Implementing and Evaluating Health Reform Processes: Lessons from the Literature

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Partnerships
for Health
Reform

PHR

Mission

The Partnerships for Health Reform (PHR) Project seeks to improve people's health in low- and middle-income countries by supporting health sector reforms that ensure equitable access to efficient, sustainable, quality health care services. In partnership with local stakeholders, PHR promotes an integrated approach to health reform and builds capacity in the following key areas:

- ▲ *better informed and more participatory policy processes in health sector reform;*

- ▲ *more equitable and sustainable health financing systems;*

- ▲ *improved incentives within health systems to encourage agents to use and deliver efficient and quality health service; and*

- ▲ *enhanced organization and management of health care systems and institutions to support specific health sector reforms.*

PHR advances knowledge and methodologies to develop, implement, and monitor health reforms and their impact, and promotes the exchange of information on critical health reform issues.

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Abstract

Health reform is a process of organizational and financial changes based on the social and political values of reformers.

This report reviews the literature on past reform experiences and discusses the lessons learned. A key finding is the importance of understanding the underlying factors at play during reform implementation. One of the report's conclusions is that these factors (the level of organizational capacity among reformers, for example) play a critical role in shaping and affecting the success of a reform package.

Finally, this report reviews evaluation methods and strategies including the key problems of evaluating public/health sector reform, approaches for evaluation that address these key problems, and critical aspects of the overall strategy of evaluation.

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Acronyms

NHS	National Health Service
NPM	New Public Management
PHR	Partnerships for Health Reform Project

Foreword

Part of the mission of the Partnerships in Health Reform Project (PHR) is to advance "knowledge and methodologies to develop, implement, and monitor health reforms and their impact." This goal is addressed not only through PHR's technical assistance work but also through its Applied Research program, designed to complement and support technical assistance activities.

The research topics that PHR is pursuing are those in which there is substantial interest on the part of policymakers, but only limited hard empirical evidence to guide policymakers and policy implementors. Currently researchers are investigating six main areas:

- ▲ Analysis of the process of health financing reform

- ▲ The impact of alternative provider payment systems

- ▲ Expanded coverage of priority services through the private sector

- ▲ Equity of health sector revenue generation and allocation patterns

- ▲ Impact of health sector reform on public sector health worker motivation

- ▲ Decentralization: local level priority setting and allocation

Each major research project comprises multi-country studies. Such cross-country comparisons will cast light on the appropriateness and success of different reform strategies and policies in varying country contexts.

These working papers reflect the first phase of the research process. The papers are varied; they include literature reviews, conceptual papers, single country-case studies, and document reviews. None of the papers is a polished final product; rather, they are intended to further the research process—shedding further light on what seemed to be a promising avenue for research or exploring the literature around a particular issue. While they are written primarily to help guide the research team, they are also likely to be of interest to other researchers, or policymakers interested in particular issues or countries.

Ultimately, the working papers will contribute to more final and thorough pieces of research work emanating from the Applied Research program. The final reports will be disseminated by PHR Resource Center and via the PHR website.

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Executive Summary

The paper addresses two main issues: first, it reviews what is understood of health reform processes; and second, it considers lessons from the literature about appropriate approaches to evaluating health reform processes. It emphasizes the importance of contextual factors in shaping and affecting the success of reform. In particular, it draws attention to the values underlying reforms, the relative power of actors in the reform process, and the importance of organizational capacity and social capital. Successful implementation of reforms requires close attention to the policy process and strong political and technical skills to manage the process of change effectively.

Four broad areas of experience are reviewed in order to determine specific lessons of research on the health reform policy process. These are: the nature of reform in general; the importance of values to reform and health system development; key issues raised by reform experiences; and the key lessons for implementation drawn from this experience.

The nature of reform in general refers to the "health sector reform package" currently being discussed and promoted across a wide range of countries, which is broadly linked to financing changes and/or to organizational changes and includes a complex array of sub-elements. Two main approaches have been suggested to reform in Europe: the public health approach associated with Health for All, and a more health services-focused reform approach. African experience suggests the dominant set of current reforms can be conceptualized in relation to three basic building blocks: finance, production, and the allocation mechanism. One of the key organizational reforms is decentralization, which commonly refers to the transfer of power from higher to lower levels of public administration.

A critical factor influencing the particular components of any reform package are the values guiding reformers and the related objectives of reform, which are generally embedded in the underlying political system. There are three types of health policy objectives: explicit, philosophical, and short-term political. Explicit objectives are modified both by the way in which health services are viewed by citizens, providers and government, which in turn are a reflection of the particular philosophical, historical, and cultural context of reform, and by short-term political strategies that tend to emphasize the importance of cost containment and using policy to support re-election. These three influences determine the "shape" of health systems and any reforms to them. In general, the currently dominant health service-focused approach to reform is rooted in an efficiency perspective. It has been argued that the primary goals of African health sector reform are financial sustainability, efficiency, and cost-effectiveness, with equity being only a secondary goal.

Key issues raised by analysis of reform experiences include the importance of actors; the importance of organizational capacity; the social capital of an organization; critical aspects of reform design and process; and contextual factors. The importance of actors within reform processes underlies, and is shaped by, the potential for conflict over values to block reforms. Organizational capacity requires both that necessary dimensions of capacity are available to support the performance of the task of focus and that the interactions of these dimensions are themselves supportive of this performance. Social capital, defined as "the informal social structure

within and on top of the official bureaucratic hierarchy within governments made up of the social networks of employees," is an often overlooked element of organizational capacity. These networks may be important factors in promoting employee concerns. It is important to consider critical aspects of reform design and process, as new values can conflict with those previously dominant. The above discussion highlights the importance of contextual factors in shaping reform processes. Wholesale reform requires favorable political conditions and strong ideological backing.

The key lessons for implementation drawn from this experience include the importance of the policy process; developing and mobilizing support; and informing the reform process. A lack of concern for process has led to a situation where policy is often implemented ineffectively and so expected policy outcomes are not achieved. Overall, it is clear that the implementation of reforms requires both political and technical skills that allow the process of change to be managed effectively. Key messages regarding developing and mobilizing support are the need for common understanding, public support, consensus, consistent leadership, and local champions. Effective approaches for strategically planning reforms involve identifying stakeholders and stakechallengers. Reformers must be able to continuously asses and learn from implementation. This is only possible if there are sound procedures for monitoring and evaluating experience.

Regarding evaluation methods and strategies, three key areas are reviewed in determining lessons for the proposed study of the health financing reform process: key problems of evaluating public/health sector reform; approaches for evaluation that address these key problems; and critical aspects of the overall strategy of evaluation. Problems in evaluating public/health sector reforms include: attribution; establishing an appropriate yardstick against which to measure change; identifying what criteria should be used to evaluate reforms; the commonly-used "snapshot" (or cross-sectional) approach; defining and measuring costs and benefits; determining what policy is; and lack of/inaccurate data. Approaches to evaluation include tackling the problem of attribution; identifying criteria and indicators of assessment; adopting a policy analysis approach; searching out the knowledge of grassroots staff; identifying data sources; and improving policy analysis data collection approaches/analytical strategies. Regarding the overall strategy of evaluation, the health literature points to the potential, and difficulties, of international comparative research in generating policy-relevant understanding of experience. Overall, the authors' approach is rooted in the understanding that democratic processes of evaluation are critical to ensure that practice is good, fair, and equal, thus ensuring that evaluation itself contributes to just social change.

Health sector reform processes are not simply technical strategies but are processes of social change that are value-laden and often conflict-ridden. Among the critical conclusions about reform that can be drawn from experience of these processes are: that values, actors, and actors' perspectives hold significant importance over the content and process of reform; that understanding whether or not reforms are "effective" is dependent on understanding societal goals and values, as well as the explicit objectives of reforms; that successful implementation requires both good political and managerial skills and strategies, and can be informed by sound processes of data gathering and dissemination; and that the institutional capacity necessary for successful reform is not only a set of skills but also a set of principles that govern relationships among the different parties. Evaluation of health sector reform should, therefore, be undertaken using both available and specially collected data to determine whether particular effects can be attributed to a specific policy change and also to understand in detail the critical factors that underlie the nature and extent of change achieved. Failure to achieve change can be as instructive as success, but policy-relevant lessons can only be demonstrated if appropriate analysis has been undertaken. The analytical

approach of an evaluation must therefore include techniques that allow causality to be considered, complemented by detailed analysis of the explanatory factors of context, actors, process, and content. Varied data sources and analytical approaches are required in this analysis, which should combine quantitative and statistical techniques with qualitative techniques. The analytical approach of an evaluation, however, is only one of two important aspects that must be pre-planned. The other is the overall strategy of evaluation, which must be undertaken in such a way as to allow stakeholder involvement and ensure evaluator openness. Although public policy evaluation is often seen as simply a technical, rational process, it is inherently political and value-laden. The strategy of evaluation must acknowledge this fact if it is to be fair and credible.

Understanding Health Reform Processes

Four broad areas of experience are reviewed in order to determine specific lessons for research on the health reform policy process. These are:

1.   the nature of reform in general;
2.   the importance of values to reform and health system development;
3.   key issues raised by reform experiences;
4.   the key lessons for implementation drawn from this experience.

What is "health sector reform"?

The "health sector reform package" currently being discussed and promoted across a wide range of countries is broadly linked to financing changes and/or to organizational changes, and includes a complex array of sub-elements.

Dekker (1994) suggests that there are two main approaches to reform in Europe: the public health approach associated with Health for All, and a more health services-focused reform approach. Whereas he characterises the former as a comprehensive and "rational" approach to reform concerned with improving health, the latter focuses on improving the efficiency of health services through changes in the administrative, financial and organizational aspects of the system. Dekker's Health for All model appears to reflect the Alma-Ata version of primary health care, whereas the current package of health reforms being implemented within developing countries is much more in line with the health service focus. As both Saltman (1994), from European experience, and Leighton (1996), from African experience, suggest, the dominant set of current reforms can be conceptualized in relation to three basic building blocks: finance (e.g., Europe: competitive mechanisms among private insurance carriers; Africa: revenue raising); production (e.g., Europe: regulation; Africa: alternative modes of service delivery) and the allocation mechanism (e.g., Europe: contracts; Africa: re-allocation).

Reforms in the area of resource mobilization and allocation are not discussed in this paper, as they have been discussed in-depth elsewhere. Such financial reforms are generally complemented by various organizational and institutional reforms also being promoted and implemented at present. Organizational reforms focus on the relationships between components of the health system. Seeing the health system as composed of a complex set of institutional relationships between the state, diverse ranges of service providers, resource institutions, institutional purchasers, other sectoral agencies, and the population, reforms can be linked to various elements of the system and, most particularly, various institutional relationships (Cassels 1995; Frenk 1995). The key principles of this "institutional reform" include: management and accountability, specifying priorities, objectives and standards of performance, monitoring outputs and outcomes, tracking the use of resources, and establishing clear institutional relationships (Cassels 1995). One particular group of institutional reforms has been labelled the "new public management" (NPM) and, drawing on commercial business management experience, aims to promote greater efficiency by bridging distance between elements of the system. Key NPM reforms include: the separation of

the policy and financing functions of government from the more operational functions (e.g., service delivery); the development of contractual relations between agencies; performance incentives for staff and setting, and measurement of the achievement of, performance objectives (Moore 1996).

One of the key organizational reforms is decentralization, which commonly refers to the transfer of power from higher to lower levels of public administration (Mills et al. 1990). The most commonly used categorization of decentralization identifies four approaches:

- *deconcentration:* transfer of some management functions to lower level field units within an agency or organization;

- *delegation:* transfer of managerial responsibility for specifically defined functions to organizations that are outside the regular bureaucratic structure and so indirectly controlled by government;

- *devolution:* transfer of power to newly created or strengthened sub-national units of government, activities substantially outside central government control;

- *privatization:* transfer of specific government functions to private non-profit or commercial organizations outside the government structure.

However, recent analysts have questioned the usefulness of this categorization given the diverse range of decentralization patterns actually identified within country experiences. Some have specifically suggested that privatization cannot be equated with decentralization, as defined above, because it transfers power outside the public sector (Collins and Green 1994). Instead Collins (1996) identifies two key patterns of decentralization, which occur through: *local bodies*, in which semi-autonomous units are usually subject to government policies, controls or financial support; and *federalism*, in which area governments derive their powers from the constitution rather than central government agencies. Similarly, the World Health Organization framework for analyzing decentralization identifies four "streams" of decentralization from country experience, involving decentralization to: *local government, lower levels of the Ministry of Health, provider institutions and social insurance funds* (Janovsky 1995). Within each stream there may be considerable variation in form between countries.

The importance of the values that underlie reform packages

A critical factor influencing the particular components of any reform package are the values guiding reformers and the related objectives of reform, which are generally embedded in the underlying political system (Walt 1995). Saltman (1994) thus suggests that there are three types of health policy objectives: explicit, philosophical and short-term political. Explicit objectives are modified both by the way in which health services are viewed by citizens, providers, and government, which in turn are a reflection of the particular philosophical, historical, and cultural context of reform, and by short-term political strategies that tend to emphasize the importance of cost containment and the use of policy to support re-election. These three influences determine the "shape" of health systems and any reforms to them.

Similarly:

- ▲ Hsiao (1992) stresses that the shape of a health system is the result of an inter-play between two broad ideological perspectives, free enterprise and government planning, which determines the relative balance between the three possible health system goals: universal access, control of health costs at an acceptable level, and the effective use of resources;

- ▲ Bach's (1994) analysis of the French health system structure notes that it is rooted in the tension between socialist principles associated with universal insurance and equity, and the liberal values associated with patient freedom and clinical freedom;

- ▲ Ovretveit (1994) suggests that within current health reform proposals in Europe there is a conflict between choice (associated with efficiency) and equity.

In general, the currently dominant health service-focused approach to reform is rooted in an efficiency perspective (Dekker 1994). Thus, Leighton (1996) identifies the primary goals of African health sector reform as financial sustainability, efficiency, and cost-effectiveness, with equity being only a secondary goal.

Key issues raised by analysis of reform experiences

The importance of actors:

A critical element of experience is the importance of actors and their potential to block reform. The range of relevant actors includes politicians, policymakers, managers, and the public. Medical professionals and providers are a particularly critical, and sometimes, overlooked actor group whose opposition to reform can slow or even de-rail reform initiatives (Bach 1994; Crosby 1996; Cassels 1995; Salter 1994). Cobb and Elder (1983) emphasize the need to recognize differences among groups within the general population—such as "identification groups," who focus attention on primary stakeholders; "attention groups," who identify only with certain issues; the attentive public, which is generally interested and well-informed; and the general public. Finally, Leighton (1996) points to the important influence of donors over many African health reform initiatives.

The importance of actors within reform processes underlies, and is shaped by, the potential for conflict over values to block reforms. As discussed, health systems are influenced by tensions between differing values and objectives—as is the need for reform and the nature of reforms initiated. Experience indicates that reforms that conflict with the values of society or of health care providers will have a limited and unpredictable impact (Cassels 1995; Ovretveit 1994). Thus, Bach (1994) and Walt (1995) suggest that reform has been difficult to implement in France/Western Europe because of public support for the existing health system and its underlying values. From African experience, Leighton (1996) highlights the importance to reform processes of conflicts between governments and donors, between the goals of financial sustainability and equity, between governments (interested in resource re-allocation) and the public (interested in curative care). Such conflicts are particularly important in the design phase of reform. Carr-Hill (1994) specifically

discusses the factors that have blocked equity-oriented reforms within health systems and identifies as critical the extent to which inequalities are recognized and seen as requiring collective or individual action, a reflection of societal values and ideologies. At the same time, the role of actors within reform processes can also be informed by self-interest—such as risk avoidance (Cooksey and Krieg 1996) and the pursuit of power (Gilson and Mills 1995).

The specific design of particular reforms can also generate conflict (Leighton 1996). Saltman (1994) suggests that conflict between policy objectives and the reform instruments proposed to achieve them can confuse providers, because apparently they are contradictory and so slow to implement. And Moore (1996) points to a specific conflict between those favoring the NPM reform package because they want to see a closer relationship between performance and incentives, and those who are concerned about the possible adverse effects of such systems and so stress the pursuit of other approaches to achieving job commitment (e.g., job career paths, non-material rewards). There can, therefore, be conflict between the general goals and values of reform, as well as over specific aspects of reform design in relation to the values key actors hold to be important.

Finally, the potential of actors to block reform processes is tied to the balance of power between different sets of actors, which is influenced by the broad economic and historical context as well the way the health system has developed historically, all of which help to explain the particular place of different actors within, and the relative importance of different values to, the health system (Walt 1995). Thus, Salter (1994) highlights the balance of power between medical professionals and managers as being of critical importance to the pattern and degree of policy implementation within the UK health reforms. While Carr-Hill (1994) identifies the relative power of those opposed to equity-oriented reform and, more particularly, the lack of power of the disadvantaged as being important in explaining the failure to implement such reform. At the same time, reforms can intentionally or unintentionally alter that balance of power and so affect the role of key actors within the health system. For example, the financing mechanism of a health system determines which stakeholders have the fiscal power to determine the budget constraint for the system and the allocation of resources within it (Hsiao 1992). The UK reforms have commonly been seen as designed to reduce the power of the medical professionals within the National Health Service (NHS).

The importance of organizational capacity:

A common message from analyses of reform experience is the importance of "capacity" to successful reform implementation. Hilderbrand and Grindle (1994) have proposed a framework for understanding public sector capacity that points to various levels of capacity including: human resource quantity and quality; the organizational environment in which people work; the public sector environment and the external environment. To have organizational capacity requires both:

- that each of the individual dimensions of capacity support the performance of the task of focus (and so, performance of the overall health system);

- *and* that the inter-actions of these dimensions are themselves supportive of this performance.

Effectively functioning "task networks" are a critical component of the organizational capacity required to implement any task, and a potential area of great capacity weakness. A task network is comprised of the range of individuals and organizations jointly responsible for

undertaking a particular task. It is not enough that individual organizational entities have the people, skills and systems necessary to implement a task, but it is also essential that these entities work together in implementation.

Current analyses of health sector reform experience stress the following aspects of capacity as being particularly important obstacles to reform (Brijlal and Gilson 1997; Cooksey and Krieg 1996; Leighton 1996; Hsiao 1992; Gilson and Mills 1995):

- limited skills to design and implement reform;

- lack of information to understand problems and design reforms;

- weak information systems that do not generate the correct information in a timely manner;

- weak personnel systems that do not promote good performance;

- weak auditing systems that do not monitor and correct identified problems;

- weak management systems that promote resistance to change;

- weak resource systems that do not generate, or allocate, adequate resources to support implementation;

- poor economic conditions that undermine resource availability;

- weak political systems that are characterized by instability;

- poor coordination among, and communication between, service providers and other actors that undermine the task networks required to work together in performing a task.

The influence of this range of factors over implementation are highlighted by Crosby (1996), who comments that policy implementors have an enormous task as they are generally excluded from the process of policy formulation and policy selection, have little ownership of the policy or process, minimal control over necessary financial and organizational resources and must operate within a environment hostile to change. At the same time, Cooksey and Krieg (1996) give special weight to the problem of inadequate political support in implementing change. In their analysis of health policy initiatives in Chicago they found that even if an initiative was undertaken at the behest of a political figure, final recommendations might not be seen as a priority and the lack of political support often made implementation difficult. These problems were tied to the political balance of power within this state, the nature of political institutions (which involved little link between state and local legislative processes) and the nature of interest group politics. The support or opposition of key political actors for health policy initiatives could, thus, be determined by short-term political objectives (as discussed earlier) and was shaped by the nature of political institutions within the state.

The social capital of an organization:

An often overlooked element of organizational capacity, which is also linked to the importance of implementors within reform processes, is the social capital of an organization. Social capital in this context has been defined as "the informal social structure within and on top of the official bureaucratic hierarchy within governments made up of the social networks of employees" (Bulder et al. 1996: 261). These networks may be important factors in promoting employee concerns for organizational goals, and in providing advice, information, esteem and emotional support to each other. The types of networks include: communication, task-oriented, and friendship-oriented networks.

However, Bulder et al. (1996) suggest that this social capital can be an important, and perhaps unintended, victim of public sector reform. Reforms such as those inherent within the NPM introduce changes in the rules of the game within an organization that undermine both the traditional mechanisms that steer and coordinate organizations—like hierarchy and standard operating rules—and the more informal social capital that binds people working within organizations. For example, organizations that are subject to change are fragile and can become unsuccessful—leading to the exodus of "old" managers and the appointment of interim managers, which in turn only leads to a further loss of trust in the organization. Similarly, Moore (1996) suggests that NPM reforms can undermine organizational functioning by being seen as unfair, so undermining trust in the organization, by emphasizing value for money over traditional public sector values such as decency and fairness and by appealing to self-interest instead of professional ethics. To be successful, therefore, NPM reforms must be implanted into a civil service characterized by honesty and transparency.

Given the importance of the roles and behaviors of providers (and patients) to the performance of the health system, it is clear that the incentives inherent within reforms will be critical to their impact (Hsiao 1992). These analyses suggest that the impact of reforms on the values and the way a core group of actors works, can perhaps unintentionally undermine the informal codes of conduct that bind organizations together by introducing conflicting incentives. As Carr-Hill (1994) suggests, the pressure for improved accountability associated with tight management based on specific objectives can lead to reactive management behavior that may undermine efficiency and effectiveness, while the pressure to consider patient satisfaction is likely to give more articulate consumers more power, possibly undermining effectiveness and equity.

Critical aspects of reform design and process:
As discussed, the design of reforms can introduce conflict into reform processes by introducing new values in conflict with those previously dominant and/or by changing the balance of power between actors within the health system. The nature of incentives introduced by reforms is a particularly important aspect of design as they will not only influence the performance of the health system, but also the values shaping it (Hsiao 1992). They can also create incentive structures that may be difficult to change, so influencing future patterns and types of reforms (Walt 1995). Moore (1996) suggests that successful institutional reform requires a balance between mechanisms and local networks that make staff responsive and accountable to patients, local communities, and central oversight mechanisms within the public sector.

Cooksey and Krieg (1996) highlight three key technical design problems: failure to consider a full range of possible design options (due to limited information on the nature of the problem); too broad policy recommendations; and no clarification of how to go about implementing the recommendations.

Leighton (1996) stresses the importance of distinguishing the design, or policy formulation, phase of reform from that of policy implementation, as the nature of obstacles to reform differs between the two. Policy conflicts, information constraints and institutional weaknesses are key obstacles in the design phase, while institutional weaknesses, incomplete health sector development and policy conflicts over design are common to the implementation stage.

Several analysts highlight the potential influence of the process of reform over its success. Thus, reforms may follow more comprehensive, rationalist processes or incremental, gradual ones (Walt 1995):

- ▲ Saltman (1994) suggests that slow and uneven progress can encourage opponents and undermine objectives and Bach (1994) identifies the gradual process of implementing reforms in France as one obstacle to introducing necessary changes;

- ▲ Mogedal et al. (1995) and Gilson and Mills (1995) suggest that incremental processes of change can be important in gathering support, adapting design and so promoting success;

- ▲ Crosby (1996) emphasizes the fact that implementation is frequently fragmented and interrupted, requiring implementors to be brokers;

- ▲ Cooksey and Krieg (1996) point to the frequent failure to involve all relevant stakeholders in the determination of design and implementation strategies (and Crosby [1996] emphasizes the dangers of not involving implementors).

Finally, Haug (1996) suggests that there is no guarantee that the "real" problems or challenges will get attention through the reform process, as reforms are often associated with issues of moment on the political agenda, in turn determined by what is politically legitimate and acceptable. At the same time reforms can have a strategic or symbolic function, i.e., they may be implemented because it is easy to achieve rapid change, or because they draw attention to a particular issue, person or institution.

Contextual factors:
The above discussion has frequently alluded to the importance of contextual factors in shaping reform processes. The philosophical, historical, political, economic and health system context influences the nature of reform and any conflict over reform; the balance of power between actors; the extent of organizational capacity and, through the political system, aspects of the process of reform. Moore (1996) suggests that wholesale reform requires favorable political conditions and strong ideological backing, as demonstrated in the NHS reforms of Britain's Margaret Thatcher.

Implementation lessons

The importance of the policy process:

Perhaps the most important lesson to be drawn from this experience is the importance of the "policy process" to the implementation of health sector reforms. Folz (1996) defines the policy process as the process by which government or society sets its activities or allocates resources.

A lack of concern for process has led to a situation where policy is often implemented ineffectively and so expected policy outcomes are not achieved (Walt 1995; Walt and Gilson 1994). Yet, "[s]uccessfully pursuing long-term reforms in democratizing environments involves not just knowing which direction to move in, but paying attention to how to get there: in essence, recognizing that policy implementation is as much a process as it is content" (Brinkerhoff 1996: 1395).

More specific implementation lessons drawn from past analyses of experience can be categorized in two ways: those concerning how to develop and mobilize support, and more "technical" lessons concerning how to inform the overall process. Overall, it is clear that the implementation of reforms requires both political and technical skills that allow the process of change to be managed effectively (Crosby 1996; Leighton 1996; Walt 1995).

Developing and mobilizing support:
Key messages in relation to developing and mobilizing support are the need for:

▲   common understanding and public support (De Leeuw and Pollman 1995);

▲   consensus (Leighton 1996);

▲   consistent leadership and local champions (Brinkerhoff 1996; Cassels 1995; Leighton 1996; Walt 1995; Kohlemainen-Aitken and Newbrander 1996);

▲   risk taking (Kohlemainen-Aitken and Newbrander 1996).

Efforts to build understanding and public support are strengthened if they can be rooted in relating reforms to commonly agreed assumptions and values (De Leeuw and Pollman 1995). While public and interest group pressure is important in getting an issue on the policy agenda (Cobb and Elder 1983), mechanisms such as "commissions of inquiry" may also be able to act as a catalyst for change—establishing an acceptable "image of reform" and generating the political leadership necessary to implement change (Chernichovsky and Chinitz 1995). Involving key stakeholders on working groups or task forces can also help to build consensus, and, if given clear guidelines and a time frame, can generate sound strategic implementation plans (Cooksey and Krieg 1996).

Crosby (1996) lists the tasks of policy implementation that focus on building and mobilizing support as including: policy legitimisation; creating new arenas of decision-making to enable wider participation; constituency building; and resource accumulation. The task of reform has been described by Cassels (1995) as "doing the doable without disappointing the often ambitious expectations of the public and political supporters," and Chernichovsky and Chinitz (1995) and Moore (1996) have suggested that if political will and leadership to change are in short supply, gradual, incrementalist approaches are essential to bringing about reform.

Finally, the careful "design" of reforms can also aid the implementation process by reducing the potential for confusion or conflict. Important features include clearly stated goals, simple technical features, clear implementation steps (Cooksey and Krieg 1996; Kohlemainen-Aitken and Newbrander 1996; Walt 1995). Various analytical approaches for aiding strategic planning have also been proposed that involve identifying the stakeholders and stakechallengers, and identifying strategies for dealing with these two sets of actors (Reich 1994; Walt 1995). Walt and Gilson (1994) emphasize the particular importance of making the values that underlie reform explicit as this will help to identify where these values conflict with those of others and so strengthen reform design.

Informing the reform process:

Various more "technical" strategies to assist implementation are highlighted by experience, largely focusing on the collection of information that can guide initial plans and later adaptations in response to implementation experience. Brinkerhoff (1996) emphasizes that implementors must be flexible, learning as they implement, and continually developing new options.

An important initial planning issue is the need to adapt reforms to the local economic conditions and to develop the infrastructure that will facilitate implementation (Crosby 1996; Cooksey and Krieg 1996; Leighton 1996). Areas where public sector organizations are likely to require adaptation to allow implementation include government budgetary, disbursement, accounting and auditing systems (Cassels 1995; Kohlemainen-Aitken and Newbrander 1996; Moore 1996). Specific lessons can be learned at the design phase by analyzing natural experiments, pilot tests, and review of international experience (Leighton 1996).

As implementation proceeds it is particularly important to develop institutional capacity through a phased approach to implementation (Leighton 1996). Kohlemainen-Aitken and Newbrander (1996) suggest that the benefits of such an approach for decentralization are that it:

- ▲ provides proper introduction and assessment of decentralized management prior to widespread implementation;

- ▲ facilitates proper training of staff for their roles and responsibilities;

- ▲ minimizes opposition to decentralization and does not raise expectations unrealistically;

- ▲ makes modifications to decentralized management role and processes, so enhancing likelihood of success (can be done by levels, by functions)

Finally, the continual adaptation of reforms in pursuit of goals is only possible if there are sound procedures for monitoring and evaluating experience (Crosby 1996; Kohlemainen-Aitken and Newbrander 1996; Leighton 1996).

Evaluation Methods and Strategies

Three key areas are reviewed in determining lessons for the proposed study of the health financing reform process in South Africa and Zambia:

1.   key problems of evaluating public/health sector reform;

2.   approaches for evaluation that address these key problems;

3.   critical aspects of the overall strategy of evaluation.

Problems of evaluating public/health sector reforms

Evaluation approaches in principle and in practice[1] tend to emphasize the importance of assessing whether or not a reform has produced the desired change(s) (e.g., McPake and Kutzin 1997). Eight main problems of such analysis can be identified from reviews and analyses of evaluations of the public and the health sector (Kroneman and van der Zee 1996; Pollitt 1995):

1.   *the problem of attribution*—the problem of identifying which of a package of reforms produced which effect or of identifying which parallel change in the political/administrative environment may have generated the observed effect (see also Janovsky and Cassels 1996);

2.   *the problem of establishing an appropriate yardstick against which to measure change*— although often used, baseline performance may not be an appropriate yardstick for evaluation, as performance may have changed from that level even without reform;

3.   *the difficulty of identifying what criteria should be used to evaluate reforms*—as criteria rooted in stated goals may be difficult to determine (because the goals are vague) and may allow unintended effects to be overlooked, thus there is a tendency to concentrate on "foreground" (or the most obvious) changes (such as changes in throughput) that may ignore background changes or side-effects, such as those in transaction costs or a loss of trust between groups, which may be more important over the longer term (see also Janovsky and Cassels 1996);

4.   *the weaknesses of the commonly used "snapshot" (or cross-sectional) approach to evaluation*—which ignores the longer-term dynamics of change and the potential of

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[1] Although only few evaluations of recent reforms have been undertaken.

learning effects that may be overlooked in assessing changes achieved (see also Carr-Hill 1994);

5. *the difficulty of defining and measuring costs and benefits*—given that the range of possible costs and benefits is wide and includes both transitional (once off) and recurrent costs and benefits;

6. *the difficulty of determining what policy is, the extent to which it has been implemented and when it was implemented*—due to the slow evolution of reforms through a gradual process of phasing and adaptation, the tendency to use broad laws to introduce change that must be complemented by detailed procedures that can be introduced over time, if change is to be effected. The situation is further confounded by the tendency for the mere threat of change to induce change before full policy development/implementation, the possibility of limited legal enforcement of unpopular reforms and the deliberate vagueness of cautious politicians;

7. *focus on the wrong level*—reforms may be evaluated predominantly at the national level although sub-national levels have increasing power as a result of the reform and so are an equally important level of analysis;

8. *data problems*—due to the use of available secondary or tertiary data that are often incomplete and may be inaccurate (see also Carr-Hill 1994), and particularly undermine cross-country, comparative studies (McPake 1996).

An additional, but very different, concern is that existing evaluations usually *do not even attempt to understand in detail the factors that mediated the nature and extent of change observed* and rather give greater emphasis to measurement of change and to seeking to ensure that the changes observed can be attributed to this reform (Walt 1995; Walt and Gilson 1994). The emphasis is placed on showing whether or not a reform had an effect rather than on asking other questions at least equally as useful for policymakers and implementors. Such questions would include: what conditions are associated with success and failure; what elements of the process of developing and implementing reform explain success and failure; what elements of process can be altered to enhance the likelihood of success and to offset potential causes of failure? (Janovsky and Cassels 1996). Given the complexity of public/health sector reform (as summarized in problem six above and in descriptions of reform experience), Haug (1996) strongly emphasizes the need to locate a reform in the social, political and cultural situation in which it developed and to analyze it with regard to what kinds of interests and whose interests it serves.

Approaches to evaluation

Tackling the problem of attribution:
    McPake and Kutzin (1997) discuss in some detail three key approaches to assessing the degree of association between indicators of financing policy development and financing policy change:

▲ an analytical description of the reform process, incorporating descriptive indicators inherently associated with the reform process, such as the nature of a reimbursement mechanism as an indicator of cost inflation (similarly, Janovsky 1995 and Janovsky and Cassells 1996 also suggest that evaluation should look for plausible, not causal, links between changes and effects, based on a backward analysis involving the following questions: to what extent are observed changes in performance linked to observed changes in organizational processes and systems? to what extent are those changes linked to the reform of focus e.g., decentralization?);

▲ a longitudinal assessment in which the timing of the policy change is compared with the trend in the indicator concerned (such an assessment may be implemented retrospectively using routine and recall data, or prospectively using routine or special data collection);

▲ a cross-sectional analysis in which observations across which policy implementation varies are compared.

Although these approaches are best combined, for example to offset the danger of the snap-shot approach, this is not always possible. A critical need in all of the approaches is to control for the influence of external factors over effects, by looking for explanations other than the reform of focus for any observed changes. Quasi-experimental approaches to evaluation, in which intervention and carefully selected control sites are compared,[2] may be particularly useful in ruling out external factors as causes, but can be difficult to implement. Alternative approaches include:

▲ looking for discontinuities in trends before and after a discrete policy change (but note the difficulty of determining when and if policy change was implemented that is discussed above);

▲ looking for changes that are sufficiently large to exclude the likelihood of a long-term trend;

▲ generating and testing hypotheses of alternative explanations of observed changes (information to generate such hypotheses could be collected through broad-based and often qualitative assessments, providing a comprehensive analysis of the features of context and process that are likely to influence the impact of reform [Janovsky and Cassells 1996]).

Janovsky and Cassells (1996) suggest that such approaches should allow substantial policy effects to be detected, but more sophisticated multi-variate statistical techniques may sometimes be necessary to develop greater certainty about the impact of policy change. Kroneman and van der Zee (1996), for example, propose a specific approach to dealing with the problem of determining what policy is, the extent to which it has been implemented and when it was implemented through statistical analysis. They suggest that a quantitative "reform implementation index" can be introduced into time series analytical models.

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[2] Site selection should be based on factors that can be assumed to have a possible influence over effect, so that their influence can be ruled out in the end analysis.

Overall, McPake and Kutzin (1997) propose a useful seven step process in evaluating the impact of reforms:

- ▲ define what you want to study (i.e., the policy change of focus)

- ▲ formulate research hypotheses, questions and indicators (e.g., what is the expected effect of reform?)

- ▲ identify alternative causes of effects (i.e., other than the policy change of focus), and consider how the effects of these factors might be considered in analysis

- ▲ define methods (using some combination of the above approaches)

- ▲ describe the policy change and its implementation, including content, timing and the process of implementation

- ▲ data collection and analysis around the indicators of focus

- ▲ assess causality by reaching an informed judgement about the extent to which observed changes were caused by the policy change of focus or by other factors.

Identifying criteria and indicators of assessment:

Various analysts proposed criteria that can be used in assessing the impact of reforms in terms of objectives such as efficiency, equity and financial sustainability (see Annex 1 and, in particular, McPake and Kutzin 1997). Review of experience suggests that issues such as accountability and equity tend to be ignored in evaluations but are important possible areas of effect (Politt 1995).

McPake and Kutzin (1997) suggest that the problem of establishing an appropriate yardstick can be tackled by looking only at changes that are sufficiently likely to be related to a discrete policy change or large enough to rule out their being part of long-term trends. Politt (1995) suggests that this problem instead needs to be addressed by establishing a counterfactual, i.e., an estimate of what the performance level against specified criteria would probably have been without the reform at the time of evaluation, compared against what it is with the reform. However, establishing a counterfactual is clearly a difficult exercise!

Equity is a particularly difficult criterion to use in evaluation because of differences in the understanding of it. Carr-Hill (1994) suggests that it is essential to document societal definitions of equity as a starting point of analysis, and then to use both these definitions and relevant criteria as well as those external to the society in assessment. This approach echoes the more general concerns of the evaluation literature, that the process of evaluation should be open to, and influenced by, varying views and opinions (see below).

Pollitt (1995), finally, stresses the importance of considering both intended and unintended effects in evaluation and of undertaking as thorough as possible an analysis of possible costs and benefits. He suggests that it is important to spell out the unstated value premises or criteria that may underlie apparently common-sense policy objectives. Not only does such a comprehensive approach strive to ensure that some potentially important effects are not overlooked (even though

not obvious or immediate) but it also focuses on the interests and values of actors, a potentially important influence over the nature of reform and the extent of its implementation. He also points to the range of costs and benefits that could be considered, including: transitional costs and benefits, direct and opportunity costs, Hawthorne-effect benefits (i.e., those generated by the very process of research) and recurrent costs and benefits (including changes in transaction costs).

Adopting a policy analysis approach:
    The analytical approaches suggested by those who focus on the measurement and analysis of change, such as McPake and Kutzin (1997), include consideration of factors that may influence the nature and extent of implementation in order to strengthen the ability to attribute effects to cause. A more comprehensive approach to consideration of these factors would generate information which not only allows stronger judgements of causality but equally, seeks to understand the critical influences over implementation. Such an understanding will cast light on what conditions might be important to successful implementation and how the process of implementation can itself contribute to successful implementation. A particularly important element of such an evaluation, that is not considered at all by approaches focusing on the measurement of change, is the important role of actors and their values in the reform process.

    Everitt (1996), writing from a broad evaluation perspective, stresses the importance of continually evaluating social welfare practices to ensure that they are developed and implemented through democratic and fair processes that have equality as an underpinning goal.

    Walt and Gilson (1994) provide a framework for such analysis that identifies four key and inter-linked groups of issues for examination:

- ▴ factors of context: such as situational, structural, cultural and exogenous factors;

- ▴ factors concerning actors: who they are and their interests and values;

- ▴ factors of content: the nature and design of the reform of focus; and

- ▴ factors of process: the timing, phasing, and strategies of implementation that are used.

    Ideally, such analysis should be undertaken within a longitudinal assessment that allows the dynamics of change to be observed and described, so generating a detailed description of reform experience (Politt 1995).

Searching out the knowledge of grassroots staff:
    Within a comprehensive policy analysis framework several authors stress the particular importance of understanding how middle and junior managers and users experience reforms (e.g., Politt 1995).

    The analysis in Bulder et al. (1996) regarding the importance of the social capital of an organization also highlights the issue. Analysis of this social capital must be rooted in assessment of the knowledge and practice of grassroots staff, and their views. The various networks can be assessed by looking at factors like: the extent to which there is communication and interaction

between people, the extent to which information and advice on work-related issues is exchanged, and the links between people and the embeddedness of officials in networks.

Data sources:

Kroneman and van der Zee (1996) provide a useful overview of the various sources of data and their strengths and weaknesses:

▲ documentary sources are useful starting points for analyzing reforms, providing global insights and allowing determination of a point where further investigation is necessary because inconsistencies are discovered or available information is incomplete or insufficiently specific;

▲ primary sources reveal exact official figures/statements but regulations may be incompletely enforced or have unintended side effects;

▲ expert consultation allows, for example, an initial overview to be discussed and corrected, with various stakeholders, including implementors.

The data problems associated with one source can be offset by combining data from different sources, through a process of "triangulation."

Policy analysis data collection approaches/analytical strategies:

In addition to considering relevant/appropriate sources of data, it is important to think about data collection and data analysis approaches.

Barker (1996) and Walt (1995) provide useful summaries of some important methods for policy analysis, which include:

▲ simple observation;

▲ random and purposeful sampling to collect information from the public;

▲ focus group interviews;

▲ group interviews;

▲ asking experts through brainstorming, scenario writing, computer modeling;

▲ media analysis;

▲ stakeholder analysis;

▲ the Delphi technique; and

▲ consensus development conferences.

The overall strategy of evaluation

The health literature points to the potential, and difficulties, of international comparative research in generating policy-relevant understanding of experience.

In contrast, the general evaluation literature strongly emphasizes the importance of thinking about the strategy of evaluation in parallel to identifying the issues of focus and the analytical techniques that will be used. Everitt (1996), for example, identifies the two steps of evaluation as: generating evidence about practice and making judgements about the value of practice. Evaluation can never be value-free as practice is itself not value free but rather comprises sets of processes that are continuously negotiated by all those involved. Practice is also always "political" in that people's interests in practice constitute political interests, i.e., concerns about who loses and who gains.

There is, therefore, general agreement among those writing the Fourth Generation Evaluation (Everitt 1996; Karlsson 1996; Laughlin and Broadbent 1996; Radaelli and Dente 1996) that the process of evaluation must directly involve all stakeholders, allowing them to lay out their concerns and interests in relation to the subject of evaluation. The stakeholders include political, bureaucratic, professional and citizen/user groups, and it is particularly important to ensure that the same stakeholders are not systematically excluded from the evaluation process. Weak stakeholders often include implementors and citizens/users.

Everitt (1996) suggests that good practice in evaluation requires:

- recognition of the importance of moral debate and that everybody, irrespective of power, status and position, has the right to legitimate opinions;

- recognition of power, powerlessness and empowerment;

- the development of a genuine dialogue between users and those within the organization and between groups within the organization itself;

- the encouragement of openness, questioning, complaints and criticism from outside and within the organization;

- that the "otherness" attributed to those lower in the hierarchy, to users and to those relatively powerless in the community is removed;

- scepticism of rational–technical modes of practice;

- that attention is paid to the fundamental purpose of the organization rather than being diverted solely into demonstrating productivity (use goals of organization as values by which to judge organizational performance).

Karlsson (1996) also stresses that good evaluations should allow even disadvantaged groups to have voice, through a process of dialogue. He specifically emphasizes the need to involve

different groups in making judgements about practice, either by simply describing practice and then letting the groups make their own judgements using their own criteria or by negotiating criteria to use through a process that ensures that the relatively powerless have a voice.

In practice, Karlsson (1996) suggests that evaluators must see themselves as interrogators who are trying to help participants see the possibilities for development. They must take particular steps to maintain credibility in the political context, for example by:

- presenting clear details of the full scope of issues;

- addressing the range of questions raised by those involved;

- maintaining communication;

- forming advisory groups to ensure the study has the appropriate scope to address major points of debate;

- including a clear statement of limitations in final reports and summaries;

- include non-technical statements of findings in final reports.

Overall, these analysts' approach is rooted in the understanding that democratic processes of evaluation are critical to ensure that practice is good, fair and equal (Everitt 1996), thus ensuring that evaluation itself contributes to just social change (Karlsson 1996) .

Conclusions

Health sector reform processes are not simply technical strategies but are processes of social change that are value-laden and, often, conflict-ridden. Among the critical conclusions about reform that can be drawn from experience of these processes are:

- the importance of values, actors and actors' perspectives over the content and process of reform;

- that understanding whether or not reforms are "effective" is dependent on understanding societal goals and values, as well as the explicit objectives of reforms;

- successful implementation requires both good political and managerial skills and strategies, and can be informed by sound processes of data gathering and dissemination;

- the institutional capacity necessary for successful reform is, however, not only a set of skills but also a set of relationships and principles that govern those relationships.

Evaluation of health sector reform should, therefore, be undertaken using both available and specially collected data to determine whether particular effects can be attributed to a specific policy change, and also to understand in detail the critical factors that underlie the nature and extent of change achieved. Failure to achieve change can be as instructive as success, but policy-relevant lessons can only be demonstrated if appropriate analysis has been undertaken. The analytical approach of an evaluation must, therefore, include techniques that allow causality to be considered, complemented by detailed analysis of the explanatory factors of context, actors, process and content. Varied data sources and analytical approaches are required in this analysis, which should combine quantitative and statistical techniques with qualitative techniques.

The analytical approach of an evaluation, however, is only one of two important aspects that must be pre-planned. The other is the overall strategy of evaluation, which must be undertaken in such a way as to allow stakeholder involvement and ensure evaluator openness. Although public policy evaluation is often seen as simply a technical, rational process it is inherently political and value-laden. The strategy of evaluation must acknowledge this fact if it is to be fair and credible.

Annex: Possible criteria for evaluation

Carr-Hill 1994:

- ▲ efficiency: level and growth of health care expenditure

- ▲ equity: horizontal vs. vertical; centrally controlled community participation may lead to less inter-community inequity, unclear what happens to intra-community equity, emphasis on outcomes can disguise the moral wrongness of the act producing the outcomes

- ▲ equity: who are public hospital patients (income level) and what is incidence of user fees

- ▲ accountability: associated with patient satisfaction

- ▲ outcomes: measurement made difficult by the attribution problem resulting from simultaneous treatment, co-morbidity, difficulty of determining an end-point of the intervention

Hsiao 1992:

- ▲ finance structure: extent of universal coverage provided, equitable distribution of financing burden according to individual's ability to pay and administrative efficiency of system

- ▲ relative efficiency of public and private institutions depends on extent to which services are integrated and coordinated and on ability to balance supply and demand

- ▲ need to look at total expenditure on health care (absolute levels, % GNP) and outcomes (IMR, LEBs, etc.), including patient satisfaction, access (value in itself!: utilization rates)

Kutzin 1995:

- ▲ equity in finance: progressivity of different financing sources, and change in progressivity over time, compare income & assets of paying vs. non-paying patients

- ▲ equity in utilization relative to need: is utilization related to patient need or income level? what is incidence of health care subsidy across different population groups? how has the distribution of disease burden across population groups changed over time/since reform? to what extent does distribution of service use reflect disease burden of different groups?

- ▲ geographic equity in service availability and use: distribution of personnel, facilities, budget and utilization per capita by region; patient origin surveys

- ▲ allocative efficiency: share of tertiary hospitals in overall public spending, shares of preventive vs. curative spending, changes in rates of use of medical technologies, compare case mix of health centers and hospital OPDs and change over time, changes in facility bypass and referral rates,

- ▲ technical efficiency: unit costs of service provision allowing for quality and patient mix differences

- ▲ financial sustainability: changes in funding sources for health services and patterns of expenditure from these revenue sources, comparison of medical price index with general consumer index, share of total spending as % GDP and of health as % total government, per capita utilization rates for high-tech services, drugs

- ▲ institutional sustainability: cost of administering system, costs of monitoring and evaluation for reform, skills and systems needed to make reform effective

- ▲ acceptability to consumers: linked to quality, so any changes over time in quality?

- ▲ satisfaction: expanded choice for consumers? rates of facility bypass, rates of participation in voluntary health insurance schemes, surveys of community perceptions

- ▲ acceptability to providers: interviews, analysis of roles of different groups

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