

Poland Health Policy:

**Democracy and Governance At Local Levels
In International Perspective**

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Introduction

The DDM project is designed to assist local governments achieve two basic objectives:

- 1) improve their capacity to provide appropriate health care to the local population and
- 2) improve local democratic practices. Both of these objectives involve a decided political dimension: improving local capacity often involves political processes in order to change existing health systems and democratic practices are by definition political.

It is important to keep in mind that, although these two objectives are often compatible, many observers perceive an inherent conflict between the “technical” solutions to providing appropriate health care and the “political” processes of democracy. These observers suggest that technocratic options are proposed by health care experts and economists based on a review of experiences and theory that suggest optimal solutions. These optimal solutions may involve changes in payment mechanisms, insurance coverage, and allocations to primary care which do not satisfy the specific interests of any single stakeholder. For instance, citizens may lose freedom to choose their providers, physicians may have to accept lower payments, hospitals may be forced to reduce beds and staff, insurance companies may have to accept lower premiums and higher regulations, etc.. What is optimal to society in the view of the technical experts may not be optimal to any one or group of the stakeholders. Technically defined “public welfare” may also not be what political actors, even as a collectivity, would define as desirable or feasible.

On the other hand, it is also often argued that those concerned with promoting democracy, focus on issues of participation, consensus building, competitiveness of political parties and interest groups, ways to avoid capture of political institutions and bureaucracies by special interests and increasing the “voice” of the poor in the political process. These “political” experts are less concerned about optimal solutions to health system problems and more concerned about the process by which decisions are made in the health sector. They argue that a good democratic process is more important than a good health system.

We disagree with this dichotomy. Our objectives in this project force us to bridge this potential gap between these two approaches. We want to assist local governments develop technical capacity to develop optimal solutions to health system problems and we want to promote democratic processes to achieve these solutions. This involves both an awareness of the political and policy processes that constrain technical solutions and an implicit manipulation of those processes to achieve both better technical solutions (if not optimal) and more democratic practices. We want our “technical” experts to become politically astute and we want our “political” experts to promote democratic processes which achieve technically good solutions.

Issues of Decision-making Structure and Process

Most of the literature on health policy and processes focuses on the national level. Classic works on the politics of health policy which look at the role of interest group politics more than the technical objectives include Theodore Marmor's *The Politics of Medicare* and Harry Eckstein's analysis of the British case in *Interest Group Politics*. This approach which stressed the interplay of interest groups and individual stake holders as the determinant of politics continues to be a strong model despite many challenges.¹ This approach sees policy choice as the outcome of competition among different political actors -- both groups and individuals -- in an ongoing process of decision-making through agenda setting to policy formulation and implementation. In health care policy much of the attention of this literature has focused on the interplay of 1) organized interest groups of health care professionals; hospitals; insurance industry; 2) representatives of labor and employers; 3) government bureaucracies; 4) politicians; 5) community representatives and the general electorate. Many of the dynamics of interest group policy making at the national level are repeated at local levels.

Our concerns are 1) to create an awareness among those who approach the "technical solutions" that they need to either play the game of politics or find skilled political actors who will adopt and use their technical solutions in the political process; and 2) strengthen stakeholders -- especially interest groups that will favor the "technically optimal" solutions -- by giving them information on health care options, and both technical and political skills to navigate the policy process.

An attractive tool for doing this kind of analysis on a specific case-by-case basis is the Political Mapping software that has been designed by Michael Reich through the DDM project. We will be using this approach in some of the analysis of the project.(see below)

Decision-making Space in Gmina and Voivodships

We must first establish the range of choice that is available to local decision-makers. What authority and responsibility is allowed by law, regulation, and practice to each arena of decision-making? The new law of November 24, 1995 appears to have opened the space for local decisions at the gmina level. This decision-making space may however, be defined in quite a flexible way given the transition of political processes and institutions in the current environment. Different degrees of choice may be allowed by different circumstances. For instance, in some voivodships the opportunity to change health policy may be greater because of special relationships between the voivoid physician and the voivoid, and some municipalities may have decided to assume responsibilities that are allowed by law, while others have refused to accept these responsibilities.

The structure and process of decentralization is crucial to defining decision-making space. We often assume that legally defined authority and responsibility has shifted decision-making power to local governments, when in fact significant mechanisms of control remain in the hands of the national government. For instance, in the U.S., categorical grants from the federal government require state compliance with norms and standards and significant commitment of local funds even though formal authority remains with the state government. Few state governments can afford to refuse the grants in order to exercise their formal authority.

Local Government Decision-making Actors and Arenas

How is the local government structured to make decisions in health care? There are a variety of arenas in which decisions can be made. The local legislature or council can address health issues through local laws and regulations. The local executive (Mayor, Voivoid) is also an arena of decision-making. The local health bureaucracy -- health office -- often makes decisions which

¹ The classic analysis of different approaches to decision-making is still vibrant today: Graham T. Allison, *The Cuban Missile Crisis*.

change health systems. This bureaucracy acts as a decision-making arena (even if it is only the Chief Health Officer who decides) and it also acts as a political interest group in other arenas (local legislature, voivodship, national level) where it lobbies for its proposals and interests.

Other actors are important: the local political parties, unions, professional associations, employers associations, insurance associations, etc. These interests can be analyzed through the DDM political mapping methodology which identifies each stakeholder in terms of its position on issues, commitment to that position, and relative power in the decision-making process.

Beyond the organized interest groups there is also broader civic society which exercises its power through elections, community fora, surveys, and media. In recent analysis of Italy, Robert Putman has suggested that the power of civic networks (choral groups, soccer groups, etc.) has a more enduring influence on the effectiveness of political processes.² He argues that civic society can create trust and expectations that constitute social capital which strengthens the political processes of democracy. Civic society is engaged in a variety of arenas: such as local elections, community discussions, hearings.

When in the Political Process do these Actors Affect Policy?

Policy making is usually a continuous and varied process with many participants and many detours and revisions. Nevertheless, it is often useful to think of the process in stages in which problems are identified, solutions are proposed, support is generated, laws are passed and then implemented and evaluated. These stages often involve different networks of stakeholders, different strategies for coalition building and for gaining public support, and different roles for technical expertise.

An important part of the political process is agenda setting: placing health care reforms on the policy agenda of local decision-making arenas. In systems which have not experienced significant change for decades, the power to place new issues on the agenda may be particularly important. Here technical experts have an important role to provide ideas and options that could become local policy. Particular interest groups, however, are often key advocates for placing specific health problems on the agenda for public policy.

Formulation of options is a second stage in the process in which different options are proposed. Again the technical experts are often particularly important at this stage; however, interest groups often have well developed options for new policy. This stage is followed by a period of negotiation and consensus building -- in which coalitions of stakeholders form around specific sets of options and in the process often significant tradeoffs are made to create a compromise option that has sufficient support to become adopted through law or decree. It is the political process of log-rolling and tradeoffs to create consensus within a winning coalition that is the dominant activity; however, the role of technical experts is important for clarifying the tradeoffs.

Implementation and evaluation are the final stages in this analytical model. Implementation also involves significant political bargaining -- requiring the maintenance or construction of a coalition that can sustain the selected policy options or modify them to accommodate new interests. Technical expertise here is also often important to evaluate the implementation process and provide mid-course corrections.

² *Making Democracy Work: Civic Traditions in Modern Italy*. Princeton: Princeton University Press, 1993.

Promoting Democracy

Many of the decisions that have been made historically in Poland did not involve local participation, so a central objective of this project is to strengthen the emerging structures and actors which participate in health care decision-making processes. However, since we also have objectives of promoting better technical solutions we do not want to encourage the dominance of interests which are opposed to change or have special interests which could conflict with optimal solutions for society.

We therefore are concerned with creating and developing interest articulation institutions and processes which allow greater participation, a balance of interests which is likely to favor optimal solutions and avoid "capture" by special interests, and flexibility to be responsive to change. This involves strengthening the capacities of interest groups (and potential interest groups) to be aware of health issues, articulate their interests in these issues, engage in consensus building activities, negotiate and lobby in different decision-making arenas, and participate in implementation and monitoring of health sector reforms.

However, we know that some interest groups are more likely than others to be able to organize themselves and articulate their interests effectively. Interests which are concentrated, have significant investment, have continual long-term stakes and have financial and status resources to bring to bear in the policy process -- such as physicians, hospitals, insurance companies -- are likely to effectively promote their interests. Interest groups which are diffuse, do not have significant investments, have periodic rather than continual stakes, and have low resources, -- such as patients, especially poor patients; general taxpayers, etc. -- are less likely to effectively promote their interests.³ While we may want to prioritize means of articulating the interests of patients and other diffuse and periodic interest groups, we know from experience that it is difficult to develop effective organizations from the top down.

We are also interested in promoting civic networks and broader interest in health concerns to strengthen the basis for democratic life. In electoral systems, the opinions of the broader public are tracked by politicians and assessed for their impact on elections. Opinion surveys and community discussions through hearings and other fora are important tools for articulating popular interest in health care issues and reforms.

Local Reform and National Reform

Often local reforms are seen as pilots for national reform. Experiments that are initiated at local levels, if carefully evaluated, can provide guidance for changes in national policy. Often local reforms are adopted by other localities and as the number of localities increases, pressure for national reform to establish a uniform framework or to avoid pernicious competition among localities (such as attracting welfare cases from localities with less generous welfare policies).

In addition, local interest groups are often part of a wider national network of interest groups -- i.e. physicians association, political parties, associations of municipalities. These interest groups are able to lobby at the national level both for increased decision-making space and greater intergovernmental transfer of resources, as well as, for strong positions for national level health care reform.

³ James Q. Wilson, *The Politics of Regulation*. New York: Basic Books, 1980.

International Examples

It is difficult to find examples that have been well studied from a political process point of view. I will present a few cases that are suggestive. I have chosen several cases from the U.S. and one from Europe. I should note a significant difference between the U.S. and European approach to health politics that may have bearing on their applicability to Poland. European models -- Germany, France, and Sweden (I have chosen to present Sweden because of its emphasis on local decision making) -- follow a tradition of long legitimized social welfare states and a corporatist tradition of organizing interest groups through "peak associations" -- such as federations of physician's associations, hospital associations, unions and employers. In the U.S. there has been an enduring distrust of government, a fleeting and unstable support for the welfare state, and only minor success in the creating of corporatist "peak" associations, and little incorporation of such associations in formal policy making.

Health Systems Agencies in the U.S.

Health Systems Agencies (HSA), created by the National Health Planning and Resources Development Act of 1974, were an explicit attempt to incorporate local community participation in decision making processes in the U.S. health system.⁴ They followed other attempts in War on Poverty programs but what was unique about these local agencies were their explicit attempt to reduce medical professional dominance of local decision-making by mandating that a majority of members be from the community. The HSA format varied from state to state since governors of the states were allowed to determine the number, jurisdiction, and selection process for membership within the federal guidelines. The wording of the law however was so vague that competing community representatives constantly challenged the selection processes in court to be given representation on the agencies. While the HSAs were given a wide variety of functions, including broad planning functions, their major role soon became reviewing petitions for capital expansion and recommending certificates of need as a cost containment measure. The HSA's had local representatives and local staff, however they were also supervised by the national government: the Department of Health Education and Welfare (now Health and Human Services), which threatened to abolish HSA's which did not recommend cost containment measures.

The HSAs have in general been seen as having failed to achieve their central purposes, especially the objective of limiting the escalation of health care costs by restricting capital investments through the process of Certificate of Need. The major limitation however was not so much the choices that the HSA's made but rather their lack of enforcement authority. The agencies were solely advisory and their recommendations could only be enforced by other agencies -- such as local health offices with little direct representation of community interests.

What is interesting about the HSA experiment is that in many cases, regardless of the political and economic interests of the board participants (and in some cases in contrast to initial positions of the members) they did become representatives of cost containment and resisted "capture" by the local health professionals, hospital industries (which were often divided -- recently expanded hospitals favoring certificate of need restrictions on their competition), and insurance companies. Buttressed in some cases by well-trained professional staff committed to public health objectives, but also threatened with extinction by HEW, the community representatives in HSA's across the country, tended to impose unpopular "technical" solutions to cost containment. That they failed to be effective had more to do with their advisory capacity than their failure to represent community interests in pursuing an objective of public good.

The central lesson from this case for Poland is that community representation can avoid capture by local interests -- especially the famed supremacy of the medical professionals -- and can pursue "technical goals". However, in this case, the important role of the national level HEW imposing its "technical solution" and threatening the local agencies with extinction were major factors in resisting the power of local politics. It is also important to recognize that although there was considerable attendance, debate and public interest in the HSA, they were only advisory so the organized interests did not have to focus their interest group pressures and lobbying on the HSAs.

Oregon Plan

Oregon initiated an innovative reform in its public health insurance system for the poor -- Medicaid -- the categorical grant partnership between the federal government and states, in

⁴ This case is drawn from James A. Marone, *The Democratic Wish: Popular Participation and the Limits of American Government*, USA: Basic Books, 1990, Chapter 7; and James Marone and T.R. Marmor, "Representing Consumer Interests: The Case of National Health Planning," *Ethics* 91, April 1981, pp. 431-50.

which the federal government sets minimum standards of access, benefits, and quality of care, and requires state counterpart funding. The federal program allows states to innovate through a waiver process in which a state may request a suspension of some of the norms or regulations in order to experiment with alternative mechanisms.

The major Oregon innovation involved “rationing” through a major reduction in the standard benefits covered by the Medicaid package in exchange for broader coverage of all people under the federal poverty line.⁵ Oregon with a population of almost three million had an uninsured population of almost half a million. The Oregon Plan pays for the increased coverage by selecting a prioritized list of benefits services that matches the funds available. The prioritized list combines cost-effectiveness criteria with community participation to select the services that will be funded.

The process of innovation began with a citizen group, Oregon Health Decisions, which since 1982 sought to raise ethical health issues at the community level. In 1987-8 Oregon Health Decisions lead a series of 19 public discussions on priorities for health care, ending with a “Citizens Parliament” which publicized fifteen principles as guidelines for legislation and practice. Not so coincidentally, the chairman for these discussions was State Senator John Kizhaber. Senator Kizhaber was able to translate the results of the “Citizen Parliament” into the state legislative arena and gain sufficient support to pass three bills that constitute the “Oregon Plan”. He worked in the context of a general belief that Medicaid was in need of reform, and that its budgetary requirements at the state level were increasingly onerous. Also in 1987, the legislature had already initiated an incremental step in revising the standard benefits package to remove coverage for most organ transplants. The Senator was also able to get private funding of a demonstration project to illustrate the process of selecting a prioritized list of services.

The initial laws of the Oregon Plan created a Health Services Commission of 11 members composed of 5 physicians, one public health nurse, one social worker, and four consumers. The members were appointed by the governor with fixed four-year terms. This commission was charged with developing the priority list and soliciting public involvement at the community level in design of the plan. The Commission established panels of provider experts to establish clinical relationships between health problems and treatments. In coordination with Oregon Health Decisions and using surveys, it established popular preferences for states of well being that would be used in calculating the priority lists. After producing a preliminary report, the Commission held seven public hearings and then presented its findings to the state legislature.

Through this process the Commission was able to gain the political support of a coalition of interest groups including: businesses, unions, health providers, the professional associations, and consumer groups. Each joined the coalition for different reasons but there was enough in common to keep them together. Their opponents were special interest consumer groups, mainly those in favor of organ transplants and advocates for child welfare -- the Children’s Defense Fund.

In order to gain decision-making space, the Oregon authorities had to gain waivers at the end of their process from the Health Care Financing Administration in Washington. This authority was initially denied by the Bush Administration but was approved when Clinton became President. Since the waiver approval, a reduction in state financing forced the reduction in the rationing list by 25 interventions (leaving 588 now covered) and the introduction of modest co-payments and sliding scale monthly fees; however, the plan is still widely supported even by physician groups.

⁵ This case study is based on Michael J. Garland, “Setting Health Care priorities in Oregon,” *Health Matrix*, 1991), 1(2), pp. 139-156; Howard M. Leichter, “Rationing of Health Care: Oregon Comes Out of the Closet,” in Howard M. Leichter, ed., *Health Policy Reform in America: Innovations from the States*, Armonk, NY and London: M.E. Sharpe, 1992. pp.117-146. and Howard Leichter, personal communication April 29, 1996.

What does this process show that would be useful in Poland? At the state level it was possible to initiate an innovation in health care through a process that involved a significant level of community "civic" participation -- through active discussion, hearings and surveys -- and through the creating of a coalition of interest groups which were able to support the reforms through legislative process. It also shows the importance of individual leadership of a key actor -- Senator Kizhaber. Expert participation was involved both in the Health Services Commission and in the panels of professional experts. However, this whole process depended on the granting of decision-making space by the federal government.

Comprehensive Reform in Washington State

The State of Washington passed an innovative reform law in 1993 during the period of national debate on health care reform.⁶ This reform anticipated and paralleled many of the elements of the Clinton Plan: employer mandate, community rating, uniform benefits package, managed care mandate. The process of reform began in 1991 with the formation of a Health Care Commission by the state governor. This 17 member commission included representatives of all the major stakeholders: physician's association, insurance, labor unions, large and small businesses, legislators, and state purchasers of health care. The Commission held hearings throughout the state for one and a half years and presented their findings to the governor in the fall of 1992. The proposals developed with a variety of technical advice -- including a special health policy department at the University of Washington -- were based on many of the new ideas of health reform that would emerge in the Clinton Plan. They were supported by the new governor who ran on a health reform platform, and were endorsed by the Washington Medical Association. The major stakeholders supported the comprehensive health reform bill which passed in April 1993. A five member commission was appointed to implement the law -- all representatives of private sector stakeholders.

The law however has only partly been implemented -- mainly changes in insurance regulation requiring some community rating and limits on pre-existing conditions. It appears to have failed for three reasons: the failure of national health reform, the failure to get waivers from the national government to allow employer mandates, and the failure to gain broad-based popular support. The comprehensive reform was seen as a precursor of the anticipated national health reform. As the options for national health reform faded, support for the state reform also declined. Some of the key elements of the reform required national government approval which was not forthcoming, especially after the republican sweep of Congress in 1994. However, in the judgement of at least one major participant, the failure to gain broad popular support was a major error. In contrast to the Oregon Plan which was based on wide community participation, the Washington State reforms were based on stakeholder consensus which was not sufficient to gain broad popular support, especially during the period of hostile national debate.⁷

Lessons for Poland of the Washington State experience may be that stakeholder consensus at the local level may not be sufficient for successful implementation of health reform in a context of an intense national debate. It may be important also to generate broad community based support.

⁶ This case is based on personal communication with Susan Crystal, Special Assistant to the Governor for Health Policy, Washington State, April 29, 1996.

⁷ For a similar argument about the disjuncture between elite and popular visions at the national level see: Daniel Yankelovich, "The Debate that Wasn't: The Public and the Clinton Plan," *Health Affairs*, Vol 14, No. 1 (Spring 1995), pp. 7-23.

Sweden -- County Council Control

In Sweden the local health authorities are the counties.⁸ The process of decentralization was lengthy, initiated in the 1960's, the full devolution of authority to counties in Sweden did not occur until the early 1980's and even then the central government retained control through strong planning and strict allocation rules until 1993. The 1983 Health Services Act granted full authority to the 26 county health authorities with the sole stipulation that they would provide health care "on equal grounds" to their populations. This authority is exercised by an elected county council and appointed health boards. The elections for county council occur at the same time as national elections and most political parties are represented at both levels -- although local parties are on the increase. The county councils usually meet once a month on open meetings well covered by local media.

The county councils control financing and local taxation. Over 80% of health financing at this level is funded by local income taxes. With increasing national efforts to reduce social welfare spending, there has been "corporatist" negotiation between the national government and county councils to reduce health care spending. In recent years there has been an emerging split between purchaser and provider in many county councils with the role of county council becoming the representative of the patients and citizenry and not to represent the interests of the providers. This is reinforced by the corporatist negotiation between unions of providers and the national and local governments for salary and payment decisions. The county councils often use surveys, panels, committees and public hearings to gain better understanding of the "public will". There does not seem to be the active participation of organized consumer groups or of activist community interest groups as in the U.S. -- although there are some organizations of disabled and of retired people who lobby for specific interests. Only when threatened with the closure of local hospitals do communities go beyond the traditional channels of participation to voice a collective view in opposition to decisions made by local governments. On the other side, however, there is a tendency in Sweden to respect the expertise of planners and of the staff of local health boards -- perhaps more so than in the U.S. where distrust of experts and government is much stronger.

Lessons for Poland. The Swedish case is one of long term experience with both local government and with strongly legitimate social welfare state. Although since the 1980's there has been an alternation of power between social democrats and neo-liberal parties; as in the rest of Europe, even the social democratic parties are supporting change in the welfare state. In Sweden the locus of decision-making is at the county level rather than regional or national levels. However, even here, there is a strong legacy of respect of nationally defined technocratic solutions which are resisted by local community only in extreme cases. Local participation is primarily through elected officials and a respect for the corporatist style of government bargaining -- both between government and providers for wage negotiations and between national and local levels of government.

⁸ This case is based on Richard B. Saltman, "Nordic Health Policy in the 1980's," in Christa Altensetter and Stuart C. Haywood, eds. *Comparative Health Policy and the New Right: From Rhetoric to Reality*, New York: St. Martin's Press, 1991. pp. 111-128; Mats Brommels, "Contracting and Political Boards in Planned Markets," in Richard B. Saltman and Casten von Otter, eds. *Implementing Planned Markets in Health Care: Balancing Social and Economic Responsibility*, Buckingham and Philadelphia: Open University Press, 1995. pp. 86-112; Sven-Eric Bergman, personal communication April 25-26, 1996.

Local Models for National Policy

There are examples of innovations that have led to significant change in national policy: Saskatchewan province in Canada provided the initiatives that led to Canada's national health insurance. Many minor revisions of national health programs -- Medicare and Medicaid have been first initiated as waivers in some states before becoming more general national policy. In the U.S. where insurance regulation has historically been a state responsibility, changes in health insurance policy have usually been initiated at the state level.⁹ However, state initiatives face enormous obstacles -- they usually have to provide additional funding, they must obtain waivers, they must set up bureaucratic mechanisms and they must create the political coalitions necessary to overcome inertia and opposition by threatened stakeholders.¹⁰

⁹ Richard E. Curtis and Kevin Haugh, "Health Care Reform and Insurance Regulation," Forrest p. Chisman, et al, eds., *National Health Reform: What Should the State Role Be?*. Washington, DC: National Academy of Social Insurance, 1994. pp.53-70.

¹⁰ See John Holahan, et al., "Insuring the Poor through Section 1115 Medicaid Waivers," *Health Affairs*, Vol 14, No. 1 (Spring 1995), pp. 199-216.

Conclusion

Perhaps more than for the “technical solutions”, the transferability and utility of international experience in “political and democratic” processes is more questionable. Most political analysts first ask questions about the history of political institutions in a country and are aware that national culture and historical processes are likely strongly to shape the effectiveness of any political process.

Nevertheless, especially in a system which is undergoing major transformations, where old processes and institutions are crumbling and new ones are emerging (or suspended institutions are reemerging), it is important to use some international experiences as guides to analysis; to identify options for design and implementation of political processes; and to try to avoid repeating some processes which have been found lacking in other contexts.

The European models of corporatist policy making in Sweden, France or Germany, with their history of strongly legitimized welfare state programs and their structured corporatist processes of interest articulation, is one model which might be pursued. The more chaotic and pluralistic model of the U.S. is an alternative. Neither is clearly applicable directly. The corporatist model may not seem appropriate in the current context of Poland where the role of the centralized state -- associated with the discredited communist period -- has been delegitimized to the wide population for a long time, and where the emerging organized interest groups are not yet well established and not yet organized into “peak associations”. The chaotic pluralistic U.S. model and especially that of more “progressive” states like Oregon with long histories of interest group politics and of citizen participation is also at variance with the recent history of Poland. However, both models may assist us in promoting a new Polish approach to local participation.

In practical terms we should initiate a process of strengthening the role of interest group articulation -- especially for community oriented, and perhaps patient oriented groups -- in the policy process. Strengthening their tools of analysis of health conditions and options to improve their interests. We should also strengthen their capacity to analyze the interplay of interests in the policy process -- and to develop strategies for pursuing their interests through forming coalitions and networks.