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Overseas Development Institute

Briefing Paper 25
October 2007

University of London

How can the analysis of power and process in policy-making improve health outcomes?

Moving the agenda forward

Key points

- Policy analysis can contribute to meeting health objectives by untangling the complex forces of power and process that underpin change.
- Health policy analysis has not been adequately developed and applied in low and middle income countries.
- Building a critical mass of networked researchers and policy-makers provides the key to developing the field and improving its contribution to health outcomes.

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ODI is the UK's leading independent think tank on international development and humanitarian issues.

The Millennium Development Goals (MDGs) Report (UN, 2007) indicates that progress against the goals at mid point is patchy. Many of the key challenges that need to be addressed relate to health: continued high rates of maternal mortality, slow improvements in rates of child survival, and a rising number of deaths due to AIDS in sub-Saharan Africa. Many factors underlie the slow progress. These include lack of investment in weak health systems, insufficient or poorly coordinated donor resources, lack of agreement on effective technical strategies, and limited scale-up of interventions that work. An area that has received less attention but contributes to slow progress in achieving the health-related MDGs is the analysis of how and why national health policies achieve less than expected, perform differently from expected, or even fail.

New paradigms of health policy analysis began to emerge in the 1990s, focusing less on technical content of health policy (the 'what' of policy – for example whether to recommend user fees or insurance as more equitable and efficient in financing health care) and more on the actors, power and processes involved in developing and implementing policy, and the contexts within which decisions are made. These paradigms surfaced as demand grew to understand how and why certain policies do well or do not succeed and how such understanding could help policy-makers make strategic decisions about future policies and their implementation. Ten years later, what do we now know about the factors influencing the patterns and effectiveness of health policy change and how can we move the agenda forward in order to improve health outcomes?

Child survival rates show slow improvement, and are worst in sub-Saharan Africa.

What has health policy analysis taught us?

Policy-making is not just about a particular decision made at a certain point in time, but more often understood as the ongoing interaction among institutions (the structures and rules which shape how decisions are made), interests (groups and individuals who stand to gain or lose from change) and ideas (including arguments and evidence) (John, 1998). This means that the study of health policy needs to take into consideration factors such as the role of the state, the interests of various actors and the manner in which they wield power, the nature of political systems and their mechanisms for participation, and the rules of the game in so far as the informal and formal policy processes are concerned. Moreover, policy analysis must also examine the role of culture and values systems and how they are expressed as beliefs, ideas and argument, as well as international factors which are increasing inter-dependence between states and affecting state sovereignty over policy processes.

Much of the health policy analysis literature to date has helped describe what has happened in a particular policy life course and to a lesser extent has identified important determinants of policy change. This has contributed to our general knowledge about actors and processes related to health policy-making and has also demonstrated that analysis of power and process can add value to those attempting to influence policy change. For example policy analysis can:

1. Help explain why certain health issues receive political attention

Despite political will being cited as critical in getting decision-makers to display serious interest in major health problems, such as congenital syphilis and maternal mortality, we know very little about how it emerges and how it is sustained. A series of case studies examining the emergence of political commitment for safe motherhood in five developing countries has helped our understanding of factors explaining agenda setting and government action. The experiences from the case studies demonstrate that attaining public health goals is as much a political challenge as it is a medical or technical challenge, with eight generic factors of particular importance (see box 1).

2. Assist in identifying which stakeholders may support or resist reform; and can therefore be used to develop strategies to improve the prospects for pro-reformist groups

For example, Amanda Glassman and colleagues have used policy analysis to examine the challenges associated with the adoption of health reform processes in the Dominican Republic (1999). The analysis included a systematic examination of the support and opposition for a proposed policy based on an analysis of interests (who stood to lose and gain), positions (for or against), and influence of five key groups of players. Reformers benefited from policy analysis which informed the development of explicit political strategies for change. Strategies were devised to manage interest groups, the bureaucracy and technocrats, and ranged from inventing new options to create common ground, making strategic use of the media, mobilising neutral friends, creating coalitions, and engaging the opposition in technical debate.

Box 1: Politics matters – Generating political priority for maternal mortality reduction

Shiffman (2007) analyses the extent to which maternal mortality emerged on the political agenda in five developing countries (Guatemala, Honduras, India, Indonesia and Nigeria) and attempts to answer the question of why policy makers prioritise certain issues and how support for an issue can be generated and sustained (in this case with budgetary allocations). From the case studies, a number of key factors are identified as having helped maternal mortality emerge on the political agenda:

- International agency priorities, resources and medical technologies are critical but advances in maternal mortality is a national political challenge.
- Local context matters and generating will is not a formulaic process.
- Advocates are more likely to be effective in moving political elites to action if they:
  a) coalesce and form a cohesive policy community;
  b) bring into their community well connected and influential political entrepreneurs (individuals have been critical in mobilising government policy action in Indonesia and Honduras);
  c) develop credible indicators to show policy-makers the extent of the problem;
  d) organise large scale focusing events to galvanise support for the issue; and
  e) present clear policy alternatives to show the problem can be dealt with.
- Political transitions can alter priorities and change the way policies are developed. Democratic change in Nigeria has created political space for social issues, such as maternal mortality reduction, to appear on the national agenda. In Indonesia, democratic transition and reform (decentralisation) has weakened safe motherhood policy with provinces and districts placing less political priority on the maternal mortality, in favour of more visible and vote winning issues such as road building.

3. Help identify and address obstacles that undermine policy implementation and jeopardise national and global goals for improved health

In examining the influence of nurses and clinic coordinators on the implementation of South Africa's free health care policy, Walker and Gilson (2004) focused on understanding frontline staff experiences, paying particular attention to the personal and professional consequences of the policy, the factors that influenced their responses to the policy, and what they perceived as the barriers to effective implementation. Results revealed that nurses were asked to implement a policy about which they had not been consulted, and whose consequences for their routines were largely ignored. These features of the policy process as well as nurses' values, including their perceptions of deserving or undeserving patients, had significant implications for the manner in which the free health care policy was implemented in practice. The prospects of preventing distortions of policies during implementation are reduced through communication, consultation and a shared understanding of policy goals between providers, patients and policy-makers.

4. Improve the prospects that technical evidence is considered during policy formulation leading to evidence-based policy

For example, Tangcharoensathien and Jongudomsuk (2004) found that Thailand's experience of designing, adopting and implementing a policy of universal health insurance coverage relied on national capacity for health policy analysis and research on health systems which generated evidence to guide and support the political decisions that were involved. Policy change was brought about after commissioning policy studies and publicly disseminating results regarding the feasibility of universal coverage. Also influential were social and political advocates who worked closely with policy researchers to ensure that the policy changes were guided by evidence.

5. Establish more realistic expectations concerning incremental pro-poor change

A synthesis of lessons learned of donor approaches to

understanding political factors shaping development outcomes (such as the Swedish International Development Cooperation Agency's power analysis and The UK Department for International Development's Drivers of Change) reports that political analysis has generated knowledge and provided a shared language and understanding of the impact of political and institutional context, and stimulated thinking about pathways of change. These studies have also contributed positively to improved aid effectiveness by highlighting the risks of alternative strategies and investments, help set realistic timescales for change, and encourage a more incremental approach that can improve implementation of programmes.

What is the state of health policy analysis?

Although health policy analysis can increase our understanding of the complexities of health policy process and provide insights as to how best to intervene in developing and implementing policy, this kind of analysis remains underdeveloped and has limited application in low and middle income countries. Despite a number of well designed studies offering authoritative and useful findings, the existing body of published health policy analysis is surprisingly small and the bulk of it is analytically weak; typically describing 'what' has happened in a particular setting rather than explaining 'why' it was the case.

A review of published literature in the field (Gilson and Raphaely, 2007) shows that a very limited number of conceptual frameworks and theories are used by health policy analysts (see Box 2, page 4). Most studies are 'inductive' in nature, 'cherry picking' elements of theory for the purpose of the study, rather than 'deductive' with studies being set up to test a theory's application. Far too little formal comparative work is undertaken and there are few cases of bodies of work relating to specific policies across a number of countries or to a range of policies within any one country. Surprisingly, despite the central role it plays in determining policy change, the concept of power remains under-researched in health policy analysis.

Furthermore, the results of health policy analysis are not reported in the key medical journals which have the widest readership and impact. Given the considerable difficulties in undertaking rigorous policy analysis research, largely as a result of funding, data access and reporting constraints, the thinness of the field is understandable.

In short, despite ten years of calls for more health policy analysis which elucidates the determinants of policy change, the field remains in its infancy and is failing to deliver what it potentially could.

What ought to be on the health policy analysis agenda?

A workshop in London in May 2007[1] brought together over 25 health policy analysts from Asia and the Pacific, Africa, Middle East, North and South America and Europe to exchange ideas about the use of theoretical and conceptual frameworks, and methods and approaches, to investigating and understanding policy processes, the use of policy analysis to support policy change, and the approaches of development partners to policy analysis.

While the health policy analysts naturally argued that their research agenda is potentially long, three areas stand out as being particularly rewarding:

- Make better use of the existing, often descriptive, body of policy analysis through:
  - synthesis of existing case study material using theoretically robust and well-structured approaches to synthesis of findings;
  - lesson learning from country case studies that have a common topic focus or common framework; and
  - lesson learning from all the health policy analysis studies carried out within a single country.

- Ensure that future research on agenda setting and policy implementation:
  - places greater emphasis on comparative studies; and
  - increases the use of theoretical concepts and/or analytical frameworks that underpins analysis.

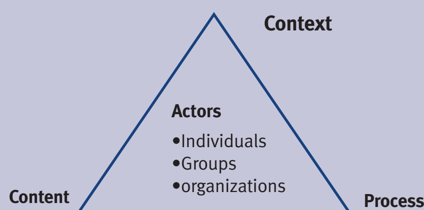
- Focus more explicitly on the methods for doing policy analysis, by:
  - increasing the methodological diversity within policy analysis by drawing more extensively on experience from other fields whilst paying greater attention to the benefits and limitations of different methodological approaches; and
  - enhancing 'reflexivity' in relation to both the relationships between researchers and policy actors and the manner in which the findings from policy analysis are used to engage with policy actors.

Policy analysis remains an underutilised tool in health development. Concrete steps are being put in place to plug this gap (see www.odi.org.uk/pppg/politics_and_governance/events/Health_Policy_Analysis). With seven years remaining to reverse and improve health-related MDGs, academia, think tanks, donors, government officials and policy activists would do well to take another look at its potential and how it might be best applied. In particular policy-makers should:

- Pay more attention to the politics of policy change.
- Consider the development of political strategies to engender change.
- Invest more in understanding these politics through better resourcing of policy analysis.
- Ensure active collaboration with researchers and public health advocates so as to generate better quality and more relevant policy analysis.

Box 2: Helping make sense of politics and process in health policy: Commonly used policy frameworks

Gill Walt and Lucy Gilson proposed a 'Policy Analysis Triangle' (see figure below) to help policy analysts think more systematically about the multitude of factors (content, process, context and actors) affecting policy and the interrelations among these factors (1994). Numerous studies on a range of health and health reform issues have used this framework to organise material to assist in elucidating what drove policy change.



Source: Walt and Gilson, 1994

The Kingdon model of Agenda Setting helps make sense of how certain health issues get onto the government policy agenda. The model suggests that policy is made through several independent processes: the problem stream, the politics stream and the policies stream. A constellation of factors coming together at the same time creates a window of opportunity to shift an issue onto the agenda. For example, as Michael Reich illustrates, the problem of ineffective and expensive pharmaceuticals had been floating in the problem stream for some time in Bangladesh but without any action being taken (1994). In 1982, General Ershad seized power and, as president, was eager to secure popular support by showing his willingness to act on recognised problems affecting the masses (change in the politics stream). A small group of Bangladeshi health professionals, chaired by a celebrated doctor and freedom fighter with an interest in community health and the indigenous pharmaceutical industry, had been concerned for some time about the drugs issue. Some of its members were hidden participants in the policy stream, collecting information and monitoring the situation whilst others were more visible participants advocating change explicitly. They recognised an opportunity to get an essential drugs policy on the agenda when the government changed and some of the members had close links to the new president. The technical feasibility, public acceptability and congruence with existing values were all judged to be favourable, and so the three streams came together, putting essential drugs on the policy agenda and resulting in far reaching and radical policy.

Paul Sabatier (1998) argues that policy change is a continuous process which takes place within policy 'sub systems' (such as the mental health policy community, the HIV/AIDS policy community) which he calls **advocacy coalitions** (Sabatier, 1988). Actors in these communities – be they government officials, journalists, doctors, and/or researchers – are organised into advocacy coalitions that compete for influence over government agencies to further their policy objectives. Policy change occurs as a result of fundamental changes in the external environment (such as a change of government) or in 'normal' circumstances, as a result of learning processes and interactions between advocacy coalitions within the specific policy community. Kubler (2001), for example, argues that the arrival of the AIDS epidemic led to the adoption of harm reduction policies, in part because AIDS policy communities coalesced with harm reduction communities to overthrow the dominant abstinence coalitions.

Michael Lipsky's Street Level Bureaucrats model examines what happens at the point where policy is translated into practice, in various human service bureaucracies such as schools, health and welfare agencies (1980). Lipsky argues that policy implementation in the end comes down to the people who actually implement it: the practitioners or 'street level bureaucrats'. Implementers tend to shape the policy in response to their understanding of it but also as a result of its congruence with their working routines, values and interests – thus directly affecting policy outcomes. Consequently, it is not enough for research to influence formal policy formulation without also paying attention to policy in practice. In order to impact on 'what policy does', research must be able to relate to the situation of the street level bureaucrats. For example, Kamuzora and Gilson (2007) examined the factors influencing low enrolment in Tanzania's health prepayment schemes (Community Health Fund) and found that district managers had a direct influence over the factors explaining low enrolment and identified in other studies. The authors conclude that in order to better achieve the objectives of prepayment schemes, it is important to focus attention on policy implementers, who are capable of re-shaping policy during its implementation, with consequences for success of the policy.

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Notes and references

1 The London Workshop was designed and hosted by the Consortium for Research on Equitable Health Systems (CREHS), the HLSP Institute, Kings College London and the Overseas Development Institute. The workshop was supported by all three institutions, the UK Department for International Development and the British Academy.

References can be found on the web version of this paper: www.odi.org.uk/publications/briefing/bp_oct07_health_outcomes.pdf

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ISSN 0140-8682

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