

## Political science and global health policy



The drive to make policy more evidence-based has prompted scholars and practitioners to call for removing politics from global health policy making. This stance is neither possible nor is it desirable, because many issues, such as what constitutes a just allocation of health resources, can only be settled legitimately through democratic deliberation. As our new *Lancet Series on Political Science and Health*<sup>1-3</sup> reveals, politics matters and should become an indispensable part of global health policy discussions.

Historically, the concept of power has been central to the study of politics. Political scientists have offered various conceptualisations that are instructive for analysing global health policy making. Harold Lasswell<sup>4</sup> provided an early and influential definition, framing politics in terms of the control of resources—“who gets what, when, and how”. Robert Dahl<sup>5</sup> offered a compulsory understanding of the concept, arguing that “A has power over B to the extent that he can get B to do something that B would not otherwise do”. Michael Barnett and Raymond Duvall<sup>6</sup> called for a more comprehensive understanding of power beyond compulsion, to include constitutive relations—the social processes that define the identity of actors and their relationships, with consequent effects on what these actors can do.

Political science provides concepts to help structure analyses of the influence of power and politics on global health policy making. For example, the papers in this Series<sup>1-3</sup> draw on the interconnected concepts of interests, ideas, and institutions.<sup>7-9</sup> Interests refer to the motivations of politicians and civil societal actors as they pursue their agendas and how these affect health policy.<sup>10</sup> Institutions pertain to the formal and informal rules and constraints created by individuals, from constitutions to traditions and customs, that shape political life and policy outcomes.<sup>11,12</sup> Ideas refer to beliefs that shape individual behaviour and policy.<sup>8,13,14</sup>

As an example, the second Series paper by Carmen Jacqueline Ho and colleagues<sup>2</sup> reveals how achieving universal health coverage (UHC) is a challenging political process. Power can be used to advance ideas and interests, and forge institutions that favour certain groups over others and determine how committed a government is to ensuring health care for all. However,

Ho and colleagues also emphasise that implementing UHC is shaped by bureaucratic capacity and the dynamic relationships between policy makers, local officials implementing policy, and non-state actors.

This analytical approach helps to explain the challenges of governmental responses to pandemics. The interests of political leaders and senior health officials may diverge due to differences in political, ideological, and scientific beliefs, as seen with the response to COVID-19 in Brazil; when combined with political decentralisation, with state governors and mayors varying in their beliefs and policy response, the differences in institutions and political situations can spell disaster for efforts to control COVID-19.<sup>15</sup> Insights from political science are also relevant for understanding the health response in other settings. Ideas of national solidarity have transformed the interests of political actors and made them more likely to prioritise health policy across India.<sup>16</sup> Boundary institutions influence ideas of national solidarity, and helped shape the nature of HIV/AIDS policy in Brazil, India, and South Africa.<sup>17</sup> And in Mexico, commercial sugar-sweetened beverage industries, which have historically had access to congressional and bureaucratic institutions, hampered the introduction of much needed policies to tackle obesity and non-communicable diseases.<sup>18</sup>

Other political science concepts offer additional insights into global health policy making. For example, the first Series paper<sup>1</sup> draws on policy framing research and provides evidence that the way global health issues are framed—as threats, ethical imperatives, and wise investments—can shape the amount of attention and resources these issues receive from global health organisations and national governments.

The concepts of path dependency<sup>19</sup> and policy feedbacks processes—ie, how health policies generate supportive coalitions which reinforces existing policies over time—underscore why nations vary in their adoption of health-care legislation.<sup>20</sup> This conceptual approach can help to explain why some governments fail to implement new approaches to global health threats, since the political and bureaucratic coalitions that created policies in response to public health challenges in the past—eg, conservative beliefs in the government’s limited role in health—strive to maintain these interests



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at all costs. As seen with the US Government's initial response to COVID-19, the literature on this conceptual approach may provide insight into how path dependent feedback process can obstruct the creation of a comprehensive central government role (overcoming the challenges of decentralisation) in testing, contact tracing, and physical distancing.<sup>21</sup> This conceptual approach can also help to explain why some countries were better positioned to respond to COVID-19. Indeed, centralised responses in countries with a history of responding to severe acute respiratory syndrome (SARS), such as those in South Korea and Singapore, are said to have been instrumental to responses in the initial months of the COVID-19 pandemic.<sup>22,23</sup>

Political science provides ideas and approaches to research that can enhance our understanding of global health policy and politics. Rather than divorcing politics from policy decision making, political science research emphasises that recognising political power dynamics is crucial in helping to identify why certain public health policies might be more likely to succeed in adoption and implementation. Political scientists also appreciate that political power shapes, and is shaped by, the rise of new policy ideas, institutions, and interests. The papers in this *Lancet Series* illustrate important contributions from political science, raise new research questions, provide policy-making recommendations, and identify future areas of research.

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- 1 Shiffman J, Shawar YR. Framing and the formation of global health priorities. *Lancet* 2022; published online May 17. [https://doi.org/10.1016/S0140-6736\(22\)00584-0](https://doi.org/10.1016/S0140-6736(22)00584-0).
- 2 Ho CJ, Khalid H, Skead K, Wong J. The politics of universal health coverage. *Lancet* 2022; published online May 17. [https://doi.org/10.1016/S0140-6736\(22\)00585-2](https://doi.org/10.1016/S0140-6736(22)00585-2).
- 3 Kickbusch I, Liu A. Global health diplomacy—reconstructing power and governance. *Lancet* 2022; published online May 17. [https://doi.org/10.1016/S0140-6736\(22\)00583-9](https://doi.org/10.1016/S0140-6736(22)00583-9).
- 4 Lasswell H. Politics: who gets what, when, how? New York, NY: P Smith Publications, 1950.
- 5 Dahl RA. The concept of power. *Behavioral Sci* 1957; 2: 202–03.
- 6 Barnett M, Duvall R. Power in international politics. *Int Organ* 2005; 59: 39–75.
- 7 Shearer J, Abelson J, Kouyaté B, et al. Why do policies change? Institutions, interests, ideas and networks in three cases of policy reform. *Health Policy Plan* 2016; 31: 1200–11.
- 8 Hall P. The role of interests, institutions, and ideas in the comparative political economy of the industrialized nations. In Lichbach MI, Zuckerman AS, eds. *Comparative politics: rationality, culture, and structure*. Cambridge: Cambridge University Press, 1997: 174–207.
- 9 Walt G. *Health policy: an introduction to process and power*. Johannesburg: Witwatersrand University Press, 1994.
- 10 Wong J. Healthy democracies: welfare politics in Taiwan and South Korea. Ithaca, NY: Cornell University Press, 2006.
- 11 North D. Institutions. *J Econ Perspect* 1991; 5: 97–112.
- 12 Immergut EM. Institutions, veto points, and policy results: a comparative analysis of health care. *J Public Policy* 1990; 10: 391–416.
- 13 Béland D. Ideas and social policy: an institutionalist perspective. *Soc Policy Administr* 2005; 39: 1–18.
- 14 Finnemore M, Sikkink K. International norm dynamics and political change. *Int Organ* 1998; 52: 887–917.
- 15 Barberia LG, Gómez EJ. Political and institutional perils of Brazil's COVID-19 crisis. *Lancet* 2020; 396: 367–68.
- 16 Singh P. *How solidarity works for welfare: subnationalism and social development in India*. Cambridge: Cambridge University Press, 2015.
- 17 Lieberman E. *Boundaries of contagion*. Princeton, NJ: Princeton University Press, 2009.
- 18 Gómez EJ. Coca-Cola's political and policy influence in Mexico: understanding the role of institutions, interests, and divided society. *Health Policy Plan* 2021; 34: 520–28.
- 19 Mahoney J. Path dependency in historical sociology. *Theory Soc* 2000; 29: 507–48.
- 20 Hacker J. The historical logic of national insurance: structure and sequence in the development of British, Canadian, and U.S medical policy. *Stud Am Political Develop* 1998; 52: 57–130.
- 21 Bali AS, He AJ, Ramesh M. Health policy and COVID-19: path dependency and trajectory. *Policy Soc* 2022; 41: 83–95.
- 22 Chua AQ, Tan MMJ, Verma M, et al. Health systems resilience in managing the COVID-19 pandemic: lessons from Singapore. *BMJ Global Health* 2020; 5: e003317.
- 23 You J. Lessons from South Korea's COVID-19 policy response. *Am Rev Public Administr* 2020; 50: 801–08.