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Comparative Analysis of Policy Processes: Enhancing the Political Feasibility of Health Reform

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November 1999

This publication was produced by the Data for Decision Making (DDM) project, which is funded by the U.S. Agency for International Development under Cooperative Agreement No. DPE-5991-A-00-1052-00 with the Harvard School of Public Health. It was done in collaboration with the Latin America and Caribbean Regional Health Sector Reform Initiative, funded by USAID under Contract No. HRN-5974-C-00-5024-00.

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1. INTRODUCTION

1.1 BACKGROUND

For the last decade and a half, many countries in the developing world and the former socialist block have embarked on a course of governmental reform. While the initial priority was to change the state's role in the economic sector, the social sector was soon to follow, with particular emphasis on health and education.

In health, most countries faced the need to transform their health systems, which had largely been operating along the same policy lines since their founding in the early post-war period. Despite important advances in the health status of their populations, there is nevertheless a growing consensus in many countries that more could be done, both to remedy longstanding problems and to prepare the systems to face future challenges of rising and changing demand, spiraling costs, increasing budget constraints, and competition from other social sectors for central government funds.

In the face of these policy challenges and in response to significant influence from the international health policy arena, there is increasing consensus among health policy makers, providers, and users about the need for structural change in the health sector. This consensus does not extend, however, to the content of a health reform agenda. The definition of the problems to be solved, the means to solve them, as well as the speed and scope of policy change all remain highly contentious issues affecting many group and individual interests.

As a result, the political dimension of health reform formulation and implementation has come to the foreground as it has proven to be a key factor in determining the feasibility of health policy change as well as its final outcome. Political analysis of both the context within which health sector reform initiatives are formulated and eventually implemented as well as the processes involved can contribute to strategies that increase the political feasibility of reform. Political analysis can also help donor agencies and policy makers promoting health reform fine-tune their support and target it to areas of relevance, thus making a more effective use of the resources directed towards initiating and consolidating health policy change.

This concept paper presents a general framework for an ongoing comparative study of health reform processes in three Latin American countries (Chile, Mexico, and Colombia) carried out under the Latin America and Caribbean Health Sector Reform Initiative. The analytical framework will be refined and modified on the basis of subsequent analysis of the three cases. The present paper includes a discussion of relevant issues concerning the research methodology.

1.2 KEY KNOWLEDGE GAPS

Worldwide, USAID has been involved in the promotion and support of health reform initiatives ranging from developing health insurance schemes and supporting health system decentralization to promoting the private sector as a vehicle for health care delivery. Consideration of this experience, coupled with several reviews of the literature, has indicated that a failure to understand policy processes is one of the key gaps in our knowledge of how to achieve health reform. Therefore, research on the

impact of the process of formulating, adopting, and implementing health reform initiatives has been singled out as a key strategy in health policy development.

There is a knowledge gap both in terms of adequate analytical models to study these processes as well as informed assessments of the processes. A formal model to analyze the health reform process is needed to lead the way to the creation of a knowledge base on our experience with health reform processes in diverse countries.

Analysis of the political economy context, the policy process, and the political strategies pursued by health reformers need to be included in an analytical framework that will build on and synthesize elements from interest group analysis, the new institutionalism, and the study of policy change teams. This approach can provide a comparative methodology to analyze health reform processes, which in turn, can be used to develop policy guidelines to improve the effectiveness of USAID support for health policy change in countries around the world.

1.3 General Analytical Objectives

Our comparative study of health reform processes has several general analytical objectives:

- To analyze the political economy context in which health reforms take place and understand the institutional framework within which the reform process evolves;
- To analyze the health reform process as it evolves in its particular political economy context and to locate the specific points in this process where the reform's political feasibility is at stake and its content prone to be significantly modified;
- To map the actors who have the capacity and intention to influence the health reform process at the various points mentioned above; and
- To analyze the political strategies used by policy makers pursuing health sector reform to buttress the state's capacity to bring about policy change, and thus enhance the political feasibility of health sector reform.

1.4 Analytical Framework For Comparative Studies

The comparative study focuses on the state's capacity to bring about health policy reform, concentrating on the political feasibility of formulating, implementing, and consolidating health policy change. The working hypothesis is that the state's capacity to bring about policy change, and thus the political feasibility of health reform is affected by three elements: 1) the political-economy context of the country, 2) the policy process, and 3) the political strategy used by the reformers.

When a health reform initiative reaches the public agenda, the country's political economy and the policy process that is unleashed within it, present a series of opportunities and obstacles for the successful implementation of the health reform. Policy makers interested in promoting the reform will follow a series of political strategies aimed at managing these opportunities and limitations in order to enhance the state's capacity to bring about policy change, and thus increase the political feasibility of the health reform.

As policy makers turn to the social sector in second generation reforms, they are shaping their strategies based, in part, on their experience with first generation reforms aimed at restructuring the economic sector and downsizing the state under structural adjustment in the 1980s and early 1990s. Highly salient among these strategies is the formation and use of change teams to formulate policy and direct the reform process. Particular attention is being given to the use of change teams as part of a package of political strategies aimed by policy makers at enhancing the political feasibility of health reform initiatives.

The proposed analytical framework looks at the political economy context, the policy process, and the reformers' political strategies as three variables affecting the state's capacity to bring about health policy reform. In doing so, it examines the intervening factors determining the political feasibility of health policy change.

1.5 POLICY RELEVANT OBJECTIVES AND EXPECTED RESULTS

Our comparative study has several policy relevant objectives and expected results. These include:

1. To elaborate an analytical framework that may serve as a tool for donors and policy makers at the country level to identify the determinant characteristics of the country's political system where the reform is going to take place;

2. To develop a set of analytical tools that will help locate the key points (nodes) in the policy process where the reform initiative's feasibility (as well as its substance) is at stake in order to concentrate donor efforts in relevant stages of policy process;

3. To locate and support the change team (with training, information about similar reform experiences, and pertinent advice) as the cornerstone of the reform process; and

4. To establish a set of policy guidelines to improve the effectiveness of USAID support for health policy change in developing countries.

2. REVIEW OF CURRENT KNOWLEDGE AND RESEARCH

2.1 HEALTH REFORMS

An increasing number of countries have incorporated health sector reforms in their policy agendas as they attempt to improve the health status of their populations, while at the same time maintaining or curtailing their public expenditure (OECD, 1995,1992; World Bank, 1993; Walt and Gilson, 1994; Frenk et al., 1994; Berman et al., 1995). In some instances, these reforms have had an important component of income redistribution, as they have tried to redress imbalances in access to health services and in the distribution of health resources (World Bank, 1993; Frenk et al., 1994; Ugalde and Jackson, 1995; Zwi and Mills, 1995).

Health care reforms have varied in content and scope, but they share common general features in that most involve changes in the institutional configuration of the health care system, in the role of the public and the private sector, and ultimately, in the type and amount of services accessible to different groups of the population (La Forgia, 1994; Berman et al., 1995).

In developing countries, health reform efforts in the last decade have centered around four main concepts or principles: 1) the separation of financing and provision of health services, 2) the introduction of cost-effectiveness analysis to establish policy priorities and resource allocation, 3) the introduction of user fees and expansion of compulsory insurance, and 4) the increase of the private sector's role in areas that were previously considered under the jurisdiction of the state (Zwi and Mills, 1995). Health reforms involving institutional change have included the decentralization of policy decision making and resource management to the sub-regional and local levels (Lee and Mills, 1982; La Forgia, 1994; Bossert, 1998) and institutional changes involved in the modernization of the state (Grindle and Thomas, 1991).

2.2 POLITICS AND THE HEALTH REFORM PROCESS

In spite of the fact that health reform initiatives have been converging into these elements—conforming to a new paradigm (Chernichovsky, 1995)—and have striking similarities in the objectives they seek, the passage of these initiatives through the political process has had varied success. In some cases reforms have encountered effective resistance, as in the 1994 reform efforts in the United States (Skocpol, 1995a, 1995b; Steinmo and Watts, 1995). In others, such as Chile's reform, the experience has proven so successful that it has encouraged other countries in the region to follow along similar lines (World Bank, 1983; Jimenez de la Jara and Bossert, 1995). But, in most cases, the political fate of health reform efforts has resulted in mixed outcomes; bringing about positive changes in some aspects of the health system, while faltering in others.

Following these experiences, policy makers and donor agencies, who until very recently had been mostly concerned with the technical soundness of health reform initiatives, have come to acknowledge that politics pervades the health reform process and exerts considerable influence on the objectives that are sought, the means that are used to attain them, and the resulting impact on the health status of the population. Thus, health sector reform is now viewed as much in terms of the political economy surrounding the policy process itself, as it was formerly perceived in relation to epidemiological, economic, and organizational considerations (Walt and Gilson, 1994).

Thus far, the majority of studies on health politics have concentrated on the analysis of groups in society—called stakeholders or interest groups —who, perceiving that their interests may be affected, try to influence the policy process by which health reforms are formulated and implemented (Reich, 1994a, 1995; Diderichsen, 1995; Makinson, 1992; Blumenthal, 1992; Blendon et al. 1995). There are a few studies that concentrate on the analysis of the political institutions that structure the health reform process, and their effect on the capacity of interest groups to effectively influence it (Dohler, 1995; Skocpol, 1995; Steinmo and Watts, 1995; Cassels, 1995; Immergut, 1992). Finally, there is a group of studies on policy change in other sectors that has concentrated on the individual reformers themselves—the change team (Schneider, 1991; Waterbury, 1992; Geddes, 1994; Evans, 1995). This latter approach has great potential for the analysis and support of health reform initiatives as an increasing number of countries are creating and relying on change teams to pursue health policy change.

2.3 Interest Groups and The Health Reform Process

Health policy analysis has often considered the political factor of health reform along the lines of interest group politics in what Morone (1994; 223) describes as "pluralistic calculations: 'groups for' versus 'groups against'." In this approach, the formulation, implementation, and ultimately the outcome of health reforms, reflect the political pressures from the groups affected by it—such as users, providers, taxpayers, and others. The health reform outcome can thus be expected to reflect the interests of the most powerful interest groups and/or the weightiest political coalition (Diderichsen, 1995; OECD, 1995a; Reich, 1994a, 1995; Walt and Gilson, 1994; La Forgia, 1993; World Bank, 1993).

In our opinion, the pluralist school—and within it interest group or stakeholder analysis—has best captured the dynamics of the bargaining process among different interest groups trying to influence the policy process, and between these groups and policy makers (Kingdon, 1995; Zajac, 1995; Lindblom and Woodhouse, 1993; Olson, 1982, 1965; Wilson, 1980; Downs, 1967). The pluralist school sees the state as a neutral actor that mediates and reflects the political bargaining among interest groups who are trying to influence the policy arena in order to secure and enhance their own interest (Olson, 1982).

While interest group analysis allows us to understand the dynamics of policy reform politics, it offers few answers in those cases where policy makers have decided to go on with a reform in spite of visible resistance from powerful social groups. A closer look at the limitations and opportunities offered by the institutional context within which they pursue their reform agenda presents a more complete picture of the political factors affecting policy change.

2.4 The Institutional Context and The Health Reform Process

In order to understand the opportunities and limitations faced by health policy reformers, some studies have shifted their focus away from interest groups in society and concentrated on the role of political institutions in the interplay among stakeholders and the mediation between the state and society that take place during the policy process. The "new institutionalism" provides an alternative approach to pluralism by addressing the institutional influence on policy making. It brings the state back into the political analysis of policy making (Evans et al., 1985) and sees policy makers as yet another interest group with particular preferences (that go beyond income maximization and endurance in power), and a position with respect to the direction public policy should take (Geddes, 1994; Steinmo and Watts, 1992; Hall, 1986; Skocpol, 1985; Mann, 1984; Nordlinger, 1981). Instead of analyzing formal

institutions as the old statist scholars did, the new institutionalism school focuses on "how a given institutional configuration shapes political interactions" (Thelen and Steinmo, 1992:6). Thus, the focus is not on institutions per se, but on institutional features or "intermediate- level institutional factors (such as) corporatist arrangements, policy networks linking economic groups to the state bureaucracy, party structures, and the role they play in defining the constellation of incentives and constraints faced by political actors in different national contexts" (ibid).

The institutional context comprises the national political system and the formal institutions of government and representation, as well as the rules of governance—both formal and informal—that direct the policy process and mediate the conflicting views and agendas of political actors ranging from individual citizens to interest groups and policy makers among others (Immergut, 1992). The underlying assumption is that a country's institutional setting sets the ground rules for political competition, thus determining the degree of access interest groups have to influence the health reform process. By the same token, institutions determine the room for maneuver given to reformers, and thus the degree of autonomy the state counts on to promote policy change. In this approach, a country's political context, particularly its institutional configuration, plays a determinant role in the nature of health reform and its political feasibility.

Immergut (1992) contends that different political institutional arrangements can explain the striking differences in the final outcomes of similar health reform initiatives promoted in Switzerland, France, and Sweden. In studying the politics of social policy in the United States, and later on, reacting to the failure of the health reform efforts in the 1990s, Skocpol (1992, 1995a, 1995b) has also placed institutions at the center of her analysis. The importance given to institutions in the political analysis of health reform has been echoed by other scholars, such as Morone (1994), who contends that the recent failure of the US health reform attempt is due in part to the lack of a careful institutional analysis. After reviewing health reform efforts in the U.S., Steinmo and Watts (1995) conclude that a political strategy including the use and modification of the institutional setting would have enhanced the chances of health policy reform.

Finally, in a comparative analysis of several industrialized countries, Wilsford (1995) looked at Germany, Japan, Canada, and Great Britain and contended that to succeed in reforming their health care systems, policy makers have tried to increase state autonomy in order to counter the interest group mobilization of providers. He points out that they have done so by carefully using the opportunities offered by each country's particular institutional setting. In his analysis, Wilsford (1995) concludes that state autonomy in the process of health reform is as much a result of the institutional framework, as it is a result of the policy makers who are leading the process. Other studies using the institutionalist approach to analyze health reforms in industrialized countries are Dohler, 1995; Schut, 1995; and Wilsford, 1989.

Nevertheless, relating the institutional framework to the outcome of policy reform is not as self-evident as it may appear. In a study of political regimes in Latin America, for example, Remmer (1990) demonstrated that there did not seem to be any empirical relation between types of regime and the capacity of states to promote policy change. Also, the content of policy reform cannot be automatically associated with a specific institutional configuration.

The distributional outcome of health reform is a case in point. Interest group studies tend to show that in a democratic regime there is a high possibility of powerful interest groups capturing the state, and thus perpetuating an inequitable status quo. The concept of “capture” refers to the possibility of having powerful interest groups consolidate their influence on the state and thus bend public policy permanently in their favor. (See Olson, 1982; Sandler, 1992). However, there have been other instances in which the

same democratic institutions have given greater access to politically weak groups who have thus been able to influence policy in their favor.

One response to this is to focus the analysis on the group of policy makers in charge of policy reform, as it is there that the political elements affecting the formulation of health policy converge. Their profiles, their agenda, their potential for maneuvering within the state, and their relations with other groups in society will play a significant role in the capacity of states to bring about policy change. As Geddes (1994:198) states the case, "To understand why governments sometimes undertake radical and risky reforms, scholars need to think about who the people are who make policies, what their interests are, and what shapes their interests."

2.5 CHANGE TEAMS AND THE HEALTH REFORM PROCESS

The particular group of policy makers in charge of formulating and promoting policy change has been referred to as a “change team” (Waterbury, 1992) and has been the subject of several political economy studies on policy change —particularly under structural adjustment and economic reform (Nelson, 1992; Schneider, 1991; Evans, 1982; Geddes, 1994). Stemming from the schools of rational choice (see Riker ,1990) and bureaucratic politics (see Downs, 1967), Geddes (1994) and Schneider (1991) focus on the political struggle that takes place within the state as different groups of policy makers compete to influence policy definition and implementation. Their basic argument is that in order to explain how and why a policy is formulated and what impact it has, the analysis should focus on the individual decisions taken by policy makers within the state, as well as their political competition within the limits of the institutions they operate in. The state is seen as a collection of self-interested individuals, and policy choice as a result of these policy makers' maximizing strategies in furthering their agenda. In other words, policy makers as rational individuals will make policy decisions based on the limitations and opportunities they perceive to pursue their policy agenda and thus secure a successful career (Geddes, 1994). The underlying assumption of these studies is that policy makers have a policy agenda that is not solely based on the pressures from interest groups in society. Along the same line, the state does not have a single position about what is to be done, but instead, it is composed of many groups of policy makers with different ideas about what needs to be done.

In the case of health reform, the change team faces pressure and competition for access to the health reform process from within the state, as much from society. Thus, just as the state needs to win the support of a large coalition of interest groups in society to bring about policy reform, the change team needs to win the support, or face the resistance of other factions within the government, such as policy makers in other sectors and the bureaucracy.

The change team can be located at different points of the policy context, depending on the institutional framework of the country (Downs, 1967; Schneider, 1991; Geddes, 1994), and may be active at several stages of the policy reform process. For instance, in a presidential system, the change team may act as an advisory committee close to the executive office, while in a parliamentary system it might operate as a congressional commission in charge of writing a bill for congress. In yet other countries, the change team could be a formal part of the civil service.

The analysis of the distinctive features of change teams, including their composition, their incentives, and the opportunities and limitations they face in pursuing their reform agenda as well as their political strategies to bring about policy reform, can provide an invaluable body of knowledge to

inform policy advice in support of health sector reform. A more detailed analysis of the health reform process and the actors involved can help fine-tune support for health reform initiatives by allowing for better targeting of financial, technical, and political support during the policy process.

2.6 THE HEALTH REFORM POLICY PROCESS

The policy process is the series of events that a reform initiative follows from the definition of the problem and its incorporation into the public agenda, to the consolidation of the intended policy change. The policy process rarely takes a sequential and unilinear form, but for analytical purposes, it may be "anchored" in five crucial stages: 1) policy formulation, 2) policy legislation, 3) policy implementation, 4) institutional change, and 5) reform consolidation[1]. As the policy reform process follows its course within the institutional framework of the county, it will pass through a number of points in which its feasibility will be affected as well as its substance. These crucial stages of the policy process occur at different points in the institutional framework, such as the President's office, the Congress, and the bureaucracy.

At each of these "policy nodes" (Immergut, 1992), the reform will be affected by those actors who are able to access these points and influence the policy process. The actors—and their agenda and power—will be different at each policy node. And their potential to influence the content of the reform as well as its feasibility will vary accordingly. PolicyMaker, a policy analysis tool, has been developed to "map out" these actors and their interests in order to make health reform formulation and implementation more responsive to the political challenges it faces at each stage (Reich, 1994).

[1] See Wildavsky (1979), Lindblom and Woodhouse (1983), Rondinelli and Cheema (1983), and Korten (1977) among others for definitions and characterizations of the policy process. See also Reich (1994) and Foltz (1996) for critiques of different approaches to the politics of the health policy process.

3. KEY KNOWLEDGE GAPS

In many parts of the developing world as well as in the former socialist bloc, USAID has been involved in the promotion and support of health reform initiatives ranging from developing health insurance schemes and supporting health system decentralization in Kenya, Jamaica, Indonesia, the Philippines, Russia, Kazakhstan, Kyrgystan, Poland, the Czech Republic, and Hungary, to promoting the private sector as a vehicle for health care delivery in Ghana and Zambia among other countries.

Consideration of these experiences, coupled with reviews of the relevant literature, enabled us to identify the need for improved understanding of policy processes as one of the key knowledge gaps in achieving successful health reform. Therefore, we argue that research on the impact of the process of formulating, adopting, and implementing health reform initiatives is a key strategy in health policy development.

There is little available in the way of formal analysis of the process of health sector reform in developing countries and former socialist economies. This knowledge gap includes both a lack of adequate analytical models to study these processes as well as informed assessments of them. A formal model to analyze the health reform process is needed to begin to build a knowledge base on the experience of health reform processes in diverse countries.

The analysis of the political economy context, the policy process, and the political strategies pursued by health reformers can be included in an analytical framework—to synthesize elements from interest group analysis, new institutionalism, and the study of change teams described above—and a comparative methodology to analyze cases of successful and unsuccessful health reform processes. The findings from case studies carried out under this framework could then be used to develop policy guidelines to improve the effectiveness of USAID support for health policy change in other countries.

4. GENERAL ANALYTICAL OBJECTIVES

Our general analytical objectives in carrying out a comparative study of the health reform process are as follows:

- To analyze the political economy context in which health reforms take place and understand the institutional framework within which the reform process evolves;
- To analyze the health reform process as it evolves in its particular political economy context and to locate the specific points in this process where the reform's political feasibility is at stake and its content is prone to be substantively modified;
- To map the actors who have the capacity or intention to influence the health reform process at the various points mentioned above; and
- To analyze the political strategies used by policy makers pursuing health sector reform to buttress the state's capacity to bring about policy change, and thus, enhance the political feasibility of health sector reform.

5. ANALYTICAL FRAMEWORK FOR THE COMPARATIVE STUDIES

The comparative studies in three countries (Chile, Mexico, and Colombia) focus on the state's capacity to bring about health policy reform. The analysis concentrates on the elements that enhance the political feasibility of formulating, implementing and consolidating health policy change. Our working hypothesis is that the state's capacity to bring about policy change, and thus the political feasibility of health reform is affected by three elements: 1) the political-conomy context of the country, including its institutions, rules of governance, and key interest groups; 2) the policy process, including state-society relations and policy makers and interest groups acting upon the opportunities and limitations of the political context to pursue their policy agendas; and 3) the political strategy used by the reformers; i.e., the political tactics used by policy makers to buttress state capacity and enhance the political feasibility of their reform agenda.

There are other elements that are equally important in determining the state's capacity to bring about policy reform. Grindle and Thomas (1991) suggest concentrating on the following elements: institutional capacity, technical capacity, administrative capacity, and political capacity. In other studies, state capacity has often been equated to its technical, administrative and institutional capacities, while its political capability to maneuver in favor of policy change is only recently being brought to the fore in the health policy field. Therefore, this study concentrates on the political aspect of the state's capacity to pursue health reform in an attempt to contribute to putting in place the elements that effectively promote health policy change. However, it is important to note that the political component is not sufficient in itself, nor can it be analyzed in isolation from the other elements cited above.

When a health reform initiative reaches the public agenda, the country's political economy and the policy process that is unleashed within it, present a series of opportunities and obstacles to its successful implementation. Policy makers interested in promoting the reform will follow a series of political strategies aimed at managing these opportunities and limitations in order to enhance the state's capacity to bring about policy change, and thus increase the political feasibility of the health reform.

As policy makers turn to the social sector in second generation reforms, they are shaping their political strategies with the knowledge acquired during their experience on first generation reforms aimed at restructuring the economic sector and downsizing the state under structural adjustment in the 1980s and early 1990s. Among these strategies the formation and use of change teams to formulate policy and direct the reform process stands out. Particular attention is given to the use of this strategy as part of the package of political strategies used by policy makers to enhance the political feasibility of health reform initiatives.

The opportunities and limitations presented by the political economy of the country and the policy process on the one hand, and the state's response to them on the other, converge in the group of policy makers who are in charge of formulating and implementing the reform; i.e., the change team. The ability of these policy makers to maneuver within this setting has a direct impact on, and reflects the state's capacity to pursue its agenda on health policy reform.

The change team (and supporting policy makers) uses a combination of technical skills and political maneuvering to build support for the reform initiative and enhance the probability of successfully challenging interest group resistance to change. The change team's capacity for strategic political

maneuvering during the health reform process will prove as critical for its accomplishment, as the team's technical capacity to formulate sound policy.

The following analytical framework looks at the political-conomy context, the policy process, and the reformers' political strategies as three variables affecting the state's capacity to bring about health policy reform. In doing so, it examines the intervening factors determining the political feasibility of health policy change.

6. KEY COMPONENTS OF THE ANALYTICAL FRAMEWORK

The analytical framework has three main components that affect the political feasibility of health policy reform: 1) political-economy context, 2) policy process, and 3) political strategy.

6.1 POLITICAL-ECONOMY CONTEXT

The political-economy context includes the political system of the country, its recent history, its socioeconomic conditions, its institutions, and the role of the state and society in defining and acting upon policy issues. It sets the institutional framework within which policy makers and interest groups operate during the policy process. Finally, this context also contains the formal and informal rules of the game that present opportunities and obstacles for policy makers and interest groups to pursue their agendas.

Policy makers willing to promote reforms that will benefit some groups while negatively affecting others, will take into consideration the interests and power of stakeholders who might favor or oppose policy change. Sociological studies have concluded that powerful interest groups "capture" the state leading reformers to reformulate their policy initiative and even to stop policy change in spite of its technical soundness and its potential for enhancing the common good (Evans et al., 1985; Skocpol, 1985)

However, experience in first generation reforms under structural adjustment shows that reformers pursued and accomplished significant policy changes—like trade liberalization and market deregulation—even at the expense of powerful actors defending the status quo. What explains this?

One possible explanation may lie in the political institutions structuring state-society relations. The political system and its institutions establish the "rules of the game" by which policy makers and social actors may act to pursue their agendas. In laying the ground for the policy process to evolve, and therefore for the political struggle aimed at influencing it, political institutions play a determinant role in empowering some actors over others both within and outside the state. Therefore, the political feasibility of a reform initiative will be determined by elements from interest group politics, as well as the shape and role of the existing political institutions.

6.2 POLICY PROCESS AND THE ACTORS INVOLVED

The policy process is the series of events that a reform initiative follows from the definition of the problem and its incorporation in the public agenda, to the consolidation of the intended policy change. It will be analyzed in its five "anchor" stages: 1) policy formulation, 2) policy legislation, 3) policy implementation, 4) institutional change, and 5) reform consolidation.

As the policy reform process takes place within the institutional framework of the county, it will pass through a number of points in which its feasibility will be affected and changes made in its substance. These crucial stages of the policy process occur at different points in the institutional framework, such as the president's office, the congress, and the bureaucracy. In each of these "policy nodes," the reform will be affected by those actors who have access to these points and who can influence the policy process.

These actors (and their agenda and power) will be different in each policy node; thus, their potential to influence the content of the reform as well as its feasibility will vary accordingly.

Policy makers will therefore use the institutional framework of the political system to the reform's advantage in an effort to limit the influence of those actors against the reform initiative. For instance, it has been argued that political systems with a strong executive branch—with constitutional prerogatives allowing it to govern without conferring thoroughly with the other branches of government—are better equipped to isolate policy formulation from interest group politics. This, in turn, would seem to enhance the political feasibility of the policy reform initiative and to facilitate a speedier implementation.

However, circumventing the channels for interest representation and limiting the access of actors within and outside the state to policy formulation may not necessarily enhance the chances of the reform's survival and consolidation. The politics that are suppressed by these means at the policy formulation stage, may simply resurface at the implementation stage demanding consensus and coalition-building strategies to ensure the political feasibility of reform.

The lack of regular use of interest representation mechanisms in reform formulation—such as the congress and political parties—also contributes to transferring political conflict over policy debate from the wider society to within the state. Here, bureaucratic politics assume greater significance and different factions of policy makers confront each other representing a wide array of views and ideologies in the political spectrum.

In first generation reform experiences affecting market regulation and other aspects of the economy, those policy makers who were able to circumvent interest representation mechanisms on the grounds that these were captured by powerful vested interests—for instance, resorting to executive decrees instead of congressional hearings—seem to have been successful in consolidating policy change. On the other hand, those policy makers who emphasized interest group participation and consensus building through institutional representation channels such as the congress seem to have had their initiatives deadlocked and effectively derailed. However, policy reform did require intense political maneuvering within the state, as different state factions debated over policy options to be implemented. Is this lesson useful in the case of health policy reform?

While market reform was basically about changing incentives and rules, and diminishing the size of the state, second generation reforms such as health policy change depend on many actors whose behavior needs to change in order to consolidate policy change. For instance, even with a more significant participation of the market, the state will still have to rely on a large group of salaried health workers and managers in order to deliver better health services. Effectively bringing these groups on board the health reform process will probably require political strategies that go beyond surprise changes on incentives and regulations, since contrary to market actors, the state's capacity to deliver a reformed health service depends on consensual changes in their behavior.

6.3 POLITICAL STRATEGY

A central element of the reformers' political strategies aimed at buttressing the state's capacity to promote policy reform is the use of change teams empowered to bring about policy change. The change team is the point where most of the reform efforts as well as political pressures to affect the reform process converge. The change team's characteristics, its ascribed power, and its location will determine its capacity for political maneuvering within the state and its ability to convey support in favor of policy

change across state and society lines. The change team's ability to formulate and pursue an effective political strategy in favor of policy reform will have a great impact on the state's capacity to bring about change, and therefore on the political feasibility of its reform agenda.

By the same token, the capacity of these policy makers to operate will depend on the parallel political strategies that are used to ensure the political feasibility of the health reform initiative. Experience in first generation reforms showed that reformers were able to “manage” interest group pressure to influence the policy process by conveying support in favor of policy change when needed, while at the same time limiting the level of influence of vested interests in the status quo. The use of highly technical skills in policy formulation enabled them to keep tighter control over the policy process by allowing them to fine tune the policy reform package according to mostly technical and strategic criteria, instead of political considerations.

Other strategies used by reformers to pursue policy change have been one time/comprehensive policy change, as opposed to an incremental approach to policy implementation, thus leaving very little time and scope for organized resistance. Little consultation and consensus building was pursued, tending to inform more than to ask—except when there was a perceived need for coalition building. There was no clear political strategy when policy reform needed the active and consented participation of other actors, such as parts of the bureaucracy and/or particular interest groups, so mixed results were obtain when policy reform contemplated not only downsizing the state, but transforming it.

The very mixed results that were obtained by reformers and their political strategies in these particular cases are of special interest for this study, since health policy reforms do need the collaborative participation of multiple actors within and outside the state in order to succeed.

While at first glance this scenario might suggest a policy recommendation calling for a more participatory and consensus—building approach (indeed, the limited literature on the subject is inclined towards this advice), a more careful analysis needs to be done in order to avoid oversimplified policy advice. To give a high priority to consensus-building and participation may simply reinforce the likelihood that the state will be captured by vested interests such as the bureaucracy and organized labor that have effectively derailed any attempts at policy change in the past. Also, unmanaged participation has led to policy deadlock bringing reform initiatives to a halt, instead of ameliorating their substance.

On the other hand, calling for an exclusionary process with a small team of experts empowered to conduct a health reform with little accountability to any other group is not the immediate answer to the previous scenario. More research needs to be done in order to clarify the range of options for designing the political strategy that falls between these two admittedly oversimplified extremes in order to be effective in enhancing the political feasibility of health sector reform without sacrificing the participation of state and society actors.

Our study attempts to ascertain the opportunities and obstacles in the political-economy context that a health reform initiative will encounter as the policy process evolves. We then assess the political strategies that have been used in the past to respond to these challenges and opportunities. Finally we establish a series of guidelines for the assessment of the political context affecting health policy change and for the formulation of context-based advice on policy strategy aimed at enhancing the political feasibility of health sector reform.

7. POLICY RELEVANT OBJECTIVES AND EXPECTED RESULTS.

Our comparative study has several policy relevant objectives and expected results. These include:

1. To elaborate an analytical framework that can serve as a tool for donors and policy makers at the country level to identify the determinant characteristics of the country's political system where the reform is going to take place;

2. To develop a set of analytical tools that will help locate the key policy points (policy nodes) in the policy process where the reform initiative's feasibility (as well as its substance) is at stake in order to concentrate donor efforts in relevant stages of the policy process;

3. To locate and support the change team (with training, information about similar reform experience, and pertinent advice) as the corner stone of the reform process; and

4. To establish a set of policy guidelines to improve the effectiveness of USAID support for health policy change in developing countries.

8. SAMPLE VARIABLES TO BE INCLUDED IN ANALYTICAL FRAMEWORK

This section presents a sketch of the analytical framework in order to illustrate the approach that is going to be used for the analysis of health reform processes. It is, at this stage, by no means exhaustive, and may be modified in use, since one of the objectives of this research project is to probe, refine, and consolidate this model as it is used in the analysis of the country cases.

TABLE 1: The Political Economy of Health Sector Reform General Framework

I. POLITICAL ECONOMY CONTEXT	II. POLICY PROCESS	III. POLITICAL STRATEGIES: CHANGE TEAMS
• CHARACTERIZATION OF THE POLITICAL SYSTEM: • INSTITUTIONAL CONFIGURATION • REGIME • FORMAL ATTRIBUTES OF RELEVANT INSTITUTIONS AND ACTORS • FORMAL RULES (INSTITUTIONAL FEATURES): I.E. ELECTORAL CYCLES, ETC. • INFORMAL RULES (INFORMAL INSTITUTIONAL FEATURES): I.E. WEIGHT OF PARTY DISCIPLINE OVER POLICY MAKERS ONCE IN OFFICE, SOURCE OF STATE'S LEGITIMACY, ETC.) • GENERAL POLITICAL MAP OF KEY PLAYERS: I.E. GOVERNORS, ELITE GROUPS, KEY INTEREST GROUPS, INTERNATIONAL DONORS, AND MULTILATERAL AGENCIES INVOLVED, ETC.)	• ANCHOR STAGES OF POLICY PROCESS: – POLICY FORMULATION – POLICY LEGISLATION – POLICY IMPLEMENTATION – INSTITUTIONAL CHANGE – REFORM CONSOLIDATION • KEY POLICY NODES/ARENAS WHERE REFORM MAY BE SIGNIFICANTLY ALTERED, INVIGORATED OR HALTED: I.E. MOMENT OF PASSING LEGISLATION, ETC. (TIME AND PLACE) • RELEVANT ACTORS IN KEY POLICY NODES • INTEREST GROUP REPRESENTATION IN POLICY DEBATE AND STATE-SOCIETY RELATIONS. • USE OF CHANGE TEAMS AS A POLITICAL STRATEGY.	• CHANGE TEAM CHARACTERISTICS: CONFIGURATION LOCATION EXPERTISE PREVIOUS POLICY EXPERIENCE • CHANGE TEAM POLITICAL MANEUVERING: VERTICAL NETWORKS—WITHIN THE STATE HORIZONTAL NETWORKS—WITHIN THE STATE POLICY NETWORKS ACROSS STATE/SOCIETY. • RELATED POLICY STRATEGIES: INSULATION VS. ENCOMPASSING/CONSENSUS BUILDING. INCREMENTAL VS. COMPREHENSIVE/ONE TIME.

9. METHODS

The project has a life span of 18 months, with in-country research analysis lasting a total of six months per case. Field work is being conducted by local consultants coordinated by the research director, who is also responsible for the comparative analysis. The following matrix presents in detail what is expected at each stage of the research development.

TABLE 2: The Political Economy of Health Sector Reform

General Framework, Methods, and Expected Outputs

I. POLITICAL-ECONOMY CONTEXT (DESCRIPTIVE)		
VARIABLES	METHODS	OUTPUT
• CHARACTERIZATION OF THE POLITICAL SYSTEM: • INSTITUTIONAL CONFIGURATION. • REGIME • FORMAL ATTRIBUTIONS OF RELEVANT INSTITUTIONS AND ACTORS. • FORMAL RULES (INSTITUTIONAL FEATURES): I.E. ELECTORAL CYCLES, ETC. • INFORMAL RULES (INFORMAL INSTITUTIONAL FEATURES): I.E. WEIGHT OF PARTY DISCIPLINE OVER POLICY MAKERS ONCE IN OFFICE, SOURCE OF STATE'S LEGITIMACY, ETC.) • GENERAL POLITICAL MAP OF KEY PLAYERS: I.E. GOVERNORS, ELITE GROUPS, KEY INTEREST GROUPS, INTERNATIONAL DONORS AND MULTILATERAL AGENCIES INVOLVED, ETC.)	• PRIMARY SOURCES: CONSTITUTION, LEGISLATION, SECONDARY LAW AND OTHERS. • SECONDARY SOURCES: LITERATURE ON THE POLITICAL ECONOMY OF COUNTRY. • INTERVIEWS: DIRECTED AT FINDING OUT MORE ABOUT INFORMAL RULES AND PROCESSES.	• INFORMAL RULES OF THE POLITICAL SYSTEM (INFORMAL INSTITUTIONAL FEATURES): I.E., EXECUTIVE'S PREROGATIVES TO ASSIGN TOP POSITIONS IN DIFFERENT SECTORS, MECHANISMS TO ENSURE PARTY DISCIPLINE TO ELECTED OFFICIALS, ELITE BUREAUCRACY'S INFORMAL ATTRIBUTES FOR DECISION - MAKING. • POLITICAL MAP AT THE MACRO LEVEL: KEY ACTORS IN THE POLITICAL ECONOMY OF THE COUNTRY OVER TIME.

TABLE 2: The Political Economy of Health Sector Reform (cont.)

General framework, methods, and expected outputs

II. POLICY PROCESS AND ACTORS (ANALYTICAL)		
VARIABLES	METHODS	OUTPUT
• ANCHOR STAGES OF POLICY PROCESS: POLICY FORMULATION POLICY LEGISLATION POLICY IMPLEMENTATION INSTITUTIONAL CHANGE REFORM CONSOLIDATION • KEY POLICY NODES/ARENAS WHERE REFORM MAY BE SIGNIFICANTLY ALTERED, INVIGORATED OR HALTED: I.E. MOMENT OF PASSING LEGISLATION, ETC. (TIME AND PLACE). • RELEVANT ACTORS IN KEY POLICY NODES. • INTEREST GROUP REPRESENTATION IN POLICY DEBATE AND STATE-SOCIETY RELATIONS.	• PRIMARY SOURCES: REVIEW OF MEDIA, POLICY DOCUMENTS TO INFER POLICY PROCESS. • SECONDARY SOURCES: LITERATURE ON REFORMS IN OTHER SECTORS. LITERATURE ON OTHER REFORM ATTEMPTS IN HEALTH SECTOR. • INTERVIEWS: TO PROBE CONCLUSIONS ABOUT THE POLICY PROCESS STEMMING FROM THE REVIEW OF MATERIAL.	• DESCRIPTION OF THE POLICY PROCESS (HOW IT HAPPENS, WHEN, AND WHERE). • POLICY PROCESS MAP (MAY BE DIFFERENT FOR DIFFERENT SECTORS). • LOCATION OF KEY POLICY NODES (VETO POINTS): WHERE?: IN WHAT PART OF INSTITUTIONAL CONTEXT. WHEN?: IN WHAT STAGE OF POLICY PROCESS. WHO?: MAP OF RELEVANT ACTORS (GENERIC) ON EACH KEY POLICY NODE. I.E. PRESIDENT'S OFFICE, LEGISLATURE, CONGRESSIONAL COMMISSIONS, ETC.) POLICY FORMULATED IN PRESIDENT'S OFFICE OR IN TOP LEVEL BUREAUCRACY OR CONGRESSIONAL COMMISSIONS. • OTHER POLICY REFORM EXPERIENCES AND THE DIVISION OF DECISION-MAKING POWER: I.E.: WHO AMONG POLICY MAKERS, PARTIES AND OTHER ACTORS INVOLVED HAVE DECISION POWER OVER PARTICULAR SECTORS OR POLICIES.

TABLE 2: The Political Economy of Health Sector Reform (cont.)

General framework, methods, and expected outputs

III. POLITICAL STRATEGY: CHANGE TEAMS AT WORK (ANALYTICAL)		
Variables	**Methods**	**Output**
• USE OF CHANGE TEAMS AS A POLITICAL STRATEGY. • CHANGE TEAM CHARACTERISTICS: CONFIGURATION LOCATION EXPERTISE PREVIOUS POLICY EXPERIENCE • CHANGE TEAM POLITICAL MANEUVERING: VERTICAL NETWORKS —WITHIN THE STATE HORIZONTAL NETWORKS – WITHIN THE STATE • POLICY NETWORKS – ACROSS STATE/SOCIETY. • RELATED POLICY STRATEGIES: INSULATION VS. ENCOMPASSING/CONSENSUS BUILDING. INCREMENTAL VS. COMPREHENSIVE/ONE TIME.	• PRIMARY SOURCES: GOVERNMENT ARCHIVES AND OFFICIAL BIOGRAPHICAL MATERIAL ON POLICY MAKERS (TO TRACK DOWN CAREER PATH AND POSSIBLE RELATION WITH 'REFORMING THE STATE,' AS WELL AS VISIBLE NETWORKS. • SECONDARY SOURCES: • LITERATURE ON TECHNOCRATIC POLICY MAKING AND TECHNOCRATIC POLITICS. • INTERVIEWS: INTERVIEWS WITH CENTRAL ACTORS INVOLVED IN THE HEALTH REFORM PROCESS, PARTICULARLY MEMBERS OF THE CHANGE TEAM IN CHARGE OF THE REFORM. (SEE INTERVIEW GUIDELINES)	• CHARACTERISTICS OF CHANGE TEAM: • CHARACTERIZATION OF CHANGE TEAM'S POLITICAL MANEUVERING. • GENERAL UNDERSTANDING OF THE OPPORTUNITIES AND HURDLES REFORMERS SEE IN THE PARTICULAR INSTITUTIONAL FRAMEWORK WITHIN WHICH THEY OPERATE. • KNOWLEDGE ABOUT OTHER POLICY STRATEGIES USED IN TANDEM WITH THE CHANGE TEAM TO INCREASE THE POLITICAL FEASIBILITY OF HEALTH REFORM. I.E. INSTITUTIONAL RECONFIGURATION, MANAGEMENT OF INTEREST GROUP ACCESS TO THE REFORM PROCESS, COALITION BUILDING, AND OTHERS. • POLICY STRATEGY CHOICES (AND DILEMMAS) CONFRONTED BY CHANGE TEAM IN ITS EFFORTS TO ENSURE A SUCCESSFUL POLICY REFORM PROCESS. I.E. TECHNOCRATIC VS. CONSENSUS BUILDING, INCREMENTAL VS. ONE TIME/COMPREHENSIVE.

10. PROFILE OF TARGET INTERVIEWEES

In the comparative studies we are interviewing a sample of approximately 25 persons in each country representing the players, the relevant stakeholders, the interested observers, and some of the country-specific experts. These categories are not mutually exclusive and may not fully represent the profile of all the interviewees, but they indicate the general nature of the target interviewees.

THE PLAYERS

The key interviewees will be mostly actors who are involved in or who have a stake in the health reform process as well as other policy processes related to state reform. Key informants will be policy makers who participated in all or a fraction of the health reform process, as well as other relevant actors in and outside the state, who were involved supporting or confronting the reform initiative. Some examples are the policy makers at the head of the health ministry during the reform process, his/her group of advisors, and those on planning units within the ministry. Their peer and counterparts in other ministries, such as the planning ministry and the finance ministry will also be interviewed, along with heads of the institutions participating or being affected by health policy change, such as the health component of the social security institutions.

THE STAKEHOLDERS

A second group of interviewees will be actors who are active in the political system, such as party members, lobbyists, and members of important interest groups who are familiar with the workings of the political system and the formal and informal rules of the game. These actors will also prove crucial in assessing the political weight, the nature, and the role of the actors in the first group. Union leaders of the health work force and health service bureaucracy, and leaders of the key associations, such as medical associations, will be targeted for interview among others. Other key actors with a stake in the reform process who will be interviewed are members of multilateral organizations and donors participating in the support of health sector reform.

THE OBSERVERS

A third group of interviewees includes academics and policy and political analysts whose articulated account of the political economy of their country, as well as the policy process may enrich the background work done in these areas with primary and secondary sources. Members of specialized think tanks will be particularly relevant, not only because of their familiarity to the process, but because on many occasions they have been direct actors as policy makers, given the flux between academic life and government activity that has characterized state reforms in the last decade and a half.

THE EXPERTS

To this latter group will be added the advice and point of views of foreign academics and policy experts with expertise in the policy area and/or the particular country under study and whose views may temper the information obtained in other interviews with a more neutral perspective. Again, the members of this group are not only relevant for their expertise and experience, but because of their active role in informing and influencing members of the international health community-particularly donor agencies and multilateral organizations-on policy choice and the strategy to follow.

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