

Health Policy Development

A Handbook for
Pacific Islands Practitioners



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FOREWORD

Developing policy is central to the role of all governments. Only through policy can they lay out the course or principles of action they plan to follow. In recent years, there has been much academic development in the fields of policy, public policy and policy analysis. In some countries, the post of 'policy analyst' has been established in government departments, and a number of formal academic and in-house training programmes have been established in the public sector in an attempt to improve the quality of the government policy-making process.

However, many governments are not in a position to provide extensive training of this nature. This problem is particularly acute in the Pacific, where many ministries/departments of health do not have many 'policy' staff. It is generally not possible for those people assigned the task of drawing up policy to take significant time away from their regular positions to participate in formal courses established in countries such as Australia or New Zealand.

The wide range of aspects covered in the field of policy development also makes it difficult for individuals to obtain a range of materials, to analyse and think about these, and to derive value for their day-to-day work from the often diverse perspectives contained in the available academic literature.

With this in mind, WHO commissioned this work from two experienced policy practitioners who have had many years of experience in the policy process, both in the field, advising ministers and governments, and in academic settings. In this publication, they set out to outline concisely the different aspects of the policy development process that are relevant and important for people currently involved in advising and making government policy in the Pacific.



Shigeru Omi, MD, Ph.D.
Regional Director

This handbook has been prepared for the guidance of practitioners involved in the policy-making or policy analysis process in the health agencies of Pacific island countries. It draws upon our experience in health policy-making in New Zealand, but also reflects the lively exchanges which took place at the health policy development workshop for Pacific island countries, held in Nadi, Fiji, in August 2002, and attended by representatives of several Pacific island countries. The handbook has, in addition, drawn from the vast body of literature on policy-making in general, and in the health sector in particular.

In our discussions in Nadi, and in preparing this handbook, we have always had in mind the challenges that face those who are involved in health policy 'on the ground' in Pacific island countries and areas. We are only too conscious that the policy process is, as we have put it elsewhere,¹ 'a messy business'. Unfortunately, the issues that have to be dealt with, the behaviour of the many actors, and the quality of the information available, are very rarely as neat and tidy as in the linear models of the textbooks. Those who provide advice and those who take decisions work within the resources, the limitations and the opportunities available to them.

We are also very conscious that policy-making is an activity that takes place within the institutions, traditions and present situation of individual countries and areas. This is a handbook, not a manual, for guidance not instructions. The importance of the national context is underlined by the provision we have made for appendices relating to organizations and the legal framework to be completed in each country. At the same time, the experience of the Nadi workshop confirmed our belief that there is a great deal to be gained by the island countries of the Pacific sharing experiences and working together.

We hope that this handbook will be of some help to those in the Pacific island countries who are committed to the goal of improving the health status of their people.

We are grateful to the World Health Organization, especially its staff in the Western Pacific Regional Office and in Fiji, who have made possible the health policy development initiative of which this publication is but a part.

John Martin

George Salmond

¹ Martin J., Salmond G. Policy Making: The Messy Reality. In: Davis P., Ashton T., eds. *Health and Public Policy in New Zealand*. Auckland, Oxford University Press, 2001.

WHAT IS POLICY?

Governments seek to make a difference — a positive contribution to their countries' welfare. Public policy is the way in which they give effect to that aim.

'Public' is a tricky term. In short, we are talking about what governments — ministers and departments² and other agencies — do. However, increasingly, and for good reason, we are recognizing that organizations and individuals outside government are becoming involved in the policy-making process. For example, the medical profession will have a view about what should be done to treat an epidemic — and that view should be listened to — but the profession's position is not itself public policy. That is the government's business.

'Policy' too is a slippery notion. We will consider below some of the many definitions, but we are on pretty safe ground if we focus on policy as 'anything a government chooses to do, or not to do'.³ It is about government decisions, including the decision to do nothing. However, policies are more than decisions. As Howlett and Ramesh put it, "public policy is a complex phenomenon consisting of numerous decisions made by numerous individuals and organizations".⁴ In most cases, the policy can be traced to a document (whether cabinet minutes, ministerial pronouncement or departmental newsletter), but on occasions policies can only be identified by working backwards — sometimes called 'creeping policy-making'.

'Policy' is often distinguished from 'administration', management, implementation or delivery. The distinction is captured by the language of 'steering' (i.e. policy) and 'rowing' (i.e. doing). This handbook is directed particularly towards policy and does not cover the processes of implementation. We cannot stress too strongly, however, that the best intentioned policies often fail because the practicalities of implementation — how can we deliver? — were neglected when the policy was under development. Success in implementation may well depend, not just on what is in a policy, but how that policy was developed.

Choice is at the heart of policy-making. Where will the scarce funds available have the best return? Is investment in high technology hospital-based services preferable to community-based primary care? More staff or new computers? Despite the absence of adequate evidence, should we do something or nothing? The aim of this handbook is to assist the processes by which those choices are made.

"Policy is a shorthand description for everything from an analysis of past decisions to the imposition of current thinking".⁵ Here, following Bridgman and Davis, we discuss just three of the many textbook approaches to policy:

² In many countries government departments are referred to as ministries, but in this publication the generic terms 'departments' or 'agencies' will be used.

³ Dye T. *Understanding Public Policy*. Englewood Cliffs, NJ, Prentice Hall. 1972: 2.

⁴ Howlett M., Ramesh M. *Studying Public Policy: Policy Cycles and Policy Subsystems*. Toronto. Oxford University Press. 1995: 7.

⁵ Bridgman P., Davis G. *Australian Policy Handbook*. St Leonards, NSW, Allen and Unwin, 1998: 4.

1.1 Policy as an authoritative choice

This is policy made by governments — the authorities who make regulations, issue directions to government officers, authorize the spending of public monies. Decisions that are part of an authoritative policy bind officials to act in certain ways. They rule out other courses of action. Citizens are able to hold to account those who take the decisions and those who carry them out. In short, policy is the exercise of authority by those who legitimately have that capacity conferred upon them by the constitution and political process of the country.

Authoritative policies do not appear ‘out of the blue’. They are the response to perceived problems. They have a purpose. They are not accidents. They are structured; those who have to carry them out, and the steps by which they are to proceed, are identified. They are political; they flow from choices made by those who represent the country’s citizens.

There is a sense of command about policy. However, it is one thing to command and another to achieve what is commanded. Not all policy that flows from the cabinet minutes or the ministerial announcement is in fact realized. Implementation may be flawed. New situations may arise that alter the basis on which the policy was designed. Without modification to bring the policy into line with those new circumstances, the policy may drift. ‘Policy failure’ is a phenomenon with which most of us are, unfortunately, only too familiar.

1.2 Policy as a hypothesis

Whether stated explicitly or not, authoritative policies are supported by theories about the world, about cause and effect — if <x> is done then <y> will follow. Such theories are built on assumptions about human behaviour in particular circumstances. Many policies contain incentives to encourage people to behave in certain ways or disincentives to discourage other kinds of behaviour. For example, the provision of vaccinations at no cost is an incentive to encourage immunization; conversely, a decision to increase the tax on smoking or alcohol is seen as a health measure to discourage consumption as much as a means of raising more revenue. Another area where assumptions must be made is the extent to which people will comply with the actions required by the policy. Policies of this nature may or may not be based on research to support assumptions about people’s behaviour. There are, nonetheless, good arguments to suggest that policy-makers should be explicit about their hypotheses.

Policies are almost always based on incomplete information. Sometimes it is simply not available. On other occasions, the urgency of the situation or the political timetable brooks no delay. In some cases, on the other hand, the wealth of information seems to be ‘overkill’

and the problem is one of selection. Equally, policies are not scientific — although there is often a scientific component in health policy — in the sense that they can be tested in the laboratory. Pilot studies and demonstration projects are often options. But, policy-makers should be wary of embarking on ‘experiments’ — people’s lives may be at stake.

‘Policy as hypothesis’ also directs our attention to the desirability of seeing policy, not as ‘the final answer’, but as a learning process. However effective the analysis and judgement that precedes a decision, there is always the possibility of unintended consequences. Formal evaluation is an important element in good policy processes, but lessons can be learnt every day.

1.3 Policy as an objective

Public policy is ultimately about achieving objectives. It is a means to an end. “Policy is a course of action by government designed to achieve certain results”.⁶

It follows therefore that policy-makers should be clear about what they are seeking to achieve. Policies that lack a clear statement of goals, aims and objectives (or outputs and outcomes) may, not only result in a loss of welfare in the community, but may also waste resources, and can be harmful. Too often, policies are announced without having an adequate hypothesis behind them. Or the aims are blurred because the policy-makers cannot agree on what they are seeking to achieve. Sometimes we have policy statements that are ‘warm fuzzies’, without explicit outcomes.

The aims of a policy should be clear. It should be promulgated and understood by both those involved within the government and those affected in the community. If not, the processes will be wasteful and often misdirected. It is also very difficult to judge the ‘success’ of policies if there is a lack of clarity about what they were supposed to achieve — whether we call them goals, objectives or targets.

⁶ *Ibid*: 6.

THE POLICY CONTEXT

Policy-making does not take place in a vacuum. The process is set within the constitutional framework of each country. It is important that policy-makers (at whatever level) are aware of the relative roles of officials and ministers; the role of the central agencies; the processes for seeking ministerial or cabinet approval; and so on. These are likely to be accessible in service-wide guidance (such as a cabinet manual), but consideration should be given to having them readily available to officials within the health agency.

Impinging on the options available in every policy domain are such factors as the economic and fiscal prospects for the country, the demographic trends, and the country's international commitments. Those who play a part in policy-making are expected to be on top of the specific matters that come within their 'job descriptions' — whether they are ministers, officials or external advisers. However, to make the maximum contribution, they also need to be aware of the contextual factors. Certainly, health policy at the government or agency level must be aligned with the policies pursued in other sectors and will be improved by the participants' understanding of the general policy environment.

2.1 Demographic trends

Information on population trends, with gender and geographical disaggregation, is basic to health planning. For example, the population by age cohorts is the starting point for the allocation of health services. Outward migration (and internal migration within national territory) is obviously another key element in health service investment. As is mortality and morbidity data, which may come from the centre or may be the responsibility of the health agency. Not only should it be possible to disaggregate demographic data by gender, age and geographical distribution but, ideally, ethnicity is becoming an increasingly important dimension in some countries where some ethnic groups are disproportionately represented in poor and marginalized communities, and it is important to be able to analyse the relationship between ethnicity and health and health outcomes.

2.2 Economic trends

The economic future of the country will provide the opportunities and the constraints within which the health service will operate. Equally, the population's level of income — itself influenced by employment — and its distribution, will impact on the nature of their health problems. Youth unemployment is a major challenge in many Pacific island countries and is associated with health problems. Poverty, wherever found, is a determinant of health status.

2.3 Fiscal trends

The budget will have an immediate impact on health policy. The process will differ from country to country, but three aspects will remain common to all:

- (1) the budget for the current year;
- (2) the forecast for, say, three years ahead; and
- (3) the crisis that forces immediate and short-term adjustments to spending plans.

These are concerns not only for the finance staff of the agency. All those involved in the policy process should understand the government's finances and, of course, the estimates of expenditure for the health agency.

If the importance of the policy context is accepted, there are a number of practical implications:

- The health policy process will be facilitated by the familiarity of policy advisers with the governmental framework and the business cycles within which they operate.
- The quality of policy advice will be improved by the level of understanding of the wider context by health policy advisers. This suggests that staff training and education should include modules on the wider policy context.
- Health policy will be affected by the quality of population and economic data available from the centre. A health agency should have the capacity to interpret (and challenge) these data. More importantly, relevant population trends should be examined.
- Economic trends will also be relevant to the analysis of most health policy, both as a background consideration and a contributing factor to public health issues. The capacity to enter effectively into discussions on these matters with the economic and financial agencies is a valuable attribute for a health agency.
- A knowledge of the budgetary situation is an essential item in the armoury of every body involved in the health policy process.

2.4 International or regional commitments

All countries are likely to have a number of bilateral or international commitments. In some cases, such agreements are directly related to health, such as the International Health Regulations or the Framework Convention on Tobacco Control. Others have direct and important links, such as various conventions and commitments related to human rights, children, people with disabilities, and so forth. A growing number of these international commitments are also related to trading relationships — some bilateral or regional and others related to WTO —and these may, for example, require opening up of the health sector to competition from foreign investors or providers, or patent protections, which can impact on pharmaceutical access.

It is important that policy-makers know about relevant current and potential future commitments, for these commitments can constrain or enable the policy choices that may be available.

2.5 Annexes

This handbook (or an equivalent resource) is intended to serve as a starting point of reference for policy staff. In order to make this more comprehensive, agencies should also consider including, or making readily available, the following resources for their policy staff:

- (1) a brief description of the principal elements of the decision-making structure and process;
- (2) key demographic data (including morbidity and mortality data) and trends (with cross-references to primary sources);
- (3) key economic data and trends — GDP per head, income distribution, employment (with cross-references);
- (4) the estimates of expenditure (and revenue) for the health agency; and
- (5) international and regional commitments made under bilateral agreements, international treaties, conventions, etc.



STRATEGIC HEALTH POLICY ADVICE

Health policy has always had a long-term perspective. 'Planning' has long had a better name in health than in some other policy domains. More recently, across all areas of public policy, the place of 'strategy' in the policy process has received a lot of attention. In part this has been a counter-balance to the political dimension of the policy process, which emphasizes results in the short term. It also owes something to the belief that the best performing business corporations are those who are strong on strategy, and that there are lessons to be learnt by the public sector from business experience.

The three characteristics of strategy (as opposed to operations) are:

- a long-term, rather than a short-term focus;
- a comprehensive, 'whole-of-business' perspective, rather than a collection of divisional business plans; and
- a concern to 'fit' the business within the external environment expected to affect the business in the longer term.

Most governments already demonstrate some of these characteristics in their policy-making — whether at the agency or whole-of-government level. Budgets, for instance, generally contain forecasts of expenditure and revenue for three- or five-year periods (or even longer), and governments increasingly articulate the 'opportunities and threats' faced by their countries or a particular sector. Many components of policy, work programmes for example, are inherently long-term. The hard question is: how can a government reconcile the short-term political realities with a desire to plan effectively for the long term in a comprehensive manner?

While a strategic focus is an essential element in good policy-making, the way that this is translated into procedures and processes is a matter for each country to determine. However, whatever the policy-making process, it should accommodate the three dimensions noted above. Already, in Chapter 2, The Policy Context, we have noted the importance of health policy advisers being aware of the future environment in which the sector will be placed. This underlines the need for advisers to be prepared to propose adjustments to existing policies and to initiate responses to new challenges that are thought likely to emerge.

In most governments, the phenomenon of ‘departmentalism’ arises from time to time – a concern that individual agencies are developing and recommending policy without sufficient attention being paid to what other agencies are doing. This is often an immediate issue and leads to changes in the way things are done: improved consultation, organizational modification, or simply changes in the people dealing with the issues. Similar issues arise within health agencies themselves; and similar solutions are sought. But, the building of ‘silos’ — where vertical relationships close out horizontal relationships — is even more damaging to strategic policy. Silos can be a particular problem in health.

THE POLICY ACTORS

4.1 Policy actors within the government

Policy is made by individuals within institutions. Both are important. Building capability and capacity within organizations is a high priority for governments, the focus being on the recruitment (and retention), education and training of policy advisers and decision-makers. However, the way in which those individuals are organized to provide advice of the highest quality is equally important. This section focuses on the systems of policy advice within the machinery of government. In the next section, we consider the important part that is played by actors outside the system — the stakeholders, the interest groups, ‘civil society’ and the community.

The essence of democratic government is that elected people are responsible to the citizens for what governments do. The health sector is no different from the other activities of government. Yet we often hear arguments that ‘politics’ should be taken out of health — that health is too important to be subject to the uncertainties of the political process. Among the points made in support of this position are:

- an emphasis on the ‘life and death’ nature of health — that only health professionals can make decisions about, for example, the choice between extending cardiac or renal dialysis services;
- that health is essentially a long-term business — immunization, health promotion and workforce policies, for example, have essentially long-term outcomes, beyond the lifetime of a particular government ; and
- that health policy is ‘technical’, requiring rigorous analysis and informed discussion before policy is determined — qualities, it is suggested, that are often missing from political debate.

All these points have some validity in themselves (for example, as is discussed later, a strong analytical basis, grounded in rigorous evidence-based research, is a precondition for effective health policy). However, they are not sufficient to support the conclusion that health should be removed from the political debate. In all countries, choices have to be made, not only about the allocation of scarce resources among sectors (such as health vs education), but also between competing health claims and related social policy initiatives. That is what politics is about.

For policy-makers the salient questions are:

- Can we determine the areas for which there are strong reasons to place decision-making in the hands of people other than the elected representatives?
- Can we set out some guidance for the relationship between ministers and officials?

4.1.1 What is not 'political'?

Here some broad observations can be made, but these are matters on which each country will determine its own way of doing things. There are persuasive arguments about natural justice and equity that support the placing of decisions affecting individuals outside the jurisdiction of ministers. For example, whether or not an individual should receive a very costly form of treatment (say renal dialysis or cardiac surgery) is a decision best left to the health professionals directly concerned. They will make their decisions within a budget and based on criteria determined elsewhere in the policy process, and ministers will set those policies on the basis of advice received from a number of sources.

4.1.2 The minister / officials relationship

The relationship between a minister and his or her officials is the crucial point in the policy process. It has been likened to 'Siamese twins', joined together inextricably. Both bring to the relationship a particular perspective. Generally, there are good reasons for ministers not to 'micromanage' their agencies. Likewise, while officials should not assume the role of the minister, they should have a political sense. If one phrase sums up the ideal relationship between ministers and officials, it is that there should be 'no surprises'. Just how that is to be translated into the policy process is a matter for individual governments — and probably for individual ministers. Some will wish to be involved closely in the development of policy from an early stage. Others may wish to be informed only when decisions are required. Often the nature of the policy issue will determine the closeness of the minister's involvement. In any event, the key values that ministers and officials will wish to nurture are mutual understanding and trust.

4.1.3 Accountability

Whatever the style of ministerial involvement, the issue of accountability arises. As discussed in section 15, The Ethics of the Policy Process, the provision of ‘free and frank’ advice is the prime characteristic of professionalism on the part of advisers. Officials should be held accountable for that advice. They are not, however, responsible for the decisions made at the political level. Just how such questions of accountability and responsibility are ordered will differ from country to country. However, from the point of view of citizens, it is unacceptable that there should be a ‘government of nobody’ in any country.

4.1.4 The central agencies

Depending on the governmental structure of each individual country, the minister and the health agency are unlikely to be the only actors concerned with health policy. The finance ministry (or treasury) will undoubtedly take a close interest in what is a large spending area in any country’s budget. The prime minister’s office will wish to be kept abreast of developments in a sector of such importance to the lives of citizens. And, because staffing costs always form a major component of health expenditure, the central personnel agency (sometimes called the public service board or commission) will inevitably be involved. (Whether there should be a separate personnel agency for health staff — given their numbers and their recruitment and retention difficulties — is a policy question of some significance, but it is outside the scope of this publication.)

The crucial topic of coordination is discussed below. It is important for the health agency to nurture its relationships with the central agencies (and indeed other agencies that impinge on health policy). ‘Going it alone’ may have short-term gains, but is likely to hinder policy-making in the longer term.

4.1.5 Coordination

Government is sometimes portrayed as a battleground of competing interests. It is suggested that agencies — departments, authorities, boards — follow their own ‘line’ and do not have proper regard for the collective interests of government. In many countries, this has resulted in a lot of attention being given to ‘whole-of-government’ (New Zealand) or ‘joined-up government’ (United Kingdom).

All governments have their own ways of dealing with this almost universal issue, usually under the broad heading of 'coordination'. Among the available instruments are:

- ministerial and interdepartmental committees;
- the activity of central agencies;
- machinery-of-government design (bringing agencies together);
- promoting a culture of collaboration among officials; and
- the budget process.

4.2 The external stakeholders

The term 'civil society' has come into vogue recently to capture the diverse groups that operate outside the formal boundaries of government. These may include the media — how newspapers, radio and television influence citizens' thinking is an important factor in policy-making. In most countries, there will be organized interest (or pressure) groups that represent people linked by common bonds — from professional organizations (such as nurses' associations / societies) through groups sharing a common cause (such as anti-smoking groups) to associations representing people who believe that they have legitimate interests to protect (such as shopkeepers required to abide by what they may regard as unreasonable and costly health protection regulations). Collectively, it has become increasingly common to describe these interested parties — whether tightly organized or loose groupings — as the stakeholders.

4.2.1 Interest groups

There are two views about the relationship of interest groups to policy-making. One suggests that the activities of such groups divert policy-makers from their proper business of working in the collective or public interest. Or, even worse, they may 'capture' the process — they are argued to have a disproportionate influence on policy, skewing the direction in their narrow, perhaps some would say selfish interests. The contrary view is that, in most countries, interest groups play a positive role — assisting the government with facts and opinion, providing the means of consultation, and sometimes even helping to administer policy through some form of contract with the government. In other words, interest groups operate in the gap between 'the governors' and 'the governed' — a gap that cannot be filled by the formal mechanisms of democracy, such as voting every few years.

Whatever views may be held about interest groups, there is little doubt that, in most countries, governments will increasingly need to take account of what they have to say. This

may be ‘institutionalized’ by statutory mechanisms requiring consultation. Or it may simply be good policy-making — and good politics — to establish procedures for consultation, either on a regular basis or as issues arise.

4.2.2 Consultation

Consultation, however well-intentioned, can often be a source of frustration to both governments and those consulted. Sometimes this is because one of the parties assumes that ‘consultation’ means ‘agreement’. It does not — but equally it means more than ‘notification’. We therefore suggest three elements to consultation, but these are shaped in accordance with statutory requirements or local custom:

- holding meetings with those to be consulted, providing relevant information and such further information as may be requested;
- participating in meetings with an open mind and taking due notice of what others have to say; and
- waiting until others have had their say before making a decision.

4.2.3 The community

The very nature of health brings the government into daily contact with its citizens. While many of these transactions involve individuals or families, others are of concern to ‘communities’ as a whole. ‘Community’ is a notion that calls out to be defined within the circumstances of each country. It may be spatial, geographical (by locality or region) or societal (by kinship grouping). There may be statutory bodies recognizing particular communities, such as forms of local government; there may be traditional representation of community interests.

Just how communities are brought within the policy process is for each country to decide. In some countries, and on some issues, such devices as ‘straw polls’ or questionnaires may be appropriate; on others, workshops, seminars, focus groups or face-to-face meetings with the whole community may be employed.

POLICY INSTRUMENTS

In very broad terms, governments have three categories of instruments available to them when considering how they might intervene to assist public welfare:

- they may regulate— by statute or subsidiary legislation they may require citizens to act (or not to act) in a particular way; failure to comply will incur a penalty imposed by the coercive power of the State;
- they may act directly — by establishing organizations to provide goods or services, sometimes in competition with non-state providers; and
- they may fund private or voluntary organizations to provide goods and services — by entering into contracts, or make grants or subsidies available.

Some commentators would add to these categories the case of exhortation or education — or more colourfully, ‘jawboning’ — the statements of those in positions of authority that, on the basis of the information available to governments, try to persuade citizens to change their behaviour without the threat of punishment or the blandishment of incentives. Some anti-smoking or obesity campaigns might be examples.

Most policies are likely to contain a mix of instruments from these categories and, in most cases, policy-makers should consider the range of possibilities before deciding on their course of action. For example, there is sometimes a temptation to choose the regulation option because it appears to be in the government’s control and is less expensive (to the government, but not necessarily to the community) than the other categories. However, that does not mean that other policy components should not be considered.

How do policy-makers select the right instruments? Bridgman and Davis pose some useful questions⁷:

- Appropriateness — is this a reasonable way of proceeding in this case?
- Effectiveness — can this instrument get the job done?
- Efficiency — will this instrument be cost-effective?
- Equity — are the likely consequences fair?
- Workability — is the instrument simple and robust, and can it be implemented?

These general criteria however, need to be supported by more detailed analysis.

⁷ Bridgman P., Davis G. *Australian Policy Handbook*. St. Leonards, NSW, Allen & Unwin, 1998: 65.

POLICY-MAKING MODELS

Theories and models of policy-making provide tools for simplifying the chaotic world we live in so that it becomes more intelligible and manageable.

Basically there are four models or approaches to policy-making. These are:

- (1) the rationalist model, which envisages an orderly progression of well-defined steps in a policy cycle;
- (2) the stakeholder approach, in which the focus is more on the interaction between principal policy actors, the stakeholders;
- (3) the participatory model, which takes more of a socially democratic and inclusive approach; and
- (4) the neo-liberal market-oriented approach, in which the 'consumer / customer is king'.

6.1 The rationalist model

Most advocates of policy-making see the rationalist model as the ideal — an orderly progression of stages in a policy cycle. Among the many models available, we start here with that of Howlett and Ramesh.⁸ The stages or steps are:

- identification of objectives — agenda setting;
- evidence gathering — formulation of options;
- decision-making — weighing the options in terms of cost and benefit;
- policy implementation — putting the chosen solution into effect;
- policy evaluation — monitoring results; and
- policy termination / adaptation / confirmation.

In reality, policy-making rarely proceeds in a rational and orderly manner. Objectives often cannot be agreed. The evidence is often incomplete or ambiguous, and political considerations often intrude at all points, disrupting the orderly sequence.

⁸ Howlett M., Ramesh M. *Studying Public Policy. Policy Cycles and Policy Subsystems*. Toronto, Oxford University Press, 1995.

Busy policy advisers will rarely have the opportunity to approach their daily work in terms of such a model. The model implies that the steps identified follow each other in a linear sequential fashion. In practice, the policy-making process tends to take place in a more haphazard fashion, driven by circumstances. Nevertheless, the labelling of the stages draws attention to the logic of a rational policy process. It underlines the point that policy-making is more than an isolated decision; it is a process in which more than one party is involved and in which the issues may be revisited in what technical literature defines as an 'iterative' process.

6.2 The stakeholder approach

The stakeholder approach tries to negotiate a pragmatic path through the often divergent values and views of the various interest groups and government agencies. In reality, stakeholder bargaining can be undemocratic and exclusive, and is often captured by the most powerful players. Stakeholders in health sector policy-making may include:

- community-based organizations and advocacy groups;
- organizations providing supplies and health services;
- organizations of professional and other health workers;
- consumer and supporter organizations;
- funding bodies — including government, insurance and development partners; and
- other government agencies with health-related interests and responsibilities.

At different times, and in various ways, all of these stakeholders are able to exert power and influence over the health system. Ways must be found to ensure that all legitimate interests are assessed and weighed in the policy-making process. The success of a policy initiative may well depend upon the extent to which the key stakeholders have been involved and are committed to supporting its implementation.

6.3 The participatory model

The participatory model of policy-making is the most recent arrival in policy studies literature, but it is by no means new. Participatory policy-making requires that policy be 'democratically legitimate'. In practice, this implies an open, inclusive, interactive and highly politicized approach.

The contention is that multiple criteria should guide policy-making processes. Such criteria could include relative dependence on expertise, the availability of an evidence base, the analytical policy support available, resource and time pressures, the political sensitivity of the issues, and the relative power of the principal stakeholders involved. In practice, an evidence-based, flexible and pragmatic approach to policy-making is the approach most likely to move things along.

Those interested in exploring these ideas further may like to refer to *Health and Public Policy in New Zealand*.¹⁰

¹⁰ Davis, P., Ashton, T. eds. *Health and Public Policy in New Zealand*. Auckland, New Zealand, Oxford University Press, 2001.

POLICY ANALYSIS

Analysis is probably the key step in the policy cycle. Good policy analysis has a cost — in terms of the staff allocated to an issue, the time made available, and the quality of the information required. Prior to embarking on the task of analysis, a judgement will have to be made on these matters, related to the perceived importance of the topic. There is also likely to be a sense among those involved as to whether the right approach is a small change to an existing programme — often labelled incrementalism — or whether a brand new approach is required — sometimes characterized as a rational-comprehensive approach.¹¹

Despite criticism over the years, the rational approach helps in focusing on an orderly way to undertake the analysis of any issue. Likely steps could include the following.

7.1 Formulate the problem

This is the process of asking questions about how the problem has arisen; who is affected; are there similar situations overseas; has the problem arisen before and what was done; can the problem be broken into parts that can be dealt with (initially at least) on their own; what agencies or other stakeholders can contribute? Often the first formulation of the problem will shift as the analysis moves on to the next stage — an iterative process.

7.2 Set out objectives and goals

What is the government trying to achieve? Clarity of objectives and recognizing where conflicts may arise are the hallmarks of good policy-making. However, we know that, in practice, not everything can be quantified or described with clinical precision, and that, even if that were possible, ministers may be reluctant to do so.

¹¹ These terms are often associated with the American scholar, Charles Lindblom.

7.3 Identify the constraints

Policy-making may be constrained by resources, time, ministerial preconditions, and the priority attached to the issue by ministers. Some discussion with the minister or senior officials at an early stage should guide the policy advisers or analysts as to the boundaries within which solutions might be found. How much funding is available — this year, in three years time? Would the cancellation or downgrading of other programmes to make room for a new policy be considered? What priority does the minister give the issue?

7.4 Search for options

Research is required here. Possible solutions may be found in past experience locally; in other countries; international literature; development agencies; consultation with stakeholders. The options need to be narrowed down, and the costs, resource demands and the likely consequences matched against the goals and objectives. Assumptions need to be stated clearly.

7.5 Choose a solution or options

The options are weighed up — much of the weighting will be subjective and this should be acknowledged in the proposal made to the government. One solution, or a range of options, will be discussed in a paper submitted to the minister, an interdepartmental committee or senior officials of the agency. Preferably, the analysis should result from a team of advisers or have been subject to testing by people with different capabilities — internal or external peer review.

If this is the process, what is the expertise that the policy adviser brings to it? The aim in most policy units is to have a range of expertise from different backgrounds available. It is probably true in many, if not in most countries, that the principal framework of policy advice is economic. In health agencies this may be matched or exceeded by the expertise of health professionals. However, policy developed only within economic or health disciplinary frameworks may be deficient. Other approaches, such as those grounded in legal or social discourse, have much to offer. Indeed, the goal to strive for is an integrated approach to health policy-making.

ECONOMIC ANALYSIS

Economics has much to offer health policy-makers. While it is not necessary to master all the techniques and econometric skills of the professional economist, much is to be gained from understanding some of the basic concepts and insights. The following are among the most important.

8.1 Opportunity cost

It is a safe assumption in policy-making that resources are scarce and choices have to be made about their use. A decision to fund <X> is a decision not to fund <Y>. The cost of a proposal is that which is foregone: for example, allocation of \$x to an immunization programme means that the equivalent value of renal dialysis treatment cannot be funded. However, that is to account only for the funds in the government's budgets. The true cost is only known when the cost and benefits of the best alternative that is foregone are known — what has been lost by not going ahead with the alternative?

8.2 Cost-benefit analysis

This technique has three principal characteristics. Firstly, it measures the costs and benefits for the country as a whole, not only those that fall on one agency or the government¹² — what costs fall on the citizens and what benefits accrue? Secondly, it translates into money terms the costs and benefits of impacts that are not usually given a quantitative monetary value. Thirdly, through the technique of discounted cash flow, it takes account of streams of costs incurred and benefits gained unevenly over time. By discounting future costs and benefits (through applying an interest rate), it brings things together on a present-value basis.

¹² The notion of externalities is relevant. These are costs or benefits caused by, but not incurred or gained by, the organization. A good example is the cost to society of pollution caused by a company that has cut its costs by investing in process that creates more pollution. This pollution may result in costs to others or cause longer term effects to the environment, but the company itself usually does not bear these costs itself.

8.3 Cost-effectiveness analysis

In essence, this variation on cost-benefit studies compares options to determine which will provide a given return at the least cost or, alternatively, which will provide the best return from the same investment.

All these techniques are open to criticism. There are obvious problems in translating intangible benefits, such as a feeling of 'well-being', into monetary values. It can also be argued that, taken by itself, the criterion of efficiency, the dominant value in economics, distorts the policy-making process. What about considerations of equity or justice? Such questions simply underline the point made at the conclusion of the last section — that policy analysis is not the property of any one discipline. Policy debates often involve a 'trade-off' between efficiency and equity. If the decision-maker decides not to adopt the most efficient option, that is likely to be because other considerations of an equity nature — about the impact on a group of citizens, for example — are judged to weigh more heavily. The decision can only be judged to be rational, however, if the best possible statement of the costs and benefits is on the table.

Useful references for further reading on economics techniques include:

Benefit-Cost Analysis. In: Weimar DL., Vining AR. *Policy Analysis: Concepts and Practice*, 3 ed. NJ, Prentice Hall, 1999: pp. 331-378. (This is a useful general text)

Connolly S., Monro A. *Cost-Benefit Analysis in Economics of the Public Sector*. NJ, Prentice Hall, 1999: 102-117.

INTERVENTION LOGIC

The textbooks offer many techniques of policy analysis, in many forms. There is no universal problem solver; quality policy advice is marked by choice of techniques that fit the circumstances. However, one tool that has received considerable attention in the last few years, and has a number of applications in health policy, is intervention (or programme) logic. This can be employed, for example, in policy design, programme planning and policy evaluation. The main concepts of intervention logic are discussed below.

As with so many aspects of policy-making, the insight that can be derived is as useful, if not more so, than the detailed operational guidance. Indeed, most policy advisers will find that, without knowing the language of intervention logic, they are already using such an approach intuitively.

An important advantage of this technique is that it focuses attention on outcomes rather than activities (or outputs) — more specifically, it links what the government does to what it hopes to achieve. At the heart of the process is the notion of a ‘hierarchy’ or ‘cascade’ of outcomes. This is not, however, to suggest that all policy-making takes place in a straight line; there is an important place for ‘feedback loops’.

As Karen Baehler of Victoria University, Wellington, New Zealand, says ¹³: “intervention logic begins with two basic premises:

- (1) Most issues which fall into the public sphere belong to highly intricate webs of problems that defy simple solutions.
- (2) The impossibility of completely disentangling knotty problems should not prevent us from trying to find the central strand of each vexing issue — the nub of the issue, its logical policy core.”

How do we get to the ‘real’ policy questions? We do so, it is suggested, by teasing out from the available information what has been called ‘the grand hypothesis’ — usually captured by a statement in the form:

if < X> then <Y>

¹³ Baehler K. Intervention Logic: A User’s Guide. *Public Sector* 25(3):14-20. September 2002.

For example, *if* we restructure the Health Department, *then* we will improve health status.

The next step is to break down the grand hypothesis or end outcome into mini-hypotheses or intermediate outcomes. To take the example above:

- if the Health Department is restructured, staff numbers will fall;
- if the Department has fewer staff, the payroll will be reduced;
- if the payroll is reduced, more funds will be available for expenditure on activities such as immunization against infectious diseases;
- if immunization programmes are expanded, mortality and morbidity statistics for diseases *m* and *n* will improve; and
- if mortality and morbidity statistics for infectious diseases improve, the country's health status will also be seen to improve.

These propositions are obviously over-simplified. For the purpose of explanation we set aside, for example, the probability that 'restructuring' involves reorganization of service delivery and other activities as well as 'downsizing'. Nonetheless, they serve to reveal the hidden assumptions underpinning the logic of the original policy hypothesis, viz. that improved health status will follow restructuring of the Health Department. By breaking down the original proposition, we are able to test the plausibility of a policy proposal before its adoption and identify the most vulnerable components of a policy already in place. In this case, we might ask questions along the following lines:

- Will fewer staff necessarily reduce the payroll? (One possibility is that, to fill the gaps, higher paid individuals may have to be recruited — professionals for whom competition from other countries is severe.)
- Can we assume that funds saved in the payroll will be available for redeployment to disease control programmes? (It could be that the Finance Ministry will seek to reclaim the savings to reduce the budget deficit or to reallocate to other uses, such as educational programmes.)

- Will infectious diseases be reduced if immunization is increased? (In the longer term this is likely, but education in such areas as food handling or improved housing might be more effective in the short term.)
- Will improved statistics for infectious diseases demonstrate improved health status? (This would be a partial view: a focus on noncommunicable diseases, such as obesity or smoking, might well have a bigger impact on national health status.)

This process of thinking through a policy proposal (or reviewing an existing policy) can be expressed in graphic form:

<u>Cascade</u>		<u>Assumptions</u>
Output:	Restructuring department	
Intermediate outcome:	Savings from reduced payroll	Assumes fewer staff
Intermediate outcome:	Expanded immunization programmes	Assumes savings will be available for health
Intermediate outcome:	Improved infectious disease morbidity and mortality statistics	Assumes immunization most effective
End outcome:	Improved health status	Assumes infectious disease control priority

A third column could be added to this simple two-column model — ‘Risk’. As Baehler puts it: “risks follow almost automatically from assumptions. Indeed risks can be defined as what happens when assumptions go wrong.” Risks can be of a kind that will impede or halt the policy. In the example above, this might include the risk that the expected ‘savings’ are reclaimed by the Finance Ministry and are not available for health programmes. Or risks might include unwanted side effects from the policy — unintended consequences, e.g., literally unexpected side effects from immunization.

In summary, intervention logic is a more sophisticated expression of the thinking process followed by good policy advisers. It emphasizes the importance of:

- focusing on outcomes as well as outputs;
- avoiding leaps from the more easily identified and immediate output — the activity to be carried out — to the often more vague and more distant outcome, without considering the intermediate steps;
- stating and questioning assumptions; and
- considering risk scenarios.

In addition to the Baehler article already cited, another useful reference is Saldanha, C., Whittie J. *Using the Logical Framework for Sector Analysis and Project Design: A User's Guide*. Manila, Asian Development Bank. http://www.adb.org/Documents/Guidelines/Logical_Framework (accessed 29 May 2006).

INFORMATION, EVALUATION, RESEARCH AND DEVELOPMENT AND LEARNING

Information, evaluation, research and development and learning are core components of policy-making. They are interrelated functions best considered together.¹⁴

Relevant, accurate and timely information is the life blood of policy-making. Without a reliable supply of high quality information, policy-makers do not have the raw material needed to practice their art.

10.1 Information systems

Gathering and processing of information can be expensive in terms of time and other resources. Systems must be designed carefully to produce the data / information required for policy-making, planning and operational purposes.

Ideally, information systems should be designed and built bottom-up, not top-down as is so often the case. The starting point should always be the front-line workers, and providing them with the information they need to carry out their tasks. The more relevant and useful information is to those at the front line, the more conscientious they are likely to be in recording the data.

As a general rule, front-line staff should not be asked to provide information which is not directly relevant and used at their level. Most information required at higher levels for policy-making and other activities can be extracted and aggregated from front-line returns.

Modern electronic information technologies have added enormously to the information potentially available to policy-makers. Computer systems can now provide up-to-the-minute information from biomedical and health services research. At the flick of a switch, that information can be available around the world, including the Pacific. As a technical resource for policy-makers, the Internet is a fabulous tool.

There is, however, a down side. The technology is expensive and can be difficult to use. There are many examples, some of them in the Pacific, to show how much money, time and

¹⁴ Youngson R. Learning organizations in health care. Healthcare Review Online. 2. April 2002: 6. Available at <http://www.enigma.co.nz/hero/website/index.htm> (accessed 29 May 2006).

effort can be spent in the development of computer-based health information systems, for relatively small gains. The problem is that often the pace of computer system development far outreaches other parts of the infrastructure, such as policy-making and planning capacity, the design of systems and services, and workforce development. Far from being helpful, the immediate results can be discouraging and, at times, counterproductive. There are places in the Pacific where previous, well designed and useful manual information systems have been abandoned in favour of computer systems which have yet to deliver.

The message here for policy-makers is that it is local evidence — relevant, accurate and timely — that is essential for policy-making. It is all very well having access to the world literature on the Internet, when what is really needed is to know what is going on in our own backyard. These matters must be of concern to all policy-makers, and particularly those whose task it is to guide the development of information systems.

10.2 Research-mindedness

Research has been described as ‘organized curiosity’ as it is characterized by a systematic approach to the asking and answering of questions. Many people see research as another worldly activity carried out by clever people who live and work in universities. This is unfortunate and certainly not helpful to policy-making.

As part of their training, all health workers should be exposed to and should recognize the key role that information can and should play in their personal and working lives. Even at the most basic levels, workers should know why and how information is gathered and used to frame and answer questions that can be used to guide their work and that of others.

In the past, workers’ education has tended to focus mainly on the learnt application of knowledge and skills. Organized curiosity has not always been encouraged in health worker training or practice. Now that education is becoming more flexible and dynamic, and concepts such as retraining, re-certification, life-long learning and learning organizations are in good currency, more health workers are being encouraged in their research-mindedness.

From a policy-making perspective, people with ideas and entrepreneurial flare are important. It is they who must be relied upon to provide, not only knowledge and skills, but also the intelligence and drive needed to initiate and lead policy-making and change in health systems.

10.3 Evaluation

Evaluation is a significant, if often neglected, step in the policy cycle.

One of the most difficult aspects of policy-making is the termination of policies. Policies fail. They may not have been well conceived at the outset. They may have been underfunded. Circumstances may have changed. Whatever the reason, the community's welfare would be improved if the resources were deployed in a different way. Hence the case is often made for 'sunset' provisions, whereby a programme will cease at some predetermined date unless specifically renewed. There are, however, powerful forces that make policy termination difficult. Those involved become committed to existing policy — their jobs may be at risk. There may be groups and individuals outside the government whose interests would be affected adversely. And, an admission of policy failure is not usually a task welcomed by ministers. For all these reasons, the evaluation phase of the policy cycle is highly significant. Of course, policy failure is rarely total; what is needed is some adjustment.

Key questions for evaluators are:

- To what extent has the policy met its stated objectives?
- How can the identified actors be held to account for any shortfall?
- How might the policy be made more effective and efficient?
- What lessons are there for the future?

Much of the effort that goes into evaluation is devoted to the implementation of policy. However, it is equally important that the policy advice is also evaluated. Were the issues identified adequately? Was consultation appropriate? Were the government's priorities assessed correctly? Were the objectives expressed clearly? Was the theoretical foundation sufficiently rigorous? Was the statistical base solid?

There is always a case for building into the initial policy proposal a commitment to a formal evaluation at a future defined point(s). Such evaluations are, however, not without cost. It is good practice for all those involved in the policy process to continually evaluate the relationship between their policy advice and the actual unfolding of the programme — the policy-making as well as the policy implementation. Again, policy development is a learning process.

Two further general references on evaluation are:

Chelimsky E., Shadish W. eds. *Evaluation for the 21st Century: A Handbook*. Sage Publications, 1997. ISBN 0761906118

Leeuw FL., Rist RC., Sonnichsen RC. eds. *Can Governments learn?: Comparative Perspectives on Evaluation & Organizational Learning*. Transaction Publishers, 1999. ISBN 0765806584.

10.4 Research and development

Evaluation is often a value-laden activity. Being assessed by external evaluators can be a harrowing experience, especially if the evaluation is 'done to' rather than 'done with' those whose work is being evaluated. It is often claimed that policy-making, policy implementation and policy evaluation are independent functions, which must be carried out separately to be fair and objective. However, is this always, or even often so?

Organizations that aspire to be learning institutions, that encourage research-mindedness and the innovative ideas of their staff, that have designed their information systems, not only to provide data for administrative and clinical purposes, but also for research and development, are well placed and likely to do their own evaluations. All that external evaluators are required to do is to inspect and validate the in-house evaluation process.

The advantages here are obvious. The staff are viewed as valued partners in the learning life and development of the organization. Their ideas and initiative may well be used to guide policy development. In such circumstances, evaluation is seen first and foremost as an internal and positive process, as an integral part of organizational development, and not as a negative and potentially disruptive and destructive external imposition.

Information, evaluation, research and development and organizational learning are core functions which characterize the culture of an organization. They are just as important as business, financial and human resource planning and management. They are not peripheral or optional extras.

Pacific countries can depend in large part on bigger, more wealthy countries to share information from biomedical and health services research. The electronic means to do this now exist. What countries should do for themselves is work out how the available knowledge can best be applied in their particular situation and within the resources available. Well-designed information systems and knowledgeable and skillful policy-making and implementation, supported by a well-focused and resource-realistic active research and development programme, will go a long way towards enabling them to do this. Having said this, however, there are occasions when external evaluation is a credible option, such as when the local decision-making process is a matter of controversy.

EVIDENCE-BASED POLICY-MAKING

We digress here to talk in some detail about evidence-based policy-making because of the emphasis it is currently being given in health and public sector management.

The New Public Management reforms introduced in New Zealand in the 1990s, and in many other countries, substantially altered the public policy-making environment. Evidence-based analysis was one of the tools promoted at that time with a view to improving the quality of policy-making and advice to ministers. An account of that New Zealand experience is available.¹⁵

Rationality, in the form of scientifically valid evidence, can enhance policy-making greatly. The concept of evidence-based decision-making had its beginnings in medicine in carefully controlled randomized clinical trials. Today, organizations such as the Cochrane Collaboration regularly review, update and publish consolidated data from controlled trials in almost every aspect of medical practice. Readily accessible electronically, this evidence is available and used internationally to inform policy-making.¹⁶

There are now biomedical and economic models that aim to measure the effectiveness and efficiency of health care delivery systems. These models are built using a hierarchy of mainly biomedical and economic information. Starting with the most credible information, the hierarchy is as follows:

- randomized controlled trials and systemic reviews (most credible);
- quantitative studies, including economic studies;
- audits and clinical reviews;
- qualitative research;
- case studies; and
- front-line consumer, carer and health worker experiences and stories (least credible).

In the light of experience, questions are now being raised about the appropriateness of this hierarchy of evidence, particularly for policy-making.

¹⁵ Bhatta G. Evidence-based analysis and the work of policy shops. *Australian Journal of Public Administration*, September 2002, 61(3): 98-105.

¹⁶ The Cochrane Collaboration website is a good place to start: <http://www.cochrane.org> (accessed 29 May 2006).

Biomedical researchers are concerned mainly with the effectiveness of specific health service interventions. Economists are concerned mainly with efficiency. Care is taken in studies to ensure that dimensions such as demographic and social variables are either controlled for or designed out of the research. Questions of equity and social justice are rarely addressed.

Most research drawn upon for evidence in policy-making uses rational or conventional research methods and a positivist reductionist approach to inquiry. Central to this approach is belief in a single reality, independent of any observer; in a mechanical explanation of cause and effect; and in the theory that universal truth exists and can be discovered, independent of time and place. The conventional paradigm is concerned with prediction through proof and certainty. Useful as such evidence can be in policy-making, it rarely sheds light on the more practical and day-to-day aspects of policy-making and service delivery.

Using what are referred to generally as ‘constructivist’ methods, social researchers can sometimes assist by using research methods that focus on peoples’ experiences in particular communities or socio-historical settings. In such studies, the investigator is an integral part of the inquiry, is a research instrument and produces, not a traditional ‘scientific’ report, but a type of narrative text or case report. Sometimes the subjects or local partners in such research tell and share their own stories. Insights from such research can often provide useful evidence to guide policy formulation.¹⁷

This should not be taken in any way to undervalue evidence-based analysis or to undermine either biomedical or economic orthodoxy, but rather to recognize their limitations. In future, the funders and providers of research and evaluation projects must invest more resources in the design of studies using both conventional and constructivist methods that examine social and public health initiatives in ways that, not only facilitate good science and good description, but also promote high quality evaluation of well-planned and managed interventions and health care delivery experiences in specific communities.¹⁸

This kind of research need not be complex, expensive or difficult to do. Well-designed action research, using a range of research methods, can produce a variety of evidence useful to policy-makers in specific settings. This has particular relevance in the Pacific.

¹⁷ Labonte R, Robertson A. Delivering the goods, showing our stuff: the case for a constructivist paradigm for health promotion research and practice. *Health Education Quarterly*, November 1996, 23(4): 431-447.

¹⁸ McIntyre S et al. Using evidence to inform health policy: case study. *British Medical Journal*, 27 January 2003, 322. 222-225.

THE SOCIAL CONTEXT

Policy-making is a social process with many dimensions. Good social process is an essential component of successful policy-making. A well-managed process, not only mobilizes and uses sound evidence, but also identifies and engages all the key stakeholders. The aim is to ensure that they are fully informed about the issues in question and understand and commit to both the policy and its implementation.

In a good process, all parties learn together. As a result of such engagement and learning, policy options may emerge in discussions that were not considered at the outset. Even if the implementation is not an unqualified success, much can be learnt if the policy-making process is sound and if it, and its implementation, are evaluated properly. There is no shame in failure if our process is good and we learn from our mistakes.

12.1 Leadership

Successful policy-making requires good and timely leadership. In health policy-making leadership may, at different times, be required at the following levels:

- government leadership from ministers and other politicians;
- bureaucratic leadership from government officials — managers and policy advisors;
- professional leadership from doctors, nurses and other clinical and public health leaders; and
- community leadership from people who represent community interests directly.

Leadership at these various levels may take a number of different forms, such as:

- broad visionary leadership to look and see ahead;
- competent executive leadership to manage policy-making and implementation;
- integrating and networking leadership to bring and keep the stakeholders together; and
- hands-on leadership at the front line to carry out the basic tasks.

At different times in the policy cycle, each of these levels and forms of leadership may be required to take the initiative.

At each leadership level, there are often a number of stakeholders whose interests in a policy must be accommodated. Leaders must, not only engage and seek to commit the stakeholders at their level, but also, by working together, guide and negotiate the policy development process between the various levels. To do this, it is usually necessary to get and to keep people talking.

12.2 Deliberation and dialogue

As already pointed out, health sector policy-making is often complex, may involve many stakeholders and lengthy iterative processes and frequently takes time.

Often, significant differences exist between the various stakeholders that cannot be resolved either quickly or easily. It is important to recognize that complex issues are multidimensional and can appear to be very different, depending upon our perspective. In other words, there may be many, quite different, but equally valid perspectives on a given issue. These differences can cause continuing misunderstandings and conflict between stakeholders. Unresolved, such conflict may impair relationships and frustrate policy-making. It is therefore important that those charged with the task of leading policy-making have the knowledge and practical skills needed to bring and keep the key stakeholders together, and talking. To do so requires knowledge and skills in the art and science of deliberation.

Deliberation in these terms is:

- a means of working together;
- a key component of policy-making and practice;
- a useful step towards stakeholder and civic engagement;
- about civic and professional duties as well as rights; and
- about building understanding and trust.

Success in policy-making often requires changing relationships among the principal stakeholders. Policies often fail because the stakeholders do not recognize or understand why differences exist between them. Often they do not talk to one another.

Deliberative processes bring stakeholders together to get and keep them talking. To succeed, the process must be well organized and well informed. House rules are needed, as well as a moderator or facilitator to guide the dialogue. Records of the proceedings and any decisions or next steps in the process should be kept. The aim is to better understand

and explore stakeholder differences, to achieve greater common understanding, to develop and explore policy options and to choose a way forward. These steps or stages in deliberation can be summarized as follows.

Stage 1. Identify and engage the major stakeholders.

Stage 2. Gather information, map and frame the issues and name the problems and relationships.

Stage 3. Probe to explore differences, gain common understanding, and choose a way forward.

Stage 4. Build the scenario and change relationships.

Stage 5. Act together to make change happen.¹⁹

For reasons already discussed, stakeholder differences are often the major obstruction to successful policy-making and implementation. Without understanding, acceptance and the active support of the major stakeholders, policy change may be impossible. Successful policy-making is often about sustaining dialogue between stakeholders, learning together and changing relationships. For more information about how to initiate and sustain dialogue and deliberation see Harold S. Saunders (1999).²⁰

12.3 Equity and social justice

In publicly funded health systems, questions of justice and equity are of utmost importance. In the reforms of recent years, economists have come to play leading roles in health sector policy-making. Traditionally, those adhering to the economic paradigm have appeared to regard economic efficiency as the dominant consideration in the provision of goods and services — including public good health services. Unable to obtain precise measures of equity and social justice, they have excluded those variables from their equations. Of course science and measurement are important, but just because something can be measured does not mean that it is important. Conversely, just because it cannot be measured does not mean that it is unimportant. When it comes to questions of equity and social justice, evidence from behavioural, social, institutional and political systems may be important — even if it is qualitative evidence.

Ultimately, communities must decide for themselves what is fair and just. It is therefore important that community views be taken into account from the outset.

¹⁹ *Public Politics in Practice: A Handbook on Deliberation*. P.O. Box 9517, Wellington, New Zealand, Social and Civic Policy Institute, 2001

²⁰ Saunders HS. *A Public Peace Process: Sustained Dialogue to Transform Racial and Ethnic Conflicts*. New York, St. Martin's Press. 1999.

12.4 Trust

Finally, in this social context, we would like to say something about trust.

In the 2002 BBC Reith Lecture Series, Professor Onora O'Neill dealt with 'a Question of Trust'.²¹ In her third lecture, entitled 'Called to Account', she spoke of accountability and trust in the health system. Without trust, she pointed out, the health system simply could not operate. When, as citizens, we find ourselves in situations where we need help, but do not have the expert knowledge or skill we require, there is risk to be managed and we must trust others. Risk in these terms is a fact of life. Trust and risk go together. If there is no risk, there is no need for trust. Trust does not develop in the absence of risk.

This is important when we think about how managers and policy-makers engage with health workers and communities in developing and implementing policies. In a well-managed, open social process that informs and engages all the relevant policy stakeholders, and in which knowledge is shared, risk explained, options explored and decisions reached by collective agreement if possible, trust is generated, the stakeholders can be counted upon to act together honourably and responsibility and accountability is established.

Unfortunately, policy-making in health services often does not engage the stakeholders in such a well-organized and sustainable dialogue. All too often, policy decisions are made at a high level — in a 'star chamber' — with little stakeholder involvement. Policy is simply handed down from the centre and micro-management measures are used to embed the change and establish accountability.

Policy-making and implementation in the health system is rarely possible this way. If the stakeholders do not engage, do not understand and do not support and have no ownership in the policy, they will not strive for its implementation. On the contrary, they may well undermine the policy and its implementation either actively or passively.

Earning and engendering trust is fundamental to the social process of policy-making.

²¹ O'Neill O. *Question of Trust*. Cambridge, Cambridge University Press, 2002. (Also online at <http://www.bbc.co.uk/radio4/reith2002/lectures.shtml>, accessed 29 May 2006.)

POLICY TRANSFER: THE INTERNATIONAL DIMENSION

The academic and practitioner communities interested in policy-making are international and there is a vast body of international literature. There is also a significant 'industry' for the provision of policy advice: the principal providers are consultants, development partners and aid donors — both bilateral and international institutions. All countries, even the large and wealthy, gain from sharing their experiences about policies that have succeeded or failed.

For smaller countries without the resources to devote to extensive primary research, the international transfer of knowledge is even more important. It is a truism, however, that lessons from elsewhere must be evaluated in the local context. While useful insights may be derived from experiences that, in magnitude and available resources (and culturally), are far removed from local circumstances, the potential benefits and risks of transplanting systems and policies from one country to another should be weighed up carefully.

Over the past two decades, there has been a general move in health systems in the Western world towards the neo-liberal approach to policy-making. The general aim of reforms has been to improve the quality of services available to consumers/customers/clients through greater efficiency in the allocation and use of health resources. In the Pacific where most health care is funded through the government, this approach has little direct application. It can, however, have significant influence, mediated largely by way of the policies of development partners and the consultants who work with them. However valuable particular ideas, schemes or projects may appear to be on their own merits, the following questions should be asked:

- How does this scheme fit into our cultural and economic setting?
- Does it fit with the government's general and health policy framework?
- Where does it rank in the government's priorities?
- What are the accommodation, workforce and other infrastructure implications?
- What distortions or inequities does it create within or beyond the health sector?
- Can we afford it in the short and longer term?
- Can we sustain it later without outside support?

Funding is always of prime importance to health policy-makers. In the Pacific, in this context, particular attention must be given to activities associated with funding provided by bilateral and multilateral development partners.²² Not only do these partners have the power to fund, or not to fund, given projects, they also have the power to influence, if not control, policy-making agendas and, usually less directly, to influence underlying ideologies and policy positions. In each country, policy-makers should seek to have these matters addressed openly and explicitly.

²² Larmour P. Conditionality, coercion and other forms of 'power': International financial institutions in the Pacific. *Public Admin Dev*, 22: 249-260. 2002.

ASSESSING THE QUALITY OF POLICY ADVICE

Policy advice does not come without cost. In direct budgetary terms, the largest item of expenditure is usually staff (often quite expensive compared with other categories); other cost items probably include a share of information technology (IT) costs, the costs of consultation, perhaps the hire of external consultants, or overseas travel. From a straight-forward ‘value for money’ position, it is sensible to ask whether the expenditure can be justified by some measure of what is delivered. However, it is also important to ask whether the advice given is effective: are ministers getting advice that contributes to good policy outcomes? What is ‘good’ in this context? What is ‘quality’ policy advice? What is ‘excellence’ in respect of policy?

A great deal of work has been done by governments recently to assist them to make such assessments. For one example, see the work of the New Zealand State Services Commission (<http://www.ssc.govt.nz>).

The first step is to identify the characteristics of policy advice in a way that can then be assessed. The following framework may be useful as a starting point.

14.1 Quantity

This heading will take its meaning from the framework established for policy advice within a particular government. It is, however, always desirable for an agency to have an understanding with the appropriate minister about a policy development work programme — more than just a list of topics, rather a costed set of projects with priorities assigned. Otherwise it is difficult to justify the funding provided for in the budget in the current year or any plans to increase the resources available in future years. The assessment of performance under ‘quantity’ can be made in relation to the completion of projects in accordance with the work programme. It is, of course, only to be expected that the work programme will be adjusted during the year to cope with projects that emerge at short notice and are given priority by the minister. A valuable by-product of having an agreed work programme is that, unless new resources are provided, a change in priorities requires a decision to be made about the project(s) to be deferred or dropped to make room for the new project. It is very easy to add policy projects to already hard-pressed staff, without providing the means to carry them out.

14.2 Coverage

Governments expect their policy-making units to provide advice on the full range of issues likely to arise. They require their policy capacity to be comprehensive. In practice, however, even in well-resourced agencies, this capacity is unlikely to be all-embracing. Advice may have to come from outside the agency: from health practitioners, consultants or international agencies. What is important is that the policy advisers are able to identify the need and know where to go for the advice that they themselves cannot provide. They must also know how to engage key stakeholders in the policy-making process.

14.3 Quality

This is an area of uncertainty. One possible measure is the judgment of the ‘client’ — usually the minister. The view of the minister is certainly very important: does he or she consider that quality advice is being given? However, it is also desirable that the minister’s judgment be complemented by assessments of projects by external reviewers, whether other agencies or outside consultants. Such reviews should cover, not only the methodology and scope of major projects, but also the clarity of the documents containing policy advice. Criteria for assessing quality might include:

1. Purpose Is the aim of the advice clearly stated?
Does it set out to answer the questions asked?
2. Assumptions Are the assumptions set out clearly and does the argument follow a logical path (see the section on intervention logic)?
3. Accuracy Are the data and information supporting the proposal clearly and accurately stated?
4. Options Is a range of options submitted?
Are their implications — costs and benefits — clearly identified?
5. Consultation Have the appropriate interests inside and outside the government been consulted?
6. Practicality Are the proposals capable of implementation within the given time-frame? Are they consistent with other policies and coherent in themselves?

14.4 Timeliness and cost

Has the policy advice been provided in accordance with the agreed timetable?

Has the policy advice project been completed within the expenditure provided?

14.5 Suggested template for planning and evaluating a policy proposal²³

- 14.5.1 Where does the policy idea come from?
Government manifesto, the minister, the agency, chief executive, policy branch, delivery staff, an interest group, a community consultation?
- 14.5.2 Is the proposal defined adequately?
- (1) Do we have a clear authoritative statement of intent of the desired outcome?
Is there agreement on the nature of the problem?
 - (2) Are there feasible solutions?
 - (3) Is it a problem for the government or someone else?
 - (4) Is there adequate 'evidence' to justify the proposal?
 - (5) What is the optimal timing of:
 - (a) the decision?
 - (b) implementation?
- 14.5.3 Is the analysis adequate?
- (1) Are the objectives and goals explicit and unambiguous?
 - (2) Has there been a thorough search for options?
 - (3) Have the appropriate methodologies (mix of policy instruments) been employed?
 - (4) Is there a preferred option?

²³ After Bridgman P., Davis G. *Australian Policy Handbook*. St Leonards, NSW, Australia, Allen and Unwin, 1998: 135-141.

- (5) Has implementation been considered?
- (6) Is legislative action required?
- (7) Has the proposal's relationship to 'the health plan' been considered?
- (8) Has a consultation process been developed:
 - (a) within government?
 - (b) with other stakeholders?
 - (c) with the community?
- (9) Have the possibilities of external assistance been explored?

14.5.4 Preparing the proposal

- (1) What is the time line for presentation to the decision maker, chief executive, minister, cabinet?
- (2) Are there dissenting views of which the decision maker should be informed?
- (3) Are the 'right' options exposed to the decision maker?
- (4) Is there a clear expression of the relationship of the proposal to:
 - (a) the budget ?
 - (b) the 'health plan' ?
 - (c) the 'national plan' ?
- (5) Are the workforce implications clear?
- (6) Are the legal implications (authority and enforcement) identified?
- (7) Has the proposed involvement of donors, including international agencies, been discussed with them? Are there concrete proposals or commitments?
- (8) Who has been consulted; who should be informed before the decision is announced?
- (9) What should be done to 'sell' the policy?
- (10) Is the implementation time line sufficiently detailed; are those to be held accountable identified?
- (11) What are the risks for the government and the community?

14.5.5 Evaluation

- (1) How will 'success' be judged?
- (2) Has an evaluation process been developed and costed?
- (3) Are there obvious 'milestones' and performance indicators en route?

THE ETHICS OF POLICY ADVICE

Health professionals are well aware of ethical dilemmas in their daily work. Policy advisers too can be required to confront difficult ethical issues. Indeed, for some officials these questions may involve conflict between the ethical code of their health discipline and the professional duty of a policy adviser. As a general rule, officials owe their duty to the government of the day — their role is to advise ministers and to implement the agreed policies.

It is often argued that officials have a duty to the ‘public interest’. This is a slippery term, but one that appears on the statute book of many countries. It is often portrayed as a higher call than duty to the government of the day. In what circumstances could an official be morally justified in, for example, speaking publicly in opposition to the government’s policy? Such action may be claimed to be in the public interest because the government’s policy is seriously damaging to the health or safety of the community. Such cases are not the norm and, in some jurisdictions including New Zealand, are covered by ‘whistle-blowing’ legislation. Beyond such legislation, general provisions relating to ‘open government’ and the free availability of official information should reduce the number of such cases.

Sometimes officials become disillusioned because the government — perhaps because of competing priorities for scarce funds — does not adopt policies that they favour. This is not a justification for actions such as ‘leaking’ information or ‘going slow’ in implementing policy - activities sometimes described as those of ‘bureaucratic guerrillas’. It is necessary to be very clear about the role of the policy adviser.

Those who work in policy-making are described variously as ‘policy advisers’, ‘policy analysts’ or ‘policy consultants’. These labels will have particular significance in different countries. However, while the employment relationships may differ, there are two common elements:

- (1) Advisers will provide free, frank and comprehensive advice, based on their experience and knowledge and that of their agencies — good policy advice is not necessarily the advice that the minister wants to hear.
- (2) The primary duty (within the law) of policy advisers, like other officials, is to the government of the day. In the much-quoted words of the American writer, Aaron Wildavsky, quality policy-making is ‘speaking truth to power’.²⁴

²⁴ Wildavsky A. *Speaking Truth to Power. The Art and Craft of Policy Analysis*. Boston, Little-Brown . 1979.

THE HEALTH CONTEXT

Up to this point, the emphasis of this publication has been on the more general aspects of policy-making. Here, in conclusion, are some general observations and suggestions about what may be seen as important contextual issues in health policy-making.

16.1 Health status improvement

The health status of individuals and communities does not depend solely upon what the medical system (doctors, drugs and hospitals) has to offer. Estimates vary, but probably less than 10% of a country's population health status depends upon the medical system. Housing, nutrition, sanitation, education, employment and good government are also key health determinants and must always be taken into consideration in developing health policy. Education, particularly the education of women, is vitally important.

Government policy intervention in health and health care is essential and a fact of life in the Pacific. If the peoples of the Pacific are to have equitable access to effective, affordable and efficient health care aimed at meeting local needs, governments must play a strong policy-making role in the protection and the promotion of health, as well as in the provision of treatment and care services. Most of the key determinants of health status are beyond the direct control of health policy-makers. Demographic factors, age, gender, ethnicity, etc., together with values, beliefs and lifestyle factors, can only be influenced indirectly. Often, more direct impact can be made in areas such as clean water, good drainage and sewage, rubbish disposal and satisfactory living and employment conditions. Items most directly within the control of health policy-makers are those concerned with the allocation and use of resources to public health, primary health care and hospital-based health services and programmes. Most of the resources available to a community to protect and promote health and to seek health status improvement lie beyond what is seen to be the conventional health system. This means that health policy-makers must be pro-active in their efforts to ensure that health improvement perspectives are taken into consideration and integrated into policy development in other parts of the government and in the wider economy.

16.2 A health paradigm shift?

As noted earlier, in recent times economists have come to play leading roles in policy development and in the funding and management of health systems. For economists, efficiency is the paramount value; often it appears to have been considered in isolation from

questions of equity and social justice in the allocation and use of health resources. Biomedical and social scientists and social policy analysts, on the other hand, have tended to consider health and other social factors in isolation from economic efficiency. Both perspectives have much to contribute to good policy-making. It may be convenient to study economic, biomedical and other health and related social factors separately but, at some point, information from all of these perspectives must be considered together in the formulation of policy.

What we are looking at here could be what is often called ‘a paradigm shift’.

‘A paradigm’ can be described as the basic set of values and assumptions, the ‘world view’, that underlies the body and practice of a given discipline. The dominant paradigm in health services has long been the medical paradigm. Typically, the medical paradigm puts more emphasis on biomedicine and medical technology — on the diagnostic and treatment aspects of health services — than it does on the more caring and supportive functions. This is despite good evidence to show that the caring functions are at least as important as the medical functions when it comes to individual and population health and well-being.

The prospects for developing new and better medical technologies are excellent, although it will be expensive. However, they must not blind us to the need to talk with, and listen to, patients and communities, and to provide them with the care and social support they require in an ever-changing world. In the end, they will decide what is fair and just in the public use of health resources.

In policy-making debates, the views of people who support other paradigms, more socially conscious and generally more democratic paradigms, are increasingly being heard. Nurses, social scientists and the disability and aged-care communities are leading the way. This has already been alluded to in the section on evidence-based policy-making — the question being what and whose evidence should be taken into account, and how should that evidence be weighed.

The emphasis in health reforms in many countries over the past two decades has been on the improvement of quality and efficiency; they have tended to focus on the ‘technical’ rather than on the ‘caring’ aspects of health care delivery. In the process, the views of health professions and communities generally were subordinated to those of the reformers. As well as having consequences for the organization of services, the reforms have impacted directly on equity and social justice within the health system. These problems are now being increasingly recognized and analysed. Recent government strategies have moved to engage health professionals and communities more directly in policy-making and planning. These developments will undoubtedly have their echoes in the social processes associated with public policy-making in health in the Pacific.

16.3 Integration and health service improvement

In summary, the following are suggested as principles to guide the integration and improvement of services:

- (1) Improvement requires clear aims for improvement. Complex systems do not improve without a clear agenda for change.
- (2) Improving a system requires leadership at all levels across the system.
- (3) Measurement is a key step towards individual and organizational learning. Measurement is not a threat, it is an opportunity to learn.
- (4) There must be whole-hearted commitment to change existing methods of work continually. There must be service redesign as well as service integration.
- (5) Change must be evidence-based. All relevant evidence must be considered. Not all changes are improvements.
- (6) The ultimate measure of improvement is whether or not it helps the users of services — patients, families and communities, as they see it. ‘Quality’ should be measured in these terms.
- (7) Reducing waste is consistent with the pursuit of ‘quality’.
- (8) Monitoring and audit alone cannot improve ‘quality’. Integration of services is not enough without research, innovation and redesign.²⁵

16.4 Questions for policy-makers

Thirty years ago, the then President of the Royal College of Physicians in the United Kingdom, Sir Douglas Black, in conversation with Kerr White, suggested a set of questions to be posed to those setting health policies and organizing services.²⁶ Those questions are still relevant today.

- (1) What are the aims of the treatment, procedure or service in question?
- (2) How many people, and of what kind, are potentially eligible for help from these interventions?

²⁵ After Berwick D M. Medical associations: guilds or leaders. *British Medical Journal*, 1997, 314: 1564-1565.

²⁶ White K. *Health care research: Old wine in new bottles*. Presented in the University of Virginia's History of Health Sciences lecture series. September 24, 1992.
(<http://www.med.virginia.edu/hs-library/historical/kerr-white/biography/oldwine.html> accessed 29 May 2006)

- (3) What proportion of these people actually get help?
- (4) What determines who gets this help and who does not?
- (5) Does this intervention do any good or make a discernable difference? If so, how much difference does it make? To whom?
- (6) What does this treatment, procedure or service cost? How do these costs compare with those of potential substitutes? Who pays?
- (7) What does the public — those served, those eligible but not served, and those ineligible — think about the intervention?
- (8) What impact might the intervention make on the demand or effectiveness of other treatments, procedures or services?