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Influencing public policy on oral health

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Abstract – *Objectives:* In policy studies, an enduring research question is why some issues are taken seriously while others never become a central focus of policy making. This study aims to analyse the predecision stage of policy making and examines the position of oral health on the broader health policy agenda. *Methods:* A study of networks of influence in health policy in the state of Victoria (Australia) is used to examine the health policy agenda, and the position of oral health within the broader health policy agenda. Social network concepts were used to structure the data collection. Nominations of influential people were collected using a snowball method, followed by interviews with a selection of those nominated. *Results:* Combining an assessment of who is seen to be influential with an examination of the issues they are interested in provides insights into how influence helps shape the policy agenda and how this changes over time. *Conclusions:* The study describes how oral health might become more central to the health policy agenda through deliberate strategies to change the network structure.

Key words: agenda setting; networks; policy process

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Policy making is often not a rational comprehensive enterprise, with a series of steps taken sequentially, from problem recognition, through an evaluation of a fixed set of alternatives, to a decision taken on the basis of which of these meets a set of value-maximizing criteria. In short, it is political rather than technical, and reliant on argument and persuasion rather than disinterested calculations (1–3). It also rests on relationships between individuals and organizations, and how these shape who has influence in any particular policy sector (4,5). Which issues these influential people are interested in is also important. This confluence of influential actors and their issues structures the policy agenda (6).

John Kingdon's landmark study of policy agenda setting (7) asked why policy makers pay attention to some things rather than others. Why do some issues become the focus of policy action while others languish on the periphery? Kingdon modified the 'garbage-can model' (8), which argued that problems, solutions, participants and choices are separate but interrelated, only coming together at certain moments. An important point to keep in mind is that while evidence of what constitutes an important health problem and what is most effective in reducing it is a necessary part of the policy process, it is not a sufficient condition. In other words, evidence is certainly used in policy making, but evidence alone is rarely enough (9).

Health policy making, like policy in other sectors, rests on the accumulation and use of power by those involved in the policy process. But examining this is far from straightforward, even when power is used transparently. A number of approaches at different levels have been used to understand power and policy making in health. One useful focus at the macrolevel is Alford's work on the dominant, challenging and repressed structural interests that shape health policy (10). However, analysis at this level reveals only a partial story of how health policy is made by well-established and powerful interests.

Examining networks of individuals provides an alternative framework for analysis at a more

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personal level. The networks of interest here consist of a set of interpersonal connections (or ties) between individuals, based on nominations of influence. This research is perceptual – it is not based on who actually made decisions in a specific instance, or who won a particular debate. Instead, it is concerned with examining who is regarded as influential by others in the same policy sector. Influence is a network resource which has symbolic utility that may or may not be used. Actors can access resources through their ties with other actors (11) in addition to their own individual resources. Mapping social networks of interpersonal ties produces a picture of ties between individuals, indicating who exercises control within the network (12).

Network concepts provide a theoretical focal point for thinking about influence in relational terms. The main network concept of interest here is structural equivalence – the idea that people within a network can be seen as equivalent in structural terms if the patterns of relations between them are similar (13). Blockmodelling is a technique that partitions actors into structurally equivalent sets within a network, based on regularities of patterns of relations among actors (14). This means establishing who nominates others in a similar pattern, and who is nominated by others in similar patterns. A second important network concept is centrality, a measure of how highly nominated an individual is by others in the network (12), and so an indicator of importance. Finally, the concepts of homophily and heterophily help in understanding network dynamics, and in this case, how the network and hence the policy agenda can change. Homophily is the 'like me' principle – people tend to form ties with those who are alike. Heterophily is the opposite – forming ties with those who are different. People have a propensity to form homophilous ties, because it takes time and effort to reach outside of familiar and comfortable relationships to engage with others (11, 15).

The study reported here aimed to examine who was seen to be influential in health policy, how these people were connected to each other, and what issues they each were interested in. It mapped who recognized whom as influential as a means for capturing health policy networks. It then explored which issues were of interest and the relationship between issues and network position. Finally, it captured these data at two points in time to examine network dynamics. The theoretical framework used and the methodological and analytical approach are explained in greater detail in other publications (15, 16).

Materials and methods

Mapping influence requires the identification of influential actors. Some methods for doing this define influential actors as those holding senior positions in relevant organizations. Other methods rely on reputation, using people to nominate others who they consider influential. The shortcoming of the first of these is assigning influence to people in senior positions in certain organizations, regardless of their ability to influence events. The second potentially leads to the nomination of those who are simply the noisiest. A reputational approach was used in this study because it is less problematic given the focus on individuals, not positions and organizations.

A nonmedically qualified academic who had held senior health policy positions in different governments across Australia was the starting point for nominations. This person was contacted and asked to nominate a list of people regarded as influential in health policy in Victoria. The definition used was:

> influence is defined as a demonstrated capacity to do one or more of the following: shape ideas about policy, initiate policy proposals, substantially change or veto others' proposals, or substantially affect the implementation of policy in relation to health. Influential people are those who make a significant difference at one or more stages of the policy process.

The process then snowballed from this first person's list, through five steps out from the starting point. Nominees were not provided with others' lists, and no set number of nominations was asked for. At the end of this process in 2001, 62 people had returned nomination forms (a 54% response rate).

In the second part of this research, which identified the issues these influential people saw as important, 20 people, spread across the blocks in 2001 (described in the next section), were interviewed. They were asked to: (i) name the issues that they regarded as the most important current issues in health policy in Victoria, and to limit this to no more than five different issues, and (ii) name any issues that they saw as being particularly difficult or as simply not having any attention paid to

them. The interviews were open ended, and they were recorded and transcribed. The issues were then grouped thematically, based on the interviewees' explanation of what each issue involved. In examining the position of oral health issues within the many issues mentioned, a search of the transcripts for the words 'dental' and 'oral' was conducted.

In 2004, the process was repeated, starting from the same initial person and the same steps in terms of snowballing. In this round 53 people returned forms (41% response) and 18 people spread across the network were interviewed using the same approach as in 2001. The list of people nominated in both years consists of senior people in important positions, who would be seen to have power through their organizational positions. This provides some indication that although the network is based on perceived influence, the people nominated are indeed likely to have some positional influence in health policy (16). This research was approved by the University of Melbourne's Human Research Ethics Committee.

Results

Network structure, based on the data gathered from the nomination forms, was analysed using a blockmodelling procedure. This generated eight blocks in 2001, two of which are very central to the structure of the network and highly nominated by the other groups as influential. Figure 1 shows a map of these blocks and their relationships to each other as a network. The size of the blocks (circles) is based on the mean number of votes for the people within each block, and the thickness of the lines indicates the strength (number) of the nominations.

There is a block containing actors in key positions which are both structurally important and highly visible. This includes the Minister of Health, the Minister's senior political advisor and the Head of the department responsible for health. This was called the core group, both because all the other groups nominated this group as influential, and because it contains people who hold important policy positions. The other most important group (called public health medicine) is not so directly made up of policy influentials. These actors are located in universities, research institutes and NGOs, all are medically trained, and eight of the nine in this group are men. Two people mentioned

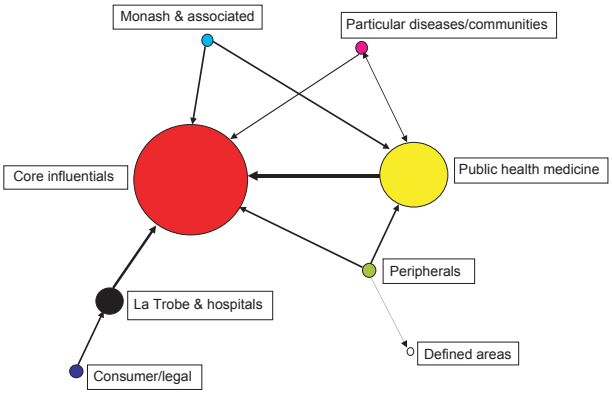

Fig. 1. Health policy network blockmodel 2001.

oral health in 2001, and they both belong to the peripheral consumer/legal group.

In 2004, the structure had changed somewhat as shown in Fig. 2. There is again a core group containing people in a similar list of positions, but the structure around this group is now more like a star, with the core group at the centre. There is a public health group which is the next most important group and has a similar composition to public health medicine in 2001, but its members are not all medically qualified. Two people mentioned oral health in 2004, and these both belong to the community-based group, which is again peripheral.

The core group in both years consists of those who have positional decision-making power in the policy process. It seems reasonable to assume that whoever occupied these positions would be widely perceived as influential and also well placed to exercise influence in policy making. All the other groups, and especially the peripheral groups, need to convince the people in this group of the importance of their issues (agenda items) in order to have their issues taken seriously and have decision-making attention focused on them.

In 2001 and 2004, two or three people from each of the blocks were interviewed. The interview material generated a list of the most often mentioned policy issues. Table 1 lists the top six issues nominated in 2001 and indicates whether they were mentioned as important or difficult. The first are those seen to be most important – workforce recruitment and retention, demand in public hospitals, split responsibilities and the quality of care. The second are those seen to be difficult, and health inequalities top this list. In 2004, the important issues were split responsibilities between levels of government, workforce structural changes,

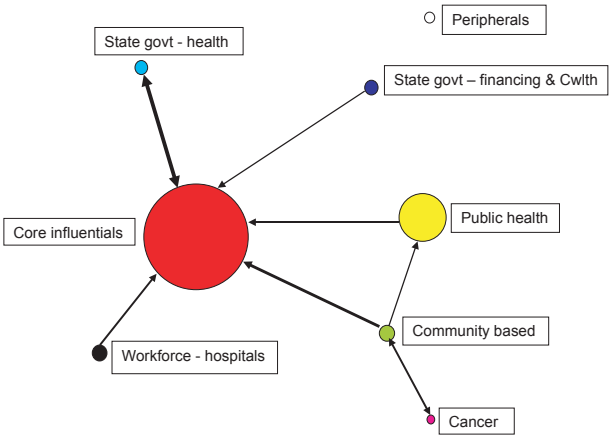

Fig. 2. Health policy network blockmodel 2004.

shifting from acute care to prevention, increasing chronic illness, demand in public hospitals and obesity (Table 2). Shifting the balance away from acute care topped the list of difficult issues.

In these two tables, the mentions of oral health issues are also noted. In both years, two people mentioned oral health in regard to a lack of access to services for disadvantaged people. This is related to dental services not being included in Australia's universal health insurance scheme (Medicare), except for some services delivered through specific programmes for people with certain target groups.

The overall structure of the network, combined with who is discussing particular issues, generates an analysis of the link between network position and issues. An examination of an individual's centrality in the network, combined with the issues that they mentioned and the combined list of issues, indicates that there is a high level of correspondence between network centrality and the importance of that person's issues compared with the overall ranking of issues. The most central people nominated the most often nominated important issues. This suggests that there is an association between which issues a person is interested in and

Table 1. Important issues and difficult issues 2001 – top six (n = 107 issues mentioned)

Issue in health policy	Important issues	Difficult issues	Total
1. Inequalities in health/ structural determinants	4	7	11
2. Recruitment and retention of health workforce/training and planning issues	7	2	9
3. Demand in public hospitals	7	1	8
4. Disaggregation, fragmentation and split responsibilities in the health system	7	1	8
5. Lack of emphasis on prevention, health promotion, public health/focus on acute care	4	3	7
6. Improving the quality of care	6	1	7
Lack of access to care for disadvantaged people (includes two mentions of dental)	3	0	3

Table 2. Important issues and difficult issues 2004 – top six (n = 96 issues mentioned)

Issue in health policy	Important issues	Difficult issues	Total
1. Split responsibilities (Commonwealth-state, primary/acute/ aged care)	13	2	15
2. Workforce structural changes	7	2	9
3. Shift balance from acute care to prevention and health promotion	6	3	9
4. Increasing chronic illness	6	1	7
5. Demand for public hospital care	5	1	6
6. Overweight, obesity, nutrition	4	2	6
Lack of access to care for disadvantaged people (includes two mentions of dental)	2	2	4

how central they are in the network (6). Those who mentioned oral health in both years were located in peripheral network positions. It is clear that this issue was not central in terms of either the number of people who mentioned it, or where they were placed in the network. It is also clear that the influentials interviewed for this study were interested in only one aspect of oral health – that disadvantaged people cannot easily get access to dental care because of the lack of publicly funded services.

Discussion

This study analysed how influence shapes the health policy agenda, by examining networks of influence and policy issues. The relative prominence given to oral health as an issue by this group of influential actors can be observed as a result. Its peripheral position as an issue has important implications for influencing health policy. Opportunities for policy change are greatest when new voices can be heard: for the agenda to change, patterns of influence must change. This analysis suggests that a decisive shift to a new agenda made up of more peripheral items (such as oral health) requires that newly influential actors with different agenda items need to become more central, and/or those who are already central will have to be convinced of the need to promote different items to the top of the agenda.

There is an implicit message in these results for those wanting to increase the importance of oral health on the health policy agenda. First, central influentials have to be interested in it as an issue either because the actors have changed or because the (still) central actors are persuaded of its importance. That is, to change the policy agenda, the network of influence must change. Second, oral health will not progress as an agenda item if it remains separate from the rest of health. It is unproblematic for others in health to ignore it, because it can be easily dismissed as not integral to health. While the institutional arrangements that mitigate against this are many and include notions of autonomy that are fiercely defended by the oral health professions, there are other pathways to change. For oral health to become a more important agenda item, deliberate attempts to change the network structure are required. Interested actors need to increase their level of engagement with the health policy process, through building coalitions with those who are important in health, outside of oral health. Scholars of social capital point to the difference between homophilous and heterophilous ties, as was noted earlier in this study. If oral health is to become an important policy issue in health, then reaching out to influential but different (outside oral health) actors who are not currently convinced that it is important is essential.

Finally, some limitations of the study should be mentioned. First, it is based on perceptions of influence, not demonstrated influence. Second, it is a focused mapping of one locality of a network that has no boundaries, and not a sample across a network. A different starting point could generate a different network locale, but the nomination of people in important positions suggests that it is representative of influence (16). Third, the lists of issues generated should not be taken to represent the health policy agenda in Victoria in 2001 and 2004. It does, however, provide insights into the link between influence and agenda setting, by mapping influential people, the issues they see as important and the link between influence and issues.

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Conflicts of interest

The author has no conflicts of interest to declare.

References

1. Majone G. Evidence, argument and persuasion in the policy process. New Haven, CT: Yale University Press; 1989.
2. Bacchi CL. Women, policy and politics: the construction of policy problems. Sage: London; 1999.
3. Stone DA. Policy paradox: the art of political decision making. New York: Norton; 2002.
4. Marsh D, Rhodes RAW, editors. Policy networks in British government. Oxford: Oxford University Press, 1992.
5. Sabatier PA, Jenkins-Smith H. Policy change and learning: an advocacy coalition approach. Boulder, Colo: Westview Press; 1993.
6. Lewis JM. Health policy and politics: Networks, ideas and power. Melbourne: IP Communications; 2005.
7. Kingdon J. Agendas, alternatives and public policies, 2nd edn. New York: Harper Collins; 1995.

8. Cohen M, March J, Olsen J. A garbage can model of organizational choice. Adm Sci Q 1972;17:1–25.
9. Lewis JM. Evidence based policy: a technocratic wish in a political world. In: Lin V, Gibson B, editors. Evidence-based health policy: problems and possibilities. Melbourne: Oxford University Press; 2003; 250–9.
10. Alford RR. Health care politics: Ideological and interest group barriers to reform. Chicago: The University of Chicago Press; 1975.
11. Lin N. Social capital: a theory of social structure and action. Cambridge: Cambridge University Press; 2001.
12. Wasserman S, Faust K. Social network analysis: methods and applications. New York: Cambridge University Press; 1994.
13. White H, Boorman S, Breiger R. Social structure from multiple networks: I: blockmodels of roles and positions. Am J Sociol 1976;81:730–80.
14. Breiger RL. Career attributes and network structure. A blockmodel study of a biomedical research specialty. Am Sociol Review 1976;41:117–35.
15. Lewis JM. Connecting and cooperating: Social capital and public policy. Sydney: UNSW Press; 2010.
16. Lewis JM. Being around and knowing the players: networks of influence in health policy. Soc Sci Med 2006;62:2125–36.