# THE NEED FOR THE ACTIVE AND STRATEGIC MANAGEMENT OF LOCAL-LEVEL POLICY IMPLEMENTATION

## CREHS

**HEALTH ECONOMICS UNIT**

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## INTRODUCTION

Policies are not implemented just because they exist on paper. When implemented, they often confound the expectations of policy makers and take forms different from the visions outlined in policy documents. This is because policy implementation processes are dynamic.

Rarely do they follow the often-hoped-for, bureaucratic logic of moving inexorably down public sector hierarchies in which the role of some is to formulate and others simply to implement. Instead, the direction of a policy is shaped by the context in which it is introduced, the relationships required to implement it and the stakeholders whose paths it crosses.

This is shown by in-depth case studies of policy implementation in two South African district hospitals. The research sought to document key influences over policy implementation, including the exercise of power by managers and frontline implementers and institutional factors such as managerial trust and organisational culture.

In unpacking these implementation influences, it focused on two examples of policy implementation practice: the Patients' Rights Charter (PRC), which guides the relationship between patients and providers, and the Uniform Patient Fee Schedule (UPFS), which regulates the payment of user fees and the granting of exemptions at public hospitals.

## KEY THINGS TO IMPROVE ABOUT POLICY IMPLEMENTATION

This research suggests a series of questions that those who spearhead policy implementation can use in thinking about improving implementation practice and success. These questions are particularly aimed at encouraging thinking about "implementation software": values, meanings, discourses, institutions and relationships that shape implementation. These questions do not primarily reflect on the "hardware" of financial resources or organisational structures that can be re-engineered. However, they nevertheless touch on issues that need to be thought through and strategised around to increase the likelihood of successful policy implementation.

care workers because it challenges the power balance between themselves and patients. The acceptance of the PRC in the one case study hospital was fairly widespread and in the other it was not implemented.

However, in both hospitals providers signalled their unease about the PRC with comments about patients abusing their rights and the need to develop an additional set of provider rights. In contrast to the PRC experience, the UPFS did not lead to similar concerns in either case study hospital.

*A* This experience suggests that those who drive policy implementation must think critically about the nature of the particular policy, about the likely implications it will have for frontline implementers and about how the latter might react to it. This will help with the identification of potential points of resistance to implementation, which in turn will affect the process by which one implements a policy. It might, for example, be relatively easy to introduce a policy that will not be subject to contestation.

## THE NATURE OF THE POLICY

*Q* *How might the nature of the policy affect implementation?*

It is clear from this and other research (London et al., 2006) that the PRC is often seen as a threat to health

However, other policies might require completely different processes, e.g. more preparatory work or more consultation with affected parties and other strategies for curbing resistance.

## Q   How do the meanings assigned to policy influence implementation?

How a policy is framed and understood has a clear impact on its direction during the implementation phase. This is shown by the experiences of UPFS implementation documented in this research.

This policy regulates both the fees charged to public patients and the granting of exemptions to those who qualify. However, UPFS implementation is essentially geared towards revenue generation rather than exemptions.

The UPFS policy document itself is drafted in a way that supports the revenue generation goal, with guidelines on how to categorise patients, the information patients need to prove their income, and the fees to be charged by income-level category. Additionally, in both hospitals the UPFS has been clearly linked to a hospital-specific revenue target and in both institutions senior managers meet regularly with administrators to discuss UPFS implementation and revenue generation.

In contrast, the procedures for determining exemption eligibility are complicated, requiring patients to gather information and seek additional documentation from other agencies to prove claims of financial need.

This combination of factors encourages the core UPFS implementers to understand policy success as being about revenue generation rather than ensuring financial protection more holistically.

## A   This means that successful policy implementation - achieving the end-goals of a policy in its fullest sense - is not just about the management of financial resources and other practicalities. It also requires the strategic management of the meanings attached to policy because those meanings shape implementers' actions and the eventual trajectory of policy.

In other words, one of the interventions that the drivers of policy implementation should consider is active communication and the active management of policy meaning to ensure that it is acceptable to stakeholders and to ensure that the meaning supports the end goals of the policy.

With regard to the UPFS it is possible, for example, to frame the meaning of the policy to take greater account of the goal of exemptions and financial protection. A practical step in this direction could be to redefine the

performance metrics associated with the policy so that it does not primarily take account of the progress towards the revenue target, but also define good performance in terms of the correct granting of exemptions and the more active consideration of financial access.

## THE CONTEXT OF POLICY IMPLEMENTATION

## Q   How does the working environment influence implementation?

Policies are ultimately brought to life by frontline implementers who work with their managers in particular work environments. These environments are local contexts that must be taken into account in order to increase the chances of successful policy implementation. They are not directly related to any particular policy change, yet they can profoundly impact on the course of specific policy initiatives.

Figure one shows the results of surveys on trust in management that were conducted in this research project's case study hospitals. In Hospital A, there were generally more trusting relationships between management and staff. This created fertile ground for cultivating staff buy-in into organisational goals and for lessening resistance to changes that the introduction of new policies inevitably entail.
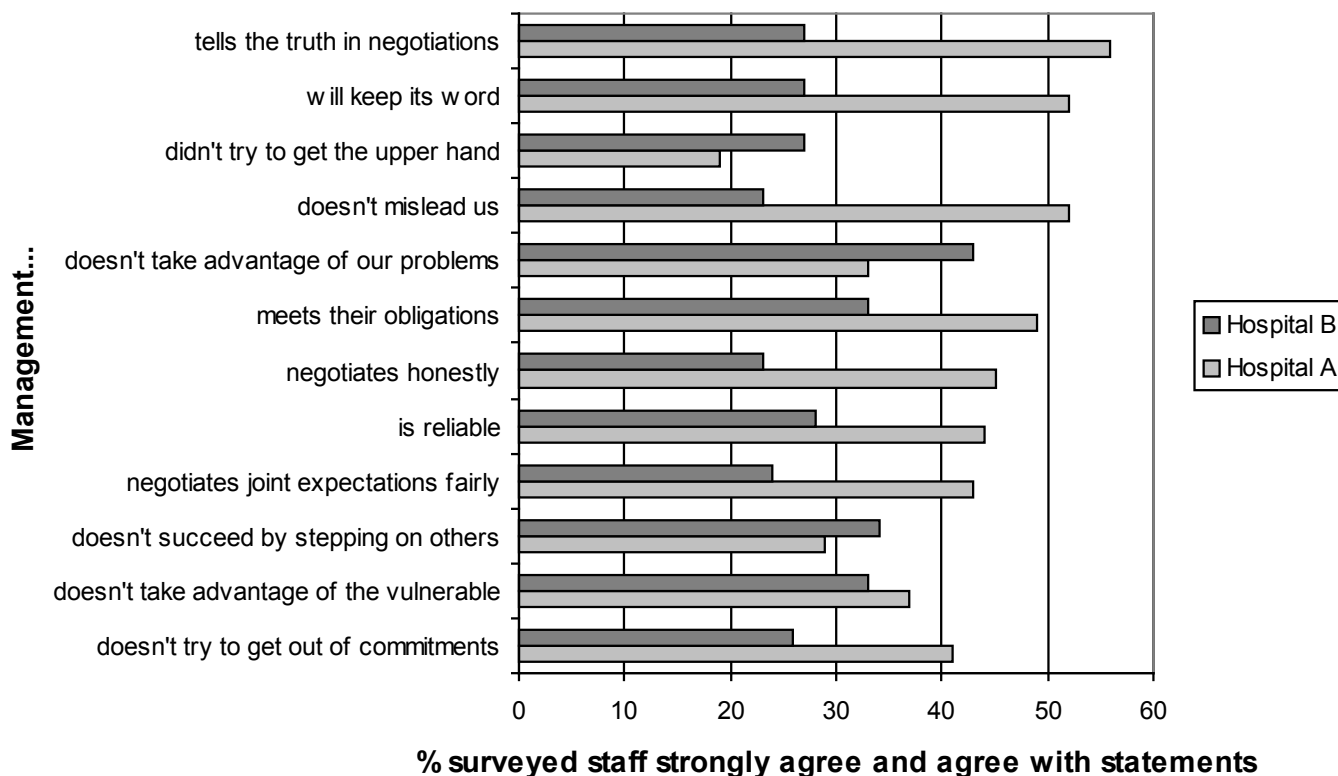
In contrast, managerial actions in Hospital B seemed to have created more distrust than trust, with some of the resistance to specific policies being rooted in these generally problematic workplace relationships rather than objections to the specific policies.

## A   The implication of this is that the drivers of policy implementation must be aware that policies are never implemented on a blank slate. It might therefore be valuable to think in advance about the environment into which a policy will be introduced and how that environment might support policy implementation or not.

One might have to do initial consultation work around a policy to build support in a difficult environment or to develop messages around the policy to offset anticipated resistance or to capitalise on strengths or anticipated sources of policy support.

Overall, from a managerial perspective there is of course the imperative to cultivate generally positive workplace relationships. These are the ultimate carriers of policy and, if not conducive, can have major repercussions for specific policy initiatives.

Figure one: Trust in management in case study hospitals



Management...

- tells the truth in negotiations
- will keep its word
- didn't try to get the upper hand
- doesn't mislead us
- doesn't take advantage of our problems
- meets their obligations
- negotiates honestly
- is reliable
- negotiates joint expectations fairly
- doesn't succeed by stepping on others
- doesn't take advantage of the vulnerable
- doesn't try to get out of commitments

Legend: ■ Hospital B ■ Hospital A

X-axis: 0 10 20 30 40 50 60

**% surveyed staff strongly agree and agree with statements**

## Q      What is the organisational culture in the facility implementing the policy?

As organisations in their own right, each hospital has an organisational culture: things they value, assumptions about the world and ways of working. These cultures can fit or clash with the nature of policies and with what policies require people to do.

In this research, the two case study hospitals' cultures differed in important ways. In Hospital A, the predominant cultural type was the clan (35%), followed by the hierarchical (30%), rational (28%) and developmental (7%) type. In Hospital B, the culture was predominantly rational (43%), followed by clan (22%), hierarchical (20%) and developmental (15%).

Arguably, the hospitals' cultural mixes did not equip them equally well to face up to the demands of both the UPFS and PRC policies.

The UPFS policy seems to fit well with key elements of the organisational cultures of both hospitals. The rational type, quite strongly present in both facilities, points to competitiveness and emphasis on achievement and meeting objectives.

A policy such as the UPFS that is clearly laid out, that requires very specific tasks and to which a precise revenue target is attached is a neat fit for this cultural type, with the revenue goal being a natural target to

aim at in the quest for the attainment of objectives. Drawing on the hierarchical elements of the cultures, the revenue goal has additional significance because it originates with and is important to high-level authorities that are very important to the hospitals.

In contrast, there seems to be a less than optimal fit between the PRC and the culture of Hospital B, which has a lot to do with the dominance of the rational type and the value consequently placed on order, control and stability. Representing a clash of values, the PRC is much less clearly defined than the UPFS, can be interpreted in many different ways, and to a large extent relies on the discretion of frontline implementers – a policy, in other words, that easily frustrates the desire for control, order and stability.

## A      The implication of this is that the cultures of implementing organisations might not equip all of them equally well to deal with the demands of different policies. This means, firstly, that implementation managers have to be aware of this possible interaction between organisational culture and policy. An organisational culture is a stable, ingrained way of thinking and doing and it is therefore very likely that it will in some way mediate the implementation of policies.

If this mediation is likely to be problematic, it might be possible to reframe elements of a policy to fit better with the organisational culture. A broad policy such as the PRC could, for example, be transformed into a series

of more specific objectives to aim at if it is such targeted goal achievement that is valued in the organisation.

There is the option to change the culture, which is usually a very complex and long-term task and perhaps more difficult than finding other ways of establishing better fits between policies and cultures.

## THE PEOPLE AND RELATIONSHIPS THROUGH WHICH POLICY IS IMPLEMENTED

*Q How are frontline implementers likely to react to policy?*

In large measure, the success or failure of a policy eventually comes down to the actions of frontline implementers and their relationships with their clients. Frontline implementers have more power than many give them credit for and this is exercised in, for example, how they speak about and categorise their clients and the discretion they exercise over clients.

This research yielded innumerable examples of this, ranging from preferential treatment of certain clients and inadequate information provision by fee clerks to, against the letter of the policy, applying pressure on clients to counter perceived cheating of the system and force fee payments. Crucially, the behaviour of frontline implementers ultimately determines how the policy is experienced clients.

*A* For a manager, the key challenge is to stimulate positive frontline implementer behaviours: behaviours that are in line with policy and that stimulate the cooperation and co-production between provider and client that is often necessary for the successful implementation of health policy.

Key things to think about here include: creating a positive working environment to lessen resistance to policy change; developing messages and meanings around policies that make them more acceptable and less threatening; being conscious of the tone one is setting as a manager and the signals one sends about the importance or unimportance of policy; and the behaviours one is role-modelling.

## CONCLUSION

The public health sector is not a machine that produces and implements policy. Good policy implementation is a complex endeavour that requires astute management and working with and through a range of contexts and relationships. As Moore says: "Public managers are explorers who, with others, seek to discover, define and produce public value; they are strategists rather than technicians".

### About the research

This briefing note draws on the report:
*Investigating the role of power and institutions in hospital-level implementation of equity- oriented policies*

The full report can be downloaded from the CREHS website at:
http://www.crehs.lshtm.ac.uk/downloads/publications/South%20Africa_final.pdf

### References

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