Power analysis in health policy and systems research: a guide to research conceptualisation

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ABSTRACT
Power is a growing area of study for researchers and practitioners working in the field of health policy and systems research (HP SR). Theoretical development and empirical research on power are crucial for providing deeper, more nuanced understandings of the mechanisms and structures leading to social inequities and health disparities; placing contemporary policy concerns in a wider historical, political and social context; and for contributing to the (re)design or reform of health systems to drive progress towards improved health outcomes. Nonetheless, explicit analyses of power in HP SR remain relatively infrequent, and there are no comprehensive resources that serve as theoretical and methodological starting points. This paper aims to fill this gap by providing a consolidated guide to researchers wishing to consider, design and conduct power analyses of health policies or systems. This practice article presents a synthesis of theoretical and conceptual understandings of power; describes methodologies and approaches for conducting power analyses; discusses how they might be appropriately combined; and throughout reflects on the importance of engaging with positionality through reflexive praxis. Expanding research on power in health policy and systems will generate key insights needed to address underlying drivers of health disparities and strengthen health systems for all.

INTRODUCTION
Power is defined as the ability or capacity to ‘do something or act in a particular way’ and to ‘direct or influence the behaviour of others or the course of events’.1,2 Relationships of power shape societies, and in turn, health policies, services and outcomes.2 Power dynamics—or the relational power that manifests in the interaction among individuals and organisations—also influence health systems, or ‘the organizations, people and actions whose primary intent is to promote, restore or maintain health’.3 The universe of power dynamics that are pertinent to the study of health policies and systems includes diverse types and locations of policy, social, implementation and political processes. Power dynamics have also influenced health systems planning and research, by defining what is seen as a health system, and the translation or adaptation of health systems models across distinct geographic contexts over time.4,5

Studying power is thus a core concern of researchers and practitioners working in the field of health policy and systems research (HP SR), an interdisciplinary, problem-driven field focused on understanding and
strenthening of multilevel systems and policies. Accelerating theoretical development and empirical research on power in this domain is crucial for several reasons. First, it provides a deeper, more nuanced understanding of the mechanisms and structures that lead to social inequities and health disparities. Second, it reveals historical patterns entrenched in health and social systems, allowing contemporary policy concerns to be seen in a wider context and lessons to be drawn from these trends.

Third, analysing power can contribute to the (re)design or reform of health systems to redress imbalances and progress towards improved health outcomes. However, explicit analyses of power in HPSR remain relatively infrequent. Lack of a power-specific lens may reflect the continued dominance of biomedical and behaviouralist approaches in health research and funding, limitations stemming from the political economy of research funding and agendas, and reluctance among institutions and individuals to examine their own role in perpetuating existing power dynamics. Power is also complex to examine conceptually, theoretically and methodologically. Seminal publications providing guidance on different aspects of power research include Erasmus and Gilson’s paper on investigating organisational power; the health policy analysis reader edited by Gilson et al.; and Loewenson et al.'s methods reader on participatory action research (PAR). Recent resources also provide conceptual overviews of power. However, there remains no comprehensive resource that can serve as a theoretical and methodological starting point for aspiring power researchers, irrespective of disciplinary orientation or area of HPSR interest.

This paper aims to fill this gap, building on the above-mentioned resources but providing a more consolidated guide to researchers wishing to consider, design and conduct power analyses of health policies or systems. Recognising the expansive and interlinked nature of power relations, we focus this article on the different ways to research power as it manifests in health policies and systems. We also engage with literature on the social determinants of health insofar as these determinants impact health policies and systems.

This project emerged from the Social Science Approaches for Research and Engagement in Health Policy and Systems (SHAPES) thematic working group of Health Systems Global. SHAPES members (SMT, VS, MS and KS) with interest and expertise in power analyses reached out to the wider network and requested other interested researchers and practitioners to join the project. Recognising that expertise can take many forms, no criteria were placed on participation other than an interest in the topic and willingness to contribute to the paper’s development. The group was ultimately comprised of researchers from academic institutions, research organisations and multilateral agencies, in both the Global North (eight) and Global South (six) all of whom have experiential knowledge of assessing and negotiating power in health systems at various levels, and a number of whom have published in this area.

The process to develop this resource began in 2019. Members of the original group (SMT, VS, MS and KS) first prepared an outline of the paper via virtual and email discussions among group members. That outline was then divided into sections on theory, methodology and reflexivity, and section leads were appointed by a process of consensus. Group members volunteered to work on a section or sections based on experience and ability to input. Literature was sourced from database searches combined with expert guidance from group members. Working group leads organised the work of these sections and led drafting. Section drafts were reviewed by each group and then the full group, and two external researchers were invited to provide feedback on specific aspects of the paper. Online supplemental appendix 1 illustrates the iterative process by which the ideas were conceptualised, synthesised and agreed on at different stages of the paper drafting. All authors also read and commented on at least one version of the final paper. As a whole, the project was collaborative and worked from the logic of crowd-sourcing among a diverse set of authors engaged in HPSR.

DOING POWER ANALYSES IN HEALTH POLICIES AND SYSTEMS RESEARCH

This paper outlines key considerations and principles for power analyses in health policies and systems research throughout the research cycle. The paper is divided into three sections. The first section starts by discussing the identification of a research topic and presents three overarching empirical ‘sites’—or discrete areas of inquiry—for power-focused HPSR. The empirical sites offer a starting point for study design by providing researchers with ways to reflect on and refine their research question. This section also highlights researchers’ positionality and its influence on the whole research process. The second section provides an introduction to (and tabular summary of) theories useful for analysing power, demonstrating each theory’s relationship to one or more of the empirical sites. Finally, the third section of the paper introduces a selection of methodologies, considers their usefulness in the context of different types of power analyses and discusses how they, too, must be selected with consideration for the research question, the researcher’s positionality and alignment with theory. The ideas presented in this paper apply to all geographic contexts; however, we draw largely on HPSR literature from low-income and middle-income countries. This paper does not engage extensively with the use of specific data collection tools or methods (eg, interviews, observations and
document review) associated with a given methodology, as other resources address these topics in detail.\(^{18} 21 23 24\)

**Identifying a topic**

Power is imposed, negotiated and contested in diverse ways in the context of health policy formulation and implementation and health systems functioning. Research into power in the field of HPSR generally focuses on how the ‘expression’ of power enables or blocks health system change or policy implementation and what types of power are implicated in the process.\(^{16} 20\) From these two broad areas of focus, we discern three main sites of empirical work on power in the health policy and systems field, recognising that these three sites overlap significantly. These are: (1) actor relationships and networks; (2) sources of power and (3) societal flows and expressions of power.

In [figure 1](#), we locate each of these empirical sites of power research around an adapted version of Walt and Gilson’s\(^{25}\) seminal Policy Triangle. This figure highlights that applied research on power cannot be conducted in isolation from the actors, context, content, structures and processes of the policy or system in focus. By demonstrating the link between actors, context, and structures and broad areas of power research, the three empirical sites are intended to provide a point of departure for the researcher to consider what is the issue or topic of interest. We expand on each of these empirical sites further below.

**Empirical site 1: actor relationships and networks**

The role and manifestations of power in actor relationships and networks comprise an important site of empirical research on power in HPSR. We list this site first because we understand health systems as social systems,\(^3\) fundamentally shaped by the values, intentions and relationships of the human and organisational actors within them. As illustrated in the central green triangle in [figure 1](#), questions about power relating to actor relationships and networks include foundational enquiries about which individuals and organisations make and influence (health) policy and system decisions, how they relate to one another and why.

**Empirical site 2: sources of power**

As outlined in Sriram et al\(^{26}\) and Moon\(^{22}\), a substantial body of theory is directed towards understanding how actors draw on power from particular sources.\(^{16} 22\) Sources of power thus represent a second important grouping of research on power in HPSR. Some methodologies, particularly those based in political science and economic theory, can describe and problematise key sources of power, such as material capital; technical expertise; political and bureaucratic position and influence; and forms of cultural capital and power gained from title, education and knowledge. Resultant research can provide analyses regarding which actors are impacting processes, from where they derive their power and how their actions impact policy and systems. This empirical site focuses our attention on ‘drivers of the drivers’, surfacing the institutions, organisations and attributes that provide a fountainhead of power in HPSR.

**Empirical site 3: societal flows and expressions of power**

A third empirical site of power research in health policy and systems relates to the societal flows and expressions of power. Research on the exercise of power shows how power is expressed, leveraged and experienced to impact health policy and systems, and ultimately, health inequities. Reflecting the intersection among context, actors and structures, research related to flows and expressions of power can generate insights regarding how formal or informal institutions shape health policy-making and service delivery, or on the impact of prevailing ideologies regarding health policy on service delivery.\(^{26} 27\) Researchers may focus on the ways that health policies and systems shape inequities or the ways that different groups have accepted, adapted and subverted health systems, such as the dictates of colonial medicine or neocolonial or internalised colonial forms of public health practice.\(^{31} 32\)

**ADDRESSING POWER WITHIN THE RESEARCH PROCESS: POSITIONALITY AND REFLEXIVITY**

In the process of issue identification and throughout the research process, it is critical to recognise the contested relationships of power that shape research itself. The nature of evidence in the fields of global health and health policy and systems research is contested,\(^{33} 35\) and the funding of evidence generation is political.\(^{36} 36\) Researchers—whether investigating power or other aspects of health and society—must be willing to consider their own role as actors in a contested process. Health research broadly tends to reward—in professional status, resourcing and publishing—positivist and utilitarian

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**Figure 1** Three empirical sites of power research in health policy and systems.

[BMJ Global Health](https://gh.bmj.com/) first published as 10.1136/bmjgh-2021-007268 on 5 November 2021. Downloaded from [http://gh.bmj.com/](http://gh.bmj.com/) on December 13, 2021 by guest. Protected by copyright.
approaches over humanistic and relativistic and/or interpretive ones,36 Northern voices over Southern ones37 and biomedical knowledge over other forms of knowledge.38 Indeed the positionality of researchers is present in the many forms of power and privilege that can distance them from the issues they are analysing. Researchers’ professional positionality in the political economy of global health, as well as their individual lived experiences and attributes relating to race, caste, gender, class, ability and more, can significantly influence the choice of questions and (as discussed further) theories and methodologies used to enact analysis of those issues.

How should researchers engage with these challenges? There is no straightforward mechanism by which to operationalise critical reflexivity. Instead, building on the work of Sultana,39 Citrin,40 Mafuta et al,41 Abimbola37 Keikelame and Swartz42 and Pratt,43 we offer a set of questions in table 1 to guide reflection on power as it impacts a given research project. Researchers should consider: for whom they are designing and conducting data collection and analysis and writing up findings? And, how does this influence ‘bad habits’ that pervade global health research?44 However, discussions of power dynamics as they manifest in politics, social norms and otherwise is not a straightforward endeavour. Those who are brought in to collaborate in research processes, whether they be community members, health services representatives or funders, might be uncomfortable with an explicit focus on power relations. Shining a light on power asymmetries could create risks for collaborators or participants.

A conscious nurturing of critical reflexivity within all stages of a research process is a necessary component of ethical and rigorous praxis. However, analysing power while simultaneously maintaining awareness of the power relationships that structure the research endeavour itself is no easy feat. These questions and processes demand a more deliberative, bottom-up, time consuming approach to defining and answering research questions than is often enacted in HPSR. Prospective researchers of power should factor this time into their work. Since the political economy of global health and health policy and systems research can create incentives that undermine reflective, inclusive and transparent approaches to defining and answering research questions,38 these considerations should be taken into account from this initial step through the dissemination of findings and beyond.

Table 1 Questions to guide reflections on power in health policy and systems research

<table>
<thead>
<tr>
<th>Preliminary steps</th>
<th>Concurrent steps</th>
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<tbody>
<tr>
<td>Why are you (or the group you are part of) interested in asking these research questions?</td>
<td>What are the mechanisms for capturing dissent or alternative views in the research process, both within the research team and with research participants and collaborators?</td>
</tr>
<tr>
<td>Who do you expect will benefit from the outcomes of the research?</td>
<td>When analysing data, how do you account for differences in power among and between research participants and researchers?</td>
</tr>
<tr>
<td>Who is part of the research team and how have you engaged with issues of positionality, personal status, and diverse disciplinary backgrounds?</td>
<td>What types of dialogue and consultations can you offer within the research team and/or partners and how frequently?</td>
</tr>
<tr>
<td>Who are you intending to work with, and what individual, group, institutional or social dimensions of power may impact these partnerships?</td>
<td>Whose voices are loudest within the process and can you do anything to shift that dynamic?</td>
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<tr>
<td>What voices or perspectives, particularly those of individuals or communities with direct experience of your research topic, might you be missing?</td>
<td>How are you building adaptive learning processes into the research to take into account diverse perspectives and modify your approach accordingly?</td>
</tr>
<tr>
<td>How will you address issues of representation in your work, whether in terms of study design or in terms of team composition?</td>
<td>What are the mechanisms for capturing dissent or alternative views in the research process, both within the research team and with research participants and collaborators?</td>
</tr>
<tr>
<td>Are equal opportunities given for authorship among the research team and/or respondents involved in the research?</td>
<td>What are the mechanisms for capturing dissent or alternative views in the research process, both within the research team and with research participants and collaborators?</td>
</tr>
<tr>
<td>Are there mechanisms in place to broaden your reach beyond ‘usual suspects’ (ie, academic circles)?</td>
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</tr>
<tr>
<td>Have you put into place any process whereby data can be stored/archived in the places where it was gathered?</td>
<td>What format will the publication(s) take and is there scope for writing in languages other than English and/or translation of results into other languages?</td>
</tr>
<tr>
<td>Are equal opportunities given for authorship among the research team and/or local collaborating institutions or individuals?</td>
<td>What other formats may results be presented in other than peer-reviewed journal articles?</td>
</tr>
<tr>
<td>How will you communicate and share the outcomes of your research, particularly with participants/partners involved in the research?</td>
<td>If the work is going to be published in a peer-reviewed journal, will the resultant article(s) be open access?</td>
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How are you building adaptive learning processes into the research to take into account diverse perspectives and modify your approach accordingly? (Concluding steps)}
REFINING THE RESEARCH QUESTION WITH THEORY AND METHODOLOGY

The three empirical sites provide a launching pad for considering avenues for power inquiry for health policy and systems. In moving from a topic of interest to a more specific research question on power, and in conjunction with considerations of their own position and power, the researcher must consider their epistemological foundation (ie, what do we consider knowledge and how do we know it), the theories that provide a relevant analytical scaffolding, and concurrently, the methodologies that will enable appropriate collection, collation and analysis of data to that end.45

Thinking about theory

Theory helps to shape what we ask about power in HPSR. As a field, HPSR aims to generate research to inform policy and action34; this has implications for theory application, with the end goals of equity and justice often informing epistemological and theoretical positions.16

Some theories are foundational and address the nature of the state, society and human interaction; others are more operational in that they focus on discrete elements of the state, society and human interaction. As part of a process of reflexive research praxis, the entire research team should consider the guiding principles they wish to follow in their research and the implications that these choices have for theory choice and application. For example, researchers with applied interests may consider frameworks designed for this purpose, such as the Power-Cube46; conversely, researchers seeking a deeper theoretical understanding of mechanisms driving power imbalances may consider foundational theories, such as Max Weber’s sources of authority,47

HPSR as a field has developed in dialogue with theories of power from diverse disciplines from the social sciences and humanities, including philosophy, sociology, political science, anthropology, feminist theory, postcolonial and gender studies, history, and international relations, among others. Most of the foundational theories cited in peer-reviewed social science literature (eg, Marx, Gramsci, Bourdieu, Foucault and Haugaard; see ref 9) originated in high-income countries, reflecting and perpetuating the discursive and material power held by scholars and academic institutions in these contexts. Many of these theories were developed in the 19th and 20th centuries, and while they describe macro-level processes that are still salient, they were not developed with contemporary phenomena—such as the proliferation of mobile technology and social media—in mind. Some scholars developed critical theories to analyse and critique power structures from the point of view of the oppressed. Theories of domination originating from feminist, postcolonial, Marxist, queer or critical race theory, among others, have been used to describe structural determinants of health, health policy and healthcare, and healthcare-seeking behaviours.36-50

Many contemporary critical theories focus on the intersectionality of systems of subordination31-35; researchers have begun to suggest ways of applying these theories in health policy analyses.34-52 Postcolonial literature and subaltern studies have not (yet) been applied extensively in HPSR29 but have increasingly been cited in discussions about how to decolonise global health53-56 and in recent scholarship on social inequities during the COVID-19 pandemic.37

Other frameworks used in HPSR, particularly those from public policy studies, draw insights from social science theories to explore power without necessarily invoking power explicitly, such as street-level bureaucracy theory58 and diffusion theory.22 In table 2, we provide an illustrative list and brief explanation of influential theories of power that have informed or been applied to studies assessing health determinants, health policy and health systems. We recognise that the approaches described in this paper do not capture the full breadth and complexity of this topic, and a more detailed version of this table can be found in online supplemental appendix 2.

Pairing theory with methodology

Different theories are better suited to analysing power asymmetries characterising each of the three empirical sites. With regards to empirical site 1, theories with potential for exploring actor relationships and networks may include Weber’s three sources of authority,47 street-level bureaucracy46; feminist standpoint theory,50 critical race theory48 and Bourdieu’s fields.59 Theories particularly relevant to examining the sources of power (empirical site 2) include Barnett and Duvall’s taxonomy of power,60 Bourdieu’s ‘fields’,59 Gramsci’s concept of cultural hegemony61 and feminist approaches.50,62 Theories relevant to expansive questions regarding how power is expressed and manifest in society at large (empirical site 3) may include Foucault’s concept of knowledge/power,63 Veneklasen and Miller’s ‘expressions of power’64 and Lukes’ three faces of power.65

While theory helps to shape what we ask about power in HPSR, methodology shapes how we ask it and how we interpret the findings (figure 2). Below we provide an overview of 10 methodologies (broadly defined) that are of use in the context of the three empirical sites. The organisation of the methodologies under the empirical sites is merely illustrative. While some methodologies may be closely associated with a given empirical site (eg, social network analysis is associated with actor relationships and networks), many others are not. In conjunction with ongoing reflexive considerations of positionality, researchers choosing a methodology should consider their theoretical and epistemological position and the context of the research question, since the assumptions underlying the application of methodologies can be different (eg, the difference between an objectivist case study and an ethnography). Selection of methodologies should also consider for whom the research is being conducted, and whether the aim is to generate or further
<table>
<thead>
<tr>
<th>Theories useful for power analysis</th>
<th>Key constructs/brief description</th>
<th>Core texts and examples of application</th>
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<tr>
<td>Three faces and dimensions of power, Stephen Lukes</td>
<td>Influenced by Marx and Durkheim, Lukes claims power is exercised in three ways: (1) the power to decide, (2) the power not to decide (ie, to set the agenda and circumscribe the limits of debate), (3) the power to influence people’s wishes and thoughts.</td>
<td>Lukes 2004,85 Buse and Hawkes 2014,120 Reynolds 2019,121</td>
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<tr>
<td>Three sources of authority, Max Weber</td>
<td>Weber described political authority as legitimate domination, distinct from concepts of coercion and force. He defined three sources of political authority: traditional (derived from established customs and social structures), charismatic (derived from the individual leader’s characteristics) and rational-legal authority (derived from the formal rules and laws of the state).</td>
<td>Weber 1948,47 Sirm et al 2018,122</td>
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<tr>
<td>‘Fields,’ Pierre Bourdieu</td>
<td>Bourdieu proposed the concepts of fields – social domains characterised by specific logics and norms, and peopled by actors with varying levels of power. Actors in fields use forms of capital (economic, cultural, social or symbolic) to advance their self-interest and preferences.</td>
<td>Bourdieu 1990,109 Shiffman 2015,133 Behague et al 2008,124 Hanefeld and Walt 2015,125</td>
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<tr>
<td>Biopower, Michel Foucault</td>
<td>Foucault’s influential concept of ‘power/knowledge’ holds that rather than being an instrument of power, knowledge is constitutive and inseparable from it. In ‘Discipline and Punish’, Foucault discusses how modern institutions and techniques of control created systems of disciplinary power. He also contrasted older forms of ‘sovereign’ power, founded on violence, with modern ‘biopower’, which influences life by administration, optimisation and regulation.</td>
<td>Foucault 1978,148 Dalglis et al 2017,142 Sen et al 2021,143 Scott et al 2017,128</td>
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<tr>
<td>Taxonomy of power, Michael Barnett and Raymond Duvall</td>
<td>Barnett and Duvall’s framework seeks to understand how states negotiate policy processes in the international sphere. They differentiate between direct forms of power (compulsory power between actors, and structural relationships) and more diffuse forms (institutional power that favours some actors, and productive power over possession and distribution of resources).</td>
<td>Barnett and Duvall 2004,40 Martin 2010,129 Moon 2019,122</td>
</tr>
<tr>
<td>PowerCube, John Gaventa</td>
<td>Gaventa’s PowerCube presents an operational model for the analysis of power. It depicts a dynamic relationship among three aspects of power – forms of power (based on Lukes’ three faces of power) – visible, invisible and hidden power; spaces where power is exercised and claimed; and, levels of power – global, national or local.</td>
<td>Gaventa et al 2011,46 Nisbett et al 2014,130 McCollum et al 2018,131</td>
</tr>
<tr>
<td>Expressions of power, Lisa Veneklasen et al</td>
<td>The four categories of power in this framework include power over (authority over others), power to (individual powers to act on something), power with (to act with others or collaborations) and power within (the ability of a person to recognise their self-knowledge, abilities or a sense of self-worth).</td>
<td>Veneklassen and Miller 2002,45 McCollum et al 2018,131</td>
</tr>
<tr>
<td>Cultural hegemony, Antonio Gramsci</td>
<td>Gramsci focuses on the concept of cultural hegemony, by which the state and the ruling classes use ideology, rather than violence, force, or economic modalities, to control and maintain capitalist power.</td>
<td>Gramsci 1999,121 Worth 2002,132</td>
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**THEORETICAL CONTRACTS RELEVANT TO HPSR**

| Feminist theories/domination | Although there are differences among various theories, feminist-informed theories broadly elevate important and previously underaddressed issues, most notably: the ways in which gender hierarchies shape health policies; what care is available; and the relationships among and between health sector employees and patients. In addition to exposing structures and manifestations of domination, feminist theories may be used as part of an approach that seeks to identify and foster empowerment and solidarity, both through research processes and results. | Young 2014,126 Morgan et al 2016,133 Theobald et al 2017,134 Parikh 2012,135 |
| Critical race theory | Critical race theory originated in US law schools in the 1980s as a way to understand how the law has been used to maintain white supremacy. Concepts and methods from critical race theory, including race conscious orientation, which require specific attention be paid to racism and its interpersonal and structural drivers, have been used to explore racial inequity in the context of health and health systems. | Borrell 2018,136 Hardeman et al 2020,137 |
| Necropolitics | Necropolitics builds on Foucault’s idea of biopower as the state’s ability to control and shape life, in contrast to the more traditional power of life and death over citizens. Necropolitics is the use of social and political power to control (differentially) how citizens live and die, with some (subjugated) bodies suspended between life and death, and has been used to understand inequalities in health and the shortcomings of current global health governance and the pluralistic (ie, market infused or market dominated) sphere of public health. | Mmbme 2019,33 Lee 2020,134 Sandset 2021,137 |
| Subaltern studies/postcolonialism/decolonisation | Subaltern people are those who are subordinated for reasons of class, caste, gender, race, language and culture; subaltern studies centres these people and the structures of subordination. Postcolonialism was initially developed in literary theory; it is concerned with narrative and representation and how this perpetuates hegemonic forms of knowledge and power. Decolonisation refers to the social science study of the process of decolonisation, as well as to a newer movement to ‘decolonize global health’ (and likely other fields and disciplines). | Spivak and Said 1988,139 Guha 1997,140 Canaj 2015,141 Kingori and Gerrets 142 McPhail-Bell et al 2013,143,144 |
Table 2 Continued

<table>
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<th>Theories useful for power analysis</th>
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</thead>
<tbody>
<tr>
<td>OPERATIONAL PUBLIC POLICY THEORIES</td>
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<tr>
<td>Models of decision making in public policy</td>
<td>Various models of public policy decision making incorporate power in different ways. Buse et al, for example, list rational and incremental models of decision making, a mixed-scanning approach to decision making and the punctuated equilibrium model. Cairney et al developed a framework to study policy stability and change to explain differences among countries in tobacco control policy, as well as why policy did not reflect the public health evidence base. These approaches can be combined with other frameworks that interrogate power.</td>
<td>Etzioni 1967145 Buse et al 2012146 147 Dalglish et al 2019147 Cairney et al 2011148</td>
</tr>
<tr>
<td>Political-economic determinants</td>
<td>Political-economic determinants of health highlight the power imbalances that emerge from the interplay between macroeconomic structures, ideas and policy.</td>
<td>Rushton and Williams 2012149 Battams and Townsend 2019150 Kentikelenis and Rochford 2019151 Bump and Reich 2013152</td>
</tr>
<tr>
<td>Health and human rights</td>
<td>The right to an adequate standard of living and to medical services were included in the 1948 Universal Declaration of Human Rights; the right to health was included in the 1966 International Covenant on Economic Social and Cultural Rights. From the late 1980s, the field of ‘health and human rights’ coalesced as a way of understanding the human rights drivers and impacts of the HIV pandemic. Human rights provides a diagnostic or descriptive framework for research on the right to health, as well as solutions for how health and other government sectors should react to that research.</td>
<td>Mann 1996153 Gruskin 2004154 Freedman 2007155 Yamin and Norheim 2014156 Forman 2009157</td>
</tr>
<tr>
<td>Street-level bureaucracy</td>
<td>Initially developed by political scientist Michael Lipsky, the theory of street-level bureaucracy is concerned with state employees who interact with citizens in the everyday conduct of their tasks, such as police officers, local government officials and health providers. These bureaucrats have some degree of discretion in their interpretation and implementation of policies. From the perspective of community members, decisions and actions taken by street-level bureaucrats constitute government policy.</td>
<td>Lipsky 1980158 Erasmus 2014158 Walker and Gilson 2004159</td>
</tr>
</tbody>
</table>

...refine a theory or produce more immediately actionable findings. A summary table of these methodologies may be found in online supplemental appendix 3.

To further make this point, table 3 provides illustrative examples of possible combinations of research question, theory and methodology. The inclusion in the table of two research questions at each of the different levels of health policy and systems function (micro, meso and macro) is intended to demonstrate (although incompletely) the breadth of potential inquiry as well as to showcase the specificity sometimes required to enable effective theoretical and methodological linkage. A key point made clear by the repeat...
Table 3 Illustrative combinations of theory and methodology paired with research questions on power in HPSR

<table>
<thead>
<tr>
<th>Socioecological level</th>
<th>Examples of research questions</th>
<th>Examples of potentially applicable theories</th>
<th>Examples of corresponding methodologies</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>EMPIRICAL SITE 1: ACTORS AND ACTOR NETWORKS</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Micro</td>
<td>How does the degree of participatory leadership style among hospital and district health directors affect hospital staff roles in accountability processes?</td>
<td>Weber’s three sources of authority.</td>
<td>Actor interface analysis.</td>
</tr>
<tr>
<td></td>
<td>How does X peer communication and mentorship programme foster health advocacy and political capabilities within a racially diverse community of commercial sex workers?</td>
<td>Lipsky’s street level bureaucracy.</td>
<td>Case study.</td>
</tr>
<tr>
<td></td>
<td>In what ways do the social networks of public and private healthcare providers differ in terms of their relationships with state level health authorities and insurers? How might these differences affect the introduction of a regulatory regime for counterfeit antibiotics?</td>
<td>Gaventa’s PowerCube.</td>
<td>Ethnography.</td>
</tr>
<tr>
<td></td>
<td>How have the formal and informal channels of in-person communication regarding the liberalised abortion law shaped how the law is interpreted and practiced by health providers in rural areas of country X?</td>
<td>Feminist theories.</td>
<td>Comparative case study.</td>
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<td></td>
<td>How did civil society representatives in country X leverage social and moral power conferred by their HIV status and other identities, to influence the country’s proposal to the Global Fund to Fight AIDS, TB and Malaria?</td>
<td>Health and human rights.</td>
<td>Actor interface analysis.</td>
</tr>
<tr>
<td>Maco</td>
<td>What attributes of social networks among representatives of large corporations involved in the production, packaging and sale of food products, Ministers of Health, and Ministers of Trade, influence the role that Countries X, Y and Z played in WHO discussions regarding limitations on advertising of unhealthy food?</td>
<td>Lukes’ three faces of power.</td>
<td>Social network analysis.</td>
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<td></td>
<td>In what ways does the discretionary power of frontline health workers influence the implementation of a new programme to provide home-based care for type 1 diabetes in country Y, and what are the determinants of how that power is exercised?</td>
<td>Bourdieu’s fields.</td>
<td>Case study.</td>
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<td>How do middle manager conceptions of biomedical expertise and primary healthcare shape the integration of community health workers into primary health care teams?</td>
<td>Foucault’s power/knowledge.</td>
<td>Ethnography.</td>
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<td>How do political authority, financial resources, cultural capital and technical expertise shape the performance of (health governance/research funding decisions) institutions in country X?</td>
<td>Gaventa’s PowerCube.</td>
<td>Case study.</td>
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<td>How do conflicts of interest in the stewardship of public and private medical education shape the recruitment, distribution and competency of human resources for health in country X?</td>
<td>VeneKlasen et al’s expressions of power.</td>
<td>Actor interface analysis.</td>
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<td>Grindle and Thomas’ policy elites.</td>
<td>Historical methods.</td>
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</table>

**EMPIRICAL SITE 2: SOURCES OF POWER**

| Micro | How do middle manager conceptions of biomedical expertise and primary healthcare shape the integration of community health workers into primary health centre teams? | Critical race theory. | Ethnography. |
|       | How do conflicts of interest in the stewardship of public and private medical education shape the recruitment, distribution and competency of human resources for health in country X? | Lipsky’s street level bureaucracy. | Case study. |
|       | How do political authority, financial resources, cultural capital and technical expertise shape the performance of (health governance/research funding decisions) institutions in country X? | Feminist approaches. | Actor interface analysis. |
|       | How do conflicts of interest in the stewardship of public and private medical education shape the recruitment, distribution and competency of human resources for health in country X? | Intersectionality. | Historical methods. |
|       | How do middle manager conceptions of biomedical expertise and primary healthcare shape the integration of community health workers into primary health centre teams? | Bourdieu’s fields. | Ethnography. |
|       | How do middle manager conceptions of biomedical expertise and primary healthcare shape the integration of community health workers into primary health care teams? | Weber’s three sources of authority. | Case study. |
|       | How do conflicts of interest in the stewardship of public and private medical education shape the recruitment, distribution and competency of human resources for health in country X? | Critical race theory. | Political economy. |
|       | How do middle manager conceptions of biomedical expertise and primary healthcare shape the integration of community health workers into primary health care teams? | Weber’s three sources of authority. | Historical methods. |

Continued
listings of theories and methodologies across the various questions in table 3 is that there are many valid combinations of theories and methodologies.

**USEFUL METHODOLOGIES FOR EMPERICAL SITE 1: ACTOR RELATIONSHIPS AND NETWORKS**

**Stakeholder analysis** is an actor-oriented methodology useful for examining the power differentials of key policy and health system actors, ranging from frontline healthcare workers to national level policy makers. Stakeholder analysis is most commonly used prospectively, as a tool for researchers and practitioners to understand the feasibility of a given policy and to develop responses to likely challenges in implementing that policy. Stakeholder analysis can also be used retrospectively, as a stand-alone study or in combination with political economy and case study approaches. Stakeholder analysis is also commonly used to consider sources of power, described in further detail below.

**Actor interface analysis** focuses on understanding individual actors (rather than organisations), examines policy through the lens of power struggles between individuals and explores how this behaviour is embedded in actors’ lived experiences and values, called actor *lifeworlds*. When used to study health policy, actor interface analysis examines how interactions among different actors shape the implementation and outcomes of the policy. Where actors interact, collaboration, contestation or resistance can be identified and analysed. This methodology brings an actor-centric lens...
to the study of power in policy implementation as compared with other (more institutionally focused) methodologies and helps to examine how policy-related decisions and action are shaped by the actors themselves.77 78 79

**Social network analysis** is the quantitative study of relationship patterns among actors, with actors being broadly defined to potentially include people, groups or organisations.79 80 This methodology draws from sociology and mathematical foundations of graph theory to illuminate how the nature of actors and ties (eg, number, strength and type of tie, such as friendship, supervisory relationship and whether information, resources or beliefs were shared) enable expressions and tools of power (eg, money, pressure, influence and knowledge) to be concentrated, spread or blocked.75 In the field of HPSR, social network analysis can be used to analyse the health system structure as it functions, including through informal personal relationships, rather than as it is formally defined.74 This can inform policy makers about how ties among actors can influence the diffusion and implementation of health reforms and programmes; how social networks influence governance and financing structures; as well as informing the public about how policy makers may be using power to include or exclude certain actors.71 75 76

**USEFUL METHODOLOGIES FOR EMPIRICAL SITE 2: SOURCES OF POWER**

**Case study design** is a form of empirical inquiry characterised by an ‘intense focus on a single phenomenon within its real-life context’77 and is particularly useful in situations where boundaries between the phenomenon of interest and the context are blurred. In relation to power in HPSR, case study research has most commonly been used to produce exploratory and explanatory accounts focusing on different actors’ expressions of power (formal and informal, overt and covert) to answer ‘how?’ and ‘why?’ certain health policy or system features exist and to assess efforts to change power dynamics.80 81 By combining an interpretivist (seeking to understand individual and shared social meanings) and critical (questioning one’s own and others’ assumptions) analytical approach, researchers may use this methodology to consciously account for the ways in which broader social and political environments influence both macropower and micropower dynamics.79 80 Comparative case studies can be used for theory building or theory testing.

**Political economy analysis** is a methodology used to identify and describe structures such as government and the law; resources (labour, capital, trade and production) and how they are distributed and contested in different country and sector contexts, and the resulting implications for policy and indicators of well-being.81 Of relevance to HPSR, political economy can draw on both quantitative and qualitative methods to explore the nature of the political landscape through mapping the power and position of key actors. Political economy can also explore how the distribution of resources influence relationships and through this the feasibility and trajectory of policy reform over time.82 83 Reflecting their roots in the comparatively more positivist paradigms of political science and economics, these methodologies have been used for purposes of explanation and hypothesis testing in HPSR, including in the context of evaluations and policy design. Consistent with HPSR’s multidisciplinary orientation, political economy methodologies can nonetheless be developed and deployed in a way that accommodates—or even centres—interpretive goals.

**Big data analytics** examines high volume, biological, clinical, environmental and behavioural information collected from single individuals to large cohorts at one or several time points.83 Big data analytics can uncover patterns in health outcomes and health behaviours84; health policy (eg, resourcing and implementation fidelity85); and health system function (eg, provider behaviours).86 87 When applied in conjunction with a power lens, big data analytics can reveal important and often masked trends or patterned experiences, prompting further explanatory work or evaluative action.88 For example, Yu et al89 use big data analytics to explore the influence of private medical providers in promoting unnecessary medical interventions.89 Big data analytics may also help identify systemic issues such as discrimination, information asymmetry and patient-provider dynamics and their influence on care quality. Nonetheless, given its volume as well as its potential interest to profit seeking entities, big data presents unique challenges for ethics, boundaries and reflexivity. Researchers should carefully consider the potential misuses of the data, the extent to which the data accurately represents the factors of interest (construct validity) and which individuals and groups are overlooked in analyses that focus on the mean (or median).89

**USEFUL METHODOLOGIES FOR EMPIRICAL SITE 3: SOCIETAL FLOWS AND EXPRESSIONS OF POWER**

**Discourse analysis** entails close examination of the use of language in texts (such as laws, policies, strategy documents or news media articles) and oral communication (such as transcribed interviews, debates or speeches) to describe the ways in which communicative acts construct shared understandings of what is normal90 91 and what is possible, legitimate, or true.63 Discourse analysis should include the study of what is present in the text, as well as what is assumed or ignored, shedding light on often unacknowledged material asymmetries and social hierarchies that pervade health policy-making at all levels.92 In this way, discourse analysis can expose and problematise dominant paradigms in global and domestic health policy-making, such as the ways that standard epidemiological risk factors obscure structural inequalities,93 the assumption that the private sector will act in the public interest,94 or that a primary function of government reproductive health programmes is to decrease the fertility rate, rather than enable reproductive autonomy.95

Ethnographers seek to understand how humans in groups interact, behave and perceive, and how meaning and value are established. Ethnography can build rich and holistic understanding of people’s perspectives, practices and cultural context96 and focuses on depth over breadth, immersive observation in natural settings (eg, non-experimental
conditions), exploratory (rather than hypothesis testing) research and describing the meaning and function of human action in context. While ethnography has its origins in colonial conceptions of ‘culture’ and colonial motivations to study them and has thus been frequently used to ‘study down’, ethnography has also been employed to research ‘up, down and sideways’. This includes work focusing on institutions and politics, political legitimacy, moral universes, tacit knowledge and discourses to provide insight into how power is constructed, solidified and wielded within and beyond health systems, the development and normalisation of certain forms of knowledge and the implicit or explicit privilege or denigration of individuals or marginalised groups accessing healthcare.

Participatory action research (PAR) seeks to build new understandings of power while also changing power relations. PAR seeks to shift control over the construction of knowledge and truth from the historically privileged to the historically marginalised and increase participant understandings of injustice (conscientisation) in order to build solidarity and transform systems and institutions. PAR explores and recognises different sources of power (eg, social position, nationality and cultural knowledge) and applications of power (eg, via citizen-led collective action). This research methodology typically entails the use of tools, such as community meetings, resource mapping, problem identification, visioning and diaries that draw out the priorities and perspectives of the communities participating, rather than reflecting a priori theory. It is apt for exploratory questions, as well as for bringing stakeholders together to cocreate solutions to health systems challenges.

Historical research aims to generate or regenerate explanatory narratives relating to past events, places or people. Historical evidence includes visual, audio and text-based materials (archival material, communications, policy documents and project reports) and first-person accounts (oral histories). The study of history can illuminate broad power-related themes that continue to be relevant, such as the interface between individual liberty and domestic governmental health objectives, medical experimentation, social control and scientific racism, corporate profit making, governmental interference and population health, and global health as a vehicle for statecraft, diplomacy, population control and Western-centric conceptions of charity.

Historical studies also offer broader explanatory value as ‘cases’ for the development of theory related to power and as case studies for contemporary policy debates. Insofar as traditional historical approaches can privilege written work, it may omit the perspectives of historically oppressed groups. To combat this tendency, alternative methods such as participatory oral historical or community-based sourcing of visual, audio and text-based records not located in ‘official’ repositories open up alternative analytical possibilities.

CONCLUSION

More research on power in health policy and systems is needed. Linking empirical inquiry with theory and methodologies, with attention to positionality strengthens the rigour of such research and can help improve the depth and breadth of knowledge regarding root causes of inequities in health. This paper guides readers through the multiple stages involved, and a range of theories and methodologies that may be used, in developing a study focused on power in health policy and systems. It also seeks to push the HPSR field to challenge the political economy of research and destabilise hierarchies of knowledge through greater honesty about how power dynamics influence the research endeavour itself. Through the analysis of power in health policies and systems, we encourage researchers to expand the boundaries of how we may address inequities of health, to surface new insights, theories and approaches pertaining to power and, ultimately, to contribute to a more just world.

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Acknowledgements Walter Flores was part of discussions during which this paper was conceived. We would like to thank members of the Social Science Approaches for Research and Engagement in Health Policy and Systems (SHAPES) Thematic Working Group of Health Systems Global for their feedback on the initial concept note. We would like to thank Prachi Sanghavi (University of Chicago) and Michelle Friedner (University of Chicago) for their review of sections of the paper during development.

Contributors SMT, MS, VS and KS conceived of the paper. SMT, MS and VS led design of figures 1 and 2 and table 2 and coordinated drafting of different components of the paper. All authors contributed to methodological synthesis and drafting of text and all provided critical input to multiple drafts. SMT, MS and VS act as guarantor to this article.

Funding This collaborative project received no special funding. SMT holds a NHMRC Investigator Award (2020-24) GNT1173004.

Competing interests None declared.

Patient consent for publication Not applicable.
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Supplementary File 1: Iterative process of paper development over several years.
## SUPPLEMENTARY FILE 2: Extended Summary of Theories Useful for Power Analysis in Health Policy and Systems Research

<table>
<thead>
<tr>
<th>Theories useful for power analysis</th>
<th>Key constructs/brief description</th>
<th>Commonly used to study power in HPSR/HPA?</th>
<th>Examples of application</th>
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<tbody>
<tr>
<td><strong>1. Theories on power from the social sciences</strong></td>
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<tr>
<td>Steven Lukes’ three faces or dimensions of power</td>
<td>Influenced by Marx and Durkheim, the social theorist Steven Lukes, in his book <em>Power: A Radical View</em>, claims power is exercised in three ways: 1) the power to decide, 2) the power not to decide (i.e. to set the agenda, circumscribe the limits of debate), 3) the power to influence people’s wishes and thoughts, even against their self-interest. The third face of power was partly inspired by Gramsci’s notion of cultural hegemony (see below).</td>
<td>++</td>
<td>(Lukes, 2004); (Buse and Hawkes, 2014); (Reynolds, 2019)</td>
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<tr>
<td>Max Weber’s three sources of authority and description of bureaucracy</td>
<td>The German sociologist Max Weber described political authority as legitimate domination, distinct from concepts of coercion, force, and power. He defined three sources of political authority: traditional (derived from established customs and social structures), charismatic (derived from the individual leader’s characteristics), and rational-legal authority (derived from the formal rules and laws of the state). Weber’s conceptualization of bureaucracy is also applied to the study of bureaucratic power.</td>
<td>-</td>
<td>(Weber, 1948); (Sriram et al., 2020)</td>
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<tr>
<td>Pierre Bourdieu’s fields</td>
<td>The French sociologist Pierre Bourdieu proposed the concepts of fields. Fields are social domains characterized by specific logics and norms, and they are peopled by actors with varying levels of power. Global health might be considered a field. Actors in fields use forms of capital (economic, cultural, social, or symbolic) to advance their self-interest and preferences, such as professional prestige, saving lives, and funding successful programs.</td>
<td>+</td>
<td>(Bourdieu, 1990); (Shiffman, 2015); (Behague et al., 2008); (Hanefeld and Walt, 2015)</td>
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<td>Foucault</td>
<td>Foucault’s work on power evolved over his lifetime. His influential concept of “power/knowledge” holds that rather than being an instrument of power, knowledge is constitutive and inseparable from it. In “Discipline and Punish,” Foucault discusses how modern institutions and techniques of control created systems of disciplinary power. In his work on external and internal controls on sexuality, Foucault claims that power is productive and built from the ground up (the ‘microphysics’ of power in a society), via a network of practices. He also contrasted older forms of “sovereign” power, founded on violence, with modern “biopower,” which influences life by administration, optimization, and regulation, etc.</td>
<td>+</td>
<td>(Foucault, 1978); (Dalglish et al., 2017); (Sen et al., 2020); (Scott et al., 2017)</td>
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<tr>
<td>Haugaard</td>
<td>Haugaard’s framework of seven ways of creating power and exercise of power in the policy systems is founded on the question of – ‘what creates power in the society’ and draws from multiple power theories. The first among</td>
<td>-</td>
<td>(Haugaard, 2012)</td>
</tr>
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The seven interrelated categories is the establishment of societal rule (power created by social order). These rules create legitimacies in the system (power created by system biases). Compatibility or conflict with these system biases then creates power differences (power created by systems of thought). Knowledge of actors about social orders, rules and thoughts makes them empowered or powerless (power created by tacit knowledge). A reification of some knowledge and creation of arbitrary social constructs can lead to new power dynamics in the society (power created by reification). Many routines in the systems prevent knowledge from becoming discursive, and these reinforce the existing order (power created by discipline). To maintain or change the exercise of power there could be incidences of violence, threats and coercion (power created by coercion).

### Taxonomy of power (Barnett and Duvall)

Barnett and Duvall, scholars of global governance, propose a framework to understand how states negotiate policy processes in the international sphere. They differentiate between direct forms of power (compulsory power between actors, and structural relationships) and more diffuse forms (institutional power that favors some actors, and productive power over possession and distribution of resources).

### PowerCube

John Gaventa’s PowerCube framework, drawing from multiple theories, brings together an operational model for the analysis of power. It depicts an intersectional and dynamic relationship of three aspects of power. Three dimensions of the cube represent – 1. Forms of power (based on Luke’s three faces of power) – visible, invisible and hidden power; 2. Spaces of power based on the participation of various actors, operationalized at open, closed and claimed spaces; and 3. Levels of power – global, national or local, based on where power is emanating from and where it is being exercised. The dimensions and elements of the PowerCube interact with each other (like the Rubik’s cube) and analysts can approach the problem starting from any plane/dimension.

### Expressions of power

VeneKlasen et al’s ‘expressions of power’ concept furthered the discourse of understanding power by departing from seeing power as an ability to influence others by domination or coercion or ‘power over’. This categorization suggests that power could have positive meanings, and power could be exercised in more collaborative and constructive ways. The four categories of power in this framework include power over (authority over others), power to (individual powers to act upon something), power with (to act with others or collaborations) and power within (the ability of a person to recognize their self-knowledge, abilities or a sense of self-worth).

### 2. General social science theories

**Gramsci**

A Marxist political theorist, Gramsci’s work on power centres on the concept of cultural hegemony, by which the state and the ruling classes use ideology, rather than violence, force, or economic modalities, to control and maintain capitalist power. Under this framework, the norms and ideas of the bourgeoisie become ‘common sense,’ and the working class identifies as good that which in fact benefits the state and the ruling class. Gramsci’s work partly inspired Lukes’ “third face” of power (see above).
There are many tensions and debates among feminist theories. Nonetheless, broadly, feminist-informed theories, including phenomenological feminist, radical feminist, socialist feminism, intersectional feminism, post-structuralism, and analytic feminist approaches raise important issues that theorists believe were previously under-addressed, most notably including the ways that gender hierarchies shape health status, health policies, the care available, the care received, and, relationships among and between health sector employees and patients. In addition to exposing structures and manifestations of domination, feminist approaches may endeavour to identify and foster empowerment and solidarity, both through research processes and results.

| Feminist theories / domination | There are many tensions and debates among feminist theories. Nonetheless, broadly, feminist-informed theories, including phenomenological feminist, radical feminist, socialist feminism, intersectional feminism, post-structuralism, and analytic feminist approaches raise important issues that theorists believe were previously under-addressed, most notably including the ways that gender hierarchies shape health status, health policies, the care available, the care received, and, relationships among and between health sector employees and patients. In addition to exposing structures and manifestations of domination, feminist approaches may endeavour to identify and foster empowerment and solidarity, both through research processes and results. | ++ | (Young, 2014); (Morgan et al., 2016); (Theobald et al., 2017); (Parikh, 2012) |
| Gender transformative/socialist feminist evaluations | Gender-transformative/socialist feminist evaluations are based on an understanding of how gender and social relations of class, sexuality, caste, abilities, religion, etc., define the exercise of power in different institutional contexts. These evaluation frameworks help to study the contribution of a policy (or interventions), for changing such power relations in favor of the marginalized groups, in the context of the larger neoliberal paradigms. Such evaluations also explore changes, if any, in gendered and social norms of implementing organizations. The evaluation process ideally reflects a gender, rights and equity lens. These frameworks can be used to examine the political nature of evaluations, by breaking down the hierarchy and power relations between who is evaluating, who is being evaluated and how are the results communicated (whose language and for whom). | + | (Chigateri and Saha, 2016) |
| Intersectionality | Initially a critique of hegemonic (white) feminism in the United States, intersectionality assesses the ways that gender hierarchies interact with other hierarchies, such as those related to race, caste, and ability. Both quantitative and qualitative approaches to exposing intersectionality surface the ways in which different hierarchies interact in different contexts. | + | (Crenshaw, 1991); (Cho et al., 2013); (Larson et al., 2016) |
| Critical race theory | Critical race theory originated in U.S. law schools in the 1980s and as a way to understand how the law has been used to maintain racial power (white supremacy), and the possibility of using the law to work towards racial emancipation. It has since been expanded for use in many other social science fields, and has been used particularly in the US-American public health literature to describe and understand racial disparities in health determinants, outcomes, and access to care. | + | (Borrell, 2018); (Hardeman et al., 2020). |
| Necropolitics | ‘Necropolitics’ builds on Foucault’s idea of ‘biopower’ or ‘biopolitics’ as the state’s ability to control and shape life, in contrast to the more traditional power of life and death over citizens. Necropolitics is the use of social and political power to control (differentially) how citizens live and die, with some (subjugated) bodies suspended between life and death, and has been used to understand inequities in health and the shortcomings of current global health governance and the pluralistic (i.e. market-infused or market-dominated) sphere of ‘public’ health. | + | (Mbembe, 2019); (Lee, 2020). |
### Subaltern studies / postcolonialism / decolonization

Building in part on Gramscian theory and growing attention to social history (as opposed to state centered history) subaltern studies developed as a field in the 1980s; many of the initial key thinkers wrote about India. Subaltern people are those who are subordinated for reasons of class, caste, gender, race, language and culture; subaltern studies centers these people and the structures of subordination. Postcolonialism was initially developed in literary theory; it is concerned with narrative and representation and how this perpetuates hegemonic forms of knowledge and power. Decolonization refers to the social science study of the process of decolonization, as well as to a newer movement to “decolonize global health” by questioning dominant paradigms and institutions from the Global North and, proposing an equitable, if not Southern based framework that engenders local innovation and diffusion, values and elevates theories stemming from the Global South, and ensures proportionate representation from people from the Global South.

+ (Spivak and Said, 1988); (Guha, 1997); (Caxaj, 2015); (Kingori and Gerrets, 2019); (McPhail-Bell et al., 2013); (Mignolo and Walsh, 2018).

### 3. Operational public policy theories with potential for power analysis

#### Political systems

Political systems can be interrogated for how they distribute power among certain actors / groups both in terms of policy-making processes and in terms of the likely beneficiaries of valued goods. Buse et al (2012) list 5 political systems: 1) liberal-democratic, 2) egalitarian-authoritarian, 3) traditional-inegalitarian, 4) populist, 5) authoritarian-inegalitarian. Dahl (1957), in describing pluralistic systems, holds the state as a neutral referee adjudicating between competing demands. Analyses can focus on how health policy issues are shaped or determined given the specific characteristics of the political system in question.

+ (Dahl, 1957); (Buse et al., 2012); (Dalglish et al., 2015).

#### Models of decision making in public policy

A number of models of public policy decision-making are available, in which analyses of power can be incorporated in various ways. Buse et al list rational and incremental models of decision-making, a mixed-scanning approach to decision-making, and the punctuated equilibrium model. Some of these are more or less ripe for power analysis (e.g. the rational model considers that decisions are made primarily on evidence), though they can also be combined with other frameworks that interrogate power more specifically.

++ (Etzioni, 1967); (Cairney et al., 2011, Buse et al., 2012); (Dalglish et al., 2019).

#### Political-economic determinants

Two frameworks address the political-economic determinants of health, highlighting the power imbalances that emerge from the interplay between macroeconomic structures, ideas and policy.

- Kentikelenis & Rochford – Power asymmetries in global governance for health: a conceptual framework for analyzing the political-economic determinants of health inequities
- Rushton and Williams – Frames, paradigms and power: global health policy-making under neoliberalism.

(Reushton and Williams, 2012), (Kentikelenis and Rochford, 2019), (Battams and Townsend, 2019).

#### Health and Human Rights

The right to adequate standard of living and to medical services were included in the 1948 Universal Declaration of Human Rights; the right to health was included in the 1966 International Covenant on Economic Social and Cultural Rights. In the late 1980s and early 1990s lawyers, physicians, and activists coalesced the field of “health

++ (Mann, 1996); (Gruskin, 2004); (Freedman, 2007);
and human rights,” as they sought to address the human rights drivers and impacts of the HIV pandemic. While the law has been criticized as a manifestation and tool of those in power, health and human rights researchers argue that human rights law outlines obligations and points to steps governments could take to realize those obligations. In this way, human rights provides a diagnostic or descriptive framework for research, as well as solutions for how the health sector and governments more broadly should react to that research.

(Yamin and Norheim, 2014); (Forman, 2009).

<table>
<thead>
<tr>
<th>Policy transfer and other international relations theories of policy diffusion</th>
<th>There are several strands in the policy diffusion literature. Policy transfer refers to the transfer of policies from what setting to another; this field of research focuses on the decision-making, motivation, and other mechanisms of transfer. Policy convergence is concerned with the role of structures – such as institutions and globalization processes – in the spread of policies. Policy translation looks at the ways that policies are modified or subverted when they are adopted. Power is integrated insofar as the actors in each of these paradigms have different degrees of power, potentially including donors, normative agencies (e.g. WHO), private sector actors, Ministries of Health, Ministries of Finance, and actors tasked with implementation.</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Brown et al., 2014); (Shiffman and Smith, 2007); (Parston et al., 2015); (Omachonu and Einspruch, 2010); (Moon, 2019).</td>
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</tr>
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</table>

Understanding how an issue ends up on the policy agenda is also explored through the lens of power. Walt (1994) described health policy as being about process and power, the process being driven by who are regarded as influencers and how these actors make the process happen. The role of policy actors was discussed by Walt and Gilson (1994) particularly how they influence the process from agenda setting to evaluation, and how they react to policies. The work of Shiffman and Smith (2007) articulated the role of actor power, ideas, political contexts, and issue characteristics in setting policy agenda as well as priority setting activities. This proposes the use of institutional framework to understand how an agenda is set according to institutional rules, norms, and behaviours about ideas that are regarded as important (i.e. policy agenda). This social constructivism (Shiffman 2009) can be considered when studying health policy agenda setting. Later on, the work by Walt and Gilson (2014) added that the role of the media should be emphasized due to their power in framing issues. The work by Grindle and Thomas (1989) on the role of policy elites in agenda setting is also be informative.

(Walt and Gilson, 1994); (Shiffman and Smith, 2007); (Shiffman, 2009); (Grindle and Thomas, 1989).

Initially developed by American political scientist Michael Lipsky, the theory of street level bureaucracy is concerned with the government employees who interact with citizens in the everyday conduct of their tasks, such as police officers, local government officials, and health providers. These bureaucrats have some degree of discretion. From the perspective of community members, the cumulation of decisions and actions taken by street level bureaucrats constitute governmental policy. Research using this theory can draw out the realities of everyday practice, including the ways in which frontline providers and officials implement or subvert policy and reinforce (or not) social and professional hierarchies.

(Lipsky, 1980); (Erasmus, 2014); (Walker and Gilson, 2004).
REFERENCES


WALKER, L. & GILSON, L. 2004. 'We are bitter but we are satisfied': nurses as street-level bureaucrats in South Africa. *Soc Sci Med*, 59, 1251-61.


## SUPPLEMENTARY FILE 3: Extended Summary of Methodologies for Studying Power in Health Policy and Systems Research

<table>
<thead>
<tr>
<th>Methodology and methods</th>
<th>Applicability to studying power in HPSR</th>
<th>Strengths</th>
<th>Methodological Considerations</th>
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<tbody>
<tr>
<td>Ethnography</td>
<td>Ethnography seeks to build rich and holistic understanding of people’s perspectives, practices, and cultural context (Hammersley and Atkinson 1995) and focuses on depth over breadth, immersive observation in natural settings (e.g., non-experimental conditions), exploratory (rather than hypothesis testing) research, and efforts to identify and analyse the meaning and function of human action in context (Creswell and Poth, 2017, Agar 1997). Ethnography can thus examine how power is manifested through, for example, the unequal distribution of resources, the privilege or denigration of individuals or sub-groups, and the development and normalization of forms of knowledge (Jain and Jadhav 2009).</td>
<td>Ethnography can expose power’s function in key HPSR spheres, such as policymaking processes (Irwin and Smith 2019; Nambiar 2013), healthcare decision-making in the home (Nyangondo 2002), relationships among actors in healthcare settings (Kapilashrami and McPake 2013), and informal practices that shape the delivery and receipt of health care and other social services (Pigg 2013). Ethnography has been shown to enable research on political issues of legitimacy, moral universes, tacit knowledge, and local discourses (Hagene 2018). While ethnography has its origins in the colonial project and has been frequently used to “study down” (Nyoka 2019), more recently, ethnography has been employed to “up, down and sideways” (González and Stryker, 2014), wherein researchers focus on the practices and moral worlds of the powerful, providing insight into how power is constructed, solidified, and wielded (Mishra and Nambiar 2018).</td>
<td>Who gets ‘to do’ ethnographic research should also be recognised as a matter of power and position. In their analysis, researchers must also be attentive to whether people can choose to participate in ethnographic research, dispute the conclusions made, or influence how ethnographic research findings are shared and used.</td>
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<tr>
<td>Case study</td>
<td>Case studies are particularly useful in situations where boundaries between the phenomenon of interest and the context are blurred. In relation to power in</td>
<td>By combining an interpretivist (seeking to understand individual and shared social meanings) and critical (questioning one’s own and others' assumptions) analytical approach researchers may use this methodology to consciously account for</td>
<td>Case studies are ubiquitous in public health, but are often a summary of a program, rather than the intended in-depth exploration of social</td>
</tr>
</tbody>
</table>

A form of empirical inquiry characterised by an “intense focus on a single phenomenon”
within its real life context” (Yin 2014)

HPSR, case study research has most commonly been used to produce explanatory accounts focussing on different actors’ expressions of power (both formal and informal, overt and covert) to answer ‘how?’ and ‘why?’ certain health policy or system features exist, and to assess efforts to change power dynamics (L Gilson, Orgill, and Shroff 2018; Shiffman and Smith 2007). Since case studies typically draw on and triangulate between multiple sources of data, this approach may be equally useful for exploring sources of power (how power emerges) and dimensions of power (how power is channelled) within a health system or health policy sphere, including across time (Sriram et al. 2018).

Discourse analysis
The study of how language and structures of meaning -- whether written or spoken -- are used in social contexts.

This research method can illuminate the construction and communication of health systems “software”, such as values, beliefs, and assumptions (Sheikh et al. 2011) through word choice, linguistic style, conversational codes (taking turns, interrupting, reacting) and non-verbal components of speech (pauses, tone of voice, gestures).

In closely examining the use of language in texts (such as laws, policy and national strategy documents, news media articles) and oral communication (such as transcribed interviews, debates or speeches) discourse analysis brings attention to the ways in which communicative acts construct shared understandings of what is normal (Steel, 2019, Sacks, 1995) and what is possible, legitimate, or true (Foucault 1972). Discourse analysis includes the study of omitted meanings and tracks contents and references that phenomena. Researchers seeking to employ case studies should be particularly attentive to aligning the purpose of enquiry with case selection, and ensuring rigor in examination of the case as well as in the application of the particular methods chosen (e.g. in-depth interviews or observation). It is also important to appropriately ‘bound’ the case in such a way that one can focus on the phenomenon at hand, but also understand the deeper mechanisms of power at play. Analysts should also ensure that there is sufficiently rigorous interpretive analysis (Yin 2014).

Discourse analysis is often conducted together with other methods. While it produces important observations on the trajectories taken by conceptualizations, from inception to oblivion, and the central role they may play in shaping policies initiatives, Discourse analysis needs to be complemented (corroborated or invalidated) with observations of
<table>
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<tr>
<th><strong>Political economy analysis</strong></th>
<th>Political economy can draw on both quantitative and qualitative methods to: i) explore the nature of the political landscape through mapping the power and position of key actors and ii) how the distribution of power and resources influence processes that sustain and transform patterns of relationships and through this, the feasibility of policy reform over time (Collinson 2003; Reich 2019). Political economy analyses may also be applied to strengthen policy processes by, for example, surfacing potential allies or opponents for policies and developing strategies to engage politically with key stakeholders (Reich 2019).</th>
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<tr>
<td>An approach that focuses on power (state structures, government and the law) and resources (labour, capital, trade and production) how they are distributed and contested in different country and sector contexts, and the resulting implications for policy and development outcomes (Reich 2019).</td>
<td>Political economy analysis is particularly appropriate for exploring the role of material and productive power in the development, implementation of (and interaction between) national and international health policies and systems (Reich, 2019), and for illuminating the intent behind particular policies (i.e., political power, financial motives, etc). Political economy analysis can reveal contradictions between political declarations and actual practices; as in the analysis of informal illegal fees charged to patients, that in some contexts are fundamental for the economy of the system, despite the official declared intentions to stop them (Croke 2012).</td>
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<td><strong>Participatory Action Research</strong></td>
<td>PAR seeks fresh insight into injustice by positioning those are kept hidden or are altogether avoided (Sieleunou et al. 2017; Yazdannik, Yousefy, and Mohammadi 2017). Discourse analysis can problematize dominant paradigms in global health, such as the ways that standard epidemiological “exposures” and factors can obscure the role of power asymmetries.</td>
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| **Participatory Action Research** | By exploring and recognising different sources of power (e.g. social position, cultural knowledge) events and actual decisions and their impact. Illuminating and critiquing structures of power demands researchers reflect on their own status, assumptions, cultural perspective, and social identity (Hodges, Kuper, and Reeves 2008). | Applying PAR to study power demands that researcher /
Aims to understand and improve the world by changing it; this is accomplished by overcoming the separation of researcher (subject) and people being studied (object).

<table>
<thead>
<tr>
<th>Methodology</th>
<th>Description</th>
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<tbody>
<tr>
<td>Actor Interface Analysis</td>
<td>Focuses on individual actors and their power struggles, which are embedded in the often-neglected lived experiences of the policy actors (Long 2001; Schutz 1962). When used to study health policy, Actor Interface Analysis examines how interactions between experiences among different types of actors and in the context of certain policies, shape the implementation and outcomes of the policy. Where actors interact, power struggles such as collaboration, contestation, conflict or resistance can be located and analysed. This methodology brings an ‘actor-centric’ lens to the study of power in policy implementation as compared to other (more institutionally-focused) methodologies and helps to examine how policy related decisions and action are shaped by the actors’ struggles or their power practices set against their lived experiences (Long 2001; Lehmann and Gilson 2013). This approach thus provides a robust conceptual as well as methodological entry point for the examination of the expressions of power (power dynamics), their underpinning elements, and their impacts on the policy process.</td>
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<tr>
<td>Stakeholder analysis</td>
<td>Explores the positions, interests, relationships. Stakeholder Analysis is an actor-oriented methodology. This methodology is useful for Stakeholder analysis is most commonly used prospectively, as a tool for researchers and practitioners seeking to understand the feasibility Assessing power and interests of stakeholders requires ‘interpretive judgements’ (Lucy Gilson et al. 2012)</td>
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Aims to understand and improve the world by changing it; this is accomplished by overcoming the separation of researcher (subject) and people being studied (object).

Affected by problems as both the primary sources of information and the primary actors in generating, validating and using knowledge for action (Loewenson et al. 2014). PAR can be used for studying power as a subject; however, its aim is to actively contribute to transforming power relations in the study of any topic in HPSR, and in other fields.

Paradoxically, PAR can be used for studying power as a subject; however, its aim is to actively contribute to transforming power relations in the study of any topic in HPSR, and in other fields.

Participants grapple with questions of collectivism, community, and solidarity. This includes critically examining how ‘community’ is defined and bounded in a given setting, the relative risks and benefits borne by those involved, whether sufficient commitment and resources are in place for meaningful action, alignment of interests in terms of research and action outcomes, and whether researchers are genuinely able and willing to shift power (Khanlou and Peter 2005).
and power relations of different stakeholders in a particular policy or practice context.

| and power relations of different stakeholders in a particular policy or practice context. | examining the sources and power differentials of key policy and health system actors from frontline healthcare workers to national level policy makers (L Gilson, Orgill, and Shroff 2018). | and prospects of a given policy and develop responses to likely challenges in formulating or implementing that policy (Abiio and McIntyre 2013). Both qualitative and quantitative methods, including network analysis (Heydari et al. 2018) can be used, and it can be useful for examining power struggles, for example, when trying to understand who will contest or oppose a policy (Lucy Gilson et al. 2012; Schmeer 1999). | which require a strong understanding of the context and analyst positionality. This method has less of a focus on identifying or explaining specific ‘interfaces’ than in Actor Interface Analysis. |

| Big data analytics | Big data analytics can demonstrate patterns in health outcomes, decision making and behaviours (OECD 2014), health policy (e.g. resourcing, implementation fidelity and outcomes (Schintler and Kulkarni 2014) and health system function (e.g. patient and provider behaviours) (Pastorino et al. 2019; Shafqat et al. 2020) | When applied in conjunction with a power lens big data analytics can reveal important (and often masked) trends or patterned experiences, prompting further explanatory work or evaluative action (Kolkman 2020). For example, Yu et al (2019) use big data analytics to explore the influence of private medical providers in promoting unnecessary medical interventions (Yu et al, 2019); while Santana show how health insurance data can be modelled as a social network to reveal the role of physician networks in referral decisions (Santana et al. 2018). Big data analytics could also help identify systemic discrimination, information asymmetry, patient-provider dynamics and their influence on care quality and responsiveness. Galetsi et al observe their potential for traditional decision making within the doctor-patient relationship (Galetsi et al., 2019). Shah et al, too demonstrate how | Given its volume and velocity, as well as its potential interest to profit seeking entities, big data presents unique challenges for ethics, boundaries, and reflexivity. In particular, researchers should consider the potential mis-uses of the data, the extent to which the data manipulated accurately represents the factors of interest (construct validity), and which individuals and groups are overlooked in analyses that focus on the mean (or median), a challenge that is inherent to most quantitative analyses (Vayena et al. 2018). |

| Big data analytics | Examines high volume, high diversity, biological, clinical, environmental, and behavioural information collected from single individuals to large cohorts at one or several time points (Auffray et al. 2016) | When applied in conjunction with a power lens big data analytics can reveal important (and often masked) trends or patterned experiences, prompting further explanatory work or evaluative action (Kolkman 2020). For example, Yu et al (2019) use big data analytics to explore the influence of private medical providers in promoting unnecessary medical interventions (Yu et al, 2019); while Santana show how health insurance data can be modelled as a social network to reveal the role of physician networks in referral decisions (Santana et al. 2018). Big data analytics could also help identify systemic discrimination, information asymmetry, patient-provider dynamics and their influence on care quality and responsiveness. Galetsi et al observe their potential for traditional decision making within the doctor-patient relationship (Galetsi et al., 2019). Shah et al, too demonstrate how | Given its volume and velocity, as well as its potential interest to profit seeking entities, big data presents unique challenges for ethics, boundaries, and reflexivity. In particular, researchers should consider the potential mis-uses of the data, the extent to which the data manipulated accurately represents the factors of interest (construct validity), and which individuals and groups are overlooked in analyses that focus on the mean (or median), a challenge that is inherent to most quantitative analyses (Vayena et al. 2018). |

| Adaptations of the objectivist life-cycle of big data research (formulate question / data collection / data | | | Adaptations of the objectivist life-cycle of big data research (formulate question / data collection / data.
### Social network analysis

The quantitative study of relationship patterns among actors, i.e., people, groups or organizations (Blanchet and James 2012; Hawe, Webster, and Shiell 2004)

This methodology draws from sociology and mathematical foundations of graph theory to examine the structure and patterns (Borgatti et al. 2009). Social network analysis can enable the study of power by illuminating how the nature of actors and connections (number, strength, type) enable forms of power such as money, pressure, influence, and knowledge to be concentrated, spread, blocked or engaged. In addition to helping understand the nature of relations between and among actors in a system, social network analysis supports examination of how relationships influence the structure of a system (Borgatti et al. 2009).

The value of SNA lies in its ability to illuminate underlying structures and networks that formally and informally influence practices, policy and programs (Blanchet and James 2012). Examples of the application of SNA to investigate power include understanding health sector reforms (Wang 2013), identifying institutional networks and their involvement in the devolution of financial resources (Etemadi et al. 2017) and exploring the relative importance of personal relationships as compared to formal hierarchical positions (Shearer, Dion, and Lavis 2014).

Quantifying relationships can be resource intensive and mask nuances in the relationships and dynamics between actors. Reflexivity in conducting social network analysis demands that researchers are self-critical and transparent about their decisions on boundaries for which actors they will include and exclude and how they choose to measure and define connections (Laumann et al., 1989).

### Social epidemiology

A subfield of epidemiology concerned with the relationships

Techniques from epidemiology are productively applied to questions of power in health systems by

For example, research into the impact of the U.S. Civil Rights Act revealed how elevated maternal mortality rates among Black women in the U.S. south was due in part to hospitals denying them...
between social factors, including social hierarchies and social phenomena, and health. Examining the impact of health and social policy on health status. Indicators of health status are the primary outcomes of interest, and can be used to explore and highlight policy priorities for health system actors such as health service coverage, financial protection, and inter-personal quality of care (Berkman, Kawachi, and Glymour 2014).

**Historical research**

Historical research aims to generate systematic explanatory narratives relating to past events, places or people. Historical evidence includes visual, audio and text-based materials (archival material, communications, policy documents and project reports) and first-person accounts (oral histories). Principles from case study research such as process tracing, entry (Almond and Chay 2006). Other quantitative and mixed methods research has shown how insurance, user fees, fee exemptions and other mechanisms for payment influence inequities in health care access and utilization (Atchessi, Ridd, and Zunnunegui 2016; De Allegri et al. 2015).

The inclusion of historical methods can surface underlying structures and systems of power as they have developed over time. In the context of HPSR, social historians may focus on the ways that health and other social policies and systems shape inequities (Szreter 1988) or, the ways that different groups accepted, adapted, and subverted the dictates of colonial medicine (Anderson 2014; Sivaramakrishnan 2006) or neo-colonial or internal colonial forms of public health practice (Cueto and Palmer, 2015; Stepan, 1991. Economic and political historians trace the impact of history can illuminate broad power-related themes that continue to be relevant, such as the interface between individual liberty and domestic governmental health objectives (e.g. Colgrove, 2004); medical experimentation, social control, and scientific racism (Gutiérrez and Fuentes 2009; Reverby 2012); corporate profit-making, governmental interference, and population health (Reubi and Berridge 2016); and global health as a vehicle for state-craft, diplomacy, population control, and Western-centric conceptions of charity (Birn 2014; Chorev 2012; Connelly and Connelly 2009; Packard 2016; Quevedo Velez 2001).

Such themes have immediate relevance as they shape phenomena such as how vaccination and other quantitative and mixed methods research has shown how insurance, user fees, fee exemptions and other mechanisms for payment influence inequities in health care access and utilization (Atchessi, Ridd, and Zunnunegui 2016; De Allegri et al. 2015).

The study of history can illuminate broad power-related themes that continue to be relevant, such as the interface between individual liberty and domestic governmental health objectives (e.g. Colgrove, 2004); medical experimentation, social control, and scientific racism (Gutiérrez and Fuentes 2009; Reverby 2012); corporate profit-making, governmental interference, and population health (Reubi and Berridge 2016); and global health as a vehicle for state-craft, diplomacy, population control, and Western-centric conceptions of charity (Birn 2014; Chorev 2012; Connelly and Connelly 2009; Packard 2016; Quevedo Velez 2001).

Using a power lens in the approach to archival research requires a consideration of “how attentions were trained and selectively cast” in the storing and cataloguing of material remains (Stoler, 2009, p. 1); relationships of power shape what is saved in official archives versus what is lost or destroyed. Insofar as traditional historical approaches can privilege written work, it may elide the perspectives of historically oppressed groups. To combat this tendency, alternative methods such as participatory oral historical or community-based sourcing of visual, audio and text-based records not.
| Discourse analysis, and other methodologies and methods delineated here could inform how the material is both sourced and analysed. | Of policy and political changes on health status (e.g. as a social determinant of health), or on the development of institutions (including formal institutions, such as WHO, and institutions as ‘rules of the game’) on the consolidation of prevailing assumptions and approaches to health policy and service delivery (Agyepong 2018; Woolcock, Szreter, and Rao 2020). | Family planning interventions are perceived by those groups who have been on the receiving end of past state-sanctioned abuses. They also offer broader explanatory value as ‘cases’ for the development of theory related to power (Szreter and Woolcock 2004) and as case studies for contemporary policy debates. | Located in ‘official’ repositories, would open up alternative analytical possibilities. Finally, the tendency in global health to extract “lessons” from history or to use history to justify certain courses of political action, can obfuscate the dynamics of power that shape the creation of historical narratives and their translation into HPSR debates. |
References


