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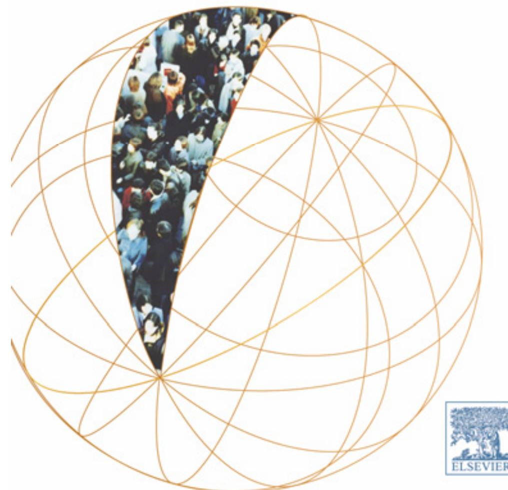

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Glassman A and Buse K Politics, and Public Health Policy Reform. In: Kris Heggenhougen and Stella Quah, editors International Encyclopedia of Public Health, Vol 5. San Diego: Academic Press; 2008. pp. 163-170.

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Kew O, Morris-Glasgow V, Landaverde M, *et al.* (2002) Outbreak of poliomyelitis in Hispaniola associated with circulating type 1 vaccine-derived poliovirus. *Science* 296: 356–359.
Landsteiner K and Popper E (1908) Mikroscopische Preparate von einem menschligen und zwei Affenruckenmarken. *Wiener Klinische Wochenschrift* 21: 1830.
Lassen HCA (1956) *Management of Life-Threatening Poliomyelitis, Copenhagen 1952–1956; with a Survey of Autopsy-Findings in 115 Cases.* Edinburgh: Livingstone.
Lavinder CH, Freeman AW, and Frost WH (1918) Epidemiologic studies of poliomyelitis in New York City and the Northeastern United States during the year 1916. *Public Health Bulletin* (Washington) 91.
Payne AM-M (1955) Poliomyelitis as a world problem. *Poliomyelitis: Papers and Discussions Presented at the Third International Poliomyelitis Conference*, pp. 391–400. Philadelphia, PA: Lippincott.
Sabin AB (1955) Immunization of chimpanzees and human beings with avirulent strains of poliomyelitis virus. *Annals of the New York Academy of Science* 61: 1050.
Wezel AL van, Steenis G van, Marel P van der, and Osterhaus AD (1984) Inactivated poliovirus vaccine: current production methods and new developments. *Review of Infectious Diseases* 6(Suppl 2): S335–S340.
Wickman I (1907) *Beiträge zur Kennis der Heine-Medinschen Krankheit (Poliomyelits acuta und verwander Erkrankungen).* Berlin: Kager.

Further Reading

Gould T (1995) *A Summer Plague: Polio and Its Survivors.* New Haven, CT: Yale University Press.
Oshinsky DM (2005) *Polio: An American Story.* New York: Oxford University Press.
Paul JR (1971) *A History of Poliomyelitis.* New Haven, CT: Yale University Press.
Rogers N (1992) *Dirt and Disease: Polio before FDR.* New Brunswick, NJ: Rutgers University Press.
Wilson DJ (2005) *Living with Polio: The Epidemic and Its Survivors.* Chicago, IL: University of Chicago Press.

Relevant Websites

http://www.who.int/topics/poliomyelitis – World Health Organization, Health Topics.
http://www.polioeradication.org – Global Polio Eradication Initiative.

Politics, and Public Health Policy Reform

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Introduction

Politics – defined classically as who gets what, when and how by Lasswell (1936) – affects the origins, formulation, and implementation of public policy in the health sector (Reich, 1995). Politics dictates, for example, who is entitled to services, which are the priority areas, who will provide services, who will be subsidized, and how the budget ought to be allocated and spent (Gonzalez-Rossetti and Munar, 2003). Because vested interests are usually affected by reforms (for example, health-care workers unions) and beneficiaries are dispersed and unorganized (for example, the poor and sick), there are inherent political difficulties associated with the definition and negotiation of the costs and benefits of reforms. Further, the implementation of reforms is often associated with new administrations or political crises, while reforms can also affect the stability of political administrations.

In spite of its acknowledged importance, there is also broad agreement that politics and political issues are rarely analyzed and frequently ignored at all stages of the policy identification, development, and implementation process in the health sector, particularly in the interactions between international donor agencies, recipient developing country governments, and their domestic political context (Buse *et al.*, 2006). There is ample documentation that politics frequently trumps evidence as a driver of policy priorities and reforms (e.g., Gilson *et al.*, 2003) and there are calls for both prospective and retrospective analyses of the politics of public health policy to improve the probability of policy implementation and impact and to understand more fully the political environments in which reforms operate (Walt and Gilson, 1994; Reich, 1995).

This article will review the major theoretical treatments of politics in the health sector in developing countries and provide examples of common issues that have emerged in the study of the politics of public health policy reform. The article does not purport to cover all of the many ways that politics affects public health policies and, in particular, omits the social medicine literature that centers on the role that politics and political regimes play as a determinant of health status. Although there is clearly overlap, the focus is rather on the analysis of politics of public health policy making and implementation in developing countries and how these analyses have been used to improve the feasibility and durability of pro-public health policies. The article presents an overview of the theoretical approaches to understanding the political dimensions of public health policy

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making, before setting out a number of common features of health sector politics. This discussion provides the backdrop to a discussion of approaches to managing the politics of sector reform.

Major Theoretical Treatments

There are three major literatures that comprise the bulk of theoretical frameworks and models used in the analysis of political aspects of public health policy. A first approach builds on the political science literature. A second literature relates to the politics of health reforms in developed countries. A final group of work deals with policy reform in developing countries mainly focused on structural adjustment reforms implemented in the 1980s and 1990s. Drawing on all three sources, Reich defines three models of policy change, reflected in most of the literature since its publication in 1995.

The political will or technocratic model assumes that decisions by political leaders or a reform champion are necessary and sufficient for policy change and that these leaders are rational actors maximizing the public interest (Alesina, 1992). Reform can occur from outside the political system – for example, via an international agency project – when will is sufficiently strong. While this model has shown its limitations when applied to the realities of the policy process in most contexts (IDB, 2006), it is a policy-making model that is frequently referenced in the public health literature as the mechanism via which to effect change in the sector (see **Table 1** for two prominent examples). The enduring appeal of this myth, which has not been directly addressed in the literature, may reflect the common finding that champions are necessary (although not sufficient) for priorities to land on the agenda and reach implementation.

The political factions or partisan or pluralist model assumes that politicians seek to serve the desires of different groups, including interest groups, bureaucratic agencies, and political parties. This model encompasses the interest group approach to policy-making, with its emphasis on the political competition of groups and ideas (Kingdon, 1984), as well as the bureaucratic politics approach, with its emphasis on how government organizations and employees seek to protect and promote their own narrow sectarian interests. Reform occurs when incentives and benefits to preferred constituencies are sufficiently large.

A variant on the model was developed by González-Rossetti (2005) building on the neoinstitutional school of thought from the discipline of political science; her approach goes beyond interest groups to analyze the formal and informal rules of the game that govern the interaction of social actors and the role of mediation played by the state in the reform process, positing that these factors determine the feasibility of reform (North, 1990). Rules of the game governing the status quo in a developing country's health system may include, for example, clientilistic hiring practices in public health facilities or extensive discretionary spending on health by entities other than the Ministry of Health.

The political survival model assumes public officials seek to protect their individual interests to maintain or expand their existing control over resources. The model reflects the principles of the public choice school, arguing that politicians operate opportunistically to maximize their own power, reflected in pre-election spending sprees, for example. Reform occurs when personal benefits are sufficient to overcome personal costs.

Reich concludes that the models co-exist in most countries' reform processes, are not exhaustive, and have advantages and disadvantages as tools to generate insights on policy-making. Recent work by Spiller and Tommasi (2003) outside the health sector helps to understand the more nuanced, process-focused view of policy making and policy outcomes that is evolving in the literature. The policy-making process itself encompasses the entire process of negotiation, approval, and implementation in which different political actors and institutions interact in formal (i.e., parliaments) and informal (i.e., back rooms) settings. The behavior of the political actors and institutions depend on the preferences and incentives faced by each, the expectations each have of the others' behavior and the rules of the game governing their interactions. These processes, like policies themselves, are complex. There are multiple actors, with differing attributes, time horizons, and incentives, interacting in different contexts, under different rules.

There are other theories, particularly used in policy analysis, which provide insights into understanding of politics in the health sector. These include the stagist model of the policy making, Kingdon's streams approach

Table 1 Examples of the political will model used in the literature

"Broad reforms in the health sector are possible when there is sufficient political will and when changes to the health sector are designed and implemented by capable planners and managers."
World Bank (1993) *World Development Report 1993: Investing in Health.* New York: Oxford University Press.
"With political will and financial support, most countries could meet the Millennium Development Goals."
Costello and Osrin arguing for a global fund for maternal, neonatal and child survival; Costello A and Osrin D (2005) The case for a new Global Fund for maternal, neonatal, and child survival. *Lancet* 366: 603–605.

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to understanding agenda setting (Kingdon, 1984), the street-level bureaucrat model concerning implementation (Lipsky, 1980), a number of variants of models that focus their analysis of the role of networks in modern policy making, as well as the so-called punctuated equilibrium model, which explains why periods of policy stability are periodically beset by reform.

In relation to the stagist model, analysts have studied the different stages of the policy-making process, used mainly retrospectively to assess health policy reforms. Gonzalez-Rossetti (2005) focuses on six reform moments: Problem definition, policy formulation, policy legislation, policy regulation, policy implementation, and policy consolidation. Nelson sets out sequential policy tasks: Getting on the agenda, reaching agreement with the executive, winning legislative approval, and implementation (Nelson, 1999). In reality, policy may not be linear as implied, and the stages may overlap and never proceed from one to the next, but the stages model helps to unravel the complexity of the politics of different phases of the life course of a given policy reform.

Still others have zeroed in on one stage of policy-making, for example, agenda-setting. The focus of Shiffman's work on generating political will for safe motherhood in Indonesia, Honduras, and other countries, which identified a series of international and domestic factors determining the priority of safe motherhood issues (Shiffman, 2007). International factors determining agenda setting included the promotion of global norms and the provision of financial and technical resources to support adoption and implementation of those norms in-country. Domestic factors included the extent of cohesion among advocacy groups, the existence of political champions, the availability of data necessary to establish the problem, the occurrence of a focusing event, the availability of feasible and affordable policy solutions, the stage of the electoral cycle, and the priority given to competing health priorities.

The politics of the implementation phase have received considerable attention, often drawing on Lipsky's insights into the considerable discretion and influence enjoyed by front-line providers of services (the street-level bureaucrats) to shape policy in relation to their values, interests and/or working routines (Lipsky, 1980). For example, in examining the influence of nurses and clinic coordinators on the implementation of South Africa's free health-care policy, Walt and Gilson (2004) focused on understanding frontline staff experiences, paying particular attention to the personal and professional consequences of the policy, the factors that influenced their responses to the policy, and what they perceived as the barriers to effective implementation. Results revealed that nurses were asked to implement a policy about which they had not been consulted, and whose consequences for their routines were largely ignored. These features of the policy process as well as nurses' values, including their perceptions of deserving or undeserving patients, had significant implications for the manner in which the free health-care policy was implemented in practice.

As the number and types of actors involved in health sector decision making has multiplied (for reasons explored in the Interest groups section), greater attention has been paid to network analysis as a tool for describing systems of interactions and interconnectedness between groups of actors. In particular, they seek to understand the extent to which variations in the number and type of participants, features of their interactions (formal and informal), the openness of the network, and relationships to other networks account for specific policy outcomes. Lee and Goodman, for example, examined a small group of internationally networked policy elites that effectively propagated the worldwide health-care financing reforms of the 1980s and 1990s (Lee and Goodman, 2002). Sabatier has focused on competition among advocacy coalitions (whose membership comprises government officials and non-state actors that shared policy goals) to dominate policy subsystems (e.g., AIDS policy). And while most would acknowledge that the role of government remains central to policy making, network analysis attempts to make sense of how the increasingly complex and mutually dependent relationships of politicians and bureaucrats with non-state actors influence policy decisions.

Baumgartner and Jones' (1991) punctuated equilibrium theory attempts to explain why policy making is characterized by periods of stability with minimal or incremental policy change, disrupted by bursts of rapid transformation – drawing attention not only to competition between networks but also between policy images and the policy venues. The policy image is the way in which a given problem and solutions are conceptualized. One image may prevail over a long period of time, but may be challenged at particular moments as new understandings of the problem and alternatives emerge. The policy venue is the set of actors or institutions that make decisions concerning a particular set of issues. These actors may hold monopoly power but will eventually face competition as new actors with alternative policy images come to the fore. When a particular policy venue and image hold sway over an extended period of time, the policy process will be stable and incremental. When new actors and images emerge, rapid bursts of change are possible.

Given the place of ideas, evidence and argument in policy making – a process described by some as an exercise in persuasion – it is not surprising that politics plays a role in attempting to shape understandings, values, and beliefs, giving rise to the use of discourse analysis in public health policy. Connelly and Macleod (2003), for example, argue that the media in South Africa has

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constructed the HIV/AIDS problem in military terms, thus making the solution more amenable to conventional national responses, and at the same time reinforcing gender stereotypes.

Approaches to Understanding the Politics of the Health Sector

While there have been many calls for greater attention to the analysis of the political dimensions of health sector reform, there has been very little guidance on how best to do so. Primary data sources for most analyses rely on in-depth interviews and document review to draw up stakeholder maps and assess power and position or to design actor management strategies (for example, Thomas and Gilson, 2004). The case study approach, often using a tracer policy or set of policies, is most common and has well-known constraints associated with such comparative methods (Reich, 1995). Alternative approaches are identified by Reich (1995), but to date have not been implemented. Although few in number, there have been some useful linked comparative case studies, for example on the politics of family planning policy (Lee *et al*., 1998) or of aid coordination and policy-making more generally (Walt *et al*., 1999).

Common Issues Identified in Political Analyses in the Health Sector

The major theoretical treatment section adopts elements of the theoretical frameworks described above to illustrate and organize some of the common themes identified in the literature as characteristic of health politics in developing countries.

Context and Institutions

The nature of the sector itself creates political challenges; Nelson (1999) refers to these as "the special politics of social service reforms." Gonzalez and Munar have highlighted the particular problems of policy reform in the health sector where the state is the central provider and where a main role of the state is as an employer (Gonzalez and Munar, 2003). This direct employment and provision role has led to clientelistic practices – provision of jobs, wages, subsidies, and benefits to provider groups and other discretionary practices in exchange for political or other support – and has played a historical role in creating political stability for fragile governments. The common content of reforms – merit-based selection and reward of employees, public–private mix based on best price and supply, standard and transparent criteria to determine entitlements to public goods and services, transparent budget allocation criteria – directly undermine the stability that may be associated with the status quo created by the clientelistic model. The political cost–benefit of the reform is thus affected and conditions the extent that decision makers pursue them in any serious way. Despite resistance, new public management reforms have been adopted in some countries.

There is also the common observation that there is not a single dominant technical consensus model guiding health reforms, as opposed to macroeconomic reforms (Nelson, 1999). This lack of consensus can itself exacerbate the political difficulty of moving reforms forward, since there are few precedents, solid evidence of impact is scarce, and choices are often difficult to explain to the public at large.

Another particular feature of the health sector has to do with the "crucial role of motivations and capacities of individual service providers in the quality of outputs" (Nelson, 1999). The principal–agent dilemma – that interests of the principal (payer) and the agent (providers) may not be aligned – is particularly acute in the sector. A payer – a Ministry of Health – may be most concerned to maximize health for funds invested, while a provider may wish to maximize her own income. It is thus particularly difficult to mobilize providers behind reforms. In a study of public hospital reforms, for example, Over and Watanabe (2003) find that hospital staff and the professional unions that represent them fear potential job losses due to reforms of almost any type.

The institutional and more general governance setting can also be critical in how political events play out around a given policy. A social security reform in Mexico (1994–2000) analyzed by Gonzalez-Rossetti (2005) found that, given the country's strong presidentialist system, the executive branch had a great deal of autonomy in policy making, so set the agenda and moved quickly through problem identification and policy design. Problems came later in implementation after the closed policy development process; unions resisted and implementation failed.

In India, the persistent gap between promised pro-poor policies such as the National Rural Health Mission (an initiative to deliver primary care to the poor intended to increase the national health budget by 1% of GDP) and budget allocation and execution is attributed in part to the practices of the Indian civil service, where frequent rotation among ministries is common, driven by political party affiliation, and expertise in a particular area, such as health, is infrequent, leading to poor follow-up and little ownership.

Interest Groups

Governments often consult external groups to see what they think about issues and to obtain information. In turn, groups attempt to influence ministers and civil

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servants. If governments make policies that are strongly disliked by the public or particular groups, they know that these may well be resisted with the result that their policies may not be implemented. In most countries, there are a growing number of groups outside government, referred to as interest or pressure groups, which want to influence government thinking on policy or the provision of services in a direction favorable to their point of view, social group, or material position. They use a range of tactics to get their voices heard, including building relationships with those in power, mobilizing the media, setting up formal discussions, or providing the political opposition with criticisms of government policy. Although the existence of interest groups indicates that political power is not the monopoly of any one group, it is clear that some interest groups are far more influential than others. In the health field, the medical profession is still the most significant interest group outside government in most countries.

Design trade-offs made as concessions to political interest groups affect the ability of policies to achieve their originally stated objectives. For example, a common contribution and financial risk pool across a new social health insurance scheme and any existing private insurers in South Africa was lost during negotiations, thus compromising the equity-improvement objective of the planned reform (McIntyre *et al.*, 2003). Dung (1996) analyzed actor perceptions during four stages of policy development in Vietnam (policy formulation, approval, implementation, and impact) and shows how the technical objectives of efficiency, equity, and quality within a policy on private sector health provision decrease in perceived value over the policy-making process as more political interest groups – public sector providers – become involved in setting policy.

Related to the above, the opposition of providers' unions and associations is a political issue in health reform worldwide. The ample literature on the role of political ideologies (socialism versus capitalism) on health status is front and center in the analysis of politics since it is so frequently cited as a characteristic of the positions of certain stakeholders in the health sector. Medical worker unions or provider associations (Dung, 1996) frequently take the position that neoliberal and privatizing reforms, regardless of their supposed or actual impact on the health systems' objectives, are likely to threaten public health worker jobs and compromise access by the poor, while reformers (usually technocrats) attempt to document how reforms will increase access for the poor or improve efficiency.

An evaluation of a pilot of hospital autonomy/purchaser–provider split/contracting out in Panama found very positive outcomes for both patients and hospital performance indicators in the intervention hospital versus two control hospitals, but attributed lack of further uptake of the model to "an environment dominated by interest groups" (Bitran, 2005). Resistance related to job security issues was observed from both medical and nonmedical staff in the nonreforming Ministry and social security hospitals.

Three further groups merit some attention in the politics of health reform in low- and middle-income countries. First, financial donors and providers of technical cooperation can and have influenced health policy, by privileging some ideas and activities over others in their funding decisions and by providing tacit support to some individuals and programs at the expense of others. Second, a range of industries, most prominently the pharmaceutical industry, play active roles supporting and resisting policy affecting their interests. Notwithstanding the comments that follow on the limited role of civil society in health policy processes, which arises in part from the institutional context in which many operate as well as from limited capacity, it is apparent that across a range of health policy issues (from essential medicines to breast milk substitutes to tobacco control), civil society organizations have set agendas and influenced policy formulation and implementation. The success of domestic nongovernment organizations can be linked on one hand to international cause groups as well as links they have to decision makers through the various networks in which they participate.

Limited Public Participation in Policy Reform

Unlike the literature on developed countries, which shows that strong and sustained public sentiment can affect agenda-setting, interest group leverage over government officials and policy makers' formulation of policy (Jacobs, 1994), little attention has been paid to the role of public perceptions in shaping politician behaviors with respect to health reform in developing countries. This is perhaps due to the still limited role of and attention paid by civil society in developing countries to the details of health policy, the limited availability of detailed information on the sources and uses of public spending for health, and the near-total absence of detailed opinion polling on health issues in developing countries. Even where opinion polling is becoming more routine, as in Latin America via the *Latinobarometro* surveys, the health data are not detailed and little used to influence policy.

Timing

Unlike economic and fiscal stabilization reforms, so called stroke-of-the-pen reforms in health sector take time, giving opportunity for opposition to be mobilized (Nelson, 1999). Further, there are political windows of opportunity where reform is feasible – at the beginning

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of political mandates, when a policy maker has a strong and narrow political coalition and when benefits outweigh costs for a government or a politician. These moments are critical, but can have an impact on the durability of a reform during implementation.

Reform Champions

Nelson synthesizes insights and commonly recommended strategies made in the 1990s to improve the feasibility of reform in the literature (Nelson, 1999). Only limited and relatively uncontroversial reforms can be realized by a single champion (the political will model above). Leadership vacuums similarly have led to lack of success in reform (Glassman *et al.*, 1999).

Since major reforms are usually controversial both inside and outside of government, internal change teams can be useful to generate consensus amongst official groups and conduct outreach to stakeholders. Gonzalez-Rossetti's analysis of Colombia credits the technocratic change team, led by a charismatic and exceptionally able minister, with passing a comprehensive health insurance scheme whose implementation has been more or less sustained over the past decade (Gonzalez-Rossetti, 2000).

Creating Political Feasibility

The main purpose of many of the analyses is to prospectively analyze political barriers necessary to reform success. Reich followed his earlier work with an applied political analysis tool called *PolicyMaker*, which focused mainly on how to prospectively design and implement a policy so as to maximize its chances of approval and implementation (Reich and Cooper, 1996). The tool facilitates the definition of the policy, the analysis of the costs and benefits facing stakeholders and institutions (party, parliament, bureaucracy, civil society, etc.), the influence and commitment of these stakeholders to the reform, the impact of these positions on the feasibility of the reform under consideration, and the design of political strategies to deal with opposition. The method has been applied prospectively in the Dominican Republic (Glassman *et al.*, 1999) and elsewhere.

Assessment of political feasibility requires stakeholder analysis – stakeholders in this case are the political actors, or players, affected by or affecting a given policy. Players can be organizations or individuals, but should be weighted differently according to their power resources. Players in health reform politics usually include:

- Public sector organizations such as ministries of health, ministries of finance, social security institutes, regulatory agencies, teaching hospitals, national laboratories, public universities, and others;
- Public sector individuals such as ministers permanent secretaries (PS), heads of programs, hospital directors, state and local government leaders, and legislative leaders;
- Private sector institutions such as private providers, pharmacies, wholesalers, drugs manufacturers and their associations, insurance companies, and private universities;
- Labor organizations such as medical worker unions, community health agent groups, civil service unions, as well as professional associations;
- Civil society organizations such as nongovernmental foundations, faith-based or other philanthropic groups, and sometimes watchdog groups focused on particular health issues;
- Media organizations such as television, print, and the Internet.

There are usually a large number of unmobilized, potentially supportive players in the political environment that can be involved in reforms to outweigh opponents. In the case of the Dominican Republic (Glassman *et al.*, 1999), for example, nurses' unions, private health management organizations, business associations, nongovernmental associations, churches, and universities, had only limited voice in public debates on health policy. Those groups and individuals that stand to benefit most can also be organized, as would be the case for example, of hospital directors if hospital autonomy is the reform under consideration. Reformers can tap these potential sources of support. Thomas and Gilson (2004) review the development of a health insurance policy in South Africa (1994–99) and also make recommendations in this regard. Involving friends in planning can help to better sequence actions and political strategies.

Leadership can also be prepared better. Technocratic reform models frequently fail if the reform champion is not also a skilled politician backed by powerful constituents and defined rules of the game. The Dominican Republic analysis by Glassman *et al.* (1999) found that in spite of millions of dollars of investment in the technical preparation of reforms, there was no bureaucratic or legislative process agreed or in place that would allow for the legal adoption of the new proposals. Leadership capacity is also deeply affected by the system of government, the credibility of government, political timing and the political effects of the technical content of reforms.

Closely linked to mobilizing support networks and building capacity is the acquisition of financial and media resources to move agendas ahead. These resources practically speaking constitute the power to move reforms. Frequently, developing country reforms receive funding to carry out small-scale studies and other technical assistance, but have no recourse to the soft monies that allow for the polling, policy option appraisal,

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convening, communications, media, and materials positioning that is so much a part of reforms in developed countries. The United States-based Kaiser Family Foundation, for example, uses many of these policy influence tools to neutrally set out facts, respond to myths perpetuated in the media, and give voice to unorganized beneficiaries through opinion polls. Such strategies and institutions might be built in developing countries with good results for pro-poor reforms.

Framing the reform and the perceptions of the reform must be a major piece of any controversial policy change, as the discourse theory points out. Reforms require new ideas and language that can change the political discourse. In Mexico, for example, where public expenditure had been regressively distributed, the Minister reframed a reform that would reallocate funds from wealthy to poor areas from a health issue to a poverty issue, which had more resonance within the Executive and the Legislature (Frenk *et al.*, 2006).

Conclusion

Politics is a reality for health policy makers, a reality which is too often ignored by public health advocates and researchers alike. The limited literature on the politics of the health sector points to the attenuation of much reform due to the specific constellation of interests and distribution of costs and benefits, with the former often concentrated and falling on well-organized interest groups while the latter are distributed widely across the poor and largely unorganized potential beneficiaries. Despite the gloomy prospective for pro-poor, evidence-informed health sector reform, success is possible, if more attention is paid to managing the politics of the process.

See also: Agenda Setting in Public Health Policy; Interest Groups and Civil Society, in Public Health Policy; The State in Public Health, The Role of.

Citations

Alesina A (1992) Political models of macroeconomic policy and fiscal reform. World Bank Policy Research Working Papers. WPS 970, September 1992.

Baumgartner FR and Jones BD (1991) *Agendas and Instability in American Politics*. Chicago, IL: The University of Chicago Press.

Bitran R, Má C, and Gómez P (2005) The San Miguelito Hospital Reform in Panama, Chapter 3. In: La Forgia GM (ed.) *Health System Innovations in Central America: Lessons and Impact of New Approaches.* World Bank Working Paper No. 57. Washington, DC: The World Bank.

Buse K, Martin-Hilber A, Widyantoro N, and Hawkes SJ (2006) Management of the politics of evidence-based sexual and reproductive health policy. *The Lancet* 368: 2101–2103.

Connelly M and Macleod C (2003) Waging war: Discourses of HIV/AIDS in South African media. *African Journal of Aids Research* 2(1): 1–11.

Costello A and Osrin D (2005) The case for a new Global Fund for maternal, neonatal, and child survival. *Lancet* 366: 603–605.

Dung PH (1996) The political process and the private health sector's role in Vietnam. *International Journal of Health Planning and Management* 11: 217–230.

Frenk J (2006) Bridging the divide: Global lessons from evidence-based health policy in Mexico. *Lancet* 368: 954–961.

Gilson L, Doherty J, Lake S, McIntyre D, Mwikisa C, and Thomas S (2003) The SAZA study: implementing health financing reform in South Africa and Zambia. *Health Policy Plan* 31–46.

Glassman A, Reich MR, Laserson K, and Rojas F (1999) Political analysis of health reform in the Dominican Republic. *Health Policy Plan* 14: 115–126.

Gonzalez-Rossetti A (2000) Enhancing the political feasibility of reform: the Colombia case. LAC HSR Working Paper. Washington, DC: Pan American Health Organization.

Gonzalez A and Munar W (2003) *The Political Economy of Social Sector Reforms.* Region II, Economic and Sector Study Series. Washington, DC: Inter American Development Bank, December.

Gonzalez-Rossetti A (2005) La factibilidad política de las reformas del sector social en América Latina. Serie Estudios y Perspectivas 39. Proyecto CEPAL/GTZ ''Equidad II'', CEPAL/Mexico.

IDB (2006) *The Politics of Public Policy*. Washington, DC: Inter-American Development Bank and Harvard University.

Jacobs LR (1994) The politics of American ambivalence toward government. In: Morone JA and Belkin GS (eds.) *The Politics of Health Care Reform: Lessons from the Past, Prospects for the Future.* Durham and London: Duke University Press.

Kingdon JW (1984) *Agendas, Alternatives and Public Policies*. Boston and Toronto: Little, Brown and Company.

Lasswell HD (1936) *Who Gets What, When, How*. New York: McGraw-Hill.

Lee K and Goodman C (2002) ''Global policy networks: The propagation of health care financing reforms from the 1980s'' In: Lee K, Buse K, and Fustukian S (eds.) *Health Policy in a Globalising World.* Cambridge, UK: Cambridge University Press.

Lee K, Lush L, Walt G, and Cleland J (1998) Family planning policies and programmes in eight low-income countries: a comparative policy analysis. *Social Science and Medicine.* 47(7): 949–959.

Lipsky M (1980) *Street-level Bureaucracy: Dilemmas of the Individual in Public Services*. New York: Russell Sage Foundation.

McIntyre D, Doherty J, and Gilson L (2003) A tale of two visions: the changing fortunes of Social Health Insurance in South Africa. *Health Policy Plan* 18: 47–58.

Nelson JM (1999) Reforming health and education: the World Bank, the IDB, and complex institutional change. Policy Essay No. 26. Washington, DC: Overseas Development Council.

North DC (1990) *Institutions, Institutional Change and Economic Performance*. Cambridge, UK: Cambridge University Press.

Over M and Watanabe N (2003) Evaluating the Impact of Organizational Reforms in Hospitals. In: Preker A and Harding A (eds.) *Innovations in Health Service Delivery: The Corporatization of Public Hospitals. Human Development Network; Health, Nutrition and Population Series*. Washington, DC: the World Bank.

Reich MR (1995) The politics of health sector reform in developing countries: Three cases of pharmaceutical policy. In: Berman P (ed.) *Health Sector Reform in Developing Countries: Making Health Development Sustainable.* Boston, MA: Harvard University Press.

Reich MR and Cooper D (1996) Policy Maker: Computer assisted political analysis. Available at http://erc.msh.org/mainpage.cfm?file=6.50.htm&module=toolkit&language=English.

Shiffman J (2007) Generating political priority for maternal mortality reduction in 5 developing countries. *American Journal of Public Health* 97: 796–803.

Spiller PT and Tommasi M (2003) The institutional foundations of public policy: A transactions approach with application to Argentina. *Journal of Law, Economics and Organization* 19(2): 281–306.

Thomas S and Gilson L (2004) Actor management in the development of health financing reform: health insurance in South Africa, 1994–1999. *Health Policy Plan* 19: 279–291.

Walt G, Pavignani E, Gilson L, and Buse K (1999) Health sector development: from aid coordination to resource management. *Health Policy and Planning* 14(3): 207–218.

Author's personal copy

Walt G and Gilson L (1994) Reforming the health sector in developing countries: the central role of policy analysis. *Health Policy Plan* 353–370.
World Bank (1993) *World Development Report 1993: Investing in Health*. New York: Oxford University Press.
Reich MR (2002) The politics of reforming health policies. *Promotion and Education* 9(4): 138–142.

Further Reading

Buse K, Mays N, and Walt G (2005) *Making Health Policy*. Milton Keynes, UK: Open University Press.

Relevant Websites

http://www.latinobarometro.org – Latinobarómetro.
http://www.kaiserfamilyfoundation.org – The Henry J. Kaiser Family Foundation.

Population and Labor Force Aging, Effect on Socio-Economic Development in Brazil, Russia, India and China

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Introduction

Aging, of both the general population of a country and specifically of its labor force, affects the economic growth rate and socioeconomic welfare and health status of both developed and developing countries. This is because the total economic productivity of a country is determined by three factors (Li and Mérette, 2005) contributing to total economic production (as measured by gross domestic product [GDP]): (1) natural resources and capital input, (2) human resources or labor input, and (3) the technological base (total factor productivity) of the economy. This latter quantity might be empirically represented, for example, by the set of patents held by citizens of a country. The rate of generation of new technology (Manton *et al.*, 2007) is a function of the level of scientific investment in research (especially in scientific manpower) and its productivity, and the efficacy of that investment will be affected by gains from prior research and redundancy in research. The latter affects the variety of new products produced and the emergence of new markets.

The primary issue we review in the following sections is the interaction of the three growth factors – capital, labor, and technology – in determining the rate of economic growth in the four 'BRIC' countries of Brazil, Russia, India, and China, which are hypothesized to grow more rapidly than other highly developed countries (e.g., the United States, Japan) and therefore dominate the global economy by 2050. Though technology affects the availability and productivity of capital inputs our review focuses more on human factors as they are modified by health-care inputs, technical training, and advances in biomedical research, which are all significantly altering the traditional relation of age to the level and duration of labor force productivity. We suggest that a currently undervalued, future avenue for national economic growth would be modifications of both aging and chronic disease processes by biomedical research and health-care system innovations. Indeed, this may require a reevaluation of human capital inputs into economic growth – especially of elderly persons.

Dramatic long-term changes in human productivity due to improved public health and nutrition were suggested by the work of Fogel and Costa on technophysiological evolution. With recent rapid improvements in public health, and health-care systems and technology, we argue that changes in human capital at later ages may accelerate in countries where large investments in the health of the elderly are now under way (e.g., Japan, United States, Western Europe [EU]). We feel the failure to aggressively address these issues in the BRIC countries could lead to a failure of the BRIC hypothesis (see section titled 'The BRIC hypothesis about the role of developing countries in the global economy'). The necessity for considering the need for further biomedical research and improvements in the health care of older populations is driven both by population aging and the need for increasing years of educational and technical training for workers in modern technologically driven economies (e.g., Bell, 1974; Toossi, 2005).

What are interesting in the proposed analyses are changes in the relative balance of the three growth factors (labor, capital, technology) in determining the rate of economic growth in developed and developing countries. Specifically, some countries have recently grown rapidly because of the ready availability of natural resources, such