A network approach to policy framing: A case study of the National Aboriginal and Torres Strait Islander Health Plan

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ABSTRACT

Aboriginal health policy in Australia represents a unique policy subsystem comprising a diverse network of Aboriginal-specific and “mainstream” organisations, often with competing interests. This paper describes the network structure of organisations attempting to influence national Aboriginal health policy and examines how the different subgroups within the network approached the policy discourse. Public submissions made as part of a policy development process for the National Aboriginal and Torres Strait Islander Health Plan were analysed using a novel combination of network analysis and qualitative framing analysis. Other organisational actors in the network in each submission were identified, and relationships between them determined; these were used to generate a network map depicting the ties between actors. A qualitative framing analysis was undertaken, using inductive coding of the policy discourses in the submissions. The frames were overlaid with the network map to identify the relationship between the structure of the network and the way in which organisations framed Aboriginal health problems. Aboriginal organisations were central to the network and strongly connected with each other. The network consisted of several densely connected subgroups, whose central nodes were closely connected to one another. Each subgroup deployed a particular policy frame, with a frame of “system dysfunction” also adopted by all but one subgroup. Analysis of submissions revealed that many of the stakeholders in Aboriginal health policy actors are connected to one another. These connections help to drive the policy discourse. The combination of network and framing analysis illuminates competing interests within a network, and can assist advocacy organisations to identify which network members are most influential.

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1. Introduction

This article presents a unique approach to analysing policy development, combining two conceptual-methodological approaches in order to concurrently examine the network structure of organisations attempting to influence national policy, and the way in which the policy discourse is framed by different subgroups within the network.

Australian Aboriginal and Torres Strait Islander (Aboriginal) people, like other Indigenous populations within colonised Western countries, experience significant health inequalities compared to the non-Indigenous population (Anderson et al., 2007; Bramley et al., 2004; Ring and Brown, 2003). Life expectancy for Aboriginal Australians is ten years less than that of other Australians (Australian Institute of Health and Welfare, 2015; Anderson et al., 2016).

2. Aboriginal health policy in Australia

Aboriginal health policy, a subsystem of health policy in...
Australia, is characterized by pressing and often seemingly intractable policy problems, and a large number of stakeholders and interest groups with competing discourses.

To many Aboriginal people, “health” is viewed as “not just the physical well-being of the individual but the social, emotional, and cultural well-being of the whole community. This is a whole-of-life view and includes the cyclical concept of life-death-life” (National Aboriginal Health Strategy Working Party, 1989, p. x). While this definition of health appears in policy documents and is widely used by Aboriginal organisations, other (sometimes perhaps incompatible) approaches have been adopted by Government departments responsible for Aboriginal Affairs policy (Sullivan, 2011).

The Australian Government has also developed a number of different policy responses to specifically address Aboriginal health (see for example National Aboriginal Health Strategy Working Party, 1989; National Aboriginal and Torres Strait Islander Health Council, 2003) and comprehensive analyses of these have been published elsewhere (Anderson and Sanders, 1996; Anderson, 2004, 2007). Despite the purported “whole of government” approach to Aboriginal affairs policy, which began in 2004, many advocates believed that Aboriginal health remained insufficiently and unevenly funded (Calma, 2005; Dwyer et al., 2004). They called for unequivocal political and public commitment to ending Aboriginal health inequality (Calma, 2008).

In 2007, following the election of a new Labor (social democratic) Government, a commitment was made “to a partnership between all levels of government to work with Indigenous communities to achieve the target of closing the gap on Indigenous disadvantage” (Council of Australian Governments, 2007, p. 2). While this policy discourse has been criticised for perpetuating a deficits approach which stigmatises Aboriginal people (Pholi et al., 2009), it coincided with increased cooperation and investment in programs to improve Aboriginal health. For example, in 2008, $4.6 billion was invested by Commonwealth, State and Territory governments as part of the landmark Closing the Gap initiative (Council of Australian Governments, 2009). The Federal Government also appointed Australia’s first ever Minister for Indigenous Health in June 2009.

3. The National Aboriginal and Torres Strait Islander Health Plan

In November 2011, it was announced that a new National Aboriginal and Torres Strait Islander Health Plan (“Health Plan”) would be developed (Roxon and Snowdon, 2011) to guide action towards achieving the Closing the Gap targets over the next decade. The Australian Government’s Department of Health and Ageing released a discussion paper (Department of Health and Ageing, 2012) in September 2012, and invited written comments and answers to specific questions from key stakeholders to inform the development of the new Health Plan.

The online submission portal was open for a period of three months. During this time, the Department received 141 submissions from individuals and organisations. Many of the organisational submissions were written by senior policy officers, while others were presented as letters from the organisation’s chief executive officer. Some submissions were written by individual academics. Submissions varied in length from one to 32 pages. Some simply provided answers to the twelve consultation questions posed in the discussion paper (Department of Health and Ageing, 2012), while others set their own direction.

The Australian Government reported that key issues raised in the submissions were used, along with the themes arising from 17 community consultation meetings, to shape the development of the Health Plan. It was published in July 2013 (Department of Health and Ageing, 2013). Details of the community consultation meetings were published on the Health Plan website, along with the written submissions. The publication of stakeholder submissions on a public website made the Health Plan a convenient case study for network analysis.

4. Conceptual-methodological approach

The number of policy process investigations deploying network theories has been increasing (Adam and Kriesi, 2007). This is unsurprising, since policy decisions result from engagement by, and reciprocally impact on, a variety of stakeholders; therefore, many of these individuals and organisations devote resources to attempt to influence the policy agenda, and each other, in order to progress their particular interests. It is suggested that these actors essentially determine policy, with the most powerful groups driving policy most significantly (Lewis, 2006).

Applying a policy network approach enables examination of the linkages between individuals and organisations who attempt to influence policy (de Leeuw et al., 2013; Lewis, 2005). While examining stakeholder involvement in decision-making is frequently a goal of policy analysis (Brugha and Varvasovszky, 2000), Holden and Lin (2012) argue that simply mapping the resources and advocacy strategies of individual actors fails to uncover the way in which stakeholders interact with and influence one another. More narrative and dynamic information on engagement between actors and what happens at network nodes is required (de Leeuw et al., 2016).

One way in which stakeholders shape the policy agenda is through framing the policy discourse. “Framing” is a sociological concept concerned with the construction of meaning. It has been defined as “the process by which people develop a particular conceptualization of an issue or reorient their thinking about an issue” (Chong and Druckman, 2007, p. 104). Framing is relevant to policy studies: it can be used to examine the way in which political actors mobilise support for their agenda. Social movement organisations craft sets of beliefs and meanings to inspire action. These shared interpretations are known as “collective action frames” (Benford and Snow, 2000, p614). Cobb and Elder (1983) empirically established that policy issues enter the political agenda when they are framed persuasively; perceived as being socially relevant; seen as pertinent to long-term perspectives; perceived as non-technical; and positioned as having few historical precedents. Application of rhetorical tools is critical in the framing process – these include metaphors, synecdoche, parable, analogy, etc. (Stone, 2012).

Both network analysis (Holden and Lin, 2012; Lewis, 2006) and framing analysis (Garvin and Eyles, 2001; Olsen et al., 2009) have been applied to provide an understanding of stakeholder activity in the (health) policy process. These approaches, however, have seldom been used together in policy analysis. One of the few studies combining these approaches concluded that they provide a robust framework for exploring collective identity of political actors, in terms of structure and culture (Tucker, 2013). A combination of two or more theoretical perspectives in a rigorous conceptual framework adds strength to research (Greenhalgh and Stones, 2010).

In combining policy network concepts with framing analysis, we wished to assess whether networks and sub-networks (“cliques”) fully align with the frames that are used. Where network configurations and frames do not align, we surmise that opportunities exist for policy change through so-called “boundary spanning” (e.g., Fernandez and Gould, 1994). We graphically represent this conceptual-methodological logic in Fig. 1. Identifying frame overlaps between network cliques would allow a boundary spanner to connect policy agendas and possibly reshape network configuration and frame rhetoric – this would create new policy process opportunity.

According to Laumann and Knoke (1987, p. 5), “policies are the
product of complex interactions among government and non-government organisations, each seeking to influence the collectively binding decisions that have consequences for their interests. This provides a rationale for hybridising network theories of the policy process and framing theories. Thus we analyse competing interests involved in a health policy subsystem in Australia. A case study of the Health Plan is presented to demonstrate how such an amalgam of theories is an appropriate way of viewing roles, characteristics and relations of policy process stakeholders.

The study aims to describe the network structure of organisations attempting to influence national Aboriginal health policy and examine how network configuration aligns with the policy frames deployed by different subgroups within the network. We examined both the nature of the connections between the organisational actors and the way in which these connections influence the way actors frame Aboriginal health issues. In doing this, we aimed to test whether policy network theory combined with framing analysis would yield information on the degree to which there are actors in the policy system that could act as boundary spanners because they straddle two discursive frames.

5. Methods

In order to understand the structural and discursive features of the network of actors attempting to influence Aboriginal health policy in Australia, qualitative framing analysis was layered onto social network analysis. The organisational approach (Laumann et al., 1985), in which organisations participate in discrete “policy events”, was used to define the boundaries of the network. The submission process used in the development of the Health Plan is the policy event examined in this study.

The data source for both social network analysis and framing analysis was the set of submissions provided by organisational policy participants in response to the Health Plan discussion paper. Of the 141 written submissions made to the Australian Government, 121 were published on its website. The remaining 20 submissions were confidential and therefore not publicly available. Since most submissions were in the public domain, it was possible to identify the majority of actors participating in this event. De-identified submissions (n = 30) and those made by private individuals, rather than organisations, (n = 11) were excluded from the sample. Applying these criteria, 80 submissions were included in the sample for analysis (Fig. 2).

5.1. Network analysis

Social network analysis involves examination of the ties between actors, who are known as nodes. In this study, each of the Health Plan submissions made by an organisation or coalition of organisations (n = 80) represented a node. The procedure for determining the ties between the nodes was adapted from the name-generator approach used in other social network studies, whereby participants are asked to name other people or organisations with whom they have a relationship or whom they regard as influential (Lewis, 2006; Lock et al., 2011; Straits, 2000). However, rather than asking actors to nominate other actors, connections were generated by recording the other submitting organisations named in each actor’s submission. Since the focus of this study was the network of organisations who made submissions to the Health Plan, only submitting organisations were included as nodes. While other organisations may also have been named, these were excluded from the network analysis.

The context in which each actor was named was also recorded in order to capture the type of relationship between the nodes. For example, some organisations stated that they endorsed the submissions of other organisations; some stated that they worked in partnership, while others quoted or cited other organisations. Each of these ties provides insight into the perceived importance of other actors in the network. Since nodes were limited to those actors who made submissions to the Health Plan, this provided a clear boundary for the network. In order to provide a graphical representation of the network, we can use a diagram to illustrate the connections and their direction.
description of the network, we used open-source Gephi network mapping software (Bastian et al., 2009).

5.2. Framing analysis

The qualitative component of the analysis draws on framing theory (Chong and Druckman, 2007). Each of the submissions was read multiple times, entered into Nvivo10 qualitative analysis software (QRS International) and coded inductively for the frames used, that is, the ways in which each organisation focused on certain aspects of Aboriginal health to construct policy ‘problems’ and advocate their preferred solutions. These codes were then grouped into common ideas, which were used to construct the “collective action frames” (Snow and Benford, 1988), or specific interpretations of Aboriginal and Torres Strait Islander health problems shared between subsets of policy actors. The initial coding and construction of frames was conducted by one investigator and then discussed with coauthors until consensus was reached. The first investigator then deductively coded all submissions using the agreed set of collective action frames.

Finally, the collective action frames identified were overlaid with the network map in order to identify the relationship between the structure of the network and the way in which organisations framed Aboriginal health problems.

6. Results

The Submissions (n = 80) were provided by a variety of Aboriginal and mainstream peak health bodies, service providers, professional associations, research institutions, Non-Government Organisations (NGOs) and Government agencies. Supplementary Table 1 summarizes the type of organisations included in the sample. The majority of submissions were from health professional groups (n = 16), followed by Aboriginal-controlled organisations or coalitions (n = 13) and mainstream health services/primary health care groups (n = 12).

6.1. Network mapping

Of the 80 submissions, 50 (63%) referred to another of the actors who submitted to the Health Plan. These references included: endorsements of other actors’ submissions; recommendations about another actor; an actor stating that they worked in partnership with another actor; a peak organisation or coalition listing its member organisations; inclusion of a quotation or reference to the work of another actor; and citing another actor in the footnotes or reference list (without mentioning the organisation in the body of the submission). This is what Knoke and Yang (2008) refer to as a multi-relational network.

These relationships were used to generate a network map depicting the ties between the actors. In total, 61 out of the 80 policy actors (76%) either named another submitting actor or were named in another organisation’s submission, and are therefore included in the network. The organisations who were not connected to the network included five research institutes, four chronic disease/consumer organisations, two health care organisations, two primary health care organisations, two government agencies, the two mainstream mental health/AOD organisation; and the two “other Aboriginal corporations” who were not community-controlled health organisations. All of the main organisation types were represented in the network.

Fig. 3 provides a visual representation of the different types of
connections between the policy actors. The colours of the ties between nodes reflect the type of reference made within the submission, and the arrows indicate the direction of the reference. The thickness of these ties represents the number of references (or any kind) made to one node by another. The colours of the nodes indicate the organisation types, with red and maroon nodes representing Aboriginal-led organisations and coalitions respectively. The size of the nodes represents in-degree, i.e. the total number of times a node was named by other nodes in the network.

From this Figure, it is clear that Aboriginal-led organisations and coalitions are central to the network. Aboriginal organisations have strong connections with one another, often referring to one another multiple times. In addition, the most central actors, such as the National Aboriginal Community Controlled Health Organisation (NACCHO) and the Close the Gap Campaign Steering Committee, have ties with multiple mainstream organisations. The colours of the ties indicate the organisation types, with red and maroon nodes representing Aboriginal-led organisations and coalitions respectively. The size of the nodes represents in-degree, i.e. the total number of times a node was named by other nodes in the network.

6.2. Network structure

The network map in Fig. 3 comprises 61 nodes connected by 171 ties. Supplementary Table 2 reports the general statistics of the network. Graph density measures how close the network is to a complete graph, i.e. what proportion of all possible connections is made. This is low at 2.7%, signifying a loosely connected network. The average degree indicates the mean number of connections per node. In other words, each actor either named or was named by an average of two other actors. When multiple references in a single submission are taken into account (weighted degree), this average increases to three connections per node.

6.3. Cliques within the network

Modularity is the degree to which a network can be divided into smaller clusters of connected nodes, known as “cliques” (Chu et al., 2013; Provan et al., 2007). Although the modularity value calculated by Gephi (0.37) is not particularly high, five cliques were identified. The largest is the Aboriginal Community Controlled Health clique, centered around NACCHO and the Close the Gap campaign steering committee. There is also a medical clique, an allied health and primary health care clique, an eye-health clique and a clique of Victorian organisations (for further details see Supplementary Table 3). A further sub-group of organisations from the state of New South Wales was also identified; however, these were not connected with sufficient density to be considered a clique. While each clique has a higher density than the overall network, the “eye health” clique is by far the most densely connected, and is the only clique which is neither centered around nor contains a peak Aboriginal organisation.

All of the central nodes of each of cliques are densely connected to one another. Fig. 4 depicts this core group of actors. This “clique leaders” sub-group has a high graph density of 57%. Both NACCHO and the Close the Gap campaign steering committee are connected to all of the other nodes in this cluster, further highlighting the centrality of these actors to the network.

6.4. Network centralisation

The significance of individual actors in the network is further illustrated by examining network centralisation data. A node’s in-degree centrality, or the number of ties it received, is a proxy for how important it is considered to be by others in the network (Chu et al., 2013). Supplementary Table 4 shows the centrality measures for the most central actors in the network, including in-degree centrality, weighted in-degree, which incorporates multiple ties from single actors, and the total degree centrality, which indicates overall connectedness of the node.

The top four actors in terms of these three centrality measures are the same: NACCHO, the Close the Gap campaign steering committee, National Congress of Australia’s First Peoples and the Victorian Aboriginal Community Controlled Health organisation. The largest nodes in Fig. 3 represent these organisations. When weighted in-degree is used, the University of Melbourne’s Indigenous Eye Health Unit (IEHU) overtakes the Aboriginal Health and Medical Research Council (AHMRC) for fifth place. This is due to the multiple references IEHU received from the other organisations within the eye health clique. When overall degree centrality is considered, other clique leaders such as the Australian Indigenous Doctors Association (AIDA) and Vision 2020 also become significant, as they each made many references to other organisations.

Betweenness centrality indicates the strategic importance of each actor in terms of its ability to act as a gatekeeper to other actors in the network (Lewis, 2006). The clique leaders were among those with the highest betweenness centrality (see Supplementary Table 4), indicating their ability to link up the smaller clusters of organisations within the network.

6.5. Framing analysis

Qualitative analysis of the 80 submissions revealed that various frames were used to represent Aboriginal health problems and advocate for policy solutions. Supplementary Table 5 lists the most common frames used in the submissions and examples of some of the actors using each frame.

Many of the submissions advocated for Aboriginal health to be addressed through the lens of culture. This “culture” frame was common among Aboriginal organisations. These submissions often called for cultural-strengthening and healing approaches to health care or for services to be “culturally safe”.

Despite the dominance of Aboriginal organisations using this frame, several mainstream organisations also adopted a culture-based frame in their submissions. The most notable example was General Practice Education and Training:

“Community based cultural education and cultural mentoring relevant to each specific community ensures the cultural and historical issues relevant to each unique community are recognised by health care practitioners” (General Practice Education and Training, p. 6)

The “Partnership” frame was used by both Aboriginal and mainstream organisations. It was particularly common among organisations associated with the Close the Gap campaign and other
mainstream medical organisations which had strong connections with Aboriginal organisations. Actors often used this frame to advocate for Governments to develop “genuine” or “meaningful” partnerships with Aboriginal organisations and communities, implying that previous attempts at partnerships had not been genuine.

“Demonstrating respect for the rights of Aboriginal and Torres Strait Islander peoples involves committing to a genuine partnership with Aboriginal and Torres Strait Islander peoples and organisations, recognising them as leaders of the plan and acknowledging their strengths and capacity to deliver lasting solutions to improve health outcomes” (Royal Australian College of Physicians, p. 4)

“System dysfunction” was another prevalent frame, used across organisation types but particularly among the peak Aboriginal health organisations. This frame was dominant within all the cliques, with the exception of the medical profession. It was used to discuss the poor performance of the Australian health care system in terms of meeting the needs of Aboriginal people. Many submissions described the health system as fragmented, uncoordinated and inequitable.

“...there are multiple providers leading to duplication of services, waste and fragmentation ... many of these services communicating poorly with each other...” (Aboriginal Medical Services Alliance of the Northern Territory, p. 11)

Policy actors using this frame often situated the problem of system dysfunction within the Federal Government and its departments:

“Without a fundamental change of approach within the Commonwealth government bureaucracy to address the issues raised here, the Plan is unlikely to have a significant impact in changing health outcomes” (Aboriginal Health Council of South Australia, p. 5)

“Self-determination” was another common frame used by the peak Aboriginal organisations. This frame was used to advocate for increased resourcing of Aboriginal Community Controlled Health Services as well as Aboriginal leadership in health. Self-determination and community control are framed by many Aboriginal organisations as vital conditions for improving health status.

“Improving health and wellbeing outcomes for Aboriginal people can best be achieved by local Aboriginal people determining and owning the process of health care delivery. Local Aboriginal community control in health is essential to the definition of Aboriginal holistic health and allows Aboriginal communities to determine their own affairs, protocols and procedures.” (National Aboriginal Community Controlled Health Organisation, p. 9)

Several mainstream organisations also adopted the self-determination frame. These were more likely to be advocacy organisations rather than mainstream health care organisations, which may see themselves in direct competition with Aboriginal Community Controlled Health Services. Mainstream organisations advocating for self-determination and community control principles often had strong connections to Aboriginal organisations in the network.

An unexpected finding was that the New South Wales Ministry of Health (NSW Health) also used the self-determination frame, and advocated for this principle to be instilled in the Health Plan. This is surprising since self-determination is predominantly a right advocated by Aboriginal organisations and communities, rather than mainstream Government departments. The framing used by NSW Health may be due, in part, to its connections with organisations holding a similar view, such as the Aboriginal Health and Medical Research Council of New South Wales (AHMRC).

“In order to harness the strengths and cultures of Aboriginal and Torres Strait Islander people, self-determination must be the foundation of the Plan” (New South Wales Ministry of Health, p. 2).

Many organisations employed the frame of self-determination alongside the related theme of human rights. The National Congress for Australia’s First Peoples (Congress) and the Close the Gap campaign steering committee championed this approach, framing health and self-determination as essential rights for Aboriginal people.

“Embedded in the human rights approach to health is: Active participation by Aboriginal and Torres Strait Islander peoples in decision-making at all levels in accordance with the United Nations Declaration on the Rights of Indigenous Peoples” (Congress, p. 5)

An alternative frame was adopted by medical and disease organisations that were not connected to Congress or to the Close the Gap campaign steering committee. While the Royal Australian College of Physicians aligned its framing with Aboriginal organisations in the network, other actors within the medical clique persisted with a biomedical frame.

“The immediate need to manage chronic and acute illnesses will mean that hospitals and their emergency departments (EDs), as the front door to this healthcare system, will be a significant care provider to these peoples into the foreseeable future” (Australian College for Emergency Medicine, p. 1)

Peak disease organisations which were not connected to the rest of the network (e.g. Alzheimers Australia and Kidney Health Australia) also adopted this frame. In fact, it appears that participation in the network, especially ties with the Close the Gap campaign, reorients medical organisations from a biomedical frame to a partnership or self-determination paradigm.

The potential impact of interorganisational ties on policy discourse became evident when the collective action frames were superimposed over the network. Fig. 5 provides a schematic map of the dominant frames deployed by the cliques within the network. The clusters of organisations within these subgroups share similar framing of Aboriginal health issues. Framing between the cliques also overlapped, most notably the “partnership” frame, which was used by members of the ACCHO, medical, allied health and Victorian cliques. The “system dysfunction” frame was adopted by all subgroups except for the medical profession. Non-medical organisations used this frame to express their frustration with the mainstream Australian health care system. These overlapping frames indicate areas of common ground among the subgroups of actors, who may otherwise be competing for the attention of policy makers.

7. Discussion

The publication of Health Plan submissions presented an
opportunity to analyse the network of actors within this policy subsystem and their framing practices. Analysis of these submissions revealed that many actors were connected to one another in a variety of ways, and that network connections aligned with the collective action frames used to influence policy development.

The network maps produced in this study provide a clear picture of the structure of the network of organisations attempting to influence national Aboriginal health policy and how this structure relates to issue framing. Peak Aboriginal organisations and coalitions are fundamental to this network, as indicated by their high in-degree and betweenness centrality. Previous studies have also demonstrated that Aboriginal people and organisations are fundamental actors within Aboriginal health policy networks (Baeza and Lewis, 2010; Lock et al., 2011).

We wished to examine how organisations in the network use their connections to attempt to influence policy. Lewis (2006), p. 2128 describes influence as “a network resource which has symbolic utility”. These resources include an actor’s own wealth, power and reputation, as well as resources which can be accessed through ties to other actors in the network. Using this conception of influence, it can be argued that the policy actors submitting to the Health Plan attempt to wield influence by aligning their organisation and their rhetoric with other actors whom they believe are influential or important. NACCHO, the peak body for Aboriginal health in Australia, had the highest in-view it as strategically important in the network. While this study did not seek to measure the impact of network position on the Australian Government’s perception of advocacy organisations, such as NACCHO, this would be a useful area for future study.

An almost equally important actor in the network was the Close the Gap Campaign Steering Committee. This coalition received the highest number of references in total, many in relation to the Close the Gap Statement of Intent (Close the Gap Campaign Steering Committee, 2008) for which it was responsible. The coalition is also highly connected both to Aboriginal and mainstream organisations. While there may be information transactions occurring through these ties, the quality of the connections is unclear from this snapshot. Sabatier (1988) highlighted the importance of advocacy coalitions comprising policy actors from a variety of organisations, who work together to lobby for policy change.

The identification of cliques further illustrated the connections formed between the two central Aboriginal actors and various subgroups within the network. However, not all advocates for specific issues were clustered in this way. The eye health clique was an example of a group of well-connected organisations who not only aligned their issue framing with one another, but also with the core Aboriginal health actors at the centre of the network. Other organisations advocating strongly for specific issues, such as nutrition or sexual health, were less well connected to one another, and were more peripheral within the network as a whole. Integration among cliques is associated with network effectiveness (Provan and Sebastian, 1998). The implication is that eye health organisations may be more effective in their advocacy, which, to some extent, is reflected in policy. The 2013–14 Australian health budget included an allocation of approximately $66 million over four years to improve eye and ear services for Aboriginal people (Department of Health and Ageing, 2013b).

Previous research has suggested that a certain level of connectivity between actors is required for networks to be effective (Hoeijmakers et al., 2007; Holden and Lin, 2012; Provan et al., 2007). For example, Baum et al. (2003) demonstrated that the overall impact and stability of networks is enhanced if cliques are centered around the core actors at the centre of the network. The significance of cliques and their integration with the network as a whole is consistent with social capital theory, in which both ties within and between subgroups positively affect social capital of the entire community (Ferlander, 2007; Prell, 2003).

The simultaneous visualization of network connections and framing patterns in Fig. 5 also reveals the apparent overlap in frames used by the central ACCHO clique and the peripheral subgroups within the network. This overlap is demonstrated by the medical, allied health and other mainstream organisations moving away from the framing used within their cliques (e.g. the biomedical frame in the medical clique) and adopting the framing favored by the Aboriginal actors in the network, such as “partnership”, “culture” and “self-determination”. This change in language could be interpreted as an attempt by these organisations to connect to the core actors in the network, who drive the policy agenda.

We were interested in the (full) alignment between the configurations of policy network cliques and the frames they deploy. Where frames transcend identified cliques, we suggest that this represents an opportunity to exploit rhetoric to reconfigure the composition of networks and thus the policy discourse, potentially leading to different policy characteristics. For example, while many
of the medical organisations maintained a biomedical framing, the “partnership” frame employed by the Australian Indigenous Doctors Association (AIDA), who led this clique but also had strong ties to the ACCHO clique, appears to have facilitated a shift in discourse for several key medical organisations (e.g. Royal Australian College of Physicians, Medical Deans Australia New Zealand). This boundary-spanning role has been identified as an important aspect of “policy brokerage” described by several theorists (Skok, 1995). AIDA has appropriately adopted its policy boundary spanning position.

The role of non-Aboriginal actors in Aboriginal policy making deserves some critical analysis. While powerful mainstream groups, may assist in raising the profile of Aboriginal health on the policy agenda, balance is required so that the “Aboriginal voice” (Lock, 2014) is not lost. It is possible that some of these organisations continue to represent western medical perspectives while mentioning key terms such as “culture” and “self-determination” and aligning themselves with key Aboriginal actors in the network. Paradoxically, if the voices of these non-Aboriginal actors become the most influential in policy formulation, the principles of self-determination and cultural safety may well be undermined.

While several of the policy frames advocated by policy actors were described as “governing principles” in the final Health Plan (Department of Health and Ageing, 2013), this document lacked detailed strategies, funding and timelines. The Australian Government changed soon after the Health Plan was released so, over two years later, a blueprint for implementing the Health Plan has only recently been published (Department of Health, 2015). This implementation plan should be closely scrutinized in order to determine whether the policy framing remains the same, and to ascertain which aspects of the policy are implemented.

Although network analysis has been used in the field of Aboriginal health (Baenza and Lewis, 2010; Lock et al., 2011), and stakeholder submissions have been analysed to examine policy processes (McDermott et al., 1998; Thuraisingham et al., 2009) this study may be the first to combine the network approach with framing analysis. While most studies of network influence rely on interviews with actors and snowball sampling, our research is based solely on document analysis, thus avoiding the limitations of sample bias and low response rate. Our data could be characterized as coming from an ‘opportunity sample’. It is therefore possible that the network map presented here does not represent the complete set of ties between organisations, and so, corroboration of our findings using other methods should be a priority for future research in this field. But unless the ‘non-response’ group could be characterized as one discrete clique or a hermetic frame, we can assume that inclusions of its members in our analysis would not have changed the direction of our findings.

The boundary-spanning role of organisations whose framing overlaps also deserves further investigation, for example, whether or not organisations recognize these areas of overlap; act on opportunities to take on this boundary-spanning role; and whether this makes a difference to policy.

Published submissions from organisations or coalitions of organisations may not be truly representative of the views of the broader stakeholder population. In addition to the submissions from organisations, there were 13 submissions from individuals and 30 which were de-identified; some of the latter may also be from organisational actors, but it is impossible to ascertain how many. Furthermore, records of community-based consultation meetings included in the policy-development process, which provided further opportunities for organisational representatives to participate, were not publicly available; thus the views of these policy participants could not be included in the analysis.

8. Conclusions

The combination of social network analysis with framing theory provides a methodology for concurrently examining the structural and discursive aspects of the Aboriginal health policy network. It has been suggested that the study of network structure and the function of actors in a policy subsystem should be integrated (Skok, 1995). The present study embraces the framework proposed by Skok, and adds the additional perspective of framing in order to analyse the actor behaviour within policy issue networks. This form of analysis can highlight competing interests within a network, and assist policy actors to identify which network members are the most influential and, thus, worth collaborating with (Barnes et al., 2010).

The network-framing approach may also assist policy implementation. Policy networks are described not only in terms of the relationships between interest groups, but also as a form of governance (Borzel, 1998). Therefore aligning framing processes with the network structure is useful for identifying areas of consensus and opportunities for cooperation and coordination. Holden and Lin (2012) suggest that engaging organisational stakeholders in policy development processes may enhance future policy implementation.

While the Aboriginal health policy network in Australia may differ from stakeholder groups in other policy domains and other countries, our analytical approach may be applicable elsewhere. It has been proposed that policy networks have discursive as well as structural properties (DeLeon and Varda, 2009). The findings of this paper support this hypothesis.

The insights gained through combining network and framing approaches to policy analysis may assist organisations to better target their collaborative advocacy. Network visualization provides actors with a snapshot of their current strategic ties and illuminates the critical organisations in the network, with whom links should be formed in the future (Provan et al., 2005). This method of relationship building is described as “reputational control” of the network (Kenis and Provan, 2006 p. 235).

The addition of framing analysis allows advocates to monitor the discourse used by key actors in the network. By doing this, peripheral actors may reframe their arguments in order to align with the core actors and bolster their reputation. The reframing of problems is key to the success of social movements bringing about policy change (Lawrence, 2004; Nathanson, 1999; Stone, 2012). Furthermore, by contributing to the collective discourse, organisations may become more central players in the network (Kenis and Provan, 2006).

The combination of quantitative network analysis with qualitative framing analysis provides useful insight into the structure and agency of the actors attempting to influence the policy agenda. Although this is a static view of the network, representing the actors participating in the policy process during one policy event, network and framing analyses may be useful techniques for monitoring how this network changes over time.

Appendix A. Supplementary data

Supplementary data related to this article can be found at http://dx.doi.org/10.1016/j.socscimed.2016.11.011.

References
