University of Victoria | HLTH 401 | Health Policy & Governance | Module 3

HEALTH GOVERNANCE

A ROAD MAP TO HEALTH EQUITY AND SOCIAL JUSTICE

University of Victoria

About the Instructor

Kiffer G. Card, Ph.D. is affiliated with the School of Public Health and Social Policy at the University of Victoria. His research focuses on the social, structural, and systemic influences shaping health and behaviour with a focus on policy change, health promotion, and harm reduction strategies for substance use, HIV, and Hepatitis C. Dr. Card's advocacy focuses on the experience of individuals who are members of systemically oppressed and culturally devalued groups. He teaches on health policy, community health, and public health research methods.

About the School of Public Health and Social Policy

The School of Public Health and Social Policy (PHSP) provides a BA in Health and Community Services with four areas of focus – disability studies, Indigenous people's health, aging, and international and global development – and a Masters of Public Health in Social Policy, Indigenous People's Health, and Public Health Nursing. As part of the Faculty of Human and Social Development (HSD), PHSP values social justice, Indigenous knowledge's, interdisciplinary collaborative practice, good governance, health and social well-being, and ethical professional conduct (See HSD's Strategic Research Plan and the University of Victoria's Indigenous Plan). For more information about our program and course offerings, visit our website.

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Course Description

HLTH 401 reviews historical and contemporary health policy as a context for understanding current health governance practices. The role of legislation, governance and regulation as essential strategies to ensure the health of the population will be explicated. The intersections of policy, health law and ethics will be explored. Course content and activities will focus on helping course participants developing a broad range of skills and competencies related to working effectively in multidisciplinary teams to develop policies and governance structures that will facilitate high quality health service delivery and community care.

Course Outline

Week	Module Type	Topic
1	Introductory Module	Introduction to the Course, Assignments, and Syllabus
2	Learning Module	Health Policy: How Health Systems Shape Health (and How to Fight Back)
3	**Learning Module**	**Health Governance: A Roadmap to Health Equity and Social Justice**
4	*Assessment #1*	*Knowledge and Skills Check for Weeks 2 and 3.*
5	Learning Module	Decolonizing Governance: Indigenous Voices and Reconciliation
6	Learning Module	Canadian Healthcare Governance: An Historical Overview
7	Learning Module	Health Governance in British Columbia: Deconstructing Healthcare Access
8	*Assessment #2*	*Knowledge and Skills Check for Weeks 5, 6 and 7.*
9	Learning Module	Implementing Health Policies and Programs: A Practical Guide and Framework
10	Learning Module	Accountability in Health Systems: Transparency, Oversight, and Evaluation
11	Learning Module	Civil Engagement and Community Health: Balancing Diverse Priorities
12	Learning Module	Health and Human Rights: Respecting Patients, Resisting Paternalism
13	*Assessment #3*	*Knowledge and Skills Check for Weeks 9, 10, 11, and 12.*

Module Objectives

Upon completion of this module, course participants will be able to:

- **describe** what *governance* is,
- **describe** what *health governance* is,
- **compare** *health governance systems*, and
- **effect change** in health governance.

Module 3 | Part 1

INTRODUCTION TO GOVERNANCE

When you signed up for this course, you may or may not have had ever read the words "*Health Governance*" before. You likely figured that it has something to do with *Health Policy*, but you may still be unsure what the connection is exactly. In Module 2, we talked about *policy* in quite a bit of depth. In this Module, we are going to do the same with *Health Governance*.

If I asked you to guess what *Health Governance* meant, I bet one of your first thoughts would be that it has something to do with *governing* – after all it shares the same root word!

> *govern (v.) late 13c., "to rule with authority," from Old French governer "steer, be at the helm of; govern, rule, command, direct" (11c., Modern French gouverner), from Latin gubernare "to direct, rule, guide, govern" (source also of Spanish gobernar, Italian governare), originally "to steer, to pilot," a nautical borrowing from Greek kybernan "to steer or pilot a ship, direct as a pilot," figuratively "to guide, govern" (the root of cybernetics). The -k- to -g- sound shift is perhaps via the medium of Etruscan. Intransitive sense from 1590s. Related: Governed; governing.*[1]

Figure 1. Diagram of Governance

In linking *governance* to *governing*, you were definitely on the right track! However, if you thought to visit the Wikipedia page for "*governance*" (which I recommend you do if for nothing else the pure joy of seeing the page's directory of the many "*governances*"), you'd quickly realize that defining *health governance* wasn't going to be as simple as connecting it to its root word.

The academic literature on *governance*, as reflected in the Wikipedia page, has defined *governance* in a variety of ways. Broadly, the World Health Organization has said that *governance* broadly includes – and I'm paraphrasing – politics, legislation, policy, public administration; the interaction of these with civil society and the private sector; the effects of these various interactions; and the evaluation of these effects.[2] **Figure 1** provides a graphical depiction of *governance* using this definition.

Before we go any further, I should note that our course is primarily focused on *health governance* and that the term *governance* itself has long pre-existed the idea of health governance. Largely, the inheritance of the term and concept "governance" by health systems leaders and researchers comes from our close association on the global stage with the international development community.

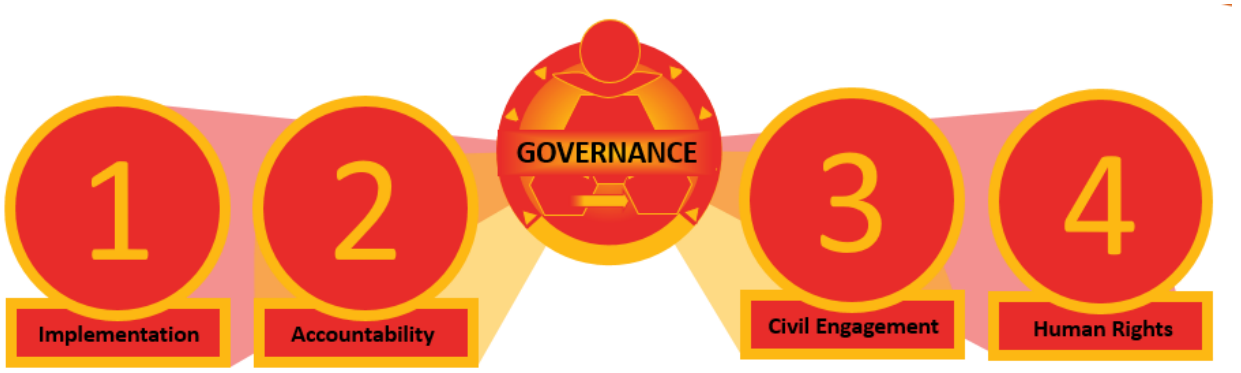

Figure 2. Broad Domains of Governance

In **Table 1** I've tried to show some of the various concepts related to governance as recognized by leading international development organizations. These can be further aggregated down into four broad categories: (1) Implementation, (2) Accountability, (3) Civil Engagement, and (4) Human Rights. *Implementation*, in my four-point schematic, describes the day to day process of what organizations do. This includes areas of work such as strategy, finance, how the organization is structured, processes of procurement, service delivery, and regulation of processes. *Accountability* describes how an organization and actors within an organization are accountable to both internal and external parties. This includes accountability to the public through the media and watchdog groups and the need to be transparent and open so that an organization can truly be held to account for it's implementation decisions. *Civil Engagement* describes how the organizations engages with local societies, special communities, the private sector, and other stakeholder groups. This is a vital part of governance and links the power to govern back to democratic principles and respect for the dignity of all persons. Finally, Human Rights describes the function of governance bodies in ensuring not only the rule of law but fighting for social justice and equity, protecting minorities, and ensuring that the basic needs of individuals are met.

Table 1. Domains of "Governance" Among Leading International Development Agencies

	The World Bank	United Nations	Overseas Development Institute	Mo Ibrahim Foundation	United States Agency for International Development
Rule of Law	•	•	•	•	•
Strategic Vision		•			•
Accountability	•	•	•		
Regulation	•				•
Effectiveness	•	•	•		•
Equity		•	•		
Responsiveness		•			
Engagement		•	•	•	
Human Rights				•	

Learning Activities

1. As we mentioned above, the term governance in the academic literature is strongly related to its use and history in the international development community. In what ways do you think this historical connection to international development might impact how we conceptualize of governance?

2. In Table 1, I've aggregated some of the various domains used by leading international development agencies and in the PowerPoint for this week's lecture I've provide these broken out into the full frameworks developed by each organization. Considering how each organization defines governance, in what ways do you think the organization itself (including their history, role, prominence, philosophy) impacts how they define governance for their organization?

3. In Figure 2, I've aggregated the various domains of governance into four broad categories. Which categories do you think each of the terms in Table 1 belongs to? After classifying each term, would you change the four-point classification scheme presented in Figure 2?

4. Figure 1 provides a graphical depiction of governance, but takes a distinctly different approach than that which is presented in Figure 2 and Table 1. Based on what you have learned about governance create a description of Figure 1 that uses this figure to explain the concept of governance

Recommended Readings

- Institute on Governance. (2019) "What is Governance?" https://iog.ca/what-is-governance/

Additional Readings

- Baez-Camargo & Jacobs. (2011). "A Framework to Assess Governance of Health Systems in Low Income Countries." Working Paper Series No. 11. Basel Institute on Governance, Basel.
- Pradhan, World Bank. (2006) "Strengthening Governance: tackling corruption the world bank group's updated strategy and implementation plan." http://documents.worldbank.org/curated/en/170861468331809051/pdf/674410BR0SecM20Official0Use0Only090.pdf

Module 3 | Part 2

INTRODUCTION TO HEALTH GOVERNANCE

In Part 1 of this Module, I introduced the concept of governance. In many ways health governance is synonymous with governance. In fact, it could be said that health governance is simply governance undertaken with the objective to protect and promote the health of individuals and communities. The World Health Organization has defined governance (sometimes referred to as "stewardship") as follows:

> *"Governance involves ensuring strategic policy frameworks exist and are combined with effective oversight, coalition building, regulation, attention to system-design and accountability."*[3]

Given that the World Health Organization is in many ways a bridge between the international development and public health communities, it is not surprising to me that their definition of governance provided above shares many similarities with the others we have reviewed. In just the three lines above, we capture hints of Implementation, Accountability, and Engagement. It's worth noting, however, that Human Rights is not included in their definition. In fact, in Table 2 the Mo Ibrahim Foundation was the only one to explicitly highlight human rights as a top-level domain of governance. I think one reason this may be is that in many organizations the community consultations and coalition building strategies are viewed as fundamental incorporation of human rights beliefs – particularly the democratic the right to self-govern as individuals and as a collective. My decision to separate out human rights from engagement is largely a practical one: communities and stakeholders that often get consulted and invited to join coalitions do not necessarily represent everyone in a community. Indeed, as you know from civics classes, the rights of the majority must be balanced against those in the minority – particularly so when recognizing that being a minority is not simply a reflection of statistical infrequency of a trait, characteristic, or viewpoint but also often includes experiences of being oppressed by the majority in power. Governance bodies must, therefore, take caution to ensure that the human rights and dignity of all persons are respected.

To get a better idea of what health governance is, consider the lists of concepts related to Health Governance provided in Table 2. This provides a similar domains framework as we provided in Table 1, with the WHO's conceptualization of health governance as well as two academic articles by Travis and colleagues (2002) and Siddiqi and Colleagues (2009). While these sources are a few years old at this point, I think they highlight the health governance frameworks exceptionally well. If you have taken the time to review the three frameworks, the biggest difference that I notice is the inclusion of Intelligence and information as a core part of governance. This reflects this standard practice of many health governance organizations in instituting disease and health outcome surveillance programs. While governments also routinely collect information on their citizens for both legitimate and nefarious purposes, the healthcare system has been granted

significant social license to engage more openly in these activities. Whether it is watching hospital admissions data to detect outbreaks of e. coli., tracking the seasonal spread of influenza, or tracking the prevalence of drug resistant strains of key bacteria, such as Tuberculosis – we expect our health systems to collect information and intelligence that can be used to guide their programs.

Table 2. Conceptualizations of Health Governance

World Health Organization	Travis et al. (2002)	Siddiqi et al. (2009)
• Policy guidance. • Intelligence and oversight. • Collaboration and coalition building. • Regulation. • System design. • Accountability.	• Formulating strategic policy direction. • Generation of intelligence. • Ensuring tools for implementation: powers, incentives and sanctions. • Building coalitions / Building partnerships. • Ensuring a fit between policy objectives and organizational structure and culture. • Ensuring accountability.	• Strategic vision. • Participation and consensus orientation. • rule of law. • Transparency. • Responsiveness. • Equity and inclusiveness. • Effectiveness and efficiency. • Accountability. • Intelligence and information. • Ethics.

Yet, we must issue a word of caution about surveillance and the other public health activities that are closely related to it. While health systems usually operate with good intentions to prevent, protect, and promote the health of people (See **Figure 3**), the capacity to collect information and gather knowledge does not give health systems unrestricted freedoms in how that data is collected, stored, or used. All surveillance programs should adhere to the other principles of good governance – especially accountability and community engagement. Honoring these concepts helps to ensure the integrity of health governance systems and helps support a systems approach that distributes the benefits of governance activities to all community members.

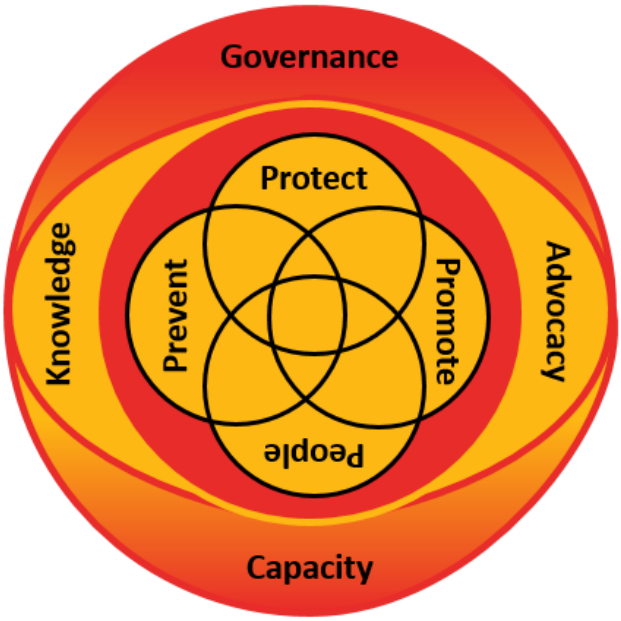

Figure 3. A Systems Framework for Health Policy – Adapted from Commonwealth Secretariat (2016)

The issues that arise from considering who should be consulted when designing new policies raises an important feature about health systems – namely, who is responsible for health governance. As shown in **figure 4**, the actually organizations that participate in governance are many and diverse. In modules 4, 6, and 7 we will discuss in greater detail the systems of health governance among Indigenous peoples (module 4), in Canada more broadly (module 6), and in British Columbia (module 7). These include high level actors, such as the ministry of health, public health agencies, health care providers, and patient groups. At each level the types of activities undertaken as part of a health governance strategy are likely very different. Governance is also shared between each level and undertaking related to health governance are often collaborative. Each organization needs to be aware of others who are involved in governance and how their governance strategies might overlap, share a common purpose, and in some cases work synergistically together. Figure 5 provides a framework for stakeholder identification often referred to as the 7P's. While this framework was developed for the context of stakeholder engagement in health research, it nevertheless provides a robust checklist for identifying potentially interested stakeholders.

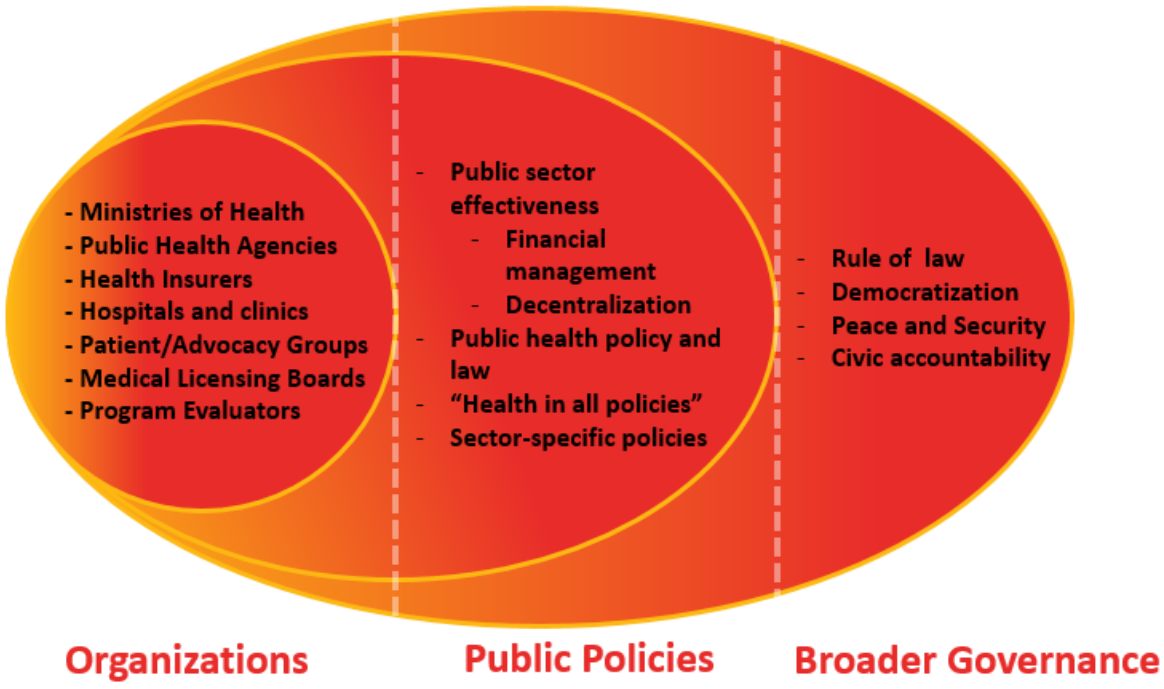

Figure 4. Governance and the Health Sector – Adapted from Fryatt et al. (2017)

While the basic functions of health governance likely differ from organization to organization within a healthcare system, there are general public policies that cut across these strata: all organizations must ensure they are effectively using the resources they've been granted, all organizations must set policies and guidelines, and all organizations must consider the health impact of all their undertakings (not necessarily those that are exclusively centered on health). Another way to think about this is to look back to **figure 2** and consider the ways in which various responsibilities fit into the aggregated domain framework for governance.

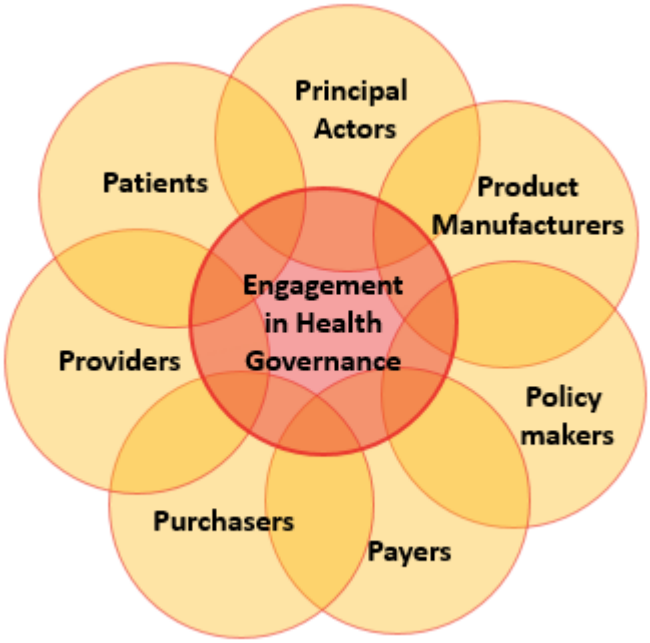

Figure 5. 7P's framework for stakeholder identification.

It is also important to note that organizations differ widely based on their role in the health system. Often times, we use the term "sector" to distinguish between areas of focus within a broader health system. For instance, my work is situated somewhere within the substance use sector, sexual health sector, and harm-reduction sector. Within this sector, there are issues and concerns that I face that somebody working in nutrition or physical activity or elderly care might never have to consider. Nevertheless, the broad principals of governance are largely the same. In each sector, organizations are responsible to **implement** effective health programs, are **accountable** to patients and the communities they serve, need to engage diverse stakeholders from across their community, and must support and sustain human rights.

For example, when it comes to accountability, health providers are accountable to patients to ensure that they are delivering the highest possible level of care and are respecting the rights of their patients while providing that care. This requires doctors to seek out the best medical practices through continuing education – a requirement of licensure and re-licensure in most health systems. It also requires that doctors provide their patients with the health services they need at a reasonable cost and on a reasonable schedule. When health systems fail to meet these needs, patients have a right to hold providers accountable. In some cases, they might be able to improve health outcomes using what Fryatt and colleagues (2017) described as the "short route" by advocating for their rights.

For example, gay and bisexual men might ask their doctor for a prescription called "PrEP" – or pre-exposure prophylaxis – which prevents HIV acquisition during sex. If their doctors don't know about PrEP, they can educate them. Health systems can support these individuals by providing them with information resources that can be passed onto care providers. Some patients might also have the luxury of seeking out new doctors or second opinions – a good source of feedback for healthcare providers. However, these solutions often require patients to have a heightened capacity for working with clinicians and understanding their health and the availability of health options. Educating the public to create awareness can be difficult. Other individuals might not have sufficient self-efficacy to advocate for their own health. In these situations, there is also a "long route" available. This involves citizens advocating and engaging in activism to pressure their governments and health systems to enact policy changes. Health governance is inclusive of both the long and short route, though not all organizations are equally positioned to enact change through these routes.

Learning Activities

1. In table 2, we described three frameworks for understanding the various domains associated with health governance. What similarities and differences do you find interesting or important when comparing these lists?

2. Based on your what you've learned, construct in your own words a definition for health governance that best captures the various domains related to health governance. Is this different from the definition you developed for governance in general? If so, why?

Required Readings

- United Nations (1948). "Universal Declaration of Human Rights." https://www.ohchr.org/EN/UDHR/Documents/UDHR_Translations/eng.pdf
- United Nations, (2007) "United Nations Declaration on the Rights of Indigenous Peoples" https://www.un.org/esa/socdev/unpfii/documents/DRIPS_en.pdf

Recommended Readings

- Fryatt, Bennett, Soucat. (2017) "Health sector governance: should we be investing more?" https://gh.bmj.com/content/2/2/e000343
- Travis et al. WHO. (2002) "Towards better stewardship: concepts and critical issues." https://www.who.int/healthinfo/paper48.pdf

Additional Readings

- World Health Organization (2007). "Everybody's business: strengthening health systems to improve health outcomes: WHO's framework for action." https://www.who.int/healthsystems/strategy/everybodys_business.pdf
- Commonwealth Secretariat. (2016). "A Systems Framework for Healthy Policy. Advancing Global Health Security and Sustainable Well-being for All. Implementation Tool for the 'Global Charter for the Public's Health'" https://drive.google.com/file/d/0B8wr6920su0aeXNVR01IeHdTYmc/view
- Maslow. (1970) Motivation and personality. http://www.peyc.eu/wp-content/uploads/2016/09/Motivation-and-Personality-A.H.Maslow.pdf
- Vicknasingam et al. (2018). "Decriminalization of Drug Use." https://www.ncbi.nlm.nih.gov/pubmed/29746420/

Module 3 | Part 3

EVALUATING HEALTH GOVERNANCE SYSTEMS

Now that you have a bit better sense of what health governance is and its relationship to broader conceptualizations of governance, I think a valuable asset and skill for you to develop is the ability to evaluate health governance systems. We will use these new found skills when discussing the Indigenous, Canadian, and BC health care systems in the modules leading up to your second learning assessment.

You might wonder, why should I develop and refine my ability to evaluating health governance systems? Well, the answer is that an evaluation of health systems can help you address many of the principal challenges facing these systems. Indeed, improving governance requires you understand what is wrong with governance. But in order to identify what's wrong with a health system, you have to understand what the goal of a health system is. There are three generally accepted health systems goals:

1. Improved health status through more equitable access to quality health services and preventive and promotion programmes,
2. responsiveness to legitimate patient and public expectations, and
3. fair financing that protects against financial risks for those needing health care

Closely related to these goals are 10 essential public health functions which are widely used to evaluate the function of health systems. These are listed in **Table 3**. The CDC recommends the use of the EPHA in evaluating public health systems and has developed tools for evaluating public health systems at the state, local, and institutional level (See them here). While there are a number of methodologies used to evaluate the essential functions of public health, many aspects of health governance can be difficult to evaluate based solely on their functionality. For example, Brinkerhoff and Bossert (2014) have identified three key challenges in health governance:

1. *the gap between good governance agendas and existing capacities,*
2. *the discrepancy between formal and informal governance, and*
3. *the inattention to sociopolitical power dynamics.*[4]

These, in turn, correspond with three basic flaws in the way we have conceptualized health governance so far. Indeed, the functional-task method for describing governance does not sufficiently address

1. *the multiplicity of societal actors in health systems,*
2. *the distribution of roles and responsibilities among those societal actors, and*
3. *their ability and willingness to fulfil their roles and responsibilities.*[4]

Table 1. Essential Public Health Functions

1. Monitor health status to identify community health problems.	6. Enforce laws and regulations that protect health and ensure safety.
2. Diagnose and investigate health problems and health hazards in the community.	**7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable.**
3. Inform, educate, and empower people about health issues.	8. Assure a competent public health and personal health care workforce.
4. Mobilize community partnerships to identify and solve health problems.	**9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services.**
5. Develop policies and plans that support individual and community health efforts.	10. Research for new insights and innovative solutions to health problems.

In other words, evaluating health governance systems forces us to change the way we think about health governance. We know, that governance is a dynamic and interconnected process for solving challenges to health, but when evaluating a health governance system within a specific institution, we must also consider the institutional perspectives related to who has authority, what are the roles and responsibilities of individuals, what formal and informal, tangible (e.g., budgetary restraints) and intangible factors (e.g., systems of oppression and hierarchy) put pressure on the system to be structured the way it is; and finally, what are the consequences that result from the way we structure organizations. These question areas highlight health systems evaluation as one fundamentally rooted in understanding the relationships between the various governance bodies within a health system. In the words, of Pyone et al. (2017),

> *"Governance is not an 'apolitical' process, and there are no absolute principles that define governance; it is a diffuse concept that cuts across disciplines, and borrows from a range of social science theories. However, whether it is applied to health systems or political science, governance is concerned with how different actors in a given system or organization function and operate and the reasons for this. In the context of health systems governance, we believe a multidisciplinary approach to assessment is necessary."*[5]

Supporting this assessment, several theoretical approaches have been undertaken to evaluating health governance systems. The most commonly use approaches include those based on (1) principal-agent dynamics, (2) institutional analysis, and (3) common pool resources theory. **Table 4** provides an overview of these approaches adapted from the systematic review by Pyone and colleagues (2017).

Table 3. Common Systems-Focused Approaches to Health Governance Analysis

Principal-Agent	
Description	Brinkerhoff and Bossert (2014) Examines the amount of value that agents (i.e., those funded to accomplish a task) produces which should go back to them in the form of incentives (i.e., pay) in return for the services rendered (i.e., health services), acknowledging that information asymmetries may result in the over- or under-valuing of an agent's worth.
Application	The USAID health system assessment team used Brinkerhoff and Bossert's (2014) governance framework in their manual for assessing health systems. According to Health Systems 20/20, the manual is currently used in 23 Health Systems 20/20 projects funded by the USAID in countries in East, West, and Southern Africa, as well as in the Caribbean islands.
Institutional Analysis	
Description	North (1990) assumes that markets are created and maintained by institutions, which consist of formal rules and informal constraints while organizations consist of groups of individuals with common objectives.
Application	Siddiqi et al., 2009 propose a comprehensive framework to assess governance based on Institutional Analysis. This framework includes ten principles, disaggregated into 63 broad questions under three relevant domains: context, processes and outcomes.
Common Pool Resources	
Description	Ostrom (1990) Focuses on creating different institutional arrangements to manage open resources which are finite. Communities can form self-organized networks or systems composed of interested actors who will develop incentives and sanctions to manage the resources on their own. Asserts that these self-regulated markets are more effective.
Application	Abimbola et al. (2014) developed a multi-level framework to analyse primary healthcare (PHC) governance in low- and middle-income countries. The authors borrowed the concept of 'governing without government' in situations where overall governance situations are not functioning. In such situations, communities with similar interest might develop their own rules and arrangements to manage the common pool.

Learning Activities

1. Imagine that you were asked to evaluate the essential functions of public health with regards to the opioid academic. What are actions and undertakings that you might look to evaluate related to each of the 10 essential functions?

2. What is primary difference between the Essential Functions of Public Health framework and the other theory-based approaches to health governance? Is there one theory based-approach that you find most similar to the EFPH approach?

3. Review each of the three implementation frameworks for the three theory-based approaches to health systems evaluation. Which of these assessment tools do you think is the easiest to use and would result in the highest quality assessment. Why did you choose the one you selected?

4. Having reviewed each of the three theory-based approaches, how do you think these evaluation approaches could be leveraged to (1) improve health systems, (2) advocate for social justice, and (3) advocate for health equity?

Required Readings

- Pyone, Smith, van den Broek (2017). "Frameworks to assess health systems governance: A Systematic Review." https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5406767/

Recommended Readings

- Siddiqi et al. (2009) "Framework for assessing governance of the health system in developing countries: gateway to good governance." https://www.ncbi.nlm.nih.gov/pubmed/18838188
- UNAIDS (2017) "Health Systems Assessment Approach: A How-to Manual" https://hsaamanual.org/
- Abimbola et al. (2014). "Towards people-centred health systems: a multi-level framework for analysing primary health care governance in low-and middle-income countries." https://www.ncbi.nlm.nih.gov/pubmed/25274638
- Martin-Moreno (2016) "Defining and Assessing Public Health Functions: A Global Analysis" https://www.annualreviews.org/doi/full/10.1146/annurev-publhealth-032315-021429

Module 3 | Part 4

EFFECTING CHANGE IN GOVERNANCE

Evaluations of governance are essential to advocating for the health and wellbeing of individuals and communities because they help you to understand when things are going well and when things are going poorly. I hope that you have by now reviewed the common evaluation frameworks on your own. Doing so should give you a better sense of the types of information these evaluations emphasize. I imagine that you might have developed some ideas from these activities of how they could potentially be used to shape *policy* – the definition and development of which was discussed in greater detail throughout module 2.

In this section of the module we are going to bring together these various components outlined in the last paragraph to develop our picture of how governance systems can change or be changed. Then, over the next three weeks, we will explore the historical development of health governance systems serving Indigenous peoples (module 5), Canadians (module 6), and people living in British Columbia (module 7); and how we might effect change within these systems using policy and governance tools. Those upcoming modules will leverage what we discuss below to understand how we can effect change for the improvement of these health systems.

The first thing we should consider when discussing our ability to effect change witching a health system should be to distinguish between four closely related terms: *advocacy*, *activism, advising*, and *lobbying* (See **Figure 6**). A good primer for beginning to think about these distinctions is a podcast that was created at UBC a few years ago titled "*Advocate or Activist: What is the best way to effect change?*" There is a link to it in the recommended reading section for this part of the module. One of the important take home messages for me from the podcast is that there are many ways to take action in shaping governance, and their best use depends on the situation. So don't mistake my decision to cover *advising* and *advocacy* first as an unspoken prioritization of advocacy over other forms of participation. In fact, in module 10 we will dive deeper in discussing the roles of *activism* and *lobbying* in health systems change. With that said, let's look at four definitions for these terms:

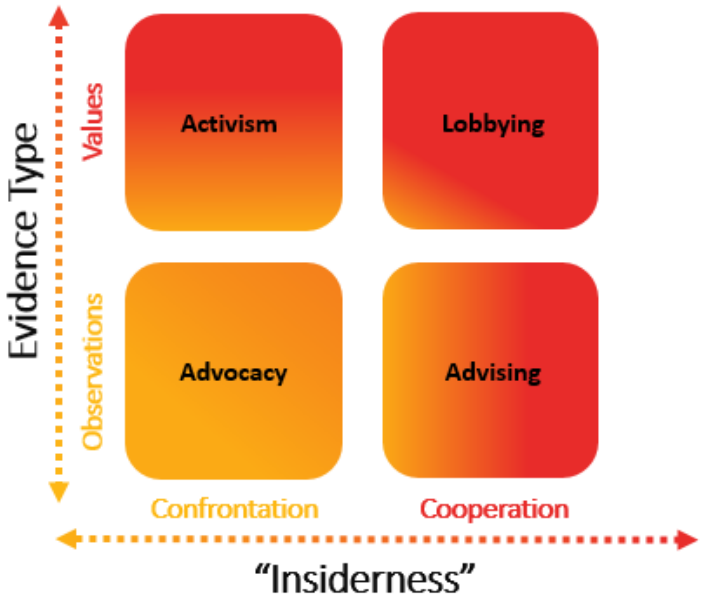

Figure 6. Cooperation/Evidence Model of Political Action

Evidence-Based Action

1. **Advising** includes activities which are undertaken by those in positions of trust or authority to provide advice to policy and decision makers. Two of the most common activities used in advising are the creation of *briefing notes* and *policy recommendations*.
2. **Advocacy** includes activities often undertaken by outside experts such as researchers, health professional organizations, patient-groups, and community-based organizations. Common activities associated with advocacy include the preparation and dissemination of reports.

Values and Interests Based Action

3. **Activism** includes activities undertaken by outsiders who confront policy and decision makers in the public sphere in an attempt to raise awareness and build public pressure for change. Activism can include online petitions, letter writing campaigns, marches, and distribution of advertisement or informational materials developed for lay readers.
4. **Lobbying** includes activities undertaken by outsiders who collaborate with policy makers to push privately for special interests or values. Corporations are perhaps the most famous lobbyists. One paper found that lobbying by corporation provides a substantial return on investment – as much as 22,000% in some cases.[6] Other organizations, including countries, lobby governments and governance systems to advance their values and interests. In many countries lobbyists must be registered. However, informal lobbying is common, particularly when lobbyists have close working or personal relationships with policy makers and decision makers.

As you might have picked up on, the type of action you might take is highly dependent on who you are, and how you're situated in relation to those in power. The options available to you can be severely restricted based on the particular context and situation. This is especially true for governance structures that are not doing well – which often makes effective implementation of governance evaluations difficult. In a poorly functioning governance system, accountability structures, including transparency; as well as systems of local engagement may all inhibit your ability to effect change. That said, there are four common characteristics that anyone who wants to be a change agent will need. These are known as the "four P's:"

1. **Passion**. care deeply about the problem, and be convinced of the value of the new idea;
2. **Position**. have access to key people;
3. **Power**. have status and influence, across parties;
4. **Persuasiveness**. have the credibility to be taken seriously and make the case convincingly.

As you can imagine, there have been a number of frameworks for impacting policy developed over time. Furthermore, so-called "implementation science" frameworks are increasingly used by researchers and academics to study how to effectively implement evidence-based findings into healthcare settings. The logic of these models is similar to those which guide implementation of evidence from internal evaluations. In module 9 we will visit this area of scholarship again to discuss some of these implementation models. In this module I want to focus our attention on just one of the many frameworks that you might choose from: The Overseas Development Institute's RAPID framework (Research and Policy in Development). An overview of this framework is provided in **Figure 7**. In Brief, this framework describes the interaction between political contexts, evidence, and the links that can be leveraged to drive change.

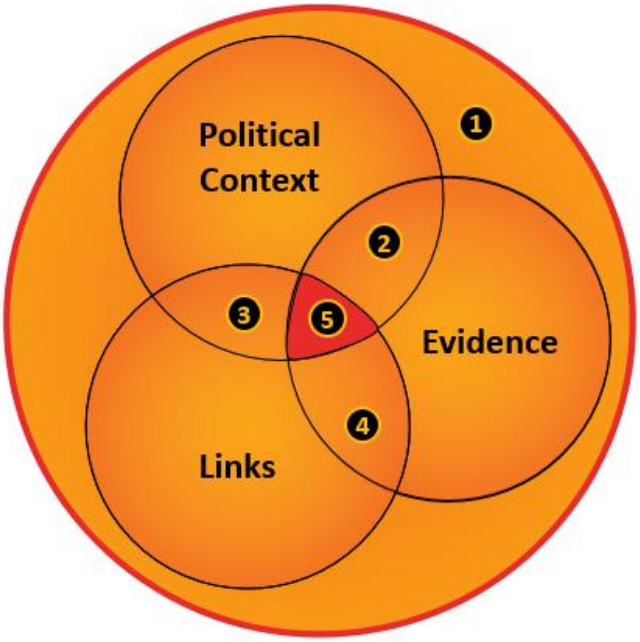

Figure 7. The RAPID Context, Evidence, Links Framework

Political contexts include systems related to politics and policy making. Questions used to assess the political context might be: "Who are the policy makers?" "Are they interested in new ideas?" "Are there sources of resistance?" "What is the policy making context?" "What are the opportunities at this time?"

Evidence describes the values, interests, and empirical observations that impact and shape policy. Questions used to assess evidence might include, "What is known or believed about this policy?" "Are their divergent views?" "What sorts of evidence will convince policy makers?"

Links describe the ways in which policy and decision makers might be impacted. Questions to consider might include "Who are the key stakeholders?" "What links and networks exist between them?" Who are the intermediaries, and do they have influence?"

In addition to these three key ingredients the RAPID model is also concerned with:

(1) **External Influences**, which describe how broader political, institutional, or situational factors impact and shape the policy process, the divergence of beliefs about evidence, and the ability to get change done at a specific moment in time;
(2) **Advising and Advocacy**, which occur at the intersection of political context and evidence;
(3) **Activism and lobbyism**, which occur at the intersection of political context and links;
(4) **Knowledge Exchange**, which occurs at the intersection of links and evidence;

(5) and finally, **the outcome**, which occurs when all these activities are brought together to determine the outcome (i.e., change vs. status quo) of the entire health system's effort to either promote or resist a change in policy or governance.

With this framework in mind, I want to shift your thinking to some key issues related to change. In module 2 we talked about the policy cycle framework, which is an idealized model of the six stages of developing policies (agenda setting, formulation, adoption, implementation, evaluation, maintenance) and how there are opportunities to impact the development of policies at each stage. We also talked about the concept of policy windows, and how timing and current events can significantly impact whether or not policies are changed or the status quo is maintained. These concepts raise an important question: "Can we create policy windows?" The answer is yes, and one of the key tools in doing so is *framing*.

Framing is a key strategy for positioning your policy to taken advantage of emerging policy windows and other circumstances within the political context. In advocacy work we distinguish between two key types of framing. The first of these is *framing for access*, which involves shaping a story to get the attention of key individuals so that they will care about your proposed policy change. *Framing for access* can be used to open policy windows. The second is framing for content, which is how evidence will be shaped and interpreted in order to achieve your policy goals. The Alberta Health Service has previously offered guidance on *framing for content*, with four important steps: (1) Emphasizing the social dimensions of the problem, (2) Shifting the primary responsibility away from the affected individuals to those whose decisions affect these conditions; (3) Presenting policy alternative as solutions; and (4) Ensuring that policy options have practical appeal. Framing policy recommendations such that they follow these general steps can not only make for an effective argument, but they can also support people whose health or behaviour is stigmatized by reframing the issue with attention to the underlying and systemic root causes. Another widely used framing strategy is to ensure that arguments appeal to Ethos (credibility or character), Pathos (emotion), Logos (reason). If these terms are unfamiliar to you, I have provided descriptions below:

(1) **Ethos** describes the appeal of an argument that is focused on the person delivering that argument. For example, if I were to say "As a gay man...," my message might be received differently than if I were to say "As a researcher…".
(2) **Logos** is another rhetorical appeal strategy that makes appeals to logic and reason. For instance, if I introduce research evidence showing that free school lunch programs result in better grades for low income students the argument would be received considerably different than if I were to share my own story of growing up in a family where we did not have enough money for lunch and so I relied on the school lunch program to eat.
(3) **Pathos** is about appeals to emotion. Often times the appeal is made to emotional goodness. However, one might also appeal to anger or discontent or any other emotion that might strengthen the chances of our success.

Learning Activities

1. Review one of the advocacy documents of the Public Health Physicians of Canada and consider whether they engaged with pathos, logos, and ethos. Do you think a good balance was struck? If not, how might you improve the advocacy document you chose to review.

2. Review Tillmann and colleague's Lancet article on public health advocacy in the UK. What specific policy recommendations did they advocate for? How might you use the RAPID Context, Evidence, and Links Framework to assess whether these recommendations are implementable?

3. Listen to the podcast I mentioned earlier on Advocacy and Activism. Where do you see you and your career being positioned with regard to our Activism, Advocacy, Advising, Lobbying framework for political action? In what way do you think the "four P's" shape where you position yourself?

4. In Table 2 of Christoffel (2000) describes how various participants can engage in advocacy. Do you agree with the proposed assignment of responsibilities? If not, Why?

5. Chapman et al. (2001) describes a case study on public health advocacy that focuses on banning smoking in the workplace in Australia. How does this case study highlight for you the work undertaken to effect policy?

Recommended Readings

- UBC. "Advocate or Activist: What is the best way to effect change?" https://www.alumni.ubc.ca/event/toronto-advocate-or-activist-what-is-the-best-way-to-effect-change/
- Overseas Development Institute. Start & Holland. (2004). "Tools for Policy Impact: A Handbook for Researchers." https://www.odi.org/sites/odi.org.uk/files/odi-assets/publications-opinion-files/194.pdf

Additional Readings

- Alberta Health Service (2009). "Public health advocacy." https://phabc.org/wp-content/uploads/2015/07/Public-Health-Advocacy.pdf
- Christoffel. (2000). "Public health advocacy: process and product." https://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.90.5.722
- Chapman. (2001). "Advocacy in public health: roles and challenges." https://academic.oup.com/ije/article/30/6/1226/651750