Masters in Public Health

UNDERSTANDING AND ANALYSING HEALTH POLICY

Module Guide

2016

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University of the Western Cape
Module Registration Number: SPH851

Value of module: 15 credits

Study time required: 150 notional learning hours

Pre-requisites: Completion of core modules

Study Materials for this module:
Module Guide & Module Reader

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MODULE INTRODUCTION

Letter of Welcome

Dear colleagues

Welcome to the module Understanding and Analysing Health Policy.

This module is based on a course first developed at the Centre for Health Policy, University of the Witwatersrand, and has been adapted and taught by several academic institutions across Africa since.

Health policy analysis is a small but growing area within the field of health policy and systems research. It aims to give researchers and practitioners the insights and tools to better understand what health policy is, how it is developed and implemented, what the factors are that shape it, and how people (actors in the health system) can influence and shape it.

By the end of the course participants will be able to:

• Demonstrate understanding of the varied and iterative nature of policy change processes.
• Understand and discuss the role of implementation in a policy change process.
• Identify key components and factors facilitating and constraining policy and implementation processes.
• Conduct comprehensive analyses of policy and implementation processes.
• Apply theoretical frameworks and approaches in understanding policy and implementation processes and apply specific policy analysis tools.
• Use policy analysis for strategic planning.

I hope you enjoy the module and look forward to working with you.

Regards,

Uta

Prof Uta Lehmann
Module convener
Email: ulehmann@uwc.ac.za
Module outline

The module has nine sessions:

- **Session 1 - What is policy? What is the policy process? What is policy analysis?**: will introduce you to the varied and complex nature of ‘policy’ and policy processes and how policy analysis can help to understand what drives and influences these processes and their consequences.

- **Session 2 - Understanding the policy process**: shows the complexity and often messiness of the policy process and illustrates the interdependence of different elements of the process.

- **In Session 3 - Analysing policy processes**: you will be introduced to the process of policy analysis using a case study approach – identifying key factors and using theoretical frameworks to explain how various factors interact to influence policy.

- **Session 4 - The central role of actors**: focuses on the central roles that actors play in policy processes. You will discover that there are different types of actors and that they play various roles; that their actions are influenced by belief and value systems, their interests and power relationships. This session also introduces some of the key theoretical concepts relating to actors and their roles in policy processes.
  - **Session 5 - Considering content**: introduces a characteristics analysis and language analysis approach to the study of policy content. Such analyses can show that different actors may interpret policy in different ways, and that this has implications for policy process and outcomes.

- **Session 6 - Considering contexts**: shows how theoretical frameworks can be used to categorise different contextual factors in order to understand how they influence actors and policy processes.

- **Session 7 - Stakeholder analysis**: introduces stakeholder analysis, an analytical tool that can help to assess the political feasibility of a policy and its implementation. This session follows closely on Session 1 in Unit 2 which discusses the central role of actors in the policy process.

- **Session 8 - Developing strategies to support policy change**: explains how understanding actors’ interests, values, beliefs and ideas can inform strategies to build support for, and/or reduce opposition to, a proposed policy. Understanding the interrelationships between content, context, actors and process is crucial for strategy development.

- **Session 9 - Thinking in an integrated way**: focuses on the interactions between all the elements that influence policy – actors, content, context and process.

To engage you in a dialogue as you read, we have included a range of opportunities for you to reflect or tasks for you to undertake:
• **Reflection**: we want you to pause and think for a moment so that you can become more aware of your assumptions, or the knowledge or opinions you already have about an issue. We often focus your thinking by asking direct questions.

• **Feedback on the reflection**: here we provide you with information against which you can compare the thoughts you had during the reflection.

• **Reading task**: this requires that you read a specified piece before you continue.

• **Self-study task**: here you are asked to do some writing based on a reading, case study or on text given in these materials. These tasks may also ask you to draw on your own experience, to offer your own thoughts, or to apply what you are learning to something from your own work life.

• **Feedback on tasks**: here we again provide information against which you can compare your own responses produced within a task. This is so that you can build your knowledge as you go – but try not to look at these until you have done the task yourself!

• **Discussion groups** – which require you to engage with all module participants on a particular topic in the discussion forum (see tab on the menu bar). You will be asked to post and further discuss insights and thoughts with your colleagues within a specified time (given to you in the task in each session and the course co-ordinator will then moderate your discussion). These tasks will not be marked, but you will be expected to be active in the groups.
ASSIGNMENTS

The module has two assignments as detailed below. In addition you are expected to actively participate in discussion groups on Ikamva.

If you have any questions regarding the assignments or have problems to get onto the Ikamva platform, please contact the module convener for help (ulehmann@uwc.ac.za).

**Assignment 1 (40 marks):**

Please select a policy scenario in your country and describe its focus and relevance in 4-5 pages. Focus on the following in your description:

- What is the focus of the policy?
- Why is it important to you?
- Who are the key actors involved in and affected by the policy? What are their beliefs, mindsets and interests?
- What are its key contextual factors?

In thinking about and answering the questions above, please make use of what you learned in sessions 1-4 of this module.

It does NOT need to be a big national policy. You can also consider a small-scale policy or set of guidelines.

Please submit this outline to me for feedback by 9 August (deadline for final submission of assignment 1 is 13 September).

**Assignment 2 (60 marks) (3000 – 4000 words):**

Analyse the process of formulation and implementation of the policy described in assignment 1, using the policy triangle and some of the tools introduced in the module:

- Conduct a stakeholder analysis.
- Sketch the policy context.
- Do a policy characteristics analysis.
- Explore the strategies employed in policy implementation.
- Argue what you think the strengths and weaknesses of the policy process have been, and how actors, contexts and policy content have interacted with each other
- Make two or three suggestions about measures which could have improved the policy process and success and motivate each with a few paragraphs. Draw particularly on the last two sessions of the module and what you learned about strategies for policy change.

Please submit an essay of between 3000 and 4000 words. Use the literature used in this module and reference correctly.

Please submit you draft assignment by 27 September (deadline for final submission is 25 October).
Session 1:
What is policy?
What is the policy process?
What is policy analysis?

INTRODUCTION

In this session you will learn about the varied and complex nature of ‘policy’ and policy processes and how policy analysis can help to show what drives and influences these processes and their consequences.

LEARNING OUTCOMES OF THIS SESSION

By the end of this session you should be able to:
• identify different uses of the term ‘policy’;
• distinguish between policy as intent and policy as understanding and practice;
• describe different forms of policy analysis.

READINGS

You will be referred to the following reading during this session:

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WHAT IS POLICY?

Reflection: WHAT YOU ALREADY KNOW ABOUT POLICY

Before you read anything about policy in this session, please do the following:

First, start by thinking about your home and family function. Can anyone at home just do whatever they please? What influences the behaviour of family members, or how things are done in the home? How do you make decisions in the family on issues that affect the family as a whole? These *rules, practices, decisions* can be considered *policies*, and in this session we will explain why this is so.

So, think further:
- How do these policies come into existence? Who develops them? What factors influence the types of policies that come into existence in your home and family?
- How are these policies known? Are they ever written down?
- How are the policies communicated to children or visitors? And how are they influenced by people’s values and beliefs?

Secondly, writing down what you understand policy to be.
- Write down as many words, ideas or concepts that answer the question ‘What is policy?’ – be these at work, or in the country more generally.
- Why do we have policies? What is their purpose?
- How do these policies come into existence? Who develops them? What factors influence the types of policies that come into existence in a workplace or as a country?
- What form do policies take? Are these policies always written down or are some of them unwritten? If policies are not written down, how are they communicated to the public at large or those responsible for implementing or complying with them?
Feedback on the reflection above

*Policy may take different forms.*

- Policy is a way of working, a vision, duties, responsibilities, accountability, or an unwritten cultural or ethical code that guides behaviour.
- Policies can be laws, documents, procedures, guiding principles, statements of intent, working frameworks to achieve certain objectives, a programme of action, rules and regulations.

Different environments and people have different policies

For example:

- Staff in a supermarket: a dress code; how to deal with customers’ demands
- Staff in an office: a procedure for booking leave; pay policy
- Members of a household: the times children should be in bed; who helps with the household chores

Policies can be developed in different ways

- They may be negotiated as a way of resolving conflict.
- They may be developed through repetition and habit.
- They may be cultural practices or taken-for-granted ways of doing things.

Policy can be implemented in different ways

- Through decree (‘because Dad says so’).
- Through convention (‘because that’s what everyone else in the office does’).
- Through negotiation (‘if you do this you will get ...’).
- Through a shared understanding of an ethical code of conduct (for example the implementation of a Patient’s Rights Charter may be influenced by people’s expectations about how things should happen, even though the details may not be written down).
WHAT IS PUBLIC POLICY?

Formal public policy, as developed by governments, is intended to influence the many actors working within a sector or system and the procedures and processes built into it, in ways that guide them to work together to achieve common goals and purposes. In general, public policies seek to generate ‘public value’; that is, they seek to produce things of value to the public at large in any country and to build public institutions, such as hospitals and clinics, that operate in ways that the public judges as fair and accountable.

The notion of ‘public value’ is an important one for policy making in the health sector as it suggests that the outcomes of policy developed and implemented in the health sector should be considered valuable by the public at large, as well as by political stakeholders and policy makers. A health system for example, may not only be seen by the public as valuable because it offers treatment in times of sickness, but also because it stands ready to act as a safety net for all, and particularly the most vulnerable, in times of personal and health crisis; or because it promotes processes that the public deems valuable in themselves – such as participatory decision-making practices or public accountability mechanisms.


Public policies are those that influence:

- the direct provision of services or commissioning of services - such as health services;
- the provision of information, education, advice - for example regarding health of individuals or populations, or health service procedures;
- the establishment of laws, tax rules, penalties, and the policing of these - such as laws underpinning the performance and financing of the health system;
- the use of economic instruments, like taxes, subsidies, or social benefits/grants - such as taxes to finance the health system or ‘sin’ taxes intended to discourage people from smoking or alcohol use;
- the regulation and behaviour of markets - such as legislation governing tobacco advertising, or pharmaceutical production and advertising, or the conditions under which new private health providers can start or continue to operate in a country;
- procedures and rules concerning staffing and operations of various government agencies - such as the recruitment and management of staff in state health organisations like national and provincial health departments, and health facilities themselves;
establishment of citizens’ rights - such as patients’ rights charters.\(^1\)

All of these types of policies are themselves the result of many decisions taken by those with formal responsibility in particular policy areas. These might include the decision to consider an issue as a problem worthy of attention by policy makers; the decision to develop a particular approach (policy) to addressing that problem; the decision to allocate financial and human resources to that policy; the decision to develop a law to underpin the new policy or to regulate the behaviour of some actors linked to the problem and policy, and so on. These sets of decisions are sometimes seen to follow a fairly linear path - namely from problem identification to priority setting to policy formulation, implementation and, via, evaluation, back to problem identification. But in reality, policy decision making much less straightforward and subject to many influences (as we will discuss later).

Overall, formal public policies reflect the *intention* of the state to take action on a particular problem. They provide the vision, goals, principles and plans that seek to guide relevant activities, as well as establish accountability and responsibility for those activities. From the perspective of a citizen or patient, health policies can be seen as a societal agreement to address a health problem or use an opportunity to promote health in a particular way. For a public manager, health policies are authorisations to use public resources to achieve health goals through specified means.\(^2\)

Public policy can, therefore, be generally understood as:

\textit{a set of decisions (course of action), authorised by the state (parliament, courts, government officials), and intended to create public value.}\(^3\)

However, policy can also result from what are called ‘non-decisions’. A ‘non-decision’ occurs when a decision is deliberately made not to address an issue; or when tackling an issue is simply avoided; or is a result of an oversight. In these cases, the ‘non-decision’ may still influence the behaviour of actors and the operation of the system it is intended to influence.

Non-decision making is also sometimes an expression of actor power – when one actor works to ensure that an issue is simply not put on the decision-making agenda, perhaps to protect their own interests. Think of a committee situation, where the secretary or chair or other powerful person works to keep an issue in which they have a personal interest off the committee’s agenda so that precedents and rules about the issue are never developed. For example, for many years the global tobacco industry worked very hard within and across countries to prevent evidence about the links between smoking and cancer being taken seriously by policy makers, thus limiting the possibilities of anti-tobacco legislation being developed.

\footnotesize{\textbf{Reflection}}

Can you think of another example of a non-decision that influenced a policy process?

\footnotesize{\(^1\) Adapted from Mulgan G (2009).} \\
\footnotesize{\(^2\) Moore, 1995.}
Formally, public policies often take the form of written documents. These can be documents which are actually called policies, but can also be regulations, guidelines or legislation, for example. However, policies can also be in the form of more informal written documents – such as memos or circulars communicating central-level decisions to those working in facilities or communities; or posters outlining rules and procedures and displayed in health facilities.

Public policy may also take the form of formal public statements - such as ministerial budget statements in parliament which lay out plans of action for ministries in the years ahead. Even informal public statements by those with authority can be understood by the general public or other health system actors, even if incorrectly, as statements of policy. When a Minister of Health announces a decision and, perhaps, even gives timelines for its implementation (as has happened with the removal of user fees in several countries) then this becomes the policy statement – and the formal policy document has to catch up with the public announcement.

In reality, however, formal policies only really come alive and take effect for patients and citizens through the ways in which they are implemented and they way they are practised in the health system. For these groups, policy is experienced through the resources made available and through the daily practices of those working in the health system, be they nurses, doctors, clerks, cleaners, community assistants, managers. For example, there may be a Patient’s Rights’ Charter but the attitudes and behaviour of health workers may not necessarily reflect the intentions of the Charter. At the same time, many daily operations of the health system as experienced by patients or citizens may not reflect formal policy. For example, managerial practice or custom, rather than formal policy, is more likely to influence the management of patient queues, the distribution of health staff and the way time is used within facilities – all of which are important factors in how patients experience the health system. Yet these practices may have significant consequences for how services are delivered, for patient understanding of advice given and for patient satisfaction.

In addition what patients and citizens do themselves, partly as a result of their experience of the health system, is also a way in which some policies are brought alive; for example, whether they ‘comply’ with medical advice, or whether their behaviour conforms with a Patients’ Rights Charter. So, in effect the formal policy of the patients’ rights charter may be much less important to citizens and patients than the informal policies (customs and practices) of service providers and service users – for example, whether they are treated with respect; whether staff communicate with them; whether they are left waiting; whether facility managers are proactive in allocating staff where the need is greatest.

Similarly, operational policies in the health services, for example on human resource management and budget allocation, only really come alive through the way in which they are being implemented: whether they have the necessary equipment and supplies to do their job; whether they have opportunity to develop their skills; whether they feel supervised and supported by and accountable to their manager; whether performance appraisal is developmental and supportive rather than punitive. Their experience of these types of policies may, in turn, influence the way they behave and act in implementing other
policies, such as Patients’ Rights Charters, and this in turn will influence how patients and citizens experience policy.

Ultimately, therefore, the decisions influencing whether and how policies take effect and are acted on (i.e. are implemented) are taken by groups who are often thought to have little formal power in policy making, eg. health service managers and frontline staff. Their daily, operational decisions often become the lived and experienced policy— for example, through health workers’ decisions not to follow formal guidelines, or to adapt those guidelines to better meet operational realities. Although not formally understood as policy, these practices, in effect, become the form that policy takes in reality - and they influence whether and how a policy achieves its original intentions.

Example:
The South African Government’s health policy says that all essential drugs should be available in public clinics and hospitals for common conditions like arthritis, TB, paediatric illnesses, high blood pressure and cardiac cases. However, patients complain that this does not happen. In Mdantsane, East London, patients at NU13 clinic complained that each time they visit their clinic, all they get is Panado. This means that government in the Eastern Cape is not fulfilling its obligation to provide functioning public health care and to make it available in sufficient quantity.

‘Managing medicine supply in the Eastern Cape’, Health-e website,
27 February 2004

Sometimes what a policy intends to achieve does not happen in practice. Can you think of any examples in your own experience – either as a professional or as a citizen in your country?

In the theoretical literature, Gill Walt describes health policy in the following overarching way

“We sat after lunch, five of us, arguing about the meaning of health policy. For the economist from the World Bank it was about the allocation of scarce resources. For the Ugandan health planner it was about influencing the determinants of health in order to improve public health. For the British physician it was about government policy for the health service. The Brazilian smiled. ‘In Portuguese the word “politica” means both policy and politics’, she said. For her, health policy was synonymous with health politics.
So health policy means different things to different people. ... For me health policy is about process and power ... it is concerned with who influences whom in the making of policy, and how that happens”. 3

More concretely, policy the health sector can be understood as the ‘courses of action (and inaction) that affect the sets of institutions, organisations, services and funding arrangements of the health system. It includes policy made in the public sector (by government) as well as policies in the private sector. But because health is influenced by many determinants outside the health system, health policy analysts are also interested in the actions and intended actions of organizations external to the health system which have an impact on health (for example, the food, tobacco or pharmaceutical industries)’ (Buse et al., 2005: 6).

In summary, public health policy should be understood to include formal statements of intention as well as the informal, unwritten practices that bring it alive and shape whether and how it achieves its intentions.

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**WHAT IS POLICY ANALYSIS?**

The question of how to analyse health policy and what to analyse is at the core of this module. Let us therefore now look more closely at what policy analysis means and entails.

We understand **policy analysis to be the systematic study of all factors, people, processes that impact on the way in which a policy is developed, formulated and implemented**. This conceptualisation is a bit different from other understandings which focus on **the technical work that underpins the development of policies and the work that is entailed in appraising new and existing policies**. This latter understanding includes, for example, epidemiological analysis that identifies risk factors for particular diseases and so targets/identifies necessary health interventions which are then included in the policy; or the analysis of cost-effectiveness that identifies which of several possible interventions to use to address a particular health problem on the basis of its providing the best value for money. Such policy analysis is, if you like, a technical input into a process that generates a policy document. And from this perspective, a policy is considered ‘successful’ if it is evidence-based and if the initial problem is adequately addressed by the policy action.

**The gap between policy and implementation**

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3 Walt, 1994:1
However, experience shows that even where policy documents are technically sound in presenting new approaches to addressing problems, this is often not enough to bring about the real changes in the operations in the health system such that it can be said that a policy has really been implemented and taken effect. There is often a gap between the intentions of policy - represented in formal documents and statements - and the reality of what people on the ground in the health system do, be they doctors, nurses, managers or patients and citizens. Sometimes powerful policy actors prevent new policies from going beyond being a formal document because they fear their interests will be threatened. This has been the case in the debates about a social health insurance in South Africa for example (see Stephen Thomas and Lucy Gilson. Actor management in the development of health financing reform: health insurance in South Africa, 1994–1999. Health Policy Plan. (2004) 19 (5): 279-291 (http://heapol.oxfordjournals.org/content/19/5/279.long):

Health reform is inherently political. Sound technical analysis is never enough to guarantee the adoption of policy. Financing reforms aimed at promoting equity are especially likely to challenge vested interests and produce opposition. This article reviews the Health Insurance policy development in South Africa between 1994 and 1999. Despite more than 10 years of debate, analysis and design, no set of social health insurance (SHI) proposals had, by 1999, secured adequate support to become the basis for an implementation plan. In contrast, proposals to re-regulate the health insurance industry were speedily developed and implemented at the end of this period. The processes of actor engagement and management, set against policy goals and design details, were central to this experience. Adopting a grounded approach to analysis of primary interview data and a range of documentary material, this paper explores the dynamics between reform drivers engaged in directing policy change and a range of other actors. It describes the processes by which actors were drawn into health insurance policy development, the details of their engagement with each other, and it identifies where deliberate strategies of actor management were attempted and the results for the reform process. The primary drivers of this process were the Minister of Health and the unit responsible for health financing and economics in the national Department of Health Directorate of Health Financing and Economics, with support from members of the South African academic community. These actors worked within and through a series of four ad hoc policy advisory committees which were the main fora for health insurance policy development and the regulation of private health insurance. The different experiences in each committee are reviewed and contrasted through the lens of actor management. Differences between these drivers and opposition from other actors ultimately derailed efforts to establish adequate support for any form of SHI, even as regulatory proposals received sufficient support to be enacted in legislation. Drawing on this South African experience together with a simple analytical framework, the authors highlight five potential strategies by which reform drivers of any policy process could create alliances of support sufficient to overcome potential opposition to proposed policy changes. As little is currently known on how to manage the process of engaging actors in reform processes, these findings provide a foundation for further analysis of this issue.
At other times, important policy implementers may simply not take on board new understandings and practices that are different from, and perhaps in conflict with, existing ways of doing business (as was the case with the Patients Rights Charter in South Africa mentioned earlier). Ultimately, policies often do not achieve what was intended because of these kinds of forces.

**Public policy as a process**

In contrast with the common understanding of policy analysis, this module therefore adopts a more political and organisational approach in which decision-making at all stages of the policy process by all actors in the process, in their various contexts are the focus of analysis. The analysis investigates the political, social and organisational forces that influence how and why policies come about and take effect, or do not. This approach recognises that not only is policy designed to change a given situation, but also that that situation itself changes quite quickly, giving rise to new pressures for further policy changes. Given that policy is constantly developing in this way makes it useful to think of policy as itself a process.

Furthermore, policy never starts out from a ‘blank slate’: It is never the case that government or another agency simply comes to a ‘new’ situation where there is no current influence of policies. Instead, there are always pre-existing policies at work in a situation – in the health system, these influence and shape the practices of the health workers and the patients/citizens active in that situation, including through their resistance to those policies. And there are also always other pressures over these practices - such as changing population and health needs, or changing economic circumstances - that themselves give rise to the need for new policies to adapt practices in ways that better address those needs. So as new policies are introduced, they interact with the existing policies in ways that are hard to predict, as a result of which they often have unexpected consequences. And as new policies are being implemented a range of other forces may undermine their relevance or their impact on practices, again leading to new pressures for policy change.

Therefore, this approach to policy analysis understands the term ‘policy’ to encompass more than the documents, legislation and guidelines often seen as the end point of ‘policy making’. Instead, policy analysis takes a holistic view of policy in its environment, the central role of policy actors - including beneficiaries and those responsible for implementation - and their expectations and understandings about the meanings of those documents and how they translate them (adopt, adapt, revise, reject) into their daily practices. So, policy analysis encompasses attention to, and investigation of, the formal, the deliberate decisions people make to do things differently, as well as their failure to take action or to change the routines and practices that are experienced as the reality of health systems.

This form of policy analysis might be seen as something that academics do. However, we argue here that policy analysis can (and should) be conducted by practitioners (leaders and managers) who develop or engage with policies – to understand better why certain policies are not being implemented as intended and/or have unintended outcomes; or to think
prospectively through the different aspects of and factors which might influence a policy process.

Policy analysis can be undertaken during a policy process, with the intent of intervening to support that process, or it can undertaken to learn lessons from the past about policy change.

Self-study task: SUCCESSFUL AND FAILED POLICIES

1. Identify a policy you thought was successful. Why do you think it ‘succeeded’?
2. Now identify a policy you thought failed. Did it fail because the original intention was not worthwhile or for other reasons? What were some of the reasons? (For example, was it due to lack of resources or a problem with the process which alienated a key group of people?)
3. When thinking about the success and failure of policies you know about, what kind of thought processes did you use? What were the indicators and the evidence you used to determine whether the policies were successful or failed? Did you think about the content and impact, and/or the process? Why did you think like that? What are the strengths of your approach and how might it weaken your analysis?

Discussion group:

In order to recap and test your understanding, jot down the key insights you gained from the section above:

- What is new to you?
- What is surprising?
- What do you need to understand better?

Please share your insights in the Ikamva discussion group by 25 July. We will hook in to the discussion on 29 July to comment on your discussions.
Feedback on self-study task: Successful and failed policies

Policies are often assessed as successes or failures based on the approach and interests (the particular perspective or lens) of the person doing the assessment (whether analyst, manager, service user or any other actor). In the examples you thought about above, were you more interested in the impact the policy had on the people who were affected by it, whatever its intentions, or did you assess it on the basis simply of whether the policy effectively tackled the issue it set out to address?

Policies may be ‘successful’, in the sense of addressing the issue it set out to tackle, while also adversely affecting the people whose interests you support. Does this mean they are a failure? For instance a policy to evict the people living in ‘illegal’ shacks built on private land without permission and to destroy the structures may successfully address the issues of trespassing and private land ownership – and the routine evictions and destruction of these dwellings may indicate that the policy was successfully implemented. But you may think it a failure as it did not take into account the interests of the people who were displaced and socially vulnerable.

As the policy analyst you are also an actor in the policy process – particularly if you had been doing the analysis during the policy development process and wanted to influence the outcome using your analysis. Unit 2 will talk more about actors in policy processes – but the point here is that no-one is neutral.
FURTHER READINGS

For the really interested:


SESSION SUMMARY

In this session we have introduced you to the idea that the term ‘policy’ has a wide range of different meanings – and that there are policies in many kinds of settings, from governments to workplaces and organisations and even households. Policies made by governments are public policies – which includes the majority of health-related policies.

Policy is a set of decisions and non-decisions and can be either formal or informal and can be written or unwritten – even in the case of public policies. Policies are developed through a process which are seldom simple as they are affected by a variety of actors and their interests and the contexts in which the issues live. This means that the stages in policy processes sometimes have to be repeated or ideas reviewed. In addition, interests and contexts can change, both while the policies are being developed or during implementation.

Policy analysis can be used to understand and/or to intervene in policy processes -and the analysts themselves invariably have interests.
Session 2:  
Understanding the policy process  

INTRODUCTION

This session shows the complexity and often messiness of the policy process and illustrates the interdependence of different elements of the process.

LEARNING OUTCOMES OF THIS SESSION

By the end of this session you should be able to:

- recognise the complexity of the overall policy process
- understand the inter-linkage of policy development and implementation processes

READINGS

There are no separate readings in this session.
WHAT IS THE NATURE OF THE POLICY PROCESS?

The overarching process of making and implementing policy is called the policy process, or sometimes in this module, the process of policy change – indicating that the changes which make up and are part of the policy process occur during both development and implementation. At the heart of this process are the many and complex sets of decisions and actions entailed in developing policy and putting policy into effect.

As noted earlier, these decisions are sometimes understood as a set of steps that follow one another in a fairly linear way, as in the ‘stages’ model in Figure 1 below.

Figure 1

The ‘stages’ model suggests that the four main stages of any policy process are:

1. **agenda setting** – which entails the identification of problems or recognition of issues, and setting priorities for what needs to be addressed. What does, and does not, get onto the policy-making agenda determines what policies are formulated and is influenced by policy actors’ interests and concerns.

2. **policy formulation** – which entails actors with formal policy authority making decisions about the details of policy content, using various decision-making strategies, and perhaps involving other policy actors.

3. **policy implementation** – which entails implementation of the policy content through various strategies and by various structures and people, including the adaptation or non-implementation of the policy by these policy actors.
4. **policy evaluation** – which entails assessing the success of the policy, either during its development and implementation (sometimes with a view to influencing this process), or after these periods, as a basis for further policy action.

However, experience of policy making and planning shows that, in reality, the ways in which problems are identified for policy attention and in which policies are formulated, negotiated and implemented do not entail a simple linear process in which there is a clear and almost automatic decision to move from one stage to the next. Instead, the processes of policy making and implementation take place over many years, sometimes moving forward across the stages above, sometimes moving in stops and starts, and sometimes moving forwards, and backwards and sideways.

A great illustration of the complexity and inter-dependence of policy processes is Steven Wallis’ diagram of drug and alcohol policy in Scotland:

![Diagram of Drug and Alcohol Policy in Scotland](image)

A policy issue may be identified at a particular political moment and suddenly receives priority attention, moving from formulation to implementation quite fast. Election promises, for example, such as the abolition of user fees, may receive priority attention when a new government comes to power. They may be implemented by a new government quite quickly. Or they may fall down the list of priorities after elections. Or they may be opposed by those who have to implement the policy, because implementation is a great cost to them. Alternatively, implementation experiences may generate new problems to be addressed. To stay with the example of user fees: a new government may quite quickly and easily announce the abolition of user fees. But the implementing health authority may then face reductions in income which may lead to service delivery bottlenecks. Or frontline service...
providers may be unhappy and angry about the government announcement because they experience increases in workloads as health care becomes more affordable.

In practice, therefore, the overarching policy process and the range of decisions involved in bringing about policy change, is much more complex, often haphazard and certainly much more contested than a linear, uni-directional model such as the ‘stages’ model suggests. Among other things it involves conflict and negotiation among policy actors and interest groups, sometimes over long periods of time. Ultimately, as Gill Walt notes, “Health policy is about process and power” (1994: 1) - that is, it is a political, not a technical, process.

The recognition of the political nature of the policy process and of its complexity has generated rich and diverse academic debate, as is evident from the two short text extracts below, taken from two influential books in this field of work. We have included them here for your reading both to give you a sense of the complexity of policy processes and of the rich and very diverse ways of understanding and discussing them.

SIMPLIFYING A COMPLEX WORLD

For a variety of reasons, the policy process involves an extremely complex set of elements that interact over time:

1. There are normally hundreds of actors from interest groups, governmental agencies, legislatures at different levels of government, researchers, journalists, and judges involved in one or more aspects of the process.

Each of these actors (either individual or corporate) has potentially different values/interests, perceptions of the situation, and policy preferences.

2. This process usually involves time spans of a decade or more, as that is the minimum duration of most policy cycles, from emergence of a problem through sufficient experience with implementation to render a reasonably fair evaluation of a program’s impact (Kirst and Jung 1982; Sabatier and Jenkins-Smith 1993). A number of studies suggest that periods of twenty to forty years may be required to obtain a reasonable understanding of the impact of a variety of socioeconomic conditions and to accumulate scientific knowledge about a problem (Derthick and Quirk 1985; Baumgartner and Jones 1993; Eisner 1993).

3. In any given policy domain, such as air pollution control or health policy, there are normally dozens of different programs involving multiple levels of government that are operating, or are being proposed for operation, in any given locale, such as the state of California or the city of Los Angeles. Since these programs deal with interrelated subjects and involve many of the same actors, many scholars would argue that the appropriate unit of analysis should be the policy subsystem or domain, rather than a specific governmental program (Hjern and Porter 1981; Ostrom 1983; Sabatier 1986; Rhodes 1988; Jordan 1990).

4. Policy debates among actors in the course of legislative hearings, litigation, and proposed administrative regulations typically involve very technical disputes over the severity of a problem, its causes, and the probable impacts of alternative policy solutions. Understanding the policy process requires attention to the role that such debates play in the overall process.

5. A final complicating factor in the policy process is that most disputes involve deeply held values/interests, large amounts of money, and, at some point, authoritative coercion. Given these stakes, policy disputes seldom resemble polite academic debates. Instead, most actors face enormous temptations to present evidence selectively, to misrepresent the position of their opponents, to coerce and discredit opponents, and generally to distort the situation to their advantage (Riker 1986; Moe 1990a, 1990b; Schlager 1995). In short, understanding the policy process requires knowledge of
the goals and perceptions of hundreds of actors throughout the country involving possibly very technical scientific and legal issues over periods of a decade or more while most of those actors are actively seeking to propagate their specific “spin” on events.

Given the staggering complexity of the policy process, the analyst must find some way of simplifying the situation in order to have any chance of understanding it. One simply cannot look for, and see, everything. Work in the philosophy of science and social psychology has provided persuasive evidence that perceptions are almost always mediated by a set of presuppositions. These perform two critical mediating functions. First, they tell the observer what to look for; that is, what factors are likely to be critically important versus those that can be safely ignored.

Second, they define the categories in which phenomena are to be grouped (Kuhn 1970; Lakatos 1971; Brown 1977; Lord, Ross, and Lepper 1979; Hawkesworth 1992; Munro et al. 2002). To understand the policy process, for example, most institutional rational choice approaches tell the analyst (1) to focus on the leaders of a few critical institutions with formal decisionmaking authority, (2) to assume that these actors are pursuing their material self-interest (e.g., income, power, security), and (3) to group actors into a few institutional categories, for example, legislatures, administrative agencies, and interest groups (Shepsle 1989; Scharpf 1997). In contrast, the advocacy coalition framework tells the analyst to assume (1) that belief systems are more important than institutional affiliation, (2) that actors may be pursuing a wide variety of objectives, which must be measured empirically, and (3) that one must add researchers and journalists to the set of potentially important policy actors (Sabatier and Jenkins-Smith 1993). Thus, analysts from these two different perspectives look at the same situation through quite different lenses and are likely to see quite different things, at least initially.


Self-study task

Please watch the following two videos on Youtube, which illustrates the complexity policy processes: the first one discusses policy to regulate the international migration of health workers (http://www.youtube.com/watch?v=iCau2jZ7yNc). The second one illustrates the policy process to reform the National Health Service in England (http://www.youtube.com/watch?v=8CSp6HsQVtw). Both flag several of the themes we will be talking about in the course of this module, in particular the importance of actors (or stakeholders) and their mindsets and interests, and the importance of context.
FURTHER READINGS


SESSION SUMMARY

We discussed above that the processes of policy change are neither linear, not always rational, and that a number of theoretical models have been developed to understand and explain these processes. Sabatier, in particular, points to the often vast number of actors involved in or affected by a policy process. Similarly, policy processes do not take place in a vacuum, but rather impact on and are influenced by other policies and context issues as discussed in the previous session.
Session 3
Analysing policy processes

INTRODUCTION

In this session you are introduced to the process of policy analysis through a case study approach, through which you will identify key factors and use theoretical frameworks to explain how the factors interact to influence policy.

LEARNING OUTCOMES OF THIS SESSION

By the end of this session you should be able to:

• understand the focus and nature of policy analysis
• recognise the complexity of the overall policy process
• understand the inter-linkage of policy development and implementation processes
• identify the key elements interacting within these processes

READINGS

There are no separate readings in this session.
Reading task

Please read the case study on ‘Separating drug prescribing and dispensing in South Korea’ below. We will use this in the rest of the module to illustrate many of the elements of the policy process and how these interact with each other, so this scenario is a core reading around which much of the module is organised. Please read it completely now, and then come back to it for different exercises as directed.

Case study: SEPARATING DRUG PRESCRIBING AND DISPENSING IN SOUTH KOREA

1. Policy issue

In all countries, expenditure on pharmaceuticals (drugs) impacts on the total cost of providing health care. A high and increasing cost of drugs puts pressure on national health budgets and often makes health care unaffordable for poorer groups.

Pharmaceutical expenditure levels are driven by:

- drug prices (which include the cost of drug production and the pharmaceutical companies’ profits); and
- drug prescription practice – particularly whether generic or brand name drugs are prescribed. Generic drugs and brand name drugs are equally effective, yet generic drugs are cheaper.

In South Korea as early as the 1980s, drug prescription practice was identified as the key factor influencing what was considered to be an unsustainably high level of pharmaceutical expenditure.

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5 By the 1990s Korea spent 31% on pharmaceuticals (rising to over 40% when physician fees for prescribing and dispensing were included) compared to the average of below 20% in other high income countries.
expenditure. It was also noted that South Koreans consumed more drugs than people in other high-income countries, particularly injectable drugs. This over-consumption resulted in an increased level of resistance to antibiotics.

1. These drug prescription problems were linked to the activities of two groups of actors: physicians and pharmacists, who prescribed and dispensed drugs (which was traditional practice in oriental medicine); and

2. pharmaceutical companies, who attempted to influence which drugs were prescribed and dispensed.

The majority of health care providers (pharmacists, physicians and hospitals) work in the private sector. They provide care on a ‘for-profit’ basis. Within the South Korean national health insurance system, all health care providers are paid on a ‘fee for service’ basis. The fees are paid after the service has been provided and the rates for the fees are tightly regulated. Before 2000, the government set the rates at which it reimburses health care providers for drug provision, on the basis of information provided by pharmaceutical manufacturers and wholesalers.

To encourage providers to prescribe ‘their’ drugs, pharmaceutical companies sold drugs to providers at prices that were less than government reimbursement levels. (In this way they increased sales.) Therefore, drug providers could generate a maximum profit by prescribing the drugs that cost them least to buy (relative to the government-set reimbursement level) and by prescribing more drugs than were necessary.

As a result of this financial incentive, pharmaceutical companies and drug providers would often work together in illegal and unfair ways to sustain their own profit levels.

In practice, therefore, drug prescription practice was based on which drugs gave providers higher profits, rather than on which drugs were the best quality or most cost-effective for the condition being treated. Nonetheless, government bureaucrats turned a blind eye to such practice for a decade or so. Even though the existing policy only allowed physicians to claim a maximum level of profit for drugs (24% of cost), this was not enforced.

The patients’ lack of knowledge was also seen as a factor affecting drug prescription practice. Lack of knowledge limited patients’ ability to challenge provider practices. In addition, patients’ preference for some form of medication, reflecting oriental medicine practice, encouraged providers to over-prescribe drugs.

2. Policy change

On July 1st 2000 the Korean government introduced a new health policy to prevent physicians and pharmacists from both prescribing and dispensing drugs. Under the new policy (in relation to those drugs categorised as prescription drugs) physicians would only be

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6 In 1997, 62% of consultations in physician clinics included injections, for example, compared to only 8% of outpatient visits.

7 Pharmacists have traditionally played the role primary health care providers in Korea, given past shortages of physicians.
able to prescribe, and pharmacists to dispense.

The reform aimed to reduce the overuse and misuse of drugs, and enhance the patient’s right to know about their medication. Under the new policy, physicians could prescribe either brand name or generic drugs. When dispensing, pharmacists could substitute a generic for a brand name drug if an equally effective generic drug (as verified by a bioequivalence test) was available.

3. Chronology and experience of implementing pharmaceutical reform

Government actions to introduce reform

Since 1963 attempts to amend the law in order to separate drug prescribing and dispensing had been made. However, these had been unsuccessful due to opposition from physicians and pharmacists, whose strong professional associations actively lobbied against the proposed changes.

However, the 1994 amendment to the Pharmacy Law specified that the separation of prescribing and dispensing would occur by 1999.

In 1997 the national committee on health care reform proposed a model for separation, including a gradual implementation process between 1999 and 2005.

A new president came to power in 1998, after the demise of the previous authoritarian regime, determined to implement this reform as it had been one of the key elements of his presidential election campaign.

In May 1998 the Ministry of Health and Welfare established a steering committee to prepare for the separation. To facilitate implementation, the committee made a revised proposal for the reform and classified drugs as either prescription or non-prescription. The civil servants made no special efforts to negotiate these proposals with the affected stakeholders. Apparently they believed that they could implement policy by instruction, as under earlier authoritarian regimes.

Reaction from civil society

The democratisation of South Korean society provided more opportunities for interest groups to shape policy processes, and increased their bargaining power relative to the state.

In November and December 1998, the medical and pharmaceutical associations appealed to Congress to defer the reform. They also appealed to the public for support by emphasising that:

- the new system would make it very inconvenient for consumers to obtain drugs; and
- it would not lead to reduced costs or other benefits.

Their activities were opposed by civic groups, mainly progressive academics and political activists, who had previously opposed military rule and who were aligned with the new President. These groups made pharmaceutical reform a major social issue, and deliberately
revealed the huge hidden profits made by physicians. This information initially caught public attention and mobilised support. It led Congress to reject the medical and pharmaceutical associations’ appeal.

However, neither the civic groups nor the government put much effort into persuading consumers to support the reform. Little publicity was given to the reason for the reform, and its potential benefits to consumers; and little effort was made to address the providers’ claim that it would make consumer access to drugs more difficult. The civic groups also apparently did not take account of the possibility that revealing physician profit levels to the public would strengthen the physicians’ resistance to the new policy.

**Negotiations**

Although the medical and pharmaceutical associations’ appeal was rejected, their resistance and obvious power led the ruling party to enter into negotiations with them. As a result of which, the government accepted the professional associations’ request to defer final implementation until 2000. This was on the basis of:

- an agreement made in March 1999 by the Korean Medical Association on behalf of physicians that they would work with civic groups to develop a final proposal for the reform;
- the medical and pharmaceutical associations’ acceptance, in May 1999, of the civic groups’ proposals, which had been discussed in five public hearings.

In December 1999 Congress passed the revised Pharmacy Law that provided the legal basis for the reform.

**Implementation of a ‘no-margin’ policy**

In November 1999, the government implemented the ‘no-margin’ policy. This policy cut the drug reimbursement fee that government paid drug providers close to the price that providers actually paid to the pharmaceutical companies. This strategy was intended to remove the physician’s financial incentive to dispense drugs and so encourage their compliance with the separation reform. It was put through with little consultation or negotiation.

The ‘no-margin’ policy showed the physicians how great an impact the separation policy would have on their profit margins (as the effects of the two policies were the same). They decided to go back on the attack.

In February 2000 about 40,000 physicians demonstrated against the reform. They were led by a splinter group of physicians that rejected the authority of the Korean Medical Association. This was followed by a series of other strikes (on April 4-6, June 20-26 and August 11-17). In the second strike more than 90% of general practitioner-type physicians went on strike. In addition, strikes by resident doctors in teaching hospitals (the vast majority of doctors in those hospitals) began in July and lasted for three months.

The Korean health system is extremely vulnerable to strikes by private sector physicians. It is heavily dependent on general and teaching hospitals for both inpatient and outpatient care. Only 7% of acute hospital beds are owned by the government. Therefore, the government
not only agreed to raise the physicians’ general reimbursement rates by up to 44%, but also to exempt many injectable drugs from the mandatory separation (although the latter was ostensibly to avoid patient inconvenience). At the same time, in order to offset the threat of further strikes, they increased dispensing rates for pharmacists.

The policy of separating drug prescribing and dispensing was, nonetheless, eventually implemented in July 2001.

**Considering policy impacts**

It is still too early to assess the impacts of the policy. However, three points can be noted:

1. The increases in reimbursement rates won by health care providers will limit the impact of the policy on total health expenditure levels, and may raise total costs for consumers.

2. Consumers will also have to bear the impact of reduced access, and this has already led to consumer complaints about the policy.

3. Physicians (in particular) have clearly demonstrated their power to influence the Korean health policy process – suggesting that the battle to contain the costs resulting from their practices is not yet over.

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**THE POLICY ANALYSIS TRIANGLE**

The policy process is about who makes what decisions and why, and how and when they are made in the course of developing and implementing policies. It considers the influences on whether, and how, policies

- are designed;
- are implemented;
- are seen as solutions to problems;
- influence practice; and
- generate specific outputs and outcomes.

The Policy Analysis Triangle (Figure 1) is a simple model for understanding the various sets of factors that are at work within any policy process. It emphasises the central role of policy actors, but also highlights the links between actors and three other factors that influence decision making: context, content and process. So while the figure may look simple, the complexity of the policy process results from the interaction between the factors.
Although each of the four elements of the triangle is considered in more detail in other Units, here we provide a brief, initial overview of the four elements. As you work through this section, you will use the Korean case study above to work through an example of a policy process to help you get a feel for the different elements of the triangle and the way they interact in the particular example.

**Actors**

Policy actors are those who:

- identify problems or issues as worthy of attention;
- prevent problems or issues being considered;
- shape the design of proposed policies;
- block the implementation of proposals;
- develop the strategies through which policies are developed and implemented; and
- shape the practice of implementation and so influence the impacts achieved through policy changes.
We use the term ‘actors’ instead of ‘stakeholders’ as ‘stakeholder’ does not take account of ‘hidden’ actors – those who may influence policy but have no obvious ‘stake’ in the process. It is important to identify the full range of actors in policy processes and the roles they play, including those who are less obvious - e.g. members of the general public - and how they may influence policy by their ‘non-action’.

**Self-study task**

1. Make a list of the actors in the case study on ‘Separating drug prescribing and dispensing in South Korea’
2. In what ways did each of them influence the policy?

(Feedback is given later in this module.)

**Content**

Policy content – what has been agreed to – is the substance of the policy which is embedded in legislation, policy documents, regulations and guidelines.

The text of a policy generally describes its objectives and may give various details, including the structures or mechanisms for implementation, resource availability, indicators for monitoring and evaluating progress. However, the policy content also represents a set of values – either overtly or in a less obvious way. For example the objective and implementation details of a termination of pregnancy policy promote values that will be supported by some and opposed by others (e.g. those who believe it opposes a right to life).

The substantive content of policies is influenced by the actors involved in or shaping policy formulation decisions as well as by the contexts in which it is developed and implemented, such as levels of resource availability. Whatever the text of policy documents, however, policy content only comes alive in the actual practices of implementing policy actors.

In addition, past policies influence current problems and current policies influence actors’ positions on policy and the feasibility of implementation.

**Self-study task**

In the South Korean example, how did past policies affect the current problem of over-prescription of drugs? How did the content of the ‘no-margin’ policy influence the policy effort to reduce the overuse and misuse of drugs and to reduce the high level of pharmaceutical expenditure in South Korea?

(Feedback is given later in this module.)
Context

By policy ‘context’ we mean the environment or situation in which policy processes occur – be they international, national or local settings. Context includes structures and resources as well as ideas and values. So, for instance, the context in which a termination of pregnancy policy is developed would include the capacity of the country’s health system to provide abortions, as well as the range of values and feelings expressed by groups within society, be they faith-based, feminist, children’s rights groups, etc. The influence of different sets of values and feelings over key decision makers is likely to strongly influence the nature of the policy that is developed and implemented.

History and tradition also need to be considered as they can influence the environment in which a policy is developed or implemented. For instance in a country where women are beginning to be allowed to participate in public spaces for the first time, a policy that requires equal representation of men and women on local government structures will be heard differently to the same proposal being made in a country where gender equality has been a long-held practice.

Context can influence policy in a number of ways, then. It can affect the perceptions and understanding of current problems, as well as actors’ policy concerns and their decision-making power. And through the formal structures of decision making - such as the position and power of the President versus the Cabinet, or the party of government versus the Parliament - it can impact on the processes and scope of decision making. Finally, contextual factors can influence the feasibility of policy implementation policy - e.g. through affecting the resources that are (made) available or people’s willingness to provide or use a service.

Self-study task

What contextual factors were at play in the South Korean case study?
In what ways did these influence the policy?

(Again feedback is given later in this module.)

Processes and strategies

Every policy change process takes place over time, and understanding the chronology of the steps within it is always important to thinking about and understanding the process of change. Within any process of policy change, a range of specific processes and strategies
may be deployed (or overlooked) that will enable or support the decision making entailed in developing the policy, as well as its implementation.

The specific process options include those regarding

- the style of decision making - which can range broadly from consensus-based to instructional decision making;
- the information and knowledge available and used in decision making;
- the speed and timing of decision making;
- the way in which consultation takes place and the communication strategies employed;
- the extent to which attention is paid to managing actors in the process of policy change, and the strategies used to do this;
- the venue or location of decision making – including the use of structures specially established as fora for decision making (or non-decision making), versus routine committees and meetings;
- the scale and timing of implementation of proposed changes, and the sequencing of different activities and tasks.

**Self-study task**

Please give examples of some of the specific processes and strategies used in the policy process in the South Korean policy experience.

(Feedback is given later in this module.)

**Interaction between the factors**

In every policy process, the four factors of the Policy Analysis Triangle interrelate and affect one another. So if, for instance, a new health minister is appointed who supports a policy which has long been side-lined, the context will shift and the policy process will be altered. Or if many babies and old people die for a third year in a row following annual cholera epidemics, discussions about the content of policy action to address cholera may shift to include more forcefully the ‘upstream’ issue of the right to clean water.
Self-study task:

In the self-study tasks 1 above you used the Policy Analysis Triangle to identify the various factors influencing the South Korean policy processes.

To consolidate what you understand about this case study, and building on your notes from the previous exercises, please do the following:

1. Summarise the goals/aims of the policy – i.e. what it was trying to change and what measures it proposed to bring about that change (the content).

2. Identify the key steps/stages in the process – and who was involved in each step (the actors).

3. Using your notes from the self-study tasks, identify and explain five main issues or factors that strongly influenced the policy change process.

4. Decide whether, overall, you consider this policy process to have been a success or a failure? What are the reasons for your conclusion?

5. Identify whether there were any unintended outcomes. If there were, give examples and suggest possible reasons for these.
**Feedback on the self-study tasks: analysis of the South Korea drug dispensing and prescribing policy**

<table>
<thead>
<tr>
<th>Category of issue</th>
<th>Issues raised</th>
<th>Issue links to/ influences over other issues</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Context</strong></td>
<td>Cost escalation due to pharmaceutical expenditure a policy problem identified in 1980s (partly past policy)</td>
<td>Underpins drive for policy change</td>
</tr>
<tr>
<td></td>
<td>Health care providers paid on fee-for-service basis (past policy)</td>
<td>Provides incentive to over-prescribe drugs, underpinning policy problem</td>
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<td></td>
<td>1998: new President came to power with mandate to implement policy</td>
<td>Election gave power to implement new policies</td>
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<td></td>
<td>1998: move from authoritarian to democratic regime opened space for actors outside government to influence policy processes</td>
<td>Created space for civic groups supporting policy, but for those opposing, also allowed opportunities to influence policy; Bureaucrats could not adjust to transition, and continued to work in authoritarian and controlling way</td>
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<td></td>
<td>Government owns only 7% of acute hospital beds and does not employ general physicians (past policy)</td>
<td>Gave physicians considerable power in post 1998 processes</td>
</tr>
<tr>
<td><strong>Actors &amp; interests</strong></td>
<td>Physicians, pharmacists and pharmaceutical companies – who work on for-profit basis</td>
<td>Have interests in maintaining profit levels – underpins policy problem &amp; their opposition to new policy</td>
</tr>
<tr>
<td></td>
<td>Pharmaceutical companies offer drugs to physicians at lower rates than those paid by government to encourage sales of their drugs</td>
<td>Underpins policy problem, by giving physicians financial incentive to prescribe company-provided drugs</td>
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<tr>
<td></td>
<td>Patients generally lack knowledge about drugs and had preference for antibiotics</td>
<td>Underpins policy problem because it contributes to cost escalation</td>
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<td></td>
<td>Government bureaucrats ignored past collusion between physicians &amp; pharmaceutical companies in price setting, and used to operating in very controlling way</td>
<td>Past lack of action underpins policy problem and makes future action more difficult; controlling approach causes problems for policy change</td>
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<tr>
<td></td>
<td>Physicians and pharmacists have strong professional associations, and</td>
<td>Enhances their power in lobbying</td>
</tr>
<tr>
<td>Content</td>
<td>Processes of policy change</td>
<td></td>
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</tr>
<tr>
<td>Pharmacy Act 1999 (implemented 2000) sought to separate roles of prescribing and dispensing between physicians and pharmacists, to encourage use of generics over brand name drugs - and to educate patients</td>
<td>1997: National Committee on health care reform proposed model for policy change timeline</td>
<td></td>
</tr>
<tr>
<td>Nov 1999: ‘No-margin’ reimbursement policy implemented to reduce reimbursement rates to physicians</td>
<td>Committees composed of bureaucrats developed policy without consultation and with assumption that could control top-down process of change, despite changing political context – but caused backlash</td>
<td></td>
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<tr>
<td>Encourage use of cheaper but effective drugs</td>
<td>May 1998: steering committee to prepare for separation, made revised proposal for reform</td>
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<tr>
<td>Reduce irrational drug demands of patients</td>
<td>Dec 1998: Professional associations appealed to Congress to delay reform and appealed to public to oppose reform because would reduce their access to drugs</td>
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<tr>
<td>Reduce profit margins of physicians</td>
<td>Actors seeking power in policy process by lobbying other actors, and for public, using messages that would capture their attention</td>
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<tr>
<td>Remove incentives to physicians to over-prescribe</td>
<td>As above, with some unexpected consequences – but Congress did reject physicians appeals</td>
<td></td>
</tr>
<tr>
<td>Both policies undermine interests of physicians and pharmaceutical companies, and (partially) pharmacists – generating opposition and oppositional alliances</td>
<td>Civic groups also lobbied in support of policy change, revealing huge profits made by physicians in order to gather public support – but only generated more resistance among physicians by threatening their self-esteem</td>
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<tr>
<td>Sometimes worked in alliance against change</td>
<td>1998-99: Given physician power, Negotiations among actors affect</td>
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</table>
government negotiated with physicians and reached agreement (March 1999) that physicians would accept policy but final policy implementation would be delayed until 2000

overall plans regarding timing of reform implementation

May 1999: professional associations accept civic groups reform proposals, discussed in five public hearings, and passed into law in December as Pharmacy Act 1999

Negotiations among actors lead to apparently acceptable proposals which reach legislation

November 1999: government implemented parallel policy (no-margin policy) – cutting drug reimbursement price close to levels physicians actually paid

Policy again developed without consultation or careful thought, and again resulted in backlash

Feb 2000: physicians go on strike in protest at ‘agreed’ policy change, crippling health system – and leading government to raise reimbursement rates

Clear exercise of power with impact that reduced effect of Pharmacy Act on overall cost escalation, and reaffirmed influence of physicians in health policy arena

**APPLYING THEORY TO ANALYSING POLICY PROCESSES**

The South Korean policy case study – and Figure 2 below - demonstrates that in the policy process

- policies are often re-formulated as time goes by, rather than remaining static;
- there are many influences over what happens, including chance;
- conflict is common, as power relationships among policy actors are embedded in the process;
- compromise and negotiation are almost inevitable;
- success, in the form of achieving policy objectives, is elusive and needs to constantly pursued over time.
Through focusing on power and processes, policy analysis can help to explain why policies do, or do not, achieve what was intended. As we have already noted, existing practice may not be supporting the achievement of the goal, and technically sound documents and ideas about new ways of addressing problems are not enough to bring about change in those practices.

**The role of theory**

Given the large number of variables within policy processes, then, theory is useful in understanding policy processes as it provides generalised explanations of political behaviours involving accounts and explanations of human action.

There is a range of specific policy analysis theories that are relevant to understanding policy process. Here we simply outline a small sample from that body of work, and encourage you to read more widely (possibly using the list of further readings given at the end of this section) as you build up your policy analysis experience.
Kingdon’s agenda-setting model

John Kingdon proposes a now quite widely used model of how policy agendas are influenced under conditions of uncertainty. This model focuses on policy actors, and considers how decision makers learn about issues and how issues get to be defined as problems.

As Figure 3 above shows, this model envisages three parallel streams of action around agenda setting.

- In the problem stream, evaluators, researchers and the media, for example, generate information and ideas about policy problems worthy of policy attention through routine data, special research studies and sudden crises.

- In the solutions stream, other actors generate ideas about new policies. These actors are sometimes but not always the same people as in the problem stream, and are only sometimes working on the problems being raised in the problem stream. For an idea to come to the surface it must be technically and practically feasible, be consistent with dominant social values, be publicly acceptable and have resonance with politicians (Buse et al., 2005).

- And in the political stream, there are swings in national moods, political changes, such as elections, and campaigns by interest groups.
A policy idea only gets onto the policy agenda when all three streams come together. This may happen because a political window opens – such as a new government coming to power which is committed to tackle new problems, or to tackling old problems in new ways; or because a problem window focuses attention on the problem (as when terrorism threats resulted in the very quick introduction of new airport and airline safety measures across the world; or, more prosaically, when severe transport accidents, whether of busses, trains or airplanes, lead to new regulations).

The coming together of all three streams is also generally the result of actions by ‘policy entrepreneurs’ – who are brokers and advocates of policy innovation. Policy entrepreneurs’ can be very visible, such as a new President or prime minister, or more invisible, such as specialists in the field who also have good connections to the political stream and can create persuasive arguments about the need for a policy.

Agenda setting occurs, therefore, not through a rational decision-making process, as summarised in the stages model or the rational planning cycle discussed earlier, but through political action - and sometimes even by chance.

IMPLEMENTATION

Policy implementation processes are often theorised or categorised as being ‘top-down’ or ‘bottom-up’.

A top-down implementation process is understood to be decided at national level and then translated into operating instructions for use by lower level operatives. Implementation is seen as a technical process conducted by administrative agencies, as in the stages model or rational planning above. From this perspective, central policy actors have the power to influence the overall policy change process, and simply command change throughout the system. Implementation should, thus, be seen as a process of conformance with pre-
determined targets and standards. Hogwood and Gunn (1984) have proposed ten conditions that, if met, would allow perfect implementation. They are:

1. External circumstances do not constrain implementation.
2. Adequate resources (including time) are available.
3. These resources are available at the right stage in the implementation process.
4. Policy is based on a valid theory of cause and effect.
5. The relationship between cause and effect is direct, with few intervening links.
6. Dependency relationships are minimal.
7. Objectives are understood and agreed upon.
8. Tasks are specified in the correct sequence.
9. There is perfect communication and co-ordination.
10. Those in authority can demand and obtain perfect compliance.

However, bottom-up implementation theory sees implementation as a more complex policy-action process, in which

- it is hard to predict all the conditions that might influence policy change; and
- incremental steps of change and revision are often made, as new policies create winners and losers, support and resistance; and
- implementing actors have minds of their own.

Critically, the bottom-up perspective emphasises that the policy actors responsible for implementation are understood to have some discretionary authority within the process of policy change and are not perfectly ‘controllable’. So they can re-make policy through their practices. In doing so, they may undermine central actors’ goals and generate unexpected negative or positive consequences. Barrett and Fudge\textsuperscript{8}, thus, describe bottom-up implementation as ‘a process of interaction and negotiation, taking place over time, between those seeking to put policy into effect and those upon whom action depends’. (From this perspective, policy implementation can be seen as a process of performance – in which the discretionary authority of implementers (as allowed by rules and roles) is supported and encouraged to achieve what is politically possible, given the values and interests of various policy actors.)

The wide range of influences over the behaviour of implementing actors (including, in the health sector, health workers and managers, and patients and citizens) is highlighted by the set of models summarised in Table 1 below. Whilst the political model emphasises power and how it is used, the cultural model gives more weight to the ways policy actors make meaning of their experiences. The organic model emphasises the processes of learning possible through partnerships and interactions.

Table 1: MODELS OF POLICY IMPLEMENTATION

<table>
<thead>
<tr>
<th>The cultural model</th>
<th>The political model</th>
<th>The organic/systems model</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Human beings are meaning makers and act on the basis of their own understandings, and interpretations of events</td>
<td>• All system actors have own interests and preferences, and seek to use their power to influence outcomes of system</td>
<td>• Every system is comprised of a range of components including organisations and people – which/who interact with each other within the system</td>
</tr>
<tr>
<td>• In making meaning, they draw on a stock of shared social meanings about specific issues, including the language of politicians and policy makers</td>
<td>• Actors at the bottom of the system, including citizens, always have discretionary power (actors at the top cannot control every action)</td>
<td>• All components have varying levels and forms of power, and can learn and adapt to changes in the environment and in each other</td>
</tr>
<tr>
<td>• These social meanings shape how people respond to new ideas and policies</td>
<td>• Power is not necessarily used for personal gain, but how it is used influences outcomes</td>
<td>• A new policy may introduce such changes</td>
</tr>
<tr>
<td>• Public managers and professionals draw on and use these meanings in making policy in their own environments</td>
<td>• Policy and delivery is a result of power balances and of the strategies used by actors</td>
<td>• Partnerships and exchange among components represent action and implementation, and enable learning</td>
</tr>
</tbody>
</table>


(The range of more specific theories which consider bottom-up actors and processes, include Lipsky’s Street-level Bureaucracy, which is presented in detail in Unit 2, Study session 1: The Central role of actors.)

In practice, however, neither the top-down or bottom-up approaches entirely explain experiences of implementation, and both have their limitations.

- The top-down approach only considers the power and influence of ‘policy makers’, as its primary focus is on central actors and it ignores actors working at the periphery or outside of government. It depoliticises the implementation process and cannot take account of the policy changes that occur during implementation.
Conversely, the bottom-up approach underestimates the power of the centre – and assumes that local level experience is always insightful, raising the question about whether policy could or should be made from the bottom only.

Nonetheless, for a policy manager, both sets of theories offer useful insights about how to manage the risks inherent in policy change (see Table 2 below). For example:

- The top-down approach suggests that policy failure results from ambiguous goals, involving too many actors and a lack of information and control. It suggests that policy change is best managed by centralising control to steer the policy process.

- Bottom-up approaches, meanwhile, suggest policy failure results either from having a policy that is too rigid in its specifications, or from not involving the participation of local actors in its development or from not establishing incentives for joint action. It suggests that policy change is best managed by improving the conditions under which local actors interact (e.g. by establishing incentives for such action).

### Table 2: TOP-DOWN AND BOTTOM-UP APPROACHES TO POLICY CHANGE

<table>
<thead>
<tr>
<th></th>
<th>Top-down</th>
<th>Bottom-up</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Focus</strong></td>
<td>Relation between central ruler &amp; target groups</td>
<td>Network of actors</td>
</tr>
<tr>
<td><strong>Relations between actors based on</strong></td>
<td>Central authority</td>
<td>Interdependence</td>
</tr>
<tr>
<td><strong>Perspective of policy process</strong></td>
<td>Rational, linear</td>
<td>Interactive process in which information, goals &amp; resources are exchanged</td>
</tr>
<tr>
<td><strong>Criterion of success</strong></td>
<td>Attainment of formal policy goals</td>
<td>Realisation of collective action</td>
</tr>
<tr>
<td><strong>Causes of failure</strong></td>
<td>Ambiguous goals, too many actors, lack of information &amp; control</td>
<td>Lack of incentives for collective action or blockages</td>
</tr>
<tr>
<td><strong>Management recommendations</strong></td>
<td>Centralisation &amp; co-ordination</td>
<td>Improving conditions under which actors interact</td>
</tr>
</tbody>
</table>
Self-study task

How do the top-down and bottom-up perspectives help understand the South Korean experience? What were the consequences of the approach(es) used?

FURTHER READINGS


Other references


SESSION SUMMARY

In this session the policy process has been outlined and the value of policy analysis described.

- The policy process always combines, and is influenced by, four key factors: content, context, actors and processes. These interact with one another and can change over time.

- The policy process is rarely rational and linear, but always evolves over time and is often quite conflictual.

- Policy analysis is concerned not only with agenda setting (the development of policies to tackle identified solutions) but also with implementation of new policies and routine service delivery.

- Ideas get onto a policy agenda when different policy streams converge.
• Policy analysis is interpretive and different theoretical frameworks emphasise different ways of understanding experiences.

Session 4
The central role of actors

INTRODUCTION

This session focuses on the central roles that actors play in policy processes. You will discover that there are different types of actors and that they play various roles; that their actions are influenced by belief and value systems, their interests and power relationships. This session also introduces some of the key theoretical concepts relating to actors and their roles in policy processes.

LEARNING OUTCOMES OF THIS SESSION

By the end of this session you should be able to:
• identify key categories of actors in the policy process
• explain how actors may influence the policy process
• recognise actors’ practices and sources of power
• identify the factors influencing actors’ behaviours and roles in the policy process

READINGS

You will work with the following reading during this session:
THE CENTRAL ROLE OF ACTORS IN THE POLICY PROCESS

POLICY ACTORS’ ROLES

As we have seen in the previous session, actors are the central element of the Policy Analysis Triangle framework; they are the ‘heartbeat’ of the policy process. Given their key position, then, it is important to find out who they are, what drives them, what roles they play in the policy process, from where they derive their power and how they exercise that power.

Policy actors may be individuals, organisations or networks. They may

- **formulate policy** - the policy elites, both national & international
- **try to influence policy** - interest groups, media, both national & international
- **broker policies** or policy ‘entrepreneurs’, i.e. those who play a connecting role, linking people, ideas, problems to solutions - may include civil society activists
- **implement policies** i.e. those whose actions and ways of working directly influence how policy is experienced by service users - bureaucrats, professionals, ‘street level bureaucrats’ (explained below)
- **benefit from or resist policies** – citizens, users of services (e.g. patients)

**Self-study task**

1. Refer to the list of actors in the South Korean scenario which you made during Session 2. Now categorise them using the above groupings.
2. What was the difference between professionals and bureaucrats in terms of how they were affected by and how they reacted to the policy?
3. How did the professionals influence policy in South Korea?

In addition, policy actors can be categorised by whether they are located outside the bureaucracy or work inside it. This location has bearing both on their roles in policy change.
and on the extent of their influence over policy change. While the structures of the government bureaucracy and health system partly shape the forms and levels of influence of actors within the bureaucracy, the influence of those who are outside the bureaucracy is shaped by the country’s political system and by a range of factors like the bureaucrats’ perceptions of the outsiders’ social power, the value of their technical expertise to assisting them realise their goals etc. Both those inside and those outside the bureaucracy are also influenced by the wider distribution of power within society (see session 6 on Context, below).

**Actors outside the bureaucracy**

Policy actors who are outside the bureaucracy include those who are ‘authorisers’ of policy as well as those who represent various interests and/or are members of civil society, be they the media, citizens or beneficiaries.

**Authorizers** are those who have formal institutional authority over a policy as a result of their roles in, and the nature of, the political system of the country. They comprise

- policy elites (heads of state, ministers, senior civil servants) - who prioritise problems and policies for action (or inaction), initiate policy documents and legislation, allocate resources, establish and influence wider understandings of policy intent, and monitor implementation;
- legislators - who approve legislation; who approve and/or have oversight of the budget and expenditure as well as of the broad performance of policies; and
- courts - who act as interpreters of the constitution and the country’s laws and who might be called upon to judge the admissibility of a policy under those laws.

**Interest groups** outside government can represent sectional interests (e.g. labour, business) or they may be cause-specific (i.e. focussing on an issue like anti-smoking, disability rights etc). Sectional interest groups take the form of, for example, trade unions, business or trade associations, while cause-specific interest groups often take the form of non-governmental organisations (NGOs), community-based organisations (CBOs), religious groups or private sector groups. Interest groups aim to influence which problems are prioritised, which policies are applied and the extent of the resources allocated for them. They may also be interested in having an impact on the processes of decision making, shaping the practices of implementation, and influencing which issues are monitored and what approaches are used for monitoring. They usually do not (overtly) seek political position for themselves (although in practice, some do!).

**The media** are also actors outside of the bureaucracy. Through their reports in the print media, on radio and television (both national and international) – and increasingly in the social media - they construct ways of understanding problems and solutions. In so doing, they influence the people who are making or implementing policies, as well as the broader
contexts in which these are taking place. The media are not necessarily impartial and may well represent particular interests, be they of societal or business groups, or of the state (e.g. when a newspaper is state-owned; or when a public broadcaster is heavily influenced by the state).

Even when not directly involved in the development or implementation of a policy, **citizens and beneficiaries** have influence over policy processes. In democratic systems, citizens elect and give governments mandates for policy action – and their actions in support of, or in opposition to, governments may consolidate or threaten government legitimacy. Popular protests in opposition to governments can, as we clearly saw in Arab states in 2010-11, bring down the government of the day; and in less dramatic situations, such protests may lead to policy changes. For example, South African civil protests about service delivery over recent years have led to pressure for economic and social policies that may bring greater benefits - reasonable housing, clean water, accountable local government - for the urban poor.

Finally, as beneficiaries, citizens can accept or resist new policies. For instance, patients can vote with their feet by not using a particular service, can decide not to follow treatment or advice, or can take different action. This resistance may reflect poor communication of policies (and misunderstandings) – or a well-informed rejection of the policy itself. At this most basic level, then, without the patients’ acceptance of a policy, it is difficult for health services to promote health!

**Self-study task**

1. Identify two examples of recent reports in the media, which have been related to a policy issue.

2. What role do you think the media played - were they ‘informing’ in a relatively neutral way or were they promoting a set of interests and values? What makes you think that? If you do not think they were neutral, whose values do you think they were promoting, and why?

3. In these examples, did the media shape public opinion or reflect it – or both? What makes you think this?
**Actors inside the bureaucracy**

Those who are located inside the health sector bureaucracy include

- senior national-level health civil servants
- senior health civil servants located at sub-national level (e.g. in provinces/ states or districts)
- government managers from other sectors at various levels
- area and facility health managers
- frontline health staff - who directly influence how policies are experienced by patients and citizens.

**Reading and self-study:**

*The theory of ‘street-level bureaucrats’*

An important policy analysis theory which has particular relevance for understanding government employed health workers – who are an important and often overlooked group regarding those influencing policy implementation - is called *‘street-level bureaucracy’*. As one of the family of ‘bottom-up’ theories of implementation (mentioned in Unit 1), this theory provides insights into the role this group plays in policy implementation and the factors that shape their behaviours and actions.

The author who introduced the concept of *‘street-level bureaucracy’* in 1980 is Michael Lipsky.

Watch this short interview with him on Youtube, made on the occasion of the 30\textsuperscript{th} anniversary of his book, which also came out as a second edition in that year:\textsuperscript{9}

[http://www.youtube.com/watch?v=ZX1iygPspA](http://www.youtube.com/watch?v=ZX1iygPspA).

Street-level bureaucrats are the frontline workers - or policy implementers - in government agencies such as the health service, the police service or schools. Nurses, doctors, policemen and teachers are typical street-level bureaucrats. As a group, they are characterised by

- regular and direct interaction with citizens/clients of government services, and
- a degree of discretionary power over the services, benefits and sanctions received by those citizens/clients.

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One of the key ideas of street-level bureaucracy theory is that the decisions and actions of street-level bureaucrats actually ‘become’, or represent, the policies of the government agencies for which they work. This is because a citizen/client most often, and directly, experiences policy through the decisions that the street-level bureaucrats make in relation to the way they offer services to these individuals seeking services - such as, for example, a facility manager deciding which patients are prioritised in her clinic. Policy becomes the benefit or service to which the street-level bureaucrat gives the citizen/client access, or the sanction that the street-level bureaucrat applies to them - rather than an abstract document that outlines what should be done or a decision by a high-ranking official that they have never seen.

In this way, street-level bureaucrats can ‘make policy’ both because they have discretion in their engagements with citizens/clients and because they are often relatively free from organisational oversight and authority. Their discretion could derive from the fact that they are regarded as professionals and therefore expected to exercise their own judgement in their fields of expertise. It often also arises, however, from the fact that they perform complex tasks that cannot be completely pre-determined or reduced to formulae or protocols.

With respect to organisational oversight and authority, street-level bureaucrats may be in conflict with, or have perspectives that differ from, other groups in the organisation, such as their managers. In expressing their differences, they may choose to resist organisational expectations through, for example, going on strike, being absent from work, or through having apathetic attitudes that affect how they do their work (like taking extended tea or lunch breaks).

This combination of discretion and a degree of freedom from organisational authority, may also allow street-level bureaucrats to ‘make policy’ in ways unwanted or unexpected by policy makers higher up in the bureaucracy. As their actions and decisions may not always conform to policy directives, their agencies could end up performing contrary to their stated policies, intentions or goals. To understand exactly how this may happen, one needs to consider in more detail the nature of street-level bureaucrats’ work, the pressures they face and the kinds of behaviours that result from these.

**Challenges faced by street-level bureaucrats**

Street-level bureaucrats typically face a range of key challenges:

- **Inadequate resources**: The resources at their disposal can be chronically inadequate relative to the tasks they are required to perform. This can take various forms.
  - There can be too few street-level bureaucrats for the number of cases or clients that require attention.
- A focus on administrative tasks, such as filling out forms, can limit the time they have for clients.
- Their inexperience or lack of training may mean that they lack the personal resources required for their jobs – including the resources to deal with the often stressful nature of their work.

• **An ever-growing demand for their services:** The demand for their services tends to increase to match the supply of those services – particularly if the service is prized and offered accessibly by the street-level bureaucrats. Also, if the organisation gets more money, there will be pressure to use that money to offer or develop additional services. This means that the needs are never fully met and the addition of new policies and developments – even with additional resources – can increase pressures rather than start addressing the lack of resources (above).

• **Vague or conflicting organisational expectations:** The agencies for whom the street-level bureaucrats work often have ambiguous, vague or conflicting goal expectations. (For example is it the role of the education system to teach certain values, certain basic skills or to meet employers’ needs for workers with specific training? What exactly does it mean to have the goal of good health?) While goals may be vague, ambiguous or conflicting for many reasons, the effect of this on street-level bureaucrats is that they (have to) make choices; they interpret goals that are vague or ambiguous (often reflecting their own views and interests); they choose which goal to realise (effectively choosing not to realise other goals that are in conflict with it).

• **Challenges of performance measurement:** It is often difficult or impossible to measure whether the performance of street-level bureaucrats contributes to achieving the goals sought by the agencies they work for. This is particularly the case where there is a lack of clarity or conflict about goals as it raises the questions about what to measure. Performance measurement is further complicated by the fact that street-level bureaucrats are engaged in complex interactions with other people – presenting situations in which it may not always be easy to know what the correct thing is to do, or even if there is only one appropriate thing to do in a particular situation..

• **Services for ‘captive’ clients:** Street-level bureaucrats often either provide important services for which they are the only providers in a given area, or who provide them to people who cannot readily access similar services privately or through non-governmental organisation (NGO) sectors. This can make it extremely difficult for clients to criticise or discipline street-level bureaucrats or their agencies who often have little to lose if they fail to serve their clients well. Despite this unequal power balance, however, clients are not completely powerless in the relationship, especially where street-level bureaucrats depend on them (e.g. for the evaluation of their performance where this
includes clients’ actions or behaviour). In these kinds of cases, street-level bureaucrats will need to obtain clients’ compliance for their decisions - and will also need to exercise some control over clients.

According to the theory of street-level bureaucracy, street-level bureaucrats exercise control over their clients through:

• distributing benefits and sanctions - such as making services available or rationing them through queuing systems; and by being respectful or abusive towards different groups of patients;

• structuring the context in which clients interact with them - such as designing the patient flow system in a clinic to suit providers with little consideration of patients’ needs; and

• teaching clients how to behave ‘appropriately’ in their roles as clients in relation to providers; for example controlling the nature and choice of information clients give about their needs, or deciding whether to meet the clients’ needs to access or hold their own patient records.

In summary, street-level bureaucrats work in situations where there are not enough resources and where demand is likely to simply expand to match any additional services provided or resources acquired by the street-level bureaucracy. Within this constrained environment they have a degree of discretion in their work and enjoy some freedom from organisational authority and supervision. In seeking to do their jobs they may experience unclear or conflicting goal expectations and have difficulty measuring their performance and understanding how their performance contributes to the intended goals of their agency and public policy. In addition, street-level bureaucrats often work with non-voluntary clients, which may affect their commitment to service quality and client satisfaction.

The nature of street-level bureaucracy work, and the conditions under which the bureaucrats operate, shapes the behaviours that are common among this type of policy actor.

**The behaviours of street-level bureaucrats**

In response to the challenging nature and conditions of their work, street-level bureaucrats often develop routines and simplifications in an attempt to reduce the complexity that they face, gain greater control over their work and cope with and manage the stresses of the work. It is in these routines and simplifications that street-level bureaucrats could be ‘making policy’, through taking actions and decisions that do not correspond to formal policy directives or organisational expectations.
These routines and simplifications can have a number of purposes:

- **Rationing the services that are provided.** The need for this is influenced by the high demand for their services that street-level bureaucrats often experience. Rationing can take place in numerous ways. These include:
  - imposing monetary costs on clients;
  - imposing time costs such as providing fast service for some clients and delaying others;
  - providing information to some and not to others;
  - imposing psychological costs on clients such as communicating disrespectfully, employing different queuing techniques that favour some over others; ‘creaming’, which involves choosing only those clients who are most likely to be successful in terms of what the government programme tries to achieve; and
  - acting on their personal biases, e.g. by regarding some clients as more worthy than others.

- **Controlling clients and getting them to co-operate with client processing procedures.** Street-level bureaucrats need to control clients and gain their co-operation both as they are, to some extent, dependent on their clients - but also as they need to deal effectively with high workloads. They achieve this control and co-operation in many ways. Street-level bureaucrats interact with their clients in settings which communicate their power and suggest to them how they should act (for example, the high bench of a judge or a classroom in which all desks face the teacher). They structure their interactions with clients so that they control what will be discussed, what the purpose of the interaction will be, when the interaction will take place and how long clients will have to wait for the interaction. Street-level bureaucrats may also develop procedures to punish those who do not respect and adhere to their routines.

- **Managing and conserving street-level bureaucrats’ resources.** Street-level bureaucrats may try to conserve some of their working time and other resources, through, for example:
  - building ‘slack time’ into their days, in order to have reserve capacity to respond to unpredictable situations;
  - shifting the locus of decision making to where clients are absent in order to avoid having to deal with the reactions or demands of clients, especially if they will be negative;
  - transcribing responsibility to others - for example higher-level officials allowing lower-level officials to exercise discretion in their place, rubber-stamping decisions that others have already made, and referring clients to other workers or agencies.

- **Managing the consequences of routine practice.** Street-level bureaucrats sometimes turn to deflecting practices when their regular practices - for rationing, for controlling clients and securing their co-operation, and for conserving their resources - either do not work or generate reactions from clients that either cannot be handled through
routine procedures or which annoy them. They may refer cases to more specialised
workers in the agency or create specialised units to deal with problematic cases or the
complaints of certain groups of people. This can be innocuous (when a case is really too
complex for a certain official), but it can also serve a variety of other functions, including
protecting a street-level bureaucrat from complaints or client hostility by passing on the
complaining client. They can also use such ‘special’ channels to favour certain clients by
presenting them as cases that deserve sympathy, while doing the opposite for other
clients diverted to the same ‘special’ channel.

Summary

The term ‘street-level bureaucrat’ refers to state-employed frontline workers or policy
implementers. While they are often committed to providing good service and to doing
socially useful jobs, they can find that their jobs and work environments make it difficult to
serve all clients as they ideally should be served. In response, they develop patterns of
practice, routines and simplifications that help them to deal with dynamics, such as the
ongoing chronic shortage of resources and the often high demand for their services. While
these patterns of practice will sometimes be aligned to public policy and with what street-
level bureaucracies seek to achieve, they often produce outcomes in that are either
unintended or may even work against the agencies’ objectives of such agencies and policies.

The theory of street-level bureaucracy also illustrates a set of issues relevant to all policy
actors. It shows how an apparently relatively powerless policy actor ‘makes’ policy (even if
they do not formulate it), and how each actor’s understandings and perceptions of
problems, issues, solutions influence their responses to policy. These understandings and
perceptions are, in turn, shaped by beliefs and values and by the actor’s interests. The
theory also shows how all policy actors, even those who are apparently relatively powerless,
have some agency, some power to act. An actor’s beliefs, values, interests and power to act
are, finally, themselves influenced by a range of wider contextual factors.
Discussion group

Read one of the papers listed below, which analyse the roles and practices of street-level bureaucrats in the implementation of health policies in Ghana and Kenya respectively.

Please share your insights about the role of actors in these papers in the discussion forum. Consider how street-level bureaucrats play their roles and what drives their behaviours. Consider whether you have witnessed similar behaviours in your environment, or indeed, whether you yourself have been in such a role and what shaped your actions.

Please share your view in the Ikamva discussion group by 15 August. We will hook in to the discussion on 12 August to comment on your discussions

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Abstract:

This is an empirical case study of ‘street-level’ officials in a classic ‘regulatory’ public agency: the Environmental Health Department in Kumasi and Accra, Ghana, where privatisation and contracting-out of sanitary services have imposed new ways of working on Environmental Health Officers. Both internal and external organisational relationships are analysed to explain the extent to which these officers have adapted to more ‘client-oriented’ ways of working. Their positive organisational culture is credited with much of the positive results achieved, but was not sufficient to cope with the negative impact of politically protected privatisations on the officials’ ability to enforce standards. Nor could it entirely overcome the deficiencies in training and incentive structures which should have accompanied the changes in service delivery.

This paper is available online at: http://www2.ids.ac.uk/futurestate/pdfs/Urban%20partnerships%20DPR%20article.pdf

OR


Abstract:
The implementation of social welfare programs, including family planning programs, is strongly conditioned by the needs, desires, and agendas of those who carry them out, known as "street-level bureaucrats." In this study, the strategies of CBD agents in western Kenya are examined in order to understand how they use their job as a means to achieve their own personal goals. The concept of clientelism, borrowed from the field of political science, can help to explain what the CBD agents are trying to achieve for themselves in their communities, at the same time as they promote the use of contraceptive pills and injections. CBD agents are concerned with building up their own stocks of prestige and respect from their community members, while avoiding blame for any possible negative outcomes of family planning.

This paper is a bit more difficult to access, as it is not freely available on the web, but you do have access to it via UWC’s library website and e-journal access.

THE FACTORS INFLUENCING POLICY ACTORS’ BEHAVIOURS AND ACTIONS

Policy actors play the central role in all policy processes. Their behaviours and actions influence how the process unfolds, what problems are prioritised for action, what policies are identified as solutions and how these policies are ultimately implemented. These behaviours and actions are, in turn, often based on judgements about whether they stand to lose or gain from a policy – which critically includes consideration of whether the content appeals to, or clashes with, their values and beliefs, and whether it threatens or supports/protects their interests.

Values are the criteria people use for selecting what is good in life, while beliefs are things people accept as fact (even though it may not be scientifically proven). For each person, these are shaped by a number of factors – by their personality, personal experiences, childhood, and education and training; by their religious affiliation and the opinions and arguments of others; by organizational roles and norms, and cultural and societal norms, among others. As with most people, policy actors’ judgements are affected by their values and beliefs.

The table below summarises the sets of values and beliefs that affect policy actors’ views. Deep core values and beliefs are fundamental drivers that influence an actor’s view of the world around them, including policies. These are translated into ‘core policy positions’ – that is beliefs about policy principles that influence an actor’s response to broad policy proposals and to elements of the administrative decisions necessary to implement those proposals. Whereas views on core policy positions are difficult to change, those on secondary administrative policy aspects are easier to change (see table below).
A government has recently introduced a special health insurance programme for
government employees. Within this programme

- employees on higher incomes will make higher contributions than those on lower
  incomes; and
- employees on higher incomes will be entitled to receive a wider range of services than
  those on lower incomes.

1. Do you think this is fair? Why/why not?
2. What values and beliefs inform your thinking?
3. Which of the views given in the next box most closely match your own?
4. Which of the deep core values and beliefs on the following list below most closely
match your own?

<table>
<thead>
<tr>
<th>Deep core</th>
<th>Core policy positions</th>
<th>Secondary, administrative policy issues</th>
</tr>
</thead>
</table>
| Fundamental orientations that affect all policy issues. Reflect strong personal beliefs. | The policy positions taken reflect core values in particular policy areas. They influence questions such as:  
- Who pays for health care?  
- Which groups should participate in decision-making? | The administrative decisions and activities necessary to implement the core policy positions - for example, the administrative rules needed, the budgetary allocations. |

Difficult to change | Difficult but can be changed through experience | Moderately easy to change |

Feedback “What drives you?” reflection:

Examples of reactions to a health insurance system in which higher income groups pay more than lower income groups

a. “It’s not fair that higher income groups should pay more than lower income groups. Some poor people are just lazy.”

b. “Ideally, one should have a maximum level of service for all but if the government cannot afford it, they have to do what’s feasible.”

c. “Health care is not a commodity that can be bought. Some health conditions are out of people’s control and affect rich and poor alike.”

d. “It’s not fair. Poor people are more vulnerable to ill health.”

e. “Everyone should have access to the same standard of health care.”

f. “It’s OK if the basic health services provided are the same for the rich and poor, and those that can afford it pay extra for a higher standard of catering and accommodation.”

g. “If some people can pay for better services they should get it.”
<table>
<thead>
<tr>
<th>Deep core</th>
<th>Core policy positions</th>
<th>Secondary, administrative, policy issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>All people are of equal value</td>
<td>The health system should treat all people fairly, and actively deter discrimination of any kind</td>
<td>Includes:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Same criteria for all in deciding who gets care, and who gets care first</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Training approaches for staff</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Strategies for reaching socially marginalised communities, etc.</td>
</tr>
<tr>
<td>People are of different value</td>
<td>The health system should provide better care to those of greater value</td>
<td>Includes:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Rationing procedures that prioritise those of greater value to ensure quick access and better care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Quicker and higher quality services available to some</td>
</tr>
<tr>
<td>People are fundamentally selfish (and so try to cheat the health system through their actions)</td>
<td>The health system should be organised, structured and managed to limit cheating</td>
<td>Includes:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Tight monitoring and strong disciplinary procedures for staff</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- User fees and other mechanisms to prevent over-use of services by patients</td>
</tr>
<tr>
<td>That poor people tend to get sick more than richer people is a result of their own actions</td>
<td>A basic minimum level of care should be available to everyone, but if you can afford to pay you should be able to get more and better services</td>
<td>For example through:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- A public sector providing basic care for everyone, but mostly used by the poor; and</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- A private sector offering better services for those who can afford them</td>
</tr>
<tr>
<td>Poor people tend to get sick more than richer people due to</td>
<td>Health systems should be structured and funded to ensure that the rich pay more</td>
<td>For example through:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Tax-funded or social health</td>
</tr>
</tbody>
</table>
factors beyond their control than the poor, but that care is available to all in reflection of their needs; and special interventions should assist the poor to protect and promote their health

insurance systems

Freedom of choice is the essential human value and economic opportunity is vital in promoting human health and welfare

Macro-economic policy should favour economic growth over redistributive policies (such as state-funded health care)

• The different labour market, trade, agriculture etc strategies that could be adopted to promote economic growth

<table>
<thead>
<tr>
<th>ACTORS’ INTERESTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Like most people, policy actors have interests i.e. a personal or group goal or need about which they are deeply concerned and that influences their decision-making behaviour. This could be an interest in financial gain or in personal power/status, or it could be in promoting an issue, which reflects their set of values and beliefs. In broad terms, interests can be categorised as including:</td>
</tr>
<tr>
<td>• self-interest or vested interests - i.e. the interests of those with a stake in a particular problem, issue or policy, and so have something to lose or gain from action in relation to it;</td>
</tr>
<tr>
<td>• group interests, or class interests - e.g. the interests of labour or of business;</td>
</tr>
<tr>
<td>• political interests - such as those of particular political parties or of particular ideological perspectives; or perhaps of personal political gain or loss;</td>
</tr>
<tr>
<td>• public interest – i.e a concern for the public good and public value</td>
</tr>
</tbody>
</table>

The particular interests of the bureaucrats responsible for policy implementation influence how and when – and whether – they implement policies. They may be interested in

• the timing of events or activities, e.g. relative to elections or budget cycles or the meeting times of routine committees;
• following precedent – or ignoring it;
• being credited with achieving something, or avoiding taking the blame for something.

Their implementation may also be coloured by

• the extent to which they are willing to take risks;
• the choices they make to cope with difficult working conditions; and
whether they prioritise meeting beneficiaries’ needs over the new policy (see discussion above of street level bureaucrats).

Self-study task

1. Name the interests of the main actors in the South Korea scenario and identify what kind of interests they were: self, group, political, public?

2. How did these inform or influence what they did?

ACTORS’ POWER

In relation to policy processes, power can broadly be understood as the ability to influence and control other people’s behaviour and actions, and/or attitudes. What actors are able to do within policy processes is also shaped by their power relative to other actors. And in understanding the exercise of power in these processes, it is useful also to think about the forms of power that can be exercised, the sources of power underpinning the practices and the consequences of the practices for policy change.

Forms of power

Power can be exercised in a variety of ways and a range of power practices are likely to be found in any policy process, implemented by actors relative to each other.

In practical terms, power can take the form of, for example:

- managerial instruction
- persuasion
- the rules and procedures that structure how decisions are made in an organisation
- force or threat
- management of the environment (e.g. as in the type, height and positioning of an official’s chair designed to demonstrate their status relative to that of a citizen or beneficiary)
- the labels used to describe particular groups of clients (see discussion above of street level bureaucracy)
- bargaining and negotiation among policy actors.

More broadly, in relation to decision making, the political scientist Steven Lukes\(^\text{10}\) suggests that there are three ‘faces’ of power:

---

• the power to make decisions - for example, as held by those with formal positions on policy formulation or implementation (including the power of street level bureaucrats over citizens and beneficiaries);

• the power to keep certain issues off the decision-making agenda – as discussed earlier, this includes, for example, the power of the tobacco industry to keep evidence on the links between smoking and cancer out of policy consideration for many years; it also includes the power of the media to highlight or ignore specific problems so that they become, or are ignored as, policy concerns;

• the power of influencing others’ thoughts - (values, beliefs, understanding of interests) so that they accept or agree with your positions and decisions. For example this includes the power of religious groups to influence their adherents in ways that lead them to support or oppose certain policies (such as the opposition of the Catholic church to abortion); or the power of a charismatic politician in persuading the public to support his or her political agenda (be it Nelson Mandela in South Africa or Barack Obama in the USA); or, again, the power of the media to shape popular views on policy problems or possible solutions to them.

Whilst the first – the power to make decisions - may be seen as an overt or obvious exercise of power, the latter two – the power to keep issues off the agenda and the power of influence others’ thinking - are more hidden, or covert, and yet have vital implications for the policy process.

Sources of power
An actor’s power is derived from a range of factors – personal, organisational, ones related to the policy process itself and contextual factors. Most policy actors will draw on a range of sources, rather than being reliant on only one.

• Personal factors include the actor’s skills and knowledge, profession, personality (charisma, approach to others), reputation, and allegiances.

• Organisational factors include the actor’s position or job within their organisation, their reputation, and the organisational norms about, for example, how decisions are made.

• Factors within the policy process include their formal role and position within the process, and their alliances and networks.

• Contextual factors, finally, include the political moment – the window of political opportunity to bring about change, for example, as well as traditions and cultural norms that influence an actor’s societal status.

The wider distribution of resources (wealth, political, education, knowledge) within a society is also a vital source of power. This distribution itself reflects the particular way in which a society is structured (a contextual factor, see later). Three basic ways in which power can be distributed in society are:
• where power is dispersed widely in society so there are many opportunities for participation – as in pluralist societies;
• where power is held by particular groups, allowing few opportunities for participation – as in elitist societies; and
• where the power is held primarily by state bureaucrats & managers, allowing no opportunities for participation beyond those actors – as in statist societies.

**Reasons for exercising power**

A policy actor may exercise power to support, oppose or resist policy implementation.

Sometimes power is exercised deliberately to influence the policy process, whether overtly or covertly, while in other instances (as may be the case with street level bureaucrats) the impact on implementation is rather a side-effect, an unanticipated consequence of policy. In addition, sometimes the practice of power may in some ways go against policy objectives and so undermine the achievement of public value (as again with street level bureaucrats), while at other times it may go against policy objectives and yet enable the achievement of public value. For example, where a doctor or nurse goes beyond her job description to assist a patient in accessing referral services, or exempts a patient from fees against policy guidelines, these actions may enable the patient to access services and so contribute to public value.

There are very many academic debates and traditions of thinking, particularly in the political sciences, philosophy and sociology, about what power is, who has it, and how it is exercised. Several authors have explored concepts of power in the context of policy analysis, mostly in the field of development and community empowerment. Have a look at one of the following sources available online to familiarise yourself with these concepts and their application:

1. An introduction to power analysis and the ‘power cube’:
   http://www.powercube.net/analyse-power/


3. A lecture by Goran Hyden, who has written a lot on power and policy analysis in the context of aid and development, available on: http://www.nai.uu.se/events/multimedia/hyden_090422/.

We have written about different uses of power by a range of actors in the implementation of a CHW policy in South Africa. Please click on the following link to read: Lehmann, U. & Gilson, L., 2012. Actor interfaces and practices of power in a community health worker programme: a South African study of unintended policy outcomes. *Health Policy and Planning*:


In this paper we describe and analyse how different actors in a South African sub-district, from programme and facility managers to community health workers and community members used different forms of power to make sense of and implement a new national policy, giving it a shape which worked in their particular local context.
We will return to the importance of local actors in shaping policy implementation in later sessions of this module.

FURTHER READINGS


SESSION SUMMARY

- Actors can drive or support policy change, prevent new ideas even getting onto the policy agenda, influence which policies are taken forward and how they are designed. They can also support or resist implementation of new policies.
- Actor understandings of, positions on and responses to policies are partly shaped by their values and beliefs, as well as by their interests and how these might be affected by policy content.
- Street level bureaucrats – frontline implementers of policies mostly developed elsewhere – have significant power over how, and whether, policies are implemented. Their delivery of services is invariably how citizens/clients experience policy.
- Actors can exercise power to shape or resist policy-making, or to influence others in the process.
- Actors’ policy positions and power within policy-making is influenced by personality, process, content and context.
Session 5
Considering content

INTRODUCTION

This session introduces a characteristics analysis approach to the analysis of policy content. It shows that actors may interpret policy in different ways, which has implications for policy process and outcomes.

LEARNING OUTCOMES OF THIS SESSION

By the end of this session you should be able to:

• recognise different forms of policy content and their varying influence over the policy process
• apply policy characteristics analysis to assess how policy design influences actors
• recognise different forms of policy instruments and determine the degree to which policy complexity and/or simplicity impacts on implementation.

READINGS

You will work with the following reading during this session:

ANALYSING POLICY CONTENT

The content of a policy is made up of
• the problem the policy seeks to address
• the aim of the policy (what the policy wants to achieve)
• the nuts and bolts of the policy – what the policy makers propose be done to address the problem and achieve the aims

The content of policy is influenced by, and embedded in, the context within which it is located and the actors who will be involved in and/or affected by the policy – and it is brought to life by the processes through which it is initiated, formulated and implemented.

POLICY CHARACTERISTICS

Policies usually have a standard set of characteristics within them. Analysing and understanding these characteristics helps us to understand both the aim of the policy and what it wants to do.

The characteristics of policies are influenced by, and influence, the way in which the actors are involved in shaping policy formulation and by the context in which it is developed and implemented, such as levels of resource availability. Whatever the text of policy documents, policy content only comes alive in the actual practices of central implementing policy actors. In addition, past policies influence current problems and current policies influence actors’ positions on policy and the feasibility of implementation.

Policy characteristics usually include:
• the gains and losses of the policy to a system, to implementers, to beneficiaries etc. (Who carries the losses or benefits from the gains? How big are the gains or losses? How visible or immediate are the losses or the gains?);
• the administrative or technical resources needed to implement the policy; the level of skill required, etc.;
• the level of complexity of the policy (i.e. how difficult is the policy to implement?);
• the participation needed (i.e. to what extent does the policy depend on other people to succeed?); and
• the resources needed, including time and finances - and their availability.

It is useful to identify these characteristics when analysing policy content or when thinking prospectively about the content of a policy, as they can provide the main signposts for what
the policy is about, what is intended, how likely it is to succeed, what major stumbling blocks may arise in implementing the policy.

Some policies are simple to implement, because they need few resources or technical skills, and there is immediate benefit to large groups of people. In the case of the elimination of user fees, in addition to the ease of implementation and the benefit to many, there may well be simultaneous—substantial hidden costs. Health services would be losing an important source of income, and larger numbers of people would make use of these free services, leading to over-stretched resources and work overload among staff. The introduction of a new vaccine may also be easy to implement, as it requires limited and clearly circumscribed resources and skills: staff in clinics may need instruction on the vaccine in the form of a protocol, and pharmaceutical services need to be able to deliver the vaccine. But there is little complexity or room for interpretation in such a policy. Other policies are highly complex, as they require new skills, additional resources, and the re-organisation of existing systems. This complexity is the reason why the decentralisation of health services, are often not fully implemented.

So, changing policy can be easier or more difficult depending on the extent and nature of the changes. The table below provides a useful categorisation of characteristics of policy content which would make a policy more or less difficult (“problematic”) to implement:

<table>
<thead>
<tr>
<th>Less problematic</th>
<th>More problematic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Simple technical features</td>
<td>Complex technical features</td>
</tr>
<tr>
<td>Small changes from current position</td>
<td>Major changes from current position</td>
</tr>
<tr>
<td>One-actor target</td>
<td>Multi-actor target</td>
</tr>
<tr>
<td>Single objective</td>
<td>Multi-goal objective</td>
</tr>
<tr>
<td>Clearly stated goals</td>
<td>Ambiguous or unclear goals</td>
</tr>
<tr>
<td>Short duration</td>
<td>Long duration</td>
</tr>
</tbody>
</table>

Jake Chapman, who has written about reasons why systems fail, argues that it is useful to distinguish between the “what?” and the “how?” of policy content. He argues that it is appropriate and important for governments to determine what the priorities and directions of government policy should be, but that the “how?” of implementation should be left to those responsible for implementation. This would allow for innovation, learning and local

adaptation, as “in many areas the range of interconnections and feedback makes it impossible to predict, in advance, the detailed consequences of interventions. Indeed, the consequences are often counter-intuitive” (Chapman, 2002: 27).

Chapman describes the unintended consequences of a policy widely used to tackle the use and negative social consequences of illegal drugs:

It has been well established that the use of illegal drugs such as heroin leads to increased crime by addicts needing to purchase drugs and to the increased cost of health care for addicts. One widely used policy is to aim to reduce the supply of drugs through increased activity by police and customs officers tackling actual or potential importers and suppliers. If the policy succeeds, then the supply of drugs will be reduced. If the supply of drugs is reduced, then dealers will have to pay a higher price for a smaller quantity; so they will ‘cut’ the drugs with other chemicals in order to increase their volume and they will also raise the street price of the drugs. The raised street price means that addicts have to steal more to get their daily fix. The increased mixing with other chemicals significantly increases the health hazards associated with drug use.

Thus to the degree that this policy succeeds in reducing the supply of drugs it will exacerbate the crime and health problems associated with drug use that it intends to reduce.

(Chapman, 2002: 27)

To reduce the risk of unintended outcomes, Chapman argues for participatory and inclusive processes of setting agendas, and for policy “outputs” (= content) which should be “as unprescriptive about means as possible”. Ideally policy output should:

- establish the direction of the change required clearly;
- set boundaries that may not be crossed by any implementation strategy;
- allocate resources and provide time frames, but without specifying how they must be deployed;
- grant permissions which specify the discretion or room to manoeuvre within which local agencies or managers can exercise choice and innovate;
- specify core evaluation requirements or benchmarks, while leaving room for local design adaptation (Chapman, 2002; www.demos.co.uk).
Self-study task:

POLICY CHARACTERISTICS ANALYSIS:
SOUTH KOREAN CASE STUDY

1. On the record sheet for Policy Characteristics Analysis below, analyse the content of the South Korean ‘no-margins’ policy (as it was first proposed) using the characteristics on the record sheet as a guide. You may need to make your own judgments on some issues, as you will not have all the details.

2. What did you find difficult about doing this analysis? What seemed straightforward?

Record sheet:

POLICY CHARACTERISTICS ANALYSIS

<table>
<thead>
<tr>
<th>Costs and benefits</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrative / technical content</td>
<td></td>
</tr>
<tr>
<td>Extent of participation</td>
<td></td>
</tr>
<tr>
<td>Resources</td>
<td></td>
</tr>
</tbody>
</table>
**Feedback on self-study task: Policy characteristics analysis: South Korean case study**

| Cost and benefits | These policies intended that physicians, pharmaceutical companies and pharmacists would incur significant financial costs in terms of reduced profit margins. It also envisioned certain benefits to patients, including lower costs and enhancing their right to know about their medication. The medical and pharmaceutical associations argued that patients would also bear the cost of greater inconvenience in obtaining drugs. The experience suggests that the patients are in fact shouldering the burden of reduced access, but that the policy might end up increasing their financial costs and increasing the financial benefits received by the providers, given the increases in reimbursement rates won by the health care providers. |
| Administrative / technical content | From an administrative and technical point of view, the policies seem quite complex. On the one hand, they entail significant changes in the health care delivery and payment system as a whole. On the other hand, they involve information about prices, profit margins, etc. which can be very complicated and contested. |
| Extent of participation | These policies required the involvement of many actors to be successful. It not only asked thousands of physicians and pharmacists to do things differently, but also affected the beliefs and behaviours of consumers and patients. This was complicated further by the fact that the significant costs were so clearly concentrated on a particular, mobilised group of people, while neither civic groups nor the government put much effort into persuading consumers (the many who stood to benefit) to support the reform. |
The election of the new president seemed to bring some fresh political resources, which enabled the reforms to be taken forward. The health care providers were very successful in using a massive resource at their disposal (their dominant position in the health system) to extract concessions and compromises from the government during the policy change process.

Self-Study:

‘HIGH’ AND ‘LOW’ POLITICS

The content of some policies is likely to be more controversial than others. Some policies carry substantial political weight (high politics), and their content is shaped by the political message they want to convey. Policies regulating the termination of pregnancies (TOP), for example, are invariably ‘high politics’. TOP signals a particular world view and values, and governments may use TOP policies to signal their orientation to their population. Other ‘high politics’ policy areas in the health sector concern, for example, the introduction or abolition of user fees; the introduction of antiretroviral therapy (ART) for AIDS patients; the introduction of community or national service for young health professionals - but also the restructuring of the civil service (which might generate intense reaction in support or opposition from health workers and other civil servants).

Other policies will generate less controversy or reaction, and are therefore less likely to be shaped by, or used in, political processes (‘low politics’). Examples of such policies might include, for example, the introduction of a new health information system, or of new pharmaceutical regulations (which may be of great importance but which may not have an immediate or visible impact on most actors).
INTERPRETING CONTENT

As with all text, policy content can be interpreted differently by various people and organisations – for a number of reasons. Different understandings may simply be a result of a policy’s unclear or ambiguous wording – and/or it may be the result of an actor ‘reading’ it through their own interests and values. In addition, terms can be used emotively or can be mobilised in an attempt to influence the reader. So, for instance, when one first hears of a ‘pro-life’ policy, is it one that opposes abortion or opposes the death penalty (see “policy actors’ behaviours and values” in Session 1 of this unit)?

Policy content sometimes develops a life of its own in the labels it is given by one or other actor, which subsequently becomes synonymous with the content of the policy. In the South Korea case study, for example, the new pharmacy law which cut the drug reimbursement fee that government paid drug providers was labelled the “no-margin policy”, signalling to doctors that the policy would substantially affect their profit margins, and leading to large-scale protests. (What else could this policy have been called and whose interests would it have been reflecting?)

As you would have read in one of the papers in the previous session, in South Africa in the mid-2000s, a complex and multi-facetted community health workers’ policy became known as the “stipend policy” in some parts of the country (as it introduced regular stipends for community health workers), leading to an exclusive focus on stipends in the policy implementation process, to the exclusion of crucial policy facets to do with recruitment, roles and training of community health workers.

The point is that the way in which actors interpret the intent and content of a policy has direct implications for the way in which a policy is implemented and experienced and therefore the results it generates.

Reflection

1. Can you think of policies in your country or specific work context which acquired a specific meaning because of the labels they were given?

2. A policy maker is drafting a new policy about clients’ rights in health facilities (a Patients’ Rights Charter). What information about you and your colleagues (as health workers and health sector managers) do you think would help the policy maker draft the policy content in a way that would reduce your resistance to it?
FURTHER READINGS


SESSION SUMMARY

The content of a policy is made up of the problem the policy seeks to address; the aim of the policy (what the policy wants to achieve) and what the policy makers propose be done to address the problem and achieve the aims.

While policy content should describe what the outcomes of the policy should be, prescribing how this should be achieved can run the risk of unintended consequences, if there is little latitude to customise implementation to suit the circumstances. Policies usually contain a standard set of characteristics which directly inform their implementation. These comprise the complexity of the policy; the gains and losses it will entail for various actors; the administrative, technical and financial resources needed to implement it – and the participation required.

Analysing and understanding these characteristics helps us to understand both the aim of the policy and what it intends to do – and can help actors critique the policy or devise strategies to implement it.
Session 6
Considering contexts

INTRODUCTION

This session shows how theoretical frameworks can be used to categorise different contextual factors in order to understand how they influence actors and policy processes.

LEARNING OUTCOMES OF THIS SESSION

By the end of this session you should be able to:
• categorise the main contextual features influencing policy change
• discuss how contextual factors influence policy actors, content and processes
• recognise the particular roles of institutions and broader political systems in shaping actors' power

READINGS

You will work with the following reading during this session:

<table>
<thead>
<tr>
<th>Author(s)</th>
<th>Title</th>
<th>Source</th>
</tr>
</thead>
</table>
ANALYSING POLICY CONTEXT

Policy processes, policy content and policy actors are located within multiple contexts, such as the political systems around them, wars and conflicts, economic systems (macro contexts), as well as organizational cultures, local demographics and population profiles, local practices and norms (micro contexts). These contexts not only shape how policies are formulated but, more importantly, how they are received, understood and implemented.

When doing policy analysis, whether prospectively or retrospectively, we need to be sensitive to both the macro and micro contexts. While the macro context frames aspects of what is possible in a policy, implementation is often impacted by micro contexts, such as local ways of doing things, organisational culture, experiences with previous policies, power and trust in organisations, etc. In the South Korean case study, for example, the demise of an authoritarian regime and the democratic election of a presidential candidate who had made a new pharmacy law a key election promise created the macro context within which the policy initiative was possible. However, the structure of the health sector in South Korea and the power of the medical association provided a micro context which made successful implementation impossible, thus necessitating a re-negotiation of the policy.

Closer to home, in the past two decades, the HIV/AIDS pandemic has been the macro context to virtually all health sector policies in Eastern and Southern Africa - while low staff motivation and high absenteeism have been micro contexts in many organisations (partly caused by the HIV pandemic) which have impacted on the ability to implement some policies.

MACRO LEVEL CONTEXTS

To assist us in better understanding and taking account of contextual factors which are numerous and diverse, several authors have developed frameworks to categorise and group contextual factors. Examples are the frameworks by Leichter\textsuperscript{12} and Collins, Green and Hunter\textsuperscript{13} which categorise macro contexts.

Leichter distinguishes four factors which define context:

1. **Situational factors** which are made up of the fluid, less permanent aspects of context, including the broad political environment, such as elections and wars, but also natural disasters, such as the earthquake and tsunami in Japan, a nuclear explosion or a cholera outbreak.

2. **Structural factors** are the more permanent elements of context within which policy is embedded, such as the structure of government and how the economy of the country is


organised (e.g. state controlled or free market driven); level of decentralisation of health services, etc. These factors will determine or explain what type of policy is feasible.

3. **Cultural factors** include the values by which a society lives, religious rules and practices, whether government is trusted, etc. For example, policies which require a high degree of compliance by the population are more likely to succeed in a country where the authority of the state to instruct and direct its citizens is unquestioned and citizens trust their government. Similarly, policies which respect dominant values will be easier to implement than policies which undermine or work against such values. An example may be the effort to strengthen the use of contraceptives and particularly condoms in countries with strong Catholic values, such as Latin America. (That cultural factors can shift was seen in Brazil when, with strong political leadership, the use of condoms was supported in the face of the impending HIV/AIDS pandemic.)

4. **Environmental factors** in Leichter’s model are those which lie outside of the national political system, such as the role of multinational corporations, international financial institutions etc.

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**Figure 1:**

**LEICHTER’S MACRO CONTEXTS**

Of course, these factors are not independent of each other - and Collins et al (1999) argue that in policy analysis they may be difficult to distinguish. They therefore suggest a different framework for policy analysis in the context of health sector reform which distinguishes

1. demographic and epidemiological factors;
2. processes of social and economic change;
3. economic and financial policy;
4. politics and the political regime;
5. ideology, public policy and the public sector; and
6. external factors.

**Figure 2:**
FRAMEWORK FOR POLICY ANALYSIS

Another alternative is to distinguish between the different context features as in the table below – which gives examples of how these different features might impact on policy processes.

<table>
<thead>
<tr>
<th>Feature</th>
<th>Influence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Societal &amp; political pressures &amp; interests</td>
<td>• Influence of interest groups</td>
</tr>
<tr>
<td></td>
<td>• Policy elite perceptions of what is feasible</td>
</tr>
<tr>
<td></td>
<td>• Use of state resources for patronage</td>
</tr>
<tr>
<td></td>
<td>• Electoral cycles (windows of opportunity)</td>
</tr>
<tr>
<td>Historical &amp; socio-cultural context</td>
<td>• Legacy of past (e.g. colonialism) for governance i.e. for nature &amp; functioning of civil service; international alliances</td>
</tr>
<tr>
<td></td>
<td>• Collective memories, what public policy action is deemed appropriate, what is considered legitimate action</td>
</tr>
<tr>
<td></td>
<td>• Values of society or sub-groups e.g. trust in government, gender relations</td>
</tr>
</tbody>
</table>
International context

• Economic conditions (& policy)
• Dependency relationships with external actors

Economic conditions & policy

• Timing of policy change
• Resource support for policies

Government system

• Federal vs. Unitary systems; state controlled or free market
• Single vs. Multi-party systems
• Relations between legislature, executive & judiciary
  • role of legislature; influence of the executive
• Contribution of the bureaucracy
• Position of Ministry of Health

All these frameworks are tools to help us think in some detail how macro contexts have impacted on policy formulation or implementation in the past (when we analyse policy processes); or how it might influence policy to be developed and implemented. They provide guidance in thinking about the role actors play in the policy process, and how their beliefs and values, as well as their power is influenced by and influences context; they remind us of the importance of “political moments”, and of the impact which the structural organisation of society has on whether and how different actors can exercise power (as in the earlier session in this unit on actors and power).

You may find one of these frameworks easier to understand and apply then others; you may find that a combination of these frameworks helps you in thinking about policy retrospectively or prospectively; and you may find that there are other elements and factors missing from these frameworks which you would want to add. They are thinking tools, so you should use them in the way that works best for you.

Self study task

1. Please read the article by Collins et al which provides interesting examples of how macro contexts impacted on health sector reform in several countries. As you read their categorisation (p. 74 onwards) think about examples of macro contexts in your own country which impacted on how policy was developed and implemented.
2. **Categorise contextual factors**

   Use one of the frameworks introduced above to do the following:

   b. Identify the contextual factors in the South Korean case study. What were the
      impacts of these factors on the policy process?

   c. Using one of the models above, categorise these contextual factors, using either one
      (or a combination) of these theoretical frameworks. Which factors could be placed
      in more than one category – and what criteria did you use for making your decision
      about where to place it?
      
      If you had categorised them differently would it have changed the way you viewed
      their impact? If so, in what way?

   d. Are there any types of contextual factors that the models do not cover? Is so what
      are they?

**MICRO LEVEL CONTEXT**

The micro level context comprises the more immediate and local contexts which may impact
particularly on policy implementation. These are typically within organisations – including
among staff - or between organisations and their various local contexts.

Micro level contexts within organisations might include, for example, the skills of the
manager heading an organisation; whether or not staff feel motivated and supported in
their work; whether a given policy has positive or negative effects on those expected to
implement the policy. A policy which leads to more work, or deteriorating working
conditions, for example, is likely to encounter resistance from workers and might make
implementation difficult. This is something which policy makers should keep in mind when
developing policy.

An example of the effect on implementation of a micro context was seen in research we
conducted on the implementation of a community health worker policy in one of South
Africa’s rural health districts (see session 5). Here we found that the negative attitude of the
manager in charge of transport in the district had a direct impact on other managers’
abilities to promote the policy within the district. Poor communication infrastructure and
practices between the provincial and district office furthermore hampered a comprehensive
understanding of the policy among sub-district and facility staff, leading to a very reduced
implementation of the policy.  

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14 Lehmann, U. & Matwa, P., 2008. Exploring the concept of power in the implementation of South
Africa’s new community health worker policies: A case study from a rural sub-district. Available at:
http://www.equinitafrica.org/bibl/docs/DIS64POLLehmann.pdf.
In an article on the impact of human resource management practices on accountability in the Indian state of Koppal, Asha George\textsuperscript{15} illustrated how formal rules and hierarchies combined with informal norms and processes to create informal accountability and management structures. Although supervision structures existed, little supporting supervision existed, and most supervision activities were reduced to instruction, inspecting records, and monitoring targets, which had a demotivating effect on workers. Disciplinary action, which was meant to hold health workers accountable, was often distorted through the interference of local political leaders, or payments to managers to avoid disciplinary actions. These created a micro context of formal management, which was not encouraging for health workers. But George also showed that “health workers sometimes resort to indirect methods to protect their interests. For example, one DHO was reported to run administrative meetings late into the night, regularly insulted medical officers and was corrupt. His subordinates got him transferred by accusing him of caste-ism” (George, 2009: 13.).

A micro context can also comprise the organisational or local culture. Implementing a policy which requires people to do things that their (organisational or local) culture does not support may well lead to resistance to policy implementation. For example, a new policy requiring people to work collectively and in teams to achieve certain outcomes in a micro context which has a strong culture of working individually, could make it difficult to implement the policy. That being said, where a policy actually intends to change the culture of the context, conforming to that culture would defeat the purpose. In this case understanding the context would help to choose an approach within the policy to address it. Examples of micro contexts outside of organisations include the relationships between health services and the communities which surround them; the availability or lack thereof of resources in support of health, etc. In addition, Sarah Atkinson cited geographical and demographic characteristics as a micro context which may impact policy\textsuperscript{16} - for example whether the context is urban or rural, the size of the health district, the type of ecology in the area, the size and composition of the population and the main economic activities in that area. The more dynamic aspects of local social organisation and political culture could also affect policy - including, among others, social networks, social mores and values, the nature of leadership, the nature of ‘influence’, the relationship of local public workers to the local health district.

In summary, micro contexts comprise primarily of local and organisational factors which might include the following:

- Organisational capacity:
  - Are the right people in the right place with the right skills?


\textsuperscript{16} Atkinson, S. (2002). Political cultures, health systems and health policy. Social Science & Medicine, 55, 113-124
The author discusses the values, mind-sets and actions of providers in rendering reproductive health services in ways that should remind you of the readings about street-level bureaucrats in session 4. However, he frames his paper in terms of micro contexts, which shape actors’ perspectives and actions. Consider whether and how you agree or disagree.

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**Self-study task**


The author discusses the values, mind-sets and actions of providers in rendering reproductive health services in ways that should remind you of the readings about street-level bureaucrats in session 4. However, he frames his paper in terms of micro contexts, which shape actors’ perspectives and actions. Consider whether and how you agree or disagree.
Self-study

As part of preparing for your second assignment please sketch the context of the policy you introduced in assignment 1, not just describing, but analysing it using one of the frameworks introduced in this session.

FURTHER READINGS


SESSION SUMMARY

In this session we have seen that contexts that exist at macro and micro levels are relevant to various stages of the policy process. In order to explain the outcome of a particular policy process, you need to take into account the various macro contexts that informed the policy as well as the micro contexts in which it was implemented.

Categorising the features of a context can help to think about the effects they may have on policy. There are a number of different ways of doing this and sometimes a context can fall into more than one category. It is possible that contexts at macro level may conflict with what happens at the micro level – in addition to which contexts change – and while they can influence other factors, these other factors can also influence contexts.

While understanding contexts and keeping track of them is therefore really important, their relevance and impact will depend on how they relate to other factors, however. It is therefore important to see them in relation to the actors they affect and the content they may inform.
Session 7 - Stakeholder Analysis

INTRODUCTION

This session introduces you to stakeholder analysis, an analytical tool that can help to assess the political feasibility of a policy and its implementation, either prospectively or retrospectively. To conduct a stakeholder analysis, it is necessary to draw on understandings of how actors, content, context and processes interact within any policy process. It will also introduce forcefield analysis which can graphically summarise where actors are located in relation to each other, their support for a policy and their power to influence it.

LEARNING OUTCOMES OF THIS SESSION

By the end of this session you should be able to:

- understand the purpose and approach of stakeholder analysis and forcefield analysis
- conduct a stakeholder analysis and forcefield analysis
- assess the strengths and weaknesses of stakeholder analysis and forcefield analysis as management tools

READINGS

You will work with the following reading during this session:

<table>
<thead>
<tr>
<th>Details</th>
</tr>
</thead>
</table>
| **NHS Institute for Innovation and Improvement. Quality and Service Improvement Tools: Stakeholder Analysis.**  
| **Namazzi, G. et al., 2013. Stakeholder analysis for a maternal and newborn health project in Eastern Uganda. BMC pregnancy and childbirth, 13(1).**  
What is stakeholder analysis

A stakeholder analysis (SHA for short) is an approach, tool or set of tools used to analyse past experience to understand how polices have developed, and how actors have influenced the processes of policy development and implementation. Very importantly, it can also be used to support the management of actors in future policy change processes.

Stakeholder analyses generate knowledge about actors with a view to understanding the beliefs, behaviour, intentions, inter-relations and resources they bring to bear on decision-making or implementation processes. Stakeholder analyses work through assessing, for example,

- the nature of actors’ concerns around a policy issue, given their beliefs, values and interests;
- their levels of knowledge and understanding of an issue;
- the levels of impact of the issue on the actor;
- whether or not they are likely to support or oppose the policy; and
- their levels of power relative to others.

Stakeholder analysis is a recognised method used by researchers and policy analysts for understanding actors in policy processes, both prospectively and retrospectively. An example of the prospective use of SHA is described in a recently published paper by Gertrude Namazzi et al on ‘Stakeholder analysis for a maternal and newborn health project in Eastern Uganda’\(^\text{17}\). In it the authors discuss the implementation of a SHA to “assess and map stakeholders’ interests, influence/power and position” in relation to two planned community-based maternal and child health interventions.

Self-study task:

Please read the paper by Gertrude Namazzi et al as a ‘worked’ example of stakeholder analysis. Consider particularly what insights the intervention team will have gained which allowed them to avoid mistakes and better understand actors (their interests, mindsets and power), thus increasing the chances of success of their planned intervention.

The key limitations of a stakeholder analysis are that

- it reflects experience at only one point in time;
- it may be difficult to make judgements about actors’ positions and power, and to reconcile different interpretations of these;
- it focuses on actors’ interests, but these are not the only influences over policy change.

Some of these limitations can be offset. For example, it is good practice to conduct stakeholder analyses at different time periods, and to examine changes in actors’ positions and power over time. It is also possible to conduct such analyses in ways that draw on various views and perspectives, or which develop a collective judgement through brainstorming in a group on issues like, for example, actors’ positions and power.

**How to do a stakeholder analysis**

In preparation for the exercises below please visit and engage with the following website: [http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/stakeholder_analysis.html](http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/stakeholder_analysis.html). Read and surf around a bit to get a sense of how SHA can be used. Maybe even do a google search. There are tons of material out there. Most of it not great, but also some interesting websites.

After a bit of familiarisation the best way to understand how to do a stakeholder analysis is to practice on an example (you will also be asked to conduct a SHA as part of your second assignment).

Please start by re-reading “Lehmann, U. & Gilson, L., 2012. Actor interfaces and practices of power in a community health worker programme: a South African study of unintended policy outcomes”, and then complete the task below.
Self-study task and discussion group:

STAKEHOLDER ANALYSIS:


   You can supplement this reading by also reading the full report of this research project\(^ {18}\) which is available at [http://www.equinetafrica.org/bibl/docs/DIS64POLlehmann.pdf](http://www.equinetafrica.org/bibl/docs/DIS64POLlehmann.pdf).

2. Identify four key actors (people, groups, organisations),

3. Using Form 1 below consider the following questions for each actor:
   - What are the actor’s interests and values relating to the policy issue?
   - How is the actor likely to see the impact of the policy action?
   - Is the actor likely to support or oppose the policy action?
   - What power resources does the actor have?
   - What capacity does the actor have to mobilise resources?
   - What is the overall power level of actor?

4. Analyse the likely positions of key actors around the issue of establishing a government budget line item for family planning, considering contextual influences, the policy characteristics, and actors’ interests and values (complete form 1 below).

5. Prepare a forcefield map that predicts actor positions and power levels around the issue (complete form 2 below). This allows you to judge what level of power the actors are likely to have around the particular policy issue (‘very high to very low’); as well as whether the actor would see the impact of the policy on them as strongly positive, strongly negative or somewhere in between. It is a way to summarise the SHA.

NB! Please post your SHA and Forcefield maps on Ikamva under Discussion groups as an attachment by 5 September. I will email you a feedback document after having looked at your map.

---

Form 1. Stakeholder analysis part 1

<table>
<thead>
<tr>
<th>Actor</th>
<th>Interests, values &amp; concerns</th>
<th>Forms and level of power to influence implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>What are the actor’s interests and values of relevance to this policy?</td>
<td>What were the actor’s hopes or concerns in relation to this policy?</td>
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</table>
### FORM 2: ACTOR POWER & POSITION MAP

**Instruction:** Locate your actors on this map of support and opposition for implementation, taking account of their power level

<table>
<thead>
<tr>
<th>Power of actor</th>
<th>high support</th>
<th>&lt;&lt;</th>
<th>&lt;&lt;</th>
<th>not mobilised/neutral</th>
<th>&gt;&gt;</th>
<th>&gt;&gt;</th>
<th>high opposition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Very High</strong></td>
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<tr>
<td><strong>Medium</strong></td>
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<tr>
<td><strong>Very Low</strong></td>
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</tbody>
</table>
**Drawing a forcefield map**

A forcefield map allows you to graphically show the extent to which you think actors may help or hinder the policy process, and what level of power they have to do so. It ultimately helps you assess the political feasibility of policy action around the issue and provides a basis for developing an actor management strategy to support the process of policy change.

A forcefield map is a chart with two axes: the vertical axis indicates the actor’s power in relation to the policy (from ‘very high’ to ‘very low’); and the horizontal the extent to which they support the policy or not (‘high support’ to ‘high opposition’).

<table>
<thead>
<tr>
<th>PROONENTS</th>
<th>OPPONENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Power of actor</td>
<td>high support</td>
</tr>
<tr>
<td>Very High</td>
<td></td>
</tr>
<tr>
<td>Medium</td>
<td></td>
</tr>
<tr>
<td>Very Low</td>
<td></td>
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</tbody>
</table>

Drawing on the information in the more detailed stakeholder analysis which you have already done, you locate the actors on the chart so that their location shows their relative support for the issue at hand and their relative power in relation to other actors and the issue.

Forcefield maps suffer from limitations similar to those of stakeholder analyses. As interests and power necessarily change over time, it is important to repeat the exercise periodically – to map any shifts that may have taken place.
SESSION SUMMARY

Conducting a stakeholder analysis and a forcefield analysis enables you to:
- draw together your understandings of how actors, content, context and processes interact within any policy process
- assess the political feasibility of a policy and its implementation
- identify key potential allies and opponents relating to a policy process
- clarify the resources and power of key actors in the process; and identify the basis for developing strategies for managing actors

These analyses should be repeated at various times, as actors’ positions and power change over time and the assumptions made can become invalid. In addition drawing on various views and perspectives, or developing collective judgement through consulting others can overcome some of the limitations in these tools.
Session 8
Developing strategies to support policy change

INTRODUCTION

In the previous session you were asked to draw a forcefield map of the actors involved in implementing the new CHW policy in a South African sub-district. A forcefield analysis gives you a good idea of different actors’ location with regard to a planned change. This is particularly useful when thinking proactively about strategies which will facilitate policy change.

This session explains how understanding actors’ interests, values, beliefs and ideas can inform strategies to build support for and/or reduce opposition to a proposed policy. Understanding the interrelationships between actors and the content, context, and process is crucial for the development of strategy during policy development processes.

The session works with some of the concepts and ideas about managing people that you were introduced to in Unit 3 of the health management module. It might be good to revisit the unit to remind yourself of what you learned there.

LEARNING OUTCOMES OF THIS SESSION

By the end of this session you should be able to:

- recognise the importance of strategy to policy change and development
- apply a framework in identifying actor management strategies
- identify other types and forms of strategies
- recognise key factors influencing the processes used in policy development and implementation
- understand the relevance of policy analysis to managing policy change processes and people.
READINGS

All required reading is in this session guide, but you will be referred to a youtube video.

STRATEGIES TO SUPPORT POLICY CHANGE

WHAT IS STRATEGY?

In the context of policy change as discussed in the module strategy refers to the specific approaches one can chose as a policy actor to manage (other) actors, the context and content and the process of policy change or development – with a view to

- increasing the effectiveness of efforts to influence change;
- clarifying what is possible to achieve; and
- identifying barriers to addressing change and opportunities to maximise it.

Here are some examples of strategies:

1. Redefine the way people understand the proposed policy action so that they are more likely to support it.
2. Mobilise an influential actor to support the policy action.
3. Find and build alliances with new actors who may want to support the policy.
4. Enhance the power of an existing actor in support of the policy action, for example provide information or build alliances with others.
5. Strengthen alliances among actors in support of the policy action.
6. Directly block the power of actors opposed to the policy action.

In the examples of strategies above, you will see that each is about influencing actors so that your policy has the best chance of being adopted. How actors are located in relation to the policy being developed or changed depends on the issues raised in the session 4 – specifically their interests, value and beliefs, both personal and organisational/political. Sessions 6 and 7 introduced two tools, Stakeholder Analysis and Forcefield Analysis, which can be used to explore how actors are located in relation to a particular policy.

There are other factors to consider when developing strategies. These can include

- the political and other contextual (as discussed in session 6);
• who you are – and how this affects what you are best placed to do (For example if you are working from the outside, do you want to engage with or oppose policy formulators? If you are working from the inside, what power do you have relative to the potential opposition?)
• the resources you have and what is feasible, given the policy content, context and other actors
• the timing of particular events or processes.
• the need to be flexible so that you can adapt and respond to unexpected changes in the process.

So developing a strategy entails
• clarifying your own goals (as in the examples at the beginning of this session);
• analysing the situation (What do you need to assess? How can you gather the information you need?); and
• identifying your options.

In analysing the situation you will need to take account of all three factors:
• the different actors, identifying who you should involve, who you should collaborate with, who you should defend against; and whose activities and interests you should monitor (forcefield analysis)
• the context and how this might affect your goal
• the content - and what messages would work best for each key actor

STRATEGY AND TACTICS

But having a strategy is not enough by itself. You also need a plan to implement it, the capacity to do so and the flexibility to adapt it when required. Tactics is the practical action taken in order to achieve the strategic goal.

Different actors are likely to require different strategies and/or tactics, as their interests, beliefs/values will shape your strategic goals. Often strategy design stops at the level of addressing actors’ interests, and does not give enough consideration to their beliefs and values which fundamentally affect actors’ interpretation of policy texts and their behaviour in the policy process.

An example of strategies and tactics

Strategy: Redefine the way people understand the proposed policy action so that they are more likely to support it.

Strategic goal #1: To influence public opinion
Tactics:
   a. develop relationship with specific journalists and provide them with information
   b. hold events to capture media attention, such as demonstrations outside hospitals

Strategic goal #2: To build support among politicians
Tactics:
a. write short policy briefs that contain relevant information from research, distribute the briefs to politicians
b. run workshops for politicians who are likely to be open to the ideas in the policy

Self-study task and reflection

As you may know, polio has been re-surfacing in many parts of Africa after it was considered eradicated for several years. UNICEF and other organizations are involved in a large-scale campaign to simultaneously vaccinate millions of children in an effort to control the epidemic. In this campaign they are often confronted with resistance to vaccination, which is led by religious and traditional beliefs.

View this short video on Youtube as an illustration of the need to develop appropriate strategies to overcome resistance to a policy intervention:

“Religious resistance to polio vaccination in the DR Congo”:
https://www.youtube.com/watch?v=inr-jBSI7E4

After watching the video take a few moments to reflect on your own experiences:

• as a policy actor who wanted to introduce a change and had to think of strategies to win buy-in or overcome resistance (whether at work or at home);

• as a policy actor who resisted a change but was ‘won over’.

What were the strategies and tactics that won you and others over?
Developing a communication strategy

One of the main tactics in policy development and change is communication. It is central to promoting the content of a policy proposal – and motivating for its adoption.
Communication is likely to take place formally (through consultations, in meetings, through circulation of documents, through various forms of public media) and informally (conversations between specific actors, through developing draft documents together etc).

<table>
<thead>
<tr>
<th>Examples of channels of communication:</th>
<th>Examples of communication materials:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public statements</td>
<td>Press releases</td>
</tr>
<tr>
<td>Media briefings Inputs at parliamentary committees</td>
<td>Briefing notes</td>
</tr>
<tr>
<td>Community group meetings and activities</td>
<td>Posters,</td>
</tr>
<tr>
<td>Mass meetings, marches</td>
<td>T-shirts</td>
</tr>
<tr>
<td>Petitions</td>
<td>Training curriculae</td>
</tr>
<tr>
<td>Public hearings</td>
<td>documents/resources</td>
</tr>
<tr>
<td>High profile events</td>
<td>Memos,</td>
</tr>
<tr>
<td>Routine committees</td>
<td>Speeches</td>
</tr>
<tr>
<td>Training activities</td>
<td>Videos</td>
</tr>
<tr>
<td>Others?</td>
<td>Others?</td>
</tr>
</tbody>
</table>

But communication processes are not neutral - and different actors interpret policy content in different ways, often viewing them from the point of view of their own interests, ideologies, values and beliefs. Communication therefore needs to be handled strategically.

**Reflection:**

Think of an issue you feel strongly about – and imagine public policy is being developed around this issue.
1. What messages about the policy or issue would touch your heart? And what messages about the policy or issue would mobilise your civic/ political/ professional interest? Are these different?
2. What channels of communication would reach you? In other words what media do you read/watch/listen to regularly – and are they appropriately authoritative for this message? What networks do you belong to and might these also be a place where the message could be conveyed.
3. What communication strategy was actually adopted during the policy change in your organisation or workplace? What forms did it take and what were the main messages? Do you think it worked for the two key actors you chose? How was it different to the one you outlined?
4. In this real experience, were there resources constraints about what was possible – like budget or people to implement some of the tactics? Do you think they prioritised the tactics that would have the most impact, given the time and resources available?

5. Did unforeseen issues arise? For instance did the actors change during the process, resulting in having to repeat some of the communications?

6. Realistically what would you have done differently?

Consider and work with these questions as you work on your second assignment.

The answers to these questions will inform the development of a communication strategy – which is likely to need to be multi-facetted. While messages have to outline the proposed policy and motivate why it should be adopted, they might also include responses to ideas opposing the policy, showing why these are not viable.

**LANGUAGE ANALYSIS**

Language, the type of words used when communicating policy, can be analysed for the ‘hidden’ messages or ideas and associations that are conveyed – as in the ‘pro-life’ example given above. A subtle impact on people’s interpretation of policy can be produced by using metaphors (a figure of speech which suggests a similarity when they are not literally similar at all) and metonymys (a figure of speech in which closely associated words are substituted - such as "crown" for "royalty").

**Examples of uses of metaphor**

<table>
<thead>
<tr>
<th>Metaphor</th>
<th>Possible interpretations</th>
</tr>
</thead>
<tbody>
<tr>
<td>The organisation is like a family</td>
<td>Caring, supportive</td>
</tr>
<tr>
<td>The organisation is like a well-oiled machine</td>
<td>Efficient, all the parts work well together, no room for mistakes</td>
</tr>
<tr>
<td>Health workers are the heart of our health system</td>
<td>Values health workers, system should function to support them, if they do not work properly everything shuts down. Implies a people-centred approach, rather than a technocist approach. Would expect health workers’ concerns to be listened to</td>
</tr>
</tbody>
</table>

Different metaphors imply different values, approaches and courses of action. While they may be used to purposively influence a context for a policy action, this can produce a negative response where there is strong dissonance between the image and the reality. For
example if a manager invokes a (positive) family image when talking about the organisation, while the context is seething with mistrust and staff feel undervalued and overlooked, the metaphor which tries to reflect/create an idea of warm unified action not only fails, but can create disaffection. Or when health workers who are poorly treated are referred to as ‘the heart of our health system’ it can produce mistrust and alienation.

Language can therefore be used to try and create the reality – but may not always succeed in doing so. Using ‘spin’ in policies therefore need to be carefully considered.

<table>
<thead>
<tr>
<th>Metaphor used to describe the development of low-income suburb:</th>
<th>Likely action to be taken by developers:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scenario 1: suburb described as blighted, diseased</td>
<td>Scenario 1: Existing homes to be torn down, area to be cleared and re-built, nothing of value can be saved</td>
</tr>
<tr>
<td>Scenario 2: suburb described as a community, with formal and informal networks, a place of belonging</td>
<td>Scenario 2: The development will take a people-centred approach, participatory, development needs to maintain the existing community and social structures that have developed in the area</td>
</tr>
</tbody>
</table>

**Other strategies for policy processes**

So far this session has focussed on strategies designed to manage the support or opposition of actors in the policy process. However, there may be obstacles to policy development and/or implementation that are more directly related to other elements in the policy analysis triangle, i.e. content and context.

<table>
<thead>
<tr>
<th>Obstacle or barrier to the policy change</th>
<th>Strategy to help overcome obstacle</th>
</tr>
</thead>
<tbody>
<tr>
<td>Content: Feasibility of policy not clear</td>
<td>Pilot the policy implementation and evaluate the feasibility</td>
</tr>
<tr>
<td></td>
<td>Conduct more analysis/research</td>
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<tr>
<td></td>
<td>Look at other countries’ experience</td>
</tr>
<tr>
<td>Context Lack of capacity</td>
<td>Provide training to those involved in implementing it</td>
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<td></td>
<td>Review processes and learn through experience</td>
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<tr>
<td></td>
<td>Establish a dedicated unit to support implementation</td>
</tr>
<tr>
<td>Context A changing, unstable situation, e.g. political instability</td>
<td>Wait before proposing the new policy or piloting changes - and learn from the experience</td>
</tr>
</tbody>
</table>
Context
There is a political opportunity or opening for change, e.g. new government recently elected

Go for ‘big bang’ implementation, speedy and large-scale - or implement cautiously to learn lessons

NB!!! Consider these in relation to the policy you are discussing in your assignment.

FURTHER READINGS


SESSION SUMMARY

An actor aiming to influence the policy process needs to strategise around how to take advantage of factors supporting change, and how to overcome factors inhibiting change. The strategies available to them are invariably influenced by their own position inside or outside the political and bureaucratic system, however. While strategies need to take account of how different dimensions of context and content may influence policy change, they crucially need to focus on managing and influencing other actors. This can include deciding which actors to work with and which to oppose, as well as assessing the various other actors’ beliefs, interests and resources.

A strategy must identify information needs and how to meet them; allies and mechanisms for working with them; key messages and communication mechanisms; timing of actions. On the basis of this, tactics must be developed and resources identified to implement the strategy and its goals. Strategies – and tactics - should be constantly evaluated and changed as necessary.
Session 9
Thinking in an integrated way

INTRODUCTION

This session focuses on the interactions between all the elements that influence policy – actors, content, context and process.

LEARNING OUTCOMES OF THIS SESSION

By the end of this session you should be able to:

- recognise the ways in which elements of the policy analysis triangle combine to influence policy processes
- recognise that understanding the policy process requires an integrated and synthesized analysis of problems and experiences.
- present a clearly argued, factually correct and integrated analysis of the strengths and weaknesses of the policy process in the selected policy scenario as part of your assignment

READINGS

The reading for this session is part of the session.
In Unit 1 we learned that policy processes are complex. The Policy Analysis Triangle emphasises the central role of actors in the policy process, but also highlights the links between actors and three other factors that influence decision making – namely context, content and process. So while it may look simple, the complexity of the Policy Analysis Triangle Framework lies in the interaction between these factors.

The element of time should be added to these interactions, however, as the actors, the context and the content can change during the policy process. New actors may emerge and some may leave – and current actors may change their minds. There may be changes in context, both macro and micro – or there can be new information that requires a change in the content. And certainly there may need to be a change of strategy and tactics within the policy process as factors develop and shift.

Policy outcomes are a result of the interactions between these different elements and the changes as they have interacted with one another over time – such that

- a change relating to one element will have consequences for the others; and
- the outcomes of a policy will vary depending on the situation, even though the policy’s goals may remain the same.
1. Read about this experience of policy implementation

- Consider the key factors that you think explain the successes achieved in this implementation experience.
- Very briefly, summarise 3-5 key factors and submit them to the discussion group by 7 October.

2. One way of understanding the interaction between the three main factors is to consider the consequences of a specific change in a policy process.

a. Chose any three changes from this list:
   i. Brazil had not seen an end to military rule and democratization of society with a focus on decentralization and local accountability
   ii. Major flooding and subsequent cholera outbreaks had put great strain on the health system.
   iii. Control of the programme had been handed to municipalities entirely.
   iv. There had not been enough nurses in the public health system to supervise CHWs.
   v. A strong nursing council had opposed the scheme as they felt the professional identity threatened and they had been able to rally public opinion.
   vi. Procurement and supply chains for CHWs’ materials had been weak and CHWs had often been without equipment.
   vii. Payments for CHWs had been irregular or dried up and retention rates had been low.

b. Categorise each change using one or more of the policy analysis triangle elements (actors, content, context and process). Then consider how this change would have affected the overall policy experience. What, if anything, would be different? What, if anything, would have stayed the same? What categories of issues (according to the Policy Analysis Triangle) are affected/not affected? Submit a brief discussion of these questions to the discussion group by 7 October.

c. Please then comment on at least one other colleague’s contribution.

NB!!! This task is COMPULSORY. Please post it in the discussion group by 3 October. I will send feedback on draft assignments once I have also seen your discussion groups submissions.
Background

Brazil is a federal country, with both a national and state level governments; as well as elected mayors at municipal level. Located in the North Eastern region of the country, Ceara state is one of the poorest states (one third of the NE region’s population lived below the poverty line) with a population in the 1980s/90s of around 6.5 million. In the early 1980s the state had a reputation for poor quality governance and administration, largely as a result of the widespread mis-use of official resources for patronage purposes (to maintain political support) by political leaders at both state and municipal level.

An 18 year period of military rule in Brazil came to an end in 1984, when democratic presidential elections were held. The new Constitution of 1988 both cemented the new democratic dispensation and introduced some changes to governance arrangements. Specifically, the constitution strengthened municipalities by increasing the proportion of federal resources allocated to them and allocating greater tax generating powers. It also mandated that 10% of all municipal revenues should be spent on health (and 25%, on education). Prior to this time municipal health services were almost non existent. Only around 30% of counties had a nurse. More often there might be an ambulance and a small dispensary of prescription medicines, which the mayors commonly handed out to relatives and friends, and perhaps needy constituents, in return for political loyalty. Yet despite the new constitution, in practice the mandate to spend 10% on of municipal revenues on health was generally not met due to weak enforcement possibilities and, perhaps, the continued use of official resources for political patronage.

With the new political opportunities afforded by the democratic era, the state as whole elected two successive reformist governors for the period 1987-1994. Both governors came from the centre-left party (which is ideologically rooted in a social democratic perspective). These governors set about radically transforming governance and administration. The actions they initiated after 1987 included: better tax collection leading to more tax revenue; weeding out ghost workers from the public payroll; and initiating wide-ranging development programmes. The successes achieved in the state were widely publicised nationally and internationally (with coverage in, for example, US papers). By the 1990s both governors had significant public profiles nationally, and had moved on to hold senior positions within their party.

The CHW programme and its successes

One of the state-initiated development projects implemented under the reformist governors was the CHW programme. Initially it was a small element within an employment creating programme introduced after a drought. The initial budget, thus, came from the temporary disaster relief funds received by the state from the federal government. However, in 1989 the state decided to fund the programme itself and on a permanent basis. By the early 1990s 7,300 CHWs were employed.

The CHWs were called health agents. The agents:

• were mostly women and earned the established minimum wage of $80 per month
• had to live in the area where they worked, work 8 hours a day, visit each household at least once per month, attend all training and review sessions, and not canvass for a political candidate or wear/distribute

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The agents were directly managed by nurse-supervisors, who earned five times the minimum wage (at $300/month this was more than they could then earn in hospitals/clinics). These supervisors themselves received 3 days orientation and then subsequently met regularly with the state coordinating team for the programme. They generally only worked part-time on the programme and spent the remainder of their time working in curative care for the municipality.

Community members were also strongly encouraged to play a monitoring and support role in relation to CHWs.

Overall, by the early 1990s the programme was judged a clear success. The indicators of this success included:

- very high levels of CHW commitment and motivation to programme;
- by 1992, within 5 years of its inception, the programme had been implemented in nearly 100% of the state’s counties (meaning nurses were then located in 100% of the countries);
- by 1993, nearly 65% of the state’s population were being visited in their homes and being provided with preventive and promotive health advice;
- by 1992, there was a 36% reduction in infant deaths in the state (from 102/1000 pre 1987 to 65/1000 in 1992);
- there was a tripling of vaccination coverage for measles and polio vaccine coverage increased from 25% to 90%.

These successes were achieved for very low costs: the programme cost $2 per head served, and, in total, $7-8 million per year. This compared to the $80 per capita cost of the Brazilian health care system at that time. 80% of programme costs were spent on health agent payments.

**Programme features**

The wider context of decentralisation, including the 1988 Constitution’s allocation of additional funding, taxing power and spending responsibilities to municipalities, was reflected in the distribution of responsibilities for the CHW programme’s implementation.

**State authorities**

- established a nine member coordinating team in the state department of health who supervised the overall programme;
- established the overarching rules and guidelines governing the programme;
- funded the programme from a specific account in the office of the governor, rather than in the health department;
- contributed over 85% of total programme costs (mostly spent on health agent wages and supplies).

The state co-ordinating team
travelled throughout the state to hire for the state the municipally-based CHWs (hiring around 30-150 agents per municipality, depending on size) rather than delegating that power to municipalities;

- used a meritocratic hiring process but employed CHWs under temporary contracts, without job security or fringe benefits;

- used a hiring process that involved three stages: written applications (friends/family could help with form completion); selection of those to be interviewed; interview by 2 people (usually nurse and social worker) who travelled to each town; individual interview followed by group meeting with all applicants (and maybe second round of interviews with those likely to be selected);

- trained CHWs;

- provided supplies to CHWs (vaccines, medicines etc);

- publicised the programme widely – through radio spots and other media, and through their own visits to areas - with messages focusing on the programme’s potential for health improvements and on the need to urge mayors to hire a nurse supervisor, pay her salary and run the programme cleanly (including subtle messages of ‘don’t vote for the mayor if he does not do this’);

- awarded public prizes for good performance by CHWs;

- negotiated with mayors about the extension of the programme into their municipalities, following the established conditions.

Municipal authorities (mayors)

- employed 1-4 nurse supervisors to supervise the agents;

- often provided additional support too e.g. bicycles, canoes, donkeys for household visits;

- overall, contributed 15% of total programme costs (mostly in the form of supervisor wages) drawing on the newly mandated transfers from federal level (commonly otherwise used for patronage).

However, the expansion of the programme across the state occurred in an incremental way and not according to a pre-determined implementation plan. Mayors had first to agree to the conditions of the programme (their employment of nurse supervisors using federally mandated funds) before the state co-ordinating team would agree to initiate the process of CHW hiring. Within any municipality, the team also hired CHWs in batches over time, rather than conducting a once for all hiring process for all CHWs in that area.

The details of implementation

1. **Combining centralised and decentralised action**

   ‘Although the programme might seem to be a success in decentralisation ... the actions of the more centralised state government turned out to be more important in explaining what happened’ (p.1773), because:

   a) The state hired the CHWs and not the nurse-supervisors: although in an ideal world the state would have preferred to hire both, they had to take account of the existing decentralisation structures and needed at least the tacit support of mayors at the local level; they also had their own funding constraints (whereas mayors had new money for health)

   b) State control over the CHW hiring process reduced the mayors’ power over the programme and the use of its resources for patronage purposes. Although this reduction of power could have turned mayors into opponents, such opposition was contained because:

   - the incremental pattern of expansion and wide publicity around it, allowed news of the programme to spread informally - leading the population to put pressure on mayors who had not yet bought in to the
mayors were also pressurised by the growing profile of the programme once agents were employed: it was hard to ignore as in each municipality there were quite large numbers of agents who were very visible (all wearing informal uniforms), and who were doing work the community valued; agents also sometimes took it upon themselves to educate mayors about public health needs; and if the programme worked well and was popular, they mayors got political credit for it.

2. CHWs were committed and motivated

‘... both workers and supervisors saw their jobs as giving them more prestige and status than they normally had’ (p.1773)

Despite their lack of job security, CHWs performed well because:

a) The meritocratic hiring process ensured there were good recruits;

b) The job itself had prestige because:

- of the nature of the hiring process – which was clearly visible to the community (maybe 20-40 recruits at one time) and intimidating for applicants
- it was seen as good job for local people: although the salary was low relative to other public health jobs, to be paid at the minimum wage level was good relative to other local opportunities (school teachers employed by the municipality, for example, earned less), and the wage was higher than that for a male agricultural labourer, with full-time and year round work (as opposed to seasonal employment)
- it came with initial and on the job training, and experience from it was transportable to other jobs
- the job were satisfying compared to other alternatives because there was a greater range of tasks, and the agents had some discretion about what they did, and could developed personal relationships with their clients

c) Although, over time, there were growing complaints from agents about the lack of employment security, the state coordinating team took these complaints seriously and by the time of the evaluation, looked like it might move to offer more job security (perhaps as reward for good performance)

d) The community were encouraged to take an active role in monitoring and supporting agents – and did so, reporting both poor and good practices to supervisors (leading some CHWs to be fired). This active role was a result of:

- the prestige and importance of job to the communities
- the state coordinating team using language to encourage such action, showing it belonged to the people (‘your programme’), not the mayors (‘you have a right to demand support from mayors’) and was for community benefit (‘your community does not have to lose so many babies’)
- the state coordinating team telling those rejected in the hiring process that they should watch the selected agents and make sure they did a good job (and they were keeping all application in case those
selected did a bad job and there was a need for new CHWs in the future)

- there being very clearly established rules for the job that could be monitored and these were often repeated in the public messages on the programme, together with the message that the state team wanted to hear if CHWs were not doing their job as expected

- the community (and even CHWs) feeling supported by the state relative to the mayors and powerful local people.

e) The state coordinating team also deliberately created a positive image around the programme which added to the job’s prestige and encouraged community monitoring by:

- using language giving the job prestige and emphasising the programme mission – it was ‘an honour’ to be chosen, the people chosen were ‘community leaders’, ‘had proven commitment to the community’

- repeating these messages often and, indeed, the slow pace of expansion within and across municipalities gave repeated opportunities for the state team to spread these messages about the programme as they went about initiating and hiring agents

- deliberately publicising the programme initially through radio and TV campaigns to get people to adopt preventive health measures (funded by private companies)

- later, awarding and publicising prizes to municipalities with the best immunization coverage rates (although this was partly an action trying to get staff to take information collection seriously, it also had the effect of giving recognition to staff and enhancing their prestige)

f) The state co-ordinating team’s publicity campaigns were supported by the governors as they got political capital from the programme

g) CHWs received good supervision from well performing nurse-supervisors because they

- had more prestige and authority than in their old jobs (working as nurses in urban clinics or hospitals they had generally been treated as inferior or subordinate by the doctors whom they assisted, whereas now they managed around 30 agents, who looked up to them; and community members respected them)

- felt more valued and professional in their new jobs (they had done a lot of administrative work in their old jobs, not ‘real’ nursing work, and also did not have managerial status)

- had fair degree of control over their jobs and over programme implementation in their areas, so even if they were still not practising nursing they now felt more professional because making decisions about how to run the programme (the state did not try to standardise programme design but allowed variation in programme activities between areas depending on supervisor interests - some trained agents in more curative tasks, and others did not; some included family planning messages and some did not)

- had a higher salary than in their old jobs

h) There was limited opposition from doctors and nurses, who often oppose such programmes because

- Some nurses were co-opted as supervisors – giving them opportunities, and enhancing their status as
professionals (and although some urban-based nurses did complain about CHWs taking over curative tasks, the state engaged them over their concerns rather than ignoring them, training some agents as nurse assistants)

- The programme was based in rural areas where few physicians worked, so they had limited interest

3. CHWs developed trusting relations with their clients and the community

‘... workers voluntarily took on a larger variety of tasks than was normal, often in response to their perception of what clients needed...embedding these particular workers in a set of relations of trust with their clients’ (p.1773-4

Over time CHWs gradually expanded their scope of work and the set of tasks they carried out. This added to their motivation and commitment to their jobs, as well as building relationships of trust with their clients, and the community at large, further adding to their job satisfaction. They took these actions because:

- It was initially difficult to gain entry to households because of their use of traditional medicine and fear of government officials after military rule (which had been particularly repressive of peasant organisations in North East Brazil) – but the provision of basic curative care (removing stitches, treating wounds, giving advice on treating colds/flu or taking a sick child to hospital) from which households got immediate results gave them an entry point for the difficult and long process of encouraging health promotion and prevention

- Getting involved in community-wide public health tasks (such as pressuring workers and managers in a bakery to wear hair nets and wash hands; or working with the nurse supervisor to introduce community meetings on family planning and sexuality) and campaigns (e.g. cholera campaign) made their jobs more enjoyable and gave them a sense of mission, of being part of the broader public health movement (evening bringing them into contact with top public health officials)

- They liked the sense of respect and trust they got from clients by assisting with mundane activities (e.g. assisting mothers with cooking, cleaning or child care; time to share problems with mothers) as well as broader public health tasks.

FURTHER READINGS


SESSION SUMMARY

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In this session we returned to the start of the module, revisiting the different sides of the policy triangle and illustrating with the Ceara case study how they interacted in bringing about policy change experience.

MODULE SUMMARY

Instead of reading a summary of this module please read the brief editorial by Lucy Gilson and colleagues, in which the pay tribute to Gill Walt, and introduce a special edition of the Health Policy and Planning journal, which presents a 'state of the art of the field as of 2008: Gilson L, Buse K, Murray SF, Dickinson C. Future directions for health policy analysis: a tribute to the work of Professor Gill Walt. Health Policy Plan. 2008 Sep;23(5):291-3. http://heapol.oxfordjournals.org/content/23/5/291.full.pdf+html

I encourage you to also explore other articles in this edition.