The role of state and non-state actors in the policy process: the contribution of policy networks to the scale-up of antiretroviral therapy in Thailand

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Antiretroviral therapy (ART) is difficult in poor settings. In 2001, the Thai government adopted the policy to scale-up its treatment initiative to meet the needs of all its people. Employing qualitative approaches, including in-depth interviews, document review and direct observation, this study examines the processes by which the universal ART policy developed between 2001 and 2007, with the focus on the connections between actors who shared common interests—so-called policy networks. Research findings illustrate the crucial contributions of non-state networks in the policy process. The supportive roles of public-civic networks could be observed at every policy stage, and at different levels of the health sector. Although this particular health policy may be unique in case and setting, it does suggest clearly that while the state dominated the policy process initially, non-state actors played extremely important roles. Their contribution was not simply at agenda-setting stages—for example by lobbying government—but in the actual development and implementation of health policy. Further it illustrates that these processes were dynamic, took place over long periods and were not limited to national borders, but extended beyond, to include global actors and processes.

Keywords Policy networks, policy process, policy analysis, antiretroviral therapy, HIV, Thailand

KEY MESSAGES

- In Thailand, networks of government and non-government actors working within the country and globally have been key to scaling-up antiretroviral therapy in order to achieve universal access to treatment.
- Mapping and tracking the resources of state and non-state actors can help to understand the roles and contribution of policy networks to the development and implementation of public policies, and help to plan future strategies.

Introduction

Scaling-up antiretroviral therapy (ART) in low and middle income countries has been hindered by several factors: the high costs of antiretrovirals (ARVs) and laboratory tests, complexity of treatment administration, and lack of health system capacity including inadequate financial resources, infrastructure and an experienced workforce (Bogaards and Goudsmit 2003; Steinbrook 2004). The HIV epidemic in Thailand started in the late 1980s, and had affected almost 1 million of its 60-million population by the mid-1990s (Thai Working Group on HIV/AIDS Projections 2001). The Ministry of Public Health (MoPH) instigated a public-subsidized ART programme in 1992

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to provide free access to zidovudine (AZT) monotherapy among the poor (Thanprasertsuk et al. 2004). In 1996, the service was replaced by treatment provision in clinical research projects, since an economic analysis suggested that universal ART would be unaffordable, and therapy in adults was less cost-effective than the use of ARVs to prevent mother-to-child HIV transmission. Although this initiative continually evolved in its strategies and treatment protocols during the first decade, the medication covered only a small fraction of the population in need. A dramatic shift was introduced in 2001 when the government opted to extend therapy to meet universal coverage (The Nation 2001). By the end of 2006, the number of people living with HIV/AIDS (PHA) on ART under the national programme was 80,000, a 40-fold increase from the baseline in 2000.1

Despite the fact that Thailand was well-off, compared with many countries in the developing world, difficulties in introducing complicated treatment nationwide could be anticipated, owing to the substantial demand and existing constraints in the health sector (Ainsworth et al. 2003). This paper investigates the processes by which the universal ART policy developed. It aims to understand why the government decided to scale-up ART coverage in 2001; how corresponding programme configurations were devised; and how such policy was translated into action at peripheral health care settings where significant limitations in health delivery existed. The paper illustrates the extent to which public policy-making in Thailand may be shifting towards acknowledging a differentiated polity (Rhodes 1997) where government officials are purposively acknowledging the network society, and including civil society groups, both in dialogue and exchange about key health issues and in the actual development of health policies.

**Background**

**The shifting role of the state in health policy making**

Many scholars have noted a shift in focus from government to governance in societies that are increasingly networked (Castells 1996; Rhodes 1997; Hajer and Wagenaar 2003). Although ‘governance’ is given many different meanings, its core observation is that the process of governing, of making and implementing policies, has broadened and has become more complex with the advent of the network society (Bressers and O’Toole 1998). Where once decision-making focused on the state, which controlled the policy process, attention has increasingly turned to non-state actors, who today are both more numerous and play more significant roles in health policy processes (Lee and Goodman 2002). As electronic communications have expanded, so have domestic and international networks of actors concerned with similar issues. The investigation of non-state networks involved in policy making provides useful insights into how public policy making is changing, and with it, the role of the state. While Marsh and Rhodes (1992) say ‘...focusing on policy networks will never provide an adequate account of policy change, because such networks are but one component of any such explanation’ (p. 260), focusing on the relationship between state and non-state networks raises important questions about accountability (who sets the policy agenda for example), as well as interdependence in the policy process (where does sovereignty lie). Using networks as a lens through which to explore such fundamentals contributes to an understanding of changing policy processes and policy environments.

Scholars have used the notion of ‘policy networks’ to illustrate the complex web of policy making and the inter-relationships between different state and non-state actors. In some instances, the interactions may be highly contentious, with non-state actor networks pressing the state to shift its position. An example is the action of AIDS activists forcing a policy shift in South Africa in relation to access to antiretroviral drugs (Friedman and Mottiar 2004). In other instances, state and non-state actors create collaborative relationships where the former can achieve specific policy goals with assistance from the latter, even while pursuing their own interests (Rhodes 1988). Friedman and Mottiar (2004) show how the Treatment Action Campaign fought to change government policy in relation to antiretroviral medicines, but worked with government to oppose a pharmaceutical association onslaught on national drugs policy.

Defining the characteristics of policy networks is complex (Marsh 1998), although most agree that resource mobilization and exchange is one of the most important defining elements of policy networks (Hajer and Wagenaar 2003). Rhodes (1997) emphasizes the importance of understanding the resource exchange through which network members aim to maximize their influence over outcomes. Resources may be finance, knowledge, expertise, technologies, or the capacity to mobilize any of these as well as support from members of the network and outside it. Through their networks, participants are enabled to collaborate and coordinate activities or efforts, exchange information and construct common knowledge (Stone 2001) in ways that support the achievement of policy outcomes.

Policy networks can be classified into two categories: policy communities and issue networks (Marsh and Rhodes 1992). The two types of network differ in terms of the number of members, types of interests, cohesion, resources and power. A policy community refers to a tightly integrated group with a limited number of participants, high levels of continuity and a persistent balance of power among members, though one or two interests may dominate. In highly technical areas such as those relating to some scientific or health issues, the roles of specialists in government departments and academic institutes are crucial (Smith 1993). By contrast, an issue network is less integrated as it comprises large numbers of members with broad values and background (Marsh and Rhodes 1992). Imbalance of resources and power is more likely among members of this sort of network, and conflict may be a characteristic at certain times. With a few exceptions, policy communities lead policy decisions, while issue networks have limited access to the policy process and so may have less policy influence beyond the agenda-setting stage.

In empirical research, the policy network notion can be used as a tool for describing, exploring and understanding inter-connections between actors (Lewis-Lettington and Munyi 2004). It can also be a tool for policy-makers to use in prospective planning for policy change (see Buse 2008, this issue). While widely used in disciplines other than public health, there are limited examples of where health policy
processes have been observed through the policy network lens (Luke and Harris 2007). This paper contributes to the literature on policy analysis in developing countries, using policy networks to describe and understand the relationship between state and non-state actors in relation to ART policy development at a particular period in Thailand. It provides one example of a collaborative policy-making process between state and non-state actors, drawing on some of the characteristics of the different networks at different stages of the policy process. While its conclusions are limited and cannot be extrapolated to other policy issues, in which networks may not interact so collaboratively, it nevertheless provides insights, both retrospective and prospective, into health policy and planning processes in Thailand.

Roles of policy networks at particular policy stages

The integration of the policy network concept with the policy stages framework is useful in understanding policy development in each phase. Despite the fact that actual policy processes are repetitive and messy, the stages framework is employed as a heuristic device which helps to disaggregate these complex phenomena into a series of events. According to Baumgartner and Jones (1991), the rise of a new issue on to the government agenda and subsequent policy shifts take place only when there is substantial transformation in policy subsystems, whereby elites in existing policy communities are replaced with new clusters of actors who possess different beliefs, norms and preferences. Although policy communities are tightly restricted by technical expertise and other resources, these advantages may be disturbed in certain political situations that encourage and enable redefinitions of problems and policy alternatives. Political factors such as shifts in public opinion, movements organized by interest groups, media campaigns, and changes in the administration or responsible committees can also facilitate shifts in the policy agenda (Kingdon 1984).

At the policy formulation stage, policy options are explored, assessed, and then accepted, adapted or rejected by policymakers or appointed task groups (Howlett and Ramesh 2003). Since the actors involved at this stage are required to search, examine and justify the appropriateness of competing policy options, they have to have a minimal level of knowledge and skills about problems and solutions in the subject domain. Given that the policy formulation process is complex, iterative and often long lasting, the participants also have to be motivated by enduring interests. As Howlett and Ramesh (2003) note, those who are appointed by the authorities, such as government experts and consultants, gain advantage over others in devising public policies. However, networks of academics—so-called 'epistemic communities'—may also play significant roles (Stone 2001) in these processes. However, there may still be challenge and support from other interests, inside and outside government (Marsh and Rhodes 1992).

During the implementation phase, public policy intention is translated into action, generally by peripheral units of government. Due to factors such as ambiguous objectives, poor communication between responsible agencies, inadequate time and resources in implementation units, and problems in work environments, the policy may be adjusted, elaborated or even rejected by front-line government officials (Hudson and Lowe 2004). From Lipsky’s point of view, discretionary practice in service delivery seeks to counter implementation constraints and other unpleasant workplace experiences (Lipsky 1980). Eventually, such coping mechanisms become routine and established practices in the organizations. Implementation deficits may, thus, be generated by implementation actors who have not been involved in policy making, i.e. the policy networks that shape policies are not necessarily the same as those who put the policies into practice (Marsh 1998b). A useful review summarizes the involvement of policy networks at each policy stage, focusing particularly on the functions of civil society organization (CSO) networks in international development (Perkin and Court 2005). In agenda setting, networks draw the attention of policy-makers to important problems by organizing advocacy campaigns, promoting dialogue on research evidence, and fostering links between policymakers and stakeholders who aim to influence the government agenda. Similar roles are played by civic networks in policy formulation, i.e. they provide policymakers with the evidence necessary to assess policy alternatives. In policy implementation, however, many CSOs enhance the capacity of governments by delivering outreach services or acting as platforms for action on issues neglected by governments.

Study methods

The study’s focus was on the role of national policy networks in ART policy development, and local network involvement in policy implementation, in Thailand. Qualitative approaches, including documentary analyses, in-depth interviews and direct observation, were employed as the major data collection approaches of this study. Data on experience over the 2001–04 period were collected and analysed in 2003–04 as part of a PhD thesis (Tantivess 2006). Semi-structured interviews were conducted with a total of 80 key informants involved in agenda setting, policy formulation and implementation. A snowball technique was used in the selection of interviewees. The documents reviewed included memoranda, letters, meeting records, practice guidelines and programme manuals, research reports, conference proceedings and newspaper articles. Minutes of the meetings of MoPH advisory panels, official memoranda and government letters were particularly useful for this study as they suggested the positions, roles and resources of each network of actors at each stage of the policy. The information on policy context was drawn from a wide range of documents including those posted on the internet. Validation of information across sources, including field notes and personal communication with knowledgeable persons, was undertaken to ensure the study’s quality. The data on national policy making was mainly gathered in the MoPH’s departments, other government agencies, and NGO offices in the Bangkok Metropolitan area. Tantivess attended the meetings of a MoPH advisory panel responsible for policy formulation, as well as many conferences relating to the national ART initiative—all providing additional experience and insight to data analysis. The preliminary findings were shared with key informants to test their validity and acceptability. Data were analysed using a framework approach, which
identified themes and patterns pertaining to ART policy processes (Tantivess 2006, chapter 3).

To trace the relationship between national and provincial policy processes, field work was undertaken in two provinces, both with relatively high HIV prevalence and little experience in ART provision before the programme was scaled up. In each province, three hospitals responsible for providing ART were included in the research, one at provincial level and two district-level facilities. Interviews took particular account of the roles of policy networks in universal treatment policy implementation and ART roll-out between 2001 and 2004. Provincial interviews and documentary reviews revealed that these networks included agencies involved in the translation of treatment policy into action: Provincial Health Offices, Regional Centres for Disease Control and CSOs, as well as groups of PHA located in study provinces and the areas nearby.

Finally, additional document review, participatory observation and personal communication with Thai policy-makers and government officials involved in policy dialogue was carried out in 2006 and 2007, to identify the roles of different actor networks in treatment policy processes when Thailand issued compulsory licenses for patented ARVs. This additional work provided the opportunity to analyse how far policy networks were dynamic and adapted to changing external demands.

Results

Domestic and international context of ART expansion

Between 2001 and 2004 several reforms in Thailand’s health and bureaucratic systems affected ART scaling up. The Thai Rak Thai party came to power after it obtained a land-slide victory in the January 2001 national election. As pledged in the election campaign, the new regime instigated many large-scale, populist projects; for example, the agrarian debt relief initiative, the introduction of village revolving funds and the universal health coverage (UC) plan which benefited low-income groups (Phongpaichit and Baker 2004). The two new public health programmes—universal coverage and nationwide health promotion—required health workers to carry out additional tasks in health care settings and communities. New models of primary health care delivery were introduced in extended units outside hospitals. The greater access to disease prevention and treatment under both new policies resulted in rising service utilization as well as an increase in providers’ workload. However, the number of health professionals and paramedics did not increase (Jongudomsuk 2004; Kespichayawattana and Saengtienchai 2004). In addition, measures to downsizing and reorganize public agencies led to early retirement and reallocation of government officials, causing workforce shortages in some areas of the country.

In this period, mainstream access to HIV treatment in the developing world was beginning to be promoted globally. In 2001, Brazil was the sole middle-income country providing universal coverage for ARV-based medication. However, a number of HIV-medicine initiatives were organized by international agencies such as the World Health Organization (WHO) and United Nations Joint Programme on HIV/AIDS (UNAIDS) in collaboration with the pharmaceutical industry (UNAIDS 1998) to widen access to ARVs. Through these public-private partnerships, small-scale ART was implemented in some African and Latin American settings. Substantial efforts to expand treatment were introduced when the United Nations called for multilateral advocacy to address HIV/AIDS problems in a special session assembly in June 2001 (United Nations 2001). Then in 2002, WHO, with support from UNAIDS and the Global Fund to Fight AIDS, Tuberculosis and Malaria, established its ‘3 by 5 initiative’, aiming to get 3 million PHA on ART by 2005 (WHO 2002). Governments of industrialized countries and philanthropic organizations, including the Bill and Melinda Gates and Clinton Foundations, supported the scale-up of HIV-related services in different ways (UNAIDS 2004).

Network transformation: from outsider to insider status

After a decade of incremental changes in the national ART initiative, the Thai Health Minister declared the commitment to expand treatment to cover all PHA in need in late 2001. Many factors influenced the decision to drive the issue of treatment expansion up the government agenda (Tantivess 2006). These elements included local production of generic ARVs, drug price reductions and the NGO movement. Parallel reforms in the health sector and global efforts to expand access to HIV medicines were also important. Here we focus on the changes in ART policy networks at the time of policy innovation: in particular, CSOs, who had previously advocated treatment expansion, and were outsiders to the policy-making sphere, began to participate much more closely in policy-making processes. This was facilitated by legal changes to the Thai Constitution in 1997, whereby the rights of citizens to participate in much public policy-making were explicitly acknowledged.

The development of policy networks in HIV/AIDS could be observed from the mid-1990s and increasingly involved those living with HIV/AIDS. In 1994, 42 countries including Thailand adopted the Greater Involvement of People with HIV/AIDS principle (GIPA) at an international AIDS meeting in Paris. This principle promoted the participation of PHA and communities in policy decisions and implementation. This provided a framework to formalize PHA activities and encourage close collaboration between the government and CSOs. Coordination among HIV-afflicted people was strengthened at the national level when 50 groups of PHA throughout the country formed the Thai Network of People Living with HIV/AIDS in 1995, which then collaborated with the pre-existing National AIDS NGO Network (Wisartskul 2004).

By 2000 there was a large and multi-partnered network of groups involved in HIV/AIDS and ART. Alliances of HIV NGOs, PHA and human rights advocates, scientists in the Government Pharmaceutical Organization (GPO), HIV experts, schools of pharmacy lecturers, and intellectual property (IP) lawyers had promoted access to therapy in Thailand since the mid-1990s, when highly active antiretroviral therapy (HAART) was first distributed in industrialized countries (Ford et al. 2004). This was a highly effective and active network at the national level, which was able to draw on support from international networks too. In 2003 they filed a case at the Intellectual Property Court to revoke Bristol-Myers Squibb’s patent on
didanosine (Ford 2004), and in 2004 the company cancelled its patent—before the Court ruled. Increasingly, a few NGOs began collaborating closely with officials in the MoPH’s AIDS Division and clinicians in provincial and district hospitals, sharing field experience on HIV prevention and care delivery (Kumphitak et al. 2004). Treatment advocacy networks also had close relationships with the health system reformists who led the initiation of the UC scheme under the new regime. Nevertheless, prior to the adoption of the universal ART policy in 2001, only a few of these network members (for example some HIV specialists) joined government AIDS officials in making decisions on the national treatment initiative.

However, in March 2001, the civic groups’ campaign for ART extension was galvanized into close dialogue with government. This was because the government excluded ARVs from the UC benefit package owing to concerns about their unaffordable financial burden and programme sustainability. In several meetings with insurance officials and the Minister of Health, treatment advocates presented evidence on the effectiveness of HAART and the associated cost-savings from opportunistic infections averted in Western countries and Brazil, as well as the availability and prices of ARVs produced by an Indian generic company, Cipla (Tantivess 2006). Human rights, justice and equity were raised as the rationale of service extension. A leader of the treatment alliances argued:

Those who can afford it are now able to have a good quality of life for a long period of life. This raises the question whether drugs should be considered in the same terms as a commodity… or should it be considered an essential part of people’s needs and therefore a right. Should it be a right to people in the world to receive the drugs needed in order to support their life? (Ungphakorn 2001, p. 75)

In October 2001, the Thai GPO—the main supplier of generic ARVs to the national treatment initiative—succeeded in manufacturing a fixed-dose medicine combination, GPO-Vir. The subsequent price reduction of this first-line regimen, from 20 000 baht to 1200 baht per patient per month, publicized in October 2001 (Bangkok Business 2001a), was an important event. NGO networks promptly urged the government for further action. On 5 November, a letter co-signed by the presidents of the Thai Network for PHA and the Thai Non-governmental Coalition on HIV/AIDS was sent to the Health Minister and Prime Minister as well as circulated to the media, proposing the MoPH establish a commission of MoPH officials and NGO representatives, including the PHA network, to work out a plan to integrate ART into the UC scheme and oversee treatment extension (Tan-ud and Panichpak 2001). The letter stated that a thousand PHA and NGO staff would gather at Government House in Bangkok to hear the government’s decision on the eve of World AIDS Day, 30 November. The MoPH responded quickly. On 28 November, a government-NGO meeting was held, attended by the Health Minister, Deputy Health Secretaries, the Director General of the Disease Control Department, the GPO Director, HIV experts, and representatives of NGOs and the PHA Alliance (Ministry of Public Health 2001b). Subsequent to the discussion, an agreement was attained. The key resolution was that the MoPH agreed in principle to include ART in the UC package, phasing it in gradually. It could be said that from this moment, CSOs became ‘insiders’ in the policy process, involved in developing policy for implementation.

However, state actors also played crucial roles in this policy stage. It was the Health Minister’s urgent policy to strengthen the GPO’s capacity to manufacture affordable first-line ARVs that facilitated the expansion of ART (Bangkok Business 2001b). The progress in research and development and pilot-scale manufacture was monitored closely by the Minister and senior officials. Parallel to the meetings with civic networks, intensive internal discussions took place within the MoPH. It seemed that a group of health system reformists and economists who provided technical support to the Health Minister on UC introduction dominated the decision-making. Some of these technocrats encouraged the Minister to scale-up treatment since they anticipated not only the clinical and economic benefits of HAART, but also felt the policy would enhance the country’s reputation globally. However, they maintained that ARV medication should be delivered outside the UC scheme because its financial sustainability remained uncertain. This was partly due to the lack of evidence on treatment adherence profiles, drug resistance development and needs for second-line ARVs in the future.

As the Health Minister argued in interview in 2003 (Tantivess 2006), the universal treatment policy was adopted because the government had strong intentions to provide equitable access to all essential health services. An argument can, thus, be made that the ART policy innovation was not due to domestic or international political pressure but, to some extent, was motivated by true public interest expressed by government officials as well as CSO groups. Government had a commitment to improve treatment access. This was reflected in ministerial policies and actions, for example the programme to strengthen the GPO’s capacity in order to extend generic ARV production was, as already noted, implemented immediately after the Thai Rak Thai cabinet came to power. Such effort indicates that the government had clear objectives and strategies to address the treatment obstacles. Drug price reduction—a vital factor in the adoption of universal ART coverage—was partly the outcome of the administration’s advocacy. At the same time, government commitment to providing ART was accompanied by sustained lobbying and campaigning by networks of activists promoting the rights of individuals to health care.

Opposition to extending ART coverage came largely from a group of actors in the government sector, i.e. some AIDS officials and professionals in the MoPH and its sub-national units, who disagreed with the rapid expansion of therapy (Tantivess 2006). They were concerned about the inadequate preparedness of the health delivery system and the uncertainty of long-term financing. However, these concerns were difficult to maintain in the face of the powerful arguments of those who supported ART expansion.

Crafting a practicable pathway: the role of networks in policy formulation

Given that ART delivery was complex, the scale-up of the national treatment programme to achieve universal coverage
required substantial changes in both the existing HIV services and general health delivery. Scale-up affected the designations of responsible agencies; patient enrolment criteria; treatment protocols; and training of health workers in hospitals throughout the country. To devise the new configurations of the national ART service, the MoPH appointed four technical and administration panels, consisting of HIV officials, specialists in relevant areas from many institutes, health financing researchers, and representatives from NGOs and PHA groups (Ministry of Public Health 2001a). These formed the core of the policy community.

Although these advisory panels were active only in the year 2002, their contributions were beneficial to ART extension. Substantial changes in treatment delivery were introduced as recommended by experts, AIDS officials and NGOs as members of the four panels. These included, for instance, the suggestion to build up connections with new partners such as the Bangkok Metropolitan Local Government and public insurance schemes other than the UC, aimed at addressing the existing gaps of ART coverage in the capital city and private hospitals (Administration Advisory Panel 2002a). The revisions of ARV regimens, related clinical practice guidelines, and training programmes for workforce development were also attributed to this core policy formulation community. Another clear illustration of the administration panel’s role was that its proposals to provide opportunities for NGO and PHA participation in training and care delivery were adopted by the MoPH (Administration Advisory Panel 2002b). Moreover, the extension of ART to treatment-experienced patients—the group which was previously not eligible for ARVs under the national initiative—resulted from these panels’ advice (Administration Advisory Panel 2002b).

All of the policy recommendations made by the policy formulation panels were informed by the experience and expertise of the panel members, feedback from previous policy implementation, and the current context of the health delivery system, especially treatment challenges generated by the on-going reforms. An example is the major revisions of treatment regimens. Evaluations of the national ART programme prior to the 2001 policy innovation indicated weaknesses including inefficient procurement, poor inventory and allocation of ARVs to participating hospitals, because as many as eight complicated combinations had been adopted (Punpanich et al. 2002; Satasit et al. 2002). This led to frequent drug shortages and health providers’ mistrust of the national programme managers. The panels for clinical guideline development therefore sought to simplify the protocols, lessen the problems in treatment administration and drug management, and support mass service delivery. It was observed that not only the specialists’ expertise, but also the field experience of HIV treatment and care of NGO staff and PHA was useful and well considered in the panel discussion.

Apart from the MoPH’s panels, the Disease Control Department played a vital role in establishing NAPHA in 2003, the National Access to Antiretroviral Programmes for People Living with HIV/AIDS (ATSI 2003). This body aimed to provide an overarching umbrella to integrate the previously disjointed ART initiatives implemented by different departments of the MoPH, with different target populations. Thereafter, ART delivery was much better organized, under the single direction of the NAPHA steering committee. This group too included CSOs in its deliberations.

**Local networks: implementation on the ground**

As key stakeholders involved in the policy adoption and formulation stages anticipated, ART scaling-up during 2002 to 2004 was impeded by many factors. However, networks of sub-national actors acted to counter the impediments and to facilitate the implementation of good quality treatment. The collaboration between civic groups and their government counterparts was expanded when Thailand obtained financial support from the Global Fund to Fight AIDS, Tuberculosis and Malaria in 2003, which required NGO participation at policy-decision and operational levels of the national HIV programme. This significantly increased involvement of PHA and communities in ART scaling-up under NAPHA, especially in the HIV-endemic provinces in the north of the country (Lytleton et al. 2007).

In two study provinces (Tantivess 2006), sub-national networks formed to address problems such as inadequately experienced ART providers and the effects of HIV-related stigma on care-seeking behaviour, seeking ways to ensure service quality. Although health workers in hospitals and officials in provincial and regional health offices were key people translating treatment expansion policy into action, the role of NGOs and patient group members was also indispensable. These civic groups carried out some tasks for which health providers had only limited capacity. These included understanding the problems and needs of HIV patients, providing necessary information in lay language, and making adequate time for talking to and working with AIDS patients and their families. They also replaced the highly visible professional health workers on home visits, to help avoid any further stigmatization of individuals and families given widespread local sensitivities about the disease. In addition, ART-experienced PHA had a role in convincing high-risk and the infected persons, who had been reluctant to receive institutional care, to seek counselling and HIV testing. In an interview in 2004, one member of a self-help group in a study province pointed out that:

> Neighbours frequently asked me how my illnesses were relieved—which kinds of medicines I took. They saw me getting healthier . . . some of them had children or relatives who had the disease so they asked me for advice. They were afraid of visiting hospitals and seeing doctors. I told them not to worry . . . drugs were available and also we had organized as a group. It was better joining the group than staying desperately at home.

The local context influenced network profiles as well as patterns of collaboration. In one of the provinces, civil society activities around HIV prevention, care and impact mitigation were relatively strong; many NGOs were established in this region when the epidemic started in the late 1980s. When the number of AIDS cases rose considerably, NGOs supported these patients to form into groups, and worked closely with health workers. For example, before Thailand had its own generic antiretrovirals, alliances of NGOs, PHA and professionals in...
public hospitals helped individual patients buy generic medicines from India. The self-help groups were well accepted by hospitals and had crucial roles in promoting treatment adherence and providing information and psychological support to patients. When the national initiative was scaled up, the existing networks continued and passed on their experience to new ART providers and recipients. Patient groups in this province, especially in the provincial hospital, were also not reliant on financial assistance from health providers as they were able to generate some income from their own occupational activities. Furthermore, the networks of PHA groups at provincial and district level were well structured and managed as part of regional and national coalitions, through which technical support and funds were channelled. It seemed that the main thing these self-help groups required from their state partners was the opportunity to participate in the policy implementation process.

In contrast, only two NGOs, one on HIV and another on social development, were present in the other province. Patient groups were created and managed by health workers in the public hospitals. These groups had fewer members and were less well organized, compared with those in hospitals of the same size in the former province. However, the group leaders were helpful in treatment delivery as they visited ART recipients at home, encouraged adherence and provided information. A key feature of patient groups in this province was that they obtained very little support from the national and regional PHA alliances, and were not independent of their host hospitals. While the civic networks were relatively weak, the role of a small community of health professionals was crucial to policy implementation. The extension of treatment was hampered by a lack of experienced prescribers in this province because of the rapid turnover of general practitioners in district hospitals. To overcome this problem the small health professional group organized training courses for newly graduated doctors, pharmacists and nurses, most of whom were allocated to work in district settings. A network for consultations on clinical, laboratory and logistic issues was also established to support ART service at district level.

Ensuring treatment sustainability: domestic networks link with global networks

From 2002, access to ART in Thailand was expanded gradually, leading to rising budget needs. Like other antimicrobials, use of ARVs inevitably results in the development of viral resistance to drugs, subsequently increasing needs for second-line regimens. The sustainability of the universal ART initiative had been questioned from the beginning, as most ARVs on the market were patented and therefore expensive. In 2005 and 2006, the MoPH sought and failed to address these emerging problems through cooperation with research-based companies to reduce drug prices (Ministry of Public Health 2007). At the same time, the idea of introducing compulsory licensing for patented ARVs was raised in several policy discussions, including meetings of the National Health Security Board in mid-2006. The proposal was supported both by the Board members and by HIV treatment advocacy coalitions. However, it was not until November 2006 that the government announced its plan to implement compulsory licensing of efavirenz (EFZ), a high-priced, first-line ARV with lower toxicity than the regimens used in the national service (Disease Control Department 2006). The second compulsory license was issued in late January 2007, as the MoPH wanted to import generic lopinavir-ritonavir combination from India or other sources (Disease Control Department 2007).

These Thai actions ignited objections from the patent holders and their country governments (Gerhardsen 2006). Opposition also came from other drug research companies and international associations of pharmaceutical manufacturers, who feared that other developing countries might follow Thailand in issuing compulsory licenses for a wider range of patented medicines. Pressure was put on the Thai administration in several ways. The issue was discussed in special briefing sessions in the US Congress, where some participants from the drug industry urged the US government to introduce trade and investment sanctions. Administrators of transnational companies and diplomats from the USA, Switzerland and the European Union visited the Thai MoPH, National Health Security Office, Ministries of Foreign Affairs and Commerce, Department of Intellectual Property and Royal Thai Embassies to raise the issue of patent overriding. Abbott Laboratories—the patent holder of lopinavir-ritonavir combination—wthrew its drug registration dossiers including heat-stable lopinavir-ritonavir product, which had been submitted for market approval in Thailand (Head 2007).

Some opponents asserted that the Thai action was illegal, that the World Trade Organization did not intend the TRIPS flexibilities to be used to address the budgetary constraints of middle-income countries. They argued such flexibilities should be introduced only as a last resort, after trying ‘less disruptive ways’ to improve access to medicines (Pharmaceutical Research and Manufacturers Association 2007). Others suggested that by issuing the compulsory licenses, the Thai regime had put the country and its citizens at risk, since the violation to the rights of patent holders might prompt foreign businesses to withhold their investments including innovative drugs from the Thai market (Wong-Anan 2007). Overall, Thailand’s image was undermined as it was accused of piracy. An IP lobby group in the US put it, ‘The important distinction between theft of American assets on the streets of Bangkok and theft of American assets in Thailand’s public health care system is that the latter is sanctioned, endorsed and promoted by the government’ (IP Review 2007).

On the other hand, the compulsory licensing of certain HIV medicines for public use was applauded by international health agencies and NGOs, for example the WHO, UNAIDS, Oxfam, Medecins Sans Frontieres and the Clinton Foundation (Piot 2006; Chan 2007; Magaziner 2007). Among others, the WHO took a clear policy stance, saying in its letter to the Thai Health Minister, ‘WHO unequivocally supports the use by developing countries of the flexibilities within the TRIPS agreement that ensure access to affordable, high quality drugs. This includes the use of compulsory licensing, as described in paragraph 6 of the Doha Declaration on the TRIPS Agreement and Public Health’ (Chan 2007). Apart from expressing their appreciation for the Thai action, HIV and human rights networks, including journalists and IP experts in US universities and private law firms, helped to address the queries as to whether the
compulsory licensing was lawful or not (Love 2006; Arunmas and Treerutkuakul 2007; Steinbrook 2007). The NGOs, academics and media also publicized several examples where ‘government-use’ policies had been introduced for medicines and other patented interventions in industrialized societies. These coalitions managed to mobilize support from some US Congressmen who sent petition letters against the threats of trade sanctions on Thailand. In addition, local and international NGOs jointly condemned Abbott’s reactions and organized a campaign worldwide to boycott all products made by this company (Bangkok Post 2007).

It is noteworthy that the Thai government action took place within a lively global discourse around IP-related barriers to essential medicines and other health products, and what constitutes a public health emergency. In December 2006, a WHO-sponsored Intergovernmental Working Group had its first meeting to develop a global strategy and plan of action to overcome drug access hurdles (WHO 2007a). Progress made by the Working Group was reported to the WHO Executive Board in late January 2007 (WHO 2007b). The Thai actions to improve access to ARVs were raised as inspiring examples showing how resource-poor settings could put the flexibilities stated in access to ARVs were raised as inspiring examples showing how resource-poor settings could put the flexibilities stated in

"Discussion"

Given the complexities and costs of providing ART on a large scale, it would have been very difficult to scale-up treatment and maintain the universal access initiative without the public-civic partnerships that made up the policy networks. As Bressers and O’Toole (1998, p. 215) note, the policy network concept ‘has been fuelled in part by recognition of the complex array of actors involved in policy choices as well as the inability of contemporary government to move unilaterally without incorporating the constraints, preferences, and resources of other social actors.’ This paper illustrates the actor networks’ contributions to treatment extension in Thailand, where public resources were limited.

The roles of civic organizations in each stage of the Thai ART policy were in line with that described by Perkin and Court (2005). Focusing on agenda-setting and policy adoption, the treatment advocacy coalitions encouraged the government to pay attention and commit to the benefits, feasibility and underpinning ideals of service scale-up, and lobbied hard to get attention for the issue. However, context was also important. The shift in the ART programme took place when there was a transformation of the policy community: a new cluster of state policy-makers replaced the elites who had dominated policy decisions over the past decade. Because of this change, CSOs became members of the policy community that introduced the policy innovation. As noted by Marsh and Rhodes (1992, p. 261), policy networks can be a major source of policy inertia, unless policy equilibrium is ‘punctuated’ (Baumgartner and Jones 1991) resulting in a shift in the core policy community and policy innovation. It can be argued that the Thai Rak Thai government’s commitment to universal care was the focusing event that led to a change in policy equilibrium, and opened participation in the policy process.

The analysis also provides additional insight: core or privileged communities may form collaborations with clusters at the periphery in order to achieve their goals. In Thailand’s ART policy, there were core policy communities of a limited number and range of actors, largely MoPH officials and professionals in hospitals, who dominated the policy processes. These public servants had close connections with each other as they usually worked together and were linked through shared basic values and professional background. In parallel, groups of treatment advocates such as HIV NGOs, scientists, professionals and lawyers worked jointly for similar purpose. Some of these networks were well-integrated, consensual and shared regular activities, so that they too could be regarded as policy communities according to Marsh (1998a). Some could even be described as epistemic communities, who shared ‘a commitment to a common causal model and a common set of political values… united by a belief in the truth of their model and by a commitment to translate this truth into public policy…’ (Haas 1990, p. 41, quoted in Parsons 1995, p. 173). However, until the Thai Rak Thai government came into power, these policy communities worked relatively separately and the CSO networks were treated as relative ‘outsiders’, who put pressure on government or lobbied for change, but were not integrated into the policy process.

After 2001, however, the government policy community recognized its need to build connections with the existing networks, in order to mobilize additional resources which were not available in the MoPH and its affiliated units. The expansion of ART policy communities and resource mobilization could be observed in the policy formulation and implementation stages, where the technical expertise of HIV specialists and practical skills of, and treatment delivery support from, CSOs were required. This study found that the ultimate goal, shared by state and non-state members of the networks, was improved ART access. However, members of the network may also have been motivated by different incentives. While expressing a strong public interest in expansion of ART, the Thai Rak Thai Health Minister might also have been motivated to enhance her party’s popularity. NGOs who were in favour of extended ART for human rights reasons, may also have anticipated more financial support from donors. For HIV specialists, extension of ART and participation in the policy process gave them the opportunity to integrate their clinical research results into national HIV treatment policies. All of these motivations, however, were predicated on the recognition that it was only through the creation of a network, which used and exchanged the diverse resources of each group, that each group could achieve the overall goal.

The partnerships created by the MoPH expanded quite tight policy communities with a central core to include new members, allowing them to participate in public policymaking. As outsiders became insiders, they brought slightly different values and backgrounds and the policy community became less integrated. Compared with the core policy community members—health officials and professionals—NGOs and PHA had fewer resources and therefore less
influence, although their ability to mobilize others was a strong source of power. In contrast, the government’s authority and legitimacy to make final decisions on public policies was its most influential resource. State actors were therefore often able to dominate the policy process. The influence of health officials over civil society members could be observed at every policy stage. In agenda setting and policy adoption, for instance, it was the Health Minister and senior health officials that accepted the NGOs’ proposal to initiate formal discussion with NGOs and PHA networks on the issue of ART scaling up. However, while there was some imbalance in the relationships within the policy community, the members were nevertheless bound by common purpose and interests overall.

This paper also argues that the existence of policy networks at the international level played a crucial role in supporting Thailand’s policy to sustain its ART programme. When the country faced tough pressure from the corporate sector and industrialized country governments as a consequence of issuing compulsory licenses, the core policy communities sought collaborations with international actors well-equipped with knowledge and experience in broad areas such as HIV treatment, IP management and medicine access promotion. The support from global health agencies, and US-based academic and philanthropic organizations, helped to legitimize the Thai actions and reduce the political pressures. This again suggests that even tight policy networks will expand to include others when they need additional resources. With electronic communication, it is relatively easy to extend the network across state borders. What occurred in Thailand in late 2006 and 2007 suggests that policy networks can be extremely dynamic, and an inner core will draw on wider links in order to achieve particular aims or values.

While partnering among local and international actors contributed considerably to widening ART coverage in Thailand, the dominance of core communities could be seen in the local policy processes. It was the health officials and professionals who decided to extend the policy-making circle and draw support from selected civic groups and experts in particular ways. Within the networks at national and peripheral levels, the state actors were, to a significant extent, able to steer the process and the participation of their non-governmental counterparts. In contrast, at the international level, the policy community members could really only persuade their potential partners to back their intellectual property policy. It is noteworthy, however, that some international agencies and many international NGOs provided support with regard to this policy issue although they had never been requested to do so by Thai officials.

Other important resources of the CSO networks included the recognition and trust they had won from PHA, and in some cases, the general public. Among the international networks, complex IP-related knowledge and negotiation and lobbying capability to mobilize assistance were crucial resources that assisted Thai networks.

This paper is based on a retrospective study of ART policy process between 2001 and 2004, combined with a contemporary analysis of policy in the making in 2006 and 2007, made possible by Tantivess’s insider knowledge and participation in the policy process. The research is thus an example of the analysis of policy to further understanding. However, understanding the policy network concept can prove helpful in real-life policy making and implementation, in the analysis for policy. When the country decided to offer free-access medication and to issue compulsory licenses for the high-cost ARVs, policy-makers considered that strong policy networks to support such changes would be essential. The long-term involvement of local NGOs and PHA in HIV care prior to 2001 gave health officials confidence that civic support would be helpful and could be mobilized when needed. Moreover, given that only a few developing countries had issued compulsory licenses for medicines, and knowing that such actions had been resisted strongly by influential actors, the Thai administration expected objections from these powers. However, the health officials, who had long participated in international health policies, anticipated that in the current context Thailand would obtain support from key stakeholders worldwide, so they decided to issue compulsory licenses. If the country had been unable to mobilize support from local and international policy networks, it would not have been able to scale-up ART to meet universal coverage and make the programme sustainable.

Finally, the analysis of this one particular policy—which may be unique in case, setting and timing—offers an example of how policy processes are no longer dominated and controlled by state actors, and suggests the opportunity for more studies that test this assumption in other areas of health policy. This particular example suggests clearly that non-state actors played important roles not simply at agenda-setting stages but in the actual development and implementation of health policy, and that these processes were not limited to national borders, but extended beyond, to include global actors and processes. It would widen our knowledge and understanding of health policy analysis if more case studies could throw light on the role of non-state actors in the policy process.

**Conclusion**

This paper provides an illustration of different types of resources possessed by network members. The MoPH and its peripheral units commanded policy authority. It also had personnel with technical expertise, essential equipment, materials and facilities, and of course, a large budget. In contrast, non-state actors had field experience and skills in liaising with and treating HIV patients and their families. They were also able to mobilize network members to lobby the MoPH and government very visibly, by having good links to the media.

**Endnote**

1 When ART was limited to 2000 patients before the scale-up of the national programme in 2002, approximately 70 000 PHA required ART. However, treatment extension means that PHA live significantly longer, resulting in increased need for treatment over time. The number of PHA on ART under NAPHA will peak at 220,000 in 2015 (Revenga et al. 2006). The declining trend after that is associated with the falling number of new HIV infections and also the limited clinical effectiveness of available ARVs. The figure 220,000 does not reflect the real need for treatment, but largely the programme performance including.
adherence to treatment, affordability of second-line ARVs and capacity to recruit eligible patients.

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Addressing the theoretical, practical and ethical challenges inherent in prospective health policy analysis

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As a function of the inherently political nature of health policy, there have long been calls for, as well as guidance on, analysis of its political dimensions to inform practice. Yet there are few accounts in the literature of systematic attention to real-time documentation and analysis of political-economy factors and feedback to engender reform. The dearth of such prospective policy analysis is perhaps understandable given the many intrinsic difficulties in such an enterprise. This paper provides an outline approach of how researchers might work together with advocacy coalitions (or other political actors) to document and analyse the efforts of such coalitions to use policy analysis to influence the policy processes—agenda setting, policy formulation and policy implementation—in which they engage. In so doing, it identifies challenges based on reviews of the theoretical, methodological and empirical literature as well as the experience of the author. The aim of the paper is to generate debate to assist in resolving the myriad challenges inherent in prospective policy analysis. The paper responds to appeals for political research which addresses the problems confronting political actors so as to guide future action-research for evidence-informed, pro-poor health policy.

Keywords Health policy, policy analysis, policy process, prospective analysis, action-research, policy networks, advocacy coalitions

KEY MESSAGES

- Prospective policy analysis—analysis which seeks to understand the unfolding political-economy environment of policy change so as to support stakeholders to more effectively engage in policy processes—is an under-utilized approach to health development.
- This paper contributes to a discussion of approaches and challenges inherent in prospective policy analysis.

Introduction: the case for prospective policy research

As a function of the inherently political nature of health policy-making, there have long been calls for, as well as guidance on, analysis of its political dimensions (Thomas and Grindle 1994; Walt and Gilson 1994; Reich 1995a,b; Leighton 1996; Collins et al. 2002; Gilson et al. 2003; Kajula et al. 2004; Thomas and Gilson 2004). Michael R Reich has been most explicit in advocating for political analysis of health policy and has co-developed software for use by pro-reformers to better understand the interests, influence and positions of actors in relation to specific policy proposals (Reich and Cooper 2001). The Reich-Cooper software also assists in identifying a range of strategies and tactics which can be adopted by reformers to change the political landscape by addressing the power and position of key players as well as their perceptions of the problem and of the policy solution—which is further elaborated in ‘Getting Health Reform Right’ (Roberts et al. 2004).
Despite calls for pro-actively managing the political dimensions of health sector reform, and some retrospective analysis of attempts at doing so, there are few accounts in the literature of systematic attention to political-economy factors, forward looking, real-time documentation, immediate lesson learning (analysis), and feed-back to engender strategies to engage in policy processes—‘prospective policy analysis’ for want of a better term. Glassman (1999) provides one partial account in relation to health reform in the Dominican Republic which met with limited success. There are undoubtedly many underdocumented accounts of efforts by stakeholders to better understand the political obstacles and opportunities confronting their policy aims so as to devise strategies to improve the chances of their policy success. Moreover, there is increasing interest in undertaking such analysis to inform action, even by mainstream aid agencies such as the United Nation's Population Fund (UNFPA) through its Applied Interest Group Analysis (O’Brien et al. 2006) and the United Kingdom’s Department for International Development (DFID) in sector-level ‘Drivers of Change’ work. Nonetheless, it would appear that prospective policy analysis remains an under-explored, under-analysed and under-reported area of health development, as discussed below.

The first generation of reforms in developing countries, concerned largely with economic stabilization and structural adjustment (e.g. tariff reductions, exchange rate devaluation), were often referred to as ‘stroke-of-the-pen’ reforms because they were often single-event policy adjustments and self-executing. In contrast to these macro-economic policy changes, Joan Nelson (1999) argues that: ‘Social sector reforms are a different ball game, with far more actors, less leverage, different fields of play, a much longer playing period (with unpredictable time-outs) and uncertain scoring’. To use Nelson’s sporting analogy, is prospective (as opposed to retrospective) health policy analysis to academics like cricket is to North Americans—the timeframe far too long (a policy process might take a few years to unfold) and the play far too intricate and complicated to warrant ongoing attention?

Moreover, literature on the political economy of social sector reform suggests that the prospects for pro-poor reform are not encouraging (Batley 2004). Rational choice theory explains these outcomes by drawing attention to the asymmetries of power and incentives facing winners, losers and politicians (Olson 1974)—specifically that the potential losers are aware of their losses and quick to respond (e.g. health provider unions) while potential winners (e.g. primary beneficiaries of interventions) are less likely aware of intended benefits (which may not accrue immediately) and are less well organized. Nelson (2000) draws attention to the strong administrative and professional apparatuses that resist reform in these sectors. Political economists have focused on the role of formal and informal institutions in explaining reform failure (North 1991; van de Walle 2001). Institutional factors affect the extent to which winners and losers have access to decision-making forums, the value of their political assets, among other political variables (Swank 2002). Interests defending the status quo tend to be more powerful than reformers as they are usually the winners of prior policy contests and have rigged the rules of the game in their favour (Oliver 2006)—the so-called ‘mobilization of bias’ (Schattschneider 1960) in one literature and path-dependency in another. It may be that academic observers shun prospective analysis for fear of being left with a ‘non-event’ to explain (i.e. no change in policy) or at least a ‘no-score’, although it may be the case that there are other reasons why academics have not turned their attention to such work.\(^3\)

Yet progressive social policy reform has been possible in some Latin American countries ‘despite the odds’ identified above (Grindle 2002). Grindle does not deny the role of interests and institutions in the success, limited success, or failure of reform. However, the cases she analyses point to the importance of the policy process, the considerable agency and choices facing reform leaders and change teams (technical officers brought together from various agencies with a mandate to generate political strategies for a reform), and the use of different strategies (e.g. careful timing, creation of networks, use of information or symbolic elements to mobilize public opinion, changing venue, etc.) in explaining outcomes. Nelson’s overview of social sector reforms outlines the different tactics that can be deployed in agenda setting, getting executive approval, getting legislative and public acceptance, and launching and sustaining reform in response to the distinct political challenges at each stage of the policy process (Nelson 2000). Gonzalez-Rosetti and Bossert’s analysis of relative success in Chile and Colombia is compared with Mexican reforms and highlights the strategies of the reform team, revealing some conditions for success, but also underlining the existence of strong state-society networks buttressing the power of pro- and anti-reform groups (Gonzalez-Rosetti and Bossert 2000). Hence, despite the power of interests and institutions to resist change, reformers have ‘room for manoeuvre’ to deliberately bring about changes in public policy (Grindle and Thomas 1991). So the pro-reform game is possible, particularly with sensible coaching; coaching which could be provided by policy analysts with the luxury of stepping back from the game, but this seems the exception rather than the rule.

Eugene Bardach (2006) concurs with social sector analysts such as Grindle and Reich, that all else being equal, while interests, institutions and even ideas (due to the mobilization of bias) may be stacked against pro-reformers, success will be easier to achieve if pro-reform groups are prepared when ‘opportunities’ present themselves (Kingdon 1984). To be prepared entails some understanding of the political dimensions of the policy in question, as is made possible by prospective policy analysis.

This paper advocates two interlinked processes. First, prospective policy analysis in support of concurrent health policymaking (agenda setting, policy formulation or implementation). The policy analysis proposed itself builds on frameworks developed by other analysts, particularly Reich’s policy ‘content’ and ‘actor’-centric approach (Reich 1995a,b), Walt and Gilson’s heuristic which brings policy ‘process’ and ‘context’ into view (Walt and Gilson 1994), alongside broader models which incorporate the roles of ideas and discourse in policy, such as Peter John who views policy as the ongoing interaction of institutions, interests and ideas (John 1998). The paper further advocates that such analysis is undertaken by members of nationally based networks (specifically advocacy coalitions)\(^4\) with pro-poor aims, collaboratively with analysts (ideally by
national analysts where capacity exists and/or expatriates such as myself) where external support may be viewed by such groups as desirable and would add value given their interests and capacity in policy analysis. The purpose of the analysis is to equip the networks with information to develop strategies and tactics to engage more effectively in the policy process. Here too I borrow from Reich’s ‘PolicyMaker’ tool, but extend its range to incorporate policy context, process and discourse variables.

Secondly, the paper argues for research on the impact that structured and prospective approaches to policy analysis may have on policy processes. As such, it proposes research which sheds light on: (1) how the networks use policy analysis tools, (2) the understanding that those groups gain from such policy analysis, for example of the policy environment, including sources of power as well as the perceptions and tactics of counter-reformers, (3) how the groups use that knowledge to craft strategies and tactics to influence policy change, and (4) whether or not those strategies are effective. The proposed research will be of interest to participating networks themselves and, even if not strictly generalizable, to other groups working on other policy projects. Real-time learning to distil lessons on how the barriers to policy reform can be addressed and to inform reformist political strategies represents an under-researched and potentially rich field of enquiry (Campos and Syquia 2006). Moreover, it contributes to the development of a stronger knowledge base in health policy analysis as called for by Gilson and Raphaely (2008, this issue).

This paper proceeds in three sections. First, there is discussion of the rationale for greater interaction between policy analysts and advocacy coalitions. Second, the paper proposes an outline approach of what this action-research might look like in practice and what hypotheses it might test. Third, it identifies some of the theoretical, practical and ethical challenges inherent in such research and contributes to a discussion of possible solutions based on relevant literature and the experience of the author. The aim of the paper is to generate debate to assist in resolving the myriad challenges inherent in prospective policy analysis. Consequently, the paper responds to Shapiro’s (2005) appeal for political research which addresses the problems confronting political actors so as to guide future action-research for evidence-informed, pro-poor health policy reform.

**Supporting advocacy coalitions to do policy research**

Considerable research has been undertaken on the characteristics of networks, and the environments in which they operate, to understand what makes them effective in influencing policy (Marsh and Smith 2000). While quite distinct forms of networks have been identified, two ideal types are typically distinguished. A ‘policy community’ is a relatively small network, with a high degree of integration among members who are significantly dependent upon one another, which restricts access to non-members. Policy communities tend to be very cohesive. An ‘issue network’, by contrast, has relatively more members, less dependence of members upon one another and a looser organizational form. One form of policy community, the advocacy coalition, has received considerable attention for its role in the policy process. Advocacy coalitions are distinguished by a shared set of norms, beliefs and policy goals. They can include politicians, civil servants, members of interest groups, journalists and academics, among others (Sabatier and Jenkins-Smith 1993). Advocacy coalitions are potent forces within the policy rubric which can serve to limit participation, decide which issues will feature on agendas, shape the behaviour of participants, privilege the interests of certain groups, or manipulate the evidence reaching decision-makers (Rhodes 2006). Nelson (2004), Gonzalez-Rosetti and Bossert (2000), among others, have commented on the existence of strong state-society networks, having many of the features of advocacy coalitions, buttressing the power of pro- and anti-reform groups in the health sector. The potential of such networks to influence policy motivates my interest in working with them to support government officials with policy analytic models to better manage discrete policy reforms.

Given the imperative to advance evidence-informed policy to bring about public health outcomes, networks are ideally situated to provide a powerful conduit for evidence to reach decision-makers. Conceptualizing policy as a complex interaction of institutions, interests and ideas (John 1998) leads one to consider the relationship between evidence and policy as a messy and indirect one which may take many forms (Weiss 1979). Notwithstanding this indirect relationship, the elective affinity model holds that a decision-maker is more likely to react favourably to research findings if s/he has participated in the research process in some way, if the findings are timely in the decision-making process, and coincide with the values and beliefs of the policy audience (Short 1997). This might explain why in some contexts, advocacy coalitions—which bring researchers, advocates, managers and others in direct contact with decision-makers—have been successful in achieving evidence-informed policy (Gibson 2003). Building on these findings and recent thinking on the research-to-practice linkages, clearly more can be done to improve the knowledge transfer between researchers and decision-makers (Lavis et al. 2003). The ‘deliberative processes’ of engaging technical, scientific experts, programme managers, decision-makers and the public to collectively weigh various types of evidence (scientific evidence from different disciplines and experts as well as colloquial evidence on values and perceptions etc.), in collaborative analysis of policy options seems potentially rewarding (Lomas et al. 2005; Thompson et al. 2006). The deliberative approach may embody other valuable characteristics as it focuses on the crucial role of language, rhetorical argument, and stories in framing debate…It also brings in the local knowledge of citizens – both empirical and normative – relevant to the social context to which policy is applied” (Fisher 2003). Decision-makers will not only benefit from greater proximity to technical experts but also from better evidence concerning a range of policy relevant variables which can inform the tactics they employ to bring about change.

For their part, health scientists, activist groups and health programme managers should be concerned about the political feasibility of the policies which they pursue, for if they pursue a goal which is not politically feasible the opportunity costs are often high, including disillusionment and foregoing more attainable goals (Galston 2006).
Doing research on the use of policy analysis by advocacy coalitions

Research on prospective policy analysis must be ‘piggy-backed’ and ‘demand-led’; that is, the research relies on studying an already unfolding policy process and requires that the researchers are invited by country-level actors involved in that policy process who may wish to take a more structured approach to the political analysis, the resulting policy engagement and the proposed research on it. The research is not an assessment of the efficacy of technical interventions, but rather of the effectiveness of different strategies and tactics for intervening in the policy process. Consequently, the purpose of the research is two-fold: (1) to assist an advocacy coalition in being more effective in managing the political dimensions of the policy process; and (2) to study which strategies and tactics are more effective in changing the political dimensions of the policy process.

Policy researchers, both national or expatriate, invited into such policy processes would likely choose to work on technically appropriate, globally accepted, evidence-informed tracer policy intervention(s) which contribute to public health goals, to the extent that such an ideal is feasible.\(^8\) The policy researcher(s) would work alongside a collaborator, who is both a member of a pre-existing advocacy coalition (or issue network) and has interest, experience and/or capacity in policy analysis—a policy research ‘broker’—called here collectively, the research team. The research team would discuss issues concerning methods of policy analysis with members of the network. The research team would also learn together with network members while developing and implementing policy engagement strategies over a number of years. The researchers would document the activities and the impact (the limits of attribution are discussed later) that these strategies appear to provoke in the policy arena over the course of the intervention (e.g. in relation to resource allocation, technical recommendations, media coverage, attitudes of key stakeholders). The team would continuously update the policy analysis (indeed a major benefit of doing real-time analysis is the opportunity it provides to link theories, analytical frameworks and data collection, and to change these if alternatives appear more promising in effecting change). The results of the analysis would be periodically reviewed by the advocacy coalition so as to update and revise the policy engagement strategies. Decisions and activities would be documented by the researchers. The details of the proposed approach are enumerated in Box 1.

The research, which would piggy-back on the efforts of the coalition to implement a policy-influencing strategy, could test a number of hypotheses though the steps outlined in Box 2. Broad hypotheses which would need to be refined based on the specific policy and the context within it is being pursued include:

- More systematic approaches to the collection and analysis of policy information (e.g. concerning interests, institutions, ideas, and policy processes and context) can provide advocates with the knowledge to make an initial assessment of the prospects that the policy will be implemented.
- More systematic approaches to the analysis of policy information can alter the balance of power between advocates and anti-reformers and enable advocates to intervene more effectively in the policy process.
- More systematic approaches to analysis of policy information can shift the positions of the players involved in the policy process. In particular, bargains can be made by advocates with those that are neutral or opposed to render them more supportive or less opposed by altering the content of policy, horse trading, making promises and threats or using other strategies.
- Systematic approaches to analysis of policy information can alter the number of players involved in the issue. This could involve devising strategies to mobilize those groups which are neutral and to demobilize opposed groups or shift the venue of policy discussion.
- Systematic approaches to analysis of policy information can assist advocacy groups to alter perceptions of the problem and solutions to the policy issue. This might include devising strategies involving data, arguments, emotive appeals, emphasizing ‘doability’ and feasibility of the intervention, and/or mobilizing public opinion while challenging the arguments of the anti-reformers.

Discussion

The preceding description of one approach to prospective policy analysis throws up many unanswered questions as well as some obvious challenges which may account for the dearth of published accounts of its practice. Some of the difficulties inherent in the enterprise are elaborated, alongside a discussion of how they may be addressed.

Theoretical and methodological challenges to prospective policy analysis

Both the analysis undertaken by the advocacy coalition as well as the accompanying research on the prospective analysis and policy engagement throw up questions as to the selection of appropriate theoretical frameworks and corresponding causal relationships they describe. The theoretical underpinnings of much policy analysis are diffuse and problematic when applied in the complexity of the real world. Despite attempts by some social scientists to apply the positivist paradigm of the natural scientists to increase knowledge concerning general, causal and decontextualized relationships in the social and political sciences (e.g. King et al. 1994), emulating the natural sciences will remain a challenge in the policy field. In the natural sciences, causality refers to an account that explains an outcome through a measurable variable that exists independently of any participant/observer’s understanding. Yet, in the policy sciences, the search for explanation is intimately bound up in perceptions held both by the participant and the observer of the variable (which may or may not even account for the occurrence). Klein and Marmor (2006), for example, characterize policy-making as ‘a strange theatre’, an understanding of which requires the researcher to enter the ‘assumptive worlds’...
of the policy-makers—that is, their mental models including their interpretations of the environment and their prescriptions as to how it should be structured. The assumptive worlds of policy-makers, influencers and implementers are all important in the social construction of the problem and the policy. Interpretive theories attempt to account for why an actor behaves in a particular way and results in understanding that is both subjective and context specific. This is far from universal and generalizable knowledge generated in the natural sciences but useful in and of itself in drawing attention to factors and variables which have been perceived—by the researcher and/or subject—to be associated with, if not having accounted for, change in a particular setting (based on a particular experience and interpretation of history).
Beyond the problem of the ‘independent’ or objectively verifiable variable is the problem of the laboratory setting: the social world is not generally amenable to the approach of the natural sciences where basic research proceeds by fragmenting the world into abstract, analytical slices which are then studied individually. Etzioni (2006) argues ‘policy research at its best encompasses all the major facets of the social phenomenon it is trying to deal with’. Not only are there generally too many ‘confounding variables’ to control, even these variables remain difficult to pin down [think of the range of possible variables subsumed under the broad rubric of ‘institutions, interests and ideas’ which, according to John (1998), interact to create policy]. Immergut’s analysis of the literature on institutional constraints on policy, for example, suggests that the institutions typically studied do not conform to any ideal type (Immergut 2006).

There is similar trouble with the unit of analysis itself (i.e. policy—the dependent variable). While it may be relatively straightforward to look for the determinants of policy as conceived at the level of principles (e.g. DOTS as a general principle of ensuring drug treatments are administered under observation), policy lines (i.e. the more specific measures such as 6 months of drug therapy observed by a health worker), or measures (e.g. specific guidelines and budgetary allocations associated with DOTS) (Page 2006), or even as bundles of decisions, we all know that policy is a more elusive concept. Consider Bachrach and Baratz (1962) who argue that it is worth considering those issues that never make it on to the agenda (the ‘non-decision’) or Lukes (1974) who describes some policy as thought control. So the policy outcomes observed in policy processes may not entail a change in legislation, a policy document or technical guidelines, but may be as subtle as a shift in perceptions of an issue that sets the stage for more apparent and tangible change at a future date. The subtle and hidden manifestations of policy are very difficult to discern, observe and measure, and are, therefore, tricky to study.

The foregoing alludes to the importance of power (whether as manifest in institutions or interest groups) in the policy process as well as the importance of ideas; indeed for Majone (1989), ‘analysis of public policy, like policy making itself, is an exercise in persuasion’. This takes us back, on the one hand, to the issue of the objectivity of policy research and, on the other, to the links between ideas and interests. We are reminded by Anthony Giddens (1979) that agency shapes structures, which in turn condition agency and, consequently, we are faced with the challenge of how best to meaningfully disentangle the variables inherent in power, institutions and ideas for their analysis.

Even where policy theories emerge from some empirical test as robust, experience suggests that they do not travel particularly well, drawing attention to the problem of context. For example, Kingdon’s powerful approach to understanding agenda setting arose from an analysis of the pluralistic and fragmented political life of the federal American system (Kingdon 1984)—a system with different dynamics than those present in the core-executive system of the UK let alone the neo-patrimonial political systems entrenched in much of sub-Saharan Africa, but which has been employed usefully in a range of contexts in practice. Much the same has been said of the Advocacy Coalition Framework (Parsons 1995) which I find attractive in guiding my understanding of policy change.

A further concern relates to the dearth of theory in so far as some aspects of the prospective action components of the approach are concerned. While institutionalized authority, interest group power, and inter-personal influence have been demonstrated to have been associated with specific policy outcomes in particular settings, the literature on process-related tactical approaches to policy influencing is less theorized.

The explanatory and predictive ability of policy research is further limited by the role that chance plays in the policy process. Downs’ description of the ‘issue attention cycle’ goes so far as to argue that a dramatic event is the decisive factor in putting an issue on a policy agenda (i.e. something beyond the control of a skilled policy activist) (Downs 1972). Personally I would be wary about characterizing any factor as the decisive one, but the point is that these exogenous events may be clear to see in retrospect, but are by definition exceedingly difficult to predict in advance, let alone engineer.

This brief foray into the realm of the theory of policy analysis leads me to take a very cautious approach to defining ex ante the theoretical basis of prospective policy analysis. I conclude that identifying one particular theory which is likely to be directly relevant to explaining change or in predicting outcomes in a specific setting would be rather challenging. A more fruitful approach is to draw, eclectically, upon many theories developed by different disciplines (political economy, economics, sociology, anthropology, organizational management, history—to reveal the fabric of institutions or the hidden interests or give meaning to assumptive worlds meaning to assumptive worlds, and so on) which provide guidance on the selection of variables which can reasonably be expected to have relevance (to institutions, interests and ideas) and which will inform research strategies, methods and interpretation.

The notion of ‘reasonably expected to be relevant’ is supported by some literature. Policy analysis has been likened to a ‘mood’ more than a science, ‘a loosely organized body of precepts and positions’ (Goodin et al. 2006). Bardach (1972) argued that applying a social scientific standard in policy analysis that can offer a satisfying ‘explanation’ is elusive. He proposes in the place of explanatory power, the creation of a practical standard, ‘an intertemporal map of the foreseeable risks and opportunities that might emerge’; the purpose of the map is both to identify possible variables to monitor and analyse, and to develop prospective strategies to engage in the policy process. Similarly, the prospective action-research which I describe is not concerned with validating general causal theories but rather addressing problems in the real world as experienced by political actors (specific ones in this context, who wish to advance an evidence-informed project), on the one hand, as a means to a political end and, on the other, as a means to develop and test theories of the possibilities of politics in a given context which may provide guidance to other activists and researchers working in different contexts. In so doing, it would also add to the small but growing literature which attempts to explain health policy change.

In much the same way that prospective policy analysis would rely on multiple disciplines to inform the identification of important variables so too does it rely on various methods to
eliciting policy-relevant data. Indeed, one strength of the approach is the ability of the researchers, on the basis of reflection, to change the theories, analytical frameworks and the nature of data collected if considered useful. Given the highly subjective nature of the field and problems arising from the insider-outsider interface (see Walt et al. 2008, this volume), robust analysis would require high levels of triangulation and reflexivity, as well as other methodological checks which require further discussion beyond what is possible here.

**Practical challenges to prospective policy analysis**

The practical challenges to prospective policy analysis are many and varied. They include, for example, how to develop capacity within networks to undertake policy analysis. While ongoing training and assistance from a supportive policy analyst may constitute one approach, linking the research with a larger and coordinated effort to develop a cohort of research brokers may be more strategic and sustainable. A second issue is how to identify issue-specific networks with whom policy researchers may work. Four ‘ideal’ preconditions for network selection include those which: (1) pursue pro-poor health goals through evidence-informed interventions; (2) have an interest in improving their impact through better use of policy analysis tools; (3) have at least one member willing to act as a policy research broker; and (4) are comfortable with the efforts being documented and analysed by outside policy researchers (be they national or expatriate).

This leads to the question of how best to broker relationships and agreements among network members, research brokers, researchers and funding agencies (research or donor), and to the related question of long-term financing (for both research and policy influencing strategies, both of which may require significant resources). Dealing first with the latter, does one wait for a call for such research from a research commissioning body (will this ever happen?) or does one proactively seek out donors who might be sympathetic to the need for more policy analysis (but have little interest in research or in funding the strategies and tactics—their possible ethical objections are treated below)? It appears that the researcher, in partnership with the network, must take on the entrepreneurial task of selling prospective policy analysis, hence this paper. External finance raises the question of how to allay fears that the sponsoring agency may co-opt the coalition for its own ends or does one proactively seek out donors who might be sympathetic to the need for more policy analysis (but have little interest in research or in funding the strategies and tactics—their possible ethical objections are treated below)?

Often it would be imprudent to divulge the ‘hidden agenda’ behind seeking information on, for example, the underlying interests of a given stakeholder. It is, however, likely that an academic ethical committee would demand ex ante reassurances on informed consent as well as confidentiality or even anonymity of respondents, something that would make the exercise rather futile. One option is to eschew academia in this quest—for it does not have the final word on ethics—particularly where failure to develop political strategies and tactics to ensure the implementation of pro-poor policies will result in less cost-effective health investment. At present, it is not clear what alternative ethical bodies are available. A further ethical issue concerns how network members communicate the nature of their policy project to the wider policy community—and certainly communication will be one of the challenges since policy is so much about persuasion—but here we are dealing with how the coalition might characterize or represent its goals in a truthful manner while not jeopardizing its project.

Sporuous ethical objections have been raised in response to the prospect that external groups support (with funds or policy analytic advice and support) domestic constituencies to improve the prospects for the development and implementation of evidence-informed, pro-poor policies, but that argument cannot be sustained. To begin with, the distinction between ‘external’ groups and internal issues is hard to uphold in this context.
The main pro-poor policy goals now transcend national boundaries (e.g. the MDGs), for the good reason that achievement of those goals requires global efforts. Neither the drivers nor the blockers of the corresponding reforms are restricted to the domestic policy arena. Experience suggests that pro-poor reforms will likely be blocked by a variety of national and international groups with an interest in maintaining the status quo or in altering it in ways that may further their interests at the expense of the poor.

Secondly, the aim of prospective management of reform politics is to empower national groups (and build national capacity) to achieve reforms which have widespread technical acceptance (i.e. on the weight of economic and epidemiological evidence) and support, but which are faced with entrenched interests, either at home or abroad or both. In other words, the image of external actors foisting ill-considered policy measures on unwilling countries is entirely inappropriate. In any case, researchers (and funding agencies which support them) can minimize any risk of this sort by scrupulously supporting only coalitions that are attempting, as far as possible, to pursue technically appropriate, globally accepted, evidence-informed interventions, or are pursuing goals which would include the generation of such evidence concerning issues confronting the poor.

Indeed, the ethical boot is arguably on the other foot in that it is not ethical for the international community to agree to targets such as the MDGs without supporting groups within countries to attain them, not only with funding, but in dealing with the opposition that is put in their path.

Conclusions

Some of the political dimensions of policy change may be readily apparent, particularly in retrospect, but to elucidate the likely politics ex ante is challenging, to know how to best intervene without policy analysis is even more challenging, and to assess the impact of the interventions on the basis of such analysis is more tricky yet. Nonetheless, I would argue that the future prospects of the implementation of many evidence-informed interventions will be in jeopardy if such challenges are not confronted. While the match may be difficult and complex, the odds perennially stacked against the underdogs and the rules governing the involvement of outside analysts uncertain, it is time to move this from a spectator sport to one in which policy analysts demonstrate a willingness to try out a new playing field, i.e. one which is prospective.

Endnotes

1 Limited success is not surprising. Policy processes remain subject to chance and serendipity and, consequently, the most comprehensive and systematic attempts to collect and use information to influence policy processes may prove unpredictable and less successful than hoped for.

2 See Nelson (2004) which provides accounts of prospective analysis by national stakeholders. Some accounts are available but unpublished (due to the sensitivities of participants or the requirements of sponsors) or are published in the non-health literature, for example there is an unpublished account of DFID issue-based support to Nigeria (Pycroft and Butterworth 2005).

3 Reasons might include limited interest and skills or more likely the lack of access of researchers to advocacy groups with which they can collaborate on such research. It is also likely that because of institutional biases there is limited (and no commercial) sponsorship for the pro-poor prospective policy analysis sport.

4 Similar approaches could be used with other political actors. The rationale for the focusing on advocacy coalitions is set out below.

5 The issues raised by external participation in such processes are discussed below.

6 The benefits of an ‘outsider’ (which may or may not include an expatriate researcher) to the network undertaking research on the efficacy of the prospective analysis include greater objectivity, but insider/outsider issues are raised as discussed in Walt et al. (2008, this volume).

7 In this context, evidence refers to knowledge about the efficacy, effectiveness and efficiency of public health interventions as derived from scientific studies.

8 There may not be an evidence base for many interventions, and in many cases where evidence exists, there will be contestation, but this may be politically motivated and possible to see through. It may be useful for the policy analyst to discuss the appropriate-ness of the public health interventions with technical experts.

9 This is not to say that there is no capacity within pro-poor, health advocacy coalitions in low and middle income countries, but rather to acknowledge that there are limits to such capacity (see Gilson and Raphaely 2008, this issue).

10 In one of the few studies in the health sector which touches on this difficulty, De la Jara and Bossert explore the role of antecedents, interest groups and consensus building in the Chilean health reforms, and conclude that the processes are inherently complex and not captured by simple hypotheses (De la Jara and Bossert 1995).

11 In selecting such variables, Etzioni (2006) provides some valuable advice. In particular, he stresses the need to identify variables which are malleable, as he questions the sense of studying variables that we cannot change (e.g. sex or age composition of a population). He proposes instead to look at costs, acceptability to decision makers and the public. Social relations, including patterns of asset distribution and power, are of limited malleability whereas symbolic relations are highly malleable.

12 These challenges are not described in the literature but have been experienced by other policy analysts (personal communication) and the author.

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