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Review article

Reforming the health sector in developing countries: the central role of policy analysis

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Policy analysis is an established discipline in the industrialized world, yet its application to developing countries has been limited. The health sector in particular appears to have been neglected. This is surprising because there is a well recognized crisis in health systems, and prescriptions abound of *what* health policy reforms countries should introduce. However, little attention has been paid to *how* countries should carry out reforms, much less *who* is likely to favour or resist such policies.

This paper argues that much health policy wrongly focuses attention on the *content* of reform, and neglects the *actors* involved in policy reform (at the international, national and sub-national levels), the *processes* contingent on developing and implementing change and the *context* within which policy is developed. Focus on policy content diverts attention from understanding the processes which explain why desired policy outcomes fail to emerge. The paper is organized in 4 sections. The first sets the scene, demonstrating how the shift from consensus to conflict in health policy established the need for a greater emphasis on policy analysis. The second section explores what is meant by policy analysis. The third investigates what other disciplines have written that help to develop a framework of analysis. And the final section suggests how policy analysis can be used not only to analyze the policy process, but also to plan.

Introduction

Policy analysis is an established research and academic discipline in the industrialized world, yet its application to developing countries has been limited, and the health sector in particular appears to have been neglected.

This is all the more surprising because of the growing crisis in health systems. The initial optimism of the Primary Health Care (PHC) revolution of the late 1970s has been challenged by a number of trends: escalating costs but lower public health budgets because of economic recession; the emergence of AIDS; the increase in the number of large-scale and complex disasters; the prevalence of chronic diseases side by side with persisting communicable diseases; worsening inequities in access to services; demoralized health staff; emerging drug resistance to some diseases. In the face of severe economic constraints and shifts towards neo-liberal values, many countries have introduced structural adjustment programmes which have led to cuts in public health services, introduction of, or increased, charges for health care, and liberalization of the health sector to promote private sector development. The effects of such economic reform programmes have been harsh. Zimbabweans dubbed their Economic Structural Adjustment Programme (ESAP) the Extreme Suffering of the African People (Woodroffe 1993). Gains in health status achieved up to the 1970s are being eroded, and evidence is growing of the negative effects of health reforms on health status, especially on the vulnerable (Kanji and Jazdowska 1993; Messkoub 1992; Pinstrup-Anderson 1993).

This crisis in health is well recognized and prescriptions of *what* countries should do abound (for example in the World Bank's *World Development Report 1993: Investing in Health*). However, there is very little attention to *how* countries should carry out reforms, much less *who* is likely to favour or resist such policies. Just as the primary health care approach foundered by concentrating on content (the introduction of voluntary community health worker programmes) rather than process (how communities would be encouraged to support such workers), so recent health reforms are likely to fail because it is expected that policies will be implemented as planned without taking into consideration factors that affect implementation.

This paper argues that much health policy wrongly focuses attention on the *content* of reform, and neglects the *actors* involved in policy reform (at the international, national and subnational levels), the *processes* contingent on developing and implementing change and the *context* within which policy is developed (Figure 1). Focus on policy content diverts attention from understanding the processes which explain why desired policy outcomes fail to emerge. As Reich (1994a) has argued, policy reform is a profoundly political process, affecting the origins, formulation and implementation of policy. Policy-makers, whether politicians or bureaucrats, are acutely aware that reforms are often unpopular and can cause significant social instability. They may be reluctant to push through reforms, even when part of loan agreements. The World Bank admits that only 55% of conditions in structural adjustment loan agreements have been fully implemented when the final tranche of funds is released (Clapp 1994; 307).

New paradigms of thinking urgently need to be applied to the health sector, to understand the factors influencing the effectiveness of policy change. This approach has already been advocated for the fields of development and economic policy, by scholars questioning conventional and received wisdom about the role of the state (Mackintosh 1992), and the role of external donors (White 1990). Manor (1991; 6) has argued the need for 'thick description' rather than 'parsimonious models'. We argue that the same challenge exists for health, because the context within which health policy is formulated and implemented has changed. From a policy domain characterized primarily by consensus, health policy is increasingly subject to conflict and uncertainty, and this change calls for alternative ways of thinking about policy. We argue that

- policy analysis offers a more comprehensive framework for thinking about health reform than approaches which concentrate on the technical features of the content of reform;

- literature from political economy and other disciplines offers insights to the way policy analysis could be applied in the health sector;

- by using a simple analytical model (Figure 1) which incorporates the concepts of context, process, and actors as well as content, policy-makers and researchers will be able to understand better the process of health policy reform, and to plan for more effective implementation. The model

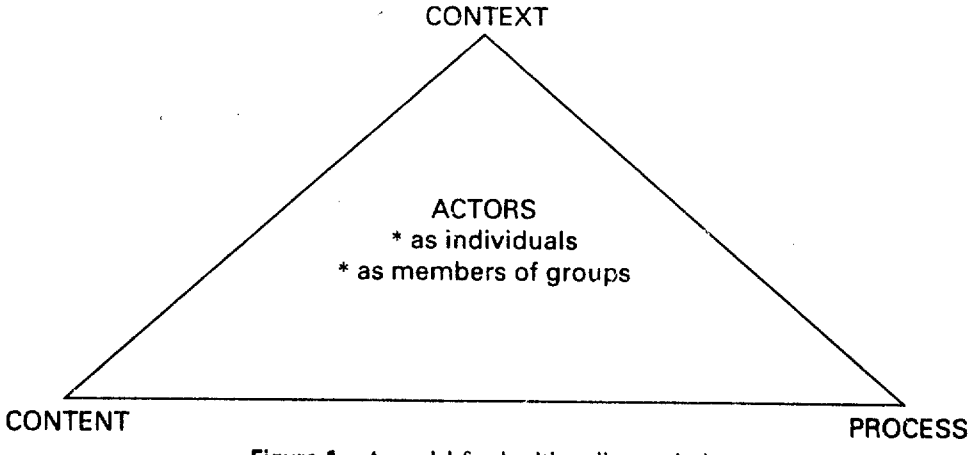

Figure 1. A model for health policy analysis

can thus be used both retrospectively and prospectively.

This is a highly simplified model of an extremely complex set of interrelationships, and gives the impression that each can be considered separately. In reality actors are influenced (as individuals and as members of interest groups or professional associations) by the context within which they live and work, at both the macro-government level and the micro-institutional level. Context is affected by many factors such as instability or uncertainty created by changes in political regime or war; by neo-liberal or socialist ideology; by historical experience and culture.[2] The process of policy-making (how issues get on to the policy agenda, how they fare once there) in turn is affected by actors, their position in power structures, their own values and expectations. And the content of policy will reflect some or all of the above dimensions. In other words, we argue that the traditional focus on the content of policy neglects the other dimensions of process, actors and context which can make the difference between effective and ineffective policy choice and implementation.

This paper is organized in 4 sections. The first sets the scene, demonstrating how the shift from consensus to conflict in health policy established the need for a greater emphasis on policy analysis. The second section explores what is meant by policy analysis. The third investigates what other disciplines have written that help to develop a framework of analysis. And the final section suggests how policy analysis can be used not only to analyze the policy process, but also to plan.

The shift from consensus to conflict in health policy

A changing development context

The scope and scale of political and economic change in the late 1980s and 1990s has been dramatic, and has led to significant political and economic policy reforms which have also influenced sectors such as health.

In the 1950s and 1960s state directed development was part of the intellectual environment of the time (Sen 1983). It was justified through economic analysis that identified market mechanisms as being inadequate in developing countries (Chowdhury and Kirkpatrick 1994; 1), legitimizing governments' role in intervening to correct market imperfections through public sector investment. It also fitted well with the interests of political rulers allowing them to establish or consolidate loyalty through extending state enterprises or bureaucracies. And in this period international aid expanded to support the state.

The return to classical economic theory – the neo-liberalism of the 1980s – was a reaction partly to positive economic growth and development in Asia (where many governments had promoted neo-liberal policies); partly to the growth of what came to be seen as over-extended and weak public sectors in some developing countries; and partly to the recognition that government preferences expressed through policies did not unambiguously promote the interests of their populations. Indebtedness, instability and, above all, inefficiency were perceived as failures in economic policy.

From the 1980s many actors played a part in expressing dissatisfaction with the state. From many different disciplines and positions writers complained of the 'self-deceiving state' (Chambers 1992) or 'the unequal state' (Bayart 1993). In central and eastern Europe people took to the streets to overturn the state in 1989. And the international financial institutions, such as the World Bank and IMF, became impatient with what were perceived to be authoritarian developing country governments. Given their central role in debt rescheduling and new loan agreements, these agencies were able to introduce significant conditions in the form of structural adjustment programmes which demanded political reforms (e.g. retraction of the civil service, introduction of multi-party elections) as well as economic reforms (e.g. trade liberalization, removal of subsidies). Economic adjustment programmes affected the health sector through cuts in budgets, promotion of the private sector, and the introduction of user charges for health services.

The tendency of those advocating policy reforms was to perceive them as technical: international experts negotiated reform programmes with national policy-makers. Although many agreed

that some reform was necessary (despite fierce debates about scope, timing and conditions), the focus on the content of reform neglected important factors such as varying political cultures and institutions, the influence of ideologies or schools of thought, and historical traditions.[3]

From the late 1980s economists and political scientists argued that complex economic reforms which had immediate and major distributional (and often drastic) effects on populations, and where benefits were long term (and major doubts existed on the extent of benefit), could not be treated as technical policies that would be automatically implemented. National policy-makers and scholars increasingly criticized technocratic approaches. Lindenberg (1989; 359) quotes an anonymous policy-maker saying

> 'Often these people who come here from international organizations to preach the gospel of stabilization and structural adjustment know as much about the political and economic consequences of what they are proposing as the medicine men who used to prescribe leeches to correct imbalances in the four humours of their patients.'

Herbst (1990) argued that structural adjustment programmes that demanded major curtailment of public enterprises in Africa did not recognize that such enterprises had been an important source of reward and patronage to African leaders for decades. Reducing their activities threatened important constituencies and could lead to weak implementation or make the state much less flexible in dealing with crises. In similar vein, Haggard and Webb (1993) observed that structural adjustment programmes were undermined by their tendency to ignore the institutional characteristics of the political system, the internal and external economy, and the design of reform programmes.

A changing health context

The changing political economy had repercussions for health policy and facilitated the idea of reforming the health sector. During the period when the state played a strong central development role, health policy had been decided largely on consensual grounds, partly because it was controlled by a medical elite. During this period health policies were largely uncontroversial, received broad (if passive) support from the population, and appeared as 'low politics'[4] issues on the political agenda. They were almost entirely concerned with the *content* of policy (e.g. how to improve access and coverage, how to increase efficiency in the use of hospital beds), and reforms were largely limited to organizational questions regarding health systems (e.g. the relationship between different levels of health service – tertiary, secondary and primary).

In the 1980s, however, as neo-liberal ideas began to dominate, health policies moved into a policy arena in which previously accepted values were challenged (e.g. by calls for 'cost sharing' and the promotion of private health care providers). A context in which market values dominate leaves little room for morality, values and feelings, and may undermine and destroy previously accepted, socially constructed concepts of public purpose, public morality and public accountability (Wuyts et al. 1992). Debates about health policy were increasingly characterized by conflict, making them, relative to previous decades, 'high politics' agenda items. This conflict inevitably generated considerable uncertainty around appropriate policy choice.

How did the change from consensus to conflict occur? The period of consensus was largely derived from a relatively restricted policy field dominated by medicine. From the 1940s to the mid 1970s health policy was fuelled by tremendous confidence in medical science. Sulphonamides, penicillin and broad spectrum antibiotics provided the tools to challenge disease. The synthesis of DDT and its application to control malaria, vaccines against infectious diseases, the advent of the oral contraceptive, all strengthened professional monopoly and lay beliefs that medicine had the answers: health policy-makers had merely to decide how to manage and organize health services to make them accessible, available, acceptable and affordable.

The domination of health policy by medical professionals was repeated in international circles. From the 1950s international and bilateral agencies became more involved in health, and established their credibility by conquering yaws, eradicating smallpox and (more controversially) helping to control malaria. They provided

technical expertise and funds for various programmes in health, including family planning.

However, by the late 1960s the medical paradigm was increasingly challenged from both within and outside the profession. Past policy which had emphasized disease treatment in centres of excellence was questioned by historians, epidemiologists and economists, who showed that much illness was poverty related (Abel-Smith and Leiserson 1978), that drugs which had appeared to be 'magic bullets' had many unintended consequences (Illich 1975), and that teaching hospitals served a small proportion of the population but swallowed large proportions of the health budget (King 1966). Social scientists increasingly encroached on the policy domain of medical professionals, raising questions about the effects of culture on health behaviour and the relative costs of different health care activities among other things.

The launching of the primary health care approach in 1978 reflected the thinking of these different groups, and expanded the health policy arena to include many other groups than medical professionals. The loss of professional monopoly opened the way for conflict in policy debates. This was manifest in global level debates about comprehensive versus selective care (Rifkin and Walt 1988), in the battle to get an international code on breastmilk substitutes and over establishing an essential drugs programme (Walt 1993).

However, even though the notion of 'political will' introduced in the Alma Ata policy document on Primary Health Care acknowledged the role of politics and conflict in health policy, it was never conceptually developed (with a few recent exceptions such as Reich 1994b; Whitehead 1990), and had little effect on donor-supported health policies implemented in many low income countries. These continued to be largely technical, vertically-organized programmes such as immunization against 6 childhood infectious diseases and control of diarrhoeal disease. Even national primary health care policies were often interpreted narrowly and expediently as vertical programmes within ministries of health (Decosas 1990), or as synonomous with community health worker programmes or expansion of rural health infrastructures (Walt 1990).

Neo-liberal policies introduced new tensions into the health policy domain. In the industrialized world there was increasing emphasis on cost containment and efficiency improvement, leading to concepts of the internal market and separation between providers and purchasers, and a controversial emphasis on the virtues of competition. Managers and economists increasingly intervened in areas previously controlled by professionals. In the developing world donors and financial institutions laid down neo-liberal conditions for debt servicing and loan agreements: these included a reduced role for the public sector, the introduction, or raising, of fees for consultations, drugs and admission to hospital, and reductions in the regulation of the private sector.

The shift from consensus to conflict in health policy served to heighten awareness about the failure of past policies. For example, by the late 1980s many aid agencies were admitting that years of experience in primary health care had shown that technical solutions, while often necessary, were not sufficient to sustain policy outcomes, especially in poorer countries. While infant mortality rates had decreased and coverage of immunization had increased in many countries, those gains came at the same time as growing social inequalities, poor quality of care, and worsening living conditions. It had become clear that the effectiveness of programmes was influenced by values and culture (both national and international), accountability, morale, and communication, among other things, but that such factors had been neglected in the belief that better techniques or technologies could by themselves tackle the causes of ill-health (Cutts 1994; Nabarro and Chinnock 1988; Heggenhougen and Clements 1987).

Looking for new policy solutions, donors promoted decentralization policies to remove control from central, distant state authorities; service delivery through non-government organizations which were perceived to be closer to local communities and which might instil a greater sense of democracy; and 'good governance' which included reform within smaller bureaucracies (performance related pay, greater flexi-

bility in recruitment and dismissal) and greater accountability.

In so doing, however, two issues were raised. One related to sovereignty, accountability and unequal power relations. Put baldly, national governments wanted loans or grants from international organizations, but received them only if they agreed to impose economic reforms. For some this reflected conditionality without responsibility (Cliff 1993). However, international agencies were themselves accountable to their own constituencies, and have been affected in some countries by scepticism expressed about the role of aid and the value of technical assistance and cooperation (Bauer 1981; Hancock 1989). Also international agencies are themselves actors of great variation; multilateral, bilateral and non-government organizations are fuelled by different goals and values. Bollini and Reich (1994), for example, differentiate between 'internationally minded' and 'nationally minded' agencies.

The other issue related to a lack of understanding of the policy process: there were huge gaps in knowledge about how bureaucracies worked or how policy-makers responded to pressure. While concerns with 'good government' demanded understanding about bureaucratic culture and decision-making processes, this knowledge was fragmented and partial. It was unclear how far implementation of reforms would be influenced by domestic policy processes given the lack of information about institutional development and how organizational and administrative systems worked. For example, while there was force behind the arguments for greater effectiveness and efficiency, there was little understanding about how this would occur in a contracting rather than an expanding economy. As Cumper (1993) argued, health planning had always been based on assumed growth, and the knowledge and techniques for originating and implementing change in contracting health systems was missing. Introducing competition, whether through internal markets, as in the UK, or through non-governmental organizations in developing countries, raised major questions about the conditions for success for which there were no answers (Broomberg 1994).

In this policy environment ideological certainty expressed through policy documents such as the *World Development Report 1993: Investing in Health* appears a great deal more robust than it is (Reich 1994a). And because of this there is a nascent acceptance that new analytic approaches are needed which offer a better understanding and more complete explanation of the policy environment. We argue that our framework for policy analysis offers such an approach.

What is policy analysis?

Policy analysis draws on concepts from a number of disciplines: economics, political science, sociology, public administration and history, and emerged as a subdiscipline in the late 1960s, mainly in the United States. It is variously defined by different scholars, comes in many guises, and offers a confusing heterogeneity of different theories ranging from highly prescriptive to descriptive (Heclo 1972).

Most policy analysis focuses on the policy process. Dror (1993; 4), for example, defines policy analysis as 'approaches, methods, methodologies and techniques for improving discrete policy decisions'. Similarly, Paul et al. (1989; 1) define policy analysis as 'the task of analyzing and evaluating public policy options in the context of given goals for choice by policymakers or other relevant actors'. The implication in these definitions of policy analysis is that policy-makers are concerned largely with the content of policy, are intendedly rational, and need to have particular skills to make proper choices among well-defined policy alternatives in the furtherance of complex but compatible goals.

These approaches are similar to those characterized by the incrementalist or rational schools of policy-making. The classical proponent of the first approach is Lindblom (1959), who is concerned with analyzing what happens in organizations or what happened in a particular decision. His is a descriptive approach which argues in favour of incrementalism and acknowledges a process of bargaining between different interest groups in the process of policy-making. The rational approach is more abstract, and deals with values and how policy-making *should* be undertaken. It offers a prescriptive and 'ideal model' of how policy-making ought to be undertaken, providing a way of improving the

effectiveness of policy-making by explicitly identifying values and goals before making policy choices and selecting the best policy options based on comprehensive information about the costs and consequences of each (Simon 1957).

These approaches centre their analysis on policy-making, although Lindblom emphasizes the role of actors as partisans in the policy process. Our approach to policy analysis goes further because, while it is concerned with the processes of policy-making, it is also centrally concerned with the behaviour of actors in formulating and implementing policy *and* the context within which policies are promulgated (Figure 1). It offers a much broader framework for thinking about health policy. In adopting this model we argue that policy is not simply about prescription or description, and nor does it develop in a social vacuum; it is the outcome of complex social, political and economic interactions.

Our model of policy analysis is thus nearer to political economy approaches, which also draw on the concepts of several disciplines but have been dominated by economics and politics. Recent political economy theorizing has been driven largely by a concern to explain the processes related to formulation and implementation of structural adjustment programmes in low income countries. The richest analyses have been provided by development theorists, economists and political scientists. What have these approaches to offer health policy analysis?

What can be learned from other disciplines?

Economics has made a major contribution to health policy over the past two decades. From the late 1960s policy-makers increasingly turned to economists for analysis of health care costs and health service financing options. Within a decade growing numbers of health economists were to be found in academic institutions, international organizations, ministries of health; they dominated health services research and health policy discussions. Economics plays an important part in appraising options in policy-making, helping policy-makers to make choices on the basis of efficiency and equity. Partly because of its central concern with the allocation of scarce resources and partly because it deals with measurable effects, economics has increasingly been seen to offer valuable techniques for policy making (Sharpe 1977).

However, while few would deny the usefulness of economics as one of the tools for policy choice, like any discipline, it has its limitations. Green (1990; 274) has argued for example, that there is a danger that economists may be seen as 'neutral technocrats, harbingers of rationality and conveyors of objectivity', although they are, as any other actors, fuelled by particular values which may or may not be articulated (or even recognized) explicitly. Fuchs (1993) gives three examples that illustrate the limitations of economics in health policy. The first is that economics is a general method or way of thinking, but does not necessarily offer solutions for health policy-makers because of the peculiarities of the health care market. For example, in most industries where there is excess capacity prices fall sharply and some firms are forced out of business. But in the health care markets of the USA there are excess supplies of hospital beds, high technology and certain surgical and medical specialists, while charges and fees remain high.

Fuch's second example is in the social and political domain: while economics helps to understand how health care costs are higher in the USA than in Canada or Germany, economics does not explain 'Canada's superior political capacity to enact and administer universal health insurance' or the greater willingness of Germans to obey centrally established rules for health expenditure. And finally, Fuchs's third limit relates to the importance of values in health policy. Conflicts over values are particularly stark in the health policy arena: for example, should advanced medical technologies be made available to all, in spite of cost, or should funds be spent on public health and the prevention of disease? Economics cannot provide guidance on which value system to favour in policy-making.

Economists themselves have increasingly recognized the need to enrich their focus and methods of enquiry with conceptual tools from other disciplines, and it is to policy and political analysis they have turned (Healey and Robinson 1992; Meier 1993).

> 'Economists are trained in the study of the operation of economic forces within political, social and moral constraints. This approach has to be supplemented (and in some cases replaced) by the study of the operation and manipulation of political, social and psychological forces within economic limits. More fundamentally, the distinction between economic and noneconomic variables may not be tenable if the aim is to understand society.' (Streeten 1993; 1286)

Development theorists have similarly re-appraised old relationships between economic growth and development, highlighting the need for different modes of analysis (Manor 1991; Chambers 1992).

Thus economists have joined with political scientists, sociologists and anthropologists to provide a better understanding of the *political environment* within which policies are decided and executed. Much of the impetus for this resurrection of the tenets of political economy was stimulated by the introduction of economic reforms through structural adjustment programmes. Initial debates revolved around the benefits and disbenefits of economic adjustment, and were concerned with timing, scale, and debates about short and long term effectiveness (Cornia et al. 1987; Mosley et al. 1991; Parfitt 1993; Stewart 1991). In other words, they were concerned with the content of structural adjustment programmes.

By the end of the 1980s, however, a number of writers were pointing to the poverty of this approach. Elliott (1988) argued that the prescriptions of structural adjustment programmes in Africa assumed that reforms would be accepted and implemented through a process of policy dialogue and that this was naive. Policy reformers did not sufficiently consider the political culture of African countries and it was the political culture that would ensure that reforms failed. Nelson (1990) and Haggard and Kaufman (1992) also argued that economic analyses world-wide had neglected the political dimensions, and without an understanding of the process of policy (and, for example, the risks political leaders were being asked to take), policy failure was likely. An analysis of economic development experience in Africa demonstrated that the continent's comparatively poor performance could have been predicted had analysis taken more account of political science concepts of the state, personal rule, history and social structure (ODI 1992).

The argument that politics and economics could not be separated in analyzing economic policy reform was captured in Lindenberg's description of 'two-legged' governments:

> 'One leg is economic, consisting of all the national economic strategies designed to improve the well being of the population. The other leg is political, because economic strategies rarely endure unless they are also politically feasible. Problems with either leg can cause a government to stumble. Poorly conceived economic strategy can result in undue national hardship. Popular reaction to ill conceived policies is sometimes strong enough to bring governments down. Similarly, politically expedient policies can keep rulers in power in the short term at the expense of national bankruptcy, increased human misery and eventual public outrage.' (1989; 359)

The implication of the thinking of all these scholars was that had policy reformers perceived governments as two-legged when they introduced structural adjustment policies, the much criticized prescriptive manner of introducing and enforcing reforms might have been avoided, and implementation tailored more to the needs of individual countries.

Many writing in the political economy field take a dynamic approach to policy analysis, believing that if policy analysis *precedes* policy choice, the chances of more effective implementation are greater. 'Policy analysis matters because it helps us to act effectively' (Wuyts 1992; 285). This position is arrived at through the development of explanatory frameworks of relationships between state and society, political actors such as governments, foreign donors and interest groups, which draw on historical, cultural and sociological concepts to add depth to explanation. While all start with the premise that political factors are a feature of all policy analysis, they offer a wide variety of approaches and frameworks. Some however, focus more on

the *macro-political context* of policy-making, and others on the *actors* involved in policy-making, although inevitably there is a great deal of overlap.

Focusing on context

Many policy analysts are concerned to make explicit the macro, contextual factors that influence policy. Their central concern is with the state and its role in economic policy reform. However they write from different perspectives.

One of the dominant questions has been about the rightful role of the state. This debate underlies all policy analysis, viewing the state *either* as having a central role in policy-making, *or* as having an increasingly marginal role. Mackintosh (1992) reviews the political and theoretical critiques of the state. The 'public interest' view of the state, which underpinned early development theory, was challenged by two critiques: the Marxist critics who saw the state as ruled by class and power relations (suggesting the state was not a disinterested institution promoting the public interest, but one exercising power in favour of dominant classes); and the 'private interest' (or public choice) theorists, who argued that the state was made up of self-interested bureaucrats and politicians who, in their search for power, would be forced to respond to majority views. This view of the state provided the rationale for reductions in the role of government and increased competition between state structures.

Mackintosh's clear analysis shows that whilst Marxist and 'private interest' analyses have some similarities, they cannot necessarily be reconciled with the 'public interest' view of the state. 'Reform of the state on a market model conflicts with reform which seeks to strengthen the state as a vehicle of social solidarity' (Mackintosh 1992; 89). Others have also criticized the 'private interest' or public choice theorists. Toye (1993; 135-6), for example, accuses them of displaying a 'profoundly cynical view of the state in developing countries', suggesting that 'to attribute individual self-interest as their exclusive motive to politicians in developing countries is to deny their sincerity, their merit and, ultimately, their legitimate right to govern'.

While many policy analysts accept the need for reform of the state, most perceive that the state must continue to have a central role in policy-making. Streeten (1993) emphasizes the role of state intervention in assisting markets to work better, not simply favouring the already powerful groups. Perkins and Roemer (1991) also observe that the state cannot be treated simply as an impediment to the proper functioning of free markets - the real debate is not so much whether the state should be involved but how state intervention should be handled. Klitgaard (1991b) argues that policy analysts need to go beyond the 'state versus market' arguments, challenging them to make both the market and the state work better.

Others have characterized the state as weak or strong, and looked for factors which helped to provide political explanations for patterns of policy. Whitehead (1990), for example, surveys 8 overlapping factors which provide explanations for differences in macroeconomic management of change in developing countries. He suggests that it should be possible to synthesize these 8 factors, identify whether states are strong or weak, and then analyze what this would mean for the speed, flexibility and likely effectiveness of various policy options. The factors Whitehead identifies as important to consider in policy analysis are: historical traditions (colonialism, independence, experience of war); socio-structural determinants (social class, ethnic and religious divisions); the self-interest of politically powerful sectors (the position of ruling elites); entrenched characteristics of the political system (democratic experience); formal properties of the political institutions (regulation of state power, authority and accountability); the influence of particular economic ideologies or schools of thought (neo-liberalism); the logic of particular sequential processes of the 'vicious circle' (growing inflation leads to speculation, high interest rates, hoarding) against the 'virtuous circle' (price stability causes prices to fall, wages to stabilize, confidence to return); and a variety of *ad hoc* or conjunctural considerations (such as accidents of good or bad timing).

Migdal (1988) also attempts to characterize states as weak or strong, but juxtaposes them against 'society', arguing that many low income countries have weak states and strong societies, which explains the partial or failed implementation of many policies. According to this view, the state

this century has had a tenuous hold on society which is why it often falls back on the military. Other institutions - religious, caste, tribe or family - have kept these societies together. Consequently, the capacity of the state to intervene effectively has always been weak. Hinnebusch (1993) has used the notion of strong and weak state and society to explain the politics of economic reform in Egypt, suggesting that the balance of power between state and society affects the policy process. For example, when there is a strong state and a strong society, he suggests there is likely to be a balance of power between the two, and therefore considerable consensus on reform. With a weak state and weak society there is little strength to reform, and unresolved problems increase the state's vulnerability to external forces, so that reform is imposed.

Writers concerned with the context of policy-making do not only focus on the state. Some are concerned with culture, and the extent to which cultural factors pervade the policy environment. Hyden (1983), for example, has argued that cultural factors are an important part of the policy context, influencing political behaviour. His description of an African 'economy of affection' explores traditional obligations at all levels of society, and illustrates how these lead to contradictory expectations of those in all levels of public office (obligations to family versus the promotion of national interest, for example). Liddle (1992; 797) argues that in Indonesian political culture the pervasive notion of *ke-Timuran* or 'Eastern-ness' must be taken into account in considering the policy environment:

> '*Ke-Timuran* has to do with the attitudes necessary to the maintenance of a harmonious society. It contains such ideas as respect for the views of others in general, deference to elders and to authority in particular, a notion that differences of opinion should be expressed privately and nonconfrontationally.'

Focusing on actors

For many writers concerned with policy analysis, the key determinant of policy change is the group of actors involved, and the focus is often on government. Lindenberg (1989), for example, reviews how the governments of Panama, Costa Rica and Guatemala managed support and opposition to their stabilization and structural adjustment policies in the mid-1980s. He concludes his analysis with a set of initial lessons which could help other governments manage the 'winners and losers during the process of economic change', although he points out these are not blueprints given each country's unique history and policy environment. In his analysis of adjustment policies in three African countries Toye (1992) concludes that the World Bank did not sufficiently take into consideration the vested interests of government leaders and rich farmers in the agricultural sector, and as a result, efforts to reform the economy faltered.

Attempting to answer the question 'Who makes economic policy in Africa?', Gulhati (1990) suggests national policy-makers are influenced by four political variables: political trends in the country, and especially the character of the ruler (he divides rulers into 'princes', autocrats, prophets and tyrants); social stratification (class, ethnic and regional loyalties); foreign donors and investors; and the size and quality of the civil service. These variables (some of which overlap with Whitehead's) focus on the actors within each category, and attempt to provide an overview of the political culture of the country. Gulhati goes on to identify points of intervention in the resulting policy environment if reforms are to be successful.

In reviewing Whitehead and Gulhati's papers, Bery (1990) suggests that both frameworks, while not that useful for national policy-makers, offer outsiders, such as donors, a way of assessing the probability of success of a particular reform effort. Perhaps because he is focusing on Africa, and Whitehead's examples are more from Latin America, Gulhati accords donors far greater influence in shaping national decisions; he also shows more concern than Whitehead for the extent to which the civil service affects the execution of policies.

Attention on the civil service is argued to be important because of the strategic roles bureaucrats play in the implementation of reforms. Some have sought to understand the influence of actors by focusing on the relationship between politicians and bureaucrats. Brown (1989), Mukan-

dala (1992) and Panday (1989) for example, argue that in Liberia, Tanzania and Nepal respectively bureaucrats have played a relatively insignificant role in the policy process, largely because of the dominance of politicians (and in Nepal the Royal Palace).[5] In contrast, Koehn (1983) has argued that Nigeria has seen so many changes of mainly military government that civil servants have controlled policy-making through their greater expertise and continuity. Charlton (1991) likewise suggests that in comparison with politicians, civil servants in Botswana played a particularly important role at independence, although the balance of power between politicians and bureaucrats changed over time. Gulhati (1991) observes that the failure to build consensus between officials and politicians on the need for reform in Zambia (and the fact that the reform measures were largely developed outside Zambia by the IMF, World Bank and foreign consultants) was one of the reasons for that country's economic impasse during the 1980s.

A few writers are concerned with societal actors, rather than policy elites within government (Ghai 1992). Tironi and Lagos (1991), for example, argue that structural adjustment policies in Latin America are bringing about profound changes in the social structure of those countries implementing them. They suggest a number of factors (the strength of the government and its administration, the dependence on multilateral financial agencies, the will and capacity of social actors to resist) will determine whether structural adjustment policies are implemented by shock measures or more gradually. They place particular emphasis on the roles of trade unions and the business community, and on marginal social groups as well as political parties and the state, exploring their relative influence on the constellation of factors that influence policy.

In his review of development policy as a process, Wuyts (1992; 283) argues that the public cannot be separated from the state: 'State institutions are influenced by public action, and in turn, provide the means through which this action is sustained or modified.' He argues that public action is not simply an additional factor in analyzing the state's role in the policy process, but is an integral part. Hyden and Karlstrom (1993; 1402) also emphasize the complexity of policy environments and interaction of actors within them:

> 'a narrow focus on the inherent values of specific policy instruments or on the presumed interests of various policy actors at a certain time is not enough. What needs to be added is a longitudinal dimension that helps us understand how various actors interact with each other on specific issues and with what outcomes.'

Liddle (1992) writes from the development (rather than economic) perspective, arguing that theories of the causes of development in the Third World have paid too little attention to policy, and are too concerned with generalization. The tendency to formulate global assessments and prescriptions in development is taken up by Uphoff (1992) who proposes an approach which 'particularizes' and disaggregates. Long and Van der Ploeg (1989) also criticize development theories for espousing rather general, mechanical models of the relationship between policy, implementation and outcomes. They take an actor perspective that starts with individuals and their households rather than with political elites in government, and argue in favour of deconstructing the process of policy implementation, looking more closely at how interventions 'enter the life worlds of the individuals and groups affected and thus come to form part of the resources and constraints of the social strategies they develop' (1989; 228).

To sum up, the papers reviewed above represent a number of publications which have appeared over the past few years which are concerned with the effects of policy. Basic to their argument is the fact that policy outcomes can only be understood within a historical context, and by identifying the different actors who may have influenced policy. However, few scholars look explicitly at the *process* of policy-making, Grindle and Thomas (1991) being the most important exception to this observation. Partly this is because each analyst comes from a different perspective or central concern, ranging from macro-political views of the state and state-societal relations, to micro-political views of how policies affect and are influenced by individuals and households. The literature is therefore diffuse and rich in its diversity and complexity, but lacks consistency and rigor.

Focus on processes

Very few of the papers described above do more than touch on the processes of policy-making: they are more concerned with explaining contextual factors or the behaviour of actors. What Grindle and Thomas (1991) provide is an analytical framework which incorporates processes to help understand how public policy is made, and who influences it. Their approach is mostly derived from economic policy reform, although they give one example of health sector reform in Mali. They focus on actors (policy elites who are largely perceived as key politicians and bureaucrats) and processes of agenda setting, decision making and implementing reform. While principally analytic, they try to map out a process and identify critical factors that affect the policy outcomes of reform initiatives, believing that this approach can help to influence the process of reform as well as to understand it. They compare the policy process in circumstances of crisis as well as routine or 'politics-as-usual', take into consideration the likely responses to particular policies (support and resistance, where it arises, and its relative strengths), the resources needed for implementation, and include judgements about enabling or constraining contexts.

Their analysis focuses on the overlapping boundaries of state and society, and although they somewhat neglect the role of vested interests and interest groups, the framework they offer is unusual because they integrate explicitly context, actors and processes of policy-making.

Health policy analysis

As has been shown, economic reform led to a spate of papers arguing that more attention should be focused on the policy environment. The result has been a valuable outgrowth of approaches, rich in diversity and explanation. However, it has hardly touched the health sector. Although health reform has paralleled economic reform in many developing countries (not to mention the industrialized world), little interest has been shown in the policy environment. In the mid-1980s Abel-Smith, for example, drew attention to the world economic crisis and its repercussions on health, demonstrating the drastic effects of recession. Structural adjustment programmes were alluded to (in terms of government cut-backs in the health sector), but the focus was on economics and not politics (Abel-Smith 1986). A few exceptions to this focus stand out. Analysis of health sector reforms in Chad and in Niger explored some of the political and economic factors that explained partial or slow implementation of reforms (Foltz 1994; Foltz and Foltz 1991). Bennett and Tangcharoensathien (1994) analyzed the context and processes of policy change encouraging the growth of private health care in Thailand, drawing on Grindle and Thomas' analytical framework. Dahlgren (1990) and Mwabu (1993) evaluate the process of introducing charges into the Kenyan health sector; Reich explored pharmaceutical policies in a number of countries using a political economy perspective (1994a).

These papers suggest that health reform is not easy, is subject to considerable external influences (external to the health sector as well as to the country) and is often resisted. A review of health sector reforms in 4 countries in Africa supported by non-project aid from the US Agency for International Development, concludes that evaluation of a number of experiences suggests that

> 'the completion of health sector reforms is more difficult than that of reform in other sectors.' (Donaldson 1993; 13)

Some of the reasons why the health sector may differ from the economic sector may lie in such factors as the peculiarities of the health care market, the status of health professionals, conflicts over values about coverage, access to high technology, and control over the quality of life.

While there is a lack of policy analysis on health reform in developing countries (as described above), there is a sparse literature which is concerned with actors and their roles in health policy-making, and with political economy approaches to health.

Ugalde (1978) focused on policy-making in the health sector in Colombia and Iran, showing that not only did medical professionals and their values dominate the policy process, but that policy-making was limited to a tight circle of top elites, especially in Iran but also in Colombia. Ugalde suggests that international donors

perpetuated this under-developed system of demand articulation in spite of rhetoric about community participation. The strong position of a small elite of health professionals in influencing health policy was also apparent in Mozambique after independence (Walt and Cliff 1986) and the authors suggest that exogenous factors such as war and structural adjustment agreements (negotiations with the IMF and World Bank began in 1985) combined to change the thrust of health policy.

Many of those writing about health policy in developing countries have been concerned about the extent to which national health policy making has been undermined since the 1980s by dependence on donors. In some countries in Africa between 60–70% of the government health budget is provided from external sources. A few case studies have explored directly how far donors are influencing health policy in particular countries (Okuonzi and Macrae 1994; Cliff 1993; Cliff et al. 1986; Linsenmeyer 1989), and others have looked at donor influence as part of the health policy arena both within less developed countries (Justice 1986) and from inside the agencies (Gerein 1986). Emerging global interdependence is also a major concern in the analysis of the increase in violence and complex, large-scale disasters (Duffield 1994). The impact of political violence on health and health services has been described as a public health issue by Zwi and Ugalde (1991) and its lasting impact on 'post'-conflict societies is illustrated by Macrae, Zwi and Birungi (1994). Duffield (1994) suggests that aid agencies have often depoliticized policy by reducing it to a technical matter of organization or good practice, and argues strongly that policy must be premised on the centrality of indigenous political relations and not imposed from outside.

There are a few political economy approaches to analyzing health policy. One of the earliest historical overviews of how political and economic systems affected the development of health care is Doyal's *Political Economy of Health* (1979). Turshen (1984) used a similar analytical approach to describe how disease experiences changed with colonial history in Tanzania, and how politics has affected public health issues (Turshen 1989). A more recent and useful review on the political economy of health transitions is provided by Reich (1994b), who distinguishes between two approaches: the government intervention school, which sees a place for public sector control over the free market, and the neo-liberal or market forces school, which rejects government intervention and looks to the private sector for advances in health policy. Morgan (1993) also takes a political economy approach in looking at community participation in health in Costa Rica. Stock and Anyinam (1992) conclude that health services have not been greatly influenced by ideology in Africa, but as neo-liberal reforms begin to bite this conclusion may be challenged. Kalumba and Freund (1989) suggest that revelations of social discrepancies within and between regions led to the eclipse of idealism in Zambia in the late 1980s.

The growth of global interdependence has highlighted the role of international and bilateral agencies in health, and their relationships with national policy-making. A critique of WHO's Health for All advocacy by Navarro (1984) explored the relationship between global political rhetoric and power. A number of international relations scholars have examined policy-making in international agencies: Sikkink (1986) looked at the agenda setting role of UNICEF and WHO in relation to the International Code on Breastmilk Substitutes; Taylor (1991) examined several international agencies, one of which was WHO, to explore the consequences of financial pressures in the UN system. One of the issues on changes in financing within WHO raises questions of where power lies within the organization (Walt 1993). Several authors have explored the role of international agencies in the development of pharmaceutical policy (Kanji et al. 1992; Chetley 1990; Reich 1987).

Although many of the above papers use a policy analysis approach, it is often implicit. In contrast, Leichter's comparative framework of 4 health policies in 4 industrialized countries offers a useful and explicit overview for policy analysis, and can be adapted to different situations. He draws on 4 contextual categories of factors which affect the policy process: situational, structural, cultural and environmental, which offer a scheme for analyzing public policy (Leichter 1979; 41).

The dearth of literature that addresses the way in which health policies are made and implemented in the developing world emphasises the need for more detailed and comprehensive health policy analysis.

Building policy analysis into health studies

We have argued that historically much health policy has been simply concerned with the technical features of policy content, rather than with the processes of putting policy into effect. As a result policy changes have often been implemented ineffectively and expected policy outcomes have not been achieved. Policy analysis cannot continue to ignore the *how* of policy reform.

While the policy environment in health was relatively consensual, the technical orientation of health policy raised few objections. However, the current policy environment is more uncertain and more conflictual, and policy debates raise fundamental questions about the values and group interests being furthered by policy change. Given that policy reforms often depend on political compromise and not on rational debate, a particular influence on their impact is the power structure within which they operate. In the health sector there are important and influential policy networks of managers and professionals and, at least in the UK, the hostility and differences between these two groups are legion (Salter 1994). In many low income countries there are large gaps between top and lower level bureaucrats, between nurses and doctors, between policy elites and managers. In such countries power is further complicated because it rests not only on internal relationships, but significantly, on external relationships with advisers, experts, aid donors and financial institutions. Policy analysis cannot continue to ignore the influence of values and group interests - the *who* of policy reform - on policy choice and implementation practices.

Our simple analytical model (Figure 1) emphasizes the critical role of these actors in the policy process, influencing the values inherent in policy and the specific policies chosen through that process, and influenced by the policy context (historical, political, economic and socio-cultural). Decisions over policy content are not simply technical, but reflect what is politically feasible at the time of policy choice. Seeing policy as a dynamic process is also key to this analysis: the policy environment is continuously shifting, transforming relations between groups and between institutions. Indeed Warwick (1979) refers to 'transactional analysis' rather than policy analysis to stress the complexity of social, economic and political interactions which include value systems.

In promoting this view of policy analysis we are aware of the arguments that are marshalled against policy analysis: that all policy is decided for political reasons, and is therefore unique in time and place; that because it is so complex, the social sciences cannot offer sufficiently specific tools to be precise about outcomes; that access to information is difficult and can be delicate; that it may become quickly outdated especially in unstable political situations; that policy analysis is based on Western concepts, which are not applicable in less developed countries. The conclusion from such points is that there is little point in doing policy analysis, apart from intrinsic understanding, because it is never generalizable and cannot lead to change.

We strongly disagree with these arguments. Indeed, one of the reasons for policy analysis is precisely to influence policy outcomes. As Grindle and Thomas (1991; 141) put it

> 'We have proposed that decision makers and policy managers can analyze their environment, in the context of a political economy framework, to see if the conditions and capacity exist for successfully implementing a reform.'

Reich (1993) has developed a method of political mapping to assist in the analysis of policy environments. As a tool, political mapping can be used for both research (retrospective analysis) and for planning (prospective analysis). For example, it offers several different ways for investigating which actors might be affected by a particular policy, and assessing their relative strengths and weaknesses. If such an exercise is undertaken before a policy is put into effect, it should be possible to assess which groups are likely to be resistant and to plan strategies to overcome opposition.

Others have similarly used policy analysis in helping national policy-makers think through the implications of particular health policies (Gilson 1993). Klitgaard describes his attempts to build analytical capacity among government officials in Equatorial Guinea (1991a) and in Bolivia (1991b).

We emphasize the critical importance of sensitivity and caution in this approach to policy analysis, recognizing the potential influence of the analyst's own values and perspectives over the analysis and even the decisions made. We also accept that policies are formulated and implemented within specific historical contexts, and outcomes are dependent on time and place. However, this does *not* mean that nothing can be done to change policy. We suggest that the current crisis in health demands rigorous and comprehensive analysis of the policy process and its influence on policy effectiveness, as input into future policy making.

Endnotes

[1] Long-term evidence for the negative effects on health of economic reforms is still difficult to interpret however, and open to dispute (World Bank 1994).

[2] Leichter (1979) refers to these as situational, structural, cultural and environmental factors.

[3] It must be acknowledged that policy-makers in international organizations are aware of their own limitations in national settings, and are not insensitive to intervening, or being seen to be intervening, in issues of sovereignty and domestic politics. Offering technical advice and assistance on the other hand, is perceived as legitimate.

[4] The terms 'high' and 'low' politics are borrowed from the international relations literature, and compare major, contentious policy issues (often crisis engendered), with routine, politics-as-usual policies (Walt 1994; 42).

[5] It is relevant to note here that one of the criticisms of policy analysis is that it is subject to continuing change: these three countries have been subject to major political changes since these papers were published, rendering these particular conclusions useful largely in historical terms.

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