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

Moving the agenda forward

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

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

What has health policy analysis taught us?

Policy-making is not just about a particular decision made at a certain point in time, but more often understood as the ongoing interaction among institutions (the structures and rules which shape how decisions are made), interests (groups and individuals who stand to gain or lose from change) and ideas (including arguments and evidence) (John, 1998). This means that the study of health policy needs to take into consideration factors such as the role of the state, the interests of various actors and the manner in which they wield power, the nature of political systems and their mechanisms for participation, and the rules of the game in so far as the informal and formal policy processes are concerned. Moreover, policy analysis must also examine the role of culture and values systems and how they are expressed as beliefs, ideas and argument, as well as international factors which are increasing inter-dependence between states and affecting state sovereignty over policy processes.
Much of the health policy analysis literature to date has helped describe what has happened in a particular policy life course and to a lesser extent has identified important determinants of policy change. This has contributed to our general knowledge about actors and processes related to health policy-making and has also demonstrated that analysis of power and process can add value to those attempting to influence policy change. For example policy analysis can:

1. Help explain why certain health issues receive political attention

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

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

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

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

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

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

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

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

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

What is the state of health policy analysis?

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

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

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

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

What ought to be on the health policy analysis agenda?

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

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

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

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

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

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

- Pay more attention to the politics of policy change.
- Consider the development of political strategies to engender change.
- Invest more in understanding these politics through better resourcing of policy analysis.
- Ensure active collaboration with researchers and public health advocates so as to generate better quality and more relevant policy analysis.
The London Workshop was designed and hosted by the Overseas Development Institute (k.buse@odi.org.uk) and Clare Dickinson, HLSP Institute (clare.dickinson@hlsp.org), with Lucy Gilson, Centre for Health Policy, University of Witwatersrand and Susan F Murray, Kings College London.

Notes and references

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

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