Its power comes from the loans it provides, as well as its authority and relationships with the borrowing countries' powerful finance ministries (Ugalde & Jackson, 1995; Buse et al., 2012). One of the main criticisms of the World Bank is that it supports projects in energy or industrial sectors, without taking into consideration the negative impact that some of these projects have on health (Ugalde & Jackson, 1995). Although the World Bank's policies have been questioned, they are usually supported by most donors, industry, and governments (Ruger, 2005).

WTO: World Trade Organization

The WTO was established in 1995, its mission being to promote international trade through the management and implementation of international trade (Bohne, 2010). As has been previously mentioned, trade has a direct impact on health through the trade of medicines, health service trade, and the emigration of healthcare workers (Howse, 2016). However, it also has an indirect impact through exposure to environmental risks as a result of trade (from airplanes, cargo ships, etc.; Howse, 2016). Because countries commit (without reservations) to modifying their policies and complying with all WTO principles by joining the organization, local/national policies dealing with trade have grown more restricted due to the WTO accords. The WTO's Trade Policy Review Agency regularly evaluates the policies of member states to ensure that they are compliant with the WTO's policies (Sampson, 2018).

Member states can also report suspected violations to the WTO (Mitchell, 2017). The WTO's committee of experts evaluate the alleged violation and makes its decision (Gostin & Katz, 2016). Several WTO agreements influence health policy, for example trade-related intellectual property agreements (TRIPS), which play a very important role in international health policy agreements because they directly influence the production of generic drugs and the policies related to the trade of medications and medical equipment (Shaffer et al., 2005; Barlow et al., 2017).

Bilateral cooperation

Bilateral cooperation pertains to collaboration, assistance, and cooperation between governments and is an ancient concept (Clarke, 2013). The three bilateral organizations that play the biggest roles in funding and promoting collaborations for development projects and offer technical support (among other things) at the international, regional, and national levels are as follows (Clarke, 2013):

1. Swedish International Development Agency (SIDA)
2. United States Agency for International Development (USAID)
3. United Kingdom Agency for International Development (DfID)

These organizations are also often the main funders of health programs commissioned in low- and middle-income countries (Clarke, 2013).

Bilateral cooperation usually includes a political aspect, whereby the organizations offering the cooperation can use the support of their offer as a means of pursuing commercial, diplomatic, or strategic objectives. Bilateral support from the United Kingdom (UK), for example, frequently benefits former British colonies (Lancaster, 2008).

Countries have a long history of cooperation in related fields (Mhembwe & Dube, 2017), although motivations for these collaborations vary. For example, countries may join forces to create public goods that can be sold globally (which governments cannot produce efficiently on their own). An example of this is the COVID-19, Oxford, AstraZeneca vaccine, which was originally developed in the UK but then manufactured across six countries, ranging from high-income countries (UK and USA), to middle income countries (Brazil, Russia, and China), to low-income countries (Thailand; Mahase, 2021). Others may join forces for a cause that benefits everyone, such as eradicating polio and researching global public health problems (Kaul & Faust, 2001; Aylward et al., 2003). Sometimes cooperation is more altruistic, such as offering humanitarian or development aid arrangements in natural (e.g., earthquakes) and man-made disasters (e.g., civil wars; McEwan & Mawdsley, 2012). However, sometimes cooperation is the result of blatant self-interest, such as when countries put other countries under surveillance without their knowledge through the support they offer, an example of which is the surveillance carried out by some high-income countries on specific low-income countries to reduce the threat of bioterrorism (Green et al., 2019).

Self-reflection/discussion

Can you think of three or four multilateral and bilateral organizations that operate in your country? (Buse et al., 2012)

Cooperation in Global Health

Until now, this unit has discussed cooperation in the context of formal interactions between countries and between countries and the UN (Lee, 1998). However, the rise of many non-governmental actors and the establishment of policies through informal channels are two aspects of today's global health scene. (Buse et al., 2012). These two characteristics need to be taken into consideration, with special emphasis on global civil society, international enterprises, and global public-private partnerships. Studies indicate that these actors are active participants in both international and national health policy processes (Buse et al., 2012).

Global civil society

Since the mid-nineteenth century, the number of global civil society groups has exponentially increased from approximately 1,117 in 1956, to around 16,500 in in the late 1990s, with this being predicted to lead to a change in the global social and advocacy landscape (Salamon, 1994, as cited in Buse et al., 2012). Many different actors in global civil society address various concerns and issues, some examples of which are

- maternal health, addressed by, for example, the International Women's Health Alliance (Seckinelgin & Albrow, 2011).
- trade agreements, addressed by, for example, the International Health Initiative, a partnership of NGOs from approximately 70 different countries (Seckinelgin & Albrow, 2011).
- landmines, addressed by, for example, The International Campaign to Ban Landmines, a committee made up of 13 organizations (Seckinelgin & Albrow, 2011).

Additionally, global civil society is a diverse but highly interlinked group of people with a shared vision, reaching across borders via the internet and other means of communication.

The Bill and Melinda Gates Foundation is an example of a civil society organization that has surpassed the World Bank in many aspects, becoming a hub of global health (Buse et al., 2012; Harman, 2016). The foundation was founded in 2000 and is now a major participant in global health, providing more than $500 million per year for health projects in low-income countries (Buse et al., 2012; McCoy et al., 2009). Due to the foundation's vast resources, they have also had a significant impact on priority-setting and health policy (Harman, 2016), playing a pivotal role in reshaping the international health system (McCoy & McGoey, 2011). While the other major health development finance organization, the World Bank, mostly lends funds to governments, this foundation has primarily supported NGOs with grants, particularly those NGOs that are the result of public-private collaborations (Buse et al., 2012). The foundation has assisted in the formation (both directly and indirectly) of many global private-public partnerships, as well as the financial backing and

training of human resources to serve on many of their governing boards (McCoy & McGoey, 2011). Although the foundation's funding, research, development, and product acquisition for neglected diseases like malaria is critical, its role in supporting and encouraging public-private collaboration on health policy issues has been potentially more instrumental to its success and renown (McCoy & McGoey, 2011). The foundation also engages in health policy in other ways, through funding and support for the development and implementation of evidence-based policy developments (Buse et al., 2012). For example, it has provided annual funds to the African Academy of Sciences to strengthen its capacity to provide evidence-based data to inform multiple government policies (van Noorden, 2017). It also backed the creation of the Global Health Policy Research Network, which generates high-impact policy assessments (van Noorden, 2017). Furthermore, because governments, NGOs, and international organizations tend to favor the sources that provide funding, they tend to take into consideration and adopt the health priorities and recommendations set forth by the foundation (McCoy et al., 2009). In addition, the Bill and Melinda Gates Foundation has direct contact and access to key stakeholders, particularly policymakers, globally, as a result of its substantial investments in international health activities (McCoy et al., 2009).

Global civil society organizations, like their local/national counterparts, have been known to play a significant role in public and health policymaking. This role includes working with international entities like the World Bank, hosting national policy discussions etc. (Stone, 2008). They also use similar strategies to some corporate executive teams, focusing on humanitarian intervention in crisis zones through global policy groups and issue networks, such as Médecins Sans Frontières/Doctors Without Borders, or outsider teams, using confrontational techniques, such as stockholder policy, or organizing client boycotts against multinational corporations, or thresholder teams, combing the strategies of both the corporate executive teams and thresholder teams (Buse et al., 2012).

Individual civil society organizations are known to inspire (through raising awareness on new issues), organize (through increasing pressure on the government/state), and track (through assessing the behavior of states and firms and ensure implementation) specific problems and policies (Falk, 2005). As a result of enhanced communication, monitoring, and evaluation, at the subnational, national, and international levels at least, global civil society plays a significant role (Falk, 2005).

The advocacy role of global civil society has been highlighted by Keck and Sikkink (1998; as cited in Buse et al., 2012). Civil society networks and coalition play a role in different sectors of world politics, such as gender-based violence or the rights of HIV/AIDs patients. Through persuasion, socialization, and involvement, such an alliance strives to alter countries' and international organizations' procedures, rules, and behaviors (Keck & Sikkink, 1998, as cited in Buse et al., 2012). The strength of such alliances stems from the sharing of information, ideas, and strategies to change the setting and methods by which a country formulates its policies (Keck & Sikkink, 1998, as cited in Buse et al., 2012). The role of advocacy coalitions and interest groups in altering HIV/AIDS views, for example, has been extensively researched (Seckinelgin, 2002). National action campaigns and the AIDS Coalition to Unleash Power (ACTUP) on a global level have reshaped the agenda and shifted the

perspective of pharmaceutical companies, prompting them to lower drug costs and reduce litigation against governments seeking to implement TRIPS agreements (Seckinelgin, 2002; Buse et al., 2012).

For a variety of reasons, the growth of global civil society has been welcomed. Some attribute this to some governments' inability to govern policy domains, such as health, while others argue that having a strong global civil society improves the policy-making process. Still others feel it reduces conflict by bringing new ideas, knowledge, and transparency into the communication process (Smith et al., 2016). Some see civil society engagement as a way to democratize the international system by giving those affected by policy decisions a voice, resulting in more contextualized policies. As a result, many individuals believe that global civil society transforms people into "global citizens" and causes them to "globalize from the bottom up." Others associate civil society with the development of a humane type of governance, as a counterbalance to the business sector's impact. Others, however, remain skeptical about the significance of global civil society, despite these assurances (Smith et al., 2016).

Example of tobacco control and the role of the global civil society

After nearly four years of negotiations, the member nations of WHO agreed on the language of the Framework Convention on Tobacco Control (FCTC) in May of 2003 (Mamudu & Glantz, 2009). The process was tumultuous and contentious, with the tobacco industry positioned against public health campaigners and scientists, with both sides attempting to sway member nations' bargaining positions. While the text serves as a foundation for national legislation in ratifying countries, the process also serves to shed light on how global civil society affects what happens at international health conferences and symposia, as well as its limitations. Interested NGOs with the WHO's "consultative status" took part in the negotiations formally, albeit in a limited way (no voting), but were permitted to utilize their status to lobby official delegations (Mamudu & Glantz, 2009).

Firstly, numerous NGOs pressured the WHO to speed up the process of foreign NGOs establishing or developing "formal relations" with the organization, and it was decided to make the FCTC process official (Mamudu & Glantz, 2009). Secondly, the WHO convened public hearings on the convention, during which various civil society organizations testified and offered written comments (Mamudu & Glantz, 2009; Buse et al., 2012). Thirdly, the Campaign for Tobacco-Free Kids and the American Society for the Prevention of Tobacco Use (ASH), a well-known civil society organization, provided educational opportunities for delegates by hosting trainings and publishing reports and daily briefs on what was happening at the convention (Mamudu & Glantz, 2009). During the discussions, a fourth, and possibly unique, duty of the civil society was to act as the public health conscience (Mamudu & Glantz, 2009; Buse et al., 2012). Some NGOs, for example, used evocative methods to draw attention to some member states' obstructionist positions and industry tactics, such as handing out awards to the groups that had made the best and worst contributions to the convention (Mamudu & Glantz, 2009; Buse et al., 2012). Finally, members of civil society organizations were able to take part in negotiations directly. During the discussions, global civil society organizations formed a framework convention alliance, aimed at strengthening group communication, and were active in systematic interaction

with small groups in underdeveloped nations. As a result, the alliance was developed with national-level actions, such as lobbying, political conversations, advocacy campaigns, and news conferences (Mamudu & Glantz, 2009; Buse et al., 2012).

Corporations with global reach

A long-running discussion has centered on the commercial (i.e., for-profit) sector's heterogeneity and the ways in which it influences domestic health policy. By pursuing their own interests, the commercial sector, particularly multinational companies, business associations, and transnational corporations, contribute to the international system (Cattaui, 1998). "Business believes that the rules of the game for the market economy, previously laid down almost exclusively by national governments, must be applied globally if they are to be effective. For that global framework of rules, business looks to the United Nations and its agencies," wrote the Secretary General of the International Chamber of Commerce (ICC; Cattaui, 1998, p. 1).

The ICC was particularly interested in the WTO's promotion of business, with the then ICC President also mentioning that the ICC should have more access to the WTO's policies (Maucher 1998, as cited in Buse et al., 2012). As a response, the ICC began to systematically engage with the UN, also launching several approaches to influence decisions, in order to agree on a framework for how to solicit such feedback and input (Maucher 1998, as cited in Buse et al., 2012). The efforts led to a joint statement by the ICC and the UN on what the shared and common values, goals and interest that legally bind major global companies without a formal and legal policy ought to be (Maucher 1998, as cited in Buse et al., 2012). The activities and roles of private international corporations should serve as a reminder of the importance of including this group of stakeholders in health policy analysis and stakeholder engagement (Waxman, 2004).

The following is a list of ways in which the commercial sector exerts influence over governmental and state organizations (Waxman, 2004, as cited in Buse et al., 2012):

- influencing the WHO and other international organizations through policy dialogues
- hindering the implementation of international legal instruments
- obstructing the adoption of a global agreement; for example, in 2003, the sugar industry's considerable opposition to the FAO/WHO's proposed international dietary standards hindered its adoption
- having a say in the content of international treaties

This list demonstrates the private sector's active participation in international organizations. For example, when the public sector is overburdened, the private sector has played a vital role in assisting the WHO in providing maternal healthcare and other essential health services, specifically in several low-income countries, such as Somalia (Ahmed et al., 2020). However, there have been serious questions raised about whether the WHO is accepting pharmaceutical industry banned donations, which would pose major concerns about conflict of interest (Day, 2007).

Partnerships between the public and private sectors in healthcare around the world

One of the hallmarks of the "globalizing world" is the tendency of stakeholders from various sectors to collaborate on policy projects, such as the corporate sector, policy communities, and issue networks (Bishop & Waring, 2016). Since the 1990s, numerous public–private health partnerships have been created, with these partnerships being one of the most apparent forms of collaborative activities between the private and public sectors (Barr, 2007).

While the term "public-private partnership" refers to many projects that involve collaboration between the private and public sectors, in general it refers to entities from the public sectors and the private sector coming together based on common values and goals, with the aim of serving the general public while pledging to work together to achieve these goals (Hodge & Greve, 2007). For example, the Global Partnership to Stop Tuberculosis includes more than a hundred different public, private, and civil society organizations (Sakamoto et al., 2019). Additionally, some partnerships form their own legal structures, like, for example, the International AIDS Vaccine Alliance. The WHO's Roll Back Malaria and UNICEF's Global Alliance for Vaccines and Immunizations are part of already established nonprofit organizations (Buse et al., 2012).

These partnerships can perform a variety of tasks. The Medicines for Malaria Venture, for example, obtains funds from governments and then gives them to biotechnology and pharmaceutical companies to fund the production and distribution of malaria vaccines, particularly in low-income countries with a high incidence and prevalence of malaria (Lezaun & Montgomery, 2015). Other public-private partnerships want to make existing products more accessible to people who might not otherwise be able to afford them, such as public-private distribution of Pfizer-donated antibiotics to nations that have a high prevalence of trachoma-related diseases (Agler & Crigler, 2019).

Some of these public-private health partnerships raise and channel finances for specific diseases or interventions, while others focus on lobbying. Others, for example, develop guidelines and policies not previously been developed by the government. However the majority of these partnerships aim to set the health policy agenda and play a role in the health policy making process (particularly during the formulation and implementation phases; Hernandez-Aguado & Zaragoza, 2016).

From a policy standpoint, what distinguishes global public-private health partnerships is that they have evolved into significant players in global and national health policy arenas (Maltin, 2019). Their power originates from the breadth and depth of resources at their disposal, giving them an edge over companies that operate independently or in a single area. Their strength is also based on their capacity to rally a large number of key policy makers around a single point of view—policymakers who would otherwise have optedfor a different policy option or even not pursue the health policy issue in the first place. As a result, public-private health partnerships have emerged as effective advocates for specific health issues and subsequent health policy responses (Maltin, 2019). However, in some cases and contexts, public-private health partnerships have been shown to have failed. For example, studies in India have shown that public-private health partnership models have failed in the settings of primary and tertiary healthcare (Virani & Ramesh, 2019).

Globalization of the Policy-Making Process

The concept of the "iron triangle" suggests that three major categories of actors are involved in the national policy process, namely elected politicians, NGOs, and interest groups, particularly from the private business sector (Cerny, 2001). A previously mentioned policy becomes more global, with international actors increasingly playing a relevant role in the national and global health policy making process, for which Cerny (2001) invented the phrase "golden pentangles" to describe these policy shifts. The five sides of the "golden pentangles" are civil society, interest groups, global and international actors, politicians, and transnational/international actors (Cerny, 2001).

Even though elected officials and interest groups continue to wield power, entities like the WTO and other international organizations also wield significant power over health policies (Blank et al., 2017). In addition, currently entities like the global health society, global private-public health partnerships, and market actors have gained a notable amount of power to influence global health policy making, any or all of which may be involved in any policy related to health whether nationally or globally, and one or more sets may dominate, depending on the issue (Blank et al., 2017). It is important for policy analysts to determine the various interests that may be at play, as well as the intricacy of the policy process. Managing the discordance of inputs into the policy system is a difficult task for most governments, but especially governments of low- and middle-income countries (Blank et al., 2017).

Low-income nations' health ministries must manage the growing number of stakeholders in the policy process, as well as multiple bilateral interactions with various donor organizations (Buse et al., 2012). In the early 1990s, the demands made on multiple ministries by funders with competing objectives overburdened the already challenged health systems in these countries. As a result, everyone agreed that improved coordination was needed, and efforts were undertaken to develop "sector-wide approaches." These tasks included developing a shared policy framework and a medium-term budget strategy. External donors were expected to only fund specific initiatives in collaboration with domestic partners (Buse et al., 2012).

However, many donors have funded projects that were not part of the initial plan, leading to poor coordination and wasted resources (Buse et al., 2012). Studies show that even though progress was made, it was frequently threatened when novel global public-private partnerships entered the picture. Several countries now have more than 20 public-private health partnerships, many of which run as vertical programs and have parallel governing systems, which, in turn, puts pressure on the Ministries of Health in different ways as they vie for attention, resources, and priority. As a result, new and high-profile appeals for country-level coherence have emerged (Buse et al., 2012). Similarly, it has been established that global coordination is essential in order for national collaboration to be possible.

The Millennium Development Goals (MDGs), renamed the **Sustainable Development Goals (SDGs)**, are the most visible manifestation of this. The SDGs were adopted by 193 countries in 2015 (United Nations, 2015). Countries, particularly low- and middle-income countries, received and continue to receive monetary support from the International Mon-

Sustainable Development Goals (SDGs) These are a series of 17 interrelated global goals, aimed at laying out a roadmap for a better and more sustainable future for all (United Nations, 2015).

etary Fund (IMF) and the World Bank, high-income countries, and the Organization for Economic Cooperation and Development (OECD) to help them achieve the goals (Miola & Schiltz, 2019; Roy, 2019). The 17 SDGs provide indicators with specific targets to measure progress, with all stakeholders being held responsible to achieve these set targets (Buse et al., 2012). Although it is still debatable whether globalization broadens the variety of policy possibilities, it appears that policy agenda-making and formulation are becoming more convergent, particularly in terms of healthcare developments (Drezner, 2001, as cited in Buse et al., 2012).

However, transferring policies from one country to the next (sometimes via international health organizations) is not a simple task (Drezner, 2001, as cited in Buse et al., 2012). Accordingly, studies have highlighted the fact the sometimes policy dialogues or incentive provision like grants and loans do not result in the transmission of policy (Drezner, 2001, as cited in Buse et al., 2012). The processes are frequently lengthy and drawn out, involving multiple organizations and networks at various stages (Drezner, 2001, as cited in Buse et al., 2012). Additionally, it is worth keeping in mind that most donor countries and donors base their decisions on national interests and geopolitical concerns when determining who gets donations to help achieve the SDGs, leaving many countries behind (Heleta & Bagus, 2021).

5.2 Health Policies within the Health-System Context

For political scientists, policy is a hazy concept that is variously defined as “the actions of government and the intentions that determine those actions” (Dye, 1992, p.2), or “anything a government chooses to do or not do” (Dye, 1992, p. 2). Some people refer to policy as simply “the plan” or “the law.” Others refer to “public policy” as formal decisions or plans of action decided by or engaged in by a governmental entity (Dye, 1992). Most people distinguish between the policy problem, how to solve it, and the strategies or policy instruments that should be employed to get there (de Leeuw et al., 2014).

Perhaps much more ambiguous is the term “health policy.” It has been categorically defined as policy that aims to improve population health by de Leeuw, Clavier, and Breton (2014). Milio (1981), who coined the latter phrase, later published a dictionary in which she stated that factors such as education, residence, nutrition, as well as access to essential services, such as healthcare services, were examples of policies that improve people’s living conditions. The impact of a policy on the health system and population health can be used to assess its effectiveness (de Leeuw, 1989).

Role and Importance of Health Policy

Healthcare policy is important because it helps to develop rules and guidelines that benefit patients, healthcare organizations, and the entire healthcare system (Blank et al., 2017). Policies can assist in something as simple as the prevention of medical errors and poor communication regarding medical decisions, to guiding big issues, such as healthcare

financing and the governance of the health system (Blank et al., 2017). Many health policies aim to ensure that the general public has access to healthcare and other resources, as well as the ability to use them to improve their lifespan and quality of life (Blank et al., 2017).

The following are several reasons why public health policy is important (Blank et al., 2017):

- access. Policies in healthcare facilities ensure that staff members' actions comply with current laws and industry rules. This helps to standardize the quality of care given in institutions across the country and around the world.
- compliance/execution. Hospital and other facility administrators' policies also serve in regulating and directing the cost and delivery of health-care services. These cost and service recommendations also promote public availability and aids in the removal of health-care access barriers.
- equity. Policies can help the public in many ways, such as limiting the spread of infections and diseases, offering education about healthier choices and practices, assuring health safety, and enhancing overall quality of life.

Health Equity

Healthcare inequity occurs when one group of people in an economy is in significantly worse health than another and has limited access to care, health inequities can be found in all countries not just low-income ones (Khullar & Chokshi, 2018). In both high- and low-income countries, health inequity has been shown to be directly related to disparities in income. According to studies, the better one's socioeconomic background is, the better their health is (Khullar & Chokshi, 2018). This can be traced back to the concept of social determinants of health, which states that factors like socioeconomic status, education level, where one lives and works, and one's physical and financial ability to access healthcare, among other things, shape one's health both directly and indirectly (Palmer et al., 2019).

Every person has the ability to achieve their optimum level of health, a concept known as health equity (Pollack Porter et al., 2018). Health equity entails collaborating with other sectors to improve the environment in which people live, by addressing the elements that influence health, while identifying how discrimination based on race, religion, ethnicity, age, or gender is a factor leading to health inequity (Pollack Porter et al., 2018). For example, as a result of racist housing policies in the USA, data show that segregation between white Americans and African Americans in terms of where they live has led to significant health disparities, resulted in worse health outcomes in the African American community (Pollack Porter et al., 2018).

The following factors can also contribute to health inequities:

- Those who come from a lower socioeconomic background are more likely to get sick due to poor living conditions, food insecurity, etc. (Graham, 2009).

- Disparities in medical treatment, whereby the best healthcare facilities and medical equipment may not be readily available in rural low-income areas (McCartney et al., 2013).
- Access to health insurance or other health coverage is lacking. Many working-class people cannot afford health insurance, nor do they qualify to be covered by governmental health insurance schemes which are reserved for the poorest. Additionally, patients' medical bills have been rising, along with deductibles, which have also been raised globally by health insurance companies (Abadía-Barrero & Bugbee, 2019).
- Poverty can be caused by poor health. Those who are sick are more prone to fall into poverty as it is difficult for them to find and keep high-paying employment. Furthermore, addiction to substances, such as alcohol, illicit drugs, and opioids may make it impossible to work continuously (Substance Abuse and Mental Health Services Administration, Office of the Surgeon General, 2016).
- Ageis also a factor, as elderly people are more likely to fall ill and are more likely to be poor (McCartney et al., 2013).

Health equity can be achieved by developing public and health policies that aim to address these health determinants using economic, social, and even political determinants. When changes in the use of land are proposed, policymakers ought to contemplate how these policies may affect historically oppressed groups, which could have negative health consequences (Dubowitz et al., 2016). This can be done by taking into consideration how a certain policy can positively or negatively affect minorities and people of color and formulating it to optimize its positive impact, while minimizing its negative impact. Additionally, it is important to formulate policies that aim to reduce health inequities through addressing the social determinant of health (Dubowitz et al., 2016).

Although politicians and policy makers are paying more attention to health inequities, there is little agreement on what can or should be done to address them. Some countries have established specific centers that study how to examine these issues and, in turn, develop potential solutions and policies for them (Graham, 2009). For example, in the USA, the National Center on Minority Health and Health Disparities (part of the **National Institutes of Health**) publishes the National Healthcare Disparities Report and looks at ways to reduce and address these disparities and inequities (Giger et al., 2007). Below are some of the other policies that countries have developed in order to address these inequities (Smith & Krieger, 2008):

National Institutes of Health (NIH)
This is the principal federal agency in charge of biomedical and public health research in the USA. It was established in the late 1880s and is now part of the Department of Health and Human Services of the United States of America.

- raising public and healthcare provider awareness of health inequities, especially in vulnerable and marginalized populations
- expanding health coverage
- increasing the capacity and number of healthcare facilities and healthcare providers in vulnerable, marginalized, or disadvantaged communities
- increasing knowledge of causes and strategies to minimize inequities
- improving access (both physical and financial) to quality healthcare services

Universal health coverage (UHC)

Research demonstrates that universal health coverage (UHC) is the most effective strategy to minimize unfairness and healthcare disparities and refers to a healthcare system, in which all people of a country or territory have guaranteed access to healthcare services (World Health Organization, 2021b). It is frequently structured around providing health services or access to them to all residents, or merely those who cannot afford them on their own, with the ultimate goal of improving health outcomes. This means that anybody and everybody can get the healthcare they require, when and where they require it, without having to pay a high price (World Health Organization, 2021b).

The full range of basic health services includes prevention, treatment, rehabilitation, and palliative care (World Health Organization, 2021b). Accordingly, the basis of any UHC scheme starts with a strong primary healthcare system that aims to prevent diseases (not just treat them) and improve the quality of life through ensuring the physical, mental, and social health of the community. Member states of the UN have agreed to work toward global UHC by 2030 as part of the SDG (World Health Organization, 2021b).

Health in Foreign Policy

States' foreign policies have traditionally been connected to their citizens' health (Feldbaum et al., 2010). Global health challenges have ascended to the highest echelons of international politics in recent years and have been regarded as valid foreign policy issues. For proponents of global health, this higher political priority is a good trend, as it has resulted in increased funding and attention for a number of global health challenges. Yet, previous experiences show that mixing global health and foreign policy has led to conflicts (Feldbaum et al., 2010).

Globalization has made global health more significant than ever before in several facets of foreign policy over the last two decades. Fidler (2004) refers to this as a "revolution" in global health politics, claiming that "nothing in the prior history of national and international efforts on public health compares to the political status public health has reached today" (Fidler, p. 46). Even though the global health community has welcomed this growing political focus, less attention has been paid to why or how global health and global health goals are incorporated into the foreign policy agendas of countries (Feldbaum et al., 2010). Moreover, according to Fidler (2005), global health is essentially a tool or an instrument (for the state), whose value is limited to its utility in serving the state's material interests and capacities. Global health, rather from being transformative, is simply another concern that foreign policymakers evaluate against other national priorities (Fidler, 2005). Fidler goes on to say "when diseases threaten, or show the potential to threaten, national security, military capabilities, geopolitical or regional stability, national populations, economic power, and trade interests, foreign policy makers take notice" (Fidler, 2005, p. 184). This viewpoint is based on realist theories of international relations and explains why global health has recently gained political relevance due to disease's expanding impact on traditional security issues (Fidler, 2005). Lastly, Fidler states that the dynamic relationship between global health and health policy is always evolving and dynamic. This means that, in many cases, global health is influenced by the foreign policy of high-income countries. Therefore, ultimately, global health is driven by the interests of

high-income countries and their foreign policies, yet this also means that the impact is reciprocal and scientific principles lead health action in clear directions, regardless of ideology and power politics (Fidler, 2005).

Evidence demonstrates that there are links between global health, diplomacy, and international trade (among others), highlighting the fact that the main driver behind health is, in most cases, foreign policy interests and not global health equity (Feldbaum et al., 2010). Secondary interests can be diplomatic (such as combating the spread of infectious diseases), economic (such as trade), or strategic (namely combating bioterrorism). But, in most cases, it is a combination of all these interests that guide health policy (Feldbaum et al., 2010). However, there is scant indication that "foreign policy is now being driven substantially by health to protect national security" (Kickbusch et al., 2007, p. 971). However, when global health and foreign-policy goals match, as in the examples of SARS and COVID-19, global health has a significant impact on the practice of foreign policy.

5.3 Public Health Policies Internationally

Over the last two decades, the field of public health policy has grown and evolved, which has been a significant advance for health policies internationally. Historically, public health policies were regarded as part of exclusive national sovereignty, with international cooperation limited to certain sectors. Today, this has completely changed.

Health Diplomacy

Diplomacy is the science and art of handling international affairs and it serves as a tool for international players to carry out their foreign policy (Baylis et al., 2020). Dialogue and the negotiation of alliances, treaties, and other agreements have traditionally been the center of diplomacy. However, the term "health diplomacy" has recently been broadened to cover health treaties, in addition to other measures that aim to promote global health goals (Feldbaum et al., 2010).

Treaty-making and international agreements

The inaugural International Sanitary Conference gathered in 1851 to discuss the collaboration to combat diseases, namely the plague, and is credited with establishing modern health diplomacy (Fidler, 2001). After observing how the movement of people by rail and ship led to disease spread and determining that national quarantine policies were often inefficient to stop the spread of diseases and in order to avoid any disruption in trade, countries tried to meet to discuss how to control the spread of infectious diseases (Fidler, 2001). Prior sanitary accords were incorporated into the International Sanitary Conventions (later called the International Health Regulations) when the WHO was established following World War II (Fidler, 2001; Baker & Forsyth, 2007). These new conventions tried to keep the spirit of the earlier discussions alive by aiming to coordinate disease control efforts so that international trade was disrupted as little as possible (Fidler, 2001; Baker & Forsyth, 2007).

Many member nations realized that these regulations were insufficient towards the end of the 20th century. They only covered three illnesses, countries often did not comply, and the WHO's ability to undertake outbreak surveillance and response was restricted (Baker & Forsyth, 2007). Even when these flaws were identified, attempts to revise the IHRs stagnated until the SARS epidemic of 2002—2003 (Baker & Forsyth, 2007). SARS exposed how diseases can lead to the disruption of global trade and pose a threat to the public health and, ultimately, was the catalyst to finish and finalize the IHR process (Keogh-Brown & Smith, 2008; Feldbaum et al., 2010). In this scenario, advancing global health diplomacy required a challenge to state foreign-policy objectives (Feldbaum et al., 2010).

However, by enabling the utilization of NGOs' surveillance reports and electronic monitoring technology, countries provided the WHO with a new power to infringe on state interests, "privilege[ing] global health governance over state sovereignty" (Baker & Forsyth, 2007, p. 90). During the SARS epidemic, certain countries' actions, particularly the attempts by China to hide information about the disease spurred on the establishment of this new WHO authority to take precedence above national interests (Feldbaum et al., 2010). Yet many still argue that the IHRs favor high-income countries at the expense of low-income countries, thus putting poor countries' health systems at risk of fragmentation (Calain, 2007). These criticisms revolve on the IHR's role in the surveillance of disease as some argue is more useful for wealthier countries attempting to avoid new infectious diseases outbreaks and leave low-income countries behind (Calain, 2007). Accordingly, opine these critics, the WHO's authority in combating infectious diseases has been expanded, because it worked well with the interests of high-income countries (Davies, 2008).

The Framework Convention on Tobacco Control (FCTC) was the second crucial diplomatic accord on health. The FCTC, which was endorsed by the WHA in 2003, was the WHO's first attempt to draft a global health treaty to curb the growth and spread of global tobacco use (Roemer et al., 2005). The FCTC, unlike the IHRs, could not count on such initiatives being a top political priority. The Tobacco Free Initiative by the WHO gathered significant research on the causal correlation between smoking and lung cancer, as well as studies on tobacco's negative economic impact in terms of how it leads to an increase in the burden of disease (Peto et al., 1992). Even diplomatic health talks, especially those considered as major wins for global health over foreign policy, are driven by state interests, as demonstrated by the IHRs and the FCTC (Peto et al., 1992; Feldbaum et al., 2010).

Health as a tool for foreign policy

States are increasingly using health programs to support secondary foreign-policy goals in what is known as "health diplomacy," and not all health diplomacy strives to accomplish global health goals. One notable example are the American Naval ships that provide health and humanitarian assistance to low- and middle-income countries (Vanderwagen, 2006).In addition to the desire to improve health, these missions are driven by a desire to win over people and voters. Foreign-policy interests also justify further USA spending on global health (Vanderwagen, 2006). The USA is not the only country that uses health initiatives to achieve foreign-policy goals, with other countries such as China also having such initiatives in Africa (Fedoroff, 2009; Lord & Turekian, 2007; Yim et al., 2009; Feldbaum et al.,

2010). Vaccines, scientific research, and catastrophe diplomacy are other terms for similar endeavors that use health as a diplomatic outreach tool (Fedoroff, 2009; Lord & Turekian, 2007; Yim et al., 2009).

To summarize, international accords to improve global health have been built through diplomacy, but in many instances the interests of high-income states play a significant role in their success or failure. The governmental use of health as a tool for foreign-policy highlights the significance of such interests in global health diplomacy, creating ethical and policy issues for the global health community (Fedoroff, 2009; Lord & Turekian, 2007; Vanderwagen, 2006; Yim et al., 2009).

Global Health Policy

Global health

Prior to discussing global health policy, it is necessary to define and explain what global health is. It should be noted that there is no universal definition for global health. However, a common interpretation shows that people believe it is putting the health of the people around the world at the forefront, dealing with health concerns that affect nations across the world (Beaglehole & Bonita, 2010). Global health is a concept which looks ahead so that countries can work together to prepare for potential issues (Beaglehole & Bonita, 2010), such as the COVID-19 pandemic, which spread rapidly over the world, bringing many countries to the brink of economic disaster.

Global health does not only deal with pandemics, but rather its main goal is to improve the access to and quality of healthcare services around the world. Therefore, global health is critical for maintaining global security (Beaglehole & Bonita, 2010). Global health considers a number of determinants, or factors, that influence health status. A few examples include diet and physical fitness, lack of access to healthcare, exposure to dangerous substances, and adherence to health and safety regulations (Birn et al., 2017). Though any country can be affected by global health disruptions, poor countries are more vulnerable due to their weaker socioeconomic infrastructures (Birn et al., 2017). Health specialists can promote wellness in a targeted manner and assist limit the consequences of diseases in a community by examining the community's personal, social, economic, and environmental variables. As a result, the economy benefits because fewer illnesses occur and productivity is not harmed (Birn et al., 2017). However, there have been challenges to policy-making using a global health focus. The COVID-19 pandemic highlighted these issues and challenges, including lack of preparedness against pandemics in most nations, as well as lack of communication between local and international health authorities (Zhang, 2021).

Global Health Disruptions Examples

The world faces a multitude of global health challenges, ranging from rising obesity rates and pollution, to humanitarian crises and the spread of antibiotic-resistant bacteria.

The WHO lists the following as some of the most serious dangers to global health:

- pathogens that are highly contagious. Infectious diseases such as Ebola and SARS continue to be a global danger. As people move to more densely populated metropolitan areas, contagious diseases spread more quickly. This expansion is accelerated in low-income areas, where basic sanitation and clean water are more likely to be scarce (Ruger & Yach, 2009; World Health Organization, 2019a).
- antimicrobial resistance. Antibiotic resistance is on the rise, and other factors including weakening health systems, wars, and increasing pathogen transfer between animal and human populations are all helping disease spread. National governments, NGOs, and other organizations have begun to address these issues by sponsoring vaccine development, extending health-care access, and taking other measures (Ruger & Yach, 2009; World Health Organization, 2019a).
- influenza pandemics. Influenza, which caused the fatal Spanish flu of 1918, is another dangerous disease. According to the Centers for Disease Control and Prevention, the pandemic killed 50 million people worldwide over the course of two years. According to the WHO, influenza continues to be a severe worldwide health issue, causing up to 650,000 deaths each year. While focusing on prevention and preparedness, health leaders collaborate to track influenza and develop vaccines and treatments (Ruger & Yach, 2009; World Health Organization, 2019a). A global strategy, as with other highly infectious viruses, is critical.
- HIV/AIDS is still one of the world's most serious health problems. According to the WHO, 38 million individuals worldwide were infected with HIV in 2019. However, as a result of a stronger commitment to fighting the virus, the number of people contracting HIV is decreasing (World Health Organization, 2019a).
- noncommunicable diseases (NCDs). NCDs, such as heart disease, diabetes, and cancer, are the leading causes of death worldwide, according to the WHO. Cigarette smoking, poor diets, obesity, high blood pressure, and high cholesterol are all key contributors. According to the International Public Health Organization, national governments should implement comprehensive and integrated steps to tackle the threat of NCDs. Countries should, for example, attempt to make testing and treatments widely available to their citizens (Ruger & Yach, 2009; World Health Organization, 2019a).
- climate change. As a result of climate change, extreme weather events such as lethal heat waves are becoming more common. Warmer temperatures, in addition to being life-threatening, can result in a loss of productivity, reduced crop yields, and excellent conditions for the spread of infectious illnesses. Researchers from all over the world have teamed up to track climate change's health effects and government responses. They've discovered that climate change affects all countries, and how they respond will have a major impact on world health (Ruger, & Yach 2009; World Health Organization, 2019a).

Global health policy

Global health policy falls under the umbrella of health policy. This type of health policy is related to evidence-based health decision-making across the globe. Its focus is on the access to and the provision of healthcare services at the level of both national and global health systems. It deals with resource distribution between countries and organizations, as well as program implementation as a means of accomplishing health objectives. Global

health policy tackles the health challenges that are faced by countries across the world regardless of these countries' levels of development, socio-demographics, and levels of wealth (Berger et al. 2019).

International Health Regulations

The IHRs were adopted in 2005 by all members of WHO. They include guidelines, standards, and best practices on how to prevent the global spread of and report on infectious diseases infectious diseases. Despite the fact that acute public health threats, including outbreaks of infectious diseases, are generally unpredictable and require a number of responses, the IHRs offer a complete framework that explains how a country must act if and when there is a global public health emergency (World Health Organization, 2021a).

Around 196 countries have signed onto the IHRs, which constitute a binding international treaty. They were established as a result of devastating diseases that ravaged the world, such as the plague (World Health Organization, 2021a). The IHRs also lay forth the criteria for establishing whether or not a situation constitutes a public health emergency of international concern. At the same time, countries who are part of the IHRs are required to constantly monitor their entry points (seaports, land ports, and airports) for potential emerging diseases. This is done through the monitoring of international health documents and, in some cases, the checking of vital signs (such as temperature) of those crossing the border. The IHR ensures the safety and confidentiality of the personal data of all the travelers and all those involved (World Health Organization, 2021a).

The IHRs require that all countries have the following means of (World Health Organization, 2021a):

- detection. Ensuring that surveillance systems and laboratories can detect possible threats.
- assessment. Working with other countries to make decisions in the event of a public health emergency.
- reporting. Informing local IHR representatives or the WHO when there may be a potential risk for an infectious outbreak that may spread globally, leading to a public health emergency.
- reaction. When dealing with public health emergencies, the IHRs also specify what should be done at the countries' entry points in case of a health emergency, as well as how to deal with unjustified travel and trade restrictions to neighboring countries.

This policy is a good example of how countries should cooperate and collaborate to tackle and solve shared health problems (World Health Organization, 2021a).

5.4 Cross-National Learning

Policies, administrative reforms, and laws spreading between jurisdictions, cities, countries, and continents can happen through cross-national learning (Schmid & Götze, 2009). The study of how learning from other countries affects policy changes, such as administra-

tive reforms, is an important, yet hotly debated, topic in policy transfer, policy dissemination, and related literatures. During the last two decades, many academics have claimed that policy developments in other nations have a considerable impact on national policies. There is extensive research that highlights how this cross-national learning takes place in numerous fields, including health policy (Schmid & Götze, 2009).

Learning from the policies of other countries, according to several researchers, is a difficult, if not outright fruitless, undertaking. A number of cognitive, administrative, and political hurdles confront policymakers, limiting the amount of learning and borrowing that may take place. Policy makers also face challenges in determining which practices are "optimal" and why, as well as comprehending how other countries go about the policymaking process and how they can learn from their experiences of policymaking in other countries (Dussauge-Laguna, 2019). They may then run into other problems that impact policymaking in general, such as a lack of money and time, as well as political/bureaucratic conflicts (Dussauge-Laguna, 2019).

Some researchers have also claimed that even when institutional conditions appear to be favorable, cross-national learning is limited. According to studies, learning from other countries has been a challenge (Bonsaksen et al., 2021). For example, the international dissemination of policy, according to some academics, has hampered learning, which has resulted in "policy (mis)learning" or "dysfunctional transfers" (Bonsaksen et al., 2021).

The diffusion and transfer of knowledge may also be sources of policy change and reform (Goldfinch, 2006). This can be done by trying to learn from reform leaders, for example, or by learning from what international organizations are doing (Goldfinch, 2006; Trein et al., 2021). However, sometimes this diffusion/transfer starts from the local level and is adopted by other countries or international organizations (Trein et al., 2021).

The story is slightly, if not entirely, different, for policy transfer and lessons learned in policymaking. In some cases, it is a simple process, but in others it is complicated, as one must consider context and the surrounding environment (Evans, 2017; Dussauge-Laguna, 2019). While scholars rarely give a precise and specific description of learning, they generally believe it happens as a result of a policymaker weighing a specific issue on their policy agenda against a possible solution offered by a policy (Evans, 2017).

Challenges

Cross-national learning is further complicated by the following factors:

- funding and availability of resources. Lack of funding and unavailability of resources can represent major challenges to cross-national learning (World Health Organization, 2017).
- language barriers. Language barriers are a challenge that may hinder the adoption of cross-national learning, as even within one country, there may be multiple languages and dialects spoken (Squires et al., 2020).
- communication difficulties. In low-income countries especially there are challenges in communication, due to a lack of phone services and internet or very slow connections (Squires et al., 2020).

- Cultural differences. Cultural differences both between and within countries may pose a challenge for cross-national learning, especially on specific topics such as sexual and reproductive health (The United Nations Population Fund, 2005).

SUMMARY

Few health policies, or countries for that matter, remain unaffected by global factors and influences. External influences have always been present in national politics, but globalization has amplified and multiplied them.

Globalization is defined in a variety of ways, but it primarily refers to the world's economies, cultures, and inhabitants becoming increasingly interconnected. Moreover, globalization has a significant impact on health, particularly infectious and communicable diseases.

Consequently, in order to mitigate global health challenges, countries have been known to cooperate when it comes to health, especially during health emergencies. Accordingly, there are several global agencies that deal with and play a role in health on a global scale in such as the UN, WHO, and WTO. Global civil society also plays a major role in global health and health policies internationally.

Health policies are important in the context of the healthcare system because they aid in the formulation of recommendations that benefit patients, healthcare organizations, and the entire healthcare system. Furthermore, health policies (particularly UHC) are critical in addressing and eliminating underlying political, economic, social, and physical determinants of health, as well as improving health equity.

Diplomacy is crucial when dealing with global health issues and, as such, there are several treaties and international agreements governing the global health landscape, such as the IHRs.

Policies, administrative reforms, and laws spread between jurisdictions, cities, countries, and continents through cross-national learning. Despite its importance, there are several challenges that hinder cross-national learning, namely funding and availability of resources, cultural differences, language barriers, and communication difficulties.

UNIT 6

LEADERSHIP IN HEALTH POLICY

STUDY GOALS

On completion of this unit, you will be able to …

- explain what leadership is and list different styles.
- discuss the historical views on leadership.
- compare and contrast leadership and management.
- explain what health, public health, and public leadership are.
- discuss multilevel governance, its history, and applications.
- explain Maxwell's leadership levels models.

6. LEADERSHIP IN HEALTH POLICY

Introduction

This unit will discuss the notion of leadership by defining leadership and explaining its history, followed by an explanation of the various different leadership styles. Then it will explain and compare the differences between leadership and management. Some of the enabling factors, as well as the challenges of leadership will be discussed and health leadership (including the different styles of health leadership), public health leadership, and public leadership will be defined and explained. The following section will discuss the notion of multi-level governance, its history, and its different types, after which the implementation of multi-level governance in health (including a case study) will be examined. Finally, one of the most widely used leadership models, Maxwell's five levels of leadership, will be explained.

6.1 Characterizing Public Leadership

Before delving into public leadership, it is necessary to define what leadership is, what the traits of a leader are, what the different styles of leadership are, as well as what main facilitators and barriers that leaders face. Differentiating between a manager and a leader is also crucial. Understanding all these concepts is important to the characterization of public and health leadership.

What is Leadership?

Leading, influencing, inspiring, and guiding people, a group or even an entire organization defines the basis of leadership (Northouse, 2018). Leadership and its definition are usually the subject of a lot of debate and discussion, with the existing literature examining a variety of perspectives on the subject, sometimes contrasting Eastern and Western leadership styles, as well as North American and European methods (Northouse, 2018).

Some scholars define leaders as a social influence procedure, in which a person enlists the participation and support of others in the completion of a common and ethical task (Western, 2019). Essentially, leadership is a significant power dynamic interaction in which the influence of one party (the "leader") encourages others to move or change (the "followers"; Grint, 2005).

Some have challenged the more traditional concepts of leadership management (which describes leadership as something that an individual has or has had because of their position or power), advocating to shift more into the multifaceted nature of leadership (Grint, 2005). Character traits, situational interactions, functions, behavior, power, vision and values, charm, and IQ, to name a few, have all been researched in relation to leadership (Grint, 2005).

Historical Views on Leadership

Historical recordings highlight that human beings have organized themselves into leaders and followers. For example, throughout history the Chinese believed that leaders must govern justly and that those they rule can overpower them if they do not do so (Guo, 2019).

Leadership is decided by one's "blue blood" or DNA, according to pro-aristocracy theorists (Wilson, 2016). Monarchy has an extreme version of the same concept using supernatural sanction to back up its claim against those of the mere aristocracy (i.e., the divine right of kings). More democratic theorists, however, have given examples of meritocratic leaders who benefited from open careers, such as Napoleonic commanders (Wilson, 2016).

Traditionalists recall the autocratic/paternalistic school of thought's role of the Roman "pater families" (Witzel, 2019). In contrast, feminist philosophy may criticize such patriarchal paradigms. Confucianism's ideals of "good living," like the Roman tradition, are strongly tied to the ideal of a male leader whose benevolent rule is supported by tradition (Witzel, 2019).

According to these traditionalists, a leader's intelligence, trustworthiness, humanity, courage, and discipline are all essential attributes (Witzel, 2019). Disobedience may result from relying solely on intelligence, whereas humanity and compassion as stand-alone traits are a sign of weakness, and violence results from a reliance on courage's strength. All of this was derived from **"The Prince,"** which served as a kind of guide for rulers or leaders ("princes" or "tyrants" in Machiavelli's terminology) on how to obtain and maintain power (Witzel, 2019).

The Prince
This work was written in the early 16th century by Niccolo Machiavelli. It highlights how people (namely leaders) acquire and keep power and create a state.

Prior to the nineteenth century, society expected deference and obedience toward kings and lords. Accordingly, it's worth mentioning that the term "leadership" was first included in the Oxford English Dictionary in 1821 (Oxford English Dictionary, 2021). After the industrial revolution, the need for a new paradigm on how to define who, what, and how an elected politician should look and act like arose. This led to theories, concepts, and notions being developed on what "leadership" was. Although the practical connection between leaders and followers has not changed, there has been a shift in accepted (if euphemistic) nomenclature (Skendall & Ostick, 2017).

The development of anarchist ideology also brought into question the concept of leadership in the nineteenth century (Skendall & Ostick, 2017). One response to this denial of elitism was Lenin's philosophy, which called for an elite core of disciplined individuals to lead a socialist revolution and establish a proletarian dictatorship. Other historical leadership approaches have examined the apparent contrasts between religious and secular leadership. For example, Christian leadership thought has always emphasized the management of divinely granted resources, both human and material, and their deployment in accordance with a divine purpose (Skendall & Ostick, 2017).

Styles of Leadership

A leader's style is defined by how they issue orders, implement ideas, and motivate others. It is the result of the leader's thoughts, personality, expertise, skills, and experience. Rhetoric experts have also created frameworks for analyzing leadership (Chestnut, 2017).

Different situations necessitate various leadership styles. For example, autocratic leadership is best in emergency scenarios, when a decision needs to be made on the spot. Alternately, when there is a need to motivate a team and encourage team members to work together as a one unit, then a more "democratic" leadership style is needed (Chestnut, 2017).

Consequently, autocratic leaders do not engage with their teams and do not take their opinions into consideration during decision-making. Instead, they decide based on their own choices and viewpoints. (Gandolfi & Stone, 2018). Leaders who are democratic or laissez-faire take an active role in decision-making, but do so in conjunction with others. They are in charge of ensuring that the decisions they make provide the desired results. They also rely on their team to make most of the decisions with little involvement on the part of the leader (Gandolfi & Stone, 2018). The most effective leadership technique is one that fulfills the group's goals while simultaneously balancing the requirements of individual members (Chestnut, 2017).

A recent military study has articulated a comprehensive point of view of what leadership is, including how a leader must dress, speak, and carry themselves. Physical presence includes military bearing, confidence, physical fitness and resilience, while a leader's intellectual capacity assists in the formulation of solutions and the acquisition of relevant knowledge for the task (Comfort, 2017). A leader's conceptual qualities include agility, judgment, inventiveness, interpersonal tact, and issue competence (Cronin et al., 2003; Comfort, 2017). In addition to technical knowledge and skills, a leader must also have an understanding of cultural sensitivities (Cronin et al., 2003; Comfort, 2017).

The most common leadership styles are described below.

Authoritarian or autocratic

In an autocratic leadership style, as with tyrants, all decision-making powers are consolidated in the leader, meaning that subordinates are not asked or considered for proposals or efforts by autocratic leaders (Harms et al., 2018). Because it provides great motivation to the boss, autocratic management has proved largely successful. Additionally, this leadership style means that decisions are made only by the leader and are only disclosed to other people when the leader decides to do so (Harms et al., 2018). It should be noted that when speaking of this particular leadership style the words authoritarian and autocratic are used interchangeably.

Democratic or participative

The democratic leadership style refers to when the leader shares authority with all the group members, in turn promoting social equality within the group. Shared leadership is another term used to describe this situation (Gastil, 1994).

Free rein

Free rein (more commonly referred to as laissez-faire) leaders give the task of decision-making to their teams and subordinates (Yang, 2015). This leadership style means not interfering with what others do, derived from the French, which literally translates to "let them do." Accordingly, teams and subordinates are given complete power, freedom, and autonomy to set goals, as well as to solve issues and problems (Yang, 2015).

Relationship-oriented and task-oriented

This type of leader forces on finishing tasks in order to meet specific goals (Tabernero et al., 2009). Task-oriented leaders tend to come up with a step-by-step solution to a specific problem or goal, sticking to strict deadlines, and obtaining desired results. A relationship-oriented leader cares about their teams' satisfaction and well-being (Tabernero et al., 2009). Leaders who value relationships encourage group communication, show trust and confidence in their subordinates, and voice approval for completed tasks (Sherwood & DePaolo, 2005; Tabernero et al., 2009). Task-oriented leaders care more about getting a specific answer in order to meet a production goal than they do about pleasing the team and, as a result, they can usually achieve deadlines, but the well-being of their team members may suffer (Sherwood & DePaolo, 2005; Tabernero et al., 2009). These leaders are focused on achieving the goal and delegating responsibility to each team member (Tabernero et al., 2009). Relationship-focused leaders care about their team's progress and the relationships that exist in it, with increased motivation and support for team members being among the advantages of working in this type of environment (Tabernero et al., 2009). However, putting a greater focus on relationships rather than getting work done may cause productivity to suffer, therefore it can be argued that relationship-oriented and task-oriented are not equivalent, but rather complementary.

Paternalism

Paternalistic leadership approaches generally reflect a father-figure perspective (Aydin, 2018). The organization of the team is hierarchical, with the leader being placed above the followers, providing guidance to team members both professionally and personally. The alternatives accessible to the members are generally limited due to the leader's heavy direction. The Latin word *pater*, which means "father," is the source of the term paternalism, in which the leader is almost always a man. ~~In Russia and Pacific Asian countries, this is a common leadership style~~ (Aydin, 2018).

Servant leadership

Due to current management practices, such as Agile, the concept of servant leadership has risen in favor as the world has transformed into an information society (Eva et al., 2019). In this approach, a leader's role is to serve the needs of the team while ensuring goals are met. This approach is known for its ability to create a positive and productive environment, differing from laissez-faire in that the leader constantly collaborates with the team to achieve common goals, but without issuing clear task directives (Eva et al., 2019).

Table 13: Pros and Cons of Leadership Styles

Pros	Cons
Authoritarian or autocratic	
• Accomplishes goals quickly • Keep individuals and groups focused on task	• Sometimes abuse their power • Tends to discourage creativity and new ideas
Democratic or participative	
• Maximizes fairness • Yields high individual productivity	• Accomplishes goals at a slow pace • Is less efficient than other leadership styles
Relationship-oriented and task-oriented	
• Encourages creativity and new ideas • Yields high job satisfaction	• Lacks accountability • Does not mentor staff
Paternalism	
• Teams feel valued • Work and good behavior are constantly rewarded	• Discipline teams in unusual ways • Motivation may decrease over time
Servant leadership	
• Builds strong, close-knit and focused teams • Inspires those around them • Inspires managerial loyalty	• Depends heavily on loyalty and trust • Requires an existing system and willingness to change or improve

Source: Mirna Naccache, (2022).

Leadership versus Management

A lot of people confuse a leader with a manager and vice versa, but it is not true that a good manager is also a good leader (Müller & Turner, 2017). This warrants an explanation of the difference between management and leadership. While both leaders and managers aim to accomplish specific goals and mobilize resources in order to attain a certain mission or vision (Müller & Turner, 2017), the main difference is that a leader has followers, while a manager has employees. In the table below is a summary of the main differences between leadership and management.

Table 14: Leadership versus Management

Leadership	Management
Goal oriented	Task-oriented
Doing the “right” thing	Doing things “right”
Long-term vision/plan	Short term vision/plan
Asks “why” and “what” questions	Asks “how” questions
Aims to take risks	Aims to minimize risk
Encourages the team	Instructs the team
Fosters ideas	Assigns tasks
Inspires trust	Expects control
Inspires innovation	Inspires stability

Source: Mirna Naccache, (2022).

Facilitators and Barriers for Leadership

There are several factors that act either as facilitators or barriers to leadership. Examples of both are listed below (Skendall & Ostick, 2017).

Some example of facilitators are as follows:

- personal development and ambition
- relationships and success
- leadership is valued and promoted
- mentorship and succession planning
- commitment to policy

Some example of barriers incllude the following:

- workplace stressors that cause exhaustion and burnout
- multiple obstacles in the workplace
- multiple sources of tension
- organizational structures and cultural organizational reform attempts
- personnel issues

Health Leadership

In health and health systems, a health leader is someone who develops strategic plans, sets objectives, and steers the stakeholders in the health sector to achieve better health-care (Figueroa et al., 2019). Health leaders are crucial for the effective management of health human resources, as well as other resources. Since modern health systems are

made up of interconnected networks with varying levels of responsibility, effective health leadership is essential to achieve the most accessible and equitable quality care at an affordable cost (Figueroa et al., 2019).

The role of health executives and managers is evolving in at the same pace as health systems. Strategic management that responds to sociological, political, economic, and technological change is essential to strengthen the health system (Figueroa et al., 2019). For example, proper management of healthcare services and their provision needs to exist, requiring sound leadership, therefore the main goal of health leadership is to identify priorities and difficulties, while effectively managing the healthcare workforce in parallel. A variety of leadership strategies can be adapted to the healthcare setting to optimize management in this highly complicated environment (Figueroa et al., 2019).

Collaborative leadership

This type of leadership is based on the notion that when people collaborate it is for the greater good of the organization (Figueroa et al., 2019). Collaborative leadership necessitates the sharing of information with all relevant stakeholder (employees, patients, etc.) so that they can base their decision on facts and data. Accordingly, this type of leadership promotes information sharing, continuous engagement, and communication between all stakeholders. Therefore, for such leadership to be effective, stakeholders must be asked to collaborate and work together (Figueroa et al., 2019).

This sort of collaboration encourages the integration and interdependence of diverse stakeholders while also allowing people to understanding different cultures and develop shared beliefs and values (Figueroa et al., 2019).

Transformational leadership

The transformational leadership paradigm stresses that employees work more efficiently when they have a sense of mission, while the transactional leadership paradigm emphasizes the importance of supervision (Jambawo, 2018). According to the transformational paradigm, leaders must express their vision in a meaningful and inspiring way in order to encourage and inspire their teams. Additionally, the paradigm stresses the fact that such leaders should be ambitious and empowering, with the ability to inspire performance beyond expectations by changing people's mindsets (Jambawo, 2018).

In conclusion, transactional leadership is based on processes and control, necessitating a rigid management structure. Transformational leadership has more to do with motivating others to follow, which necessitates significant collaboration and teamwork (Jambawo, 2018).

Conflict resolution

Although collaborative working methods are highly regarded, only a small portion of time is spent actually cooperating (Perez, 2021). Conflict may be common in healthcare organizations because they operate in a highlight stressful environment, which is exacerbated when there is a lack of proper communication. The most common origins of conflict are

individualistic conduct inside the organization, lack of communication, complicated organizational structures, and conflicts between individuals and groups. Conflicts have several phases, as follows (Perez, 2021):

- latent phases (wherein previous issues come back to the spotlight)
- perceived conflict (when the problem becomes apparent)
- manifest conflict (when the conflict takes place)
- conflict aftermath

Accordingly, leaders must take action throughout all these phases of conflict to ensure that it is dealt with promptly and efficiently (Perez, 2021). There are many conflict resolution strategies that can be used, such as compromise and encouraging communication. For example, to resolve conflicts or avoid them all together a leader can meet with their teams on a weekly basis to receive feedback and discuss any issues team members may have. The most important thing such a leader can do to resolve conflicts is to keep the conversation moving and open (Perez, 2021).

Distributed leadership

Due to globalization, tasks, responsibilities, and leadership must be shared, especially in international organizations (Kumar & Khiljee, 2016). Therefore, leaders need to have the ability to interpret the potential outcomes of the ever-changing landscape of health and their effect on the healthcare organization. They must also be able to cultivate a reputation for the organization that is based on trust and credibility. Additionally, they must work on building strong relationships with all relevant stakeholders. Accordingly, leaders need to identify their talents, strengths, and weaknesses, as all these attributes are interrelated. Because leadership is ubiquitous throughout organizations, the purpose of leadership is to create an environment in which individuals complement both each other's talents and weaknesses (Kumar & Khiljee, 2016). Competence, skill, experience, and willingness to distribute or hold leadership roles and duties are fundamental challenges to this type of leadership (Tahir et al., 2016).

Ethical leadership

This type of leader has been shown to have a significant and positive impact on healthcare institutions as a whole and, in turn, on both the job satisfaction of employees and the health outcomes of patients. Sometimes such leaders need to resist using the following methods to convince their teams (Jambawo, 2018):

- generating enthusiasm for risky tactics
- requiring a shift in core beliefs and values
- playing a role to influence decisions that may benefit some more than others

However, in some cases, the leader may ask their team to do something illegal, which may result in the public losing their trust. A good leader must not have any malevolent intentions, values, or actions, and must respect other parties' rights (Jambawo, 2018).

For example, in healthcare, a lot of the ethical considerations are based on the Belmont report, whose three main principles include beneficence, autonomy, and justice (The National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 1979).

Shared leadership

Healthcare workers have been shown to work well with authoritarian leadership (Perez, 2021). However, they have been shown to favor leaders that are collaborative, offer support, promote continuous development, delegate work and decision-making, and develop strong relations with their team (Perez, 2021). That is why shared leadership is widely regarded as the best type of leadership in health. Individual staff members learn to foster their leadership characteristics as a result of shared leadership, in addition to having greater autonomy. Despite the many advantages, there are still some obstacles to this kind of leadership, such as having no clear chain of responsibility, and that it does not work when there is high staff turnover (Perez, 2021). Many of the issues that can develop in a shared leadership model can be amplified in unpredictable conditions, such as unplanned events that make communication and engagement more difficult, resulting in higher levels of stress (Wadel, 2018).

Public Health Leadership

Public health leaders, through health promotion, evidence-based health policymaking and administration, and engagement with all the relevant stakeholders, are imperative to improving the health and wellbeing of the population they serve (Gianfredi et al., 2019). Capacity building is essential for success because trustworthy and accountable communicators can establish trust. Health leaders can have an impact on the future of public health by lobbying for new health policies to be implemented. For public health executives' professional development, competency-based education is essential for them to build abilities to manage the complex and changing needs of healthcare systems. This aligns with the World Health Organization's (WHO) plan, which lists "strategic leadership for health" as one of the ten main areas of public health practice (Gianfredi et al., 2019).

While, in most cases, public health leaders are individuals, in some cases they are groups, such as lobbyists (Gianfredi et al., 2019). Other examples include worker unions, NGOs, and civil society groups, as well as scientific associations, which also play an important role. Moreover, these groups also tend to engage in research, educate the public, and collaborate with health professionals, as well as advocating to legislators and organizations. Scientific associations are non-profit organizations that promote informative and educational networking among members by hosting dialogues, symposia, and conferences, all potentially contributing to the development of permanent and novel communication techniques (Gianfredi et al., 2019).

Public Leadership

The goal of public leadership is to achieve social outcomes in relation to society, administrative structure, and political governance (Hart & Uhr, 2008). In a political-administrative setting, public officials face a societal challenge in a period when things have become

immensely complex, change quickly, and governments are scrutinized. That is why there is a need for public leaders who can actually shape leadership via cooperation, are connected to society's capillaries, and particularly qualified to ethically serve society's interests and continue to reflect and ask the right questions in the complex environment that is the health system (Hart & Uhr, 2008). These leaders guide, motivate, and take a stand using these abilities.

In a political-administrative framework with many uncertainties, public leadership requires the ability to give direction to the organization as a figurehead and value driver, to inspire, and to take a stand (Hart & Uhr, 2008). This necessitates the ability to deal with paradoxes, react rapidly with various forms of interventions, and maintain calm. The setting and objectives of an organization, as well as the diversity in the team's composition, influence the style of leadership required to foster reflection, contradiction, and (eventually) quality. Administrative expertise and domain understanding within the team are prerequisites (Hart & Uhr, 2008).

Complexity, interconnection, and constant change characterize the civil service environment, which can be described as a dynamic world with turbulent developments (Hart & Uhr, 2008). International and national social developments, as well as technology advancements, have ramifications for society, politics, and administrative structures. Power centers are shifting internationally, from existing institutions to a range of new power centers. One can see increasing participation and collaboration in new partnerships, both within and outside of established frameworks. With more public participation, civil society takes on a more central role. In the "participation society," there is greater co-creation, with the government serving as a network partner. Citizens want to be contacted and involved by the civil service in a different way, not by a typical civil service that devises and implements goals and solutions from an ivory tower, but by one that actively engages with citizens (Hart & Uhr, 2008).

Politicians and civil workers are constantly watched, persuaded, inspected, evaluated, and held accountable by society, aided by the media's growing role and increased focus on incidents (Vogel & Werkmeister, 2021). This has sparked a political trend, wherein the desire to achieve political clout by generating measurable results that can be presented quickly is apparent. In this situation, (senior) civil servants must be able to predict long-term consequences and represent a consistent and dependable government structure that fulfills the needs of a changing community. For "implementation," policy dynamics must remain (or become) manageable. This necessitates a balance of flexibility and strength, while political accountability requires vertical lines of accountability (Vogel & Werkmeister, 2021).

The nature of public leadership

The aphorism that we want a government of laws, not men, is attributed to Aristotle (Poguntke & Web, 2005). This can be seen as the general reason why we have established democracies. Humans, however, can never be taken out of the equation of governance. Indeed, many contemporary commentators in Western-style democracies (such as Australia) claim to have observed an increasing "personalization" of politics (usually attrib-

uted to the decline of ideologies and parties and the rise of television), or an increasing concentration of previously dispersed or collegially shared power in the office of a single individual, such as the Prime Minister (Poguntke & Web, 2005).

In governments, people matter, and some matter more than others. As a result, the majority of studies of public leadership are essentially studies of the lives and specific qualities and behaviors of those who hold significant positions in government (Rhodes et al., 2007). These studies are part of a larger attempt to identify, define, analyze, and evaluate elite behavior—the actions of a select few who wield power and influence over a large number of people. Elites can be studied in a variety of ways, including through interviews, reading speeches and writings, administering surveys to them, by reviewing their résumés, collating and comparing their demographic, social, and professional characteristics, or by simply observing them as closely as possible (Rhodes et al., 2007).

However, while attempting to understand leadership by looking at individuals in positions of power is important, it is not sufficient for our objectives (Lynn, 1981). We want to learn about leadership, which is a collection of behaviors and relationships that people in positions of power and authority, as well as others, engage in. Furthermore, we aim to investigate the nature of a separate, self-aware interest in public leadership, neither as a derivative of corporate leadership, nor as a narrowed down version of executive political leadership (Lynn, 1981).

To do so, public leadership is defined as a set of distinct duties that must be performed in order for a polity to rule itself efficiently and democratically, but that are not performed automatically by the polity's public institutions, organizations, or routines. Institutions, organizations, and rituals are all important, but they only make up the skeleton of the political body. The spirit that brings them to life is provided by the people who live in and with them (Rhodes et al., 2007). When accepting the general theory that public leadership evolves as an adaptive response to the extraordinary and strategic challenges of society, duties fall into three main components of public governance. These three categories are political, administrative, and social (Rhodes et al., 2007).

6.2 Levels of Leadership

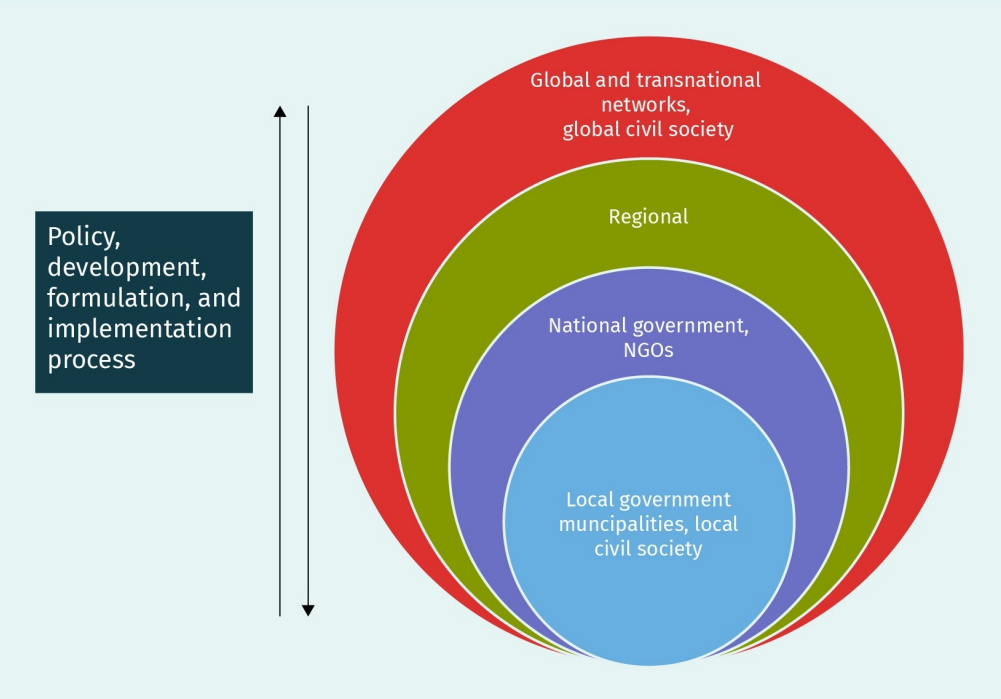
Leadership is dispersed, with several levels of leadership both in terms of public governance and when it comes to the characteristics of the leader themself.

Multi-Level Governance and Leadership

What is unique about multi-level (or multilevel) leadership and governance is how power and decision-making are spread (Cairney et al., 2019). As with other governance schemes, they are spread vertically, meaning across different levels of the government. However, with multi-level governance, power and decision-making are spread in a horizontal manner, meaning between the government and other stakeholders (namely semi-governmental organizations, civil society groups, and NGOs). This situation arises due to the fact that numerous countries have multiple levels of government, including municipal, local,

regional, and international governments, as well as a plethora of other organizations with vested interests in policy outcomes (Cairney et al., 2019). International governance also employs multi-level governance ideas (Schiller, 2018). Multi-level governance is distinct from the notion of multi-level government. Multi-level government refers to when responsibilities and duties are exchanged or shared by different governmental entities, such as ministries. Multi-level governance, however, studies the interactions between numerous levels of government and various sorts of actors (Schiller, 2018).

Figure 12: Multi-Level Governance



Source: Mirna Naccache, based on Hooghe, L. & Marks, G. (2001).

The figure above highlights how the different levels of government work in multi-level leadership and governance, whereby policy can be formulated at the local government level, then disseminated to the other levels. Other policies are formulated at the international/global level and they in turn trickle down to affect policies at the local/municipal level.

History of multi-level governance

Multilevel governance is a theoretical approach to political science and administration emerging from the study of European integration (Piattoni, 2009). In the 1990s, Liesbet Hooghe and Gary Marks first pioneered the concept of multi-level government, which they continue to work on today (Hooghe & Marks, 2001). Their arguments arose from research on the new structures established by the European Union (Maastricht Treaty) in 1992. Multi-level governance emphasizes the interdependence of domestic and international levels of authority and communicates the idea that there are multiple interacting power systems at work (Piattoni, 2009).

Multi-level governance is still considered a political science concept and governance scheme, having been formalized in the mid-2000s when several countries in Europe recognized that power has been shifted from the national state level down to subnational authorities (Jeffery & Peterson, 2020). The early attempts to comprehend this were descriptive, resulting in conceptions spawning a large body of literature (Jeffery & Peterson, 2020). Multi-level governance advocated for the sharing of power in decision-making across all the levels of governance. These ideas have spread throughout political science subfields until it reached health policy at the end of the 2010s/early 2020s (Jeffery & Peterson, 2020). Leadership is critical for governance because it connects reputation to results (Fonseca et al., 2021).

Even multi-level governance and decentralization started in Europe, however research show that is now prevalent across the world (Santos, 2021). A survey published in 2021 highlighted the fact that around 32 international NGOs exercise authority over many international policy issues (particularly health policies), impacting most countries in the world (Wilks et al., 2021). So far, in the twenty-first century, the number of international governmental and non-governmental organizations, as well as their scope, breadth, and intrusiveness, has increased substantially. Cross-border interdependence has sparked regional organization in many parts of the world, dealing with everything from pandemics, to climate change, to bioterrorism (Wilks et al., 2021).

Vertical and horizontal multi-level governance

Multi-level governance has both vertical and horizontal dimensions. The institutional, financial, and informational links that exist between lower and higher levels of government are referred to as the "vertical" dimension. Research has shown that the quality of subnational public policymaking improves greatly when there is proper capacity building for local government (for example, municipalities). Another way to improve subnational public policymaking is through the provision of incentives, namely monetary incentives (Bache et al., 2016).

Cooperation and collaboration agreements across, as well as between, local governments, municipalities, and/or regions is called the horizontal dimension. These agreements are becoming more prevalent due to their positive impact on the quality and efficiency of healthcare services provided by local governments and other local governing entities (Bache et al., 2016).

Health and multi-level governance

In the increasingly challenging landscape of healthcare, governments worldwide are attempting to try to strike a balance between the expectations of the public and the rights of healthcare providers, while ensuring the efficient use of resources (Banting & Corbett, 2002). These challenges are resolved in federal countries by political arrangements that require at least two levels of government to participate and collaborate in the formulation and implementation of health policies (Banting & Corbett, 2002). Literature has looked at how different federal systems deal with the difficulties that come with multi-level government, as well as the consequences of federalism for the formation of health services (Banting & Corbett, 2002; Putturaj et al., 2020).

There are many historical, political, and governance differences between the various worldwide governance schemes, namely the federal system and the unitary system. Yet when it comes to multi-level governance, they are quite similar in terms of how they operate on policy and political issues (Banting & Corbett, 2002; Touati et al., 2019). A comparative approach provides a far more solid foundation for evaluating the health policy implications of various political structures. Too often, analysts and observers conclude that their own political leaders' incapacity to solve serious health policy challenges is due to deficiencies in their country's political structures and procedures (Banting& Corbett, 2002).

Case Study: Multi-Level Governance during COVID-19 Pandemic

Health systems confronted huge problems and demands in 2020 as a result of the COVID-19 outbreak. It became evident that the present sophisticated approach model could not be used to combat this pandemic, as COVID-19 awoke the global public to the importance of local health organizations in general (authorities, hospitals, and local primary healthcare providers; Fonseca et al., 2021). It compelled health-care systems worldwide to adjust their services to meet the needs of the population, with national policymakers, in some cases, adopting public policies based on the dominant traditional worldview. Isolation and social distancing, as well as the installation of public health measures (for example, the wearing of masks and other personal protective equipment), quickly emerged as key methods for fighting such a pandemic (Fonseca et al., 2021). As a result of social isolation and other subsequent measures for social distancing, such as employees working from home or online, the connection between healthcare professionals and their patients evolved (Fonseca et al., 2021). National policies were surpassed by WHO rules, which constrained public health policies (Fonseca et al., 2021). A multilevel governance method was used to mitigate the consequences of this pandemic (Fonseca et al., 2021).

In Portugal, for example, the WHO, which acts at an international level, and the Direço Geral de Sade-DGS (the national health administration of Portugal), which acts at the national level, were both key forces for public health in response to the pandemic. Citizens were aware that scientists provided precise facts, studies, scenario analyses, and solutions to legislators in the current healthcare situation. Meetings were held frequently on both local and national levels, and information was made available to the public on a regular basis (Fonseca et al., 2021).

John Maxwell's "Five Levels of Leadership"

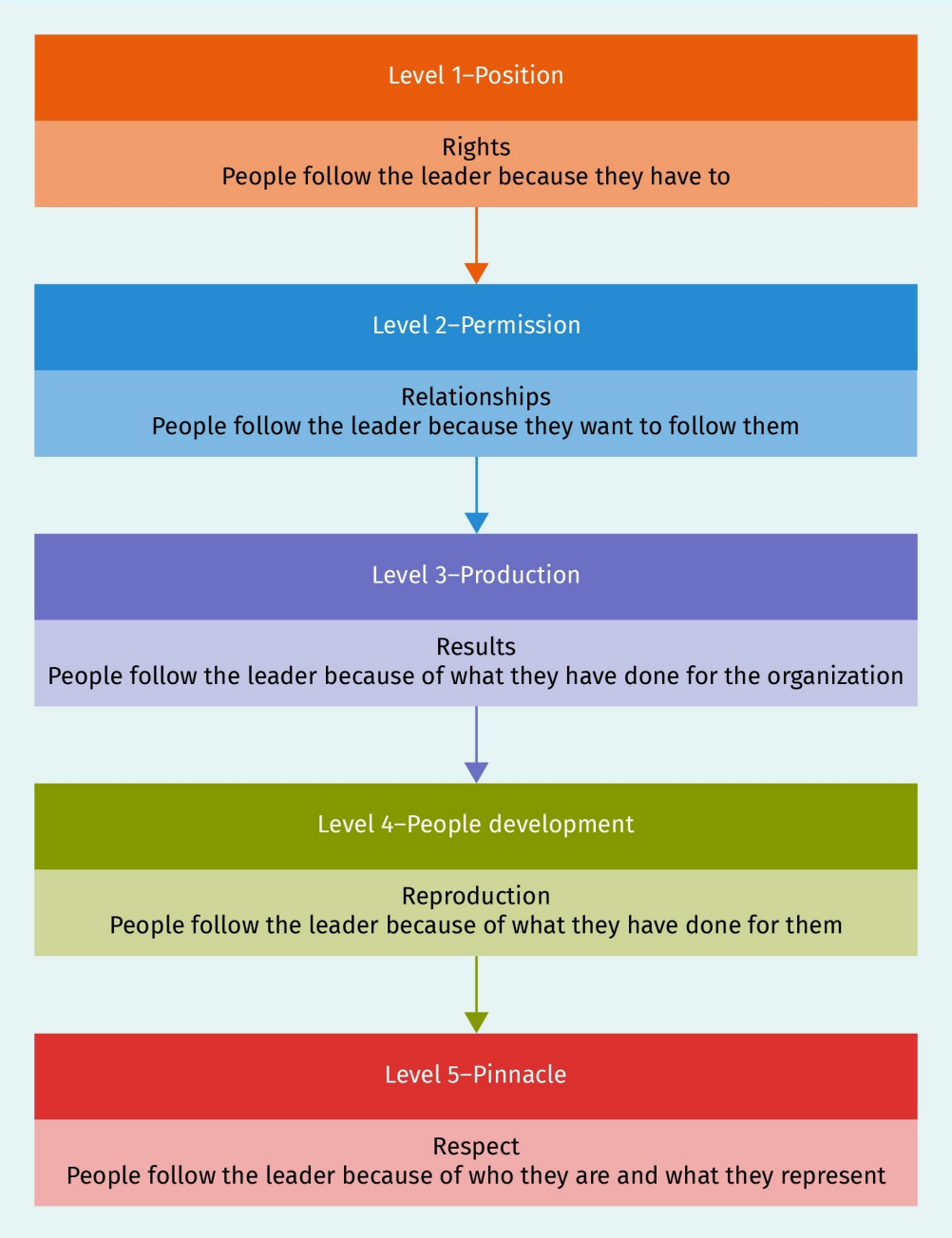
Developing leadership qualities can help one improve certain professional abilities, develop and retain relationships, and boost earning potential (Maxwell, 2013). One of many different leadership theories and approaches is John Maxwell's "five levels of leadership." The levels are (Maxwell, 2013):

1. Position
2. Permission
3. Production

4. People development
5. Pinnacle

It is one of the most widely used models, particularly in healthcare leadership (Armstrong et al., 2019; Endre, 2021; Pattison, 2020). A full explanation of the levels follows the diagram below.

Figure 13: The Five Levels of Leadership



Source: Mirna Naccache, based on Maxwell, J. C. (2013).

Level one: Position

The lowest level of leadership is entry level leadership. At level one, "bosses" will never be leaders, as they only have subordinates and not actual team members. They use rules, laws, policies, and organizational charts to keep their employees under control. Their subordinates follow their commands due to the authority they have and, as such, this level of leadership does not need any actual leadership skills. A post can be filled by anyone, meaning that such a position is a good place to start. Accordingly, every current or aspiring leader must make an effort to improve beyond this level of leadership (Maxwell, 2013).

Level two: Permission

A person's first true step into leadership occurs when they move from position to permission. At this level, leaders start to master the skills needed to influence others. People don't just follow directions, they go above and beyond, begin to take notice, and begin to follow. They do this as it is something they genuinely desire to do and because the leader has learned to influence others via relationships, rather than through position. When they feel liked, cared for, included, respected, and trusted, individuals start to accept the notion of working within a group, which has the potential to alter the entire working environment. People follow leaders with whom they get along, according to the old adage (Maxwell, 2013).

Level three: Production

What defines leaders at this level is their ability to produce results. Leaders who are effective always get things done and are successful, with the potential to have a huge impact on a company. They are not only productive on their own but can also contribute to the team's success. No one can fool anyone into believing that they are a level three leader if they are not. Either you bring in income and contribute to the company's bottom line (whatever that may be), or you do not, ~~usually due to issues related to lack of professionalism or a lack of certain needed skills~~. However, if you want to advance in your career, all you have to do is create. There is no other option. Some people never advance from level two to level three as they do not seem to be able to achieve any outcomes (Maxwell, 2013).

Level four: People development

Productivity is the main point of this level. This includes productivity on the level of the individuals working in the organization and on the level of the organization as a whole. Leaders must convert from producers to developers in order to attain the higher levels of leadership that form elite organizations, as the most important assest in any organization are its human resource. At this level, the role of the leader is to help others improve both personally and professionally. Level four leaders move their focus away from others' production and toward their potential development. According to the **Pareto Principle**, they only focus 20 percent of their attention on production, while investing the remaining 80 percent into growing and leading others. Such people are used to "doing everything and helping everyone," so this can be a difficult change, but it is one that can alter an organization and give it a brighter future (Maxwell, 2013).

Pareto Principle
Often referred to as the 80/20 law or the law of the vital few, it states that 20% of the effort or the causes results in about 80% of the results or outcomes.

Level five: Pinnacle

Leaders who reach level five are extremely rare. This level of leadership requires not just a high level of expertise and some intrinsic leadership talent, but it also involves a high level of competence and some inherent leadership talent. Helping other leaders reach level four requires a lot of time and effort, and this is what level five leaders do. Individuals who reach level five usually lead for an extended period of time and are remembered fondly in the organization. Leaders at the pinnacle stand out from the crowd and are known for bringing success and a pleasant atmosphere to whatever job they occupy. At this level of leadership, the entire organization is lifted, and an environment benefitting the entire organization and everyone in it is developed, adding to the overall organizational success. Level five executives frequently have a sphere of influence that extends beyond the business and sector in which they operate. Most executives who rise to the top of their fields do so later in their careers. This is not, however, a time for them to reflect on their accomplishments, but is rather a replicating environment in which they have the most influence. As a result, leaders who reach the pinnacle should seize the opportunity while they still have it. They should help develop other leaders and assist them while still tackling any potential challenges and always striving to positively impact their organization and their respective sector in general (Maxwell, 2013).

SUMMARY

Leading, influencing, inspiring, and guiding individuals, a group, or even an entire organization is defined as leadership. The history of leadership is long, and literature on the subject analyzes a number of viewpoints, sometimes contrasting Eastern and Western leadership methods, for example the perception of leadership according to the Chinese Mandate of Heaven versus the perception of leadership as per Machiavelli's "The Prince."

There are different styles of leadership, including authoritarian or autocratic, democratic or participative, free-rein or laissez-faire, relationship-oriented and task-oriented, paternalism, and servant leadership.

There is a distinction between management and leadership. While both leaders and managers have several things in common, the primary difference between the two is that leaders have followers and managers have employees. Furthermore, there are multiple factors acting as enablers or barriers for leadership.

In the health and public health system, a health leader is someone who develops strategic plans, sets objectives, and steers the stakeholders in the health sector to achieve better healthcare, while public health leaders play an important role in safeguarding the health and well-being of the population through a number of activities. Public leadership's purpose is to accomplish social outcomes for society.

Power can be spread vertically, across the different tiers of the state and its government. Power can also be distributed horizontally between governmental, semi-governmental, and non-governmental stakeholders. Thus, there are different levels of decision-making and governance which are local, national, regional, and international. Multi-level governance examines the interactions between multiple state levels and different sorts of players.

On a personal level, there are many different models for leadership, with Maxwell's five levels of leadership being one of the most widely used models, especially in the context of healthcare.

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