Framing the Effectiveness of Policy for Health

There is a strong belief, and in many cases a strong evidence-base, that policy impacts on our collective shaping of individual, population and global parameters of life, in terms of operations of humanity, and of the natural world of which we are such an intricate and fragile part. Unfortunately, the same could be said of the absence of policy: a failure of governments to address, for instance, global climate change may have severe health, eco-systemic and social impacts.

In looking at the effects of policy on health we therefore have to specify what we are seeking to examine, and how we will assess impact. As policies have such a profound and sweeping impact, our assessment of the effectiveness of policies for health should therefore reach beyond efforts in health sectors. Yet, at other conceptual levels we will have to limit our analysis.

A first proxy is that we will be including deliberate policy action, with the added condition that deliberate inaction, in spite of its sometimes overwhelming impact on health, is not within the remit of this chapter. Secondly, we will have to look at policy that has been implemented. This statement merits some reflection on the conceptual nature of “policy”. There are two extremes on a conceptual continuum: at the one end, there are those who believe a policy to be a rule or principle that guides decision-making. In many cases, such rules or principles might remain implicit. At the other extreme, policy has been defined as the explicit (and thus documented) formal decision by an executive agency to solve a certain problem through the deployment of specific resources, and the establishment of specific sets of goals and objectives to be met within a specific time frame. Legislation (with associated sanctions and incentives) could be regarded as ultimate policy statements. In this chapter we wish to look at deliberate decisions to solve (health) problems, and thus exclude “policy” that could be characterized as implicit general rules of principles for further decision-making. It is for this reason that we are interested not just in the decisions per se, but precisely in active implementation.

A third element that we will have to include is therefore a review of the implementation tools. Policy as an ambition needs to be translated into an operational
form if it is to be executed. These operational forms are known in the practice and academia of health promotion as “interventions”. In the political sciences they are known as “policy instruments”. Described by some as carrots, sticks and sermons, a more functional classification would distinguish between communicative, regulatory, and facilitative interventions/instruments. It is generally recognized that some optimal magical mix between the three would yield the highest policy effects. Thus, in this review we will also attempt to identify the types of health interventions/policy instruments that have been developed to implement policy.

It may be worthwhile to reiterate the fact that, in our view, “policy” is not simply equivalent to “intervention”. Policies are higher order arrangements that, in our view, frame, order and define sets of interventions.

In terms of these arrangements, three policy types can be distinguished. Redistributive policies are policies that impose costs or provide incentives to encourage the adoption of certain types of individual and systems behaviors. These costs or incentives generally come in the form of taxations or subsidies. Regulatory policies impose restrictions or inducements on defined individual and systems behaviors. They specify sanctions, for instance fines. “Allocational” policies finally fund activities and strategies with the intent to produce longer-term health benefits for the population. The more specific the policy relates to behavioural outcomes, the easier it is to evaluate its effects. Redistributive and regulatory policies are thus easier to evaluate than allocational ones.

A policy can only be effective if its constituent parts are. Policies would be more effective if these constituent parts are developed, planned and implemented, preferably synergistically, from a solid evidence-, community and theoretical base. This is the core of the argument that follows, and we will return to this in the conclusion.

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**Box 5.1. HIV/AIDS prevention and the optimal intervention mix**

Many studies have identified bars and discotheques as venues for high risk behaviour leading to infections with STDs, including HIV/AIDS. In many instances, health promotion agencies have endeavored to communicate these risks to the clientele, and advise options to limit them. One of these options would be to practice safe sex. This would involve the use of reliable condoms.

Access to such condoms could be facilitated by the installation of vending machines (or, as is common practice in some gay entertainment venues, free hand-outs).

Some local governments, after considering the impact of the communication-facilitation mix, have decided to regulate the compulsory presence and operation of these vending machines.