Health Policy Analysis

An Introduction

Hans Maarse

Maastricht
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PREFACE

This book is intended for students interested in health policymaking. A key theme in the book is that health policymaking includes more than translating empirical knowledge about the determinants of health and disease into effective policy measures. A linear path from knowledge to health policy does not exist. Though undoubtedly of great importance, empirical knowledge on the determinants of life expectancy, quality of life, infant mortality, maternity death, health disparities, and other public health parameters is only one dimension of health policymaking. An instrumental view on health policymaking falls short because it neglects what may be called its political face. Health policymaking is not only a matter of applying empirical knowledge into practice but also the outcome of political contests, ideological beliefs, commercial interests, power, and institutionalized practices. The purpose of this book is to train students in analyzing the impact of these factors on health policymaking.

I wish to express my sincere appreciation to Maastricht University Press for generously supporting the publication of this book as an open access resource, making it freely available to all those interested in health policymaking. This accessibility will undoubtedly contribute to a wider and more informed discourse on this crucial subject.

The book results from many years of teaching health policy analysis or the analysis of and for health policymaking. It could not have been written without the enthusiastic input of all students I have met in my courses at Maastricht University. It is to them I dedicate this book. I also thank Arianne Elissen, Daan Westra, and Harm Lieverdink for their comments on an earlier version of the book.

Maastricht, August 2023

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PART ONE

INTRODUCTION

CHAPTER 1

THE PUBLICIZATION OF PUBLIC HEALTH

KEY POINTS:

- As of the nineteenth century, public actors at the national, regional, and local level have become increasingly involved in the pursuit of public health. This development is conceptualized in this book as the publicization of public health.
- Public health is defined as the size and distribution of health and disease at (sub)-population level.
- Public health is influenced by health determinants which can be classified into six main categories: biological factors, biosphere- and atmosphere-related factors, social and economic factors, environmental factors, behavioral factors, and healthcare-related factors.
- Health policy has a broader scope than healthcare policy. Healthcare policy forms a part of health policy.
- The essence of the 'new public health' is that pursuing public health requires a comprehensive and intersectoral approach.
- The growth of life expectancy worldwide since the middle of the nineteenth century demonstrates the success of the health policy. However, there are still significant health problems and there is much evidence of persistent health disparities worldwide.
- Health policymaking has the structure of collective action.
- Health policymaking is a context-bound activity. It is influenced by cultural, technological, economic, demographic, political, and global factors.
- Health policymaking is likely to expand in the future but may evoke increasing public resistance.
- The commercial sector is ever more penetrating the field of public health.

Box 1.1 The fight against cholera outbreaks

In the nineteenth century, outbreaks of cholera were still common in Europe. The Netherlands, for instance, was hit by five outbreaks: 1832-1833, 1848-1849, 1853-1855, 1859 and 1866-1867. Local authorities tried to control the spread of the disease through public hygiene measures, including cleaning the streets of garbage, sewage, animal carcasses, and repressive measures such as keeping infected people isolated and imposing travel and import restrictions (the disease was assumed to have its origin in Asia). Though these measures mitigated the death toll, they failed to remove the cause of the outbreaks. Because the victims of the outbreaks were concentrated among the poor, it frequently happened that people living in the prosperous city areas blamed the victim by calling cholera the consequence of vice and dirty habits, giving it a social and political dimension.

According to the miasma theory that still prevailed in the early nineteenth century, cholera was caused by noxious air. Consequently, local authorities focused on public hygiene to control the disease. The miasma theory came under attack when some doctors with interest in public health argued that the disease was caused by polluted drinking water. In his investigation of the outbreak in London in 1854, John Snow, a founding member of the London Epidemiological Society, discovered that many people living close to or making use of the Broad Street pump for their water intake had died from cholera, whereas brewery workers and poorhouse residents using uncontaminated wells had escaped from it. Based on this natural experiment, he concluded that the water in the pump had been contaminated by bacteria in human feces. For this reason, he persuaded the London authorities to remove the pump handle, and within a few days, the already subsiding epidemic vanished.

Snow's finding fitted into the advent of a new theory that postulated that separated drinking water and sewerage systems could prevent cholera outbreaks. With this theory in mind, public health advocates in the United Kingdom and other countries – known as the Sanitary Movement – urged sanitary measures from public authorities. Although they received the support of the local bourgeoisie who had learned that cholera did not stop at their front door, it took years before public authorities effectively took up the construction of a clean drinking water system and a separate sewer system. In the Netherlands, the delay was not only due to controversies over the validity

of the new theory but also the result of widespread reluctance among local authorities to take action, and the unwillingness of the national government to obligate municipalities to guarantee their citizens access to clean drinking water. Moreover, the national government refused to support local authorities financially. This lack of support mirrored the prevailing ideology of the 'night watch state' at that time.

Sources: Houwaart, 1991; Tulchinsky & Varavikova, 2000; De Swaan, 1988.

1.1 Introduction

The history of the fight against cholera outbreaks demonstrates a new direction in protecting and promoting public health. All across the world, but most profoundly in industrialized countries, public intervention at the national, regional, and local level to protect and promote the health of the population has radically expanded as of the nineteenth century by issuing health laws, carrying out public (childhood) vaccination programs, imposing food safety and road safety standards, launching health campaigns, regulating the financing and organization of health care, setting up local and national agencies for public health, managing epidemics and pandemics, and many other activities. Each of these interventions has contributed to the transformation of health systems into what they are today: complex, extensive, and expensive systems for public health. This development is referred to in this book as the publicization of public health.

Until the nineteenth century, public interventions to protect and promote public health were still in their infancy. Caring for patients by medical doctors largely consisted of what nowadays is called lifestyle prescriptions, for instance rules for diet, exercise and rest, sleep behavior, sexual activity, body hygiene, and control of emotion. Public interventions to contain the outbreak of infectious diseases concentrated on the isolation of infected persons and the imposition of travel and trade restrictions. Various cities had also introduced a local medical police to foster public hygiene. All this would change as of the nineteenth century when medical doctors interested in public health called for a new approach. Members of the so-called Sanitary Movement, such as Edwin Chadwick (1800-1890) in the United Kingdom, Rudolf Virchow in Germany (1821-1902), and Levy Ali Cohen in the Netherlands (1817-1889),

argued that the treatment of individual patients had to be complemented by population-based interventions. Many health risks, including poverty, poor housing, or contaminated water, could only be tackled by collective action.

Initially, collective action took place mainly at the local level by civil society organizations (organizations with a social purpose) and municipalities. Civil society organizations claimed a role for themselves in providing health and social services to their clientele and perceived state intervention as an intrusion in their work field. Nevertheless, state actors have become ever more involved in protecting and promoting public health. After the state had issued its first state laws for public health and health care in the nineteenth century (the first Public Health Act in England dates from 1848), public attention to health problems rapidly expanded in the twentieth century. Nowadays, it is impossible to imagine public health without public intervention. Caring for public health has become part of the public domain.

The attention to public health draws upon the insight that many health problems can and should be prevented by interventions at the (sub)population level. The occurrence of disease is no longer interpreted as a matter of misfortune or God's punishment of sinful behavior but as the effect of a complex set of factors many of which are beyond the control of the individual. Pursuing public health requires collective action because poor working and living conditions, contaminated nutrition and drinking water, environmental pollution, and global warming, to mention a few examples, cannot be resolved at the individual level. Spectacular advancements in bio-medical knowledge and vaccination technology have also contributed to the rise and expansion of the public health agenda. Nowadays, national (childhood) vaccination programs are known as one of the most effective interventions to protect public health (Van Wijhe, 2018).

Many countries have incorporated the state's responsibility for the health of its population in their national legislation. In the Netherlands, this responsibility has been laid down in the constitution. Article 22.1 of the Dutch Constitution states that 'the government takes measures to promote public health.' Though formulated as an open

norm because the measures the government should take to promote public health remain unspecified, it is nevertheless a norm not free of obligation.

The emergence and expansion of health policy are closely associated with the creation of nation-states on the European continent in the nineteenth century. This historical development meant the introduction of national governments in charge of governing their country and taking care of the welfare of their citizens. Initially, however, national governments were hesitant to take action. Following the 'night-watch state' ideology, public health was seen as a primary concern of actors operating at the local level. This situation has undergone radical change ever since. Nowadays, national governments have taken the lead in many areas of public health, though in some countries more than in others. However, the centralization in health policymaking did not mean that local and regional governments and civil society organizations have lost their place in public health. In many countries, they are closely involved in protecting and promoting public health within a general policy framework set out by the national government. A new development is the involvement of international actors in public health such as the World Health Organization and the European Union.

1.2 What is public health?

Public health must be distinguished from medicine (health care). While medicine involves the provision of health services to individuals who have fallen ill, public health is concerned with health and disease at the population or subpopulation level. Public health is 'public' in two ways: public in the meaning of going beyond individual health and public in the meaning of requiring public or collective action (Tulatz, 2019). Collective action can be taken by various actors including, among others, the neighborhood, the municipality, charitable organizations, the state, and organizations operating at the international level. This book focuses on the role of public or state actors in the pursuit of the health of its citizens. However, this focus does not mean that other actors' activities will be left out of consideration. On the contrary, health policymaking has always been heavily influenced by medical organizations, health experts, commercial stakeholders, the media, the judiciary, knowledge institutes, and

many other actors. Member states of the European Union must nowadays increasingly reckon with European regulation and initiatives.

Definition of public health

Public health has many definitions. A well-known approach is to define the concept in terms of interventions. An example is the definition of Verweij and Dawson (2007) who describe public health as 'collective interventions that aim to promote and protect the health of the public' (p. 2). Pomerleau and McKee (2005) conceive public health as 'the science and art of promoting health and preventing disease through the organized effort of society' (p.11). These definitions have in common that policy interventions are part of public health.

Tulchinsky and Varavikova (2000) follow a similar approach. Their comprehensive definition of what they call the 'new public health' runs as follows: public health comprises 'a very wide scope of organized activities, concerned not only with the provision of all types of health services, preventive and therapeutic, but also with the many other components relevant to the operation of the national health system. These involve questions on health and the environment as well as the production of resources (personnel and facilities), the organization of programs, the development of economic support, and the many strategies required to ensure equity and quality in the distribution of health services' (p. xix). By speaking about new public health, the authors distance themselves from the medical model and individualistic orientation in public health that dominated public health for a while in the 20th century, and led Fairchild even speak about 'the exodus of public health' (Fairchild et al., 2010).

The call of Tulchinsky and Varavikova for a comprehensive approach to public health resonates with the concept of 'Health in All Policies' which holds that public policy-makers should adopt a collaborative and intersectoral approach to public health by taking into account the health consequences of their policy decisions in each sector of public policymaking. The European Union has embraced this approach, witness article 168.1 of the Lisbon Treaty, which states that 'a high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities'.

This book takes a different approach by defining public health as 'the size and distribution of health and disease in the population' (Stronks & Bugdorf, 2021: p.4). Common indicators to measure public health are life expectancy, mortality, disease incidence and prevalence, quality of life, and health disparities. Our definition keeps public health separate from public health policymaking: public health is viewed as the object of health policymaking. In other words, health policymaking is directed at the protection and promotion of public health. Public health is conceptualized as the dependent variable in the policy–public health relationship. Of course, the relationship between public health and health policymaking can also be reversed because many public health problems ask for state action. Here, health policymaking is the dependent variable in the health policymaking–public relationship (see Figure 1.1). The emphasis in this book, however, is upon public health as dependent variable.

The five P's of public health policymaking

Following Brown (2010), health policymaking comprises five main activities:

- Protection of the population against exposure to illnesses that are contagious person-to-person or health risks from environmental sources.
- Prevention of disease by identifying and arresting health threats before they strike.
- Promotion of public health by fostering 'healthy living' and creating a 'healthy living environment'.
- Prognosis by anticipating public health risks through surveillance and monitoring.
- Provision of health services to care for patients.

The provision of health services is sometimes viewed as an activity largely falling beyond the scope of health policymaking. Health policymaking takes a population perspective instead of an individualistic perspective focusing on the treatment of patients (Parmet, 2009). Nevertheless, there are good reasons to consider the provision of health services an important dimension of health policymaking because of its essential contributions to public health. For instance, the increase in life expectancy and quality of life of patients with cardiac problems is closely related to the advance of cardiology. Many types of cancer are expected to become a chronic

disease (Mackenbach, 2020). Failing access to medical care (including prescription medicines) in middle-income and low-income countries is an important cause of public health problems.

This book adopts Brown's broad interpretation of public health policymaking. For linguistic convenience, the five activities will be summarized hereafter as the pursuit and promotion of public health.

Public health as a multidimensional policy issue

No question that public health is foremost a matter of health and disease at the population or subpopulation level. However, it has many other dimensions as well. A brief overview with some examples:

- Legal dimension (health legislation; health as a human right).
- Financial dimension (healthcare expenditures; cost control).
- Social dimension (SES-related health disparities; social impact of health and disease).
- Technological dimension (the advance of the digitalization and datafication of health).
- Economic dimension (health as business model; economic consequences lockdowns).
- Political dimension (conflicts in health policymaking; power balance in the health system).
- Global dimension (health issues in international trade; health disparities between industrialized countries and the rest of the world).
- Public security dimension (health-related migration, bioterrorism).

This brief overview demonstrates that public health is no exclusive domain of health professionals. The study of public health requires a multidimensional perspective to understand its complexity and implications.

1.3 Analytical model of public health

Figure 1.1 is a simple analytical model of public health based on the health field concept of Lalonde (a former federal Minister of Health in Canada). The model defines health as the result of six major factors: genetic and biological factors; environmental factors (for example air quality, water quality, soil quality, and physical environment); social-economic factors (for example living and working conditions, inequity, and prosperity); behavioural factors (lifestyle); the organization of health systems. Figure 1.1 adds the biosphere and atmosphere as sixth factor to Lalonde's field model because these spheres are increasingly recognized as important health determinants in the future (WHO, 2018; Woodward et al., 2014; KNAW, 2023). The model sees the state as part of the health system. Following the definition of the World Health Organization (2000), this system consists 'of all organizations, people and institutions producing actions whose primary intent is to promote, restore or maintain health'.

Figure 1.1 Model of public health and health determinants

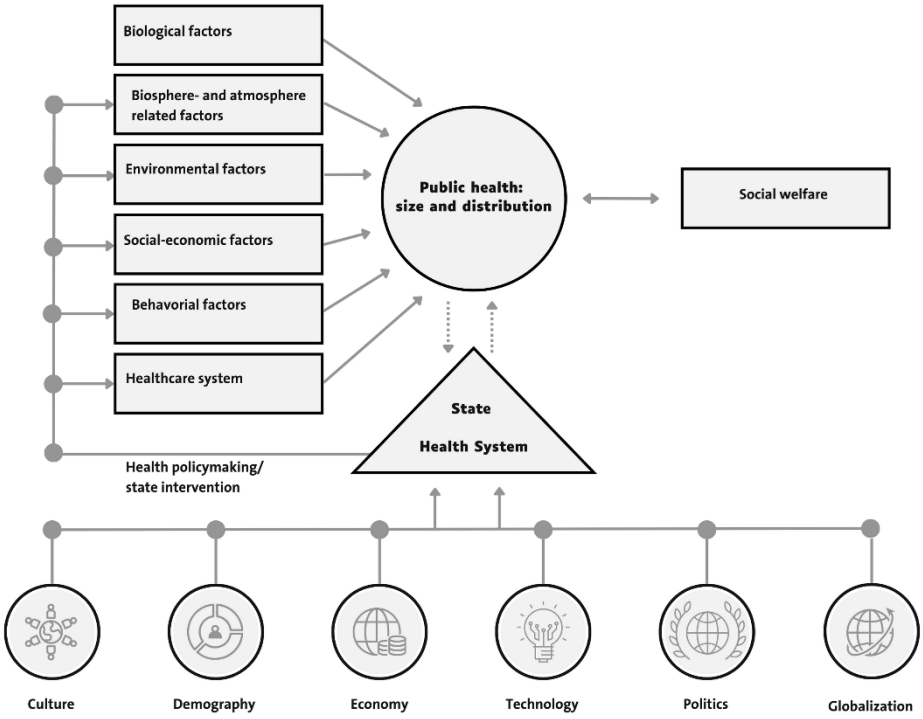


Figure 1.1 visualizes that public health is influenced by multiple factors and that health policymaking should take a comprehensive and intersectoral approach. A biomedical approach involving, for example, national screening and vaccination programs and establishing an up-to-date healthcare system, falls short because it leaves crucial determinants of public health unaffected.

In the model, the state influences public health through interventions directed at the determinants of public health. The dashed arrow from public health to the health system represents the impact of public health on the health system. Problems in public health are the reason for state intervention. Public health contributes to social welfare. Conversely, social welfare and its distribution across society influence public health. For instance, there is much empirical evidence that more equal societies perform better in many areas of public life, ranging from life expectancy to depression levels and from violence to illiteracy (Mackenbach, 2019; Wilkinson & Pickett, 2009). Contextual factors influence the health system and health policymaking. These factors are discussed in section 1.7.

The dashed arrow from the state to public health represents the impact of state policies on public health that do not primarily aim at pursuing public health yet affect public health. An example is education policy the primary purpose of which is to provide students with knowledge and insight. However, education has a positive effect on public health. Similarly, public health benefitted from state interventions to manage the financial crisis in 2009-2012 because they eased off the deep financial concerns of many people. Nevertheless, it would be conceptually wrong to consider education or financial policy an element of health policy. Conversely, state measures can unintentionally cause health problems. An example is the increased prevalence of mental health problems, particularly among young people, as a side effect of lockdowns during COVID-19 (Moeti et al., 2021; RIVM, 2022).

The call for a comprehensive approach is not unique to health policy. A similar approach has been recommended for other parts of public policy. An example is the all-hazard approach in public security the purpose of which is develop an integrated approach to emergency preparedness planning. The focus is on capacities and

capabilities that are critical to preparedness for a full spectrum of emergencies and disasters. The emphasis is upon hazard mitigation and the improvement of system resilience (https://www. alertmedia.com/blog/all-hazards-approach).

Table 1.1 illustrates the variety of state interventions concerning COVID-19 by type of health determinant.

Table 1.1. Examples of state interventions to suppress COVID-19

Target system	Interventions
Society	Closing borders, airports, schools, bars, restaurants, theatres and non-necessary shops; ban on sports events; ban on visiting sports events; gathering ban; QR-code; economic relief measures.
Health behavior	Social distancing; wearing face masks; washing hands; restriction of social contacts; remote working; curfew; sanctioning offenders.
Health care	Upscaling testing capacity and IC capacity; purchase of protective means; vaccine development; mass vaccination programs; financial support for hospitals and other care providers.

The distinction between health policy and healthcare policy

The term state intervention in Figure 1.1 refers to public policies directed at the determinants of public health. In this respect, a distinction can be made between public health policy and healthcare policy. Public health policy, or briefly health policy, is in principle directed at all health determinants, while healthcare policy concentrates on health care. In other words, healthcare policy forms a part of health policy. Health policy goes beyond the boundaries of healthcare policy. The central message of the Health for All Declaration of 1978, known as the Alma-Ata Declaration, and the call of Tulchinsky and Varavikova for 'a new public health' was that the protection and promotion of public health involve more than a well-developed healthcare system. The Declaration advocated a revision of the health agenda by moving away from the then prevalent biomedical and individualistic perspective in public health towards a population perspective. The protection and promotion of public health requires a comprehensive approach directed at the determinants of health and illness.

Interventions directed at the healthcare system

Many public health interventions are directed at the healthcare system. Central themes in healthcare policymaking are the provision of health services (including vaccination and screening programs), the financing of these services, the distribution of the financial burden of health care over the population, and the payment of healthcare workers and provider organizations. There are plenty of studies providing an excellent analysis of these themes and the pros and cons of alternative options to organize the provision, financing, and payment of health services. International comparison of national healthcare systems have demonstrated fundamental differences in the provision, financing, and payment methods and healthcare governance. A fourth central theme is health system governance which can be provisionally defined as the organization of the policymaking process.

Interventions directed at other determinants of public health than healthcare

As said above, health policy has a broader scope than healthcare policy. A comprehensive and intersectoral approach comprises interventions directed, at least in theory, at all determinants of health. The goal of these interventions is the pursuit of public health at the (sub)population level. Examples are the regulation of food safety, the provision of clean water, anti-tobacco regulation, the creation of a healthy living environment, and the regulation of occupational health to protect workers.

Although the prevention and promotion have a central place in health policymaking, there are several reasons why these activities carry much less weight in the health policy arena than the provision of medical services (health care). Effective prevention and promotion are equivalent to the non-occurrence of disease. This makes their effectiveness much less visible than the effectiveness of successful medical interventions, even more so because the effects of prevention and promotion are, for the most part, long-term effects (Haslam, 2023). The assumed causal relationship between prevention and promotion on the one hand and public health on the other hand is also uncertain. A paradoxical aspect of prevention is that effective prevention may make people believe that a disease has been eradicated, as a consequence of which they take it less seriously. In other words, the risk of effective prevention is that it may lose

its effectiveness because of its success! Third, prevention and health promotion are frequently criticized because of their patronizing image. Similar problems hardly exist in medical care.

Prevention and health promotion find themselves in a vulnerable position compared to medical care. Medical care appeals much more to one's imagination than prevention and health promotion. Medical advance also receives much more public attention and is frequently heralded as a sign of human progress. While the political pressure to cover the costs of new spectacular services is immense, political enthusiasm for prevention and health promotion often lags behind. Last but not least, the power of public health advocates in the health policy arena often tends to turn pale in comparison with the power of the medical profession (Haslam, 2023). However, there is one major exception: COVID-19. In response to the outbreak of the pandemic in 2019, governments worldwide spent large amounts of public money on the fight against the pandemic and its consequences. In the Netherlands, for instance, COVID-related expenditures amounted to EURO 87.6 billion in 2020-2023. The bulk of these expenditures went to test services and personal protective equipment as well as the financial compensation of firms for the loss of revenues due to lockdown measures. Health promotion also played a major role in the government's strategy to control the spread of the coronavirus: wash your hands regularly, keep distance in contact with other people, work at home, do not shake hands, wear a face mask, and so on.

The costs of prevention and health promotion

Health spending goes overwhelmingly to the provision of health services (health care). The fraction of all other activities in health spending (the OECD uses the term 'preventive care' to indicate these activities) fluctuates around a few percent of total health expenditures in OECD countries (OECD Health Statistics). However, this percentage underestimates total expenditures of prevention and health promotion because it only includes expenses that are counted as health expenditures. The problem with prevention and health promotion is that these activities miss clear boundaries. The costs of tobacco control measures, food safety control, clean air, water quality, and drug prevention, to mention only a few examples, should be factored in to get an accurate picture of the expenditures for prevention and health

promotion. However, where to draw the line? Which expenditures should be included and which excluded?

Van Gils and his colleagues (2020) have presented a more complete picture of the expenditures of what they call prevention. They found that the Netherlands spent in 2015 an estimated amount of €12.5 billion on prevention, of which €2.5 billion were spent on disease prevention (e.g. screening and vaccination programs), €0.6 billion on health promotion (programs to stimulate a healthy lifestyle), and 9.5 billion on health protection (e.g. protection against environmental risks, food safety, and clean water). Measured as a percentage of the Gross Domestic Product (GDP) total spending on prevention had decreased from 2.5% in 2003 to 2.5% in 2016.

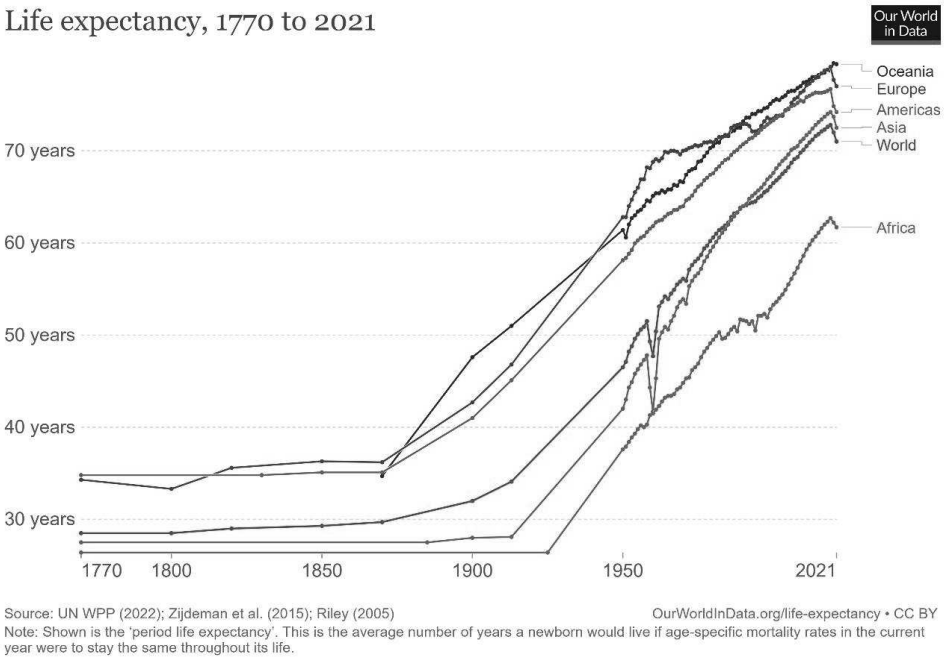
1.4 Success and failure of health policy

What is the evidence of the effectiveness of state intervention in public health? For an answer to this question, it is interesting to look at the development of life expectancy at the global level (Figure 1.2).

Figure 1.2 highlights a remarkable growth of life expectancy at birth worldwide since the second half of the nineteenth century. This growth has many fathers. Mackenbach (2020) mentions five factors that have contributed to significant changes in public health: (a) the improvement of living conditions without any human involvement (e.g. climate change); (b) social changes that have improved public health (e.g. the transition from an industrial to a service economy); (c) interventions that, as a side effect, have contributed to public health (e.g. education); (d) public health interventions (e.g. vaccination programs); (d) medical care (p. 12). Although it is difficult to disentangle the effect of each of these factors, Mackenbach makes a reasonable case for the contributions of public interventions and medical care to mortality decline.

Figure 1.2 demonstrates that life expectancy in Europe and the Americas has risen from some 35 years to over 70 years. Particularly interesting is that the rapid rise in life expectancy dates from the middle of the nineteenth century. This was exactly the period in which state intervention in public health started off in many countries.

Figure 1.2 Increase of life expectancy across the world, 1770-2021



Source: Our World in Data

In several studies, the British physician and medical historian McKeown has argued that population growth in England and Wales since 1700 had been primarily due to the decline of mortality and the improvement in the overall standards of living. The decline in infectious diseases mainly caused a decrease in mortality. His most contentious conclusion was that the contribution of medicine to the decrease of mortality due to infectious diseases had been marginal. McKeown based his challenging conclusion on the following argument. Since effective medical interventions against infectious diseases were hardly available in the nineteenth century, most of the decline in mortality in that period cannot logically be attributed to advancements in medicine. As an alternative explanation, he postulated that the decline of infectious diseases had to be attributed to other factors, including limited family size, increased food supplies, improved nutrition, and sanitation. Based on this alternative explanation, he strongly emphasized the need for prevention and a more balanced allocation of the scarce resources for public health and medicine.

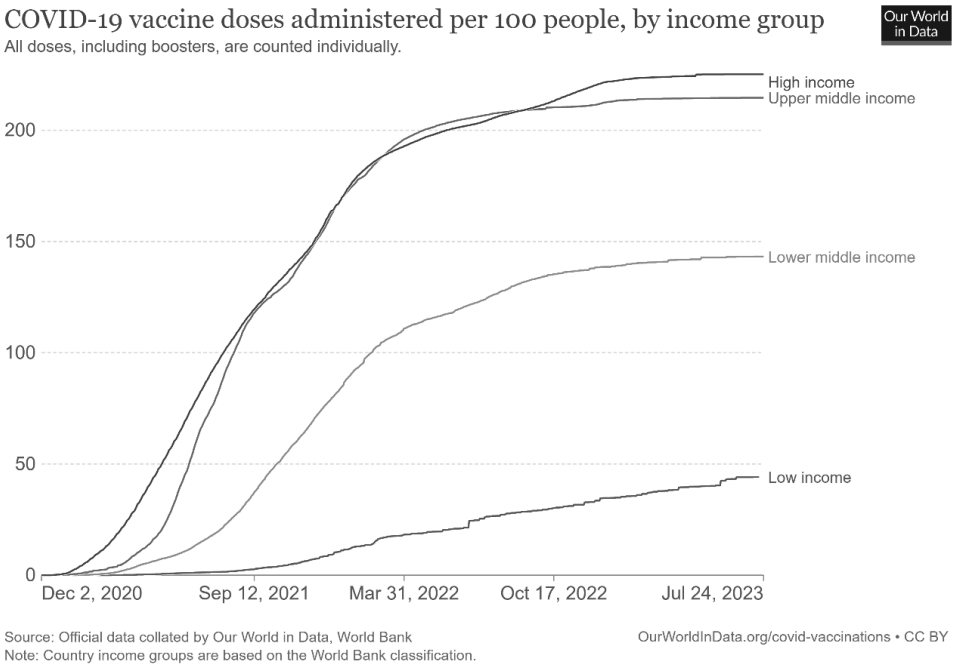
The McKeown thesis has met much criticism (e.g. Mackenbach, 1996). Critics put forward that his empirical analysis was inaccurate and that his explanation for the decline of mortality in terms of the improvement in the overall living standards missed a firm empirical basis. The nineteenth century was a period of rapid industrialization and urbanization. Many people in urban areas lived in deplorable conditions. McKeown's claim also incorrectly repudiated, his critics claim, the evidence for the contribution of medicine to public health in the 20th century (Mackenbach, 2020; Nolte et al., 2012). Nevertheless, the McKeown thesis has attracted broad attention. It resonates with the call for a 'new public health' and a paradigmatic shift in public health from a biomedical approach to an approach directed at health protection and promotion.

Figure 1.2 not only highlights the success of public health interventions but also some of their failures. It shows that the increase in life expectancy started around 1850 in Europe, the Americas, and Oceania. Asia and particularly Africa lagged almost a hundred years behind. Europe, the Americas, and Oceania are also leading regarding life expectancy in 2019, whereas Asia and Africa score significantly lower. In short, the comparison of global public health trends reveals significant life expectancy disparities, indicating that continents have not benefitted equally from the progress in public health. It is beyond the scope of this chapter to explore the causes of these differences. However, there are good reasons to mention the problems of failed states and the unequal distribution of wealth across the globe as two important causes of the unequal distribution of public health. Vaccine inequity between high-income and low-income countries during COVID-19 is only a recent manifestation of the unequal distribution of health worldwide (Figure 1.3).

Widespread and persistent health disparities across the population are another aspect of failing public intervention. While the health of the population has significantly improved over the last two decades, not all people have benefitted equally from this progress. Studies demonstrate huge health disparities across Europe (Mackenbach, 2019). In its forecast on public health in the Netherlands, the National Institute of Public Health and the Environment reported a difference of 7.5 years in life expectancy between people with low and high education in 2011-2014. The difference

in life expectancy in good perceived health between both categories was estimated at almost 19 years (RIVM, 2018). According to the latest data, the disparities have increased ever since (CBS, 2022). There is overwhelming evidence of a strong correspondence between structural factors, in particular income inequality and health inequality (Wilkinson & Pickett, 2009). It has been calculated that the average life expectancy of a person born in London drops by one year for every two stops traveling eastward on a London Underground train from Westminster on the Jubilee Line (BBC News, 20 July 2012). The correspondence between income inequality and health inequality underscores the need for a comprehensive approach. A biomedical approach only fails.

Figure 1.3 COVID-vaccine doses administered by 100 people, by income group



Source: Our World in Data

1.5 Health policymaking as collective action

A central theme in this book is that the state has become actively involved in public health. The state's central role does not mean, however, that it can protect and promote public health on its own. On the contrary, the pursuit of public health should be understood as a process of collective action.

First, it should be emphasized that the state itself is no unitary actor. It has a multi-actor structure. It consists of numerous actors that participate in health policymaking. Examples are the government (in many countries consisting of a coalition of political parties), government departments, civil service, inspectorates, regional authorities, municipalities, public health agencies, regulatory agencies, and many others. Each actor has its own policy beliefs, interests, and standard procedures. Reaching and maintaining agreement within the ranks of the government can be quite challenging.

Secondly, the state has a multi-level structure. In various countries, including England, Germany, the Netherlands, and Scandinavian countries, a great deal of health policymaking is devolved to the regional and local level. A new development is the involvement of international organizations in public health, such as the World Health Organization and the European Union.

Thirdly, the concept of state might be mistaken by the implicit suggestion of a command-and-control relationship in health policymaking. While it is a matter of fact that the state has acquired intervention power in public health, its power should not be overestimated. Nowadays, provider organizations, health funding organizations, patient organizations, commercial organizations, health worker organizations, non-governmental organizations, and many other stakeholders are also involved in health policymaking, some of them even closely. They demand action, criticise the government, make policy suggestions, warn of risks and other consequences, and so on. Health policymaking takes place in an environment of political pressure and counter-pressure as a consequence of which the margins of policy change are often limited. The absence of a command-and-control structure is even more unmistakable in global health policymaking. There exists no world government that is capable of issuing binding regulations supported by effective sanctions. Global policymaking

occurs in complex multi-level networks where nation-states negotiate agreements on common issues. Compliance with these agreements is often a matter of commitment; formal sanctions on non-compliance are absent.

Co-production and mutual dependency

State intervention in public health is characterized by a high degree of mutual dependency. The pursuit of public health requires collective action involving many more actors than the state. Health policy can only be successful with broad public support. Sanctions only to enforce compliance do not work. Furthermore, civil society organizations and the market sector should take up their role. An illustration of the importance of their role as co-producer (or co-creator) is the Dutch Prevention Covenant (2018) which aimed at a substantial reduction of smoking, overweight, and problematic alcohol use. The Covenant consisted of morally binding agreements with more than 70 civil society and market organizations to promote public health. Another dimension of co-production is the involvement of non-governmental organizations in public health. Many of these organizations provide health and relief services at the global level and call for global health problems.

State intervention has also become critically dependent upon the market sector. The success of mass vaccination programs would not have been possible without the development of effective vaccines by the pharmaceutical industry. The rapid development, production, and distribution of vaccines against the coronavirus have been invaluable in restricting the impact of COVID-19 on public health. At the same time, it is also a matter of fact that the health industry has become heavily dependent on the public purse. Many industries have the state or publicly funded care organizations as their principal client. The industry nowadays determines nearly the entire biopharmaceutical technology (Sullivan et al., 2022; Booth et al., 2022). The pharmaceutical industry benefits from public investments in medical research (Angell, 2004). The US government invested a large amount of public money to expedite the development and production of an effective vaccine to tackle the outbreak of the H1N1 pandemic in 2009 (Parmet, 2011) and the COVID-19 pandemic in 2020.

1.6 The contested nature of health policymaking

The pursuit of public health by governments has always been contested due to Ideological differences, conflicting interests, power relations, and daily politics. State intervention is not only a knowledge-driven activity but also the outcome of political conflict. Health policymaking involves complex dilemmas concerning the balance between individual, market, and public interests or the balance between individual and public responsibility. The history of health policymaking is ridden with conflicts between public authorities and the corporate sector. State regulation of tobacco, alcohol consumption, and food issues, to mention a few examples, has always met fierce opposition from the industry, which considered its financial interests at stake. Employers in the nineteenth century agitated against the introduction of the ban on child labor because of its consequences for their businesses. Already in the eighteenth century, attempts to implement global measures to prevent the spread of cholera, smallpox, and pestilence from the East to the West met with resistance from international trade companies because of their economic interests (Schama, 2023). The pasteurization of milk, a very effective public measure, was heavily contested at the point of introduction. Public protest against state vaccination programs has been common from the very beginning. 'When smallpox struck the Massachusetts colony in the early 18th century, Boston's selectmen forbade the inoculations endorsed by Cotton Miller who was rewarded with a grenade thrown through a window of his house bearing the inscription 'Cotton Matter, You Dog, Dam you; I'll inoculate you with this, with a Pox for You'' (Brown, 2010: 160). Fluoridation of drinking water in the Netherlands had to be terminated after public protests (Box 1.2). Radical state measures to fight COVID-19 which most people had never held for possible elicited furious protests from a vocal minority against what its members saw as unwarranted state restrictions on individual freedom. The political face of public health also has a global dimension (McInnis et al, 2020). Public security experts consider the unequal distribution of health across the globe a global security risk. According to Stoeva (2016), public health has changed from a 'low politics issue' into a 'high politics issue': it has become part of geopolitics.

Though state interventions to protect or promote public health can raise great emotions, it is also a matter of fact that they sometimes rapidly fade away after their

introduction. The pasteurization of milk or the obligation to wear seatbelts is nowadays a widely accepted instrument to prevent disease or injuries. Public support for tobacco control measures has significantly increased. Sometimes, protests come from a small but vocal minority. Loud protests against the mass vaccination programs during COVID-19 did not restrain most of the population from vaccination.

Box 1.2 Introduction and withdrawal of fluoridation of drinking water in the Netherlands

In many countries, the fluoridation of drinking water has proven a contested issue. Fluoridation has a long tradition in the United Kingdom, but legislation in Germany and France made its introduction impossible. Denmark even has a legal ban on fluoridation. Fluoridation has also proven contested in the Netherlands. Inspired by the scientific finding that fluoridation could preserve dental decay, the government started in 1952 a 15-year local experiment with fluoridation of drinking water, notably without informing the local population. Other municipalities did not wait for the experiment's results and also decided to fluoridate drinking water.

Fluoridation has always been criticized, initially primarily by orthodox religious groups and the anthroposophical community. At the end of the 1960s, the critique on fluoridation swelled up. Legal experts argued that the state could not coerce citizens to drink fluoridated water, more so because they could not escape from this intervention. Other opponents stated that fluoridation reeked of state paternalism. Fluoridation developed into an issue in national and local politics.

In 1976, the government ended the controversy by issuing a ban on fluoridation. The public health community and the dental profession, which had always wholeheartedly supported fluoridation, were shocked that evidence-based measures had met so much political and resistance. They considered their professional authority undermined.

Source: Edeler, 2009.

1.7 The context of health policymaking

As Figure 1.1 indicates, health policymaking does not take place in nowhere land. It is a context-bound activity. This section explores this context by briefly discussing six factors: culture, demography, economy, technology, politics, and globalization. These factors are interconnected. Our exploration mainly concentrates on the Western industrialized world.

Culture

Cultural factors influence health policymaking in various ways. In many countries, broadly shared values and social norms, including freedom of choice, equity, and respect for human life, have been institutionalized as normative principles policy-makers cannot ignore. They must respect the 'legacy of the past' to be trustworthy. Another aspect of culture is the strong value attached to health. Research in the Netherlands demonstrates that many people consider good health the most important value in their life. They hold the state responsible for organizing unrestricted access to health care and protecting them against health risks. Paradoxically, this belief may not withhold people from simultaneously claiming maximum freedom of choice. Crafting a proper balance between the common good of public health and the individual good of freedom of choice is a fundamental dilemma in health policymaking.

Health policymaking also reflects cultural changes in society. An example is the empowerment of patients in Dutch health care in the 1990s. The formalization of the right to consent, complain, or participate in decision-making on health issues was closely associated with the process of emancipation that had started in the mid-1960s. Health knowledge is nowadays only one click away. Individualization, changing modes of cohabitation, increased participation of women in the labor force, and the rise of the internet society with its fluid and unstructured interactions between individuals have fundamentally altered the cultural context of health policymaking.

The cultural context has also been mentioned as one of the explanations for differences in the handling of COVID-19 between China, South Korea, and Taiwan on the one hand and countries on the European continent on the other hand. The

collectivist type of culture in Asian countries contrasts with the individualistic cultural characteristic of Western countries, where most people attach great value to freedom of choice and are skeptical about state-imposed restrictions on social life (Han et al., 2020). Wearing face masks in public spaces is much more accepted in Asia than in the West.

Demography

Demographic changes affect health policymaking in many ways. The aging of the population confronts health systems with new challenges. The rapid increase of patients with age-related degenerative diseases requires large investments in long-term care services. In many countries, long-term care capacity lags behind the extrapolated growth of the demand for long-term care. The demographic shift constitutes a new social risk (Morel, 2006).

Another aspect of the changing population composition concerns the balance between 'productive' and 'non-productive' sectors in society. This balance, known as the old-age ratio and calculated as the ratio of persons aged 65 and older and the size of the working population, indicates the level of support available to older persons by the working-age population. In Europe, the average ratio has dropped from 5 to 1 in 1997 to almost 3 to 1 in 2017. These numbers indicate that Europe had about five persons of working age for every person aged 65 or over in 1997 and twenty later only three persons to one person (https://ec.europa.eu/eurostat). They pose big challenges to health and social policy. What makes these challenges even more complicated is the aging of the health workforce. Recruiting young health practitioners with expertise in long-term care is a new major problem.

Economy

Economic changes have always influenced public health. An illustration is the impact of rapid industrialization in the eighteenth and nineteenth centuries in Europe on public health. The transformation of the economy as an effect of the introduction of mass production was associated with rising public health problems due to long working hours, child labor, an unhealthy working environment, poor housing, alcohol abuse, and other problems. In Germany, mass unemployment motivated Chancellor

Bismarck to introduce social security legislation in 1883 to protect his subjects against the social perils of industrialization by guaranteeing them an income during illness and covering the costs of medical treatment. However, his primary intention in enacting health insurance legislation was not to preserve public health solidarity but to raise a political barrier to what he saw as socialist agitators in his country.

A dramatic example of the economy-health relationship is the impact of the financial crisis in 2009-2010 on public health in various European countries, including Greece, Portugal, and Ireland. The austerity measures imposed by the Troika (European Commission, European Central Bank, and International Monetary Fund) compelled the Greek government to implement massive budget cuts in health care with dramatic consequences for access to health care and public health (Thomson et al., 2015).

The correlation between the amount of a country's financial resources and spending on health care signifies the importance of the economy for health care. Prosperous countries can spend more national resources on health care than low-income or middle-income countries. Many healthcare facilities and access to medicines in low-income countries are substandard and compare poorly with facilities and access to medicines in rich countries. Large investments are necessary to improve access to and quality of health services and raise the standard of living of large parts of the population in low-income and middle-income countries.

Finally, economic interests frequently conflict with the goals of health policymaking. Although the health risks of smoking or air pollution, to mention two examples, are well-documented, an intensive lobby of the corporate sector has repeatedly proven a formidable barrier to policy measures to tackle these problems.

Technology

Technology influences health policymaking. Beck (1992) has argued that the modernization process has brought more welfare but also created new risks. Nowadays, mankind is exposed to great risks marked by a high level of human agency. Some of these manufactured risks have even global impact (e.g. global warming). State intervention to protect the population against these risks has

considerably extended. Some examples are road safety regulation, clean air regulation and policy measures against global warming. Modern health protection and promotion has become impossible without modern technology. COVID-19 is another example of the state's dependency on modern technology for public health. The fast development of vaccines by the pharmaceutical industry, supported by large public investments, played an important role in suppressing the pandemic. The pandemic also boosted the development of new digital technologies, for instance, track-and-tracing technology, and the QR code.

The technological push has resulted in an ever more diversifying medical corporate sector with big commercial interests in health policymaking. The impact of this development can hardly be overestimated. The sector has rapidly manifested itself as an important stakeholder in the health policy arena where it seeks to influence the direction of health policymaking. The growing dependence of the state upon its products, services, and expertise affects the power balance between the state and corporate sector within the health policy arena.

Advancements in medical knowledge and medical technology have also dramatically influenced the provision of health services. Technology is the most critical driver of expenditure growth in health care. Health problems for which no treatment was available before have become within the reach of medicine. Technological innovations have been followed by a radical extension of the service coverage of public financing arrangements. While expectations are high, breakthroughs such as genetic manipulation, stem cell technologies, personalized medicine, transplantation techniques, artificial intelligence, and e-health raise complex questions on privacy, autonomy, protection of life, limits to medical research, and other moral issues.

A final aspect of the impact of technology on public health briefly mentioned here is the digital revolution which enables patients, much better than in the past, to adapt and self-manage their health. The very fact that health information is only one click away gives a solid push for patient empowerment. Knowledge on health issues nowadays swiftly spreads across the world but this is equally true for misleading and

false information. The digital revolution also creates unprecedented options for mass surveillance (see Chapter 9 for more information).

Political Environment

The impact of the political environment on public health policymaking can hardly be underestimated. In democratic political systems, the political feasibility of contested health regulations critically depends upon the political color of the government and Parliament. No majority means that controversial issues remain unresolved. Many state policy measures are political compromises. Though contentious, there is also some empirical evidence of a positive impact of democratic political systems on public health, measured in term of life expectancy and infant mortality. Democratic systems are more than non-democratic systems responsive to the health needs of the population (Costa-Font et al., 2020). Recent empirical research shows that exposure to a democracy (measured by the number of years under a democracy) reduces health inequality. Democracies are more likely to prioritize public health goals, to invest public resources in public health, and remove barriers to health services (Costa-Font & Kunst, 2023).

The impact of the political environment on health policymaking is also visible in the basic structure of a nation's health system. The prominent role of the private, not-for-profit sector in providing health services in various Western-European countries mirrors the influence of religion-affiliated political parties' ideological line of thought. Navarro (1989) mentions the strong influence of the working class on health policy-making as the primary explanation for the creation of public health systems on the European continent. In his view, the absence of universal health insurance in the United States mirrors the relatively weak political power of the working class (see box 10.5 for more information).

A country's dominant style of public policymaking is also recognizable in the style of health policymaking. The consensual type of state intervention in public health policymaking, so characteristic of countries like Germany, Belgium, and the Netherlands, resonates with the consensus type of democratic government in these countries, and the more centralistic style of health policymaking in the National Health

Service with the comparatively more centralistic structure of the majoritarian kind of democracy in the United Kingdom (Lijphart, 1999). Similarly, it is no surprise to find an underdeveloped healthcare system in countries with authoritarian political leaders who seem primarily interested in preserving and extending their power base (Walt, 1996).

Another important aspect of the impact of the political environment on health policy-making is the rise of populism and increasing polarization in society (Rinaldi & Bekker, 2020). Though there is still much discussion among political scientists on how to define and demarcate this concept, populism is generally conceptualized as the political belief that the incumbent elite disregards the needs of the country's 'real population'. Populism is also antipluralistic. Populists see themselves as the representatives of the 'true' or native population (Muller, 2016) and distrust science and international coordination (Wilson et al., 2020).

Globalization

Health care is traditionally organized on a territorial basis. Each country built its own health system with its own specific characteristics. Yet, there are many signs of the impact of globalization on public health and health policymaking (McInnis et al., 2020). For instance, crossing national borders by patients and health professionals has increased in the European Union due to the principle of the free flow of persons, goods, services, and capital (Mossialos et al., 2010). Around 12.5% of all staff in England's National Health Service have a non-British nationality, and 5.6% of staff are Asian nationals (House of Commons Library 2018).

The impact of globalization is also manifest in the spread of diseases. The growth of international trade and tourism has accelerated the dispersion of infectious diseases worldwide because viruses do not respect national borders. Hence, effective treatment of a global pandemic requires a coordinated strategy at the global level. The foundation of the World Health Organization in 1948 marked the increased need for international coordination in coping with global health problems. However, international coordination has proven difficult to achieve in practice.

An urgent aspect of globalization is climate change. Extreme temperatures, destructive weather events, and the degradation of essential ecosystems will disproportionally hit the most vulnerable people, including children and elderly people, ethnic minorities, poorer communities, and people with underlying health conditions (Balakrishnan, 2018; KNAW, 2023). Climate change asks for global governance but is difficult to accomplish in practice because of disputes over accountability, financial issues, geopolitical tensions, and the structurally deficient system of global governance (Cadman, 2013; Harman, 2011).

Furthermore, health issues can develop as a bottleneck in negotiating treaties on international trade. The fear in the Netherlands for the American 'chlorinated chicken' symbolized the distrust of countries in food safety issues. Intellectual property rights can impair or delay access to medicines.

A final aspect of globalization mentioned here is the rise of global firms with tremendous market power. Healthcare has become an international industry with huge financial stakes. Sharon (2021), referring to companies such as Amazon, Google, Microsoft, and Facebook, speaks in this context about the 'Googlization of health'.

1.8 The future of the publicization of public health

The publicization of public health raises the question of how it will develop in the future. Will state intervention intensify in the years ahead? Is the rise of a 'health surveillance state' a real option?

The call for a comprehensive and intersectoral approach to public health could make the further intensification of state intervention appealing. Examples of how this might be done are the introduction or raise of taxes on meat, alcoholic drinks, and sweetened products, the extension of youth monitoring to preclude health and other problems in an early stage, the creation of specific health centers for every person older than 65 years to detect health risks in an early stage, large-scale monitoring of health behavior, the pricing of unhealthy behavior (e.g. by risk-rating in health insurance), and the use of algorithms, artificial intelligence, and other smart technologies to identify persons at (potential) risk. The reflex to new threats and crises is to call for additional

preventive measures and centralization of health policymaking. The inevitable consequence of this approach is more state control.

New technologies give an extra push to this development. As in medicine, new technologies create a necessity of their own. If technology is available, why not use it? Commercial interests reinforce the technological push. For instance, it is no coincidence that the providers of health screening technologies favor the extension of national screening programs. Mass screening means business for them (Hogarth, 2022).

However, the more the pursuit of public health develops as an imperative in health policymaking, the more tension between the value of health and the value of individual freedom and the state of law seems likely. Many people fear the emergence of a 'surveillance state' in which the state exercises ever more control over the behaviour of its citizens in the name of public health and public security. The tension between the protection and promotion of public health and the values of individual freedom and self-expression may stir up the politicization of health policymaking in the future (see Chapter 9).

Towards the commercialization of public health?

The publicization of public health has never meant the state's monopolization of public health. Health policy cannot succeed without the input of the corporate sector. For instance, road safety requires extensive technological equipment the corporate sector produces. The development and large-scale production of pharmaceuticals, the digitalization and datafication of health information, and the exploration of artificial intelligence in public health are only the latest illustrations of the state's dependency upon the corporate sector to achieve its health policy goals.

The penetration of the corporate sector into public health has another dimension too. Health has become an interesting market with a high growth potential. To a certain extent, this is old news. For instance, many producers of food products claim that their products are good for one's health or improve one's health, even though there is no evidence for their health claim. Physical exercise has developed as a profitable market

commodity. However, the rise of new digital technologies will give an extra boost to the corporate sector's interest in public health. Apple CEO Cook believes that his company's 'greatest contribution to mankind …… will be about health' (quoted in Zakaria, 2021: p. 106). The new tech giants promote technological innovation as the key to the future success of the prevention of disease and promotion of public health. They claim that digitalization will enhance the efficiency, accuracy, scale, and speed of interventions and could solve the urgent problem of personnel scarcity in a labor-intense practice. Large-scale collection of health information by surveillance technologies could also be used for personalized health information and personalized medicine.

As said, the contribution of the corporate sector to public health is not new. What is new, however, are the speed and scope of technological innovation and the fact that technical expertise is ever more concentrated within the corporate sector. How this commercialization of public health will unfold and how it will affect public health and health policymaking must be awaited. However, the commercialization of public health will certainly raise new issues and complex moral dilemmas in health policymaking. What will the consequences of the fact that the necessary expertise increasingly shifts in the direction of the corporate sector? How will commercial values influence health policymaking? Public health may be on the eve of fundamental changes the impact of which on health policymaking can hardly be overseen yet.

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CHAPTER 2

HEALTH POLICY ANALYSIS

2.1 Introduction

Box 2.1 gives a brief view of the history of tobacco control policy in the Netherlands. Tobacco control became a policy issue in the mid-1970s because of mounting evidence of the harmful effects of smoking on health. In reaction, the tobacco industry organized a powerful and initially successful lobby against tobacco control measures that would undermine its commercial interests. The tobacco lobby used its excellent contacts with the Ministry of Economic Affairs to protect its commercial interests within the ranks of the government. The industry's prime opponent was the Minister of Health, but her attempts in the nineties to discourage smoking and protect non-smokers against the risk of passive smoking met much political resistance. What also hindered her attempts to issue legislation was opposition in the Parliament. Right-wing political parties rejected legislation as an infringement of freedom of choice, while Christian Democrats criticized her legislative proposals as 'too detailed and patronizing'. The brief history of tobacco control policy in the Netherlands demonstrates the impact of scientific evidence, lobbying, decision-making structures, political struggle, power relations, normative beliefs, and institutional structures upon health policymaking. Health policymaking is not only a matter of setting policy goals and selecting policy instruments to attain these goals but also a political struggle between proponents and opponents of tobacco control legislation in a changing social and political context.

This book aims at presenting an introduction to health policy analysis drawing upon concepts and insights from political science. Its purpose is to familiarize students with concepts and models to study health policy choices and health policymaking from a political perspective. The focus is on the role of health policymaking by the state, but the presented concepts and models can equally be used for health policymaking at the regional, local level or international level. This chapter describes a conceptual model for health policy analysis.

Box 2.1 How the tobacco lobby influenced tobacco control policy in the Netherlands

In his study '*Tobacco control policy in the Netherlands',* Willemsen (2018) describes the Netherlands as a playground of the tobacco industry. The country housed some of the world's largest manufactories of tobacco products and had become one of the world's largest exporting countries of tobacco products. Because the industry had a vested interest in Dutch tobacco control policy, it already joined forces in the 1950s through the creation of several organizations to represent its interests in the policy arena. The retail, wholesale, and vending machine sectors manifested as important tobacco industry allies. The National Employers Association proved another influential ally. The political battle on tobacco control policy started in the mid-1970s after the publication of the Health Council Report '*Measures to Reduce Smoking*'. From then onwards, the industry defended its interests proactively.

The political battle intensified in the 1990s after the publication of a government plan for a smoking ban in public spaces to protect non-smokers. The tobacco lobby used its contacts with industry-friendly parliamentarians, top-level civil servants, and the government to get this 'infamous' plan off the table. Political parties that emphasized free choice and individual responsibility supported the industry's claim that a ban would devastate the national economy. The tobacco industry promised a system of self-regulation as a much better alternative. Although in the defensive after increasing evidence of the harmful health effects of smoking, the tobacco lobby managed to mitigate the first Tobacco Act in the 1980s. The government had to delete its plan to restrict the sales of tobacco products to specialty shops and introduce a ban on tobacco advertising from its initial legislative proposal.

For many years, the Ministry of Economic Affairs acted as the prime contact of the tobacco lobby. The excellent and 'behind the scene' connection of the National Employers Association with the Ministry was invaluable in warding off unwelcome policy measures. The lobby also used the Ministry as its main venue to support the economic interests of the tobacco industry in EU policymaking on tobacco control.

An important event occurred in 1996 when the primary responsibility for tobacco control policy shifted to the Health Department. The Minister of Health, who had a medical background, announced firm measures to decrease the number of smokers

and protect non-smokers against the risk of passive smoking. However, her plan for a workplace smoking ban was skipped in the cabinet. Other proposals were a complete ban on tobacco advertisements and sponsorship, further sale restrictions, an age limit of 18 years for the sale of tobacco products, and financial sanctions for infringements. Once again, her legislative proposal met with much opposition. The tobacco lobby and the National Employers Association responded furiously, particularly because of the Minister's plan to terminate the system of self-regulation which she held for ineffective: 'It must be clear to you that we do not accept a more paternalistic government' (p. 210). The parliamentary debate on the proposal in 2001 took almost 12 hours. Right-wing parties argued against a public smoking ban and an advertising ban. The Christian Democrats qualified the bill as 'too detailed and patronizing'. After some concessions and promises, the bill was nevertheless adopted by the Lower Chamber. The Upper Chamber followed in 2002, again after a lengthy debate.

Despite a relatively positive stance toward the tobacco industry of some recent ministers of Health, the tobacco lobby has largely lost its grip upon tobacco control policy since the turn of the century. International developments, in particular, EU policymaking on tobacco control and the adoption of the WHO Framework Convention on Tobacco Control in 2015, played a prominent role in this respect. The social and cultural context of smoking has also radically altered. Was tobacco in the past seen as usual, even on television, nowadays it is no longer.

Has the government's tobacco control been effective? Recent figures reported by the Trimbos Institute indicated that the percentage of adult smokers has dropped from 25,7% in 2014 to 18,9% in 2022. The rate of heavy smokers (a minimum of 20 cigarettes a day) was 2.4% in 2022. High-educated persons smoke less often than the rest of the population. In 2002 more than one-third of smokers had tried to stop smoking in the previous twelve months.

Source: Willemsen, 2018; website Trimbos Institute

2.2 What is health policy analysis?

Health policy analysis encompasses the analysis *of* and *for* health policymaking. Its purpose is to acquire empirical knowledge on health policy and health policymaking that can be used in the daily practice of health policymaking. In this respect, a distinction can be made between policy-issue knowledge and policymaking knowledge. Policy-issue knowledge is pertinent to a specific policy and involves specialized knowledge concerning a specific policy problem. Policymaking knowledge, on the other hand, comprises knowledge of how policy choices are made and put into practice (Dror, 1968).

Tobacco control policy illustrates the difference between policy-issue knowledge and policymaking knowledge. Policy-issue knowledge involves, among others, knowledge about the harmful effects of smoking on health. Smoking is an important cause of lung cancer and several other diseases including COPD (chronic obstructive pulmonary disease), cardiovascular diseases, gastric ulcers, and Crohn's disease. It also negatively influences the development of other diseases (e.g. degenerative diseases). Furthermore, nicotine in tobacco products has an addictive effect. Policy-issue knowledge further includes epidemiological knowledge of smoking behavior, for instance, that smokers live approximately five to ten years shorter than non-smokers. Epidemiological studies also give insight into the development of smoking behavior, the spread of smoking across men and women, youngsters smoking, and socio-economic categories. It speaks for itself that policy-issue knowledge on smoking is of critical importance for successful tobacco control.

Health policy analysis puts other issues central. For instance, what were the goals of the tobacco control policy of the Dutch government, and which instruments did it use to restrict the number of smokers? How did the quest for tobacco control reach the political agenda? Which actors played a prominent role in tobacco control policymaking? How was the anti-tobacco control lobby organized and how did its influence on health policymaking compare to the influence of the pro-tobacco control lobby? Which instruments did anti-tobacco control lobbyists use to thwart tobacco control policy? Has lobbying been successful? What was the role of science in tobacco control policy? Which normative beliefs influenced political decision-making on

tobacco control policy? Has tobacco control been effective? How has tobacco control policy in the Netherlands developed since the mid-seventies, and how does it compare to tobacco control policy in other countries? What is the role of the World Health Organization and the European Union in tobacco control policymaking?

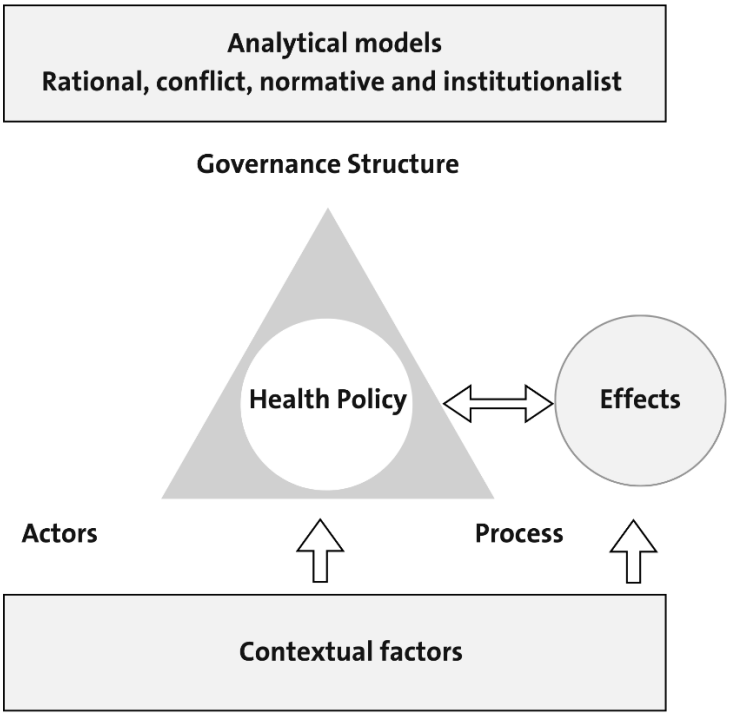
The purpose of this book is to train students in health policy analysis. Successful health policymaking requires not only policy-issue knowledge but also policymaking knowledge. However, this book focuses on the policymaking dimension of health policy. This choice has two reasons, one practical and one more fundamental. The practical reason is that many excellent studies with policy-issue knowledge on public health are available. By contrast, the policymaking dimension has received less systematic attention, though there are exceptions (Buse et al., 2005; Oliver, 2006; Walt, 1996).

The second reason for focusing on the policymaking dimension relates to the aversion to 'politics' in circles of public health professionals. Brown (2010) attributes this aversion to the subjective nature of policymaking and the role of power relations and competing interests in the health policy arena. These characteristics contrast with the alleged scientific and objective nature of public health knowledge. Health policymaking should remain free of political considerations and be unequivocally directed at the protection and promotion of public health. However, this aversion to the political dimension of health policymaking is misjudged because it ignores the daily practice of health policymaking. Although policy-issue knowledge should always be leading in policymaking, public health experts need a good understanding of the political dimension of health policymaking to be effective. It is naïve to believe that policy-issue expertise only is sufficient for success, the more so because expertise is frequently disputed. Experience shows that even hard evidence of potential interventions' (in) effectiveness never automatically finds its way to practice. Evidence never magically turns into solutions (Greer et al., 2017). Public health professionals cannot escape from this hard reality.

2.3 Toward a model of health policy analysis

Figure 2.1 is a simple model of health policy analysis as worked out in this book. It brings together building blocks (basic concepts) that are central to conducting health policy analysis.

Figure 2.1 A model of health policy analysis



Health policy in Figure 2.1 refers to the policy goals and instruments to achieve these goals, the assumptions underpinning the formulation of the policy goals, and the choice of policy instruments. Process refers to the policymaking process which involves the dynamic process of events, decisions, and actions concerning public problems. Actors refer to the persons and organizations participating in the policymaking process. Governance structure refers to the rules for policymaking. For instance, who is in charge of decision-making and policy implementation? Other key concepts are accountability, transparency, and integrity. Effects refer to the results or outcomes of policymaking. For instance, to what extent have the policy goals been

achieved (effectiveness), and at what costs (efficiency)? What is known about the side effects of policymaking, or its short-term and long-term effects? Health policymaking and health policy effects are influenced by contextual factors. The previous chapter contained a concise description of six important contextual factors (culture, demography, economy, technology, politics, and globalization) and their impact on health policymaking.

Finally, our model of health policy analysis includes four analytical models each of which provides an analytic lens alerting policy analysts to specific aspects of the policy content, the policymaking process, the actors participating in the policymaking process, the governance structure, and policy effects. The four models are the rational, conflict, normative, and institutionalist model.

Rational model

The rational model conceptualizes health policymaking as a process driven by information and argumentation. The model corresponds with an instrumentalist perspective on health policymaking. Health policymaking is analysed as an information-based attempt to resolve public health problems. A central concept is evidence-based health policymaking. What does this concept mean and what are its limits? Another theme inherent to all health policymaking is uncertainty and risk. How do policymakers seek to eliminate or restrict risks that are (potentially) harmful to public health?

Normative model

Health policymaking is fraught with complex moral dilemmas concerning the balance between the 'public good' and the 'individual good'. The central proposition of the normative model is that all health policymaking rests upon explicit or implicit normative orientations. Health policymaking should not be reduced to an information-driven and technocratic process; it is also a morally-driven activity.

Conflict model

The conflict model is the opposite of the rational model. It postulates that health policymaking is not the outcome of rational choice but the outcome of conflicts.

Power trumps evidence instead of the other way around. There are many types of conflicts in health policymaking and several strategies for conflict resolution. Two concepts closely interwoven with conflict are the politicization of information (science) and power. The power balance and power strategies influence the settlement of conflicts and, consequently, the content and outcome of health policymaking.

Institutionalist model

The institutionalist model conceptualizes health policymaking as an 'embedded' process: health policymaking is 'regulated' by formal and informal rules (institutions) on what is regarded as true or untrue, what works or does not work, and what is morally acceptable or unacceptable. These rules are often rooted in the past and create some order in policymaking. They make policymaking largely path-dependent. A central proposition of the model is that health system changes and policy changes develop evolutionary rather than radically. Two important themes are institutional continuity and institutional change.

2.4 Overview of the book

The rest of this book consists of two parts. The second part makes students familiar with five building blocks of health policy analysis.

Chapter 3 discusses the concept of public policy and its constituent elements. Attention will be paid to the political construction (framing) of policy problems, the goals, and instruments of public policy, the underlying policy paradigm or set of assumptions or beliefs underpinning the choice of policy goals and policy instruments, and the importance of an appealing policy narrative.

Chapter 4 introduces the concept of the policymaking process that can analytically be thought of as consisting of five consecutive stages: agenda-building, policy development, policy formation, policy implementation, policy evaluation, and policy termination. Furthermore, attention will be paid to two alternative analytical models of the policy process: the rounds model and the crisscross model. The rounds model postulates that policy processes consist of various decision rounds, often with

alternating policy actors in new policy arenas. The crisscross model underscores the interconnectivity of policy processes. The final topic discussed is policy path, police expansion, and policy contraction.

The focus in Chapter 5 is on actors operating in the health policy arena. It starts with the classification of actors and the concept of health policy arena. Two central concepts are policy network and interest organization. Furthermore, the chapter includes a discussion of the role of experts, provider organizations, citizen groups, media, public opinion, and the judiciary in health policymaking. The final part of the chapter examines the international health policy arena. Special attention will be paid to the role of the World Health Organization and the European Union in containing the spread of the coronavirus.

Chapter 6 discusses health policymaking from a governance perspective. What are the rules for the production of policy? How do governance rules influence the effectiveness and legitimacy of health policymaking? The chapter investigates several alternative governance models and their impact on health policymaking. The final part of the chapter analyzes the complexity of global health governance using two examples: the International Health Regulations and WHO Framework Convention on Tobacco Control.

Chapter 7 includes a discussion of policy effects. It describes various types of policy effects, including side effects and counterproductive effects, as well as the concept of system performance (problem-solving capacity) and the concept of health system resilience. Another category of effects includes political effects. These effects relate to the political construction of policy effects and their consequences for health policymaking.

The third part introduces four analytical models to study health policymaking and gives insight into how they can be used in health policy analysis. The rational model is the topic of discussion in Chapter 8, the normative model is the topic of discussion in Chapter 9, the conflict model is topic of discussion in Chapter 10, and the

institutionalist model is topic of discussion in Chapter 11. The final chapter briefly summarizes the five building blocks and four models.

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PART TWO

BUILDING BLOCKS

CHAPTER 3

HEALTH POLICY

KEY POINTS:

- Health policy is defined as the collective effort of policymakers to achieve health goals by means of policy instruments during a certain time span.
- Health policymaking is both an information-driven and politics-driven activity. Health policy is a combination of puzzling and powering.
- Health problems can be conceptualized as a political construct. The political construction of these problems involves the perception of a gap between a norm and an observed or expected situation or process, the perception of uncertainty and risk, the identification of the problem-owner(s) and problem-subject(s), and a causation story on how the problem has come about and who can be held responsibility for it.
- Problem definition and health policy are closely connected. Problem definition gives direction to policymaking.
- A distinction can be made between structured problems, moderately structured problems, and unstructured problems.
- 'The formulation of a wicked problem is *the* problem' (Rittel & Webber, 1973).
- The concept of policy resolution is misleading because it suggests the possibility of a definite solution.
- A distinction can be made between short-term, mid-term, and long-term policy goals, between intermediate and ultimate policy goals, political goals, and between quantified and non-quantified policy goals.
- A distinction can be made between authority-based, treasury-based, information-based, and organization-based policy instruments. A relatively new instrument is nudging. There are multiple criteria for the choice of policy instruments.
- Health policy rests upon a policy paradigm (policy belief) defined as the set of assumptions underpinning a policy.
- Health policy requires an appealing narrative to be effective. An effective narrative consists of a well-crafted blend of logos, ethos, and pathos.
- Two well-known stories are the story of decline and the story of control.

Box 3.1 The evolution of alcohol policy in the Netherlands

Though the debate on the need for alcohol regulation already stemmed from the early nineteenth century, it would take until 1881 for the Dutch government to issue legislation on alcohol. The main motive for public intervention was that alcohol abuse frequently disturbed public order. The 1881 Drink Act included a ban on public drunkenness and an age limit of 16 years for the sales of strong alcoholic drinks. Local public authorities had to regulate the number of points of sales in their jurisdiction. The Drink Act marked the end of a long period of state abstinence.

Alcohol legislation has undergone several changes after 1881. A revision in 1904 extended the regulation of the sales of alcoholic drinks to beer and wine. In the 1920s, the government planned further restrictions but these failed to pass the Upper Chamber. A revision of the Drink Act in 1931 only contained minor restrictions. New legislation in 1964 introduced two age limits. It forbid the sale of strong alcoholic drinks to persons younger than 18 years and the sale of beer and other low-alcoholic drinks to persons younger than 16 years. In 1991 followed a ban on the sales of alcoholic drinks in gasoline stations and in 2012 a ban on alcohol advertisements between 6 am and 9 pm. A revision of alcohol legislation in 2014 gave municipalities extra instruments to address alcohol abuse and maintain public order.

The introduction of two distinct age limits in alcohol legislation has always been controversial. Several ministers of Health have tried to set the limit of all alcoholic drinks at 18 years, but their attempts failed due to political dissension. Meanwhile, public health advocates and municipalities pressured the government to introduce a uniform age limit. It would take until 2014 for a single limit of 18 years to come into force.

The section on alcohol in the National Prevention Covenant (2018) formulated the following policy goals for 2040: reduction of the use of alcoholic drinks by women during pregnancy and youngsters under 18; reduction of alcohol abuse; making people aware of the harmful health effects of alcoholic drinks. The covenant also contained an extensive list of 'soft' policy instruments to restrain the problematic use of alcoholic drinks. However, the alcohol lobby managed to avert a substantial rise in the excise on

alcoholic drinks. More than thirty organizations, including organizations representing the alcohol lobby, signed the covenant.

3.1 Introduction

The history of alcohol policy in the Netherlands is a history of gradual intensification. In the early nineteenth century, alcohol abuse was still viewed as the responsibility of local government. Only after decades of social and political pressure the state enacted the first Drink Act. The evolution of Dutch alcohol policy followed a path of continuous revision and extension. While the 1881 Act had primarily been intended to address the problem of public drunkenness and maintenance of public order, the policy goals of alcohol legislation have gradually been extended to moderate and discourage alcohol consumption and tackle the problem of alcohol consumption at a young age. The burgeoning stock of knowledge on the adverse health effects and social costs of alcohol consumption (De Wit et al., 2014) has stimulated the intensification of alcohol policy.

As in many other countries (Madureira & Galea, 2018), state policymaking on alcoholic drinks has always been a controversial issue in the Netherlands because of economic interests and ideological division. Opponents to strict regulation warned of the emergence of a 'nanny state'. The alcohol lobby resisted, obviously for commercial reasons, each attempt to discourage the consumption of alcoholic drinks. Its message was that people should practice prudent drinking.

Alcohol policy is an example of health policy, the first building block in our model of health policy analysis (Figure 2.1). This chapter gives an overview of the basic elements of health policy. It starts with the conceptualization of public policy and the relationship between policy and politics. The purpose of health policy is to address public health problems. However, these problems have no 'objective' status and should be understood as political constructions. The next section introduces a classification of health problems. While some health problems are well-structured, other problems are ill-structured and difficult to resolve. Each policy consists of policy goals and policy instruments to achieve these goals. Two other important elements

of health policy are policy paradigm and policy narrative. The policy paradigm encompasses the system of policy assumptions undergirding the formulation of the policy goals and choice of policy instruments. The purpose of the policy narrative is to legitimize public intervention and build public support for it. The big challenge for policymakers is to craft a persuasive and appealing narrative. The final section discusses the implications of the insights gained in this chapter for health policy analysis.

3.2 What is public policy?

Policy is a concept with various meanings in the practice of policymaking (Colebatch, 2009). In some contexts, policy means a plan of action ('my policy is …') or a certain practice of thinking and doing ('our policy in these circumstances is to act as follows …..'). In another context, the concept refers to policy decisions taken during a certain period ('our policy over the last few years has been ……'). Policy is not only associated with argumentation and information ('our policy rests upon evidence and experience') but also with conflicts ('we had to fight hard for this policy'). Policy is closely associated with politics which is defined in this book as the struggle for policy (Hoppe, 2010). While politics with a 'big P' is concerned with strategic questions on policy goals and instruments, politics with a 'small p' refers to daily skirmishes on the formulation of regulations, the determination of budgets, the contacts between actors, and many other tactical issues.

According to Colebatch, policy refers to three underlying themes in contemporary Western discourse. First, the concept suggests order and consistency: policy is the opposite of arbitrary or capricious action. Second, policy is associated with authority: it is endorsed by public authorities. The third theme is expertise: the term policy suggests that the course of action draws upon analysis and judgment by experts such as economists, legal experts, or experienced administrators (Colebatch, 2009).

The concepts of policy and policymaking are closely connected with a dominant theme in Western discourse: the malleability of society. Policy is seen as a more or less deliberate strategy to direct and organize society. Policymakers see it as their task to resolve public problems. Though their resolutions may be disputed, problem

resolution is what the population expects from them. However, the term policy resolution is a misrepresentation. As will be explained below, many public health problems miss a resolution in the literal sense of the word.

Multiple definitions of policy

The multiple meanings of policy resonate in the definition of the concept in the literature on policymaking. Marmor and Klein (2012) describe a policy as 'what governments do or neglect to do' (p. 1). Their definition associates policy with government intervention and non-intervention. A problematic aspect of this definition is the explicit connection of policy with the government. As will be discussed in various places in this book, health policy must be understood as collective action with the government as only one actor among many in the policymaking process. An interesting aspect of their definition is the option of policy as 'doing nothing'. The Dutch government abstained from regulatory measures to address the problem of alcohol abuse for a long period in the nineteenth century because it considered it a matter of concern for municipalities. Two other reasons for policy abstention are that state intervention can do more harm than good, or that intervention is judged unnecessary because of self-correcting mechanisms in society.

Jenkins (1978) defines policy as 'a set of interrelated decisions taken by a political actor or group of actors concerning the selection of goals and the means of achieving them within a specific situation where these decisions should, in principle, be within the power of those actors to achieve' (p. 15). This definition includes several important elements. First, the expression 'a set of interrelated decisions' suggests order and consistency. Second, the definition associates policy with goals (or objectives) and means (instruments). Policymakers formulate policy goals and select policy instruments to achieve these goals. Third, Jenkins' definition connects policy with power: the choice of policy objectives and policy instruments should be 'within the power' of the policymaker. This element reminds us that policymakers often struggle with complex internal and external constraints such as lack of resources, formal and informal obstacles, political pressure, changing political circumstances, and sometimes even the absence of (legal) instruments. Their demanding job is to navigate between conflicting demands and interests. Desirable policy alternatives

may be beyond the scope of feasibility for political, social, economic, judicial, or other reasons. The margins for policy change in a pluralistic and democratic society are usually small. As said before, the malleability of society is in many situations less than policymakers suggest or hope for.

Definition of health policy

In this book, health policy is defined as the collective effort of policymakers to achieve health goals by means of instruments during a certain time span. This definition contains elements that need elaboration. First, it includes the terms policy goals (health goals) and instruments. Policy goals refer to a desirable situation policymakers want to achieve through the usage of policy instruments.

The term collective effort indicates that health policy is not the product of a single actor but the outcome of a process many actors participate in. The term policymaker refers to people and organizations that are closely involved in the policymaking process. Examples are the government, the minister of Health, the Department of Health, other government departments, members of Parliament, inspectorates, state agencies, and municipalities, each with its tasks, competencies, resources, and responsibilities. Stakeholder organizations representing the interests of healthcare providers, patients, citizens, the pharmaceutical industry, the tobacco industry, the food industry, the automobile industry, and many other actors participate as it were 'from outside' in the policymaking process. They exert pressure on policymakers by articulating their interests. Sometimes, some of them are so closely involved in policymaking that they actually act as co-policymaker.

The term effort in the definition expresses that a policy consists of more elements than documents and public statements. It also comprises decisions on policy goals and instruments (policy decisions) and activities to put these decisions into practice. Many policies develop their true face in the stage of policy implementation. Consequently, health policy analysts cannot confine themselves to an analysis of policy documents and public statements. They must be aware of a potential discrepancy between promises and decisions on the one hand and the 'real world' of

health policy on the other hand. In other words, health policy analysis involves an investigation of how policies are put into practice.

Finally, the definition includes the phrase 'during a certain timespan' to indicate a policy is no one-shot operation. The government's health policy is its policy during a certain period.

Problem-oriented policy and process-oriented policy

Problem-oriented policies are directed at the resolution of issue-related problems. Examples are policies to improve healthcare quality, shorten waiting times, control healthcare costs, quit smoking, or contain the spread of infectious diseases. These policies ask for expertise (policy-issue knowledge) from the medical profession, public health experts, legal experts, health economists, and other experts. Process-oriented policies on the other hand are concerned with the organization of the policymaking process. Typical process-oriented issues are the organization of decision-making or policy implementation, the development of strategies to overcome political resistance, and initiatives to foster accountability and transparency in policymaking. Process-oriented policy requires a different kind of expertise including, among others, expertise on the organization of complex organizations and inter-organizational relations, a well-developed antenna for political threats and opportunities, communicative skills, and knowledge on how to deal with media. Problem-oriented and process-oriented policies are always closely intertwined. Successful policymaking requires both a problem-oriented and process-oriented approach. The best problem-oriented policy is of little value if it gets stuck in the labyrinth of the policymaking process.

Health system reform

Health system reform is a specific type of health policy. Again, there is no universally accepted definition of health system reform. Policymakers assign different meanings to the concept and sometimes even 'sell' marginal or incremental policy changes as reforms, usually for political reasons (Saltman & Figueras, 1997: 2). In this book, health system reform is conceptualized as a collective effort directed at a major overhaul of a country's health system. It is an orchestrated effort to bring about 'system change'

drawing upon the belief that the existing system is failing or unable to respond adequately to future challenges. Health system reform can be directed at the provision of health care (e.g. substituting primary health care for specialist care or introduction of diseases management programs), the financing of healthcare (e.g. the introduction of social health insurance or extending its scope), the payment of providers (e.g. the shift from a fee-for-service model to global budgeting or a quality-adjusted payment model) or the governance of health care (e.g. decentralization of health policymaking or the introduction of a model of regulated competition in health care). A comprehensive reform aims to restructure the financing, provision, payment of providers, and the regulation of health policymaking.

Successful health system reform requires a well-crafted process-based approach. Knowing that reform plans always meet political resistance and other obstacles, reformers must develop a strategy to accommodate their reform plans to these obstacles for being successful. They must balance the need for a carefully crafted implementation trajectory and flexible adaptation to changing circumstances. Two other challenges are the balance between central direction and local discretion, and the pace of the reform process. Which room should be left for policy learning and local accommodation? Is a 'big bang' or a 'blueprint' approach the most appropriate strategy to restructure the health landscape (Tuohy, 2018)? These questions demonstrate the need for a well-designed process-oriented strategy. Even the best reform plan may be deadlocked in a swamp of political resistance, setbacks, and delays.

Health policy as a multi-layered cake

Many health policies have a complex structure. They are made up of multiple, not seldom conflicting, goals that are pursued by a broad repertory of policy instruments. What is presented as the government's policy may actually consist of many interlocked policies. Quality management and cost control cut across all health policy-making. Large parts of health policies are closely connected with other public domains, such as public security, public financing, education, and international trade. Health policy initiatives to tackle the problem of overweight, depression, or other major health problems require a comprehensive and intersectoral approach. Other factors

explaining the complex structure of health policy are the ambiguity of stated policy goals and instruments, the conversion of words into concrete action (policy implementation), the uncertainty problem and dilemmas policymakers cope with, resistance and political division as well as the involvement of many actors at different political/administrative levels in the policymaking process, each with their own goals, interests, expertise, conventions, and standard operating procedures. Other complexity-increasing factors are the co-existence of differing versions of the same policy, the possibility of a gap between the paper version of a policy and daily practice, and the occurrence of policy changes, sometimes even in a short period as happened during COVID-19, to accommodate policy activities to altered circumstances or new information and insights. Health policy can be best typified as a 'multi-layered cake' of ideas, decisions, structures, and processes. Most policies have a less coherent and consistent structure than pretended in policy documents or public statements.

3.3 The double face of health policy

As pointed out by Colebatch, policymaking is associated with rationality and deliberation. The choice of policy goals and policy instruments should draw upon information, analysis, arguments, and professional expertise. Health policymaking should be organized as an information-driven activity directed at finding 'optimal solutions' for policy problems with experts and experienced people in the driving seat. This is the instrumentalist or technocratic dimension of health policy.

However, health policymaking has a political dimension too. It involves making choices concerning the goals that should be achieved, the instruments that are used to achieve the stated goals, and the time horizon. These choices certainly contain technical elements but cannot be reduced to a technocratic exercise only. This is because health policymaking takes place in an environment characterized by divergent value orientations, conflicting interests, inter-organizational rivalries, hard and subtle power games, party politics, the need for political profiling, and so on. Many policy decisions are actually negotiated agreements (compromises) to settle conflicts rather than the outcome of an information-driven process. The absence of political escape routes sometimes results in a policy deadlock that may drag on for many

years. Health policy is, according to Hoppe (2010), the outcome of a combination of puzzling and powering. This is the double face of health policy.

The contested nature of health policymaking is no surprise. Health has become an overriding value or, as Lupton (1995) has put it, an imperative. Health issues deal ultimately with the question of who shall live and how. Health policy has direct consequences for health services' access, quality, and costs. The population also expects state protection from health risks beyond individual control. At the same time, health policy interventions frequently evoke political resistance. Population-based interventions that are obvious to public health professionals can be hard to sell to generalist policymakers, for instance, because voters assign low priority to improvements in public health or because hard evidence of their effectiveness is absent. State interventions may also stir controversies regarding their legitimacy. Besides, public health interventions frequently clash with commercial interests. Finally, public health and health care in particular have developed as a multi-billion sector with huge material interests (Starr, 1982). The history of health policymaking offers many examples of the contested nature of health policy issues such as abortion, mass vaccination, tobacco control, food safety, co-payments, health insurance legislation, doctors' revenues, or the profit-driven strategies of 'big pharma'. In many situations, the state's enforcement power appeared less strong in practice than formal decision-making and accountability rules suggest. Due to strong pressure from both inside and outside, the margins of policymaking and policy change are often small. The problem-solving capacity of health policy is less than pretended or hoped for.

Communication is another aspect of the political dimension of health policy. While some health policy decisions go unnoticed, other decisions draw public attention, particularly if they have direct consequences for people. COVID-19 is a textbook example of this situation. How must policymakers communicate about their choices, dilemmas, and uncertainties in the knowledge that public confidence is pivotal for policy success and can easily dissipate? Health policy requires a credible, persuasive, and appealing policy narrative to build and maintain public confidence where political opponents do not hesitate to discredit policy failure for political gain.

The double face of health policy means for health policy analysts that they avoid the mistake of reducing health policy to an information-driven and instrumental activity. They must understand its political dimension. Disparaging the political face of health policy is unprofessional and naïve. Accordingly, one of their tasks is to make policymakers aware of the political face of health policy.

3.4 Health problems as political construct

The purpose of health policymaking is to pursue public health by resolving public health problems. A problem refers to a perceived gap between a desired situation or process (norm or standard) and an observed or expected situation or process. The challenge is to bridge this gap.

Health problems have no objective status. They are not 'given' but a political construct. Facts never speak for themselves: they must be interpreted or framed. For instance, AIDS has been framed as a public health problem, a humanitarian crisis, a human rights issue, and a threat to security (Shiffman, 2009). Advocates adopting a 'pro-life' frame reject abortion or only allow for it under strict conditions, while advocates adopting a 'pro-choice' perspective consider it a morally justified option. Is COVID-19 a severe public health threat justifying radical restrictions to social and economic life or only a severe flu, as some fierce opponents to freedom-restricting measures have argued? Attaching the label of crisis to a problem is a well-known political strategy to legitimize direct state intervention and the extension of state power (centralization). Policymaking can be analyzed as a struggle between alternative problem constructs or problem frames. In other words, policymaking can be understood as a frame contest.

Problem formulations are not innocent because they involve moral, political, and economic implications. For instance, framing obesity in terms of individual behavior is only one step away from framing it as a problem of individual responsibility or lack of willpower (Saguy & Riley, 2005). The term 'nanny state' is a powerful frame device used by libertarians and the industry to discredit state initiatives to promote public health (Wiley et al., 2013). President Trump, obviously for political reasons, spoke about the 'China virus' to blame China for the outbreak of the pandemic instead of

using the neutral term SARS-CoV-2. He labeled the virus a 'hoax' that the Democrats used to politicize it. During the Ebola pandemic, the Western African countries involved downplayed the severity of the problem for fear of negative repercussions for tourism. The World Health Organization made a colossal mistake by adopting the general identifier 'Swine Flu' instead of 'Mexican Flu' to avoid damage to the Mexican economy. The new name had dramatic unintended consequences. The Egyptian government ordered the mass culling of all pigs in the country, and the Iraqi government the culling of three bears in a Baghdad zoo. Other countries imposed trade imports of all live pigs, pork, and pork products because of assumed risks for animal-transmitted diseases (Kamradt-Scott 2018).

Problem definition as sense-making

Defining a situation as a public problem can be conceptualized as sense-making or framing. This concept refers to the cognitive and social processes of observing and interpreting what is going on, right or wrong, justified or unjustified, and to what can or should be done. Sense-making also involves an estimation of the scope of the problem, its causes and consequences, and (potential) risks. Perceptions and judgments are mediated by culture, power, and interests. Sense-making is a collective process (Douglas, 1986). Sense-making from a top-down perspective can considerably deviate from sense-making from a bottom-up perspective. It explains why people 'at the bottom' feel unheard or ignored.

The political construction of health problems as public or collective problems involves the claim that their resolution requires state intervention. The history of Dutch alcohol policy illustrates that the acceptance of state responsibility is not evident. Box 3.1 showed that the state held for decades to the prevailing political concept of the 'night watch state': it had to concentrate its interventions on the maintenance of public order and protecting its citizens against foreign threats. The pursuit of public health was considered something for which the state did not feel a political responsibility of its own. It viewed public health as a matter of concern for municipalities and civil society organizations.

Constructing public health as a public problem the state must address is an important dimension of the political construction of policy problems. This is also true for risk perception. Policymakers can overlook health risks or underestimate their magnitude but also perceive them as serious problems. Sometimes, it is in the interest of policy actors to deny risks or, conversely, magnify risks to draw public attention, call for hard measures or an extension of its intervention power, claim a larger budget, discredit incumbent policymakers for policy failures, and so on.

Another dimension of the political construction of problems concerns the identification of the problem owner(s) and problem subject(s). The problem owner is the person or organization held accountable for resolving a problem. Problem subjects are the victims of a (potential) problem. Who are they and how large is the category of problem subjects? Which criteria should be used to demarcate the category of problem subjects? These questions can have far-reaching repercussions for policymaking in terms of scope, costs, and responsibility.

Finally, the construction of health problems includes a causation story (Stone, 1988). Policymakers need explanations for problems to find indications of how to resolve them. This is the instrumental role of causal stories: investigating the causes and ramifications of health problems and working out policy alternatives. At the same time, however, causation stories have a political dimension. They are an instrument to identify who should act, who should be held accountable for policy failure, and who should compensate the victims of policy failure. Blame games in policymaking rest upon a politics-driven causation story (Box 3.2).

The impact of the political construction of public health problems upon policymaking can hardly be overstated. A pro-life or pro-choice perspective on abortion directs the route policymakers will take. Seeing obesity as a matter of individual responsibility or as a result of an obesogenic social and economic environment influences the direction of policy resolutions. Solution fits problem. Interestingly, the reverse – problem fits solution – is equally true. For instance, it is no coincidence that libertarians are likely to attribute obesity to a lack of willpower or that policymakers who prefer public solutions are likely to underscore the role of factors beyond

individual control in explaining and tackling obesity. Their preference for certain types of policy resolutions directs their construction of the obesity problem. You should not be surprised to hear market believers advocating competition in health care as their standard resolution of what they call system inefficiencies.

Box 3.2 Crisis exploitation and frame contests

In their analysis of crises, Boin and his co-authors argue that crises 'typically generate a contest between frames and counter-frames concerning the nature and severity of a crisis, its causes, the responsibility for its occurrence or escalation, and its implications for the future' (p. 82). They distinguish between three alternative frames and investigate each frame's policy impact (instrumental dimension) and political impact (political dimension). In the first frame, a crisis is downplayed as an unfortunate incident or twist of fate. The occurrence of a crisis is denied. Consequently, there is no reason for a fundamental revision of policymaking nor for blaming accountable policymakers, although political opponents will try to do so. The occurrence of a crisis may alternatively be framed as a threat. The policy impact of this frame is that effective countermeasures must be taken to defend the status quo. Political opponents will exploit the crisis frame to start a blame game. They claim that accountable policymakers must be punished for their ostensible failures and demand for new elections to benefit politically from the incumbent government's failure: 'to explain is to blame'. Finally, a crisis can be framed as an opportunity to demonstrate the need for fundamental reform to avoid its re-occurrence in the future (policy impact). Political opponents will exploit the crisis again as an instrument to benefit politically from.

Source: Boin et al., 2009.

3.5 Structured, moderately structured, and unstructured problems

Some public problems in health policymaking are, at least in theory, relatively simple. Their solution is mostly a matter of legal, economic, medical, or other 'technical' expertise that can easily be mobilized. However, in practice, even seemingly simple

problems may unexpectedly unfold as complex problems (Turnbull & Hoppe, 2019). The purchase of personal protective equipment for healthcare workers is a relatively simple (structured) problem for experienced purchasers but not in the context of a pandemic outbreak and huge equipment scarcity.

Most problems in health policymaking miss a simple structure. They have not only a public health dimension but also a legal dimension, a political dimension, an economic dimension, a public confidence dimension, and so on. Problems are also often interlocked. The outbreak of the mad cow disease in the United Kingdom demonstrates how public health problems escalated into a major and transboundary crisis with an international dimension in only a short period (Box 3.3).

Box 3.3 The outbreak of the Mad Cow Disease in the United Kingdom

The outbreak of the mad cow disease or BSE (bovine spongiform encephalopathy) in the United Kingdom took place in the middle of the 1980s. Cows suffering from the disease made spastic movements. The authorities rapidly detected the connection between the disease and livestock production problems that did not meet international standards. A staggering conclusion was the presence of contaminated meat in the human food chain because infected cows had been slaughtered before their disease had become manifest. Hence, the problem extended from the animal food chain to the human food chain. As a consequence, the crisis had consequences for the export of meat, because foreign countries forbid the import of meat from the United Kingdom. The government also ran into political trouble because of its failing oversight and its indecisiveness at the outset of the crisis. Besides, the political crisis developed into a public trust crisis: could citizens still trust their government? Another dramatic aspect of the crisis was the large-scale culling of more than four million animals and the daily reports and pictures in the media on this activity. Opponents of the bio-industry seized the opportunity to demand another model of food production.

Source: Van Zwanenberg & Milstone, 2005.

Hoppe (2010) distinguishes between three types of problems: structured problems, moderately structured problems, and unstructured problems. Structured problems require relatively little discussion on what the goal of public intervention should be (high consensus) and the knowledge necessary to resolve these problems can easily be mobilized (high expertise). There are two types of moderately structured problems. The first type combines a lack of goal consensus with a high level of information. The problem with abortion is not a lack of expertise but a fundamental disagreement on how to judge abortion from a moral point of view. Technical expertise cannot resolve the dispute between proponents and opponents. The second type of moderately structured problem combines a high level of goal consensus with uncertainty on how to reach these goals. During the outbreak of the Q-fever in the Netherlands from 2007 to 2010, policymakers agreed on the priority of public health over economic interests but disagreed on the necessity of hard policy measures to get the epidemic under control (see Box 5.1 for more information). A policy problem is unstructured if instrumental knowledge is missing or contested and there is no goal consensus. Escalating healthcare expenditures are an unstructured problem. Fundamental disagreement on facts, explanations, and the effectiveness and acceptability of policy interventions to control expenditure growth goes hand in hand with fundamental disagreement on the need for expenditure cuts or other cost control measures.

Hoppe's classification of policy problems is an ideal typology. There are no clear boundary lines between each type of problem and public problems may combine the characteristics of structured, moderately structured, and unstructured problems. Nevertheless, the typology is a useful analytical instrument for the analysis of public problems. Each type of problem has repercussions for the organization of the policymaking process. An instrumental (technocratic) approach may work well to resolve structured problems but prove a ticket to misery for unstructured problems. The resolution of problems ensuing from a lack of goal consensus requires another approach than the resolution of problems ensuing from a lack of information or lack of consensus on the effects of alternative policy instruments.

It should be noted that moderately structured (or structured) problems can turn into unstructured problems, and conversely. The outbreak of the mad cow disease in the

United Kingdom rapidly shifted from a moderately structured problem into an unstructured issue because of its repercussions for the human food chain, international trade, and public trust. Health policymakers struggling with unstructured problems must convert unstructured problems into moderately structured or structured problems to make them manageable.

Tame and wicked Problems

Rittel and Webber (1973) have coined the term 'tame' problem and 'wicked' problem for structured and unstructured problems respectively. They point out that wicked problems miss a definite formulation and a stopping rule. Solutions are neither true nor false but either good or bad. There is no immediate or ultimate test for solutions and solutions may have irreversible effects. Every wicked problem is essentially unique and a symptom of another or deeper problem. There are always alternative explanations for a wicked problem and by implication alternative resolutions. What also makes wicked problems difficult to handle is the involvement of a large number of actors with differing views, expertise, and interests. Rittel and Webber conclude: 'The formulation of a wicked problem *is* the problem' (p. 161).

3.6 Problem resolution: a misleading concept?

A basic assumption underpinning health policy concerns the malleability of society. Well-crafted health policies are a blessing for mankind. The burgeoning stock of knowledge on health and disease makes it possible to overcome health calamities mankind has struggled with for centuries. Many diseases that were once incurable have become curable. When the Spanish Flu broke out in 1918, governments had only non-pharmaceutical interventions at their disposal to fight the disease that cost tens of millions of people their life. How different was the situation during COVID-19!

Nevertheless, there are good reasons to be skeptical of the malleability assumption. First, the term 'policy resolution' is misleading because it assumes a non-existent degree of malleability. Many health problems cannot be resolved in the same way technical problems can be resolved. Even worse, public health experts expect the outbreak of new pandemics in the future. The question is not whether they will break

out but when and how. The best strategy to prepare is to reinforce the resilience of their health systems to cope with new pandemics.

A second reason for skepticism is that solutions often create new problems. The more medicine has been able to avert amenable death, the higher the prevalence and incidence of other diseases, such as cancer and Alzheimer's disease. Gruenberg 2005 spoke in an article with the striking title *'Failures of Success'* about 'the surprising fact that the net effect of successful technical innovations used in disease control has been to raise the prevalence of certain diseases and disabilities by prolonging their average duration (p. 779). 'As the result of advances in medical care, we are seeing a rising prevalence of certain chronic conditions which previously led to early terminal infections, but whose victims now suffer from them for a longer period' (p. 781). This paradoxical result is not unique to medicine and health policy. Many public interventions are intended to resolve self-inflicted problems. 'Policy as its own cause', according to Wildavsky (1987).

Third, the term problem resolution suggests consensus on how a solution should look like. As pointed out before, this suggestion rests upon a serious misconception. In a pluralistic society, fundamental disagreement on the best solution is common.

A fourth reason to criticize the malleability assumption has to do with the inherent weaknesses of so many health policies. Poor knowledge, lack of capacity, the transboundary and interlocked structure of health problems, uncertainties, risks, as well as political, legal, and moral constraints are important explanations for why a 'definite' resolution is an illusion. There is good reason for modesty. Nevertheless, policymakers prefer to talk in terms of policy resolutions pretending that real resolutions are available. Acknowledging the impossibility of definite resolutions is no option for them because it would suggest powerlessness and failure. The media reinforce this attitude. Journalists want to hear immediate resolutions from policymakers: 'Minister, what is your solution to this problem?'

However, the illusion of a definitive resolution does not mean that nothing can or should be done. Health policymakers can mitigate people's problems by removing

barriers to access to health care, making extra budgets available to relieve persons with serious psychiatric disorders, issuing legislation to improve working and living conditions, introducing incentives to promote health or disincentives to discourage unhealthy behavior, and so on. However, a radical or 'definite' resolution is in many situations unfeasible. Much health policymaking is little more than 'moving away' from a problem instead of 'moving towards' a solution (Braybrooke & Lindblom, 1963).

The interconnectivity and multi-level structure of policy problems also confront policymakers with a dilemma. Should they tackle the deeper causes of a policy problem or only direct their activities upon its symptoms? Is an ambitious approach preferable to an approach of small steps? Feasibility and the political imperative of immediate action influence their choices. In many situations, incremental interventions to confine or mitigate the problem are the only realistic option. The Austrian-British philosopher Karl Popper (1957) even manifested himself as a fierce opponent of what he called utopian solutions. His alternative was 'piecemeal engineering' to avoid policy disasters. Unsurprisingly, this alternative has been criticized as equivalent to 'muddling through' with potentially serious consequences for later.

3.7 Policy goals

The legitimization of health policymaking is to achieve policy goals or policy objectives. A policy goal can be defined as a desirable situation policymakers set out to achieve. The formulation of policy goals is a critical component in all health policymaking. The investigation of health policy goals is an important theme in health policy analysis. However, it is in many situations no easy task.

Ambiguous policy goals

The content of most health policy goals is ambiguous. For instance, the government declares to improve the quality and efficiency of health care, preserve solidarity in health care financing, eliminate unfair health disparities, or transform health care from a 'supply-driven' system into a 'demand-led' system. The question is what these policy goals really mean. Each of them shines in abstractness. Agreement on abstract

policy goals never guarantees agreement on their concrete meaning. This explains why so many conflicts in health policymaking concentrate on making abstract policy goals concrete. Policymakers agreeing on the need for an efficient and universally accessible system of healthcare provision may fundamentally disagree on how such a system should look in practice. Efficiency and universal access can be interpreted in many different ways.

Identically worded policy goals may hide different ambitions. See, for instance, how governments have formulated the primary goal of their COVID-19 policy. Everywhere, they declared the containment of the spread of the coronavirus the cornerstone of their policy. Nevertheless, there were noticeable differences in how they made this policy goal operational. While some governments (e.g. China, South Korea) chose for a radical eradication of the coronavirus, other governments aimed at the mitigation of the spread of the virus ('flattening the curve') to avert an overwhelmed hospital sector (e.g. the Netherlands). A third alternative was to opt for group immunity (e.g. Sweden). These differences in goal formulation are not semantic but correspond with remarkable differences in how governments sought to fight the pandemic (Greer et al., 2021).

The pursuit of public health, the enhancement of the quality of health care, or the improvement of universal access to health care, are textbook examples of aspirational policy goals: they only set out the direction but do not make concrete what exactly must be achieved for whom and when. Aspirational goals have a mobilizing function. They are a linguistic instrument to mask conflicts, smooth out inconsistencies, build popular support, or mobilize public resistance. Furthermore, abstract goals are invaluable in negotiations because they enable each participant to interpret these to their advantage (Stone, 1988).

Multiple policy goals

Health policies usually contain several policy goals, mostly without a clearly formulated priority order. A frequent problem with multiple policy goals is that they conflict with each other. Not everything can be achieved at the same time or to the same degree. Equity often sits uneasily with efficiency. Conflicting policy goals and

scarce resources confront policymakers with policy dilemmas: how to craft a balance between two or more conflicting goals? The 2006 Health Insurance Act in the Netherlands involved a complex balancing act between the policy goals of two conflicting goals. A primary goal of the reform was to give each person greater freedom of choice in health insurance. At the same time, the new legislation had to respect the principle of solidarity in health insurance. To uphold solidarity, the new legislation included various restrictions on freedom of choice. One of these restrictions was to make health insurance mandatory (Jeurissen & Maarse, 2021).

'Empty goals'

Policy goals make no sense without instrumentation. What policy goals really mean for public health depends on the choice of policy instruments (instrumentation) to attain them. Which instruments do policymakers choose, and how many resources are they willing or able to spend on their attainment? Policy goals without effective instruments are 'empty' goals with only political or symbolic value.

Classification of policy goals

There are several models to classify policy goals. First, it is common to distinguish between long-term, mid-term, and short-term goals. The emphasis on short-term goals is mostly at the expense of long-term goals. A second distinction is between primary and secondary policy goals. Primary goals have a higher priority than secondary goals. However, priority setting frequently appears as a source of political trouble. The minister of Health may set other priorities in times of budgetary scarcity than the minister of Finance. Third, a distinction can be made between ultimate and intermediate policy goals. Policymakers set intermediate goals to achieve ultimate goals. Thus, intermediate goals play an instrumental role in attaining the ultimate goals. For instance, the introduction of regulated competition in Dutch health care in 2006 has never been intended as the ultimate goal of the market reform. The creation of the market was intended as intermediate goal to increase freedom of choice and make health care more efficient, innovative, and client-driven. An imminent risk of intermediate policy goals is that their instrumental role is lost out of sight and that they gradually develop as a policy goal of their own. Fourth, a distinction can be made between problem-oriented goals (e.g. improving access to health services) and

process-oriented goals (e.g. a re-ordering of the relationship between state, market, and civil society in health policymaking). Policy goals can also be political such as the preservation or extension of one's power base. The pursuit of an electoral victory is a respectable political goal of political parties. Sometimes political goals remain obscured.

A final distinction is between quantified and non-quantified policy goals. Though most health policy goals are qualitative or aspirational (see above), quantified goals are not uncommon. For instance, it is the government's policy goal to save (x) billions of euros in a given period, keep health expenditures under a predetermined ceiling or reduce alcohol consumption in a given period by (x) percent relative to a pre-selected baseline year. Another method of quantification is to specify the year a policy goal must be achieved. The purpose of quantified goals is to make health policy more ambitious and concrete and force policymakers to take effective measures to attain them. Quantified policy goals also make it easier to measure the success or failure of health policy. Nevertheless, policymakers can be hesitant to formulate quantified policy goals for fear that they will be pinned down on their attainment. Disagreement on the realistic character of quantified policy goals and political resistance are other reasons to abstain from quantitative goals. A final reason is the risk of legal claims if a quantified goal is unattained.

3.8 Policy instruments

The pursuit of public health requires policy instruments defined by Howlett and Ramesh (2003) as 'the actual means or devices governments have at their disposal for implementing policies' (p. 87). Because policy goals without policy instruments are 'empty' goals, the study of policy instruments is crucial in health policy analysis. The study of policy instruments not only yields information about the assumptive world of policymakers (next section) but also information on the concrete meaning of policy goals and the importance policymakers attach to them.

Classification of policy instruments

There are several classifications of policy instruments. Bemelmans-Videc and her colleagues use the metaphors stick, carrot, and sermon to describe three types of instruments to influence the behavior of individuals and organizations (policy subjects). The stick is the most coercive instrument: it makes a certain kind of behavior mandatory and sanctions noncompliance. Carrots are intended to encourage policy subjects to adopt or abstain from a particular behavior. For instance, governments make vaccination costless to motivate the target population to get vaccinated (incentive) or raise taxes on tobacco products to discourage smoking (disincentive). Incentives and disincentives are, strictly speaking, non-coercive instruments. In practice, however, the distinction between coercion and (dis) encouragement gets easily blurred. High taxes can make smoking so expensive that low-income people can no longer afford to purchase tobacco products. Even if vaccination is voluntary, people may still feel coerced to be vaccinated. The same problem may arise for the sermon as an instrument to persuade policy subjects to adopt a desired type of behavior through information or a moral appeal (Bemelmans-Videc et al., 2011).

Howlett and Ramesh (2003) distinguish between authority-based instruments, treasury-based instruments, information-based instruments, and organization-based instruments. Authority-based policy instruments rest upon a control-and-command model. The most common type is regulation through obligations and prohibitions that are supported by sanctions to punish norm-breaking behavior. Authority-based instruments can also be used to pressure opponents (e.g. using threats in negotiations). Central to the concept of authority-based instruments is the existence of a power relationship between the power holder and the power subject. The category of treasury-based instruments contains a broad range of instruments: taxing, tax incentives and disincentives, financial transfers, loans, expenditure cuts, user charges, and many others. The purpose of these instruments is, among others, the collection of financial resources, the facilitation of programs, and the encouragement (incentives) or discouragement of behavior (disincentives). Information-based instruments are intended to influence behavior by conveying information. Examples are public information campaigns, persuasion, consultation, doing or commissioning

research, recommendations, moral appeals, and naming and shaming. Marketing and propaganda also fall into this category. Besides, information can be used as a political instrument to create confusion, for instance, by overwhelming the population with abundant information or spreading false information.

The distinction between authority-based, treasury-based, and information-based policy instruments in part overlaps with the distinction above between the stick, carrot, and sermon. This is not the case for what Howlett and Ramesh call organization-based instruments. These instruments are directed at the provision of goods and services to the population. Examples are hospital care, vaccination programs, social and healthcare services for long-term care, family care, pharmaceutical care, and the accomplishment of a healthy living environment. The category of organization-based instruments also includes other instruments including centralization and decentralization, reorganization, privatization, market creation, and outsourcing of publicly-funded services. Table 3.1 illustrates the classification of policy instruments that have been used to fight the COVID-19 pandemic.

Table 3.1 Classification of policy instruments to suppress COVID-19

Instrument	Examples
Organization-based instruments	Upscaling capacity of IC-units; purchase of protective equipment; mass vaccination programs; upscaling track and tracing capacity; international coordination of the purchase and distribution of vaccines.
Authority-based instruments	Public health legislation; lockdown; quarantine; travel restrictions; closing borders; restricting social contacts; QR-code to regulate access to public spaces; closing schools and public spaces.
Treasury-based instruments	Compensation of loss of revenues; free of charge testing; investments in the development of vaccines; free of charge vaccination; non-compliance fines.
Information-based instruments	Appeal for keeping distance and regularly washing hands; press conferences to inform the general public; request to stay at home in case of a (suspected) corona infection; public websites with COVID-related information

The classification of policy instruments gives no information on their concrete shape. For instance, the design of authority-based instruments may be very strict or offer policy subjects some freedom of choice. It matters whether regulations are supported by hard or soft sanctions. The discouraging effect of 'sin taxes' on tobacco products, alcoholic beverages, or sweetened drinks depends on the tax rates. Sometimes, treasury-based instruments represent little more than a 'pocketful of money': the government makes a budget available to tackle a problem but largely leaves open how to spend the money in practice.

Nudging

A policy instrument receiving much attention in current health policymaking is nudging. Nudging comprises a broad range of psychological techniques to motivate people to adopt behavior without forcing them to do so or eliminating choices. People remain free to make their own choices but are in a subtle way encouraged to make 'better' choices. For instance, they are unconsciously incentivized by psychological techniques to choose healthy food or exercise daily. Examples are the presentation of healthy food at eye level and the framing or numbering of choice options (Thaler & Sunstein, 2008). Empirical research demonstrates that organ donation legislation based upon the opt-out principle (individuals refusing donorship must explicitly opt-out) yields more potential donors than legislation based upon the opt-in principle (persons opting for donorship must explicitly opt-in): the default option 'steers' individual choices. Nudging techniques also make use of individual biases in decision-making including inertia, preference for short-term rewards, uncertainty reduction, and risk aversion. Using peer pressure or referring to social norms are other techniques to motivate people to change their behavior (Oliver, 2013). Nudging is often propagated as a strategy to influence individual behavior without being paternalistic. For this reason, Sunstein and Thaler (2005) consider nudging a morally acceptable instrument to promote public health: 'Libertarian paternalism is not an oxymoron' is the provoking title of their article on this issue.

Criteria for policy instruments

Policymakers use many criteria to justify their choice of policy instruments. A brief overview:

- Necessity: an instrument is considered a precondition for attaining the stated policy goals. There is no alternative (TINA).
- Effectiveness: an instrument must contribute to achieving the stated policy goals.
- Efficiency: policy goals should be reached with the least possible resources. Waste means inefficiency.
- Proportionality: an instrument should constrain behavior no more than strictly necessary.
- Avoidance of negative side effects.
- Precautionary principle: uncertain but potentially severe (health) risks must be avoided. Better safe than sorry.
- Feasibility: an instrument must meet the test of economic, judicial, political, organizational, or social feasibility.
- Equity: the distribution of the costs and benefits across the population must be fair.
- Timing: which instrument(s) should be tried first?
- Political opportunity: an instrument must serve political interests, for example, the preservation of the power balance.

This overview highlights the complexity of the instrumentation of health policy. The choice of policy instruments does not depend on a single criterion. It is always the outcome of a balancing act. Instrumentation involves weighing of the pros and cons of alternative instruments on the basis of multiple and ambiguous criteria. What the criteria of necessity or proportionality, to mention two examples, really mean is a matter of judgment based on knowledge, normative choices (e.g. how to weigh effectiveness versus proportionality?), and political estimation. What also complicates the instrumentation of health policy is that criteria may lead to different outcomes. For instance, a potential trade-off may exist between effectiveness and equity or between efficiency and feasibility. Another problem relates to the sequence in which policy instruments are used. Policymakers may opt for the immediate use of coercive instruments but also follow an alternative strategy of starting with non-coercive policy

instruments to attain their goals (e.g. persuasion) and switching over to coercive instruments if non-coercive instruments have failed.

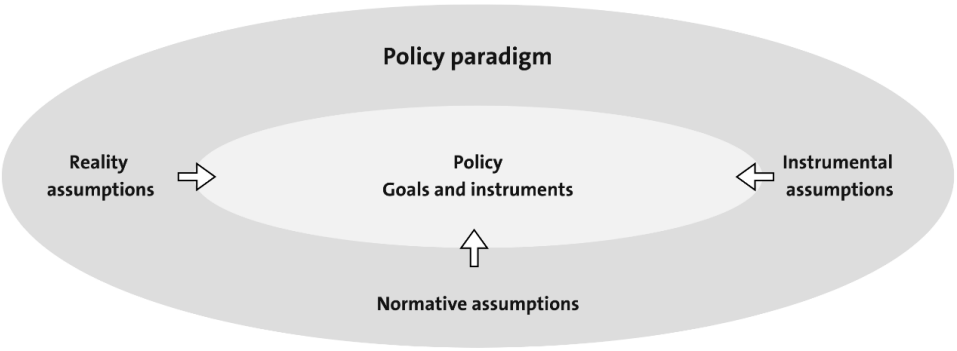
3.9 Policy paradigm

Each policy rests upon assumptions. Health promotion is based upon the normative assumption that the state should take policy measures to foster healthy behavior. The call for a shift from post-care to pre-care draws upon the assumption that disease prevention and health promotion help to avert that people fall ill. Holding the state morally obligated to guarantee its citizens broad access to health care is a moral assumption underpinning state intervention to protect and promote public health. Co-payments are assumed to temper the demand for health care. Competition is assumed to foster the efficiency and quality of health care.

A policy paradigm can be defined as the set of assumptions underpinning a policy. Hall (1993) describes it as 'a framework of ideas and standards that specifies not only the goals of policy and the kind of instruments that can be used to attain them but also the very nature of the problems [policymakers] are meant to be addressing' (p. 279). In other words, a policy paradigm directs the framing of policy problems, the formulation of policy goals, and the choice of policy instruments. A policy paradigm can be coherent or incoherent, explicit or implicit, rest upon empirical evidence or personal experience, root in tradition, ideology or theory, serve as a justification of private interests, and so forth. Some alternative terms circulating in the policy literature are belief system (Sabatier & Jenkins-Smith, 1999), assumptive world (Vickers, 1965), policy theory, and policy discourse (Hajer & Wagenaar, 2003).

Figure 3.1 visualizes the structure of a policy paradigm. Policy assumptions are divided into three main categories: (a) reality assumptions about facts, causal relations, and expectations; (b) instrumental assumptions about what works and does not work in problem resolving; and (c) normative assumptions about what should be done or omitted. The distinction between these three types of assumptions is analytical. In practice, they are closely interconnected.

Figure 3.1. Relationship between policy and policy paradigm



Some policy paradigms have a long history and sometimes even the structure of an unshakeable belief. They can be deeply rooted in the collective memory. Sabatier and Jenkins (1999) distinguish in this respect between deep core and policy core beliefs. While deep core beliefs include 'basic ontological and normative beliefs', policy core beliefs entail 'basic normative commitments and causal perceptions across an entire policy domain or subsystem'. Examples of deep core beliefs are the Christian, socialist or liberal body of thought. The belief in the merits of state planning or competition is an example of a policy core belief. Deep core beliefs are relatively most resistant to change, whereas policy core beliefs are more flexible. Finally, Sabatier and Jenkins introduce the category of secondary beliefs which, if necessary or opportune, can be adjusted to new information, experience or strategic considerations.

Health policymaking can be conceptualized as a contest between rivalling policy paradigms. Examples are the struggle between the Sanitary Movement and local authorities in the nineteenth century on the need for a fundamental reorientation of local health policy to control cholera outbreaks (Box 1.1), the struggle between the proponents and opponents of mandatory childhood vaccination or the struggle between the believers in competition and the believers in state planning.

Policy paradigm and policy reform

The call for a fundamental reorientation in health policy corresponds with a call for a new policy paradigm. Reform advocates argue that the old paradigm fails and

postulate the need for an alternative paradigm or in the terminology of Rein and Schön (1994) 'policy reframing' (Box 3.4). However, the call for a paradigm may turn into a protracted ideological trench warfare, not only because the hegemonic paradigm is not easily given up but also because a paradigm shift can impact material interests and power relations. A new paradigm that is perceived as a threat to established rights will meet much resistance. This aspect of policy reform will be further discussed in Chapter 11 in the section on institutional change and continuity.

Box 3.4 From an individualistic perspective to a population perspective in health policy

In her article '*The Struggle for the Soul of Public Health*', Wiley advocates a fundamental shift in the orientation on prevention in public health. She welcomes the centrality of prevention to public health in the United States but criticizes the individualistic approach to prevention 'Prevention policy is dominated by individualistic strategies that rely heavily on willpower with minimal impact on population health' (p.1084). Health is mainly seen as a matter of individual responsibility and prevention strategies are mainly directed at influencing the behavior of individuals. Commercial interests and mounting legal obstacles (protection of commercial speech and broad pre-emption of local government authority) are often at odds with what she calls the population perspective. 'The powerful resonance of ''personal responsibility'' indicates deep-seated antagonism to understanding health as socially determined (.....)' (p.1085). An effective approach to health injustice requires a new policy paradigm by shifting 'from the dominant "portrait" frame (characterized by individual choices such as what we choose to eat) to a "landscape" perspective that includes how policies, institutional behavior, structural and historical issues fundamentally shape health outcomes' (p. 1094).

Source: Wiley, 2016.

Alternative policy paradigms for policy failure

Hood (1998) has developed a typology of policy paradigms of policy failures, or in his terminology, responses to public-management disasters. The first paradigm is the hierarchist paradigm which attributes policy failure to a lack of hierarchy and stresses the need for expertise and management. Poor compliance with established procedures and lack of expertise are viewed as important causes of failure. Consequently, the remedy is sought in greater expertise, tight procedures, in short, more hierarchy. Watchword is 'steering'. The egalitarian paradigm sees hierarchy and expertise as the main explanation of failure. Top-level policymakers are accused of power abuse. The solution is sought in more democracy and empowerment of people at the bottom. Watchword here is 'participation'. The individualist paradigm constructs policy failure as the result of faulty incentive structures through 'overcollectivization' and lack of price signals. Market-like mechanisms, competition, league tables, and information to support rational decision-makers are recommended as the most effective response to failure. Watchword here is 'enlightened self-interest'. The fourth paradigm is the fatalist paradigm which sees failure as inherent to human action. The world is unpredictable and unintended effects are unavoidable. Policies never work as intended. The best remedies are minimal anticipation and ad hoc responses after the event. Watchword of this paradigm is 'resilience'.

3.10 Policy narrative

Health policy is more than a system of policy goals and instruments. It also involves a storyline or narrative about what is going wrong, what will happen if no action is taken, what should be done, what will happen if no action is undertaken, and so on. Successful policymaking requires a persuasive narrative that goes beyond a 'technocratic' enumeration of facts, graphs, and tables. The story must connect information with normative convictions and arouse emotion. In short, a successful policy narrative is a well-crafted blend of logos, ethos, and pathos (Hood, 1998). Crafting an effective narrative is a matter of framing and sense-making. Facts only to convince and mobilize people are not enough or as Lakoff (2009) has put it: 'The truth will not set you free'. Crucial is to touch the right chord of people (Westin, 2008). Trust and credibility are other factors influencing the mobilizing impact of policy narratives.

Policy narratives accomplish three main functions. The instrumental function is building support for policy choices, the empowering function helping people to make informed choices, and the political function legitimating public action and fostering public confidence in public authorities. Opponents use a policy narrative as an instrument to mobilize political resistance (Boin et al., 2021).

In her analysis of the role of narratives in policymaking, Stone discusses two popular problem narratives. The first narrative is the story of decline, which goes as follows: if nothing is done, a collapse will ultimately follow. This narrative is frequently used in health policymaking, for instance, in stories about escalating healthcare expenditures. Opponents use the story of decline as a rhetorical weapon to discredit policy decisions. For instance, critics of cost control measures warn of the risks of these measures for the accessibility or quality of health care. The second popular narrative is permeated with optimism and involves the story of control. What was once beyond our control can now be controlled! For instance, we are able to prevent disease because we now have better knowledge of its determinants. Disease is no longer a twist of fate but something amenable to handling. The story of control underscores human agency. There is a choice. The story can also be used to unmask the industry that has concealed the truth to its benefit (Stone, 1988).

There are more policy narratives. For instance, policymakers claim that their decisions are necessary or inevitable (the 'there-is-no-alternative' (TINA) argument). They deliberately frame a problem as a 'crisis' to underscore the seriousness of a problem and legitimize radical intervention. Another strategy is to refer to external factors or 'foreign agents' to explain the cause of a problem. Sometimes, policymakers hide themselves behind the limits of hierarchical control to mask their incompetence. In a polarized political context, problems are often personalized by holding high-ranking persons responsible for failures and requesting their punishment ('t Hart & Boin, 2001). A storyline popular among alt-right populists is to discredit state intervention in public health as a conspiracy of a world elite (e.g. the World Economic Forum) to control all people across the world.

Stone underscores the role of rhetorical devices in crafting a policy narrative. Well-known rhetorical instruments are synecdoche and metaphor. The synecdoche is a figure of speech by which a part is put for the whole. Policymakers refer to 'typical instances' or 'prototypical cases' to describe a larger problem (Stone, 1988: 116). For instance, the long waiting time of an individual patient is presented as representative of the 'waiting time problem' in health care. A single dramatic number can make a policy narrative persuasive. Metaphors are used to accentuate a problem by comparison. The 'war on drugs, the 'medical arms race', the 'slippery slope' argument, the 'iceberg under the water surface', or the 'fight against the coronavirus' are examples of metaphors in policy narratives.

That terminology matters is illustrated by Boin et al (2010) in an analysis of the vocabulary of crisis communication (Box 3.5). They analyze crisis communication as a 'layered cake'. For instance, an 'explosion' (first layer) is reframed in a later stage as a 'disaster' or 'catastrophe' (second layer) and finally as 'a deep crisis' (third layer).

Box 3.5 Crafting crisis narratives in COVID-19

One of the challenges for governments in dealing with COVID-19 was to craft a compelling policy narrative. Terms like 'crisis' and 'worldwide pandemic' had to convince the general public of the great risks of the coronavirus for public health and the inevitability and legitimacy of unprecedented policy measures to control its spread. French President Macron developed a 'war' framework. He spoke of a 'fight' against the virus requiring 'general mobilization' and 'national unity' (Or et al., 2021)). The Dutch Prime Minister Rutte chose another strategy by calling for solidarity, voluntary compliance, and admiration for the 'heroes' in hospitals. He also crafted the term 'intelligent' lockdown to distinguish the Dutch strategy from the 'strict' lockdown pursued in many other countries. Besides, he recognized that 'the government had to take 100 percent of the decisions with only 50 percent of the information'.

During the first stage of the pandemic, the government's narrative worked quite well. It was the stage of rallying around the flag. Gradually, however, its effectiveness started dissipating under the influence of counter-narratives that were voiced in the media. In some narratives, the government was criticized for not taking necessary measures or

being too late with taking necessary measures. Some politicians denied the seriousness of the pandemic by calling COVID-19 a 'severe flu'. Conspiracy theories on the role of Bill Gates, George Soros, Big Pharma, or Deep State started flourishing in social media. The pandemic elicited an 'infodemic' by an avalanche of opinions on what was going on and how these opinions were misleading the population.

Source: Boin et al, 2021.

3.11 Conclusion and suggestions for health policy analysis

Health policy rests upon the belief that society is, at least to a certain extent, malleable and that well-crafted state intervention can improve public health. This book defines the concept as a collective effort of health policymakers to achieve health goals through instruments during a certain time.

Health policy and health policy decisions are based on a political construction of the problem(s) to be addressed and a policy paradigm (assumptive world). Another defining characteristic of health policy is the narrative (storyline) told to justify the policy decisions made and build public support for these decisions.

Health policy has a double face. On the hand, a policy is information-driven. Policymakers claim to base their decisions on information and analysis. This is the instrumentalist face of health policy. The other face is political. Health policy is the outcome of a struggle between divergent value orientations, conflicting interests, and power games.

Health policy analysts should use the concepts presented in this book as the analytical starting point for an empirical study of health policy. This study starts with an analysis of the political construction of the policy problem. How is a situation or process constructed as a problem? What do policymakers see as the main causes of the problem and what do they expect to happen if no action would be taken? The answer to these basic questions gives insight into the policy paradigm or assumptive world of policymakers. A second important topic of research concerns the formulation

of policy goals and the choice of policy instruments. Which policy beliefs, normative criteria, and political considerations have influenced the formulation of policy goals and the choice of policy instruments? Which dilemmas policymakers had to cope with in their formulation of the policy goals and the choice of policy instruments? How did the political context and other contextual factors influence the formulation of the policy goals and the choice of policy instruments? Which policy narrative did policymakers present to frame the problem, explain and motivate their decisions and mobilize public support for their choices?

Health policy is not just words. Crucial are decisions and actions to put these decisions into practice. Therefore, the study of health policy should go beyond a study of written documents and public statements and include an analysis of what policy-makers have concretely done to achieve their policy goals. Health policy analysts should always be alert to a big gap between words and promises and what is actually done or, put differently, between theory and practice.

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CHAPTER 4

HEALTH POLICYMAKING PROCESS

KEY POINTS:

- Health policymaking is defined as the dynamic process of events, decisions, and actions regarding public health.
- The stage model conceptualizes health policymaking as a cyclical process consisting of five sequential stages: agenda building, policy development, policy formation, policy implementation, and policy evaluation. The sixth stage is policy termination.
- The rounds model conceptualizes health policymaking as a sequence of decision rounds. The focus of analysis is on the interaction between actors in each decision round.
- The crisscross model postulates that health policymaking intersects with other policy processes inside and outside the health sector.
- Agenda building is the process of asking for the attention of policymakers for salient problems in society.
- Problem development involves the identification and investigation of policy alternatives.
- Policy formation involves the assessment of policy alternatives and final decision-making, including democratic control.
- Policy implementation is the process of putting a policy into practice.
- Policy evaluation involves the analysis and assessment of the policymaking process, policy results, and governance structure.
- Policy termination involves the ending of a policy, often by replacing it with an alternative policy.
- A policy path passes through a series of consecutive cycles during a certain period. Current policy is the latest version of a policy in the process of consecutive accommodations to changing circumstances, new insights, and the political context.
- A distinction can be made between two types of paths: policy expansion and a path of policy contraction.

Box 4.1. The introduction of the human papillomavirus (HPV) vaccination program in the Netherlands

After the authorization of Gardasil, a vaccine to prevent cervical cancer, by the European Medical Agency, members of Parliament asked the Minister of Health to investigate the usefulness of the vaccine for admission to the National Vaccination Program (NVP). Due to the fall of the government in 2006, it was not until March 2007 that the new Minister of Health formally asked the Health Council for advice (a requested procedure). Meanwhile, the European Medicines Agency authorized a second preventive vaccine (Cervarix) against cervical cancer.

In March 2018, the Health Council advised the Minister to extend the NVP with a vaccination program for girls aged 12 years and prepare a catch-up campaign for girls 13-16 old. The Council based its advice on the prevalence of cervical cancer, the scientific evidence of the effectiveness and safety of the new vaccines, and economic considerations.

In July 2008, the Minister informed the Parliament that he would follow the positive advice of the Health Council and charge local public health agencies with the implementation of the vaccination program and the National Institute for Public Health and Environment with monitoring the vaccination rate. The start of the program was scheduled for September 2009 but was suspended for half a year because of the outbreak of the Swine Flu (H1N1 virus).

In the meantime, concerned members of Parliament sent critical questions to the Minister about the high costs of the vaccine, the aggressive marketing of the pharmaceutical industry, and the quality of the Health Council's advice. Were the safety and effectiveness of the vaccine guaranteed? Other critical remarks concerned the incomplete information to the target population and the organization of a lottery to motivate girls to choose for vaccination (girls who had received all three doses could win an iPod).

Initially, the vaccination rate was disappointing: only 45.5% of girls born in 2003 had been vaccinated (RIVM, 2018). In response to questions about this result, the Minister announced an investigation to determine how the vaccination rate could be raised. In

particular, what could the Netherlands learn from Belgium, where the vaccination rate had peaked at 90% (Letter to the Parliament, 12 July 2018)?

Ever since the vaccination rate has risen. In 2019, 53% of all girls born in 2005 and 58,5% of all girls aged 14 years and older had chosen for vaccination.

Source: Van der Putten et al., 2019; RIVM, 2020.

4.1 Introduction

The extension of the Dutch National Vaccination Program with HPV vaccination illustrates a relatively simple policymaking process. The authorization of two newly developed vaccines against cervical cancer by the European Medicines Agency set a process in motion that eventually resulted in a new national vaccination campaign. The introduction of the vaccination was delayed as a consequence of the unforeseen fall of the government and the outbreak of the Swine Flu.

This chapter introduces the health policymaking process, the second building block in our model of health policy analysis. Health policy can only be well understood with knowledge of the health policymaking process. Health policy is the outcome of a process of initiatives, calls for action, political pressure, accommodation to altering circumstances, practical issues, and contextual factors. The chapter starts with a description of three alternative policymaking models: the stage model, the rounds model, and the crisscross model. The following sections explore the health policymaking process in greater detail. Successively, attention will be paid to agenda building, policy development, policy formation, policy implementation, policy evaluation, and termination. The chapter ends with a discussion of the concept of policy path.

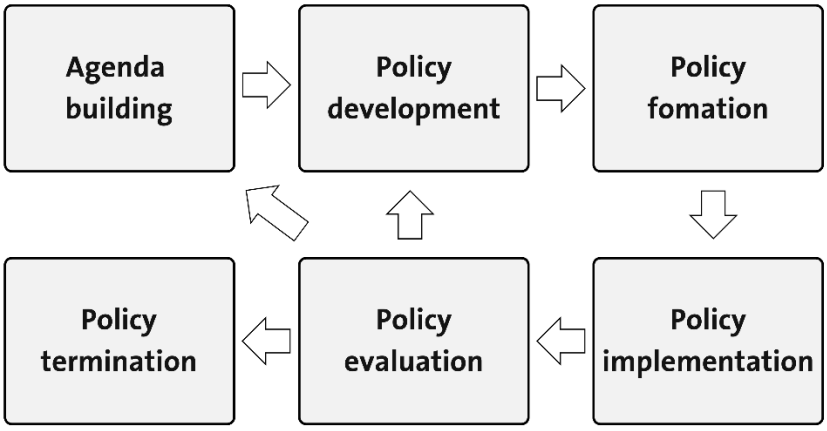
4.2 Stage model

The health policymaking process is defined in this book as the dynamic process of events, decisions, and actions concerning public health. Most policymaking

processes miss a clear beginning and a clear ending. Consequently, there is no simple way of delineating a policymaking process. The resolution of this problem is to focus on policymaking during a preselected period. There are several analytical models of the policymaking process: the stage model, the rounds model, and the crisscross model. This section contains an introduction to the stage model of policymaking. The rounds model and the crisscross model are discussed in the next sections.

The stage model or phase model conceptualizes policymaking as a cyclical process consisting of several sequential and distinct stages (Hill, 2005; Howlett & Ramesh, 2003). The number and names of these stages vary in the literature. This book distinguishes between six stages: agenda building, policy development, policy formation, policy implementation, policy evaluation, and policy termination.

Figure 4.1 Stage model of health policymaking



The stage of policy formation comprises the process of decision-making on policy goals, policy instruments, and the organization of policy implementation. In the stage of agenda building problems are recognized and brought to the attention of policymakers. The policy development stage includes the exploration of policy alternatives to approach these problems. The stage of policy formation comprises the process of decision-making on policy goals, policy instruments, and the organization

of policy implementation. Hereafter follows the stage of policy implementation during which the policy decisions taken are put into practice. The stage of policy evaluation comprises the analysis and assessment of the policy effects. If a policy does not work anymore or is heavily criticized, policymakers can decide to terminate it. A more likely outcome is that a new policy cycle starts.

The stage model conceptualizes policymaking as a linear process that is akin to the solution of technical problems (problem → investigation → decision → action → evaluation). Each stage gives direction to what happens in the next stage, and each stage logically follows upon the previous one. After the completion of the cycle from agenda building to policy evaluation, a new policy cycle commences. Policymaking is a process of continuous adjustments to changing circumstances. New insights and developments, disappointing policy results, and a political crisis are some critical factors that may set a new cycle in motion. The history of health policy can be conceptualized as a path of subsequent policy cycles (section 4.11).

Except for the stage of policy termination, all stages are clearly recognizable in the policymaking process concerning the extension of the National Vaccination Program with HPV vaccination. Members of Parliament put the issue on the political agenda. In the stage of problem formulation, the Health Council investigated the safety and effectiveness of the vaccines against HPV. In the stage of policy formation, the Minister of Health decided to follow the positive advice of the Health Council. Despite critical remarks, the Parliament approved the extension of the National Vaccination Program. The stage of policy implementation included the planning and execution of the vaccination program, and the stage of policy evaluation the monitoring of the program. The disappointing vaccination rate motivated the Minister to start a campaign among girls to improve the vaccination rate (new cycle).

The duration and structure of policymaking cycles vary. The extension of the National Vaccination Program is an example of a relatively short cycle. Policymaking in an enduring crisis requires continuous accommodation of policy measures to changing circumstances and lessons learned. In these circumstances, policymaking follows a

pattern of cycles rapidly following one after another. A textbook example is the policy-making process concerning COVID-19. Policymaking had the structure of a cyclical process of upscaling and downscaling policy measures in a short period. The erratic course of the pandemic, including several mutations of the coronavirus, uncertainty about the spreading and infection rate of the virus, and lack of information on the effects of the policy measures taken, repeatedly compelled governments to revise their strategy. Table 4.1 presents a concise overview of the policy measures of the Dutch government to control the spread of the virus and avert the occurrence of the 'black scenario' in which hospital care would become completely overwhelmed.

Table 4.1 Overview of the timeline of policy measures to suppress COVID-19 in the Netherlands

Year 2020	Policy measures
March 12	Social distancing; appeal to stay-at-home with coronavirus-related health complaints; appeal to work-at-home; closure of concert halls, museums and theatres; ban on gatherings of more than 100 persons
March 15	Closure of bars/restaurants, schools, day care centers
March 23	Introduction of an 'intelligent lockdown'
May 11	Reopening schools (50 percent); relaxation of some restrictive policy measures
June 1	Termination of lockdown with some restrictions; face mask obligated in public transport
October 14	Closure of bars/restaurants
October 16	Extension of obligation to use a face mask
December 14	Closure of schools and non-essential shops
Year 2021	
January 23	Announcement of curfew from 9 pm to 4.30 am
April 28	Termination of curfew; terraces open to 6 pm
June 26	Relaxation of various restrictive measures
September 25	Relaxation of 'one-and-a half-meter' society; QR pass obligated in bars
October 19	Non-essential shops must close at 6.00 pm; bars and restaurants at 8 p.m.
November 19	Start of booster campaign
November 28	Announcement of 'evening lockdown'; bars and restaurants must close at 5 pm
December 18	Announcement of new lockdown until January 14, 2022
Year 2022	
February	Stepwise relaxation of lockdown and restrictive measures

Source: Coronavirus tijdlijn|Rijksoverheid.nl

A strong aspect of the stage model is its heuristic value and its emphasis on the cyclical structure of policymaking. The model conceptualizes policymaking as a recursive process. If policy measures do not work well or circumstances have altered, reconsideration and adjustment may follow. Its heuristic value explains why the stage model has remained popular, not only in the analysis of policymaking but also in the analysis for policymaking (De Leon, 1999). The well-known Plan-Do-Check-Act (PDCA) cycle presupposes a stage model of policymaking. Nevertheless, the model has been criticized for its simplicity and descriptive inaccuracy (Sabatier & Jenkins-Smith, 1999). The assumed logical sequence of the policy stages and central orchestration of the policymaking process ignore the erratic structure of much policymaking. The assumption of clear boundaries between each stage is flawed. The transition from one stage to another stage is fluid, and stages often overlap each other to some extent.

4.3 Rounds model

The rounds model of policymaking (Teisman, 2000) does not conceptualize policymaking as a logical sequence of distinct stages, but as an interactive process between actors, each with their specific expertise, normative convictions, policy preferences, interests, and bureaucratic procedures. The focal point of analysis is their interaction in each decision round. The model divides policymaking into a number of 'decision-making rounds' which may follow upon each other but also coincide in time. Decisions are taken at various moments by various actors and at various political/administrative levels. While some actors participate in each round, other actors get involved at a later moment. Examples are the installment of ad-hoc expert committees to investigate new policy alternatives or the creation of an informal committee to work out a compromise that all participants are willing to accept. Actors playing a prominent role at the beginning of a policymaking process may fade into the background in later rounds. Although formal decision-making procedures cannot be bypassed, it is no exception that 'real decision-making' occurs in an informal setting.

The rounds model accentuates better than the stage model the complexity of policymaking. Much health policymaking has an erratic (non-linear) rather than a linear structure running straight from problem to solution. New (political)

circumstances, new information, public resistance, unexpected developments, and setbacks are some factors that cause delays or motivate policymakers to reconsider earlier plans or policy decisions. Sometimes, policymaking even comes to a (temporary) standstill. The introduction of the market reform in Dutch health care which had started in the late 1980s was declared 'politically dead' in 1992 but resumed by the end of the nineties (Jeurissen & Maarse, 2021). The challenge for researchers using the rounds model as the conceptual basis for their analysis is to demarcate 'the most crucial decisions of decision-making in retrospect' (Teisman: p. 944).

The rounds model stipulates that policy decisions are not linked to a single actor. The outcome of a decision round is a collective 'product' that each actor will interpret and appreciate in their way. Furthermore, the model does not conceptualize policymaking as an orchestrated process as is implicitly assumed in the stage model. Policymaking on controversial issues is likely to pass through several rounds before the situation is rife for final decision-making. Deadlocks and delays are no exception. Actors sometimes even disagree on which stage of decision-making they are in. Box 4.2 illustrates how the settlement of a deep conflict between health insurers and self-employed medical specialists required several decision-making rounds.

Box 4.2 Decision-making on the tariffs of self-employed medical specialists in Dutch health care from 1986 till 1991

Claiming that the tariffs of specialist care were disproportionally high, sickness funds urged lower tariffs in the mid-eighties. Unsurprisingly, medical specialists reacted furiously against this 'infamous' policy initiative. It sparked off a conflict that would drag on for several years. Prominent actors in the conflict were the peak associations of sickness funds, private health insurers, and medical specialists, the Minister of Health, and the newly created Central Health Care Tariffs Board as the formal locus of decision-making. During the conflict, private insurers joined with the sickness funds in their claim for lower tariffs. The main interests of the Minister were to restrict expenditure growth and maintain peaceful relations between insurers and doctors. Sickness funds and specialists played simultaneous games at several chess

boards. They negotiated with each other both in formal and informal settings. At some moments, the Health Department was actively involved, but over time it opted for a more distant role. Sickness funds made strategic use of formal instruments in the new Healthcare Tariffs Act to put the specialists under pressure. After several failed attempts by mediators to settle the conflict, sickness funds, private insurers, hospitals, specialists, and the Minister eventually agreed on a compromise that came to be known as the 'Five Parties Agreement'.

Contrary to formal legislation, the Healthcare Tariffs Board did not function as the formal locus in the policymaking process. Negotiations took largely place in an informal setting. Although the Board expressed concerns about the legal aspects of the agreement, it eventually accepted the agreement for strategic reasons and worked it out in new regulations. An attempt by some medical specialty groups to overturn the agreement in court failed.

Source: Lieverdink & Maarse, 1995.

4.4 Crisscross model

The crisscross model draws upon the rounds model. Its central claim is that policy-making processes intersect. Policymaking on a given issue cannot be well understood without considering its 'interaction' with policymaking in other policy sectors. Health policymaking in a given sector (e.g. pharmaceutical care or prevention programs) can be closely linked to policymaking in other parts of health policy (e.g. healthcare cost control) and other public sectors. For instance, complex connections exist between health policy and public policymaking on social security, public finance, income policy, housing, privacy, public security, education, and international trade. EU regulations and policies often have significant consequences for health policymaking in the member states. Sometimes, 'neighboring' processes create opportunities and fasten policymaking. In other situations, however, they restrict the room for policymaking or cause policy delays. Political factors such as electoral competition, party politics, the fall of the government, or the installment of a new government may heavily influence the course and outcome of health policymaking. Sometimes, a government change creates an unexpected opening in a process that has dragged on for years without the

prospect of a soon way out. An example is the political switch of the UK government in the policymaking process on the European ban on tobacco advertisements. After Blair had won the electoral vote in 1997, the UK government gave up its resistance to introducing a European ban. The UK's remarkable switch was followed by the Dutch government which had joined the UK in its political resistance to a ban because of economic interests. The switch of British and Dutch governments meant that the blocking minority in the European Council no longer existed (Boessen & Maarse, 2009).

The crisscross model differs in several respects from the stage model. It replaces the 'vertical' structure of policymaking that is implicitly assumed in the stage model with a 'horizontal' structure of policymaking in multiple settings. The crisscross model also rejects the logical sequence of processes in the stage model. Another difference is the absence of a unitary actor who has the authority or power to steer policymaking top-down. The difference between the crisscross model and the rounds model concerns the focal point of analysis. While the focus in the rounds model is upon the interaction of actors in sequential decision-making rounds in public policymaking, the crisscross model puts the interaction between simultaneous policymaking processes and the impact of this interaction upon policymaking central. Much policymaking resembles simultaneous chess-playing.

4.5 Agenda building

The previous section gave a brief overview of three alternative models of health policymaking. This section and the following sections explore this process further based on the stage model. It is recalled that the boundaries of each stage are fluid, that stages may partially overlap, and that the assumed logical sequence of the stages mostly does not exist in the real world of policymaking. Furthermore, it should be noted that the rounds model and crisscross model are useful analytic models to study each stage in the policymaking cycle separately.

Agenda building is the process of asking the attention of policymakers for salient societal problems. Political parties, interest organizations of care workers and patients, research institutes and experts, government departments, international

organizations, citizen groups, or other stakeholders call for attention to their problems, urge the government to make an additional budget available, insist on the coverage of a new experimental medicine, argue for the abolition of market competition in health care, warn of the risks of doing nothing, and so on. The media play an important role in agenda building by reporting on problems and scandals, posing critical questions, influencing public opinion, and conducting investigative journalism. Kingdon (1984: 3) describes the agenda as 'the list of subjects or problems to which governmental officials, and people outside of government closely associated with those officials, are paying some serious attention at any given time'.

As spelled out in the previous chapter, policy problems are never given or 'objective' but politically constructed or 'subjective'. Actors trying to put policy problems on the political agenda need an appealing narrative or policy frame to create public awareness. There is nothing more helpful to bridge the gap between public and political agendas (see below) than an effective problem frame. Persuading people with facts, arguments, analysis, or reason (logos) only does not work. The challenge is to convince policymakers that something can and should be done.

While some problems form a more or less institutionalized part of the health policy agenda (e.g. cost control, access to health care, payment of doctors and hospitals, quality of health care, or the market authorization of new medicines), other problems are relatively new. Technological innovations, demographic and epidemiological developments, and the growing body of knowledge on health and disease have fundamentally altered the health policy agenda. Examples of new themes are the aging of the population and the corresponding need for long-term care, the rising number of patients with multimorbidity, the call for more emphasis on the prevention of disease and promotion of health, the reduction of health inequalities, the potential impact of e-health, big data, artificial intelligence upon health care and the penetration of the commercial sector into the health sector. Scandals and policy failures also influence the health policy agenda, albeit usually for only a short period. The issue-attention cycle (Downs, 1972) often appears short-lived. In contrast, COVID-19 radically changed the health policy agenda worldwide for some two years.

Agenda building as a filtering process

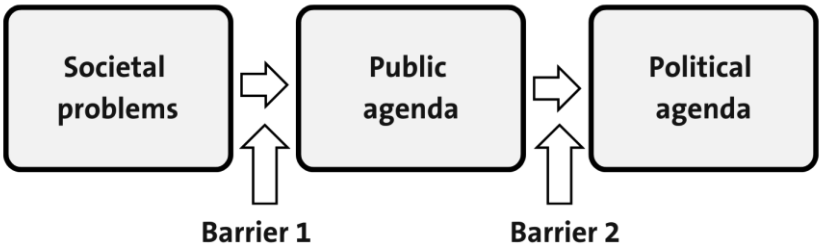
Not each problem in health care draws the attention of policymakers. While some receive attention, others are ignored or, for whatever reason, put aside. In this respect, it is helpful to make an analytical decision between societal problems, the public agenda, and the political agenda. The public agenda refers to salient societal problems that are brought to the attention of policymakers (government). The political agenda comprises problems the government deals with. Regarding the political agenda, Kingdon distinguishes between the governmental agenda and the decision agenda. He defines the governmental agenda as 'the list of subjects that are getting attention' and the decision agenda as 'the list of subjects within the governmental agenda that are up for an active decision' (p. 4).

Figure 4.2 demonstrates that societal problems must pass two barriers to reach the political agenda. First, they must reach the public agenda, and next the political agenda. Agenda building can be analyzed as a selection or filtering process in which actors compete for the attention of policymakers (Cobb et al., 1976). While some actors have plenty of resources and excellent venues to get an issue on the political agenda, other actors miss effective resources to pass the barrier from problems to the public and political agenda respectively. Differences in agenda power, defined as the power to set the political agenda, make that agenda building may be structurally biased to the advantage of some and disadvantage of others. Dominant values, political ideologies, the organization of the policymaking process, power structures, and lack of knowledge or repudiation of what is happening in society influence agenda building (Bachrach & Baratz, 1970). The barrier model highlights the possibility of a structural gap between people who feel unheard and the government. Their problems do not reach the public or political agenda.

Agenda building is not only a matter of drawing the policymakers' attention to specific problems but also a matter of effective problem-framing. This aspect is known as second-level agenda setting (Bleich, 2002) or the politics of problem definition (Rochefort & Cobbs, 1994). Policy problems such as cost control, obesity or the moral consequences of research on rest embryos can be framed in many ways. Viewed from this perspective, agenda building can be analyzed as a process in which

alternative problem frames or narratives compete for attention. Agenda power also involves definition power. The framing of policy problems is an essential element of political communication.

Figure 4.2 Barrier Model of Agenda building



Sometimes, stakeholders or policymakers have an interest in keeping issues off the political agenda or, as Bachrach and Baratz put it, in 'non-decisions'. There are several strategies for nondecision-making, ranging from raising formal barriers, and postponing decision-making to controlling the media or silencing opponents. Another common tactic is to remove a contentious issue from the political agenda by installing a commission of wise men and women who are requested to study the issue, investigate the evidence, and formulate policy recommendations.

Models of agenda building

Drawing upon the distinction between insiders and outsiders in public policymaking, Cobb distinguishes between three agenda building models. The leading question is: who initiates agenda building? The outside initiative model is characteristic for pluralist societies. In this model, 'issues arise in nongovernmental groups and are then expanded sufficiently to reach, first, the public (….) agenda and, finally the formal (political HM) agenda'. Groups articulate grievances and urge the government to take action. To be successful, they forge alliances with other groups by framing their grievances as part of a wider public problem or opportunistically join in other public issues on the political agenda (e.g. the ban on tobacco advertisements also hurts the advertisement business or set restrictions to freedom of speech). Although agenda building is conceptualized as an open process, the outside-initiative model does not

assume equal agenda power. Some stakeholders are more successful than other stakeholders in lobbying policymakers to pay serious attention to their problems. The mobilization model is the opposite of the outside initiation model. In this model, leading policymakers put policy problems on the political agenda and seek public support for their policies. The third model is the inside initiation model. In this model influential groups with special access to policymakers are able to place their issues on the political agenda but, contrary to the mobilization model, abstain from mobilizing the public for pragmatic or political reasons (Cobb et al., 1976).

Kingdon (1984) has worked out an alternative approach to agenda building. He investigates under which conditions problems will most likely reach the political agenda. In response to this question, he proposes an analytical distinction between three imaginary streams. The problem stream consists of the set of conditions that are viewed as problems that should be addressed. The policy stream involves a set of ideas and alternatives to address these problems. The political stream' refers to the political climate. His central thesis is that the chance of a public problem reaching the political agenda is greatest if the problem stream, policy stream, and political stream intersect. Pressing problems, new policy ideas, or changed political conditions are not enough to reach the political agenda, and particularly the governmental agency. The intersection of the three streams creates a window of opportunity for successful agenda building. Critical is the presence of an experienced political entrepreneur who seizes the momentum and builds political support for policy change. Kingdon's model is akin to what Tuohy has called 'accidental logics': some policy changes have only a chance of success under specific conditions (Tuohy, 1999).

4.6 Policy development

Modern health policy analysis underscores the need for analysis in policy development. Designing an effective problem-solving strategy requires a systematic analysis of problems and the potential effects of alternative policy instruments or a combination of policy instruments. Handbooks are filled with analytical models and techniques to perform this task. Examples are forecasting techniques, scenario writing, econometric modeling, cost-benefit analysis, cost-utility analysis, cost-effectiveness analysis, disease modeling, and budget impact analysis.

However, policy development goes beyond the technical or instrumental investigation and elaboration of policy alternatives. It also involves a critical analysis of the underlying assumptions undergirding these alternatives and a critical normative assessment of alternative policy choices. For instance, what are the policy goals to be achieved, and how could they best be formulated? How to judge the economic and political feasibility of these choices and their longer-term consequences? What is the general public expecting from the government, and how might it respond to alternative policy choices? How to communicate policy choices?

Policy development can, just like agenda building, pass through several cycles. Policymakers ask for new analyses or a critical review of the available studies or alternatives before entering the policy formation stage. New developments or accidental events may let them consider the time for decision-making not yet rife for decision-making. Policymakers may also feel a need for extra input from experts, sometimes for no other reason than postpone decision-making (see rounds model). Political arguments also influence the choice of organizations or experts that are requested for advice, or the formulation of the policy questions they must answer (Cairney, 2021)

Organization of policy development

Policy development is a matter of organization. Stakeholders are invited to give their opinion and articulate their policy preferences in consultation meetings. Standing advisory bodies and research institutes are requested to inform the government about public problems and alternative policy proposals. Commissioning research, installing ad-hoc expert committees, consulting interest organizations, and organizing hearings are other common strategies to investigate policy problems and explore policy alternatives. Box 4.3 contains a concise overview of important advisory bodies in Dutch health policymaking.

Box 4.3 Standing advisory organizations for health policymaking in the Netherlands

The Health Council of the Netherlands (*Gezondheidsraad*) is an independent scientific advisory body whose legal task is to advise ministers and Parliament on public health and healthcare issues. Ministers ask the Council for advice to substantiate their policy decisions. The Health Council also has an "alerting" function and can give unsolicited advice (www.healthcouncil.nl).

The National Institute for Public Health and the Environment (*Rijksinstituut voor Volksgezondheid en Milieu*) plays a central role in infectious disease control, prevention of diseases, and population screening programs. The institute conducts research and acts as an expert center for the prevention and control of health incidents and diseases (www.rivm.nl). It advises the national government and other government bodies, health professionals, and citizens on a broad range of public health themes. Other tasks are the implementation of prevention programs and the monitoring of public health. (www.rivm.nl)

The National Health Care Institute (*Zorginstituut Nederland*) advises the government on the standard benefits package of the statutory health insurance schemes and carries out various implementing tasks in these schemes. The institute is also closely involved in programs directed at enhancing healthcare quality (www.zorginstituutnederland.nl).

The Council of Public Health & Society (*Raad voor de Volksgezondheid & Samenleving)* is an independent advisory board consisting of state-appointed experts advising the government on strategic questions arising outside treatment rooms and consultation tables in the healthcare sector and social domain (www.raadrvs.nl).

The Netherlands Scientific Council for Government Policy (W*etenschappelijke Raad voor het Regeringsbeleid*) is an independent organization advising the government and Parliament on strategic issues with critical political and societal consequences (www.wrr.nl). The advisory task of the council is not confined to health issues.

The CPB Netherlands Bureau for Economic Policy Analysis (*Centraal Planbureau*) advises the government and others on the economic consequences of public policies and the potential financial implications of alternative policy strategies. As for public health and health care, its focus is mainly on healthcare expenditures and employment issues (www.cpb.nl). The Council of State (*Raad van State*) is the highest advisory body of the government. The government must ask the Council on all legislation and governance. The Council also functions as the highest administrative court (www.raadvanstate.nl).

4.7 Policy formation

Policy formation is commonly viewed as the 'beating heart' or the central stage of the policymaking process. It is the stage of decision-making on policy goals, policy instruments, and the organization of implementation. The stage of policy formation is closely interwoven with the preceding stage of policy development. Policy formation may even largely boil down to putting a stamp on 'predigested' policy proposals. However, policy formation can also evolve as a complex process consisting of multiple decision rounds in various networks at various levels before the time is ripe for final decision-making. Legal issues, technical details, political dividedness, coordination problems, altering conditions, uncertainties, and risks require further research and intensive consultation. If policy proposals are politically sensitive or the stakes are high, there is a big chance that policy formation politicizes and that the final outcome remains uncertain until the last moment. Other factors influencing policy formation are deficient rules for policymaking, lack of enforcement power, and involvement of many stakeholders ('problem of the many hands').

Policy formation as a two-stage process

Much health policy formation has the structure of a two-stage process. The first stage involves decision-making on a general policy framework and the second stage the elaboration of this framework in concrete policy decisions. The general policy framework sets out the direction and organization of second-stage policy formation.

Second-stage policy formation can be delegated to the accountable Minister or regulatory agencies at arms' length of the government. An alternative model is to decentralize second-stage policy formation to lower political-administrative levels in the state hierarchy (states in a federal system, provinces, regions, municipalities).

The organization of health policy formation as a two-stage process is a common model in health policymaking. In their scoping study of the organization and financing of public health in Europe, Rechel and his colleagues (2018) give an overview of the great variation in the organization of health policymaking. For instance, Germany has decentralized a great deal of policymaking to the states (Länder) and Italy to the regions. In the Netherlands, municipalities fulfil a policymaking role in public health. France, on the other hand, has traditionally a more centralized structure (see Chapter 6 for more information).

A critical aspect of policy formation as two-stage process concerns the degree of policy discretion left to policymakers in the second stage. Do they have sufficient decision power to accommodate first-stage policymaking to local or regional circumstances, or is their decision power (quite) constrained? This question is a recurring and delicate theme in political discussions on the distribution of power and decision rules in governance (see Chapter 6).

The politics of policy formation

What frequently complicates health policy formation is political resistance because of conflicting interests or ideological struggle. Building a majority in a divided parliament can be an immense political challenge requiring intensive consultations and substantial concessions. Last-minute changes in legislation are common. Policy formation in an ideologically divided political landscape may drag on for many years. Even if the necessity of hard decisions is broadly recognized, political resistance can block forceful interventions. In these circumstances, policymakers have no other option than waiting for a window of opportunity to strike a deal that had been unfeasible until then. A breakthrough requires more than appealing policy ideas. Equally necessary are favorable political conditions and a deeply felt sense of urgency.

Other preconditions for successful policy formation are political leadership, resoluteness, and a good antenna for seizing opportunities and avoiding pitfalls.

Political resistance frequently results in political compromises and incrementalism. Policy formation involves lengthy negotiations before an agreement is within reach. Policymakers must accept considerable concessions or reconcile themselves with a halfway compromise. The failure of national health insurance in the United States demonstrates that Presidents Roosevelt and Truman missed the necessary power base to pass through a comprehensive health insurance scheme, even though there was ample public support for such a scheme (Box 4.4).

Box 4.4 The failure of national health insurance in the United States

Contrary to other Western industrialized nations, the United States has never passed comprehensive national health insurance legislation, despite broad popular support for it in the post-war period. President Roosevelt presented health care reform as a prime target in his presidential term but concluded that pushing through would put his entire social security agenda at risk. For this reason, he sacrificed health care reform in return for the approval of other parts of his policy agenda in Congress. President Truman, too, supported the idea of comprehensive national health insurance and even presented it as a centerpiece of his presidential campaign. Although 82 percent of the population favored a reform that would make it easier for all people to access health care, he failed. With President Eisenhower in the White House, healthcare reform more or less disappeared from the political agenda, but the Johnson Administration resumed it in the 1960s. Again, political circumstances forced the President to content himself with a second-best solution: the introduction of Medicare (a federal social health insurance scheme for older people) and Medicaid (a federal insurance scheme covering people under the poverty line). His successors proved unable to extend the scope of national health insurance. A reform plan of President Clinton in the 1990s even blatantly failed. Ultimately, President Obama managed to get his Affordable Care Act accepted by Congress.

There are many reasons for the failure of a broad national healthcare reform in the United States. One explanation is the strong opposition of interest organizations of

doctors and health insurers who did not stop warning of the danger of 'socialized medicine' that would contrast with the American culture of freedom of choice and entrepreneurship. Another explanation is the highly fragmented political structure which enabled party leaders and chairpersons of key Congressional committees to block reforms they did not consider in their political interest.

Source: Steinmo & Watts, 1995; Blumenthal & Morone, 2010; Navarro, 1989.

The history of national health insurance in the United States is emblematic of much health policy formation. Health policy formation has repeatedly turned out to be a politically sensitive issue because proposals conflicted with vested interests or deep-seated moral beliefs. Policy decisions restricting access to health care or associated with the rise of the 'nanny state' (Wiley et al., 2013) are always good candidates for raising opposition and offering politicians an opportunity to profile themselves. Policy formation on controversial issues is not the outcome of rational design, based upon information, analysis and a well-thought policy paradigm, but rather the outcome of a complex mixture of rational design, institutionalized beliefs, vested interests, power factors, and political compromise.

Health policy formation in pluralist political systems involves intensive consultations with interest organizations within and outside the health sector. Powerful stake-holders representing the interests of doctors, hospitals, health insurers, patients, the corporate sector and other groups, lobby government officials and members of Parliament in formal and informal settings to ask attention to their problems and demands. Due to political pressure, the government may be unable to break through the clay layer of organized interests. Its actual decision power is often more constrained than its formal decision power suggests.

A state of emergency can radically change the standard rules for policy formation. How the necessity of an immediate state response can erode democratic control has been well described by Wagner in his book '*Emergency State'* on health policy formation on COVID-19 in the United Kingdom (Box 4.5).

Box 4.5 Health policymaking in the 'Emergency State': the case of the United Kingdom

In his book '*Emergency State*' Wagner describes how COVID-19 turned the democratic rules of policy formation on their head during COVID-19. In normal circumstances, big decisions are not taken overnight. Intensive debates in public and private spaces precede debates in the Parliament. The enactment of legislation is the endpoint of a lengthy process of deliberation. Democratic procedures are an antidote to hurried decision-making that could lead to policy disasters. None of this happened in the first stage of COVID-19. 'Unlike the months of debates, votes and amendments usually required to pass primary legislation, the Coronavirus Bill took eight days. It was debated for around six hours in the House of Commons and seven and a half hours in the House of Lords'. (….) Parliamentarians could only vote 'yes' or 'no' when reauthorizing and could not propose amendments' (pp. 49-50). In other words, the standard democratic safeguards were put out of action. Only a small minority of regulations were voted on by the Parliament before they came into force, and a significant number were never debated at all. Wagner acknowledges the necessity of rapid response to confine the rapid spread of the coronavirus. The government was indeed confronted with a state of emergency. Nevertheless, he is critical of what he calls the 'scrutiny vacuum' (p.92). 'With the government imposing the most severe restrictions of freedom for eighty years, this was nothing short of a democratic tragedy' (p. 56).

Source: Wagner, 2022.

4.8 Policy implementation

Policy implementation is the process of putting a policy into practice or, in other words, the process of converting words into concrete activities. Policy implementation is the hour of truth in policymaking because 'the proof of the pudding is in the eating.' Policies show their real face during policy implementation. What a policy concretely means for people or organizations manifests in policy implementation. This explains why policy implementation can politicize, sometimes even more than policy formation. Implementation decisions are not abstract; they have concrete

consequences for concrete people and organizations. Implementation lays bare the consequences of ill-thought policies.

Policy implementation is a crucial stage in every policymaking process. Implementation problems are due to many factors, including ambiguous and conflicting policy goals, lack of resources (people, knowledge, money, organizational capacity or time), a hasty preparatory trajectory, or neglect of the organization of implementation. Political compromises are another important cause of implementation problems, particularly, if policymakers demonstrate little interest in their practical feasibility. Other factors are coordination and communication problems, unclear accountability structures, ICT problems, (inter)organizational rivalries, failing central steering and oversight, lack of public support, or unexpected setbacks.

The organization of policy implementation

There are various basic organization models of policy implementation. The first model is to charge one's organization and staff with policy implementation. This model enables policymakers, at least in theory, to exert direct control of the implementation process. An alternative model is to delegate implementation to lower-level administrative levels (e.g. region or municipality), non-profit organizations (e.g. non-profit health insurers), or regulatory agencies at arms' length of the state (e.g. the Dutch Healthcare Authority or the Care Quality Commission in the United Kingdom). A third model is to outsource implementation to private companies by public tenders. The implementation of a great deal of health policy rests upon a combination of these models (chapter 6). While the implementation of some tasks is kept under central control, other implementing tasks are delegated or outsourced.

The organization of health policy implementation usually has a complex structure. On closer inspection, even the implementation of a relatively simple policy may consist of numerous activities that must be coordinated. Another complicating factor is the involvement of many actors at various administrative levels. Coordination and information problems are always lurking and may have unexpected consequences for policy outcomes (Pressman & Wildavsky, 1973). Many factors, including institutionalized practices, ideological considerations, the capability and expertise of organizations, political lobby, and power relations influence policy implementation.

Large-scale outsourcing or delegation of policy implementation is not without risks. If the policymaking organization (e.g. the Health Department) is hardly involved in the daily practice of policy implementation, a kind of 'mental gap' may develop between the world of policymakers and implementing agencies. This risk of two separate worlds is even more acute if policymakers demonstrate little interest in practical implementation issues or ignore the warnings of implementing agencies of feasibility problems. A risk of large-scale outsourcing of implementation to private companies is that policymakers become heavily dependent on the expertise of the market sector.

Levels of implementation

An analytical distinction can be made between macro-implementation, meso-implementation, and micro-implementation. Macro-implementation encompasses the (political) steering of implementation, meso-implementation the development of an implementation strategy at the local level, and micro-implementation the implementation of a policy in individual cases. Macro-implementation corresponds with a top-down perspective on policy implementation and micro-implementation with a bottom-up perspective. Meso-implementation takes a middle position. Agencies involved in meso-implementation must develop an implementation strategy. Examples of issues in meso-implementation are organization-building and maintenance, priority setting in the context of scarce resources, and developing guidelines for decision-making in individual cases. Micro-implementation is concerned with the interaction between implementing agencies and policy clients. In his study of street-level bureaucracy, Lipsky (1980) investigated how front-line implementers may interact in practice with policy clients. They develop coping strategies in their contacts with clients in response to scarce resources, ambiguous or conflicting guidelines, or non-voluntary clients. Aggressive behavior of patients has necessitated the development of such mechanisms in health care (Harwood, 2017). Micro-implementation can also involve (lengthy) negotiations between implementing agencies and policy clients, for instance, on a license, a recovery plan, or a time schedule.

Successful implementation presupposes well-informed clients. However, this condition can cause problems: clients may not be well-informed, may not understand

or read the regulations, may forget to respond timely, may make mistakes in filling in forms, and so forth. Resistance to participation in national vaccination programs does not only arise out of skepticism or religious grounds but may also result from information problems, health illiteracy, and misinformation. The number of clients experiencing problems with the digitalization of implementation is substantial (Plugmann & Plugmann, 2021).

Two models of policy implementation

There are two alternative models of policy implementation: the control model and the evolution model. The control model conceptualizes implementation as a largely programmed process. Implementing agencies are bound by detailed regulations. Policy implementation has the structure of a technical, bureaucratic, and increasingly digitalized process. Policy implementation contrasts with policy formation by its emphasis on expertise, neutrality, and loyalty. The downside of detailed programming is the absence of sufficient leeway for accommodation to individual circumstances. The digitalization of policy implementation has aggravated this problem. Policy clients risk getting lost in the labyrinth of detailed bureaucratic regulations, or becoming the victim of regulations that do not fit their specific situation.

The evolution model of policy implementation draws upon the notion that the complete regulation of policy implementation is an illusion. The course of policy implementation is paved with obstacles many of which were unforeseen or ignored during policy formation. During implementation, numerous problems may arise for which a practical solution must be found. Policy implementation requires adaptive behavior in response to situations like these. It is for this reason that Majone and Wildavsky (1978) conceptualize policy implementation as an evolutionary process. While it is true that policy shapes implementation, it is equally true that implementation shapes policy. Policy implementation is a learning process and requires adjustments to the 'reality of practice'.

The control and evolution model are ideal types. In practice, policy implementation is mostly a combination of both models. Policy decisions and regulations set out a clear direction of what policymakers strive for but also create room for accommodation in

practice (see below). Even tightly formulated norms require interpretation in practice. This may lead to a situation in which the legal framework remains unchanged but practice has changed. An example is the practice of euthanasia in the Netherlands (see Box 9.7 for more information on Dutch legislation). In its fourth evaluation of this practice, a research group signaled some noteworthy developments in how legislation is put into practice. One of these developments is that the patient's subjective experience of suffering is given more weight in the current practice than in the past in assessing whether the physician has met the legal criteria of due care (ZonMw, 2023).

Ambiguous rules

A general problem with rules is that they often appear ambiguous, multi-interpretable, and sometimes even conflicting in individual cases. It is up to policy implementers to find a way out. Sometimes, ambiguous regulations undermine the legitimacy of state intervention, particularly if they impose severe restrictions on social action. They are both confusing for policy implementers and ordinary citizens who have no clear notion of what is permitted or forbidden. An illustration of this situation occurred in the United Kingdom during COVID-19 (Box 4.6).

Ambiguous rules frequently elicit litigation procedures to challenge their interpretation in concrete cases. Court rulings may compel policy implementers to revise their decisions or implementation strategy.

Box 4.6 The implementation of corona regulations in the United Kingdom

To control the spread of the coronavirus, the UK government issued a large number of regulations that imposed severe restrictions on social interactions. It charged the police with supervising the compliance of these regulations. The police were given wide power to 'take such action as is necessary to enforce any requirement'. For instance, the police could sanction rule breaches by imposing offenders a financial penalty the amount of which could rise astronomically.

In his study '*Emergency State*' Wagner observes that the police were charged with a mission nearly impossible. The regulations shined in ambiguity and inconsistency. The wording of the regulations was sloppy (e.g. what is necessary action?) and the police

had at best a shaky understanding of them. Other complications were that the enforced social distancing policies diverged across England, Wales, Scotland, and Northern Ireland, were frequently altered, and contained several exceptions.

How to deal with a situation of police overreach? On the same day the first lockdown law came into force, the Policy Federation and College of Policing issued the '4Es' guidance: Engage, Explain, Encourage, and Enforce as the last resort. The guidance was clearly intended to avoid 'the 'bond of trust' between state and citizens would be broken, if it turned out that what was being described as a 'rule' was in fact merely advice or imploring' (p.59). Nevertheless, the '4Es' did not withhold the police from a severe way of acting in case of rule violations.

There was also much confusion among the population on what was permitted and forbidden. People were hopelessly confused as a consequence of which many of them inadvertently breached the regulations. Many people had a lockdown hobby to see how far they could go. Confusion on the meaning of regulations is of course something that should be avoided anyhow, but most urgently in situations in which regulations impose severe restrictions on social action.

What made the situation even more problematic was that some top-level officeholders ignored the regulations themselves. There were several party-gates in Downing Street 10 and the Health Secretary had to resign after he had been caught engaging in an extramarital affair with an aide at work which according to rules was explicitly forbidden (p. 89).

Source: Wagner, 2022.

4.9 Policy evaluation

Policy evaluation includes the analysis and appraisal of policymaking. A great deal of policy evaluation focuses on policy outcomes. Have the policy goals been achieved and which (unforeseen) side effects have occurred? What are the short-term and long-term outcomes of health policymaking, and for whom? Does a policy have political effects? Plenty of handbooks describe how to set up policy evaluation studies

in a systematic and methodologically appropriate way (Pawson & Tilly, 1997; Greener & Bent, 2014; Patton, 1990).

The policymaking process can also be the object of evaluation. For instance, did stakeholders have sufficient opportunity to voice their opinion? Was policymaking dominated by corporate interests? Did policymakers listen to their advisors and critically question the information and recommendations they received from them? Was policy implementation given sufficient attention and did oversight work? In the case of policy failures, the focus in process evaluations is not on the question of which failures have occurred (these are known) but on the question of why they have occurred and which lessons could be learned from them (Box 4.7).

Box 4.7 The fipronil case

After an anonymous tip about the use of fipronil in the poultry sector in 2016, the Netherlands Food and Consumer Product Safety Authority initially concluded that this practice did not constitute a public health risk because the product was only used for the disinfection of stables. There was no evidence for its presence in eggs for human consumption. This situation changed in 2017 when the Authority found that the eggs of eight poultry farms had been contaminated with fipronil. Because it considered the presence of this substance in eggs an acute risk to public health, supermarkets were forced to take away millions of eggs from the shelves. Millions of eggs were destroyed and more than 1.5 million chickens were culled. The fipronil crisis also hit some other countries including Belgium and Germany.

The outbreak of the fipronil crisis was reason for the Dutch Safety Board (an independent research organization) to investigate the robustness of the food safety system in the Netherlands. The Board found several vulnerabilities in the system. In its view, the Netherlands had no well-structured system to signal and assess emerging health risks in the food chain. The increased complexity of the international production and foreign trade of food products made the development of such a system even more urgent. Moreover, the Board concluded that the fipronil problem was no isolated case. There were serious concerns about the risk of pathogenic organisms in vegetables and

fruit (in the United States assumed to be the most important cause of food-related infections).

The Board formulated several policy recommendations. The safety of food products had to be organized systematically and timely and the cooperation within the EU had to be intensified.

Source: OVV, 2019.

The governance of policymaking is another important theme in policy evaluation. For instance, how do decision-making rules influence the effectiveness and legitimacy of policymaking? What are the strengths and weaknesses of centralized or decentralized governance systems in times of an enduring public health crisis? How transparent is the policymaking process? Why does the coordination of policymaking fall short?

In a pluralist society policy evaluation is not confined to what policymakers make of it. The Parliament can start a systematic investigation on its own and interrogate respondents under oath. Non-governmental organizations, research institutes, observatories, and interest organizations frequently publish critical evaluations to inform policymakers and the wider public about their findings and judgments. The task of the ombudsman is to critically review policymaking from a citizen's perspective. Besides, the media play an important role by reporting on what is going on, fiascos, scandals, and so on. Courts can hold policymakers formally accountable for misconduct.

Policy evaluation as policy learning

The purpose of much policy evaluation is policy learning. Policy evaluation should policymakers inform on what has gone well or wrong and what should be done to perform better. An example of a policy learning study was published by the House of Commons on how the UK government had handled the first year of the COVID-19 pandemic. The report titled '*Lessons Learned to Date*' called the UK's failure to do more to stop the spread of the coronavirus early in the pandemic one of the worst-ever public health failures. The initial government approach, backed by its scientific

advisors, to abstain from an immediate lockdown had cost thousands of lives. At the same time, the report called the roll-out of the vaccination program a great success. It even described the whole approach to the vaccination program - from research and development through to the rollout of the jabs - as "one of the most effective initiatives in UK history" (House of Commons, 2021).

Policy learning is no sinecure. There are many potential pitfalls restricting its usefulness. Reliable and timely data are often lacking and nobody knows what would have happened if the government had followed another approach. Simple comparisons with policymaking in other countries may be deeply biased. A simple causality argumentation model that solely focuses on what has gone wrong and why without taking relevant contextual factors into account runs the risk of simplification and policy recommendations that do not work. Another problem concerns the choice of evaluation criteria. For instance, an evaluation of how Western countries had anticipated the outbreak of COVID-19 is likely to conclude that their preparedness for crises like this one has ostensibly failed. The countries' documents on how to handle these circumstances appeared 'phantasy documents' in practice. This is a conclusion that governments should certainly take seriously. However, evaluation may take an alternative perspective and focus on the resilience of a country's health system to deal with unknown pandemics. Such an evaluation may sketch a more nuanced picture of how governments have handled a pandemic, despite all unavoidable errors made (De Bruijn & Van der Steen, 2021).

The politics of policy evaluation

Policy evaluation is closely connected with accountability. In a well-functioning democratic system, public authorities are requested to accept the accountability of their policy decisions. Accountability is an instrument for reflection and policy learning. Public authorities demonstrate accountability for policy failure by resigning. In a deeply polarized political atmosphere, however, policy evaluation no longer works as an instrument for reflection and policy learning but as a stick for firing political opponents. Evaluation turns into a blame game (Hood, 2011).

The politics of evaluation may prompt a struggle on methodological issues such as the formulation of the research questions, the delimitation of the research topic, the choice of the evaluation standards, the design of the research model, the selection of the information sources and data, the composition or independence of the evaluating body, and so forth. Other sensitive issues are the formulation of conclusions and policy recommendations. The conclusions of an evaluation from the perspective of policy clients or stakeholders may radically differ from the conclusions from the perspective of the policymakers' policy goals. Political contestants bombard each other with alternative evaluations and policy recommendations.

The political dimension of evaluation (Bovens et al., 2009) also pertains to communication. Drawing public attention to one's evaluation and influencing public opinion requires carefully crafted public messages. There are many ways to communicate the conclusions of policy evaluation. For instance, disappointing policy results can either be framed as lessons to learn, as a policy failure, as a big and foreseeable mess, or as the such-and-such evidence of incompetence.

4.10 Policy termination

In the stage model of the policymaking process, policy evaluation is followed either by policy adjustments or policy termination. There are several reasons for policy termination. A policy does not work, has adverse consequences, turns out to be costly, meets strong public resistance, or is simply perceived as outdated. Several arrangements for cost-sharing that were introduced in Dutch health care to control healthcare expenditures in the late 20th century were only short-lived because of the fierce opposition of the medical profession, high administrative costs, protests from patients and doctors, and disappointing results.

Sometimes, policy termination is planned by 'horizon legislation'. For instance, several policy measures of the Dutch government to control the spread of the coronavirus were based upon new temporary legislation that permitted the government, after approval of the Parliament, to impose freedom restrictions (e.g. lockdown or curfew) but only for a three-month period. The duration of the legislation could be prolonged for a new three-month period but only after approval of the Parliament. The refusal of

the Upper Chamber to accept prolongation in 2022 automatically meant the termination of the legislation.

4.11 Policy path

All health policymaking roots in the past and is part of a policy path. A policy path passes through a series of consecutive cycles during a certain period. Current policy is the latest version of a policy in a process of consecutive accommodations to changing circumstances, new insights, and the political context. The policymaking process concerning the outbreak of COVID-19 and alcohol consumption exemplifies the unfolding of a policy path. However, the structure of these paths was quite different. Whereas policymaking on COVID-19 had the structure of cycles swiftly following upon each other to adjust policy measures to the latest information, the path of alcohol policy is characterized by relatively long cycles. Alcohol policy has been regularly revised but mostly only after a longer period.

The concept of policy path invites policy analysts to carry out a historical analysis of health policymaking and the cycles it has passed through. A historical view on health policymaking gives insight into the redefinition of health problems over a longer period and the impact of social, political, economic, and other factors upon the (re)definition of health problems. The analysis of a policy path may further contain important lessons on how state interventions play out in practice and the politics of state intervention.

The development of alcohol policy is an example of the evolution of health policy over a longer period. The reasons for framing alcohol consumption as a social problem warranting state intervention have changed over time. The history of alcohol policy is not simply a history of how alcohol-related harms were addressed but also a history of how they were identified and constructed. Was alcohol consumption in the past primarily framed in terms of public disturbance, social decay, or immoral behavior (think of the influence of the Victorian temperance movement in some countries), presently its adverse health effects get more emphasis. The international scene has also dramatically changed. The production of alcoholic beverages has developed as a transnational industry with huge economic interests and a powerful lobby to

influence political decision-making on age limits, selling points, tax instruments, and so on. The emergence and growing popularity of non-alcoholic beers and wines may mark a new stage in alcohol policy (Nichols & Kneale, 2015).

An approach to investigating a policy path is to make a distinction between two paths: policy expansion and policy contraction. The evolution of alcohol policy in the Netherlands is a good illustration of policy expansion. With time, its goals have been broadened and policy measures to reduce alcohol consumption have been extended and intensified. The publicization of public health since the beginning of the nineteenth century is another illustration of policy expansion. State intervention to protect and promote public health nowadays radically differs in scope and intensity from state intervention in earlier times. Policy expansion also affects the policymaking process at later stages. Past policy decisions restrict the room for new decision-making. Once–fought rights will be heavily defended. Moreover, the health policy arena has become much more crowded than in the early stage of the policy path. The impact of path dependency on health policymaking will be discussed in Chapter 11.

Policy contraction is the opposite of policy expansion. Examples are the termination of a policy program, the removal of health services from the benefits catalog of statutory health insurance, the restriction of the scope of regulation, the tightening of eligibility criteria, and the imposition of expenditure cuts. Some contractions occur subtly, for instance, by not adapting the healthcare budget to the increasing demand for health care or by not adding new medical services to the benefits catalog of public health insurance.

4.12 Conclusion and suggestions for doing health policy analysis

Health policymaking is a second basic concept in health policy analysis. The focus is not on the content of health policy but on the dynamic process of events, decisions, and actions with regard to health problems. Each stage of the policymaking process influences the content and results of health policy. Health policy and its outcomes cannot be well understood without an analysis of the health policymaking process. The study of this process helps explain why certain public problems have reached the

political agenda, how policy decisions have been made, and why health policy has proven success or failure or a combination of success and failure. The study of health policymaking is an important part of health policy analysis.

There are various strategies to study health policymaking processes. The first strategy is to focus on the stages policymaking passes through. Some leading questions are: who put a policy problem upon the political agenda and how was the problem framed? Who won the framing contest? Has agenda building been successful? Which actors were involved in the processes of policy development and policy formation? Did the formal locus of decision-making coincide with the informal locus? How did policy implementation unfold? How was it organized? Did policymakers pay serious attention to policy implementation? Has policy implementation proven a bottleneck and if so, why? How did policy evaluation evolve? Is there evidence of a politics of evaluation?

An alternative strategy is to focus on preselected decision rounds. The first step in this strategy includes the identification and selection of decision rounds and the second step the identification of the actors in each decision round and their input to decision-making. Another research theme is the relationship between the selected decision rounds. Did they follow each other logically or linearly or in a non-linear structure, for instance, because earlier decisions were revoked at a later moment?

A third strategy is to investigate the intersection of policymaking processes and its impact on the policymaking process under study. This strategy is particularly suited to the investigation of how health policymaking has been influenced by public policymaking in other areas.

A final strategy is to study the policy path over a more extended period. This strategy requires the selection of a starting point and end point of the policy path. The study of a policy path can give insight into how a policy has evolved over a certain period and, in particular, how it has been accommodated to changing circumstances and changing insights. Does policymaking follow a path of policy expansion or policy contraction or a combination of expansion and contraction?

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CHAPTER 5

ACTORS IN THE HEALTH POLICY ARENA

KEY POINTS:

- An actor is an individual or organization participating in health policymaking. Their number has exponentially increased.
- The health policy arena involves all actors participating in health policymaking, the relations between actors, and the formal and informal rules regulating the interactions between actors
- Actors participating in policymaking can be divided into six main categories: policy actors, experts, interest organizations and lobbyists, citizen groups, producer organizations, the media, and the judiciary.
- Actors interact in a network of relations with each other to coordinate their activities. These networks are called policy networks. The health policy arena can be conceptualized as a system consisting of various policy networks.
- There are different types of policy networks: insider networks, policy communities, issue networks, epistemic communities, and policy advocacy coalitions.
- Policy actors are professionally involved in health policymaking and play various roles in the policymaking process. Policymakers are closely involved in making policy decisions and carry responsibility for these decisions.
- Policymakers need expertise and recruit experts for advice. A distinction can be made between core insiders, specialist insiders, peripheral insiders, and outsiders.
- Interest organizations represent the interests of their members in the health policy arena. Their number has explosively risen. Interest groups fulfill an articulation and information function in the policy arena. Some organizations are so closely involved in health policymaking that they actually operate as co-policymaker.
- Differences in power resources between interest organizations and lack of transparency undermine the integrity of health policymaking.
- Citizen participation in health policymaking is not new and has extended over the last few decades. Participation is for the most part issue-oriented and largely dependent upon volunteers.

- Producer organizations provide goods and services necessary to achieve health policy goals. Their role in health policymaking marks the state's growing dependence upon the market sector for achieving its policy goals.
- The media are closely involved in frame contests in health policymaking. Social media have become a source of misinformation and confusion.
- Court rulings can have important consequences for health policymaking. Public law litigation is an instrument to dispute state legislation.
- A salient aspect of the globalization of public health is the role of international governmental organizations and international nongovernmental organizations in addressing global health problems. The World Health Organization and the European Union have been closely involved in controlling COVID-19.

5.1 Introduction

The description of how the Dutch government dealt with the outbreak of Q-fever (Box 5.1) is a story of slow action uptake in a complex political-administrative setting with many actors, conflicting interests, lack of direction, inadequate legal instruments, and absence of a decision-making center with enforcement power. Policymaking unfolded in a divided policy arena in which the public health and farmers' communities did not concur on an effective approach to managing the outbreak. The agricultural community pressured the government to abstain from what it perceived as disproportional measures without hard evidence. It took more than two years before the government ordered the culling of approximately 60.000 goats.

This chapter investigates the role of actors in health policymaking. The chapter starts with the introduction of the concept of actor and health policy arena. Actors in this arena coordinate their activities in policy networks (policy subsystems). The health policy arena can be thought of as consisting of various policy networks. Next follow a series of sections that explore the role of policymakers, experts, interest organizations, citizen groups, producer organizations, the media, and the judiciary in health policymaking. The final part of the chapter is devoted to the global dimension of health policymaking. Attention will be paid to the role of intergovernmental organizations (IGOs) and non-governmental organizations (NGOs) and the

involvement of the World Health Organization and the European Union in the struggle against COVID-19.

Box 5.1 Managing the Q-fever outbreak in the Netherlands in 2007-2010

Q-fever is an infectious disease transmitted from animals to humans. Q-fever in humans must be reported to public health agencies. The absence of disease-specific complaints makes a micro-biological test necessary for a definite diagnosis.

The outbreak of Q-fever concentrated in two provinces (Gelderland and Noord-Brabant). In 2007, the number of reported cases amounted to 168 and rose to 1000 in 2008 and 2354 in 2009. The percentages of hospitalized patients were 17% in 2008 and 15% in 2009. In 2008, one person died from Q-fever, in 2009 six persons, and in 2010 seven persons. Many years after the outbreak, a sizeable group still suffers from the disease. Lawsuits have been filed for claiming financial compensation.

Roughly speaking, the actors involved in managing the outbreak can be divided into two imaginary columns: a public health column and a farmer column. The public health column included, among others, the Department of Health, the Institute for Public Health and the Environment (RIVM), the Center for Infectious Diseases Control, the Healthcare Inspectorate, and the local public health agencies operating in the most hit areas. Important actors in the Agricultural column were the Department of Agriculture, the Central Veterinary Institute, the Animal Health Service, the Netherlands Foods and Consumer Product Safety Authority, and stakeholder organizations representing the interests of farmers. The coordination between both columns was in the hands of the Outbreak Management Team (OMT), a top-level administrative coordination team and, as of November 2008, an expert council. Some actors, including the head of the province of Noord-Brabant and a few city majors, belonged to neither column.

The outbreak of Q-fever sparked a fierce debate on the causes of the disease and the necessity and proportionality of policy options. However, active public intervention failed to occur for a long period, even after a significant death toll rise. For instance, it took until mid-June 2008 that farmers were obligated to report on the presence of sheep and goats with Q-fever. Vaccination of animals on a voluntary basis only followed in 2008. The government also abstained from measures to restrict or forbid

the transport of animals. Names of farms with infectious animals were not made public for privacy reasons. It took till the end of 2009 that policymaking gained momentum. Just before Christmas, approximately 60.000 goats were culled. The government has always denied that a TV broadcast of Zembla in December 2009 about indolent government action had triggered this draconic decision.

The handling of Q-fever is an instructive illustration of administrative busyness at several government levels. Decision-making dragged on for a long time, and the coordination between the Departments of Health and Agriculture advanced with great difficulty. Experts and administrators struggled with the cause of infection and spoke as it were in different languages.

The lack of formal intervention power partially explains the slow uptake of effective policy measures. Legal considerations and privacy reasons delayed the duty to report. The involvement of many actors, each with their preferences and interests, also contributed to policy delay. While each of them said to endorse the priority of protecting public health, there was nevertheless much disagreement on the strategy to be followed. As so often, economic interests conflicted with the interest of public health. Representatives of the farmers said to accept drastic measures but only based on hard scientific evidence. As long as such evidence was not available in their view, they held hard measures for disproportional. The involvement of two ministers and the absence of a minister with enforcement power also hindered effective policymaking. The absence of an adequate response was not only due to conflicting interests but also the result of a deficient governance structure.

Source: Evaluation Commission Q-fever, 2010.

5.2 Actors and health policy arena

Health policymaking is the work of actors. An actor is an individual or organization participating in the policymaking process. Each actor represents specific values or norms, stands up for particular interests, or brings in expertise or other resources needed to protect and promote public health. The number of actors in health policymaking has dramatically increased over the last two centuries. In the nineteenth

century, only a handful of civil servants at the national level dealt with public health issues daily. A separate Ministry of Health did not exist. The regulation of public health and the medical profession was still in its infancy. Most activities took place at the local level by mutual aid organizations and municipalities.

All this has radically changed ever since. Presently, a vast variety of actors participate in health policymaking. A brief impression: minister of Health, Health Department, other government departments, politicians, international public organizations, public authorities at the regional and local level, public health agencies, public organizations with regulatory and/or supervisory tasks, interest organizations, implementing agencies, advisory bodies, knowledge institutes, healthcare providers, health insurers, other financial agencies, citizens and non-governmental organizations operating at the global level.

Health policymaking can be situated in an imaginary health policy arena which is defined as the set of actors participating in health policymaking, the relations between these actors, and the formal and informal rules regulating the interactions between actors. The focus of this chapter is on actors and the connections between them. The regulatory dimension of the health policy arena is explored in the next chapter.

Classification of actors

Actors can be divided into seven main categories: policymakers, experts, interest organizations, citizen groups, producer organizations, media, and judiciary. These categories may partially overlap each other.

- Policymakers are closely involved in the making of policy decisions. Examples are ministers, top-level civil servants, and politicians.
- Experts contribute to health policymaking based on their general or specific knowledge (expertise).
- Interest organizations represent the opinions and interests of their members in policymaking and seek to influence policymaking in accordance with their views and interests.

- Citizen groups (activist groups) seek to influence health policymaking. Contrary to interest organizations, they are mainly issue-oriented and mostly dependent upon volunteers.
- Producer organizations contribute to policymaking by providing goods and services needed for the achievement of the goals of health policymaking.
- The media report on health issues and provide an outlet for policymakers and other actors to inform the public.
- Courts fulfill the role of arbiter in conflicts and the role of decision-maker in unchartered areas.

The classification of actors highlights the multi-actor and multi-level setting in which health policymaking occurs.

5.3 Policy networks

Actors develop and maintain a network of relations with each other to coordinate their activities because of common interests. These networks are called policy networks (Provan & Kenis, 2007). The health policy arena can be conceptualized as a system consisting of various policy networks, for instance, a network for curative medicine, a network for long-term care, a network for pharmaceutical care, a network for prevention, or a network for occupational health. Policy networks are also referred to as policy subsystems (Freeman & Stevens, 1987). The strength of the linkages between these networks ranges from strong to weak. Policy networks may also (partially) overlap each other by shared membership.

The structure of policy networks varies. While some networks are 'open' (inclusive structure), access to other networks is restricted (exclusive structure). While some networks have a tight structure with intensive member contacts, the structure of other networks is loose. While some networks have a mixture of public and private policy actors as members, others consist exclusively of public or private actors. While the state has a leading role in some networks, its role in others is subordinate. While some networks have a more or less formal structure, others operate without formal rules of the game. While some networks possess multiple and vast resources to influence health policymaking, others struggle with a lack of resources. While members in some

networks actively seek close cooperation to attain a collective goal (integrated network), members in other networks act more like each other's competitors (competitive network).

There are several classifications of policy networks. The insider network can be described as the locus of policymaking. It encompasses all actors closely involved in decision-making. Its boundaries are fluid. The handling of the conflict on tariffs of specialists in Dutch hospitals (Box 4.2) illustrates that an insider network does not necessarily coincide with the formal locus of decision-making. The presumption of a single hierarchically structured network ignores the complex structure of the health policy arena.

Rhodes (1997) makes a distinction between policy communities and issue networks. The characteristics of a policy community are: a limited number of participants with some participants consciously excluded; frequent and high-quality interactions between all members of the community; consistency in values, membership, and policy outcomes; and consensus in values and broad policy preferences. Issue networks, on the other hand, consist of many participants; interactions fluctuate and are based on consultation; consensus is limited; conflicts are always looming, and power can be unequally distributed. It is plausible to expect that policy communities exert more power in policymaking than issue networks, in particular if their members maintain direct contact with members of the inner circle of policymaking or participate directly in the inner circle.

Haas (1992) has introduced the concept of epistemic community which he defines as 'a network of professionals with recognized expertise and competence in a particular domain and an authoritative claim to policy-relevant knowledge within that domain or policy area. Although an epistemic community consists of professionals from a variety of disciplines, they have a share of normative and principled beliefs (.....), shared causal beliefs (.....), shared notions of validity (....) and a common policy enterprise' (p. 3). An example is the epistemic community of public health experts that advised the government on COVID-19 issues.

Sabatier and Jenkins-Smith (1999) conceptualize policymaking as a struggle between two or more policy advocacy coalitions, 'each composed of people from various governmental and private organizations that both (1) share a set of normative and causal beliefs and (2) engage in a nontrivial degree of coordinated activity over time' (p.120). The handling of the outbreak of Q-fever in the Netherlands can be analyzed as a struggle between a 'public health advocacy coalition' and an 'agriculture advocacy coalition' (Box 5.1). The term coalition suggests that the coordination within a coalition may rest upon common beliefs or interests but also upon more opportunistic or strategic considerations.

Passarani (2019) used the policy advocacy coalition concept in her analysis of the political controversy on the proposal of the European Commission to clarify and update the existing food labeling legislation and provide consumers with clear and understandable information on food packaging. She distinguished between a 'food industry coalition' and a 'coalition of public health and consumer organizations'. While the latter group called for a food traffic light system to inform consumers in making choices on food, the group of food industries opposed such a system as simplistic, demonizing food, and costly. The political struggle on gun control policy in the United States is another example of a fight between two rivaling policy advocacy coalitions (Box 5.2).

Box 5.2 The failure of gun control policy in the United States and its consequences for public health

The lack of effective gun control in the United States seriously threatens public health. Between January 1 and October 1, 2022, there were 515 mass shootings (shootings of more than four people) and 21 mass murders (murder of four or more people in a mass shooting). During this same period, 15 547 persons were murdered (intentional and unintentional homicide, defensive gun use), and 18 348 persons committed suicide with a gun (Kapadia, 2022).

Gun control is a heavily politicized issue in the United States. Cook and Goss (2014) make a distinction between two policy advocacy coalitions (they use the term movement): the gun rights coalition and the gun control coalition. Both coalitions

consist of numerous organizations operating at the federal, state, and local levels. Yet, there are important differences between these coalitions: the gun rights coalition can mobilize much more power in policymaking than the gun control movement. The gun rights movement dominates the narrative around gun control and has even set the rules of gun control (regulatory capture). While the tobacco, food, and sugar-sweetened beverages industries are subjected to extensive regulation for marketing products causing health-related harms, gun control has remained largely unregulated.

Cook and Goss mention various factors to explain the powerful position of the gun rights coalition. Its members are very committed to their gun rights and able to mobilize tremendous power at all levels of government. The NRA has excellent political venues to political circles to preclude gun regulation and has managed to pass federal legislation largely immunizing gun makers, distributors, and dealers from a broad range of lawsuits. A structural problem for the gun rights movement is that it must pass several 'veto points' in the political arena to get regulative measures approved. In contrast, each veto point provides the gun rights coalition an opportunity to obstruct regulation. Other factors explaining the relatively weak power of the gun control coalition are disagreement among themselves over which option would be most effective and the fact that regulative measures restrict individual liberties, a highly valued good in American culture.

Sources: Kapadia, 2022; Cook & Goss, 2014.

5.4 Policymakers

Health policymakers are actors who are closely involved in health policymaking because of their formal tasks, expertise, and responsibilities. Health policymaking is no exclusive activity of the Minister of Health and the Health Department. As will be worked out in the next chapter, a great deal of health policymaking is devolved to the level of regional (in federal states to the level of states) and local public authorities or public organizations operating at arm's length of the state. Policymaking can also be delegated to privileged interest organizations (Chapter 6). A new development is the involvement of global actors in health policymaking.

Health policymaking has developed into a multi-actor, multi-level activity, and multi-sectoral or transboundary activity. Other departments than the Health Department are closely involved in health issues. Examples are the Department of Finance (e.g. health care expenditures), the Department of Social Affairs (e.g. statutory health insurance), the Department of Education (e.g. training of health professionals), the Department of Public Security (e.g. handling patients with psychiatric disorders), the Department of Economic Affairs (e.g. international trade regulation) and the Department of Foreign Affairs (e.g. geo-political aspects of public health). Policymakers in a political system with democratic control must build a political majority for their decisions. Exploring what is politically feasible requires close contact with Members of Parliament.

The multi-actor, multi-level and multi-sectoral dimension of health policymaking highlights that the state should not be viewed as a unitary actor but as a set of actors, each with their expertise, interests, viewpoints, and routines. Although the government formally acts as a unitary actor, its policy decisions often result from a complicated political and bureaucratic struggle within the 'state machinery'.

5.5 Experts

Prudent policymakers recruit experts to make their decisions information-based. Experts, according to Cairney (2021) in his analysis of how the UK government dealt with COVID-19 up to and during the first lockdown, were of great importance for the government in coping with the many uncertainties and ambiguities of the unexpected crisis. Government officials missed crucial knowledge on the scale of the problem and the likely impact of policy interventions. There was also much debate on the problem definition: how serious was the problem and how urgent the need for state intervention? Should state intervention be directed at the elimination or containment of the virus, and what were the most appropriate amount and timing of state intervention? Cairney points out that policymakers select advisors based on their beliefs and policy position. Inclusion is more likely if experts support government policy or the government's definition of policy problems. Another criterion is the value they attach to the experts' resources regarding group size, ability to represent a broader population, importance to society and economy, and policy-relevant knowledge. Experts must also be willing to follow the informal rules of the game for

advising including, among others, keeping discussions and debates in-house and adopting a pragmatic attitude. Building upon Jordan's (1974) and Mahoney's (1997) work on the insider-outsider model of interest representation Cairney distinguishes between for categories of experts:

- Core insider or senior government scientific advisors. This category comprises employed civil servants in government departments and other public organizations.
- Specialist insiders. These advisors are recruited to specific government advisory bodies 'on tap'. During COVID-19 this category mainly consisted of public health ex-perts, virologists, clinicians, data scientists, statisticians, and other bio-medical experts.
- Peripheral insiders. These experts work for other organizations (e.g. universities, think tanks, research institutes) and seek inclusion in policymaking. Lack of familiarity with the informal rules of advising hinders their impact on policymaking.
- Outsiders or experts trying to influence policy externally. These experts primarily act as critical commentators along the sideline and seek to generate interest from external audiences.

Cairney's classification model offers a useful analytical point of departure for the study of the 'politics of expertise'.

5.6 Interest organizations

Nowadays, hundreds of interest organizations seek to influence policymaking at the national and international level (Coen & Richardson, 2009). An interest organization is a non-state organization representing the interests of its members in the health policy arena through the aggregation and articulation of these interests. While some organizations represent health sector-specific interests (e.g. the interests of general practitioners, health insurers, and patients with cardiac problems), others represent the interests of their members across policy sectors (e.g. employer organizations, worker organizations, consumer organizations) or the interests of the corporate sector. Some interest organizations concentrate their activities upon specific public health issues

(e.g. safety at work) or medicine-related issues like abortion or medical assistance in dying at the patient's request. There are also interest organizations whose mission is to protect and promote public interests, if necessary, by filing a lawsuit against private companies or agencies that violate these interests in their view (Box 5.3).

Peak or umbrella organizations represent the interests of their associated interest organizations. Examples are the Royal Dutch Medical Association representing the interests of the associated professional organizations, the Dutch Patient Federation representing the interests of the associated patient organizations or, at the international level, the Confederation of European Community Cigarette Manufacturers and the European Federation of Pharmaceutical Industries and Associations. These organizations' strategic goal is to reinforce their members' influence in policymaking. Speaking with one voice, though, is complicated if the interests of the associated organizations do not run parallel. For instance, the tobacco industry has a much more homogeneous structure than the highly diversified food sector.

Box 5.3 The struggle of the Pharmaceutical Accountability Foundation against excessive pricing in pharmaceutical care

The Pharmaceutical Accountability Foundation (PAF) was created in 2018. Its mission is 'to further affordable access to medicines and medical technologies'. The organization achieved great success through the fine on Leadiant Biosciences imposed by the Dutch Competition Authority. The Authority sentenced the company for its anti-competitive practices. The company that had raised an orphan drug's price by 500% was also fined in Spain, Italy, and Israel. In 2021, PAF sent a letter of liability to Abbvie, the producer of Humira, which is a medicine against, among others, rheumatism, and Crohn's disease. The foundation called Abbvie to account for the excessive pricing it had charged for this medicine in 2014-2018 while it was still protected by patent.

According to PAF, pharmaceutical companies abuse their market power and act purely profit-driven. In its view, pharmaceutical companies have a care duty. Their unfair

market behavior has created access barriers to health care, resulting in a severe loss of Quality Adjusted Life Years.

Source: Annual Report 2022.

Considerable differences exist in the organizations' resources of interest to influence health policymaking. While giants such as the tobacco industry, the pharmaceutical industry, the food industry, or the automobile industry can mobilize huge budgets for interest representation, other organizations must work with a small budget to have their voices heard. The financial resources of most public health interest organizations pale into significance when compared to the resources of organizations representing corporate interests. Other important resources are prestige, credibility, a large constituency, and, last but not least, excellent venues to (interest-friendly) ministers, top-level civil servants, and members of Parliament. It also happens that interest organizations employ insiders from the government or, conversely, that their employees switch to influential government posts (revolving door mechanism).

Public health organizations sometimes benefit from the policy initiatives of public authorities. These initiatives offer them an opportunity to get access to the health policy arena through joining advisory committees or participating in consultative meetings. EU programs such as 'Europe against Cancer' or 'Europe against AIDS' also included large budgets for public health research (Greer, 2009). Sometimes, public authorities explicitly stimulate the creation of counter-interest organizations to promote their objectives. An example is the financing of the European Bureau for Action on Smoking Prevention (BASP) by the European Commission in 1989. BASP had to provide information and argumentation the Commission could use in its initiative to ban tobacco advertising within the European Union. However, BASP was only granted a short life. Due to an influential lobby of Germany, the United Kingdom, and the Netherlands – all countries with a large tobacco industry - as well as internal pressure from the Directorate-General of Agriculture and the Directorate-General of Social Affairs in the European Union, the Commission had to stop the financing of BASP. Two newly established organizations, the European Network for Smoking

Prevention (ENSP) and the European Network on Young People and Tobacco (ENYPAT) were explicitly forbidden to engage in lobbying (Boessen & Maarse, 2008).

Explosive growth of the number of interest organizations

The number of interest organizations has exploded. Doctors, nurses, hospitals, insurers, patients, the pharmaceutical industry, the food industry, and numerous other organizations with a stake in health issues have organized themselves to articulate their interests. The stakes are high in terms of euros and employment. Particularly in the second half of the twentieth century, the health sector has transformed into a market with tremendous financial interests (Starr, 1982). Commercial interests explain why the corporate sector has organized itself or hires specialized firms to lobby the state. Because state initiatives to restrain the intake of unhealthy food, stop smoking or limit alcohol consumption, to mention a few examples, have potentially big repercussions for the profitability of the manufacturers of these products, they spend millions of dollars to block, mitigate, or delay legislation that would harm their commercial interests. Health policy is no longer the exclusive playground of the medical profession. Globalization has also profoundly altered the structure of interest representation. Nowadays, thousands of accredited interest organizations lobby European institutions (Coen & Richardson, 2009).

The explosive growth of interest representation has resulted in a crowded health policy arena. It has made policymaking more complex, the more so because the interests of interest organizations often widely diverge. The protection of established interests restricts the margins of policy change. A great deal of interest representation has developed as a conservative force in policymaking. Pierson (1996) gives an instructive example of this effect in his analysis of the 'new politics of the welfare state' (Box 4.5).

Box 5.4 The new politics of the welfare state

In his comparative study of the fate of state retrenchment programs to keep public expenditures affordable in four countries (the United Kingdom, Germany, Sweden, and the United States), Pierson describes the politics of retrenchment as a distinct process

that fundamentally differs from the process of welfare expansion. The distinctive structure of the politics of retrenchment stems from different political goals (extension versus contraction) and the emergence of a new political context. 'Large public social programs are now a central part of the political landscape (.....). With these massive programs have come dense interest-group networks and strong attachment to particular policies, which present considerable obstacles to reform' (p. 146). An illustration of this thesis is the fact that the Thatcher government in the United Kingdom (in charge from 1979 through 1990) had to back off repeatedly from options to privatizing the National Health Service after these options had provoked public outrage. By the end of the decade, the government's repeated promise had become 'the NHS is safe with us' (p. 163). Even a government with much-centralized power had proven unable to break through the clay layer of institutionalized interests.

Source: Pierson, 1996.

Functions of interest organizations

The primary function of interest organizations is to influence the health policy agenda and direct problem formulation and policy formation so that the outcome matches their interests. On many occasions, interest organizations of the medical profession have sought to put their stamp on health policymaking. To have his plan for introducing the National Health Service in the United Kingdom accepted, the government had to concede to the British Medical Association that doctors with private practice would not be integrated into the NHS but connected to the Service by contracts (Klein, 1983). Opposition of the medical profession in Switzerland hindered the reform of national health insurance for almost a century. The doctors cleverly used 'veto points' in the Swiss governance system (Immergut, 1992). The history of the relationship between doctors and the state in France is a long sequence of conflicts regarding professional autonomy and revenues. In concord with the mutualities, doctor organizations did not hesitate to discredit the centralization of medicine as the 'Sovietisation of French health care' which would threaten *'la médicine liberale'* (Wilsford, 1991). The structure of the US health system is the outcome of countless political battles between the federal and state governments and the

powerful associations of doctors and health insurers (Starr, 1982; Marmor & Barer, 2012; Blumenthal & Morone, 2010).

Interest organizations are also engaged in informational lobbying by informing policymakers about new developments, the level of support among their members for policy initiatives, technical issues, and acute practical problems their members are facing. The need for information makes public authorities dependent on the input of interest organizations, particularly if in-house expertise is absent. Their privileged position sometimes enables these organizations to penetrate the inner circle of health policymaking. It even happens that interest organizations act as the principal writer of the regulations they will be subjected to. This phenomenon is known as regulatory capture (Mindell et al, 2012).

The functions of interest organizations indicate no 'one-way traffic' between government and interest organizations. Interest organizations are a valuable source of information for the government and can play a legitimizing role. The legitimacy of health policymaking benefits from the signature of leading interest organizations under a common agreement with the government. However, an intimate relationship between the government and interest organizations also entails risks for both. Interest organizations risk being squeezed between their constituency's demands and the government's. On its part, the government must accept concessions in striking a deal with interest organizations. The practice of negotiated agreements between government and interest organizations also raises questions from the viewpoint of democratic control. What is room for the Parliament to reject or amend a hard-won compromise with leading interest organizations?

Lobbying strategies

Effective lobbying requires a keen strategy concerning the what, when, and how of lobbying (Van Schendelen, 2002). It has developed as a professional activity. A strategic issue is which policymakers at which political level and at which moment must be contacted as the primary target of demand articulation. The tobacco lobby followed a two-pronged strategy in its struggle against tobacco control legislation by targeting its lobby both at policymakers in Brussels and government officials in the

member states. The Dutch tobacco lobby maintained intensive contact with the Department of Economic Affairs which it saw as the main protector of its commercial interests (Box 2.1) (Willemsen, 2018).

The international pharmaceutical industry deliberately chose the 'Brussels route' for its initiative to start an experiment with direct-to-consumer advertising of their medicines in the European Union. The industry considered this strategy superior to the strategy of lobbying individual member states because they were expected to adopt a critical stance to its initiative. The industry employed its close contacts with the Directorate-General Enterprise of the European Union instead of the Directorate-General for Health and Food Safety (DG Santé) to get the experiment on the political agenda of the European Union. DG Enterprise and its commissioner were seen as the industry's natural ally because of the Commission's ambition to make the Union highly competitive and leading in industrial innovation in a globalizing world. Other reasons for targeting DG Enterprise were the relatively weak power base of DG Santé and the fact that the experiment with direct-to-consumer advertisement (later for strategic reasons reframed as direct-to consumer information) required adaptations in market regulation. Despite several attempts by the Commission, the experiment has never come off the ground because of resistance from the European Parliament and the Member States. There was much fear that it would increase pharmaceutical expenditures (Boessen, 2008; Passarani, 2019).

Interest organizations may also forge third-party alliances to build up more leverage. An example is the initiative of the tobacco industry to set up the Committee for Freedom of Expression and its appeal to the media and advertising groups to raise their voices against the proposed ban on tobacco advertising (Boessen, 2008).

Table 5.1 gives an overview of the tactics interest organizations may use in promoting or defending their commercial interests taken from Galea and Castro (2022). The authors point out that public health advocates should gain in-depth knowledge of the playbook of tactics of the corporate sector to develop effective counter-strategies. They should give up the naïve belief that evidence of the effectiveness of public interventions will trump the resistance of the corporate sector.

Table 5.1. Tactics and methods of the corporate sector to protect and promote its commercial activities in public health

Tactics	Methods
Fear	Fear mongering by industry takes diverse forms. It includes lawsuits or threats of lawsuits on the grounds of infringing industry's commercial rights including in intellectual property and economic freedom. It also includes generating fear that constraining the industry would have a disproportionate impact on the economy and on employment.
Funds	Industry funds are used to win over support to protect corporate interests from interference. These include direct support to political campaigns and politicians, corporate social responsibility efforts to whitewash or "greenwash" their credentials, and, where allowed, using sponsorship and marketing budgets to gain allies in the media, sport, and cultural scenes.
Fronts	Corporate power is exerted through front groups that claim to represent the interests of the public or of other industrial sectors. Curbs on public smoking or imposition of licensing hours, for instance, are often initially opposed by the tourism and hospitality industries as being detrimental to their viability, even though these industries are usually found to benefit commercially when the laws are enacted and enforced. Corporate interests also use front groups (such as "smoker's rights" groups) to undermine the confidence of policymakers by belittling or denying the support of the public for effective public health measures.
Denialism	Denialism is a reflexive action of the corporate sector to deny the link between its products and health effects, by impugning the findings of health research or the researchers involved.is a reflexive action of the corporate sector to deny the link between its products and health effects, by impugning the findings of health research or the researchers involved. Denialism was a strong feature of the tobacco industry response to the initial findings linking tobacco and cancer and has since become an established part of the playbook for other industries. This systematic deployment of doubt with the support of corporate interests has also, at times, acquired an ideological and political motive.

Deflection	Industries deflect attention on them and their products using several tactics. They claim health benefits (e.g., "the benefits of red wine"). They fund alternative research directly or through foundations, such as the Foundation for a Smoke Free World to create confusion. They also deflect liability by running campaigns focused on individual responsibility, blaming the consumers rather than the industry itself, for instance, in the ubiquitous "drink responsibly" campaigns. Faced with the prospect of regulation, industry reverts to the trope that voluntary agreements, self-regulation, partial bans, or even public-private partnership are more democratic or market-friendly.
Division	While the resolution of alternate hypotheses is inherent to the scientific method, corporate tactics have used it to delay effective action on curbing consumption of their products. The claims of protective effects of alcohol under certain conditions creates a language divide, constraining public health work to addressing the "harmful use of alcohol", implying there is a beneficial use and obfuscating the fact that any level of alcohol consumption is carcinogenic.

Source: Galea & Castro, 2022.

Critique on interest representation

Interest organizations see their input into health policymaking as their democratic right. Interest representation is, in their view, a defining characteristic of democracy. Nevertheless, the role of interest organizations is contested. One reason for criticism concerns the unequal distribution of resources these organizations can mobilize for lobbying, as a consequence of which public policy can be biased to the interests of the powerful. Differences in resources may have a profound impact on policymaking. Policy decisions are frequently biased toward the interests of the most powerful interest organizations.

A second reason for critique is the lack of transparency and integrity. There is evidence of undue influence, unfair competition, and regulatory capture to the detriment of the public interest. Some interest organizations are even silent about their sponsors. 'The more silently, the better' is the mantra of the Dutch National Employers Association (Andeweg & Irwin, 2009: p. 15). For this reason, various

countries and the EU work on a regulatory framework to improve transparency and guard the integrity of public policymaking (OECD, 2013; Coen & Richardson, 2009).

5.7 Citizens

The participation of citizens in health policymaking is not new. From the very moment vaccinations became available, citizens have protested against vaccination on religious grounds or for fear of adverse health effects. Public protests against mass vaccination campaigns and other freedom-restricting policy measures like the introduction of QR-code and the digital passport fit a long historical tradition.

Citizen participation in health policymaking has extended over the last few decades under the influence of the growing stock of knowledge on health risks. Participation is foremost issue-oriented. Citizens, either as individuals or in a group, write letters to Members of Parliament, participate in public inquiry procedures, or conduct research to support their claims. They demand effective state action against the emission of hazardous substances in their neighborhood or resist government activities (e.g. G5 masts or windmills) because of an assumed health risk. In many countries, abortion arouses public emotion. State measures perceived as patronizing can arouse public commotion.

A new development is experimenting with citizen forums in public policymaking. A forum consists of a limited number of individuals forming a cross-section of the population. The purpose of the forum is to discuss complex policy problems and formulate policy recommendations. They are expected to do so with an open mind and the willingness to change one's opinions because of new information or good arguments. Its members have access to all information they need. Experts should provide them with this information in an impartial way. Citizen forums have also been experimented with in health policymaking. There is some evidence that they can open new directions in dealing with complex health policy issues (see section 8.3 for more information).

Another development is the impact of the internet and social media on citizen participation. The new information technology enables citizens to set up new

networks and platforms to share information and influence health policymaking outside the channels of institutionalized interest organizations. As a consequence, interest articulation become much more fragmented than in the past when incumbent interest organizations sought to aggregate the interests of their members. The immediate access to information – information is only one click away – also affects the relationship between citizens, experts and the state. Citizens are less inclined to accept the 'truth' told by experts and the state which says to rely on expert information. Two problematic aspects of this development are the abundance of information and the toxifying impact of the widespread false information on the public debate and the relationship between citizens, experts (science) and the state (see section on media).

5.8 Producer organizations

Producer organizations provide goods and services necessary for the achievement of health policy goals. Presently, for-profit producer organizations provide many goods and services, including, among others, pharmaceuticals, medical equipment, financial services, technical services, information, and research. Many activities have been outsourced to the market sector. The increased role of producer organizations in health policymaking marks a growing dependence of the state on the for-profit sector. Conversely, medical companies are often dependent upon public investments in innovation (Mazzucato, 2021). Examples are large public investments in developing anti-COVID vaccines, new antibiotics, and orphan medicines.

As described in the first chapter, the state's increased dependence upon the for-profit sector is closely connected with the extension of state intervention. Some fields in medicine are largely controlled by the bio-medical industry with a clear commercial interest in expansion. The public control of air, water, and soil quality requires ever more technical expertise to be hired. Newly developed trace-and-track technologies played an essential role in the management of COVID-19.

5.9 Media

The role of the media in modern health policymaking can hardly be underestimated. The media do not confine their role to informing the public about health affairs but also influence the political agenda by reporting about problems and scandals and informing the public about information acquired from or leaked by anonymous sources. Investigative journalists have laid bare various examples of rent-seeking and misconduct in health care. The media also play an important role in frame contests. Their selection of the news and framing of health problems and policy initiatives influence how people perceive and assess these problems and initiatives.

Besides, the media are an indispensable medium for politicians and stakeholders to have their stories told and generate media attention. News management and political communication (Wolfsfeld, 2011) have become essential in current public policy-making. An 'army' of spokespersons and spin doctors is every day in action to influence public communication and avoid political harm to the minister they serve. Conversely, the media are interested in good contacts with policymakers for access to information. The relationship between media and politicians is reciprocal.

Risk communication

The media play a critical role in risk communication during major and enduring public health threats like COVID-19. Their challenge is to inform the public as best as possible. Media information is crucial in situations of great uncertainty and anxiety among the population. Gollust and her colleagues (2020) have argued that media information on COVID-19 has reinforced the dividedness among the American public. The media were actively involved in frame contests by reporting the pandemic in politically filtered ways. Right-leaning news sources were more likely than other media sources to disseminate specific pieces of misinformation and conspiracy theories. President Trump used these news sources to downplay the severity of the pandemic by calling it a hoax and blaming China for its outbreak ('China Virus'). In press conferences, he also recommended therapies missing any scientific ground (e.g. hydroxychloroquine). No surprise that Republican voters were less likely than Democratic voters to consider the virus an imminent threat and take precautions. The

authors conclude that Trump's use of the media contrasted with the basic principles of risk communication.

Social media

A new development is the impact of social media on public opinion. For many people, social media have become the prime source of information. Millions of people nowadays have direct access to information that is just one click away. Within seconds, information can spread across the country and the global world. Social media are a medium with multiple faces, particularly during a pandemic when there is a great need for information and many people live in fear and anxiety. Public authorities can avail of social media as a channel to inform the public on health issues and give information on how people can protect themselves against infection. On the other hand, however, social media have become a source of confusion and a medium for the large-scale spread of misinformation, fake news, and pseudo-therapies (Banerjee & Meena, 2021). Social media were one of the main causes of the outbreak of an infodemic described by the World Health Organization as 'too much information including false or misleading information in digital and physical environments during a disease outbreak' (www.who.int/health-topics/infodemic). An avalanche of information can cause confusion and risk-taking behavior and undermine public trust in the government. Because digital disinformation can threaten public health (McNeill Brown, 2020), unmasking disinformation and fake news has become a new challenge for public health authorities. Finally, social media can stir up stigmatization and polarization through spreading fake news and conspiracy theories for political gain.

5.10 Judiciary

Courts do not directly participate in policymaking and are bound by the law. Nevertheless, court rulings can have a significant policy impact. For instance, the introduction of the Social Support Act in the Netherlands, which made municipalities responsible for providing social support services, was followed by hundreds of lawsuits from clients who disagreed with the type or amount of social support they received from their municipality. Some court rulings forced municipalities to revise their implementation strategy policy. Claims for financial compensation are also on

the rise. Victims of Q-fever have filed a lawsuit against the state, arguing that the state had failed to take appropriate policy measures to protect their health.

Another development is public law litigation (Greer, 2008): individuals or organizations dispute the lawfulness of state decisions and ask the court for a judgment. An example is a judicial review of the legality of the March 2020 lockdown regulations in England. A few businessmen alleged that these regulations breached various public law principles and violated human rights. However, the Court of Appeal dismissed the claim entirely (Wagner, 2022). Likewise, the German government asked the European Court of Justice to annul the EU Directive on the ban on tobacco advertisements in the EU because it missed, in its view, an appropriate legal basis (Boessen, 2009). Some countries (e.g. Germany) have a constitutional court that can be asked to judge the lawfulness of legislation or international treaties.

Some court rulings have a considerable impact on health policymaking. An example is the landmark decision of the United States Supreme Court in Roe v. Wade in 1973 on the constitutionality of laws that criminalized or restricted access to abortion. The court ruled that the right to privacy extended to a woman's decision to have an abortion in the early period of pregnancy. The Supreme Court annulled this decision in 2022, arguing that the American Constitution does not regulate abortion and that the right to abortion cannot be derived from the Constitution. The Court's ruling implies the abolition of the federal right to abortion; regulation of abortion is left to the states. While some states have issued or planned legislation to protect women's right to abortion, other states have introduced legislation that only permits abortion under strict conditions (a woman's health is at risk or rape). The Court's rulings underscore the importance of its composition. The nomination of new judges has become a political issue with potentially big consequences for (health) policymaking.

Similarly, the ruling of the European Court of Justice in 1998 that the principle of free movement of persons and services applied to cross-border health care, unless the application of the principle would harm health care in a member state to a significant degree, had major consequences for member states. This ruling and other rulings on cross-border care have compelled member states to revise their restrictive policy in

cross-border care (Palm & Glinos, 2010). After lengthy negotiations, they eventually agreed on a European Directive on regulating cross-border care to fill the regulatory gap. The Directive came into force in 2013.

5.11 International health policy arena

A salient aspect of the globalization of public health is the rise of organizations operating on a worldwide scale and carrying out a broad range of activities ranging from assistance to nations in fighting the outbreak of infectious diseases and building up a health system that serves the needs of their population to programs directed at saving children's lives and protecting people's health. The number of these organizations has steeply increased after the Second World War. Nowadays, it is impossible to imagine international public health without the input of these organizations.

A global distinction can be made between two categories of organizations. The first category consists of international governmental organizations (IGO's). These organizations have been created by states to pursue a collective good. The World Health Organization, the United Nations Children's Fund, and the World Bank are well-known examples active in public health. The latter organization is a major international funder of health sector activities in low-income countries. Non-governmental organizations (NGO's) make up the second category. Examples are Red Cross, Medicines without Borders, Care International, and Human Rights Watch. NGO's are mainly dependent on private (for-profit) donor organizations for the funding of their activities. A well-known charitable foundation is the Bill and Melinda Gates Foundation which supports various programs directed at enhancing healthcare and reducing extreme poverty. Over the years, the foundation has spent hundreds of million dollars on the eradication of malaria and tuberculosis and programs to improve family planning, essential nutrition, and basic sanitation. The World Health Organization has become increasingly reliant on financial contributions from NGOs as well as private donor organizations, letting Huisman and Tomes (2021) conclude that public-private partnerships nowadays dominate global health policymaking. Conversely, national governments and IGOs give financial support to the activities of NGOs. NGOs and IGOs also collaborate in global health networks.

A great deal of the activities of IGOs and NGOs consists of providing technical assistance. These activities are mostly organized around a particular issue (e.g. malaria and aids). Some NGOs, such as Medicines without Borders, concentrate their activities on international refugee and disaster relief. NGOs can also act as stakeholders in the international public health arena by calling attention to public health problems and participating in global policy networks.

The emergence and rapid growth of the number of NGOs in the field of public health has fundamentally altered the international scene. Nowadays, mixed coalitions of NGOs and IGOs play a leading role in fighting global health problems. Some observers have argued that the role of NGOs has surpassed the role of IGOs. In his study of global governance, Weiss (2013) even considers intergovernmental organizations 'the weakest link in the chain that collectively underpins global governance' (p. 15).

It should be noted that contributions of private donor organizations to public health in low- and middle-income countries have a double face. The fight against HIV/ AIDS is a good example. On the one hand, their contributions are indispensable to overcoming the limited capacity of these states to raise sufficient funds to establish an adequate public health system. In some countries, the level of HIV/ AIDS donations compares in magnitude to the country's total budget for public health. On the other hand, there are concerns that the high level of donor funding attention distorts priority-setting in these countries' health policies (Shiffman, 2007). Donor organizations are also free to withdraw their donations. Finally, one should not forget that taxpayers subsidize donations because philanthropic organizations receive tax privileges for donations (Costa-Font et al., 2020).

Global networks for public health

Global public health has grown into a field in which international governmental and non-governmental organizations, including for-profit organizations, cooperate in global networks or transnational public-private partnerships for public health. The members of these networks seek collaboration in more or less formal networks while retaining their independence of action. The networks have an independent extra-governmental status, though they may be incorporated into formal governing

frameworks (Ansell et al., 2012). Global networks respond to the challenges of global governance in public health and other transboundary problems like climate change, the proliferation of weapons of mass destruction, terrorism, or financial instabilities. They can be viewed as an organizational vehicle for coordinating activities of the public sector, the private sector, and civil society in a world where coordination through hierarchical direction ('world government') is politically and practically unfeasible (see next chapter).

Currently, numerous global networks are active in pursuing public health. An example is the Global Alliance for Vaccines and Immunizations (GAVI). Dedicated to 'immunization for all', the organization operates in countries with few resources to save children's lives and protect people's health by increasing access to immunization (website GAVI). Other examples are the World Food Program, the Coalition for Epidemic Preparedness Innovations, and the Global Fund to Fight AIDS, Tuberculosis and Malaria. The World Food Program (WFP) is the world's largest humanitarian organization saving lives in emergencies and using food assistance to build a pathway to peace, stability, and prosperity for people recovering from conflict, disasters, and the impact of climate change. Governments are the principal funder of WFP but corporations and individuals make substantial contributions as well (website WFP). The Coalition for Epidemic Preparedness Innovations (CEPI) was founded in 2017 at the World Economic Forum. Its mission is to develop vaccines against emerging infectious diseases. Important donors are the Bill and Melinda Gates Foundation, the Wellcome Trust and a consortium of nations. The European Union also participates in it (website CEPI). The Global Fund to Fight AIDS, Tuberculosis and Malaria, which started its activities in 2002 is a global partnership that aims to 'attract, leverage and invest additional resources to end the epidemics of HIV/AIDS, tuberculosis and malaria and to support attainment of the Sustainable Development Goals established by the United Nations' (www.theglobalfund.org). The Fund with the Bill and Melinda Gates Foundation as one of its first donors supports various programs run by local experts to accelerate the end of AIDS, tuberculosis, and malaria as epidemics in more than a hundred countries.

Another example of a global network is the Global Outbreak Alert and Response Network (GOARN). In evaluating this network, Ansell gives an informative overview of

its strengths and weaknesses. The claim is that these strengths and weaknesses are not unique to GOARN but characteristic of the potential and limits of global network governance (Box 5.5).

The next two sections discuss the role of the World Health Organization and the European Union in global health. Specific attention will be given to their involvement in the fight against the COVID-19 pandemic.

Box 5.5 The Global Outbreak Alert and Response Network

The Global Outbreak Alert and Response Network (GOARN) is a coordinating mechanism for rapid response to infectious disease outbreaks of international concerns. It has more than 100 partner organizations and is housed by the World Health Organization which acts as the lead organization of the network. Because several of the partner organizations are network organizations themselves, GOARN describes itself as a 'network of networks''. The main activities of GOARN are the mobilization and coordination of multilateral resources and experts providing technical and operational support to countries and areas struggling with an outbreak of an infectious disease. Contrary to many other global networks, GOARN is not set up as a policymaking body. It does not formulate or enforce global standards or seek to mobilize the international community to take action.

Since its establishment in 2000, the network has been active in over seventy global disease outbreaks in over forty countries. According to Ansell, GOARN has been relatively successful. By mobilizing partner organizations as a technical community, GOARN facilitates rapid coordination of support. Moreover, GOARN operates as the carrier for nations preferring bilateral aid during an outbreak. However, the experiences of GOARN cast light upon several problems global networks encounter in carrying out their activities. First, the coordination of the activities of many partner organizations appears an immense task in itself. Internal rivalries and preference for bilateral deployment can frustrate the cooperation between the partner organizations. The second problem is that GOARN has no clear face of itself. Confusion exists about its status. Though GOARN is formally an independent network, local authorities often perceive the network as the operational arm of the WHO. The fact that the WHO acts

as the lead organization and houses GOARN reinforces this perception. What further complicates its activities are problems with information sharing. Though timely information sharing is critical in fighting the outbreak of an infectious disease of international concern, countries can be reluctant to share information for political, economic, and social reasons. The International Health Regulations also constrain early access to information via GOARN because the release of information is bound to strict conditions (see next chapter for further details). Source: Ansell et al., 2012.

5.12 World Health Organization

The World Health Organization (WHO) was founded in 1948 as a specialized agency of the United Nations. Its mission, defined in Article 1 of its constitution, is 'the attainment by all peoples of the highest possible level of health'. The organization is governed by an executive board, a secretariat (both based in Geneva), and the World Health Assembly in which all member states have a representative. As the agency's decision-making body, the Assembly elects the Director-General, sets goals and priorities, approves the organization's budget and activities, and elects an executive body consisting of health specialists. A great deal of operations are devolved to six semiautonomous regional offices.

In the aftermath of the SARS pandemic, WHO started negotiations with its members on the need for a system of International Health Regulations (IHR) to ensure a quick and adequate response to the outbreak of infectious diseases of international concern. The regulations, introduced in 2005, obligate states to share information about outbreaks within their borders, to give WHO powers to gather and share data, and to declare 'public health emergencies of international concern' (PHEIC). States are required to provide 'a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade' (article 2 on the purpose and scope of IHR). A weak element of the regulations is the absence of an effective enforcement mechanism. The regulations recognize the states' sovereignty in health affairs. WHO has no enforcement power.

The organization carries out a wide range of activities to ensure that 'a billion more people have universal health coverage, to protect a billion more people from health emergencies, and provide a further billion people with better health and well-being' (www. who.int/about/what-we-do). WHO has sought a leading role in public health, among others, through the eradication of smallpox, the near-eradication of polio, and the development of an Ebola vaccine. Its current priorities include various communicable and non-communicable diseases, healthy diet and food security, occupational health, and substance abuse.

WHO faces fundamental challenges (Kavanagh et al., 2021). First, it struggles with a balkanized governance structure. The General-Director has remarkably weak authority over the regional offices. Second, the organization has always been subject to competing priorities of its 196 member states and non-state donors. The organization must act diplomatically to avoid that states feel brushed off. The optimistic atmosphere of international cooperation in the immediate post-war period has largely waned. Third, its budget bears no relation to its immense tasks. The organization is heavily dependent on unstable voluntary contributions, which at present account for up to 80 percent of its budget. The spending of these grants is constrained by the priorities of the donors.

In its early days, WHO functioned as a pragmatic and mainly biomedical-oriented organization. However, after the organization had embraced the concept of the new public health (Chapter 1) and underscored the need for strengthening the focus on primary care, some of its activities have become contested (Siddiqi, 1995). The activities of the organization take place in a polarizing political context. On some occasions, the organization faced ferocious opposition from industrial sources. For instance, WHO's promotion of infant foods met heavy resistance from the food industry, and its Action Program on Essential Drugs met heavy resistance from the pharmaceutical industry (Walt, 1996).

Managing the outbreak of infectious diseases

Managing the outbreak of infectious diseases is a core task of the World health Organization. The organization has done much work in the past by collecting

epidemiological data, issuing recommendations on strategies to contain the impact of the outbreak, and providing technical assistance. An important step was the introduction of the International Health Regulations in 2005 to streamline international coordination. The IHR are 'an international instrument to help countries work together to save lives and minimize the impact on livelihoods by events that cause the international spread of diseases' (www.who.int/ihr).

However, the organization's track record in managing the outbreak of pandemics is not without failures (Kamradt-Scott, 2018). One of these failures was the management of the outbreak of the H1N1 pandemic in 2009. To avoid the label of 'Mexican Flu' (the pandemic had emerged in La Gloria in Mexico), the organization chose 'Swine Flu' as an alternative label. This unfortunate decision motivated some governments to order the mass slaughtering of pigs or impose bans on importing pigs and pork products to stop the spread of the virus. All this happened without any scientific evidence for the transmittance of the virus from pigs to humans. When it became clear that the H1N1 virus had caused only mild illness in the majority of the cases and that its death toll had turned out to be relatively moderate, the organization removed its guidelines from the organization's website. This was a remarkable move in the context of its earlier decision to declare the outbreak a public health emergency of international concern (Kamrath-Scott, 2013).

The organization's management of the 2014 West African Ebola outbreak crisis has also been criticized. One reason for criticism was its slowness in responding to the outbreak which concentrated in Liberia, Sierra Leone, and Guinea. It took several months before WHO declared the outbreak a pandemic. Rather than challenging the data of the respective governments which had an economic interest in mitigating the seriousness of the outbreak, the WHO secretariat took the government's statistics at face value. It failed to collect reliable data about the size and unfolding of the Ebola virus. Another failure was the poor coordination of efforts to stop the spread of the virus. Miscommunication and rivalries between the Geneva-based headquarter and the African headquarter have been mentioned as an important explanation for this failure (Kamrath-Scott, 2013; Ebola Interim Panel, 2015).

These failures exemplify the organizational and political complexity WHO must cope with in daily practice. Lack of resources, economic interests, and political circumstances complicate its activities. Countries may give political and economic considerations higher priority than the pursuance of public health. The failures also demonstrate that the International Health Regulations did not work well. Various countries ignored the regulations they had signed only a few years ago.

Managing COVID-19

The World Health Organization had a hard job in tackling COVID-19 (Kavanagh et al., 2021). Many of the problems mentioned in the previous section re-emerged in its management of the new pandemic that allegedly broke out in late 2019 in Wuhan in China. Sharing epidemiological data was a major problem in the early stage of the pandemic. Particularly, the role of China proved problematic. Since openly criticizing China for its lack of complete openness was politically risky, the Secretary-General chose the alternative route of negotiating information and seeking collaboration with China in investigating the pandemic outbreak. He praised China for its rapid response to the pandemic. Not everyone, however, appreciated this attitude. The secretary-general was criticized for being close to China, and the organization's independence was said to be at stake. President Trump even announced the withdrawal of the United States from the organization, but this decision has been revoked by his successor Biden.

Another vital task was to issue evidence-based guidelines on how to respond to the pandemic. Here, too, the organization faced problems. Technical recommendations quickly became political. Countries neglected the advice to abstain from travel restrictions and quarantine, even though there was no evidence of the effectiveness of these measures and much evidence of their disruptive effect upon global trade. As had happened before, countries did not follow the International Health Regulations. Furthermore, the organization created much confusion about the effectiveness of some interventions. For instance, it advised for many months against mask mandates but later changed its position on this issue. Similarly, WHO was initially critical of whether COVID-19 was technically airborne (Kavanagh et al., 2021).

The organization's call for international solidarity and a worldwide strategy has largely fallen on deaf ears, despite public manifestations to the contrary and some praiseworthy initiatives such as the Access to COVID Tools Accelerator (ACT-A) to expedite the development and production of test materials, treatments, and vaccines. International solidarity is hard to organize if it contradicts the interests of powerful states. Actually, the organization's struggle against 'vaccine nationalism' has largely failed.

In their analysis of how WHO has responded to COVID-19, Kavanagh and his co-authors underscore the strong political pressure the organization is subject to. Everything the organization does or does not do runs the risk of becoming political. The organization faces great challenges in combining science, politics, and diplomacy effectively. The notion of international cooperation and transparency leading just after World War II and a source of inspiration for its founding has largely dissipated. The rise of nationalist and populist rhetoric in some countries has stirred up resistance to international interference in domestic affairs. Populists see the International Health Regulations as a new piece of evidence for their claim that national interests are made subordinate to the interests of the international community and that crucial decision are taken by unaccountable international elites (Wilson et al., 2021).

5.13 European Union

In contrast to WHO, the European Union (EU) has the structure of a supranational organization. Its Member States have transferred a defined set of sovereign powers to the EU to establish a free internal market (free movement of people, goods, services, and capital). In areas where the Union is formally competent, national legislation is subordinate to EU legislation. Enforcement mechanisms are in place to sanction violations of EU regulations, directives, and decisions.

The key players are the European Commission, the European Parliament, the Council of Ministers, the European Council, and the European Court of Justice. The European Commission operates as the EU's executive body and has the right to take policy initiatives. The European Parliament acts together with the Council of Ministers as co-legislator. There are several councils: the Health Council consists of the health

ministers of the member states. The European Council includes the heads of state and sets out, together with the Commission, the main directions in EU policymaking. The European Court of Justice acts as the final arbiter of European law (Greer et al., 2019).

The European Union has created several agencies to carry out specific tasks. Relevant agencies in the field of public health are the European Medicines Agency (EMA), the European Centre for Diseases Prevention and Control (ECDC), the European Food Safety Authority (EFSA), the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), the European Agency for Safety & Health at Work (OSHA) and the Consumers, Health, Agriculture and Food Executive Agency (CHAFEA) (Greer et al., 2019).

The protection of public health is declared an important goal of EU policymaking. Article 168 in the Lisbon Treaty (2009) mentions 'a high level of public health protection' as a leading principle in all Union policies and activities. Nevertheless, the formal competencies of the Union in the field of public health have always been restricted. Article 168 sub 7 of the Lisbon Treaty states that 'Union action shall respect the responsibilities of the Member States for the definition of health policy and for the organization and delivery of health services and medical care. The responsibilities of the Member States shall include the management of health services and medical care and the allocation of resources assigned to them'.

Its restricted competencies have not withheld the European Union from starting activities to protect and promote public health since the mid-1980s. These measures were largely confined to encouraging cooperation between member states and issuing incentive measures designed to protect and promote public health. Two examples are the 'Europe against Cancer' program launched in 1985 and the program 'Together for Health: a strategic approach for the EU 2008-2013'. Despite their appealing titles, the impact of these soft-measures programs on public health should not be overstated. Of much greater importance are the consequences of the regulations of the single market (Mossialos et al., 2010). With some exceptions, health care is not exempted from the basic principles of the free movement of people, goods,

services, and capital. For instance, various rulings of the European Court of Justice on cross-border issues have confirmed that the principle of free movement of persons and services applies to cross-border care. As discussed earlier (section 5.10), Member States are only permitted to impose restrictions on cross-border care if the principles of free movement harm their healthcare system to a significant degree (Palm & Glinos, 2010). The European Union has also used the principle of free movement for issuing regulations directly impacting public health. Examples are EU regulations on tobacco control, food safety, pharmaceuticals, health and safety at work, the environment, and consumer protection (Greer et al., 2019).

Managing COVID-19

At the beginning of the pandemic, coordination between the member states in controlling the spread of the virus was painfully absent. Each state took its measures to protect its population and care workers, such as the closure of their borders (a violation of the Schengen Agreement), and the solo purchase of personal protective equipment (PPE). France claimed all supplies and production lines of PPE, and Germany ordered an export ban on these materials. Each country implemented its measures to counter the spread of the virus and unlock the country after the infection rate had declined.

Despite the Union's restricted competence concerning public health, the Commission sought an active role by taking initiatives in response to the outbreak of the largest public health crisis in recent history. Its initiatives in collaboration with the member states radiated a high degree of improvisation (Van Middelaar, 2021). Examples are the coordination of the repatriation of some 500.000 worldwide stranded EU citizens in the first stage of the pandemic; the coordination of national measures to ensure the cross-border travel of vital workers; the launch of financial programs to support research on the coronavirus and investments in the development of effective and safe vaccines; the organization of a joint procurement procedure for the purchase of vaccines resulting in contracts with pharmaceutical companies on the delivery of vaccines to the member states and the distribution of the vaccines across the member states. These initiatives can be qualified as an unprecedented example of

collective action without experience and formal competences in the field of public health.

The Commission also launched a massive financial program to counter the consequences of the fall-out of the economy and gave financial support to non-EU member states. Another decision was to activate the general escape clause of the Stability and Growth Pact to enable member states to take necessary financial measures to support those parts of the economy which were hit most by the lockdown. A detailed overview of all measures taken can be found on Timeline of EU action | European Commission.

In its document 'EU Strategy for COVID-19 Vaccines' published in June 2020, the Commission unveiled its strategy to accelerate the development, manufacturing, and deployment of vaccines against COVID. The Commission's goals were to secure swift access to vaccines in member states and accomplish an equal distribution of these vaccines among member states. There would be no room for unilateral decision-making and lack of coordination that had dominated the member states' approach in the first stage of the crisis. Instead, the crisis required a common approach based on cooperation and solidarity. The protection of public health was defined as a collective interest that could only be effectively addressed through collective action orchestrated by the EU (Van Middelaar, 2021).

An instrument to achieve its policy goals and suppress vaccine nationalism was the Advanced Purchase Agreement with the pharmaceutical industry. In this contract with the industry, the Commission agreed to finance in part the upfront costs of vaccine developers in return for the right to purchase a specified number of vaccines. Furthermore, the Commission approved an accelerated procedure for the market authorization of COVID-19 vaccines by the European Medicine Agency (EMA). After an intense political dispute, the Commission also announced a financial support and recovery package of EURO 750 billion and a contribution of EURO 2,2 billion to COVAX – a worldwide initiative for an equitable delivery and distribution of vaccines and other essential products.

In June 2021, the Commission released a new document with ten key lessons from the pandemic. The central message in this document was that the EU had to build up an effective surveillance system to increase its preparedness for future pandemics and that 'coordinated measures should become a reflex for Europe' to avoid the practice of unilateral action that had dominated the approach of Member States during the first stage of the crisis. The Commission underscored the strategic need for building a ' European Health Union ' to improve the coordination of public health measures across the EU and make a swift crisis response possible. Another central message was the need for reinforced public-private partnerships and stronger supply chains to avoid the shortfall and inequalities in the supply of key products such as medicines, ventilators, and face masks.

5.14 Conclusion and suggestions for health policy analysis

Health policymaking in a pluralistic society is the work of numerous people and organizations. Nowadays, dozens of policymakers, experts, interest organizations, and many other types of organizations are involved in health policymaking. Health policymaking is no exclusive domain of the Health Department and health professionals. Health policymaking takes place in complex national, subnational, and global policy networks with complex relationships between these levels. Interest organizations seek to influence health policymaking and ward off 'unwelcome' decisions. The media report on health policymaking and are involved in frame contests by their selection and presentation of the news. Courts are involved in health policymaking by arbitrating conflicts and judging the lawfulness of state intervention (public law litigation). They must also decide on policy issues in unchartered terrains. The globalization of public health and the creation of global policy networks signify that health policymaking is no longer a mainly local or national issue. The simple fact that viruses do not respect national borders reminds policymakers of the necessity of international coordination in handling the large-scale outbreak of infectious diseases. However, international coordination has remained a politically sensitive topic despite the introduction of the International Health Regulations. Nevertheless, the European Union has seized COVID-19 as an opportunity to intensify the coordination of health policymaking between the member states, particularly through the joint purchase and distribution of COVID-vaccines.

Insight into health policymaking requires insight into who is involved in which role in the policymaking process. Identifying actors and examining their role and interaction in the health policy arena and policy networks are two important elements of health policy analysis. Other main research topics are the structure and type of policy networks, the structure and impact of interest representation on health policymaking, and the impact of the media, including social media and court rulings, on health policymaking. A final topic of research concerns the global dimension of health policymaking. What is the degree of involvement of non-governmental organizations, the World Health Organization, and the European Union in health policymaking, and how has their involvement extended over the last few decades? The next step in health policy analysis is the investigation of the formal and informal rules of the game for health policymaking. These rules will be discussed in the next chapter.

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CHAPTER 6

THE GOVERNANCE OF HEALTH POLICYMAKING

KEY POINTS:

- Governance is defined as the system of rules (governance rules) for the production of public policy.
- A governance gap indicates a mismatch between the existing and required governance structure and decreases the problem-solving capacity of health systems.
- The effectiveness and legitimacy of governance concern the extent to which governance rules contribute to the effectiveness and legitimacy of policymaking respectively.
- Governance rules can be divided into authorization rules, participation rules, decision rules, coordination rules, compliance rules, financing rules, transparency rules, accountability rules, integrity rules, and legal protection rules.
- Based upon the modus of decision-making and compliance, a distinction can be made between the anarchic model, the hierarchical model, the majority-voting model, the network model, and the market model of governance. Each governance model has its strengths and weaknesses concerning the effectiveness and legitimacy of health policymaking.
- Based upon the locus of decision-making, a distinction can be made between the state governance model, the self-governance model, the state-local model, the state-agency model, and the corporatist model. Each governance model has strengths and weaknesses concerning the effectiveness and legitimacy of health policymaking.
- Motives for centralization fall into two main categories: enhancement of the effectiveness and legitimacy of governance. The same motives are put forward to argue for the decentralization of governance.
- The restructuring of health governance is a priority in health system reforms.
- Global governance is an attempt to navigate between the impossibility of a world government and the failure of anarchy.
- The International Health Regulations and the WHO Framework Convention on Tobacco Control are examples of global governance.

Box 6.1 Fighting the COVID-19 pandemic in the Netherlands

In its evaluation of how the government had acted during the first half year of the COVID-19 pandemic, the Dutch Safety Board concluded that the pandemic had laid bare some structural deficiencies in public health governance. There had been no adequate crisis structure and on several occasions the horizontal and vertical coordination of policymaking between the authorities at the national, regional and local level had left much to be desired. Due to its lack of effective steering power, the government had to spend a lot of energy on making agreements with regional and local authorities on a coordinated approach to the pandemic. A telling example was the observation that the Health Department saw the regional public agencies as implementing agencies. In contrast, these agencies did not see themselves as a continuation of the Health Department. The Board also concluded that the government had repeatedly ignored or underestimated the complexity of policy implementation. It described policy formation and policy implementation as two distinct worlds.

Another complicating factor was the fragmented structure of governance. The public health agencies fell under the jurisdiction of the municipalities. Hospitals were not under direct state control. Consequently, policymaking required frequent and intensive consultations to agree on a common approach. In an interview with a newspaper (Trouw, 19 December 2020), the Prime Minister hinted at the need for more centralization: 'With eight-thousand know-all general practitioners, hundred hospitals, eight academic centers, and seventy public health agencies, we have a world-fame healthcare sector. Nevertheless, we must draw lessons from what has happened.'

The Safety Board observed that a great deal of policymaking had taken place in informal settings and parallel structures. Coincidence, personal networks, and goodwill played a decisive role in coordination. To organize central coordination, ad-hoc national coordination centers had been set up, for instance, to streamline the distribution of COVID-patients among hospitals, purchase personal protective equipment, and organize the distribution of these materials among provider organizations. The purchase of vaccines had been transferred to the European Union.

The crisis also affected decision-making at the national level. The primary locus of government decision-making was not in the Cabinet but in informal settings that

preceded formal decision-making. The government heavily leaned on the advice it received (on request) from the Outbreak Management Team, an expert committee of health experts.

A pressing governance problem concerned the lack of an appropriate legal basis for state interventions to control the spread of the coronavirus. As a temporary solution, the government used an emergency ordinance to give its interventions a legal basis. However, this ordinance had never been intended for an enduring crisis like COVID-19. Moreover, it did not provide for effective democratic control. The resolution to this problem was sought in the introduction of the Temporary Act on COVID-19 which, after much debate, came into force on December 1, 2020. The duration of the act was set at three months. If the pandemic required the continuation of restrictive measures, its duration could be prolonged, each time by an extra period of three months. The new legislation made policy interventions subject to political control of the Lower Chamber and gave mayors more options to enforce the compliance of restrictive measures at the municipal level.

Source: OVV, 2022

6.1 Introduction

The problems described in box 6.1 are governance problems. These problems concern the organization of the policymaking process rather than the content of policymaking. The lack of an adequate crisis structure to manage an enduring public health crisis, the absence of effective steering capacity, the crowded health policy arena, the prominent role of informal and parallel structures for consultation, decision-making and coordination, and the absence of an appropriate legal basis for far-reaching policy measures are each a manifestation of a deficient organization of the policymaking process. In the absence of an adequate governance structure and information on the spread and infection rate of the virus, a great deal of policymaking rested upon improvisation. The formal crisis structure was not equipped for an enduring and deep crisis affecting society. Crisis contingency plans appeared no more than ‘phantasy documents’ (Boin et al., 2021).

This chapter offers an introduction to the governance dimension of health policymaking. The focus is not on the content of policymaking (formulation of policy goals, choice of policy instruments, and so on) but upon the organization of the policy-making process, the interaction between policy actors, and the written and unwritten rules that structure interaction. A related theme concerns the impact of governance on the problem-solving capacity (system performance) of health systems.

The chapter starts with a discussion of the concepts of governance, governance gap, and the impact of governance on the problem-solving capacity of health systems. Hereafter follows an overview of basic governance rules. The next two sections describe alternative governance models based upon the modus of decision-making and compliance and the locus of decision-making respectively. A discussion of multi-level governance models and the centralization and decentralization of health system governance follows this overview. The final part of the chapter discusses the problem of global governance.

6.2 What is governance?

The term 'governance' is nowadays frequently used in theoretical and practice-oriented discussions about the (lack of) steering of society (Kjaer, 2004). The broad interest in the concept mirrors an intellectual development that can be summarized as an attempt to move away from the traditional state-centric approach to the steering of society. Though the prominent role of the state in public health remains undisputed, health policymaking cannot be reduced to a state-centric activity only. Such a view ignores the pressure from the outside upon state health policymaking as well as the state's dependence upon the market and civil society in achieving its objectives. Health policymaking does not work without the input and cooperation of non-state actors: it asks for collective action.

A second reason for the increased interest in governance (Greer et al., 2016; Kjaer, 2004; Bevir, 2013) is that governance influences the effectiveness and legitimacy of health policymaking. Many policy failures find their main cause in a deficient governance structure. Hence, it is no coincidence that a great deal of health system reforms is directed at the structure of governance. The purpose is to strengthen the

problem-solving capacity of a country's health system by redesigning its governance structure.

Sometimes, the interest in governance has a clear political background. For instance, the popularity of decentralization in Central European countries after the fall of the Berlin Wall was closely associated with the desire to move away from the state-directed type of governance characteristic of the old political system (Sitek, 2010). Intellectual modes in governance may also play a role. An example is the emergence of market governance in Belgium, the Czech Republic, Germany, the Netherlands, Slovakia and Switzerland (Van Ginneken, 2016). The interest in market solutions reflected the influence of the neo-liberal wave in public policymaking. In short, the structure of governance influences the problem-solving capacity of health systems (governance as the independent variable), but it is, for its part, influenced by political and intellectual developments (governance as the dependent variable).

Alternative definitions of governance

The World Bank (2000) represents a traditional state-centric approach to governance. The Bank defines governance as 'the institutional capacity of public organizations to provide the public and other goods demanded by a country's citizens or their representatives in an effective, transparent, impartial, an accountable manner, subject to resource constraints' (p. 48). The attention of the World Bank is particularly directed at measuring the quality of a country's governance system. Its operationalization of governance captures three dimensions: (1) the process by which governments are selected, monitored and replaced; (2) the capacity of government to effectively formulate and implement policies; (3) respect of citizens and the state for institutions that govern economic and social relations (Kaufman, 1999).

The state-centric approach to governance is also manifest in the definition of Pierre and Peters (2000), who define governance as 'the capacity of the government to make and implement policy, in other words, to steer society' (p. 12). Bartolini (2011), on the other hand, represents the modern approach to governance. He loosely describes the concept as 'a system of co-production of norms and goods where the co-producers are different kinds of actors' (p.8). Following this 'framework concept' of governance,

he identifies five dimensions of governance: the identity of the co-producers, the level of involvement in co-production, the ways of achieving co-production, the institutional context of co-production, and the modes of implementation. His conceptualization of governance mirrors the view of governance as collective action with the state as an important but not the only relevant actor.

The definition of Greer and his colleagues (2016) has much in common with Bartolini's definition. They describe governance as 'the systematic, patterned way in which decisions are made and implemented. Governance shapes the capacity of health systems to cope with everyday challenges as well as new policies and problems' (p.4).

Rhodes (1997) takes a somewhat different view on governance by stating that 'governance refers to self-organizing, interorganizational networks characterized by interdependence, resource exchange, rules of the game, and significant autonomy from the state' (p.15). In this definition, governance occurs in policy networks in which the state no longer plays a central role as in the state-centric approach.

Bartolini's and Rhodes' approach to governance highlights that government is not the same as governance and that governance does not necessarily involve government action (governance without government). The state-centric approach fails to comprehend health policymaking as collective action in a multi-actor and multi-level setting.

Definition of governance

This book draws upon the modern approach to governance. Governance is defined as the system of rules (governance rules) for the production of public policy. Governance rules regulate the relations and interactions between actors in the policymaking process. They regulate, for instance, the organization of the decision-making and policy implementation or access to the inner circle of policymaking. Other examples are the regulation of horizontal and vertical coordination in health policymaking or the regulation of the accountability and transparency of health policymaking. Governance rules are a prerequisite for collective action. Our approach to governance leaves the role of the state in health policymaking open.

Governance has a structural and processual dimension. The structural dimension refers to the system of rules, and the processual dimension to the practicing of these rules. A distinction can be made between formal and informal rules. Codes of conduct are an example of informal rules. For instance, while formal rules allow for hierarchical decision-making, the code of conduct may 'prescribe' that policymakers should opt for consultation and negotiation. Policy conflicts should preferably not be settled formally by top-down decrees but by means of a compromise that is acceptable to all policy actors. This practice constitutes the heart of the practice of 'polderen' (Visser & Hemerijck, 1999). Informal rules may also fill structural holes in the formal governance structure. The management of COVID-19 in the Netherlands is emblematic of this practice. In no time, new informal governance structures were set up to handle the scarcity of personal protection equipment and organize the spread of patients across hospitals. These examples demonstrate that the study of governance should not be confined to the formal governance structure but should include an analysis of the informal governance rules. In many situations, the practical structure of governance differs markedly from its formal structure.

6.3 Governance gap

In its evaluation of how the Dutch government has managed the first stage of COVID-19, the Dutch Safety Board pointed to a mismatch between the existing governance structure and the complexity of a deep and enduring public health crisis surrounded by multiple uncertainties. The Board concluded that its fragmented structure had hindered a rapid and adequate response. A great deal of policymaking took place in informal and parallel structures. The government issued emergency ordinances as the legal basis for its interventions, but these ordinances had only been intended for emergencies of short duration. They provided no appropriate legal basis for radical policy measures such as lockdowns and curfews. In essence, the Board observed a gap or mismatch between the existing and required governance structure. This diagnosis was reason to recommend more space for central orchestration to be better prepared to manage an enduring public health crisis.

Sometimes, governance rules are largely or completely absent. One may speak of a governance gap. Hajer (2003) describes this situation as an 'institutional void'. For

instance, providers seek coordination but miss an adequate governance structure for coordination. A compartmentalized governance structure appears to be a formidable obstacle in policymaking on transboundary issues. An effective and broadly accepted governance system for global action is largely illusory (see section 6.10). According to Weiss (2013), the only feasible route to resolve the governance gap in global governance is to negotiate a network governance model. However, negotiating governance rules costs a lot of time and agreement on effective sanction mechanisms to enforce compliance is challenging.

The problem of collective action

The protection and promotion of public health require collective action: actors must coordinate their actions to achieve a common goal. However, collective action is difficult to achieve without a central authority that can impose binding rules and sanction the violation of these rules. In this situation, coordination is only possible if actors voluntarily agree on coordinating their actions. Several factors explain why voluntary coordination may fail (Olson, 1965).

The first factor is the absence of strong incentives to coordinate activities. Actors give priority to their private interests or play the role of free-rider by benefiting from coordination but not participating in it. Lack of information is a second factor. If actors are not informed about each other's behavior or do not trust each other, they may prefer to abstain from collective action, even though they endorse the need for it. They do not want to be exploited by other actors. The third factor is political. Disputes about the distribution of the costs and benefits of collective action hinder collective action. Another problem is that collective action involves the transfer of some sovereignty. Loss of sovereignty for a common purpose is always a delicate political issue, even more so in a polarizing world with geopolitical rivalries (Cadman, 2013). The World Health Organization must operate cautiously to avoid a collision with powerful nation-states (chapter 5). As said earlier, populists distrust international coordination by the World Health Organization, the European Union and other international organizations arguing that they only serve the interests of the global elite and hollow out national sovereignty (Wilson et al., 2020).

The magnitude of the problem of collective action varies. Collective action is, ceteris paribus, easier to organize if the number of actors involved is small. A small number makes it easier to agree on a joint approach and more difficult for actors to adopt the role of free-rider. Free-riders run the risk of severe punishment if they shirk out of coordination. Costa-Font speculates that collective action at the global level is more likely in preventive care than in curative medicine. Given increased disease mobility, nations have a common interest in the eradication of communicable diseases, particularly if these diseases are life-threatening. In this situation, public health has the structure of a public good. Collective action to ensure people across the world access to curative medicine is much more difficult to organize because rich nations will be inclined to give priority to their own citizens (Costa-Font et al., 2022). This is a painful observation in the context of the growing incidence of non-communicable diseases such as cancer, cardiovascular diseases, and diabetes in low- and middle-income countries.

6.4 Governance and problem-solving capacity

Governance rules have consequences for the problem-solving capacity of health systems. A simple example is the risk of policy paralysis inherent to the unanimity rule in decision-making. If each actor has veto power, policy deadlocks are imminent. The solution to this problem requires a revision of the decision-making rules, for instance, by the introduction of (qualified) majority voting. Lack of transparency, absence of a decision-making structure well-geared to the multidimensional or transboundary structure of public problems and lack of enforcement power are other factors undermining the problem-solving capacity of health systems.

The problem-solving capacity of governance has two dimensions: effectiveness and legitimacy. Effectiveness refers to the extent to which governance rules contribute to effective policymaking and legitimacy to the extent to which these rules contribute to policymaking that is accepted as legitimate. Sometimes, effectiveness and legitimacy are at odds which each other. This situation occurred in the Dutch response to COVID-19. The effectiveness of state intervention urged a quick and radical response for which, in the view of legal experts, no appropriate legal basis existed. Following this reasoning, the legitimacy of the policy interventions taken was questioned. The

enactment of new legislation (the Temporary Act on COVID-19) had to solve this problem. Another example to illustrate the tension between effectiveness and legitimacy is transparency. Transparency contributes to the legitimacy of health policymaking but may undermine its effectiveness. Negotiating a delicate compromise in all openness does not work.

6.5 Classification of governance rules

Health policymaking is, as pointed out in the preceding chapters, a collective activity of state and non-state policy actors. Policymaking requires broadly accepted rules for interaction in the health policy arena. Governance rules influence the problem-solving capacity of health systems. Good governance can be conceptualized as governance that contributes to the effectiveness and legitimacy of policymaking.

A distinction is made between the following types of rules: authorization rules, participation rules, decision rules, compliance rules, coordination rules, financing rules, transparency rules, accountability rules, integrity rules, and legal protection rules. This list of rules is an extended version of the TAPIC framework which stands for Transparency, Accountability, Participation, Integrity and Policy Capacity (Greer et al., 2016).

Authorization rules

Authorization rules regulate whether a policy actor has formal (or informal) competence to take binding decisions. The rule of law holds that the state (or another policy actor) must be authorized to take action. Lack of or unclear authorization rules puts the problem-solving capacity of health systems in two ways at risk. First, necessary policy decisions cannot be taken or are contested because they miss a proper legal basis. Second, lack of or ambiguous authorization rules hollow out the legitimacy of policymaking. Authorization rules are essential to good governance and protect citizens against state arbitrariness.

Participation rules

Participation rules regulate access to the health policy arena. Inclusive participation rules allow for broad participation, free speech, and free media, while exclusive rules

restrict access. Participation rules also regulate the kind of participation ranging from the right to be heard to more active forms like participation in decision-making processes or policy implementation.

Decision rules

Decision rules regulate the organization of the decision-making process. Examples are hierarchical decision-making, delegated decision-making, and decision-making by (qualified) majority voting. Decision-making in policy networks predominantly rests upon informal rules for consultation, persuasion, or negotiations. The absence of decision rules and unclear decision rules are a risk to the effectiveness and legitimacy of policymaking. The unanimity rule can paralyze policymaking, and decision rules that restrict democratic control undermine the legitimacy of policymaking.

Compliance rules

Compliance rules regulate the binding of policy decisions. These rules determine, in combination with authorization and decision rules, the enforcement power of policymakers. Compliance rules are a critical element of each governance system.

Coordination rules

Health policymaking requires horizontal and vertical coordination of decision-making in a multi-actor and multi-level setting. The purpose of coordination rules is to achieve that activities are properly geared to each other. Inconsistent or overlapping coordination rules are a risk for good governance.

Financing rules

Financing rules regulate the taxing capability of actors. Lack of fiscal space makes regional or local governments dependent on financial grants from the national (federal) government and restricts their decision space.

Accountability rules

Good governance requires policy actors to know for which part of policymaking they carry accountability. Accountability rules are essential for understanding what has

gone wrong and which policy lessons should be learned. They must prevent that responsible policymakers shirk out of their accountability. A frequent problem with accountability rules is confusion on who is accountable for what to whom, and how. If everybody is accountable, nobody is accountable.

Transparency rules

Good governance involves a transparent policymaking process. Democratic control of health policymaking is impossible without rules guaranteeing openness and access to information. Transparency rules regulate, among others, the right to public information, freedom of information, and independent research institutions. They are indispensable for investigating behind-the-scene decision-making, malfeasance, and other dubious practices.

Integrity rules

Integrity rules regulate ethical conduct in policymaking. Good governance means that policy actors respect each other, act trustfully in social interaction, and abstain from misleading action, corruption, or any other form of unethical behavior.

Legal protection rules

This category of rules constitutes a central element of the state of law. Citizens and organizations must be able to protect themselves against policy decisions they consider for whatever reason wrong. An independent agency must be in charge of judging the legal basis of policy decisions.

6.6 Governance models: modus of decision-making and compliance

Most governance systems have a complex structure. The devil is always in the detail. Besides, the practice of governance often markedly differs from its formal structure. Governance systems also change over time. They are not cast in concrete. How do policy analysts escape the risk to get lost in the labyrinth of detailed regulations? An effective strategy is to use a typology of governance models to unravel their

complexity. Each model describes the basic characteristics of a specific governance system and abstracts from its details. No model exists in pure form. All governance systems have a hybrid structure.

This section and the following section present two typologies of governance systems. The first typology rests on the modus of decision-making and compliance. The second typology takes the locus of decision-making as point of departure. This section discusses governance systems from the perspective of the modus of decision-making and compliance. The second typology will be presented in section 6.7.

A central characteristic of each governance system is the organization of collective action. How is decision-making organized, and which instruments are in place to effectuate compliance with the decisions made? In response to these questions, the following typology can be constructed (table 6.1).

Table 6.1 Typology of governance models according to modus of decision-making and compliance

Governance model	Decision rule	Compliance rule
Anarchy	None .negotiated agreement	None
Hierarchy	Top-down	Binding
Majority voting	Voting	Binding
Network	Negotiated agreement, persuasion	Weak binding
Market	Voluntary contract	Binding

Anarchic governance model

At first sight, it seems strange to conceive anarchy as a governance model, because the term anarchy suggests a 'non-structure'. There is no governance center and the actions of actors are driven by self-interest, opportunism, and their estimation of the balance of power. The model does not exclude the possibility that actors agree on common rules of the game to create minimum order (collective interest). However, these rules are easily broken if they no longer serve an actor's self-interest.

It speaks for itself that the anarchic governance model scores low on problem-solving capacity. Problems requiring collective action remain unaddressed and negotiated agreements on collective action are easily broken. Effective sanction rules are absent. On the other hand, the model can enhance the effectiveness and legitimacy of governance if problem-solving requires creativity and innovation. Central direction and bureaucratization run the risk of destroying creativity and innovative power. The principle of 'the wisdom of the crowd' rests upon this idea (Surowiecki, 2004).

From an empirical viewpoint, the anarchic governance model seems to have little relevance for health policymaking. Actors complain more about an oversupply than a shortage of governance rules. Anarchy-like situations, however, are not uncommon. Reports on lack of direction, non-cooperation, self-interest, or unresolved disputes about problem ownership, accountability, and authorization, to mention a few examples, may be interpreted as signals of anarchy. What in theory looks like a well-crafted governance system functions in practice as a chaotic and unworkable system.

Hierarchical governance model

Decision-making in the hierarchical governance model has a top-down structure with a center that is authorized to make decisions. The model is associated with decisiveness, effectiveness, and leadership. It allows, at least in theory, for rapid and binding decision-making. Hierarchical governance reduces the transaction costs of decision-making because the policy center has the formal power to cut the knot and give binding instructions. The hierarchical governance model is also referred to as the command-and-control model.

The practical meaning of the model is limited. State bureaucracies function in practice much less top-down than the formal governance structure suggests. In many situations, hierarchical decisions are pre-digested at lower hierarchical levels and may be little more than negotiated agreements with powerful interest organizations. Health policymaking is mostly not a matter of unilateral top-down action but a matter of co-production in the context of mutual dependency. From this perspective, it is hardly surprising that top-level policymakers often complain about the lack of enforcement power and argue for more hierarchy. The sigh of the Dutch prime minister about the government's lack of decision and enforcement power during COVID-19 is emblematic of this complaint (Box 6.1).

There are also other reasons for not overstating the problem-solving capacity of hierarchical governance. Persuasion and soft speak may work better than command and control. Information problems restrict the effectiveness of policymaking because policymakers at the apex of the hierarchy are unable to collect and process all necessary information. Besides, there is always a risk of being misinformed. In short, the picture that the state can dictate health policymaking is usually a caricature of what really happens in practice.

The legitimacy of hierarchical governance is not without problems too. The model contrasts with a culture of participation, consultation, and shared responsibility. Hierarchical governance can even be unfeasible because of constitutional restrictions or deeply rooted political objections against transferring decision power (sovereignty) to a hierarchical center. This problem is not only manifest in countries with a federal governance structure (e.g. Germany and the United States) but also a formidable obstacle in policymaking on global problems such as global warming or pandemics. A 'world government' does not exist and will (probably) never exist.

Majority-voting governance model

The majority-voting governance model is an essential element of democratic governance. Decisions are taken by the members of a community or their representatives in a decision-making body (e.g. parliament). Decision-making is binding. Decision rules require a simple or qualified majority and can entail specific

requirements to avert premature decision-making, for instance, concerning decision-making on constitutional issues.

Governance by majority voting can increase both the effectiveness and legitimacy of policymaking. Majority voting is an instrument to reduce transaction costs by ending policy deadlocks (the majority decides). It also contributes to the legitimacy of policymaking by giving the members of a community or their representatives a voice in the decision-making process.

The problem-solving capacity of the model has some limits. Building a majority can be time-consuming and result in policy incrementalism if a majority for radical policy decisions is beyond political reach. The need for political compromises may degenerate into muddling through and policy inertia. This problem worsens in a polarized political context where opponents seize every opportunity to delay or thwart legislation. The problem-solving capacity can also be limited if decision rules require a majority in two distinct democratic bodies with different political majorities. The legitimacy of majority voting is at risk if the majority can push through decisions without seriously taking the preferences of the minority into account or if the representativeness of the decision-making body is under attack. The latter critique is, as spelled out earlier, popular among populists who argue that the needs of ordinary people in society are not given priority and are made subordinate to the priorities of what they call the 'ruling elite' (Muller, 2016).

Network governance model

In this model, collective action is organized in policy networks. Decision-making takes place through consultation and negotiation in a multi-actor setting. Hierarchical decision-making and decision-making by majority voting do not (well) fit in network governance. Compliance usually rests on agreements and moral commitment rather than on formal obligations.

The network governance model is viewed as the best option for resolving complex policy problems (Mayntz, 2016). Hierarchical governance and governance by majority voting are unfit for this task. Network governance enables policymakers to bridge the

gap between the formal governance structure and the complexity of multidimensional and transboundary public problems. Policy networks create a platform for policymakers, interest organizations, and experts to discuss policy issues, settle conflicts, connect policy sectors, and work out (technical) solutions for policy problems. They are a vehicle for collective decision-making, shared responsibility, and the organization of public-private partnerships (Provan & Kenis, 2007). Network governance is considered the only realistic model for resolving global problems. Given the impossibility of a 'world state' on the one hand and the pressing need for global action on the other hand, network governance serves as a 'half-way house between anarchy and hierarchical direction' (Weiss, 2013).

However, network governance is not without weaknesses. Agreement on common rules for policymaking may require time-consuming negotiations. There is always a risk that these negotiations get stuck in disputes on authority, decision procedures, distribution of power, sanctions, or other sensitive issues. Though network members realize the need for collective action, they may nevertheless find it difficult to give up some of their independence and authority. Opportunism and distrust may flourish. Another weakness concerns the coordination of policymaking between networks. Network governance involves the risk of adhocracy. Decision-making may be biased toward the interests of powerful network participants. Besides, network governance can hinder democratic control. A potential risk of public-private partnerships in network governance is that commercial interests constrain the room for public action.

Provan and Kenis (2007) mention four critical factors for effective network governance. First, network participants must trust each other and be willing to engage in collaborative relationships. Second, the effectiveness of networks is affected by the number of participants. A large number of participants is in principle a risk for effective governance. Third, there must be a sufficient degree of goal consensus within the network. Participants must agree on the urgency and goals of collective action. The fourth condition is that the necessary competencies for effective coordination are present in the network.

Market governance model

The market governance model is closely associated with the neo-liberal wave in public policymaking. The model finds its intellectual basis in neo-classical economic theory which postulates that market transactions yield maximum welfare. Collective action should be organized by voluntary contracts that are binding. Collective action is achieved by 'the invisible hand of the market'. There are several versions of market governance: privatization of public organizations, outsourcing public tasks, contracting, pricing externalities, public tenders, and regulated competition. Its advocates promote the model as the alternative to hierarchical (state-directed) governance which they associate with inefficiency, bureaucracy, lack of innovation, and lack of freedom of choice. Market governance encourages entrepreneurialism and fosters efficiency and innovative power. Citizens are viewed as active consumers who should have freedom of choice to enforce providers, insurers, and other purchasing agents to optimal performance in terms of quality and costs. Clarke and Newman (1997) describe the switch from hierarchical governance to market governance as the transition from the 'bureaucratic state' model to the 'managerial state' model.

The advocates of market governance recognize that the problem-solving capacity model only works under certain preconditions, including freedom of choice, complete information, consumer protection, many suppliers and demanders, free entry and exit, and the absence of external effects. These preconditions assume a decision-making center (the managerial state!) capable of issuing strict regulations. In other words, the market governance model is, strictly speaking, a hybrid model. A political issue is the scope of regulation: should regulation be kept to a minimum or include regulations to protect public values like universal access to health care, quality of care, and fiscal sustainability (Enthoven, 1993)?

The effectiveness and legitimacy of market governance are much disputed. Critics put forward that the model only works in some areas of public health and will eventually hollow out public health values. Public health and health care, they argue, are no market commodity.

6.7 Governance models: locus of decision-making

An alternative approach to constructing a typology takes the locus of decision-making as the analytical point of departure. Where does decision-making take place? This section gives a concise description of the state-governance and self-governance model. Multi-level models are discussed in the next section.

State-governance model

The state-governance model accords the state a central role in health policymaking. The central role of the state rests upon two main grounds. First, state governance is considered a precondition for effectiveness because of its power to enact and enforce legislation and mobilize the necessary resources. State governance also contributes to the economies of scale and scope. Second, state governance is a precondition for legitimacy. Moral principles such as universal access, respect for the integrity of the body, autonomy, and equal treatment require legislation subjected to democratic control. In sum, state governance is a precondition for good governance.

However, the model has some weaknesses. Two reasons for not overstating its problem-solving capacity are that the state's decision and enforcement power is often less strong than formal decision and enforcement rules suggest and that the concentration of power into the hands of the state as single policy actor can put the effectiveness and legitimacy of policymaking at risk. Accommodation of policymaking to local circumstances by decentralization of decision power enables local communities to accommodate national policies to local conditions and exercise democratic control upon policy decisions that affect their everyday life.

Self-governance model

The self-governance model, also called the self-regulation model, is the opposite of the state-governance model. Its basic characteristic is not top-down but bottom-up policymaking without (much) state involvement. The model has a long tradition in health care. The prominent role of mutual aid organizations in the nineteenth century and the first half of the twentieth century in providing and financing health care rested upon the principle of self-governance. These organizations claimed a sovereign position in the financing and provision of social and health services for their

constituency. Self-regulation is also common in the professional medical community. Most medical guidelines and quality standards result from self-governance (Freidson, 2001). Aside, self-regulation is defended on communitarian grounds. The community is better suited to resolve public health problems than the state. The state should only intervene if the community cannot take care of its members.

There are several motives for self-governance. The first motive is ideological and arises from the principle of subsidiarity. The organization of society should be the result of 'internal' action instead of 'external' state action. This was the principal argument of the civil society sector to protect its independent position in the provision and financing of health care. The second motive pertains to expertise. Regulation should be left to professional organizations because of their acknowledged expertise. The third motive is defensive. Interest organizations frequently opt for self-governance to avert state regulation.

Soft regulation and compliance are known as the Achilles heel of self-governance. Compliance may only rest upon moral commitment. Formal sanctions to punish non-compliance are lacking or ineffective. This does not mean, however, that there are no informal instruments to foster compliance. Examples are loss of reputation, public exclusion, monitoring, and naming and shaming.

6.8 Multi-level governance models

Multi-level governance models assume that good governance requires the division of decision power over several decision levels. The concentration of all decision power at a single level is rejected for two main reasons. The first reason is effectiveness. Policy problems should be addressed at the most immediate level that is consistent with their resolution. This line of reasoning is known as the principle of subsidiarity. The upper division level in governance should be concerned with problems requiring central direction, while the lower decision level should take the lead in resolving problems that can best be addressed at that level. Subsidiarity is obviously an abstract principle that is open to multiple interpretations and different choices regarding the division of decision power. Unsurprisingly, it is also an object of political dispute. The second reason for multi-level governance is legitimacy. The

concentration of decision power at the national or federal level is a risk for democracy. Multi-level governance enables people and organizations at lower levels to set their own priorities in policymaking.

Multi-level governance is a common model in public health. In many countries, power and responsibility are distributed among state actors at the central, regional, and local level. Box 6.2 presents some international examples.

Box 6.2 Country examples of multi-level governance

In the United States, Medicare (a federal program for the elderly) and Medicaid (a federal program for people with low incomes) are jointly administered by the federal government and the states (Bodenheimer & Grumbach, 2012). Health governance in Denmark is spread over three administrative levels: state, region, and local. While planning and regulation are organized at both the state and local level, the state holds the overall regulatory and supervisory functions and fiscal functions. The state also assumes responsibility for more specific planning activities, such as quality monitoring and planning the distribution of medical specialties at the hospital level. The five regions are, among other things, responsible for hospitals, self-employed healthcare workers, and municipalities for disease prevention and health promotion (Olejaz et al., 2012). Governance in the National Health Service of the United Kingdom has a more hierarchical structure (Steel & Cyclus, 2012). In Germany, many public health issues are dealt with at the state level within a general policy framework set out by the federal government (Busse & Blümel, 2014).

State-local government model

This model accords a distinct role to local (or regional) government alongside the state in health governance. Local government is assumed to be better informed about the local situation and better equipped to accommodate national policies to local circumstances. Moreover, local government can best develop and implement an intersectoral approach at the local level given its policy tasks in housing, public transport, schools, welfare, physical infrastructure, public security, and so on. The

involvement of local government also draws upon the assumption of strengthening democracy (Box 6.3). A risk inherent to the state-local model is the failure of vertical coordination.

Box 6.3 The governance of public health in Europe

The governance of public health in Europe features a high degree of variation. A more or less uniform governance system does not exist. The great variety is partly due to the concept of public health itself. Public health services comprise a broad range of activities to protect and promote public health and prevent the occurrence of disease. While some activities fall under the jurisdiction of the Health Department, other departments are in charge of environmental regulation, food safety control, or road safety control.

The governance of public health reflects the constitutional situation of that country. In countries with a tradition of decentralization in public policymaking, public health governance has a comparable structure. For instance, given the traditionally prominent position of the cantons in the Swiss constitutional system, it is no coincidence that a great deal of public health governance is decentralized to the cantonal level. Likewise, it is no surprise to find a high degree of shared responsibility in the governance of public health in Germany, a high degree of decentralization to the regions in Spain, and a high degree of centralization in Eastern Europe. Germany has a federal governance system, Spain has devolved many public functions to the regional level, and Eastern European countries have a tradition of centralized governance. The variation indicates that public health governance has little to do with public health considerations.

As a general observation, one may argue that the governance of public health always has a multi-level structure. While some parts of policymaking are organized at the national (or supranational level), others are decentralized to lower government levels. The degree of decentralization varies per activity. An example is the governance structure of public health in the Netherlands. The more medically-oriented tasks, including infectious disease control, environmental public health, and screening programs give local government little policy discretion. Local governments operate here as implementing agencies of detailed national protocols. For other policy tasks, the Public Health Act accords municipalities more leeway. They must consider the

national priorities in public health but are free to determine how to convert them into a local plan for public health and how to organize their local public health service. The national priorities include diabetes, depression, smoking, alcohol consumption, overweight and physical exercise.

COVID-19 has put public health governance in every country to the test. Voices are calling for a revision of its complex structure to be better capable to combat a public health crisis through central direction.

Source: Rechel et al., 2018; Sagan et al., 2021.

State-agency model

In the state-agency or agentification model, regulation and oversight are put in the hands of (public) agencies at arm's length of the state. These agencies are referred to as (quasi-) independent regulatory agencies. Examples are the Dutch Healthcare Authority, the Care Quality Institute (CQI) and the National Institute for Health and Care Excellence (NICE) in the United Kingdom Box 6.4), and the Food and Drug Administration (FDA) in the United States. Agencies carry out their policy tasks within a regulatory framework set out by the state. The relationship between agency and state varies. Board members are either appointed as independent members or as representatives of a specific category of stakeholders (a combination is also possible).

The leading motive for governance by regulatory agencies is depoliticization and effectiveness. Regulation and oversight must be based on expertise and objectivity and be insulated from political influence as much as possible (Majone, 1999). A drawback of the model is the risk of a democratic deficit because regulation and oversight are only indirectly subject to political control. Two other risks are the reduction of the government's decision power and a rising distance between state policymaking and policy implementation. Problems may also arise if a regulatory agency is dependent upon the financial contributions of organizations they control. For instance, The Food and Drug Administration in the United States is authorized to

collect user fees from pharmaceutical companies to assess the effectiveness and safety of their medicines. According to critics, this funding model may compromise the assessment procedure. In their view, the FDA must be entirely funded by taxpayers-as-consumers: 'The FDA should entirely be clear about whom it serves' (Light et al., 2003: p. 9).

Box 6.4 Regulatory agencies in the United Kingdom

The Care Quality Commission is the independent regulator of health and adult social care providers in England. It was established in 2009 as a merger of the Healthcare Commission, the Commission for Social Care Inspection, and the Mental Health Act Commission. It has a specific duty to protect the rights of vulnerable people, including those with mental illnesses. The Care Quality Commission licenses, monitors, and inspects health and social care organizations and enforces national legal requirements for the organizations in its purview. These organizations include hospitals, care homes, dentists, home services, and, as of 2014, general practitioners.

The National Institute for Health and Care Excellence (NICE), established in 1999, is a non-departmental public body. Its name was changed from the National Institute for Health and Clinical Excellence to the National Institute for Health and Care Excellence, reflecting the extension of its tasks to developing guidance and quality standards in social care. NICE is accountable to the Department of Health. Independent committees make NICE guidance standards and other recommendations.

Source: Cyclus et al 2015; Williams, 2016.

Neo-corporatist governance model

In the neo-corporatist model (alternative names are association model or private governance model), the state accords a privileged place in health policymaking to leading non-state organizations representing the interests of major stakeholders (associations). These organizations share 'in the state's authority to make and enforce binding decisions' on policy (Streeck & Schmitter, 1985: p. 131). The model explicitly rests upon the concept of shared responsibility for health policymaking.

A minimum version of the neo-corporatist model is regular consultation of privileged interest organizations (e.g. the interest organization of health professionals, hospitals, and health insurers) in the policy development and formation stage. The purpose of consultation is to collect information, allow interest organizations to express their policy preferences, and build support for policy initiatives. Participation rules can formally prescribe the consultation of interest organizations.

Neo-corporatist governance can go beyond consultation and involve collective bargaining with privileged interest organizations. This version explicitly draws upon the notion of shared responsibility. To achieve its policy goals, the state must seek cooperation with these interest organizations. The corporatist governance model offers them the opportunity to influence health policymaking. On its part, the government prefers a common approach to hierarchical decision-making for effectiveness and legitimacy.

In the more radical version of neo-corporatist governance, the state delegates a sizeable responsibility for health policymaking to privileged interest organizations. Health policymaking is organized as a two-stage and multi-level process. In the first stage, the national (federal) government sets out a general framework for policymaking. In the second stage, privileged organizations work out this framework in concrete regulations and are charged with policy implementation. A great deal of health policymaking in Germany rests upon this version of neo-corporatist governance (Box 6.5).

The strength of the neo-corporatist governance model lies in the principle of shared responsibility. The model builds upon consensus and cooperation rather than antagonism. However, the model has some weaknesses. A serious risk is that shared responsibility results in policy incrementalism and, consequently, undermines the effectiveness of policymaking. The privileged position of stakeholders also involves the risk of private interest government and the risk of undermining democratic control.

Box 6.5 Germany's governance structure in social health insurance

Blümel et al (2020) summarize the governance structure of social health insurance (SHI) as follows: 'The most striking aspect of the decentralized health care system in Germany is the delegation of governmental power to corporatist institutions within the SHI system. Most of the legal rights and responsibilities are vested in corporatist associations of payers and providers in a system of self-governance, while institutions at the federal level (e.g. the Federal Ministry of Health) are responsible for setting the legal framework and the supervision of the main corporatist bodies (e.g. the Federal Joint Committee and the Federal Association of SHI physicians). Both the delegation of regulatory power to corporatist institutions and the system of self-governance are the result of a long historical process (……). However, the reliance on self-governance is continuously at the centre of political debate with the Federal Ministry of Health lately assuming a more direct regulative role' (pp.29-30).

6.9 Centralization and decentralization

So far, governance has been discussed as a set of procedural rules for policymaking. Our leading questions were: how do these rules look, and how do they affect the problem-solving capacity of health systems? An alternative way is to study governance as a target of reform. How should the governance of health systems be organized to enhance their problem-solving capacity? Redesigning the governance structure is a priority in many health system reforms.

Two approaches to governance reform are centralization and decentralization. Centralization involves an upward transfer of decision and enforcement power. Decentralization is a downward transfer of decision and enforcement power (Saltman & Bankauskaite, 2006). A distinction can be made between geographical and functional (de)centralization. Geographical (de)centralization involves the transfer of decision power from the national to local (or regional) authorities, and functional (de)centralization the transfer of decision power to specialized bodies.

The scope of decentralization varies from restricted to broad. In the restricted version, the decision space of local or regional actors is restricted to mainly administrative tasks. The legislative framework leaves these actors little discretionary space. The alternative model is to offer local or regional policymakers considerable leeway in policymaking. In this model, the national government confines its role to setting out a general policy framework for decentralized policymaking. A critical aspect of decentralization is the coupling of policy responsibility and financing. A mismatch between policy responsibility and fiscal space is an important source of problems: either local or regional policymakers do not receive the financial resources necessary to carry out their policy tasks properly or their taxing capacity is restricted as a consequence of which they cannot properly carry out the decentralized policy tasks.

Motives for centralization and decentralization

Table 6.2 summarizes the main motives for centralization and decentralization. These motives relate to the efficiency and legitimacy of health policymaking.

Reinforcing the efficiency of governance through concentrating decision power at the central level is a common argument for centralization. The dispersion of decision power across various governance levels is viewed as an important cause of policy fragmentation and lack of political direction. Particularly in times of a deep and enduring crisis such as COVID-19, the need for centralized policymaking is strongly felt. The central government wants to take over the lead in crisis management for reasons of effectiveness, efficiency, and communication. An enduring crisis asks for strong and visible leadership and consistent communication. Framing a public health problem as a crisis is less innocent than it might seem at first view because it can be

a deliberate prelude to centralization. A second motive for centralization from the viewpoint of effectiveness and efficiency is the reinforcement of negotiating power. This motive has motivated the member states of the European Union to transfer the negotiations with the pharmaceutical industry on purchasing a vaccine to terminate COVID-19 to the European Union. Furthermore, centralization is used as argument to achieve economies of scale and scope, resolve the problem of vertical coordination and reduce transaction costs in policymaking.

Table 6.2 Motives for centralization and decentralization

Motives	Centralization	Decentralization
Effectiveness	Centralization is an instrument to strengthen health policymaking through central direction. Centralization is an instrument to achieve economies of scale and scope	Decentralization is an instrument to accommodate policymaking to local circumstances. Decentralization is an instrument to foster innovation and entrepreneurialism.
Legitimacy	Centralization is an instrument to ensure equal access to health services. Centralization is an instrument to resolve the problem of democratic deficit.	Centralization is a risk to democracy Decentralization is an instrument to reinforce local democratic control

Centralization is also advocated from the viewpoint of legitimacy. It has been propagated as an instrument to resolve the problem of unequal access to health services. If local policymakers are left free to make their own choices, one should not be surprised to find great variation in the provision of health services. A senior Swedish planning official phrased the concern on unequal access once as follows: 'We are one country, and we should have a single health policy' (Saltman & Bankauskaite, 2006: p. 132). Additionally, centralization is used as a motive for resolving a democratic deficit. Fragmentation of decision power hinders political control. Outsourcing regulatory tasks to regulatory agencies at arm's length of the

government is a risk to democratic control upon regulation. Reassertion of the role of the state should resolve this control problem.

Paradoxically, effectiveness and legitimacy are also mentioned as motives for decentralization. Decentralization is in this line of thought a governance arrangement to enhance the problem-solving capacity of health systems. It enables local or regional policymakers to accommodate policymaking to their local situation. A one-size-fits-all approach does not work or is at best suboptimal. Local or regional policymakers are best informed about the local situation. Besides, their involvement in other policy areas makes it possible to develop an intersectoral approach and exercise political control at the local or regional level. Concentrating all decision and enforcement power in the hands of the state is a risk to democracy and may end in the abuse of power. Division of power is good in itself.

Sometimes, the central government opportunistically uses the effectiveness argument to justify expenditure cuts. If local government is in the best position to accommodate health policy programs to the local situation, it is also in the best position to increase the efficiency of these programs. Because greater efficiency means fewer public resources are required to attain the programs' policy objectives, expenditure cuts are assumed to have no repercussions for goal attainment. The decentralization of a great deal of health-related social services to local government in the Netherlands as part of the 2015 reform of long-term care rested upon this policy belief (Maarse & Jeurissen, 2016).

Swinging pendulum

The history of health policymaking can be analyzed as a swinging pendulum or a history of successive processes of decentralization and centralization (Saltman et al., 2007). Decentralization was a leading policy concept in countries with a traditionally state-centric governance model. After the fall of the Berlin Wall in 1989, countries in Central and Eastern Europe opted for decentralization as the main strategy to resolve the gross inefficiencies in their Semashko-type of health care system (Marrée & Groenewegen, 1997). Important characteristics of this system were a high degree of centralization and solid political control on the governance of health care. The purpose

of the reforms was to enhance the effectiveness and legitimacy of their health system by moving away from the hierarchical and state-directed governance model toward a model with more freedom of choice for payers and provider organizations (Sitek, 2010).

Decentralization was also a leading concept in the reform of the Norwegian healthcare system in the 1970s. The central argument for transferring decision power from the central to the regional level was to bring health policymaking 'closer to the people'. However, the state retained its broad strategic and regulatory authority and maintained control over hospital financing. Because the formal separation between decision-making and financing did not work well, the government partly reversed the decentralization in 2002. A similar development took place in Denmark where the government, with some exceptions, centralized back fiscal and political responsibilities to the national government in its major reform of health governance in 2006 (Saltman., 2008).

Health governance in the Netherlands is another example of a swinging pendulum between centralization and decentralization. In the nineteenth century, the gravity point in the health governance system was still with local government. Municipalities were held politically responsible for public health. Furthermore, civil society (mutual aid) organizations claimed sovereignty in providing and financing health care. Gradually, however, the structure of governance has fundamentally altered. The publicization of health care has gone hand in hand with a considerable centralization of decision power. The structure of governance has become increasingly state-centric. The market reform in Dutch health care in 2006 and the reform of long-term care in 2015 signified a new direction in health governance. The market reform had to increase the decision power of health insurers and hospitals and the reform of long-term care the decision power of municipalities in providing health-related social services. At the same time, however, insurers, hospitals, and municipalities had to bear the financial consequences of their decisions (Jeurissen & Maarse, 2021; Maarse & Jeurissen, 2016). The 2008 Public Health Act confirmed the role of municipalities in public health by charging them with the elaboration of the state's public health spearheads into local public health plans (box 6.3). How governance will unfold in the

future remains uncertain, but dissatisfaction with the restricted role of the state in the market governance model and the limited problem-solving capacity of the health system to manage an enduring public health crisis may induce a new swing in governance toward a reassertion of the role of the state.

6.10 Global governance and its limits

Health policy is traditionally a nation-bound activity. The basic principle is that each country operates its health system to serve its population. The principle of sovereignty explains the diversity in national health systems and policies. At the same time, however, there is mounting evidence of the need for international coordination in health care. For instance, in border regions, healthcare quality can benefit from practical agreements on cross-border blood transfusion or the transport and hospitalization of patients in emergencies. Agreements on the transfer of patients in emergencies are another example of international coordination. Coordination is the outcome of negotiated agreements between the participants in regional cross-border policy networks.

The need for international coordination is clearly manifest at the global level. The outbreak of COVID-19 in 2020 reminded public authorities of the simple fact that viruses do not respect national borders. The number of studies reporting on the alarming consequences of climate change for public health is rapidly increasing (Balakrishnan, 2018; KNAW, 2023). Countries with a poorly developed health system are unable to cope with transboundary health threats their population is exposed to. The unequal distribution of health and disease on a global scale – in the view of many observers potentially a threat to international security (Stoeva, 2016; Cadman, 2013) – cries out for global collective action at the global level.

However, the organization of collective action to protect people from health risks and improve public health is challenging. There is no 'world government' that is capable to take effective and binding policy measures. Hierarchical governance is simply an illusion. Given that neither anarchy nor the market can provide effective solutions, the only workable alternative is to organize collective action in international or global policy networks. Weiss (2013) describes global governance in global policy networks

as a 'half-way house between the international anarchy (……) and a world state' (p. 25). The main problem of global governance is 'that the evolution of intergovernmental institutions, and the form of collaboration they engage in, lags well behind the emergence of collective problems with trans-border, especially, global dimensions' (p.2).

Global governance occurs in international policy networks in which states and national and/or international non-state organizations set up structures for international collective action to address global public health problems. Coordination rests upon negotiated agreements between the participants in the network (section 6.3). Reaching an agreement is challenging because ideological considerations, national interests, political pressure, and power relations influence the negotiating process. Geo-political rivalries also frustrate global governance. The only option is to negotiate a compromise (McGinnis et al., 2020). Compliance is also problematic. Commitments are frequently not met. The absence of effective sanctions worsens the problem of non-compliance.

The remaining part of this section describes two initiatives of the World Health Organization to organize global collective action for public health: the International Health Regulations and the WHO Framework Convention on Tobacco Control.

International Health Regulations

The International Health Regulations (IHR) are an international legal instrument under the auspices of the World Health Organization that is formally binding on 196 State Parties across the globe, including all the Member States of WHO. However, the regulations explicitly respect national sovereignty in health matters. To resolve the tension between sovereignty and binding regulations, the regulations rest upon the principle of 'shared responsibility'. They involve a complex balancing act between sovereignty and formal binding. An effective sanction mechanism is absent (Sridhar, 2022).

The purpose and scope of the IHR are 'to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are

commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade.' If a State Party has evidence of an unexpected or unusual public health event within its territory, irrespective of its origin or source, which may constitute a public health emergency of international concern (PHEIC), the Party shall hand over to the World Health Organization all relevant information. The Director-General determines, after the advice of an independent Emergency Committee and based on all information available, whether the reported event constitutes a PHEIC following the criteria and the procedure set out in the Regulations. The IHR consist of recommendations, general obligations, and public health measures (www.who. int/ihr).

A contentious aspect of PHEIC is its binary structure: a situation is an emergency or isn't. There is nothing in between. This complicates the declaration of a PHEIC. While a timely PHEIC is of vital importance for effective risk communication, its declaration may confront countries involved with huge financial damage because of loss of trade and tourism. Another problem is limited information. As a consequence, the decision to declare a PHEIC comprises a complex balancing act between the benefits of a rapid response and political and economic costs in a context of uncertainty.

A second problem is compliance. This problem became manifest in handling the Ebola Crisis in West Africa (Guinea, Liberia, and Sierra Leona) in 2013-2014. A panel of international experts reported serious shortcomings in compliance with the regulations. There had been little signs of shared sovereignty. For instance, some member states had failed to develop certain core public health capacities under the regulations. The panel also found that there had been strong disincentives for countries to report outbreaks quickly and transparently for fear of travel and trade restrictions of other countries. Furthermore, the panel criticized the delay in declaring the outbreak of Ebola a PHEIC. The World Health Organization, the panel concluded, had no culture of rapid decision-making and tended to adopt a reactive rather than a proactive approach to emergencies. Its health emergency response capacity had clearly been substandard during the Ebola crisis (Report of the Ebola Interim Assessment Panel, 2015).

WHO Framework Convention on Tobacco Control

The WHO Framework Convention on Tobacco Control (FCTC) is the first treaty negotiated under the auspices of the World Health Organization. The FCTC is an evidence-based treaty that reaffirms all people's right to the highest health standard. The FCTC represents a paradigm shift in developing a regulatory strategy to address addictive substances. In contrast to previous drug control treaties, the Convention asserts the importance of demand reduction strategies and supply issues. It includes price and tax measures and non-price measures to reduce the demand for tobacco products. By signing the Convention, member states indicate that they will strive in good faith to ratify, accept, or approve it, and show political commitment not to undermine the objectives set out in it (www.who.int/fctc/text).

Once again, compliance is not without problems. There are notable international differences in the scope and pace of policy measures restricting the demand for smoking products. Eastern European countries appear to be poor performers. The Netherlands, too, was in some respects reluctant to carry out the Convention properly. The government held the opinion that the Netherlands strictly complied with the regulations, which was untrue. Clean Air Netherlands (an interest organization) filed a lawsuit against the government for its decision to exempt small cafes from the smoking ban. The Supreme Court ruled that this exemption conflicted with the regulations in the Convention. Contrary to the regulations, the government also failed to exclude the industry from tobacco policymaking, reasoning that the sale of tobacco was a legal activity and that the government needed to stay in contact with the tobacco industry to carry out its policy measures. Although the government won a lawsuit on this violation of the Tobacco Framework Convention filed by the Youth Smoking Prevention Foundation, it nevertheless published a protocol to clarify its implementation of the Convention. The protocol stated that government officials had to restrain their contacts with the tobacco industry 'to prevent the industry from having influence on policy'. Contacts had to be restricted to 'matters of technical execution' (Willemsen, 2018: 156-158).

6.11 Conclusion and suggestions for health policy analysis

The problem-solving capacity of health systems is not only a matter of policymaking but also a matter of governance. Health governance is defined as the system of rules (governance rules) for the production of public policymaking. It forms an essential dimension of their problem-solving capacity. The structure of health governance is often the target of reform to strengthen the problem-solving capacity of health systems.

A central aspect of public health governance is the need for collective action. Actors must coordinate their activities to protect and promote public health. However, there are various reasons why collective action fails. The study of health governance cannot be confined to an investigation of the formal governance rules only. An in-depth understanding of governance requires knowledge of informal governance rules and how formal and informal governance rules are implemented. The practice of governance may differ markedly from its formal structure. A fascinating aspect of governance systems is structural variety. There exists no single system. The structure of a country's health governance system reflects the structure of its overall governance system and the impact of political influences.

The governance of health policymaking is an important topic of research in health policy analysis. Understanding health policymaking requires knowledge of the formal and informal rules of the game for policymaking and the governance structure in health policymaking. The study of governance gives insight into the problem of collective action in health policymaking and the presence of governance gap(s) influencing the effectiveness and legitimacy of health policymaking. The classification of governance rules and typology of governance models according to modus and locus of decision-making can be used as analytical models for studying governance of health systems and the impact of governance upon their problem-solving capacity. A specific topic of research concerns the structural weaknesses of global governance and the instruments used to overcome these weaknesses.

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CHAPTER 7

HEALTH POLICY EFFECTS

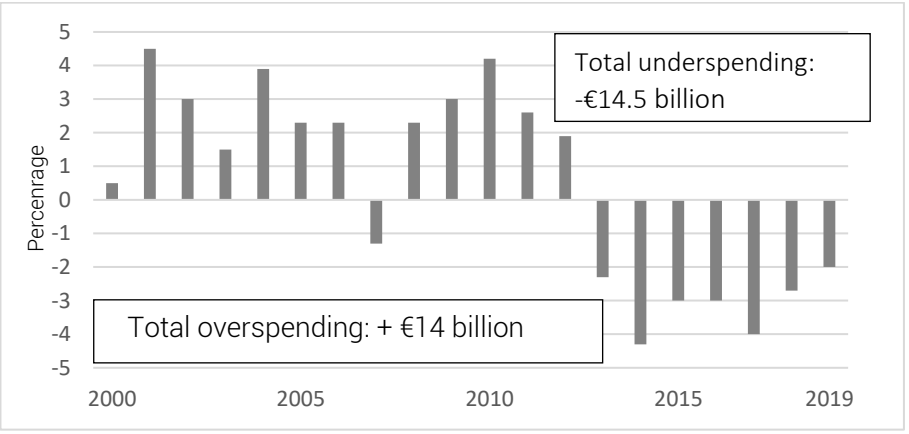
KEY POINTS:

- Policy effects are defined as changes that are attributed to the use of policy instruments.
- The study of policy effects assumes a causal model between policy instruments and policy effects. There are several reasons for caution in causal reasoning: the non-existence of a causal relationship; the risk of ignoring context; the multiplicity of policy instruments; and the openness of policy instruments.
- Health policy output must be distinguished from health policy outcomes. Policy output corresponds with the intermediate goals of health policy and policy outcomes with its ultimate goals.
- Political effects constitute a specific type of policy effect. They relate to the political construction of policy effects
- The effectiveness of health policy is defined as the degree to which the instruments of a policy have contributed to the achievement of the stated policy goals.
- Policy failure can be due to theory, implementation, and compliance failures.
- Health policy can have side effects (balloon effect or waterbed effect and fill-effect).
- Two specific policy effects are counterproductive effects and distributive effects.
- Ranking health systems is a new trend in measuring health system performance.
- A specific aspect of health system performance is health system resilience which can be defined as the health system's ability to prepare for, manage (absorb, adapt, and transform) and learn from a sudden and extreme disturbance.
- Health policy failure can elicit a blame game (political effect)
- Political trust can be conceptualized as a political system effect. There is evidence that political trust has declined.

Box 7.1 Success and failure of the annual global budget cap in Dutch health care

An important instrument of the Dutch government to control healthcare expenditure growth is to set an annual global budget for health care to restrict expenditure growth to a predetermined level (budget cap). Up to 2012, the Minister of Health determined the budget. Ever since, it has been part of the framework agreements on the annual growth of healthcare expenditures between the government and the national organizations of insurers and providers. How did the budget cap work in practice?

Figure 7.1 Overspending and underspending as percentage of the global budget for health care in the Netherlands



Source: Health Department

Figure 8.1 demonstrates that budget caps were not effective until 2012. Except for 2007, healthcare expenditure outstripped the cap each year. However, since 2013 the picture has reversed. The framework agreements have proven effective in controlling healthcare expenditure growth.

Source: Jeurissen & Maarse, 2021.

7.1 Introduction

Health policy is no goal of itself but a strategy to foster health system performance. Central in the study of policy effects is whether state intervention has been effective. Have the policy instruments contributed to the achievement of the stated policy goals? Referring to box 7.1, has the budget cap proven effective in keeping healthcare expenditure in check? At first sight, this seems indeed to be the case since 2013. Nevertheless, it is always possible that factors other than the budget cap explain the observed underspending. More questions need answers to get a good picture of the policy effects. For instance, which side effects (external effects) have occurred? What are the policy's long-term effects, and how do they compare to its short-term effects? What do the results mean for the capacity of health systems to achieve their objectives? Each of these questions fits an instrumental perspective on health policy: health policy is conceptualized as a problem-solving activity.

Health policies may also have political effects. These effects concern the political construction of the effects achieved and the impact of this construction on health policymaking. For instance, health policy failure may elicit a blame game, contribute to declining public trust in the government and science, or have electoral consequences (Bovens et al., 2011).

This chapter consists of three parts. The first part starts with briefly exploring the concept and measurement of policy effects. The second part discusses the non-political effects of health policy. It starts with an analysis of the effectiveness of health policy and the causes of policy failure. Next follows a discussion of the financial effects of health policy, the occurrence of side-effects, counterproductive effects, and distributive effects. These effects have in common that they are connected to a single policy. An alternative approach is to analyze the compound effect of health policymaking. What is the impact of health policymaking on health system performance and health system resilience? The political effects of health policy are central in the third part of the chapter.

7.2 The concept of policy effect

The effect of a policy is defined as a change which is attributed to the use of policy instruments. Policy effects can be intended or unintended, expected or unexpected, direct or indirect, known or unknown, become manifest immediately or later, and so on. The concept of policy effect presupposes a causal model: the (non)occurrence of an observed change is attributed to the use of a specific policy instrument or combination of policy instruments: X (instrument) is viewed as the cause of Y (effect). There are four reasons for caution in assuming a causal relationship between instrument and effect. First, it is uncertain to what extent an observed change can indeed be attributed to the instrument used to achieve this change. Goal attainment does not guarantee policy effectiveness because other factors than the policy instrument(s) used may explain the observed change. Policymakers very seldom have the opportunity to carry out a policy experiment with a control group to investigate policy effects because they are expected to act, preferably as soon as possible. It is also uncertain whether an experiment would yield complete insight into the causal relationship between instrument and effect because of measurement problems and the impossibility of a comparable control group.

Second, simple causal models ignore context. The occurrence of an intended change seldom results from a single factor (policy instrument). Contextual factors always influence policy effects. Policy instruments may only work under some conditions but not under other conditions. For instance, the state's call for social distancing worked well in the first stage of COVID-19 but lost some of its effectiveness in later stages of the pandemic. Decentralization of health policymaking (policy instrument) to regional authorities may work in countries with a tradition of decentralized policymaking but not in countries missing such an experience. Ignoring the impact of contextual factors is an important cause of policy failure. Conversely, policymakers sometimes benefit from the luck of a favorable context. However, the success of today does not guarantee the success of tomorrow. Drawing policy lessons from policy success and failure must, for this reason, include an analysis of the impact of contextual factors on the observed effects.

The third problematic aspect of simple causal models is that most health policies include a broad repertory of instruments to achieve the stated policy goals. For instance, the instruments used in cost control may consist of price controls, global budgets, co-payment regimes, hospital planning, blunt expenditure cuts, etc. A combination of instruments makes it difficult to disentangle the effects of each distinct instrument. Sometimes, lack of information on the effects of distinct instruments becomes a political issue. An example is the political controversy over some policy instruments' effectiveness in managing the coronavirus outbreak in the Netherlands. The instrumentation of the government's policy prompted a political debate on the (added) effectiveness of wearing face masks and freedom-restricting instruments such as the lockdown, QR code, and curfew. Critics requested the government to present a sound foundation of these instruments' effectiveness, but the government could only give a calculated guess of their impact on the course of the pandemic.

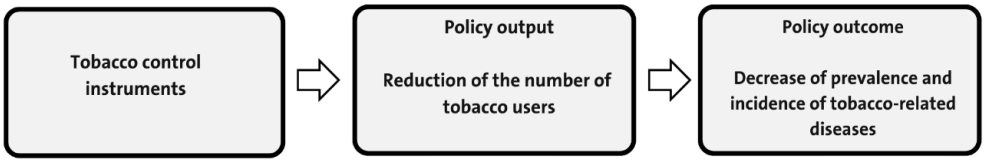
The fourth problem concerns the ambiguity or 'openness' of many policy instruments. Policy effects are influenced by how they are applied in practice. Variety in implementation practices makes it difficult to draw hard conclusions on the effects of a policy instrument. An example: the effectiveness of decentralizing policy tasks to regional or local authorities to foster the efficiency of service provision (chapter 6) is contingent on how these authorities use their discretionary power in service provision. The investigation of policy effects requires an in-depth study of policy implementation. A pocketful of money for a stated policy goal contains no information on how to spend this money.

Policy output and policy outcomes

Health policy effects can be divided into two main categories: policy output and policy outcomes. Policy output refers to the immediate effect of a policy instrument and policy outcomes to its ultimate effect. The intended policy output is an instrumental goal to achieve the ultimate goal. The following example illustrates the distinction between policy output and policy outcome. Over the last few decades, governments have introduced various policy instruments to discourage the use of tobacco products (Willemsen, 2018). The ultimate goal of tobacco control policy is to decrease the

prevalence and incidence of tobacco-related diseases. Assume that the number of smokers has reduced by x% compared to a predetermined baseline year. This percentage is the policy output of tobacco control policy and the observed decrease in the prevalence and incidence of tobacco-related diseases the policy outcome (Figure 7.2). The attainment of the intended policy outcome is contingent on the effectiveness of the achieved policy output.

Figure 7.2 Distinction between policy output and policy outcome



The distinction between policy output and policy outcomes is usually complex. Most health policies include several intermediate and ultimate goals. For instance, the government makes a budget available to improve healthcare quality, defined as shorter waiting times and fewer medical accidents. One part of the budget is spent on extension of staff and the other part on training programs. Policy output is measured as the extension of staff and attendance to training programs. The measured shortening of waiting times and decline in the number of medical accidents are policy outcomes. Another problem is that the path from policy instrument to policy outcomes may include first-order outputs, second-order outputs, and so on. For instance, concerns about food safety are the reason for the government to raise the budget of the food inspectorate (instrument) to intensify its control of food safety. The extension of the food inspectorate is the first-order output, the number and intensity of extra inspections the second-order output, and the impact of these inspections on food safety is the policy outcome.

The distinction between first-order output and second-order output demonstrates that the path from instrument to policy outcomes can consist of several consecutive steps. Each output is a crucial link in the causal chain between instrument and

intended outcome. The distinction between policy output and policy outcome also contains an important lesson: the achievement of an intended output does not guarantee the accomplishment of the intended outcome. The achievement of the ultimate policy goal depends on the effectiveness of the realized policy output. In the above example, the realized extension of staff (policy output) does not guarantee food safety (policy outcome). Nevertheless, it frequently happens that the realized output is presented as evidence of the policy's effectiveness. Policy output is used as proxy for policy effectiveness. It speaks for itself that this practice can easily lead to wrong conclusions.

The measurement of policy effects

Many textbooks have been written about measuring policy effects and the methodological problems that arise in measuring these effects (Patton, 2017; Pawson & Tilly, 1997; Fischer, 1995; Cook & Reichardt, 1979). Important methodological problems are the content of the analytical model and its underlying assumptions for the measurement of policy effects, the ambiguity of policy goals and policy preferences used as the normative framework to assess policy effects, the operationalization of policy output and policy outcomes, the availability, validity, completeness, and reliability of the data, and the period that is taken in consideration to measure policy effects. Consequently, information about policy effects is manufactured information (see next chapter). Using other data or an alternative measurement model may produce another picture of policy effects. Because methodological choices influence the results, the results can become the object of political dispute. While some actors claim success, others are skeptical or even speak of policy failure. Material interests may also play an important role. For instance, in the years of budget overruns (Box 7.1), government and hospitals in the Netherlands frequently struggled about their actual magnitude. Hospitals rejected the government's calculation of overspending and filed a lawsuit or threatened to do so to annul the recoup of the assumed budget overrun.

7.3 The effectiveness of health policy

The effectiveness of health policy is defined as the degree to which the policy instruments have contributed to the achievement of the stated policy goals. Health policy

is called successful to the extent these goals have been achieved and a failure to the extent they have not been achieved. Policy success and failure may go together: while some goals have been achieved (or only in part), other goals have not been achieved (or only in part). Whether policy effects are considered a success or failure depends upon political preferences: what one actor sees as a success, another actor may frame as a failure (Chapter 4).

As spelled out in Chapter 1, the history of health policy is a history of success and failure. Some parts of health policy have proven quite successful. The introduction of public financing based on the ability-to-pay principle has considerably contributed to universal access to health care. The eradication of smallpox and other communicable and non-communicable diseases by mass vaccination programs has also proven successful. Social legislation has improved working and living conditions. At the same time, there are plenty of examples of policy failure. Healthcare cost control has been less successful than policymakers hoped and has remained a great concern. Attempts to reduce health disparities have largely failed so far. The success of policy instruments to tackle the problem of overweight and obesity turns pale compared to the relative success of tobacco control instruments.

The measurement of the effectiveness of health policy is a complicated exercise because of uncertainty about what would have happened, had no policy action been undertaken. Another problem concerns the ambiguity of health policy goals. Many goals only indicate the direction of change aimed at. Enhancing the quality of health care is an example of an aspirational goal. Without clearly stated goals, the effectiveness of policy instruments cannot be determined.

Furthermore, policy instruments that work in the short may fail in the longer run. For instance, the effectiveness of cost control in health care has proven only temporary. In this respect, Schwartz (1987) spoke about 'the inevitable failure of current cost-containment strategies' because they have little or no influence on three key factors explaining real expenditure growth: population growth, higher input prices, and technological innovation and diffusion. The results achieved are small and, for the most part, only temporary. Cost control may also be a reason for the postponement

of investments and lead to a cost explosion later to catch up. What also may happen is that interventions lose some effectiveness just because of their effectiveness. The effectiveness of childhood vaccination against measles has made some parents believe that the disease had disappeared and that there was no good reason anymore to vaccinate their children.

Policy success and policy failure

Many policymakers fail to resist the temptation of dealing asymmetrically with policy success and failure. If a policy instrument has proven effective, they claim policy success. That today's success does not guarantee tomorrow's success is not questioned. The situation is different for policy failure. Policy failure is often ascribed to external factors such as misfortune or sabotage. Failure is not the policymaker's fault.

Both policy success and policy failure require an explanation. Why has a policy been a success? Why did an instrument work or not work? To what extent was the success due to favorable circumstances? The causes of policy failure can be manifold. The first cause of failure is that the stated policy goals were unrealistic or only paid lip service. The choice of policy instruments may also rest upon false assumptions. Sometimes, the optimism of policymakers on the effectiveness verges on naiveté. For instance, reliance on self-regulation by the industry to stop the production of products that harm public health has, in many cases, proven naïve. More than two decades of experience with outsourcing and privatization of the production of public goods and services should have policymakers learned that these organization-based instruments may prove less successful than claimed by their advocates (Pollock, 2004; NAO, 2011).

A second explanation of policy failure is implementation failure. Policies are not implemented as intended because of a shortage of staff, lack of expertise, information problems, failing instructions, regulatory inconsistencies, lack of effective central steering, organizational rivalries, or other factors. Implementation failure may also be

due to the policymakers' ignorance, underestimation, or plain disinterest in implementation issues. Political compromises often appear as a source of implementation problems.

The third explanation is compliance failure: the target population (policy subjects) did not respond to policy instruments as expected. For instance, the failure and success of voluntary mass childhood vaccination programs are contingent on the parents' willingness to have their children vaccinated. Other causes of compliance are lack of information and lack of bureaucratic competence. In practice, most implementation and compliance failures ensue from policy failure.

7.4 Side effects

Many policy instruments have unintended side effects (external effects). They can be foreseen or unforeseen and assessed as either positive or negative. Negative side effects or the risk of negative side effects such as precedents is an argument for policymakers to abstain from certain instruments or take measures to minimize their occurrence.

There are many types of side effects. While some are immediately visible, such as the economic and social consequences of lockdowns (for instance, the closure of bars, restaurants, museums, or the ban on sports matches with spectators), others become manifest only in the long run. An example of a side effect that became manifest later is the occurrence of mental problems in the aftermath of COVID-19 (Bourmistrova et al., 2022; RIVM, 2022a). Some side effects are directly visible but taken for granted because of the urgency of other problems. The Netherlands Institute for Public Health and the Environment has calculated that, due to the priority given to COVID-patients, about 305,000 non-urgent operations had been postponed in 2020 and 2021 (about one-sixth of the expected number of operations). The loss of life-years in good health as a consequence of postponed operations was estimated at 320.000 (RIVM, 2022b).

A well-known dilemma in health policymaking is the occurrence of a conflict between collective and individual interests. The announcement of a lockdown served a collective interest (arresting the spread of the coronavirus) but restricted personal

freedom (negative side-effect). Health promotion programs may simultaneously improve public health (intended effect) and enlarge health disparities. The explanation for this unintended side effect is that persons with higher education tend to be more responsive to these programs than persons with lower education.

Some side effects wipe out the intended policy effects. An example is when policy interventions directed at cost control in a specific healthcare sector generate higher costs at a later moment or in another field of health care. This effect is known as the balloon effect or waterbed effect. Co-payments lower healthcare expenditures (intended effect) in the short but may cause higher expenditures later because sick people have abstained from necessary care for financial reasons (Van Esch et al., 2017). The introduction of a co-payment regime for mental care in the Netherlands caused a drop in the demand for mental care (intended effect) and simultaneously an increase in expensive crisis interventions and compulsory admissions (Ravesteijn et al., 2017). The introduction of a co-payment for prescription medicines for hypertension in 1983 in Dutch health care had a double effect: the number of prescriptions per patient dropped by 20 percent in the year of introduction but the number of medicines per prescription increased by 12 percent (Starmans, 1998).

The fill effect is another type of side effect that may cancel out the intended effect. An example is when health professionals start new activities to compensate for the loss of revenues (Klink et al., 2017) or when the tobacco industry responds to tobacco control policies by exploring new markets.

The risk of unintended effects has been a reason to criticize competition in health care from a moral perspective. The commodification of medical care, the argument goes, will invoke value drifting. Money-making will get priority over good treatment. These developments undermine the trust relationship between doctor and patient (Berenson & Cassel, 2009; Pellegrino, 1999). Competition is not a morally-free zone. As Sandel (2012) formulated this problem in his study on the moral limits of markets: 'Putting a price on every human activity erodes certain moral and civic codes worth caring about' (p. 121).

7.5 Counterproductive effects

Sometimes, policy instruments have effects that are opposite to their intended effects. An example of counterproductive effects is an experiment at six daycare centers in Haifa which struggled with the problem that parents were late picking up their children at the end of the day. The solution was sought in imposing a fine on these parents. The disincentive failed to work and had even a counterproductive effect because parents reacted to the fine by doubling the time they arrived late. After the centers had decided to revoke it, the parents' enhanced tardiness persisted (Gneezy & Rustichini, 2000).

Box 7.2 The Mid-Staffordshire NHS Trust disaster in the United Kingdom

Particularly under the Labour government in the 1990s, performance measurement developed as a popular policy instrument to improve the efficiency and quality of health service management. NHS hospitals (or 'Trusts') could qualify for a new type of status – Foundation Trust – which would release them from much top-down control of the Health Department. Many hospitals successfully met the targets set by the government and received the status of NHS Foundation Trust. In some cases, however, the performance measurement program had disastrous consequences.

An example of a disaster was the Mid-Staffordshire NHS Trust (Stafford Hospital). The executive board of this hospital decided to meet the government targets in order to get Foundation Trust status no matter what. The hospital had to reduce its overspending in a short period to meet strict budgetary guidelines. Much of this was achieved by merging clinical units, cutting staff numbers (particularly qualified nurses), and reducing the skills mix in several departments, including the emergency department and surgical wards. These decisions are estimated to have caused between 400 and 1,200 unnecessary deaths in the hospital (i.e. 27-45% higher than could be anticipated) between 2005 and 2008. This finding led to a series of high-profile investigations into the systemic failure of the hospital management team, which had ''*lost sight*'' of its responsibility to provide adequate levels of patient care. Sir Bruce Keogh, Medical Director of the NHS, described the failures as a *"gross and terrible breach of trust"*, but others suggested that the government targets themselves had *"directly impaired safe*

clinical practice, and money and greed for Foundation Trust benefits had taken priority over patients' lives".

Source:www.telegraph.co.uk/telegraphtv/5010153/VIDEO-EMBED-Damning-report-into -Staffordshire-Hospital-care.html

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De Bruijn (2007) has described various dysfunctions of performance measurement. This instrument is used to inform organizations about their performance compared to other organizations and motivate them to (further) improve their performance. Performance measurement can be used to reward well-performers and punish poor-performers. The risk is that the instrument induces organizations to develop strategic adaptive behavior, for instance, by brushing up their performance or giving priority to measured activities while neglecting other ones. Another potential dysfunctional effect is that performance measurement undermines professionality. Each of these effects obfuscates the effectiveness of performance measurement and may lead to disasters and scandals (Box 7.2).

7.6 Distributive effects

Policy effects may differ per group and region. Some groups may benefit more from an instrument than other groups. The enhanced freedom of choice of consumers in Dutch health care after the introduction of the market reform in 2006 illustrates the occurrence of a distributive effect. The new Health Insurance Act allows consumers to switch to another insurer by the end of each calendar year. Insurers are obligated to accept each applicant without restriction. There is evidence that persons in the age category 18-39, persons with higher education, and persons perceiving their health as good have switched relatively more frequently than older persons, persons with low education, and persons perceiving their health as poor (De Jong et al, 2015). This result indicates that the first category has benefitted relatively most from their increased freedom of choice. There is also some evidence that voluntary deductibles elicit adverse selection. Persons with higher previous and future healthcare costs are less likely to choose a €500 deductible. Some groups suffer more from policy instruments than other groups. The impact of a co-payment regime to discourage the

use of unnecessary care is likely to be stronger in low-income groups than in high-income groups. Distributive effects can also occur as a consequence of post-code rationing. A potential effect of decentralization of the provision of health services is that some local governments follow a less strict need assessment procedure than other governments.

7.7 Administrative costs

Nowadays, the attention to the administrative costs of health policy is growing. Contract negotiations with multiple insurers, complex regulations, procurement procedures, activity-based funding models and recurrent revisions of these models, complex accounting procedures, risk reduction, supervision, and the detection of inappropriate care or fraud are frequently mentioned as factors pushing up administrative costs. Unfortunately, the measurement of administrative costs is problematic because they are not only made by typical administrative bodies (e.g. Health Department, regulatory agencies, advisory bodies, or the administrative department of healthcare providers) but also by caregivers at the shop floor who must record their activities, fill in forms, follow instructions, and so on. Administrative costs have a multi-level structure. While some of these costs are visible and easily measurable, others remain obscured (Hagenaars, 2021).

The size of administrative costs is a research topic in international comparative studies. In their comparison of the gap in health administrative spending between the United States and Canada, Himmelstein and his co-authors (2020) conclude that this gap reflects the inefficiencies of the United States' market-based healthcare system. While Canada's administrative costs in 2017 amounted to 551 dollars per capita, insurers and providers in the United States spent more than four and a half times more per capita (2497 dollars). The fraction of administrative costs in US health spending was 34.2% and in Canada only 17%. The prices of medical care in the United States comprise a substantial surcharge to cover their administrative burden. The authors argue that the gap in administrative costs widened between 1999 and 2017. They ascribe this gap to the efficiency of Canada's single-payer system and the inefficiency of the multi-payer system in the United States.

High administrative costs are a source of frustration among caregivers, not only because administrative activities crowd out the time for patient care but also because they perceive many of these activities as of low value. Health professionals in two Dutch academic hospitals and one teaching hospital said to spend 52.3 minutes daily on quality registrations. The average number of quality measures was 91, with 1380 underlying variables. Only 36% of these measures were perceived as useful (Zegers et al., 2021).

7.8 Health system performance

An alternative strategy to investigate health policy effects is to investigate the compound effect of policy instruments on health system performance. Health system performance can be described as the degree to which health systems achieve the stated policy goals. The purpose of performance measurement is 'to monitor, evaluate and communicate the extent to which various aspects of the health system meet key objectives' (Smith et al., 2009). They mention the following list of headings under which these objectives can be summarized: population health, patient-reported outcomes, clinical quality and appropriateness, financial protection, health systems responsiveness, equity of access to health care, and finally, productivity and efficiency (p. 8). Performance measurement is intended to inform health systems as well as health organizations about their performance and how their performance compares to the average or best performance.

Table 7.1 is an example of how health policymaking affects health system performance. The table exhibits how Dutch health policymaking plays out in terms of per capita consumption of health services per level of education and the per capita distribution of the financial burden of health care. The consumption of health services is influenced, among others, by the benefits catalog of statutory health insurance and long-term care legislation, and entitlement criteria. The distribution of the burden of finance results from the complex set of regulations concerning premium setting, social contributions, subsidy instruments, and co-payments. The table demonstrates, not surprisingly, that persons with low education consume on average more health services than persons with high education. Conversely, the burden of finance is highest for persons with high education. The regulation of the burden of finance has

a redistributive effect. This effect is strongest for long-term care. Notice that the distribution of consumption and finance is not only influenced by health insurance legislation but also by various contextual factors, in particular the distribution of health and illness across the population.

Table 7.1 Average healthcare consumption and burden of finance per person and education, Netherlands, year 2011

	Primary school	low	middle	high
Health care				
Consumption (*€1000)	2.1	2.2	1.8	1.7
Finance (*€1000)	1.2	1.4	1.7	2.2
Long-term care				
Consumption (*€1000)	1.1	1.0	0.4	0.4
Finance (*€1000)	0.6	0.8	1.2	1.7
Total				
Consumption (*€1000)	3.2	3.2	2.2	2.0
Finance(*€1000)	1.8	2.2	2.9	4.0
Consumption as percentage of income	40.8	33.7	17.4	10.6
Finance as % income	22.8	23.1	22.7	20.5
Net	18	10.6	-5.3	-9.9

Source: CPB, 2013.

Ranking the performance of health systems

A prominent research strategy in performance measurement is to compare the performance of health systems to find out which system performs best and learn from the best performers. Comparative health system performance research and system ranking has become a new trend in health policy analysis. An example of measuring and ranking the performance of 191 countries was undertaken by the World Health Organization in its report '*World Health 2000*' (WHO, 2000). The researchers used five indicators to measure system performance: health status, health distribution, responsiveness level, responsiveness, and fair financing. The scores on each indicator were based on available statistical data per country and a non-representative internet-based questionnaire among WHO staff and people who had visited the WHO

website. The critical step in the measurement procedure was the construction of a composite index to calculate a performance score per country. The report published two scores: overall health score and overall health system performance score. France scored best in terms of overall system performance and fourth best in overall health performance.

The report has been heavily criticized. The main points of critique were: the choice of indicators, the quality of data used, and the opaque construction of the composite indexes. The performance scores were utterly artificial. In a critical review of the report, Williams (2000) concluded that the report was 'not robust enough to support the flimsy structure that has been created from it. The underlying database is skimpy and of dubious quality (p. 10). He did not believe that the report had any policy-learning potential.

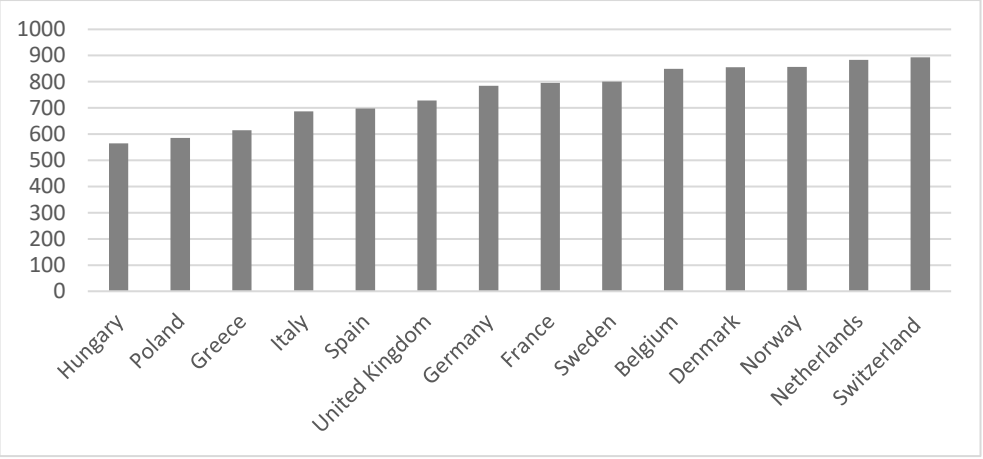
An alternative attempt to construct a league table of health systems is the Euro Health Consumer Index, published by the Health Consumer Powerhouse since 2005. The ranking is based upon six groups of indicators: patient rights and information (10 indicators), accessibility/waiting time (6 indicators), outcomes (9 indicators), range and reach of services (8 indicators), prevention (7 indicators) and pharmaceuticals (6 indicators). There are three possible scores for each indicator: good (three points), so-so (two points), and not-so-good (one point). The relative weight per group of indicators varies from 100 points (pharmaceuticals) to 300 points (outcomes). The maximum score a country can attain is 1000. Figure 7.3 presents the ranking of countries for 2018.

Though the EHCI uses more indicators than the World Health Report 2000, the methodological pitfalls of constructing league tables are similar. The list of indicators is biased toward medical care, and only one indicator explicitly refers to long-term care.

In their critical assessment of using composite indicators to measure the performance of healthcare systems, Goddard and Jacobs (2009) identify serious methodological problems with composite indicators to measure healthcare system

performance. Major problems are the choice of units to assess and organizational objectives to encompass; the choice of indicators (data availability, type of indicators, collinearity between indicators, and combining indicators to create a composite); the transformation of individual indicators (weighting, decision rules to assign scores). They underscore that a single indicator has some advantages because it gives quick insight and probably captures policy attention more quickly than measuring the performance level by many diverse indicators and facilitates communication about performance issues with the public. Nevertheless, a single score remains an oversimplification of the complexity of healthcare systems and possibly masks serious shortcomings in health care. Moreover, a single score is not helpful from the viewpoint of policy learning because it does not inform policymakers of the source of failures and the remedial action required.

Figure 7.3 European Health Consumer Index (EHCI) 2018 total score



Source: Consumer Power House: Euro Health Consumer Index 2018

A final example of a cross-national comparison of healthcare system performance is presented in the report '*Health at a Glance'* published yearly by the Paris-based Organization of Economic Co-operation and Development (OECD). In its reports, the organization abstains from constructing composite indexes to measure system performance. Instead, the report presents a number of 'country dashboards' in which

countries per indicator are classified as better, worse, or in close distance with the OECD average (measured by the standard deviation from the average). The 2017 report presents dashboards on five classes of indicators (table 7.2).

Table 7.2 OECD-dashboards for health system performance measurement

Aspect of health care	Indicators
Health status	Life expectance, life expectancy at 65; ischaemic mortality; prevalence of dementia
Risk factors for health	Smoking, alcohol, obesity, exposure to air pollution
Access to health care	Population coverage; share of out-of-pocket expenditures for health; waiting times for cataract surgery; consultations skipped due to cost
Quality of care	Asthma and COPD hospital admissions; antibiotics prescribed; acute myocardial infarction mortality; colon cancer survival; obstetric trauma
Resources for health care	Healthcare expenditure; doctors per capita; nurses per capita; beds per capita

Health system resilience

An alternative way to investigate health system performance is to focus on health system resilience. Health system resilience has been defined as the 'health system's ability to prepare for, manage (absorb, adapt, and transform) and learn from a sudden and extreme disturbance' (Sagan et al., 2022). The focus here is on the ability of health systems to respond effectively to sudden crises and how health system resilience can be strengthened.

The attention of health policy analysts to health system resilience has strongly increased in the aftermath of the COVID-19 pandemic. In its study of how governments have responded to COVID-19, the European Observatory on Health Systems and Policies has presented a scheme for evaluating the resilience of health systems. Based upon an extensive review of the strategies from Europe and beyond, the Observatory identified twenty key strategies to enhance resilience during COVID-19. Nine strategies relate to leading and governing the COVID-19 response; three

strategies to the financing of COVID-19 services; three strategies to mobilizing and supporting the health workforce; three strategies to strengthening public health interventions; and two strategies to transforming the delivery of health and social care services to address COVID-19 needs (Sagan et al., 2022).

7.9 Political effects

All effects discussed so far fit in an instrumental perspective on health policy. The leading question was: has the policy worked as intended, and is there evidence of unintended effects? The investigation of policy effects should provide knowledge on how to strengthen the problem-solving capacity of health policy and how its potential negative side effects can be averted. These effects must be distinguished from political effects, which relate to the political construction of policy effects and its consequences for policymaking.

The political effects of health policymaking can take on many forms. An example is the impact of the influenza pandemic in 1918 on the rise of fascism in Italy in the early 1920s. Using a multivariate regression model, Galofré-Vilà and his colleagues (2022) found a remarkable correlation between the number of influenza deaths per capita in 1918 and the vote share of the Fascist Party in 2024 in seventy cities. The researchers also presented some historical evidence based on a qualitative archival analysis of the newspaper Il Populo d'Italia from June 1, 1918, until July 31, 1919, to underpin their conclusion. The rise of fascism suggests that voters held the government politically responsible for the dramatic consequences of the pandemic on social and economic life. Note, however, that methodological limitations make the researchers cautious in drawing firm conclusions about the impact of the influence of the pandemic on the rise of fascism. They claim no hard evidence for causation.

In their study '*Deaths of Despair*', Case and Deaton (2019) also suggest a relationship between health and voting behavior. Using observational data, they conclude that 'the fraction of people in an area who voted for Donald Trump in 2016 is also strongly correlated with the fraction in pain' (p. 87). The more people reported pain in an area, the higher the probability that Donald Trump won in that area. For obvious reasons, the correlation is no hard evidence for a causal relationship between pain and voting

behavior. Voting behavior is influenced by many factors. However, the researchers draw attention to the fact that pain correlates with many distressing factors, joblessness, broken families, addiction to pain killers, and little perspective toward a better life. It is despair that influences voting behavior.

Political effects are sometimes closely associated with policy scandals and crises. Examples are the fall of the government, broad media coverage, public outrage, blame games, and legal action (Bovens et al., 2001). An instructive example is the political investigation of the blood scandal in France that occurred in the 1980s and drew much public and media attention. Eventually, the Penal Court investigated whether three former ministers could be held accountable for the scandal (Box 7.3).

Box 7.3 The contaminated blood scandal in France

The death of hundreds of French hemophilia patients after transfusion with HIV-contaminated blood in 1983-1985 has become a political and social scandal of immense proportions. The practice of administering HIV-contaminated blood had continued for a while despite knowledge of the high risk of these blood products for patients. An order of the Department of Health to the blood centers in 1983 including a set of guidelines on questions on sexual behavior and the identification of AIDS-related clinical symptoms had not been implemented either. Professionals in the blood centers had not followed the ministerial order because they considered their donors as safe, perceived the order as unnecessary interference with their work, and argued that screening would cause a shortage of donors (blood collection in risky places like 'red district' urban areas and prisons had been intensified since 1982).

Political and commercial factors contributed to the scandal as well. In reaction to a political campaign on 'national decline' started by the upcoming Front National, the gay association and the socialist government criticized donor screening as 'anti-gay racism' and 'an indiscrete incursion into private life'. The market authorization of an American test to screen blood on HIV contamination was purposely delayed to enable the Pasteur Institute to develop its own test. The French market had to be protected from US competition. The evaluation of the blood scandal led to a fundamental restructuring of the governance structure of blood transfusion centers to reinforce the

position of the Ministry of Health regarding the blood centers. Before the scandal, the sector had captured the Ministry, and public supervision on the centers had been minimal. Another important change was to prioritize public health by taking appropriate precautionary measures in case of uncertain health risks (see chapter 8). The scandal did not remain without political consequences. Four top executives were sentenced to imprisonment. Three former responsible ministers had to stand trial in a penal court but were eventually acquitted of manslaughter. That the scandal was not covered up was also the result of relentless efforts of hemophiliacs and relatives of the victims to have the responsible public authorities put to trial and receive fair compensation. The scandal received wide media coverage. The court's challenge was to give an answer to the complicated question of who could be held accountable for what.

Source: Steffen, 2001.

Political effects are always influenced by the political context. Political opponents may frame policy failures as just another manifestation of the overall incompetence of the incumbent government to resolve public problems.

Policy failures in a polarized political atmosphere are a reason for a political hunt on policymakers and other office-holders who are held personally accountable for what has gone wrong. The political mechanism consists of four elements: (a) policy failures have causes; (b) these causes are traceable to individuals; (c) these individuals must be held accountable for policy failures; (d) they must be punished personally for their failures by resignation or prosecution if their actions were unlawful or exhibited gross neglect of duty (as in the contaminated blood scandal in France). Boin and 'Hart (2009) speak about the rise of an 'inquisition democracy' in which personal attacks and blame games have become the new normal. However, the rise of an Inquisition democracy as new political culture is not without risks. The focus on the accountability of individual persons can undermine a serious investigation of the structural causes of policy failures and, consequently, policy learning. Another risk is the erosion of political trust in the state and public policy.

7.10 Political trust

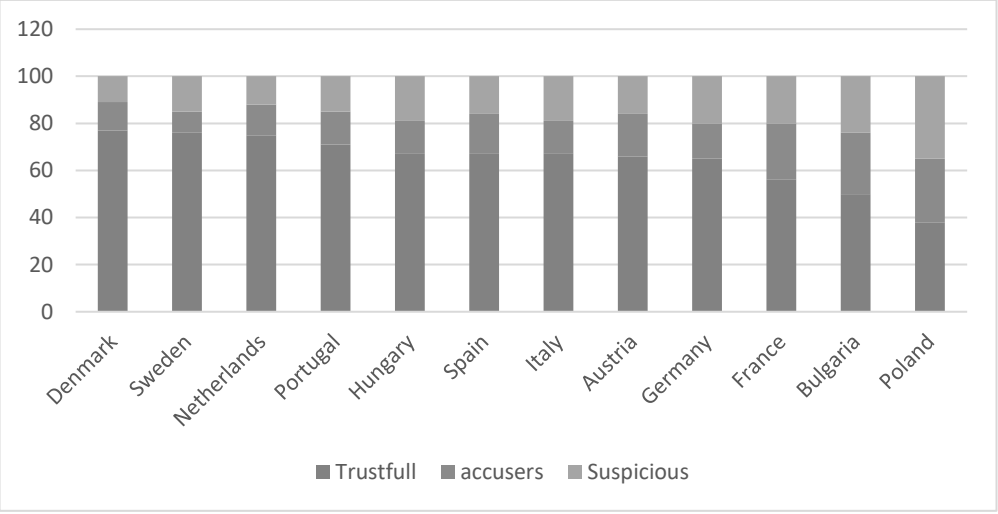
The level of political trust indicates how citizens evaluate the performance of political institutions. Van der Meer (2017) defines the concept as 'citizens' support for political institutions as government and parliament in the face of uncertainty or vulnerability to the actions of these institutions'. He conceptualizes trust as 'a relational concept that links the subject (who trusts) to the object (that is trusted)'. Trust has four elements: '(a) trust in the objects competence to act in the subject's interest; (b) trust that the object is benign to the subject; (c) trust that the commitment of the object can be enforced by the subject or that the object can be otherwise held accountable; (d) an trust that the of the object is predictable.' Van der Meer emphasizes that 'the absence of trust should not simply be equated to the presence of distrust. A crucial middle category is made up by the category of skepticism, the attitude to suspend judgment awaiting additional information. Political cynicism, by contrast, is the attitude that assumes the worst of the nature of political objects (actors, institutions) as reflected in their perceived incompetence and selfishness'.

An interesting question concerns the degree of political trust in the government's policy to manage the coronavirus outbreak. The picture is diverse. A cross-country survey in June 2021 in Europe found that 46% of Europeans were very or fairly satisfied with how their government handled the pandemic; 49% said to be dissatisfied. Satisfaction was highest in Malta (75%), Portugal (75%), and Ireland (68%) and lowest in the Czech Republic (40%), Slovakia (40%), France (36%), and Germany (33%) (Flash Eurobarometer Survey, June 2021). Public support for the UK government's handling of the pandemic showed a persistent gradual decline throughout 2021. The inability to sustain the elevated political trust at the onset of the pandemic had made the management of the pandemic increasingly challenging (Davis et al., 2021).

According to Krastev and Leonard (2021), Europeans were divided over what they believed to be the government's motivations behind restrictions to control the pandemic. They observed a generational divide, with the young more likely to blame governments for the impact of the pandemic than the elderly. They also reported notable cross-country differences in how the population judged the government's

motivations behind its lockdown measures (Figure 7.4). In this respect, they distinguished between the trustful who have faith in government, the suspicious who believe rulers want to cover up their failings, and the accusers who believe that governments seek to increase their control over people. In most countries, the percentage of persons trusting the government's motivations was more than 60%; the lowest percentages were found in France, Bulgaria, and Poland. Conversely, these countries had the highest percentage of suspicious persons.

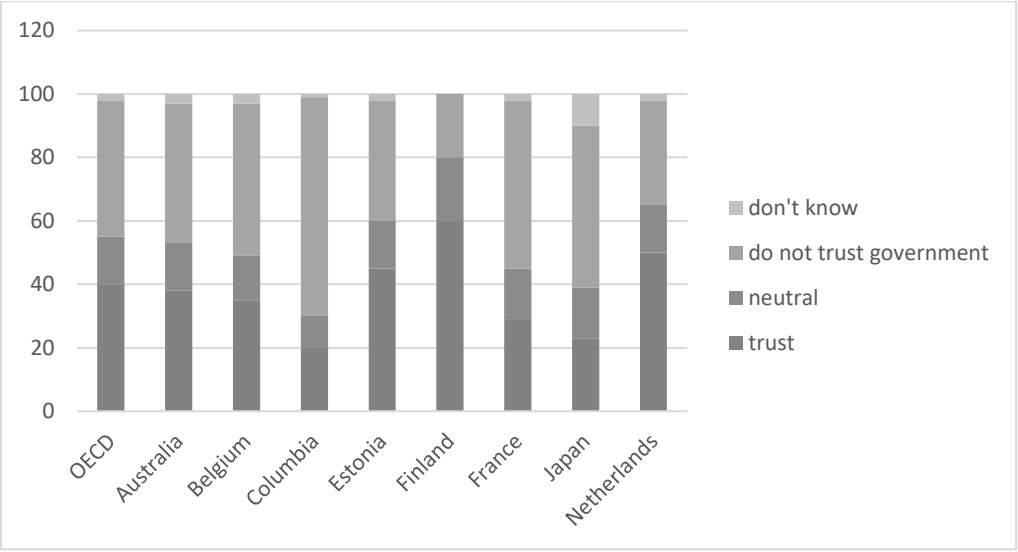
Figure 7.4 Public trust in the government's motivations behind lockdown measures



Empirical research indicates a partisan divide in how people assess the government's policy measures to manage COVID-19. International comparative research found that approval ratings of the government's policy measures correlate to differences in political support and pre-pandemic approval ratings (Chen & Fan, 2022). Likewise, the Pew Research Center found wide differences between supporters of the Republican Party and the Democratic Party in the United States over the threat to public health from the coronavirus outbreak. While 82% of the 'Democrats' considered the outbreak in February 2021 a significant threat, only 41% of the Republicans agreed (Dean et al., 2021).

The (declining) level of political trust in the government's handling of COVID-19 is no isolated phenomenon. It must be understood as part of a broader political development that can be described as declining trust in overall government policy. Figure 7.5 shows an even split between those who trust the government and those who distrust the governance.

Figure 7.5 An even split between those who trust and those who distrust the government



Source: OECD, 2022.

7.11 Conclusion and suggestions for health policy analysis

The investigation of policy effects forms an important part of the task of health policy analysts. The central question is to what extent the goals of state intervention have been achieved or, put differently, to what extent state intervention has been effective. However, the analysis of policy effects should go beyond an analysis of effectiveness and include other effects as well, such as costs, side effects, long-term effects, distributive effects, and counterproductive effects. Knowledge of these 'other' effects may throw a different light on the results. Health policy analysts should also wonder why observed changes are assessed as positive or negative (or a combination of positive and negative). Another issue concerns the assumed causal relationship

between intervention and observed change. How to judge the validity of the assumed causal relationship, and which uncertainties exist in this respect? Which (accidental) contextual factors have influenced the observed results? To what extent are the observed changes an artifact of the measurement model? Answers to these fundamental questions should protect policymakers against false conclusions.

The study of the effectiveness and other effects of policy instruments fits in the instrumentalist approach to health policymaking. Health policymaking consists of interventions directed at achieving a desired situation, but these interventions can also have unexpected and undesired effects. Another category of effects of interest for health policy analysts is political effects. How is state intervention appreciated by policy clients or the population? Health and health policymaking influence people's trust in government and science? What is its impact on voting behavior? Does policy failure have political consequences? Policy analysts must make policymakers aware of the potential political effects of (the absence of) health policy interventions.

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PART 3

MODELS IN HEALTH POLICY ANALYSIS

CHAPTER 8

THE RATIONAL MODEL IN HEALTH POLICY ANALYSIS

KEY POINTS:

- The rational model of health policy analysis underscores the critical role of information in health policymaking.
- In the synoptic model, rational policymaking consists of a number of consecutive steps. Policymakers choose the policy alternative that yields the optimal result, given the best information available.
- The deliberative model underscores the importance of argumentation, interpretation, multiple advocacy, and justification in making rational policy decisions.
- Policymaking involves sense-making, which can be described as inferring information from observations and imbuing information with meaning (interpretation).
- The synoptic version of rational policymaking puts analytical information based upon 'objective' analysis central. In the deliberative version, policymakers tap from multiple sources of information.
- The call for evidence-based policymaking resonates with an optimistic belief in the power of science for resolving policy problems.
- Science-based information has three main functions in health policymaking: an instrumental function, an enlightenment function, and a political function.
- There are several limits to the scientification of health policymaking. Science cannot bridge the gap between 'is' and 'ought' and cannot cope well with the complex structure of many health problems. Another problem is lack of information. Policy-makers may also purposively pass over information.
- A logical gap exists between the 'logic' of science and the 'logic' of policymaking.
- Uncertainty and risk are inherent to all health policymaking. Uncertain risks may involve substantial threats to public health.
- Strategies to deal with uncertain risks are: doing policy research, consultation, reducing complexity, doing by learning, applying the precautionary principle, building a resilient health system, covering up, and risk denial.

Box 8.1 Role of experts in responding to COVID-19

In 2020, the COVID-19 pandemic rapidly spread across the world. Although the origin of the pandemic has never been fully clarified so far, the city of Wuhan in China is assumed to be the most likely place of the outbreak by the end of 2019. In the Netherlands 'patient zero' was confirmed on 27 February 2020. What government and public health experts did not realize at that time was that the coronavirus had already infected many people. On the contrary, many experts believed that the disease would hardly affect the Netherlands and that the Dutch health system was well-prepared for a pandemic outbreak.

From the very beginning of the pandemic, the Dutch government, in the words of the Prime Minister, said to base its strategy on the expert knowledge of the outbreak management team (OMT) consisting of public health experts under the chairmanship of the director of the unit of infectious diseases of the National Institute of Public Health and the Environment. The pandemic had to be countered by evidence-based policy measures. Nevertheless, the Prime Minister also emphasized in his address to the nation on March 16, that the government had to make '100 percent of the decisions with only 50 percent of the information'. Later, he acknowledged that 50% had been an optimistic estimate.

The Dutch experience with COVID-19 was not unique. In many countries, public health experts underestimated the pandemic's magnitude and overestimated their country's preparedness. 'We are prepared for this' said the Director of the Center for Disease Control in the United States. Ministers of Health assured the population that their healthcare system could care for sick people. Laboratory capacity, hospital bed capacity, and the number of IC beds were considered sufficient. Health authorities also bragged about the quality of their contingency plans. They would soon learn, however, that these plans were little more than 'fantasy documents'. The real lesson of COVID-19 was that existing expert paradigms badly failed. They suffered from a 'failure of imagination'

Source: Boin et al., 2021.

8.1 Introduction

In Chapter 3, we have seen that Colebatch (2009) associates policy with order and consistency, expertise, and authority. The strategy of the Dutch government and governments in numerous other countries to manage the pandemic illustrates the reliance on expert knowledge to justify unprecedented decisions. State interventions should not be the outcome of political struggle, ideological convictions, or power conflicts but rest upon the best information available. Rational policymaking requires insight into the effectiveness and efficiency of the policy instruments, potential side effects, financial consequences, practical feasibility, and lawfulness. Health technology assessment must precede decision-making on the benefits catalog of public financing schemes ('package decisions'). The effectiveness and safety of vaccines must be undisputed. Nothing would be more detrimental to public confidence in mass vaccination than fiddling around the effectiveness and safety of vaccines. Policy measures to discourage smoking, ensure food safety, or control healthcare expenditures should have a firm scientific basis, and so on.

The central claim of the rational approach is that health policymaking based on a systematic collection and well-crafted analysis and appraisal of information will yield the best policy results. Information-based health policy is superior to policymaking based on private interests, ideological contests, political games, and power.

This chapter discusses the rational model of health policymaking. The focus is on the role of information and analysis in health policymaking. The chapter starts with an overview and discussion of two alternative models of rational policymaking: the synoptic model and the deliberative model. Though noticeable differences, both models underscore the need for information. Next follows a discussion about the critical role of sense-making in policymaking. Sense-making is defined as the collective process of inferring information from data and imbuing information with meaning. The third theme concerns the fact that policymakers use multiple sources of information. Scientific (research-based) information is only one source of information and in many situations not the most important source. Hereafter follow three sections on the 'scientification' of health policy. What does the scientification of policymaking mean? How can science contribute to policymaking, and what are its

limits in policymaking? The final part of the chapter discusses the problem of uncertainty and risk in health policymaking and describes several strategies policymakers practice to cope with uncertain risks.

8.2 Synoptic model

The synoptic model (Braybrooke & Lindblom, 1963) is a good starting point in discussing rational policymaking. The model focuses on decision-making. Rational decision-making in the synoptic model consists of a number of steps logically following each other. The model assumes a problem that is not further problematized. The first step includes the formulation and ordering of policy goals and the second step an inventory of alternative policy instruments to attain the stated policy goals. Next follows an assessment of the expected effects of these instruments to find out which instruments or combination of instruments will best contribute to the attainment of the stated policy goals. The final step is to choose the instrument or combination of instruments that promises the best result, which is defined as the maximum difference between input (resources) and output (effects). Policy in the synoptic model is the outcome of rational choice.

The synoptic model does not describe how decision-making proceeds in practice but how it should be organized to achieve the best result. It is a prescriptive model for decision-making and assumes a simple relationship between policymaker and policy analyst. While policymakers carry responsibility for ultimate decision-making, the task of policy analysts is to feed them with the best information available.

Elements of the synoptic model are recognizable in how the Dutch government informed the nation about its policy measures to fight the pandemic. The government said to base its interventions upon the expert knowledge of the OMT. In turn, the OMT declared to base its policy recommendations upon the latest scientific insights and a complex quantitative disease model fed with the most recent updates on the spread and infection rate of the coronavirus. However, the OMT always asked explicit attention to uncertainty. The course of the pandemic, its impact on the healthcare system, the effects of policy measures, and particularly the effects of distinct policy measures (e.g. the extra effect of the curfew) could not be precisely forecasted.

Estimates were surrounded by confidence intervals. Furthermore, the OMT concentrated on the epidemiological dimensions of the pandemic and its consequences for population health and the healthcare system. The social-economic consequences, the consequences for mental health and patients on the waiting list due to lack of capacity, to mention only a few examples, were largely left out of consideration. Thus, the scope of expert information the government said to rely upon was limited.

In their seminal study '*A Strategy of Decision',* Braybrooke and Lindblom discuss several reasons why the synoptic model has little prescriptive value for decision-making. First, the model assumes a given problem. This assumption ignores the multidimensional and unstructured nature of public policy problems. What is called the problem often consists of a cluster of interlocked problems with interdependent solutions and multiple dimensions. In other words: 'the formulation of a wicked problem is *the* problem' (Rittel & Webber 1973: p. 161).

Second, Braybrooke & Lindblom refute the assumption of consensus on clearly defined and well-ordered policy goals. This assumption obscures the role of value pluralism and judgment pluralism in policymaking (chapter 9) and repudiates the multiplicity and ambiguity of policy goals. Even if policymakers say to agree on policy goals, they may nevertheless interpret these goals differently or set different priorities. The operationalization of abstract goals into concrete goals and activities is also frequently controversial. Besides, what is important today may be less important tomorrow. Weighing the costs and benefits using a well-defined and commonly accepted evaluative method is illusionary in public policymaking, despite the optimism on the merits of cost-benefit analysis.

Third, the synoptic model assumes a clear dividing line between facts and values. Facts belong to the sphere of activity of policy analysts, while policymakers are responsible for value judgments. However, a clear-cut dividing line between facts and values does not exist. Values and 'facts' may intersect each other in each stage of the policymaking process (chapter 9). The more policymakers lean on the input of policy experts, the greater the risk of a technocratic style of policymaking.

Fourth, the model reduces policymaking to a purely analytical and information-based activity to find the best or 'optimal' solution for a given policy problem. It assumes (near) complete information on policy instruments and their effects. However, even near complete information does not exist. Uncertainty is inherent to all policymaking and always confronts policymakers with the problem of how to cope with it. According to Nobel Prize winner Simon (1997), the synoptic model disregards the 'bounded rationality' of man. Policymakers are unable to collect complete information. Neither can they deal with complete information because of cognitive limitations. Moreover, the collection of information is costly. In urgent situations, policymakers also miss the time to figure out which policy alternative will work best. They are expected to act immediately. For the most part, policymaking evolves as a process of trial and error or, in the terminology of Braybrooke and Lindblom, as a process of serial and remedial action.

Fifth, information is a potential source of confusion because of inconclusiveness and contradictions. Informational abundance has a similar effect. In practice, much of the struggle in policymaking concentrates on the validity and reliability of information and how information should be given meaning (section 8.3).

Sixth, the synoptic model of rational decision-making ignores the impact of interest conflicts, power relations, and the disjointed governance structure of public policymaking. Actually, the model assumes a neatly structured hierarchy for policy-making and features 'a deep-seated suspicion of 'politics'' (Hajer & Wagenaar, 2003: p. 18).

Finally, the model assumes broad public trust in policymaking based on the best information possible. This assumption is problematic in the context of the declining level of public trust in public authorities and science-based policymaking. Rational policymaking does not guarantee public trust and legitimacy.

Despite these critical observations, many textbooks on policy analysis take the synoptic model as an analytical point of departure. For instance, policymaking should begin with investigating the scope and structure of policy problems to arrive at a

common formulation of the problem, the policy goals, and the priority order. Policymaking also requires a systematic investigation of policy alternatives and their potential effects. Policy analysts have an extensive toolbox of methods and instruments for this task at their disposal. Examples are operations research, cost-benefit analysis, cost-effectiveness analysis, risk analysis, policy impact analysis, budget impact analysis, forecasting, disease modeling, simulations, strengths weaknesses estimates, opportunities/threats estimates, etc. The ideal of the synoptic model also resonates with the call for evidence-based health policymaking.

Braybrooke and Lindblom not only refute the prescriptive value of the synoptic model. They also observe a considerable gap between the synoptic ideal and the daily practice of decision-making. They describe policymaking as a process of 'muddling through' in which the challenge for policymakers is more on reaching an agreement through a process of mutual adjustment than on making rational means-ends choices. In practice, a great deal of policymaking consists of reacting to the moves of other actors (Lindblom, 1959).

Majone (who prefers the term decisionist model) criticizes the synoptic model for its exclusive focus on decision-making. Sometimes, prudent policymaking requires the postponement of decision-making, because the time is not yet ready for decision-making and the consequences of premature decisions can do more bad than good. A wait-and-see strategy can be preferable to respond adequately to unexpected developments. Furthermore, he criticizes the exclusive preoccupation of rational decision-making with outcomes and the neglect of the structure of the decision-making process. The acceptance of a policy not only depends on its outcomes but also on the organization of decision-making. Rational decision-making requires both output legitimacy (does it work?) and procedural legitimacy (is the organization of decision-making accepted as legitimate?). In fact, the decisionist model assumes a hierarchy-like organization of the decision-making process the outcomes of which are not questioned because they are assumed to be 'optimal'. It is a top-down model of decision-making that leaves little or no room for bottom-up contributions (Majone, 1989).

8.3 Deliberative model

The deliberative model draws upon the insight that 'policy analysis is more than data analysis or a modeling exercise: it also provides standards of argument and an intellectual structure for public discourse' (Majone 1989: p. 7). The model underscores the crucial role of argumentation, interpretation, multiple advocacy, and justification in policymaking. Policy analysts play a supportive role in this process, but their role is not confined to feeding policymakers with information based upon abstract models and, preferably, quantitative analysis. Instead, their task is to support policymakers as 'producer of arguments' (p.23). Argumentation differs from formal demonstration. The formal demonstration that instrument X will produce effect Y or that Y will happen if no action is undertaken is insufficient to persuade. Policymakers need arguments to convince others in the health policy arena. The challenge of policy analysts is to provide policymakers with good arguments based on a critical analysis of policy assumptions, dilemmas, uncertainties, risks, longer-term consequences, and contextual factors.

The critical role of argumentation in the deliberative model follows from the insight that policymaking takes place in an arena with multiple values, multiple views, multiple interests, multiple dilemmas, and multiple uncertainties (Hajer & Wagenaar 2003). There is no such thing as a 'single truth'. Understanding the multi-faceted and interlocked structure and dynamics of public problems requires input from multiple sources. Deliberation requires an open debate on problems and solutions with room for alternative voices. Articulation and exchange of arguments are critical for arriving at reasonable decisions and an effective antidote to 'policy myopia'. Arguments instead of power and vested interests should ultimately be decisive. Besides, argumentation is an effective strategy to question institutionalized belief systems and develop new ideas for policymaking.

The deliberative model underscores the critical role of information in policymaking. Policymaking without information or ignoring relevant information is a ticket to misery. However, the model postulates that information is not discovered but

manufactured and that information must be interpreted to be meaningful for policy-making. Deliberation requires a critical inspection of information and how it is given meaning (see next section).

Furthermore, the model assumes a pluralist or democratic organization of the policymaking process. Nothing is more useful in policymaking than an exchange of information and viewpoints from different perspectives. According to Majone, multiple advocacy contributes to the legitimacy of policy decisions.

The deliberative model stresses the normative dimension of policymaking. Majone speaks in this respect about the critical role of norm-setting and norm-using in policymaking. Policymaking cannot be reduced to a mere 'information process'. Rationality should 'not be defined in instrumental terms, but as the ability to provide acceptable reasons for one's choices and actions' (p. 23). Policy analysts and policy-makers must explain which moral judgments have directed their problem formulation and policy choices. Policymaking involves a complex balancing act between alternative normative viewpoints and criteria.

Finally, Majone distinguishes between the processes of discovery and justification. Discovery is concerned with how policy decisions have been reached, while justification includes persuading people of the necessity and reasonability of these decisions. Policymaking is not only a matter of well-reasoned decisions but also a matter of building public trust and using appealing symbols. Policies must be legitimized to be accepted. They require a convincing narrative.

Majone presents his deliberative model of policymaking as an alternative to the information-driven and 'technocratic' synoptic model. A critical aspect of the deliberative model is the assumption of an open mind. Policymakers and the wider public must be willing to listen to each other and receptive to alternative views. However, the open-mindedness may not exist in the daily practice of health policymaking. The model does not work in a polarized atmosphere. The deliberative model also assumes enough time for decision-making which is not available in times of an acute crisis.

The pragmatist turn in policymaking

In their plea for a revision of the science-policy relationship in times of crisis and the need for a pragmatist turn in policymaking, Greenhalgh and Engebretsen (2022) also reason from the premises of the deliberative model. They argue that the following tendencies characterized the management of COVID-19 by the UK government at several occasions:

- Scientism: excessive reliance on science to produce solutions.
- Reductionism: Conversion of complex problems into simple ones.
- Abstraction: neglect of context and a strong focus on generalizability.
- Linearity: knowledge should precede action.
- Scientific elitism: policymakers rely on an 'inside track' of trusted advisers.
- Exclusionary epistemology: only a limited range of scientific methods and moral views are acceptable for policymaking.
- Polarization: the tendency for scientists to separate in 'camps' rather than engage in dialogue.

The pragmatist turn they argue for rejects each of these tendencies and calls for less exclusive reliance on science, for embracing complexity (anti-reductionism), for attention to the contextual factors (anti-abstraction), for acting judiciously under uncertainty instead of waiting for hard evidence (anti-linearity), for multiple advocacy (anti-scientific elitism), and for epistemological pluralism and dialogue instead of polarization. Furthermore, the pragmatist turn emphasizes the need for social interactionism in policymaking. Policymakers must understand what facts and interventions mean for people and factor these meanings into their policy decisions and communication on these decisions.

Role of citizen forums in deliberative decision-making

The citizen forum is a relatively new instrument for organizing deliberative policy-making. A forum (alternative terms are council, assembly, and panel) consists of a limited number of individuals forming together a cross-section of the population. Selection of the forum members takes place through a (stratified) lottery. The forum discusses complex problems in a limited number of sessions and formulates policy recommendations to the policymakers in charge. Members are fed with all

information they need. A precondition is that each member has an open mind for information, is prepared to listen and change opinion based on good arguments. Thus, deliberation of arguments instead of the mere exchange of arguments.

Citizen forums are complementary to representative democracy. They are intended as an instrument to resolve some structural deficiencies in the representative democracy model, such as an overrepresentation of persons with high education in representative bodies, the impact of lobbyists on public policymaking, power-driven party politics, short-term horizon decision-making, and 'phantom' citizen participation. Citizen forums give ordinary citizens a role in public policymaking which should help to restore public confidence in public policymaking. A critical aspect of forums is how policymakers deal with their recommendations. They have no feature if policymakers put their recommendations aside.

There are several examples of citizen forums in health policymaking (Box 8.2). The United Kingdom Citizens Council consisting of a representative group of 30 people regularly provides the National Institute for Health and Care Excellence with a public perspective on overarching moral and ethical issues that the Institute needs to consider. A citizen forum in the Netherlands discussed acceptable criteria for decision-making on the composition of the benefits catalog of statutory health insurance. The forum identified sixteen acceptable criteria for making 'package decisions' two of which related to the disease (e.g. medical necessity), eleven to the characteristics of the treatment (e.g. effectiveness, availability of alternative treatments, and costs), and three to the person (e.g. age and lifestyle). It did not reach a consensus on the operationalization and the relative weight of these criteria in concrete situations (Bijlmakers et al., 2020).

Box 8.2 How a citizen forum changed Ireland's abortion policy

A noticeable demonstration of the impact of a citizen forum on health policymaking is the change in Ireland's abortion legislation. The Irish Constitution traditionally contained a strict legal ban on abortion. Abortion was even prohibited for women who had been raped or whose health was at risk due to pregnancy. Public calls for legalizing abortion under strict conditions had no chance in the Irish parliament. To break the political deadlock on abortion, the Irish Prime Minister decided in 2015 to organize a Citizen's Assembly of 100 persons to discuss the abortion problem and formulate policy recommendations. After six weekends of deliberation, the major part (>90%) of the Assembly recommended permitting abortion under strict conditions; 64% of the members even voted for a substantial liberation of abortion, a result nobody had expected. The Irish government ultimately accepted the recommendations and organized a referendum because the ban on abortion was constitutionalized. After a majority of the population had voted for liberalization, the government has made abortion legally possible during the first twelve weeks of pregnancy, and later in cases where the pregnant woman's life or health is at risk or in the case of a fatal fetal abnormality

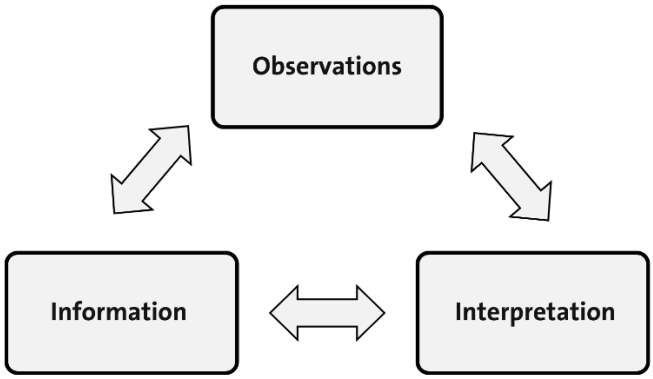
Source: Rovers, 2022.

8.4 The observation-information-interpretation relationship

Central in the rational model is the emphasis on the role of information in policymaking. Policy decisions should rest on the best information available to disentangle the complex structure of public policy problems and investigate the effects of alternative policy interventions, including the (administrative) costs and the feasibility of these interventions. Information is a precondition for rational decision-making and avoiding mistakes. But what is information, and how is information made meaningful for policymaking? To answer these questions, an analytic distinction must be made between observations, information, and interpretation (Figure 8.1).

The first step in the model is the conversion of observations (data) into information. The second step involves the conversion of information into policy-relevant information. The interpretation of information is the third step. Each step assumes a conceptual model that directs the collection of the observations, the inference of information from observations, and the interpretation of information. Interpretation requires a normative framework to judge information. The relationship between observations, information, and interpretation is reciprocal: observations are the raw material for information and information asks for an interpretation. At the same time, however, the need for information directs the collection of observations. Likewise, the interpretative framework directs the collection of observations and the conversion of observations into information.

Figure 8.1The observation-information-interpretation triangle



The observation-information relationship

The inference of information from observations assumes a conceptual model or conceptual filter to 'steer' the collection of observations. An illustration is the measurement of a nation's level of healthcare expenditures. How much a country spends on health care is contingent on the definition of healthcare expenditures as well as the reliability and completeness of the observations. Which expenditures are counted as healthcare expenditures, and which are not taken into account? A single answer to this question does not exist. There is much variation in how countries

calculate their healthcare expenditures. The definition of healthcare expenditures influences information on healthcare expenditures. To make reliable international comparisons of healthcare expenditures possible, the Organization of Economic Coordination and Development (OECD) has developed the System of Health Accounts to determine which expenditures must be recorded as healthcare expenditures and which expenditures must be left out of consideration. The OECD definition produces a different picture of healthcare expenditures than national accounts (Box 8.3).

Box 8.3 How much does the Netherlands spend on health care?

According to the National Statistical Office (CBS), the Netherlands spent €100,9 billion on health care in 2018, however following the international definition of the OECD €77,2 billion. The explanation for these sizeable differences is that the National Statistical Office uses a definition of healthcare expenses that is much broader than the definition used by the OECD. Contrary to the CBS figure, the OECD figure only includes a restricted fraction of expenditures for elderly care, long-term mental health care, and care for people with a handicap. The CBS figure also comprises various social welfare expenses that are left out in the international definition of healthcare expenditures.

There are countless examples of how the underlying conceptual model influences information. A simple answer to at first sight simple questions such as how many hospital beds or IC units a country has or how long patients must wait for medical treatment does not exist. The path from observations to information is paved with methodological obstacles, even more so if the information is gathered on abstract concepts such as quality of care, primary care, long-term care, accessibility of health care, quality of life, or health and sickness. Information is critically contingent on the operationalization of these concepts, the completeness and reliability of the observations, the validity of the underlying causal model to estimate future trends or policy effects, the selected time span, the research methods, and the baseline period. The important lesson is that information or 'facts' is actually manufactured or constructed knowledge: information is not discovered but inferred from observations based on an explicit or implicit conceptual model. An alternative model may produce

other information. A great of policy discussions and political contests concentrates on the validity of the conceptual model.

The information-interpretation relationship

Suppose a country spends 10 percent of its Gross Domestic Product (GDP) on health care. What does this percentage mean? Is 10 percent a problem? The answer to this question depends on the interpretative framework for giving meaning to this percentage. Whether 10 percent is considered a problem depends upon the normative framework used. The country's level of healthcare expenditure is only meaningful information for policymaking if it is considered problematic. Policy problems are social or political constructs (chapter 3). Information does not derive its meaning from its intrinsic qualities but from the meaning given to it. Where optimists speak about a glass half-full, pessimists talk about a glass half-empty. Interpretation also involves the contextualization of information. Finally, interpretations are not cast in concrete; they can be revised later.

Interpretation is also indispensable with regard to uncertainty. Uncertainty is inherent to all policymaking and policymakers must somehow deal with it. They can follow various strategies to reduce uncertainty but the problem cannot be completely resolved by collecting extra information. As a consequence, policymakers must fall back on interpretation to fill 'information holes'. Finally, interpretation is critical in filtering information. Which information is considered relevant for policymaking? Who is believed and what is taken as true and relevant?

The process of inferring information from data and imbuing this information with meaning is called sense-making. Cognitively, sense-making takes place in the brains of the individual but it is foremost a collective process influenced by numerous factors, including institutionalized belief systems, political considerations, power relations, the group individuals belong to, standard operating procedures, domain conflicts, and the structure of the governance system (Douglas, 1986; Boin et al., 2021). Sense-making is closely related to political communication and public imaging (McNair, 2003). What sense does the population make of policy decisions? Facts only are not enough. Policymakers must convince the people by a credible interpretation

of what is going on and what they want to achieve. The critical role of public imaging cannot be underestimated.

The concept of sense-making highlights an important difference between the synoptic and deliberative model of health policymaking. The synoptic model ignores the critical role of sense-making in policymaking. Information has an instrumental function in policymaking that is used to select the optimal mix of policy instruments to achieve the stated policy goals. For its part, the deliberative model of policymaking makes sense-making a central part of rational policymaking. Rational policymaking requires a critical stance on information and interpretation.

The distinction between observations, information, and interpretation has implications for health policy analysts. A crucial aspect of their task is critically investigating the inference of information from observations and the conversion of information into policy problems (interpretation). Such an investigation requires detailed policy-issue knowledge.

8.5 Sources and utilization of information

Policymakers can tap into multiple sources of information for policymakers. Which information resources are available to them and how they use it?

Sources of information

A distinction can be made between the following sources of information:

- Policy-oriented research

  Policy-oriented research aims to collect information about policy problems, future developments, the effectiveness of policy instruments, potential policy risks, public opinion and public confidence, and so forth. Sector policy analysts have an extensive toolbox of instruments at their disposal for quantitative and qualitative policy-oriented research.

- Evidence-based information (science-based information)

There exists no sharp dividing line between evidence-based information and information collected by policy-oriented research. Evidence-based information has to meet stricter methodological standards than policy-oriented research and is based upon theoretical hypotheses subjected to (rigorous) empirical testing. Most policy-oriented research is descriptive and case-oriented.

- Expert information

Sector-bound specialists and advisory bodies are an important source of information for policymakers to gather expert information on judicial, economic, organizational, international, social, technical, and other relevant aspects of alternative policies. Nowadays, health policymaking is unthinkable without a well-developed intelligence system or knowledge infrastructure to inform policymakers (box 4.3).

- Statistical information

Statistical information has become an indispensable instrument for policymaking. Policymakers need statistical data to substantiate their plans. Plans based on quantitative data are considered superior to plans based on qualitative information only.

- Experience-based information

Experience is another important source of information for policymakers. Past experience contains valuable lessons for what works or will fail.

- Colleague information

Contacts with domestic or foreign colleagues about their experiences in health policymaking may open information that otherwise may not be accessible. Particularly, information about crucial details easily is of great value in this respect.

- Political information

Political information concerns the political context of policymaking. Important issues are the level of political support and public confidence, the identification of potential partners and adversaries, an estimation of their

strategies, and information about how partners and adversaries could be involved in the policymaking process.

- Information provided by advocacy organizations

Advocacy organizations can provide policymakers with valuable information about their policy preferences, policy alternatives, policy effects, and policy risks and give insight into the level of support for policy plans.

- Media information

Policymakers read newspapers, watch TV and strip social media to find out what is happening in society and learn about public opinion and emotions. Occasionally, media information immediately influences the political agenda.

- Information based upon trial and error (policy learning)

Finally, policymakers learn by trial and error. For this reason, policymaking should not be designed as a 'one-shot' operation but rather as a process of adaptation to changing conditions and new information.

Utilization of information

If policymakers can tap into multiple sources of information, the question arises which sources of information they use in practice. The synoptic version of the rational model of policymaking puts the utilization of analytical information derived from policy-oriented research, scientific insights, expert information, and statistical sources central. Information from these sources is assumed to be superior to 'subjective' information from other sources. Rational policymaking rests on 'objective' information. The task of policy analysts is to feed policymakers with this kind of information. The rational approach radiates great confidence in the problem-solving power of what is assumed to be objective information.

The deliberative version of rational policymaking follows a different approach. All information considered relevant for policymaking should be given attention, irrespective of the source where it comes from. Creating room for counter-argumentation can protect policymakers from making errors. Detailed information of concerned citizens on how policy measures will play out in practice is as important as

information derived from modeling. Ignoring political information is asking for difficulties.

What about the policymakers' use of information? Which information are they most interested in? We confine ourselves to a few general observations. The first observation is self-evident: the use of information is contingent upon the type of information needed. If policymakers need legal advice, they will consult legal experts; if they need epidemiological advice, they will consult epidemiological experts, and so on. The problem formulation plays a directive role in this respect. It is no coincidence that policymakers based their policy decisions on COVID-19 almost exclusively on epidemiological and biomedical information provided by a select group of experts (Lohse & Canali, 2021). Second, policymakers do, in most situations, not rely upon a single source of information. Instead, they tap information from multiple sources. In this respect, it is noteworthy that they use a broad definition of evidence. Evidence is for policymakers every piece of information they hold for true and relevant. Science-based evidence competes with other kinds of information and is, in many situations, not the most important source of information to them (Lomas & Brown, 2009). Third, it should be noted that the use of information is always selective. Institutionalized beliefs, political considerations, obstructed communication channels, time pressure, power relations and experience, personal preferences, professional background, and lobbying influence information filtering. Sometimes, policymakers even seclude themselves from information to preserve internal unity. This social-psychological process is known as groupthink (Box 8.4). The fourth observation concerns the prominent role of quantitative information: unless they need specific qualitative information, policymakers tend to prefer quantitative rather to qualitative information. A few insightful statistics often count more than qualitative analyses. The fifth critical factor is the credibility and source of information. Influence requires that information-givers (experts) have acquired a trust position and developed good contacts with relevant policymakers.

Box 8.4 Groupthink

Groupthink has been described as 'an excessive form of concurrence-seeking among members of high prestige, tightly knit policymaking groups' (Janis & 't Hart 1991: p. 247). Information from outsiders that does not fit in the group's convictions is put aside. Groupthink may cause a 'tunnel view'. A strategy to counteract the risk of groupthink is to extend the group of experts with new members with different professional backgrounds or to replace its members regularly. Groupthink may occur in the inner circle of policymaking and in advisory bodies.

The implicit assumption is that policymakers are interested in information. Understanding the importance of being well-informed, they will do their best to acquire information. It is an open question whether this is always the case. An abundance of information can be confusing. Collection of information may take much time, cost a lot of money, and not lead to better insights. Policymakers may also feel it necessary to act at short notice. Writing about public policymaking, Keynes once observed in a frank mood that 'there is nothing a government hates more than to be well-informed; for it makes the process of arriving at decisions much more complicated and difficult' (Skidelsky, 1992).

Sometimes, policymakers even show disrespect for information. An example is President Trump's way of acting during the COVID-19 pandemic. On several occasions, he blatantly disregarded the information of respected American public health experts on the magnitude and risks of the coronavirus for public health. He even deliberately misled the population by telling his audience that hydroxycholoquine was a simple medicine to cure or prevent an infection of the coronavirus without any conclusive evidence for its effectiveness. Even worse, scientists warned of cardiac toxicity and other harmful effects (Christakis, 2021).

8.6 Evidence-based health policymaking

Nowadays, there is a call for evidence-based policymaking in public policymaking. Evidence-based policymaking 'helps people make well-informed decisions about policies, programs and projects by putting the best available evidence at the heart of policy development and implementation' (Davies et al 2000; p. 3). Its advocates claim that policymaking based upon scientific evidence will yield better policy results than policymaking without science input. The 'scientification' of policymaking is viewed as a precondition for rational policymaking and an effective antidote to policy pitfalls.

Confusion exists on what the term evidence-based means. Most advocates of evidence-based policymaking hold the opinion that the term evidence should not be restricted to science-based or research-based information. They choose a broader interpretation of evidence. For instance, Davies and his colleagues reserve an explicit place for other kinds of evidence than science-based evidence by defining evidence-based policymaking as 'the integration of experience, judgment and expertise with the best available external evidence from systematic research' (Davies et al., 2000; p. 13). This view on the role of evidence in decision-making corresponds with Sackett's definition of evidence-based medicine as 'the integration of the best research evidence available with clinical expertise and patients' values' (Sackett et al., 2000: p.1). Evidence based on randomized-controlled trials (RCT) is not the only type of accepted evidence. Some authors prefer a broad definition of evidence-based policymaking. For instance, evidence-based policymaking is described as the process of integrating evidence-based interventions with community preferences to improve the health of the population (Kohatsu et al., 2004; Brownson et al., 2009).

Though the broad interpretation of the concept of evidence-based policymaking makes sense, it also obscures the distinction between evidence-based and not-evidence-based. Where to draw the line? This is not a purely theoretical issue because, as discussed in the previous section, policymakers use a very broad definition of evidence. They interpret all information they consider valid and relevant as evidence that must be factored into decision-making. Whether this information is evidence-based in the meaning of science-based or research-based is irrelevant in this respect.

The concept of evidence-based policymaking should not be misunderstood. It does not mean that policymakers must do what experts advise them to do. Advocates of evidence-based policymaking underscore that policymaking can never be completely evidence-based. Policymakers remain in charge of making policy decisions and always carry responsibility for their decisions. However, they should base these decisions as much as possible on evidence-based information.

In some areas of public health, evidence-based policymaking has a long history. For instance, public vaccination programs to protect the population against various diseases, including measles, mumps, and rubella (MMR), had a scientific basis. There is evidence that these programs have saved many lives. In his analysis of the effectiveness of the national vaccination program in the Netherlands, Van Wijhe (2018) estimated that mass vaccination campaigns had averted between six and twelve thousand deaths among those born between 1953 and 1992 and had reduced the number of reported disease cases, ranging from 50% for rubella to 90% for polio. The containment of COVID-19 by mass vaccination programs would not have been possible without the input from science.

The advance of health technology assessment in 'package decisions' is another manifestation of the role of evidence-based information in health policy. Rigorous research meeting the highest scientific standards is required to test the safety and (cost-)effectiveness of medical interventions. The need for evidence-based policymaking is also voiced in other areas of health policymaking. For instance, systematic empirical research into the effects of cost control policies should give insight into what works or does not work. Furthermore, evidence-based information on health risks has gained importance. Failing risk assessments can lead to expensive claims for compensation. Risk aversion and the ongoing juridification of relationships in modern society require evidence-based regulation to minimize health risks.

The concept of evidence-based health policy resonates with an optimistic belief in the power of science to contribute to health policymaking. However, this optimism is not undisputed because science mostly gives fewer answers than expected or hoped for. For this reason, some authors find it more appropriate to speak about 'opinion-based'

policymaking (Segone & Prone, 2004) or 'evidence-informed policymaking (Bowen & Zwi, 2006). There are also outright critical voices about the relevance of evidence in policymaking. Klein (2003) considers the concept of evidence-based health policymaking 'a Delphic oracle difficult to decipher and apt to be misinterpreted'. He considers health policymaking a process of trial and error and holds the assumption of a linear road from evidence to policymaking for 'woefully inadequate' (p. 429). Klein does not deny that science can contribute to policymaking, but the scientific community should give up the 'delusional vanity' of evidence-based policymaking. Rigorous and fast evaluations to learn from previous policies work better. History itself constitutes an important source of valuable information for policymakers.

Meanwhile, the call for evidence-based information in policymaking is not without risks. For instance, in her study of the role of evidence in the formulation of the European regulation on the provision of food information to consumers, Passarani (2019) observed that it had been easier to quantify the costs of food information for the industry and the retail sector than the benefits of food information to the public. Because policymakers were inclined to take quantitative evidence as more convincing than qualitative information, the public health community was disadvantaged. Likewise, Ter Meulen has warned of some potential ethical risks of evidence-based medicine. Declaring randomized-clinical trials (RCT) the 'golden standard' for evidence may exclude other kinds of research, such as observational research and qualitative studies, for building evidence with the result that treatments that are not suitable for a RCT have fewer chances to become reimbursable in health insurance. Patients are the ultimate victims of an exaggerated reliance on RCT in health policy (Ter Meulen et al., 2005). Finally, it should be kept in mind that scientific consensus can consign collegial critics to the margins and ultimately even result in ex-communication. Did not all scientists before Copernicus believe that the Earth was the center of the universe?

8.7 Contributions of evidence-based information to health policymaking

According to Weiss (1979), evidence-based information (Weiss uses the term research-based information) can have an instrumental, enlightenment function and political function in policymaking.

The instrumental function refers to the practical application of evidence-based information in policymaking. Information has an instrumental role if policymakers collect information for problem-solving. For instance, they need information on the size and structure of policy problems or information on the potential effects and risks of alternative interventions. The instrumental function of evidence-based information also captures the application of basic scientific research in policymaking. New knowledge derived from basic research finds its way into practice. Weiss emphasizes that the findings of basic research in natural science are usually more compelling and authoritative than the findings of social research.

Secondly, evidence-based information can have an enlightenment function. Here, science is a source of new concepts and theoretical perspectives permeating the policymaking process. Science connects information in a causation model that gives insight into the relationships between observations. Nothing is as practical as a good theory. Several paradigmatic shifts in health policymaking root in research. For instance, the emphasis upon health protection and health promotion draws upon research into the impact of external factors on health and disease. Research on the origins and spreading of cholera shed new light on how cholera outbreaks could be prevented.

Finally, evidence-based information can serve political goals. For instance, policymakers ask for more research to delay action or justify inaction, arguing that prudent policymaking requires more information. Another example is to create confusion. The tobacco industry has followed this strategy by spending large amounts of financial resources on research projects, the only purpose of which was to cast doubt on the relationship between smoking and lung cancer (Oreskes & Conway, 2011). Sometimes, policymakers refer to evidence-based information to

legitimize their policy decisions. When the Dutch Prime Minister said that the government heavily relied upon the policy recommendations of the Outbreak Management Team on how to respond to the COVID-19 pandemic, he used the latest available epidemiological information as legitimation for the government's radical decisions to fight the pandemic.

8.8 Limits to the scientification of policymaking

There are several reasons for not overestimating the role of evidence-based evidence in health policymaking. First, all public policymaking is essentially a value-based activity to achieve something desirable. Science can support policymakers in accomplishing this task but cannot bridge the gap between 'what is' or 'what works' on the one hand and 'what ought to be' on the other hand. There is no definite scientific evidence for arguing that healthcare financing should rest upon the principles of solidarity: the choice for or against income solidarity is a political choice! Policymaking is a 'trans-scientific' activity (Majone, 1989). This is even true for the resolution of seemingly technical problems. For instance, scientists can inform policymakers on the toxicity of chemical products but cannot determine which level of toxicity is tolerable from a public health perspective. Setting standards is ultimately a value-bound activity requiring a political decision.

A second reason is that health policymaking cannot be reduced to an information-based process. According to Cairney (2016), the call for science-based policymaking ignores the dynamics of the policymaking process. Ideological convictions, material and immaterial interests, and power considerations always influence the course and outcome of policymaking. Policymakers always cope with uncertainties. By its focus on information, the call for science-based information perfectly fits in the instrumental approach to policymaking and neglects its political dimension. Actually, the call for science-based policymaking is tantamount to a call for the depoliticization of health policymaking.

Third, there is a fundamental gap between the 'logic' of science and the 'logic' of policymaking. Policymakers and researchers seemingly live in two different communities (Caplan 1979). While science is directed at building knowledge,

policymaking is pragmatic, action-oriented, and often focused on short-term issues. While scientific knowledge is propelled by systematic doubt, policymakers hate doubt and want to radiate confidence in the rightness of their decisions. Policymakers also feel uncomfortable with the abstractness and sometimes esoteric nature of scientific theories which they consider at odds with the complexity of the real world they act in. Error terms and confidence intervals which are common in econometric analysis are not helpful for policymakers pretending certainty. What further complicates the science of science-based information is that scientists frequently speak with many voices, confusing policymakers about who is right and wrong. It should be noticed, however, that the problem of many voices also creates opportunities for selective shopping or cherry-picking. Both policymakers and opponents use the scientific input that best suits their preferences. The risk of a confirmation bias ('myside bias') is always lurking.

There are more reasons for a skeptical attitude towards the 'scientification' of policymaking. For instance, it is a matter of fact that the complexity of moderately structured and particularly unstructured problems is (largely) beyond the problem-solving capacity of scientific research (Hoppe, 2011). Research can help to unravel these problems or explore the potential effects of alternative policy interventions but cannot fully grasp their complexity. Doing science is being selective and making simplifying assumptions. Relevant contextual factors are often left out of consideration (decontextualization). Other reasons are that evidence-based knowledge is not available, incomplete, or too late. The outworn phrase that 'more research is needed' is not helpful for policymakers being under political pressure to take action.

Advocates of a scientific approach to policymaking proclaim that information should precede action to avert mistakes. There are two problems with this 'knowledge-then-action' approach. First, much relevant information is only gained by doing. In other words, policymaking means policy learning. Second, opponents to the 'knowledge-then-action' approach warn of the risks inherent to this approach. Abstaining from action because of the quest for certainty or more information can do much harm.

Learning by doing is an alternative and pragmatic approach (Greenhalgh & Engebretsen, 2022).

Finally, policymakers may demonstrate disinterest in scientific evidence. Sometimes, commissioning research to give policy decisions a scientific base is little more than an obligatory ritual dance. Research is not commissioned to buttress policy decisions with evidence-based information, but to legitimize these decisions that have already been made at an earlier stage (Box 8.5).

Box 8.5 Role of evidence in European health policymaking

In her study of the role of evidence in European public health policies, Passarani found much evidence of the legitimatizing role of evidence. For instance, in her case study of the formulation of the directive on the application of patients' rights in cross-border health care, several respondents were quite skeptical about its role. 'I wonder how many stakeholders genuinely read them (impact assessments HM) from start to finish because I think people recognize that in reality there is so much political shaping' (senior policy officer; p. 86). 'The impact analysis is not science. It is pure journalism. You decide what you want to do. And this decision is taken politically. Then you go off and find the evidence to support this decision (.....)' (Head of Unit, European Commission: p.86).

In her case study of the Directive on the Provision of Information to the General Public on Prescription Medicines, several respondents responded that a lot of literature on the harmful consequences of direct information to consumers for public health had been ignored in EU-commissioned studies. 'There is actually quite a body of evidence out there that they could have referred to that wasn't referred to at all' (researcher on information to patients; p. 112). 'There was hardly any concrete piece of evidence used during the whole debate (European Parliament political advisor: p. 116)

Source: Passarani, 2019.

Finally, it should be kept in mind that the predilection for science-based policymaking is not without risks. Policymaking dominated by scientific experts may become a technocratic activity (Weingart, 1999). Through hiding themselves behind these experts, real power passes from policymakers to experts and fundamental policy choices may remain concealed. At the same time, a dominant role of scientific experts in public policymaking can put them in a vulnerable position. They run the risk of becoming involved in political disputes.

8.9 Uncertainty and risk

The rational model accords information a central place in policymaking. Policy decisions should rest on the best information available. But what if information is not or only partly available and policymakers see themselves confronted with uncertainty? Actually, this is the default situation. Uncertainty is inherent to all policymaking. Policymakers never possess complete information about what is going on, what the effects and costs of their policy measures will be, how opponents will react, what the next day may bring, and so on. Policymakers claiming the 'truth' fool themselves. Overconfidence has proven to be a source of avoidable policy failures. Policymaking during the outbreak of COVID-19 resembled in many respects sailing in the fog (Box 8.6).

Box 8.6 Health policymaking in a fog of uncertainty

At the beginning of the COVID-19 pandemic, public experts nor health policymakers had a clear picture of what was happening. Everybody felt seized. In the United Kingdom, public health experts used an influenza-based disease model to acquire information on the spread of the coronavirus and its consequences for healthcare. However, this information was seriously flawed for two main reasons. First, the model did not take account of the asymptomatic transmission of the coronavirus. Second, there was a dramatic shortage of data because of a self-inflicted lack of testing. Many public health experts also held it impossible that the coronavirus would 'travel' from Asia to the United Kingdom. Consequently, they underestimated the impact of the

pandemic with dramatic consequences because every week of delay counts in pandemics (House of Commons, 2021).

Information problems did not only arise at the start of the pandemic but also in later stages. The Dutch Institute of Public and Environment used the infection rate of the Delta variant (detected by the end of 2020 in the United Kingdom) to predict the impact of the Omicron variant (detected in South Africa in late 2021) on the number of hospitalizations. As a consequence, the institute warned of the risk of a rapid increase in the number of hospitalizations and IC admissions. The government used this information to announce a new lockdown in December 2021. It soon turned out that the estimations were wrong: the Omicron variant was indeed more infectious than the Delta variant but much less pathogenic. The information the government used to justify a third lockdown was seriously flawed because of wrong assumptions in the disease model.

Uncertainty is linked to risks. While some risks are known, other risks are unknown. There are even unknown unknowns. Risk can be defined as the probability of an occurrence multiplied by the extent of damage, injury, or loss. The problem with this definition is that it fails to understand risk as a social construction. Risk has not only an 'objective' but also a 'subjective' or man-made dimension. What one individual perceives as a big risk, another may perceive as a small risk. Objective risks can even be completely overlooked, and small risks be dramatically overestimated. Risk perception is a matter of sense-making influenced by historical, social, and cultural factors (Douglas, 1986). Furthermore, it can be influenced by political and bureaucratic skirmishes within the state 'machinery' in which participants ventilate their own version of the risk that must be encountered (Christensen & Painter, 2004). If policymakers or stakeholders have an interest in emphasizing, amplifying, or mitigating the magnitude of risks, risk perception can easily become politicized. Risk perception is also critical in policy narratives (Versluis et al., 2019).

Of great interest in health policymaking are uncertain risks which Van Asselt and Vos (2006) define as 'uncertainties that may inhibit danger'. Uncertain risks frequently arise for food safety, occupational health, and environmental hazards. Vaccination

programs have always raised questions about potential adverse reactions and long-term effects. Uncertain risks are the product of technological innovation and are central to what Beck has called the 'risk society' (Beck, 1992). Policymakers may perceive these risks differently. See, for instance, how the World Health Organization, the European Union and its member states dealt with the Swine flu (Box 8.7).

8.10 Strategies to deal with uncertain risks

Policymakers follow various strategies in coping with uncertain risks. A distinction can be made between the following strategies: (a) doing policy research; (b) consultation; (c) reduction of complexity; (d) learning by doing; (e) application of the precautionary principle; (f) building a resilient health system; (g) covering up; (h) risk denial. Notice that the strategies of cover up and risk denial do not fit in the rational model of policymaking but in the conflict model (chapter 10). They are mentioned here for the reason of completeness.

Doing policy research

Doing or commissioning policy research to gather information on policy problems and strategies to resolve these problems is a straightforward strategy to deal with uncertain risks. However, policy research is no guarantee for success because of information problems, simplistic assumptions, false inferences, or ignorance of relevant data. Conclusions and recommendations may be biased for political reasons and contain serviceable truths.

Consultation

A second strategy is consultation. Many policy failures could have been avoided, had policymakers better listened to well-informed experts or well-informed stakeholders. Consultation can also bring uncertainty information to light (Van Asselt & Vos, 2006). However, expert or stakeholder information can be wrong, selective, or biased for political reasons. Furthermore, more information does not necessarily mean less uncertainty. If experts or stakeholders disagree with each other and feed policymakers with contradictory information, consultation may even result in (more) confusion, for instance, on the safety of food additives, growth promotors in animal food, or the effectiveness and safety of new vaccines.

Box 8.7 The outbreak of the Swine Flu: same data, different interpretations

The H1N1 pandemic, also called Swine flu, was first detected in April 2009 in California and a week later in Mexico. In July, there were confirmed cases in 12 countries across the world. On 11 June 2009, the global pandemic was officially declared by the World Health Organization (WHO). One year later (10 August 2010), WHO announced its end.

Various policy actors were involved in managing the pandemic. While WHO informed about the spread of the disease and what had to be done to contain it at the global level, the European Centre for Disease Control ECDC) acted as an important provider of information to the member states of the European Union. National health authorities were responsible for taking adequate policy measures at the national level.

An analysis of Versluis based upon a review of the literature and document analysis shows that the authorities dealt differently with scientific expertise. WHO was most convinced about the severity of the pandemic. However, its policy reports contained little uncertainty information about the pandemic. The organization has been criticized for its lack of openness in internal and external evaluation reports. For instance, the names and declarations of interest of the members of the Emergency Committee that had advised the Director-General on the pandemic secret were kept secret.

ECDC showed more caution in its statements on the pandemic. It was open about the lack of hard evidence to justify firm statements on the seriousness of the pandemic and already downgraded its impact on public health much earlier than WHO did (January 2010).

Health authorities in EU member states responded differently to the crisis. While the United Kingdom spent some € 1.3 billion on H1N1 vaccines and the Netherlands prepared a mass vaccination, Denmark opted for a limited vaccination program.

Source: Versluis et al., 2019.

Reduction of complexity

Reduction of complexity by only considering small or incremental policy changes is a third strategy for coping with uncertain risks. The rationale of the strategy is to reduce the need for information. The probability of unanticipated risks is lowest if policy-makers abstain from ambitious policy change. Reduction of complexity is central in the strategy of 'incrementalism' (Braybrooke & Lindblom, 1963). They describe this strategy as 'moving *away* from social ills rather than moving *toward* a known and relatively stable goal' (p. 71). Policymaking is a process of serial and largescale incremental policy changes. If a change appears unsuccessful, it can be repaired by remedial action. Braybrooke and Lindblom claim that incrementalism is a reasonable strategy in the context of multiple uncertain risks. Radical policy plans like reforms run the risk of doing more bad than good. On the other hand, however, incrementalism has been criticized for being a risk in itself. Piecemeal engineering or 'muddling through' will fail in the context of major threats and (creeping) crises (Boin et al., 2020).

Learning by doing

A common element of the above strategies is that information precedes decision-making. An alternative strategy is learning by doing. This strategy is inspired by the experience that much relevant information on the effects of policymaking can only be collected in practice. Pragmatic decision-making enables policymakers to adapt their policies to changing or unforeseen circumstances.

Application of the precautionary principle

An alternative strategy to cope with uncertain risks is to make use of the precautionary principle. According to this principle, policymakers are legitimized to make protective decisions in the absence of conclusive evidence for the occurrence of an uncertain risk. Rationality calls for caution. The application of the principle is closely associated with technological change. Technological change is heralded as a manifestation of progress but often surrounded by concerns about uncertain risks. If these risks cannot be excluded, what then is an acceptable risk? Which risk standards must a product meet for market authorization? Questions like these play an important role in market regulations within the European Union. Governments also referred to the

precautionary principle in fighting the COVID-19 pandemic. Absence of evidence is not evidence of absence!

The precautionary principle is closely associated with the uncertainty paradox (Van Asselt & Vos, 2006). This paradox holds that science cannot provide the conclusive evidence policymakers are hoping for to substantiate and legitimize their policy decisions. The dilemma of policymakers is that they nevertheless must make a decision. The precautionary principle offers them a way out. It legitimizes them to take action without hard evidence.

The precautionary principle is an open principle. When is it opportune to resort to it? Is any scientific dispute reason for resorting to it? Can the principle do more harm than good? The principle is also silent on the question of which policy measures should be taken and how it relates to other principles.

The precautionary principle plays an important role in setting risk standards. In the aftermath of various food-safety scandals (BSE, dioxin, salmonella, and others) health authorities have imposed ever stricter standards in an attempt to restore public confidence in food safety (Vos, 2004). Strict procedures for testing the safety of vaccines and post-market surveillance are in place to avoid public health disasters that have taken place in the past.

Building a resilient health system

It is a no-brainer that public health crises cannot be well predicted. Public health experts have frequently warned policymakers of the potential outbreak of new pandemics, but they could not inform them about the when, where, and how of these pandemics. How, then, should policymakers prepare themselves for the outbreak of a pandemic? A rational strategy is to build a resilient health system which can be described as a system that is able 'to prepare for, manage and learn from a sudden and extreme disturbance. Resilience is about maintaining the core health system functions' (Sagan et al., 2021: ix). A study of the European Observatory on Health Systems and Policies on how countries had dealt with the COVID-19 pandemic identified twenty lessons for how to strengthen the resilience of health systems,

including, among others, effective political leadership, the development of a clear and timely policy response, strengthening monitoring, surveillance and early warning systems, transferring the best available evidence to policy, effective coordination within (horizontal) and across levels of government (vertical), and ensuring transparency, legitimacy and accountability in policymaking (Sagan et al., 2021). Other requirements are the need for buffer capacity that can be rapidly mobilized, the organization of crisis simulations, and the reflection of normative dilemmas that may occur during a public health crisis.

Covering up

Sometimes, policymakers pursue a strategy of cover-up. In their analysis of the politics of SARS which caused fear and panic in 2002, Christensen and Painter (2004) concluded that China in the initial stage of the crisis had deliberately chosen this strategy. Important information about the event was kept from the public for 'security reasons'. Many of SARS statistics were not just state secrets but even 'military secrets'. Fear of economic damage also played a role. A delegation of experts from the World Health Organization that had planned to investigate the outbreak of SARS did not get immediate access to the Guangdong province. To divert attention, the then-Chinese government blamed Hong Kong for the outbreak in Beijing. Christensen and Painter speculate that the strategy of cover-up cannot be separated from the political climate at that time. The crisis coincided with a period of leadership transition. Political leaders wanted to avoid any trouble and maintain calm and stability. After new leadership had come into power, China made a U-turn by promising more transparency and greater international cooperation. Restoring confidence in China became a priority.

Risk denial

Risk denial is a purposive strategy to soften or ignore risks. Risk denial occurs when policymakers underestimate or overestimate risks against their better judgment. Former President Trump repeatedly used this strategy to downplay the impact of COVID-19. The Atlantic published a long list of what it called 'An unfinished compendium of Trump's overwhelming dishonesty during a national emergency' (Paz, 2020). On several occasions the president publicly contradicted his main public

health advisors including the director of the US Center for Disease Control and his chief medical advisor. In February 2020 he told the nation that 'the outbreak would be temporary: 'It's going to disappear. One day, it's like a miracle—it will disappear.' He also boasted that 'Coronavirus numbers are looking MUCH better, going down almost everywhere,' and cases are 'coming way down.' He said this when coronavirus cases were increasing or plateauing in most American states (Christakis, 2021).

8.11 Conclusion and suggestions for health policy analysis

The rational model postulates that policymaking should not be the outcome of political struggle, ideological convictions or power relations but rest upon the best available information. The synoptic model describes how policymaking should ideally be organized to achieve the best results. The alternative deliberative model underscores the role of argumentation, interpretation, multiple advocacy, and justification in policy analysis. Policymaking requires the use of various sources of information.

The rational model has important implications for health policy analysts. As researchers, they must study the role of information in the policymaking process. Suggestions for research questions are:

- Which information from which sources do policymakers refer to in justifying their policy choices, the organization of the policymaking process, the structure of the governance system, and the lesson they draw from policy evaluation?
- Which information and information sources are undervalued or not taken into account? How do policymakers convert observations into information? What is the conceptual model that underlies the selection of observations, the conversion of observations into information, and the interpretation of the information?
- Is health policy organized as a technocratic process dominated by field experts or is there ample room for deliberation, argumentation, and multiple advocacy?
- How much importance do policymakers attach to evidence-based or research-based information warranting their policy assumptions and

choices? Which factors influence and restrict the use of this type of information?

- Does essential information reach the inner circle of policymaking (decision-center), and which factors filter the influx of this information to this center?
- Which uncertainties must policymakers deal with? Are they sufficiently aware of these risks and which strategies do they follow to cope with them?

In their role of policy advisor, the task of health policy analysts is to feed policymakers with information and, in the awareness that information is always manufactured knowledge, to scrutinize its validity and credibility. 'Speaking truth to power' (Wildavsky, 1979) to preserve policymakers from avoidable mistakes means that they must build up policy-issue expertise to sift the wheat from the chaff. The role of 'producer of arguments' (Majone, 1989) requires personal credibility. However, policy-issue knowledge only is not sufficient. Health policy analysts must also acquire policymaking knowledge to be effective. They must know when and how to feed policymakers with information to ensure they are well-informed in their decision-making. In addition, well-informed means that policymakers are fed with information on uncertainties and risks. Last but not least, well-informed means that policymakers are aware of political obstacles and the role of information in political conflicts. This is the topic of chapter 10.

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CHAPTER 9

THE NORMATIVE MODEL IN HEALTH POLICY ANALYSIS

KEY POINTS:

- The formulation of health policy goals and the choice of policy instruments are value-bound activities that involve a normative (moral) judgment.
- The normative model in health policy analysis conceptualizes health policy as the outcome of normative choices inspired by explicit or implicit moral beliefs.
- The normative model aims to study moral judgments as empirical phenomena and their impact on health policymaking.
- Public health ethics is concerned with the societal responsibility to promote and protect the health of the population as a whole. The purpose of public health ethics is to foster well-reasoned choices on moral issues and dilemmas based on a systematic conceptual framework.
- Values are abstract normative principles involving a reasonable degree of intersubjectivity and stability.
- Norms indicate what is permitted, rewarded, or penalized. A distinction can be made between legal, moral, and social norms.
- Value pluralism relates to the presence of multiple values in health policymaking.
- Judgment pluralism means that values can be interpreted differently and that value conflicts can be resolved differently.
- The extension of state intervention, the growth of knowledge on health determinants, technological innovations, sociocultural changes, and the globalization of health issues have increased normative problems in health policymaking.
- Empirical and moral statements are often closely intertwined in health policymaking.
- Health policymaking involves moral dilemmas. Five well-known dilemmas are individual versus community rights; balancing benefits, harms, risks, and costs; paternalism versus individual responsibility; privacy versus public health; priority setting.
- The settlement of moral conflicts is complex. Moral conflicts can be politically divisive. The value of evidence in settling moral conflicts is restricted.

Box 9.1 The politics of motorcycle helmet laws in the United States

The 1966 National Highway Safety Act included a provision that withheld 10 percent of federal funding for highway safety programs to states that did not enact mandatory motorcycle helmet laws. From the very beginning, the act was disputed because it conflicted with the libertarian US motorcycle culture. In reaction to state helmet laws, motorcyclist groups under the aegis of the American Motorcycle Association built a powerful antihelmet lobby. In various states, they mounted constitutional challenges to these laws arguing that they constituted an infringement of their motorcyclist liberty. In several cases, the state court accepted this complaint. For instance, the Illinois Supreme Court argued: 'The manifest function of the headgear requirement in issue is to safeguard the person wearing it (….) from head injuries. Such a laudable purpose, however, cannot justify the regulation of what is essentially a matter of personal safety.' Courts in other states upheld legislation arguing that the helmet use protected the safety of other motorists: '(a) flying object could easily strike the bareheaded cyclist and cause him to lose control of his vehicle'. In political discussions on legislation, some politicians referred to the individualistic culture in the United States. One Republican representative summarized his position in only three words: 'It's my head'.

In reaction to political opposition and the lobby of the American Motorcycle Association, many states repealed their mandatory helmet laws. Their decision created a natural experiment. Advocates of mandatory helmet laws demonstrated that states without such laws had much higher traffic accident rates than states with such laws. However, this evidence did not convince the opponents of legislation.

A revision of federal legislation in 1991 continued to make federal support of highway safety programs contingent upon mandatory helmet laws, but the penalty or states abstaining from such legislation was lowered to 3 percent.

1992 was a historic year in helmet legislation. In that year, California enacted a universal mandatory helmet law. However, this brief moment of public health optimism was only short-lived when conservative Republicans took control of Congress. The federal 3% highway safety fund penalty was repealed. In 2006, only twenty-five states had required helmet use for all ages, twenty-one states required helmet use for minors only, and three states did not require helmet use at all. In their analysis of the legislative

process, Moser Jones and Bayer conclude that the 'history of motorcycle laws in the United States illustrates the profound impact of individualism on American culture and how this ideological perspective can have a crippling impact on the practice of public health' The success of the lobby against helmet legislation 'shows the limits of evidence in shaping policy when strongly held ideological commitments are at stake' (p. 215).

Source: Moser Jones & Bayer, 2007.

9.1 Introduction

The politics of motorcyclist helmet legislation in the United States highlights the pivotal role of normative or moral convictions in public policymaking. Proponents and opponents were diametrically opposed to each other. While the anti-helmet advocacy coalition prioritized individual freedom, the pro-helmet advocacy coalition found it reasonable to sacrifice some individual freedom to save lives. The case also plainly demonstrates that health policymaking cannot be reduced to an information-driven process. Even hard evidence of the life-saving effect of helmet legislation could not win opponents over legislation.

The central proposition of the normative model is that health policymaking involves explicit or implicit normative issues about right or wrong, just or unjust, legal or illegal, acceptable or unacceptable, appropriate or inappropriate, fair or unfair, and so on. None of these issues has an easy 'yes-no' or 'right-wrong' answer. At the same time, they can deeply divide society. Health policymaking includes 'by definition' normative or moral choices because it is directed at achieving something considered desirable. Sometimes, these choices spark passionate discussions. For instance, how far may or should the state go in protecting people against health risks? Where to draw the line between the public good of public health and the individual good of freedom and privacy (Dawson, 2011)? How to interpret the principle of individual responsibility in health protection (Schmidt, 2009; Nys, 2008)? Is there a risk of state overreach? Is it acceptable to use rest-embryos for medical research (Dondorp & De Wert, 2019)? Are abortion and medical assistance in dying at the request of the patient morally

acceptable medical interventions? Is it morally acceptable that some pharmaceutical companies make excessive profits?

Moral issues also concern the choice of policy instruments. For instance, is mandatory vaccination of healthcare workers against the coronavirus a proportional policy instrument? Are 'cash for sterilization', the selling of a kidney, and cash benefits for healthy behavior ('pounds for pounds') morally acceptable instruments? Are there any moral limits to markets or, in the words of Sandel (20123), are there goods or services 'what money can't buy'? Even seemingly pure technical issues have a normative dimension. The determination of a maximum emission rate of a toxic substance is not just a matter of technical expertise. Expertise certainly contributes to prudent decision-making, but determining an emission norm ultimately requires a normative judgment about what is an acceptable risk from the perspective of public health.

Health governance also involves normative choices. Participation rules or decision rules require a normative model of good governance. Transparency rules, accountability rules, integrity rules, and legal protection rules are fundamental to the conception of the constitutional state of law.

This chapter discusses the normative dimension of health policymaking. Health policy is viewed as the outcome of choices inspired by moral beliefs. Health policymaking cannot be reduced to a merely technocratic activity fed by information, analysis, and expertise. The chapter consists of three main parts. The first part starts with a distinction between two alternative approaches to the study of the normative dimension of health policymaking. Other discussion topics are the concept of values and norms and the implications of value pluralism and judgment pluralism in health policymaking. Finally, the first part briefly discusses the increase of normative issues in health policymaking and the intricate relationship between analysis and appraisal. The second part is devoted to five fundamental moral dilemmas in health policymaking: the tension between individual and community rights; the balancing of the benefits, harms, risks and costs of public health interventions; the tension between paternalism and individual responsibility; the tension between privacy and public health; the problem of priority setting. The third part includes a discussion of the

politicization of normative issues in health policymaking and the implications of the normative model for health policy analysis.

9.2 Purpose of the normative health policy analysis

There are two alternative strategies to study health policymaking from a normative perspective. The first strategy is to judge the morality of public health decisions based on moral principles such as welfare, liberty, health, respect for human life, justice, privacy, and autonomy. This strategy has a long tradition in medicine. Medical ethics has developed as a distinct field of expertise and studies the ethical aspects of clinical practice with the purpose to formulate a well-reasoned point of view on these aspects (Beauchamp & McCullough, 1984). Particularly in the late twentieth century, public health ethics has emerged as a new branch of ethics. Its purpose is to develop a conceptual framework for a systematic debate about moral issues and dilemmas in policymaking on public health. Public health ethics is concerned with 'the societal responsibility to promote and protect the health of the population as a whole' (Buchanan & Miller, 2006; 729). Protection against health risks, infectious disease control, population screening, birth control, mass vaccination, and health inequities are examples of frequently discussed topics in publications on public health ethics (Dawson, 2011).

An alternative strategy is to study ethical (moral) issues from an empirical perspective. This strategy aims not to judge the moral status of arguments put forward in health policymaking but to investigate their role and impact in this process. For instance, what moral arguments do policy actors use to justify their position? How do they translate normative principles into concrete policy decisions? How do they deal with value pluralism? What is the role of evidence in the resolution of normative dilemmas? Which moral arguments remain unheard in normative policy debates?

This chapter follows the second strategy. A critical appraisal of public health policymaking from a moral perspective is beyond its scope. The purpose is to study the normative dimension in health policymaking from an empirical perspective and make health policy analysts aware of normative issues and dilemmas in dealing with public health problems. Notice, however, that the distinction between both strategies

is less absolute than it might seem at first sight. The empirical study of normative issues greatly benefits from a deep knowledge of normative theories about mankind and human action. Consequently, health policy analysts need training in public health ethics.

9.3 Values

Moral judgments in health policymaking draw upon values. Value orientations drive actors: they have ideas about what is important in their life, what they expect from the government, what they consider fair or unfair, and so on. Value orientations are explicit or implicit, context-bound, shift over time, due to social influences, and can be different for each person or group. But what does the concept of value mean? In his study on this question, Pepper (1958) chooses a broad definition: 'anything good or bad ….' (p.7). Vitality, health, freedom, solidarity, conscientiousness, progress, sincerity, beauty, and truth are examples of values. The problem with this definition is its non-selectivity and relativism. Anything can be taken as a value, even a very personal or questionable taste. Restrictions are necessary to demarcate the concept and make it useful for policymaking (WRR, 2005).

First, one may argue that it only makes sense to speak about values in relation to health policymaking if they refer to the 'public interest' or 'common good'. Philosophers have spent their whole life on exploring the meaning and role of fundamental values such as welfare, freedom, solidarity, or virtue in human and social life (Sandel, 2008). Books have been written about the justification of political authority (Kymlicka 2002; Heywood, 2015).

A second restriction is that values should have a reasonable degree of intersubjectivity and stability. They are normative institutions or, put differently, institutionalized rules for making normative judgments. Values root in history. For instance, the contemporary emphasis on autonomy in medical and public health ethics has been described as the heritage of the Enlightenment in European cultural history (Ten Have et al., 1998). However, a reasonable degree of stability does not exclude value shifts or alterations in the meaning attached to values. The current emphasis on freedom of

choice in health care and patient empowerment indicates a process of individualization in modern society (Ter Meulen, 2018).

While changes in moral judgments often take a more extended period, there are also examples of the contrary. An example is the rapid turn in the normative judgment of in vitro fertilization (IVF). The initial reactions to the birth of Louise Brown in 1978, the first IVF baby were negative. Opponents denounced IVF as an anti-nature activity. The pope reacted that artificial insemination could lead to women being used as 'baby factories'. Nevertheless, the original critical stance towards IVF rapidly faded away and nowadays, the initial excitement about the new technology seems distant (Swierstra & Rip, 2007).

The importance of values lies in their directive effect on policymaking. Policymakers refer to values to motivate and legitimize their standpoints and choices. Values also have a mobilizing function. Referring to values in policy narratives is a well-known strategy to build popular support for or mobilize opposition to policy initiatives. The abstractness of values (see below) is of great help in this respect. Making values concrete easily causes political division.

Ultimate and instrumental values

A distinction can be made between ultimate and instrumental values. Ultimate values are also mentioned intrinsic values and instrumental values extrinsic values. While ultimate values are values of themselves, instrumental values derive their value from their contribution to the realization of ultimate values. Examples of ultimate values are health for all, autonomy, freedom of choice, universal access, equity, fairness, solidarity, integrity of the human body, and privacy. Examples of instrumental values are effectiveness, efficiency, fiscal sustainability, accountability, and transparency.

Though helpful, the distinction between ultimate and instrumental values is somewhat problematic. Health is an example. Many countries have formulated the right to health as a leading normative principle in their constitution. To materialize this principle, the state must protect and promote the health of the population and protect the rights of patients (Wiley, 2009; Daher, 2015). International treaties on human rights

accord citizens a right to health care (chapter 1). However, health can also be viewed as an instrumental value because it is a precondition for working, earning money, enjoying one's life, and so on. Neo-classical economic theory postulates consumer sovereignty (the economists' terminology for freedom of choice) as a precondition for the maximization of social welfare (ultimate value). Yet, there are good reasons to classify effectiveness, efficiency, fiscal sustainability, accountability, and transparency as instrumental values. They have a lower moral status than the ultimate values. Ultimately, health policymaking is not about efficiency, accountability, or fiscal sustainability but about providing universally accessible and high-quality care according to need (Box 9.2). A strong emphasis on instrumental values is a risk for the 'soul' of health policymaking. It can degenerate into a technocratic approach in which the ultimate values are made subordinate to instrumental values.

Box 9.2 Value-based purchasing

Value-based purchasing (VBP) has become a widely favored strategy in current healthcare policymaking. It takes various forms but its underlying logic holds that payers (government agencies, health insurers, employers) should do more than pay for health services. Instead, they should pay for the optimal combination of value and price. Doing more is not necessarily better than doing less, and high-cost services do not necessarily yield better outcomes than low-cost services.

The focus in VBP is on efficiency. The value of healthcare is defined in terms of efficiency (Porter & Teisberg, 2006). VBP is driven by the pursuit of efficiency or, as Tanenbaum writes in her critical analysis of VBP, 'more bang for the buck' (p. 1037). But how are health outcomes and costs measured? The problem with outcome measurement is that measures are rudimental and may not capture what patients consider really important. This problem is particularly acute in the case of patients with comorbidities or serious and potentially life-ending chronic conditions. The measurement of costs is also problematic because only the immediate costs to the payer are incorporated. In short, the patient's perception of value-based care may significantly differ from the definition of value-based care in VBP. Tanenbaum criticizes VBP as a 'technocratic solution to a political problem. (……) It has the uncontested goal of quality improvement plus cost control and offers to reach it

through carefully engineered provider incentives (….). By defining, documenting, weighing, scoring, updating, and costing out 'value', VBP sponsors attest to its objectivity and technicality and obscure its essential ambiguity, epistemological overreach, and distributional effects) (….). Fundamentally, VBP is an instance of counting, with all that that entails' (p. 1040).

Source: Tanenbaum, 2016.

9.4 Norms

For impact on behavior and policymaking, values must be concrete. Whereas values are 'open', norms indicate or structure what is permitted, rewarded, or penalized. Norms are formal or informal rules of the game for behavior. Formal or informal sanctions support compliance with norms. Though norms are more concrete than values, even concrete norms often appear indeterminate and multi-interpretable in individual cases. Paraphrasing Streeck and Thelen (2005), one may say that the practical enactment of a norm is as much part of its reality as its formal structure.

A distinction can be made between moral norms, legal norms, and social norms (WRR, 2005). Moral norms indicate what is right or wrong, just or unjust, fair or unfair, and so on. Which moral norms should guide decision-making and how to interpret them are two recurrent issues in health policymaking. Various moral norms are deep-rooted in a country's culture. Box 9.3 contains a framework of general moral considerations for public health interventions formulated by Childress and his colleagues.

Legal norms are the centerpiece of the state of law. They confer obligations and rights upon the state and its citizens. Legal norms protect citizens against abuse of power by the state (vertical norms) and the misbehavior of their fellow citizens (horizontal norms). Legal norms offer a normative framework for judging the state's and its citizens' behavior in terms of legal or illegal. The purpose of public law litigation is to test the lawfulness of state intervention or non-intervention on the basis of constitutional norms or international treaties.

Box 9.3 General moral considerations for public health interventions

In their mapping of the terrain of public health ethics, Childress and his colleagues formulate the following what they call 'general moral considerations for public health. These considerations can be conceived of as basic norms for public health interventions:

- producing benefits;
- avoiding, preventing and removing harms;
- producing the maximum balance of benefits over harms and other costs (often called utility)
- distributing benefits and burdens fairly (distributive justice) and ensuring participation including the participation of affected parties (procedural justice);
- respecting autonomous choices and actions, including liberty of action;
- protecting privacy and confidentiality;
- keeping promises and commitments;
- disclosing information as well as speaking honestly and truthfully (often grouped under transparency; and building and maintaining trust.

The challenge for health policymakers is how to make these general considerations specific and concrete enough to guide action and how to resolve conflicts between them. This requires a complex process of specifying and weighing of these considerations in a cultural context.

Source: Childress et al 2002: 171-172.

Social norms are part of the prevailing culture in society (*mores*) and 'regulate' what people should do or refrain from. One may speak of social conventions. 'Polderen' is an example of a social convention in Dutch health policymaking: the social norm is that policy actors must negotiate a compromise. Compromise is no bad word. The policy style of consensus-seeking is considered superior to the policy style of confrontation. Social norms do not easily change. However, there are exemptions. The acceptance of seatbelts in cars was initially disputed as a patronizing state measure. Nowadays, seatbelts are widely accepted as an effective safety instrument in road

traffic. Another example: only a few decades ago, smoking was still widely accepted, even in the doctor's room. Presently, the social acceptance of smoking is significantly lower. A representative of the tobacco industry wrote in this respect that the centrality of social norms was 'just a justification of our analysis that the social acceptability issue will be the central battleground on which our case in the long run will be lost or won' (Willemsen 2018: p. 94). The trend towards polarization in some Western democracies can be interpreted as a signal of altering moral conventions in the political arena.

Moral and social norms overlap each other if moral norms institutionalize as social norms. Legal norms may root in social and moral norms and become institutionalized as social and moral norms.

The role of norms in health policymaking

Norms are an important tool for policymakers. Legal norms regulate in great detail the relationship between the state and its citizens. State intervention in public health has resulted in an 'explosion' of regulations of the financing, planning, quality, and safety of health care, patient rights, ethical issues, and the protection and promotion of public health (public health law).

Social and moral norms can also be used as policy instruments. Persuasion is a strategy to internalize these norms. In countries where parents are free to decide on the vaccination of their children, public health authorities nevertheless encourage the vaccination of children by referring to the moral principle of solidarity: vaccination not only protects your own children but also children who cannot be vaccinated for medical reasons. Vaccination is only effective if the number of vaccinated children reaches a certain threshold (Hendrix et al., 2016). A similar moral appeal to the citizenry was done during COVID-19. In respect of everybody's principal right to freedom of choice, most governments abstained from making vaccination mandatory. Nevertheless, they made a forceful appeal to all citizens to get vaccinated. 'Only together can we overcome the pandemic!' was the slogan of the Dutch government.

An important theme in policymaking is whether state intervention by legal and moral norms can be effective without the social norm of obedience. The answer to this question is self-evident: the effectiveness of state intervention is contingent upon the degree citizens accept the state's authority to issue norms, irrespective of whether they are legal or moral. Sanctions only to punish non-compliance do not work. Effective intervention requires a high degree of public support. The problem, however, is that obedience and support have become less self-evident than they were in the past. A few decades ago, law-abiding behavior was, generally speaking, stronger than it seems nowadays (although there are certainly big differences within and between countries). Health policymaking was accepted as the responsibility of public health experts and the state. Public critique of state intervention was, with some exceptions (e.g. mandatory vaccination), uncommon. This situation has changed. Nowadays, people are more critical of state intervention than they used to be in the past. The decline of trust in the government means they do not automatically accept or abstain from what the state tells them to do or abstain from. Many of them also question the science-based arguments for state intervention. Individualization means, among others, that people are inclined to determine for themselves what they consider right or wrong or what they are willing to accept or not (see Chapter 7).

Value pluralism and judgment pluralism

Value pluralism relates to the presence of multiple values in health policymaking and judgment pluralism to the fact that there are several answers possible to resolve value conflicts (Dawson, 2011: 9). Value pluralism and judgment pluralism are central to a democratic society: people have divergent ideas about what they consider most valuable in their life and about how to find a proper balance between conflicting values.

Value pluralism confronts policymakers with moral dilemmas for which no simple solutions are available. The challenge is to maximize each value to the degree possible without threatening other values. How much of a certain value should be sacrificed for another value? If one cannot have it all, what then is a good balance between conflicting values? Much health policymaking boils down to a complex balancing act. An example is the new health insurance legislation in the Netherlands. Policymakers

had to find a balance between freedom of choice and solidarity in health financing. Public ethics aims to enable policymakers to help policymakers and the population to make reasonable choices in these moral dilemmas.

What complicates the resolution of moral dilemmas is judgment pluralism. Values are abstract concepts that are open to differing interpretations. The relative weight given to each value may be different. Context is always important: what is an acceptable resolution in a given context can be unacceptable in a different context.

Value pluralism and judgment pluralism are important sources of political conflicts that can deeply divide society. The struggle for mandatory motorcyclist helmet legislation was more than an ideological struggle on the balance between individual freedom and road safety. It was also a political struggle along party lines between the pro-legislation and anti-helmet advocacy coalition the outcome of which was contingent on the power balance in the political arena. Presently, just nineteen states have legislation requiring all riders to wear a helmet; in other states, this is left to individual choice for riders over twenty-one.

There are many examples of value conflicts. For instance, doctors who are critical of the introduction of market competition and the commodification of health care complain about the interference of management norms with the professional norms of good medicine. They reject the notion of health care as a product or production line and see health care as a trust-based instead of a contract-based service to patients. Price gauging during COVID-19 demonstrates how economic behavior can conflict with moral norms. Is it from a moral point of view acceptable that smart businessmen exploited the scarcity of essential protective equipment to make huge profits or that various pharmaceutical industries made windfall profits (Hannan et al., 2021)? Do they have a well-developed moral compass?

The resolution of normative dilemmas and conflicts is always context-bound. Under extreme conditions, a single value can have such a high priority that competing values largely lose their weight. Such a situation occurred during COVID-19. The exponential increase in the number of patients with COVID, the high death toll, the risk of a

completely overwhelmed hospital sector, and great uncertainty on the development of the pandemic created a state of emergency in which the protection of public health was given the highest priority. The radical restrictions to public life meant that standard human rights were largely put aside. In the first stage of the pandemic, there was much sympathy among the population. In later stages, however, public sympathy started gradually crumbling. Critics of freedom-restricting policy measures called for a more balanced weighing of values and some of them even denounced these measures as a fundamental infringement of the state in private and public life. Some of them filed a lawsuit against the state to overrule these measures (Wagner, 2022).

Value pluralism and judgment pluralism are two important topics in comparative health research. They also offer an interesting starting point for the analysis of cultural differences between countries. What do countries value most and how do value judgments influence their health policymaking? An example is the difference in interpretation of the moral principle of distributive justice in the United States and Europe. Stone (1993) has shown that distributive justice has quite a different meaning in the States than in Europe, with far-reaching implications for the organization of health insurance (Box 9.4).

Box 9.4 The meaning of distributive justice in health insurance

In her article 'The struggle for the soul of health insurance', Stone explains that health insurance in the United States rests upon a specific interpretation of the normative principle of distributive justice. The fundamental question is whether medical care should be distributed as a right of citizenship or a market commodity.

On the European Continent, distributive justice in health insurance is interpreted in terms of solidarity. Medical care should be distributed according to need. Consequently, health insurance should remove financial barriers to medical care. For this reason, individual contributions should be income-dependent and not be related to medical risk.

The commercial health insurance industry in the United States is based upon quite a different interpretation of distributional justice. Distributive justice is interpreted in

terms of actuarial fairness. According to this principle, there should be a relationship between the premium insured pay for health insurance and their medical risk: the higher the risk, the higher the premium. Some other strategies to apply actuarial fairness are exclusion waivers, waiting times before being accepted, or termination of health insurance. These strategies explain why in 2003 some 35% of the 19-64 adults in the United States (Schoen et al., 2005) had no insurance or were underinsured and why sickness could lead to individual bankruptcy. The purpose of the failed reform of Bill Clinton and the Affordable Care Act of Obama was to address this problem and make health insurance affordable to all Americans.

Stone argues that 'actuarial fairness – each person paying for his own risk – is more than an idea about distributive justice. 'It is a method of organizing mutual aid by fragmenting communities into ever-smaller, more homogeneous groups and a method that leads ultimately to the destruction of mutual aid' (p. 290). The principle serves as the moral backbone of the commercial industry. It is their business strategy. 'The very redistribution from the healthy to the sick that is the essential purpose of health insurance under the solidarity principle is anathema to commercial insurers' (p. 294). Indeed, ideological hard-liners even discredit social health insurance as socialized medicine or something akin to communism.

Sources: Stone, 1993; Light, 1992.

9.5 Mounting normative issues in health policymaking

Medicine and health care have always raised normative issues. The Hippocratic Oath of doctors even dates back to the fifth century before Christ. Compassion and social responsibility motivated charitable organizations to support people long before the state introduced social welfare programs. The founders of hospitals and sickness funds considered access to health care a matter of social justice.

The number and complexity of normative issues in health policymaking have considerably increased over the last two centuries. Each extension of state intervention raised moral issues about the role of the state in public health, the relationship between the state, civil society, and the market, the room for freedom of

choice, the role of individual responsibility, and many other normative issues. Restrictions on the production or consumption of goods and services to protect and promote public health have not only been contested on economic grounds but also for moral reasons. The fundamental question is how far the state should go in influencing the lifestyle of its citizens.

Global health has become a source of fundamental moral problems. For instance, what is a reasonable balance between trade liberalization and the control of health risks? COVID-19 has again made clear that viruses do not respect national borders. Worldwide access to vaccination is not just a matter of effectiveness but, most notably, a matter of social justice. Wide health disparities across the world raise fundamental normative questions about unequal access to health care.

The advance of medical science also raises moral questions. New innovative interventions have made diseases once incurable curable. While most of these interventions were welcomed as a great success and a sign of progress, they also elicit critical questions. Should everything technically possible be permitted, and under which (strict) conditions? How to weigh the benefits of new treatment options against their costs? Organ transplantation, robotics, e-health, big data, and nanotechnology raise complex questions about the meaning of good and responsible care (e.g. Beauchamp & McCullough, 1984).

Moral disputes on new interventions are anything but new. For instance, Jenner's discovery of a vaccine against smallpox at the end of the eighteenth century (Riedel 2005) provoked heated disputes on the legitimacy of a state-imposed vaccination duty to protect public health. The dispute about the pros and cons of vaccination during COVID-19 is just a repetition of what happened so often in the past (Box 9.5).

Box 9.5 Vaccination politics

Mass vaccination programs have always raised controversy. The Dutch liberal Statesman Thorbecke (1798-1872) considered a state-imposed vaccination duty in the new Health Act an effective instrument to combat regular outbreaks of infectious diseases. In his view, a vaccination duty was justified because of the indifference and recklessness of many people. However, his view was contested. Orthodox religious communities denounced vaccination as an unacceptable intervention in God-given life and an objectionable consequence of the Enlightenment. The Protestant political leader Abraham Kuyper (1837-1920) rejected a vaccination duty on fundamental grounds but did not reject vaccination as an instrument to protect public health. Opponents to vaccination also put individual responsibility central and some of them warned of negative side-effects: they said to have information that vaccination had caused an increase in the prevalence of other diseases (Maas 1988).

Alternative evidence can stir up controversy on vaccination. An example is the MMR (measles, mumps, and rubella) vaccination controversy after Wakefield had claimed a causal relationship between MMR vaccination and autism. His study drew widespread attention in the media some of which did not refrain from depicting children and parents as victims, pharmaceutical companies as villains, and scientists as conspirators who helped the government to hide the truth about the adverse effects of vaccination. Even after the study had been unmasked as completely flawed, many parents still refused their children to be vaccinated, believing that MMR vaccination could cause autism (Gostin, 2015; Walkinshaw, 2011).

Comparable resistance to vaccination could be observed during COVID-19. Apart from principal reasons against vaccination and doubts about the safety of the vaccines which had been developed in a very short period (one year), opponents referred to complot theories to explain their negative attitude to vaccination, for instance, that the pandemic was complot of deep state or that vaccines contained a chip that enabled Bill Gates to control mankind (Bolsen & Palm, 2022).

A final example of how emergent technologies raise new moral questions is the rapid datafication of everything, artificial intelligence, and deep learning. Although much is unknown yet, this development is expected to have far-reaching consequences for public health. Searching for information nowadays means being searched. What does this mean for freedom of choice and privacy? There are serious concerns about the risk of being watched and controlled on an unprecedented scale (Box 9.6).

Box 9.6 Surveillance Capitalism and public health

In her book *The Rise of Surveillance Capitalism,* Zuboff (2019) argues that our use of the internet produces a surplus (information on behavior). Big internet players including Google, Facebook, and Amazon have been very successful to convert the surplus into prediction products for commercial ends. These products have made it possible to optimize the targeting of advertisements or the targeting of electoral campaigns on specific groups of voters. The next step is to exploit the surplus for developing signals to modify individual behavior. Zuboff speaks in this respect about a new species of power and calls the use of this power to condition human behavior instrumentarianism.

Public health is an attractive market for surveillance capitalists. Nowadays, numerous reliable wearable sensors render an increasing range of information on biometric data, including data about body temperature, heart rate, brain activity, muscle motion, blood pressure, energy expenditure, sweat rate, and so on. It is just a matter of time before this information will be commercially exploited for the promotion of public health or the development of personalized insurance premiums. However, there are serious privacy concerns and concerns about how newly available surveillance techniques will be used for private and public control of public health.

Sharon (2021) investigates the normative risks of what she calls the 'Googlization' of society. Using the example of automated contract tracing, she admits that new technologies offer several advantages over traditional contact tracing methods which are known as very time-consuming. However, she also warns of moral risks beyond

the risk of loss of privacy. Building upon the theory of justice of the American political philosopher Michael Walzer, she mentions two specific risks. The first risk is the crowding out of essential 'spherical' expertise. The Googlization of public health can lead to a reshaping of the values of these sectors [health and medicine – JM] to align with the values and interests of non-specialist private actors' (S52). In other words, digitalization and datafication in public health 'risks' may erode practices, norms, and values that have always been central to the sphere of health and medicine. Instrumental (commercial) values such as efficiency, speed, and optimization may push out traditional sectorial norms and values. The second risk is that the Googlization of public health will propel the privatization of public health by making the state increasingly dependent on new technologies developed and provided by the private sector. New technologies give 'tech giants' enormous leverage to influence health policymaking in the future.

Towards a health-surveillance state?

The publicization of public health can be analyzed as a transformational social and political process. The question is how it will further evolve in the future. Critics have warned of the rise of the 'nanny state' (Wiley et al., 2013). Health tends to become an overriding value. Lupton (1995) speaks in this respect about the 'health imperative' and Frissen (2023) about state control 'behind the front door, between one's ears, and under one's bed'. In this respect, it is helpful to pay brief attention to a critical analysis of the extension of state control by the French philosopher and historian Michel Foucault.

Foucault distinguishes three global periods in the emergence of state intervention in public health. In the seventeenth century, the sovereign abstained from intervention unless it was indispensable to protect the population. His example is the fight against leprosy. The sovereign used his/her power to isolate persons with leprosy in separate camps where they were left for themselves. Medical assistance did not exist. In the eighteenth and nineteenth centuries, public interventions were gradually directed at disciplining the population through surveillance techniques. Here, Foucault's favorite example is pestilence. Infected persons were isolated and put under strict control. Violations of prescriptions were sanctioned. Gradually, control became increasingly

impersonal. Aware of being under permanent control, people internalized the regulations they had to observe with the result that public control transformed into self-discipline and mind control. In the eighteenth century, state intervention entered a new stage with the emergence of what Foucault called 'biopolitics' which connected human biology with politics 'to ensure, sustain, and multiply life, to put this life in order'. Examples of bio-politics are mass vaccination (Foucault's example), birth control, family planning, health promotion, and issues of life and death. Interventions increasingly draw upon health statistics and epidemiology (Foucault, 1976; 2008).

Foucault's analysis of the emergence and intensification of state control is central to his theory on the intimate relationship between knowledge and power in society. The fundamental question is how state intervention will evolve, particularly in the context of increasing technological options for the surveillance of health and health behavior at a distance. Will public control extend and, if so, to what extent and for what purpose? How much and which information may the state collect to control the health behavior of its citizens? Which limits should it respect? Are we heading towards the emergence of a 'health-surveillance state' in which the protection and promotion of public health have become such an overriding value that other essential values, in particular human rights, are made subordinate to it? The pursuit of an all-hazard approach to public health seems a self-evident and noble goal in itself but it raises serious moral dilemmas. A related question is to what extent public health is malleable.

9.6 The fact-value intersection in health policymaking

Textbooks on policy analysis often assume a sharp distinction between facts and values or between analysis and appraisal. Analysis is presented as fact-based or value-free activity, and appraisal as value-bound. The formulation of policy goals and the choice of policy instruments are value-bound activities, the identification of policy instruments and investigation of their potential effects a value-free activity. The role of health policy analysis is to provide policymakers with 'objective' information for decision-making and the role of policymakers to make normative choices.

The distinction between facts and values draws upon the logical gap between 'is-statements' and 'ought-statements'. 'Is' does not logically imply 'ought'. For instance, the availability of a new costly medical treatment does not automatically mean that it should be covered in a public financing scheme. Not everything that can be done should be done. While advocates of new technologies herald the benefits of new technologies for mankind or postulate the inevitability of their application (if we don't do it, our competitors will do), critics warn of unforeseen side effects and the risk of habituation and moral corruption (Swierstra & Rip, 2007).

In the practice of health policymaking, however, moral views and analysis influence each other. Obesity is an instructive case to unravel the intersection of analysis and appraisal. The World Health Organization frames obesity as a public health problem of epidemic proportions. In their analysis of frame contests on obesity in the United States, Saguy and Riley (2005) set out that the WHO frame of obesity is only one way of constructing obesity as a public health problem and that alternative frames compete for the attention of policymakers. Each of these frames has potential moral implications. They discuss four alternative frames. The first frame builds on traditions of anti-discrimination and human rights and constructs obesity as body diversity. In this 'fatness as body diversity' frame, weight is considered largely beyond personal control. There is nothing wrong with obesity. Body diversity should be accepted as a normal twist of nature. Representatives of the 'obesity as risky behavior' frame assume body weight to be under personal control and connect obesity with unhealthy behavior. This construction is not without moral implications: risky behavior is implicitly perceived as immoral (blaming the victim). Although its representatives recognize the impact of structural factors on obesity (obesogenic environment), they usually fall back on the risky behavior frame by advocating health education as the prime resolution. The third frame constructs obesity as a disease. While this 'obesity as disease' frame removes the blame associated with it in the previous frame, obese persons are morally obliged to undergo medical treatment. Medicalisation of obesity lurks in this frame (Conrad, 1992; Moynihan et al., 2002). The final frame constructs obesity as a contagious epidemic. This 'obesity as epidemic' frame opens the door for stigmatization. Saguy and Riley conclude 'that what might be assumed to be strictly arguments over scientific method and empirical facts are actually heated

struggles over framing and morality' in which medicine has become the new 'moral authority' (p. 912).

The four frames of obesity (or four models of sense-making) illustrate how analysis and normative considerations may intersect in health policymaking. Each frame has its researchers to support its credibility and its activists to push the frame on the political agenda. Searching for facts and evidence and choosing theories to explain policy problems and explore solutions are not fact-free activities but correspond with a moral frame.

The intersection of analysis and morality resonates with how corporate interests respond to obesity. Corporations with commercial interests in providing goods and services to tackle obesity (e.g. weight-loss products) are likely to frame obesity as a disease or an epidemic. Both frames serve their commercial interests. Producers of unhealthy food and drinks, however, underscore the role of individual responsibility to protest against policy measures such as age limits or 'sin taxes' that threaten the profitability of their business.

The intersection of analysis and values is also manifest in the political debate on competition in health care. Advocates of competition put the concepts of freedom and efficiency central and attribute many persistent inefficiencies in health care to a lack of freedom. Consumer choice and competition compel providers and payers to enhance efficiency. Opponents of competition warn of moral corruption. In his critical analysis of limits to competition, Sandel mentions two main reasons why markets are no morally-free zone. The first reason is inequality: differences in wealth mean that some people have access to market goods and other people cannot buy these goods. Second, the unfettered market implies that 'some of the good things in life are corrupted or degraded if they turn into commodities' (Sandel, 2012: 10).

9.7 Moral dilemmas in public health policymaking

The basic challenge in health policymaking is to balance the 'public good' and the 'individual good'. For instance, how to balance the right to the confidentiality of a patient (individual good) in the event of a deadly infectious disease and the

responsibility of the state to protect the health of its citizens (public good)? Is putting individuals with a disease that is known to be a great risk for public health into quarantine an acceptable strategy to protect public health? Is fluoridation of drinking water an acceptable public intervention if nobody can escape from it? Which moral principles should prevail: the right of the individual or the right of the community? None of these questions has a simple answer. Public health ethics is a new branch in ethics that seeks to develop a reasoned opinion on moral dilemmas (Dawson, 2011).

There are several theoretical approaches to public health ethics. A well-known approach is the utilitarian approach, also known as the consequentialist or practical approach. It takes the achievement of the greatest good for the greatest number of people as the leading normative principle. Decision-making requires a cost-benefit calculus to find out whether the public benefits of a public intervention outweigh individual costs. If so, the intervention is in principle justified. The utilitarian approach contrasts with the duty-based approach, also known as the deontological approach which gives absolute priority to a single moral principle (Sandel, 2008). Mass vaccination is an instructive case. Assuming the availability of hard evidence of the effectiveness of vaccination, utilitarians are in principle sympathetic to mandatory mass vaccination, even if there is a slight risk of adverse health effects. Deontologists, on their part, may reject mandatory vaccination because of prioritizing the principle of individual freedom, even at the expense of the public health gain of vaccination. This view does not necessarily imply a rejection of vaccination. It only means that vaccination must be voluntary.

The utilitarian and deontological approaches only indicate a general direction to decision-making on balancing the individual and public good. There are many unanswered questions. For instance, what do the individual and public good mean in a concrete situation? Under which strict conditions is the infringement of the individual good to protect the public good justified? Is state intervention to protect the public good at the expense of the individual good effective and proportional? Context is always relevant. What seems a reasonable balance in a specific context may be a less reasonable balance in another context.

The remainder of this section briefly discusses a couple of moral dilemmas that frequently arise in public health policymaking (htpps://health.researchnet.com). It should be emphasized that the resolution of these dilemmas is not just a matter of reasoned opinion. The political, cultural and economic context, and public opinion always influence the resolution of these dilemmas.

Individual and community rights

A moral dilemma arises when individual rights conflict with community rights. The classic example in public health policymaking is balancing individual and community rights in the event of an individual's contagious disease involving a health risk for other individuals (other-regarding harm). The containment of the disease requires control over individual behavior. The famous philosopher John Stuart Mill stipulated that restrictions of individual rights are justified to prevent harm to others. Complete freedom does not exist. If necessary, the state is justified to take all reasonable measures to protect the health of others, including the restriction of individual freedom. The right to liberty in the European Convention of Human Rights (article 5) contains an exception for 'the lawful detention of persons for the prevention of the spreading of infectious diseases'.

The problem with this utilitarian type of reasoning is that it leaves important questions unanswered. The identification and reporting of infectious people are standard practices to monitor the spreading of the disease but under which conditions are more radical interventions a reasonable and justifiable option? Under which conditions are restrictions to individual liberty to protect public health justified? How serious should public health be at risk to warrant restrictions to individual liberty? What kind of restriction is justified, and for how long? Who is the community to be protected? Restrictions should not only be effective but also proportional and lawful.

None of these questions are new. In the past public authorities have frequently resorted to strict control measures such as isolation and quarantine to contain the spread of infectious diseases like leprosy, typhoid, plague, cholera, smallpox, and many others. The tension between individual and community rights was also clearly manifest in COVID-19. Governments declared the protection of vulnerable people and

the threatening collapse of the nation's healthcare system as a community right that justified radical interventions, including lockdowns, curfews, and the obligation to wear face masks in the public space. These interventions were considered effective and proportional. However, each country went its own way in balancing individual and community rights (Greer et al., 2021). While some countries (e.g. France and Spain) implemented a strict lockdown, other countries (e.g. the Netherlands) opted for a less restrictive 'intelligent lockdown'. Sweden chose a policy of individual responsibility (Brusselaers et al., 2022). While some countries made vaccination mandatory (e.g. Austria) or mandatory for specific groups (e.g. care workers), other countries opted for voluntary vaccination, although only vaccinated persons could access public spaces. These differences in interventions demonstrate the impact of the political environment on state intervention. The role of context can also be inferred from the fact that public protests against freedom-restricting interventions increased with the lapse of time: interventions considered reasonable and legitimate in the early stage of the pandemic lost in the view of its critics much of their reasonableness and legitimacy after a while.

Balancing benefits, harms, risks and costs

Interventions in public health require balancing benefits, harms, risks, and costs. Because of potential adverse reactions to vaccines, vaccination campaigns always have an associated risk of harm. COVID-19 exemplifies the dilemma. From the very beginning, policymakers and public health experts considered the development of effective vaccines the fastest route to stop the pandemic. To expedite market authorization, it was decided to replace the standard procedure of sequential steps to assess the efficacy and safety of corona vaccines with a procedure of parallel steps. After some pharmaceutical companies had managed to develop vaccines in a very short period and the responsible authorities had provisionally authorized these vaccines, national governments had to decide about the launching of a population-wide vaccination campaign. Because the benefits of vaccination outweighed potential adverse health risks and these risks were assessed as very small though not wholly absent, they gave the go-ahead to mass vaccination.

Though resistance to vaccination campaigns is no new phenomenon in health policymaking, it can be argued that the complexity of balancing their benefits, harms, risks, and costs has increased, now public acceptance of risks and public trust in the government and the industry have declined and (fake) information on these risks is only a few clicks away. Nowadays, governments and industries have to inform the population extensively about the benefits and risks of interventions in a context of uncertainty and conflicting information. Other measures to acquire and preserve public support are the creation of a truly independent system of market authorization to avert the market release of unsafe medicines, the organization of an independent post-surveillance system to detect the occurrence of harmful side effects in the earliest stage possible, and the introduction of a fair compensation scheme for vaccine-related injuries without unreasonable legal obstacles (Parmet, 2011; Parasidis, 2016).

COVID-19 demonstrates another aspect of the complexity of balancing benefits, harms, risks and costs in health policymaking. For instance, which benefits and harms should be weighed against each other? Only benefits and harms for public health or also the economic damage of the lockdown? What about the consequences of lockdowns for mental health or the harm experienced by people whose care was suspended because of lack of capacity?

Paternalism or individual responsibility?

Health promotion by fostering a healthy lifestyle is a relatively young branch in health policymaking. It took an important place in the Alma Ata Declaration under the auspices of the World Health Organization in 1978. The basic idea is that some diseases can be self-inflicted due to an unhealthy lifestyle. The purpose of health promotion is to encourage people to adopt a healthy lifestyle and create a healthy environment through legislative measures (e.g. reduction of the sugar level in food products), incentive measures (e.g. high-taxed unhealthy food and low-taxed healthy food) or informational measures (e.g. health campaigns).

Paternalistic interventions are not justified by referring to a potential external health risk for other people. They are justified with a view to the welfare of the persons they

are directed at (Nys, 2008; Buchanan, 2008). Paternalistic interventions should prevent people from making decisions they may later regret. A distinction can be made between hard and soft paternalism. Hard paternalism includes a ban on risky behavior (e.g. a ban on swimming in poisoned water), soft paternalism only makes healthy attractive or unhealthy behavior unattractive or difficult. Soft paternalism leaves, at least in theory, freedom of choice unaffected.

Because the risky behavior of an individual does not entail a health risk for other people, paternalistic interventions do not involve balancing a public good against an individual good. In practice, however, it is difficult to determine a clear dividing line between the individual and public good. For instance, one may argue that self-inflicted diseases cause high healthcare expenditures or a risk for employers who may lose respected employees. A second problem is under which conditions self-regarding harms can be accepted as a sufficient moral ground for interference with a person's voluntary choices (Nys, 2008). Sunstein and Thaler (2003) defend the position that, 'equipped with an understanding of all influences of bounded rationality and bounded self-control, libertarian paternalists should attempt to steer people's choices in welfare-promoting directions without eliminating freedom of choice' (p. 1159). In other words, they are willing to accept nudging as an instrument to promote healthy behavior. What they call libertarian paternalism is no oxymoron!

Paternalistic interventions have always been contested, not only on moral grounds but also on economic grounds. Radical libertarians argue that paternalistic state interventions, whether hard or soft, fundamentally conflict with the principles of individual freedom and personal responsibility. They frame these interventions as evidence of the emergence of a 'nanny state'. People should be able to make their own choices and take personal responsibility for their choices. Moderate critics are concerned about state overreach: the state should be reserved in referring to the risk of self-regarding harm as a motive for public intervention. Unsurprisingly, corporate interests hide behind the principles of freedom of choice and individual responsibility. When Mayor Bloomberg of New York announced his plans for a ban on the sale of sugary beverages in containers larger than 16 ounces, the producers of these

beverages pulled out all the stops to ridicule these plans as un-American and an unacceptable infringement of personal responsibility (Wiley et al, 2013).

The case of mandatory motorcyclist helmet legislation in the United States exemplifies how the paternalism-individual controversy may evolve in the health policy arena. While public health advocates followed a utilitarian-type of reasoning (saving lives), opponents of mandatory legislation used libertarian arguments to underpin their position in the debate. The case also casts an interesting light on the role of evidence in controversies on the justification of freedom-restricting measures. Public health advocates referred to empirical evidence as an argument pro mandatory legislation. Their opponents sought to undermine this evidence or denounced it as a valid argument to justify mandatory legislation. The case also highlights how policy-makers tried to resolve the dilemma with money transfers.

Privacy and public health

Privacy is important individual good in modern society. States have issued strict legislation to protect individual privacy. Legislation also protects the use of personal data in medical and epidemiological research. Names must be anonymized and researchers are forbidden to collect or exchange personal information without informed consent.

The privacy issue was prominent on the political agenda during COVID-19. While timely, secure, and reliable data access and sharing were critical to understanding the spread of the virus and developing effective strategies to fight the pandemic, concerns over privacy called for caution and restrictions. For instance, contact-tracing technologies provided crucial information (though not perfect information) on the spread of the virus but this information, if left unchecked, could also be used for collecting and sharing personal data, mass surveillance, limiting individual freedoms, and challenging democratic governance. Given the sensitivity and urgency of the issue, countries introduced legal frameworks to support their extraordinary policy measures to control the spread of the virus while protecting the privacy of their citizens. In some cases (e.g. Germany), governments had to withdraw their original version of the framework because critics considered it too great an incursion of

privacy. Privacy concerns were also prominent in discussions on developing a corona-app for tracing and warning purposes. While acknowledging the potential value of the app, the Dutch Privacy Authority argued that technical safeguards in the app were insufficient. The Authority had in particular concerns about the operating system and the risk that tech giants could misuse data for private purposes (DPA, 2020).

Priority setting

The need for priority setting in health care is associated with the scarcity problem. Scarcity of personnel, space, equipment, or budget compels policymakers to make (hard) choices. Who or what should be given priority? Should a new costly medicine be covered in statutory health insurance? Is the aging of the population a reasonable argument for prioritizing long-term care? Who should be given priority in vaccination campaigns? How to set priorities in a situation of shortage of IC capacity during COVID-19 (the so-called 'severe triage scenario')? Is it reasonable to prioritize COVID-patients at the expense of other patients? To quote the American health economist Fuchs (1974): '*Who Shall Live?*'

Some strategies for resolving the scarcity problem have a low 'moral status'. Rationing by organizing a lottery or applying the principle of 'first come, first served' could mean that sick persons will be deprived of necessary health care. Rationing by market principle implies that people with ample financial resources have better access to health care than other people. Each of these rationing strategies has distributive effects that, in their opponents' view, conflict with the basic principles of social justice. Following a utilitarian line of reasoning in a situation of scarcity, those patients should be given priority who are most to rely on health care and, if that is unachievable, to those patients with the best medical prognosis.

9.8 The politicization of normative conflicts

Value pluralism and judgment pluralism are potential sources of conflicts. However, conflicts may not hinder practical cooperation. For instance, contestants can decide to bury their disagreements for a while or agree to disagree. By contrast, the settlement of normative conflicts can be complex. Negotiating a compromise on

material issues (e.g. the quest for extra budget) compares relatively easily to resolving conflicts on deep-seated moral principles. The strategy of 'give and take' in settling conflicts on material issues is of limited value in a situation of conflicting moral judgments. The politics of motorcycle helmets in the United States demonstrates the limited value of evidence in politicized conflicts. Opponents simply refused to accept the evidence. Freedom of choice was an absolute priority for them.

However, negotiating a compromise on morally controversial issues is not impossible. Binding the execution of a contested practice (e.g. research on rest embryos) to strict conditions, making exemptions for specific categories of people (e.g. exemption from vaccination), or making controversial policy measures temporary (e.g. a lockdown or curfew) are examples of strategies for the settlement of moral conflicts. Moral conflicts can also be settled by majority voting. The new Dutch Donor Act which came into effect in 2020 and involved a switch from the opt-in model to the opt-out model to raise the number of potential donors was eventually approved by a one-vote majority. Sometimes, the political majority pushes through highly controversial regulations. An example is the decision of the government of the state of Texas in 2021 to ban abortion from as early as six weeks and allow anyone to sue involved in the procedure. What also happens is that court rulings play an important role in depoliticizing moral dilemmas and paving the way for a broadly accepted solution. An example is the introduction of legislation on euthanasia and other forms of medical assistance in dying (Box 9.7).

Box 9.7 Policymaking on euthanasia and other forms of medical assistance in dying in the Netherlands

In 2002, the Netherlands formally legalized euthanasia and medical assistance in dying at a patient's request. The Act on the Termination of Life on Request and Assisted Suicide permits euthanasia, defined as the active termination of life at the patient's voluntary and well-informed request, under strict conditions. These conditions involve a repeatedly expressed voluntary and earnest patient request for euthanasia and unbearable suffering without hope for improvement. Patients do not have a right to euthanasia, nor are physicians obligated to perform euthanasia. Regional review

committees assess in retrospect whether legislation has been applied properly. Physicians who fail to fulfil the due criteria can be prosecuted.

The passing of the bill on euthanasia marked the provisional end to a development that originated in the late 1960s and early 1970s under the influence of the progressing secularization and individualization in society. Since the issue was highly controversial, the government sought to depoliticize and remove it from the political agenda by repeatedly asking for external advice. In various publications, the Dutch Royal Medical Association came up with suggestions for strict criteria under which euthanasia could be permitted. Meanwhile, courts had to judge several cases of active medical assistance in dying. Because the Criminal Code did not recognize euthanasia as a legitimate intervention, they formulated criteria under which strict conditions euthanasia by a physician could be excused. Actually, courts had to fill the gap in legislation left by the government and the Parliament. The 2002 legislation largely codified the existing judicial practice.

To a great extent, the political controversy on euthanasia corresponded with the dividing line between religion-based and secular political parties. While proponents spoke out for it on the principle of human dignity and freedom of choice, opponents reasoned that life was God-given and that mankind had no right to terminate it. Other arguments opponents put forward were the fear of a slippery slope, the risk that severely ill patients would feel social pressure to request euthanasia, and the availability of good alternatives to euthanasia. The 2002 legislation has never stopped the debate. New issues were whether euthanasia is permitted if people feel lonely and tired of life without unbearable suffering, and how to deal with people with dementia who can no longer express their own will. The practice of euthanasia indicates that the interpretation of the set of strict conditions under which it is legally permitted has gradually been stretched after its legalization in 2002.

Source: Andeweg et al, 2019.

Moral issues can be politically divisive. One explanation for this is the collective nature of public health regulation. The obligation to wear a seatbelt when driving a car or set speed limits to save lives are regulations nobody can escape from. Politicization is

also likely to happen if deeply seated normative beliefs (core beliefs) clash. In many countries, emotionally charged issues such as medical assistance in dying at the voluntary request of the patient or abortion have elicited heated political debates. Policy measures with coercive impact, such as mandatory childhood vaccination programs or the obligation of healthcare workers to be vaccinated against COVID-19, have also proven highly controversial. Opponents filed lawsuits with the request to repeal these measures. In the United States, the Supreme Court decided in 2022 that the landmark decision in Rue versus Wade missed a legal basis in the Constitution. This highly controversial decision meant that the right to abortion was no longer protected by federal law.

Politicization fuels polarization if moral beliefs coincide with political dividing lines and are used as a political tool to discredit opponents. In various countries, populists, driven by a profound distrust of 'elites' or 'political cartels', seized the pandemic to profile themselves in the political arena. A populist party in the Netherlands denounced the government's decision that visitors of public spaces (e.g. bars, restaurants, public spaces, and sports matches) had to show a QR-code as evidence of being vaccinated as an attempt to introduce 'a medical apartheids-state with QR-slaves' (De Volkskrant, 17 September 2021).

A defining characteristic of polarized debates on moral issues is the adoption of a deontological style of reasoning. A single value is given so much weight that there is little room for other values and a balanced perspective. Weighing the benefits and costs of alternative strategies – the essence of the utilitarian model of reasoning in value dilemmas – is absent.

The politicization of moral issues is associated with distrust in science and government. Evidence is contested, ignored, or discredited as 'fake news' or 'just another opinion'. Social media are an excellent platform to spread alternative theories for which often no evidence exists. 'Cherry picking' by the selective use of evidence confirming one's own beliefs or the creation of alternative facts nowadays spreads rapidly. Government information is systematically cast into doubt by a vocal minority. Hard-core opponents to mandatory vaccination are skeptical of the safety of vaccines

and warn of concealed adverse health effects. Some argue that the state works hand in hand with the profit-driven pharmaceutical industry. In her analysis of the role of law in the H1N1 vaccine campaign in the United States, Parmet (2011) cites Fisher, who described the federal government's subsidization of the development of pandemic vaccines, the large-scale purchase of these vaccines and legal immunity for vaccine manufacturers as a 'pharmaceutical company stockholder dream scenario' at the expense of the taxpayer (p. 145).

9.9 Conclusion and suggestions for health policy analysis

The central proposition of the normative model in health policy analysis is that health policymaking involves normative or moral choices. Health policymaking cannot be reduced to an information-driven process. The ultimate value in health policymaking is health. Health policymaking aims at the protection and promotion of public health. However, health is not only a value of itself. It is also an instrumental value for economic prosperity. Because of the presence of multiple values in society (value pluralism), policymakers are confronted with moral dilemmas for which no easy solutions are available. The resolution of these dilemmas is a complicated issue because of judgment pluralism which means that actors in most situations have differing ideas about their resolution. Value pluralism and judgment pluralism are important sources of normative conflicts.

The purpose of the normative model is to focus the attention of health policy analysts on the explicit or implicit normative choices in health policymaking. Below is a list of research suggestions from a normative perspective:

- Which values are prominent in health policymaking (value pluralism), and which actors stand for these values? Which value conflicts or moral dilemmas are policymakers and other actors confronted with?
- Which concrete meaning do they give to these values, and what is their resolution of moral dilemmas (judgment pluralism)?
- Which contextual factors influence the resolution of moral dilemmas?
- Can an increase in value conflicts be observed? Which are these value conflicts?

- Which normative choices underlie problem formulation, the choice of the policy goals, and policy instruments? Which value orientations form part of actors' assumptive world (policy paradigm)?
- Do values and analysis intersect in each stage of the health policymaking process?
- Which normative choices underlie the governance structure of health policy-making?

The normative model in health policy analysis has implications for the advisory role of health policy analysts. They must develop a good understanding of the normative 'face' of health policymaking and support policymakers with critical questions about their (normative) policy beliefs and choices and the normative implications of these beliefs and choices. Furthermore, it is their task to advise and assist policymakers in approaching moral dilemmas and conflicts in health policymaking. This task requires that health policy analysts are trained in public health ethics.

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CHAPTER 10

THE CONFLICT MODEL IN HEALTH POLICY ANALYSIS

KEY POINTS:

- The conflict model postulates that health policymaking is the outcome of conflict.
- Conflict, conceptualized as a condition, refers to a situation in which two or more actors have incongruent preferences concerning an issue (or set of issues) and seek to influence decision-making following their preferences.
- An alternative model is to conceptualize a conflict as a process. A global distinction can be made between three main stages: emergence, struggle, and settlement.
- There are many different types of conflicts: moral conflicts, informational conflicts, boundary conflicts, distributive conflicts, coordination conflicts, and power conflicts. Another distinction is between content-related and process-related conflicts
- Conflicts with a common interest to achieve an agreement must be distinguished from conflicts without a common interest. The settlement of conflicts is easier for conflicts with a common interest than for conflicts without a common interest.
- The conflict potential of health policymaking has increased.
- Conflicts are an essential dimension of health policymaking in a democratic and pluralistic society. Without conflicts, legitimate interests and values would be neglected or downplayed. Nevertheless, conflicts can undermine the problem-solving capacity of health systems.
- The politicization of science involves the process of science becoming an instrument in or object of political conflict.
- Conflict resolution strategies are hierarchical decision-making, majority voting, negotiated agreement, broadening the negotiating field, arbitration and reconciliation, litigation, conflict avoidance, conflict displacement, and politicization.
- There are various types of power. In its simplest form, power is the ability of actor A (power holder) to determine the behavior of actor B (power subject). Related concepts are power resources, formal and informal power, enforcement power, and veto power.
- The conflict model of health policymaking postulates that power trumps evidence.

- The power of the state in public health has considerably extended since the onset of the 19th century. However, state power should not be overstated.
- The medical profession has always held a strong position in healthcare. However, its traditional power has weakened.
- Corporate interests exercise considerable power in health policymaking and restrict the state's room for policymaking.

10.1 Introduction

The creation of the National Health Service in Britain (Box 10.1) is a historical example of a deep conflict in health policymaking. Although the concept of a National Health Service drew upon an overarching consensus on the need for freely accessible and comprehensive health services, bitter conflicts between competing claims and interests profoundly impacted its shape. Only by accepting substantial concessions to the doctors' demands Bevan managed to build political support for his reform. The creation of the National Health Service in 1948 did not terminate the conflict on its structure. Ever since, each reform of the NHS has sparked off conflicts between stakeholders on a wide range of issues concerning, among others, the public budget for health care, cost control measures, the payment of doctors, the governance of the NHS, the ongoing privatization of health service provision role, waiting times, and the shortage of personnel (Klein, 2012).

The introduction of the NHS demonstrates another aspect of the conflictual nature of health policymaking: the impact of power on decision-making. Whereas doctors had excellent access to the health policy arena, other stakeholders, including the Approved Societies (health insurers) and voluntary hospitals, were largely excluded from the inner circle in the health policy arena. Despite its involvement in hospital funding, local governments proved unable to take a hard line. Patients were even completely absent. As a consequence, the organization of the health policy arena was profoundly biased to the advantage of powerful stakeholders.

Box 10.1 The birth of the National Health Service in the United Kingdom

The birth of the National Health Service in 1948 made a provisional end to many years of reports, discussions, and disputes on the new organization of health care in Britain. Nobody denied the need for its restructuring. Already in the aftermath of the First World War, inadequate coverage and substandard quality of health care had been widely recognized. For instance, the 1911 legislation on health insurance only covered general practitioner services, and coverage was limited to manual workers excluding family members. Moreover, the funding of voluntary hospitals had become unsustainable. In this context of what was generally considered a profoundly deficient healthcare system, the notion of health care as a public good gained increasing political support. The influential Beveridge report (1942) underscored the state's responsibility to ensure free and comprehensive health care to all citizens. The leading policy narrative declared health care a right based on need.

However, this overarching consensus did not result in a rapid overhaul of the old system. The road from abstract values and principles to concrete plans was paved with multiple conflicts on how to give direction to the reform. The Conservative Party and Labour Party were deeply divided on the shape of the new healthcare system. The doctors' organizations engaged in the political debate to articulate their (material) interests. Intensive contact with politicians and government officials put them in a privileged position compared to other stakeholders such as insurers and voluntary hospitals. Though local governments had largely taken over the role of principal funder of hospitals from charitable organizations, they were more or less excluded from policymaking. Doctors were internally divided. In some cases, the interests of the Royal Colleges (consultants) clashed with those of general practitioners.

It was clear from the very beginning that the reform could never succeed without the support of the doctors. Bevan, who served the Labor government as minister of Health from 1945 to 1951 and became known as the architect of the National Health Service, well recognized the need for political compromises. For this reason, he accorded a special status to teaching hospitals and promised consultants a seat in the Regional Boards and Hospital Management Committees. Consultants also kept the right to private practice in public hospitals (the so-called pay beds). General practitioners whose nightmare had been that the reform would terminate their private status were

permitted to continue their private practice. To avert the threat of being turned into salaried state employees, the British Medical Association opposed any reform that would threaten the sacred principles of private practice, professional autonomy, and freedom of patients to choose their doctor. The political compromise held that general practitioners would be connected to the new National Health Service by means of a contract.

Source: Klein, 1983.

The British experience with the politics of health care reform is by no means unique. Deep political divisiveness has frequently been the main explanation for the absence of national health insurance in the United States (Blumenthal & Morone, 2009). It is true that President Obama managed to build a majority for his Affordable Care Act, but not without bitter conflicts in Congress and many concessions to powerful interest organizations and mighty members of Congress. Ultimately, no Republican Congress member voted for it (Cohn 2021). In various countries, doctors have fought bitter disputes over payment issues (Marmor & Thomas, 2012; Wilsford, 1991). In Switzerland, doctors were able to block the reform of health insurance legislation for almost a century (Immergut, 1992).

Protracted conflicts about the organization and financing of health care have also left their imprint on the structure of Dutch health care. The introduction of statutory health insurance for employees took almost forty years. Successive proposals for a statutory scheme the first of which had already been presented in 1905 had failed because of deep differences of opinion between the state, doctors, and insurers. The doctors' fear was to be degraded to an employee of sickness funds and subjected to the sick fund bureaucracy. Besides, they did not want to give up their profitable private patients. Sickness funds, on their part, were afraid of a loss of autonomy. The German occupier eventually settled the conflict in 1941 through the introduction of the so-called Sickness Funds Decree. After the war, however, old conflicts flared up again. The enactment of the Sickness Fund Act in 1964 was little more than the codification of the German Sickness Funds Decree. The 'market reform' in Dutch health care was no

easy political ride either. It took almost twenty years of debate and struggle before the Health Insurance Act came into effect in 2006 (Jeurissen & Maarse, 2021).

Likewise, state regulations to protect and promote public health have elicited numerous conflicts. The introduction of the ban on child labor in the nineteenth century (in the Netherlands in 1874) proved a contested issue because of heavy resistance of employers. The tobacco industry was long successful in casting doubt on the harmful health effects of its products and resisting legislation that would erode its profitability. State programs to promote public health have frequently been denounced as patronizing and an infringement of freedom. Moderate proposals for restrictions on the sale of guns in the United States were effectively blocked by the political lobby of the National Rifle Association with an appeal to the Second Amendment of the American Constitution. Even mass shootings have not changed this pattern (Spitzer, 2020). Public protests against the (quasi-)mandatory character of mass vaccination programs to end the COVID-19 pandemic are still fresh in the memory. Conflicts on health issues also frequently appear as an important stumble block in negotiations on international trade treaties and in decision-making on regulations and directives in the European Union.

The conflict model of policymaking is radically antithetical to the rational model. Its central proposition is that health policymaking is the outcome of conflicts rather than the outcome of rational choice. Actors with incongruent policy preferences seek to influence the outcome of health policymaking accordingly. Powerful actors carry more weight in policymaking than actors without powerful resources. Politics is the struggle for policy (Hoppe, 2010).

This chapter provides an introduction to the conflict model in health policy analysis. It consists of two main parts. The first part starts with a conceptual analysis of conflicts. A conflict can either be conceptualized as a condition or a process. Next follow the presentation of some classifications of conflicts and a brief discussion of the increased conflict potential of health policymaking. An important question is how conflicts influence the problem-solving capacity (system performance) of health systems. Do they undermine its problem-solving capacity or are there reasons for an

alternative view? It will be argued that conflicts are inherent to health policymaking in a pluralistic society and an effective mechanism to counter the dominance of specific values and interests. Conflict-free health policymaking would come with great risks for society. The first part ends with the presentation of a number of conflict-resolution strategies.

As said above, the conflict model is closely connected with power. This concept is central in the second part of the chapter. After a concise overview of the dimensions of power follows a discussion of information as an instrument of power and the politicization of science in health policymaking. The concept of power also raises the issue of the (changing) power balance in the health policy arena. In this respect, attention will be paid to the power of the state and non-state actors respectively. The chapter ends with a brief exploration of some research suggestions of for health policy analysis.

10.2 Conflict as condition

A conflict can be defined as a condition in which two or more actors with incongruent preferences to an issue or set of issues seek to influence decision-making on this issue following their preferences. In this book, we are particularly interested in conflicts on state intervention (or non-intervention) as the object of conflict. Conflicts vary in intensity ranging from mild to intense. While some conflicts ensue from deep-felt normative beliefs, for instance, conflicts on abortion, medical assistance to dying, or state interventions restricting freedom of choice, other conflicts concentrate on material issues such as conflicts on payment issues, working conditions, or regulations that the corporate sector perceives as a threat to their business. Another contested issue is the structure of governance, particularly the distribution of decision power in the health system. Notice that ideological beliefs may mask material interests. This is, for instance, the case when corporations frame state interventions to moderate the consumption of sweetened drinks as an infringement of individual freedom.

Conflicts are usually associated with the policy formation stage in the policymaking process because policy formation is considered the stage *par excellence* to struggle

on regulations, budgets, moral issues, governance rules, power relations, accountability, etc. Building a political majority for a heavily contested piece of legislation requires lengthy negotiations and skillful political maneuvering. Nevertheless, it should be emphasized that conflicts occur in each stage of the policymaking process. For instance, powerful actors use their agenda power to frame policy issues to their advantage or depoliticize sensitive political issues (non-decisionmaking). Unresolved political conflicts can be passed on to policy implementation through ambiguous and incoherent compromises as a consequence of which the political struggle continues in the stage of policy implementation. In some situations, policy implementation even becomes more politicized than policy formation. Policy evaluation and policy termination are other potential sources of conflict.

10.3 Conflict as process

An alternative approach is to conceptualize a conflict as a process. While some conflicts drag on for many years or even decades, other conflicts have a relatively short duration. A global distinction can be made between three stages: emergence, struggle, and termination. In the stage of emergence, actors realize that they are confronted with a (potential) conflict. Their focus in this stage is on recognizing the conflict, determining one's interests that are at stake, and assessing the potential repercussions of the conflict. The stage of struggle comprises the development and implementation of strategies to protect one's interests, the identification of (potential) allies and adversaries, and the process of moves and countermoves to serve one's interests. The conflict ends or fades away in the stage of termination. Conflict termination does not necessarily imply the definite resolution of a conflict. Mutual adjustment through an ambiguous compromise or halfway solution may only provide temporal relief. The boundary lines between emergence, struggle, and termination are fluid.

Another approach is to distinguish between the stages of mobilization, negotiation, and acceptance. In the mobilization stage, actors mobilize their constituency by formulating firm claims and demonstrating to opponents their unitedness and willingness to get their claims accepted. The second stage involves negotiating an

agreement which each negotiator must sell as the best result achievable in the acceptance stage. The distinction between mobilization, negotiation, and acceptance highlights the internal and external dimensions of policy conflicts. The external dimension refers to the mobilization of the constituency and the acceptance of the negotiated agreement, and the internal dimension to the negotiation process.

Some conflicts have a pattern of successive conflicts during a certain period. Decision-making in the European Union on the ban on tobacco advertising took almost a decade (Boessen, 2009). As spelled out above, the introduction of social health insurance in Dutch health care even dragged on for several decades. While some conflicts in no time escalate, other conflicts develop slowly. Policy interventions that were hardly controversial in the beginning may become controversial at a later point. For instance, governments in many countries learned that the initial broad public support for their measures to contain the spread of the coronavirus ('rallying around the flag') started crumbling after some months. A growing number of critical commentators began questioning the necessity and proportionality of the draconic policy measures the government had taken. Retailers and the hospitality sector were dissatisfied with the financial compensation they received. The priority given to COVID patients was criticized because of its consequences for non-COVID patients needing hospital care. The (quasi-) mandatory character of the government's vaccination strategy provoked fierce protests from some groups. After a few months, the initial 'crisis honeymoon' was largely over.

On the other hand, numerous conflicts lose much of their intensity with time. Regulations once dismissed as unacceptable have become gradually accepted or even considered self-evident. The contest about the ban on child labor in the 19th century is hardly conceivable nowadays. Public opposition to strict tobacco regulation has also largely vanished.

Some conflicts have no end. Healthcare reforms may remain contested. An example of 'post-reform politics' is the continuation of the political struggle after the enactment of the Affordable Care Act ('Obama Care'), which even intensified under

the Trump Administration by its attempts to undermine its implementation and repeal the legislation altogether (Patashnik & Oberlander, 2018; Rocco & Haeder, 2018).

10.4 Types of health policy conflicts

Health policy conflicts occur in many versions. One model is to classify conflicts according to the five P's of public health policymaking (chapter 1). Conflicts on food-safety standards or emission rates are conflicts on protecting the population against exposure to illnesses that are contagious person-to-person or health risks from environmental sources. Mass vaccination programs have elicited conflicts on prevention. Health promotion programs have been criticized as paternalistic and programs directed at the identification and anticipation of public health risks through surveillance and monitoring (prognosis) as a risk for privacy and individual freedom. Conflicts on healthcare financing or the state's role in health care have colored the history of the provision of health services.

An alternative is to classify policy conflicts according to the type of conflict. Each type draws attention to a specific dimension of policy conflicts. A distinction can be made between the following types of conflicts:

- Moral conflicts are conflicts on normative issues. For instance, is the state permitted to take coercive measures restricting individual freedom to fight a pandemic?
- Informational conflicts are conflicts about the inference of information from observations. Actors contest each other's figures, explanations, predictions, assumptions, analytical models, and inferences.
- Boundary conflicts are conflicts on where to draw the line. Classic examples are conflicts on the scope of state intervention in public health, conflicts on the benefits catalog of statutory health insurance, and conflicts on the limits to health care.
- Distributive conflicts entail conflicts on the allocation of scarce resources and the distribution of the costs and benefits of health care.
- Coordination conflicts arise from the collective nature of health policymaking. A frequent cause of coordination conflicts is that actors prioritize their private interests at the expense of collective interests.

- Power conflicts ensue from the pursuance of power.

Finally, a distinction can be made between problem-oriented and process-oriented conflicts. Examples of problem-oriented or content-related conflicts are conflicts on budgets, the payment of doctors, tobacco control regulation, food-safety standards, healthy-living initiatives, or moral issues. Process-oriented or governance conflicts pertain to the rules of the game for policymaking. Examples are conflicts on the relationship between state, civil society, and market in health policymaking, conflicts on participation and decision rules, and conflicts on the scope of professional autonomy.

10.5 Conflicts with a common interest and without a common interest

Many conflicts in health policymaking have the structure of a mixed-motive conflict: actors have incongruent preferences concerning an issue but also a common interest in reaching an agreement (Bacharach & Lawler, 1981). For instance, they agree on the need to resolve a policy problem but disagree on how such a resolution should look. Political parties in a government coalition are deeply divided on a specific health issue but have a common interest in averting a coalition crisis that would necessitate new elections. Therefore, they do their utmost best to negotiate a compromise. Actors may also opt for a compromise in the knowledge that they need each in other or future dossiers. Mutual dependency implies they have to fall back upon each other in other situations, as a consequence of which a conflictual atmosphere is detrimental for both contestants. The relational dimension in conflicts forces them to find an acceptable compromise and preserve a cooperative relationship.

The settlement of conflicts without a common interest ensues from deep ideological division. These conflicts are by comparison hard to settle, particularly if they arouse strong emotions. Society is so deeply divided that a political compromise is extremely difficult. Conflicts have the structure of a zero-sum game instead of a positive-sum game as in the case of conflicts with a common interest. The political struggle for the Affordable Care Act in the United States occurred in a very hostile political

atmosphere. Opponents denounced the plan as 'socialized medicine'. In an attempt to win voters, the Republican vice-president candidate Sarah Palin did not even refrain from framing the provision of end-of-life counseling in ACA as a recipe for 'death panels' (Tuohy, 2018). With the slogan that 'the only thing that can stop a bad man with a gun is a good man with a gun', the National Rifle Association has uncompromisingly taken action against most proposals for gun regulation (Spitzer, 2020). The controversy over using embryos for medical research in the Netherlands illustrates how moral considerations can thwart legislation for many years (Box 10.2).

Box 10.2 Embryo-politics in the Netherlands

The political debate on embryo research started in the early 1980s after Louise Brown had born as the first IVF baby in the United Kingdom. The introduction of in vitro fertilization raised the question of whether the use of 'left-over' embryos for medical research could be permitted. This question divided the government coalition. A second divisive issue was whether creating embryos for medical research would be morally acceptable. Proponents insisted on the moral importance of research on embryos to acquire new insights for the treatment of diseases. Opponents, on their part, reasoned that such research would conflict with the moral principles of human dignity and respect for life. The consequentialist (practical) pattern of argumentation practiced by the advocates of research clashed with the deontological (fundamental) pattern of argumentation followed by the opponents. The conflict sparked a debate on the moral status of embryos. Proponents considered an embryo a small number of undifferentiated cells and embraced the term 'pre-embryo' as better suited to reflect what was at stake. Opponents saw in this phrasing a thin attempt to define a problem away instead of facing it. It took until 2002 when the Embryo Act came into force.

Why did the introduction of legislation take so long? While it is true that there has always been discussion on the moral acceptability of embryo-research and that new developments complicated the discussion from the very beginning, the main explanation must be sought in the political constellation. With its religion-motivated views on embryo protection the, the Christan Democrats stood in the center of political power in 1982-1994 and used its power in the coalition government and Parliament to block any legislation allowing for embryo research. The political situation altered in

1994-2002 when the Christian Democrats did not participate in the government coalition. A coalition of three secular political parties managed to build a majority for the 2002 Embryo Act, which allowed for research on 'left-over' embryos but included a ban on the creation of embryos for medical research. Since 2002, the Christian Democrats and other religion-based political parties, either inside or outside the government collation, have successfully prevented the lifting of the ban on creating embryos for research.

An important change took place in 2021 when the coalition partners, including two Christian parties, agreed that the government would start the preparation of new legislation that would allow, under strict conditions, the creation of embryos for purposes other than procreation.

Source: Dondorp & De Wert, 2019.

The distinction between conflicts with and without a common interest is not absolute. Much depends upon the context in which they are fought. Changed political circumstances sometimes compel contestants to strike a deal on an intensely disputed issue. The price of a non-agreement is higher than the price of an agreement.

10.6 The conflictual nature of health policymaking

Conflicts are a normal part of social life: a society without conflicts does not exist. Public health is no exception. From its very beginning, health policymaking has raised conflicts on state intervention to pursue public health. Disputes on the necessity and direction of state intervention or the degree of coercion in state intervention have permanently colored health policymaking. There are several reasons for arguing that its conflictual nature has increased. Health care has grown into a large economic sector or 'industry' representing the interests of providers, care workers, and manufacturers of health products and services. Another factor is the differentiated structure of health care. Doctors, nurses, hospitals, patients, third-party payers, public health experts, and other stakeholders have interests that may not run parallel. The technological advance in medicine has not only extended the range of treatment

options for ever more categories of patients but simultaneously raised fundamental normative questions about the moral acceptability of these options and the limits to health care. The pharmaceutical industry has developed tremendous market and political power to protect and promote its commercial interests. The tobacco industry has a legendary history of resisting legislation to discourage the use of its products (Neumann et al, 2002). The automobile industry has used its contacts at the highest political levels to mitigate or delay 'unfriendly' legislation to reduce the emission of toxic aerial particles. The digitalization and datafication of public health will fundamentally alter power structures in the future health policy arena.

The number of global conflicts is also rising. During the outbreak of Ebola in Africa, various countries prioritized their national interests and disregarded the International Health Regulations they had signed only a few years earlier. The way China initially dealt with the SARS pandemic, the use of the term 'China virus' by the Trump administration, the export bans on personal equipment means and ventilators within the European Union in the early stage of COVID-19 and the uneven distribution of vaccines against the coronavirus highlight the increased global dimension of public health conflicts. Public security experts consider the unequal distribution of health across the world a global security risk. At the global level public health has transformed from a low politics issue into a high politics issue.

Finally, the emergence of populism should be mentioned here (Box 10.3). Right-wing populist politicians claim a close link between welfare state problems and immigration. They plea for 'welfare chauvinism' by restricting welfare benefits largely to the native part ('ethnically defined community') of the population (Greer, 2017). As pointed out earlier, populists also exhibit a deep skepticism of evidence-based medicine, which they denounce as an instrument of a worldwide political elite to restrict freedom of choice.

Box 10.3 Four strategies of populist leaders in approaching COVID-19

Populist political leaders may follow several strategies in dealing with COVID-19. McKee and his colleagues (2021) describe four alternative strategies. The first strategy follows an insider-outsider narrative. Political leaders try to gain politically from the pandemic by appealing to groups left behind in society (insiders) by blaming others (outsiders such as immigrants or China) for its outbreak. The second strategy is contempt for institutions that, in their view, are populated by 'enemies of the people'. Hindering the work of public health organizations, for instance, by budget cuts or leaving key positions unfilled, also fits in this strategy. The third strategy is denialism by rejecting evidence and failing to take appropriate measures to contain the outbreak of the pandemic. The fourth strategy is taunting the mainstream media because of their critique of the government's weak response to COVID-19.

Source: McKee et al., 2021.

10.7 Impact of conflicts on the problem-solving capacity of health systems

Discourses on policymaking resonate with a preference for rational policymaking. Health policymaking should draw upon information and analysis: it should be information-based. Rational policymaking maximizes the problem-solving capacity or system performance of health systems. Following this line of reasoning, conflicts have a negative connotation. They are seen as unproductive and result in policy incrementalism or policy inertia. Technocrats harbor 'a deep-seated suspicion of politics (Hajer & Wagenaar, 2003: 18).

Do conflicts restrict the problem-solving capacity of health systems? This question requires an answer to a preceding question: how to measure the problem-solving capacity of health systems? On conceptual and methodological grounds, there is no simple answer to this question (chapter 7). A universally agreed definition of optimal problem-solving capacity does not exist, and what is optimal is also context-bound.

Urgent health problems in lower and middle-income countries differ from urgent problems in rich countries.

That conflicts can undermine the problem-solving capacity of health systems is evident. If necessary interventions due to enduring and bitter conflicts do not come off, problems will continue to exist and may even worsen. The risk of a political stalemate in health policymaking is imminent if conflicts connect with deep political cleavages in society are purposively exploited by politicians to profile themselves and react against their enemies. Such cleavages help explain the political struggle for universal health insurance in the United States or the political struggle for introducing statutory health insurance in the Netherlands over half a century.

On the other hand, however, it should be realized that conflict-free policymaking also entails great risks. Conflict-free policymaking would mean that legitimate values and interests are downplayed or ignored. Conflicts are inherent to policymaking in democratic and pluralist societies. Mutual adjustment by negotiating compromises is an effective and respectable way to bridge differences of opinion and conflicting interests peacefully. It is a strategy that respects the legitimacy of conflicting preferences. Finding a middle path is preferable to a command-and-control style of policymaking that shows no respect for deviating opinions. Besides, conflicts can help to avoid policy disasters and stimulate creativity.

Meanwhile, the negative impact of conflicts on the problem-solving capacity of health systems should not be overstated. The need for compromises to bridge incongruent preferences has not hindered the creation of relatively-well functioning health systems. Current health systems perform much better than in the past, although some countries do better than other countries. Life expectancy has increased worldwide since the middle of the nineteenth century. Many more people than in the past have access to medical care nowadays. State legislation has removed or mitigated many health risks.

The need for coordination also limits the impact of conflicts on the problem-solving capacity of health systems. Multiple mutual dependencies make contestants need a

modus vivendi to pursue their objectives. Fighting only is no productive strategy. Health policymaking is a process of give and take. Finally, ideological conflicts may perfectly go together with cooperation on practical issues. In sum, conflicts are inevitable and part of the game. Health policymaking without conflicts does not exist and may be a risk.

10.8 Politicization of science

In the previous chapter, we discussed the call of public health advocates for evidence-based or at least evidence-informed health policymaking. The 'scientification' of health policymaking will improve its effectiveness. The politicization of science is the mirror image of the scientification of policymaking. Politicization means that science becomes an instrument in or object of political conflict. Science is either disputed for political reasons or serves as a political weapon in policymaking (Cairney, 2016).

Before discussing the politicization of science in health policymaking, it is important to understand why science is an easy victim of politicization. First, science is inherently uncertain: 'Scientific information is always, to some degree, vulnerable to concerns about uncertainty because scientists are trained on uncertainty' (Dietz, 2013). Second, scientists see it as one of their challenges to criticize and challenge extant knowledge: falsification is the driving force of better knowledge. This makes science vulnerable in political debates. Third, scientists speak with many voices, making it easy for policymakers to pick up the voices that best suit their preferences and interests. Contradictory information stirs polarization and makes scientific expertise a plaything in the political game. Fourth, there is poor science that does meet methodological standards (poor science) but nevertheless attracts widespread public attention. Even after Wakefield's contention of a causal relationship between MMR vaccination and autism had been shown up as completely false, anti-vaxxers continued to refer to his allegations that such a relationship did exist (Davidson, 2017). The very critical stance toward mainstream science sharply contrasted with the uncritical acceptance of poor science.

A recent example of how political interests and polarization cause a deep fissure between science and politics is how President Trump dealt with the COVID-19

pandemic. From the very beginning, Trump politicized the pandemic. On many occasions, he mitigated the impact of the pandemic and publicly contradicted what his health experts had told him. He called COVID-19 a 'new hoax' deliberately politicized by the Democrats to undermine his re-election as president (Bolsen & Palm, 2022). President Bolsonaro of Brazil is another example of a politician publicly demonstrating disdain for expertise and planting uncertainty about scientific knowledge. His strategy to fight the pandemic radically contrasted with the strategy of New Zealand's Prime Minister Ardern (Box 10.4).

Box 10.4 'Speaking truth to power' versus 'speaking power to truth'

In their comparative analysis of how New Zealand and Brazil sought to manage the COVID-19 pandemic, Donadelli and Gregory point to a fundamental difference in how the governments of these countries dealt with scientific expertise. New Zealand's government attached great value to scientific expertise. Prime Minister Ardern repeatedly said to rely on the expertise of epidemiologists and statistical models in making policy decisions. On several occasions, she started her announcements with 'On the advice of the director-general of health'. Later in the pandemic when the government came under attack for its strict measures because of their painful consequences for individual freedom and the economy, the impact of public health experts on policymaking weakened. The prime minister also adapted her phraseology: 'After a discussion with the director-general of health' the government had decided to lower the alert level. The director-general had advised against doing so.

Brazil's government followed a different strategy. From the very beginning, president Bolsonaro denied the severity of the pandemic. Scientific advice was constantly delegitimized, for example, regarding mask usage and public gatherings. The minister of health, an oncologist, was fired because of his evidence-based critique of the government's strategy. Bolsonaro delayed the purchase of COVID-19 vaccines and publicly questioned their efficacy and safety. At the same time, the government's approach came under political attack by state governors who started publishing their own guidelines and purchasing vaccines. They also published basic COVID-related information on their website after the Federal Ministry of Health had stopped to do so.

Donadelli and Gregory conclude that New Zealand followed a rather technocratic approach, in particular in the first stage of the pandemic. They depict the prominent role of public health experts as 'speaking truth to power'. The Brazilian approach reflected the country's highly polarized political context in which the relationship between truth and power was radically reversed: 'speaking power to truth'

Source: Donadelli & Gregory, 2022.

This example demonstrates again that the risk of politicization of science is most acute in a polarized political environment. Democrats and Republicans told different stories about the risks of the coronavirus. Consequently, public support among Democrats for precautionary measures was stronger than among Republicans (chapter 7). In other countries, too, opponents to freedom-restricting measures exploited COVID-19 to profile themselves and discredit their opponents. Populists agitated against what they called the elite and 'deep state' by purposefully disseminating misinformation, conspiracy theories (Douglas, 2021), and fake news via social media. Their political goal was to undermine public trust in government and public health experts. Strict state measures to fight the pandemic, such as a lockdown and a ban on social interaction, were not just framed as an unacceptable restriction of individual freedom but as a thin attempt of the world elite to suppress the population and get complete control over it.

The denial or rejection of the results of scientific research is no recent phenomenon. The history of health policymaking offers plenty of examples of these practices. A telling example is the politics-driven rejection of the results of a scientific report by the National Cancer Institute and American Cancer Institute on the effectiveness of breast cancer screening. The screening was proved effective but did not reduce breast cancer mortality in the category of 40-49 aged women. For this reason, screening was no longer recommended for this age category. The study immediately prompted a heated debate, and one mammographer suggested that the research panel was actually condemning women to death. Politicians remained silent because they did want to risk an electoral punishment. A couple of years later, under the Obama

Administration, a new panel of experts with women on board concluded again that breast cancer screening of women younger than 50 years did not make sense. The report got confused with the much bigger problem of cost control. Opponents even spoke about 'death panels'. The responsible State Secretary quickly distanced herself from the findings of the report, obviously for political reasons (Welch, 2011).

Motivated reasoning

Another aspect of the politicization of science is motivated reasoning which can be described as 'the people's tendency to seek out information that confirms their prior beliefs' (Druckman, 2017). The phenomenon is also known as confirmation bias or myside bias. An instructive example of this bias was how anti-vaxxers dealt with Wakefield's false claim of a causal relationship between MMR vaccination and autism. They embraced his findings because these confirmed their prior belief in the adverse health effects of childhood vaccination. Even after Wakefield's claim had proven to be completely false and the Lancet had retracted his article, anti-vaxxers continued to refer to his claim to demonstrate that they were right (Davidson, 2017). What makes motivational reasoning puzzling is the extreme unbalance between the critical attitude to research findings that contrast with prior beliefs and the uncritical attitude to 'research findings' confirming these beliefs.

Motivated reasoning is no new phenomenon, but the context in which it takes place has radically changed. First, the amount of scientific or so-called scientific publications has enormously increased. The outbreak of the COVID-19 pandemic triggered an explosion of publications many of which had not been peer-reviewed. Consequently, it became relatively easy to find research that confirmed the receiver's prior beliefs or suited the receiver's interests best. Second, there was much media attention to research findings. However, media messaging could be influenced by political color. For instance, research has brought to light that right-leaning news sources in the United States (Fox News, Breitbart, Limbaugh) were more likely than other sources to disseminate specific pieces of misinformation, for instance, that coronavirus was a conspiracy (Gollust et al., 2020). Third, the world-wide-web has made it possible that information is nowadays only one click away. The transformational power of the web has substantial implications for the public impact

of science and how science itself proceeds (Drucker, 2017). Social media messages compounded the politicization of the virus through the wide circulation of false claims on the transmission of the virus and pseudo-scientific health therapies (Motta et al., 2020).

Interests of scientists

Scientists have interests that may influence their relationship with policymakers. An influential role in policymaking gives them prestige but requires them to abstain from forceful critique, at least in public (Cairney, 2021). Preserving their influential position may seduce them to deliver 'serviceable truths' (Jasanoff, 1990), for instance, through weakening or accentuating the conclusions of commissioned research projects. Self-interest can also motivate scientists to keep a conflict of interest hidden. There is much evidence of scientists who failed to disclose their relationship with the pharmaceutical industry in advising the health authorities on the merits of prescription medicines or vaccination programs (Angell, 2004; Brevis, 2008). Weingart (1990) concludes that 'science is one actor among many in the political system' (p. 155). He also observes that many scientists do not refrain from providing recommendations 'far beyond their realm of expertise' (p. 157) and emphasizes that 'scientific knowledge cannot be separated as neatly from value judgment as both the decisionist and technocratic model of advice suggest' (p.156).

The politics of the expert-policymaker relationship

Another aspect of the politicization of science concerns the expert-policymaker relationship (Cairney, 2021). The classic model of this relationship is simple: experts advise, and policymakers decide. In practice, however, the relationship can be much more complicated. The first complicating factor is disagreement among experts. Because disagreement undermines the weight of its advice, an expert committee is interested in maintaining internal unity and speaking with one voice. Consequently, its advice to the government can be negotiated knowledge. Nothing would be more detrimental to the committee's prestige than demonstrating internal division. Second, if governments say to rely heavily on expert advice to justify hard policy decisions, experts risk getting involved in political disputes. Critics of these decisions will argue that the expert committee instead of the government is in the lead. In their joint

evaluation of how the British government had managed the first stage of COVID-19, two committees of the House of Commons concluded that the government had failed to take a critical stance on the advice it had received from public health experts. The government should have given critical attention to the many uncertainties about the spread of the pandemic, the infection rate, the reproduction factor, and other issues (House of Commons, 2021).

10.9 Conflict resolution strategies

Conflicts need to be settled but how? This section gives an overview of important conflict resolution strategies. These strategies can be pursued in combination.

Hierarchical decision-making

A hierarchical institutional structure makes it possible to settle conflicts through top-down decision-making. The responsible decision-maker or decision-making body is formally competent to make binding decisions. The practical meaning of this conflict-resolving mechanism should not be overstated. As spelled out in this book, the picture that policymakers can unilaterally impose binding decisions upon insurers, professional communities, regulatory agencies, and large provider organizations is a caricature of how health systems really work. Hierarchical decisions are usually 'predigested' in consultations and negotiations before ultimate decision-making takes place. What further makes conflict resolution by hierarchical decision-making less attractive is the lack of legitimacy in political and health systems with a political tradition of consultation and consensus-seeking. Conflict resolution by hierarchical decision-making is a strategy of last resort.

Majority-voting

Conflict resolution by majority voting is often the endpoint of a long trajectory of negotiations and revisions of legislative proposals to build a political majority in the Parliament. The formal decision-making procedure determines in which situations majority voting is necessary and which kind of majority (simple or qualified majority) is requested. The majority decides. Majority voting is considered an essential element of liberal democracy. If no majority can be built, policymaking inevitably stagnates. Box 10.2 illustrated how the absence of a political majority in the Dutch Parliament

blocked the adoption of legislation on embryo research for many years. Conflict settlement by majority voting requires a governance structure that allows for this type of conflict resolution. Majority voting is problematic in policy networks in which actors are used to negotiating on par to reach an agreement.

Negotiated agreement (compromise)

Negotiating an agreement or compromise is the most common strategy to settle policy conflicts. The strategy is most effective when actors with differing preferences have a common interest in striking a deal (mixed-motive game). A process of give and take often settles distributional conflicts. Although the settlement may require tough negotiations, distributional conflicts are relatively easy to fix compared to governance conflicts. Conflicts on governance issues such as decision-making procedures or accountability structures miss an easy settlement because of their impact on future policymaking. Negotiating an agreement by give and take is also problematic in conflicts on moral issues, such as the authorization of a disputed new medical technology. A possible way out is to negotiate strict conditions for its use in practice. Negotiating detailed procedural arrangements for decision-making is another strategy to settle highly contested issues.

Broadening the scope of negotiating

This strategy aims to facilitate the reaching of a negotiated agreement by extending the number of issues in the negotiating process. The strategy's rationale is to make accepting a loss on a specific issue easier in return for a win on another issue.

Arbitration and reconciliation

If a conflict cannot be resolved by hierarchical decision-making, majority voting or negotiation, contestants may decide to install an arbitration committee consisting of trusted experts and an independent chairman to come up with a binding decision. The governance structure may also contain specific regulations on how to deal with deadlocks in decision-making. An example is the conciliation procedure in the European Union to settle conflicts between European Council and European Parliament (Greer et al., 2019).

Litigation

Filing a lawsuit is a frequently used strategy to settle conflicts. This strategy is used in situations where two or more actors conflict with each other on a specific issue and where actors request the court to revise or annul a policy practice. An example is the European Court of Justice ruling in 1998 that cross-border care was, in principle, not exempted from the principles of free movement of persons and services applied. Another example is the successful attempt of pro-life advocates in the United States to repeal its decision on the acceptability of abortion.

Conflict avoidance

All strategies mentioned so far are explicitly intended to settle a conflict. An alternative strategy is conflict avoidance. Policymakers do not engage in a conflict, fearing that none of them might win the battle or considering it opportune to evade a conflict, at least for a certain period.

Conflict displacement

Policymakers can alternatively choose a strategy of conflict displacement by agreeing on a compromise that each actor interprets in its way. The conflict is not really resolved but postponed to later or displaced to another arena with other actors. Conflict resolution often appears only temporary.

Depoliticization

Finally, actors may follow a strategy of depoliticization, for instance, by waiting for better times, installing an expert body to study the issue and advice on new solutions, or agreeing on a cooling-off period. Alternative strategies are starting a dialogue in an informal setting or agreeing to disagree.

10.10 Power

Power and conflict are inextricably connected. Accordingly, the conflict model of health policymaking underscores the impact of the power balance on decision-making in the health policy arena. Health policymaking and the organization of health systems are not the result of an information-based rational design but mirror the

impact of the power balance in the health policy arena. The idea that health policymaking is primarily a morally-driven or information-driven activity directed at the optimal protection and promotion of public health is naïve because it ignores the role of power in policymaking, Policymaking, according to Hoppe (2011), is a matter of puzzling and powering.

Conceptualization of power

What is power? In its simplest form, power can be defined as the ability of actor A (power holder) to determine the behavior of actor B (power subject). The power holder can decide what the policy subject must do or not do. Noncompliance is sanctioned. A subtler form of power is when the power holder is able to shape the political agenda or prevent sensitive policy issues from reaching the political agenda. This type of power is called agenda power. A radical face of power is thought control. Here, the power holder is capable to shape what power subjects should believe and prefer (Lukes, 1988). The emphasis on health education and promotion can be interpreted as a 'light' form of thought control. Thought control in its most extreme form is indoctrination and brainwashing.

Power is often distinguished from influence. While power refers to the ability to determine policymaking, influence is defined as the ability to shape policymaking through some form of pressure (Heywood, 2004). A clear demarcation line between power and influence does not exist. Interestingly, however, policymakers often prefer to speak about influence instead of power because of the negative connotation of the term power. They do not appreciate being seen as the power holder and prefer to mask their power in policymaking.

Power is both an instrument and a goal in itself. Actors use power as an instrument to influence or direct policymaking. Power is a precondition for them to align decision-making with their convictions and interests. At the same time, actors fight for power. They aim to protect or reinforce their power base. The pursuit of power belongs to the 'heart' of politics. Electoral loss means less power. Governance rules greatly affect the power balance in the health policy arena. The fact that these rules critically influence policymaking explains why contests on governance rules can be bitter.

Power resources

Power rests upon resources or objective power. Important power resources in policymaking are formal position, governance structure, information and expertise, financial and human resources, majority of seats in the Parliament, direct access to policymakers, technical capabilities, friendly media, and authority. Actors seek to strengthen their power resources by forging alliances. However, power does not depend only on power holders' objective resources. It is as much a matter of perception or subjective power. Both power holders and power subjects can overestimate or underestimate the power of the other. Influencing each other's perception of the power balance is therefore an important component of negotiating processes and power games. Bluffing is a well-known strategy to manipulate the opponent's perception of the power balance (Bacharach & Lawler, 1981; Lewicki al., 2006).

Formal and informal power

Formal power differs from informal power. Actors with formal power may not act as the most powerful players in health policymaking. Top-level civil servants, individual members of Parliament, or leaders of major interest organizations can build up such a strong position in the health policy arena that they are able to direct decision-making. The inner circle of health policymaking does not necessarily coincide with the formal locus of policymaking.

Actors often derive their informal power from the collective structure of health policymaking and the corresponding high degree of mutual dependency in the health policy arena. Achieving health policy goals requires coordination between public and private actors, each of whom possesses specific resources such as expertise, capital, organizational capability, and formal competencies. If policymakers are heavily dependent on the resources of other actors and have no alternatives for these resources at their disposition, the owners of these resources can be tempted to exploit their strong negotiating position. This is what happened in the first stage of COVID-19 when countries had to pay skyrocketing prices for face masks and other protective equipment. The monopoly on the production of medicines enables pharmaceutical companies to follow a similar strategy.

Exercise of power

Power holders can exercise power in many ways. The exercise of power is most visible if the power holder uses authority-based instruments to push policy decisions through and enforce compliance with these decisions. Authority-based power strategies comprise a broad set of options, ranging from formal instruments to informal instruments, such as threats and intimidation. A subtler way of wielding power is the exercise of economic power or informational power. Actors who possess large financial resources to pay the best experts are likely to exercise more power than actors with fewer resources. This is why the struggle between corporate interests and public health advocates often resembles a struggle between David and Goliath. Another important form of wielding power is to push up the (political) price for cooperation. Actors make their willingness to cooperate contingent upon the extent to which their demands are accepted.

Enforcement power versus veto-power

From a policy perspective, power can be conceptualized as the capability of an actor to get something done. 'Power to' or enforcement power requires effective resources, including political and psychological capabilities (e.g. courage and perseverance) to overcome resistance to change. Important barriers limiting the state's 'power to' are deficient governance rules, lack of financial resources or legal competencies, failed organizational capabilities, political fragmentation, and polarization. Notice that enforcement power involves more than the capability to push policy decisions through. Policymakers must also be able to implement these decisions and enforce compliance. The inability to implement policy decisions and enforce compliance indicates weak states.

The mirror image of enforcement power is veto power. An actor with veto power can mitigate, delay or obstruct the policy initiatives of another actor (in particular the state), for instance, through a successful lobby, a legal procedure to annul legislation, or the threat to do so. Other factors restricting the enforcement power of the state are political fragmentation, political division, and lack of legal competencies. Box 10.5 describes how medical associations in Switzerland, France, and Sweden made clever

use of veto points in their country's governance and political system to protect their interests in national health insurance.

Box 10.5 How doctors used veto-points to influence health insurance legislation in three Western European countries

In her study '*Health Politics: Interests and Institutions*' Immergut investigates the impact of what she calls the institutional context upon interest representation of the medical profession. She is particularly interested in how doctors in Switzerland, France, and Sweden used institutional opportunities to oppose national health insurance. These countries were selected for comparative analysis because health insurance legislation developed in quite different directions. Her main conclusion is that the explanation for this divergence lies in fundamental differences in the institutional context of these countries. In Switzerland, the constitutional right of citizens to challenge legislation provided doctors with an excellent veto point to oppose unwelcome legislative reforms. Even a threat to call for a referendum could be enough to lock legislation and gain concessions from the policymakers. In France, the problem-riddled parliaments in the Third and Fourth Republics offered opportunities for doctors to protect their interests. Unstable parliamentary coalitions impeded legislation. Doctors were well-represented in the Parliament, and it was not uncommon that government parties and opposition parties forged a temporary coalition to obstruct reforms they considered a threat to the *médicine liberale* in France.

Doctors in Sweden were politically disadvantaged in influencing health insurance legislation. They had to compete with employers and trade unions on health insurance issues and were in many situations less successful in influencing political decision-making. The pattern of executive dominance enabled the Swedish government, in collaboration with employers and trade unions, to implement national health insurance and introduce salaried employment for hospital doctors.

Immergut concludes 'that the political impact of a particular (interest) group is contingent on strategic opportunities stemming from the logic of political decision processes. In sum, we could say that 'we do not have veto *groups* within societies, but

rather veto *points* within political systems' (p.8). The institutional context is not policy-neutral.

Source: Immergut, 1992.

10.11 Power and information

The central claim of the rational model in health policy analysis is that information-based policymaking is superior to policymaking driven by private interests, ideological struggle, and political games. In other words, evidence should trump power. The conflict model follows a different line of reasoning. Information is not conceptualized as input for policymaking but as an instrument in power games. Actors controlling access to information control the outcome of policymaking. Evidence does not trump power but, conversely, power trumps evidence. Thus, the conflict model puts the relationship between information and power on its head (Hoppe, 2011).

There are several ways for power holders to use information to serve their interests. The first way is to withhold or manipulate information. An alternative method is to use or produce information to influence policymaking. Unsurprisingly, corporations spend huge amounts of money on commissioning research that serves their interests. Actors who do not argue on the basis of 'hard facts' are in a disadvantaged position to actors who can refer to research to make their point. According to the European Corporate Observatory (2016), trade lobby groups and the food industry actively sponsor research projects to raise doubt about the health risks of their products and set industry-friendly parameters in legislation. The tobacco industry, well aware of the dangers of smoking as early as 1953, hired in top-scientists to obscure the truth of the causal relationship between smoking and lung cancer. 'Doubt is our product' ran the famous memo of the industry in 1969, ' since it is the best way of competing with the 'body of facts' that exists in the minds of the general public' (Oreskes & Conway, 2010: p. 35). Recruiting experts who are sympathetic to their ideas and interests is a third method to influence policy decisions.

Power ultimately determines which information is accepted as 'true' or 'untrue' and how it should be interpreted. This is most salient in contests on information and the interpretation of information. Furthermore, power plays a decisive role in how policymakers deal with uncertainty. If information falls short, power ultimately fills the information gap. The power holder can be an astute and experienced actor but also a myopic or ideology-driven actor demonstrating disregard for information or politically unwelcome information.

Information is also an instrument of public health advocates. They use the instrument to influence the public and political agenda by raising attention to pressing public health issues, exploring uncertainties, bringing dubious practices to light, and unveiling the lobbying strategies of the corporate sector in health policymaking.

10.12 The changing power balance in the health policy arena

The power balance can be defined as the distribution of power in the health policy arena. Two questions are central in the analysis of the power balance. First, how can this balance be measured empirically? Second, what does the structure of the power balance in health policy arena care look like, and which changes can be observed in this structure?

Mapping the power balance

There are various methods to map the power balance in public policymaking. The first method is taking the formal position of actors as an indicator of their power. Two major problems with this model are that formal and informal power may not coincide and that the impact of mutual dependency between actors is underestimated. Consequently, an analysis of the formal power balance based on formal positions may give a biased picture of the real balance. A governance structure that looks on paper centralistic may work in practice much less centralistic. An alternative method is to measure power by taking an actor's power reputation as an indicator. This method allows for identifying other actors than the formal power holder(s) as real power holder(s). However, the reputation of actors may be biased, and respondents may

disagree about the reputation of actors as power holders. A third method is to conduct a detailed analysis of the policymaking process to determine which actors most influenced the policy decisions made. Though this method overcomes the methodological problems inherent to both previous methods, it can be very difficult to determine with certainty who exercised power when and where, and for which policy issue. Decisive events behind the scene may remain unobserved.

Aside from these methodological problems, mapping the power balance in the health policy arena is difficult, most notably because the scope of health policy has enormously extended over time and because, parallel to this development, the health policy arena has become densely populated. The power balance is also issue-bound and contingent upon political, economic, and social conditions. The rest of this section briefly discusses five trends.

The increased power of the state

The power of the state has significantly increased, particularly in the 20th century. The publicization of public health (chapter 2) meant that the state has adopted political responsibility for ever more aspects of public health and built up an extensive repertoire of authority-based, treasury-based, information-based, and organization-based instruments to attain its health policy goals. Present-day state intervention is incomparable to state intervention in the 19th century, both in scope and intensity. Nevertheless, there are reasons for not overstating its real power. Lack of effective legal instruments and financial resources, manpower shortages, absence of a firm political majority, a political struggle within the government, the lobby of powerful interest organizations, mutual dependency, the need for political compromises, the fight for the preservation of established rights and the presence of veto-points restrict state power. The margins for policy change in a pluralistic and democratic society are small. The state must deal with multiple constraints to its power and cautiously navigate between conflicting preferences and interests. Implementation of policy measures is always a critical issue. The globalization of many public health problems requires ever more international cooperation.

The rise and decline of the power of the medical profession

Through successful initiatives to organize themselves in interest organizations in the nineteenth century, doctors in many countries were able to build up a strong position in the health policy arena. The profession viewed medical care as its exclusive responsibility backed up by state regulation to guarantee the quality of medical care (Freidson, 2001). The profession also successfully fought for the preservation of its material interests. On various occasions and in many countries, doctors successfully thwarted or accommodated policy initiatives they perceived as a threat to their exclusive position or material interests (Wilsford, 1991; Marmor & Klein, 2012). Remember that the introduction of the National Health Service in the United Kingdom could only be realized after Bevan had struck a compromise with the consultants and the British Medical Association. Nevertheless, the traditional power of the medical profession has weakened. The enormous differentiation within the profession resulting in ever more specialties makes it difficult to speak with one voice. Nurses and patients have organized themselves to articulate their interests. Another important factor is the penetration of the health policy arena by the corporate sector. Health has become business with huge financial interests.

The declining power of employers and employees

Employers and employees have always had a stake in health policymaking. The primary interest of employers was to contain costs of health care and the primary interest of employee organizations to improve access to health care and achieve a fair distribution of the financial burden of health care. On the European continent employee associations have always supported the introduction of public financing arrangements to establish a solidarity-based distribution of the financial burden. In the United States, they have been less successful. Navarro mentions the absence of strong unions in combination with the lack of a mass-based socialist party as the most important explanation for the fact that the United States has no national health insurance or national health service (Box 10.6).

Employers and employees have lost some of their traditional strength in health policy-making. An important cause of this development is the emergence of new powerful actors in the health policy arena.

Box 10.6 Why have the United States no national health insurance or national health service?

In his article *Why some countries have national health insurance, others have national health services, and the U.S has neither* Navarro criticizes authors who ascribe the absence of national health insurance or national health services in the United States to popular choice and the power of the doctors and insurers. The popular choice explanation holds that a comprehensive and universal government health program runs counter to the deep-seated belief of American society in freedom of choice and the efficacy of market solutions to resolve social problems in combination with widespread resistance to federal interference. Navarro rejects this explanation for the simple reason that a majority of American people supported the introduction of a comprehensive and universal government scheme in the after-war period. People wanted it but did not get it. He is also critical of authors who explain the absence of such a scheme by referring to the resistance of powerful groups, including, among others, the medical profession, hospitals, academic centers, and the health insurance industry and the pro-business attitude of successive governments. The problem with this 'power group' explanation is not that it is wrong but incomplete. In Navarro's view, the explanation focuses on the activity of the most visible interest groups and neglects that the United States is the only major capitalist country without a mass-based socialist party and strong unions. As a consequence, the opportunities for the establishment of a national health program were greatly diminished. Navarro sees the absence of a comprehensive national plan for health guaranteeing each American access to health care as the outcome of a fundamental conflict between the powerful class of corporate interests on the one hand and the weak power position of the working class on the other hand.

Source: Navarro, 1989.

The rising power of the corporate medical sector

The emergence of a vast corporate medical sector, including large provider organizations (both for-profit and not-for-profit), health insurers and other financial agents, the pharmaceutical industry, and the providers of medical equipment and ITC

services has fundamentally altered the power balance in the health policy arena. A sector with immense financial interests is the pharmaceutical industry. Research shows that the industry nowadays controls nearly the entire biopharmaceutical chain in cancer care and does so with clear economic interests. The invention of new medicines is closely associated with the rise of the pharmaceutical industry as an economic and political power in health care. The industry has set up a vast network of national and transnational organizations to represent its commercial interests in policymaking at the national and international level (e.g. the European Union). Key topics for the industry are market authorization of new medicines, price regulation, patent regulation (extension of monopoly rights), and international trade regulation (Angell, 2005). The sky-rocketing prices of new medicines illustrate how the industry is able to exploit its market power governments have been unable to cope with effectively. An interesting question is whether government and non-governmental organizations representing public interests can restrict the industry's market power. In some European countries, state agencies have successfully fined the industry for unjustified skyrocketing prices.

What has been said about the rising power of the pharmaceutical industry also applies to other corporate players. The rise of a vast health insurance industry has fundamentally altered the traditional power balance between industry and the medical profession. A new development with potentially far-reaching consequences for the structure of power relations in health policymaking is the 'Googlization' and datafication of health care (Sharon, 2021). The consequences of this development can hardly be overseen yet, but one may expect a further penetration of the new information industry into public health. Paradoxically, this development also enhances the toolbox of the state to control social life for reasons of public health.

The rise and power of new commercial interests

The extension of the scope of health policymaking to more fields in public and social life has boosted interest representation. Emblematic is the fight of the tobacco industry against tobacco control regulation. However, the tobacco industry is not the only corporate sector that has used its power to obstruct unwelcome legislation (Mindell et al., 2012). For instance, the producers of alcoholic drinks also have a

history of lobbying against market regulation and taxes to restrict or discourage the use of alcoholic beverages (Savell et al., 2016; Atkinson et al., 2021) and the food industry against, among others, soda taxes, unrealistic food safety standards, and state-sponsored dietary advices (Nestle & Wilson, 2012; Corporate European Observatory, 2016). The industry also successfully fought against an initiative of the European Union to regulate the provision of food information to consumers (Nestle, 2002; Nestle & Wilson, 2012; Grant & Stocker, 2009) by arguing that this initiative reeked of paternalism and that soda taxes would lead to social injustice because persons on low-income would no longer afford to pay for their products. New regulation in the United States has made it easier for companies to challenge government-funded research they do not appreciate. After the World Health Organization had issued a list of recommendations on food milk, US producers, in vain, used its political influence for lobbying a withdrawal of the United States from this organization (Nestle & Wilson, 2012).

An interesting new development concerns the initiatives of non-governmental organizations to file lawsuits against the industry for unethical practices. There are some examples of success. For instance, pharmaceutical companies that were accused of abuse of their market power at the expense of public health have been compelled to admit the production and admission of generic medicines against HIV in South Africa. In some countries, including the Netherlands, the Pharmaceutical Accountability Foundation has successfully started a legal complaint against a pharmaceutical company (Leadiant) that had raised the price of an off-label medicine by 500% after it acquired exclusivity status of the European Medicines Agency (box 5.3).

10.13 Conclusion and suggestions for health policy analysis

The conflict approach to health policymaking fundamentally differs from the rational approach. Whereas the rational approach conceptualizes health policymaking as an information-driven or intellectual search for the best solution, the conflict approach postulates that conflicts shape health policymaking. Health policy and health systems are not the result of a consistent design but rather the product of past political

compromises between actors with incongruent preferences. Conflicts are inherent to policymaking in a democratic and pluralist society. Though conflicts are a risk to the problem-solving capacity of health systems, the reverse is equally true: conflict-free policymaking is a risk to the problem-solving capacity of health systems.

Conflict and power are inextricably interconnected: the outcome of policy conflicts is contingent on the power balance in the health policy arena. Information is an important policy instrument in the hands of the power holder to direct health policymaking. Science (expertise) is politicized by making it an object of or an instrument in political struggle. The power balance in health systems has a complex structure. While it is true that the state has strengthened its power base in health policymaking, its power should not be overstated. The political pressure of interest groups constrains the room for state health policymaking. Corporate interests use a variety of tactics to pursue their interests and resist legislation that will harm their profitability.

The conflict model opens an important field of research in health policy analysis. Below is a list of research suggestions:

- Which conflicts dominate health policymaking concerning preselected state interventions? What is the object of these conflicts, and which actors are involved in it? Does the conflict ensue from (deep-rooted) normative convictions, clashing interests or both?
- How did a conflict unfold over a more extended period of time? Has the conflict an incidental structure or does it extend over a longer period?
- What type of conflict is it (moral, informational, distributive, and so on)? Is it a conflict with or without a common interest?
- Has the conflict-potential of a given policy issue increased or decreased and which factors explain the increase or decrease of its conflict potentiality?
- What is the impact of conflicts on the problem-solving capacity of the health system?
- Are there indications of a politicization of science? Is science the object of a conflict or used as an instrument in a conflict? Are there indications of motivated reasoning?

- Are there indications of politicization of the expert-policymaker relationship?
- Which strategy or strategies are used to settle a policy conflict?
- What is the structure of the power balance in health policymaking and which changes in this balance can be observed? To what extent does the formal power balance coincide with the informal balance?
- Which factors increase or decrease the enforcement power of the state in health policymaking? Are there any veto-points in the governance structure and how are these exploited in the policymaking process?
- Is information used as a power instrument, and, if so, by whom and in which way?

The conflict model has consequences for health policy analysts in their advisory role to policymakers. Their task is to support policymakers in unraveling conflicts, reflecting the conflict potential of state intervention, considering the consequences of conflicts for policymaking and relationships in the health policy arena, identifying the potential proponents and opponents of state intervention, and developing strategies to overcome resistance or build up a political majority. Another task is to support policymakers in understanding their opponents' strategies and developing effective counterstrategies.

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CHAPTER 11

THE INSTITUTIONALIST MODEL IN HEALTH POLICY ANALYSIS

KEY POINTS:

- Institutions are broadly accepted rules of the game giving direction to social action: social action comprises what actors take for granted or assume (belief system) and established patterns of social interaction.
- A central proposition of the institutionalist model is that society cannot endure and prosper without institutions. Institutions are indispensable for social order.
- The institutionalist model postulates that health policy changes unfold gradually rather than radically.
- Health systems can be conceptualized as a complex pattern of institutions regulating medical practice, patient expectations, organizational behavior, and health policymaking.
- Healthcare reform is a combination of institutional change and institutional continuity.
- A reciprocal relationship exists between institutional structure and health policymaking. Institutional impact is the impact of the institutional context on health policymaking; institutional change is the impact of health policymaking upon the institutional context.
- A distinction can be made between three types of institutionalist models of health policy analysis: the rational choice model, the sociological model, and the historical model.
- Path dependency means that once taken policy choices tend to persist by feedback mechanisms limiting the margin of policy change.
- Factors explaining institutional continuity are the force of habit, sunk costs, functionality, power relations, and legitimacy.
- Factors explaining institutional change are external shocks and endogenous processes.
- Successive incremental policy changes can fundamentally change the institutional structure and performance of health systems.

- Differentiating between the process and results of change four types of institutional change can be distinguished: reproduction by adaptation, survival and return, replacement after breakdown, and gradual transformation.
- There are several models of gradual transformation: displacement, layering, drift, conversion, and exhaustion.

Box 11.1 The enactment of the 2006 Health Insurance Act in Dutch health care

The Health Insurance Act (*Zorgverzekeringswet*) that came into effect by the 1st of January 2006 integrated the sickness fund scheme with all other, mainly private, schemes into a single mandated scheme covering the entire population and a broad package of health services, including general practitioner care, hospital care, pharmaceutical care, maternity care, and many other services. To induce competition between insurers, consumers were free to choose their insurer, type of health plan and switch to another insurer by the end of each year. The new legislation permitted insurers to set their premium rates but obligated them to apply community rating. Experience rating was explicitly forbidden. Furthermore, insurers had to accept each applicant without restrictions. Persons on a low income could apply for an income-related care allowance to uphold income solidarity.

The reform formally started in 1986 with the installment of the Dekker committee (a group of independent experts) which in its report '*Willingness to Change*' (published in 1987) recommended the government to reform Dutch health care according to the principles of regulated competition. The reform marked a historical moment in Dutch health care because it put an end to the bifurcated health insurance landscape with sickness funds (covering about two-thirds of the population) and other, mainly private, insurers. It also included other system changes. Insurers were charged with the purchase of health services on behalf of their customers. Providers and insurers had to negotiate contracts on prices and quality. Selective contracting by insurers was permitted. The state defined its responsibility for health care as 'system responsibility', an ambiguous term that meant that the state's primary responsibility was to promulgate market regulation and organize effective oversight of competition. Only if

access to or quality of health care would be at risk, the state could directly intervene in the market.

At the same time, however, the reform reflected in many ways the old system. For instance, the Health Insurance Act would have been politically unfeasible without hard provisions for risk solidarity and income solidarity. Its benefits package largely coincided with the benefits package of the sickness fund scheme. The mandated structure of the new scheme was rooted in the tradition of the sickness fund scheme. Furthermore, the reform mirrored the traditional public-private mix in Dutch health care (public financing in combination with private provision) and the divide between basic and supplementary health insurance. In short, the market reform constituted a complex mix of institutional change and institutional continuation.

Source: Jeurissen & Maarse 2021.

11.1 Introduction

The historical context and political circumstances always influence health policymaking. The political struggle on what has come to be known as the 'market reform' in Dutch health care demonstrates the impact of this context. An important reason why the Dekker Committee's recommendations to reform Dutch health care on the basis of the principles of regulated competition got bogged down in a long political struggle was that they clashed with deeply rooted beliefs on the organization of Dutch health care. Opponents argued that competition would hollow out solidarity in healthcare financing and undermine universal access to health care. Some critics warned of the risk of a two-tier healthcare system. Health care was, in their view, simply unfit for competition. Eventually, it took almost twenty years before the government managed to build a political majority for a major reform. This success would never have been politically feasible without hard conditions for a solidary system of healthcare financing. Hence, the new legislation included various provisions to preserve risk solidarity and income solidarity. The main challenge in the political struggle was to craft a proper balance between the principle of solidarity to guarantee universal access and the principle of competition to foster efficiency and innovation.

The new Health Insurance Act can indeed be understood as a complex balancing act between efficiency and solidarity.

The market reform in Dutch health care demonstrates a mixed face. On the one hand, it was directed at system change. On the other hand, however, it involved much continuity. For this reason, the reform can be understood as a complex mix of change and continuity (Helderman et al., 2005). This observation highlights the central proposition of the institutionalist model: the institutional context heavily influences health policymaking. Reforms that radically differ from institutionalized beliefs and interests meet strong opposition if seen as an unacceptable infringement of established rights and intended. As a consequence, policy changes are gradual rather than radical. Changes that, for political reasons, are sold as 'reforms' most of the time appear as a complex mix of change and continuity. All health policymaking is rooted directly or indirectly in history which constrains the room for change. Policy changes involving a radical breach with the past have little chance of crossing the finish.

This chapter contains an introduction to the institutionalist model in health policy analysis. It starts with a discussion of the concept of institution, the concept of institutional pluralism, and the problem of institutional incompatibility. Hereafter follows an analysis of the reciprocal relationship between health policymaking and institutional context (or institutional structure). There are several versions of the institutionalist model. Three versions will be briefly discussed: the rational, sociological, and historical model. The final part of the chapter is devoted to two main themes in the institutionalist model: institutional continuity and institutional change. These themes are discussed in the final part of the chapter. The chapter ends with a brief exploration of the implications of the institutionalist model for health policy analysis.

11.2 What is an institution?

There exists no single definition of the concept of institution. The literature offers a variety of models and definitions. Political scientists following the 'old institutionalist' model were particularly interested in the (comparative) analysis of the structure and dynamics of the central state organizations in a country, most notably the

government, the Parliament, the state bureaucracy, and the judiciary. They called these organizations institutions. A basic assumption underpinning old-style institutionalist analysis was that a country's institutional structure heavily influences the problem-solving capacity of the state and society and the strength of its democracy (Peters, 1999).

This book follows a different model. An institution is conceptualized as a system of broadly accepted rules of the game giving direction to social action whereby action comprises both the belief system (assumptive world) of actors and established patterns of social interaction. This alternative approach to institutions draws, among others, upon the work of Scott (1995), who emphasizes that 'institutions provide stability and meaning to social behavior' (p. 33). They 'discipline' social interaction by a common frame of reference ('frame' or 'script') for interpretation and interaction. Scott argues that social life would inevitably end in chaos without effective institutions. Institutions 'normalize' social interaction. He makes a distinction between normative, cognitive, and regulative institutions. Whereas normative institutions are beliefs (or mind set) about 'good' and 'bad', 'appropriate and 'inappropriate' or 'right or wrong', cognitive institutions are widely accepted ideas about 'what is', 'how to explain', 'what works' and 'what does not work'. Regulative institutions consist of rules of the game for how people should interact with each other.

Institutions either have a formal or informal status. A formal institution of the constitutional state is that state intervention requires a proper legal basis, that any discrimination based on religion, philosophy of life, political conviction, race, sexual disposition, or any other basis is forbidden, that legislative proposals must be approved by a (qualified) majority in the Parliament, that people have the right to demonstrate, and so on. A central theme in the institutionalist model is that many rules regulating social action are informal rules that have developed over a more extended period. Examples are widely shared values and norms, habits, traditions, social conventions, convictions, mutual trust, and public confidence in the state and in science. Sanctions to reward rule compliance and punish rule violations can also be informal. Examples of informal sanctions are trust and promotion (positive sanctions) and loss of reputation, exclusion, and 'naming and shaming' (negative

sanctions). Informal rules can be converted into formal rules. A considerable part of the constitution of nations builds upon practices that have developed in the past (codification).

As said, the institutionalist model postulates that society cannot endure and prosper without broadly agreed and appropriate rules regulating social interaction between people and organizations (Leftwich, 2005). In other words, institutions are understood as a precondition for social order. The linkage between social order and institutions is recognizable in the definition of Streeck and Thelen (2005), who describe institutions as '*building blocks of social order*: they represent socially sanctioned, that is collectively enforced expectations with respect to the behavior of specific categories of actors or to the performance of certain activities. Typically they involve *mutually related rights and obligations* for actors, distinguishing between appropriate and inappropriate, 'right' and wrong', 'possible' and 'impossible' actions and thereby organizing behavior into predictable and reliable patterns' (p. 9).

Nobel-prize winner North (1991) conceptualizes institutions as an established practice. He defines institutions as 'humanly devised constraints that structure political, economic and social interaction' (p. 97). With many others, North underscores the role of institutions in creating social order and reducing uncertainty in social interaction. The focus of his empirical work is on the historical development of formal and informal institutions that have stimulated economic growth and the flourishment of trade. North concludes that institutions are indispensable for prosperity because they reduce transaction costs (the costs of negotiating, monitoring, overseeing, and so on). For instance, nothing reduces transaction costs more than mutual trust, and nothing is as costly as mutual distrust. He stipulates that institutions 'evolve incrementally, connecting the present with the past and the future: history in consequence is largely a story of institutional evolution in which the historical performance of economies can only be understood as a part of a sequential story.' (p.1).

Institutions are also central in how March and Olsen (1976) conceptualize organizations. They distance themselves from the idea of an organization as a

purposeful system regulating the behavior of its members by rationally-designed formal rules. Organizational behavior is largely regulated by informal rules (organizational culture). Not the 'logic of the consequences' prevails in organizational behavior but the 'logic of appropriateness'. Organizational behavior following the logic of the consequences is based upon systematic analysis and assessment of the consequences of alternative options, whereas organizational behavior following the logic of appropriateness is regulated by social norms. The logic of appropriateness refers to the impact of organizational culture on the functioning and performance of organizations.

If we abstract from the mainly subtle differences between these definitions, it is clear that they have much in common. Each definition emphasizes that institutions, whether formal or informal, constrain action and make action predictable to a certain degree. However, some institutions are more compelling than others. The same applies to sanctions. By its emphasis on the institutional context of human action, the institutionalist model of policymaking contrasts with what is known as methodological individualism in social and political analysis. This analytical model of human behavior postulates that individual subjective motivation explains social phenomena. These phenomena are viewed as the result of individual decisions. Consequently, the adherents of methodological individualism demonstrate less interest in the impact of institutions on individual decision-making (ref). The rational choice model in neo-classic economy takes the preferences of actors even as given (exogenous) and assumes that individual behavior is driven by self-interest. In doing so, methodological individualism abstracts from the impact of institutions upon individual decision-making. Scharpf (1997) takes a middle position in the debate on methodological individualism. Institutions, he argues, only constrain action; they reduce action variance but have no determinative effect on it. Actors always interpret institutions and can give these a twist of their own. Sometimes, they may even ignore or violate the rules of the game. Hence, a study of institutional structures only cannot explain policymaking well. Policy analysts must also investigate how actors deal with the rules of the game in decision-making or other activities. On the other hand, actor decisions cannot be reduced to purely individual choices. Hence, policy analysts must

study the impact of the institutional context in which they make decisions. This is the core of Scharpf's model of actor-centered institutionalism.

Problem-oriented and process-oriented institutions

A distinction can be made between problem-oriented and process-oriented institutions. Problem-oriented institutions give direction to the formulation of policy problems and policy goals as well as the choice of policy instruments. An example is the principle of solidarity that had to be respected in the market reform of Dutch health care. The reform would have been politically infeasible had the new health insurance legislation not contained regulations to protect this 'public value' in a market-based healthcare system. Likewise, the call for a shift from a predominant medical perspective to a comprehensive perspective of public health (Chapter 1) can be understood as an attempt to rewrite the health policy agenda by institutionalizing new leading principles for health policymaking.

Process-oriented institutions regulate the process of health policymaking and health system governance. The prominent role of self-regulation in the medical sector exemplifies a deep-seated normative principle in Western industrialized countries (Tuohy, 2003; Freidson, 2001) which sharply contrasts with the institutionalized subordinate role of the medical profession in many Central European countries before the fall of the Berlin Wall in 1989 (Sitek, 2010). The so-called 'implicit concordat' between the state and the medical profession in the National Health Service is another example of an institutionalized rule of the game in UK health policymaking. The concordat means that the state accepts the autonomy of the medical profession in decisions about the use of resources in return for the medical profession's acceptance of the right of the state to set budgetary constraints (Klein, 2012). The decentralized governance structure in public health in many countries (Chapter 7) reflects the influence of historical notions on the most appropriate structure of state governance. Polarization can be conceptualized as the institutionalization of a new political culture: politicians make much of ideologically-driven differences of opinion, seek confrontation instead of collaboration, and love personal attacks.

Institutions and politics

Viewed from an institutionalist perspective, politics is a struggle over the rules for policymaking. Institutions shape the power structure in society and the policy arena. For instance, institutions regulate the role of accountability and transparency in policymaking or which actors have access to the inner circle of the policymaking arena. Acemoglu and Robinson (2012) conclude from their research that inclusive economic and political institutions foster social welfare and prosperity (system performance). In contrast, extractive economic and political institutions are an important cause of poverty. They define extractive economic institutions as institutions that do not allow private property. Contrary to inclusive economic institutions, extractive institutions are designed to extract incomes and wealth from one subset of society to benefit a different subset. Inclusive political institutions, on the other hand, correspond with a pluralistic type of society. Power is not concentrated in the hands of a narrow elite. According to Acemoglu and Robinson, politics is about choosing economic and political institutions.

11.3 Health system as institutionalized system

Health systems can be conceptualized as a set of established rules of the game regulating, among others, medical practice, patient expectations, organizational behavior, health policymaking, and political decision-making. According to Payer, medical practice resembles in several respects a culture (Box 11.2).

Box 11.2 Medicine and culture

In her comparative study of varieties in medical treatment in France, Germany, the United Kingdom and the United States, Payer (an American medical journalist with a background in biochemistry) found remarkable institutionalized differences in the doctor's attitude to patients, prescriptions, testing, and diagnostics. Her initial assumption that medicine is science-based and hence an international activity proved incorrect. In her view, medicine is a matter of culture. 'Why, for example, did the French talk about their livers all the time? Why did the Germans blame their hearts for their fatigue where there didn't seem to be anything seriously wrong with them? Why did the British operate so much less than the Americans? And why did my French friends

become upset when I said I had a virus? (p.15). Payer concludes that 'the choice of diagnosis and treatment is *not* a science. While scientifically conducted studies can show us that a certain cause of action or treatment can result in certain benefits and risks, the weighing of those benefits and risks will always be made on a cultural scale' (p. 154).

Source: Payer, 1988.

Institutions guide how health policy actors make sense of problems and settle conflicts. They regulate the interaction between actors in the health policy arena. Policy implementation offers many examples of established practices that influence health system performance.

Institutional change and continuity are also manifest in health systems. Examples are the gradualist transition from a hierarchical (paternalistic) relationship between doctor and patient to a more horizontal kind of relationship, the shift from trust-based accountability to contract-based accountability in health governance, and the advance of digitalization and datafication of public health. Each of these changes has major repercussions for the structure and performance of health systems. Institutional change, however, usually takes a long period. A dramatic example of the tenacity of an established practice in the history of medicine is the slow uptake of a ground-breaking finding by the Hungarian doctor Ignaz Semmelweis. Resistance to change is an important cause of institutional continuity (Box 11.3).

The publicization of public health or the process of growing state involvement in public health also indicates a process of gradualist institutional change. New rules of the game hold the state responsible for the health of its population. Citizens expect protection from health hazards. Other manifestations are the progressive jurifidication and bureaucratization in health policymaking and the present-day emphasis on transparency, accountability, and integrity. None of these manifestations are unique to health policymaking; they are visible in all public policymaking. Likewise, one can interpret the call for a 'new public health' by moving away from the prevalent bio-

medical approach and individualistic orientation towards a comprehensive approach as a call for institutional change. It asks for a reorientation of the causes of health and disease and a new health policy agenda (Cribb, 2005; Wiley, 2016).

Box 11.3 Semmelweis' tragedy

Semmelweis discovered that the high mortality maternity death rate – on average 25 percent of the women died in childbirth in the Vienna hospital where he worked – was caused by a lack of hygiene. Doctors and nurses were not accustomed to washing their hands in medical practice. Semmelweis demonstrated that maternity death could radically drop by appropriate hygienic measures. However, his call for these nowadays self-evident measures remained contested in the medical community, which was also caused by the fact that Semmelweis' political-liberal ideas were controversial in Vienna at that time. Although he had published his ground-breaking findings already in 1861, it took some twenty years before his ideas became widely accepted.

11.4 Institutional pluralism and institutional incompatibility

In society, multiple institutions co-exist. While some institutions pervade all spheres of social life (for example, politeness norms), other institutions are sector-specific. Distinct institutions regulate social action in the market sector, the judicial sector, the not-for-profit sector, the political sector, the administrative sector, and so on. Professional training is directed at the institutionalization of sector-specific rules of the game. For instance, legal experts will reason more in terms of legal principles than in terms of efficiency and profit-making than students trained in business administration. Likewise, the rules of the game for scientific research differ from the rules of the game for policymakers: the exploration of what is true or false asks for other rules of the game than trying to get something done, preferably as soon as possible.

Institutional pluralism raises the issue of institutional compatibility. Alternative institutions can peacefully coexist in a pluralistic society but also cause institutional friction or incompatibility. Compatibility is an important theme in institutional analysis.

For instance, how do market principles in health care relate to ethical principles in the provision of health care? The medical profession has repeatedly said that competition conflicts with the ethical code of rendering patients the best possible medical care (Berenson & Cassel, 2009; Pellegrino, 1999). Advocates of competition on their side argue that the rules of the game of competition will ultimately make health care more efficient and patient-driven (Herzlinger, 1997). The risk of value erosion can be prevented by strict regulations (Enthoven, 1993).

The issue of institutional compatibility was also a central theme in the market reform of Dutch health care. Opponents of the reform argued that competition and entrepreneurialism conflicted with deep-rooted principles of solidarity in healthcare financing and universal access to health care and might ultimately lead to the emergence of a two-tier healthcare system nobody wanted. Mol (2006) put it this way: the 'logic of health care' is antithetical to the 'logic of the market'. In his analysis of the prospect of economic development in Third-World countries, Leftwich pointed to the risk of institutional incompatibility between democracy and development (Box 11.4).

Institutional (in)compatibility is also a central theme in Sitek's comparative analysis of healthcare reform in Poland, the Czech Republic, and Hungary. After the fall of the Berlin Wall in 1989, these four countries embarked on a reform to overhaul their state-dominated healthcare system with 'Back to Bismarck' as the leading motto. Doctors naively believed that the introduction of social health insurance would end their subordinate position in the public arena. Policymakers, on their part, naively assumed that the reform would increase efficiency and innovation and make health care provision more patient-driven. The reality turned out to be quite different. While the reform proved relatively successful in the Czech Republic and Hungary because of the concentration of authority and longevity of governments, it was much less successful in Poland because of political instability, frequent changes of government coalitions, and the weak position of the minister of Health within the ranks of the government. The absence of strong political leadership and political instability were major stumbling blocks in the reform process. The political structure was not conducive to the intended reform of the nation's system of health insurance (Sitek, 2010).

Box 11.4 Democracy and development: is there institutional incompatibility?

Leftwich starts his analysis of development with the observation that, contrary to a few decades ago, economic and social development cannot be achieved without a strong role of the state. Development is not the same as economic growth. Development in relatively low-income countries or highly unequal economies involves radical and rapid changes in these countries' social, economic, and political structures. What crucially distinguishes development from growth is the issue of the distribution of the benefits of growth. Development requires a more equal distribution of the benefits which in turn requires a radically different political structure and distribution of power.

How likely is it that such a transformational process will be successful? An effective state capable of maintaining the institutions of a competitive democracy does not exist in most countries, as a consequence of which the risk of quick corruption is imminent. Leftwich also holds it questionable that the informal institutions of democracy will be respected: will the losers of power accept defeat, and will the winners agree to exercise restraint? A winner-takes-all culture will only exacerbate the political conflict and make development even harder to achieve.

Source: Leftwich, 2005.

11.5 Relationship between institutional structure and health policymaking

The central message in the previous sections was that institutions matter. They make social action predictable. Without institutions, social chaos would follow. This message also applies to health policymaking: institution sets constraints to health policymaking. Policymakers cannot ignore the institutional structure they are acting in. Their policy decisions are, to a great extent, a 'product' of this structure. On the other hand, however, health policymaking influences the institutional structure of health systems. The goal of healthcare reforms is to alter the institutional structure of

these systems to improve their performance. The relationship between institutional structure and health policymaking is thus reciprocal (Figure 11.1).

Figure 11.1 The relationship between institutional context and health policymaking

The impact of the institutional structure on health policymaking is called institutional impact. The concept of institutional change refers to the impact of health policymaking upon the institutional structure of health policymaking.

Institutional impact

Institutions influence health policymaking in many ways (Clemens & Cook, 1999). The rules of the game influence who has access to the health policy arena, who belongs to the inner circle of health policymaking, how decision-making is organized, which policy options are acceptable or unacceptable, lawful or unlawful, and so on. Established power relations also form part of a country's institutional structure. However, as spelled out earlier, institutions have no determinative impact on social action. A one-to-one relationship between the institutional structure and health policymaking does not exist. Discussing the role of values (a normative institution!) in policymaking, Marmor and Klein (2012) conclude that the impact of values on the organization of health care is mediated by a complex combination of factors, including the countries' political structure, the accommodation of clashing interests in the past, power relations, and what Tuohy has called 'accidental logics' by which she meant 'that key features are 'accidental' in the sense that ideas and agendas shaped them in place at the time a window of opportunity was opened by factors in the broader political system' (Tuohy, 1999).

Institutions shape policy preferences and expectations (Clemens & Cook, 1999). Policy preferences are endogenous instead of exogenous as assumed in methodological individualism. They are context-bound. Consequently, the institutionalist model focuses on the impact of structural and cultural influences on social action rather than on individual behavior. Individual decisions are much less individual than adherents of methodological individualism assume.

An example of an informal rule in health policymaking is the institutionalized practice of consultation and mutual adjustment in Dutch health policymaking. Though the atmosphere may polarize now and then, government and national organizations of doctors, hospitals, health insurers, and other stakeholders do their best to settle conflicts by negotiated agreements (compromises). This practice is known as 'polderen' (Visser & Hemerijck, 1997). The predominant practice of self-regulation in health policymaking in Germany and other Western-European countries is another example of an institutionalized practice.

A concept underscoring the impact of institutional structures on policymaking is policy style. Richardson and his colleagues (2018) describe this concept as a 'system of decision-making' that structures policy choices (including choices in policy implementation) in predictable ways. The study of policy style does not focus on the content of the decisions taken but on the values, norms, and standard operating procedures that 'regulate' the decision-making process (Howlett & Tosun, 2018). Policy styles can widely diverge, for instance, regarding the role of research and evidence in policymaking, the extent to which policymakers are driven by ideological or pragmatic considerations or the way policymakers deal with risk and uncertainty. Polarization is a new policy style. Godt's international-comparative study of healthcare reform and strategies to deal with organized interests demonstrates differences in dominant policy style (Box 11.5).

Box 11.5 Three alternative policy styles: confrontation, consent, and corporatism

In his comparative analysis of state strategies in France, Germany, and Great Britain in the 1960s and 1970s to control healthcare expenditures and meet resistance of the medical profession Godt concludes that these countries followed, generally speaking, different strategies (his synonym for policy style) to resolve conflicts between the interests of the medical profession and public interests. The British government pursued a strategy of consent or diplomacy of mutual adjustment to win the support of the medical profession for its cost control policy. The government understood that its policy could never succeed without the doctors' commitment. The federal government of Germany followed a different strategy. Building upon the German tradition of corporatism, the federal government delegated much of the responsibility for health policymaking to the representative organizations of doctors and insurers at the state level. Health policymaking was seen as a matter of shared responsibility (*Konzentierte Aktion*). In response to the confrontational policy style of the doctors over payment issues, the French government resorted to a counter-confrontational strategy 'using pluralist politics to manipulate various actors and pit them against one another' (p. 474). Godt emphasizes that each of these styles (strategies) mirrors the impact of the institutionalized political-administrative context of each country.

Source: Godt, 1987.

Institutional change

Health policymaking is not only influenced by the institutional structure it is embedded in. It also affects this structure. Seen through an institutionalist lens, healthcare reform is an orchestrated attempt to overhaul an established institutional structure based on a new model or paradigm for the provision, financing, regulation, and payment of health services ('policy reframing'). The new model entails new rules of the game for policymaking and the relationship between the state, market, and civil society. In short, new rules for action in the health system to improve its performance. Tuohy's analysis of the transition from a trust-based to a contract-based model of

accountability offers an insightful analysis of institutional change and the counter-reaction it has provoked (Box 11.6).

Box 11.6 From trust-based to contract-based accountability in health governance

Accountability has always been a central issue in health governance: how to hold doctors accountable for their provision of medical care to patients? Accountability is a multidimensional concept involving the identification of accountability or who should be held accountable for what, the provision of information, and the availability of sanctions. Accountability represents a complex problem in health care because of three specific characteristics of health care: information asymmetry, the difficulty of evaluating the product, and the high costs of error (Arrow 1963).

Using a principal-agent model, Tuohy analyzes a fundamental shift in mechanisms to hold doctors accountable for the provision of medical care. In the old situation, accountability was based on trust. The state in its role of principal had to trust doctors (agents) because of the specific characteristics of health care mentioned above. Accordingly, the state relied on self-regulation by the medical profession to achieve that health care met professional standards. Accountability rested upon trust, collegiality, and self-correcting mechanisms in the professional community. Self-regulation was complemented by some formal mechanisms to punish unprofessional health care.

Tuohy argues that the trust-based model of accountability has to a great extent been replaced with a contract-based model of accountability. This development started with the interference of the state in healthcare finance and healthcare quality. Even more important was the rapid advance and diffusion of information technology that made it possible to collect large amounts of information on healthcare needs, the costs of health care and healthcare quality, and, last but not least, the experiments with managed care and regulated competition. These developments had major consequences for the relationship between the state, doctors, payers, and patients. Nowadays, complex contracts between payers and providers with numerous specific regulations of costs, quality, and many other issues regulate accountability.

Market adepts argue that the relationship between doctors and patients should be

reshaped as a contract-based type of relationship. A pronounced advocate of this view is Herzlinger (1997) in her book *Market-Driven Health Care*. However, as could be expected, there is much resistance to a contract-based type of relationship among doctors. Doctors warn of high-administrative costs and an erosion of the trust-based relationship between doctor and patient they hold for essential in medical care (Berenson & Cassel, 2009; Pellegrino, 1999).

Source: Tuohy, 2003.

11.6 Three institutionalist models

There are several versions of the institutionalist model. This section briefly discusses three alternative models: the rational choice model, sociological institutionalism, and historical institutionalism (Peters, 2001).

Rational choice model

The rational choice model investigates the impact of institutions on actor behavior under the assumption of rationality. A classic example is the Prisoner's Dilemma in which two actors, A and B, have two strategic choices: cooperation and non-cooperation. The actors achieve their best collective result if they cooperate, but if one chooses cooperation and the other non-cooperation, the cooperator will end up with the worst individual outcome and the non-cooperator with the best individual outcome (and vice versa). If both actors choose for non-cooperation hoping that the other actor will choose for the strategy of cooperation or expecting that the other actor will choose for the strategy of non-cooperation, both will end up with the second-worst outcome. Because none of them wants to run the risk of being exploited by the other, non-cooperation is the dominant strategy. The main lesson of the Prisoner's dilemma is that individually rational behavior can produce irrational collective outcomes! None of them can individually escape from this trap because of the risk of exploitation unless they decide to collective action by common rules of the game, including effective sanction mechanisms to punish non-cooperation.

A practical application of the Prisoner's dilemma is the Tragedy of the Commons (Hardin, 1968). This model describes a situation where individual users acting in their self-interest have open access to a common pool of resources. Without effective formal or informal rules regulating access and use, the common pool will soon be depleted to the detriment of all users. The lesson is again that uncoordinated action inevitably ends in tragedy. Overfishing, global warming, air population, or escalating healthcare expenditures eroding the financial sustainability of health care are illustrations of the Tragedy of the Commons. These problems can only be effectively remedied by collective agreements and regulations supported by effective sanctions.

The rational choice model takes an outer position in the institutionalist model of health policymaking. In contrast to its alternatives, the model premises methodological individualism by taking players' policy preferences as given (exogenous) and assuming that they are driven by self-interest. Institution formation is a central theme in the rational choice model. The challenge is to develop formal rules of the game to resolve the problem of collective action (see Chapter 6). The actor-centered model developed by Scharpf (1997) is a variation of the rational choice model. Postulating that institutions only structure but do not determine interactions, the way actors use their choice options influences the outcome of interaction (or policymaking). For instance, if the government is formally authorized to take regulatory measures to address a pressing problem, it can nevertheless opt for soft measures (e.g. persuasion) or even non-intervention to reach the same result. Policy analysts using an actor-centered model do not confine themselves to investigating the impact of institutional structures on policymaking. They also examine how policy actors choose their policy goals and 'play' with institutions to achieve them.

Sociological institutionalism

Scott (1995) is a representative of the model of sociological institutionalism. The leading thought is that the behavior of people and organizations follows certain patterns or routines. Institutions offer a script or framework for how to think and act. Institutions are considered necessary for social order. A central claim of the model is that institutionalized interaction patterns tend to be resistant to change. Tradition and habits work as formidable barriers to changing behavior. Research on the de-

implementation of institutionalized practices of low-value care demonstrates the tenacity of tradition and habits in providing health services (Nilson et al., 2020).

Institutional change is conceived as the outcome of more or less non-orchestrated processes spanning a more extended period. Institution formation is not a matter of design as in rational choice models but the outcome of gradual transformation. For instance, the advance of medical knowledge and the introduction of new technologies have gradually radically changed the understanding of health and disease. Likewise, the emancipation process in Western industrialized societies has affected the relationship between patient and doctor. The patient-doctor interaction pattern has become more 'horizontal' than it used to be only a few decades ago when it still had a relatively 'vertical' or paternalistic structure. The 'spontaneous' emergence of new practices have also resulted in new legislation establishing and reinforcing patients' rights (e.g. the right to consent, the right to complain, and the right to participate in decision-making).

Historical institutionalism

The third version is historical institutionalism. At its core, this model postulates that history always matters in policymaking. The simple idea is that policy decisions taken in the past create an institutional context that influences later policymaking. Past decisions are assumed to have an enduring influence on policymaking at later stages: they induce a self-reinforcing policy trajectory (policy path). Policymakers operate as 'agents of history' who must respect 'the legacy of the past'.

A central concept in the historical institutionalist model is path dependency. Policy changes are path-dependent. The best predictor of a policy at point (t) is the policy at point (t-1) or even (t-10). Initial policy choices tend to persist by feedback effects; they set the course for policymaking over a long period (Krasner, 1984). In other words, historical institutionalism postulates that policy change is inevitably locked in. Historical institutionalism does not exclude institutional change. However, the model emphasizes that institutional change is not a 'one-shot operation' (a radical reform) but the cumulative result of gradual or incremental changes over a longer period (North, 1979). The concept of path dependency explains why most health

policymaking follows an evolutionary rather than a radical path. Even fundamental policy reforms appear less radical than policymakers had in mind or hoped for. Policymakers cannot ignore the past and must respect established rights created in the past. The 2015 reform of long-term care policy in the Netherlands is an instructive example of path dependence. The initial policy decision of a distinct statutory scheme for long-term care set out the course for policymaking in later years (Box 11.7).

Box 11.7 Path dependency in Dutch long-term care policy

1968 was a crucial year in the history of Dutch long-term care. The introduction of the Exceptional Medical Expenses Act in that year terminated four decades of political discussion fueled by conflicting ideological convictions about how to organize and finance long-term care. The act would function as the regulatory flagship of long-term care for almost 50 years. The essence of the established regime was that the state assumed political responsibility for long-term care by introducing a distinct statutory insurance scheme financed by social contributions. The act conferred each citizen meeting the eligibility criteria the formal right to publicly-funded services of long-term care. The provision of these services remained in the hands of private, not-for-profit providers, as had been the case in the past. Initially, the new act covered only residential care for vulnerable older persons in nursing homes and handicapped persons. Over time, however, service coverage of the regime extended at a large scale. As a result, long-term care gradually transformed into a labyrinth of specific regulations for ever more specific target groups.

A remarkable aspect of the history of the Exceptional Medical Expenses Act is that the extension of coverage continued despite warnings of the then state-secretary of Health in the early 1980s that the financing of long-term care would become unsustainable and for this reason required fundamental restructuring. However, his cry for reform remained unanswered. It took until 2015 before an overhaul of the organization of long-term care came into force.

How to explain this course of events? The initial decision to introduce a separate statutory regime for long-term care had a lasting impact on the following policy decisions. The new regime created new rights that recipients did not want to give up.

Provider organizations also benefitted from the public regime because it guaranteed them the financial resources to continue and expand their activities. As a consequence, the need for reform mainly received lip service.

The 2015 Long-term Care Act as the successor of the Exceptional Medical Expenses Act respected the fundamental principles of the old legislation. As its predecessor, the new legislation is shaped as a statutory health insurance scheme financed by social contributions; clients meeting the eligibility criteria retain their right to long-term care services, as in the old situation, provided by private providers. The reform involves some restrictions on the right to long-term care, gives clients more freedom of choice, restructures the organization of long-term care organization, and includes last but not least, a sizeable package of expenditure cuts that was largely undone soon after. All in this together, the reform did not bring about a major revision of Dutch long-term care: it was, in many respects, a path-dependent reform.

Source: Maarse & Jeurissen 2016; Companje 2013.

11.7 Explaining institutional continuity

As spelled out in the introductory section of this chapter, the central proposition of the institutional model of public policymaking is that policy changes are incremental rather than radical. Institutional continuity defined as the continuation of established rules directing social interaction prevails. Radical change only occurs under exceptional conditions (see next section). Policy change is conceptualized as an evolutionary process of continuous accommodations to altering circumstances. This is also true for healthcare reform. Most reform rhetoric suggests more change than actually takes place.

How to explain institutional continuity or the persistence of institutions? Institutional continuity is often ascribed to the force of habit, lack of knowledge, and disbelief. For instance it took many years before the Semmelweis' insights about the role of hygiene in maternity care were accepted by the medical community. Resistance to change can also be motivated by material interests.

Mahoney (2000) mentions four alternative models for explaining institutional continuity. His first model links institutional continuity to sunk costs. Radical changes (e.g. reforms) are costly making them unattractive. Furthermore, radical changes divert attention from other urgent issues. Hence, it is prudent to follow the route of successive accommodations to enhance system performance.

The second model relates institutional continuity to functionality. If a certain rule or practice has a central function in the overall system, there are strong forces against institutional change because of its spill-over effects. For instance a new payment system for doctors may have big administrative consequences for healthcare management.

The other models connect institutional continuity with power and legitimacy (see also Kuipers, 2004). As spelled out in section 11.4, institutions 'define' a power structure that powerful agents will not easily give up. Loss of power motivates them to thwart institutional change. Consequently, the room for institutional change is contingent upon the power balance in the health policy arena. One of the conclusions of an evaluation of the 'political death' of the market reform in Dutch health care in the early 1990s was that the government had been unable to break through the clay layer of vested interests and that it took till the end of the 1990s that the reform process was resumed. (Willemsen Committee, 1994).

Finally, broadly accepted values and established rights restrict the room for institutional change. Reformers must respect these values and rights. The incumbent political elite can refer to these values and rights to discredit reform plans. The same is true for the beneficiaries of state programs who are eager to preserve their established rights.

11.8 Explaining institutional change

A frequently mentioned weakness of the institutionalist model in health policy analysis is the tendency to underestimate the role of institutional change. The model misses powerful analytical concepts to explain institutional change and capture variations of institutional change and its consequences for social systems. The proposition that

most institutional changes involve minor adaptive adjustments to altered circumstances causes what Streeck and Thelen (2005) call the 'conservative bias' in institutionalist analysis. The challenge is giving institutional change a firm place in the institutionalist model. How to explain institutional change, and which types of institutional change can be discerned?

The dominant model in the institutionalist model of policymaking is to assume a causal link between the occurrence of external shocks or major threats and institutional change. Examples of such 'critical junctures' are natural disasters, wars, political revolutions, and financial meltdowns. These events disrupt an existing institutional system and demand radical institutional adaptation. This model of institutional change is known as the punctuated equilibrium model: extreme external conditions disturb a state of equilibrium.

The outbreak of COVID-19 in 2020 caused by an infinitesimal particle (Christakis, 2020) is a textbook example of a major shock that compelled governments to take unprecedented policy measures to protect vulnerable people in society and avert a 'meltdown' of their healthcare system. The pandemic brought serious weaknesses in health systems to light. Despite earlier warnings from public health experts, most systems were not well-prepared for the pandemic outbreak. The policy lessons of a few earlier outbreaks (SARS in 2003/4; H1N1 ('Swine Flu) in 2009; MERS in 2012) had not been learned well. Will COVID-19 bring about fundamental institutional changes in health systems (Box 11.8)?

Box 11.8 Three potential post-COVID scripts in health policymaking

In their investigation of the potential impact of COVID-19 on health policymaking, Boin and 't Hart stress the importance of crisis framing. Crises elicit what they call a 'meaning-making battle' (or sense-making battle). They refer to Spector, who has written that 'facts (of the events) never speak for themselves [and] always await the assignment of meaning'. An archetypical storyline emphasizes the impact of exogenous forces (geography, war, weather, international markets, and so on). Crises

are, at least to a great extent, unforeseeable and highlight the policymakers' limit of control. An alternative storyline gives endogenous factors a central place in explaining crises. The outbreak of a crisis is the outcome of policy failure. The incumbent policy elite has failed to take appropriate measures to prevent the crisis or to be well-prepared if a crisis occurs.

Boin and 't Hart distinguish between three potential post-COVID scripts. In the crisis→ learning →adaptation script, policy failures trigger a need for policy learning that results in policy adaptations to do better in the future (e.g. making a budget available to improve 'pandemic preparedness'). Policy learning is mainly left to experts. The reaction to the crisis must be non-political and evidence-based.

An alternative script is the crisis→exploitation→reform script which conceptualizes a crisis as an opportunity to call for fundamental reform, including the need for centralization of power to enable responsible officeholders to take firm measures. Whether or not the explanation of the crisis is sought in exogenous or endogenous factors does not matter. What matters is that policymaking has failed and that policy changes are required. Policy lessons and policy changes are more radical in the crisis→exploitation→reform script than in the crisis→learning→adaptation script.

The crisis→blame contest script follows a different line of reasoning. Political adversaries exploit the crisis as an excellent opportunity to blame the incumbent policy elite for its innocence and incompetence. They frame the crisis as the outcome of endogenous factors. This script particularly flourishes in a polarizing context.

Source: Boin and 't Hart, 2022.

Though critical junctures may trigger institutional change, the conceptualization of institutional change as the consequence of exogenous shocks only fails for two reasons. It ignores the influence of endogenous changes and misunderstands the cumulative effect of successive incremental changes on health systems. Most institutional changes develop gradually (Streeck & Thelen, 2005). For instance, consecutive advances in medical technology have been an important driver of institutional change. Consequently, modern healthcare provision radically differs from

what it used to be only a few decades ago. The increased knowledge of the impact of environmental factors and health behavior on health and disease has stimulated a paradigm shift in health policymaking. Likewise, the process of emancipation has changed the patient-doctor relationship. Each of these institutional changes took place gradually.

Another explanation of institutional change is the absence of a one-to-one relation between institution and behavior. This is unsurprising, given that most institutions are ambiguous and leave room for interpretation and policy discretion. Streeck and Thelen argue that 'the practical enactment of an institution is as much part of its reality as its formal structure (p. 18)' and that 'the enactment of a social rule is never perfect' (p. 14). Most of the time, there is no single way of putting a rule into practice. For instance, policymakers or implementing agencies can decide for a strict or less strict rule application. The room for 'rule mutation' depends on the specificity of the rule. Specific rules leave, in theory, little room for mutation though practice shows that even strict rules may appear indeterminate in individual cases. In contrast, ambiguous rules (e.g. values and open norms) lead to differing practices (Clemens & Cook, 1999). Other endogenous factors triggering institutional change are conflicts on rule implementation and efforts of agents to reinterpret regulations, seek loopholes in the regulations, circumvent regulations, and likewise strategies.

Policy reform can be conceptualized, as spelled out earlier, as a pre-designed attempt to bring about institutional change. Proponents of reform argue that the old policy paradigm fails and call for a new model to enhance system performance. The existing institutional structure must be redirected. However, the practice of health policy reform demonstrates that policy reframing (Rein & Schön, 1994) is difficult and may take much time. Opponents to reform will hold on to the entrenched belief system for reasons described in the previous section. Reforms also fail because of political chaos, polarization, weak democratic institutions, or disrespect for the unwritten rules of democracy. Successful healthcare reforms may require concomitant reforms in the political-institutional structure which are not self-evident (Leftwich, 2005; Sitek, 2010). Disputes on the rules of the game for policymaking are also a well-known phenomenon. 'Political institutions are not only periodically contested; they are the

object of ongoing skirmishing as policy actors try to achieve an advantage by interpreting or redirecting institutions in pursuit of their goals, or by subverting or circumventing rules that run counter to their interests' (Streeck & Thelen, 1995: 19). The likely result of these skirmishes is a gradual change in the structure of governance.

Streeck and Thelen introduce an interesting typology of institutional change. They distinguish between two dimensions of change: the pace of change which varies between incremental and abrupt and the result of change which varies between continuity and discontinuity.

Figure 11.2 Types of institutional change: processes and results

		Result of change	
		Continuity	Discontinuity
Process of change	Incremental	Reproduction by adaptation	Gradual transformation
	Abrupt	Survival and return	Breakdown and replacement

Source: Streeck & Thelen, p. 9

Reproduction by adaptation means that minor adaptive adjustments to altering circumstances (incremental policy changes) leave the health system largely unaffected. Survival and return happen when political and social forces to resume old practices are so strong that an abrupt change eventually leaves a system largely unaltered. Survival and return can also result from the 'normalcy bias' or the human tendency to believe that the old situation will return or has returned despite warnings of the contrary (Drabek, 2012). Another possible result is that the system breaks down and is replaced with an alternative structure. Gradual transformation occurs if institutional change results from successive incremental changes with

transformative effects over a certain period. Streeck & Thelen consider gradual transformation the most common type of institutional change. Evidently, the typology only gives a stylized overview of institutional change. Various gradations of change can be discerned. A combination of the four models is also possible.

11.9 Models of gradual transformation

How does gradual transformation take place? Which types of gradual transformation exist? In response to these questions, Streeck and Thelen distinguish five types of gradual transformation that may occur simultaneously. The boundaries between the types are fluid.

Drift

Drift is the process of gradual erosion of an institutional structure. On the surface, institutional structures appear stable but gradually erode in reality. An example is Hacker's analysis of 'the hidden politics of US welfare state retrenchment'. The declination of conservative politicians to adapt existing policy programs to changing economic circumstances and new social risks has led to emerging gaps in coverage and, consequently, the privatization of social risks. Institutional change by drift is not the result of a single major policy intervention or a master plan but rather the cumulative effect of successive incremental changes or non-decisions (Hacker, 2005). Drift can also result from minor but successive changes in the implementation of healthcare regulations that go unobserved yet have significant consequences for system performance. Without active maintenance, values and norms run the risk of gradual erosion. In this respect, opponents to the market reform in Dutch health care have always warned of the creeping erosion of public values of health care. Critics of managed care and regulated competition fear that a contract-based relationship will eventually hollow out the trust-based relationship between doctor and patient (Tuohy, 2003). Likewise, critics of the penetration of tech giants into health systems and the concomitant digitalization and datafication warn of unnoticed 'surveillance creep' (Sharon, 2021).

Layering

Institutional change by layering results from adding new elements to an existing institutional structure. Persistent and intractable problems, policy disputes, or the need for new coordinative structures are resolved by creating additional structures or layers. An example is the organization of quality control in Dutch health care. The call for outcome measurement and transparency at the turn of the century elicited various initiatives for quality measurement. These initiatives did not replace the pre-existent quality control system but introduced an extra layer in quality control. Lack of coordination resulted in a disjointed structure of quality control. The creation of the National Health Care Institute in 2014 was an attempt to streamline and coordinate quality measurement and improvement. The institute has formal enforcement power to resolve deadlocks (Van den Bovenkamp et al., 2013).

Conversion

Institutional change by conversion means the redirection of existing institutions to new goals, functions, or purposes. For instance, policymakers respond to new environmental challenges by reorganizing established institutional structures. Healthcare reform is an orchestrated attempt to substitute new structures for old ones. Conversion may also result from changes in the power balance: new powerholders seek to convert the power balance to serve their political agenda. Streeck and Thelen emphasize that conflicting interests, political contestation, and the need for political compromise restrict the scope of conversion.

Displacement

Displacement occurs when previously taken-for-granted practices disappear because of the diffusion of new models. Just as the old typewriter has disappeared, established medical practices are continuously displaced by new practices.

Exhaustion

Institutional change by exhaustion occurs when an institutional system sets a process in motion that ultimately leads to its destruction or breakdown. An example is a generous but costly and unsustainable system of benefits. The difference

between exhaustion and replacement is that the collapse is gradual rather than abrupt.

11.10 Conclusion and suggestions for health policy analysis

This chapter discussed the institutionalist model in health policy analysis. Institutions are broadly agreed rules of the game that give direction to social action. Health systems can be conceptualized as a set of established rules 'regulating' medical practice, patient expectations, organizational behavior, health policymaking, and the state-society relationship. Two central propositions of the institutional model are that society cannot endure and prosper without institutions and that institutional changes are gradual rather than radical. Initially, the emphasis in the institutionalist model was primarily on institutional continuity. Presently, institutional change and its underlying mechanism are given a more solid place. Successive gradual changes can fundamentally alter the institutional structure of health systems (gradual transformation). Healthcare reform can be conceptualized as a combination of institutional change and institutional continuity. Institutions set constraints on the pace and scope of reforms. Institutional change can take various forms: drift, layering, conversion, displacement, and exhaustion.

The institutionalist model provides an interesting starting point for studying health policymaking. The model sheds specific light on the basic concepts discussed in the previous chapters. The fundamental idea is that health policymaking cannot be well understood without insight into the institutional structure in which it is embedded. For this reason, health policy analysts should study the impact of this structure on policymaking. Insight into this institutional impact also helps explain the content and outcomes of healthcare reforms. Below is a list of research suggestions in health policy analysis from an institutionalist perspective:

- Which institutions influence the problem frame, formulation of the policy goals, and the choice of policy instruments in health policymaking? What is the dominant policy paradigm influencing these policy elements? Which institutional change are reform plans directed at?

- Which institutions influence the structure and course of the policymaking process? What is the dominant policy style in each stage of the policymaking process? Do science and research have an 'institutional place' in each stage of the policymaking process? What is the institutional impact on the success and failure of policy implementation? Which institutional incompatibilities can be observed, and what is their impact on health policymaking?
- Which institutions influence the structure of the health policy arena? Which institutional changes can be observed, for instance, concerning the structure of policy networks and interest representation, the role of the media, and the impact of the judiciary on policymaking? Another research theme concerns the institutionalization of international (global) structures for health policymaking.
- What are the formal and informal rules of the game in health system governance? Which institutional changes can be observed? How does a country's health governance system fit into its overall governance system? Which institutional factors hinder collective action in health policymaking? Does an institutional gap exist between governance structure and system performance?
- What is the institutional impact on health system performance? Has health policy reform brought institutional change?
- What is the impact of path dependency on health policymaking and health system governance? Does history matter in health policymaking?
- Which factors (barriers) explain institutional continuity? Which indications of institutional continuity can be observed?
- Which factors explain institutional change? Which indications of institutional change and type(s) of institutional change can be observed?

The institutional model has implications for health policy analysts in their advisory role to policymakers. Their task is to inform policymakers on the impact of institutional factors on policymaking and policy outcomes. Another task is to inform them on the processes of institutional continuity and change in policymaking and the mechanisms explaining these processes. What are the consequences of institutional

continuity and change for policymaking, and how can these processes be broken or promoted?

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CHAPTER 12

CONCLUSION

12.1 Why this book?

Health policy analysis, described as the analysis *of* and *for* health policy-making, informs health policy analysts on how health policymaking works and offers them knowledge for supporting health policymakers in practice. A distinction can be made between two types of knowledge. Policy-issue knowledge is pertinent to a specific policy and involves specialized knowledge concerning a specific problem. An analysis of policy interventions to tackle, for instance, the problems of obesity, chronic obstructive pulmonary disease, or health disparities requires substantive expertise of these health problems. However, policy-issue knowledge only falls short. Needed is also policymaking knowledge or knowledge on how policy choices are made and put into practice. Although policy-issue knowledge should always be leading, policymakers must be familiar with the structure and political dynamics of health policymaking to succeed. They must understand the complex relationship between information and policymaking, the pressure of interest organizations upon policy decisions, the governance structure, the problem of collective action, the role of power in policymaking, the impact of the context on health policymaking, and so on. There is no 'linear path' from policy-issue knowledge to what is eventually decided and implemented.

This book concentrated on the health policymaking process from a political science perspective. The first reason for this choice was that, so far, health policymaking has received little systematic attention in the study of public health. Most studies on public health focus on policy-issue knowledge. By its focus on the health policymaking process, this book is complementary to studies presenting policy-issue knowledge of public health. The second reason is that public health experts often tend to underestimate the complexity of health policymaking. In their view, health policymaking should be driven by evidence and research, not by politics and power relations. In doing so they accentuate the instrumental dimension in health

policymaking but misjudge its political face. In their view, health policymaking should be depoliticized as much as possible. This reasoning fails for the simple reason that health policy is political. Health policy rests upon political choices that could have been different. Health policy analysts must understand the political dimension of health policymaking.

12.2 Building blocks as starting-point of health policy analysis

The second part of the book presented five building blocks health policy analysis: policy content, policymaking process, actors and policy arena, governance and policy effects. Each block focused upon a specific aspect of health policymaking. The study of the content of health policy gives insight into the political construction of health problems (problem framing), the policy goals of state intervention, and the instruments to achieve these goals. The challenge in health policy analysis is to map these elements and investigate the policy paradigm (assumptive world) underpinning the problem framing and the policy decisions made. The choice of policy instruments entails information on the concrete meaning of policy goals and the priority given to each of them. Policy analysts must be aware that policy statements should not be confused with policy choices and actions. For this reason, they should not confine the analysis of the policy content to policy documents and verbal statements only, but include an investigation of what policymakers actually decide and what they do to put these decisions into practice.

The health policymaking process consists of the dynamic process of events, decisions, and actions concerning health problems. The study of health policymaking highlights its non-linear structure: there is no straightforward path from problem to action. There are several strategies for studying health policymaking. The first strategy is to conceptualize health policymaking as a cyclical process consisting of subsequent stages. This strategy starts with an analysis of the stage of agenda-building and problem framing. Who has access to the policy agenda? An important aspect of the policy development stage is what kind of expertise has been mobilized to underpin the policy choices in the policy formation stage. If these choices are contentious, an important research question is which attempts policymakers have

made to bridge political differences. Ultimately, health policymaking is (also) a matter of the exercise of power. Health policy analysts should not make the error of underestimating the impact of policy implementation on the policy effects. Policy implementation is the Achilles Heel of all policymaking. The next theme is policy evaluation. Here, the key question is how policy effects are evaluated, which information sources are used for evaluation, which evaluative conclusions are drawn by whom, and whether these conclusions are reasons for policy accommodation or policy termination. The second strategy is to focus the investigation upon the successive decision rounds in the policymaking process during which key decisions are made, revised, and sometimes revoked. Third, health policy analysts can investigate the interdependence between policymaking processes. Health policymaking is always part of a complex set of processes influencing each other back and forth. The challenge is to disentangle the interconnections between these processes. Finally, policy analysts may investigate how a policy has developed over a certain period and how it has been accommodated to changing insights and circumstances. The study of a policy path gives insight into the historical dimension of health policymaking and the political dynamics of policy expansion and contraction.

The third building block is policy actors and health policy arena. Health policymaking takes place in an imaginary health policy arena consisting of all actors participating in health policymaking, the relations between these actors, and the rules regulating the interactions between them. A distinction was made between policymakers, experts, interest organizations, activist groups, producer organizations, the media, and the judiciary. Actors operate in policy networks. The composition of these networks is an important topic of research in health policy analysis. Which actors participate in which policy network, and what is the structure of this network? Other research topics are the relationship between policymakers and policy experts and the role of interest organizations, the media (including social media), and the judiciary in health policymaking. The analysis of the health policy arena often demonstrates how a thick clay layer of vested interests restricts the political room for policy change. Another research topic is the role of governmental and non-governmental organizations in the global health policy arena.

Understanding health policymaking requires knowledge of the formal and informal rules of the game for health policymaking called governance rules (fourth building block). The study of governance rules helps explain the effectiveness and legitimacy of health policymaking and gives insight into the problem of collective action and governance gaps. Governance rules include authorization rules, participation rules, decision rules, compliance rules, coordination rules, financing rules, accountability rules, transparency rules, integrity rules, and legal protection rules. Health policy analysts should use typologies of basic models to unravel the complexity of governance systems. Based upon the modus of decision-making and compliance a distinction was made between the anarchic model, the hierarchical model, the majority-voting model, the network model, and the market model. An alternative typology built upon differences in the locus of policymaking. Here a distinction was made between the state-governance model, the self-governance model and several multi-level governance models. Each of these models has its strengths and weaknesses regarding the effectiveness and legitimacy of health policymaking. Another topic of research is the centralization and decentralization of health system governance and the impact of these changes in governance structures on health system performance.

Policy effects are the fifth building block. Health policy is not a goal of itself but a strategy to bring about desired changes. The leading question is to investigate to what extent these changes have been achieved and which side effects and counter-productive effects have occurred. Other research topics are long-term and distributive effects (the costs and benefits of health policymaking across the population). Health policy may also have political effects. Classic examples of these effects are scandals, public outrage, and political crises. A research theme attracting increasing attention is the development of public trust in government and science.

12.3 Four analytic models

The third part of this book presented four analytical models for health policy analysis: the rational model, the normative model, the rational model, and the institutionalist model. Each analytical model provides an analytical lens alerting health policy analysts to specific aspects of health policymaking.

The rational model postulates that policymaking should not be the outcome of political struggle, ideological convictions, or power relations but instead should rest upon the best available information, including evidence-based information. The synoptic model describes how policymaking should ideally be organized to achieve the best results. An alternative is the deliberative model, which underscores the role of argumentation, interpretation, multiple advocacy, and justification in policy analysis. Rational policymaking in the deliberative model requires multiple sources of information. An important research theme is how policymakers deal with risk and uncertainty in policymaking and which strategies they pursue to reduce risk and uncertainty.

The central proposition of the normative model in health policy analysis is that health policymaking cannot be reduced to an information-driven process. It always involves normative choices. A distinction can be made between ultimate and instrumental values. A common critique is that ultimate values may become subordinated to instrumental values. Because of the presence of multiple values in society (value pluralism), policymakers are confronted with complex moral dilemmas for which no easy resolution exists. Judgment pluralism means that actors have different opinions of a good solution. Value pluralism and judgment pluralism are a source of normative conflicts. The purpose of the normative model is to investigate the explicit or implicit normative choices in health policymaking and how policymakers deal with complex normative dilemmas.

The conflict model postulates that health policy and health systems are not the result of a consistent and information-based design but the product of past political compromises between actors with incongruent preferences. Conflicts are inherent to policymaking in a democratic and pluralist society. Though they are a risk to the

problem-solving capacity of health systems, it should be emphasized that conflict-free policymaking also presents a risk to the problem-solving capacity of health systems. The outcome of policy conflicts is contingent on the power balance in the health policy arena. Information is a policy instrument in the hands of the power holder. Science (expertise) is increasingly politicized by making it an object of or instrument in political struggle. The power balance in health systems has a complex structure. Although the state has gained more power in health policymaking, its power should not be overstated. The room for state health policymaking is constrained by political divisiveness and political pressure of interest groups. The conflict model is a source of interesting research questions. For instance, which conflicts dominated policymaking? How did the conflict evolve over time? Which conflict resolution strategy or strategies have been used to end the conflict? How did the power balance influence the conflict and conflict resolution? Had the actors a common interest in resolving the conflict? What is the use of science in policymaking? Is there evidence for the politicization of science?

The institutionalist model focuses on how institutions, defined as broadly agreed rules of the game that give direction to social action, regulate medical practice, patient expectations, organizational behavior, health policymaking, and the state-society relationship. Three central propositions of the institutional model are that society cannot endure and prosper without institutions, that institutions influence actor behavior, and that institutional changes are gradual rather than radical. Successive incremental changes can nevertheless fundamentally alter the institutional structure of health systems over a more extended period (gradual transformation). Healthcare reform can be conceptualized as a combination of institutional change and continuity. Institutions set constraints on the pace and scope of reforms. Some research questions ensuing from the institutionalist model are: which institutions dominate the content, process, and effects of health policymaking? To what extent are policy decisions path-dependent? Which factors influence institutional continuity and change?

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Health Policy Analysis - An Introduction

Prof. Hans Maarse

This textbook focuses on health policy analysis for students interested in public health and policymaking. It reveals health policymaking as a multifaceted process, challenging the linear path from knowledge to policy. While empirical knowledge is crucial, the book emphasizes the political face of policymaking, incorporating contests, beliefs, and interests. It equips students with critical skills to understand and shape health policies. An authoritative resource born from years of teaching experience, it is a must-read for aspiring health policymakers.

Biography:

Prof. Hans Maarse is an emeritus professor of Health Policy Analysis at Maastricht University, with a background in Political Science from the Catholic University Nijmegen. He has published extensively on Health Policymaking and Market Reform in Dutch Health Care. He is still actively involved in teaching Health Policy Analysis at University College Venlo.