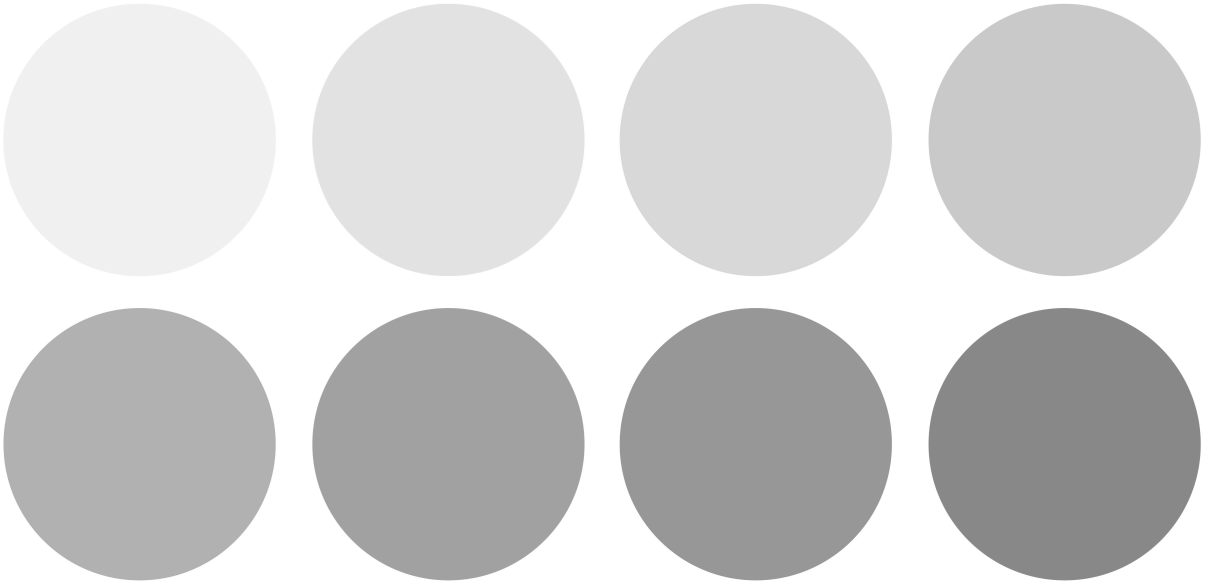
A Guide to Health Reform

Eight Practical Steps



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Abstract

A Guide to Health Reform: Eight Practical Steps instructs readers on how to navigate the complex challenges of doing health system reform. The Guide builds on the 2004 book *Getting Health Reform Right: A Guide to Improving Performance and Equity* (GHRR), which presents a framework for understanding and achieving successful health reform. The GHHR framework (also known as the "control knob" model) is the foundation of this Guide's Eight Practical Steps. The step-by-step guidance is presented in easy-to-read language and general terms, so that government policy makers, analysts, advisors, advocates and other stakeholders in any country can use the Guide to plan and implement health reform.

The Eight Steps are: 1) Decide to start the health reform process; 2) Create a health reform team; 3) Assess the health system's performance and define its performance problems; 4) Diagnose the causes of performance problems; 5) Decide on a reform package; 6) Conduct political analysis and design political strategies; 7) Manage the implementation of health reform to achieve results; and 8) Evaluate impacts and create sustainability for health reform.

The Guide describes each step in a short chapter, highlighting between four and six key actions and noting additional references for more details. The Eight Steps can be read (and applied) in a different order depending on the needs and circumstances of health reformers. The Guide includes 12 worksheets, 5 appendices and a glossary, to assist readers of the Guide to adapt and apply the Eight Steps to the real-world complexities of health reform.

Preface

A Guide to Health Reform: Eight Practical Steps was created in 2023 as part of the India Health Systems Reform Project at the Harvard T.H. Chan School of Public Health. The Project's primary objective is to conduct collaborative research and capacity building to improve equitable and affordable access to good quality healthcare in India. This Guide is intended to support India's central and state governments with their ongoing health system strengthening efforts. It is written in accessible language for health policy makers, analysts, and other stakeholders to use in shaping health reform efforts.

The key concepts and structure of this text are based on the book *Getting Health Reform Right: A Guide to Improving Performance and Equity*, which was published two decades ago by the late Marc J. Roberts, William Hsaio, Peter Berman, and one of this Guide's coauthors (MRR). *Getting Health Reform Right* (*GHHR*) presents an approach to health system analysis and reform that is often called "the control knob framework." This framework has been adopted (and adapted) for national and state health system reforms around the world.

This Guide is designed to serve as a companion text to *GHRR*, with a focus on the practice of health reform. We hope the Guide will prove relevant and useful to analysts and policymakers in India—and also to people working to improve the performance of health systems in other countries around the world.

We believe that there is room for improvement in any system, including our systematic approach to health reform. We look forward to hearing from you, the readers, about your experiences with using this Guide, and to receiving your suggestions on how to improve the Guide to support strengthening the performance and equity of health systems around the world.

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Acknowledgments and Contributions

The authors of *A Guide to Health Reform: Eight Practical Steps* are grateful for the support of the India Health Systems Reform Project at the Harvard T.H. Chan School of Public Health, which is funded by the Bill and Melinda Gates Foundation.

The Guide is based on the book *Getting Health Reform Right: A Guide to Improving Performance and Equity* (Oxford University Press, 2004, 2019, by Marc J. Roberts, William Hsiao, Peter Berman, and Michael R. Reich).

We appreciate the comments and suggestions of colleagues who reviewed earlier drafts, especially Veronika Wirtz, William Hsiao, Adolfo Rubinstein, Susan Sparkes, Sian Tsuei, and Peter Berman. We thank Rodrigo Bianco of Argentina for his design of Figure 3-1.

The writing of this Guide was divided as follows: Michael R. Reich drafted the Introduction and Steps One, Five and Eight; Anuska Kalita drafted Steps Three and Four; Paola Abril Campos drafted Steps Six and Seven; and, Anya Levy Guyer drafted Step Two. Winnie Yip reviewed the entire Guide and provided additional text throughout, especially for Steps Three and Four. Reich and Guyer made revisions based on reviewers' feedback and edited the full document.

Abbreviations and Acronyms

CHE	Catastrophic Health Expenditure
GHHR	Getting Health Reform Right: A Guide to Improving Performance and Equity
HIC	High-income country
LIC	Low-income country
LMIC	Low- and middle-income country
MIC	Middle-income country
OECD	Organization for Economic Cooperation and Development
OOPE	Out-of-pocket expenses
PM	Prime Minister
PM-JAY	Pradhan Mantri Jan Arogya Yojana insurance

Introduction

What is this Guide?

This Guide is designed to accompany the book *Getting Heath Reform Right: A Guide to Improving Performance and Equity*, which was first published in 2004 and then republished with a new preface in 2019. Over the past two decades, *Getting Health Reform Right (GHRR)* has been read by tens of thousands of people and used in hundreds of courses on strengthening health system performance around the world. The book presents a systematic approach to doing health reform, based on principles and practices from a range of disciplines, including economics, political science, organizational theory, and ethics. The book discusses in great depth why and how to engage in health reform, and provides academic references and actual experiences to support its analysis of health reform goals and processes.

This Guide is shorter than *GHHR* and presents more practical guidance on how to manage the eight steps of doing health reform. The Guide's goal is to provide strategic and practical guidance for people who seek to be health reformers. We explain in (relatively) simple terms how to grapple with the complex, conflictual, and controversial processes of health reform.

The Guide offers both instruction and sample tools to help you apply the concepts and methods from *GHRR* in your specific setting. Because we are writing for a global audience, our guidance sometimes is both idealized and generalized. For example: you may be reading this Guide because you already have a good sense of the health system problems you want to address and how you want to address them. If this is the case, the assessment and diagnosis processes may appear redundant. However, we still recommend going through those steps, as they are actually critically important. Other readers will be at other stages of considering and doing health reform. Policy reform processes in the real world can be frustratingly slow for long periods—and then suddenly move quickly. This Guide can help you prepare to use both the urgent and slow periods well.

We invite you to adapt the ideas and materials of the Guide to make the health reform process work for you. For instance, you may take the steps in a different order (or even to skip certain steps) depending on what you aim to achieve, how you plan to go about it, and where you work. Our intention is that you will reshape and adapt the broad ideas and suggested steps we present in order to support your particular objectives, address your particular challenges, and make them appropriate for your particular environment and health system. In short, this is *not* a cookbook with simple recipes. Instead, it is more like a guide to becoming a good cook. We expect you to adapt the "recipes" in this Guide to make use of locally available ingredients, to work well in your kitchen, and to satisfy your tastes and preferences.

What do we mean by "health reform," "health system," and "performance"?

There are many ways to interpret the term "health reform," so let us begin by presenting our operational definition. We consider "health reform" to be *the purposeful use of policy options to effect changes that are intended to improve the performance of the health system*.

This statement, of course, raises another question: What is a "health system"? Our operational definition of a "health system" starts with the premise that *the health system is the means to an*

end: namely, the wellbeing of a population. The "means" that comprise the system is the network of institutions, people, policies, and processes that together work toward that end. *GHHR* notes three important characteristics of a health system—"its complexity, its resistance to change, and the diversity of perspectives within it" (p. 5). These three features affect how health reform occurs.

We also need to define "health system performance." Performance, in the language of *GHRR,* encompasses how well the health system achieves six separate, but related. goals. Three are "intermediate" performance goals[1]:

1) *Access:* Ensuring health services are available to and used by the population
2) *Quality:* Delivering health services in ways that increase clinical effectiveness, patient safety, and patient-centeredness
3) *Efficiency:* Using inputs to the health system to produce optimal outcomes with limited wastage

The other three are the "final" performance goals of the health system[2]:

1) *Health status:* Improving the health of the population
2) *Financial risk protection*: Protecting people from financial ruin due to health care costs
3) *Public satisfaction:* Increasing how satisfied citizens with the health system

Each goal is a complex concept with various definitions in the literature. The short definitions above do not adequately address or explore the many issues involved in each goal. These concepts are discussed in more detail in Step Three below (and in *GHRR-Chapters 5* and *6*).

For each goal, it is critically important to consider both the overall impact *and* whether the benefits are distributed in a just and fair manner across various groups in a population. As noted in *GHRR,* "From a reformer's point of view, the distribution of outcomes—across regional income or ethnic groups—will generally be the most relevant consideration" (p. 92). This is the principle of "equity," and it is so central to our approach to health reform that it is explicitly mentioned in the full title of *GHRR*.

Now that we have briefly stated the goals, we can understand health reform as government "efforts to…reorganize their health-care systems" to improve performance with a focus on achieving equity within their national population (*GHRR*, p. v). Some examples of health reform mentioned in *GHHR* are policy changes: to improve primary care delivery; to introduce social insurance models; and, to change hospital governance and payment systems, rather than leaving them to occur solely in response to market forces. Health reform traditionally focuses on health care delivery systems, but it can also address changes in other sectors (such as infrastructure, agriculture, technology, and education, to name a few) that affect the health of the population.

[1] In both *GHRR* and this Guide*,* the intermediate performance goals are also called intermediate performance measures, outcomes or objectives.
[2] In both *GHRR* and this Guide, the final performance goals are also referred to as ultimate goals, measures, outcomes or objectives.

What is the scope of health reform?

Health reform efforts can have a range of intended scopes, from incremental improvements to system-wide overhauls. *GHRR* and this Guide focus mostly on what we call "large R" reforms—namely, efforts that aim to achieve transformative and system-wide changes. Much of the guidance and principles, however, are also applicable to incremental (or "small R") reforms with a narrower scope.

For the sake of clarity and simplicity, this Guide presents health reform as a discrete and orderly process. In practice, however, health reform is a continuous, iterative, and messy process that can generate new problems even as it addresses existing concerns. Thus, the 2019 preface to *GHRR* notes that health reform:

> …is not a one-shot effort but typically continues over many years (and even decades), as a major reform is introduced and then adjusted and modified as new problems arise and are addressed. Reform is not simply about creating a law and getting it adopted; it is a years-long process of learning how to improve the performance of a health system, through trial-and-error, measurement and evaluation, systematic thinking, and analysis. (p. x)

In sum, we view health reform as the process of developing, adopting, and implementing policies that: provide good technical solutions to health system problems; are politically viable; and, advance socially-determined ethical principles. In our approach, health reform seeks to advance the overall goal of improving health system performance.

Who is the audience for this Guide?

Our primary audience in writing this Guide is people seeking to do health reform while working within a government. This includes the policy and personal advisors of the political leaders and government officials charged with carrying out health reforms and health system strengthening. (Top policymakers, such as ministers of health, are also welcome to refer to this Guide. But we expect that their advisors are the ones who will examine the Guide's details as they develop suggestions, strategies and questions for the decision makers.)

Our second audience is the group of people who make up "the Health Reform Team." This team, discussed below in Step Two, comprises the officials whose work is to make health reform happen through diligent planning, negotiating, promoting, communicating, and pushing the health reform process forward. We hope that they find the guidance in this document both practical and useful.

Other important audiences sit both inside and outside of government. Within government, key health reform stakeholders include legislators, bureaucrats in various agencies, and local political and health system leaders. Outside government, health reform stakeholders include advocacy and interest groups (such as health professionals, professional associations and health worker unions), hospital administrators, health workers, healthcare companies and organizations, pharmaceutical companies, health foundations and donors, patient groups, and the population at large. All of these groups have profound interests in how health reforms turn out, so they also need to understand how to do health reform.

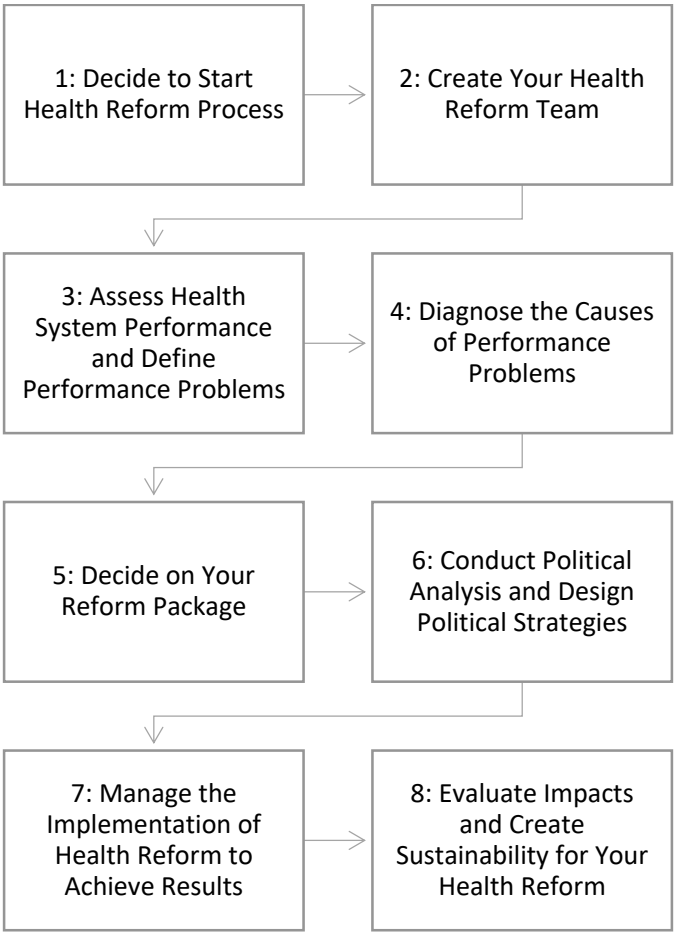
A final audience for the Guide is students learning about health systems, health policy, and reform processes. We hope that the Guide will be a useful accompaniment when studying *GHRR* and when doing course projects on health reform.

Regardless of which audience you fall into, you need to be prepared to grapple with the significant challenges involved in designing and enacting health reform. These challenges span many domains, including the technical, political, economic, social, ethical, organizational, bureaucratic, and legal. The authors of *GHRR* used their engagements with health reform in many countries to highlight the challenges that arise when seeking to improve health system performance, and they share strategies to address those challenges. In this Guide, as well, we highlight common challenges and relevant strategies for health reformers.

How is this Guide organized?

In writing this Guide, we have kept the text relatively short so that it can serve as both a strategic support and a resource directory to help you navigate the health reform process. Please remember that this Guide is intended to be used as a companion to *GHRR*. In some ways, the full book of *GHHR* serves as a detailed atlas of the health system, filled with high-resolution maps of the various obstacles, roads, rivers, cities and mountains that make up the terrain. The atlas has critically important information in it—but the details may be overwhelming as you plan out your health reform journey. This Guide, on the other hand, provides you with an overview map of the journey, broken down into Eight Practical Steps (Figure Intro-1). We hope that the Guide helps you in planning, step by step, your trip and moving forward with your health reform expedition.

Figure Intro-1: Overview of Eight Practical Steps in the Health Reform Process



Each step is presented in a separate chapter:

The individual chapters on each step include core concepts, key actions to consider, and sample worksheets to use in collecting necessary information. We present straightforward suggestions and implementable instructions, as well as concrete examples and accessible references. The appendices provide more detailed technical information for several of the steps. We also provide supplementary materials: 12 worksheets, five appendices, and a glossary. The first worksheet, Worksheet Intro-1, provides an overall checklist of each of the key actions mentioned for all eight steps. Finally, we provide a glossary of key terms used in the Guide.

We hope you find this Guide readable and usable. We have tried to make it both easy to understand and practical, with ideas that you can actually use in real-time and real-world settings. We also tried to make the discussion of each step somewhat independent, in case you are focusing on just one step or are reading out of order. In seeking succinctness, we have sometimes sacrificed specifics—but the details are readily available elsewhere. Throughout the Guide, we indicate the relevant *GHHR* chapters where you can look for more detailed discussions of the central concepts and analytical methods. We also provide other selected resources for each step.

To sum up this introduction: Figure Intro-1 and Worksheet Intro-1 provide a strategic view of the health reform terrain, from 30,000 feet. The rest of the Guide provides maps for each step (including the Guide's worksheets and appendices, and references to other resources) and directs you to the relevant pages in *GHRR* for more details.

If you are reading this Guide *after* studying *GHHR* and *before* you start to engage in health reform, we hope that this document will help you consider such questions as: How do I figure out where I want to end up? What does the full process look like? What do I do first? You may even ask yourself: Do I really want to engage in health reform, and why?

Alternatively, you might decide to read this Guide *first*, to get an overview of the reform process, and then go to *GHHR,* as you undertake each task, for more detailed discussions of the specific concepts and methods. Used in this way, the Guide can help you navigate the content of *GHHR*, figuring out what to read and in what order, depending on where you are in the policy cycle.

Before you get started

When we began writing this Guide, it seemed we had set ourselves an impossible task. We knew that we could never answer *all* the questions that arise when doing health reform. And, of course, using this Guide cannot guarantee the success of health reform efforts. There will always be other factors—sudden events, contextual challenges, and political conflicts—that you do not anticipate or cannot influence.

With all that in mind, however, we are happy to share this Eight Steps approach, based on real-world experiences, with you. Our goal with this Guide is to assist you to do health reform *better*. We hope that the guide will reach many groups of readers: policymakers, technical experts, advocates, policy advisors, civil society advocates, health workers, patients and caregivers. We aim to help you understand how to apply the concepts and methods from *GHRR* as you work to improve your health system's performance.

In short, this Guide is intended to make *GHRR's* detailed analysis and discussion of key principles more accessible to practitioners as you work towards your destination of improved health system performance.

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Roberts MJ, Hsiao W, Berman P, Reich MR. 2004. Getting Health Reform Right; A Guide to Improving Performance and Equity. New York, NY: Oxford University Press.

Step One: Deciding to Start a Health Reform Process

A core principle of *GHRR* and this Guide is that health reform requires combining technical analysis with ethical and political analyses. Viewing health reform solely as a technical process is a recipe for failure. Doing health reform better requires paying equal attention to all three dimensions: technical, ethical, and political. This principle has significant implications for each of the eight steps of this Guide, including the first step: Do you really want to engage in health reform?

The decision to do health reform for any entity (whether a nation, a state, a municipality, or an organization, public or private) is not trivial. Health reform requires being willing and able to negotiate and compromise, with both allies and opponents, to achieve a viable health reform. Regardless of the scope of your health reform, the process requires significant resources of various kinds—budgetary commitment, political capital, human resources, and the time and attention of key people, often including top leaders.

Bigger reforms require more resources, as addressing bigger problems typically involves influencing multiple aspects of the system and confronting multiple challenges. Health reforms often end up requiring more resources than initially anticipated due to unexpected events, controversies, and obstacles—even when plans are made for the unexpected.

So how do you reach a decision to do health reform? We encourage you to take the decision to start the health reform process carefully and with reflection on all three aspects: the technical objectives of improved performance, the political risks (and opportunities), and the ethical values of the society. Here are four key actions that can help you make the decision:

Key actions in Step One:

☑	Top political leadership reflects on core values that shape social expectations of the health sector, especially the role of market and state in their society, in consultation with a small circle of key advisors, allies, and experts
☑	Identify ethical principles for health system performance (related to consequences, rights, and community virtues) that provide reasons for selecting certain problems as the basis for starting a reform process
☑	Examine the benefits and risks of engaging in health reform and the political opportunities to achieve reform, in order to decide whether to move forward
☑	Decide to start a health reform process, in consultation with a small circle of key advisors, allies, and experts

Engage political leaders in articulating core values

The decision to engage in a major national health reform often involves the Minister of Health or a top national leader (such as the President or Prime Minister (PM)). There are many examples in recent history, such as when Mexico's Minister of Health Julio Frenk initiated and led that country's health reform efforts in the early 2000s, producing the landmark (but ultimately short-lived) *Seguro Popular* (Gomez-Dantes et al., 2015). Another example is Turkey's Minister of Health Recep Akdağ, who led that nation's Health Transformation Program efforts for a decade,

from 2002 to 2012 (Akdağ, 2015). The United States serves as a case in which the top political leader, President Barack Obama, became deeply and personally involved in pushing for health reform, such that, when it was achieved in 2010, it was informally called Obamacare (Oberlander, 2020). India's experience is similar: in 2018, Prime Minister Narendra Modi and his administration became the main proponents for health reform. While that effort is officially called Ayushman Bharat, it is popularly known as Modicare. As Richard Horton, editor of the *Lancet*, wrote, "Modi is the first Indian Prime Minister to prioritize universal health coverage as part of his political platform" (Horton, 2018). In these—and many other—instances, the top political leadership (of either the nation or the health sector) seized responsibility for pushing health reform. They took on the role of the key "policy entrepreneur," to use John Kingdon's perceptive term (Kingdon, 1984).

We do not mean to suggest that health reform *must* be driven by a top political leader. Cases exist where other factors precipitated or drove health reform. In Taiwan in the late 1980s the government planning commission initiated the design of national health reforms (Hsiao, 2019). And in Ghana in 2003, electoral competition between political parties drove the launch of its National Health Insurance Scheme (Novignon et al., 2021). But often, the high stakes of health reform mean that high-ranking political leaders must be involved in order to address risks, shape who benefits, assess political timing, and take final decisions. Advocacy for health reform may come from outside of government, such as from civil society, public health experts, or private companies. Ultimately, however, major reforms must involve the top political leaders to achieve success.

Identify performance problems

This Guide follows *GHRR* in arguing that the reform process starts with identifying some specific *problems* in health system performance. The final decision about which "problems" to focus on requires a systematic assessment of performance, based on available data and newly collected data and thorough analysis, as described in Step Three below. But advocates for reform and political leaders considering reform typically begin with a strong intuitive sense of "the problem." At this early point, the intuitive sense of performance problems provides a starting point for deliberation, especially regarding the ethical dimensions of health system reform. Deciding on "the problem" to be addressed through reform requires deliberate considerations of ethics and social values.

Ethical theory and health system performance

The key point in this section is: understanding the principles of moral philosophy can be helpful in making difficult decisions about health reform. Coming to agreement on the ethical and moral principles that underpin health reform goals helps policymakers and policy analysts be more effective in their work (*GHRR*, p. 20). Chapter 3 of *GHRR* focuses in detail on using ethical theory to judge health system performance. As in the book, we start with the "deep conviction that judging health-sector performance requires ethical analysis" (*GHRR*, p. 40).

The book explores three forms of moral philosophy: *utilitarianism,* which focuses on well-being and consequences; *liberalism*, which focus on rights, both positive and negative; and *communitarianism*, which focuses on virtues embodied in communities. We will not repeat the details of that discussion here, except to note that a basic understanding of ethics provides the

foundation for critically important discussions and decisions about which health inequities and problems are important to your society. There is an infinite set of questions that can only be answered if you have clarity about the underlying ethical values. For example: Should your reform focus on the health problems facing rural or urban residents? On people with social security or those without? On people requiring treatments for infrequent but high-cost illnesses or on treatments for common low-cost illnesses? On vaccines for which illnesses and which populations?

Ethical theory also provides a foundation for defining the roles of markets and the state in shaping the health sector in your society. For example: Should the state deliver services at no cost to the population? Where? Where should the market be allowed to sell services with limited government intervention? Which parts of the health sector should be regulated by the government? Where should both the state and the market provide similar services with different quality and cost to patients?

One example that demonstrates the important relationship between ethical principles and health reform priority-setting is China, whose national approach to health reform has shifted multiple times since 1978 when it began to liberalize its economy (Yip and Hsaio, 2015). For two decades, China left markets to offer health care with limited government intervention; however, this approach led to rising costs and low quality health care. In the early 2000s, when government priorities had shifted to promoting equity and a "socialist harmonious society," top leaders then initiated a major reform to introduce social health insurance, eventually covering more than 95% of the population. Subsequent reforms have since reintroduced a more "pro-market" approach to health resource allocation—even as it continues to explore how to cope with increasing rates of non-communicable diseases and expanding financial risk protection (Li et al., 2023).

Neither this Guide nor the book argue that all health reforms should take a particular ethical position. We do suggest, however, that people who are considering health reform, as a serious journey, should begin by clarifying their values in relation to health system performance.

Step One, therefore, is engaging political leaders and policy makers in a process of ethical reflection, before deciding to move forward with health reform. The process of reflection can help identify ethical goals to serve as the foundation of the health reform, and can propose performance problems that go against some of the defined ethical principles (*GHRR*, Chapter 3; Roberts and Reich, 2002). Worksheet 1-1 presents an overview of the types of questions that can be used in deliberations about the ethical principles for health reform.

There is no single formula or strategy for ethical reflection. The process needs to be adapted to the society and culture, the leaders and their advisors, and the experts on social values of each specific environment. Even when there is no dedicated process, key ethical principles for reforms may be found in party platforms, speeches by political leaders, and government planning documents. Some countries have appointed Steering Committees that collectively establish a set of explicit principles (these committees may also continue monitoring the reform). The committee members should be drawn from a range of social sectors and backgrounds, but it helps to have ethicists or other people with experience in applied ethical analysis to guide the discussions.

The identification of ethical principles and associated performance problems helps provide the justification for starting a health reform process. It also shapes the specific government interventions adopted to improve performance. Revisiting your ethical principles and analysis periodically when moving through the reform process can help keep the effort focused on its core purpose.

Risk assessment for health reform

The process of ethical reflection may also help you identify potential risks of undertaking health reform. Similarly, you should also quickly review the other steps described in this Guide to estimate the various resources (time, money, effort, political commitment, etc.) that undertaking the process will require. As you do this, consider the potential risks of pushing for health reform. These, again, will vary depending on the context, as well as the specific focus, scope and timing of your proposed reform. Regardless of the details of your reform, there are three categories of risks to consider:

1) What are the risks of pushing for health reform?

2) What risks do you anticipate if the reform effort succeeds?

3) What risks do you anticipate if you pursue the reform but fail to achieve it?

For example, a successful reform effort can trigger new social problems, while unsuccessful reform efforts risk losing various types of resources. These may be material resources (such as the money invested in the health reform effort) and less tangible resources (such as political power, social capital, and authority, as well as your job).

Worksheet 1-2 provides a list of questions to guide you through an informal risk analysis. In this situation, and at this stage of thinking about health reform, risk analysis is not a scientific or exact process—it is an assessment based on objective data and subjective judgments. Identifying the potential risks and benefits allows you to assess whether you think the benefits outweigh the risks, and whether to start the reform process. If you decide to move forward, you can now include risk mitigation strategies to lessen the risks you have anticipated. You can also reevaluate the risks periodically as the situation evolves.

Decide to start the reform process

Step One concludes with the decision of whether to start the reform process (or not). As we have discussed, there are several related factors to consider. The commitment of a top political leader is especially critical in Step One, because the leader will play essential roles in: communicating the health reform plan and the reasons for reform; negotiating with key stakeholders both inside and outside the government at different steps; and, deciding on how to address opposition to the reform as it arises. In some cases, the top leader may become the public face of the reform as well. In addition to the ethical and risk analyses, we also recommend reviewing all the steps described in this Guide and estimating the different resources required at each step (and then include more).

Once you decide to start a health reform journey, your next challenge is Step Two: creating the Health Reform Team. This group will be responsible for constructing and implementing plans for

the technical, ethical and political analyses and actions, collecting, doing and interpreting empirical studies, indicators, and analysis, and proposing interventions to improve performance problems.

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Step Two: Creating a Health Reform Team

Designing, gaining approval for, and then implementing your health reform is a massive endeavor. As *GHHR* notes, health reform is a team effort. It requires assembling a group of people with diverse skills and connections to focus on a single mission: pushing your health reform forward. *GHHR* calls this group the "change team" while in this Guide we call it "the Health Reform Team."

GHHR states: "The change team requires, not only technical capacity for policy design, but also the political capacity to mobilize relevant groups and individuals" (pp. 140-141). The size and nature of your team will depend on the scope of the reform you are proposing. Furthermore, different steps in the health reform process require different kinds of skills and expertise, so the Health Reform Team may need to add new members periodically, and may spin off other teams to focus on certain key tasks (such as assessment in Step Three or implementation in Step Seven).

The following steps will guide you to build your core Health Reform Team:

Key actions in Step Two:

☑	Using the policy cycle, sketch out a preliminary health reform process
☑	Using your policy cycle sketch, identify the key skills and areas of expertise you need on the Health Reform Team for each step
☑	Identify and recruit a small group of people with the necessary skills and expertise to start as the core group of your Health Reform Team
☑	Position and provide resources to the Team
☑	Support the Team to develop a shared mission, effective methods of communication and collaboration, and strategies for managing the rest of the health reform process steps
☑	Support the Team to create technical and advisory groups, network with partners and stakeholders, and engage consultants to fill gaps and bolster support for the proposed health reform

Create a team appropriate for the policy cycle stage

In order to decide on members for your Health Reform Team, you need a sense of the activities they will need to undertake. That requires a basic understanding of what is required at different stages of the policy cycle. Figure 2-1 shows the stages of the policy cycle: problem definition, diagnosis, policy development, political decision, implementation, and evaluation. As discussed in Chapter 2 of *GHRR*, the policy cycle is a model for how public policy gets developed, adopted, and implemented. The policy cycle is also the conceptual basis for the Eight Practical Steps of this Guide.

Figure 2-1 The Policy Cycle

Source: GHRR, p. 22.

In order to move your proposed reform through the policy cycle, you need people on your Health Reform Team with expertise relevant to each step. You may decide to start with a small team of trusted experts and advisors, for example, with expertise on the policy process and on health system assessment; then gradually expand the team as you move forward.

Worksheet 2-1 provides an outline you can fill in as you identify the skills and expertise you want on your Health Reform Team. The worksheet is intended to generate a sketch, not a definitive picture, as your strategies will change and expand as your reform effort progresses. However, this initial exercise can help you begin to identify the kinds of skills, expertise, and networks you will need. As you consider the other seven Steps, use the worksheet to note the tasks and functions that will be needed—and to explore what kinds of team members would fulfill those needs.

Build a team with the right skills and areas of expertise

The key questions in Step Two are: Which are the most important skills to have represented on the Health Reform Team at the start of your health reform journey? Who is appropriate and available from your own organization? And which skills do you need to obtain externally, from consultants or partners?

It is important to have a multi-disciplinary Health Reform Team, but it works best when the team remains small enough to have excellent internal communication and collaboration. The group needs to work *as a team*. Use the worksheet to highlight the skills and experience that you need on the Health Reform Team and focus on recruiting people who match those requirements.

In addition to their professional background, it is also important to consider the social connections of potential Health Reform Team members. That is: do members of your Health Reform Team have effective access to both the experts you need as advisors and the decision-makers whose support the reform needs?

The types of expertise you select for your team will vary depending on your intended reform and local context, as well as the stage in the policy cycle. In general, you need people with the following sets of skills:

- Understanding the technical requirements of the proposed reform. This person (or people) will be responsible for determining how the proposed policy reforms would lead to the intended outcomes. This person may be directly involved in designing the details of the reform, or may delegate some functions to technical working groups that this person coordinates. However, the technical expert(s) must be able to lead the process of evaluating all proposed components to consider whether they would achieve the intended effects.

  People with this type of expertise may be found working as health policy professors, researchers at think tanks, or analysts working in health care delivery systems, health care companies, and government health agencies.

- Assessing the political landscape and building support for the reform. As will be discussed in depth in Step Six, if you wait until all the technical details are worked out before you consider the political landscape, your health reform is likely to fail. Most successful health reforms efforts begin negotiating with key stakeholders early on—to ensure that their perspectives are understood and to build core support. These stakeholders may include, for example, representatives of the legislature, sub-national governments, the national medical association, the pharmaceutical industry, and labor unions. Your team political expert(s) should be involved from the outset to guide the team on assessing political feasibility and proactively engaging a wide range of stakeholders for their input and support.

  People with this type of expertise typically include the staff of successful politicians, professors of political science, journalists who cover politics, and lobbyists and staff of advocacy organizations.

- Communicating effectively about complex topics. Health reform is complicated, which sometimes makes it difficult or overwhelming for non-experts. And inherently, health reform aims to change the status quo—this can make it hard or even frightening to imagine. It is therefore important to consider from the beginning how you will promote and communicate about your proposed reform. In order to do this, you should have

communications/public relations expertise on the Health Reform Team to guide the group on how to present your work to key stakeholders and to the wider public. The communications expert(s) can also coordinate communications consultants and work with supportive stakeholder groups to determine the types of messages they would find useful.

People with relevant expertise in policy communication may be working for media outlets, in corporate public relations, in politics or in education.

- Leading and coordinating the Health Reform Team. Every team needs a leader—your Health Reform Team leader may or may not be you. In many cases, the person who initially comes up with an idea for health reform may have significant technical expertise or a vision for a more equitable and just society, but they may not have the strategic or managerial skills (or the interest) to lead a team.

  The Health Reform Team leader needs to be able to keep big picture goals in mind, lead the creation of a strategy to achieve the goals, and inspire and manage the team to implement that strategy, with practical problem-solving skills. It is also critical that the team leader has a strong and trusting relationship with a political leader who can champion the health reform effort.

  People with these skills and relationships may include political strategists, chiefs of staff, chief executive officers and others with high-level management experience.

Create a structure, budget and office for the Health Reform Team

Once you have gathered team members and selected a leader, you need to bring the group together under a structure that enables them to actually do the work. In *GHHR* the authors note: "the composition, location, incentives and power of the change team can make a critical difference in the changes for successful health-sector reform" (p. 141).

Deciding where the team sits (literally) is a key decision. The closer you can locate the team in relation to key decision-makers, the more visibility the health reform can have throughout the process of developing it. In Step Five you will determine which key decision-makers you are targeting; this is done in part to strategically situate your team. If you need legislative approval, who are the key legislators you can work with? If you need executive approval, can the team sit within the President's or Prime Minister's office? However, remember that it may make it difficult to operate efficiently if the team is constantly supervised and micro-managed. Finding the right balance is important.

You also need to ensure that the team gets the budgetary, administrative, and material resources they need to undertake their work. This necessitates thinking about how long the health reform effort will take, what it will cost to pay the salaries of the health reform team, what activity costs you can anticipate, whether you need to hire consultants and what contracting mechanisms you can use, and, in general, where funding can be found for all of these costs.

Placing the team in a well-funded, well-run, and prominent office within a ministry or administrative department can be helpful. While this might be in the health ministry, it also might not. In some cases it may be more strategic and more effective to place the Health Reform Team at, for example, the finance ministry or the vice president's office, depending on whose support you need and can secure. In some situations, it may be better to locate the Health Reform Team outside of an existing bureaucratic agency in order allow for more independence, creativity, and capacity to change existing structures.

Bring in other expertise as needed

As mentioned above, while you want to have a robust team, you also want to keep it lean in order to be both focused and manageable. Consultants and consulting companies can be hired to do specific tasks as needed. Further, there are various options for structures you can use to widen the range of expertise available to the Health Reform Team, including:

- **Advisory groups:** AGs are generally made up of high-level experts who meet periodically to review and provide high-level guidance on your proposed strategies. You may wish to create, for example, a Political Advisory Group, a Communications and Outreach Advisory Group, and a Policy Advisory Group that can advise the relevant team members.
- **Technical working groups:** TWGs typically include people with deep technical expertise who meet regularly to hash out details on one area of the proposed reform. They are most likely to work directly with your team's technical lead.
- **Stakeholder groups:** As you identify the range of stakeholders who will be affected by your proposed changes (see Steps Six and Seven and *GHRR-Chapter 4*), you can create platforms to invite their input on relevant elements of the reform. Proactively engaging with stakeholders will both enhance the analysis your team can do and help built wider support for the reform.

Summary

Creating, locating, motivating and protecting a strong Health Reform Team is a critically important part of doing health reform successfully. *GHHR* presents examples of change teams in three Latin American countries, leading to the conclusion that "the creation of a change team thus represented a significant political strategy in itself" (p. 141). Finding the right people to join your Health Reform Team, building the team's capacity and focus, and providing them with the resources to get the work done is an important foundation for a successful reform.

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Step Three: Assessing Health System Performance and Defining Performance Problems

Step Three is systematically assessing the health system in order to identify problems to address through reform. This involves measuring various dimensions of health system performance, and then using the findings to help you select specific performance problems for deeper examination and reform interventions. The primary objective of Step Three is to identify both the areas in which your health system is performing well and those in which it performs poorly. This information allows you to select which areas your reform will focus on; it also establishes a baseline for monitoring and evaluating changes over time (as described later in Step Eight). Step Three has four key actions:

Key actions in Step Three:

☑	Decide what to assess, including the kinds of performance problems to assess (based on the intermediate and final performance objectives), and the types of analysis and analytic skills required
☑	Decide who will do the assessment, considering both external analysts outside of government and people internal to the Health Reform Team and government agencies
☑	Design the assessment, including the scope of assessment, time and resources required, existing data sources, and new data to be collected, with deadlines for deliverables
☑	Analyze both primary and secondary data to generate a comprehensive assessment, identify major problems, and prepare for diagnosis (Step Four)

Decide what to assess

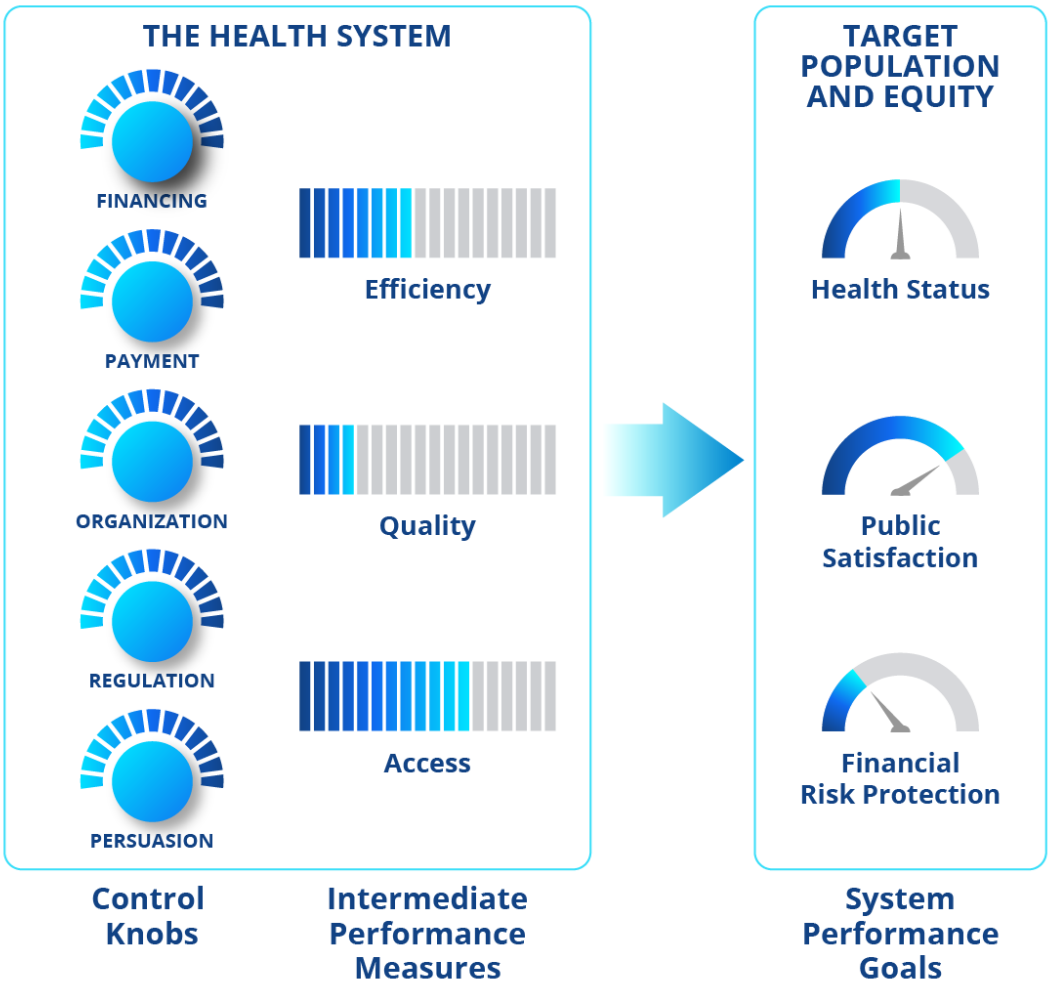
The first action is to decide which aspects of health system performance you will assess. This requires a clear understanding of how to define and measure the "performance" of a health system.

What is a health system? As noted in the Introduction, both *GHRR* and this Guide view the health system as a means to achieve certain ends. In our model, the means cover five policy controls (also called control knobs, or policy levers) that are commonly available to policymakers: financing, payment, organization, regulation, and persuasion. The ends are represented by three final outcomes for a health system and three intermediate outcomes. The three final performance objectives are: (1) health status, (2) financial risk protection, and (3) public satisfaction with the health system (*GHRR-Chapter 5*). The three intermediate outcomes (which can be influenced by the policy controls) are: (4) access to health services, (5) quality of care, and (6) efficiency in the health system (*GHRR-Chapter 6*). In our view, how well a health system performs should be assessed by how well it achieves these six objectives. These achievements, according to this model, should be assessed in two ways: the level of achievement, and how equitably the benefits achieved are distributed across the target populations. (There are, of course, other models of health systems and health system performance—these are not addressed in this Guide.)

Figure 3-1 shows the *GHRR* model of health system performance, illustrating how the control knobs affect the intermediate performance measures, which, in turn, determine the achievement of

the three ultimate performance outcomes. Appendix 3-1 presents detailed definitions for the six performance outcomes and outlines common ways to measure and interpret each one.

Figure 3-1: Health system control knobs, intermediate and final performance measures



Source: adapted from GHRR, p. 27.

What you choose to assess, and how you conduct the assessments, is determined by several factors, including: how much time is available to generate and analyze evidence, the timelines of key decision-making processes, the priorities of supportive political leaders, the available analytical capacity, and the budget. The spectrum of assessments ranges from *comprehensive* (such as the India Health Systems Research Project's assessment of the health system in the state of Odisha (Yip et al. 2022)) to *simple*. A comprehensive assessment typically involves collecting primary data, a sophisticated design and expert analyses—and therefore requires a significant amount of

time and budget. A simple assessment uses existing data and examines fewer performance measures, and is thus less resource-intensive. However, it may produce a less detailed, and less reliable or narrower assessment. Most assessments fall somewhere between the extremes.

Deciding what you will assess has important implications, as the assessment influences the scope and timeline of the health reform process. It is therefore a topic for discussion with top political leaders in addition to the Health Reform Team. Assessment decisions shape (and reflect) the overall directions of the health reform process. Deciding what to assess is not a simple technical decision; like every step in the health reform process, it has political and ethical implications.

Decide who will do the assessment

Finding the right group to undertake the assessment depends on two key factors: 1) what is being assessed, and 2) what resources are available for the assessment. Regardless of the scope of the assessment, some governments prefer to hire external assessors, such as consulting agencies or academic experts, often selected through a competitive bidding process. Conducting a comprehensive assessment of all six performance outcomes typically requires hiring an external group of experienced analysts and a substantial budget. Commissioning a comprehensive assessment, with primary data collection, of health system performance of a nation (or a state in a large country) can easily cost one million US dollars or more, involve dozens of analysts, and require two years for data collection, analysis, and report development.

The other option is using an internal assessment group (such as one located within a government agency or a government-related research group). This option has different risks and benefits. It may cost less. However, the quality of the assessment may be compromised if the group does not have the right expertise or experience. Using an internal group can also constrain the objectivity of the assessment if the analysts are subject to pressure from government officials seeking to influence the results.

The ideal health system assessment team has people with extensive experience in assessing *system performance*. Typically, the team needs members who have expertise in health system analysis, quantitative research methods (for designing and analyzing household surveys, claims data, medical records, and other large datasets), and qualitative research methods (for designing and analyzing key informant interviews, focus group discussions and other qualitative datasets). The Health Reform Team should work closely with the assessment group in order to facilitate access to data sources (for example, administrative data or policy guidelines), provide necessary financial resources, and offer overall guidance. Close collaboration and communication between the assessment group and the Health Reform Team can ensure that the health system assessment is aligned with the ethical, political, and economic priorities of the overall reform effort.

Design the assessment

The design of the performance assessment must be informed, first and foremost, by the decision about *what to assess*, i.e., which performance outcomes are the focus of the assessment. Defining the key questions for the assessment determines the appropriate methodologies to use, the relevant data sources, and the time and resources required. A well-designed assessment has data collection

tools linked to each performance outcome. Thus a comprehensive assessment likely requires a combination of existing and new data sets, and both quantitative and qualitative methodologies, while a simple assessment needs less data and fewer resources.

Identify and analyze existing data sources

Regardless of the assessment's scope, the first activity (for either the Health Reform Team or the assessment group) is to do a landscape analysis of available information and secondary data about the different performance outcomes. By identifying existing data sources, you develop a sense about the extent to which these data can inform the assessment, discover critical data gaps, and identify questions that require collection of new data.

Analyses of secondary data are an important part of the assessment's design. Health systems generate reams of statistics from different sources like management information systems, insurance claims systems, national, state, and district-level health surveys, and national and state health accounts, to name a few. The OECD and World Health Organization also collect significant amounts of national data on health. The assessment team should determine which data sets are relevant for assessing the selected performance outcomes. (Some common data sets and their interpretations are presented in Appendix 3-1 by performance outcome.) Carefully collating and analyzing secondary data can go a long way towards generating a broad assessment of the health system on several performance outcomes. Even if secondary data are not sufficient for the full assessment, they can be used to begin the analysis, identify important data gaps and inform decisions on new data collection.

The decision of how much to rely on secondary data depends on the availability and quality of the data. Most high-income countries (HICs) and some middle-income countries (MICs) like Brazil and Malaysia have extensive and robust data sets that could allow health system assessments, covering almost all six performance outcomes. However, many low- and middle-income countries (LMICs) and most low-income countries (LICs) have limited or irregular secondary data.

Additionally, not all six performance outcomes have equally complete and robust data. Most countries can effectively assess their populations' health status and access to care with secondary data from vital registrations and Demographic and Health Surveys. Most countries also have some data on public satisfaction and financial risk protection, or can add a few additional questions to existing national or state-level surveys. For the quality outcome, however, most countries will likely need to design new assessments, as many health systems do not collect clinical effectiveness or patient safety data through national surveys or health information systems.

Identify data gaps and collect new data

By doing a landscape analysis of data sources and analyzing secondary data, the Health Reform Team will likely discover several important data gaps. You may then choose to undertake (or commission) new research to allow for a more complete assessment of the health system or to develop a nuanced understanding of underlying causes behind poor performances (more on this in Step Four, Diagnosis).

Designing new research starts with defining research questions and selecting appropriate methods to answer them. Then the assessment group can design data collection instruments. Depending on what data you are seeking, these may include survey questionnaires, clinical vignettes, or interview guides. Whenever possible, we recommend utilizing indices and instruments that have already been validated and used internationally. However, if there are research areas without comparable indices, the assessment group might have to create new instruments and go through the process of validating them locally. Again, Appendix 3-1 lists some existing instruments and data sets that have been used globally to measure health system outcomes.

Data collection is usually outsourced when primary data collection is required, for two reasons. First, significant expertise in designing and collecting data is necessary to ensure quality. Second, using a third party for data collection helps to maintain independence and objectivity. The necessary skills for data collection teams, and the costs involved in data collection, will vary depending on the type of data and the size of the data set. For example, a nationally representative household survey will need a large team; in some countries, you will need multiple teams fluent in different local languages. Conducting chart reviews or standardized patient interview for assessing quality, on the other hand, needs data collectors with clinical training.

Here again, the Health Reform Team will inevitably need to consider available funds and timelines. An assessment that uses secondary data is both faster and far less expensive than one that requires collecting new data. New research could cost anywhere between a few thousand US dollars to upwards of a million US dollars, depending upon the scope and research questions. For example, a hospital chart review to assess clinical effectiveness may be fairly quick and inexpensive compared to a large household survey to assess financial risk protection or public satisfaction. Time is another important consideration. If you are trying to link your health reform effort with election or budget cycles, there may not be time for extensive primary research. In short, the Health Reform Team will decide on the assessment design based on these contextual realities and the proportions of secondary and primary research required.

A comprehensive health system assessment with both secondary data analysis and extensive primary data collection using the *GHRR* model was undertaken in the Indian state of Odisha by the Harvard India Health Systems Reform Project (Yip et al., 2022). Secondary data were used to assess health status and benchmark outcomes like financial risk protection and access to health services (outcomes where secondary data covered some but not all indicators). Health system assessments in Malaysia and Turkey using the *GHRR* model were conducted primarily using secondary data, with only limited new data (Atun et al., 2019; Johansen & Guisset 2012).

Thus, health system assessment does not always require resource-intensive collection of new data. While desirable if time and resources permit, a comprehensive assessment with extensive primary research is not necessarily a prerequisite for health reform. An assessment based on secondary data analysis, or assessing some but not all of the performance outcomes, may be sufficient, depending on your specific objectives for improving health system performance.

Analyze the data to prepare for *Step Four: Diagnosis*

The rest of Step Three is analyzing the various data collected using appropriate quantitative and qualitative analytical approaches. Once the assessment team has generated the relevant statistics and performance measures, they should work with the Health Reform Team to identify and compare your health system's performance to suitable benchmarks.

Identify benchmarks for comparison

Comparing the findings on your system's performance metrics with benchmarks is necessary to interpret whether performance on a particular outcome is good, average, or poor (see *GHRR*, Chapter 6, p. 123). For example, simply stating that "a country's infant mortality rate is 20" or that "out-of-pocket expenses constitute 30% of the country's total health expenses" does not give you a sense of *what the findings mean*.

Thus, statistics must be compared against standard benchmarks or measures. An example of a global standard measure is: out-of-pocket (OOP) expenses on health that exceed 10% of a household's total consumption are considered "catastrophic." Knowing this, you can tell that the 30% finding cited above indicates very poor performance.

Benchmarks can be determined using national averages, statistics from other states within the same country, or from other similar countries. For example, countries commonly compare health status indicators such as mortality rate and life expectancy with other countries with similar levels of economic development. For clinical effectiveness measures, clinical guidelines and standard treatment protocols are generally used as the benchmarks, as they are usually highly standardized and accepted across countries. Benchmarks for other outcomes, such as public satisfaction and patient satisfaction, are less standardized.

If improving equity among groups within your population is one of the goals of your health reform, you may choose to use internal benchmarks. Consider a health reform intended to reduce infant mortality: if the national infant mortality national rate is 20 per 100,000, but the rate is 3 per 100,000 among the wealthiest 10% of the population, you may choose to use the latter figure as the benchmark against which you compare your reform's overall performance.

The assessment group needs to identify (and provide justification for the selection of) appropriate benchmarks for comparison as part of analyzing your data. In addition to the additional details provided in Appendix 3-1, *GHRR (Chapter 6)* includes a discussion of different benchmarking strategies.

Summary

In Step Three, the Health Reform Team conducts a health system assessment to understand how well or poorly their health system performs on its intermediate and final performance goals. This will help you prioritize which performance goals to focus on for reform. Most importantly, the assessment lays a foundation for Step Four, Diagnosis, by identifying performance problems that need further examination. It also lays the foundation for Step Eight, Evaluation, by establishing baselines and identifying what should be monitored and evaluated going forward.

The *GHRR* framework emphasizes the importance of data analysis and health system assessment. However, in reality some health reform efforts have been carried out without rigorous assessments or even baseline data. This may seem like an easier path (especially when the reform effort faces time constraints or when "everyone knows" what the problems are). The reform process may even proceed smoothly. However, these efforts typically fail to generate meaningful improvements in the final performance outcomes of health systems. Without first understanding the status quo (by conducting an assessment in Step Three) and then investigating the root causes of the problems identified (which will be the focus of Step Four), you cannot confidently select appropriate reform options.

The assessment of health system performance is a foundational step in doing health reform. And it need not be a one-time activity. Health Reform Teams may decide to undertake assessments of different performance outcomes at different points in time. You may also decide to vary the scope and depth of assessments based on contextual factors, such as the availability of resources, current political priorities, policy timelines, and windows of opportunity for change. In addition, these assessments can serve as the baseline for monitoring and evaluation of the impacts of the reform, as discussed below in Step Eight.

References

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Step Four: Diagnosing the Causes of Performance Problems

In Step Four, we diagnose the causes of health system performance problems. Just as a doctor diagnoses a disease based on the symptoms presented by a patient, the Health Reform Team seeks to diagnose the underlying cause(s) of the performance problem(s) that the health system assessment found. *The primary objective of Step Four is diagnosis—that is, to examine the possible reasons for specific performance problems by tracing the reasons to one or more of the five policy areas represented by the control knobs*.

And just as the doctor uses the diagnosis of a disease to determine an appropriate course of treatment, the findings from the diagnostic process in Step Four form the foundation for designing appropriate reforms based on the policy control knobs. Focusing on the policy areas represented by the control knobs will help you avoid a common mistake made in this step: tracing the cause of poor performance to determinants or factors that are beyond the influence or control of policymakers.

In this Step, the Health Reform Team takes four key actions:

Key actions in Step Four:

☑	Decide which performance problems to diagnose, using the assessment(s) from Step Three as well as the priorities defined by the Health Reform Team and political leadership
☑	Decide who will do the diagnosis, considering both external analysts outside of government and internal analysts (on the Health Reform Team and in government agencies), including the time and resources required
☑	Using a systems approach, describe the structure and functioning of the current health care system that is facing the selected performance problems
☑	Using a systems approach, construct a diagnostic tree, using primary and secondary data, to reveal the root causes of the performance problems
☑	Link the root causes to the policy control knobs (and identify linkages among the underlying causes) to identify areas for intervention (in preparation for selecting reform options in Step Five)

Decide what to diagnose

The first action in this Step is to decide which performance problems to examine in your diagnostic analysis. The health system performance assessment conducted in Step Three typically uncovers many performance problems in the health system. From that set of identified problems, the Health Reform Team now has to select a few specific problems for deeper diagnosis.

As you make this selection, the Health Reform Team should take several factors into account, including your reflections on the health system's ethical principles, current political and economic priorities and opportunities, socio-cultural norms, current public health emergencies, and others.

The Odisha Health System Assessment, as discussed in Step Three, found multiple performance problems (Yip et al., 2022). Regarding the system's final outcomes, the assessment concluded that: health status had improved, but chronic diseases were on the rise; financial risk protection was

poor; and, public satisfaction with the health system was low among vulnerable population groups. On the intermediate outcomes, there were notable achievements in access to care, but quality of care and efficiency were problematic. Significant equity issues existed for both final and intermediate measures.

So how do you decide which challenges to focus on for diagnosis?

Start from ethical principles. If Odisha's political leaders have declared that equity and distributive justice are key ethical priorities, the Health Reform Team might begin by focusing on diagnosing the reasons for inequities among socio-economically disadvantaged groups in public satisfaction and access to care. On the other hand, given that the state government had already invested in establishing a flagship health insurance program, Odisha might instead prioritize analyzing the causes behind the low achievement in financial risk protection. Yet another possibility: in light of the health crisis of the COVID-19 pandemic, Odisha's government might see improving the quality of care delivered by the system as the most critical performance problem, and thus might decide to make clinical effectiveness the top priority for diagnosis.

Diagnosis requires significant time and effort to identify the underlying causes of performance problems. Thus the selection of which performance problem to focus on has important implications, as it will affect the scope of the reform, the budget required, the timeline, and the necessary capacity of the Health Reform Team. In deciding what to diagnose, the Health Reform Team must have direct and honest discussions with top political leaders about what will be required. This decision will shape (and reflect) the overall strategic direction of the health reform process. These discussions may need to take place off the record in order to fully communicate the ramifications and implications of the choice.

Once again, a decision in the health reform process—in this instance, deciding what to diagnose—is not a simple technical decision. As with previous decisions, the Health Reform Team must consider the overall political and ethical objectives of the health reform process, as well as technical feasibility. The decision about what to diagnose ultimately shapes the overall scope of the health reform effort, including how ambitious it is and what kinds of improvements in health system performance are targeted.

Plan a diagnostic process

Once you have decided on the performance problem(s), you can plan out a diagnostic process (keeping in mind that the primary goal of diagnosis is to trace the determinants of poor performances to the root causes in the five policy control areas). This step also requires the Health Reform Team to develop and incorporate a clear and shared understanding of the policy control knobs, as these will be used, together with the performance assessment results from Step Three, to identify underlying causes of poor performances. Diagnosing the causes of performance problems and identifying the relevant policy control knobs, in turn, form the basis for Step Five (designing health reform options). The feasibility of various reform options will be constrained by how the health system currently functions.

Decide who will do the diagnosis

Generating a good diagnosis is challenging. Therefore, it is important to engage analysts and experts with qualifications *and* prior experience in health system analysis (again, emphasis on *systems*). They should be familiar with key concepts, relevant theories and methods, and the empirical evidence that links the five control knobs with health system performance.

In addition to health system experts, you also need people with subject matter expertise on the selected performance problem(s). For example, analysts with training in health economics, actuarial science, and public finance can lead diagnosis of financial risk protection problems, while medical clinicians who have experience in quality improvement can support diagnosis of quality of care problems, and epidemiologists can focus on diagnosis of health status problems.

As with the assessment process in Step Three, finding the right mix of people to undertake diagnosis is critically important. The selection process is determined by what you seek to diagnose and the resources available for the diagnostic process. Just as a doctor may order multiple pathology and imaging tests to be conducted by specialists in order to make a diagnosis, the Health Reform Team may need multiple analyses and expert inputs. And again, budgets, timelines, and contracting rules are key considerations as you determine whether to use an internal group (located within a government agency or research group) or to hire an external group of experts.

It is advisable for some core members of the Step Three assessment group to continue on as members of the Step Four diagnostic team. This will ensure familiarity with the assessment findings and contribute to continuity when thinking through the diagnostic questions.

Finally, as in Step Three, the Health Reform Team needs to work closely with the diagnostic group. Close collaboration and communication with the Health Reform Team can help to align the diagnosis process with the ethical, political, and economic priorities of the overall reform effort, as well as with the timeline.

Describe the existing healthcare system

The five policy control knobs linked to health system performance (shown in Figure 3-1) are each discussed in detail in a separate chapter in *GHHR.* The policy control knobs are:

- **Financing** refers to how money is raised, risk pooled, and allocated—and how this affects both performance and equity in the health system. (*GHRR-Chapter 8*)
- **Payment** focuses on which organizations and individuals in the health system are paid, how and how much they are paid, and the incentives created by those payments. (*GHRR-Chapter 9*)
- **Organization** focuses on how activities in the health system are divided among public and private entities, the degree of reliance on market competition, and distribution of functions among centralized and decentralized agencies, clinics, and hospitals, as well as internal organizational management issues. (*GHRR-Chapter 10*)
- **Regulation** refers to government efforts to alter behavior in the private and the public sectors by imposing rules that are backed by sanctions. (*GHRR-Chapter 11*)

- **Persuasion** refers to efforts to convince health system actors (doctors, patients, policy makers, etc.) to change certain behaviors through education, social marketing, and other behavior change interventions. (*GHRR-Chapter 12*)

Describing the current healthcare system requires collecting information about the current state of each policy control knob. Depending on how familiar the Health Reform Team is with the current system, and how well it is documented, this may be more or less difficult to do. Worksheet 4-1 presents a table of key types of information to gather for each control knob, as well as likely sources of information and the common connections to health system performance.

Undertake an analysis to construct a diagnostic tree for each performance problem selected

Once the Health Reform Team has an accurate description of the health system, you can begin your analysis to reveal the root causes of a selected problem. *GHRR* advises the use of a "diagnostic tree" to systematically map different "branches" of various causes that contribute to your selected performance problem. Starting with the performance problem and then working backward to seek underlying causes, leads you in the direction of generating potential solutions.

A common pitfall when doing diagnosis is confusing the symptoms with the causes of a problem. One way to avoid such confusion is to ask "why" five times in order to work your way from a problem to its causes. Repeating the question "why" pushes you to discover causes that lie behind and beneath the obvious symptoms (Serrat, 2009; American Society for Quality).

Answering each "why" is not a simple process. Answers should be based on well-defined theory, analytical logic and, when possible, evidence, data, and prior studies in the scientific literature. The appropriate theories, analytical logic, and data for a diagnostic analysis will be determined by the performance problems being examined and the probable underlying causes of poor performance. Depending on the problem under examination and the specific situation, the Health Reform Team may decide to undertake (or commission) additional studies to further explore the causes of some performance problems. Getting a good grasp on the probable causes of critical problems is important, because it shapes decisions about what to do to improve performance.

Returning to the example of the Odisha Health System Assessment, consider a diagnostic process of the causes of the problem of low financial risk protection, as indicated by the high out-of-pocket expenses (OOPE) documented during the performance assessment (Haakenstad et al., 2022). During the assessment, it was determined that the majority of OOPE is spent on medicines. Figures 4-1A and 4-1B below provide two simplified diagnostic trees (more detailed versions of these diagnostic trees are included in Appendix 4-1) that result from asking "why" multiple times. They show that the problem of high out-of-pocket expenses has several levels of causes. Keep in mind: these two diagnostic trees are only indicative—there are other possible causes, and other diagnostic trees, that the Health Reform Team could consider.

These illustrative diagnostic trees trace two possible causes of low protection from healthcare-related financial risk: (1) Figure 4-1A addresses inadequate insurance coverage; (2) Figure 4-1B addresses high OOPE on outpatient care in the public and private sectors. We repeatedly ask "why" a particular problem exists in order to work our way backwards through the chain of causality,

using theories, logic, experiences from other contexts and local data to identify the answers at each branching point of the diagnostic tree. We continue asking "why" until we reach one of the five policy control knobs—financing, organization, payment, regulation, or persuasion—as a possible root cause for the performance problem.

It is essential to continue asking "why" until you reach the policy control knobs because they represent ways of addressing the performance problem through health reform interventions. When you examine Figures 4-1A and 4-1B, you will notice that we only arrive at causes related to the policy control knobs on the fourth or fifth branch of "why." With these causes identified, we can move to Step Five to identify possible health reform interventions, based on the five policy areas, to address the performance problem.

Figure 4-1A: Sample diagnostic tree diagnosing causes of low financial risk protection, 1st branch

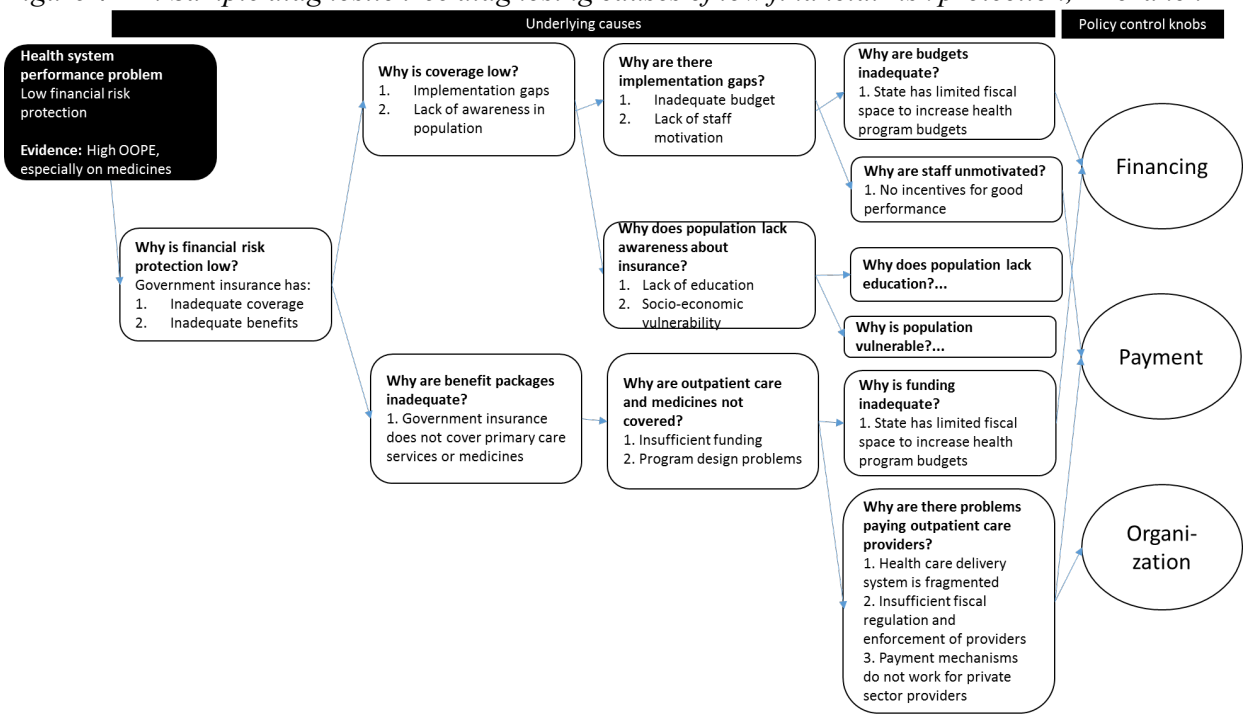
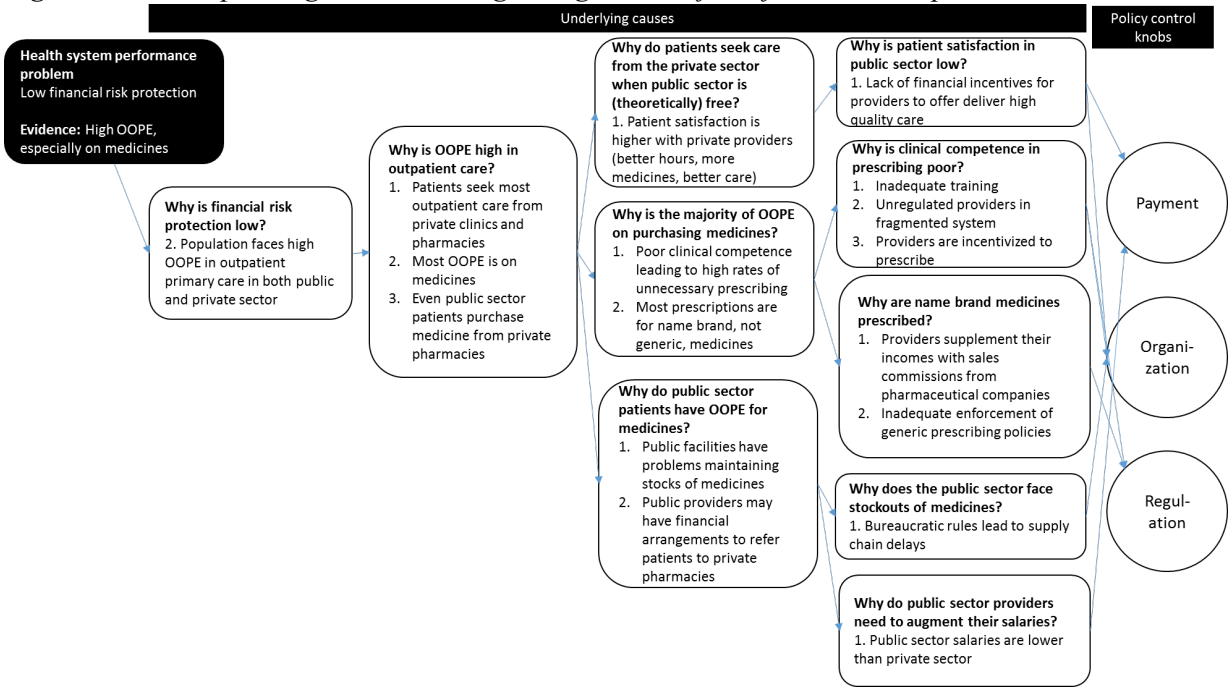


Figure 4-1B: Sample diagnostic tree diagnosing causes of low financial risk protection, 2nd branch



Apply a Systems Approach

Regardless of which analysis you are conducting (including performance assessments, health care system descriptions, and diagnostic trees), the *GHRR* framework emphasizes the importance of using *a systems approach*. This means considering how each indicator or outcome measure relates to multiple different aspects of the health system. Taking a systems approach generally leads you to identify multiple causes for performance problems and multiple interventions to improve performance.

It is especially essential to take a systems approach in diagnosis. The root causes of most problems do not lie in only one single policy control knob. Instead, the underlying causes are typically systemic. This is evident in the Odisha example. Patients are choosing to use private pharmacies rather than going to public clinics, because public clinics do not have convenient opening hours and do not stock the medicines the patients want. Instead, they visit private pharmacies, even though these stores are largely unregulated in both quality and pricing. Private pharmacies generate supplier-induced demand, and sell patients unnecessary and expensive medicines. Why are public sector opening hours inconvenient and medicines unavailable? Root causes can be traced to several sources: poor management at public hospitals, lack of incentives for doctors to show up for work in public sector facilities, and the fact that public facilities are not held accountable for performance. These factors combine to contribute to high OOPE by patients and families.

Health systems are complex and dynamic. The causes and effects of performance problems can interact, occur simultaneously, act in concert to mutually reinforce each other, or act in opposition, canceling each other out. Any given policy intervention can give rise to multiple changes, both intended and unintended. Taking a systems approach as you develop the diagnostic tree helps identify linkages among problems and causes. This will help you prepare for possible effects of the reform interventions decided next in Step Five.

Analyze linkages among causes and possible effects, and prepare for *Step Five: Designing Reform Options*

Our sample diagnostic trees highlight a few potential causal chains for a performance problem, demonstrating that diagnosis does not result in simple answers. Health system performance outcomes are linked to each other, as are their root causes. For example, Figure 4-1B shows how financial risk protection is linked to quality of care. Possible causes in the third level of "why" are poor quality clinical care and the prescription of multiple, and often unnecessary, medicines. Both can lead to high OOPE.

You may also notice that, while the first-level causes are different in the two figures, the final set of root causes are common at a high level of generalization. In this example, the root causes behind low financial risk protection in Odisha are traced to four of the five control knobs: financing, organization, payment, and regulation. Now that we have arrived at causes that can be addressed through government policy action, we can generate possible policy options to address the performance problem. In Step Five, we discuss how to select a package of policies for our health reform.

Once you select the policy option you will pursue, you may want to create another tree. Instead of working backward as you did above, however, in this tree you project forward from the intervention to predict how the changes in your reform are likely to affect health system performance (including both improvements and possible unintended or negative consequences that may occur).

Summary

In conclusion, Step Four enables the Health Reform Team to develop a clear understanding of why the health system is performing poorly on the selected intermediate and final outcome(s). Understanding the multiple causes does not definitively determine which reforms you should then pursue, but accurate diagnosis of the causes of the problem is a necessary step toward devising a set of potentially effective solutions.

Diagnosis thus sets the foundation for Step Five: Designing Reform Options, by helping identify the root causes for performance problems and indicating which policy controls could be used to address these problems. As with the other steps, diagnosis of performance problems may not be a one-time activity. The Health Reform Team may decide to undertake diagnoses of different performance problems at different points in time during the reform process. They might also decide to diagnose newly emerging problems in the same area of performance periodically to trace changes in root causes engendered by the policy reforms or other factors.

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Step Five: Deciding on Your Reform Package

In many ways, Step Five is the most important point in the health reform process. This is when you decide on the actions you will take in order to improve performance in your health system. Deciding what to do is not easy (and this Guide cannot cover all the possibilities). Instead, in this section of the Guide we focus on pointing out the factors you must consider. We also suggest a process for decision-making.

Key actions in Step Five:

☑	Decide on the scope of your reform using evidence from the diagnosis, assessment, and policy studies.
☑	Decide on a package of interventions to include in your reform, considering the five policy control knobs.
☑	Decide whether to start with pilot tests or a full-scale approach.
☑	Decide on a mechanism for enacting reform (legislation or executive decree)
☑	Decide on a name for the reform package.
☑	Decide on the timing of the reform effort.

In this step, the Health Reform Team uses various types of evidence to identify interventions that are likely to create pathways by which the health reform package would lead to your intended outputs and outcomes. These interventions should be related to the available policy control knobs. As noted in the previous Step, *GHHR* discusses each policy control knob that affects health system performance in a separate chapter:

- Financing (*GHRR-Chapter 8*)
- Payment (*GHRR-Chapter 9*)
- Organization (*GHRR-Chapter 10*)
- Regulation (*GHRR-Chapter 11*)
- Persuasion (*GHRR-Chapter 12*)

The evidence that the Health Reform Team should use includes: the health system assessment from Step Three, the diagnostic findings from Step Four, and any available studies or reports that examine how particular policy changes can affect performance. Examples of interventions undertaken in other (similar) countries or states can provide persuasive evidence to support the particular reform actions you decide to propose.

In order to increase the likelihood of achieving your desired results, we again recommend taking a systems approach. During this Step, a systems approach typically means combining several interventions to address a performance problem. This means you will probably be taking action using more than one of the policy control knobs, and need to consider any possible interactions among the chosen interventions. This will be especially true if you have decided to address *major* performance problems in your health system (for example, inequity in health outcomes across

geographic units, low levels of public satisfaction with public facilities, or a high incidence of catastrophic expenditure in low-income groups due to OOPE on medicines).

As in the previous steps, you should consider who to involve in the process of identifying and selecting the policy actions to include in your health reform. In order to make appropriate choices about policy interventions, your Health Reform Team needs members (or consultants) with technical expertise in the areas you are focusing on and experience with systemic reform. Therefore, you may need to bring new people into the team.

This Guide does not address the technical details that different reforms involve. Instead, we explore some of the broader strategic questions and considerations about *how* you decide on your package of reform interventions. Readers interested in exploring the technical dimensions of the five policy areas should consult the relevant chapters in *GHRR*.

Decide on the scope of your reform

As mentioned in the Introduction, one of the key decisions you must consider is scope, or how ambitious your reform will be. This decision begins with selecting how many, and which, of the performance problems you have identified and diagnosed you will now seek to address. Here is what *GHRR* says about deciding on the scope of your reform:

> Some might choose to focus quite narrowly on one or two specific performance parameters (like high infant and maternal mortality rates in poor rural areas). Such a problem definition is likely to lead to a relatively targeted set of reforms; the development of new reimbursement mechanisms or selective investment in certain facilities or training programs, for instance. On the other hand, broader problem definitions are likely to lead to a broader and more complicated reform agenda. Concern about widespread simultaneous failures of risk protection, popular dissatisfaction with the health-care system, and high costs could lead reformers to a much more ambitious reform program. The country might decide to create a new social insurance fund, new payment schemes for doctors and hospitals, and new forms of hospital organization—all at once. In making decisions about the scope of problems to tackle, reformers are well advised to think carefully about the administrative and political feasibility of a more or less ambitious agenda. (p. 123)

Thus the question of "scope" refers to whether you are seeking targeted incremental changes or broad-scale systemic changes (Reich et al., 2019). As stated, this Guide (and *GHRR*) focus more on efforts aimed at "large-R Reform"—that is, *for efforts seeking to achieve major systemic transformations aimed at improving multiple significant performance problems*. However, our approach can be easily adapted to gradual, incremental changes (or "little-r reform" efforts), such as those that are directed, for example, at managerial adjustments, or at particular health facilities. Little-r reforms typically *seek to change particular inputs* into the health system, such as the use of funding, management of human resources and medications, and the role of information. When adopting little-r reforms, you still need to be concerned about overall policy coherence and whether these changes are aligned with a particular health system performance goal. Little-r reforms can be important in improving health system performance (and can still face significant challenges in

adoption and implementation). Sometimes, therefore, a Health Reform Team may decide to start with a little-r reform to test the appetite for larger systemic reform—or while waiting for a window of opportunity to open for large-R Reform.

The wider, more transformative, and more systemic the reform, the more interventions with several control knobs are typically required. Big-R reform, according to the new preface to *GHRR* (2019):

> …is not a one-shot effort but typically continues over many years (and even decades), as a major reform is introduced and then adjusted and modified as new problems arise and are addressed. Reform is not simply about creating a law and getting it adopted; it is a years-long process of learning how to improve the performance of a health system, through trial-and-error, measurement and evaluation, systematic thinking, and analysis. (pp. x)

Deciding on the scope of your reform incorporates the results from the previous four steps (deciding to do reform, creating your health reform team, conducting a health system assessment to identify performance problems, and diagnosing the causes of the identified problems). The decision to undertake large-R Reform should not be taken lightly—here is where risk analysis is critical—as these efforts involve major political risks, economic costs, and personal commitments of time and energy, plus all sorts of uncertainties. And large-R Reform does not happen often. It can only be achieved at those rare historical moments when a window of opportunity opens for major social change. It therefore pays to be prepared so that, when you determine such a moment has arrived, you are able to move quickly before the window closes.

Decide on your package of interventions

The key operational decision in Step Five is to decide on the package of interventions, that is, the set of actions that you propose to include in your reform to improve health system performance. In both this Guide and in *GHRR*, we urge you to select interventions based on the performance problems that you want to address and the results of your diagnostic journey. Together with the Health Reform Team, consider: *What package of interventions is most likely (according to your diagnostic analysis and your reviews of examples from other places and the literature) to improve your selected performance problems?*

For example, look back at the illustrative diagnoses provided in Step Four (in which high OOPE, particularly on medicines, created the problem of low financial risk protection for the population). The diagnosis identified a number of possible interventions, including: 1) Change payment and incentive systems for state officials to cover implementation gaps in the government health insurance program; 2) Increase government financing to improve policy implementation; 3) Expand outpatient benefits so that patients can receive more services and pay less out of pocket; and 5) Improve the effectiveness of regulation and enforcement so that providers do not misuse insurance funds.

Consider whether to start small or go big

As you select the package of policy interventions, you must consider whether to "start small," for example by undertaking pilot projects to test out your proposals, before you "go big" (that is, do a

full scale implementation). Conducting a pilot test is generally considered good practice, especially for large-scale reforms (or in large countries). In China, for example, pilots have been successfully used to test out options for payment reforms (Yip et al., 2019). However, it is not always feasible, depending on the available financial resources, political timeline, and policy experiences. (Occasionally a pilot test may be unnecessary, especially if you have clear and incontrovertible evidence available from other health reform efforts.)

Pilots can have various purposes, including:

- Demonstrating the feasibility of the reform to political leaders and key stakeholders
- Identifying implementation challenges that the reform interventions will face
- Learning how providers/the population react to the changes the reform interventions create in the health system
- Determining if the proposed package of interventions actually produces performance improvements as intended in your setting

Pilot projects are thus useful for testing "proof of concept," enabling you to show with some certainty that the proposed reform will have the desired effects.

In addition to generating empirical evidence for the proposed package, undertaking pilot projects can also help generate visibility and public support for the reform. However, be forewarned that rigorous assessment of a pilot project can take significant time and resources to conduct, analyze, and write up. You need to balance these requirements with the reality that you have a limited amount of time and funds to produce change. While you are waiting for additional certainty, the opportunity to produce change may pass.

On the other hand, when you implement a package of untested reforms widely, you may not actually be able to improve health system performance. Assessing this critical trade-off—between increasing certainty and making use of opportunity—should be a topic for frank and detailed discussions within the Health Reform Team that can inform decisions by political leaders.

Decide on executive decree or legislative action to adopt your reform

Where and how will you get your health reform adopted? While it is not possible to cover all possible strategic options in this Guide, there are, broadly, two choices for adoption:

1) through executive action (within an existing government body), or
2) through legislative action (by amending a current law or passing a new law).

Your decision on the instrument and setting for adoption has important implications for your reform's trajectory, including how the package is presented, who has to be contacted, negotiated with, and persuaded to adopt it, and how the reform will be implemented. Your decision on where and how to adopt the reform will depend on the specific political and legal contexts where you are working. But the choice between the executive and legislative pathways is a critical decision point that can affect the success of your reform efforts.

In general, adopting your reform through executive action gives you more control over what happens, especially if the motivation and main advocate of the reform is a major political figure (such as the national leader or minister of health). However, declaring policy changes through executive decree may limit the scope and complexity of the reform, depending on the political context, and can make the reform vulnerable to reversal by a subsequent political leader. Military dictators under martial law, for example, may be able to declare broad policy reforms without going through a legislative process, as happened with Bangladesh pharmaceutical policy after a 1982 military coup (Reich, 1994). Under normal democratic conditions, however, the scope of reform that can be enacted through executive action (without legislative review and approval) is usually more limited, according to constitutional law and practice. On the other hand, executive action gives the political leader more control over how the reform is designed, since it does not require negotiation with legislators to achieve approval.

If the party in charge of the executive branch also controls the legislature (either through its own party or a coalition), then a legislative path for reform becomes more attractive. Mexico's President Andrés Manuel López Obrador, for example, accomplished his radical restructuring of the national health system (eliminating the previous reform enacted in 2003 and creating a new organization) through a legislative action that amended the General Health Law in November 2019. This was possible because his political party gained majority control of both houses of the Mexican Congress in the 2018 general elections (Reich, 2022). The number of seats the ruling party holds in the legislature can affect the ease of getting a reform package passed—but keep in mind that even a majority can get stalled, blocked or otherwise derailed by a well-organized minority. It may be necessary to negotiate (and compromise) some aspects of the reform to gain support from the opposition.

Sometimes governments combine the two approaches. India's landmark health reform program of Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (PMJAY), for example, was launched by the national government through an "executive notification" in September 2018 (Sharma, 2019). The launch occurred prior to India's general elections in 2019, and the new insurance reform was a prominent agenda item in the campaign (Dubey et al., 2023). Implementation began through the establishment of a National Health Authority and signing of Memorandums of Understanding between the central government and states. The National Health Authority helped to draft legislation to provide the framework and statutory basis for the policy (Sharma, 2019), but the bill was not put forth in the Lok Sabha (India's legislature). Subsequently, Right to Health legislation in different Indian states reopened the opportunity to create a statutory basis for Ayushman Bharat.

Finding the right form and forum for adoption of your health reform is a critical decision that has important judicial, political, implementation and continuity implications. These decisions need to be made carefully according to the specific characteristics of your reform and your context. How your reform is adopted is an important element in creating and assuring its political resilience over time and through changes in regimes.

Decide on the name of your reform

The name given to a health reform package sends signals to different audiences. It can symbolize the overall goals and vision of the reform, especially if the reform seeks systemic transformation. Hence, deciding on the name deserves serious consideration. This task may be undertaken by the Health Reform Team or by the top political leader in consultation with key allies and advisors. You can also seek advice and suggestions from public relations or policy strategy firms. Naming your reform helps shape the public image and understanding of what the reform does and what it seeks to achieve.

Consider the names of some recent prominent health reforms. President Barack Obama's reform in the United States was formally called the "Affordable Care Act" but became widely known as Obamacare. This name cemented the linkage of the reform to Obama and his political legacy, but also made the reform into a major political target for the Republican party and the Trump administration. In Mexico, the name of "*Seguro Popular*" sent a positive message of "insurance for the people" and "popular security." However, it also exposed the reform to attacks by the political opposition, who declared it as "*ni seguro, ni popular"* (not secure, not popular) and contributed to its elimination by President Andrés Manuel López Obrador.

India's example also illustrates the importance of reform names. Prime Minister Narendra Modi named his health reform "Ayushman Bharat" (sometimes translated as "bless India with long healthy life"), reflecting his populist leanings and the reform's electoral purposes. It included the national insurance program named Pradhan Mantri Jan Arogya Yojana (PM-JAY), which translates to "the PM's (Prime Minister's) program for the health of the people." Interestingly, the pronunciation of the acronym PM-JAY in several Indian languages translates as "victory to the PM." The reform also acquired the name of "Modicare," echoing Obamacare and directly connecting the policy to Modi's legacy.

A good name alone does not guarantee policy success or political survival. But it is a key part of the communication strategies that can contribute to policy implementation and political resilience.

Decide on the timing of your reform

Finally, the timing of your reform is crucial, especially in relation to the timing of elections and political campaigns. A potentially controversial major reform may be best introduced immediately after an election, when leaders have "political capital" to spend, reliable majorities to mobilize, and time to demonstrate positive impact. This is especially true if you are using a legislative path for adoption. On the other hand, a political leader with a firm grasp on their political party and the legislature (with majority control) may decide to announce a major reform just before an election (as PM Modi in India did in September 2018) as a campaign strategy to promise rewards to voters.

Summary

Step Five is the pivotal moment in a health reform process: when the main policy interventions to be included in the reform are selected. From this point forward, the process shifts its focus to building widespread support for (and reducing opposition to) the health reform (Step Six),

implementing the health reform as efficiently and effectively as possible (Step Seven), and tracking whether it has the intended effects through evaluation (Step Eight).

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Step Six: Conducting Political Analysis and Designing Political Strategies

Policy reform is a profoundly political process, and advocates need to manage the politics of change, through careful political analysis and innovative political strategies. Understanding and managing the political context of health policies is crucial to improving the chances of effectively designing, adopting, and implementing health reforms that can achieve their intended objectives. Step Six involves assessing the political feasibility (i.e., doing applied political analysis) of each proposed reform option and then designing political strategies and adapting proposed reforms as needed through negotiation to improve the political feasibility of the reform options (*GHRR-Chapter 4*).

Applied political analysis: A systematic investigation of the interests, positions, and power of stakeholders regarding the formulation, adoption, or implementation of a policy, and includes the development of political strategies to assist in managing change.

Applied political analysis helps you improve your chances at success in changing public policies by:

- Designing strategies to put a particular topic on the policy agenda (topics such as: introduce new cadres of health workers, create new forms of health insurance, or control pharmaceutical prices).
- Increasing the likelihood of support of important groups for a proposed policy and decreasing the opposition of other groups.
- Managing key stakeholders affected by a proposed policy (such as physicians' associations, different government agencies, health worker unions, associations of pharmaceutical companies, insurance organizations, taxpayers, and patient groups).
- Identifying implementation risks early on.
- Assisting in communication among different organizations (by working with journalists, creating regular press conferences, and reaching out via social media).

Political analysis is not a one-off exercise. Instead, it should be done early and often, using the following key actions:

Key actions in Step Six:

☑	Identify stakeholders (persons or organizations) with a vested interest in your policy and the potential to influence related decisions
☑	Assess the position, interest and power of your stakeholders
☑	Design and implement a set of political strategies to increase the likelihood of success
☑	Evaluate your strategies and re-do your analysis as often as needed

You can use Worksheet 6-1 to prepare to conduct a political analysis for health reform.

Identify stakeholders

The first step in political analysis is identifying key stakeholders; Worksheet 6-2 provides guidance on identifying your stakeholders and a table for documenting your findings. Whether you are identifying a health issue, designing solutions to address it, or implementing solutions already adopted, you are likely to encounter the stakeholders shown in Figure 6-1.

Figure 6-1: Stakeholders

- **Political leaders** – executive and legislative branches of government, and political parties
- **Donors** – external actors or partner organizations who are invested in the issue
- **Financial decision-makers** – those who control the budget and financing of the solution.
- **Beneficiaries** – those who will (directly or indirectly) benefit from the solution.
- **Bureaucracies** – those who carry out the work of government, from ministries to front-line workers (known as "street-level bureaucrats"), and a range of agencies and directorates.
- **Interest groups** – associations of persons or organizations with an interest in the issue or solution who are (often) trying to affect policy, such as the private sector, lobbying groups, civil society, non-governmental or non-profit organizations, professional associations, the media, etc.

Source: Campos and Reich, 2019

The list of stakeholder categories in Figure 6-1 is not exhaustive and should be adjusted based on your context and reform package. You can think of any other group of stakeholders that may be relevant to your objective, for example, expert academics. Actors at different levels need to be considered, including national, state, and community levels. Remember that these actors can be from the health sector or from other sectors that have an impact on health, such as energy, finance, labor, transportation, and education.

Assess the position, interest and power of your stakeholders

Once you have identified your key stakeholders, you need to come to know them better. Knowing your stakeholders means clearly understanding: what is at stake for them, what motivates them, what interests them, and how best to work with them. Knowing your stakeholders enables you to seize opportunities, anticipate and navigate challenges that are bound to arise, and determine how best to collaborate and communicate with them.

One way to learn more about your stakeholders is to conduct interviews with them. (If you decide to conduct interviews, consider asking interviewees if they can suggest other stakeholders to consult.) But interviews are not the only way to understand the perspective of stakeholders—media articles, position statements, and other written materials can also be used.

Use the information you gather to assess each stakeholder's position on the proposed health reform and how much power they have. This is not an easy task. It requires a careful triangulation of perspectives across interviews and other data (i.e., published and unpublished documents).

Here are some questions that can guide your analysis (and help you decide whether you need to conduct interviews to answer the questions):

- Who are the most important stakeholders for the issue your reform addresses? Who holds power related to the issue? Who has access to decision-making processes?
- What is each stakeholder's position on the proposed reform? Do they support it, are they neutral, or do they oppose the reform? With what level of intensity?
- What are the stakeholders' interests in the issue? How would the reform affect them?
- Which stakeholders have (or might form) alliances?

The aim of stakeholder analysis is to establish the position of each stakeholder (support, non-mobilized, opposed, and the intensity of support or opposition as high, medium, or low); their power (financial and administrative resources, access to decision-making process, also assessed as high, medium, or low), and their formal and informal relations with other stakeholders.

Assessing the power of key stakeholders is also partly based on identifying the political resources available to each player. Those resources can include material and financial resources, capacity to mobilize an organization or votes, and symbolic resources (such as leadership charisma or social media followers), as well as actual decision power over a specific policy arena. Asking different stakeholders about who holds the most power over a specific policy decision can be used as an input in assessing the power of stakeholders. Worksheet 6-3 provides further guidance on analyzing your stakeholders and presenting your conclusions.

The PolicyMaker software (https://michaelrreich.com/policymaker-software) can be used to help you through this process, including to produce a visual representation of the "political map" of stakeholders in the policy landscape. This map will help you in the next step, identifying key areas of opportunity or challenge for which strategies to improve the political feasibility of the reform can be developed. One example of applied political analysis that uses the PolicyMaker software is provided by Glassman et al. (1999).

Design and implement a set of political strategies to increase the likelihood of success

Stakeholder analysis is not an end in itself but rather a means to managing change. Just describing the political landscape is not sufficient to produce change. The results of the stakeholder analysis should be used to develop strategies to change the political landscape in ways that improve the political feasibility of the desired policy reform.

How does categorizing the various stakeholders help us understand who might support, resist, or obstruct the implementation of a proposed reform? And how does it help us figure out what you to do? Implementing health reform successfully requires an active commitment to engaging stakeholders. You are more likely to be successful in enacting health reform if you can figure out how allies can be mobilized, how neutral stakeholders can be turned into allies, and how opponents can be managed or disarmed. All of these efforts require *political strategies*.

Political strategies have four main purposes:

- seeking to change the power of actors;
- seeking to change the position of actors;
- seeking to change the number of actors (in support or opposed)
- seeking to change the perception of the problem or the solution.

These four factors (power of actors, position of actors, number of actors, and perception of problem and solution) all influence the political feasibility of adoption of a proposed policy or the political feasibility of implementation of an accepted policy. Appendix 6-1 provides additional questions to help you develop a set of political strategies.

For each salient stakeholder, the reform team can identify a strategy that will improve the political feasibility of the proposed reform: the specific action to be taken, the expected impacts of that action (on power and position and number of actors), and any anticipated problems with the action. (Indeed, the creation of a change team itself can be considered a political strategy, to ensure that different stakeholders are involved in the reform and that explicit attention is given to the political dimensions of change.)

Political strategies can be creative, but they can also involve risks and potentially adverse consequences. They are also often time-limited. They may only work for so long, or may be relevant during one administration but not another. So the reform team should periodically assess whether its current political strategies are having the intended effects. If not, it is time to start the process over again.

You may also find that the proposed reform itself needs to be reshaped through negotiations with opponents. Changing the contents of the proposed reform thus can be considered a strategy to improve political feasibility. One key challenge in making compromises to improve political feasibility is to avoid reducing the technical effectiveness of the proposed interventions.

Past experience in the local context (in the health sector and in other sectors) is one great source for ideas. You can also look further afield. Applied political analysis has been used to help reformers successfully manage the processes of adopting health financing reforms in Mexico (Gómez-Dantés et al., 2015) and Turkey (Rossetti, 2004). The published literature includes many case studies on health policy processes and political strategies used to promote adoption or implementation. Finally, the PolicyMaker software (available at: https://michaelrreich.com/policymaker-software) includes a "toolbox" of around 30 possible political strategies that can be adapted to different contexts.

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Step Seven: Managing the Implementation of Health Reform to Achieve Results

In Step Five, you decided on a package of health reform interventions related to the policy control knobs; then in Step Six, you learned how to use political analysis to design political strategies to support the adoption and implementation of your interventions. Now, in Step Seven, we bring all these pieces together to develop, plan for and manage the implementation of your reform package. This section suggests tools and approaches to help drive implementation of your reform package.

Implementation is the complex and uncertain process of turning policy into practice. This is an ongoing process that requires the Health Reform Team to make decisions that ensure the new policy results in its intended changes. In addition to technical decisions, implementation requires continuous monitoring, periodic course corrections, and sustained stakeholder engagement. In some instances, implementation can result in significant changes in the policy reforms adopted previously. Implementation thus can become a kind of policy-making process itself.

As in the previous steps, implementation involves many considerations. Implementing health reform involves more than just providing instructions regarding a policy document or even designing standard operating procedures. It necessitates continuing your engagement with key stakeholders as you: integrate the technical and political analyses to put your reform into practice; define target goals and design strategies; and establish systems and methods for measuring progress. We first discuss typical implementation challenges and then address how to develop an implementation plan, create a communications strategy, and finally prepare for Step Eight, monitoring and evaluating implementation. These efforts will enable you to build and sustain the support and engagement required to implement your reform.

Key actions in Step Seven:

☑	Assess your team´s capacity to drive delivery and implement your proposed interventions
☑	Conduct an analysis of the politics of implementation
☑	Develop an implementation plan with clearly-defined goals, targets, team assignments and timelines
☑	Communicate effectively with stakeholders
☑	Track progress towards objectives (through monitoring) and address problems that arise

Challenges of implementation

The challenges of implementation are well known, especially for reforms that are seen to threaten the interests and values of some stakeholders. The classic first text on implementation, written by Pressman and Wildavsky in 1973, included the lengthy and wonderful subtitle: “How Great Expectations in Washington Are Dashed in Oakland; Or, Why It's Amazing that Federal Programs Work at All, This Being a Saga of the Economic

Development Administration as Told by Two Sympathetic Observers Who Seek to Build Morals on a Foundation."

If your Health Reform Team does not anticipate and manage the challenges of implementation, your chances of successfully having an impact on health system performance drop sharply. Beware the realities of implementation.

Although *GHRR* does not include a separate chapter on implementation, the book emphasizes the importance of paying attention to "matters of practicality and implementation" (p. 5) throughout the health reform process. In particular, each chapter on the policy control knobs includes a "practical guidance" section with suggestions on how to use its concepts in real-world settings. Chapter 2 of *GHRR* lists multiple challenges of implementation for the Health Reform Team to consider (pp. 33-35):

- Health reform implementation requires organizations and individuals to change their behaviors.
- Change typically has costs for specific groups and individuals.
- New procedures and arrangements take time and effort to learn.
- Existing hierarchies can be upset.
- People and organizations often find it difficult to give up familiar ways of thinking and acting.
- Few people have experience in leading and managing change in health systems (and Ministers of Health usually serve short terms in office, leaving government before implementation can be fully accomplished).
- If key actors and interest groups feel they have not been consulted sufficiently in the design of the reform, they may undermine implementation.

In short, implementing reform is not easy. Health system reform requires organizations and individuals to behave differently. Yet modifying behaviors is a difficult task and change is almost always resisted. Change disrupts established power structures and ways of getting things done; it requires both breaking old habits and relationships and starting new ones. Transforming a newly-adopted policy into specific activities, outputs and outcomes involves the redistribution of resources and responsibilities (Campos and Reich, 2019).

In this Guide, we provide some practical guidance for managing the implementation process specifically for *health reform*. The implementation guidance in this Guide borrows many principles and best practices from the field of implementation science. Implementation science uses a research approach to bridge the "know-do gap" (that is, the difference between what is known to work and what is actually put in place to improve population health) (Peters et al., 2013). There are many definitions of implementation science; the University of Washington has defined it as "the scientific study of methods and strategies that facilitate the uptake of evidence-based practice and research into regular use by practitioners and policymakers" (UW, 2023). The Guide also draws on other approaches, including performance management, the science of delivery, and "deliverology."

Assess your capacity before beginning implementation

Before beginning implementation of the chosen interventions, the Health Reform Team needs to assess the health system's *capacity to deliver* (Barber, 2011). This is important because, as Barber notes, making change happen requires two things: first, a clear understanding of the ecosystem of people and organizations that will play a role in implementing your reforms; and second, a set of defined activities that will push delivery forward. To gain a clear understanding of the "ecosystem"—that is, the complex administrative context the proposed policies will affect—health system reformers need to first analyze two key areas: (1) the system's delivery capacity, and (2) the politics of implementation.

Delivery Capacity Review

To review the health system's delivery capacity, begin by asking: Who are the main actors in the health system? What are their roles? What are their relationships with each other? As starting points for finding the answers to these questions, revisit your health system assessment (Worksheet 4-1) and stakeholder analysis (Worksheet 6-2). You may wish to create a visual "map" of the system, or you can just create a list.

Once you have a clear picture of the current system your reform will affect, you expand the analysis to include a focus on each stakeholder's capacity to implement (or obstruct) the adopted reforms. This entails assessing the ability of each organization in the system to drive the implementation of the selected interventions.[3] Worksheet 7-1 provides a series of guiding questions to guide this work. For the delivery capacity review, we recommend a small cross-cutting group that brings together members of the Health Reform Team with people who represent key stakeholders and political leadership.

While the delivery capacity review is important, it should be conducted quickly, not as a comprehensive academic exercise. However, the time required will depend on the system's complexity and the availability of team members. Depending on what data are available (and what resources you have), you may even need to conduct additional surveys, hold focus groups or interviews, observe committee meetings, or review past meeting minutes to identify the delivery capacity of system actors at all levels.

The delivery capacity review examines the system's current capacity to deliver on the proposed reforms and highlights the gaps in capacity. To fill those gaps, you may need to find ways to improve delivery capacity (with implications for adding additional staff to the Health Reform Team). This review should inform how the Health Reform Team focuses its attention and energy during implementation. You may even discover that the system currently does a poor job of understanding its own performance (including the underlying

[3] This is a complex undertaking—for one set of instructions on how to conduct a delivery capacity review see Barber's book *Deliverology* (2011).

causes of performance problems)—in this case, monitoring and evaluation (which are discussed in Step Eight) should be identified as a priority area when doing implementation.

Stakeholder analysis for implementation

Successful implementation depends on the active participation of system stakeholders. Thus stakeholder analysis is a key tool used in implementation science. In addition to the delivery capacity review, the stakeholder and political analyses that you conducted in Step Six will help the Health Reform Team understand the roles that various groups—such as community leaders, political parties, the medical society and others—could play in implementation. The important stakeholders should be considered for your implementation team.

You can draw on your political analysis from Step Six to assess the interests, positions and power of each stakeholder involved in implementation, and to develop effective strategies to manage stakeholders as you move the implementation forward. In particular, consider whether there are implementation risks from stakeholders whose participation is required to transform the reform into practice. For example, health workers and their unions that were not involved in the reform design or approval process may play an essential role in implementing the new policies. Similarly, subnational government units may be required to take on new roles, such as regulating reform activities or funding new health programs, and will need adequate administrative guidance and financial support.

Campos and Reich (2019) identify six categories of stakeholders that need to be managed during implementation: beneficiaries, bureaucracies, donors, financial decision makers, interest groups, and political leaders. They suggest thinking about stakeholder management for implementation as a process of managing in six directions (managing down, managing within and around, managing donors, managing money, managing outside, and managing up) to reach each stakeholder category. The Health Reform Team can use Worksheet 7-2 to develop a table on stakeholder management as an input for the implementation plan.

Once the stakeholders are clearly defined, the Health Reform Team can invite key individuals and organizations to form an Implementation Team. This team includes members of the Health Reform Team and representatives from the various organizations involved in implementation. (In addition to collaborating on planning and overseeing implementation, the Implementation Team also needs to create systems for internal learning and feedback. However, these kinds of management strategies are beyond the scope of this Guide.)

Develop an implementation plan

Health reform implementation works best when a systematic approach is used to actively manage the change process. This includes being able to measure progress in moving towards your objective to assess if you are on track at any given time.

An implementation plan will help you:

- Be clear about the performance problem that your reform addresses and the solutions that you plan to implement

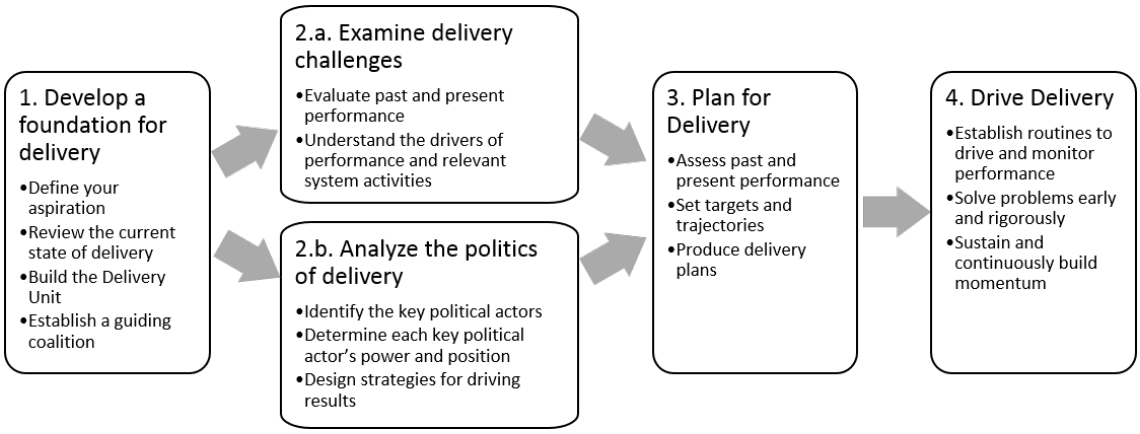
- Be clear about your goals and targets (the changes that you expect to see and by when)
- Be clear about what you will implement and how (the interventions based on the policy control knobs)
- Define clear roles and responsibilities
- Establish a shared vision of success, including processes, targets and milestones
- Set progress-tracking routines (such as regular data collection and meetings to assess progress)
- Communicate effectively with your stakeholders

An implementation plan can be presented in many different ways. You need to determine what works best in your context and for your implementation team. Worksheet 7-3 provides a set of guiding questions for preparing your plan, and Worksheet 7-4 is a sample template that you may choose to use or adapt. There are other resources that provide additional assistance. The book *Deliverology*, for example, examines in detail "the science of delivering results" (Barber et al., 2011).

An implementation plan should summarize your goals and then connect each goal to objectives, activities, and expected outcomes that will drive progress towards the health reform's targets. At a minimum, your plan should list the main activities, the responsible actors, measures of success, and resources required. It should also acknowledge any anticipated potential risks and how they will be identified and handled. An important part of creating the plan is defining indicators to monitor the progress and the impact of implementation. As we discuss in Step Eight, tracking progress on the indicators regularly allows the Implementation Team to correct the course of implementation as needed.

Deliverology outlines four actions that drive implementation and deliver results in public sector endeavors. In Figure 7-1 we present an adapted version of a figure from the book to which we have added a fifth recommended action (as action 2.b): analyze the politics of delivery.

Figure 7-1: Driving Implementation and Delivering Results



Adapted from: Barber, Moffit and Kihn, Deliverology, 2011.

Managing implementation and communicating effectively

Thoughtful planning for implementation is important but not sufficient. Concrete actions and follow-up are key. One way to drive action is to hold regular progress-tracking meetings. These serve to hold the various actors accountable for their assigned actions and enable the team to identify whether implementation is on track. During these meetings and other progress tracking routines, the Health Reform Team should ask the following questions:

- Are we doing what we said we were going to do under this health reform?
- By doing what we said we were going to do, are we delivering on commitments made to the people and communities we aim to serve?
- Are we implementing effectively and efficiently?
- Are the indicators moving in the right direction?
- Are we measuring the right indicators to assess implementation progress?
- What can we do to improve/accelerate/scale up implementation?
- What bottlenecks or implementation challenges are we facing and how can we address them?

Collaboratively engaging stakeholders in tracking implementation is key to successfully solving problems. In some cases, this means involving other groups in monitoring specific indicators; in others, it means ensuring that they are kept informed about the process and progress. This leads us to our final consideration for implementation: communication.

Communicating with stakeholders

Transforming reform into practice is complicated. You cannot "just" implement your health reform; there is no magic wand. In short, implementation requires hard work. You also need to convince the people and organizations that will be affected that your health reform is important, beneficial to them, and worth their attention and action. Doing this means both

involving them in the health reform implementation process and regularly communicating with them to ensure they are up-to-date (and also engaged in supporting) your health reform program.

You need both formal and informal communication strategies to assure key stakeholders that they are respected by the Health Reform Team, and to encourage them to remain committed to the reform process and its goals. Formal communications include written and oral statements about the health reform package. Written materials may include: informational brochures on the key components of the health reform package; regular updates (via newsletters or via social media) on the progress of policy development and implementation; active social media strategies and presence on multiple platforms; a health reform website and other social media marketing materials; media briefing materials; and academic articles and evaluation reports. Oral communications include official speaking engagements by members of the Health Reform Team and core supporters of the health reform. These presentations generally require preparing bulleted talking points or full speeches to ensure that the key messages are clear, consistent and accurate. Informal communications can include: one-on-one conversations with key individuals in meetings, social events, and video calls; social media posts by individuals; and any other unscripted or unplanned interactions during which the health reform is discussed.

As noted in Step Two, you may choose to engage professional experts in communications as members of your Health Reform Team. You may also decide to hire a dedicated communications consulting firm. Either way, everyone on the Health Reform Team should be fully aware of the requirements of your communication strategies and key messages. Creating effective communication strategies is a core component of your implementation. Note that we say "strategies," not "strategy." You need to adapt your communications to reach different audiences. Worksheet 7-5 provides a set of guiding questions to help develop your communication strategies for implementation.

Your communication needs and strategies will evolve over the course of the implementation process. Assessing about what you are communicating to each target audience is an important practice, as is determining whether they are understanding and responding to your messages as you hope they will.

This leads to a final point: Communication should be interactive. Information should flow back to you as well as being sent out. Your communication plan should involve creating forums and processes through which you listen to your audiences' viewpoints on how the health reform is going, getting their feedback both on the content of the reform and on whether you are successfully communicating with them. If you are not successfully reaching and convincing your audiences, you can use the simple framework above to determine whether the problem lies with the message, the medium, the messenger, or the timing of the communication.

Summary

We have emphasized throughout this Guide that doing health reform is intended to change the health system's performance. The Health Reform Team needs to keep its focus on the outcomes of health system performance. Efforts to improve health system performance face many of the common challenges of policy implementation. The Health Reform Team needs to learn how to work with and through multiple actors and organizations to: communicate policy objectives, ensure availability of resources, achieve ownership of the policy by implementers, manage conflict and cooperation, and develop strategies to sustain your policy changes through successive governments and political parties in power (Campos and Reich, 2019).

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Step Eight: Evaluating Impacts and Creating Sustainability for Your Health Reform

As we have emphasized throughout this Guide, the purpose of engaging in health reform is to improve the performance of the health system, especially on the performance problems selected as targets for action. Step Eight focuses on evaluating how the interventions selected influence health system outcomes. Do your interventions actually improve health system performance? While we have placed evaluation at the end of the Guide, monitoring and evaluation should in fact be considerations throughout each step. Similarly, *GHRR* presents evaluation as the important last stage in the policy cycle (Figure 2-1 above). The book does not include a separate chapter on evaluation, but Chapter 2 of *GHRR* does include a summary discussion of evaluation.

As mentioned in Step Five, a best practice is to try proposed interventions in pilot tests (or field trials) to demonstrate that they will have the intended impact. When this occurs, it is typically done after assessing the feasibility of implementing the interventions in a real-world context (Step Seven). However, implementation of health reform is sometimes pushed through without preliminary trials. Even in these cases regular monitoring is critical to implementation, and comprehensive evaluations should be conducted after implementation of the health reform plan.

Key actions in Step Eight:

☑	Decide on your evaluation strategy early in the reform process, before starting implementation, especially whether you will use before-and-after comparison, or control groups, or region-by-region implementation at different times
☑	Decide on how you will collect data needed for evaluation, including who will collect the data, how much it will cost, measures to assure reliability, and how to avoid collecting too little or too much data
☑	Decide whether to use an external organization or an internal agency to perform the evaluation (after assessing the advantages and disadvantages of both approaches)
☑	Answer five questions for planning the evaluation: 1. Why conduct an evaluation? 2. Who does the evaluation? 3. What do you evaluate? 4. Who are the main audiences and how to you communicate the evaluation? 5. Who will evaluate the evaluators?

Decide on your evaluation strategy

It is worthwhile to distinguish between *monitoring* and *evaluation* as concepts.

- *Monitoring* refers to data collection and analysis done while you are implementing your reform measures so that you can take corrective action during implementation to improve both the process and effects of your efforts. The intention of monitoring is to create relatively rapid and simple feedback loops on how you are doing, to provide information that assists in making immediate changes and in achieving specific targets. As noted in Step Seven, monitoring is typically conducted by the Implementation Team for its own use.

- *Evaluation*, on the other hand, occurs after significant implementation has been completed (either at the end of a project or at regular points in implementation, such as after one year or every couple of years) in order to determine whether the reform is achieving its intended goals. Some evaluations seek to determine whether the reform interventions are actually the drivers of changes in performance; others may be designed to capture data on unintended consequences of reform efforts.

Evaluation should be conducted by an entity with some (arm's-length) objectivity. It could be performed by (or contracted to) an external agent, by an audit group within the government, or by a group situated at some distance from the implementers. Assigning evaluation to an internal group involved with implementation can create conflicts of interest that may undermine the legitimacy, rigor, and conclusions of the analysis and conclusions. The rest of Step Eight focuses on evaluation.

The Health Reform Team should begin considering the evaluation strategy at the start of the reform process, and continue thinking about evaluation throughout.

There are different types of evaluations to consider. For example, should you plan to do a before-and-after comparison evaluation? If so, the Health Reform Team needs to collect baseline data *before* starting implementation and set up administrative systems to collect (and preserve) relevant information during implementation. Another option is to include control groups (where the reform is not implemented, or more often is implemented after a certain period) in order to enable the evaluation to draw causal inferences between the interventions and the outcomes. If the latter option is preferred, then control groups need to be carefully selected and data collection begun at an appropriate time before implementation starts. If a reform is implemented region by region over time, this can create a kind of natural experiment to assess impacts (King et al., 2007). Broad strategic questions about evaluation designs need to be discussed, debated and decided on by the Health Reform Team early in the health reform process.

Decide on data collection for evaluation

GHRR (Chapter 2) presents several lessons and cautions about data collection for evaluation: First, data collection is not free, and better data typically cost more to collect. Second, the costs of data collection typically fall on the people doing the reporting. If the costs to them of gathering good data are too high, they will usually provide poor data. Third, it is possible to collect too much data, creating "data cemeteries" in which piles of "dead" data accumulate but are not analyzed.

For certain types of evaluations (such as those requiring household or facility surveys, for example) and as discussed in relation to the performance assessment in Step Three, the Health Reform Team may decide to hire an external organization to collect data and do the analysis. The extent of data collection required for evaluation depends on many factors, including the evaluation's objectives, budget, and timetable, as we discuss next.

Plan the evaluation of your health reform

As the Health Reform Team plans to evaluate the health reform, the following five questions can be used to guide strategic and operational decisions. (They may seem very similar to questions asked in the previous steps—however, the answers will vary in each step.)

1. Why conduct an evaluation? Think about the technical, ethical and political reasons for evaluation. Evaluation serves important technical objectives by seeking to determine whether the interventions selected are having the intended consequences on key measures of health system performance (both intermediate and final outcomes). The lessons from evaluation can provide lessons about how to improve the reform's impacts on health system performance and can promote learning about the reform by many audiences.

   Evaluation also can help assess core ethical concerns, including the transparency and accounting of using public resources as well as achieving important distributional and equity goals (for example, in improving maternal mortality of disadvantaged ethnic groups or of specific geographic regions). Are the intended beneficiaries actually receiving the services targeted at them, with the expected impacts on outcomes?

   Evaluation can also serve political purposes, for instance, in seeking to create evidence for the effectiveness of the health reform in achieving an administration's promised improvements in the health system, with the potential for rebutting possible future efforts to roll back or even eliminate the policy changes introduced. In this sense, evaluation, by showing that the reform is having its intended impacts, can serve as a kind of insurance policy against potential political opposition.

2. Who does the evaluation? As noted above, an evaluation is usually not conducted by the organization responsible for implementation, but a decision still must be made about whether to use an evaluation group within government or outside government. This decision, along with the allocation of financial resources and budget, can affect the quality, timetable, and accountability of the evaluation. Using an external organization may require a competitive bidding process; it will usually require a contract and negotiation with the evaluation group, to assure that the evaluators have the necessary technical skills and capacity to complete the evaluation in the required time (which can be influenced by political factors, such as the end of an administration and upcoming elections). The selection of the evaluation group also has important implications for the legitimacy and influence of the evaluation and final report.

3. What do you evaluate? An evaluation can focus on specific outcomes as measurable objectives as well as various processes required for implementation. The decision about what you evaluate will determine the kinds of quantitative and qualitative methods that are used in assessing health reform interventions. The design of the health reform may include specific objectives as targets. The evaluation group may also decide to assess performance achievements according to benchmarks, using other similar entities (other states within a

country, or nearby countries for a national level evaluation). The evaluation can include an assessment of health system processes, using qualitative methods, as well as specific numeric targets, using quantitative methods. The decisions about what to evaluate should be clearly defined in the contract with the evaluation group, and will be shaped by the overall evaluation strategy (as discussed above, for example, a before-and-after evaluation versus an evaluation with control groups). The contract can include specific benchmarks on what and when the evaluation group decides to evaluate, to allow for sufficient discussion and negotiation between the evaluation group and the Health Reform Team.

4. Who are the main audiences for the evaluation and how do you communicate with them? Deciding on the audiences for your evaluation is critical to shaping your communication plan for the evaluation and its conclusions. The audiences could include the top political leaders for the country, national legislators, administrators for different parts of the health system, labor unions for the health sector, and the general public—as well as international experts, multilateral organizations, and donor agencies (depending on the country and the reform). Each audience could require different messages and communications strategies, ranging from social media to top-ranking scientific journals. For a major health reform evaluation, it may be appropriate and necessary to hire a professional communication strategy company to plan the messages and their effective delivery. This decision is best made early in the evaluation planning process. As noted above, evaluation has technical objectives as well as ethical and political objectives. Evaluation is more than a technical exercise, and the Health Reform Team needs to manage the process and perceptions of evaluation carefully to help assure success of the overall reform process.

5. Who will evaluate the evaluation? This question concerns the legitimacy and credibility of the evaluation. Three possible mechanisms to support positive perceptions of the evaluation are: to assign the evaluation to an institution with a strong international reputation for rigorous studies; to seek publication of the evaluation in a high-reputation international peer-reviewed scientific journal (such as *Lancet*, *Nature*, or *Science*); and to create a blue-ribbon advisory committee to oversee the evaluation process. These mechanisms, however, may not be sufficient, in a polarized political environment, to deter public and opposition criticism of an evaluation and its underlying reform.

Examples of evaluations

There are many textbooks, guides, articles, courses, and other publications on how to do evaluations of health policies. We will not attempt here to review the array of materials on policy or program evaluation, due to limited space and objectives of this Guide. Appendix 8-1 highlights and provides references for a selection of health reform evaluations to illustrate what can be done, depending on your objectives, capacity, budget, and reform, as noted above. These examples can give your Health Reform Team some possible "models" of different kinds of evaluations.

Promote the sustainability and resilience of your reform

A positive evaluation of a health reform and its impacts, by itself, does not guarantee policy sustainability and political resilience. The continuity of your health reform into the future depends on multiple factors, including financial resources, political competition, and public support for the policy changes that have been implemented. There is a tendency among policy makers to assume that path dependency will occur, that positive feedback loops from key beneficiaries will sustain the reform against opposition (Pierson, 2000). But things do not always happen that way. The near demise of President Barack Obama's health reform in the United States, which survived an attempted rollback by one single vote in the US Senate (from Republican John McCain), shows how precarious that expected "path dependency" can be (Scott and Kliff, 2017). And the elimination of *Seguro Popular* in Mexico, by the government of President Andrés Manuel López Obrador, demonstrates that "path dependency" can be reversed even after 16 years of implementation, if a political opponent gains power and control of government (Reich, 2022).

The key question for the Health Reform Team is: How can you build in political resilience against the low probability event that your opposition will come to power and seek to weaken or reverse or eliminate your reform? How can health reformers build legislative and judicial safeguards so that their changes will be sustained if the political enemy comes to power? How can health reformers create political support among key stakeholders, and popular understanding and support among the general public and beneficiaries?

In a real sense, the success of a health reform is measured not only by its policy impacts (its consequences for key health system performance indicators), but also by its political resilience (its ability to survive and continue when the political opposition comes to power).

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WORKSHEETS

Worksheet Intro-1: Complete checklist of key actions for each Step of health reform

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Worksheet Intro-1: Complete checklist of key actions for each Step of health reform

Step One: Deciding to Start a Health Reform Process

- ❑ Top political leadership reflects on core values that shape social expectations of the health sector, especially the role of market and state in their society, in consultation with a small circle of key advisors, allies, and experts
- ❑ Identify ethical principles for health system performance (related to consequences, rights, and community virtues) that provide reasons for selecting certain problems as the basis for starting a reform process
- ❑ Examine the benefits and risks of engaging in health reform and the political opportunities to achieve reform, in order to decide whether to move forward
- ❑ Decide to start a health reform process, in consultation with a small circle of key advisors, allies, and experts

Step Two: Creating a Health Reform Team

- ❑ Using the policy cycle, sketch out a preliminary health reform strategy
- ❑ Using your policy cycle sketch, identify the key skills and areas of expertise you need on the Health Reform Team
- ❑ Identify and recruit a small group of people with the necessary skills and expertise to serve as your Health Reform Team
- ❑ Position and provide resources to the Team
- ❑ Support the Team to develop a shared mission, effective methods of communication and collaboration, and strategies for managing the rest of the health reform process steps
- ❑ Support the Team to create technical and advisory groups, network with partners and stakeholders, and engage consultants to fill gaps and bolster support for the proposed health reform

Step Three: Assessing Health System Performance and Defining Performance Problems

- ❑ Decide what to assess, including the kinds of performance problems to assess (based on the intermediate and final performance objectives), and the types of analysis and analytic skills required
- ❑ Decide who will do the assessment, considering both external analysts outside of government and people internal to the Health Reform Team and government agencies
- ❑ Design the assessment, including the scope of assessment, time and resources required, existing data sources, and new data to be collected, with deadlines for deliverables
- ❑ Analyze both primary and secondary data to generate a comprehensive assessment, identify major problems, and prepare for diagnosis (Step Four)

Step Four: Diagnosing the Causes of Performance Problems

- ❑ Decide which performance problems to diagnose (using the assessment(s) from Step Three as well as the priorities defined by the Health Reform Team and political leadership)
- ❑ Decide who will do the diagnosis, considering both external analysts outside of government and internal analysts (on the Health Reform Team and in government agencies), including the time and resources required
- ❑ Using a systems approach, describe the structure and functioning of the current health care system that is facing the selected performance problems
- ❑ Using a systems approach, construct a diagnostic tree, using primary and secondary data, to reveal the root causes of the performance problems
- ❑ Link the root causes to the policy control knobs (and identify linkages among the underlying causes) to identify areas for intervention (in preparation for selecting reform options in Step Five)

Step Five: Deciding on Your Reform Package

- ❑ Decide on the scope of your reform using evidence from the diagnosis, assessment, and policy studies.
- ❑ Decide on a package of interventions to include in your reform, considering the five policy control knobs.
- ❑ Decide whether to start with pilot tests or a full-scale approach.
- ❑ Decide on a mechanism for enacting reform (legislation or executive decree)
- ❑ Decide on a name for the reform package.
- ❑ Decide on the timing of the reform effort.

Step Six: Conducting Political Analysis and Designing Political Strategies

- ❑ Identify stakeholders (persons or organizations) with a vested interest in your policy and the potential to influence related decisions
- ❑ Assess the position, interest and power of your stakeholders
- ❑ Design and implement a set of political strategies to increase the likelihood of success
- ❑ Evaluate your strategies and re-do your analysis as often as needed

Step Seven: Managing the Implementation of Health Reform to Achieve Results

- ❑ Assess your team´s capacity to drive delivery and implement your proposed interventions
- ❑ Conduct an analysis of the politics of implementation
- ❑ Develop an implementation plan with clearly-defined goals, targets, team assignments and timelines
- ❑ Communicate effectively with stakeholders
- ❑ Track progress towards objectives (through monitoring) and address problems that arise

Step Eight: Evaluating Impacts and Creating Sustainability for Your Health Reform

- ❑ Decide on your evaluation strategy early in the reform process, before starting implementation, especially whether you will use before-and-after comparison, or control groups, or region-by-region implementation at different times
- ❑ Decide on measures for data collection needed for evaluation, including who will collect the data, how much it will cost, measures to assure reliability, and how to avoid collecting too little or too much data
- ❑ Decide whether to use an external organization or an internal agency to perform the evaluation (after assessing the advantages and disadvantages of both approaches)
- ❑ Answer five questions for planning the evaluation:
    1. Why conduct an evaluation?
    2. Who does the evaluation?
    3. What do you evaluate?
    4. Who are the main audiences and how to you communicate the evaluation?
    5. Who will evaluate the evaluators?

Worksheet 1-1: Guiding questions for defining ethical principles for health reform

GHRR states: "This book is based on [a] deep conviction that judging health-sector performance requires ethical analysis." (p. 40)

It is important to define the ethical values underpinning a health reform at the beginning of the process. Clear ethical principles can serve as a guide to the Health Reform Team, political leaders, and other stakeholders as they make many complex decisions.

However, agreeing on shared ethical principles is easier said than done. How your team goes about this complex undertaking can vary widely. Some health reformers use ethics case studies as a basis for collaborative deliberations, while others consult with experts (such as philosophers) to define the principles. Your process must be determined by what is appropriate and effective in your specific political and social context.

Regardless of which process you use, the goal is to reach agreement on a few clearly-stated ethical principles for the overall health reform effort. The Health Reform Team (or process facilitator) should work with the people involved in the consultation to prepare a memo or other written document that details the ethical principles articulated through the process. This document can then be referred to throughout the rest of the health reform effort.

The following questions can help you prepare for, conduct, and document the results of the deliberation process:

Considerations for creating a process to define the ethical principles of your health reform

- **Who facilitates the process?** The process facilitator should have expertise and skills in both ethical analysis and in leading difficult discussions. It might be important to use an external facilitator, such as an expert facilitator from another country, to guide the process, as someone seen by all participants as "objective" can be helpful. On the other hand, the facilitator must also have sufficient local standing to authenticate the process.
- **Who is involved in the process?** Consider including a wide range of stakeholders who are affected by and involved in the health system (including people from diverse socioeconomic backgrounds and with relevant experience in ethical analysis).
- **What process is used?** It is important to create time and space for meaningful deliberation, but the process also needs to be goal-oriented and time-limited.
- **Do the deliberators have a shared vocabulary for the discussions?** Ensuring that they do may require presentations on ethical perspectives (such as the three highlighted in *GHRR:* utilitarianism, liberalism, and communitarianism) and other relevant issues (such as measurements of population health and individual health).

Sample topics for deliberation

- How should we measure healthiness and well-being? How do we compare the importance of short-term and long-term impact? Which aspects of health and well-being will this reform prioritize?

- Whose well-being does this health reform aim to improve? Do we invest in the health of all people equally or scale investments based on people's actual needs? What is the population this reform targets?
- Which civil and human rights pertain to health? Which aspects of health care are the responsibility of the government and which are the individual's? How will this reform contribute to meeting the government's obligations to promote human rights?

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Worksheet 1-2: Guiding questions for an informal risk assessment

The questions in this table provide starting points for doing a basic analysis of the possible risks and benefits of doing health reform.

As you identify possible risks and harms, assign each two ratings (of low, medium or high). One rating is the likelihood of this risk occurring; the other is for the magnitude of the possible harms that would result.

Once you have identified the most concerning risks (either because they are highly likely to occur or because they would create significant harm if they occur), you can prioritize developing risk management and mitigation strategies for them.

Guiding questions	Your Notes	Likelihood (low, medium, high)	Magnitude of harm (low, medium, high)
Ethical considerations			
What ethical values would be advanced if the health reform is enacted?			
Who opposes these values?			
What harms could occur if opponents mobilize against the reform?			
What ethical values would be undermined if the health reform is enacted?			
Who opposes these values?			
What harms could occur if supporters mobilize against the reform?			
Political considerations			
Which stakeholder groups would be affected by the health reform?			

Guiding questions	Your Notes	Likelihood (low, medium, high)	Magnitude of harm (low, medium, high)
Which groups would gain and which would lose?			
What harms could occur if the "losing" stakeholders mobilize against the reform?			
What harms could occur if the "winning" stakeholders are strengthened by the reform?			
Which political leaders/parties would benefit if the reform is approved? What would they gain? (power, influence, achievement of campaign promises, institutional authority, access to resources, etc.)			
What harms could occur if these political leaders/parties accrue gains?			
Which political leaders/parties will be harmed if the reform is approved? What would they lose? (power, influence, achievement of campaign promises, institutional authority, access to resources, etc.)			
What harms could occur if these political leaders/parties incur losses?			
What would be the political ramifications if you undertake the reform and it fails to be enacted?			
What political harms would occur if the reform fails?			

Guiding questions	Your Notes	Likelihood (low, medium, high)	Magnitude of harm (low, medium, high)
Technical considerations			
What are the possible repercussions if the effort health reform package you select is enacted—but fails to improve health system performance?			
What harms could the failure of the health reform package create for the population? (health status, confidence in the state and the health system, financial risk, etc)			
What harms could the failure of the health reform package create for health care providers?			
What recurring costs would be generated if the health reform succeeds? Where will the resources come from? What endeavors would be defunded?			
What harms could come from allocating the required resources toward the reform?			
What harms could occur if the reform is enacted and then later repealed?			
Other considerations			
What resources are required to go through the process of designing, passing and implementing health reform? Where will they come from?			
What harms could occur by allocating resources to pursuing health reform?			

Guiding questions	Your Notes	Likelihood (low, medium, high)	Magnitude of harm (low, medium, high)
What harms could occur to you and other proponents of the reform if it is fails to be enacted?			
What harms could occur to you and other proponents of the reform if it is enacted but fails to create improvements?			

What are the three most likely risks? What strategies could be implemented to manage or mitigate these risks?

1.

2.

3.

What are the three most potentially harmful risks? What strategies could be implemented to manage or mitigate these risks?

1.

2.

3.

Worksheet 2-1: Sketch your reform process to identify skills and expertise needed on the Health Reform Team

	1: Decide to do reform	2: Create a team	3: Assess performance	4: Diagnose performance problems	5: Decide on reform package	6: Conduct political analysis	7: Manage implement -ation	8: Evaluate impacts
Key tasks								
Expertise areas								
Competencies/ skills								
Stakeholders								
Candidates with expertise, competencies and/or stakeholder access								

Worksheet 4-1: Information required to understand the policy control knobs in the current healthcare system

Control Knob	Information Needed	Suggested data sources	Affected outcomes
Financing	**Resource mobilization:** Figures and multi-year trends of: • Total health expenditure (THE) per capita • THE as % of GDP • Government health expenditure (GHE) as a share of government expenditure (to assess the government's priority given to health) • Government spending as a share of GDP (assess fiscal capacity of a country)	National Health Accounts Government budget	Financial risk protection Equity
	Risk pooling • Compare % of THE from various sources, including: OOPE, GHE, social health insurance (SHI), community based insurance, private insurance, international/donor aid • How many SHI schemes are there? For each one, identify: % of the population covered; eligibility criteria; amount of premiums/contributions; who pays premiums/contributions; % of eligible population actually enrolled • If private insurance exists, in addition to the information asked for from SHI, also documnt: What does it typically cover (e.g. does it replace or augment public coverage)? Is it: indemnity policy, group health insurance sold via employer, rider policy for life insurance?	National Health Accounts Policy documents from SHI agencies and private insurance schemes Interviews	Equity Financial risk protection Access and (un)equal access
	Resource allocation • % GHE spending by type of facility (hospitals, clinics, public health, etc) • % GHE spending by function (curative, preventive, primary care, secondary/tertiary care, public health) • SHI benefit packages (what services and/or providers are covered; cost sharing)	National Health Accounts SHI policy documents	Efficiency (allocative) Access and (un)equal access
Payment	**Public provider payment mechanisms** • How are public hospitals/clinics paid (by the government, SHI programs, patients, etc.)?	Interviews	Efficiency Quality

Control Knob	Information Needed	Suggested data sources	Affected outcomes
	• At public hospitals/clinics, how are healthcare personnel paid (including specialists, physicians, nurses, other staff)? What is the mix of fixed salaries and incentives? If yes, incentives are provided, how are they determined? **Private sector provider payment mechanisms** • How are private-sector health facilities typically paid? If they are contracted/empannelled by SHI programs, how are they paid? • How are personnel in the private sector typically paid (including specialists, physicians, nurses, and other staff)? How are financial incentives determined?	SHI policy documents	

Organization	**The roles, scale and scope of public and private providers in healthcare delivery**
	• Share of public, private for-profit and private not-for-profit providers' admissions/visits (at tertiary, secondary and primary levels), beds
	• Share of inpatient services at public vs private facilities (disaggregated by urban/rural and by income level)
	• Share of outpatient services at public vs private facilities (disaggregated by urban/rural and by income level)
	• For inpatient services (tertiary and secondary), how do the public and private facilities differ regarding:
	  ○ Services provided (e.g. general vs. specialty)
	  ○ Locations
	  ○ Opening hours
	  ○ Amenities
	  ○ Patients' perceptions of clinical and personal quality
	  ○ Fees
	• For outpatient/primary care, how do public and private differ in terms of:
	  ○ Services provided (e.g. general vs. specialty)
	  ○ Locations
	  ○ Opening hours
	  ○ Amenities
		Government statistics
		
		Surveys
		
		Informant interviews
			Access and (un)equal access
			
			Quality
			
			Efficiency

Control Knob	Information Needed	Suggested data sources	Affected outcomes
	○ Patients' perceptions of clinical and personal quality ○ Fees ○ Care provider qualifications (including informal providers) • Why do people choose public vs private sector? • To what extent does "dual practice" exist? • Are there any "vertically integrated" delivery systems? If yes, describe or find a case study • What is the distribution of different types of providers across different geographies? • If there is SHI, do they empanel public and private providers? What are their criteria for empanelment?		
	Market Level Organization • Describe in general the market structure and dynamics for inpatient services. For example, are they: ○ Dominated by the public sector, with the private sector playing a complementary or supplementary role? ○ Dominated by a few large public and private hospitals? ○ Competitive? If so, what do they compete on?	Existing studies Informant interviews	Efficiency Quality
	Institutional Level Organization • Public hospitals and clinics: ○ What are their primary sources of funding (e.g. government budget, SHI payments, patients' direct payment)? ○ How are physicians/other staff employed? How are they paid? What promotion criteria/opportunities exist? How are positions assigned? Do they use contracts or a tenure system? Is dual practice common (and is it allowed or just occurs in practice)? ○ What autonomy do hospitals/clinics have? ▪ autonomy in hiring/firing staff ▪ financial autonomy (E.g., are they allowed to raise additional capital? Can they decide on use of savings	Existing studies Organizational policy documents Informant interviews	Efficiency Quality

Control Knob	Information Needed	Suggested data sources	Affected outcomes
	or investments? Do they procure and pay for their own supplies?) ○ What is the accountability structure? What are they accountable for, to whom, and what consequences do they face? • Private (describe for-profit and not-for-profit institutional systems separately) ○ Who are the owners of the institutions? ○ What are the institutions' primary objectives/missions? ○ What relationship do the institutions have with the physicians and other staff? Are they contracted or employed as staff? What are the arrangements for compensation, privileges, cost/revenue sharing, etc.?		
Regulation	What are the main government regulatory agencies and authorities involved in the health care delivery system? What regulations exist, and how are they enforced, (for public, private for-profit and not-for-profit, formal, and informal service providers) regarding: • Entry • Prices/fees • Quality/safety • Advertising What regulations exist, and how are they enforced, regarding pharmaceuticals? • Is there an essential drug list? If so, set by which agencies? • How are the prices of medicines set and regulated? • How are medicines procured? • Is advertising allowed? What regulations exist, and how are they enforced, for: • SHI (if it is present)	Policy documents Existing analyses Interviews	Quality Access

Control Knob	Information Needed	Suggested data sources	Affected outcomes
	• Significant private insurance schemes How are professional associations (e.g. medical associations, hospital associations, associations of pharmaceutical manufacturers, etc.) involved in developing and enforcing regulations?		
Persuasion	What major government efforts (excluding financial incentives) exist to persuade various key actors (doctors, patients, general population, policy makers, etc.) to change their behaviors? Examples include: • Public education campaigns • Social marketing campaigns • Behavior change interventions • Information dissemination on SHI eligibility, enrolment, benefit packages	Government documents/ websites Informant interviews	Access Quality

Worksheet 6-1: Getting ready to do your applied political analysis

In preparing to do your applied political analysis, you should discuss and decide the following:

Item	Key information
Audience/Client for the political analysis: Who will read your report?	
Who will put into action the political strategies suggested by your analysis?	
What is the key health system performance problem to be addressed by the reform?	
What is the current stage(s) of the health reform in the policy cycle?	
Policy proposal: What is the proposed solution to the performance problem you have identified?	
What are the key elements of the policy proposal?	
What is the current level of stakeholder knowledge about the proposal and its details?	

Worksheet 6-2. Identifying your stakeholders

Consider the following questions as you complete the table of stakeholders (on the following page) for each category:

- Who is affected by the health system performance problem? Who is currently disadvantaged or benefitting from the status quo?
- Who is likely to be affected by the changes that would result from the implementation of your policy reform? Who will be affected positively or negatively?
- How will these benefits or losses be distributed across different groups or sub-groups?
- Who are the key actors making decisions about the performance problem or the policy reform to be implemented? Who has influence over them?
- Who will lead the reform's implementation?
- Are there any civil society groups that might influence the perception of the issue, or the alignment of actors for or against your chosen solution?

In compiling your list of stakeholders, think of groups that are already mobilized around the performance problem, including groups that are affected directly by it, groups that will have a major role in deciding on whether and how the performance problem is addressed, and groups that would like to shape whether and how the problem is addressed. Experienced policymakers, political advisors and activists often have in their minds their own list of important stakeholders, with a good intuitive sense of each stakeholder's position, level of power, and interest in an issue. Find someone you trust, and use them as a guide in the political analysis.

Your list of stakeholders should seek to be complete, but not so long that it is hard to manage. There is no "correct" number for your list of stakeholders. But the Health Reform Team (or a sub-team on political analysis) should discuss each potential stakeholder and come to a group judgment and decision about which groups to include in the stakeholder analysis.

The table on the next page is designed to help you create a preliminary list of stakeholders, your initial estimate of their position on the health reform, and how you might contact them.

List of Stakeholders

Stakeholder Category	Stakeholder	Estimated Position on Reform	How to Reach Them
Beneficiaries			
Interest Groups			
Bureaucracies			
Financial decision-makers			
Donors			
Political Leaders			

Worksheet 6-3. Analyzing the positions, power and interests of your stakeholders

Once you have created your list of potential stakeholders, you can expand the table from Worksheet 6-2 using the format on the following page to analyze each stakeholder's position on the reform, their level of power, and interest in the effort.

You can also use PolicyMaker software (available at: https://michaelrreich.com/policymaker-software) to create a position map (with power and position) that presents your findings in a graphic format.

How can you ensure that your assessments in the position map are accurate?

One way to systematically assess stakeholders' positions on your health reform proposal is to conduct interviews with key individuals. If you decide to conduct interviews, you need to develop an interview guide.

Keep in mind that some stakeholders, even in a direct face-to-face interview, may not state their positions and interests explicitly. Other stakeholders may refuse to participate in interviews.

Deciding on the position and power of stakeholders can be assisted by triangulation of information across different interviews (including the views of other stakeholders) and sources (such as public statements, news articles, social media posts, and published and unpublished documents).

Assessing the power and position of stakeholders inevitably involves some degree of subjective judgment. This subjectivity can be reduced to some degree by discussion and debate among members of the political analysis team.

For additional instructions on how to conduct an applied political analysis, see:

Reich MR, Campos PA. 2020. A Guide to Applied Political Analysis for Health Reform. Working Paper No. 1. Boston, MA: India Health Systems Project, Harvard T.H. Chan School of Public Health. https://www.hsph.harvard.edu/wp-content/uploads/sites/2216/2020/08/Guide-Applied-Political-Analysis-final-2020.08.29-FINAL.pdf

Worksheet for political analysis of stakeholders

Use this worksheet to identify key stakeholders for your reform, and their position, level of power, and level of interest in the reform.

STAKEHOLDER	POSITION (support/oppose; low/med/high)	LEVEL OF POWER (low/med/high)	LEVEL OF INTEREST IN REFORM (low/med/high)

Worksheet 6-4. Develop and track your political strategy implementation

Use this worksheet to develop and track your political strategies, including goals.

Start with the most important stakeholders, in your Team's assessment. Add rows for additional stakeholders, as needed.

Stakeholder/ Position and Power	Purpose of the political strategy	Political strategy	Expected impact	Anticipated problems	Responsible person	Milestone 1	Milestone 2	Result

Worksheet 7-1: Guiding questions for a Delivery Capacity Review

The following questions can be used to guide your Delivery Capacity Review process:

- Do the organizations important for implementation and their top leaders share the objectives embodied in the reform?

- Is there a coalition that can drive and lead the pursuit of those objectives? What capacity do they have? If committees and taskforces already exist, how often do they meet and can they take on additional efforts?

- Does the Health Reform Team understand the delivery challenges?

- Does the Health Reform Team have the ability to collect and analyze performance data related to your reform objectives? Do the Team's leaders use these data to understand the most important patterns of performance? Do they regularly assess the drivers of their biggest performance challenges?

- Do the Health Reform Team's leaders have a written strategy for implementation of the reform? Have they done a rigorous and evidence-based analysis of that strategy's capacity to influence the performance problems? Does the Team have sufficient data to set ambitious but realistic targets?

- Does the Health Reform Team have defined strategies to drive delivery? What regular routines have been established to ensure that leaders are getting the information they need, on a regular enough basis, to know whether the implementation is on track? When problems arise, what is their approach for solving them quickly?

Worksheet 7-2: Stakeholder analysis for health reform implementation

Use this table format to summarize and track: key stakeholders; any challenges you anticipate each will face (or create) during implementation; and the political management strategies you could to use to address the challenges. (You will definitely need to add more rows in each category.)

You may want to consider: have you defined appropriate strategies for managing in all six "directions" shown in the figure at right?

Stakeholders	Anticipated political challenges during the implementation	Political strategies to mitigate implementation risks
Beneficiaries		
Bureaucracies		
Interest Groups		
Political leaders		
Financial decision makers		
Donors		

Worksheet 7-3: Implementation plan questions

The following questions can be used as a guide when developing an implementation plan:

- Is a specific and complete set of implementation activities detailed in the plan? (Are the interactions/intersections between the various activities well-defined?) Does each activity have a target timeframe defined?
- Is each implementation activity clearly connected to one or more of the reform's objectives? Does every objective of the health reform have activities associated with it?
- Is there an "owner" (a person or stakeholder group responsible) for implementing each activity?
- Is it clear who else (in addition to the owner) needs to contribute to implementing each activity? Is it clear when and how these contributions will happen?
- Is there an indicator of success (or progress) for each activity? Does the plan describe how to measure "success" for each activity?
- Is there a target for each indicator? (A target is the desired performance level you want to achieve on an indicator. It should be defined as specifically as possible, including a number and a point in time)
- Do you have systems in place to effectively *collect* and *analyze* implementation monitoring data?
- Does the plan include a reasonable schedule for reviewing monitoring data (and other assessments of progress)? How will the results of reviews being communicated back to the implementers?
- Does the plan identify the top anticipated risks that could prevent achieving each objective?
- Does the plan include reasonable strategies to identify, mitigate, and manage these risks?

Worksheet 7-4: Template for progress-tracking table

This table provides a sample template for implementation planning and tracking that you can adapt as needed:

	Activity	Who is responsible? (leader, team)	When will it be done? (Timeline)	What is the indicator of success?	Budget (or other required resources)	Anticipated risks	Current Status/ Date
1							
2							
3							
4							
5							
6							
7							
8							

Worksheet 7-5: Guiding questions for developing communications strategies

The following questions can guide you as you develop your communication strategies:

- Who are your audiences?

  You will have multiple target audiences, including, for example: the various stakeholder groups, supportive political leadership, oppositional political leadership, providers and other staff working in the health system, your intended beneficiaries, and the population at large. You also have internal audiences, including the members of your Health Reform Team and other experts and consultants you have brought into the effort.

- What message do you want to convey to each audience?

  Knowing your different audiences allows you to shape your messages. This is the core of your communication strategy: framing your work specifically in order to appeal to each audience. Your messages should be presented in simple language and framed to demonstrate how the health reform fits with the audience's ethics and values. As you develop your messages, consider: what do you want each audience to learn, understand, or do?

- How do you reach each audience?

  This consideration includes three components of communication: medium, messenger, and timing. When you have determined what messages you want to deliver, then you have to figure out: the best way to deliver it, who you want to be seen representing the health reform, and when the audience is open to receiving information. These can vary depending on your local context and the reform package. Are members of the Health Reform Team influential enough to deliver your messages (for example, on talk radio programs) or do you need a celebrity spokesperson to draw attention? Are written materials and a passive website enough to share information or do you have to train community advocates to go house-to-house to share details on the reform package?

- What resources are required to develop and deliver your communications?

  Think about the budget (how much, where it comes from, what restrictions it comes with, what reporting is required, etc.). Also, think more broadly about resources, such as: staff time and skills, expert guidance, technological requirements, materials and supplies, access to mass media and social media, time to prepare and test messaging with intended audiences, and time and effort involved in engaging and educating spokespeople and other influential supporters.

APPENDICES

Appendix 3-1: Measuring health system performance outcomes

This appendix details the following information for the six health system performance outcomes (health status, financial risk protection, public satisfaction, access, quality, and efficiency):

- How is the outcome defined?
- How is it commonly measured?
- What data are generally available?
- What are common interpretations of this outcome (i.e., what can and cannot be concluded from the relevant data)?
- What are the common data gaps?

For further information, refer to Appendix 3-2 of this Guide (which lists additional resources for understanding assessments of the different outcomes), to *GHRR,* and to the India Health Systems Reform Project website (https://www.hsph.harvard.edu/india-health-systems/).

Final outcome #1: Health Status	
How is it defined?	The first goal of a health system is to improve the "health status" of the population it serves. Health status refers to health outcomes, indicated by disease prevalence, disease incidence, morbidity rates, and mortality rates in the population or a subgroup of the population.
How is it measured?	A wide range of health outcome measures are available for assessing health system performance. Most are highly standardized. The key indicators for measuring health status are: rates of mortality, fertility, and morbidity; life expectancy at birth; self-rated health; and, summary measures such as disability-adjusted life years (DALYs) and quality-adjusted life years (QALYs). Health outcomes can be assessed at the level of the country, state, district or other geographical unit. They can be disease-specific (e.g., prevalence of tuberculosis or hypertension in the population) or life-stage specific (e.g., maternal, infant, and neonatal mortality rate). Broader population-based health status indicators include crude birth and death rates and life expectancy at birth. Measurement of health status need large datasets, as from surveys or records about births and deaths, verbal autopsies, or causes of death.
What data are commonly available?	Most countries have sufficient secondary and administrative data to assess health status without collecting new data specifically for a health system assessment. Health status data can be sourced from vital registration systems, the Demographic and Health Surveys (DHS) (https://dhsprogram.com/) and other population health surveys, global estimations such as the Global Burden of Disease Studies (https://www.healthdata.org/gbd) conducted by the Institute for Health Metrics and Evaluation (IHME), and other national- or state-level administrative data that estimate mortality and morbidity burdens.

	Disease-specific indicators are available in several WHO databases (e.g., the TB database https://www.who.int/teams/global-tuberculosis-programme/ or the HIV database https://www.who.int/teams/global-hiv-hepatitis-and-stis-programmes/). The OECD does comparisons across countries every other year in its *Health at a Glance* reports (https://www.oecd-ilibrary.org/social-issues-migration-health/health-at-a-glance-2021_ae3016b9-en)
What are the common interpretations?	Population-level measures of health status indicate the population's health as a whole. However, analyses disaggregated by sociodemographic characteristics (focusing on race/ethnicity, age, gender, geographical and rural-urban differences, among others) are necessary to assess the distribution and inequities of health status.
What are the common data gaps?	Most health outcome surveys, including the DHS, focus on infectious diseases and maternal and child health. Data on the non-communicable diseases, mental health, accidents, and injuries that constitute major burdens of disease are usually missing from these surveys, especially in lower-income countries. Vital registration systems, hospital records, and verbal autopsies may not be sufficiently robust or regular to assess mortalities and morbidities.

Final Outcome #2: Financial Risk Protection	
How is it defined?	"Financial risk protection" is achieved when direct payments made to obtain health services do not expose people to financial hardship and do not threaten their living standards. It combines two key questions: (1) What is the extent to which the health system protects people from the financial risks of disease? (2) Do healthcare costs require households to forego other essential goods and services (such as food, housing, or education)?
How is it measured?	Measures of financial risk protection focus on out-of-pocket (OOP) or direct payments made to healthcare providers when goods or services are received. It includes two components. The first is the total amount of money spent in accessing healthcare (which includes the amount of direct health expenditures, e.g., expenses on hospital fees, medicines, diagnostic tests, etc., and the indirect expenditures, e.g., wage loss and travel costs to access health services, informal payments or bribes to access care, etc.). The second component is how the system protects households from the unpredictability (or "shock") of paying for an unplanned health event. One common measure of financial risk protection is "catastrophic health expenditure" (CHE), when OOP spending exceeds a pre-defined share of household income or household consumption spending. The second common measure is "impoverishing health expenditure" (IHE), which measures whether a household's consumption expenditure falls below the poverty line after health spending is

	subtracted. Usually, OOP expenditures exceeding 10% of total household consumption expenditure are considered CHE, and those exceeding 25% are considered IHE.
What data are commonly available?	The data for financial risk protection are generated from surveys in which households report on their spending, total expenditures, and income. If this data is unavailable, analysts may also consider: the OOP costs of a healthcare encounter or episode of illness; distress financing (i.e., whether patients sell assets or borrow funds to cover healthcare costs); and, foregone care due to healthcare costs. Common data sources are: the National Health Accounts (https://apps.who.int/nha/database) undertaken by many countries, national household surveys and administrative data on consumption expenditures and insurance coverage (e.g., the National Sample Surveys in India or the National Survey of Household Consumption and Expenditure in Mexico), and the WHO and World Bank Global Health Expenditure databases (https://databank.worldbank.org/databases/health-financing) that compile data on various health financing and financial risk protection indicators for most countries. DHS data in most countries also includes basic financial indicators including health expenses, household income, and insurance coverage (https://dhsprogram.com/)
What are the common interpretations?	Some financial risk protection metrics make the health system look like it is performing well but fail to consider access to care and the need for health services. For example, CHE and IHE may be low, but it may be because high OOP costs deter people from seeking necessary health services. Analyses of CHE and IHE should also be disaggregated by income level and sociodemographic characteristics in order to generate nuanced assessments and indicate equity.
What are the common data gaps?	In most lower-income countries, a common gap is disaggregated data on OOP expenses (e.g., What households are spending on—is it outpatient or inpatient care? And which components of care: medicines, diagnostics, indirect expenses, etc.?)

Final Outcome #3: Public Satisfaction	
How is it defined?	"Public satisfaction" is the degree to which citizens (or the general public) are satisfied with the services provided by the health system. It pertains to the satisfaction of both users *and non-users* of the available healthcare services. It incorporates peoples' experiences with service provision with broader factors, such as: trust in the health system, confidence that one would receive care if one falls ill, and perceptions about whether the health system needs major changes.
How is it measured?	Public (or citizen) satisfaction is measured primarily by surveys, which ask respondents who are representative of the population of

	interest to report their satisfaction with the health system. These surveys involve face-to-face interviews with individual representatives of households. The response categories almost always use a Likert scale with four or five points. Due to the nature of this outcome, citizen satisfaction is mostly measured for the national or state health system. (Levels below that, such as for individual facilities, are addressed through patient satisfaction assessments, which are discussed under quality of care below).
What data are commonly available?	Some of the most prominent surveys that regularly measure citizen satisfaction are: the Eurobarometer Survey (https://europa.eu/eurobarometer/), which measures public satisfaction among European citizens in 15 member states of the European Union; the Commonwealth Fund's health policy surveys (https://www.commonwealthfund.org/publications/surveys), which measure healthcare consumer satisfaction in selected countries; and, the Gallup World Poll (https://news.gallup.com/poll/4708/healthcare-system.aspx), which measures satisfaction with a range of public institutions (health, education, and justice) across many countries. Several studies across the world have successfully adapted the Commonwealth Fund's International Health Policy Survey questions to measure different aspects of public satisfaction. Additionally, a number of (mostly high-income) countries have questions about satisfaction in national health surveys.
What are the common interpretations?	Public satisfaction is a politically valuable outcome to assess citizens' perceptions of government programs and policies. Approaches to measuring citizen satisfaction are not as standardized as health outcome or financial risk protection measures. Health system analysts must think critically about how satisfaction questions are asked and interpreted in any given context. Because expectations mediate public satisfaction, it can be complicated to assess this outcome. Lower levels of public satisfaction among disadvantaged populations can indicate systemic inequities. However, evidence shows that disadvantaged populations sometimes have lower expectations. Therefore, they may report a higher level of satisfaction with the health system even when objective metrics of service provision, access, quality, financial risk protection, and inequities indicate significant problems. Public satisfaction needs to be interpreted carefully and contextualized to sociocultural realities.
What are the common data gaps?	Public satisfaction data are not measured by national- or state-level surveys in most lower-income countries. In 2002-4, the WHO World Health Survey (https://apps.who.int/healthinfo/systems/surveydata/index.php/catalog/whs) collected data on some public satisfaction-related variables, e.g., the responsiveness of health systems, from multiple countries. However, the findings are now out-of-date. Other studies have assessed public satisfaction and explored concepts such as citizens' trust and

	confidence in the health system across LMICs, but these data have not been collected regularly.

Intermediate Outcome #1: Access	
How is it defined?	Meaningful "access to health care" means that the appropriate healthcare provider or service is supplied in the right place and at the right time to meet the prevailing needs of the population and that the population utilizes the services. Thus, access does not just mean physical availability (of health facilities, healthcare providers, medicines, vaccines, diagnostics or other medical products). It also means that the population knows what is available, seeks out healthcare and uses it to prevent, manage, and treat health conditions.
How is it measured?	Access is measured through both supply-side and demand-side indicators. Data to measure the supply-side (what is offered) aspects of access are collected using facility/provider surveys (which are undertaken at national- or state-level in most countries) or health information systems (HIS) that generate data about the number of facilities and health workers in a given geographical unit. Indicators of the supply side of access include various assessments of physical and human resource *inputs* (including: the ratio of doctors to nurses, the number of hospital beds per 1000 population, or attributes of health care facilities, such as whether they have water, electricity, essential medicines, and equipment). Demand-side aspects of access are measured through large household surveys conducted at national-, state-, or district-level. Indicators for the demand side of access include: utilization of healthcare services, number of fully vaccinated children, number of institutional births, and the percentage of women receiving antenatal care. In some cases, a "care cascade" measure is used—this tracks the entire process of care from the time the individual "enters" the health system, beginning with seeking care, through management and treatment, to rehabilitation. Care cascades are commonly used to measure access for chronic diseases that require continuous use of health services.
What data are needed for assessment?	Access to care is one of the most commonly measured outcomes. Most countries have extensive and regular data on both supply- and demand-side access indicators. Common datasets that are available for most countries are: the Demographic and Health Surveys (DHS) (https://dhsprogram.com/) that capture indicators on utilization of services (e.g., antenatal care, institutional childbirths, vaccinations, etc.); Service Provision Assessments (SPA) that are conducted as part of the DHS (https://dhsprogram.com/methodology/Survey-Types/SPA.cfm) to collect data on supply-side indicators related to physical and human resource attributes; the Service Availability and

	Responsiveness Assessments (SARA) conducted by WHO (https://www.who.int/data/data-collection-tools/service-availability-and-readiness-assessment-(sara)); the World Bank's Service Delivery Indicator Survey (https://datacatalog.worldbank.org/search/dataset/0042030), and health information systems used in most countries, which report number of health facilities, ratios of health personnel, vacancies, etc.
What are the common interpretations?	Access to care measures are useful for assessing the *inputs* invested in the health system. These measures are also closely associated with other outcomes—thus access to care cannot be meaningfully interpreted without also understanding the affordability and quality of the services available. Further, the physical availability of health services does not indicate whether the services are effective or if they are being used by the population. Similarly, uptake/utilization of health services by the population does not indicate that people are receiving high-quality care or that good health outcomes are being produced. As with other indicators, access to care also needs to be disaggregated by sociodemographic characteristics of the population to examine equity.
What are the common data gaps?	While most countries have extensive data on access, these are usually limited to the public sector and formal healthcare providers. Private-sector providers, including informal or unlicensed providers, are rarely included in supply-side facility surveys—even when a majority of the population receives care from private providers. Another major data gap is on care cascades. Most demand-side surveys focus on access at one point in time (or for specific visits), but this does not capture people who need care but either forego or drop out of care, especially in the case of chronic diseases.

Intermediate Outcome #2: Quality of Care	
How is it defined?	"Quality of care" is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes. Quality healthcare has been defined in many ways, but there is growing acknowledgment that it includes three main aspects: 1. *Clinical effectiveness*–providing evidence-based healthcare services to the people who need them while avoiding overuse of inappropriate care and underuse of effective care. 2. *Patient safety*–avoiding causing harm to the people receiving care. 3. *People-centeredness*–providing health care that responds to and respects the preferences, needs, and values of the people who need services.

How is it measured?	Each of the three aspects of quality has its own measurement processes and indicators. 1. *Clinical effectiveness* is measured by comparing the care provided with current evidence on effective diagnostic and treatment guidelines. Assessments of clinical effectiveness measure the extent to which a diagnostic process, diagnosis, or treatment is based on standard guidelines shown to impact health outcomes. Most methods of measuring clinical effectiveness require having clinically-trained data collectors and analysts. Clinical effectiveness can be measured using: clinical vignettes to assess provider knowledge; standardized patients to assess provider practices and "know-do" gaps (that is, the difference between what providers know and what they actually do); direct observations of patient-provider interactions; and reviews/audits of claims data, patient records, charts, and prescriptions that assess the correctness of treatments. Examples of clinical vignettes and standardized patient interview guides can be found here: https://www.ahrq.gov/ncepcr/tools/healthier-pregnancy/presentations/vignettes.html. 2. *Patient safety* is measured by assessing the number of adverse events or errors at a facility. At hospitals, this may include, for example, incidents of patients receiving infusions of the wrong blood type, patient falls during hospital stays, sponges left inside surgical sites, allergic reactions to medicines not recorded in the patient record, etc. The Hospital Survey of Patient Safety Culture (HSOPS) (https://www.ahrq.gov/sops/surveys/hospital/index.html) is a globally validated survey instrument that assesses the perceptions of clinicians and other staff of the culture of safety in their health facilities. It assesses the context and enabling systems that encourage reporting of adverse events. 3. *People-centeredness* is frequently measured using exit interviews and surveys with patients about their experiences with health care. Different surveys are used assess different aspects of the visit, including the patient's satisfaction with the entire visit and/or the provider, perceptions about convenience and physical aspects of the visit (e.g., wait times, privacy, during the consultation, etc.), and their interactions with providers (e.g., time spent with the patient, respectfulness, etc.). Patients typically rate the aspects of the visit on Likert scales. The globally validated patient survey instrument called the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) (https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalHCAHPS) have been adapted and used in several countries.

What data are commonly available?	Robust and regular quality of care data are rarely available for LMICs and LICs; MICs and HICs also have major data gaps. Clinical vignettes and chart review assessments are used by several HICs as part of their health information systems and routine evaluations of physicians. Audits of prescriptions and insurance claims data can be used for assessing quality, although identifying gaps in provider knowledge or know-do gaps is not possible with administrative data. Patient safety data can be generated through internal error reporting systems in hospitals and hospital audits. Patient satisfaction surveys are increasingly becoming common in health systems around the world, including in LMICs.
What are the common interpretations?	Different measurement methods assess different aspects of quality. Clinical vignettes, for example, only assess a provider's knowledge, not their actual practice. As such, vignettes often produce an overestimation of clinical effectiveness. Combining standardized patient interviews with vignettes can be used to indicate both knowledge and practice. Chart reviews, prescription audits, and insurance claims assess provider practice, but without indicating whether the condition was diagnosed correctly. Patient safety data need to be interpreted in the context of the culture and systems for adverse event reporting. A report of zero adverse events does not mean that care is completely safe—it might mean that either providers are not reporting adverse events or that a system for reporting does not exist or is not enforced. People-centeredness is linked to people's expectations of the quality of care. If expectations are low, patients might report high levels of satisfaction even when objective measures indicate poor care quality. E.g., patients from socio-economically disadvantaged groups are more likely to have lower expectations from public services and, therefore, may be more easily satisfied with a healthcare visit. Additionally, patients are not able to judge the clinical quality of care and may use visible markers/proxies as indicators of high quality. E.g., patients might rate a provider who prescribes multiple medicines and diagnostic tests highly even though several of these prescriptions might be unnecessary or even potentially harmful.
What are the common data gaps?	Data on the quality of care is scarce, especially on clinical effectiveness and patient safety. Although there are studies from LMICs on clinical effectiveness, these have been relatively small research studies. Most insurance claims data are not sufficiently disaggregated to assess clinical effectiveness. Patient satisfaction data on aspects like abuse, safety, and corruption are rare in most

	health systems. Additionally, satisfaction ratings are often not weighted or disaggregated by patients' sociodemographic characteristics to assess equity and the effect of lower expectations leading to high ratings.

Intermediate Outcome #3: Efficiency	
How is it defined?	The concept of efficiency is based on the relationship between a health output and the inputs required to produce it. In an efficient system, the amount of input utilized should result in the production of the maximum amount of output that is possible. Efficiency is usually defined in three ways: 1. Technical efficiency (TE) - when the maximum possible output is produced from a given set of inputs. Alternatively, this implies minimizing the amounts of inputs used to produce a given amount of output. TE involves making sure that the right mix of physical inputs, such as personnel, equipment, supplies, and facilities, are used to produce a health output. 2. Price efficiency (PE) - when the maximum possible output is produced at the lowest possible cost of inputs. PE refers to the right mix of monetary inputs used in the production process. PE incorporates the idea of TE since minimization of costs can be achieved by reducing the misuse of inputs as well as reducing unnecessary expenditures. 3. Allocative efficiency (AE) - when more than one output is produced in a health system, the question of how the inputs are distributed among the production of each output becomes relevant. AE captures the extent to which the inputs are being used to produce the correct mix of outputs that maximize health status gains
How is it measured?	Two broad approaches have been commonly used to measure the efficiency of a health-providing unit – ratio-based and frontier analysis. 1. Ratio-based measures are the most common efficiency measure. It is a ratio of a health system input to the output that it produces. A ratio indicates the resource used per unit of health system output; the greater the ratio, the more efficient the health-providing unit. TE is calculated by dividing any measure of health output by the physical unit of input. E.g., a physician's productivity is calculated as the total number of hours the physician spent in patient care (input) divided by the number of visits (output), which is a measure of TE. Similarly, the generic prescribing rate, the total number of generic

	medications prescribed in a day divided by the total number of patients examined in a day, is also a TE measure. Using input costs as the denominator generates an indicator of PE. Cost per episode is an example where the output is a bundle of services, including visits, medications, procedures, and urgent care services provided for the care of a specific illness, and the input is the monetized total costs of the care. 2. Frontier analysis measures are based on the production function, the relationship between the health inputs and outputs, and the efficiency of a health-providing unit involves comparing its actual performance with the optimal performance located on the production frontier. Since the true frontier is unknown, an empirical approximation is needed. That is, efficiency scores for each unit are based on the frontier function estimation, followed by the distance of the unit from the efficient frontier. These methods can be used to obtain technical, price, or allocative efficiency scores depending on the function – production, cost, profit – that is estimated. There are different ways to estimate the production function, but two methods have been typically used in the study of health systems – data envelopment analysis and stochastic frontier analysis.
What data are commonly available?	Data on health inputs and outputs are needed to calculate any measure of efficiency, and the information is usually available at different levels of the health system (national, state, district, facilities, providers, and households). The choice of the data source depends on the unit of analysis, e.g., is efficiency calculated at the country level or facility level. Common data sources include health information systems that provide a count of the number of health inputs like the number of physicians/nurses, hospital beds, medical equipment, etc. Budget and expenditure data can be used to calculate the cost inputs; other data sources like the Service Provision Assessment (SPA) (https://dhsprogram.com/methodology/Survey-Types/SPA.cfm) could be used to assess the health system inputs and service provision outputs (e.g., total number of physician hours spent in patient care). If the efficiency analysis is focused on health outcomes, then health surveys like the ones mentioned under Health Status, like the Demographic and Health Surveys (DHS) (https://dhsprogram.com/), or insurance claims data can be used.
What are the common interpretations?	Ratio-based efficiency indicators are useful when the intent of the focus is on a particular input or part of the production process. A ratio also allows for comparison across health systems or health-providing units of different sizes/levels. However, each ratio provides a very narrow view of efficiency without accounting for the many interdependent inputs that go into the production of multiple health outcomes. A key advantage of the frontier-based efficiency measures is that they account for multiple inputs and also

	allow for the statistical testing of hypotheses on the relationship between external factors (unit ownership, competition, etc.) and the estimated efficiency scores. However, these measures are complicated to implement and require specialized software and econometric training among analysts.
What are the common data gaps?	Health facility-level data on inputs and potential outputs are often difficult to obtain. Facilities, especially for-profit providers, may not be willing to share this information. Even when available, most input data focuses on hospitals, and there is very scarce data about primary care providers or individual providers. The other gap is in meaningfully linking the inputs to outputs. While health outcome data are available, they are determined by various factors, including those outside the health system. This makes it difficult to attribute outputs to the inputs in efficiency assessments. Usually, health service provision indicators are used as a proxy, but disaggregated data on these indicators are difficult to obtain in many lower-income country health systems.

Appendix 3-2: Additional resources on assessing health system outcomes

Financial Risk Protection
Video training session: https://www.youtube.com/watch?v=2AHR7GN3Omw
Reading:

- Wagstaff A, Flores G, Hsu J, Smitz M-F, Chepynoga K, Buisman LR, van Wilgenburg K, Eozenou P. 2018. Progress on catastrophic health spending in 133 countries: A retrospective observational study. The Lancet Global Health, 6(2), e169–e179. https://doi.org/10.1016/S2214-109X(17)30429-1

Public Satisfaction
Video training session: https://www.youtube.com/watch?v=UxE1CU23Mgk
Readings:

- Blendon RJ, Benson J, Donelan K, Leitman R, Taylor H, Koeck C, Gitterman D. 1995. Who Has The Best Health Care System? A Second Look. Health Affairs 14(4), 220–230. https://doi.org/10.1377/hlthaff.14.4.220
- Blendon RJ, Kim M, Benson JM. 2001. The Public Versus The World Health Organization On Health System Performance. Health Affairs 20(3), 10–20. https://doi.org/10.1377/hlthaff.20.3.10

Access
Video training session: https://www.youtube.com/watch?v=bR4mAq3o4J0

Quality of care
Clinical effectiveness
Video training session: https://www.youtube.com/watch?v=CFaTmPjG5KQ
Readings:

- Das J, Holla A, Das V, Mohanan M, Tabak D, Chan B. 2012. In Urban And Rural India, A Standardized Patient Study Showed Low Levels Of Provider Training And Huge Quality Gaps. Health Affairs, 31(12), 2774–2784. https://doi.org/10.1377/hlthaff.2011.1356
- Holla A. 2013. Measuring the Quality of Health Care in Clinics. World Bank Group. https://www.globalhealthlearning.org/sites/default/files/page-files/Measuring%20Quality%20of%20Health%20Care_020313.pdf (Accessed 2 August 2023)
- Kruk M E, Gage AD, Arsenault C, et al. 2018. High-quality health systems in the Sustainable Development Goals era: Time for a revolution. Lancet Global Health, 6(11), e1196–e1252. https://doi.org/10.1016/S2214-109X(18)30386-3

Patient Safety
Video training session: https://www.youtube.com/watch?v=3c4KXF4h6ik
Readings:

- DiCuccio MH. 2015. The Relationship Between Patient Safety Culture and Patient Outcomes: A Systematic Review. Journal of Patient Safety, 11(3):135–142. https://doi.org/10.1097/PTS.0000000000000058
- Fontana G, Flott K. Dhingra-Kumar N, Durkin M, Darzi A. 2019. Five reasons for optimism on World Patient Safety Day. The Lancet, 394(10203):993–995. https://doi.org/10.1016/S0140-6736(19)32134-8
- Jha AK, Larizgoitia I, Audera-Lopez C, Prasopa-Plaizier N, Waters H, Bates DW. 2013. The global burden of unsafe medical care: Analytic modelling of observational studies. BMJ Quality & Safety, 22(10), 809–815. https://doi.org/10.1136/bmjqs-2012-001748

People centeredness

Video training session: https://www.youtube.com/watch?v=mkXkZ6Xwpo8

Reading:

- Larson E, Sharma J, Bohren MA, Tunçalp Ö. 2019. When the patient is the expert: Measuring patient experience and satisfaction with care. Bulletin of the World Health Organization, 97(8), 563–569. https://doi.org/10.2471/BLT.18.225201

Efficiency

Video training session: https://www.youtube.com/watch?v=oRDLX2QkHHs

Readings:

- Yip W, Hafez R. 2016. Improving health system efficiency: reforms for improving the efficiency of health systems: lessons from 10 country cases. Geneva: World Health Organization. https://apps.who.int/iris/handle/10665/185989
- Hafez R, ed. 2020. Measuring Health System Efficiency in Low- and Middle-Income Countries: A Resource Guide. Joint Learning Network for Universal Health Coverage. https://www.jointlearningnetwork.org/resources/resource-guide-for-measuring-health-system-efficiency-in-low-and-middle-inc/
- McGlynn EA. 2008. Identifying, Categorizing, and Evaluating Health Care Efficiency Measures. Final Report (Publication No. 08-0030). Rockville, MD: Agency for Healthcare Research and Quality. https://library.ahima.org/PdfView?oid=81708 (Accessed 2 August 2023)

Appendix 4-1: Expanded Versions of the Diagnostic Trees

Figure 4-1A: Expanded diagnostic trees for low financial risk protection

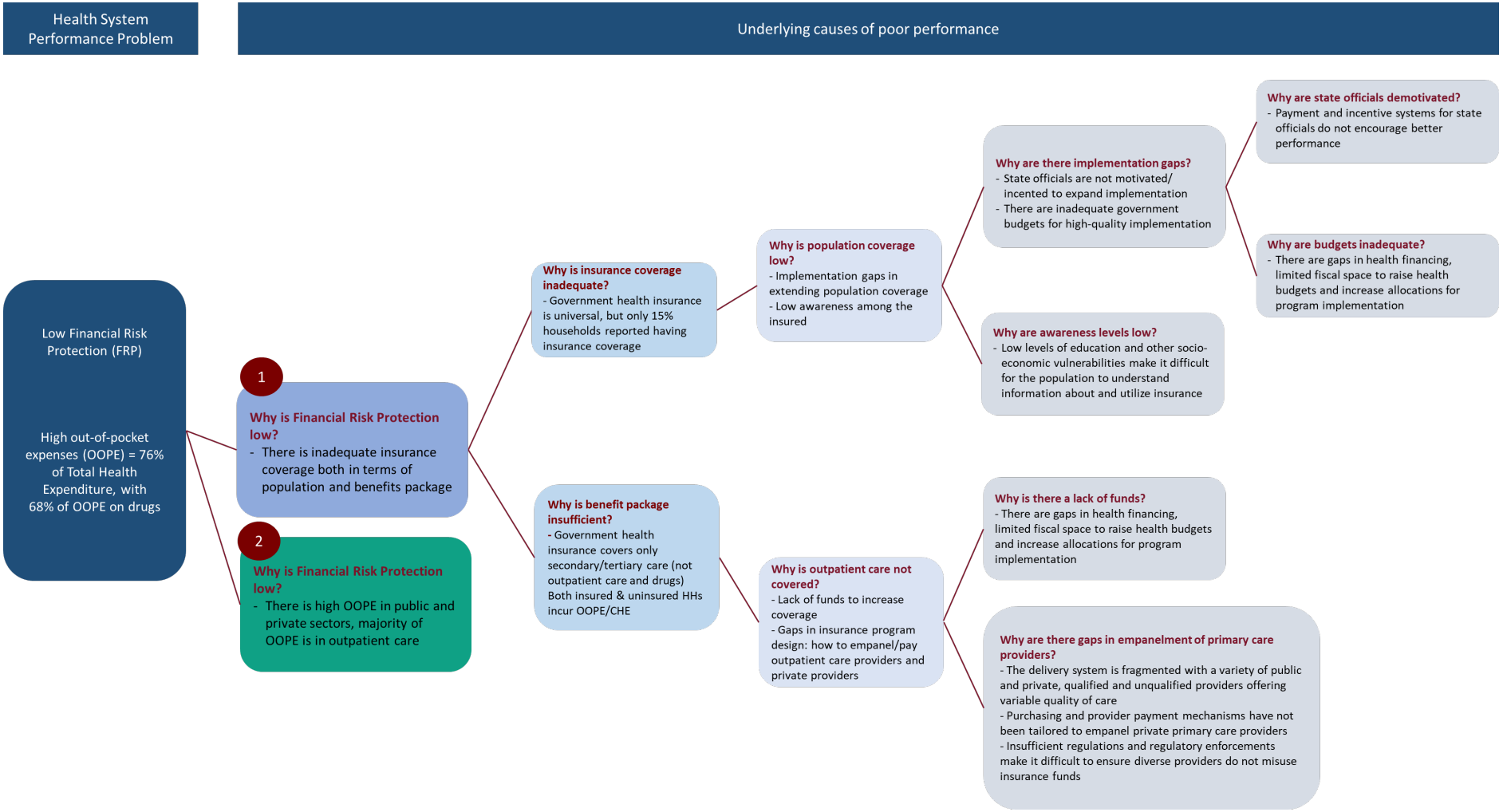
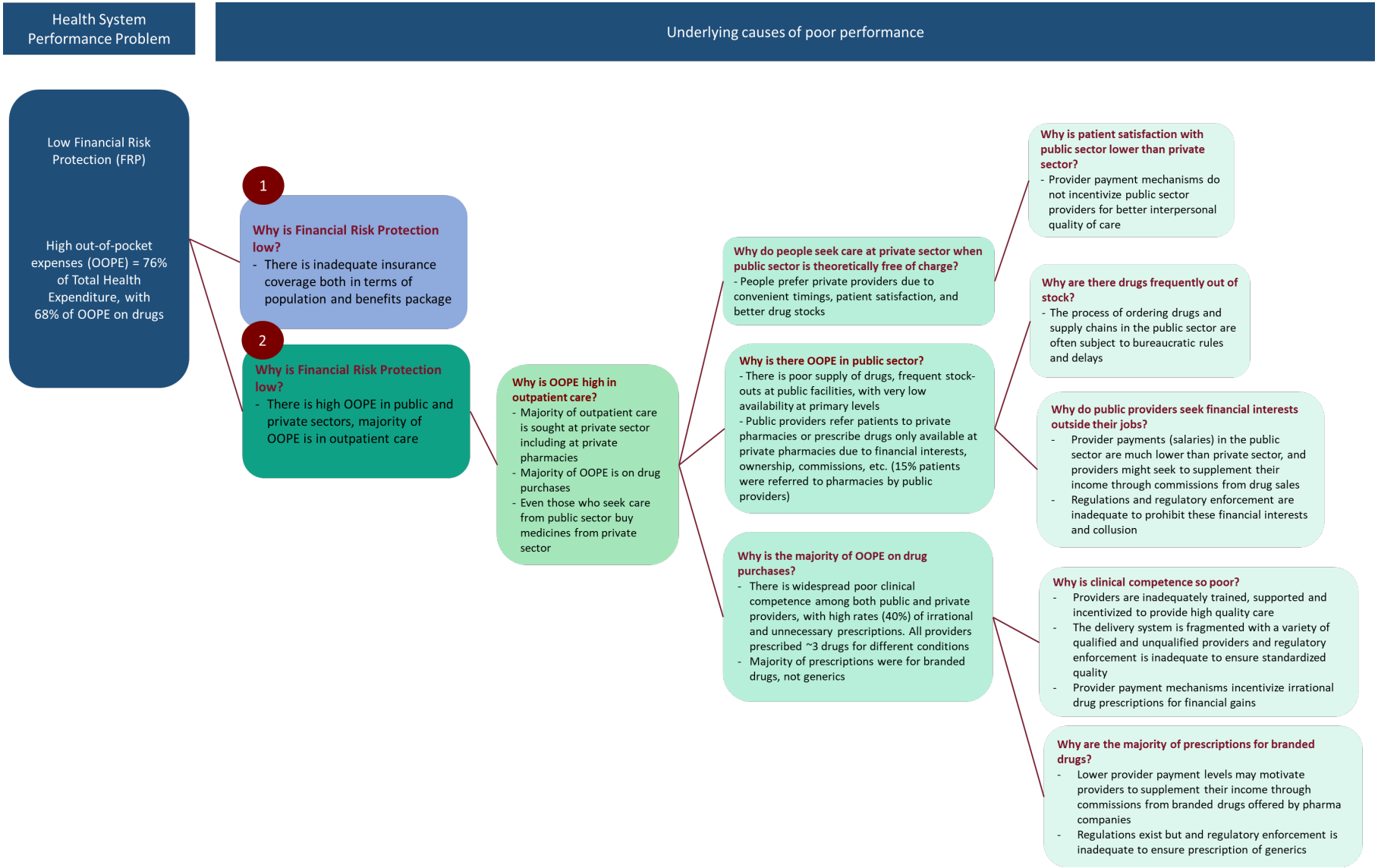


Figure 4-1B: Expanded diagnostic trees for low financial risk protection

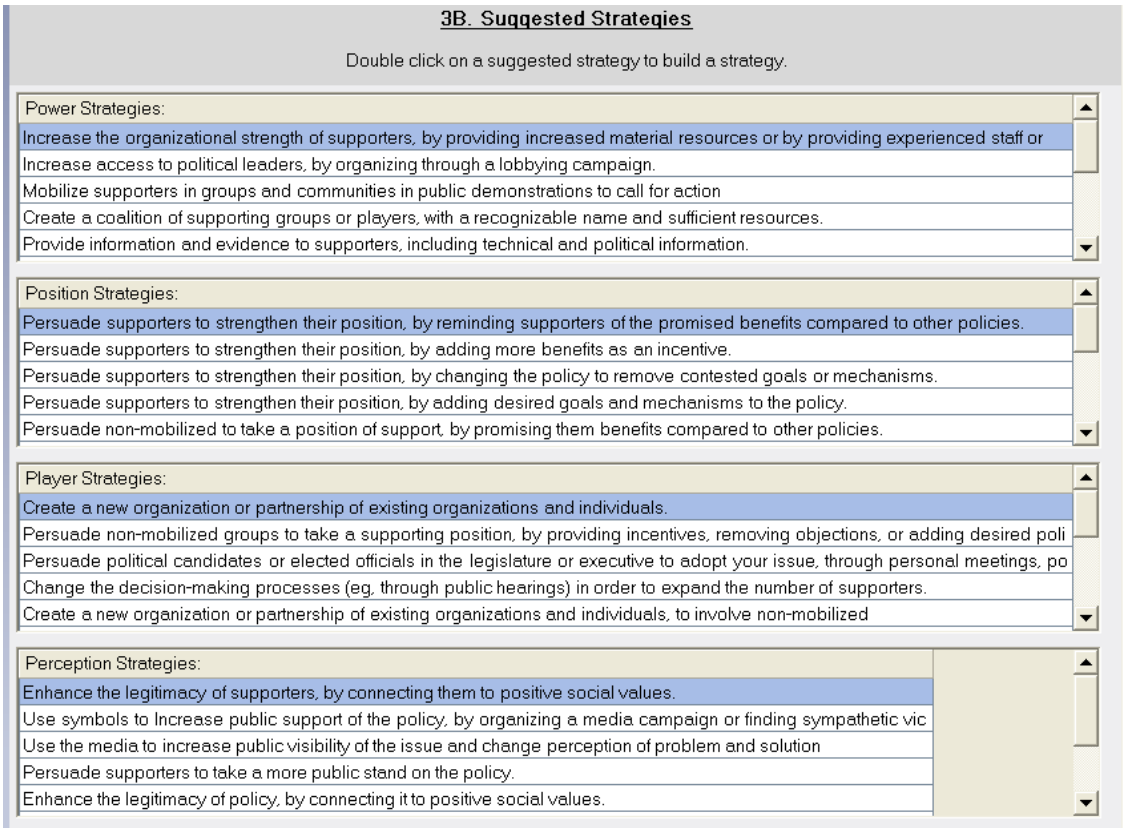


Appendix 6-1: Developing a set of political strategies

These questions can help you develop of a set of political strategies to influence key stakeholders.

Objective	Guiding question	Sample political strategies
Change the position of opponents	How can a key opponent be persuaded to change its position from high opposition to low opposition—or even support?	Negotiate a change in a technical aspect of the policy Provide desired resources elsewhere
Decrease the power of opponents	How can the power of opponents be decreased?	Publicly question opponents' motives Reduce opponents' public visibility Deny opponents material resources
Increase the power of supporters	How can the power of supporters be increased so that they have more influence over the policy process?	Increase the financial resources available to supporters Increase supporters' visibility in media and public dialogues
Increase the number of supporters	How can the number of supporters be increased?	Mobilize neutral actors (providing them with technical analysis about how the policy would benefit them; offering them incentives to show public support for the policy)

The PolicyMaker software (available at: https://michaelrreich.com/policymaker-software) includes an expanded set of suggested strategies, organized by the categories of power, position, player, and perception. Here is a sample of what the software includes:



Appendix 8-1: Examples of different models used to evaluate health reforms

King G, et al. 2009. Public policy for the poor? A randomised assessment of the Mexican universal health insurance programme. Lancet 373: P1447-1454. This high-quality technical evaluation was conducted 10 months after the start of implementation, to assess impacts on both intermediate and final performance objectives. The study found a reduction in catastrophic health expenditures, but not in medication spending, health outcomes, or health service utilization. This assessment contributed to the health reform's continuity across two subsequent administrations in Mexico, but not when a new opposition government came to power in 2018. https://doi.org/10.1016/S0140-6736(09)60239-7

Nigenda G, et al. 2015. Evaluating the impact of Mexico's health reform: the case of Seguro Popular. Health Systems & Reform 3:217-228. This articles combines information from four external evaluations of Mexico's health reform (conducted by a team at the National Institute of Public Health) to do a process evaluation on the use of financial resources in purchasing health services. The article focuses on implementation processes related to the federal government's financial transfer mechanisms to the states, the purchase of medicines, and the contracting of health workers. The assessment found a number of significant challenges and identified various government responses to problems that have sought to improve performance, "with mixed results." https://doi.org/10.1080/23288604.2015.1031336

Blanchet NJ, et al. 2012. The effect of Ghana's National Health Insurance Scheme on health care utilization. Ghana Medical Journal 46(2): 76-84. This study examines the impact of Ghana's health reform, implemented in 2003, on utilization of health services, by using data from the Women's Health Study of Accra on medicines and health services. The assessment found that women with health insurance are "significantly more likely" to obtain prescriptions, visit clinics, and seek health care from formal providers when sick. In short, they have been access—an important intermediate objective for health reform. This academic study, however, was not conducted with the goal of a government-sponsored evaluation of the policy. PMID: 22942455

Bergkvist S, et al. 2014. What a difference a state makes: Health reform in Andhra Pradesh. Washington, DC: The World Bank Development Research Group. Policy Research Working Paper 6883. This World Bank study assesses Andhra Pradesh's Aarogyasri health insurance scheme, which provides coverage for around 900 high-cost procedures delivered in secondary and tertiary hospitals. The study found that patients still paid "quite large" out-of-pocket expenses during hospitalization, even for services covered by the scheme. A comparison with a neighboring state (Maharashtra), however, found that Andhra Pradesh showed better access (higher rates of inpatient and surgery admissions) and better financial risk protection (lower growth rates of certain costs). The report indicated a number of areas for improvement in the health reform, although this was not an official government evaluation. https://doi.org/10.1596/1813-9450-6883

GLOSSARY

Note: This glossary is excerpted from one prepared for the USAID Health Finance and Governance Project's Workshop on the Flagship Learning Program. (The Flagship Learning Program and its Framework are both based on the *GHHR* approach to health system reform.) For the full glossary, visit: https://www.hsph.harvard.edu/michael-reich/flagship-program/ or https://www.hfgproject.org/workshop-on-the-flagship-learning-program-for-the-next-decade-summary-for-dissemination/.

TERM	*DEFINITION*
ACCESS	In the Flagship Framework, access is an intermediate performance goal that refers to how health services are made available to, and are reached by, the people who need them. Access combines the concepts of "effective availability," "physical availability" (see separate entries) and utilization of services.
ANALYSIS, ETHICAL	A process for assessing and selecting health policy according to a philosophical and values-driven point of view.
ANALYSIS, POLITICAL	A process for assessing the political factors that affect the feasibility of adopting or implementing a selected health reform.
ANALYSIS, TECHNICAL	A process of determining what resources and capacities are required to address a health problem in society, and how they should be applied, in order to adopt and implement health reform. A technical analysis may include epidemiological, economic, demographic, and implementation analyses.
AVAILABILITY, EFFECTIVE	The degree to which it is possible for members of the population to find and receive appropriate health care for health needs, despite barriers such as high prices, limited hours of operation, or cultural appropriateness.
AVAILABILITY, PHYSICAL	The degree to which health goods and services (including providers, beds and commodities) are present and usable when and where the population needs access to them.
BENCHMARKING	The process of using the example (and measure) of one health system's performance (or some other external standard) to assess the performance of another one. Benchmarking is often used as the starting point for a discussion of performance problems.
CAUSAL CHAIN	The series of successive explanations of the sources of a performance problem; a series of explanations within a causal tree created when causal analysis is conducted.
CHANGE TEAM	See "Health Reform Team"
COMMUNITARIANISM	The ethical perspective of communitarianism posits that the values of a community depend on the characters of those who are part of it, and that public policy should ensure that individuals can develop "virtue" (as defined by the community) in order to produce a good society. A "universal communitarian" believes that there is a single

TERM	*DEFINITION*
	and universal model for a "good" individual and society, while a "relativist communitarian" believes that the definition of "good" is inherently contextual and varies across different societies.
CONTRACTING	A payment arrangement in which a written agreement ("contract") is created between a buyer, who agrees to provide a certain amount of money to the seller, and the seller, who agrees to provide certain goods or services within a given period of time. Contracting allows the parties to create detailed and flexible incentives and can foster market competition among sellers. All parties need to have certain technical and administrative capacities to manage the negotiation and implementation of contracts, and a system needs to exist to impose penalties if the terms of a contract are not met.
CONTROL KNOB (OR POLICY INSTRUMENT)	An area of the health sector that can be changed by public policy, is typically under the control of policy makers, and which affects the performance of the health sector. The Flagship Framework proposes five control knobs (or policy instruments): financing, payment, regulation, organization and persuasion (see separate entries).
CONTROL KNOB, PERSUASION	The government's ability to influence how individuals act (in other words, to persuade them to change their behavior) on a population-wide basis to protect and promote health systems performance. Many persuasion control knob activities aim to change behavior through information, education and social marketing, as well as other “nudge” activities; behavior control knob activities can also be more coercive, such as indoctrination or prohibitions. This control knob is typically directed at providers or patients.
CONTROL KNOB, FINANCING	The government's ability to use different mechanisms to mobilize and allocate money to fund health sector activities. Financing (raising money) determines how much money is available, who bears the financial burdens, who controls the funds, how risks are pooled, and whether health care costs can be controlled.
CONTROL KNOB, ORGANIZATION	The government's ability to shape how the health system is structured and how individual institutions function. Four primary characteristics of a health system included in "organization" are: the mix of institutions (public versus private) providing health care services; how activities are divided among these institutions; how these institutions interact with each other and with other political and economic systems in the society; and, the internal administrative structures and management of the institutions.
CONTROL KNOB, PAYMENT	The structures and mechanisms by which health providers (physicians and facilities) are paid for delivering health services. Different payment methods create different kinds of incentives for the buyers and sellers of health services; these incentives influence

TERM	*DEFINITION*
	their behaviors and can be adjusted to change health system performance.
CONTROL KNOB, REGULATION	The government's ability to use coercive power to impose constraints on or change the behaviors of individuals and organizations in the health sector, both public and private. Regulatory actions can be used to organize and improve the functioning of markets, including protecting consumers against market failures. Regulation can include various forms of legal instruments to establish guidelines, set requirements and impose penalties for non-compliance.
DELIVEROLOGY	A systematic approach to driving progress and creating results in the implementation of public policy; the term was popularized by Sir Michael Barber.
DIAGNOSTIC TREE	An analytical tool for determining and representing the series of causes of a problem. In a diagnostic tree of a health system performance problem, branching points represent possible causes for a situation, and multiple causes for a problem can co-exist.
EFFICIENCY	A measure of how much can be accomplished towards set goals with a finite set of resources. A health system can be considered "efficient" when the right services are produced, and are produced in the right way, to achieve the desired goals. (See separate entries on technical efficiency and allocative efficiency.)
EFFICIENCY, ALLOCATIVE	The degree to which a system, such as a health system, produces the most gains possible in a performance outcome (such as health status) through appropriate distribution of resources across different activities. Allocative efficiency affects what is produced, and seeks to produce the optimal set of outputs to achieve the given goal. It is typically determined by planners and budget allocators, more than by managers or providers.
EFFICIENCY, TECHNICAL	The degree to which an output (such as a health service or commodity) is provided or produced at the minimum possible cost per unit. Technical efficiency depends on how inputs are used to create outputs, and is often determined by managers and workers. (This concept is also known as “productive efficiency.”)
EQUITY	The degree to which every individual (or group) experiences the same benefits of a policy as every other individual (or group). It can be measured horizontally (among individuals within a group) or vertically (among different groups). (See separate entries below.)
EQUITY, HORIZONTAL	The degree to which a public policy has a similar impact on all people within a single income group.
EQUITY, VERTICAL	The degree to which a public policy has a similar impact on all income groups in a population.

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FINANCIAL RISK PROTECTION	An ultimate goal of health reform in which individuals and households are able to avoid unexpected expenses or extreme impoverishment due to poor health and the costs of paying for health services.
FISCAL SPACE (OR FISCAL CAPACITY)	The set of available financial resources from different sources within a society that can be mobilized to pay for health expenditures.
GOVERNANCE	A complex set of political processes undertaken by a government or other authority related to defining priorities and decision-making about policies and implementation. In addition, governance involves establishing regulations, assuring transparency, and enforcing accountability.
HEALTH BENEFIT PACKAGE	An explicit list of health services and products that are provided for individuals covered by a health insurance scheme.
HEALTH INSURANCE, PRIVATE	A non-governmental (either for-profit or not-for-profit) system in which insured parties voluntarily pay a premium in return for guarantees of specific compensation or benefits if certain unpredictable events (such as ill health) occur in the future.
HEALTH INSURANCE, SOCIAL (SHI)	A system in which all eligible individuals must enroll and pay premiums in return for guarantees of specific compensation or benefits if certain unpredictable events (such as ill health) occur in the future. Many social insurance systems levy premiums as a percentage tax on an individual's wages. Social health insurance systems may have a wider pool of risk, as well as of revenue sources, than private health insurance systems.
HEALTH REFORM CYCLE	A model describing how policies for the health sector are designed, implemented and evaluated. In the Flagship Framework, the health policy cycle is an iterative process that involves: problem definition, causal diagnosis, policy development, political decision, implementation and finally, evaluation. Evaluation leads to identification of new problems and the cycle begins again.
HEALTH REFORM TEAM	A group of people who collaborate to shepherd a health reform through policy design and adoption. Change team members are often people with policy expertise and the political capacity to mobilize others in support of the reform. The composition, positioning and power of a change team has a significant impact on the likely success of the reform efforts.
HEALTH SECTOR REFORM	The complex process of designing and implementing policies that purposefully seek to influence the societal and institutional policies and organizations that create, protect and promote the health of the population.
HEALTH STATUS	A measure of how healthy a population is, often assessed using an index that combines various measures such as life expectancy,

TERM	*DEFINITION*
	mortality and morbidity rates, or prevalence of priority health problems.
HEALTH SYSTEM	A complex arrangement of treatment providers, prevention services providers, financiers and intermediaries, input producers, planners, administrators and regulators whose collective efforts result in the provision of health care services. The Flagship Framework views the health system as the means to achieve three ultimate goals: health status, customer satisfaction, and protection from financial risks related to health care expenses.
HEALTH SYSTEM STRENGTHENING	A complex process and set of actions intended to improve structures and processes in the health system in order to improve the system's performance in achieving its ultimate aims, namely: improved health status of the population, consumer satisfaction with health services, and financial risk protection from the costs of health care.
IMPLEMENTATION	The process through which a public policy is carried out in practice to produce social impacts.
INCENTIVE	A benefit that accrues to individuals or groups if they adopt the desired new behaviors.
INTEREST GROUP	A social group that has a set of common interests and seeks to influence the government (or other institution) to move in a particular direction to protect those interests. Examples of interest groups in the health sector include consumer groups, medical associations, and pharmaceutical industry associations.
INTERSECTORAL ACTION	An intervention or action that involves multiple government sectors (such as health, education, and agriculture) working together, often in a coordinated and integrated way, to improve health status in society.
LIBERALISM	An approach to ethics, based in the work of philosopher Immanuel Kant, that ascribes fundamental rights to all people on the basis of each individual's capacity for "moral action." See also the entries for positive rights (the foundation of "liberal egalitarian" perspectives) and negative rights (which underlie "libertarian" perspectives).
MONITORING AND EVALUATION (M&E)	Monitoring and evaluation are two, often complementary, approaches to assessing how a program or intervention is working. Monitoring focuses on tracking and analyzing the extent of progress toward the goals and objectives of an intervention, while evaluation is an assessment of the significance and impact of an intervention on final outcomes.
NATIONAL HEALTH ACCOUNTS	A framework and tools for measuring and tracking data on a nation's health expenditures.
PAYER	The entity (such as a government or an insurance plan) that decides on what health services to pay for and which manages the methods used to pay for them.

TERM	*DEFINITION*
PAYMENT, OUT-OF-POCKET	A payment method in which the patient pays for health services and medicines from the patient's own resources.
PAYMENT, PROVIDER	A general term that refers to the method used to pay physicians and other health services providers for services offered. Payment options include: fee-for-service, capitation, salary, or salary plus bonus. Each method creates different incentives related to technical efficiency and quality of health services.
PERFORMANCE GOALS	The core aims of a health system. In the Flagship Framework, a health system's ultimate performance goals include: the health status of the population, citizen satisfaction with health services, and financial risk protection from health expenditures (see separate entries).
PERFORMANCE MEASURES, INTERMEDIATE	Health system characteristics that can be influenced by policy change and are a means to having an impact on ultimate performance goals. The Flagship Framework focuses on three intermediate performance measures: efficiency, access, and quality (see separate entries).
PERFORMANCE PROBLEM	An area of health system functioning that is targeted for priority attention and reform. The Flagship Framework focuses on selecting a performance problem of a specific ultimate health system goal as the starting point for conducting a diagnostic tree.
POLICY CYCLE	The process by which policies are designed and utilized. (See separate entry: health reform cycle.) The Flagship Framework's cycle is: Problem definition → Diagnosis → Policy development → Political decision → Implementation → Evaluation; the Flagship Framework also emphasizes the role of ethics and politics throughout the policy cycle.
POLITICAL FEASIBILITY	The likelihood that a proposed health policy or reform can successfully be adopted and implemented within a particular society. Political feasibility depends on the relevant players, their levels of power, their positions on the proposed reform, and perceptions of its likely impact.
PRIVATE PROVIDER	Individuals and institutions that deliver health care outside of the public sector.
PUBLIC SATISFACTION	A measure of how the public (including patients, other health system customers, consumers, citizens, and taxpayers) evaluate the health care they receive.
PURCHASING, STRATEGIC	Deliberate decisions about what to buy, from whom to buy, and how to buy health services and commodities to effectively strike a balance between gains in efficiency and improved quality and delivery of services.

TERM	*DEFINITION*
QUALITY, CLINICAL	An assessment of how the skills of health care providers, inputs, and the system of health care delivery result in increased likelihood of the desired health outcome.
RESOURCE ALLOCATION	Decision-making about how finite funds, supplies and human resources are distributed to address the needs of a particular population.
RIGHTS, NEGATIVE	Protections that guarantee individuals' freedom to choose what they want to do with their own lives and property, without intervention by the government. Negative rights are the basis for libertarian ethical perspectives that see the role of the government as taking minimal actions to protect individual property rights and personal liberty.
RIGHTS, POSITIVE	Protections that guarantee individuals a certain level of services and resources (such as a minimum level of income, shelter, education or health care) that makes other meaningful life choices possible and establishes equality of opportunity. Positive rights are typically associated with liberal egalitarian ethical perspectives that seek to redistribute social resources to help the worst-off and provide all individuals in a population with equal opportunities.
RISK POOLING	Including people with widely varying levels of risk for disease in a health insurance program. Risk pooling recognizes that illnesses and the associated health care costs are distributed unevenly among the people in a population. By combining people with diverse levels of risk into a program, the contributions of those at low risk of needing health care subsidize the costs incurred by those who need health services.
RISK PROTECTION	An ultimate performance goal of a health system is to ensure that an individual does not become impoverished as a result of paying for health services. (See separate entry: financial risk protection.)
SECTOR (PUBLIC OR PRIVATE)	A sub-section of the economy, such as the health sector. Public sector refers to the set of organizations controlled by the government, while the private sector is comprised of organizations controlled by individuals, private corporations or non-governmental organizations.
STAKEHOLDER ANALYSIS	The process of determining which individuals and groups have an interest in a particular policy, what their positions on the policy are, and the level of power that each has, in order to develop strategies that improve the political feasibility of adopting or implementing a public policy by strengthening supporters and weakening detractors.
TOTAL HEALTH EXPENDITURE (THE)	A measure of spending on health that combines all public and private payments within a society, often presented per capita.
UNIVERSAL HEALTH COVERAGE (UHC)	A health system that ensures that everyone obtains the health services they need without financial hardships.

TERM	*DEFINITION*
UTILITARIANISM	A philosophical perspective that advocates assessing interventions by analyzing their consequences and selecting those that maximize the amount of well-being (or "utility") that can be created for the population.
UTILITY	A concept in classical economics articulated by Jeremy Bentham in 1789 that encompasses the feelings of happiness, satisfaction or well-being achieved when an individual's preferences are met.
UTILIZATION OF HEALTH SERVICES	The rate at which members of a population use health services, which can be measured in, for example, hospital admissions or outpatient visits per capita.