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Aligning Tobacco Free Living Agendas in a Community Health Improvement Plan: A Case Study on Democratic Participation and Economic Interests in U.S. Health Policy Development

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This paper addresses the gap in studies which use democratic policy making frameworks to analyze health policy development in Community Health Improvement Plans (CHIPs). The study describes and analyzes three streams of the tobacco free living policy cycle in a Community Health Improvement Plan implemented in a Mid-Western Region of the United States from 2016 to 2020. The roles of public health interest, economic interests, and democratic participatory rights in Tobacco free health policy making are assessed. The policy making process is assessed within an integrated framework of analysis that weaves pluralist, power elite, critical democratic theories, and participatory governance paradigms into Kingdon's (2003), streams framework which includes problems, policy, and political streams. The results of the analysis are as follows:1. There was a deficit in democratic participation, and a preeminence of state institutions and economic interest in tobacco free living policy development to the disadvantage of public health interests; 2. Both the policy making process and policy outcomes are anticipated and explained by the governance-driven democratization paradigm and elite dominance theories 3. Democracy driven governance paradigm, democratic theories, and critical theories, illuminate the shortcomings of the policy making process and design. These frameworks also provide a pathway for improving the policy practice components of Community Health Improvement Plans. Specific recommendations are provided for future designs and implementations of policy development components of Community Health Improvement plans.

Keywords: *Inter-Jurisdictional community health policy development; aligning policy agendas in community health planning; democratic and critical theories and community health policy making; democratic participation in community health policy making; elite dominance frameworks in community health policy practice.*

Public health policy making is increasingly collaborative (Tataw & Rosa, 2011; Naik et al.,2017; Watson et al., 2023), and health behavior is driven by ecological factors including a variety of social environmental forces such as organization factors and collaborative public policy development (Trickett, & Rowe, 2012; Alegria et al., 2019; Mkabile & Swartz, 2022). In a collaborative spirit, health policy development in Community Health Improvement Plans, often involves alignment of agendas within and across public health jurisdictions. Community Health Improvement Plans (CHIPs) are Local Health Department initiatives developed collaboratively with other local/regional stake holders such as health care organizations, community-based organizations, chambers of commerce, institutions of higher learning, school districts etc., to improve the health of their populations (Shah et al., 2019); CDC, "Assessment and Plans—Community Health Assessment," n.d.). Local/regional and statewide policy agenda alignments were designed to advance tobacco free living initiatives in a Community Health Improvement Plan (CHIP) implemented in a Mid-Western Region of the United States from 2016 to 2020. In their pursuit of local/regional and statewide policies to advance tobacco free living, CHIP partners sought policy advocacy agenda alignment among local/regional plan partners, and between local/regional plan partners and other statewide stakeholders.

This study describes and analyzes three streams of a Tobacco free living policy cycle and assesses the role of public health, democratic participation, and economic interests in the tobacco free living policy making process. The analysis also seeks to determine the implications of the findings in this study for participatory governance and democratic policy making in the context of existing policy making frameworks. Tobacco free policy making analysis is conducted within an integrated framework that weaves major US policy frameworks including pluralist theories, elite dominance theories, critical theories, and participatory governance paradigms into Kingdon's (2003) streams framework.

While participatory governance frameworks have been used to analyze community health planning (Volenzo & Odiyo, 2018; Baldwin, 2020), there is a dearth of scholarship on the use of policy making conceptual or practice models to analyze health policy development in Community Health Improvement Plans (CHIPs). This paper addresses the paucity of studies which use democratic policy making frameworks to analyze health policy development in CHIPs. Findings from this analysis should inform the design and implementation of future policy practice initiatives in Community Health Improvement Plans. The case study methodology is used to explore the interplay among policy advocacy agenda alignment, the democratic policy making process, and tobacco free living policy decisions.

Rationale and Literature Review

Rationale

Community health policy development routinely includes community-level and state-level planning (Turmock, 2016). Local Public Health Departments in the United States usually develop Community Health Improvement Plans (CHIPs) in collaboration with other stakeholders in their communities so as to leverage community capacity and resources (Carlton & Singh, 2018; Grumbach et al., 2017). Policy development is now an integral part of community health improvement plans and it usually involves alignment of agendas within and across public health jurisdictions. The primacy of public interest and the integration of democratic processes are assumed and encouraged in community health policy development (IOM, 1988). In the CHIP tobacco free living policy initiatives, there were tensions between

economic and public health interests which played out at both the local/regional and state levels.

Tobacco Free Living Initiatives and Population Health

Many deaths and diseases, including multiple types of cancer, chronic obstructive pulmonary disease, cardiovascular disease, pregnancy complications, cataracts and osteoporosis can be traced to smoking (Duaso & Duncan, 2012). Tobacco control programs and policies reduce tobacco use, raise revenue, and prevent health and economic harms (Sung et al., 2005; Bhat & Henrichs, 2017; Maciosek et al., 2020). Most tobacco control programs and policies in the United States are implemented at local and state levels (Maciosek et al., 2020), and usually lead to reduced expenditures on medical care (Maciosek et al., 2020), lower mortality rates (Bowser et al., 2016), increases in tobacco free living (Tautolo et al., 2017), and overall improvement in population health (Bowser et al., 2016).

In the Mid-Western US region under study, tobacco free living is an issue that was salient in 2016 because the region and the state as a whole, continue to lead the nation in the prevalence of risky tobacco use behavior. Also, tobacco use is linked to the top causes of death in the region (State Dept. of Public Health,2013; Health Policy Foundation, 2013, 2017). The development of both state and local/regional tobacco free initiatives was driven by compelling public health interests.

Democratic Participation in Health Policy and Planning

Participatory governance involves citizenship participation in community health (Aston et al., 2009; World Health Organization (WHO), 2003); shapes the social contexts that affects population health outcomes by democratizing planning; and promoting social justice by enabling disadvantaged groups to influence policy making (Volenzo & Odiyo, 2018; Baldwin, 2020). Participatory governance could involve organized and non-organized mobilizing to improve the quality of democratic participation (Geissel, 2009); with the state and society jointly responsible for policy decisions (Mahmood & Muntane, 2020). Participatory governance also seeks to increase effectiveness and legitimacy of policy making (Ansell & Gash 2008; Bekemans. 2018; Elstub & Escobar 2019), even as it sometimes falls short of full democratic participation and community empowerment (Fung 2015; Rana & Piracha, 2020). Its shortcomings notwithstanding, participatory governance leads to active participatory assessment and planning, social learning, community empowerment, and public accountability (Volenzo & Odiyo , 2018; Rana & Piracha,2020).

Two contemporary paradigms of participatory governance include governance-driven democratization (Warren, 2014); and democracy-driven governance (Bua & Bussu,2021). Governance-driven democratization seeks to both address the legitimacy challenges of institutions and experts, and to improve policymaking by incorporating new voices, interests, and sources of information. In contrast, democracy-driven governance is more critically oriented and bottom-up and attempts to bring social movements into the state in pursuit transformative change (Blanco et al., 2020; Sintomer, 2018). The choice for CHIP leaders and statewide tobacco free policy alliances, is the incrementalism of governance-driven democratization (Warren, 2014), or transformative policy making that deepens democracy by building from bottom up (Bua & Bussu, 2021).

Tobacco free policy initiatives were developed and advanced within a framework of participatory governance at both local/regional and statewide levels using local and state partnerships. The Community Health Improvement Plan leadership advanced these initiatives through democratic policy making processes at both the local/regional and the state levels.

Institutional Contexts and Processes in Community Health Policy Development

Due to jurisdictional limitations and institutional contexts, some CHIP goals can only be realized through state level action. Local Health Departments'(LHD) policy development authority could be limited by state law. This necessitates collaborative policy making including the alignment of policy agendas with other statewide stake holders including governmental and non-governmental actors.

The United States intergovernmental structure embedded in federalism, has been the most important contextual factor in public health policy making including environmental health (Black et al., 2020), the Affordable Care Act(Beland et al., 2014), tobacco and vaccines (Pacheco & Boushey 2014), and the ongoing pandemic (Kettl, 2020; Crigler, 2021; Agnew, 2021). Public health activities in the United States are carried out by an intergovernmental network of state and local public health agencies working with the federal government. Laws at all levels of government bestow the basic powers of government and distribute these powers among various agencies and levels of government in the US federal system (Turnock, 2016; Wilensky & Teitelbaum, 2018).

Due to jurisdictional limitation, CHIP local/regional tobacco free initiatives were realized in a number of preventive strategies and actions in the local region. However, the statewide policy initiative was realized through tobacco free policy agenda alignment with other statewide stakeholders to advance legislation that would reduce the harms of smoking through a tax increase at the state level. This was because tobacco tax policy authority resided in the state government.

Regardless of the structure and process of policy making, laws and policies do not always favor the best interest of public health and sometimes laws and policies favor for-profit interest over the interest of the members of the community as policy makers balance competing values, interests, and goals (Wilensky & Teitelbaum, 2018). Various policy frameworks have advanced our ability to understand how different policy designs balanced competing interests and values in democratic policy making. Democratic policy frameworks clarify the democratic policy making process at the statewide level and participatory governance paradigms bring clarity to planning and implementation of tobacco free initiatives at the local/regional level.

Classical and Contemporary Policy Making Frameworks

Both classical and contemporary policy making models can contribute to our understanding of tobacco free living policy making in the Community Health Improvement Plan. Policy making models can guide policy analysis (Perl, et al., 2018), and theories of public policy shape our understanding of policy practice (Gal and Weiss-Gal, 2015), and illuminate limitations of policy designs (Schneider and Ingram, 1997). Feldman (2020), identified four policy theories including neo-institutional theory, elite theory, resource mobilization theory, and interdependent power theory**;** and conceptualized four different types of policy practices that would be informed by the four policy theories including institutional policy practice, elite policy practice, resource-based policy practice and radical policy practice. Classical policy making frameworks including power elite (Mills, 1956, Domhoff, 1990, 2018, 2020), and pluralist (Dahl, 1956, 1989), and their contemporary iterations (Harthman, 2007; Mayville,2015; Kelly, 2016; Wedel, 2017; Potulski, 2022) have historically dominated the conceptualization of public policy in the United States and cut across the four practice policy types identified by Feldman(2020) above. CHIP leadership developed and implemented a traditional institutional and elite policy practice in a governance-driven democratization

culture. The democratic policy making process through which tobacco free policy was made could be framed either through a power elite dominance lens or through the democratic pluralist lens.

The dominant perspectives in classical policy making models and stakeholder participation in the United States, pit the idea of power concentrated in a unified elite advanced by power elite theorists (Mills, 1956, Domhoff, 1990; 2018; 2020), with the argument of pluralist theorists who posit that power is distributed across a plurality of groups with no clear-cut public interests (Dahl, 1989). These conflicting perspectives are relevant to the IOM'S (1988) call for public health policy that is mindful of US "democratic processes" and the public interests. Classical power elite models assert that the United States and most of its local communities are far more elitist than pluralism acknowledges (Mills, 1956; Bachrach and Baratz, 1961; Manley, 1983; Domhoff, 1990). Economic interests and the professional forces set policy agendas (Bachrach and Baratz, 1961), preclude consideration of certain perspectives (Lukes 1974), determine selection of options at both the formulation (Lowi,1979)), and policy implementation stages (Lowi, 1964,1979) of the policy stream.

Empirical studies within the years have shown greater support for elite theories as opposed to pluralist theory (Kerbo, 1979; Domhoff, 2018, 2020; Potulski, 2022). The most powerful individual group within the ruling class consists of the major representatives of capital, that is, the top executives of the large corporations and the most important shareholders and entrepreneurs. The successes and failures of the business elite, as well as of the entire ruling class, depend largely on the power relations in society as a whole which are usually tilted to the disadvantage of interests that are in opposition to the power elite. These societal power relations have contributed markedly to reduced influence of both unions and left-wing or classic social-democratic parties and organizations. In short, "The ruling class will as a rule turn to its account whatever opportunities are offered it by the state of the power relations in society." (Harthman,2007). These trends have been steadily maintained in studies on diversity, inequality, country development, global developments, social democratic actions, and the US Constitution.

The monopoly and exercise of economic, political, and social power by a few has been both persistent as well as regressive for decades. Though the political thought that informed the design of the United States Constitution largely neglected the danger posed by socioeconomic elites, John Adams, was almost alone, in separating himself from other federalists such as Hamilton and Madison and recognizing the existence of an elite of wealth, birth, and beauty which retained overwhelming power even after the abolition of formal distinctions. This elite he maintained, posed a threat of aristocratic tyranny-specifically, the tendency of the elite few to undermine both popular representation and effective government (Mayville, 2015). Also, despite the growing diversity among the power elite, its core group continues to be wealthy white Christian males, most of whom are still from the upper third of the social ladder. Women, blacks, Latinos, Asian Americans, and openly homosexual men and women are all underrepresented, but to varying degrees and with different rates of increasing representation (Zweigenhaft,1998). Consistent with the questions of the dominance of economic elite and the threats to population representation in government decision making, this study examines the roles of the economic power elite, the public interest, and democratic participatory rights of marginalized groups in determining tobacco free policy development in a Community Health Improvement Program (CHIP).

Studies across countries including Turkey, Russia, Nigeria, France, and Britain have revealed that the dominance of the power elite was a global phenomenon. A cursory view of power distribution in modern Turkey might reveal diffused and fragmented decision making

among many people or elite groups which parallels pluralist models. However, consistent with the main power elite thesis, decisive and effective power has been concentrated and centralized in the hands of the small number of elite groups which are the most powerful in the national power structure (Turk, 2004). Analysis of decision making in the Russian system between 1991 and 2008 shows the role of the business elite as political-decision makers (Gaman-Golutvina, 2008). In Nigeria, the phenomenon of power elite "recycling" including civilian and military elites explains the numerous challenges the country faces in its efforts to consolidate democracy(Adesola, 2010). Building upon the writings of Pierre Bourdieu on power and domination, a cross-national comparative study demonstrated the extent to which power remains concentrated in the French and British corporate sectors; and showed how power elites function through governance networks to promote institutional and organizational goals (Maclean, et al., 2010).

Since Mills and Domhoff, other scholars have both confirmed and reframed our understanding of the power elite as a group and the manner in which they exercise influence. Contemporary scholars, particularly in the first, second, third decades of the 21st century, have reframed the power elite theory as a concept of how the balance of power is maintained within societal structures, such as securing legislative underrepresentation of the Hispanic population in the state of Texas (Kelly, 2016), the corporate dominated media always casting current debates in ways that do not seriously threaten elite power (Rapp & Jenkins, 2018), or the dominance of elite preferences over that of ordinary citizens in congressional policy making (Gilens & Page, 2014).

Furthermore, a revisit of the classic works of C W. Mills and William Domhoff, reveal that societal power relations persistently favored the power elite with occasional pressure from below which allowed for a few social democratic victories. After more than half a century, the works of Charles Wright Mills are still relevant to democratic and policy degeneration in contemporary society. Negative aspects of modern society such as: mass society, disappearance of the public sphere, bureaucratization and concentration of corporate power in the hands of the "power elite," explain the causes of contemporary processes of democratic regression (Potulski,2022). An analysis of power relations in the classic, *Who Rules America?* by Domhoff and eleven sociologists and political scientists , fifty years after its original publication in 1967, provided fresh insights on many contemporary topics. These included : school privatization movements, foreign policy and expanding role of the military-industrial power elite; the successes and failures of union challenges to the power elite; the ongoing and increasingly global battles of a major sector of agribusiness; and the successes of advocates of social democracy in enacting crucial banking reform in the aftermath of the Great Recession (Domhoff, 2018). In a later book, Domhoff demonstrates why the three ascendant theories of power in the early twenty-first century--interest-group pluralism, organizational state theory, and historical institutionalism--cannot account for the complexity of events that established the power elite's supremacy and led to labor's fall. The analysis reveals how a corporate-financed policy-planning network, consisting of foundations, think tanks, and policy-discussion groups, gradually developed in the twentieth century and played a pivotal role in all three issue-areas (Domhoff, 2020). This study therefore examines the influence of state level corporate financed networks representing tobacco farmers and national level tobacco products manufacturers on tobacco free living policy development at the state level.

In addition, other contemporary elite dominance perspectives have expanded the definition of the elite class, and their analysis of elite activities and strategies. Elite class is expanded to include business leaders and their perspectives of “enlightened self-interest”

(Mizruchi,2017), and authoritative government experts (Amurov, 2020). Other contemporary elite dominance perspectives paint a picture of elites who operate under the radar of democratic scrutiny by infiltrating social movements (Pichardo,1995), and coordinating influence from multiple and fluid domains, inside and outside official structures (Wedel, 2017). These conceptual transformations, when considered alongside the broader view of political power described by Mills, Domhoff, and other pioneer power elite theorists, clarify the contexts and processes that shape public health policy development within communities and across state political systems. The dominance of economic interests is not always transparent, and the professional class might in some cases be considered part of the elite class.

Critical and democratic theories which focus on social justice, power, social constructions, and how identities are formed insist that the policy making process has disempowered citizens. They also advocate for substantive norms of egalitarian justice with inclusive political and economic processes for all structurally constituted social groups (O'Neill, 2005; Hilmer, 2010; Leiviskä, 2018; Hansen & Caterino, 2019), and argue that many policy designs are derived from a social construction of issues and target populations in a process that favors the interest of the powerful (Schneider and Ingram (1997). Contemporary scholars of critical and democratic theory call for an expanded social justice which includes more participants and more sectors of participation in political decision making (Leiviskä, 2018; Hansen & Caterino, 2019). Critical and democratic theorists provide the road map to winning more social democratic victories as articulated in Domhoff' s "pressure from below" moments (1990, 2018, 2020).

Governance-driven democratization paradigms (Warren,2014), which are elite driven, align with elite policy making framework's view of how policy is currently made. On the other hand, democracy-driven governance paradigm (Bua & Bussu,2021), aligns with the policy making improvement recommendations from the perspective of critical and democratic policy theories which position grass roots citizens as drivers of governances in a social justice context which would realign processes, structures, and cultures. It is at the intersection of participatory governance and democratic decision-making frameworks, that this case study examines the interplay of democratic health policy making processes, intra and inter-jurisdictional policy agenda alignment, and tobacco free living initiatives in a Community Health Improvement Plan.

The Community Health Improvement Plan Setting

Demographics

The CHIP covers a four- county region of about 400,000 in a state of 4.5 million residents. In the twenty years before the implementation of CHIP, the region has seen increases in population and changes in ethnic make-up of residents. The general population increased by 17.8% but the white population decreased from 94.5% of the population to 89.7%. The Hispanic population saw the fastest increase from (1.3% to 3.2%), followed by the African American population (2.4% to 3.6%)(U'S Census Bureau, 2017).

There are significant variations in education and income among counties in the region under study. High school graduation rates range from 82% to 92% as compared to 86% in the U.S. Rates for bachelor's degree or higher range from 11% to 30% as compared to 29% in the U.S. Median household income ranges from $46,159 to $67,225 compared to $53,046 in the U.S. Poverty rates range from 8.7% to 20.1% compared to 14.8% in the U.S. (U'S Census Bureau, 2017).

Health Status

The Health of residents has seen a downward trend. The top causes of death are: 1. cancer (rate = 186.8 per 100,000); 2. heart disease rate = 170.4 per 100,000); 3. unintentional injuries and accidents (rate = 70.8 per 100,000)**;** 4. chronic lower respiratory diseases (rate = 56.6 per 100,000); 5. Stroke (rate = 36.4 per 100,000)**;** 6. diabetes (rate = 31.0 per 100,000); 7. alzheimer's disease (rate = 24.7 per 100,000)**;** 8. influenza and pneumonia (rate = 15.9 per 100,000); 9. suicide (rate = 13.9 per 100,000)**;** 10. kidney diseases (rate = 12.2 per 100,000) (State Dept. of Public Health, 2013). Infectious diseases and communicable diseases include hepatitis C, sexually transmitted infections, human immunodeficiency virus (HIV). Unhealthy behaviors include tobacco use, low or no physical activity, poor nutrition habits; mental health and substance use disorders driven by opioid and heroin addiction crisis. Residents are also confronted by environmental health issues such as air quality and water sewage systems; and access to health care barriers including insurance and attachment to a regular source of care (Health Policy Foundation, 2013, 2017; Tataw & Ekundayo 2019; Tataw, 2020a, 2020b; Tataw et al., 2021)

The Community Health Improvement Plan: Policy Issue Selection

A Mid-Western Region of the US implemented a Community Health Improvement Plan (CHIP), covering the period 2016 to 2020. A collaborative process combined four different assessments related to different aspects of community health and developed by individual steering committee member organizations of the community partnership and constituted a plan leadership made up of a steering committee of 6 members (The Health Department, 2016 a,).

The plan was developed around three health issue areas including healthy behaviors; health care capacity, access and delivery; and changes in policy, systems, and environment which were each linked to plan goals (The Health Department, 2016 b). Health Behaviors encompassed goals 1-3 as follows: goal 1. good nutrition; goal 2. active living; and goal 3. tobacco free living. Healthcare Capacity, Access, and Delivery encompassed goals 4 to 8 as follows: goal 4. Health Care Coverage; goal 5. Medical Homes; goal 6. Heart Care; goal 7. Behavioral and mental health services; and goal 8. Treatment for Substance Use Disorder. Changes in Policy, Systems and Environment covered goals 9 and 10, as follows: goal 9. Health Workforce Transformation and goal 10. Aligned Advocacy agendas. This paper focuses on two issue areas: health behaviors and changes in policy, systems, and environment.

Study Objectives

The purpose of this study is to describe and analyze three phases of the Tobacco free living policy cycle based on Kingdon's (2003), stream's framework including problems, policy, and political streams, and to assess the role of public health and economic interests in tobacco free living policy making through Kingdon's three streams. The analysis also seeks to determine the implications of the policy development process for participatory governance and democratic policy making in the context of existing policy making frameworks.

The purpose of this paper is achieved through the following objectives:

1. To describe and analyze the three phases of the tobacco free living policy life cycle at both the local/regional and state levels of decision making, including problems, policy, and political streams.
2. To describe the role of economic interest in Tobacco policy making at the local and statewide levels

3. To discuss the implications of the findings from 1 and 2 above for democratic governance, democratic public health policy making, and policy practice in Community Health Improvement Plans.

Framework of Analysis

Tobacco free policy making analysis was conducted within an integrated framework that weaves major US policy frameworks and participatory governance paradigms into Kingdon's (2003) streams framework. Major policy making frameworks in the United States focus on agenda setting and decision making in a manner that integrates policy, power, and politics into democratic decision making. Using major frameworks of policy making to assess both the policy agenda alignment process and the results of tobacco free policy, provides the space for considering implications for democratic policy making. The character of the policy problem, the contexts in which policy development occurs, the policy making process, the content of the ultimate law, and the impact of the law and programs are all interrelated and co-exist in US state and local democratic political processes. Participation, planning, and implementation are best understood via participatory governance paradigms. The IOM's 1988 call, was for the integration of all these elements through the US democratic political process so that public health policy grows from the people and their social systems.

Policy Streams Framework: The mapping of the tobacco free policy cycle was guided by Kingdon's agenda setting streams framework. Kingdon's (2003), streams framework, conceptualizes a three-phase policy life cycle including problems, policy, and political streams. In the problem stream, issues are identified and defined based on various indicators or events. The policy stream represents solutions generated about the issue. The political stream describes factors that bring a problem into focus or favor a specific policy solution, such as national concern about an issue.

Major US Policy Frameworks: The problem, policy, and political streams will be analyzed using US policy frameworks and participatory governance paradigms. Policy frameworks of interest included pluralist, power elite, and critical democratic theories. Participatory governance paradigms deployed in the analyses were governance-driven democratization paradigm (Warren ,2014), which aligns with power elite theorists' perspectives of policy making and democracy-driven governance paradigm (Bua & Bussu,2021), which aligns with policy making directions recommended by analyses in critical and democratic theories. Also, the governance-driven democratization paradigm is consistent with institutional and elite policy practice while democracy-driven governance paradigm aligns well with radical policy practice (Feldman, 2020).

Methods To Assess Tobacco Free Policy Cycles

Design

This is a case study employing a mix of quantitative and qualitative techniques and a variety of data sources including participant observation, extant literature, survey data, evaluation reports, and cigarette utilization studies. The author was both a member of the CHIP implementation team and the lead evaluator.

The case study method is utilized in this analysis because its interpretive and critical approaches (Macpherson et al., 2000), are designed to investigate the rich complexities of social phenomena and the social environments in which they are situated (Stake, 2012; Yin,2014). The use of thick descriptions and rich understandings of unique social contexts

(Macpherson et al., 2000; Yin, 2014), make the case study method an effective analytic method for formation and implementation of public policy (Macpherson et al., 2000). States are at the center of tobacco and other public health policy (Pacheco & Boushey 2014), and the variability and uniqueness of state level policy actions and processes have been well documented (Kettl, 2020; Agnew, 2021). The case study method creates space for the consideration of each unique dimension of tobacco free policy development and outcomes, and captures the description and analysis of contextual factors, processes, local/regional and state program initiatives, as well as the relevance of existing policy frameworks in informing analysis and policy practice. In addition, this analysis relies on a variety of data sources which enable triangulation of evidence around context, process and jurisdiction (Yin, 2014).

Data Sources and Analysis

Assessment of the policy making process was guided by streams framework (Kingdon, 2003), including problems, policy, and political streams. Within the three streams, the following measures were covered: impact of public health and economic interests on three agenda setting streams; types and patterns in agenda alignment activities at local and state levels; patterns in advocacy activities; impact of decisions on health , state revenues, and interest groups; representativeness of marginalized groups and their degree of participation in decision making in policy advocacy organizations and CHIP leadership.

Data sources included CHIP results of a 2019 survey administered to CHIP steering committee members covering policy issue identification , advocacy, policy selection, issue selection criteria, partnership, and collaboration for policy advocacy. Other secondary data sources included published health department reports such as the Community Health Assessment and the Community Health Improvement Plan, newspaper accounts on statewide tobacco free living campaigns, legislative reports, Community Improvement Plan Mid-Point evaluation reports, and national cigarette utilization reports such as the Maxwell Report (2019), and published literature on CHIP. Some of the data came from participant observations of the author who participated in steering committee and program evaluation activities. Steering committee activities included meetings, advocacy events, and collaborative meetings with groups outside the steering committee.

Various descriptive, interpretive, and analytic techniques were used to obtain enough information to organize and report data from secondary sources, participant observation, and policy framework analysis. Data analysis included description of activities and processes, categorization of qualitative data and policy processes, comparisons of jurisdictional and contextual realities, and interpretive analysis that merged policy frameworks to various data results.

This study was approved by the Institutional Review Board of the University Partner as an exempt study.

Results

Summary

The results section presents the tobacco free policy cycle description and analysis including problems, political streams, and policy options at the local/regional and statewide levels. Problems cover the disease burden related to tobacco use. Political streams include plan leadership representation and policy decision making including perceptions of the CHIP steering committee members related to policy advocacy alignment and democratic participation; policy advocacy agenda alignment, statewide interest groups; and alignment of policy advocacy activities. Policy solutions will cover the following: Local/regional smoking

reduction programs and their outcomes; local/regional intervention results; statewide tobacco free policy; and state tobacco free policy results.

Tobacco Free Policy Problem Streams

CHIP tobacco free programs and policy initiatives were covered under goal 3 (Tobacco free living) in the Healthy Behavior priority issue and goal 10 (the alignment of advocacy agendas) in Policy, Systems, and Environment priority issue. Tobacco free living is an issue that was salient for the region because the region and the state as a whole, continue to lead the nation in the prevalence of risky tobacco use behavior. Also, tobacco use is linked to the top causes of death in the region including cancer, heart disease, and chronic lower respiratory disease (State Dept. of Public Health, 2013; Health Policy Foundation, 2013, 2017; Tataw, 2020a, 2020b; Tataw et al., 2021). Finally, this was an issue where most member organizations and steering committee members could come together on a solution they were all willing to live with.

Tobacco Free Political Streams

Plan Leadership Representation and Policy Decision Making

This section presents the results of a 2019 survey administered to CHIP steering committee members related to policy advocacy decision making . A description of the decision-making structure for the Community Health Improvement plan steering committee is also presented.

Perceptions of Steering Committee Members

Survey results on the perception of steering committee members related to policy agenda alignment revealed that members had an overall positive perception of the work of the partnership, even as they saw opportunities for growth. They believed the partners spoke with one voice to policy makers on health issues and they recognized achievements in the policy, systems and environments priority issue. Identified achievements realized by CHIP members included policy action, advocacy and collective action for local/regional and statewide health interventions, and policy issue selection; and they were convinced the partnership was inclusive. Tobacco free living was listed as an important policy initiative that was collectively advanced, particularly the cigarette tax. However, local/regional tobacco use prevention initiatives were not listed as examples of policy advocacy alignment success stories (Tataw, 2020a; Tataw & Ekundayo, 2019; Tataw et al., 2021).

Within the plan steering committee, steering committee members reported a systematic and democratic process used to identify policy issues for collective advocacy in which every effort was made to arrive at a consensus. However, members also noted a need for the expansion of the representativeness of the steering committee and for improvement in policy advocacy. Some steering committee members believed that more local/regional leaders needed to join the collective advocacy efforts (Tataw, 2020a; Tataw & Ekundayo, 2019; Tataw et al., 2021).

Steering Committee Decision Making Structure and Culture

The steering committee was made up of a local health department, a local/regional health system , a major public university, two major non-profit organizations, and the chambers of commerce. Absent from the steering committee were organizations that represented marginalized communities such as the homeless, religious minorities such as muslims, social justice groups, school districts, Hispanic community groups, and Black churches to name a few. Also, while policy advocacy decisions within the steering committee were collectively

made in a democratic and participatory manner through consensus, the plan advocacy decisions that affected the entire region of four counties were made without representation from some communities , particularly marginalized groups because they were not on the steering committee. It is hard to say if issues pertinent to these communities ever made it to the policy agenda.

Policy Advocacy Agenda Alignment

Local/regional Tobacco free initiatives were realized in a number of preventive strategies and actions in the region. The statewide policy initiative was realized through tobacco free policy agenda alignment with other statewide stakeholders to advance legislation that would reduce the harms of smoking through a tax increase at the state level. At the local level, CHIP partners were decisions makers and aligned local/regional policy agendas with other plan partners to implement tobacco free living programs. At the state level, the partners represented an interest group in the state health policy making process and aligned their advocacy agendas with like-minded interest groups to advance tobacco free living policy in the state legislature.

Statewide Interest Groups

The community partners aligned their advocacy agenda with a statewide campaign to reduce tobacco consumption led by other tobacco cessation interest groups. The campaign to advance tobacco free living was led by a 145-member statewide coalition made up of a diverse group of stakeholders who have formed a statewide organization speaking with a single voice to improve the health of populations by reducing tobacco use and protecting state residents from the dangers of secondhand smoke and other tobacco-related emissions. Members of the statewide coalition included the following: American Cancer Society Cancer Action Network, American Heart Association American Stroke Association, American Lung Association, Major Health Providers in the state, Tobacco-Free Organizations, Insurance Companies, Health Foundations, Cancer Foundations, Smoke free Institutes, Association of Health Departments, Council of Churches, Social Justice organizations, Chambers of Commerce, State Medical Associations, State Nurses Associations, School Boards Association, and State Hospital Associations.

The main opposition to the proposed law was from a Richmond, Virginia-based Altria Group, the parent company for Philip Morris USA and U.S. Smokeless Tobacco Company. Altria employs several legislative lobbyists in the state, according to the state Legislative Ethics Commission. There was also significant opposition from state Tobacco growers who lobbied state law makers extensively to not pass the legislation.

Statewide Campaign Missing Parties

Despite the robust representation in the statewide campaign, some key constituencies were missing. Missing parties included restaurant workers, retail workers, convenient store clerks, workers in big warehouses etc. who are on the frontlines of second-hand smoke exposure.

Alignment of Policy Advocacy Activities

Policy Advocacy activities to advance tobacco free living were aligned both within the local community and across the state through individual and collective initiatives by partners. These included joined phone call campaigns, new conferences, and social media campaigns. Individual CHIP steering community members worked through their state organizations to support the smoking reduction policy campaign. For instance, the local/regional chambers of commerce worked through the state chambers of commerce, health providers worked through

the State Hospital Association, and the Health Department worked through the State Health Departments Association.

Programmatic and policy agendas were more aligned among community partners when participating in local/regional initiatives than for statewide initiatives. Consensus was quickly forged for the development and implementation of local/regional smoking reduction programs. When it came to reaching consensus on a cigarette tax rate, CHIP steering committee members struggled hard to agree on a rate and some steering committee member organizations did not join the statewide campaign. The alignment of policy agendas among CHIP community partners was harder when issues were tough and opposition from economic interest was high. Reticent CHIP partners who did not join the statewide initiative include local public entities who were not sure of the position of the state governor and legislature on the policy issue. Some did not just want to go against the economic power of tobacco manufacturing and agricultural interests.

Tobacco Free Policy Options and Solutions

There were two policy options which were finally passed and implemented at both the local/regional and state levels. At the local/regional level several smoking cessation programs were implemented as part of the CHIP while at the state level a cigarette tax law was passed albeit at a much lower level than public health advocates pushed for. More aggressive measures such as workplace and business premises restrictions which could have curtailed second hand smoke never made it through the agenda setting stream as policy options to be voted on. The two policies which were enacted and implemented are described below.

Local/regional Smoking Reduction Programs

The Community Health Improvement Plan included several programs within the local region to improve tobacco free living. These included five organizational and community level action steps to implement tobacco free policies in the health district, eleven community, organizational, policy and systems level action steps to implement evident based smoking cessation strategies and programs at the organizational and community level. There were also five individual level action steps implementing education and media campaigns to reduce tobacco use, and exposure to secondhand smoke in the target population (The Health Department(2016 c).

Local/regional Intervention Results

A formal Mid-Point evaluation of the Community Health Improvement Plan revealed that the local/regional smoking rate for adults rose from 24.9% in 2013 to 29.9% at the end of 2017, while rates for youths increased from 26.3% to 28.00% (Tataw & Ekundayo, 2019; Tataw et al. 2021). The smoking rates for both adults and youths were 50 percent worse than the Community Health Plan Target of 20%.

Statewide Tobacco Free Policy

The policy solution that the Tobacco free living campaign came together to support was an increase in the price of tobacco by $1.00 a pack. The state legislature ultimately passed a bill that was signed into law in March 2018 and took effect July 1,2018. As part of the bill, the tax rate for cigarettes was increased from $0.60 to $1.10 per 20 cigarettes and a proportionate rate for packs of 25s as of July 1, 2018. The increase was $0.50 or 50% short of the target.

Statewide Tobacco Free Policy Results

This section documents the state of tobacco free living after both statewide initiatives and community initiatives in the Community Health Improvement Plan have been implemented. Within the first 12 months (July 1, 2018 to June 30, 2019), of implementing the 50-cent-per-pack state excise tax increase, cigarette sales went down by 10.1 percent and the state raised $140 million in tax revenues. This decline in cigarette purchases was much greater than in recent state trends and higher than the nation as a whole. For example, from 2016 to 2017, state cigarette sales declined 3.5 percent. During fiscal 2019, nationwide sales declined 6.1 percent (The Maxwell report , 2019). In a poll conducted in August, September, and October of 2019 by a local university and paid for by a statewide health foundation, 39 percent of smokers reported cutting down on smoking due to higher prices.

Discussion

Summary

This study describes and analyzes the Tobacco free living policy cycle implemented in a Community Health Improvement Plan and assesses the roles of public health interest, democratic participation, and economic interests in the policy making process. The policy making process is assessed within an integrated framework of analysis that weaves pluralist, power elite, critical democratic theories, and participatory governance paradigms into Kingdon's (2003), streams framework which includes problems, policy, and political streams. Both the policy making process and policy outcomes are anticipated and explained by the governance-driven democratization paradigm and elite dominance theories. More so, the democracy driven governance paradigm, as well as democratic and critical theories, illuminate the shortcomings of the policy making process and the policy design. They also show the pathway to improving policy practice components of the Community Health Improvement Plan (CHIP) from institutional and elite policy practice to radical policy practice (Feldman, 2020).

Convergence of Patterns

There is a significant convergence of patterns in the results from different data sources. The CHIP leadership survey, participant observation, and structural representation in the CHIP leadership and decision making pointed to a deficit in democratic participation. Also, patterns in perceived and actual outcomes for interventions in both local/regional and state jurisdictions were congruent. Survey results pointed to the need to expand representation in the CHIP coalition, while structurally, there were no marginalized groups in the steering committee despite the rise in minority populations and low-income serving organizations in the region. To a lesser extent, statewide campaigns were missing some important stake holders. In addition, quantitative data pointed to greater economic and health outcomes for the statewide tobacco free living initiative compared to the local/regional initiatives. Consistent with quantitative data, qualitative survey responses did not identify the local/regional tobacco free initiatives as one of the important policy success stories but pointed to the statewide cigarette tax initiative as a successful policy agenda alignment story. This seems to confirm the pre-eminence of the state jurisdiction and institutions in tobacco free policy making.

Local/regional Versus Statewide initiatives and Economic Interests

Despite the higher intensity of interventions to advance tobacco free living at the local/regional level and the limited scope of state legislative action; statewide tobacco free

initiatives were more successful than local/regional initiatives in advancing population level outcomes. Secondary data revealed higher behavior outcomes for tobacco free living in statewide initiatives compared to local/regional initiatives. These findings suggest that mandatory remedies that affect all residents involved in the targeted risky behavior are more effective than programs that are voluntary and do not necessary reach all people engaged in a risky behavior during the intervention period. The economic and health outcomes result for the statewide level tobacco free policy initiative, are consistent with findings in other studies. Prior studies show that tobacco tax increase and other mandatory policies pay off through reduced expenditures on medical care, increase in revenue, and reduction in health and economic harms (Sung et al., 2005; Bhat & Henrichs, 2017; Maciosek et al., 2020); lower mortality rates (Bowser et al., 2016); increases in tobacco free living (Tautolo et al., 2017); and overall improvement in population health (Bowser et al.,2016). As a win for economic interest and a loss for public health interest, a list of mandatory policy options discussed below, which could have been more impactful in reducing tobacco use in the state, did not make it to the policy making agenda.

Though the tobacco free tax policy was passed into law and the results were better than expected, the target of the advocacy coalition was not achieved and many alternative policy options were never allowed to get to the political agenda due to the influence of both cigarette companies and tobacco growers who both represent economic interests in the policy making process. The preeminence of state institutions in public health policy making and in state and local public health policy interactions, has been documented in the literature (Pacheco & Boushey 2014; Black et al., 2020). The study findings which confirmed the dominance of economic interest in tobacco free living policy making are anticipated in both classic and contemporary elite dominance policy making frameworks (Mills, 1956, Domhoff, 1990,2018, 2020; Hartman, 2007; Gilens & Page, 2014 ; Kelly, 2016; Rapp & Jenkins, 2018, Potulski, 2022). These findings are also consistent with some nationwide studies which show interest groups as minor players in state tobacco actions (Pacheco & Boushey 2014). Furthermore, the findings are affirmed by the conclusions in Domhoff' s recent analysis of power elite dominance which demonstrated why the three ascendant theories of power in the early twenty-first century--interest-group pluralism, organizational state theory, and historical institutionalism--cannot account for the complexity of events that established the power elite's supremacy (2020).

Democratic Policy Making Process: Elite Dominance and Participation

Elite Dominance

The policy activities and outcomes in both local/regional and state jurisdictions superficially appear to be significantly consistent with conceptualizations in a number of opposing frameworks including: elite dominance theories (Mills,1956; Domhoff, 1990, 2018,2020; Gilens & Page, 2014; Wedel, 2017); governance-driven democratic paradigms (Cornwall & Coelho, 2007; Warren, 2014); and interest group activities anticipated in pluralists' democratic policy frameworks (Dahl, 1956,1989). On the other side of the coin, the policy development process and policy design lacked the recommended elements in democracy-driven governance paradigm (Bua & Bussu,2021); and democratic and critical theories (Barb, 2018; Hansen & Caterino, 2019).

A casual observer of this policy development might mistake the presence of interest groups such as the professional class and the economic interests for the existence of competing interests engaged in bargaining and negotiating policy solutions, just as anticipated in pluralist democratic policy models (Dahl, 1956,1989). However, a closer look reveals the

dominance of economic interests which is consistent with elite dominance models where elites shape the policy options and ultimate policy solutions (Mills,1956; Schattsneider,1960; Domhoff, 1990, 2018, 2020; Gilens & Page, 2014; Wedel, 2017). This reality is evidenced by the timid tobacco free living initiatives that were finally passed into law. The $1.00 compromised tax target was further reduced to $.05. Also, statewide mandatory policy solutions that would limit tobacco smoking in work and public places or regulate business enterprise behavior in any significant way were excluded due to pressure from dominant economic interest groups representing tobacco farmers and cigarette manufacturers.

Consistent with contemporary elite dominant theories, the elite class was both part of the movement to achieve tobacco free living and the opposing interest group. The compromised $1.00 target was possible because business interest represented by the chambers of commerce which was part of both the local/regional and statewide alliances negotiated the target down to $1.00. This seem to be consistent with suggestions of contemporary elite theories which posit that dominant business leaders now adopt a moderate and pragmatic approach to politics (Mizruchi, (2017), or usurped social movements in order to obstruct progress (Pichardo,1995); and sometimes operated under the radar of democratic accountability by coordinating influence from multiple and fluid domains, inside and outside official structures (Wedel, 2017).

The popular and massive advocacy campaign for tobacco free living policy and programs led by the professional class might give the impression of Domhoff' s (1990, 2018, 2020) "pressure from below," but a more critical analysis shows weaknesses in democratic participation within the advocacy groups which excluded lower and marginalized classes in a degenerative policy and program design as articulated by Schneider and Ingram (1997), undermined popular representation(Mayville, 2015) and advanced democratic regression (Polutski ,2022). The steering committee of the Community Health Improvement Plan was dominated by the professional class and select organizational leaders while excluding both the larger community and the marginalized populations. Also, the statewide initiative was predominantly a professional class affair. Some contemporary elite scholars consider the professional class as part of the pollical elite (Amurov, 2020).

Weak Democratic Participation

Tobacco free living policy development players did not fully consider democratic participation. The findings in this analysis show a tobacco free living public health policy development process with a gaping deficit in democratic participation at both the local/regional and state levels. While the policy advocates answered IOM's (1988) clarion call by aggressively pursuing public interest in community health policy development, and by working within US democratic processes, democratic participation was still significantly challenged at both the local/regional and state levels of public health policy development. Findings of weak democratic participation are inconsistent with democracy-driven participatory governance which carries a transformative ambition to advance social justice so that citizens from the bottom are agenda drivers **(**Blanco et al. 2020; Sintomer 2018; Bua & Bussu,2021**).** They are also inconsistent with the laments of critical and democratic theorists who advocate for substantive norms of egalitarian justice with inclusive political and economic processes for all structurally constituted social groups (O'Neill, 2005; Hilmer, 2010; Leiviskä, 2018; Hansen & Caterino, 2019). The Community Health Improvement Plan policy practice was handicapped by structures which limited popular mobilization from marginalized sectors (Fung 2015); and failed to actively engage with marginalized stakeholders (Rana & Piracha,2020). These factors weakened the movement's ability to deal

with the root causes of the tobacco policy problem and diminished the political power of advocates to enact fundamental change such as robust mandatory policies through tax and work place measures. These findings suggest the need for CHIP to transition from institutional and elite policy practice to radical policy practice (Feldman,2020), and from a governance-driven democratization paradigm to a democracy-driven governance.

Limitations

The findings in this analysis should be considered in the context of the study limitations including the scope of survey questions and the generalizability of a case study findings. The study of democratic participation was limited to the CHIP leadership and structural representation in advocacy movements and organizations. In addition, there were no questions on policy advocacy or democratic representation on the community outcomes surveys from which CHIP evaluation outcomes data was obtained. Future researchers and planners should consider including partnership and participation questions in community wide evaluation surveys. Other study designs that would advance the generalizability of findings should be considered including multiple case studies or survey research evaluation with a sample drawn from several CHIPs.

Conclusion and Recommendations for Community Health Practice and Research

This was an analysis of inter-governmental public health policy development to advance tobacco free living in a Mid-Western region of the United States which was performed at the intersection of participatory governance and democratic decision-making frameworks. The case study examined the interplay of democratic health policy making processes, intra and inter-jurisdictional policy agenda alignment, and tobacco free living initiatives in a Community Health Improvement Plan.

This study arrived at important findings that are relevant to the policy practice goals and activities of the Community Health Improvement Plan leaders and other planners of health and social care policy initiatives in communities. The findings suggest that economic interests and powerful corporate interest groups remain dominant in public health policy making at both the local/regional and state levels. The economic power elite were able to both limit the impact of enacted policies and to eliminate certain options from consideration. Though occasionally, the professional class might mount campaigns to make public health policy changes in the public interests, a main stay of decision making in tobacco free living policy at both local/regional and state levels, is limited citizenship participation due to systematic exclusion of low income and marginalized populations from the public health policy development process. The preeminence of the state institutions and economic elite class was further illuminated by variations in community and state- level tobacco free policy outcomes and the shifting solidarity in agenda alignments when the governmental decision-making points change from local to state levels or issues faced powerful economic interest opposition. Elite dominance theories and paradigms explain the societal power relationships which enabled the dominance of economic interests; while democratic and critical theories both shine the light on shortcomings in current practice and analytic paradigms, and point the way to improvements.

Based on the findings discussed above and the future pathways recommended in both democracy-driven governance paradigms (Blanco et al. 2020; Sintomer, 2018; Bua & Bussu,2021**)** and egalitarian justice perspectives of critical and democratic theorists which call for inclusive political and economic processes for all structurally constituted social groups (O'Neill, 2005 ; Hilmer, 2010; Hansen & Caterino, 2019; Leiviskä, 2018), the

recommendations below are submitted for future designs and implementation of Community Health Improvement Plans in the region under study and beyond. The current paradigm for policy development to advance tobacco free living in the Mid-Western USA region under review, is to seek compromise in the middle and move policy incrementally, nibbling on the edges of a vexing health problem, and avoiding tough decisions necessary to reverse the widening disease burden and mortality generated by tobacco use. To change these trends, future public health policy development efforts addressing difficult problems such as tobacco free living should consider expanding citizenship participation by adopting grassroots efforts that include low income and other traditionally marginalized groups. Also, Community Health Improvement Plan initiatives which address tough problems such as tobacco use, should adopt elements of democracy-driven governance and democratic and critical theory recommendations for transformative transitions to citizen driven agendas with inclusive structures, processes, cultures, and framing. These are the kinds of radical actions and strategies (Feldman, 2020) which have allowed pressure from below to secure a few social democratic wins in a societal context dominated by the power elite (Domhoff, 2018, 2020).

Furthermore, as discussed in the limitations above, the generalizability of the findings in the study is compromised by the single case method adopted in this study. The recommendation is for studies of tobacco free living policy development or any other community health policy issue, to consider a multiple case approach or survey research that covers multiple Community Improvement Health Plans. The recommended study designs would improve the generalizability of findings from studies on policy development in US Community Health Improvement Plans.

Author's Biography

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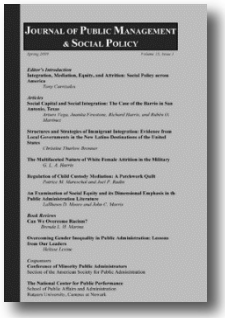

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