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Bringing the Mind into Health Policy

How neuroscience and contemplative practice can strengthen public-health leadership, professional practice and health outcomes

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Bringing the Mind into Health Policy

How neuroscience and contemplative practice can strengthen public-health leadership, professional practice and health outcomes

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Public health has long understood that health is shaped not only by biology, but also by poverty, power, policy and the conditions in which people live (Commission on Social Determinants of Health, 2008). Neuroscience and other contemporary fields are shedding light on another dimension: health outcomes are also shaped by how our brains and minds work - those of patients, policymakers and the health practitioners who care for them. When we bring this knowledge together with contemplative practices that have been refined across cultures and millennia, we may find additional ways to influence health policy, strengthen professional practice and improve health outcomes. Research on meditation and mindfulness provides plausible psychological and neurobiological mechanisms, while also cautioning that effects vary by practice, population and outcome (Goyal et al., 2014; Tang et al., 2015).

For generations, public health has documented how income, education, housing, gender, political power and access to services shape patterns of illness and survival. We speak fluently about social determinants, equity and health in all policies. Yet our institutions repeatedly separate clinical decisions from the systems that make those decisions possible, affordable or fair. We give far less systematic attention to how attention, emotion, perception, prior experience and cognitive bias shape clinical and policy decisions, even though decision science, behavioural public administration and health-policy research show that these human processes matter (Walt and Gilson, 1994; Battaglio et al., 2019; Ko et al., 2025).

When I entered medical school 40 years ago, I believed that becoming a good doctor meant learning to diagnose illness and treat patients. I still believe that clinical competence matters

profoundly. Some aspects of medical education have evolved, as I witnessed during my daughter's training, with more attention to communication and public health. We all agree that a patient may need a medicine, but whether she receives it can depend on its price, the availability of a health worker, an insurance rule, a gender norm or a budget decision. We know these forces matter. We too often treat them as background conditions rather than causes that demand action. A further gap, increasingly illuminated by research on cognition and clinical judgement, concerns the role of the mind through which evidence and experience are interpreted (Ko et al., 2025).

I began as a doctor working close to communities. Later, at the World Health Organization, I entered some of the rooms where global policies were debated, negotiated, communicated and implemented. I saw strong evidence change practice. I also saw evidence set aside when it threatened interests, technically sound policies collapse during implementation, and familiar lessons rediscovered after each crisis. I saw individuals without senior titles change what institutions considered possible because they understood both the evidence and the system around it.

The challenge for the next generation is therefore not simply to discover that health is political or that systems matter. It is to stop behaving as if knowledge alone will change those systems. Medical students and young health professionals already influence policy through what they notice, record, normalize, challenge and bring to the attention of decision makers. They must also remain open to new evidence and ways of thinking that could improve people's health.

The mind of the practitioner is part of the health system

Health outcomes depend on more than the patient's biology and the policy environment. They also depend on the brains and minds of those shaping policy decisions and delivering care. Every clinical encounter passes through human attention, perception, memory, emotion and judgement. The practitioner does not merely apply neutral knowledge to an objective case. Under uncertainty and pressure, the practitioner interprets what is seen, decides what matters and chooses whether to pause, inquire, escalate or act (Allan et al., 2014; Ko et al., 2025).

That mind carries expertise, but it also carries prior experience, habits, assumptions and bias. Stress can impair attention, concentration and memory, while cognitive shortcuts can

produce anchoring, premature closure and other errors in judgement. Research in clinical decision making increasingly recognizes metacognition, deliberate reflection and cognitive forcing strategies as ways to identify and reduce these risks (Allan et al., 2014; Ko et al., 2025).

The relational qualities of the practitioner also matter. A recent meta-analysis of 28 randomized trials found that interventions designed to strengthen the patient-clinician relationship produced small but significant improvements across healthcare outcomes, although the evidence was heterogeneous and its overall certainty was low (Neal et al., 2026). Psychological safety within healthcare teams also affects whether people ask questions, report concerns and speak before harm occurs (LaPlante et al., 2025).

This is why I place the Mind-Heart Axis at the centre of the MC3 architecture. I propose it as a way to strengthen consideration of the uniquely human lens through which decisions are made in health, other helping professions, and leadership across the public, private and not-for-profit sectors.

MC3 stands for mindful discernment, compassion, connectedness and courage. Mindful discernment develops the capacity to notice what is happening in the patient, the system and one's own thinking. Compassion keeps the person from disappearing behind the diagnosis or procedure; self-compassion may also support practitioner wellbeing, although it should complement rather than substitute for organizational action on workload and working conditions (Neff and Germer, 2013; West et al., 2016). Connectedness enables listening, trust and coordinated action with the patient, client or supervisee and with others in the wider system. Courage allows a practitioner to question an assumption, acknowledge uncertainty, hold a difficult conversation or challenge an unsafe norm, while building resilience under pressure.

MC3 is a proposed architecture, not a validated clinical intervention. It brings together capacities that existing evidence associates with reflective judgement, stronger relationships and practitioner wellbeing. Mindfulness and contemplative practices are already being studied in clinical, psychological and workplace settings, but the evidence is heterogeneous and should not be overstated (Krasner et al., 2009; Goyal et al., 2014; Good et al., 2016). The integration and structure of MC3 being prepared for collaborative empirical investigation.

Lifelong learning as leadership practice

Public health has traditionally directed our attention upstream, towards the social and structural causes of health. MC3 invites us to look inward as well. The mind through which evidence, policy and human suffering are interpreted is itself part of the causal pathway to health outcomes. The architecture therefore offers a framework for continuous professional development and lifelong learning. Leadership research describes learning agility as the willingness and capacity to learn from experience, seek feedback and apply that learning in new and challenging situations (Bouland-van Dam et al., 2022). Curiosity and lifelong learning are also expected to become increasingly important as professional and organizational environments change (World Economic Forum, 2025). I would go further and call lifelong learning a leadership superpower: the capacity to keep examining and developing ourselves as we lead patients, clients and teams and seek to change organizations and society.

Health policy in a fragmented world

Public health already recognizes that health policy extends beyond ministries of health. The more difficult question is whether we consistently act on that understanding. Health policy comprises the decisions, actions and sometimes inactions through which governments and other actors influence health outcomes. It determines how systems are organized and financed, how responsibilities and resources are distributed, and who can obtain which services under what conditions. Policy operates from the local clinic to the national legislature and the global negotiating table (Walt and Gilson, 1994; Walt et al., 2008).

Policy is goal oriented, but it is never purely technical. It reflects competing priorities and values, distributes benefits, burdens and risk, and exposes trade-offs: what receives funding, what must wait, which evidence counts and whose experience is heard (Walt and Gilson, 1994; Walt et al., 2008).

Young health leaders will inherit a disrupted world. Pandemics, climate shocks and displacement cross borders. Health has become entangled in ideological and geopolitical conflict. Public needs continue to grow while fiscal space and political commitment tighten. Misinformation and institutional failure have weakened trust in science and authority. The 2025 global monitoring report on universal health coverage estimated that 4.6 billion people lacked full coverage by essential health services in 2023, while 2.1 billion people experienced financial hardship from health spending in 2022 (World Health

Organization and World Bank, 2025). These figures reveal more than technical shortfalls. They point to failures of priority, financing, governance and implementation.

Health governance therefore resembles a network rather than a world government. WHO has a constitutional mandate to direct and coordinate international health, but most formal authority remains with states (World Health Organization, 2020). Governments, regional institutions, development banks, civil society, researchers, professional associations, foundations, businesses and communities all influence decisions. Choices made in finance, trade, agriculture, education, climate and technology may shape health as powerfully as those made by ministries of health (Frenk and Moon, 2013; Hill, 2011).

The practical lesson is straightforward: when confronting a health problem, do not search only for the person formally in charge. Map the system of authority, influence, resources, interests and relationships.

See the system before prescribing the solution

The Health Policy Triangle developed by Gill Walt and Lucy Gilson offers four connected lenses. Content asks what a policy proposes and what evidence supports it. Context examines the political, economic, historical and cultural conditions surrounding the decision. Actors directs attention to authority, influence, interests and power. Process follows how a policy is formulated, negotiated, implemented and reviewed (Walt and Gilson, 1994).

Medical education trains us to focus on content: What intervention does the evidence support? That question is essential, but incomplete. Technically sound content can fail when decision makers ignore the context, exclude key actors, misread incentives or treat implementation as an afterthought (Walt et al., 2008).

Context, actors and process are not impersonal elements of policy. They are shaped by the people within them: by their assumptions, prior experiences, perceptions, cognitive shortcuts, emotions and responses to uncertainty or perceived threat. Research across psychology, behavioural public administration and decision science shows that judgement is rarely purely rational, including among experts and public officials (Tversky and Kahneman, 1974; Lerner et al., 2015; Battaglio et al., 2019). These mental processes influence how health problems are framed, which evidence receives attention, whose knowledge is trusted and how policies are negotiated, approved and implemented.

Consider vaccination policy. The scientific evidence may be strong, but evidence alone does not ensure public acceptance or effective implementation. Success also depends on financing, procurement, supply chains and convenient access. Health workers must understand and trust the guidance, while communities must consider vaccination accessible, credible and relevant. Frontline professionals exercise discretion as they translate policy into individual encounters with patients and families (Erasmus, 2014). Vaccination decisions are also shaped by confidence, perceived disease risk, practical barriers, information seeking and a sense of responsibility towards others (Betsch et al., 2018). Political ideology, institutional trust and polarization can further influence vaccine attitudes, from national policymakers to parents deciding whether to vaccinate their children (Baumgaertner et al., 2018; Wróblewski et al., 2024). Understanding vaccination behaviour therefore requires attention to the full spectrum of beliefs, emotions, social identities, relationshipsand material constraints through which people interpret scientific evidence.

Before prescribing a policy solution, diagnose the system. Ask not only what should be done, but who must act, under which conditions, with what authority, incentives and resources, and how people will experience the proposed change. Then examine the human processes operating within that system. Cognitive and neuroscientific research shows that perception is not a passive recording of reality: prior knowledge and expectations influence what people notice and how they interpret it (de Lange et al., 2018). This does not mean reducing complex policy behaviour to the brain. It means recognizing that effective health policy must account for both the structures surrounding people and the minds through which those structures, risks and choices are understood.

Nigeria and the distance between law and life

I developed this article from an August 2026 keynote on health policy for the Nigerian Medical Students' Association. Nigeria's National Health Insurance Authority Act of 2022 offers a timely example of the distance between improving a legal framework and changing people's lives. The Act repealed the earlier NHIS legislation, established the National Health Insurance Authority, made health insurance mandatory, strengthened regulation of state schemes, provided for a basic minimum package and established the Vulnerable Groups Fund (Federal Republic of Nigeria, 2022). Nigerian researchers have described these provisions as

important corrections to weaknesses in the previous scheme (Ipinnimo et al., 2022; Alo et al., 2023).

The fair critique is not that the Act lacks ambition. It is that legal entitlement, financing, enrolment, service readiness and accountability must all work together before that ambition becomes effective protection (Ipinnimo et al., 2022; Wada et al., 2023). The available evidence remains sobering, although much of it measures the early period after enactment and should not be treated as a final judgement on the reform.

A nationally weighted People's Voice Survey conducted in 2023 found that only 7% of adults reported any health insurance and about 2% reported coverage through the national scheme. Higher income and education predicted government-sponsored coverage, suggesting that public insurance was not yet reaching poorer Nigerians equitably (Croke et al., 2026). The 2024 Nigeria Demographic and Health Survey recorded insurance coverage among only 3% of women and 4% of men aged 15-49 (National Population Commission and ICF, 2025). These household survey estimates differ from higher administrative enrolment figures reported by government; the measures, populations and data sources are not directly interchangeable. The survey findings provide a baseline during an evolving transition, not proof that the 2022 Act has failed.

Evidence from state-supported schemes shows both progress and uneven implementation. A six-state qualitative study reported perceived improvements in access, infrastructure and health financing. It also identified low public awareness, slow governmental processes, inadequate or delayed capitation, insufficient funding amid inflation, workforce shortages, inaccessible facilities and insecurity as threats to coverage and sustainability (Effiong et al., 2025b). A related multi-state survey found enrolment below 5% in four of six states, while other states performed substantially better, demonstrating how strongly implementation varies across Nigeria (Effiong et al., 2025a).

The Vulnerable Groups Fund is therefore more than a compassionate provision in a statute. Its stated purpose is to subsidize coverage for people who cannot afford contributions, but delivery requires predictable public financing, workable federal-state arrangements, credible identification and enrolment, capable providers, appropriate purchasing and transparent monitoring (National Health Insurance Authority, n.d.). A peer-reviewed policy analysis warned that political, administrative and fiscal conditions would determine whether the Fund

could close gaps left by the Basic Health Care Provision Fund and extend protection to vulnerable populations (Wada et al., 2023).

The Health Policy Triangle becomes concrete here. The content is a stronger law. The context includes Nigeria's federal structure, constrained public financing, large informal economy, workforce limitations and regional inequality. The actors include federal and state authorities, the NHIA, providers, health maintenance organizations, professional groups and communities. The process extends far beyond enactment into funding, regulation, enrolment, purchasing, service delivery and public accountability (Ipinnimo et al., 2022; Effiong et al., 2025a; Effiong et al., 2025b).

This gap between policy on paper and policy as lived is where leadership and human decision-making matter. Doctors and students can document barriers, explain reforms accurately, bring patient experience into formal discussions and press for transparent implementation. They should also recognize progress where it occurs. Serious policy leadership replaces easy criticism with evidence, specificity and sustained attention.

Shape the opportunity because evidence does not move itself

Evidence rarely travels into policy through its own force. People organize and move it. Research on political priority in global health shows that serious problems gain attention when advocates build cohesive networks, frame the issue persuasively, work with the political context and connect the problem to a credible solution (Shiffman and Smith, 2007).

The Multiple Streams Framework offers another useful explanation. Policy change becomes more likely when decision makers recognize a problem, a feasible policy response exists and the political environment becomes receptive. Their convergence opens a policy window. A crisis, election, budget cycle, court decision, new dataset or change of leadership may create that opening, but the opportunity can close quickly (Hoefer, 2022).

Serious policy work therefore begins before the public moment of change. Someone gathers and interprets the evidence. Someone develops relationships and builds a coalition. Someone refines the proposal, identifies the decision route and prepares a clear ask. When the window opens, they can act.

Advocacy is often mistaken for speaking loudly. Effective advocacy requires disciplined influence: understanding the decision maker and the issues that concern them, framing the

issue in terms that matter now, building allies and proposing a feasible action. A credible advocate can explain what should change, who has the authority to change it, why the moment matters and who will support the decision.

You already exercise policy power

Students and young professionals often imagine leadership as something that begins with promotion. Yet people experience policy through everyday decisions at the frontline. Doctors, nurses, administrators and community health workers interpret rules when resources are limited, guidance is ambiguous or individual circumstances differ (Erasmus, 2014).

Whether someone receives an explanation, a referral or respectful care may depend on these choices. A stock-out can be recorded and escalated, or quietly normalized. Discrimination can be challenged, or allowed to become part of institutional culture. Patient experience can enter the evidence base, or remain invisible. Research using street-level bureaucracy theory shows why this frontline discretion is part of policy implementation rather than a departure from it (Erasmus, 2014).

Power also takes more forms than formal authority. Knowledge power comes from understanding the evidence. Relationship power grows through trust. Convening power brings the right people into the same conversation. Narrative power explains why an issue matters. Implementation power demonstrates that change can work. Moral power draws attention to what institutions would prefer not to see.

Leadership begins when you recognize something that must change and accept an appropriate share of responsibility for changing it. This does not justify acting beyond your competence or making claims without evidence. It asks you to become a careful observer, a trustworthy messenger, a skilled coalition builder and a responsible participant in the institutions around you.

The inner work of policy leadership

Policy frameworks help us understand how systems behave. They say less about the inner capacities a person needs to act wisely within those systems, particularly under pressure. This is the space addressed by the Mind-Heart Axis and the MC3 Leadership Architecture that I am developing through The Wisdom House.

To recap: the Mind includes evidence, attention, critical thinking and judgement. It also includes metacognition: the capacity to observe our own thinking, question assumptions and use deliberate strategies to reduce error (Ko et al., 2025). Medical education strengthens analytical intelligence, but intelligent people can still lead badly. Knowledge can detach from humanity, while confidence can harden into certainty.

The Heart represents values, emotional awareness, ethical purpose, care and responsibility. It does not ask us to replace evidence with sentiment. It asks what and whom our intelligence serves. Alignment between Mind and Heart allows technical expertise to mature towards wisdom.

Three human capacities express that alignment. Compassion keeps people and suffering visible, including those absent from the decision table. Connectedness makes collective action possible across disciplines, institutions and differences in status or belief. Courage helps us confront what must change, speak honestly and accept appropriate risk. Evidence supports the importance of relational quality and psychological safety in healthcare, while the specific integration of these capacities within MC3 remains a proposition to be tested (Neal et al., 2026; LaPlante et al., 2025).

In policy practice, compassion asks who experiences the consequences and who remains excluded. Connectedness asks who must work together. Courage asks what needs to be said or changed. Mindful discernment continues to test the evidence, context and our own assumptions. These capacities are sometimes dismissed as soft skills. Evidence from healthcare relationships, team psychological safety and workplace mindfulness suggests that such capacities can influence whether technical knowledge becomes trusted action, although effects depend on context and implementation (Good et al., 2016; LaPlante et al., 2025; Neal et al., 2026).

A practical pathway for emerging health leaders

For ease of practice, I propose a simple pathway: see the system, shape the opportunity and sustain the change.

Seeing the system requires attention to evidence, context, actors, power and process. It also means seeing people whose experience may be absent from official data. Shaping the opportunity involves framing the issue, developing a feasible solution, building coalitionsand recognizing the right moment for influence. Sustaining the change demands continued

engagement after the announcement or legislation. Leaders must follow implementation, frontline behaviour, feedback, unintended effects and accountability.

A student association can become a policy platform. A clinical placement can reveal a recurring implementation failure. A research project can translate lived experience into credible evidence. A professional network can convene stakeholders who seldom meet. Digital communication can clarify an issue and build support, provided that it remains accurate, fair and transparent about uncertainty.

Begin by choosing one issue you care enough to stay with beyond a single campaign. Map who experiences it, who decides, who influences those decision makers and what blocks action. Then make one specific, feasible ask supported by evidence and allies. Start at a scale where you can act credibly, while keeping the larger system in view.

Your reputation will become part of your influence. Accuracy matters. Fairness matters. Keeping commitments matters. These behaviours help build trust, a crucial condition for the legitimacy and effectiveness of public institutions (OECD, 2024).

Begin where you are

The future of health will not be determined only in Geneva, Abuja or the offices of powerful institutions. It will also be shaped in hospitals, universities, communities and professional associations, through choices made by people who understand both the evidence and the human consequences of policy.

Do not wait to be declared a leader. Learn how the system works. Stay close to the people it should serve. Use evidence with courage and build trust across difference. Continue developing your skills throughout your professional life. Focus on inner development, too, and consider the often invisible but critical role of the mind.

You are not waiting to become health-policy leaders. You are already becoming them. The question is what you will do with that responsibility.

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