Published by Oxford University Press in association with The London School of Hygiene and Tropical Medicine *Health Policy and Planning* 2008;**23**:361–368
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doi:10.1093/heapol/czn021

HOW TO DO (OR NOT TO DO)

# How to start thinking about investigating power in the organizational settings of policy implementation

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**Accepted** 22 June 2008

Power, a concept at the heart of the health policy process, is surprisingly rarely explicitly considered in the health policy implementation literature for low and middle income countries. In an attempt to support empirical research on power, this paper outlines some of the key insights on power from implementation theory. It then describes examples of power that might be seen in health policy implementation settings, such as hospitals, clinics and the local bureaucracies in which these are embedded, and concludes with suggestions for ways of investigating power and ensuring sound judgments are made about its existence and its influence over policy implementation.

**Keywords** Health policy, power, implementation, policy analysis, methods

**KEY MESSAGES**

- Power, a key factor in health policy processes, is rarely explicitly examined in the health policy implementation literature, particularly in low and middle income countries.
- More work needs to be done to support the systematic empirical study of power, as well as to consider its consequences for policy implementation.
- Explicit analysis of power has the potential to yield better conceptualizations of health policy processes and to benefit managerial practices and efforts to improve policy implementation.

## Introduction

This paper aims to guide more explicit empirical investigation of the practice of power and its consequences for health policy implementation, particularly in low and middle income countries (LMICs).

Power is at the heart of every health policy process (Walt 1994), and is central to sociological investigations of the provider-patient interface (Maeside 1991), the sharp end of much health policy implementation. Yet in empirical work, health policy analysis has generally paid only limited attention to issues of power in service delivery (Open University, no date), and specifically, in LMICs (Gilson and Raphaely 2008, this issue). Empirical work from such settings, nonetheless, illustrates that power matters to implementation and policy outcomes. The practice of power, for example, can generate mis-understanding among implementers, or mis-understanding between providers and patients; it underpins the ways in which implementers re-formulate policies in implementation, with both negative and positive consequences for beneficiaries, or excludes beneficiary groups from decision-making (Zakus 1998; Atkinson *et al*. 2000; Harrison *et al*. 2000; Seidel 2000; Foley 2001; Kaler and Watkins 2001; Penn-Kekana *et al*. 2004; Gilson *et al*. 2006).

So, what do researchers need to consider as they begin to think about how to investigate practices of power in health policy implementation? Here we, first, and quite briefly, outline some of the key theoretical starting points for thinking about implementation and power. Unfortunately, LMIC health policy work too rarely draws on, or even shows knowledge of, relevant theory (Gilson and Raphaely 2008, this issue; Walt *et al*. 2008,

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this issue). Then we bring alive that theory by presenting concrete examples of the different forms and sources of power in policy implementation, paying particular attention to the more subtle and less well recognized exercises of power. Knowing what to look out for and being able to recognize practices of power is an essential requirement for empirical work. Finally, we provide some practical advice on relevant approaches to data collection and analysis drawn primarily from our own experience. We encourage others to share their methodological experiences in this field.

To be clear, the paper is particularly concerned with the exercise of power in organizational settings, such as clinics and hospitals and the local-level bureaucracies in which these health facilities are embedded. These are key, but often overlooked, sites of health policy implementation. Relevant relationships include those between managers and employees within health organizations, between managers and citizens and providers and patients, as well as those between the various sets of organizations involved in health care delivery. All of these are, however, nested within broader macro-political structures and relationships.

## Theoretical starting points

Reflecting on 20 years of implementation work, a leading UK scholar has re-stated some of the key theoretical insights on the practice of power in implementation (Barrett 2004). The top-down model of implementation emphasizes power as the co-ordination and control (of others) by those with authority located at the upper reaches of the bureaucratic or organizational hierarchy, in pursuit of pre-determined policy objectives. These objectives are established through political processes, and implementers are simply tasked with executing plans to achieve them.

The diverse range of bottom-up theories, including those examining the policy process as organizational process (e.g. Elmore 1978), focus on the micro-political dynamics of intra- and inter-organizational behaviour, with some emphasizing that the dynamics involve consensus-building to gain influence and others, conflict and power bargaining. One view is that power is primarily exercised to pursue or protect each actor's own interests and preferences, rather than to pursue legitimate public policy goals. Bottom-up theories have also specifically highlighted the extent of discretionary power exercised by implementing actors, because their work is complex and central decision-makers cannot foresee all of the circumstances that must be addressed in implementation decisions. Indeed, Elmore (1979) argues that authority relations within organizations are always reciprocal: formal authority runs from top to bottom, but the informal authority necessary for problem solving runs from bottom to top. Indeed, as Sharp *et al*. (2000) discuss, power not only encompasses the ways in which certain actors manage to control or direct the actions of others, but also the ways in which people are able to resist or subvert such control.

Discretion in implementation is generally seen negatively by top-downers, because it undermines conformance with the pre-determined policy objectives or targets set through political processes. It could, for example, undermine the use of common standards or achievement of equity goals and might be particularly problematic if actors pursue their own interests and preferences. However, bottom-uppers generally have a positive view of discretionary power, because its exercise may reflect implementers' efforts to adapt policies to local circumstances in ways that secure broad policy and performance gains (Barrett 2004). Such adaptation is particularly important in health care, given the need to respond to varying patient circumstances. Yet again, in street-level bureaucracy theory, implementers' use of their discretionary power is seen as a way of coping with the challenging environments of public sector street-level bureaucracies, including central actors' efforts to control or direct their actions, rather than as a more deliberate act to promote either their own interests or achieve performance gains (Lipsky 1980). The practice of discretionary power may also represent implementers' resistance to the imposition of efforts to control or direct their actions.

Building on these debates, Hill and Hupe (2002), in a leading recent text, propose three images of implementation, or, as they call it, operational governance, each outlining different ideas about the exercise of power. They build on Etzioni's definition of power as 'an actor's ability to induce or influence another actor to carry out his directives or any norms he supports' (1961: 4). From the enforcement perspective, implementers are bureaucratic subordinates managed by a form of coercion, as reflected in accountability rules and internalized formal authority. Such coercion is accepted by implementers as part of their broader acceptance of public ideals and responsibilities. The performance management perspective sees implementers as agents contracted by principals and managed by material power, in the form of incentives or sanctions. Finally, in the co-production image, implementers have relative autonomy and work within a joint framework. They have power because their professionalism and expert judgement is trusted; but that power is constrained by the series of relationships they have with others to whom they are accountable. Implementation is essentially about co-producing shared results.

A different approach to understanding power is presented by those who understand policy as 'meaning making' (Open University, no date). This body of work suggests that the language of policy and the meanings that people give to that language themselves become policy and influence individuals' responses to policy interventions. Policy language is constructed not only by politicians and senior government officials, but also by implementers, the managers, professionals and public service staff who interpret policy for themselves as well as clients and the wider community. However, Fischer (2003, p. vii-viii) specifically argues that:

> ideas and discourses can have a force of their own independently of particular actors . . . Discourse, in this view, does more than reflect a social or political 'reality'; it actually constitutes much of the reality that has to be explained . . . Instead of understanding power only in negative terms – such as power to control or manipulate others – the approach . . . also emphasizes that discursive power can determine the very field of action, including the tracks on which political action travels.

Overall, these theoretical positions indicate that practices of power are multi-layered. Implementers may exercise power in

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pursuit of their own interests, but also, or as well, in reaction to the challenges of their working environments, or central actors' efforts to control them, or in adapting policy interventions better to address their own understandings of local need. Implementers' interpretations of policy also have a power of their own, to shape how policy ideas are understood by others.

## Seeing power: concrete examples

Theory does not, however, give a particularly clear sense of the concrete ways in which power is exercised—for this, we turn to empirical examples.

The exercise of control or resistance can be direct and visible: as when a subordinate, in a characteristically top-down way, is ordered to perform an implementation task and complies, or when employees go on strike to resist a management decision.

However, organized resistance might be fairly rare in the organizational contexts of health policy implementation and even some forms of top-down control are less obvious. Resistance can include, for example, front-line providers who develop their own working routines, such as when nurses take tea breaks and for how long, to give them greater control over their clients and tasks. It can also be seen in a small act such as the non-completion by a dissatisfied health worker of parts of the records needed to collect fees from patients for certain procedures. Although not reversing the policy of fee collection, such an act might require other colleagues to work harder to find and capture the information, as well as reducing the amount of fees collected, thereby affecting both the process of policy implementation and the extent to which the intended goals are achieved.

Less obvious exercises of power often have a discursive flavour, as when negative labels or identities are assigned to others. Indeed, this is a common practice:

> Those seeking to discipline subordinates and colleagues frequently seek to dismiss their resistance by imputing negative motives. So, for example, derogatory labels or identities such as 'trouble-maker', 'whinger', 'chip on their shoulder', 'jealous' and 'looney feminist' frequently have significant symbolic and disciplinary impact on those considering resistance. (Collinson 1994, p. 48)

Front-line providers also commonly exercise power over patients in this way. Research on the implementation of the Patients' Rights Charter in South Africa documented the health worker complaint that there was too much emphasis on the rights of patients and too little on their responsibilities, as well as the related notions that the Charter enables patients to do as they please and that patients do not adhere to the responsibilities set out for them in the Charter (London *et al*. 2006). Being assigned the negative labels of 'being irresponsible' and of 'taking advantage' serves to de-legitimize patients, and to impede the rebalancing of power in the patient-provider relationship sought through the Charter. However, the research also suggested that providers act in these ways towards patients as a response to the content of the policy itself, poor management practices within the health system, the hierarchical organizational culture and the recent experience of massive top-down health system reform (London *et al*. 2006). The one exercise of power can, therefore, be understood, at least in part, as a reaction to and as situated in the context of the other.

The ways in which policies are framed by and for implementers can be another often overlooked exercise of power that influences outcomes, as seen in two South African examples. Higher level managers have framed the hospital fee policy, which includes provision for exemptions, as essentially being about revenue generation, leading to an under-emphasis on the provision of exemptions (Nkosi *et al*. 2007). Recent community health worker policies, meanwhile, have been framed by higher level managers as being essentially about paying stipends to a selected few, so many former volunteers have withdrawn their services, with consequences for coverage (Lehmann 2008).

Yet another example of the exercise of discursive power is the use of humour to resist and criticize what is difficult to challenge openly. Griffiths (1998) discusses how humour has been used by a UK team of community mental health workers to resist the instructions of powerful colleagues and to undermine professional hierarchies. Nurses and social workers use humour to interrogate the case histories put forward by powerful psychiatrists and to question the basis for referrals to them (Box 1). This practice helps the nurses and social workers to reduce the number of patients referred to them, so managing their heavy workloads, and avoids direct disagreement and confrontation over the views of the psychiatrists.

> The significance of humour in hierarchical work organizations is that it allows subordinates to signal dissent, short of a serious statement of opposition or withdrawal

**Box 1** Humour as an exercise of power

A man is divorcing his wife. She has appropriated some of his possessions; he has attempted suicide, assaulted her, is drinking heavily, living in an empty house and seems to be suffering from depression. In the meeting about the case, a nurse responds to the statement that the man's wife had stolen and sold his car with 'Good for her' and shortly thereafter 'That's my girl', while another laughs. His attempted suicide on New Year's Eve, after drinking, is interpreted by the nurses as something many people do because they can not face the new year. Later on, while talking about the empty house the man lives in, a social worker suggests that he needs a lawyer more than anything else. And so they move away from a medical diagnosis to an image of this man as suffering all kinds of more general difficulties. The conclusion is that there is 'insufficient information' for the community mental health team to proceed with the referral.

*Source*: Griffiths (1998, p. 879-84).

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> of cooperation. Humour signals that social tensions exist, without exposing the dissenters to the consequences that would follow from a direct challenge to authority. (Griffiths 1998, p. 875)

Together these examples indicate that even apparently isolated or fairly trivial practices can represent exercises of power. They also show that resistance is not only seen as the active and instrumental pursuit of a particular oppositional goal (Collinson 1994; Sharp *et al*. 2000) and is not judged only on its ability to reverse control or domination. Indeed, in the organizational contexts of policy implementation these less obvious ways of influencing or subverting the implementation processes and outcomes of health polices might be more prevalent and important than very organized, direct and instrumental resistance. Studies of policy implementation must, therefore, adopt data collection and analytical approaches that allow their investigation.

In such studies it is also always important to look out for the sources of power. Beyond the formal or discretionary authority highlighted by implementation theory is the power derived from professional role (e.g. doctor or nurse), knowledge, personal characteristics such as charisma, and links to networks, alliances or other powerful actors. The 'normal way of doing things', as embedded in organizational culture, is another source. The major and often overlapping divisions or hierarchies in a society or community, for example those constituted along class, gender, racial or ethnic lines, also shape the sources of power available to actors. Finally, given the dynamism of policy processes, it is important to see sources of power as relational and context-dependent, rather than as fixed possessions or properties of actors. Actors can gain or lose sources of power over time and might be able to exercise power over certain actors in a particular context, while being comparatively powerless in another.

## Data collection

### Observation

Generating information that reveals the influence of power over policy implementation is not very straightforward, even in relation to the common method of interviews.

One approach is observation. It can identify visible, direct and open exercises of power, but observations over time can also sensitize the researcher to deeper structures and balances of power, to the rules of the game that govern particular settings and the ways in which policy actors might be trying to re-shape those rules. For example, through observation we learnt that fee clerks were exercising their discretionary power by not properly informing clients about how to access exemptions from hospital fees. Observation in a particular hospital setting also revealed the absence of promotional material on the Patients' Rights Charter. This indicated that someone (as we later learnt, senior hospital management) was exercising power in opposition to the expected standard of displaying such material and the intent of the policy (Nkosi *et al*. 2007).

Methodological texts usefully outline a range of issues to be considered when embarking on observation. Mason (1998), for example, emphasizes the need to think through the reasons for doing observation, the role of the researcher on the spectrum between observer and participant, and the relationships the researcher develops in the setting. As the observer is rarely a completely neutral presence, it is necessary to reflect on the role s/he will play, how to behave towards others, and the relationships that might be formed with key informants—as well as how these experiences will be perceived by research subjects, and so influence their behaviour and the observer's access to the research settings. Ethical considerations are also key to the observation process, with one fundamental question being whether the observation will be overt or covert. Most ethical codes are likely to demand that people are made aware they are being observed.

In our own work, we have employed several complementary observational strategies. The first is to spend considerable time in a specific setting observing a particular group of people (e.g. nurses in a particular ward), and later reflecting on what we observed in relation to our subjects of interest. We have also asked fieldworkers to note and record their key impressions about the organization implementing the policy (relative to the objectives of the research), even if these occur to them outside the observation of specific people in specific settings. The researchers are, in other words, encouraged to 'soak up' and record information about the settings in which they are conducting research.

We have also used relevant theory to develop a provisional list of categories around which to make observations, as presented in Table 1. The left-hand column identifies issues drawn primarily from literature on organizational culture (e.g. Schein 2004) that might be relevant to power, in addition to illustrating other norms and values in the organization. The right-hand column contains ideas on how observations related to the broad categories might yield information relevant to power dynamics. Some observations, for example of physical objects related to policy, might not provide direct access to exercises of power, but could provide leads as to which organizational actors to observe more closely or to interview about power dynamics. In this list, categories such as the routine organization of tasks, common language and conceptual categories and encounters between clients and staff are likely to relate to the subtle exercises of power discussed earlier. However, other items could also provide insight into sources of power, such as status differentials between implementing agents, the ways in which formal roles and positions shape actions, and the influence of different levels of knowledge over the interactions between clients and street-level bureaucrats. Such lists not only assist in operationalizing the slippery concept of power but also help to structure the observational activity, and may have particular value when several researchers are involved in a study. However, the lists are not used in a mechanical way because those conducting the observation are free to add categories and to note any other feature of the environment judged to be relevant to the objectives of the research.

### Interviews

A second approach to data collection on power in policy implementation is that of individual in-depth interviews. Such interviews afford respondents the opportunity to reflect on their

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**Table 1** An example of an observation checklist

| Observation category | Possible examples (and links to issues of power in policy implementation) |
|---|---|
| Physical objects related to policy | • Posters<br>(These might point to people who have power over implementation, for example the official or committee adjudicating patient complaints about poor service.) |
| Objects not directly related to policy | • Mission or strategy statements<br>(These might reflect dominant discourses or construct key implementation relationships in a certain way, for example a discourse on cost-saving promoted by a powerful government department.) |
| The organization of workspaces and symbolic meanings attached to places | • Does the space intimidate? For example, officials sitting on elevated platforms. (This might affect the power balance between clients and officials and the uptake of services.)<br>• Do people have particular associations with places? For example, a negative name for the building where management is located. (This might provide information about how staff members perceive the exercise of power by management.) |
| The routine organization of daily tasks / the way people go about their jobs on a day-to-day basis | • Routines in wards, for example starting times for consultations, the order in which patients are seen<br>(This might provide information on who directs activity and is therefore able to exercise power in this way. It might provide information on how routine decisions are made and whether these always favour certain people, for example if decisions always accommodate the most senior nurses.) |
| Organizational style: how people dress, talk to each other etc. | • For example, someone being called 'sir', while first names are used for others.<br>• Is the manager polite when speaking to nurses, but rude to other staff categories such as clerks?<br>(It might indicate who is accorded more status and behaviours such as rudeness might represent practices of power, for example intimidating people.) |
| Common language and conceptual categories | • For example, staff of the same cadre are constructed as 'family' and patients as 'aggressive'.<br>(Labels can have consequences for the interactions between actors, for example negative labels can discredit the concerns of patients.) |
| Encounters between clients and staff | • How do staff members respond to requests for information? Do they give helpful information or are clients left in the dark?<br>• Are patients strategic about the information provided to bureaucrats in order to try and secure a positive outcome?<br>(Such exercises of power might affect the uptake of services or the relationships between providers and patients.) |

*Source*: Centre for Health Policy and Health Economics Unit (2006).

role in the implementation process, their relationships to other actors and their views on the ways in which policies have been implemented and can therefore be used to explore both forms and sources of power. As Gaskell (2002, p. 45) points out, the questions in individual interviews (and group interviews) are in a sense 'an invitation to the respondent to talk at length' and therefore do not entail a completely standardized set of exchanges or response categories. An important part of achieving a successful individual in-depth interview of this kind is building rapport and establishing a certain degree of trust between the interviewer and respondent. The respondent might find the interview situation strange or uncomfortable and the likelihood of this is perhaps greater when the topic is power, something that might be threatening or controversial in the context of the implementing organization. Such trust or rapport can be achieved by, for example, starting the interview with non-threatening questions, the way in which one poses questions, and using positive and reinforcing non-verbal cues and body language. Gaskell (2002, p. 52) provides some examples of question phrasing relevant to individual in-depth interviews: 'Could you tell me about the time you . . .?', 'Can you tell me more about . . .?' and 'What comes to mind when you think of . . .?'.

Because of the potential difficulty of the concept and sensitivity of the topic, we have avoided very direct or blunt questions on power. Instead, we have opted for questions that we judged had the potential to yield relevant information in a more roundabout way. Questions drawn from our own work on power in implementation, and their intentions, include:

- Who are the really important people in terms of making decisions about the policy? Please explain?
  – Here the aim is to identify powerful actors by getting respondents to think about decision-making in the policy implementation process.
- I would like to understand the relationship between the supervisors and managers, and other staff in the hospital. Can you describe an interaction or event that illustrates how good or bad the relationship is? (Explore the extent of trust in the relationship and the consequences of the relationship for hospital functioning/the implementation of the policies of focus).
  – Here the aim is to get at exercises of power through a broad question about the nature of the relationship; exploring behaviours that have either built or destroyed trust might provide clues about the nature of the exercise of power.

A different approach to gathering information on power from people and their interactions with each other is that of the power cube (Gaventa 2005). Concerned with spaces of engagement, the places and levels where this participation occurs and the forms of power found in them, the power cube approach has, for example, been applied in workshop and focus group settings. An appendix to Gaventa's (2005) paper contains a variety of questions that can help the investigator look

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**Box 2** Policy discourse

Hastings' (1998) analysis of the policy New Life for Urban Scotland contains an example of the link between discourse and power. This policy deals with the regeneration of disadvantaged areas in Scotland. One of the author's arguments is that the policy does not construct the people living in disadvantaged areas as conscious agents that can exert power over events or other actors in the policy process. This effect is achieved, in part, through nominalization (turning actions into nouns). 'Inner city dwellers demanding better living conditions' becomes 'the overwhelming demand for better housing', so downplaying and hiding the agency of residents. This contrasts with the way in which government, the private sector etc. are constructed as agents and portrayed through action verbs.

for power, such as: who is not participating and what is keeping certain issues from being raised publicly?

### Review of documents

Lastly, information on power that is relevant to health policy implementation might be obtained from a review of documents such as minutes of meetings, reports compiled by the implementing organizations, circulars, memoranda and policy documents. Such documents can contain information on issues such as the actors involved in implementation, disputes around policy implementation, non-compliance with policy prescriptions and the key strategies for promoting the implementation of the policy as originally intended—information that can be coherently understood from a power perspective. Flyvberg (2001), for example, reports the excitement of realising that five lines from the minutes of a local government meeting revealed the critical influence of the local Chamber of Industry and Commerce, a private interest group, over key urban planning decisions in a Danish city. Until noticing from the minutes that this group was actively brought into decision-making by the local political authorities, he had not been aware of the hidden power relations between them.

Documents can also provide an entry point into the language or discourses that are used in relation to a particular policy, and so, in a sense, constitute it (Babbie and Mouton 2001). A discourse might, for example, characterize managers as very pro-active and front-line implementers as lacking capacity and a strong work ethic, so promoting the relative empowerment of the managers and the relative disempowerment of the front-line implementers. Box 2 provides an example of this type of discourse, and shows that the use of language is intimately linked to relations and exercises of power. Other data collection strategies can, of course, also provide entry points for exploring power from this angle. By their very nature as verbal exchanges, in-depth interviews might reveal language use or discourses relevant to policy implementation, but it is also something that can be tackled through observation, as illustrated by the category of 'common language and conceptual categories' in the observation tool in Table 1.

## Analysing data and making judgements on power

Working with the concept of power in policy implementation requires judgements to be made. Some of them might be thought of as more descriptive; for example, judging the nature of power relations between actors, whether power has been exercised and the sources of actors' power. Other judgements are more clearly normative; for example, when there is a need to characterize exercises of power as 'good' or 'bad' in some way. Indeed, Moore (2005) argues that our views of and reactions to power are always bound up with our ideas about matters such as the good society and good governance, and that the judgement criteria that underpin these views and reactions are often not explicit.

It is, therefore, important to consider how to ensure that sound judgements are made. One suggestion is to gather information on power through a variety of data collection techniques, for example observations and in-depth interviews, as this provides the opportunity for cross-checking understandings developed through different data collection approaches. It might also be helpful to create opportunities for the researchers to check and debate each other's judgements, actively testing their ideas against each other. It may even be possible to test researcher judgements with respondents, although the potential sensitivity of power issues may make this problematic. Importantly, it is always important to remain firmly attuned to the context of the work and the nuances of the information with which one is working. Steps such as these can help researchers to make sound judgements about issues such as forms and sources of power, but are also relevant to more normative judgements.

With regard to policy implementation, it seems that such normative judgements could be made, whether by researchers or other actors involved in the implementation process, with reference to a range of potential focal points or concerns. First, some might be motivated by an over-riding concern with the goals of the policy and will judge exercises of power by whether it furthered or subverted the policy goals. Second, the perspective of others might make them more inclined to consider the overall organization implementing a policy and to ask whether power dynamics are productive or unproductive relative to the overall goals of the organization, downplaying the outcomes with respect to a specific policy. Exercises of power that further the achievement of narrow policy goals might be judged negatively because they cause conflict between union representatives and management in the implementing organization as a whole. Third, yet other actors might consider the relevant yardstick to be even broader concerns relating to the impact of exercises of power on the people involved or the community or society as a whole, thereby having as an over-riding concern neither the narrow policy nor the implementing organization.

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Judgements of this kind seem to be fundamentally linked to the perspective, context and criteria of the actor. A manager responsible for implementing a policy might be very critical of acts of resistance that subvert the policy goals, while a policy activist might think them justified because they are understood to contribute to the democratization of the workplace. Similarly, two people might disagree about whether certain power relations contribute to a better or worse community because they have different conceptions of what is desirable.

Judgements about the nature and consequences of exercises of power need to be rooted in the context in which the exercises of power occur and must take explicit account of the perspectives of those making the judgements, their over-riding focal points or concerns, and the criteria underpinning their judgements. In line with bottom-up theorists, we would also argue that it is useful, despite the concern with policy implementation, to incorporate into one's judgements broader notions of 'the good' (e.g. achieving health equity or giving people more control over their destinies) and not just to judge exercises of power by whether they further or undermine the achievement of specific policy goals. The latter approach implicitly privileges specific perspectives, for example of those charged with policy implementation, and loses sight of the idea of policies as means or instruments of broader social change, not ends in themselves.

## Conclusion

Power is recognized as a key influence over the development and implementation of health policies, yet it is a concept that is rarely explicitly considered or unpacked in empirical analyses from LMIC settings. Clearer and more comprehensive understandings of power are needed to build-up rich and nuanced descriptions of the forms, practices and effects of power in health policy implementation. We see such understandings as a foundation for more critical thinking about policy change and its consequences, as well as about health system management practice, in such settings.

This paper highlights some relevant aspects of policy implementation theory, and offers some practical and concrete ideas about the practice of power in implementation as well as approaches to empirical inquiry. It represents only a first step in encouraging further work on power in health policy implementation.

## Acknowledgements

This paper is derived from two programmes of work in which the authors have recently been involved, supported by EQUINET (The Regional Network on Equity in Health in Southern and Eastern Africa, funded by the Canadian International Development Research Centre: http://www.equinetafrica.org) and CREHS (The Consortium for Research on Equitable Health Systems, funded by the UK's Department for International Development: http://www.crehs.lshtm.ac.uk). We thank both groups for their support, and colleagues within them and the Centre for Health Policy, University of the Witwatersrand, for comments on the ideas presented here. We are also grateful to Leslie London and Zelda Holtman, University of Cape Town, for the opportunity to work with them in investigating the South African Patients' Rights Charter, an experience drawn on in this paper.

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