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Published in:
International Journal of Public Health

DOI:
10.1007/s00038-007-0241-x

Publication date:
2008

Int J Public Health 53 (2008) 121–122
1661-8556/08/030121-2
DOI 10.1007/s00038-008-0241-x

Public health facts – why don't they lead to healthy public policy?

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Organizing public health might seem to be an easy task. Universities or other research institutes produce epidemiological data on health-risk behaviour such as smoking or negligent driving, or produce forecasts on the likely future burden of various diseases or disabilities. These data can then be used to organize a country's public health system in a way that decreases the prevalence of risk-taking behaviour and disease, or at least ensures that the related risk factors are directly addressed with the outcome being a decrease in risk-taking behaviour and disease.

The paper in this volume on the Slovenian struggle for an optimal public health system[1] shows that the situation is not always that simple. However, the general question that must be considered is whether problems with adapting public health structures to the public health needs of the population exist only in Slovenia, or whether it reflects the norm, with such problems being found in most countries. If the latter is true, the question of what is behind these policies, which seem rather irrational and unpredictable from an epidemiological and public health point of view, might also arise.

Answers to these questions must address other issues such as agenda building and the decision-making processes of government. Political scientists have studied these topics, and their findings are relevant for public health researchers who wonder why the government is not simply implementing the evidence-based policy upon which it has been advised.

Not every issue which public health experts consider to be a problem is seen to be a problem by the wider public. People need to be convinced that something should be done to change the particular situation before it is recognized as an issue on the wider agenda[2, p119]. In relation to the issue of change, Bachrach and Baratz[3], who were interested in discovering why there was such an enormous degree of poverty in a society as prosperous as the USA, developed an analytical model which helped them to understand this situation[4, p54]. They depicted the policymaking process as a kind of pipeline or tube containing four valves or barriers. The first valve concerns community values, which permit or hinder an issue from coming onto the agenda at all. When the issue has reached this stage, it has to pass through the second valve, which consists of many kinds of procedures, committees and institutions which need to modify the issue so as to make it acceptable within the decision-making arena. The third valve is the decision-making process itself, while the fourth valve leads to the implementation process. All four valves can be open or closed. If the latter is the case the attempt to change a certain policy cannot succeed. In other words, an issue has to pass through all four valves successfully before a new policy will be successful, with one closed valve being enough to derail the intended policy.

All the valves in the model are operated by groups of people who are in favour of preserving the status quo and thus want to keep the valves closed, while other groups in favour of change want the valves to be opened and try to use their influence to achieve this. Opening the valves is only possible for a coalition of groups who at a certain moment have the same interests and are prepared to cooperate throughout the process. Getting an issue such as the use of seat belts onto the agenda is not enough, as the issue also has to pass through the policy formulation valve with a law on this issue being drafted. Such a law must then be passed by parliament, acting as the third valve, while the fourth valve refers to the implementation of the law and the monitoring of it by the police. In this example, public health experts occupied the position of those who wanted change, while the car industry was most probably in favour of preserving the status quo. In different countries these groups looked for different partners in an attempt to influence the valves of the model.

Kingdon[2] also points out the necessity of stable coalitions. Coalitions are often not stable over time. If there is a high degree of media attention being paid to the issue, politicians will be in favour of change, but after a few months the media will have a new focus and the politicians attention will lie somewhere else. Also, internal changes or problems within the network of groups advocating change may lead to a decrease in the strength of the network and consequently a weakening of the change process.

An issue will enter the policy agenda more readily if it originates within government rather than coming from outside[5]. In practice this means that public health experts should develop good relationships with the Ministry of Health as a vital element in achieving any intended change. Furthermore, there are two aspects of any issue that should be taken into consideration. The more complicated the manner in which an issue is formulated, the lower the chance that it will reach the agenda[6]. This means that for scientists the most subtle scientific distinctions are not always the most useful tools when it comes to changing society. Secondly, the more an issue is perceived to be likely to change the distribution of values in society, the more difficult its life will be as a policy issue[7]. Consequently, an issue should be presented as simply and as rigorously as possible in order to increase the chance of it being accepted.

At this point, an observation by Lindblom might be quoted: "… democracy plays a cruel joke. It gives power to the citizen, but it also gives power to all other citizens"[8, p 124]. As a consequence, when a fairly small group of public health experts wants to change something in society, it is likely that it will encounter other groups reacting against the intended change. It is due to the organization of society what we estimate as the "least worse" option.

In such a society, epidemiological facts are just one of the determinants of public health policy. Together with other conditions such as financial restraints and public or political support they form the mix from which public health policy is made. Is this a gloomy view? It is when one has high expectations of policy based on expert knowledge, in other words, when one is a "policy optimist" in the sense that after having published epidemiological data, one expects that the government will formulate policy in line with the outcomes of the research. However, those who have more realistic expectations of policy are aware of the fact that after producing the data much still has to be done to influence the public health agenda, such as marketing the data and forming coalitions with partners who have the same aim. If we consider such activities as "not belonging to research" then we should not wonder why our very important epidemiological data is not converted into public health policy.

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