

# The politics of reforming health policies

■ Three main questions were raised at the IUHPE conference in June 2002 on “new dimensions in promoting health,” with a particular focus on the process of policy change:

- How should people with an interest in promoting health across sectors, approach the policy change process?
- What skills are needed to engage in the policy change process?
- How do we build collaborations across the policy arenas?

In short, the answer to all three of these questions is “politics.” First, the policy change process needs to be approached through politics. Second, engagement in policy change requires political skills. And third, collaboration across policy arenas requires management of the political process.

A decade ago, in his election campaign for President of the United States, Bill Clinton made famous the slogan, “It’s the economy, stupid!” He plastered those words on the wall of his campaign headquarters in Little Rock, Arkansas—to remind him and his supporters that winning the election required a focus on economic promises (Broder, 2000).

But the policy change process is driven itself by politics. Indeed, more attention by Bill and Hillary Clinton to the politics of health care - from “it’s the economy, stupid”, to “it’s the politics, stupid!” - might have improved their chances of passing health reform in the United

States in 1994 (Skocpol, 1995). The failure of the Clinton reform plan highlights the importance of the political process for promoting policy change, and the risks of underestimating political challenges. This article first reviews three political themes about the policy reform process, and then presents a systematic approach to the development of political strategies for reform, using examples of health policy.

## 1. Political will

The concept of political will persists in statements and commentaries about public policy. It is most frequently invoked to explain lack of action. Frequently one hears about the lack of public action on some dire problem due to “the lack of political will.” Usually this means that some politician has not shown sufficient personal courage or good sense.

One interesting example of resorting to political will as an explanation is the 1993 World Development Report, published by the World Bank, on how to reform health systems in developing countries. The report recognised some difficulties in promoting health reform, but asserted, “Broad reforms in the health sector are possible when there is sufficient political will and when changes to the health sector are designed and implemented by capable planners and managers” (World Bank, 1993, p.15).

Unfortunately, the World Bank authors did not provide any evidence to support the assertion that “sufficient political will” is a necessary condition for health reform; nor did the report define the concept of political will in a succinct or explicit manner—a pattern criticised elsewhere (Reich, 1994b). It might have been helpful if the report had included this political concept in the introductory section on “definitions and data notes”, along with explanations of such economic concepts as cost-effectiveness, allocative efficiency, and disability-adjusted life year.

Some analysts of policy reform continue to use the concept of political will to explain inaction. For example, a recent report on world hunger is titled, “Fostering the Political Will to Fight Hunger” (Committee on World Food Security, 2001). This report seeks to promote implementation of national pledges agreed to at the World Food Summit in 1996. The Food and Agriculture Organization decided that the problem is “political determination.” The FAO concluded, “To the extent that the means exist to eradicate hunger ... its continued existence on a vast scale is a consequence of either deliberate political choice ... or incompetence in applying possible solutions.” The FAO’s calls for more political will, however, did not succeed in generating much political interest or determination, as shown by the poor attendance of national leaders at the conference on hunger, which was held in Rome in early June 2002 (Reuters, 2002).

This focus on political will has a number of problems for understanding the process of policy reform. It personalises policy change and emphasises individual leaders. It suggests that all you need is political will by leaders for policy to change. The leader makes a decision and makes it happen, implicitly assuming a strong state, good institutional capacity, and adequate political capital. The focus on political will, moreover, tends to ignore the political constraints and the political risks to policy reform. In this viewpoint, policy reform occurs when political leaders simply exercise their “will.” If reform does not occur, then there is a lack of political will. Recognising these problems, policy analysts typically consider political will to be a flawed concept. Grindle and Thomas called the term a “catch-all culprit” that has “little analytic content,” adding that “its very vagueness expresses the lack of knowledge of specific detail” (Grindle and Thomas, 1991, pp. 122-124).

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On other hand, political leaders do need to exercise their will-power to enact public policy. Robert Coles wrote about this process in his book on *Lives of Moral Leadership: Men and Women Who Have Made a Difference*. He described how Robert Kennedy, as the junior Senator from New York in 1967, helped a group of doctors present their findings about hunger among America's poor children (Coles, 2000). Coles stressed how the personal choices of leaders can make a difference in public policy by selecting problems for public consideration. He quoted Kennedy, "There are a lot of issues out there, but it's our job to decide which ones matter most" (Coles, 2000, p.27).

But Kennedy did more than just speak up; he knew how to transform the doctors' moral outrage and scientific report into a public issue. He had political skill as well as political will. This example emphasises the point that data alone are rarely enough to promote policy reform. Often, policy advocates need to create incentives for political leaders to engage in reform, which involves creating and managing the political benefits of change. To do this, they need political skills in two key areas—political analysis and political strategies. These factors, which will be considered next, help create the political feasibility that is needed for policy reform to succeed.

## 2. Political analysis

The first skill is to assess the political intentions and actions of stakeholders. Stakeholders include individuals, groups and organisations who have an interest in a policy and the potential to influence related decisions. Political science has a long history of studies concerned with the role of groups in governmental decisions (Truman, 1951). Recently, health policy analysts concerned with developing countries have given increasing attention to the importance of stakeholder analysis (Brugha and Varvasovsky, 2000).

Political analysis of stakeholders needs to consider all the individuals and groups that could be affected by policy reform. The list should include interests who will be helped and hurt, as well as interests perceived as being helped and hurt. Political analysis should identify whose

toes will be stepped on, who expects their toes to be stepped on, and how different groups are likely to react when their toes are stepped on, or when they think their toes will be stepped on.

The distribution of political costs and benefits among stakeholders is a critical question for political analysis. Often, health policy reforms confront a particular kind of distribution, with concentrated costs falling on well-organised groups and dispersed benefits intended for non-organised groups:

- **Costs:** Health policy reform efforts commonly place concentrated new costs on well-organised, powerful groups, for example, on physicians (often well-organised in a national medical association), or on the pharmaceutical industry (often well-organised in an industry association). This problem of concentrated costs can create significant political obstacles to reform, since the high-power groups tend to become mobilised to oppose the reform, to protect their interests.
- **Benefits:** Health policy reform often seeks to make new benefits available to non-organised groups, for example, the poor, marginalised or rural residents. Such groups often are not well-organised or politically well connected. In addition, these changes may only result in modest future benefits for each individual. Dispersed benefits among low-power groups make it more difficult to mobilise significant political support for reform.

The combination of concentrated costs on well-organised groups and dispersed benefits on non-organised groups constitutes what Mancur Olson called a collective action dilemma (1965). This distribution of costs and benefits creates disincentives for collective action to promote policy change. Overcoming the politics of this collective action dilemma is a major challenge for health reform advocates.

Even dictators, however, need political analysis to assess the stakeholders involved in policy reform. In 1982, when Bangladesh's new military dictator, H.M. Ershad, decided to introduce a new national policy for medicines, to give priority to essential drugs, he needed to

analyse the stakeholders, even under marshal law (Reich, 1994a). He needed to consider the position and the power of the Bangladesh Medical Association, the Teachers Union, the Bangladesh domestic pharmaceutical industry, the multinational pharmaceutical companies, the governments of major donor countries, the World Health Organization, and international consumer groups. In short, he needed a political analysis of the major stakeholders involved.

Unfortunately, public health professionals tend not to be well trained in political analysis. More often, they are trained to believe that finding the right technical answer (in epidemiology or economics) is sufficient. Anyone with real-world policy experience knows the limits of this approach.

Bill Clinton learned this point the hard way. He confronted an array of stakeholders when he sought to reform the health system in the United States in 1993. Enormous pressure emerged from interest groups. At that time, the health care industry involved one-seventh of the US economy—and these stakeholders worked to shape the legislative debate in ways that would protect their interests. According to the Center for Public Integrity, the debate over health reform was "the most heavily lobbied legislative initiative in recent U.S. history," involving hundreds of lobbying organisations and a total of more than \$100 million (1994). Although a number of key interest groups (including the American Medical Association, and the three main business lobbies in Washington) initially supported the idea of health reform, these groups eventually shifted to a position of absolute opposition (Judis, 1995). According to one observer, "one of the main reasons the reform plan failed was that it did not enlist the cooperation of the medical profession" (Relman, 1996).

Good politicians know how to analyse the players in a policy arena—through repeated practice, experience, and learning. But sometimes even good politicians need assistance with political analysis. Those of us who are not born politicians need training and help, especially in public health. This training can be obtained through a tool for applied political analysis: a Windows-based computer software programme that provides a step-by-step method for

analysing stakeholders, developing political strategies, and assessing political feasibility (Reich and Cooper, 1995-2000).

Political analysis, thus, needs to be accompanied by strategies for policy reform, which will be considered next.

### 3. Political strategies

Political strategies are causal predictions about the future. Strategies are formulated in the structure of, "If I do *x*, then I expect *y* to happen." Good politicians have an intuitive sense about the strategies that are likely to work in a particular situation, based on their accumulated experience with political life. Inexperienced politicians need to develop these skills, if they are to survive and succeed in policy reform.

The literature on agenda-setting for public policy shows that the decisions on policy priorities can be unpredictable. But a determined and skilled policy entrepreneur can make the unthinkable become thinkable. A crisis can focus attention and alter political calculations about a problem, creating an unanticipated window of opportunity for policy change. Political scientist John Kingdon (1995) has argued that the best chances for successful policy change occur when three streams of events come together: 1) the objective situation - the problem stream, 2) the availability of a possible solution - the policy stream, and 3) the flow of political events - the political stream. When these three streams converge, according to Kingdon's theory of agenda-setting, some policy response is likely to result, although the response may not resolve the problem. Within these streams, the political strategies adopted by policy advocates can make a critical difference.

President Clinton and his advisers, for example, recognised a window of opportunity to reform the U.S. health system in 1993, but they incorrectly assessed how wide the opening was and how long the window would stay open (Skocpol, 1995). They also adopted some strategies that created political problems. These decisions included: the decision to appoint a technocrat with limited Washington political experience as head of the health reform task force; the decision to give overall responsibility for health reform to Hillary Rodham Clinton;

and the decision to leave political bargaining over the plan until after the entire package was presented to Congress. Their strategies unintentionally mobilised opponents into an effective coalition, and failed to mobilise supporters into anything approaching an effective coalition. This combination helped kill the chances for reform.

In general, political strategies are needed to address four factors that determine the political feasibility of policy change (Roberts *et al.*, in press).

The four factors are:

- **Players:** The set of individuals and groups who are involved in the reform process, and might enter the debate over the policy's fate.
- **Power:** The relative power of each player in the political game (based on the political resources available to each player).
- **Position:** The position taken by each player, including whether the player supports or opposes the policy, and the intensity of commitment toward the policy for each player (i.e., the proportion of resources that the player is willing to expend on the policy).
- **Perception:** The public perception of the policy, including the definition of the problem and the solution, and the material and symbolic consequences for particular players.

Next we consider political strategies for these four factors.

#### Strategy #1: Players

Reform advocates can consider political strategies that try to change the set of players, by creating new friends and discouraging foes. These strategies seek to mobilise players who are not yet organised and demobilise players who are already organised. It means changing the number of mobilised players, as supporters and opponents, by recruiting political leaders to the health policy cause, and away from the side of the opponents. New players can be persuaded to enter the game and take controlling positions, and current players can be influenced to leave, become inactive, or wait on the sidelines. Policy

advocates who want the political system to decide in favour of reform need to consider all such options—in order to influence the political feasibility of reforming health policy.

Mobilising groups requires convincing people that they should pay the costs of getting involved in an issue they have so far ignored, or the substantial costs of organising a new group. Sometimes, mobilising an existing group may require simply bringing the issue to the group's attention. Once the group knows what is going on, it may decide to take a position.

The case of national policy for safe motherhood in Indonesia shows how a skilled policy entrepreneur can mobilise key players and shape the policy agenda (Shiffman, in press). In this instance, a bureaucrat moved from the national family planning agency to the Ministry of Women's Roles and developed an effective campaign to raise attention to the persistent high rate of maternal mortality (390 deaths per 100,000 births in the Indonesian Demographic and Health Survey published in 1994). This individual succeeded in mobilising the president, the Ministry for Home Affairs, provincial bureaucracies, and donor agencies, by defining the problem as a broad issue involving the well-being of pregnant women and the low status of women in society.

Another example of creating a new organisation and mobilising a broad coalition of groups for policy reform is the successful campaign to introduce a 25-cent tax on each pack of cigarettes in California, in November 1988, through a state-wide initiative (Meyers, 1992). This initiative succeeded after many failed efforts to introduce legislation, reflecting the tobacco industry's enormous lobbying power (Field, 1996). Supporters for this policy called themselves "the Coalition for a Healthy California," and they involved the American Cancer Society, the state hospital association and medical association, as well as a major environmental group and the firefighters' union. By defining the issue as a health issue and an environmental issue (because of forest fires from cigarettes), the policy advocates formed a broad coalition that helped create the conditions for successful reform.

## Strategy #2: Power

A second set of political strategies is designed to change the distribution of power among key players, strengthening power among friends and weakening power among enemies. Since a group's impact on the policy process depends partly on its resources, reform advocates can adopt strategies to enhance the political resources of supporters and decrease those resources of opponents. Here are some examples:

1. Give or lend money, staff, or facilities to groups that support the reform;
2. Provide information and education to supporters to increase their expertise;
3. Give allies expanded access to lobby key decision makers;
4. Provide allies with media time and attention to enhance their legitimacy. Focus attention on their expertise, impartiality, national loyalty, and other positive social values.

A tough political strategist can do the same in reverse to opponents, seeking to reduce their access to political resources.

One example where power-based strategies contributed to policy reform is the introduction of health insurance for school children in Egypt in 1992 (Nandakumar *et al.*, 2000). In this instance, the minister's personal commitment to reform made a significant difference in passing a new law through Egypt's parliament. The minister used various political strategies to confront opposition from within the government bureaucracy and from opposition politicians: he removed a high-ranking bureaucrat from office; he negotiated with politicians to agree on a financing source for the programme; and he appealed to the highest levels of political support when progress slowed. Once the law was passed, the minister accelerated implementation of the programme, to cover all school children with the new health insurance programme within one year. The case shows that how policy reform can become politically feasible when driven by a high-ranking politician.

## Strategy #3: Position

The third set of political strategies involves bargaining within the existing

distribution of power, to change the position of players. This can involve threats, promises, trades, and deals. Interest groups sometimes use public threats to protect their policy positions. For example, strikes by physicians in Korea forced government to make major changes in health policy reforms, in order to protect physician incomes and interests. Physicians in Korea forced the government to delay its implementation of the Diagnosis-Related-Group-based payment system, and compelled the government to raise the reimbursement fees to physicians substantially in one year (Kwon, in press).

Consumers can also use boycotts to promote their policies and compel others to change their positions. A famous international example is the consumer boycott of Nestle products to protest corporate policies on infant formula marketing in developing countries. This boycott helped force Nestle to change its marketing policies for infant formula and helped create an environment for the World Health Organization to pass the "International Code of Marketing Breast-Milk Substitutes" in 1981 (Sethi, 1994).

## Strategy #4: Perception

A public appeal to change perception of an issue can be an effective political strategy, especially in political systems that are open and competitive. This approach can be effective in influencing bureaucratic and political leaders as well as the public. Political strategies for perceptions seek to change how people think and talk about policy reform, how the issue is characterised, and which values are at stake. The perception of an issue also affects how it is connected (or not) to important national symbols or values. Is this reform going to advance the nation's identity in some fundamental way?

Perception strategies relate to how the human mind works. Human beings often have trouble grasping complex fact patterns and seek ways to make sense of a confusing reality. This is especially true in situations where reality is complex, outcomes are uncertain, and conflicting goals are involved—all of which occur for health policy reform. In such cases, policy advocates need to manage public perceptions, because these change how problems are defined and which answers

are acceptable. At the center of the political debate is a contest over image and language, over the symbols for health reform (Edelman, 1977). How is the problem characterised, how are the choices described, and how is the issue framed?

In the Dominican Republic, efforts to reform the health system in 1996 were designed to transform the state's role from direct service provider to financier and regulator. Similar approaches were adopted at the time in many Latin American countries, with financial support from the multilateral development banks. In the Dominican Republic, however, the press interpreted these efforts as "privatisation" of health services, and the supporters of health reform were unable to create an alternative public perception of the plan (Glassman *et al.*, 1999). This perception of the proposed policy created a strong reluctance among both politicians and bureaucrats to support the reform—especially when opposition arose from the powerful medical association and from non-governmental organisations active in the health field.

In the failed Clinton health reform, the opposition won the public perception battle, hands down. Certain health industry interest groups engineered a public relations campaign and organised a grassroots opposition movement that transformed the political environment of health reform. A classic example was the television commercials of Harry and Louise, a middle-class married couple, who presented the Clinton plan as undermining their lives. Sponsored by the health insurance industry, these ads raised deep fears that the Clinton plan would limit the freedom of choice for existing health insurance and would produce a "government-run" health system (Johnson and Broder, 1996). The campaign connected to deeply felt social values in the American middle-class today: the growing sentiments against government bureaucracy, and the fears of an eroding standard of living. In contrast, the proponents of the Clinton health reform failed in the arena of public perceptions. They created a complicated package that defied simple explanation. The reform proponents failed to find effective symbols to explain how the Clinton plan would work, what the plan would do, or how it would

connect to core social values. As one key technocrat later reflected, "Many people couldn't understand what we were proposing. There were too many parts, too many new ideas, even for many policy experts to keep straight" (Starr, 1995).

#### 4. Reflections on the politics of health policy reform

This review of political strategies for managing health policy reform has important implications for the theme of "new dimensions in promoting health." The bottom line is, "It's the politics, stupid!" But politics here is not just big "P" politics of major politicians, but also little "p" politics of what goes on within and between all sorts of organisations and people. Health promotion—through environmental policy, employment policy, education policy, and other policy domains—requires an engagement in practical politics and the application of political skills.

To be effective, public health advocates need to become better at politics, learning how to create political incentives for leaders and how to deal with political risk. At the IUHPE conference in London, Richard Parish, the Chief Executive of the Health Development Agency in England, said, "We need to persuade politicians that the risks of not doing something are greater than the risks of doing something different." This political persuasion requires courage, creativity, and a capacity to recognise opportunities for change. One of the under-appreciated benefits of globalisation is that it can sometimes make leaders aware of the advantages of change and reform, that the old ways of doing things are not always the best. Advocates for reforming health policies need to manage the politics of change, through hard-nosed political analysis and innovative political strategies.

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#### Acknowledgments

This article is based on a Keynote Address to the 5<sup>th</sup> International Union for Health Promotion and Education European Conference on the Effectiveness and Quality of Health Promotion, held in London, 11-13 June 2002. The article's ideas are developed and applied to health sector reform in a forthcoming book (Roberts *et al.*, in press, Chapter 4).

## Promotion & Education

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