



Health Policy and Management: in praise of political science

Comment on “On Health Policy and Management (HPAM): mind the theory-policy-practice gap”



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Abstract

Health systems have entered a third era embracing whole systems thinking and posing complex policy and management challenges. Understanding how such systems work and agreeing what needs to be put in place to enable them to undergo effective and sustainable change are more pressing issues than ever for policy-makers. The theory-policy-practice-gap and its four dimensions, as articulated by Chinitz and Rodwin, is acknowledged. It is suggested that insights derived from political science can both enrich our understanding of the gap and suggest what changes are needed to tackle the complex challenges facing health systems.

Keywords: Health Policy, Health Management, Political Science, Leadership

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Introduction

There has never been a time when health systems globally have faced so much scrutiny and pressure to undergo transformative change. Demographic changes and the rapid rise of non-communicable diseases, largely the result of lifestyle behaviours, are the principal drivers for change. Although many of us are living longer, not everyone is living healthier lives. Problems of obesity, alcohol misuse and poor mental health and so on are linked to growing health inequalities both within and between countries (1).

Since the start of the century we have entered a third era of health and healthcare embracing the whole health system (2). Whereas the two earlier eras focused respectively on improving life expectancy and reducing disability, era 3 is about optimising health and well-being. The healthcare system is evolving from simple relationships among hospitals, doctors, patients, and health organisations to complex, interdependent organisational models.

Against this context of the complex challenges facing health systems, Chinitz and Rodwin's (3) observations on health policy and management are both timely and apposite. According to their critique, successive reforms of health systems have failed largely as a consequence of ignoring the connections between theory, policy and practice. They highlight four problems in particular: the dominance of microeconomic thinking – and by extension, although they do not mention it explicitly, the appeal of New Public Management (4); the lack of learning from management theory; the disconnect between higher level health policy and management on the one hand and those toiling on the frontline on the other; and a failure to expose medical students to issues of health policy and management.

Health system reform: the triumph of ideology over evidence

The critique is to be welcomed and a rethink in how health systems are analysed and reformed is long overdue. To assist in this task, Chinitz and Rodwin are surely correct in advocating for a wider range of disciplines from the behavioural and social sciences to be employed in the field of health policy and management. But a puzzling paradox permeates public policy which urgently needs resolving if real progress is to be made. On the one hand, there is a welcome focus on evidence-informed policy and practice. The limitations and negative unintended consequences of evidence-based medicine are being recognised (5) and giving way, albeit slowly, to new ideas about how evidence can inform policy and practice through approaches including knowledge transfer, exchange and brokerage. Policy-makers appear fixated on ‘what works’. For example, the United Kingdom (UK) government has set up several what works centres in selected social policy areas (6).

But these efforts may be contrasted with, and overshadowed by, governments seeking to impose their particular ideological preferences, mostly devoid of convincing evidence, on health systems. Despite the existence of a significant body of robust evidence identifying how, and how not, to reform complex systems, invariably such lessons are either conveniently forgotten or wilfully ignored. The misconceived reform of the UK National Health Service (NHS) between 2010 and 2013, with which the service is still coming to terms, is a case in point and holds many lessons for other health systems. It is rapidly becoming a classic case study in how not to reform a complex system while disregarding the evidence in a manner bordering on recklessness (7).

The NHS changes were prosecuted in a manner which amply affirms the four problems comprising Chinitz and Rodwin's analysis. Market-based solutions were favoured regardless of the evidence demonstrating that they would fragment services, incur additional costs and would not axiomatically improve quality of care; senior health service managers who could have drawn on their own experience and tacit knowledge to challenge the proposals chose instead to collude with policy-makers in 'selling' the changes to a sceptical public and to those running health services. The vast majority of frontline health service staff and their professional bodies were opposed to the changes for reasons that have since become all too apparent. Needless to say, as in respect of previous reorganisations, bemused medical and nursing students had little understanding of the changes and their impact on them as they looked to an uncertain future in the NHS.

Viewing health policy through a political science lens

How can the conundrum noted above be explained? How can a rhetorical commitment to evidence-informed policy proceed in tandem with a complete disregard for unwelcome evidence and a highly selective approach to evidence which purports to support a particular policy? Why do market mechanisms and neoliberal thinking persist in dominating the policy debate even when their solutions are known to fail (8)? According to Draca (9), faith-based policies triumph over evidence as a result of 'institutional corruption' emanating from the ideologies of those funding policy 'think tanks' and the lobbyists fraternising with policy-makers and advocating policy positions which advance the interests of their clients. A 'revolving door' operates between political parties, government and health service officials, and global corporate interests thereby ensuring that any evidence that runs counter to the favoured ideology is dismissed or ignored.

Although Chinitz and Rodwin do not explicitly mention it, of all the social sciences, political science perhaps has the most to offer both in understanding the increasingly complex world of health systems and in accounting for the failure of policy-makers to reform their health systems effectively and in ways which draw on the evidence. Senior healthcare managers must share the responsibility for this state of affairs. A factor accounting for their refusal to do so has been their growing politicisation (10). They have been the chief beneficiaries of market reforms and have gained most, both materially and in terms of additional power. But their elevated position has come at a heavy price – progressively they have become conduits for doing policy-makers' bidding rather than what their own frontline staff, patients or public regard as important. In this respect, managers are different from other healthcare professions whose values and expertise flow from a mix of evidence-based training and their craft as professionals. Managers' actions are not for the most part driven by evidence or of what has, or has not, worked in the past. Managers may be characterised as 'change junkies', continuously reorganising structures and systems as demanded by their political masters and mistresses. Little wonder that the challenges involved in improving health and healthcare remain unresolved and intractable problems. The political nature of the policy process is therefore central

to any understanding of a complex system characterised by various vested interests exerting power to maintain their perks and privileges. Largely ignored and unappreciated, political science has much to offer those seeking a deeper understanding of current health systems, how they operate, and what needs to occur if they are to undergo effective and sustainable change.

Political science is concerned with professional values, organisational cultures and with why things happen, or not, and for what reasons. Health is inescapably political. In Rudolf Virchow's (11) famous aphorism 'medicine is a social science, and politics nothing else but medicine on a large scale'. The theories and insights offered by political science (12) are well suited to providing a deeper understanding of the context of policy-making. It is all too easy to oversimplify complexity by ignoring or understating the interplay between politics and power. Complexity is not simply there being 'many moving parts' but about what happens when these parts interact in ways which cannot be predicted but which will nonetheless heavily influence or shape the probabilities of later events (13). Many frameworks can be enlisted to understand the politics of health systems but two are briefly reviewed here for their particular relevance. Alford's framework has stood the test of time well and remains useful as a way of exploring and understanding the evolution of health systems from a political science perspective. Made up of three groups of structural interests – dominant professional interests, challenging corporate and managerial interests, and the repressed community interests – Alford shows how the shifting relationship between the three groups lie at the heart of the changing shape and fortunes of health systems (14). In recent decades, the rise of the challenging managerial interests have been a key feature of health systems and accounts for much of the malaise in the field of health policy and management to which Chinitz and Rodwin draw attention.

But Alford goes further and characterises health system reformers as falling into one of two camps: 'market reformers', who hold state involvement in healthcare and bureaucratic complexity responsible for the ills apparent in healthcare systems; and 'bureaucratic reformers', who claim that the defects are all the fault of those who subscribe to markets and competition that obstruct the orderly planned provision of effective healthcare and have no place in medicine or healthcare. The history of health systems is one marked by a constant oscillation between these reform models with the dominance of microeconomic thinking and market mechanisms, which Chinitz and Rodwin note, being especially pervasive since the 1980s.

If politics is about power and who gets what when and how, then the Advocacy Coalition Framework (ACF) is useful to explain changes in public, including health, policy (15). Policies are the product of the belief systems of those actors present in a policy subsystem and they include not only politicians but civil servants, interest group representatives, academics and the media. Policies then emerge from the negotiations between different coalitions of actors. The value of the ACF lies in its ability to offer an explanation of why inducing significant change in policies is so difficult in the face of deeply held core beliefs which are hard to shift but also why external events, and changes therein, provide

opportunities to shift the power balance between actors and offer a chance of achieving significant change. If the dominance of microeconomic theory is to be challenged, as advocated by Chinitz and Rodwin, the ACF sets out what has to happen to assemble a coalition of interests of the willing to achieve such a goal. It is also a testament to how difficult it is in practice to put such a coalition in place.

Leadership for third era health systems

Lying at the heart of much of Chinitz and Rodwin's critique, although they do not use the term itself, is the place of leadership in health systems. Despite the vast outpouring of books and academic papers on the subject, what we understand by and want from leadership in complex settings has, if anything, become fuzzier and less enlightened. What is needed, in keeping with Chinitz and Rodwin's call for vertical organisational learning, is investment in building leadership capacity and capability at local level drawing on real-life challenges facing health systems. Leadership is not about generic competencies which simply require aspiring leaders to tick the boxes. In complex settings, leadership is contextual and is about understanding, influencing and shaping organisational politics to achieve sustainable solutions to wicked problems.

The challenges of change and transformation cannot be driven from the top via a directive or mandate. Locally-led cultural change rooted in particular contexts with a bespoke approach to using fewer competencies is the way forward, not a system of leadership development which ignores context, is structured around a fixed set of competencies and favours a 'sheep dip' approach to churning out leaders. Successful leadership in one situation or setting may not occur or survive in a different context - one size does not fit all.

The health challenge requires an end to silo-thinking and the shoring up of potentially failing organisations at the cost of inappropriate patient care. Leaders should be recruited with knowledge and understanding of complex systems and whole system approaches to transformational change. They must be able to work with, and through, others to influence and bring about intra- and inter-organisational change and do so utilising a range of leadership forms and styles, including adaptive, engaged and collaborative leadership.

Leadership trends follow societal changes. The economic downturn, coupled with big failures in the banking and business sectors, means that the age of the individual organisational leader working in isolation has gone. Consequently, leaders are required who do not assume they know it all and have all the answers but who are able to ask questions and draw on a range of knowledge and skills to address problems for which there are no simple or easy answers. Above all, leaders should be working to ensure that trust and not suspicion exists between health system professionals and managers, and between the workforce and government. Paying attention to the development of relationships and the 'soft power' issues of leadership has never been as important. Only then is there a likelihood of transformational change taking root across a whole system rather than in isolated pockets. The issue of scaling up change, sharing and spreading it across a whole health system, has never been effectively tackled because models of reform

focusing on structure rather than on acquiring the knowledge and 'body of wisdom', as Chinitz and Rodwin put it, to secure sustainable change have been given preference.

Given the centrality of the political nature of the policy process and the importance of leadership in bringing about sustainable change, being able to practice political astuteness is an essential skill future leaders will require. The successful leader appreciates that they act within a social and political context (16). These political forces operate both locally and nationally. The savvy leader has a keen sense of who needs to be involved in decision-making, who needs to be 'kept on board', when is the best time to move on an issue, and when it is best not to fight a particular battle. All that has been said above about the leadership challenge in complex systems, like health, points to the need for political awareness at various levels but especially when it comes to challenging policy failures and advocating a different approach (17). But, as Alford's structural interest framework shows, relationships between the professional and managerial interests within health systems have been problematic and have resulted in systemic failure, with managers often peddling solutions favoured by their political masters but which lack a sound evidence base.

Conclusion

Health systems have never been more complex or politically driven. Through a political science lens, it is possible both to illuminate and explain not only what has gone wrong in health systems in recent years and why but also to chart a different way forward identifying the factors and obstacles which need to be navigated if the default option of path dependency is to be avoided. It is no longer sufficient to produce leaders of healthcare services – we need leaders and leadership which can add value to health through adopting a whole systems approach which embraces the upstream factors impacting on health as well as those contributing to illness and disease. But it is also beholden on those leaders to demonstrate political astuteness and acquire coalition-building skills if they are to succeed in their ambition to transform health systems.

Seeking to reduce these complex requirements to a set of simple precepts to be resolved by a range of competencies is both simplistic and seriously misses the point about what is required of, and from, leadership for health in the 21st century.

Ethical issues

Not applicable.

Competing interests

Author declares that he has no competing interests.

Author's contribution

DJH is the single author of the manuscript.

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