Political Analysis for Health Policy Implementation

Paola Abril Campos¹ and Michael R. Reich²,*

¹Doctor of Public Health Candidate, Harvard T.H. Chan School of Public Health, Boston, MA, USA
²Taro Takemi Research Professor of International Health Policy, Harvard T.H. Chan School of Public Health, Boston, MA, USA

ABSTRACT—Any effort to improve health system performance must address the challenges of policy implementation. This article examines one aspect of implementation—the politics of policy implementation for the health sector, particularly the management of stakeholders in order to help change teams improve the chances of achieving policy objectives. Based on a literature scan of political analyses and descriptions of health policy implementation in low- and middle-income countries, we propose six major categories of stakeholder groups that are likely to influence implementation: interest group politics, bureaucratic politics, budget politics, leadership politics, beneficiary politics, and external actor politics. The categories of stakeholders can be overlapping. We examine the politics of these different stakeholder categories, and then present selected examples of published case studies that show the types of implementation challenges that arise for each category and how implementers can use political strategies to manage specific stakeholder groups and related political processes. Understanding the political dimensions of implementation can help those responsible for implementation drive policy into practice more effectively. Understanding and addressing conflict, resistance and cooperation among stakeholders are key to managing the implementation process. Systematic and continuous political analysis can help decision makers and change teams improve the chances for successful implementation.

INTRODUCTION

Any policy effort to improve health system performance must address the challenges of policy implementation.¹ But health policy analysis, in general, tends to emphasize issues of policy design and adoption over questions of policy implementation. Although these policy cycle phases may overlap and share common challenges, a focus on policy implementation is still needed. This article seeks to correct this gap in the literature. We build on existing knowledge about health policy implementation in low- and middle-income countries to propose
This article examines one aspect of implementation—particularly the management of stakeholders in order to improve the chances of achieving policy objectives. We provide a characterization of stakeholder groupings that are relevant for all phases of policy reform, but we focus on the challenges for health policy implementation.

Throughout the article, we refer to health policy or health reform implementation with the understanding that health reform usually involves multiple policies seeking to achieve system-wide change. By health policy, we mean a government decision and plan of action to make progress towards the goals of the health system: improved population health status, increased financial risk protection, and increased client satisfaction; or the intermediate outcomes for health systems, under which we include: quality, access and efficiency.1

The conceptual framework for this article draws on the theoretical literature in political science and sociology while being practice-oriented. The article is intended to assist people tasked with strategic planning for health policy implementation; these people include government policy makers and high-level implementers but may also include policy actors outside of government. They may belong to a stakeholder category themselves. We call these people “policy implementers” or “change teams,” although in practice, they may not be officially formed teams with a clear implementation mandate. Our argument, in short, is that a group of people need to plan and manage health policy implementation for it to be successful, and they will often confront political challenges in dealing with implementation stakeholders. This article may also assist those responsible for designing health policy, in helping them anticipate implementation challenges that can be addressed in the design phase.

**The Challenges of Implementing Health Policy**

The implementation of a new health policy demands more than providing instructions around a policy document or designing a set of standard operating procedures.14 Effective health policy implementation requires “the aggregation of the separate actions of many individuals, and [an understanding of] how and why the actions in questions are consistently reproduced by the behavior of individuals.”5 One fundamental implementation challenge is that the responsibility for health policy implementation usually rests with a different set of governmental actors than the ones who designed the policy.6 Policy designers often do not understand the perspective of the implementers. The process of policy implementation thus requires working with and through a set of actors and organizations to communicate policy objectives, ensure availability of resources, achieve ownership of the policy by implementers, manage conflict and cooperation, and sustain policy changes. To start a new program and maintain it, joint efforts and contributions from multiple governmental agencies or private actors are needed. This frequently results in delays, renegotiation of resources and responsibilities, and confusion among the beneficiaries.6 In short, implementation is messy.

To move health policy forward into practice, implementers must realistically consider the difficulties of implementing a policy in their particular national context.1 Policy implementers or change teams need to recognize the complexities and characteristics of the administrative context in which their policies will become operational.7 Those leading policy implementation need “persistence, discipline, and rigor” to work within their particular contexts, and they need to make difficult decisions regarding staffing, organizational structure, and relationships with stakeholders8 to make policy implementation happen. Doing all of this in real time is not easy.

**Different Approaches to the Study of Policy Implementation**

Given the complexity of policy implementation as a social phenomenon, it is no surprise that multiple approaches exist to study and understand it. Here we discuss a few of the different approaches and their conclusions.

Starting in the 1970s, political science as a discipline began to recognize that public policies were rarely implemented as designed and that policy outcomes were rarely achieved as desired. The seminal book by Pressman and Wildavsky9 brought the challenges of policy implementation front and center. They coined the term “implementation deficit,” referring to when the linkages get fractured between levels of government and among organizations at the local level. According to the authors, “the longer the chain of causality, the more numerous the reciprocal relationships among the links and the more complex implementation becomes.” The book’s subtitle remains striking in its length and its message: Implementation: how great expectations in Washington are dashed in Oakland: or, why it’s amazing that federal programs work at all, this being a saga of the Economic Development Administration as told by two sympathetic observers who seek to build morals on a foundation of ruined hopes. The book...
persists as a classic and required reading in the study of implementation.9

From this time forward, studies of implementation began to expand in political science and in the field of public administration. The term “implementation gap” appeared to refer to a judgment made after comparing what is achieved and what was expected from policy.10,11 “Implementation studies” sought to explain why policy implementation failed and to identify effective approaches for affecting “what happens.”11 These studies sometimes contrasted “top-down” approaches with “bottom-up” approaches to improving the chances of implementation. Hill and Hupe identified a key implementation challenge in the governance arrangements that occur in different policy layers, also called the “multi-layer problem.”7

More recently, “implementation science” has appeared. In public health, these studies seek to bridge the gap between what is known to work and what can be put in practice to improve population health. This is also called the “know-do gap.” Implementation science uses multidisciplinary methods to systematically drive progress in scaling up evidence-based interventions. Implementation science has its own methods and set of tools, including stakeholder analysis, effectiveness evaluations, and mathematical modeling, all used to scale up and sustain evidence-based interventions.12

Another approach to the study of implementation is called Deliverology, “the science of delivering results,” which provides a package of methods to drive progress and deliver results in government and public policy.8 The main proponent of Deliverology is Michael Barber, who served as Chief Adviser on Delivery to the British Prime Minister Tony Blair (starting in 2001) and headed the Delivery Unit for the public policies of the Prime Minister. Barber developed these methods for many kinds of public policy, including health, education, agriculture, and other areas of public service. The methods are designed to measure and drive progress for specific public policy targets by focusing on outcomes.

As mentioned above, this article focuses on only one aspect of implementation—the politics of policy implementation for the health sector—particularly the management of stakeholders in order to improve the chances of achieving policy objectives. Attention to diverse stakeholders is a common theme in various approaches to the study of implementation. The focus on the politics of implementation shares with other approaches the common objective of seeking to make implementation more effective in delivering policy goals.

**Why Study the Politics of Policy Implementation?**

Health sector reform requires organizations and individuals to behave differently.1 Yet modifying behavior is a difficult task because change is almost always resisted. People resist change because change disrupts established power structures and ways of getting things done13; change often requires breaking old habits and relationships and starting new habits and relationships. Furthermore, turning an adopted policy into specific activities, outputs and outcomes involves a redistribution of resources and responsibilities. In short, policy implementation inevitably involves politics.

The politics of policy implementation is about managing actors, organizations and institutions that have a stake in health reform. Barber talks about “the alchemy of relationships”—referring to the process of building constructive relationships with all the ministers and officials involved with implementing the prime minister’s ambitious agenda, in order to assure delivery.9 Implementation requires paying attention to the interests of the actors involved in a policy and to the structured relationships between them.7

Implementation often entails consensus building, conflict management, and power bargaining among stakeholders located in different corners of the policy environment: members of budget and oversight committees in the legislature; formal and informal policy advisors for political leaders; affected organizations and interest groups; political appointees in charge of the implementing agency; bureaucrats across various agencies; and beneficiaries both powerful and powerless. The complex bargaining process required for implementation can result in the “adaptation, modification, negotiation, replacement or even undermining of policy goals.”7

**Implementation in the Policy Cycle**

Policy processes for health (and other fields) can be viewed as a cycle. According to one theoretical perspective, public policy moves through a cycle of six stages—problems are defined, a causal diagnosis is made, plans are developed, a political decision is made on reform initiatives (policy adoption), the reforms are then implemented, and their impact is evaluated.1 This logical and linear sequence, however, rarely occurs in the real world. In practice, health policy efforts begin in different places and skip stages, or several stages may occur at the same time. For example, as John Kingdon pointed out, policy entrepreneurs for certain solutions often seek out social problems that create opportunities for adopting the solutions they support.14 This sequence reverses the logical relationships among the stages of the policy cycle; solutions actively pursue problems, rather than having a rational analysis of problems produce solutions.

Policy *adoption* and policy *implementation* thus have a complex relationship:
Policy adoption can require compromises that complicate implementation; in order to assure adoption of a policy, it may be necessary to change the content of policy (to win the support of certain stakeholders), for example, in ways that reduce accountability and thereby reduce the likelihood of effective implementation.

Policy makers may not anticipate implementation requirements; the separation between policy makers and policy implementers may make it difficult for the designers to fully understand how a policy will be accepted in the field.

Policy makers may not want to see a policy implemented and may use the expected implementation gap to assure ineffectiveness of a policy (i.e., “the policy was well-intended but there were implementation challenges”).

Implementation can re-shape the statutory policy. The decisions of “street-level bureaucrats” (those in direct and regular contact with citizens) create established routines and devices to cope with work pressures and uncertainties, which transform statutory policy into the public policies that are carried out. Policymaking thus continues in the implementation stage.

Policy development and implementation may overlap. Often policies are hastily adopted, without attention to details, resulting in concurrence of policy development and implementation; policy designs are finalized as the policy is implemented.

Policy implementation may come before policy adoption, for example, when pilot projects occur before a political decision on the policy has been made.

These examples illustrate the complex dynamics between policy development, adoption and implementation. When designing a policy, it is important to look forward in the cycle to matters of political decisions, implementation, and evaluation. Policy development is important, because it shapes implementation; but as noted above, implementation can change what the policy is.

Policy evaluation represents the last stage in the theoretical policy cycle—when policy processes, outputs and outcomes may be assessed, depending on the type of evaluation. But in practice, evaluation may also happen out of cycle. Evaluation may occur before a policy has a chance to produce robust results—for example, when a government seeks to show some results before an administration ends; or when a government seeks to show no results in order to eliminate a policy. Or an evaluation may be delayed for a long time, in order to avoid showing limited outcomes that might embarrass a government in power.

The main point is that the policy cycle is a useful heuristic device, to think about how a logical sequence of events could occur in the field of public policy. But it should not be confused with what happens in public policy in practice.

METHODS

For this review, we conducted a literature scan of political analyses of health policy implementation in LMICs in PubMed and Google Scholar. Due to the limited available literature, we broadened the scope of the search to include descriptions of health policy implementation, including some articles that use an historic lens to discuss particular health policies, to draw insights and inferences about the politics of implementation. We decided to look at health policy implementation according to six major categories of actors that participate in health policy implementation in LMICs. These six categories are explained in the next section. Each category relates to a significant group of stakeholders involved in health policy implementation and also at a broader conceptual level, to a significant theoretical literature in political science.

To illustrate the varying roles of different stakeholder categories, we selected examples of published case studies on the challenges policy implementers may encounter and how they can use different political strategies to promote, slow-down or resist effective implementation related to specific stakeholder groups. The examples we use do not necessarily illustrate the most common strategies nor are they necessarily applicable to other contexts. As mentioned before, decision makers need to consider and address the challenges of implementing a policy idea in their particular national context.

Four of the seven illustrative examples we use are from Asia (at the request of the sponsor for the original background paper, on which this article is based). We refer to examples in other parts of the world to illustrate key concepts, given the limited availability of published studies of health policy implementation in LMICs in Asia.

CONCEPTUAL FRAMEWORK

One way to think about the politics of policy implementation is to identify stakeholders involved in the process. For implementation of health policy, we identified six different categories of stakeholders that need to be managed in promoting implementation. Understanding their interests, their positions and their power are key to developing effective strategies to manage the stakeholders and move implementation forward.

We believe that officials responsible for implementing health policy, change teams or policy implementers, need
to consider management in six different directions for different kinds of stakeholders:

- “Manage outside” by managing interest groups that may resist or promote policy implementation to protect their interest.
- “Manage within and around” by managing bureaucrats working in the multiple layers of administrative organizations.
- “Manage money” by managing financial decision makers within the system.
- “Manage up” by managing their superiors, often political leaders to ensure their commitment to policy implementation.
- “Manage down” by managing the intended beneficiaries of the policy and mobilize their engagement and elicit their feedback.
- “Manage donors” by managing external actors that may fund health policies and influence implementation, especially in low-income countries.

Implementers also need to manage themselves, to drive a high performing change team. Setting up systems for self-directed learning and feedback is one key aspect of creating an effective implementation team. However, this aspect is beyond the scope of this essay.

Figure 1 presents these six groups of stakeholders for implementation.

MANAGING THE STAKEHOLDERS OF POLICY IMPLEMENTATION

This section is written from the perspective of the policy implementation team. For each stakeholder group, we provide a general assessment of the political circumstances of implementation related to those stakeholders, and then discuss how the implementation team can manage those political dynamics. We then present a brief case study, as an illustrative example of the complexity of managing stakeholders. The example is not intended to be exhaustive or complete, but rather illustrative.

The categories of stakeholders can be overlapping; bureaucrats can be beneficiaries at the same time, if a health policy affects, for example, their access to health care; leaders can be part of an interest group, in the case, for example, of political leaders with a medical degree. It is also important to bear in mind that stakeholders may use similar strategies or a mix of overlapping strategies to promote, block or slow-down policy implementation.

Interest Group Politics (“Managing Outside”)

Interest groups often seek to influence health policy at different stages of the policy cycle, to minimize their losses and maximize their gains from the proposed changes. Producer groups that typically seek to influence health policy include medical professionals, health insurance companies, hospital owners, and producers of pharmaceuticals and medical technology. For example, in India, the medical association mobilized to block workforce policy reforms that would have diminished medical professionals’ control over health markets.15

Groups on which concentrated costs of policy changes are perceived to fall (such physicians, insurers, employers) are typically better organized and more powerful than groups of beneficiaries who tend to be not well organized and less powerful (general consumers, rural residents, and poor people). This creates what Mancur Olson called a “collective action dilemma.”16 However, consumer groups are becoming increasingly important in many LMICs, especially with the rise of social media and with economic and political development.

Interest groups use various political strategies to influence implementation. For example, interest groups can capture the regulatory agency responsible for decisions to obtain increased influence over how policy is put into practice. The concept of regulatory capture17 is used to describe the takeover of government agencies by interest groups that seek to weaken regulation and enforcement or shape regulation to fit the industry’s interests, and thereby advance their agendas. In effect, the regulatee takes over the regulator. Interest groups

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FIGURE 1. Policy Implementation Stakeholders
can also resist policy implementation by using discretion to exercise authority as they interact with beneficiaries.

How can an implementation team resist these efforts by interest groups? When a powerful interest group actively resists or passively ignores a policy, the implementation team may need to design policies to counter the group’s influence or may need to create incentives (financial or symbolic) to mobilize the interest group to implement the policy (see Example 1 below). When an interest group does not exist to support a policy (see Example 2 below), the implementation team may need to create a new organization that has direct interests in promoting implementation or mobilize beneficiaries to act as an interest group in favor of policy implementation. Civil society can be mobilized to monitor policy implementation. This was the case, for example, of the participation of women's groups in ensuring that actions followed the commitments about sexual and reproductive health stipulated in the 1994 International Conference on Population and Development (ICPD) in Cairo and the 1995 fourth World Conference on Women in Beijing.

Example 1 illustrates the use of discretionary power by an interest group to resitst implementation. In this case, Indian medical practitioners were successful in opposing the efforts of authorities to enforce HIV testing guidelines. These less visible ways of influencing the implementation processes and the outcomes of health policies might be more prevalent and important than very organized, direct and instrumental resistance.

Example 1. Resisting Implementation by an Interest Group in India

In 2006, India’s National HIV/AIDS Prevention and Control Program launched its third phase. The program was the official source of national policies and guidelines for HIV care and treatment including HIV testing. Some of the guidelines applied to the behavior of doctors, including the requirement of taking written informed consent before prescribing an HIV test, and maintenance of strict confidentiality around test results.

Practitioners in both private and government hospitals attempted to resist or subvert the efforts of regulators to enforce the guidelines. One senior physician said:

“Everybody knew that there is this policy, but nobody knew where it has come from. And they all agreed with me—they said yes, there is no reason for it. I visited people in NACO [National AIDS Control Organization] … Nobody could tell me where this has come from. Finally [a senior HIV/AIDS program official] agreed—they have this, but they don’t know where it has come from. He just said ‘it’s there’.”

Doctors widely resisted the regulator’s authority and protected their interests in different ways entailing either subversion or simple disregard of official norms.

Example 2 shows a different way that interest groups can affect implementation. Hawkes and colleagues show how the lack of interest groups can result in a low level of implementation of evidence-based interventions.

Example 2. Low Implementation Due to Lack of Interest Groups Supporting the Policy

Screening pregnant women for syphilis has long been a recommended intervention for reproductive health programs; treating women found to be serologically positive is a simple and highly cost-effective intervention. The treatment relies on penicillin, which is inexpensive and on WHO’s essential drug list. Many countries have had syphilis screening policies in place for years. Despite the existence of policies, however, the same countries often lack functioning screening programs. Programs exist, but they have not been scaled up or sustained beyond successful pilot interventions. Hawkes and colleagues analyzed why syphilis screening programs have not been effectively implemented and concluded that one important reason is that few interest groups stand to gain economically from major efforts to diagnose and treat this disease. Interest groups such as pharmaceutical companies are not financially interested in supporting the implementation of syphilis screening programs. In addition, those who stand to benefit from the program, pregnant women, are not aware of the problem and are not well-organized. There seems to be a lack of interest group mobilization associated with syphilis treatment.

Bureaucratic Politics (“Managing within & Around”)

Bureaucrats are often the key actors responsible for implementing health policy. Even if they are not part of the policy design process, they are nonetheless tasked with implementation. Furthermore, when multiple government agencies have responsibility for a given health policy, interagency collaboration may be challenging. Competition and conflict can arise among different government agencies to control policy and its implementation, as different agencies seek to expand their own authority, budget, personnel, and general influence. This kind of horizontal fragmentation, across different government agencies, can disrupt implementation, which can be compounded by budget politics (discussed below). Competition can also arise within a single agency between departments or units.

Implementation of health policy also depends on the actions of street-level bureaucrats. Lipsky’s theory of street-level bureaucracies claims that the exercise of discretion by
implementers is a critical component of what frontline workers do in their regular contact with citizens. Street-level bureaucrats’ discretionary use of authority to change, block, or promote the delivery of benefits to beneficiaries turns them into de facto frontline policy makers, as they shape what policy implementation means in practice. Workers at the frontlines “ultimately translate policy intents into practice, influencing the lived experience of patients and citizens.” Managing a decentralized bureaucracy has its challenges because bureaucracies cannot simply be led from the center through command-and-control approaches. Gilson proposes the use of distributed leadership to promote policy implementation through chains of leaders located across levels and positions within the health system. This strategy uses a flow of energy and power to harness the wide range of actors across the system to achieve collective goals. Reich and colleagues echo the need to think about how to create leadership that involves “many systems, many levels, many leaders”—from the national, to the regional, to the point of health delivery.

Adopting this more participatory approach to leadership encourages challenges due to ingrained habits of centralized decision-making, individualized decision-making by top leaders, and the dominance of the medical profession. Implementation teams need to invest time in finding common ground across stakeholders and in building credibility and trust.

High-ranking bureaucrats benefit from a varying degree of bureaucratic autonomy from organizational authority and may draw on various resources that make them key players in health policy processes. This point is illustrated by the decision of high-level bureaucrats in Thailand to implement a new UHC policy as a “national pilot project”—before the policy was passed as law by Parliament, to avoid potential delays in implementation by the new government and to avert expected pressure from the medical profession. The policy implementation team must consider the critical roles of both high-ranking bureaucrats and frontline workers in designing strategies to promote implementation.

Example 3 illustrates bureaucratic conflicts that arose when an interest group, the tobacco industry, became part of the bureaucracy in China and created significant challenges to an administratively weak Ministry of Health in implementing tobacco control policies.

Example 3. When an Interest Group Becomes Part of the Bureaucracy: Tobacco Policies in China

This case shows the challenges of implementing WHO’s Framework Convention on Tobacco Control (FCTC) in China because of the political power of the pro-tobacco interest groups within bureaucratic institutions and policy networks. The FCTC is a treaty that obliges member states to adopt national legislation and implement specific policies to reduce the prevalence of smoking.

China ratified the FCTC in 2003 and 2005, but little progress has been made in implementing the policies, compared to Brazil and India, due to powerful domestic stakeholders. China has the largest tobacco industry in the world with the state-owned China National Tobacco Corporation (CNTC). After the ratification of FCTC, China set up institutional arrangements that legitimized the CNTC as an official stakeholder in the implementation of the FCTC. When the FCTC took effect in 2006, China’s State Council established a cross-ministerial task force to implement it comprised of the MOH, the Ministry of Foreign Affairs, and China’s State Tobacco Monopoly Administration (STMA). Then after 2008, the Ministry of Industry and Information Technology (MIIT) became the agency tasked with implementing FCTC, with one of the eight standing committee members being STMA, the political representative of the tobacco industry.

The MOH is the weakest bureaucratic agency in the FCTC-implementing institutions in China, and the STMA has successfully managed to block implementation of the FCTC with its political connections and financial power. It is like “having a proxy for Philip Morris appointed to the US Federal Drug Administration to make tobacco control policies.” Without an increase in the relative power of the MOH compared to tobacco industry representatives in the bureaucratic institution responsible for implementing tobacco control, it will be difficult for the FCTC policies to be effectively realized in China.

Budget Politics (“Managing Money”)

A major challenge in health policy implementation is that available or allocated financial resources may not be sufficient for the activities required for effective policy implementation. Health policy is often about redistribution of resources and equity considerations, which make the budget process politically sensitive. The ministry of finance allocates public resources across different sectors with competing interests. The ministry of health often fails to provide persuasive technical evidence on the potential financial implications of their health policy proposals. Furthermore, election campaigns often trigger promises to implement ambitious health schemes that may not have sufficient financial resources to be implemented or sustained. In addition, systems of budget allocation and budget expenditure are often not transparent or well understood. The politics of deciding and disbursing budgets, therefore, has great impacts on policy implementation. While bureaucratic actors are usually at the center of budget politics, we have separated
bureaucratic politics from budget politics because of its importance in health policy implementation.

Implementation teams, therefore, need to develop effective strategies to create alliances with the ministry of finance and with legislative committees that oversee budget development and approval. In Mexico, for example, the Ministry of Health created an economic analysis unit that could undertake studies that would be understood and accepted by the Ministry of Finance, and the Minister of Health supported policies proposed by the Minister of Finance in order to develop a relationship of trust at the highest personal level (even if the proposed policies had some political costs for the Health Minister).\textsuperscript{25}

Example 4 illustrates how Thailand’s Prime Minister used his leadership position and political skill to expand the country’s fiscal capacity and change the way budgets were decided in order to ensure adequate funding for UHC policy implementation.\textsuperscript{26}

Example 4. Securing Adequate Policy Budget by high-Level Political Actions in Thailand\textsuperscript{26}

In 2001, Prime Minister Shinawatra obtained a victory for his Thai Rak Thai (TRT) Party. Just two months before the election, the TRT announced, as part of its policy platform, the “30 baht treat all” scheme for universal access to subsidized health care. Under the scheme, people would pay 30 baht (about $1.00 USD) for each visit or admission. The time, the gross national income (GNI) per capita was not high ($1990 USD per capita), and the domestic fiscal space was small (government tax amounted to 13% of GDP).\textsuperscript{26}

In 2002, PM Shinawatra created a new institution, the National Health Security Office, through which he implemented his policies and channeled government funds. He took the financial resources from the Ministry of Public Health and channeled most of the health budget through the new institution. The Prime Minister was able to redirect the funds from hospital construction to the operation of the 30-baht scheme. He was able to do this because of his power as the leader of a majority party; for the first time in the democratic era of Thailand, a single party had won a majority in parliament.\textsuperscript{27,28}

The Prime Minister also had the leadership ability and capacity to mobilize an additional 30 billion Thai Baht from general taxes. He adopted closed-end budgets, per capita budgets based on unit cost and utilization rates of different types of services, and capitation payments which facilitated the projection of total funding needs and hence the assessment of financial feasibility.

Leadership Politics ("Managing Up")

It is well known that the commitment and competence of leaders to a policy profoundly affect its adoption and implementation. Indeed, health systems need leaders with strategic vision, technical knowledge, political skills, and ethical orientation to direct the processes of policy formulation and implementation.\textsuperscript{29} Overcoming the many sources of resistance to change (that arise in response to adoption and implementation of new policy ideas) requires sophisticated leadership and management skills. Few health system leaders have had experience as the chief executive of a large organization, and they rarely fully grasp the importance of management skills.\textsuperscript{1}

To assure policy implementation, leaders must promote, enable, and support decision-making and execution by actors at all levels of the health system. Ultimately, policy takes effect or is blocked at the frontlines of service delivery and community engagement,\textsuperscript{4} far from the center of policymaking—but obstacles can arise at all levels in a health system. In a decentralized or federal political system, the center has limited capacity or direct leverage to promote effective action at lower levels, as a form of vertical fragmentation. Sub-national units led by other political parties often make their own political calculations and take an independent position. Sometimes a sub-national unit (a state or province) may openly refuse to adopt a national policy even when significant economic incentives are offered by the center (as has occurred in India and the United States for health policy).

Sometimes, an implementation team needs to call on and mobilize higher political leaders in order to assure implementation of a controversial health policy. This relationship with the top political leader can also be critical in the adoption of major health reform, as illustrated by the case of Mexico’s Seguro Popular.\textsuperscript{25} In that instance, the Minister of Health presented the health reform effort in terms of “democratization” to align with President Vicente Fox’s priorities for Mexico, and thereby gave higher attention to health reform as a political goal for the administration.

In Example 5, Turkey’s Minister of Health confronted obstacles from the Ministry of Labor, which resisted his efforts to unify the nation’s hospitals under his Ministry. He ultimately needed to call on the Prime Minister to transfer the social security hospitals, managed by the Ministry of Labor, to the Ministry of Health in a sudden and strong political move.\textsuperscript{30}

Example 5. Managing Your Boss in Turkey\textsuperscript{50}

In 2003, the incoming Minister of Health, Recep Akdag, introduced a series of reforms under the Ministry of Health’s (MoH) Health Transformation Program (HTP), with the goal of providing health coverage to all citizens through a unified system. Even with a parliamentary majority of the AK party, Minister Akdag’s proposal to create a single-payer system was not universally accepted within his political party. He also confronted opposition from the
bureaucracy, executive leadership and judicial branch. The Minister of Health and his team of advisors therefore designed and used political strategies to address and overcome opposition.

The health reform sought to bring together Turkey’s three separate social security institutions: SSK and Bag-Kur managed by the Ministry of Labor and Social Security (MoLSS), and the Emekli Sandıği managed by the Ministry of Finance. The three social security institutions were funded through a combination of payroll taxes, employer contributions, and general government tax revenues. There was also a Green-Card Program for the unemployed and informal workers.

One of the main opponents to this merger was the MoLSS, because the unification policy would diminish its power and influence in the health sector. As part of the reform, the MoLSS had to transfer its health facilities to the MoH. However, the MoH was unable to persuade the MoLSS to transfer its SSK hospitals to the MoH. Minister Akdag and his team therefore “managed-up” by requesting direct intervention by the prime minister to ensure the transfer of hospitals. After months of back-and-forth discussions between the MoH and MoLSS, “the prime minister personally called the Minister of Labor and Social Security to inform him that all SSK hospitals would be moved under the MoH virtually overnight.”

Beneficiary Politics (Managing Down)

For health policy implementation to be successful, the implementation team needs to consider how the new policy will change existing benefits. Some beneficiaries may see their benefits limited or decreased; others may see their benefits increase or improve. To implement a new health policy, it is important to build trust with new beneficiaries, solicit feedback from them, and sometimes mobilize them into action. Implementers may encounter situations where beneficiaries are not informed about the new benefits or are not interested in the new health policy, which may pose obstacles for enrollment. Another challenge is that beneficiaries’ opinions about the new health policy may be swayed by competing visions of other stakeholders. Effective, early and regular communication with beneficiaries can be essential to policy implementation.

Health systems have opportunities for engaging with beneficiary communities to improve the delivery of health services and achieve better health outcomes. Engagement with beneficiaries is important to drive implementation towards intermediate performance goals—quality, access, efficiency—and equity of the three ultimate goals: improved health, satisfaction, and financial protection. For this, beneficiaries may be encouraged to participate in planning meetings, in health committees; raise their needs and concerns; and collaborate with state actors in assessing implementation performance and problems. Feedback from beneficiaries is key to monitor implementation and adjust it along the way.

With adequate institutional incentives, community engagement can strengthen direct accountability relationships between the users of health services, the government and service providers to improve health outcomes. However, this requires adequate investment by the state, and usually, it requires more and not less investment. And sometimes it can require that other stakeholders (such as the central or state government) give up some power. National governments need to set up support and incentives to encourage service providers to recognize and respond to beneficiaries’ feedback and changing needs. Without such institutional arrangements, local officials may be incentivized to focus their attention upwards, towards their superiors, rather than downwards.

Digital technologies open new opportunities for beneficiary engagement. For example, social media, and mobile apps can serve as platforms for informing citizens on their rights and minimum service standards; accessing information; providing mechanisms to hold service providers accountable; raising awareness; or developing easily accessible complaint mechanisms. These technologies can help address collective action dilemmas by facilitating the mobilization and organization of beneficiaries.

Example 6 illustrates the case of patient navigators for the implementation of the Affordable Care Act in the United States. It shows how beneficiaries can be engaged to ensure policy implementation by creating a new role with the explicit responsibility of engaging with beneficiaries. “Navigators” are insurance brokers and/or non-profit groups that explain to the public just what exactly a “health exchange plan” is. The example also shows how implementation was made difficult through targeted efforts to undermine the implementation of the patient navigators program by certain states (and later the Trump administration), seeking to prevent people from being informed and engaged.

Example 6. Creating New Roles for Beneficiary Engagement: “Obamacare’s Navigators”

In 2010, the United States embarked on a comprehensive health care reform. The example of Obamacare’s “navigators” highlights how the government planned for “beneficiary engagement” to ensure successful implementation of the Affordable Care Act.

Previous experience with Medicaid, for example, showed the difficulty in getting people enrolled. The ACA’s success was said to depend on enrolling eligible people into plans. The position of “navigators” was created as the first contact point to explain to people how to apply, show available
insurance options, and guide consumers through the new system.\textsuperscript{36}

States were required to establish navigator programs through their health benefit exchanges, a marketplace where consumers purchase insurance. The Affordable Care Act provided 67 million USD in federal grant money to local community groups to hire navigators.\textsuperscript{37}

The implementation of this strategy to enroll beneficiaries confronted various challenges. Lack of funding, competing priorities, and the influence of interest groups made the navigator program a difficult one to run. In at least 17 states across the country, Republican legislatures and officials used bureaucratic roadblocks to stop the programs. They imposed high fees, background checks, tests, extra training, certifications, and threats of civil penalties to stop the program from running, and thereby obstruct implementation of the ACA.\textsuperscript{37}

Contact with health beneficiaries can also have political implications in LMICs. In China, for example, household visits to collect contributions for the New Cooperative Medical Scheme were used as a mechanism for social mobilization.\textsuperscript{38}

**Donor Politics (Managing Externally)**

Effectively implementing health policy in LMICs (especially in low-income countries) can involve managing external actors, including bilateral aid organizations, multilateral agencies, and international financial institutions, as well as external non-state actors (non-governmental organizations and private for-profit entities). The influence that donors can exert on national health policy processes due to the control over funding sources or perceived stronger technical expertise creates multiple challenges but also opportunities.\textsuperscript{38} Some of these challenges include overshadowing of countries’ existing programs, ignoring the capacities of national health systems, giving bad advice based on ideology or inappropriate experience in other countries, and derailing national priorities.\textsuperscript{39} For example, there is an ongoing debate, with mixed results from studies, about whether externally funded vertical programs (such as HIV treatment programs) strengthen or weaken the existing health systems.\textsuperscript{40}

Donor politics can also result in positive contributions to national health policy processes. Recently, there has been a trend towards reduced conditionality on funding and increased direct budgetary aid, to ensure that donor engagements contribute positively to national goals. For example, the Sector Wide Approach (SWAp) channels all significant donor funding for the sector to a single sector policy under government leadership.\textsuperscript{41} The SWAp approach (compared to the traditional project approach) is thought to increase health sector coordination, strengthen national ownership, and strengthen countrywide management and delivery systems. In Nepal, for example, all Global Fund grants are being captured within the health sector budget; subsequently, TB and malaria services were found to be well integrated into the public health-care delivery system.\textsuperscript{42} Countries can also leverage external actors to provide technical analyses to underpin reform efforts such as occurred for health reform in Turkey.\textsuperscript{43}

In example 7, we present the results of a study about the impact of donor funding for human resources for health (HRH) on health systems strengthening.\textsuperscript{39}

**Example 7. Donor Politics: Human Resources Funding and Health Systems Strengthening**\textsuperscript{39}

The Global Fund to Fight AIDS, Tuberculosis and Malaria (The Global Fund) is the largest external funder of human resources for health. Six countries included in this study were awarded a total of 47 grants amounting to $1.2 billion USD and human resources for health budgets of $276 million USD. The funds were invested in disease-focused in-service and short-term training activities. Bangladesh, Ethiopia, Indonesia, Malawi, Ukraine, and Honduras used the funds as salary top-ups, performance incentives, extra compensation and contracting of workers for part-time work, and to pay health workers.

The study found several challenges in the implementation of HRH policies due to donor politics.

Short-term approach: the majority of Global Fund-supported trainings were targeted at in-service, short-term activities. Due to national restrictions on the use of external funds, it was difficult to use Global Fund grants for direct salary support.

Sustainability concerns: In Ukraine, Bangladesh and Indonesia, there were no formal mechanism or plans in place to continue paying for the salaries that were funded by the Global Fund. Only in a few countries did the Ministries of Health develop plans to absorb the salaries of workers previously covered by the Global Fund.

Lack of coordination: minimal coordination occurred between Global Fund HRH activities and national HRH programs and strategies (except in Malawi). The lack of coordination with respect to training led to “duplication, excessive spending on in-service training, and inefficiency in HRH planning and activities.”\textsuperscript{39}

Policy makers need to manage donors to guarantee they contribute to implementation in a way that is consistent with national goals and likely to continue after external funds stop. Country ownership of the processes of implementation is important to guarantee efforts that external funds are aligned to meet national policy objectives. But the power dynamics of relationships with external donors can make it difficult for domestic priorities to win out.
CONCLUSIONS
Understanding the political dimensions of implementation can help those responsible for implementation to drive policy into practice more effectively. A political analysis of the position, power and interest of the stakeholders involved in health policy implementation helps to understand their role in promoting, resisting, or blocking implementation, and the dynamics of their interactions. The framework presented in this article is a tool to think ahead about the challenges in health policy implementation. As we have noted, however, the categories of stakeholders are not mutually exclusive, as illustrated by some of the examples, and not all categories may be relevant, depending on the context.

Understanding and addressing conflict, resistance and cooperation among stakeholders are key to managing the implementation process, but they are also important during the policy design and adoption phases. This framework, therefore, may have broader application beyond implementation. Systematic and continuous political analysis of stakeholders can help decision makers and high-level implementers improve the chances for successful policy design and implementation.

It is important to recognize that some challenges in implementation may be the result of poorly designed health policy, intentionally or unintentionally. For example, during elections, politicians may knowingly announce ambitious health policies that are not financially or administratively feasible (in the short or medium term). Some policies may be adopted for aspirational purposes and in order to drive budgetary or organizational changes that are necessary for implementation. But some implementation challenges cannot be solved at the implementation stage; some challenges may require re-designing the policy.

This article identifies the different challenges and provides examples of effective strategies to manage policy implementation for health policy. We need to expand on the strategies available to policy implementers to manage stakeholders who may resist or block implementation, and also add to strategies for managing those who support or promote implementation. The examples presented above could be expanded to include more political strategies available to policy implementers to address implementation obstacles, persuade or overpower opponents, and mobilize those in favor of policy implementation.

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ORCID
Michael R. Reich http://orcid.org/0000-0003-3338-0612

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DISCLOSURE OF POTENTIAL CONFLICTS OF INTEREST
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