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## PUBLIC POLICY MAKING: THEORIES AND THEIR IMPLICATIONS IN DEVELOPING COUNTRIES

Ferdous Arfina Osman

Public policy making is not merely a technical function of government; rather it is a complex interactive process influenced by the diverse nature of socio-political and other environmental forces. These environmental forces that form the policy context lead to the variation in policies and influences the output and impact. Due to the contextual differences, public policies of the developed countries significantly differ from those of the developing countries. Although the policies of developed countries have proved their effectiveness in many cases, those cannot be applied in understanding the dynamics of the policy process of developing countries. Public policies in the developing countries possess certain peculiarities of their own by virtue of being influenced by an unstable socio-political environment, and face various problems and challenges. Poverty, malnutrition, ill health, illiteracy, low standards of living, unemployment and other common phenomena of these countries have also been creating a growing pessimism about the effectiveness of public policies. Given this situation, in developing countries, policy studies deserve urgent attention. The existing theories of policy making provide useful guidance for analysing the policies of developing countries but they are not quite sufficient for undertaking a comprehensive analysis. This is because most of the policy making theories were derived from the studies of industrially developed societies, which in most cases, are found insufficient to explain the policies of developing countries due to the contextual variations. The objective of this paper is to analyse the factors that make the existing theories inadequate to explain the policies of developing countries. To this end, the paper at first, briefly discusses the basic concepts of public policy making and identifies certain theories of policy making in general that are not suitable for explaining the policy making process of developing countries. Then to make the focus of the study more specific, the theory of 'health policy making' has been discussed as a case and shows exactly how a theory derived from a industrially developed country is inadequate to

examine the health policy making process of a developing country like Bangladesh. At this attempt the paper distinguishes the policy context of developing countries from that of the developed countries and also the policy context of Bangladesh from other developing countries.

### 'Public Policy Making': Concepts and Theories

In its simplest sense, 'policy' refers to a broad statement that reflects future goals and aspirations and provides guidelines for carrying out those goals. Hill (1993: p.47) defines 'policy' as 'the product of political influence, determining and setting limits to what the state does'. To be more precise, when a government takes a decision or chooses a course of action in order to solve a social problem and adopts a specific strategy for its planning and implementation, it is known as public policy (Anderson 1975). Policy scientists argue that public policy is best conceived in terms of a process (Jenkins, 1978, Rose, 1976; Anderson, 1978). This is because policy decisions are not 'something confined to one level of organization at the top, or at one stage at the outset, but rather something fluid and ever changing' (Gilliat, 1984:p.345). Rose (1969: p.xi) also made a similar argument when he said, 'policy making is best conveyed by describing it as a process, rather than as a single, once-for-all act'. This process involves negotiation, bargaining and accommodation of many different interests, which eventually give it a political flavour. These political interactions happen within the network through which decisions flow, programmes are formulated and implemented and inter organisational dependencies and interactions take place. Thus 'policy making' is not a simple rather a complex dynamic process involving series of actions and inactions of varieties of groups with varieties of interests at different stages. Here it is important to note that public policy making not only involves the public bodies or public officials as policy actors; rather, private or non-official groups also play a very active role in policy making. This public private interaction constitutes the structure of the political system within which policy actors influence the policy process. The structure of the political system greatly differs from the developed and developing countries. This makes the existing theories or models of public policy making derived from the developed countries inadequate to explain the policy making process of developing countries.

In the existing literature, policy making has been viewed from varieties of approaches like rational approach, incremental approach, mixed scanning model, group theory, elite theory, pluralist theory and political system model. Of these approaches, it is popularly believed that Easton's (1965) 'Political System Model' can be employed to explain the policy making process of developing countries. Easton's (1965) 'political system' model views the policy process as a 'political system' responding to the demands arising from its environment. The 'political system' as defined by Easton is composed of those identifiable and interrelated institutions and activities in a society that make authoritative decisions (or allocations of values) that are binding on society. He explains that the environment provides inputs to the decision process/political system in the form of demands and supports. Inputs into the system are provided through outside interests particularly from pressure groups, consumer groups and interest groups. These environmental inputs are converted through the political system into outputs or policies.

Easton's model was originated from the studies of a developed country like the United States. In the American context along with other developed countries, although the interactive stages of policy making, input-throughput-output-feedback, are quite practical, it is highly variable in developing countries. In these countries policy making does not always follow the chain of actions identified by Easton. Particularly, presence of feedback mechanisms is very infrequent in policy making of developing countries. Moreover, the nature of the influence of demands, supports and resources that generate policy as argued by Easton widely varies from the American society along with other developed countries to the developing countries. Compared to the developed countries, policies of developing countries are less responsive to the demands of the environment. On the other hand, support from the society as input for decision making is also less significant in the developing country context. Walt (1994) rightly observes that in developing countries, there exist huge examples of retaining power by the governments without popular support. While support from social groups is given considerable importance in the developed countries. Therefore, without studying the particular policy context, it can not be argued that the policy making process, particularly in developing countries, always follows the stages suggested by Easton. Thus although the existing theories of policy

making provide broad outlines for studying the policies of developing countries, for a minute or a comprehensive analysis, they are less adequate. Conceiving it a very broad, general conclusion, the following sections of the paper give a very precise example of this particular phenomenon through undertaking the theory of 'health policy making' as a case and its application in Bangladesh as a developing country.

#### Theory of Health Policy Making

'Health policy' can be conceived and interpreted in different ways. One of the simplest ways of defining 'health policy' is as 'authoritative statements of intent, probably adopted by governments on behalf of the public, with the aim of altering for the better the health and welfare of the population' (Lee & Mills, 1982: p.28). Thus health policy consists of a series of governmental decisions about what type of care is to be provided for the betterment of the health of its population and how it will be done. Heidenheimer et. al. (1990: p.59) in identifying the components of health policy say that it is about the 'choice of Governments, direct or indirect, regarding which kinds of personnel may provide what kinds of medical care'. But health policy should not be narrowed down only to health care provision. Along with health care provision, health policy is concerned with social, economic and organizational effects on health. Walt (1994: p.41) focuses on these aspects in her definition of health policy:

'Health policy embraces courses of action that affect the set of institutions, organizations, services, and funding arrangements of the health care system. It goes beyond health services, however, and includes actions or intended actions by public, private and voluntary organizations that have an impact on health.'

This definition provides a broader view about health policy by indicating the involvement of different actors and factors in achieving the policy goal. Government assumes a major responsibility of making health policy. But Paton (1996: p.3) argues that seeking a strategy for health implies policy and action from a wide range of government and non-government agencies. Along with the state actors, various interest groups like professional organisations, health insurance companies, political parties, and the community have influence over the process. The health policy of a country is the product of a diverse

range of conflicts, interests and demands from these varieties of groups. These groups and institutions and their interactions form the 'political system' as termed by Easton.

We see, therefore, that like the policy process in general, the health policy process involves a wide and complex range of interests, actors and institutions. Focusing on the power struggle amongst the interest groups within the structure of the health care system, Alford (1975) presented his theory of structural interests in the context of the U. S. health care system. His theory has been widely accepted as a very comprehensive and realistic approach to studying the relative power of interest groups and their interrelationships within the structure of a health care system. Alford's (1975) theory of structural interests in health care has proved influential and has been identified as a useful heuristic device by several authors (Ham, 1981; Allsop, 1984; Ham & Hill, 1993; Wistow, 1992). Supporting the importance of this theory, Wistow (1992: pp.52-53) notes that 'it remains of considerable value as a framework both for identifying the essential interests of the three main categories of participant in health service policy making and for analysing the changing balance of their respective influences over time'. Alford's theory has been summarised below.

#### Alford's Theory of Structural Interests in Health Care

Alford (1975) views the total health care system as a network involving different structural interests. His theory of structural interests determines which group within the structure is powerful and to what extent and what is the interest of particular groups within the health service structure and how they are interdependent with each other. By using the term 'structural interests' he means the interests that gain or lose from the form of organisation of health services. In this regard, he identifies three different types of structural interests termed as dominant interests, challenging interests and repressed interests.

##### A. Dominant Interests

Alford (1975) has portrayed the interests of the medical profession as the 'dominant structural interest' in health care policy. Alford argues that the medical profession is in a dominant, exclusive and monopolistic position within the health sector. He states that professional autonomy is represented by a diverse nature of professionals involving physicians in private or group practice,

salaried physicians, and those in other health occupations holding or seeking professional privileges and status. Amongst all these groups 'physicians are the most important interest group representing professional monopoly' (p.194). All of these groups have different interests and are related to the health system in different ways. As a result, Alford says, 'their interests are thus affected differently by various programmes of reform. But they share an interest in maintaining autonomy and control over the conditions of their work, and professional interest groups will— when that autonomy is challenged— act together in defense of that interest' (p.192). Explaining the source of such hegemony of the professionals, Alford argues 'these interests are at present the dominant ones, with their powers and resources safely embedded in law, custom, professional legitimacy, and the practices of many public and private organizations' (p.191). Thus the existing socio-political institutions provide the source of power to the professionals. Society depends on doctors due to special knowledge they have and the state depends on medical profession in order to implement its health programmes. By virtue of special knowledge, the profession enjoys clinical autonomy (i.e., application of expert knowledge to treat illness without any interference from outside) as well as self regulation (i.e., regulation of access to the profession, training, and of working environment). Due to their self-regulatory capacity, the profession controls their own income and career prospects. Thus along with the clinical autonomy, the physicians also do have economic autonomy. State dependency also gives power to the medical profession by enacting laws/medical acts legitimizing their self-regulating authority. Thus the professional monopoly derives from the society and state policy rather than their interest group organisation. All these reasons explain why, as long ago as 1975, Alford identified doctors as the dominant interests.

##### B. Challenging Interests

Professionals exercise autonomy and dominance within an institutional set-up which in turn challenges their power. Alford argues, 'the changing technology and division of labour in health care production and distribution and the shifting rewards to social groups and classes are creating new structural interests which I label corporate rationalization' (p.15). The structure within which professionals function is termed by Alford as 'corporations'. By its definition, 'corporation' refers to 'a group of people producing goods and services

under clearly defined legal structures' (Wohl, 1984: p.177). According to Alford, health service is produced and managed by large scale organizations or corporations like hospitals, medical schools and public health agencies at all governmental levels and health planning agencies. These large-scale organisations represent an increasingly powerful structural interest, which Alford calls 'corporate rationalisation' (p.191). Professionals are subject to the rules, plans and priorities of these organisations. Professionals are never challenged by the existing laws, customs and society rather they are most often challenged by persons occupying the top positions in large scale health organisations like hospital administrators, government health planners or bureaucrats, directors of city health agencies who represent the structural interests of corporate rationalizers. Alford calls their interests as 'challenging interests'. Although each of these organizations compete with each other for power and resources, they share a common goal of maintaining and extending their control 'over the work of the professionals whose activities are key to the achievement of organizational goals' (p.192).

Professionals work within the boundary of rules, job descriptions and priorities of the hospitals. They are free to diagnose and prescribe but the types and numbers of cases they handle are controlled by the hospital management and their performances are appraised by internal audit. The economic autonomy of professionals is challenged when they are paid by hospitals/government.

Apart from the micro level challenge, Alford argues that the medical profession is also challenged at the macro level in terms of control over hospitals through licensing, accreditation and certification. Another example of attempted corporate rationalization at the macro level is the state requirements that 'expansion of health care facilities need to be approved by an administrative decision' (p.202). The role of the state in health care leads to an apparent diminution of the profession's privileged status in health policy decisions at the centre.

### C. Repressed Interests

Alford has termed the 'repressed interests' as 'negative structural interests', 'because no social institutions or political mechanisms in the society insure that these interests are served' (p.15). Repressed

interests are heterogeneous with respect to their health needs, ability to pay, and ability to organise their needs into effective demands. Interests of the community population are portrayed as 'repressed interests' as they are not organised as are the other interest groups. Although they are not organized, they share a common interest 'in maximising the responsiveness of health professionals and organisations to their concerns for accessible high quality health care' (p.192). Access of this group to the health services is also restricted.

This is the central thesis of Alford. Alford's theory encompasses almost all the key interest groups influencing the health care system. This theory provides an understanding of the changing balance of influence within the policy network through examining to what extent are the professional monopolizers under challenge, by whom and to what effect, whether the corporate rationalizers challenge them on particular issues or at particular periods; and how far the community interests remain repressed. Thus Alford identified three distinct structural interests in health care but he cautioned against overemphasizing the difference between the dominant and challenging interests as both of them are the modes of organizing health care.

Alford's theory is considered very useful in identifying the principal actors/interest groups, the nature of their interactions influencing the health policy process of a country and above all, to examine the health policy network of Bangladesh. But due to contextual variations, full employment of this theory in case of a developing country like Bangladesh, is a more complex task. Poor economic condition, political instability and other common phenomena of developing countries generate different types of health care systems, which widely vary from the health system of the USA dealt by Alford. Therefore, it is not sensible to employ Alford's theory to analyse a case of developing country like Bangladesh without substantive modifications. The next section points out the major determinants of contextual variations between the developing and developed countries along with the United States from where Alford's theory was originated and how this theory is inadequate to explain the case of Bangladesh as a developing country.

### Inadequacies of the Theory of 'Health Policy Making' in Explaining the Case of Bangladesh

This paper considers Alford's theory useful to analyse the health policy making process of Bangladesh through identifying the structural interests in health care systems. But this theory is very closely influenced by the political and economic trends in the world's richest and most advanced country i.e. the United States, which reduces the suitability of employing them directly for studying the health policy of a developing country like Bangladesh because of their widely different policy contexts. Certain distinct features of the American society that influenced Alford's theory can be identified.

Firstly, American society is basically a pluralist society. Decentralised political structure of the USA (from federal level to local level i.e. counties, municipalities, townships) has created multiple sources of power and has contributed to shape a 'pluralist' society. Paton (1990: p.7) describes how a decentralized political system has originated a pluralist American society. He states:

'The fact that many areas of jurisdiction provide a greater scope for 'democracy', in that one's life is not in the hands of only one government or tier of government, is rather academic compensation for the fact that many 'power centres' are thereby rendered powerless in many ways.'

Thus pluralism which dismisses the monopoly of the ruling class has provided the source of power to the structural interests. For instance, neglecting the state as a source of power by pluralist theorists reflects the influence of the political tradition of a less powerful state in the USA. Alford's theory has also been influenced by this less powerful state, which helps make the professionals excessively dominant in the health care arena. Mead (1977: p.44) agrees that American politics is reluctant to impose ironclad control over groups or individuals through authority and America's health system's freedom from public control is unusual compared to other advanced countries. He adds that both the market (due to cost-based reimbursement) and the government leave the professionals remarkably free to determine the price and supply of health services by themselves. Such a political context influenced Alford labeling in the professionals as 'dominant interests' in health care system.

Secondly, the market economy is another dominant feature of the American society as well as of the developed countries which has influenced Alford's theory. Alford categorized the management power as 'corporate rationalizers' from the capitalist context of America. The US health system is mostly a corporate health system where large for-profit hospitals/public health agencies compete with each other and employ the doctors and tend to control their activities to attain their goals. These types of competitive large-scale organizations in the health sector are less evident in developing countries due to weak economic structure.

Thus Alford's theory of health policy making contains profound influence of the industrially developed society of the United States, which makes it difficult to apply in explaining the cases of developing countries. There are certain common socio-political and economic features of developing countries that lead to a quite different policy context from the developed countries. These features are the following:

Firstly, in contrast to the American society, pluralism is least practised in developing countries. In these countries, societies are not well organized to place their demands as there exists a persistent lack of interest among the citizens about the national policies. Paarlberg (1987: pp.20-21) observes that 'in the developing countries, and especially where imperial rule has suddenly been withdrawn, state elites frequently find themselves facing weak and disorganized societies. Their own autonomous preferences can thus play a large role—at least initially'. In addition to a colonial legacy, illiteracy, poverty might be the reasons for such disorganized society. Less organized interest groups thus cannot become dominant over the state machinery and in the same way, professionals in developing countries are less dominant than their counterparts in the developed countries.

Secondly, decision making in developing countries is highly centralised. In developing countries the state assumes the key role in policy making. Grindle & Thomas (1991: p.43) rightly note that the state actors in developing countries are 'frequently the most important actors in placing issues on an agenda for government action, assessing alternatives and superintending implementation'. As a

result, decision making is highly centralized in the hands of the state and the societal forces get lesser scope to voice their demand. This trend also reduces the power of professionals. Walt (1994: p.103) states that professionals in the developing countries particularly in India and Latin America, appear to have much less power than their Western counterparts due to the absence of control over recruitment, training and regulation of their members.

Thirdly, in most developing countries, health sector has not yet emerged as a corporate system as it is in the capitalist society of America and in most of the developed countries. As economy of developing countries is mostly agrarian and informal, market is less developed in these countries. Due to poor economic condition also, people are less able to provide a market. In absence of a strong market, the state has emerged as the key player. This is because in most of the developing countries, despite the predominant role of the private sector in providing services, the health sector is mostly controlled by the state. The governments of developing countries, particularly in Africa and Asia, 'have a major role in directly providing health care, in owning facilities, and in employing health staff' (Green, 1992: p.12). As a result, mainly the government health planners instead of diverse nature of 'rationalizers' challenge professionals in developing countries.

Fourthly, scarcity of financial resources in developing countries has made donor agencies another dominant policy actor which is non-existent in developed countries. Health systems of developing countries are significantly dependent on foreign aid, which influences policy priority, allocation of resources and creates scope to the donor agencies to emerge as important policy actors. In addition, due to the unavailability and inaccessibility of health services provided by the government, voluntary agencies emerge as another policy actor in developing countries, which is not evident in developed countries. These voluntary agencies popularly known as NGOs (Non-governmental Organizations) play important role in providing health services to the poor.

Although almost all the developing countries share the above mentioned common policy environment in general, the nature of their implication is highly variable among countries again. Likewise, the

Bangladeshi policy context also has certain special features that are distinguishable from other developing countries. They are the following:

Firstly, the legacies of long history of British colonial rule and subsequent military rule have left the political system of Bangladesh mostly autocratic. Consequently, national decision making including the health sector decisions has become highly centralized compared to neighbouring India and Srilanka. The Ministry of Health is responsible for the formulation and implementation of the national health policy as well as for the organization and management of the delivery of health services. While in India the Ministry of Health is mainly responsible for policy formation and regulatory functions and the policy is carried out by the states (Roemer, 1991). The centralized decision making system in Bangladesh leaves lesser scope to the professionals and other interest groups to be dominant over the policy.

Secondly, professionals in Bangladesh are mostly challenged by the government as most of them are government employees. As the health system is centralized, professionals are accountable to higher level government instead of local level managers. This system contrasts to the Srilankan system as well as the Chinese system where health professionals are accountable to local bodies for their performance who act as the challengers of their interests. Thus the composition of challenging interests of Bangladesh also varies from other developing countries. Although the health sector of Bangladesh is almost privatised, most of the private practitioners are the government employees and as the private sector is managed by small-scale carers, interests of private employers as 'corporate rationalizers' are less prominent here.

Thirdly, resource scarcity and incapacity of government to provide quality service have generated two significant policy actors in Bangladesh: NGOs and the donor agencies. Influence of donors over the health policy of Bangladesh is highly pervasive compared to even in neighbouring India. This is because India is much less dependent on foreign aid (0.6% of GNP in 1996) than Bangladesh (3.9% of GNP in 1996)\*. On the other hand, in Bangladesh, hundreds of NGOs are

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\* World Development Indicators, 1998; The World Bank, Washington D.C. USA

playing the key role in providing health services in contrast to another neighbouring country Pakistan. In Pakistan, Roemer (1991: p.496) notes that there are a small number of nongovernment but nonprofit health activities performed by religious missions and voluntary agencies. The World Bank (1995) has also termed the Bangladeshi NGOs as 'unusually strong'.

Given these differences of policy contexts of developed and developing countries and also of Bangladesh from other developing countries, it is seen that theories derived from the studies of industrially developed countries can not be instantly applied for studying the health policies of developing countries. As even the contexts of developing countries also vary from each other, it is argued that it would not be useful to apply the existing theories to the case of Bangladesh without a factual study of the Bangladeshi system. Varieties of socio-political and economic forces peculiar to every single country shape a specific nature of policy context which in turn, produces a different kind of health policy. As a result, although Alford's theory as well as other theories of policy making derived from the studies of developed countries can provide the basis of a systematic analysis of the health policy of a developing country like Bangladesh, they can not be utilised directly without an empirical study of the Bangladeshi system.

#### Conclusion

In conclusion we must keep it in mind that the objective of the paper was not to abandon the existing theories in analysing the policies of developing countries. Rather we must admit that the existing theories of policy making provide a unique sense of direction for empirical analysis of a policy in general. What the paper has tried to show is that the implication of these theories in case of developing countries is not that much wide-ranging. Although for a broad, general understanding of the dynamics of the policy process of developing countries the existing theories provide useful guidelines, they are found less adequate for an in-depth analysis. This is because every policy has got its own policy network which varies depending on

policy contexts. Socio-economic and political conditions of a country determine or shape the network of a particular policy. Due to these contextual factors, as the paper shows, theories originated in the developed countries cannot sufficiently explain the policies of developing countries. The paper has identified certain contextual factors why Alford's theory of structural interests in health, despite all its strength, is insufficient to explain the health policy of Bangladesh. As even the contexts of developing countries also vary from each other, it is suggested that it would not be useful to apply the existing theories instantly to the case of a country without a factual study. Therefore, it is very important to understand the policy context first while employing a theory to analyse a policy.



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W. P. Ker, *Epic and Romance* (1909; rpt, New York : Dover, 1957), p. 16.

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To make policy in a way that makes it stick, policy makers cannot merely issue edicts. They need to persuade the people who must follow their edicts if those are to become general public practice. In part, that involves persuasion of the public at large: Teddy Roosevelt's "bully pulpit" is one important lever. In part, the persuasion required is of subordinates who must operationalize and implement the policies handed down to them by nominal superiors.