Introduction to Policy

**Session**

**1**

Analysis, Stakeholder

Analysis & Policy Briefs

Introduction

This first session of the module is divided into three parts:

* Session 1a: Policy Analysis
* Session 1b: Stakeholder Analysis
* Session 1c: Policy Briefs

Session 1a focuses on a theoretical understanding of the concepts relating to policy analysis, while Session 1b is a more practical session, in which you will do a stakeholder analysis based on a case study.

Session 1c is a short introduction to the topic of Policy Briefs, which will be addressed in more detail in the session on *Policy Briefs*, leading into Assignment 2 - the writing of a policy brief on a topic of your choice. The concept of policy briefs is being introduced at the beginning of the module to enable you to start thinking about and identifying your topic for the policy brief.

Introduction to Policy

**Session**

**1a**

Analysis

Introduction

Policy-making processes have been described as interactive and complex processes of bargaining and accommodation of many different interests. Health policy analysis is a growing field that includes multidisciplinary approaches that aim to understand the policy process. It often includes attention to the influence of people (actors in the health system), the contexts and processes within which policy unfolds to better understand what health policy is, as well as how it is developed and implemented.

This session is based on a course first developed at the Centre for Health Policy, University of the Witwatersrand, and has been adapted and taught by several academic institutions across Africa since, including the Understanding and Analysing Health Policy course offered at the School of Public Health, University of the Western Cape.

This session will introduce participants to the varied and complex nature of ‘policy’ and policy processes and how policy analysis can help to understand what drives and influences these processes and their consequences. In this session you will learn key principles such as definitions of policy, policy processes and policy analysis. These concepts will become clearer as you proceed through the session, and will also be applied in other sessions of the module.

Session Contents

1. What is policy?
2. What is public policy?
3. What constitutes the policy process?
4. What is policy analysis?
5. Politics and policy
6. Session summary
7. References

Timing of this Session

There are three readings in this session and three additional (optional) readings which you are encouraged to access for more information. There is also one Activity for you to complete, two Reflection points, and a set of questions to frame your contribution to the Discussion Forum. The session is likely to take you about three hours to complete.

Learning Outcomes of this Session

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| ***Public Health Outcomes***  By the end of this session, you should be able to:   * Identify different uses of the term ‘policy’ * Distinguish between policy as intent and policy as understanding and practice * Identify the role of public policy in promoting public value * Identify key components and factors facilitating and constraining policy and implementation processes * Understand how the study of policy can help to explain the successes and failures of current and past policies as well as inform future policy development and implementation. | ***Academic Learning Skills***  In the session, you will practise these skills:   * Identifying specific information in texts * Applying concepts to your own context * Reading information presented in graphic form * Making notes to use in a discussion |

Readings

Buse, K., Mays, N., & Walt, G. (2005). *Making Health Policy*. Open University Press. Maidenhead. Chapter 1 pages 4-14; 16-17. Add links

Walt, G. (1994). *Health Policy: An Introduction to Process and Power*. Johannesburg. Witwatersrand University Press. Chapter 4: pages 59-61.Link

Walt, G. (1994). *Health Policy: An Introduction to Process and Power.* Johannesburg. Witwatersrand University Press. Chapter 3: pages 40-44.Link

**Additional readings**

Walt, G. & Gilson, L. (1994) Reforming the health sector: the central role of policy analysis. *Health Policy and Planning*, 9(4), pages 353-370. (p.353 – Introduction, p.358 – What is policy analysis; p.362 - Focusing on actors) <https://academic-oup-com.ezproxy.uwc.ac.za/heapol/article/9/4/353/649125>

Walt, G. et al. (2008). “Doing” health policy analysis : methodological and conceptual reflections and challenges. *Health Policy and Planning*, 23, pages 308–317

<http://academic-oup-com.ezproxy.uwc.ac.za/heapol/article/23/5/308/617219>

1. **What is policy?**

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

So, think further:

* How do these policies come into existence? Who develops them? What factors influence the types of policies that come into existence?
* How are these policies known? Are they ever written down (this is the difference between informal and formal policies)?
* How are the policies communicated to children or visitors? And how are they influenced by people’s values and beliefs?

**Policy therefore exists everywhere:**

* In households for example, think of how things are done in the home, i.e. the time we set for children to be back home;
* Social groups such as Christian organisation groups where services are set on a particular dates;
* Big organisations including for example the University with rules and procedures about how teaching should be done or businesses which have rules and guidelines for their day to day operations;
* Government with laws and policies;
* Society: so think about entering a bank and how people will line up waiting to be served, it has almost become an unwritten rule for society.

Policy includes both the intention (the vision, goals, understandings, principles, and plans that seek to e.g. guide activities, establish accountability & responsibility) as well as the practice (routine decisions, activities, understandings & actual achievements).

Also think about where policies are normally found. Policies are presented in documents, regulations, laws, ministerial statements etc. and this is usually what we think of when we hear the word policy. However, policies are constructed and exist in what happens in practice and in the expectations, principles, understandings that shape practice.

For example: The Pharmacy Law has a list of policies or guidelines found in the compendium (an example of where policies are found). These guidelines are all grounded in particular intentions that govern the Pharmacy profession (such as health as a basic human right or access to safe, efficacious and cost-effective medication). But they also provide the principles of how a Pharmacy should run. However, even policies found in these laws (compendium) only become constructed when practiced by Pharmacists and Pharmacist’s Assistants and so the practice of these guidelines because the way policies are constructed.

And so,

**Different environments have different polices:**

For example:

In a supermarket: a dress code; how to deal with customers’ demands

In an office: a procedure for booking leave; pay policy

In the home: the times children should be in bed; who helps with the household chores.

**Policy can be developed in different ways:**

Polices may be negotiated as a way of resolving conflict: (For example due to the high load HIV/AIDS patients, the prescription law was amended to allow nurses to prescribe particular medications and start patients on anti-retrovirals)

They may developed through repetition and habit: (Pharmacist’s assistants dispensing routine medicines especially in remote areas where there are no pharmacies and eventually this has become like a policy).

There may be cultural practices or traditional ways of doing things, for example in some health facilities especially local clinics, there may be particular days designated for particular services for example Mondays for immunisations and child care and Tuesdays for chronic care. Over time this becomes a policy as it is viewed as the common way of doing things within that particular facility.

**Policy can be implemented in different ways:**

* Through decree (‘because Dad or the president says so’)
* Through convention (‘because that’s how it is done in this facility or this hospital’)
* Through negotiation (‘if you do this you will get …or if you do this, you will get that’)
* Through a shared understanding of an ethical code of conduct (for example the implementation of a Patient’s Rights Charter may be influenced by people’s expectations about how things should happen even though the details may not be written down).

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| **Activity 1: Respond to questions about your own experience of ‘policies’ in your day-to-day work environment**  1. Was your interaction with policy through decree, convention, or negotiation?  2. Have you ever been involved in any form of policy-making?  3. If so, what were some of the ways these policies were developed and implemented - was it through decree, convention, or other means? |

**Feedback**

Everybody interacts with policy on a day to day basis at home or work and sometimes without realising that they are interacting with policies. Some may be involved in roles that involve developing policies or implementation while others could be operating within the boundaries of specific policies for example the announcement of the budget speech by the minister of finance will affect the cost of living which impacts all persons living in the country.

Now read the following pages from a key text on health policy. This section focuses on what health policy is, including types of policies, and how policy is made. As you read, take note of the types of policies described and try to think of examples of the different policy types.

**Reading**

Walt, G. (1994). *Health Policy: An Introduction to Process and Power.* Johannesburg. Witwatersrand University Press. Chapter 3: pages 40-44.Link

**2 What is public policy?**

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

The notion of ‘public value’ is an important one for policy making in the health sector: Think about policies such as immunization guidelines which not only protect the individual but also have value for society as a whole.

**And so public policies are those that influence**:

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

Public policy can be generally understood as:

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

* establishment of citizens’ rights - such as patients’ rights charters.

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

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

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| Policy actors are defined as any individual or group that is directly or indirectly, formally or informally, affiliated with or affected by the policy process at any stage. They can include governments, businesses, NGOs, civil society organizations and communities as well as individuals. |

**Reflection**

Can you think of examples where non decision making has occurred in your contexts?

**Feedback**

One of the most common non-decisions that exist currently in Sub-Saharan African countries is the lack of or limited regulation guidelines regarding traditional, complementary and alternative medicines (TCAMs). It has been shown that the general population uses traditional and complementary therapies alone or combined with conventional medicines (James et al. 2017). The lack of any concrete regulations or policies to provide guidelines for the use and distribution of TCAMs can be considered a non-decision by most governments. By failing to make any policies or any decisions, this in itself becomes a policy.

The reading below, which you should now undertake, is one of the key texts in health policy literature, and provides an overview of what policy is, and more definitions regarding public policy. Pages 5-10 provide definitions regarding policy and public policy which will complement sections 1 and 2 of these notes.

Think about the following questions as you go through the text:

* Why is health policy important?
* What are the different ways of defining policy?

**Reading**

Buse, et al. (2005) *Making Health Policy*. Chapter 1; pages 4-14.Link

The next reading is from Gill Walt. She is among the founding scholars of health policies in Low and Middle Income Countries. In her book entitled ‘*An Introduction to process and power’* she describes non decision making as a form of policy in her chapter on agenda setting. Read Chapter 4, page 59-61, for an extensive example on how non-decision making in itself becomes a policy.

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| **Reading**  Walt, G. (1994). *Health Policy: An Introduction to Process and Power.* Chapter 4; pages 59-61. Link |

**3 What constitutes the policy process?**

The overarching process of making and implementing policy is called the policy process, indicating that the changes which make up and are part of the policy process occur during both development and implementation. At the heart of this process are the many and complex sets of decisions and actions entailed in developing policy and putting policy into effect. These decisions are sometimes understood as a set of steps that follow one another as in the ‘stages’ model in Figure 1 below.

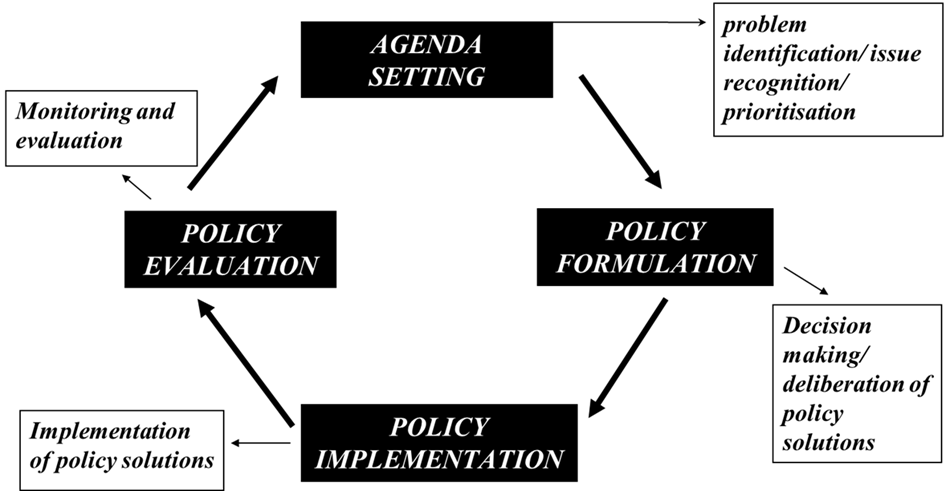


Figure 1: The Stages Model

Source: Sabatier P and Jenkins-Smith H (1993). Policy Change and Learning. Boulder, CO: Westview Press

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

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

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

3. Policy implementation – which entails implementation of the policy content through various strategies and by various structures and people, including the adaptation or non-implementation of the policy by these policy actors.

4. Policy evaluation – which entails assessing the success of the policy, either during its development and implementation (sometimes with a view to influencing this process), or after these periods, as a basis for further policy action.

However, experience of policy making and planning shows that, in reality, the ways in which problems are identified for policy attention and in which policies are formulated, negotiated and implemented do not entail a simple process in which there is a clear and almost automatic decision to move from one stage to the next. Instead, the processes of policy making and implementation take place over many years, sometimes moving forward across the stages above, sometimes moving in stops and starts, and sometimes moving forwards, and backwards and sideways. In addition, policy making does not always begin in agenda setting, policies can be re-formulated after implementation failure or may not even get to implementation.

4 What is policy analysis?

Policy analysis is the systematic study of all factors, people, processes that affect the way in which a policy is developed, formulated and implemented. Experience shows that even where policy documents are technically sound in presenting new approaches to addressing problems, this is often not enough to bring about the real changes in the operations in the health system such that it can be said that a policy has really been implemented and taken effect. There is often a gap between the intentions of policy - represented in formal documents and statements - and the reality of what people on the ground in the health system do, be they doctors, nurses, pharmacists, managers or patients and citizens.

Reflection

Is what a policy intends to do the same as what happens in practice? Can you think of any examples in your own experience – either as a professional or as a citizen in your country?

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| Feedback: One example is of the unintended consequences of the removal of user fees for maternal and child services in South Africa in 1994, which was the increase in the number of patients attending facilities for curative services. Although the intention of the policy was to improve access to services especially the most vulnerable, increasing numbers of patients may result in a loss of other services in the effort to cope with the demand of patients such as preventative services. |

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

• are designed;

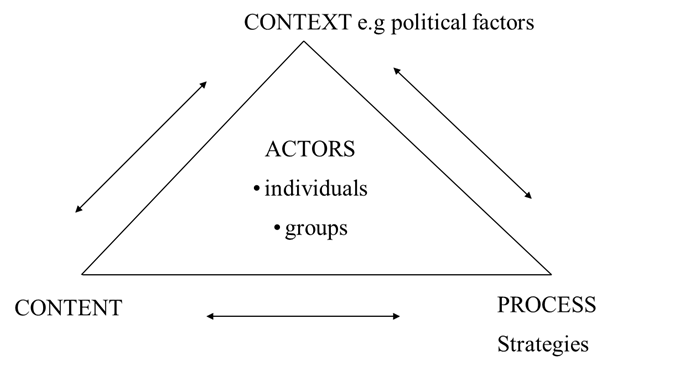
• are implemented;

• are seen as solutions to problems;

• influence practice; and

• generate specific outputs and outcomes.

The Policy Analysis Triangle (Figure 2) is a simple model for understanding the various sets of factors that are at work within any policy process. It emphasises the central role of policy actors, but also highlights the links between actors and three other factors that influence decision-making: context, content and process. So while the figure may look simple, the complexity of the policy process results from the interaction between the factors. Actors are rarely a homogenous group, they can have different interests, positions, and values which can affect policy processes and will be covered later in stakeholder analysis.



**Figure 2: The policy analysis triangle**

**Source**: Walt, G. & Gilson, L. (1994). Reforming the health sector in developing countries: the central role of policy analysis. Health Policy and Planning, 9(4): 353-370.

In the next readings from Buse, et al. (2005) give a detailed explanation of the role of the policy analysis triangle in policy analysis and its emphasis on the content of policy, the processes of policy making and how power is used in health policy. Read pages 8-10 to get a more detailed explanation of the policy analysis triangle and consider the emphasis on the central role of actors who make policy as you read the text.

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| **Reading**  Buse, *et al.* (2005). *Making Health Policy,* Chapter 1; pages 8-10 and 16-17 for more explanations regarding the policy analysis triangle. Links |

Policy analysis helps us to better understand the interactions between the different factors (such as actors, context, content and process) impacting on policy process resulting in either a success or failure and to think about strategies to manage the process. In every policy process, the four factors of the Policy Analysis Triangle interrelate and affect one another. So if, for instance, a new health minister is appointed who supports a policy which has long been side-lined, the context will shift and the policy process will be altered. Or if many babies and old people die for a third year in a row following annual cholera epidemics, discussions about the content of policy action to address cholera may shift to include more forcefully the ‘upstream’ issue of the right to clean water.

Sometimes what a policy intends to achieve does not happen in practice. Unintended consequences happen! Policies often don’t achieve what was intended because of power & processes. Gill Walt defines process and power in the following way:

“Health policy is about process and power … it is concerned with who influences whom in the making of policy, and how that happens.” (Walt, 1994)

So, policy analysis encompasses attention to, and investigation of, the formal, deliberate decisions people make to do things differently, as well as their failure to take action or to change the routines and practices that are experienced as the reality of health systems. This form of policy analysis might be seen as something that academics do. However, we argue here that policy analysis can (and should) be conducted by practitioners (leaders and managers) who develop or engage with policies – to understand better why certain policies are not being implemented as intended and/or have unintended outcomes; or to think prospectively through the different aspects of and factors which might influence a policy process.

Policy analysis is included at the start of this module to introduce you to concepts such as the role and influence of actors, power, politics, context and processes that shape the development of all health policies. Understanding the concepts and the role of policy analysis provides a good foundation that will enable you to better engage with the upcoming sessions.

Policy analysis can be undertaken during a policy process, with the intent of intervening to support that process, or it can be undertaken to learn lessons from the past about policy change. Policy analysis is therefore commonly understood to comprise of two different approaches:

* Analysis **of** policy – Analysis of policy tends to be retrospective and descriptive. This involves looking back at how a policy was developed or its content and whether it achieved its intended outcomes. For example if one was to analyse the development of National Health Insurance schemes in countries such as Ghana to examine the impact on availability, affordability and quality of medicines. This would be a form of retrospective analysis **of** policy.
* Analysis **for** policy – This is usually prospective in order to inform the formulation of a policy as it is ongoing or to anticipate how a policy might unfold when it is introduced (e.g. how other actors might respond to the proposed changes). An example could be of examining an ongoing policy development or implementation process such as the scale up of mobile phone technology for health-related purposes (m-health). Another example of analysis **for** policy would be any analysis done to inform the ongoing policy process or to predict the effects of implementation.

1. **Politics and Policy**

**How does politics affect health and pharmaceutical policies?**

The state plays a key role in any national health system. This is because the political system determines the participation of people in policy-making, thereby determining people’s potential to influence public policy. Politics or political systems determine who can be involved, how decisions are taken and ways in which citizens are able to influence policy i.e. if citizens can vote for political representatives who support their views. The extent to which people can participate in the political system either directly or indirectly is partially a function of the culture and nature of the political system. Different systems exist in a dynamic state and are classified according to how open the system is to deliberation of alternatives (how liberal or authoritarian). The five systems are outlined in the box below:

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| * 1. **Liberal-democratic**: This category is marked by governments that operate with relatively stable political institutions with considerable opportunities for participation through a diverse number of mechanisms and groups: elections, political parties, interest groups, and ‘free media’. It includes the countries of North America, Western Europe as well as countries such as India and Israel.   2. **Egalitarian-authoritarian**: Characterized by a closed ruling elite, authoritarian bureaucracies and state-managed popular participation (i.e. participation regimented and less a democratic opportunity than an exercise in social control). Close links often exist between single political parties and the state and its bureaucracies. During the 1970s, the Soviet Union, China, Vietnam, Angola, Mozambique and Cuba might have been included. These countries had well-developed social security systems and health care was financed and delivered almost exclusively by the state (private practice was banned in some cases) and treated as a fundamental human right. Few egalitarian-authoritarian political systems now exist.   3. **Traditional - inegalitarian:** These systems feature rule by traditional monarchs which provide few opportunities for participation. Saudi Arabia and Swaziland provide an example of this increasingly rare system. Health policy relies heavily on the private sector with the elite using facilities in advanced countries as the need arises.   4. **Populist:** These are based upon single or dominant political parties, highly nationalist and leadership tends to be personalized. Participation is highly regimented through mass movements controlled by the state or political party. Elites may have some influence on the government either through kinship with the leader or membership of the political party – as long as they support the nationalist and populist causes. Many newly independent states of Africa and South America began with populist political systems. While the colonial health services had only been available to the ruling elite, populists attempted to provide health for all as a basic right.   5. **Authoritatian – inegalitarian:** These political systems have often occurred in reaction to populist and liberal democratic regimes. They are often associated with military governments and involve varying degrees of repression. In the mid-1980s, over half the governments in Sub-Saharan Africa were military – and many were marked by autocratic personal rule. Health policy reflected the interests of a narrow elite: a state-funded service for the military while others had to rely heavily on the private sector. |

**Source:** Buse, et al. (2005). *Making Health Policy*. Chapter 2, page 37)

These five political systems are vastly different. One of the most important features is the extent to which they encourage or stifle participation. This in turn has major implications for how health policy is made and whose interests health policies serve.

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| **Discussion Forum**  Think about the following questions and make notes to use in the Discussion Forum:  Which political system are you currently living in and what impact does it have on access to healthcare? How are health policies developed within the particular political system? And whose interests are served with those policies?  You will be informed when the Discussion Forum will take place so you can plan your participation. |

**6 Session summary**

These are the take-home messages you should have got from this session. We hope you are clear about these points.

* The term policy has a wide range of different meanings
* Governments, organizations and even households have policies
* Public policy is government policy for the public good or for public value, including, importantly, relating to health, especially public health, and including medicines.
* Policy can be formal and informal, and can include non-decisions
* Policy arises from a process and policy problems are often generated by failings in that process
* Politics matters and impacts policy development at every stage of development and implementation
* Policy analysis can be used to understand policy processes

**7 References**

James, P.B., Wardle, J., Steel, A. and Adams, J. (2018). Traditional, complementary and alternative medicine use in Sub-Saharan Africa: a systematic review. *BMJ global health.*

Stakeholder

**Session**

**1b**

Analysis

**Introduction**

This session will introduce the central role of actors in the policy process, which applies to medicines policy as well as to other health policies, and the impact of their interest, values and beliefs on policy processes. Stakeholder analysis as an approach will be discussed including its benefits and limitations. The session will then use a case of a policy development process and unpack how stakeholder analysis tools were used to map out the stakeholders and their impact on the policy process.

A stakeholder is a person who has something to gain or lose through the outcomes of a policy process. In the health policy analysis field, most frameworks and tools identify the importance of actors and stakeholders, who can be individuals, organizations or networks. Actors influence policy processes in various ways including formulating policy content and implementation. Given their key position in policy processes, it is usually important to find out who they are, what drives them, what roles they play in the policy process, from where they derive their power and how they exercise that power.

Stakeholder analysis is an approach or tool that allows a researcher to generate knowledge about actors’ behaviors, intentions and interests. It is used to assess the influence and resources they bring which affects the overall policy process. Stakeholder analysis can therefore be used to both analyse the past experience of a policy to understand how policies are developed and the influence of actors, as well as to support the management of actors for an ongoing or future policy change process. To conduct a stakeholder analysis there is a need to consider how actors, content, context and processes interact.

**Session contents**

1. Stakeholder Analysis – what is it?

2. The purpose of stakeholder analysis

3. Conducting a stakeholder analysis

4. Session summary

**Timing of the session**

The main activity in this session is a stakeholder analysis based on a case study. In addition you are referred to 3 short readings. The session should take you about 3 hours to complete.

Learning Outcomes of this Session

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| ***Public Health Outcomes***  By the end of this session, you should be able to:   * Identify the role of actors in policy processes * Understand the purpose and approach of stakeholder analysis * Assess the strengths and weaknesses of stakeholder analysis as a management tool | ***Academic Learning Skills***  In the session, you will practise these skills:   * Identifying specific information in texts * Using forms to record information from a case study * Analysing information * Presenting information in graphic form * Summarising information |

Readings

Buse K., Mays, N., & Walt, G. (2005). *Making Health Policy*. Maidenhead: Open University Press, Chapter 10 pages 179-184. Add link - Mod resources

Gilson, L. et al. (2012). Using stakeholder analysis to support moves towards universal coverage: lessons from the SHIELD project. *Health Policy and Planning*, 27 Suppl 1, pages i64–76. <https://academic-oup-com.ezproxy.uwc.ac.za/heapol/article/27/suppl_1/i64/602445>

Varvasovszky, Z. & Brugha, R. (2000). How to do (or not to do) a stakeholder analysis. *Health Policy and Planning*, 15(3), pages 338–345.

<http://dess.fmp.ueh.edu.ht/pdf/Zsuzsa_Varvasovsky_2000_stakeholder_analysis.pdf#http://dess.fmp.ueh.edu.ht/pdf/Zsuzsa_Varvasovsky_2000_stakeholder_analysis.pdf>

**Additional readings**

Brugha, R. & Varvasovszky, Z. (2000). Stakeholder analysis: a review. *Health Policy and Planning*, 15(3), pages 239–246. <https://academic-oup-com.ezproxy.uwc.ac.za/heapol/article/15/3/239/573296>

**1 Stakeholder analysis – What is it?**

Stakeholders are all those who have something to gain or lose through the outcomes of a policy process. They are also actors in the policy process, but are particularly those whose interests are at stake in some way or another, as opposed to those actors who merely play a role in the process, but will not necessarily be affected by the outcome. The role of stakeholders is therefore important to understand when planning or evaluating a policy development.

Remember from the first session that actors have their own understandings and perceptions of problems and policies, based on their own values and beliefs. They make their own calculations of risk and gain around policies, based on their interests (self-interest vs public interest). This influences how they understand policy problems and likely impacts on them of policy content.

Stakeholder analysis is therefore an approach, tool or set of tools for generating knowledge about key actors (both individuals and organizations) so as to understand their behaviour, intentions, inter-relations and interests; and for assessing the influence and resources they bring to bear on decision-making or implementation processes.

**2 The purpose of stakeholder analysis**

There are two purposes of stakeholder analysis:

* The first is to analyse past experience in order to understand how polices have developed, and how actors have influenced that process. For example when doing an analysis OF a past policy such as the introduction of multi-drug resistant TB guidelines we can use stakeholder analysis to analyse how the guidelines were developed and how actors influenced the process.
* The second purpose is as a strategic management tool: to assess the feasibility of future policy directions; to facilitate the project implementation; to develop strategies for stakeholders. This is crucial particularly when doing and analysis FOR policy, where one wants to influence the ongoing process and so a stakeholder analysis is done in this case in order to identify stakeholder positions and develop strategies to ensure they will act in favourable ways to ensure policy success.

Stakeholder analysis can help you to understand actors; to determine, for example, stakeholders’ concerns about an issue, their level of interest and power, how much they know about the issue, whether or not they are likely to support or oppose the policy.

However, stakeholder analysis is limited in that:

* It reflects experience at only one point in time: actors concerns and perceptions about an issue could change over time and so an analysis only reflects a moment in time;
* It may be difficult to make judgements and reconcile different interpretations. Stakeholder analysis relies on one’s interpretations, as you will note during the activity, and so analysts become stakeholders themselves.
* It focuses on actors’ interests, but these are not the only influences over policy change.

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

Varvasovszky and Brugha have published an article that outlines all the key steps on how to conduct a stakeholder analysis as well as how to navigate some of the limitations. Before conducting the stakeholder exercise in section 3 below, to enable you to get an overview of stakeholder analysis, read the article and pay particular attention to pages 338-340 of the article. Think about the role of the analyst during the process of stakeholder analysis as you read the paper.

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| **Reading**  Varvasovszky, Z. & Brugha, R. (2000). How to do (or not to do) a stakeholder analysis. *Health Policy and Planning*, 15(3), pages 338 – 345. |

1. **Conducting a stakeholder analysis**

In this section you will be introduced to and asked to perform a stakeholder analysis. The readings and questions provided should prepare you for this task.

For an example of how stakeholder analysis becomes vital in developing managing strategies for various actors see Gilson, et al. (2012). Refer particularly to pages i64-i76 on ‘Using stakeholder analysis to support moves towards universal coverage: lessons from the SHIELD project’. (<https://academic-oup-com.ezproxy.uwc.ac.za/heapol/article/27/suppl_1/i64/602445> ) Look for and note the particular strategies suggested for building support and offsetting the opposition after conducting a stakeholder analysis.

Also read Buse *et al* (Chapter 10, pages 179-184) in which they too briefly discuss strategies one can consider after conducting a stakeholder analysis including distributing power resources and changing perceptions.

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| **Readings**  Gilson, L. et al. (2012). Using stakeholder analysis to support moves towards universal coverage: lessons from the SHIELD project. Pages i64–76. <https://academic-oup-com.ezproxy.uwc.ac.za/heapol/article/27/suppl_1/i64/602445>  Buse K., Mays, N., & Walt, G. (2005). *Making Health Policy*. Chapter 10; pages 179-184. |

There are various toolkits available for stakeholder analysis. As part of this session, we will introduce you to one set of tools and guide you through the process of conducting a stakeholder analysis.

As the first step in this activity, familiarise yourself with the case study below, which describes the policy process of separating drug prescribing and dispensing in South Korea in the late 1990s.

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| **Case study: Separating prescribing and dispensing of medicines in South Korea**  **Policy issue**  In all countries, expenditure on pharmaceuticals (drugs) impacts on the total cost of providing health care. The high and increasing cost of medicines puts pressure on national health budgets and often makes health care unaffordable for poorer groups. In South Korea as early as the 1980s, prescription practice was identified as the key factor influencing what was considered to be an unsustainably high level of pharmaceutical expenditure. This over-consumption resulted in an increased level of resistance to antibiotics.These medicine prescription problems were linked to:  a. the activities of two groups of actors: physicians and pharmacists, who both prescribed and dispensed medicines (which was traditional practice in oriental medicine);  and  b. Pharmaceutical companies, who attempted to influence which medicines were being prescribed and dispensed.  To encourage providers to prescribe ‘their’ medicines, pharmaceutical companies sold medicines directly to providers at prices that were less than government reimbursement levels. (In this way they increased sales.) Therefore, medicine providers could generate a maximum profit by prescribing the medicines that cost them least to buy (relative to the government-set reimbursement level) and by prescribing more medicines than were necessary. As a result of this financial incentive, pharmaceutical companies and medicine providers would often work together in illegal and unfair ways to sustain their own profit levels.  The patients’ lack of knowledge was also seen as a factor affecting medicine prescribing practice. Lack of knowledge limited patients’ ability to challenge provider practices. In addition, patients’ preference for some form of medication, reflecting oriental medicine practice, encouraged providers to over-prescribe medicines.  **Policy change**  On July 1st 2000 the Korean government introduced a new health policy to prevent physicians and pharmacists from both prescribing and dispensing medicines. Under the new policy (in relation to those medicines categorised as prescription medicines) physicians would only be able to prescribe, and pharmacists to dispense. This new policy also allowed physicians to prescribe either the brand name or the generic medicine. However, when dispensing, pharmacists could substitute a generic for a brand name medicine if an equally effective generic medicine (as verified by a bioequivalence test) was available.  **Chronology and experience of implementing pharmaceutical reform**  Since 1963 attempts to amend the law in order to separate prescribing and dispensing of medicines had been made. However, these had been unsuccessful due to opposition from physicians and pharmacists, whose strong professional associations actively lobbied against the proposed changes. The 1994 amendment to the Pharmacy Law specified that the separation of prescribing and dispensing would occur by 1999. A new president came to power in 1998, determined to implement this reform as it had been one of the key elements of his presidential election campaign.  In May 1998 the Ministry of Health and Welfare established a steering committee to prepare for the separation. To facilitate implementation, the committee made a revised proposal for the reform and classified medicines as either prescription or non-prescription. The civil servants made no special efforts to negotiate these proposals with the affected stakeholders. Apparently they believed that they could implement policy by instruction, as under earlier authoritarian regimes.  **Reaction from civil society**  The democratisation of South Korean society provided more opportunities for interest groups to shape policy processes, and increased their bargaining power relative to the state. In November and December 1998, the medical and pharmaceutical associations appealed to Congress to defer the reform. They also appealed to the public for support by emphasising that:  • the new system would make it very inconvenient for consumers to obtain medicines; and  • it would not lead to reduced costs or other benefits.  Their activities were opposed by civic groups, mainly progressive academics and political activists, who had previously opposed military rule and who were aligned with the new President. These groups made pharmaceutical reform a major social issue, and deliberately revealed the huge hidden profits made by physicians.  This information initially caught public attention and mobilised support. It led Congress to reject the medical and pharmaceutical associations’ appeal. However, neither the civic groups nor the government put much effort into persuading consumers to support the reform. Little publicity was given to the reason for the reform, and its potential benefits to consumers; and little effort was made to address the providers’ claim that it would make consumer access to medicines more difficult. The civic groups also apparently did not take account of the possibility that revealing physician profit levels to the public would strengthen the physicians’ resistance to the new policy.  **Implementation of a ‘no-margin’ policy**  In November 1999, the government implemented the ‘no-margin’ policy. This policy cut the medicine reimbursement fee that government paid medicine providers close to the price that providers actually paid to the pharmaceutical companies. This strategy was intended to remove the physician’s financial incentive to dispense medicines and so encourage their compliance with the separation reform. It was put through with little consultation or negotiation.  The ‘no-margin’ policy showed the physicians how great an impact the separation policy would have on their profit margins. They decided to go back on the attack. In February 2000 about 40,000 physicians demonstrated against the reform. This was followed by a series of other strikes (on April 4-6, June 20-26 and August 11-17). In the second strike more than 90% of general practitioner-type physicians went on strike. In addition, strikes by resident doctors in teaching hospitals (the vast majority of doctors in those hospitals) began in July and lasted for three months.  The Korean health system is extremely vulnerable to strikes by private sector physicians. It is heavily dependent on general and teaching hospitals for both inpatient and outpatient care. Only 7% of acute hospital beds are owned by the government. Therefore, the government not only agreed to raise the physicians’ general reimbursement rates by up to 44%, but also to exempt many injectable medicines from the mandatory separation (although the latter was ostensibly to avoid patient inconvenience). At the same time, in order to offset the threat of further strikes, they increased dispensing rates for pharmacists.  The policy of separating medicine prescribing and dispensing was, nonetheless, eventually implemented in July 2001.  In summary, three points can be noted as emerging from this medicines policy case:  a. The increases in reimbursement rates won by health care providers will limit the impact of the policy on total health expenditure levels, and may raise total costs for consumers.  b. Consumers will also have to bear the impact of reduced access, and this has already led to consumer complaints about the policy.  c. Physicians (in particular) have clearly demonstrated their power to influence the Korean health policy process – suggesting that the battle to contain the costs resulting from their practices is not yet over. |

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| **Activity 2: Conduct a stakeholder analysis of a pharmaceutical reform policy**  Using the above scenario which details the implementation of pharmaceutical policy reform in South Korea to separate prescribing and dispensing of medicines as a strategy to decrease/control expenditure on pharmaceuticals, follow the steps below to conduct a stakeholder analysis of the policy.  1. Identify four key actors in the case study (people, groups, organisations),  2. Consider the questions below for each actor. Using the questions below fill in the information for each actor in ***Form 1*** which you will find in your Module Resources folder in iKamva.  • What are the actor’s interests and values relating to the policy issue?  • How is the actor likely to see the impact of the policy action?  • Is the actor likely to support or oppose the policy action?  • What power resources does the actor have?  • What capacity does the actor have to mobilise resources?  • What is the overall power level of actor?  It is important to attempt to determine each stakeholder’s real interests, position and level of commitment for a proposed policy. This knowledge will play an important part in designing political strategies to affect change.  3. Prepare a force-field map that predicts actor positions and power levels around the issue (complete ***Form 2*** in the Module Resources folder). This allows you to judge what level of power the actors are likely to have around the particular policy issue (‘very high to very low’); as well as whether the actor would see the impact of the policy on them as strongly positive, strongly negative or somewhere in between. It is a way to summarise the stakeholder analysis and predict which actors should possibly be targeted for future interventions such as mobilisation activities.  4. Drawing on the information in the more detailed stakeholder analysis which you have already done, and from Form 2, locate the actors on the force field chart (***Form 3***) so that their location shows their relative support for the issue at hand and their relative power in relation to other actors and the issue.  A forcefield map allows you to graphically show the extent to which you think actors may help or hinder the policy process, and what level of power they have to do so. It ultimately helps you assess the political feasibility of policy action around the issue and provides a basis for developing an actor management strategy to support the process of policy change.  A forcefield map is a chart with two axes: the vertical axis indicates the actor’s power in relation to the policy (from ‘very high’ to ‘very low’); and the horizontal the extent to which they support the policy or not (‘high support’ to ‘high opposition’). Once the actors are plotted on the force-field map, one can then devise strategies to move them from for example high opposition to supportive of the policy process. Remember that each position map will look different depending on the policy content, actors and context.  To guide you into completing this activity, one actor has been filled (physicians) for you and placed on the forcefield map.  ***Submit your stakeholder analysis (Form 1) and force field map (Form 2) in iKamva, after which you will receive general feedback.*** |

4 Session Summary

In this session you saw, in the pharmaceutical policy case study, how conducting a stakeholder analysis and a force field analysis enables you to:

* + draw together your understandings of how actors (particularly stakeholders), content, context and processes interact within any policy process
  + assess the political feasibility of a policy and its implementation
  + identify key potential allies and opponents relating to a policy process
  + clarify the resources and power of key actors in the process; and identify the basis for developing strategies for managing actors

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

The stakeholder analysis also forms the first step in developing policy briefs as one can identify which actors need to be mobilised or engaged with. One of the ways of engaging with actors in order to change their positions on various policy issues is through the development of a policy brief, which will be introduced in Session 1c.

Introduction to Policy

**Session**

**1c**

Briefs

Introduction

**What is a policy brief?**

A policy brief presents a concise summary of information that can help readers understand, and likely make decisions about, for example, government policies. A policy brief may give objective summaries of relevant research, suggest possible policy options, or go even further and argue for particular courses of action. A policy brief may also act as a vehicle for providing policy advice or recommendations.

A policy brief is usually a short, concise document that can be written for a variety of policy actors. Exactly who a policy brief is written for depends on the aim of the specific policy brief and the level of its application, for example, local, national, regional or private. Finding the right policy actor to target is crucial to ensuring that it will be read and to determine the language and information that should be included in the policy brief.

Policy briefs will be covered more details in the session on *Policy Briefs*, and at the end of the module you will be expected to critique a given policy brief and also develop a policy brief based on a particular issue. As you go through the next sessions, it would be a good idea to start identifying potential policy topics that you could analyse and use to develop your policy brief at the end of the module.