

Stakeholder Convergence on Nutrition Policy: A Cross-Case Comparison of Case Studies in Costa Rica, Brazil and Canada

Ellen Vogel (1), Sandra Burt (2)

(1) Faculty of Health Sciences, University of Ontario Institute of Technology

(2) Department of Political Science, University of Waterloo

In collaboration with an International Technical Cooperation Team¹

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Technical Working Groups in Canada², Costa Rica³ and Brazil⁴

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² Pilot Canadian Case Study Technical Working Group (Phase 1) included Ann Ellis, Nora Lee, Christina Zahaluk, Barbara Legowski, Ranu Sharma, Lise Mathieu.

³ Pilot Costa Rican Case Study Technical Working Group included Luis Tacsan, Roberto del Aguila, Melany Ascencio, Ana Eduvigis Sancho, Fernando Herrera, Guiselle Guzmán, Lorena Agüero, Ileana Quirós, Gabriela Solano, José Alberto Sequeira, Marta López, Gioconda Padilla, Jessica MacDonald.

⁴ Pilot Brazilian Case Study Technical Working Group included Dr. Denise Bomtempo Birche de Carvalho, Dr. Deborah Carvalho Malta, Dr. Elizabeth Carmen Duarte, Lenildo de Moura, Otaliba Libânio de Moraes Neto, Ana Beatriz Vasconcelos, Anelise Rizzolo, Marília Leão.

Introduction

Studies conducted by the World Health Organization's (WHO) CINDI⁵ and CARMEN⁶ networks have documented common health policy challenges across the Americas (Pan American Health Organization, 2005). Currently, there are a paucity of data to assist decision-makers in evaluating policies aimed at both preventing and controlling chronic non-communicable diseases (NCDs) namely, obesity, diabetes mellitus, cardiovascular disease, hypertension and stroke, and some types of cancer (WHO, 2004). Mortality, morbidity, and disability attributed to the major chronic NCDs now represents about 60% of all deaths and 47% of the global burden of disease. These figures are expected to rise to 73% and 60%, respectively, by 2020 (WHO, 2002). Health economists caution that significant costs associated with the projected chronic NCDs epidemic must be factored into already over-taxed national health budgets.

In 2003, recognizing the need to strengthen chronic NCDs prevention and control measures, Member States of the Pan American Health Organization (PAHO), requested that Canada assume a lead role in establishing the first CARMEN Observatory On Chronic Non-communicable Diseases Policy in the Americas⁷. The goal of the observatory was to support the development of integrated chronic diseases prevention policies⁸ through the systematic analysis of policy formulation, approval and implementation processes. In 2004, funding from Health Canada's International Affairs Directorate moved the concept of a policy observatory forward.

An initial project involved the design of three pilot case studies implemented in Costa Rica, Brazil and Canada in 2005-2006. Each study examined nutrition policy formulation and approval processes aimed at preventing and controlling chronic NCDs at the country-level. Importantly, the case studies utilized a common methodology to address three research questions:

- What were the processes by which nutrition policies were formulated and approved?

⁵ Countrywide Integrated Noncommunicable Diseases Intervention programme, an initiative of the World Health Organization's Regional Office for Europe

⁶ Spanish acronym for *Conjunto de Acciones para la Reducción Multifactorial de las Enfermedades No-transmisibles* [Initiative for Integrated Prevention of Non-communicable Diseases in the Americas]. CARMEN, an initiative of the Pan American Health Organization's Regional Office for the Americas, and promoted by the World Health Organization

⁷ The World Health Organization's Collaborating Centre on Non-communicable Diseases Policy is located in the Centre for Chronic Diseases and Control, under the auspices of the Public Health Agency of Canada (formerly Health Canada). The Centre plays a lead role in the development of the CARMEN Observatory On Chronic Non-communicable Diseases Policy.

⁸ Integrated chronic disease prevention refers to the determination and simultaneous confrontation of risk factors common to several chronic non-communicable diseases; interventions that address common risk factors through the health system and other existing community structures; a comprehensive approach that combines varying strategies for implementation; intersectoral action to implement health policies to address the major determinants of health that fall outside the remit of the health system; efforts to combine population and high-risk approaches by linking prevention actions of various components of the health system, including health promotion, public health services, primary care and hospital care (adapted CARMEN Management Group Meeting, Glossary of Terms, March 18-19, 2007)

- What were the key conditions and factors influencing the formulation and approval of the nutrition policies?
- What were the salient lessons learned about intersectoral approaches to nutrition policy formulation and approval?

Rationale for Case Study Research

Industrialization, urbanization, economic development and market globalization have resulted in significant diet and lifestyle changes over the past decade (WHO, 2003, p. 1). Current evidence indicates that negative health and nutrition outcomes in populations, particularly in developing countries and in countries in transition, are the result of these political, economic, social, and environmental shifts:

While standards of living have improved, food availability has expanded and become more diversified, and access to services has increased, there have also been significant negative consequences in terms of inappropriate dietary patterns, decreased physical activities and increased tobacco use, and a corresponding increase in diet-related chronic diseases especially among poor people (WHO, 2003, p. 1).

To implement more effective and sustainable policies to deal with escalating public health challenges, experts call for a new platform, “not just of dietary and nutrient targets” (WHO, 2003, p. 2), but of a broader examination of the determinants of nutritional health (e.g., ecological, societal, and behavioral aspects beyond causation mechanisms). This platform, proposed by the WHO, is highly congruent with the components of a population health approach⁹--a key orientation of Health Canada since the mid-1990s (Health Canada, 1994).

While nutrition has emerged as a major modifiable determinant of chronic NCDs, in many developing countries food policies remain focused only on undernutrition and fail to address the prevention of chronic NCDs (WHO, 2003). In Canada, decision-makers recognize that to address complex issues (e.g., prevention of chronic NCDs and/or food insecurity¹⁰) nutrition considerations must be integrated into health, agriculture, education, social and economic policies and programs (Health Canada, 1996). However, taking action has proved challenging and examples of effective intersectoral nutrition policy innovation in the Americas are limited. Experts emphasize that long-term and sustainable nutrition policies require actively involving non-health sectors in meaningful deliberations; improving the coordination of nutrition policymaking across jurisdictions; and examining virtually all public policy through a health and nutrition lens (Cash, 2004).

⁹ The goal of the population health approach is to reduce inequities in health among population groups. An essential feature is directing interventions towards broad, systemic determinants, many of which lie outside the traditional healthcare system. Thus, developing, fostering and supporting collaborations between multiple sectors (e.g., government, industry and voluntary sector) are critical success factors.

¹⁰ Food security implies that all people, at all times, have access to sufficient, nutritious, safe, personally acceptable and culturally appropriate foods that are produced, procured and distributed in ways that are environmentally sound, socially just, and sustainable (adapted from Fairholm, 1999).

In this international research project, we posit that a cross-case comparison of findings emerging from three nutrition case studies will add to the current evidence-base by (a) illuminating a range of effective policy levers in both preventing and controlling chronic NCDs; (b) describing requisites for policy formulation and approval in diverse settings; (c) assessing capacities for systematic data collection and analysis at multiple levels; and (d) initiating intersectoral technical support in policy review and analysis.

Research Design

The policy cycle has five stages: agenda-setting, policy formulation, decision-making, implementation, and evaluation (Howlett & Ramesh, 1995). Some analysts suggest that the first stage (i.e., agenda-setting) is the most important as it “sets the stage” for later events. This is the point in the policy cycle when governments generally, or departments specifically, decide to take action on an issue. The way in which the issue is framed, or conceptualized, will affect the shape of the policy that emerges. Early agreement among stakeholders on a common issue frame has been shown to facilitate the policy development process (Campbell et al., 2005).

In this study we focus on the first three stages in the policy cycle in order to impose boundaries on a complex research design, international in scope, and requiring significant coordination and monitoring. However, we recognize that issues related to later stages in the cycle may have an impact on the policy formulation process. In our Conceptual Framework, presented in Appendix 1, we consider the following: (a) formal and informal processes, (b) nature and availability of evidence, (c) human and fiscal resources, and (d) policy-making capacities¹¹ at the level of the individual, organization and system. Implicit in our analysis is the recognition that a major goal of policy formulation is to achieve consensus (i.e., stakeholder convergence) on how best to address a policy idea.

A unique strength of the case study is its ability to deal with a full variety of evidence (Yin, 1989). Data collection in the three countries drew extensively on multiple sources of information. This strategy served as an internal validity/credibility check (triangulation) such that data obtained by one method could be checked against data obtained by another method (Miles & Huberman, 1994). Data-collection methods included: (a) extensive document review (e.g., peer-reviewed articles; government reports; “expert knowledge” of individuals, groups and networks; parliamentary records; media reports; and (b) key informant interviews¹². Key informants were identified through a “snowball sampling” process (Patton, 1987) and all agreed to sign an informed

¹¹ Capacity-building refers to a long-term and ongoing process of developing enabling environments with appropriate policy and legal frameworks; institutional development including community participation; human resources development; and strengthened managerial systems. More specifically, capacity-building refers to the development of technical expertise to plan, implement and evaluate policies, action plans and programs, as well as interventions aimed at preventing or controlling non-communicable diseases in a variety of settings. (CARMEN Management Group Meeting, Glossary of Terms, March 18-19, 2007)

¹² In Costa Rica, 20 key informant interviews were conducted; in Brazil, 16 key informant interviews were conducted; and in Canada, 24 key informant interviews were conducted.

consent in keeping with research ethics protocols at the country-level. Each interview, approximately 90-minutes in duration, was completed using a semi-structured interview guide¹³ (translated and back-translated in English, Spanish and Portuguese).

An overview of the case studies follows. In this paper we focus on a selection of requisites identified through the research including leadership; intersectoral partnerships and coalitions (i.e., policy networks¹⁴); and demonstrated political support. In analyzing policy networks, we use a descriptive tool entitled, policy community diagrams¹⁵, to indicate the relative position of key stakeholders (e.g., government agencies, NGOs, advocacy groups, media and interested individuals) *vis-à-vis* their relationship to government decision-makers at two points-in-time, the beginning and the end of the policy formulation process. These policy community diagrams, developed for each case study during the final stages of the process, are presented in Appendices 2, 3 and 4. In the concluding paragraph we provide a “snap-shot” of lessons learned specific to each case.

Costa Rican Case Study Overview: “Formulation of the Policy on Fortification of Wheat Flour with Folic Acid”

In 1996, a national nutrition survey in Costa Rica identified nutritional deficiencies including vitamin A, iron and folate. A national decree on the fortification of wheat flour with folic acid, approved in 1997, was designed to decrease the prevalence of congenital defects, including neural tube defects¹⁶, which constituted the second leading cause of infant mortality in Costa Rica. The goal of the case study was to analyze the development, negotiation and approval of the decree in order to generate evidence on the drafting of public health policy.

In the 1980s and early 1990s, there were complex transformations in the economic, social and political infrastructure in Costa Rica. For example, during this period the country transitioned from an economy regulated by the State to an economy open to free trade. The underlying premise was that international trade would serve as an “engine for

¹³ Readers interested in obtaining a copy of the CARMEN Key Informant Interview Guide should contact Dr. Ellen Vogel at ellen.vogel@uoit.ca or Dr. Sandra Burt at sburt@watarts.uwaterloo.ca

¹⁴ Network refers to formal or informal social relations and links between individuals and/or institutions that may provide access to, or mobilize support, information and resources (CARMEN Management Group Meeting, Glossary of Terms, March 18-19, 2007)

¹⁵ The concept of policy communities was introduced by Paul Pross in 1992. The “bubble diagram” tool allows researchers and/or policy analysts to visualize the relative positions of key stakeholders and to better understand their influence in the policy development process. Information gleaned through the data analysis determines where researchers position each stakeholder group within the policy community diagram. By examining the “shape” of a specific policy community at different points, it is possible to track shifts in stakeholders’ positions over time. Generally speaking, significant movement towards the centre of the diagram suggests that stakeholder convergence was achieved with decision-makers on a policy issue. Importantly, the descriptive tool is not intended to provide researchers with information pertaining to the substance and/or content of the policy.

¹⁶ Neural tube defects refer to abnormalities of the brain and spinal cord apparent at birth and believed to be related to a woman’s folate intake before and during pregnancy (Sizer and Whitney, 2006, p. GL-11)

economic development”, requiring that Costa Rica become competitive with foreign markets.

Historically, Costa Rica imported wheat flour from the United States. In the late 1960s, an “*import substitution model*” was developed and, in 1967, the first domestic wheat processing industry was established under the Industrial Development Act. For the next decade, the supply of wheat flour was heavily regulated by the State through the *Consejo Nacional de Producción* [National Production Council] and one mill produced 100% of the country’s flour. With the liberalization of the national economy, a second mill was established in 1979. As a result of Costa Rica adopting free trade practices, the National Production Council lost control over the importation of wheat and, in the 1980s, import barriers and price controls for both wheat and bread were no longer in effect.

In the wheat flour fortification policy, a working group comprised of Ministry of Health officials, with responsibilities for nutrition surveillance and monitoring, established strong alliances with the regional health authorities, “*becoming their advisors in matters of nutrition, and lending technical support to the policies proposed by the new government.*” The health authorities, on the other hand, provided the resources necessary to facilitate the technical processes. In this way, the working group team successfully managed to include the policy idea in the spectrum of health priorities established by the new government.

Policy actors included representatives of government organizations, NGOs, academic institutions, media, pharmaceutical industry and two milling companies (Appendix 2). Consumer advocacy groups are not represented in the policy community diagram as findings suggested that they did not have a significant role to play. The authors emphasize that the health authorities did not engage industry stakeholders in a discussion on the feasibility of fortifying wheat flour with folic acid. Rather, their strategy was to secure industry support for a policy decision already enacted by the Ministry of Health. However, the working group realized that industry collaboration was critical to success: “*an authoritarian attitude [on the part of government] would not facilitative an environment conducive to implementing the policy.*” This understanding assisted the Ministry of Health officials in convincing industry of the importance of the measure and in achieving a sustainable alliance.

Key success factors identified through the research include “*approaching the policy process from a technical point of view*” (i.e., weighing the strength of the scientific evidence); highlighting the cost effectiveness of the proposed intervention; and emphasizing historical precedents (e.g., alliance with the salt industry in which iodine fortification proved to be a highly effective public health measure). Consulting with expert international bodies such as the Food and Agriculture Organization of the United Nations was also deemed helpful.

■ “Snap shot” of lessons learned

The nutrition policy was formulated, negotiated and approved in a favourable national and international environment, although in the early stages industry stakeholders expressed both technological and financial concerns. A clearly articulated political decision, combined with the efforts of a highly motivated and knowledgeable team situated within the Ministry of Health, and a business sector that was receptive to change, all facilitated consensus-building and the mobilization of policy actors to obtain and ensure the sustainability of a social good. The authors identified facilitators in the policy formulation process namely, effective political-technical and public-private alliances; a strong body of scientific evidence; a feasible implementation strategy; teamwork; and most importantly, social responsibility.

Brazilian Case Study Overview: “*Process for Setting an Agenda and Formulating Public Policy on the Prevention, Control and Surveillance of NCDs in Brazil: An Analysis of the National Diet and Nutrition Policy (1999-2005)*”

This case study analyzes the formulation of the Brazilian National Diet and Nutrition Policy¹⁷ (PNAN), a complex, highly ambitious and leading-edge directive formulated on a constitutional principle (i.e., “*adequate food as a basic human right*”). The Ministry of Health assumed a lead role, in partnership with other ministries including: Planning, Budgeting and Management; Social Development and Hunger Alleviation; and Education. In 1999, the Ministry of Health approved PNAN as part of the National Health Policy in Brazil.

In 1996, Brazil experienced a State crisis that resulted in the dismantling of the *Instituto de Alimentação e Nutrição (INAN)* [Diet and Nutrition Institute]. The PNAN was initially envisioned “*with the studies and programs conducted and/or coordinated by INAN under the direction of Dr. Bertoldo Cruze Grande de Arruada*” and its design was facilitated by the preparation of a report presented to the World Food Summit in Rome (1996). At this stage, a group of nutrition professionals, public policy managers, and researchers was charged with coordinating PNAN formulation within the Ministry of Health. The group was comprised almost entirely of technical experts and/or managers who had been employed by INAN, prior to the mid-1990s. Thus, former INAN staff continued to play a lead role, together with the National Diet and Nutrition Council; Tripartite Commission; academic institutions, media, and international organizations such as WHO and UNICEF (see Appendix 3).

The PNAN is a set of government policies, implemented by the health sector, with a goal of incorporating the universal human right to food and nutrition into the national health policy. The policies are supported by a regulatory framework including: (a) intersectoral actions that provide universal access to food; (b) quality assurance mechanisms applicable to both food products and services; (c) nutrition surveillance and monitoring; (d) promotion of healthy eating habits and lifestyles; (e) prevention and control of nutritional disorders and illnesses associated with food and nutrition; (f) promotion of research; and (g) human resources development and training (Ministry of Health, 2003).

¹⁷ The Brazilian Food and Nutrition Policy, part of the National Food And Nutrition Policy, is available in English at <http://www.saude.gov.br/alimentacao>

Reflecting on the breadth of PNAN, and the significant cross-sectoral involvement, one key informant compared the complexity of the policy formulation process to constructing a patchwork quilt: *“it was like a patchwork quilt, stitching together different thematic issues, concepts, and strategies that were fundamental for determining the aims of the policy.”*

The authors caution that the adoption of the PNAN does not necessarily guarantee effective implementation. Accomplishing the goal of *“food as a basic right”* was contingent on a high degree of intersectoral action and, in this policy process, considerable effort was required to test the programmatic implications of the policy discourse. For example, it was not uncommon for policy actors to ask: *“What does this new discourse [human right to adequate food] mean? Is it primarily rhetorical, or, does it have programmatic consistency?”* The debate centered on how implementation of PNAN would change the nature of the relationship between government institutions and the “beneficiaries” of public services. Embedding PNAN in the Universal Declaration of Human Rights meant that individuals could no longer be seen as passive recipients and/or “targets” of public policies. Rather, civil society must now be considered an active participant in all stages of the policy process. This change in mindset necessitated that professionals, especially those involved with the delivery of health and social services, participate in ongoing training and continuing education programs.

Case study findings suggested that at the organization level (i.e., within the federal government) there were key success factors for intersectoral nutrition policy formulation, including, but not limited to:

“a national issue translated by the epidemiological relevance of the problem and placed on the government’s public agenda to respond to social demands that were seen as significant public health challenges; a favorable climate in the Ministry of Health in that the department of diet and nutrition (human, technical, and financial resources) was being reorganized; and political pressure from government and civil society players interested in redefining government priorities and actions in the field of diet and nutrition.”

Barriers to the formulation of PNAN included disputes between experts (physicians and nutritionists); fragmentation of chronic NCDs policies and programs in the Ministry of Health; challenges associated with establishing regulatory frameworks for food production; marketing and labeling issues; and lack of political and technical agreement on terminology (i.e., definitions of hunger, malnutrition and food security). Further, establishing effective partnerships with the private sector (e.g., food industry) was challenging. One government decision-maker suggested a Code of Ethics to assist with private sector negotiations:

“the trend is to retreat and not to want a lot of dialogue, because we are afraid of conflicts of interest and even more in a time of crisis . . . this is something that the policy [PHAN] does not deal with and that we will have to tackle at some point.”

Despite the barriers, PNAN was formulated in a highly participatory manner with significant involvement of civil society. The authors posit that the policy formulation process was largely responsible for re-focusing national diet and food policies on the prevention and control of chronic NCDs, and not solely on undernutrition.

■ “Snap shot” of lessons learned

Placing the topic of food security on the national agenda by adopting a policy on diet and nutrition that includes a regulatory framework (ministerial directive) served to raise awareness of chronic NCDs in Brazil and importantly, the need to take preventive action. Policy actors consider PNAN to be “*advanced and modern*” and the guidelines were successfully implemented in the early 2000s (e.g., *bolsa-alimentacao* [cash transfers for food] introduced in 2003; and the *bolsa-familia* [cash transfers for low-income families] introduced in 2004). The policy process resulted in the increased participation of government and civil society and it was strengthened by other chronic NCDs prevention initiatives (e.g., anti-tobacco mobilization). International cooperation was helpful as was the high level of political support that drove the process nationally.

Canadian Case Study Overview: “Stakeholder Convergence on Nutrition Labelling: Building Consensus on a Complex Issue”

In 2002, mandatory nutrition labelling was introduced in Canada. The scope of the regulations place Canada at the forefront of nutrition labelling, and the initiative is widely regarded as ground-breaking from a health policy perspective. Over the next 20 years, the accrued benefits to Canadians will be in the range of \$5 billion, an estimate based on reductions in direct and indirect costs associated with cancer, diabetes, coronary heart disease and strokes (Health Canada, 2003).

Under the new system, the labels of most pre-packaged foods sold in Canada must carry a *Nutrition Facts* table. Consumer interests and health needs, combined with recent advances in nutritional science, contributed to the innovative design and content of the *Nutrition Facts* table. The mandatory regulations include updated criteria for nutrient content claims to better address consumer health issues. For the first time in Canada, diet-related health claims are allowed that highlight the relationship of certain nutrients and foods with the reduction of heart disease, cancer, high blood pressure and osteoporosis.

The 2002 regulations address three inter-related topics (i.e., nutrition labelling, nutrient content claims, and health claims). Importantly, the policy development process for these initiatives “followed separate collaborative routes of documentation, expert and stakeholder consultations and feedback.”¹⁸ However, an unexpected result, was the regulations pertaining to nutrition labelling, nutrient content claims, and health claims being merged into one comprehensive “policy package” in the publication of the Canada Gazette, Part II (January 1, 2003).

¹⁸ Memorandum To The Minister, Amendment to Food and Drug Regulations, Schedule No. 1172, *Nutrition Labelling*, (undated). Health Canada, p. 1.

Health Canada used a criterion-based, decision-making process that involved consensus-building together with regular, relevant and sufficient communication with policy actors. Individuals from a wide variety of backgrounds were recruited for consultation through the lengthy process. The nutrition labelling policy community included academics and key representatives of trade associations; advocacy and consumer organizations; professional associations; health groups; topic experts; and other federal government departments (Appendix 4). Of special importance was the Federal/Provincial/Territorial Group on Nutrition, described by a key informant as a “*sounding board*.”

Findings provide strong evidence that the nutrition labelling policy-making process was complex, often chaotic and unpredictable, hampered by a shortage of human and financial resources, and negatively affected by policy silos¹⁹. In spite of formidable barriers and very tight timelines, a high degree of stakeholder convergence developed and this convergence facilitated the process of ground-breaking policy development. Stakeholder convergence on nutrition labeling was largely due to three main factors: (1) a common health policy frame adopted by all participants in the consultative process; (2) the emergence of strong “champions” within the federal government’s health policy sector; and (3) the implementation of an innovative policy development process overseen by an intersectoral Nutrition Labelling Advisory Committee.

The study conclusions position findings within a framework depicting policy-making capacity (PMC) at three levels: individual, organization and system. Evidence indicates that high PMC at both the individual and system levels, combined with medium PMC at the organization level, resulted in stakeholder convergence on issue frames, and ultimately, in policy adoption. Gaps in PMC, particularly at the organization level, included barriers in securing resources necessary to enforce the new mandatory regulations. The dichotomy between policy formulation and implementation²⁰ suggests that, while there was convergence at the policy development stage, there may be challenges at the implementation stage (e.g., enforcement of the nutrition labelling regulations).

■ “Snap shot” of lessons learned

The findings suggest that when organizational policy-making capacity is weak, partially as a result of resource shortages and/or restructuring, policy makers must implement strategic change management practices in order to overcome roadblocks. Further, policy silos at the organization level (e.g., health and agriculture sectors having different

¹⁹ Note: Policy silos, as described by Lavis (2001), refer to the lack of organizational capacity to transcend non-traditional policy boundaries to produce harmonized policy outputs across sectors.

²⁰ Note: The idea pertaining to a “dichotomy between policy making and implementation” was partly informed by the following article: Sutton, R. (1999). *The Policy Process: An Overview*. London, UK: Chameleon Press, p. 22.

mandates and priorities with respect to nutrition labelling) can sabotage intersectoral policy-making. However, the authors conclude that these barriers can be mitigated, and stakeholder convergence achieved, when policy-making capacities at both the individual and system level are high.

Comparing the Three Cases

Costa Rica

Costa Rica, located in Central America, has a surface area of 51,100 km, a population of just over 4 million inhabitants, with a life expectancy at birth of 78.4 years and under-five mortality at 11 per 1,000. Its publicly-funded, comprehensive and universal healthcare system is considered leading-edge and has brought Costa Rica's health indicators in line with those of OECD countries. Currently, the per capita health expenditure in Costa Rica is \$562; public healthcare as a percentage of GDP is 4.9; and private healthcare as percentage of GDP is 2.3²¹.

Since 1949, Costa Rica has had a strong democratic tradition. More recently, the country has gone through a series of economic crises that have negatively affected the capacity of the country's healthcare system. Further, in the 1990s, the country moved from a state-regulated to an open market, free trade economy. In 1994, Costa Rica implemented a Health Sector Reform Project in response to an emerging healthcare crisis, with heavy reliance on support from international organizations such as the World Bank and the Interamerican Development Bank.

Brazil

Brazil occupies most of the eastern part of the South American continent. It is exceeded in size by four other countries world-wide: Russia, Canada, China, and the United States (including Alaska). In 1996, the population of Brazil was estimated at 160 million inhabitants, with a life expectancy at birth of 72.2 years. Per capita expenditures on healthcare grew from US \$36.3 to US \$100.5 between 1980-81 and 1990-95, or about 177%. In contrast, the increase in public health expenditure was 6.6%.²²

In comparison to Costa Rica, Brazil has had a more turbulent political history. After years of dictatorship (1964-1990), Brazil moved to democratic elections in 1990. In the years that followed, the leadership was fragile and unstable. Fernando Collor de Mello was elected President in that year, and began the shift to a free-market economy. But the country did not perform well economically, with a monthly inflation rate of over 80%. In 1992, the President was charged with widespread corruption. After an impeachment process, he resigned, and was replaced by Itamar Franco. There was yet another shift in leadership in 1995, with the election of Fernando Henrique Cardoso.

²¹ Costa Rican Health Care: A Maturing Comprehensive System (Greg Connolly, 2002)

²² World Bank, 1995

Canada

In 2006, the population was estimated at just over 33 million inhabitants, with a life expectancy at birth of 79.7 years, and under-five mortality at 7 per 1,000. For over 30 years Canadians have been very proud of their universal healthcare program (Medicare). However, escalating costs and decreasing consumer satisfaction levels are causing serious challenges. The situation is exacerbated by the fact that the ten provinces, responsible for most of the administration, are now allocating close to 30% of annual provincial budgets to healthcare. Governments at all levels are examining a range of solutions including a degree of privatization; fee-for-service options, as well as major restructuring of the healthcare system to ensure its long-term viability. In 2004, per capita health expenditure in Canada was \$2,792; public healthcare as percentage of GDP: 6.8; and private healthcare as percentage of GDP: 2.8.²³

In comparison to both Costa Rica and Brazil, Canada is more developed economically, and has a much longer tradition of democratic practice. The country had a majority Liberal government, led by Jean Chrétien, during the time that the nutrition labelling policy formulation process occurred. Similar to both Costa Rica and Brazil, Canada underwent significant economic restructuring throughout the 1990s, as it moved away from a welfare state model to neoliberal economic policies of free markets and privatization.

Summary

It is important to note that, among the three countries, there are commonalities including a neoliberal ideological umbrella. Further, each country is experiencing significant healthcare stresses (e.g., rising costs associated with aging populations, escalating rates of overweight and obesity, and associated increases in the prevalence of chronic NCDs). In the mid-to-late 1990s, all three countries adopted health promotion strategies, with a growing emphasis on consumer education, and a focus on healthy eating and active living choices. Increasingly, the World Health Organization's definition of food security is a key factor in policy development and it underpins national action plans on nutrition. Over the past decade, nutrition was ranked as a higher priority on the agenda of the national government in each of the three countries.

Methodologically, the cross-case comparison was facilitated by the research teams' adoption of a common methodological framework (Appendix 1). Further, the three studies were all concerned with aspects of nutrition policy, although they focused on different aspects of the health promotion process. Costa Rica's initiative was the most specific, while Brazil tackled the complex issue of food security, a multi-pronged directive including food quality, promotion of healthy dietary practices, and universal access to food. Canada's policy initiative was middle-range, including nutrition labelling, nutrient content claims and health claims.

The Cross-Case Conceptual Framework

²³ Canadian Health Care: The Universal Model Evolving (Greg Connolly, 2002)

In order to carry out the comparative analysis, we use a framework adapted from the work of Shelley Bowen and Anthony Zwi (2005). Bowen and Zwi propose that we can obtain a good understanding of the policy-making process by focussing on three different levels of capacity: individual, organization and system. The authors are inconclusive about the relative importance of these three levels of capacity. Their work is preliminary, and focussed on suggesting ways in which “evidence” can inform health policy.

In our cross-case comparison we refine the Bowen and Zwi (2005) model, and explore the relative significance of each of the categories within each capacity level, as well as the importance of the levels overall for successful policy outcomes. Our general finding is that, when there is medium-to-high policy-making capacity at the individual and system levels, a policy proposal can move forward to a successful policy outcome, even when capacity at the organization level is medium. We base this conclusion on the combined evidence of the document reviews and key informant interview results, summarized below:

Policy-making Capacity Level	Costa Rica	Brazil	Canada
Individual	Medium → High	High	High
Organization	Medium	High → Medium	Medium
System	Medium → High	High	Medium → High

1) Individual Capacity

In the context of this framework, individuals include policy champions within government, as well as policy advocates in the surrounding stakeholder community. Individual-level capacities refer to individual skills and competencies in the areas of *negotiation* and/or *communication*; *leadership* abilities; establishing *partnerships* and/or *coalition-building*; and the ability to *mobilize technical resources*.

We created five individual-level variables including: values (or frames); leadership; knowledge and skills; resources; and partnerships/networking. In all three countries, individual capacity was high on the first three measures, and medium-to-high on both resources and partnerships/networking. For example, government officials in Costa Rica experienced difficulty initially in establishing alliances with leaders in the food industry. However, this hurdle was overcome when the group of officials responsible for nutrition monitoring within the Ministry of Health presented clear evidence of cost benefits to the flour industry, and called on the help of their allies in the salt industry, where fortification had occurred earlier. The intervention of international bodies also facilitated the networking process in Costa Rica.

Cross-case findings suggest that some individual-level capacities are more important than others. Of particular significance is convergence on the policy frame. Members of the policy networks in all three countries were united by a concern for population health. The driving forces behind this convergence differed somewhat in the three countries, and

this reflects their various political cultures. In Costa Rica and Brazil, international organizations like the WHO and UNICEF's Global Strategy on Diet, Physical Activity and Health were instrumental in convincing stakeholders of the importance of focussing on nutrition in order to improve population health. In Brazil and Canada, consumer demand was a prominent mobilizing factor. This convergence around a population health frame has been found to be a significant factor for the development of health policy in other areas, and in particular in the area of tobacco control (Campbell et al., 2005). The convergence around a population health frame resulted in the creation of policy networks (Pal 1992, p. 12) that brought government "champions" and policy advocates closer together, in a concertation²⁴ network in Costa Rica, and a corporatist network in both Brazil and Canada.

2) Organization Capacity

A closely related factor is organization capacity. Organizations include government departments and branches responsible for the policy area (in this case, national health departments). At this level, capacity refers to the ability of state agencies to *leverage financial resources, forge partnerships with other key government departments, as well as access technological expertise.*

We created five organization-level variables, four of which we rank, on the basis of the case study findings, in descending level of importance, once again building on the work of Bowen and Zwi (2005): leadership; knowledge and technical skills; policy processes and procedures; resource allocation. Cross-case findings indicated that the fifth variable, (i.e., partnerships with other key government departments), varied in significance depending on the scope of the policy. It proved to be very important in Brazil given the sweeping nature of the food security initiative, but of lesser importance in both Costa Rica and Canada. On these measures, we found some organization weaknesses in all three countries, but that the leadership capabilities of individuals in the lead agencies were crucial for moving the policy initiatives forward. This is consistent with our findings pertaining to concertation and corporatist networks.

In each country, there was a strong group of committed government officials who steered the policy process. These "champions" had the support of technical experts both within and outside of government who were able to present clear findings about the health benefits of implementing the policies under consideration. The strength of the scientific evidence proved significant in achieving stakeholder convergence. "Champions" inside government were also adept at modifying existing policy-making practices in order to

²⁴ Leslie Pal defines a corporatist network as one where the state agency is strong and autonomous; there are a few large and powerful groups in the associational system, usually representing both consumer and producer interests; and both the groups and the state agency participate in the policy formulation process. A concertation network is similar, but brings together only the state agency and one organization in the associational system (in the case of Costa Rica, the flour mills). These are apparent in the policy network Appendices 2-4.

overcome existing or potential opposition from the stakeholder community. In Brazil, government officials convened a series of meetings or seminars to engage members of the policy community. They also made compromises designed to encourage industry buy-in. For example, they opted to label the policy as a health sector initiative, rather than a food security initiative, in view of the lack of consensus on a food security agenda. In Canada, officials within Health Canada created a new “corporate approach” that focussed on building partnerships with key stakeholders. For example, they created an intersectoral advisory policy group that operated on the consensus model (Health Canada, 1996, p. 2). Incidentally, this process was consistent with the government’s commitment to new public management practices, and contributed to the department’s credibility.

Importantly, neither the Costa Rican nor the Canadian governments committed sufficient financial resources to their respective policy initiatives. For example, Health Canada did not receive funding for a promised national public awareness campaign on nutrition labelling. Additionally, as discussed earlier, policy silos emerged between Health Canada and Agriculture & Agri-Food Canada, responsible for the Canada Food Inspection Agency (i.e., agency charged with implementing the nutrition policy). In both Canada and Costa Rica, medium-to-low policy-making capacities on these two variables (i.e., resource allocation and partnerships with other key federal government departments) failed to keep the policy proposals from advancing to legislation. However, lower rankings on these two variables may prove to be significant at the implementation level. In Brazil, findings alluded to inter-professional tensions (e.g., between physicians and nutritionists), however policy silos, for the most part, were not considered significant. This was a critical success factor given the complex, intersectoral nature of the food security policy formulation process.

3) System Capacity

The system refers to the entire policy community, including government, interest groups, and the attentive public. At this level we identify four variables: *values* (support of powerful lobby groups, opinion leaders, and government); *ideology* (epistemic communities); *politics* (political will, advocacy strategies, the overall political agenda); and *economics* (funding for implementation; evidence of cost effectiveness).

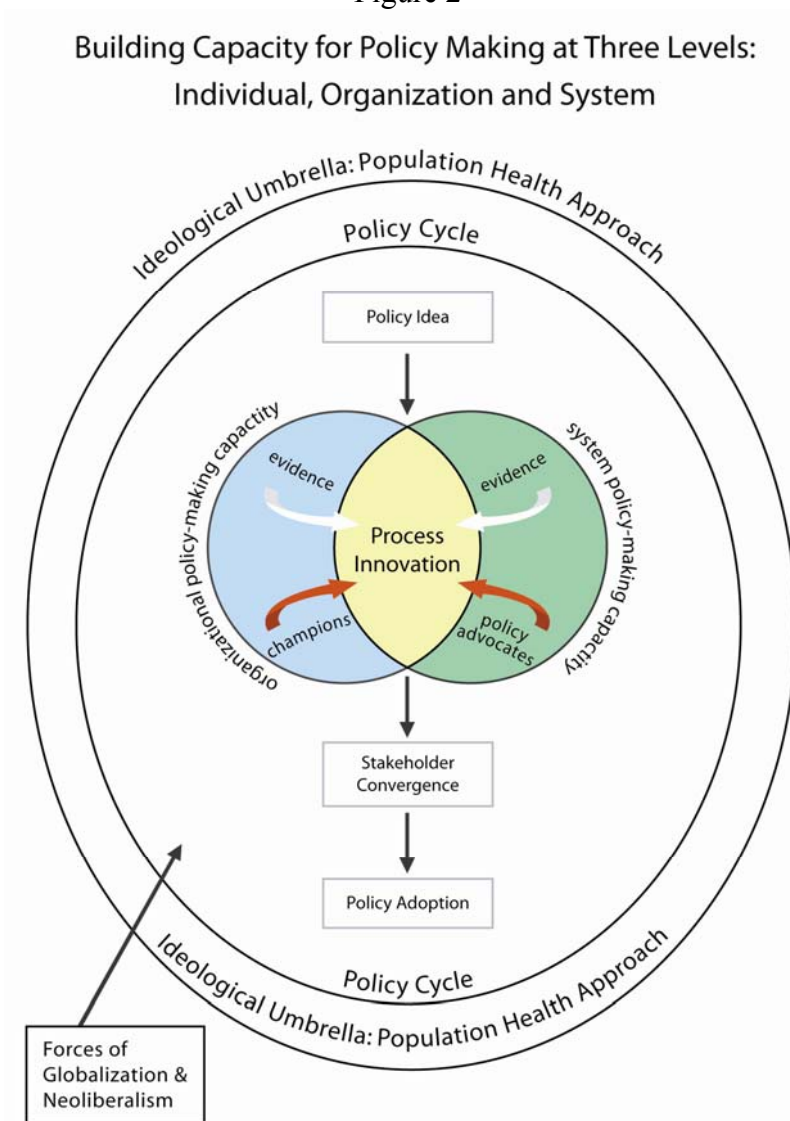
Without exception, the countries ranked high on the first three variables at the system level, with the values dimension shifting from medium-to-high as the processes evolved, reflecting the excellent work done by the internal “champions.” In all countries, the fourth variable (i.e., economics) was ranked as medium-to-high. Cross-case findings confirmed that policy actors in Costa Rica, Brazil and Canada were challenged by a shortage of financial resources, especially in the initial stages of the policy formulation processes. As a result, government officials were forced to be very creative in securing financial support and/or in-kind donations from the stakeholder community.

We are struck by the consistency of the findings at the system level. Without exception, population health was a uniting value for members of the policy networks, and a driving force in moving the nutrition policies onto the political agendas of the three countries.

However, in the case of both Canada and Brazil, high policy-making capacities at the system level were partly a reflection of compromises made by government officials during the policy formulation process (e.g., Brazil’s decision to work within a health frame rather than a food security frame, and Canada’s decision to include some of industry’s requests in the final policy).

Cross-Case Conclusions

Figure 2



In Figure 2, we recast the cross-case findings in a diagram that captures the three levels of policy-making capacities, as well as the significance of the population health value umbrella and important contextual factors such as globalization and neoliberalism. We represent individual policy-making capacity using two red arrows corresponding to “champions” (internal to government) and policy advocates (external to government).

The interactive model depicted in Figure 2 captures the complexity of the policy-making process, as well as the intersection between the three levels of policy-making capacity. The diagram also clearly identifies that our cross-case analysis ends at the adoption stage of the policy cycle.

We conclude that each case study tells an important story of successful nutrition policy innovation and adoption in that all of the stakeholders obtained at least some of their goals. However, until we examine the policy implementation processes in each country (phase two of our study), we cannot be confident that the goals have, in fact, been successfully realized. Our recommendations for future research include a longer-term, comprehensive evaluation to determine whether these policy initiatives have achieved the ultimate goal namely, improving population health.

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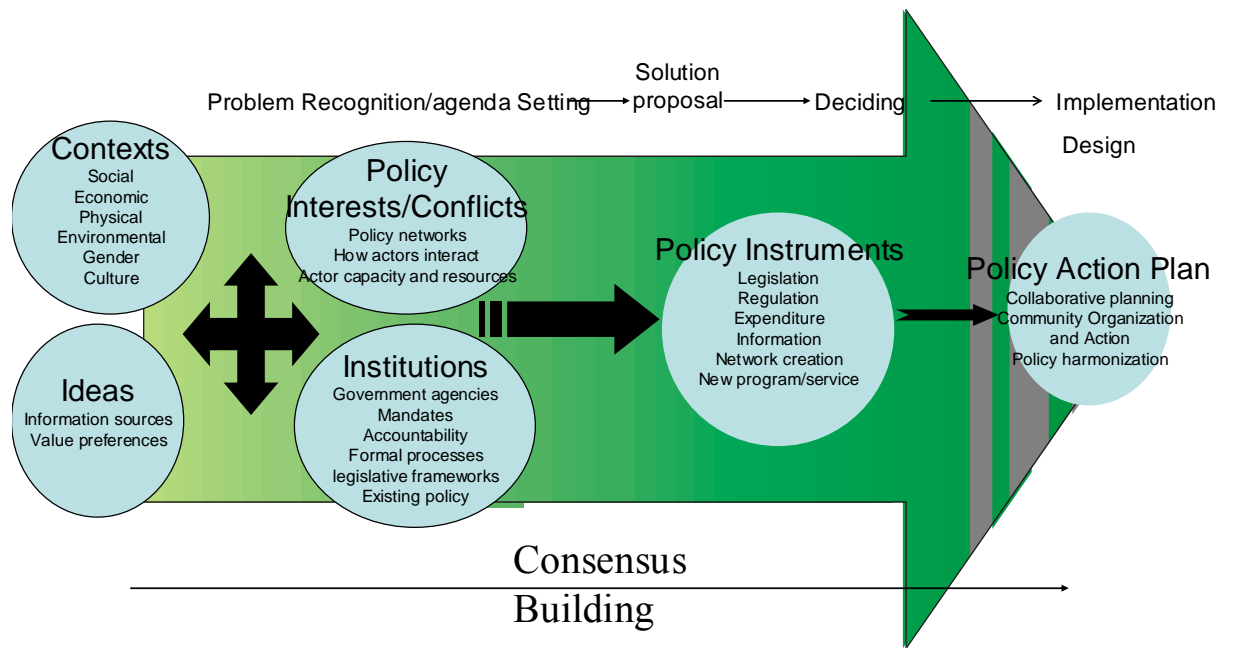
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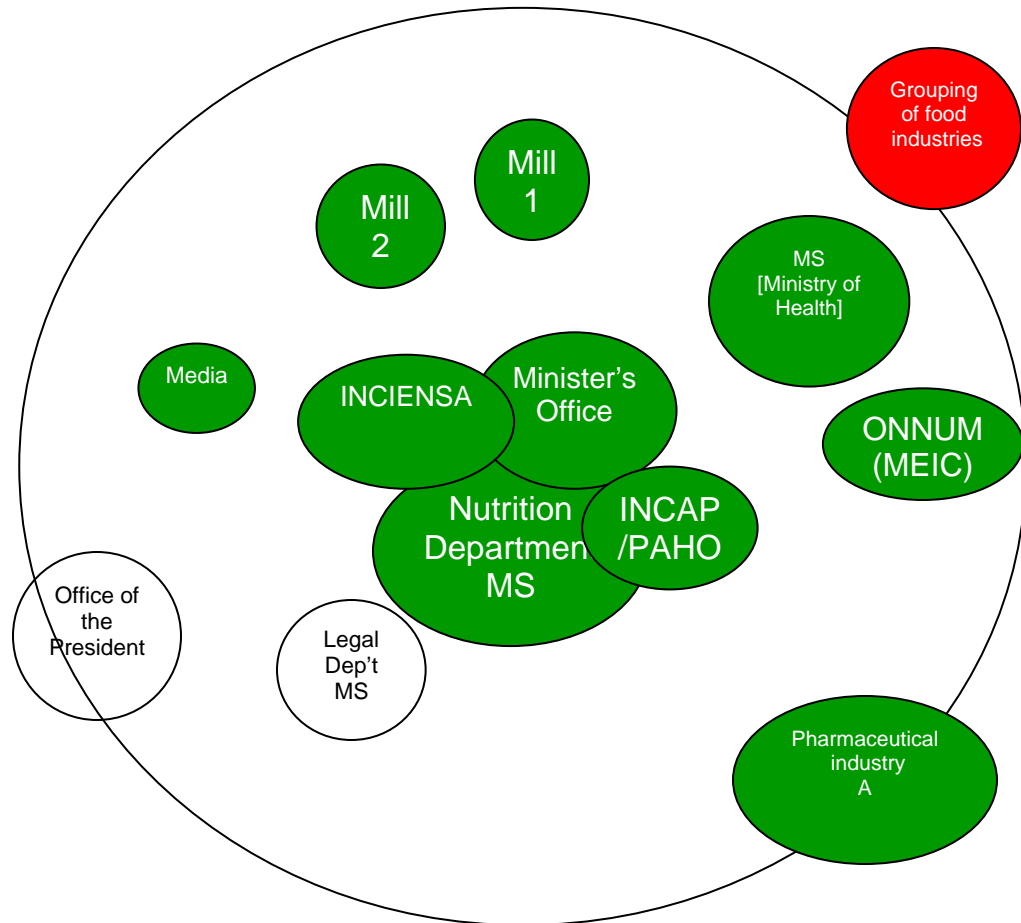
Appendix 1

Analytic Framework - Policy Formulation Stage



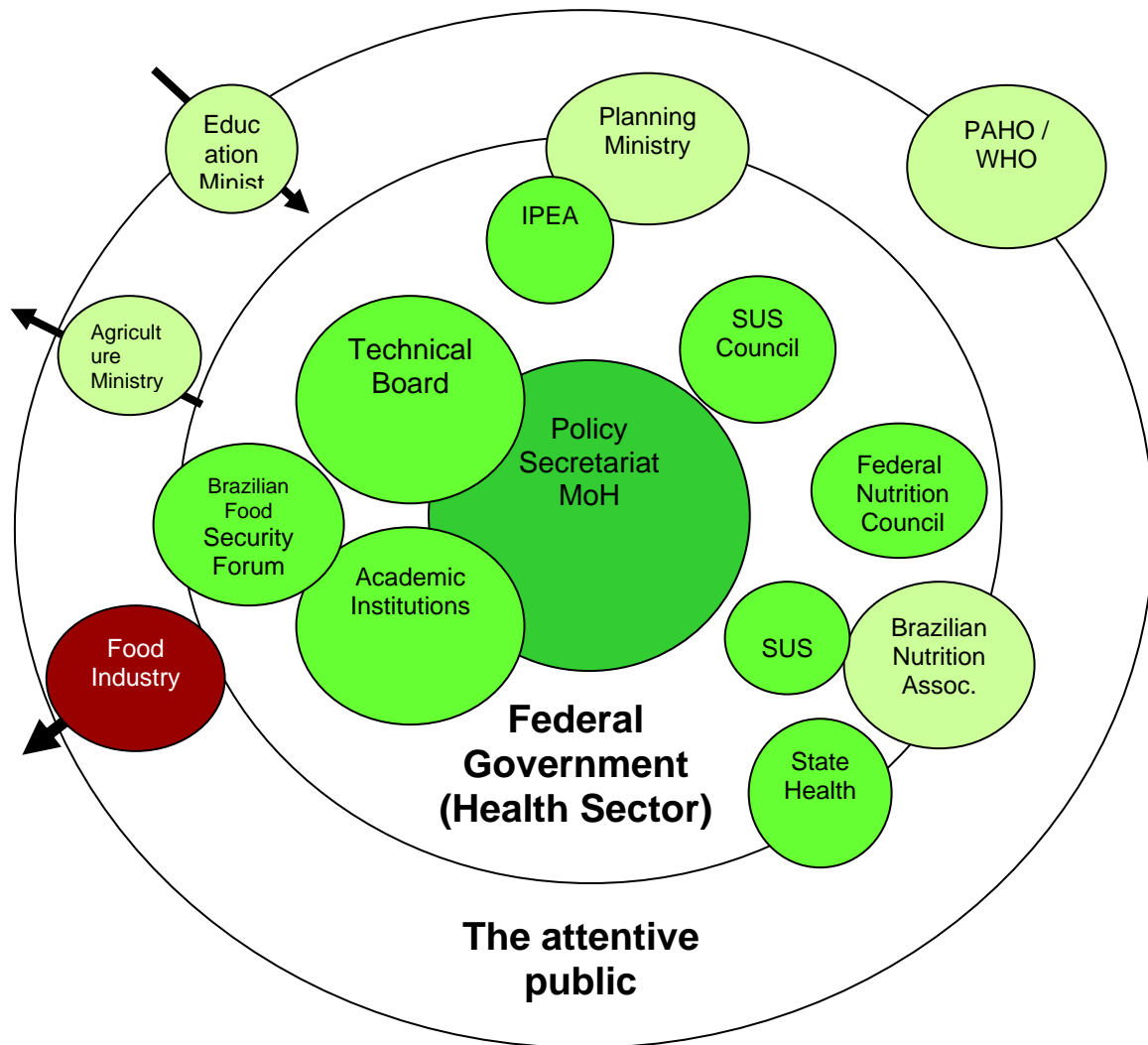
Appendix 2
Policy Community Diagram: Costa Rica (1997)

Diagram 5: Participation by actors in formulation of the policy

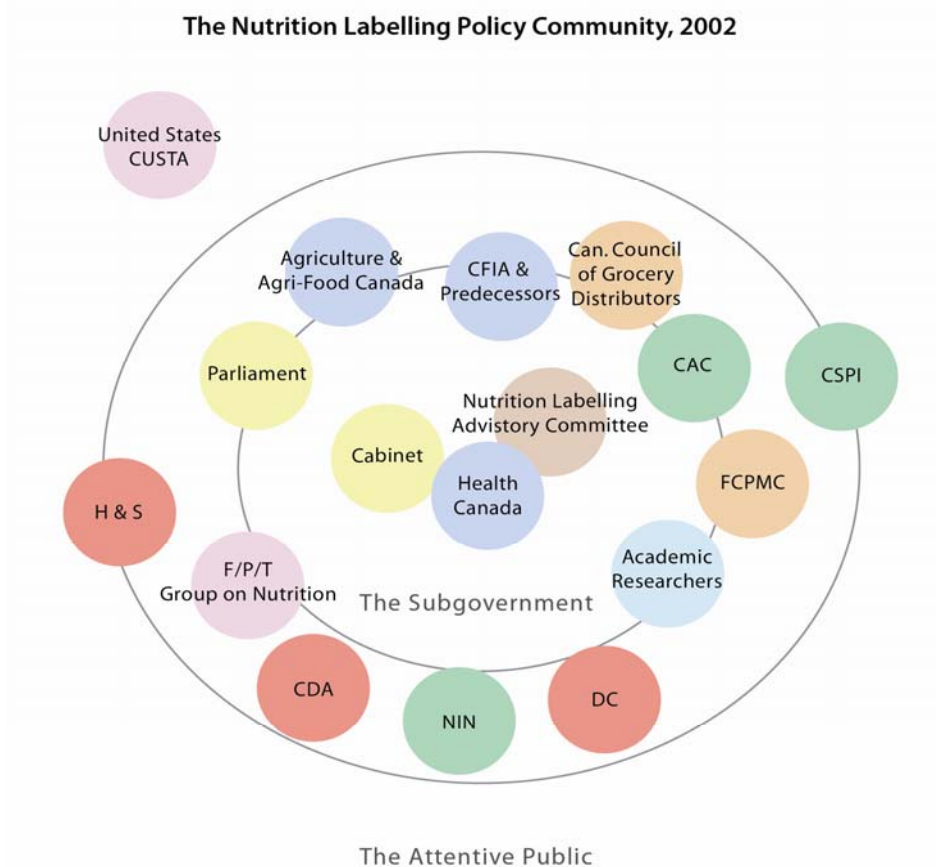


Appendix 3
Policy Community Diagram: Brazil (1997-1999)

Brazilian National Food and Nutrition Policy Community -
1997-1999



Appendix 4 Policy Community Diagram: Canada (2002)



Note: In the diagram above, the intent is not to represent every stakeholder group and/or organization that participated in the highly collaborative policy process. Those that are included played a significant role in the nutrition labelling initiative, but, it is important to acknowledge that there are many others not represented in the diagrams, primarily due to space limitations. The colour coding and abbreviations used in the diagram are as follows:

- RED: H&S (Heart and Stroke Foundation of Canada); CDA (Canadian Diabetes Association); DC (Dietitians of Canada)
- PEACH: FCPMC (Food and Consumers Products Manufacturers of Canada); Canadian Council of Grocery Distributors
- GREEN: CSPI (Centre for Science in the Public Interest); CAC (Consumers' Association of Canada); (NIN) National Institute of Nutrition
- TURQUOISE: Academic Researchers
- BLUE: Agriculture and Agri-Food Canada; CFIA (Canadian Food Inspection Agency) and its predecessors; Health Canada

- MAUVE: F/P/T Group on Nutrition (Federal/Provincial/Territorial Group on Nutrition); CUSTA (Canada-U.S. Free Trade Agreement)
- YELLOW: Parliament and Cabinet
- LIGHT BROWN (Nutrition Labelling Policy Community, 2002): Nutrition Labelling Advisory Committee

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