POLICY BRIEF

CENTER FOR HEALTH SYSTEM AND POLICY RESEARCH

MARCH, 2016

Policy Implementation Gap: A multi Country Perspective

Health policies once adopted are not always implemented as envisioned to achieve the intended outcomes. The challenges associated with policy implementation create gaps widely attributed to factors ranging from problematic policies to lack of governance and resources. LMICs continue to experience implementation gaps in their bid to translate policy into outcomes. This study highlights the complexity associated with health policy implementation and why implementation gaps are increasingly widening in low-and-middle income countries.

Photo by

Key Messages

Implementing health policies is a complex phenomenon that triggers unintended consequences and intangible factors often ignored by policymakers, yet having critically impacts on policy processes and outcomes .

Key Lessons

- Introducing new policies or interventions do not automatically solve the health problems due to the complexity of the health system and numerous challenges faced in LMICs
- Policy interventions no matter how well intended require political buy-in and key stakeholder engagement to enable align the policy to stakeholders priorities
- Policy reforms and interventions if not aligned to existing policies, actors' capacities and competencies will create implementation gaps.

In the real world, policy implementation is messy, it is influenced by actors' decision-making, beliefs and values, the practices and power of other actors, their networks and context [13,14]

Issue 1 ll 2016

In this 1st Issue

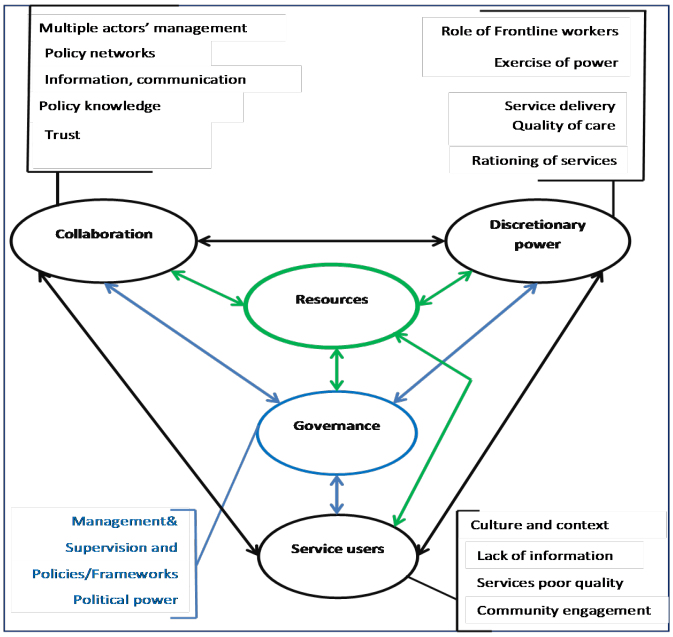
- We explore factors leading to policy-implementation gaps during health reforms and interventions
- Next **Issue**: Disaster Management and Emergency Response in Ghana

Introduction

Implementation experience in low-and-middle income countries (LMICs) shows that policies once adopted, are not always implemented as envisioned and do not always achieve intended results [2,3,4]. The process of translating policy into outcomes, practice or specific programs has long been recognised by policy makers, governments, practitioners and researchers as fraught with difficulties, hitherto affecting the intended outcomes or leading to policy failures. Key stakeholders in LMICs are increasingly concerned with policy failures, the widening gap between policy intentions and implementation, and why these challenges are difficult to fix or not prevented [5]. Understanding the nature of policy implementation in LMICs is relevant to unpacking the causes of this challenge. This study seeks to understand the complexity associated with health policy implementation and why implementation gaps are increasingly widening in LMICs.

Evidence

A thematic data synthesis from the three case studies in Ghana, Malawi and Botswana showed the major contributing factors creating gaps during policy implementation to include; collaboration, discretionary power, resources, governance and service user experiences.



Coordination

Health policy implementation is organised around multiple actors and factors, making collaboration a critical contributor to policy implementation in the health system. Effective collaboration or lack of it may result from the factors: implementation strategies adopted, multiple actor engagements and management, coordination and policy networks, information sharing, communication and trust. The challenge of multi-actor role in policy implementation is managing the relationships, power, trusts and levels of commitments among them.
.

Discretionary Power

Policy implementation in health systems is inadvertently influenced by the actions or inactions of frontline workers who whom health services are provided. In cases of health services delivery, the discretionary role of frontline workers (FLW) in taking decisions, interpreting policies, responding to contextual factors and providing services to meet varied needs is critical [6,7] . FLW have direct interaction with citizens in the course of their work, giving them substantial discretion in their treatment of clients in the health systems [8]. In the three cases, providers demonstrated great discretionary power in responding to different client needs in terms of how they influenced services provided, interpretation and application of policies, allocation of resources, and rationing of services to accommodate their limitations peculiar to specific contexts.

Resources

Resource constraints experienced by implementers, frontline workers, health leaders and service users, indiscriminately affect implementation they tend to alter services, policy process and how actors deal with policies and programs. In all the countries, lack of organisational and personal resources created pressure for which service providers had to adopt coping behaviours to manage high demands and time pressures during service delivery. Providers work in contexts of infrastructural, financial, logistics and technical constraints further compounded by the various social factors such as culture and religious values. The constraining environments compel them to re-create and re-translate policies to reclaim some level of their operational control and to respond to their working conditions

Voices of Actors

: *"… Sometimes you compare the kind of medication you give to the clients… once I told a patient, I could have written this drug for you but once you do not have insurance, if I prescribe it, you can't pay…..*" (Healthcare Provider: Ghana)

"*The PMTCT related resources constraints have negatively affected beneficiaries and delayed their ANC initiation. … women had gone to clinics to register, but had found no nurse or midwife available, and nobody else able to assist them*" (MOH: Botswana).

Despite the high numbers of patients requiring HIV services there are no special health workers fully dedicated to HIV services or special rooms for HIV patients ...sometimes this challenge staff capacity and space for privacy (Public Provider: Malawi).

They (healthcare providers) will not help you if you do not attend ANC when you are still pregnant and you just come when you are having the baby. I was afraid of them."(Service User: Botswana)

Governance

Governance drive policy processes through leadership, management and power influence. Its structures can transformed the health systems and implementation, but weaknesses in it have can be detrimental to policy outcomes. The cases showed national politics and direct government interference were predominant during implementation at the national levels in Ghana, Botswana and Malawi. Yet at the organisational level, the leadership direction and governance structures were not well defined to allow effective outreach and follow-ups for among actors/organisations. At the health facilities, leadership and management were highly influenced by policy acceptance, an understanding of the policy reforms and programs and commitment to implementing them. Yet in all the cases, facility managers and frontline workers noted that they were excluded from the policy formulation and planning phases. Therefore, their abilities and capacity or inability to action these policies were ignored.

Service User

Service Users: The role of service users as community members, patients or groups in health policies and program implementation is very crucial yet often ignored. Service users' experience of policies and programs are determined by their involvement in the planning, implementation, ability to ensure quality, availability of and accessibility to services. But in all the cases, community involvement was largely limited to passive service usage. Patients lack the ability to seek for quality care or increase in access to services. Hence, the expressions "*They (healthcare providers) will not help you if you do not attend ANC when you are still pregnant and you just come when you are having the baby. I was afraid of them*."(Service User: Botswana).

Discussion

The complexity inherent in health policy implementation is evident around: the complexity of putting policy into actions; the impact of policy content, context and operational clarity; the embedded nature of policy implementation; and power dynamics, governance and leadership. Health policy implementation requires multiple actors and institutions at different operational and implementation levels to work together or collaborate on various aspects of their functions and sectors to achieve efficiency, participation and sustainability of the programs [9]. Policymakers failed to acknowledge the nature of the policy process as a social construct requiring the multiple actors to make meaning of the policies, in reference to their practice and experience in a complex and ever-changing environment. Therefore understanding how actors make sense of policy processes from their perspective and context [10] had bearing on policy outcomes and actors' ability to collaborate effectively towards policy processes. Similarly, power, politics, leadership and governance factors are often overlooked or the ability to effectively monitor and regulate policy actions.

Also, contextual factors during implementation influence outcomes and the extent of policy action. Despite the evidence that resources and structures were inadequate, the sociocultural appropriateness of the policy to the context within which it is being introduced, both at the organisational or community levels, was a critical contributor to policy outcome, acceptability and community participation. Health policies and programs are often viewed in isolation from the problems and policy goals and not as complex processes – with many embedded parts, roles and actors that are dependent on each other or have the capacity to affect one another both directly and indirectly. The challenges surrounding policy implementation in Ghana, Botswana and Malawi [as shown in this brief] points most significantly to the need for systems thinking. The reality of policy implementation is that it does not occur in a vacuum, but embedded in context and often influenced, shaped, enabled or constrained by various contextual features [11,12].

Conclusions

In implementing health policies, several factors contextually and remotely impact on the process. These contextual features must be recognised during policy development and implementation to allow optimal alignment between policies and implementation outcomes. Yet the linkages among the various features or factors are not always linear or straight forward but emergent, unpredictable, requiring dynamic feedback loops. The health system is a living phenomenon, consisting of hard and software factors with features that may be tangible or intangible. Therefore, reforms and implementation processes associated with the health systems tend to be complex demonstrating the dynamic manner in which the health systems interact.

At the organisational level, the interaction between the hardware and software factors is demonstrated by how factors such as the financial, human and logistical resources, governance and leadership, service provision interaction and impact on software issues such as trust, power, politics, values, culture and communications. This demonstrate how policy intentions change during implementation making the process rather complexity, messy and unpredictable besides the fact that the process and boundaries between policy reforms and implementation is of the processes and the fuzziness of policies themselves

Contact Us

Email: info.chespor@gimpa.edu.gh

Facebook: https://www.facebook.com/Chespor/

Website: www.gimpa.edu.gh/chespor

WhatsApp: +233240948104

Tel: + 233 263501114

Credit

This Policy Brief was prepared and edited by **Dr. Gina Teddy**. It is part of a health policy series compiled by the Centre for Health Systems and Policy Research (CHESPOR) & a journal co-authored with Dintle, Martina & Boroto at Cape Town.

Key References

1. Walt G & Gilson L (1994) Reforming the Health Sector: The Central Role of Policy Analysis. Health Policy and Planning 9 (4): 353–370.
2. Calista D (1994) Policy Implementation. In: S. Nagel, Encyclopedia of Policy Studies. New York: Marcel Dekker. pp. 117–155.
3. Love A (2004) Chapter 3: Implementation Evaluation. In: HHJS Wholey, The Handbook of Practical Program Evaluation. San Francisco, CA: Jossey-Bass, Inc. (pp. 63–97)
4. Bhuyan A, Jorgensen A, & Sharma S (2010) Health Policy Initiative, Task Order 1.Taking the Pulse of Policy: The Policy Implementation Assessment Tool. Washington, DC: Futures Group.
5. Spratt K (2009) Policy Implementation Barriers Analysis: Conceptual Framework and Pilot Test in Three Countries. Washington, DC: Futures Group, Health Policy Initiative, Task Order 1.
6. Walker L & Gilson L (2004) 'We are bitter but we are satisfied': nurses as street-level bureaucrats in South Africa. Social Science and Medicine, 59: 1251–61.
7. Rothstein B (1998) Just institutions matter: The moral and political logic of the universal welfare state. Cambridge: Cambridge University Press.
8. Lipsky M (1980) Street-level bureaucracy: dilemmas of the individual in public services. New York : Russell Sage Foundation.
9. Montjoy RS & O'Toole LJ (1979) Toward a theory of policy implementation: An organizational perspective. Public Administration Review, 39(5): 465-76.
10. Lehman U & Gilson L (2012). Actor interfaces and practices of power in a community health worker program: A South African experience of unintended consequences. Health Policy and Planning Advance Access (Advance Access - July 23), 1-9.
11. Hunter DJ (2003) Public health policy. Cambridge, Polity Press.
12. Grundy J, Hoban E, Allender S, & Annear P (2014) The intersection of political history and health policy in Asia – The historical foundation for health policy analysis. Social Science & Medicine, vol 117:150-159.

CENTRE FOR HEALTH SYSTEMS & POLICY RESEARCH

(**Strengthening health systems, policy research and practice**)

The Centre for Health Systems and Policy Research (CHESPOR) is established to extend the emerging field of health policy and systems research (HPSR) in Ghana and the sub-Saharan African region. We aim to provide the space to address and debate health systems issues in the region. Through informed research and training, CHESPOR is promoting systems thinking and innovation that will contribute towards understanding, developing and strengthening the field of HPSR across boundaries, disciplines and sectors.

GIMPA