Published by Oxford University Press in association with The London School of Hygiene and Tropical Medicine
Health Policy and Planning 2012;**27**:i64–i76
doi:10.1093/heapol/czs007
© The Author 2012; all rights reserved.

Using stakeholder analysis to support moves towards universal coverage: lessons from the SHIELD project

Lucy Gilson,[1,2]* Ermin Erasmus,[3] Jo Borghi,[2] Janet Macha,[4] Peter Kamuzora[5] and Gemini Mtei[4]

[1]School of Public Health and Family Medicine, University of Cape Town, South Africa, [2]Department of Global Health and Development, London School of Hygiene and Tropical Medicine, UK, [3]Independent consultant, South Africa, [4]Ifakara Health Institute, Tanzania and [5]Institute of Development Studies, University of Dar es Salaam, Tanzania

*Corresponding author. School of Public Health and Family Medicine, University of Cape Town, Health Sciences Faculty, Anzio Road, Observatory, 7925, South Africa. E-mail: lucy.gilson@uct.ac.za

Accepted 11 January 2012

Stakeholder analysis is widely recommended as a tool for gathering insights on policy actor interests in, positions on, and power to influence, health policy issues. Such information is recognized to be critical in developing viable health policy proposals, and is particularly important for new health care financing proposals that aim to secure universal coverage (UC).

However, there remain surprisingly few published accounts of the use of stakeholder analysis in health policy development generally, and health financing specifically, and even fewer that draw lessons from experience about how to do *and* how to use such analysis. This paper, therefore, aims to support those developing or researching UC reforms to think both about how to conduct stakeholder analysis, and how to use it to support evidence-informed pro-poor health policy development. It presents practical lessons and ideas drawn from experience of doing stakeholder analysis around UC reforms in South Africa and Tanzania, combined with insights from other relevant material. The paper has two parts. The first presents lessons of experience for conducting a stakeholder analysis, and the second, ideas about how to use the analysis to support policy design and the development of actor and broader political management strategies.

Comparison of experience across South Africa and Tanzania shows that there are some commonalities concerning which stakeholders have general interests in UC reform. However, differences in context and in reform proposals generate differences in the particular interests of stakeholders and their likely positioning on reform proposals, as well as in their relative balance of power. It is, therefore, difficult to draw cross-national policy comparisons around these specific issues. Nonetheless, the paper shows that cross-national policy learning is possible around the approach to analysis, the factors influencing judgements and the implications for, and possible approaches to, management of policy processes. Such learning does not entail generalization about which UC reform package offers most gain in any setting, but rather about how to manage the reform process within a particular context.

Keywords Universal coverage, insurance reform, stakeholder analysis, political management, political viability

Downloaded from http://heapol.oxfordjournals.org/ by guest on April 5, 2016

KEY MESSAGES

- Stakeholder analysis is an important approach to apply in order to enhance the political viability of universal coverage proposals.
- Doing stakeholder analysis requires patience and careful judgement, and particular attention to the contextual influences shaping policy actors' interests, positions on new policy proposals and relative power.
- Given the dynamic nature of policy change, repeated stakeholder analyses are likely to offer clearer insights to support policy change than a single analysis representing experience at only one time.
- Stakeholder analyses can be used both to think through the political viability of new policy proposals and to develop broader political management strategies to support policy change.

Introduction

There is long-standing recognition that health system reform has both technical *and* political dimensions (Reich 1995). Data on stakeholder perceptions of policy problems and options are seen as an important input for evidence-based policy making (Lavis 2009), and viability, defined as 'consumer acceptability, acceptability to professional organisations and political acceptability' (WHO 1993: 8), is a recognized criterion for assessing financing policy. The political stewardship needed to move towards universal coverage (UC) must, therefore, take account of diverse societal preferences (Carrin *et al*. 2008).

The most commonly recommended analytical tool for gathering information on these issues is stakeholder analysis (SHA): 'an approach, tool or set of tools for generating knowledge about actors - individuals or organisations - so as to understand their behaviour, intentions, inter-relations and interests; and for assessing the influence and resources they bring to bear on decision-making or implementation processes' (Varvasovszky and Brugha 2000: 338).

However, the few available empirical studies reporting SHAs undertaken on health policy issues rarely report on the details, challenges and usefulness of this tool in understanding and informing policy change.

This paper, therefore, aims to support those developing or researching UC reforms, specifically, to think both about how to conduct stakeholder analysis, and how to use it to support evidence-informed pro-poor health policy development (Buse 2008). It presents practical lessons and ideas drawn from experience within the SHIELD project which has supported such reform in Ghana, South Africa and Tanzania (Strategies for Health Insurance for Equity in Less Developed countries: http://web.uct.ac.za/depts/heu/SHIELD/about.htm). The project encompassed financing and benefit incidence analyses, modelling future policy options for expanding coverage and, in South Africa and Tanzania, stakeholder analysis to support policy formulation. Analysis of the Ghanaian experience of health insurance policy formulation is already available (Rajkotia 2007; Agyepong and Adjei 2008). Drawing on the SHIELD experience in Tanzania and South Africa, and wider literature, the paper is structured in two main sections. In the first, guidance on how to conduct an SHA in relation to UC reforms is presented; and in the second, ideas are presented about how to use an SHA in managing policy change, for those seeking to manage or influence the process of policy change (policy drivers).

Lessons of experience 1: Doing SHA

The key steps in a SHA

SHA can be conducted either as a formal research exercise, involving data gathering through document review, media analysis and in-depth interviews (Schmeer 1999), or through brainstorming amongst knowledgeable participants (Bryson 2004). In either case, it is important to prepare for the SHA by clearly identifying the policy issue of focus (Schmeer 1999) and the purpose (e.g. rapid situational analysis vs comprehensive analysis: Hyder *et al*. 2010).

Three key steps follow (Roberts *et al*. 2008):

(1) Identifying the groups and individuals (the stakeholders) relevant to the policy issue of focus;
(2) Determining the current position (in terms of support or opposition) of each stakeholder on the issue;
(3) Determining the relative power of each stakeholder over the issue.

The analysis of this information can then be presented visually to allow understanding of who the key stakeholders are around the policy issue, what positions they take on it and what power they have to influence decisions around it. Analysts must also recognize how their own positions and resources, and contextual understandings, influence their interpretive judgements.

Determining purpose and focus

Following Hogwood and Gunn (1984), SHA might be conducted retrospectively (Gonzales Rossetti and Bossert 2000; Gilson *et al*. 2003) to generate knowledge *of* policy and the policy process, or prospectively (Mathauer *et al*. 2007; Mathauer *et al*. 2008; Lalta 2009; Hyder *et al*. 2010; Surjadjaja and Mayhew 2010) to generate knowledge *in* the policy process and so support policy change (Glassman *et al*. 1999). Retrospective analysis is primarily to understand how policy actors' positioning and relative power influenced the process of policy change. Prospective analysis more directly informs the process of policy change, for example by generating ideas about how to change policy design in ways that address critical actor concerns or the likely areas of contestation that will need to be negotiated or deliberately managed. It might also be used in such negotiation, to draw out reasons for differences and provide a basis for addressing them.

Downloaded from http://heapol.oxfordjournals.org/ by guest on April 5, 2016

However, simply deciding the focus and purpose of an SHA in relation to UC can itself be a challenge. The fluidity of the broader policy environment in South Africa and Tanzania, and the absence of clear proposals for financing reform, were, for example, difficulties faced at the start of the SHIELD work (2006). By 2010 (the time of writing this paper), comprehensive policy proposals were still not available in either country. Nonetheless, a 2009 policy decision resulted in the Tanzanian Community Health Fund (CHF/TIKA, the largest voluntary scheme covering the informal sector) being taken over by the largest mandatory formal sector scheme, the National Health Insurance Fund (NHIF); whilst in South Africa, political momentum around National Health Insurance (NHI) was building. Dynamism is a common feature of policy change, particularly around 'high politics' issues (Walt 1994) such as UC, which impact directly on the general public as well as powerful policy actors, involve wide-ranging changes in various health system elements, and may have been an area of political debate and contestation over many years. Indeed, Varvasovszky and Brugha (2000) suggest that, with such reforms, SHA should be an ongoing process rather than a once off activity, to allow for change in actors' positioning.

In both South Africa and Tanzania, therefore, we conducted an initial SHA in 2007–08 with the primary objective of providing a sense of stakeholder concerns and interests concerning the broad policy direction of reforms that would promote health system equity, as an input into our future work [15 key informant interviews in Tanzania and, building on earlier work (Gilson *et al*. 2003), 12 in South Africa]. Only limited further work was possible in South Africa given the lack of clarity around policy proposals and political sensitivity around the issues (two group brainstorms and a media review in 2009–10). In Tanzania, however, a second round of 13 interviews in 2010 allowed consideration of stakeholder views on different options for expanding insurance and around one particular policy action (the 2009 take-over of the CHF/TIKA by the NHIF). In total six stakeholder groups were considered in Tanzania (Ministry of Health, politicians, donors, researchers, civil society groups, insurance schemes) and five in South Africa (government officials, private health insurers, professional groups, trade unions and independent analysts).

Identifying stakeholders

For any policy issue, stakeholders can be identified by considering both who has formal bureaucratic and political authority to make relevant decisions and who has interests in the outcome of a decision (Moore 1995). A large array of stakeholders from political, governmental, health system, business and social sectors are, therefore, likely to have interests in UC reforms in any setting. In addition, it is important to consider those whose rights may be affected, that is the public at large (patients and citizens), whatever their level of power (Bryson 2004; Mayers 2005).

Stakeholders include not only whole organizations, but also different units or groups within them, which may themselves hold different positions on the same policy issue. Governments, for example, may comprise groups championing the reforms (such as Ministries of Health) and other ministries championing competing reforms (such as social security expansion); whilst Ministries of Finance are often circumspect about any policy with clear fiscal implications. Ministries of Health, meanwhile, include not only the political head, the Minister, and the most senior civil servants, but also other groups—both those driving reform (e.g. in Tanzania, the Health Policy and Planning Department of the Ministry of Health and Social Welfare), and those who may be concerned about the impact of UC reforms on their role and positions [e.g. if new insurance organizations are established, officials within national ministries of health may lose power (Tangcharoensathien and Jongudomsuk 2004)]. Other stakeholders include individuals playing important roles in resisting reform implementation and moving it forward; both political champions of reform and individuals who get their ear—as in South Africa in the late 1990s (Gilson *et al*. 2003).

Comparison of South African and Tanzanian experience around UC reforms (Table 1) shows, moreover, that:

- Some stakeholders are common across countries, e.g. political parties in government and opposition, officials from the national Ministries of Health and Finance, commercial companies and a range of social sector stakeholders; at the same time, the general public is not an obvious or vocal stakeholder in either country, although civil society organizations are on the fringes of the debates.
- Differences in relevant stakeholders between countries are likely due to:
  - Their broader political and governance systems (e.g. one Trade Union federation is an important political grouping in South Africa because of its political alliance with the party in government; and provincial stakeholders are also important because of the quasi-federal governance structure of the country);
  - Differences in the nature of the health system itself (e.g. the much stronger private sector in South Africa than Tanzania brings a wider array of private health stakeholders into play in UC debates);
  - The level of economic development (the role of international actors is much stronger in Tanzania than in South Africa, given its higher level of aid dependency).

The media is not identified in Table 1 but did influence the ways in which NHI was spoken about and understood in South Africa. In 2009–10, for example, media reports, commonly portrayed NHI as a threat to the health system and an inappropriate policy option for the country (often presenting the perspectives of particular individuals).

Given the large numbers of policy actors interested in UC reform in any setting, it is useful to try to prioritize which actors to consider in an SHA, recognizing that every policy process is unpredictable. Perhaps the least risky approach is to identify an initial set of influential stakeholders based on in-depth knowledge of the particular context, including interactions with some policy actors. A 'snowball approach' could be used, for example, where initial informants are asked 'who has influence in current policy debates around issue xx?' (adapted from Lewis 2006), to identify those actors commonly seen as important. However, it is always important also to consider the potential role of less visible or powerful actors, who might

Downloaded from http://heapol.oxfordjournals.org/ by guest on April 5, 2016

Table 1 Examples of key stakeholders in health insurance reform from different sectors (2007–10)

Stakeholder group	South Africa	Tanzania
Political	• African National Congress, ANC (party in government) • Democratic Alliance (main opposition party) • COSATU (Congress of South African Trade Unions, in political alliance with ANC) • National President, national Minister of Health and other senior national Cabinet members • Provincial Ministers of Health and Finance	• Chama Cha Mapinduzi, CCM (party in government) • Chama Cha Democracia na Maendeleo & Civil United Front (main opposition parties)
Government	• National Treasury (Ministry of Finance) officials • National Department of Health officials • Provincial Health Department officials • Local government officials • Officials in other national government departments with insurance reform interests	• National Ministry of Finance officials • National Ministry of Health officials • Prime Minister's Office—Regional Administration and Local government officials (national level, responsible for local government) • Officials in parastatals with interests (e.g. National Social Security Fund) • National Health Insurance Fund
Health system (outside government)	• Private hospital companies • Private health insurance organizations • Health professional organizations • Health sector trade unions	• Large private hospital managers • Private health insurance organizations • Association of private hospitals • Other informal community health insurance
Business	• Commercial companies	• Commercial companies
Social sector – Civil society	• Treatment Action Campaign • Individual academic analysts	• Trade Union Congress of Tanzania • Civil society organizations • Individual academic analysts
International	• Not applicable	• Bilateral agencies (Swiss, German, Danish, USAID) • Multilateral agencies (World Bank, WHO)

Note: USAID = United States Agency For International Development.

frame how others think about an issue from behind the scenes (e.g. the media), or who may be affected by the issue even though having no obvious or vested interest in it (e.g. the public, civil society organizations). It will also be important to repeat the SHA over time, to identify and track new actors that emerge as influential players.

Gathering perspectives on key issues

As noted, three key issues are considered within any SHA—interests, positions and power—and none are easy to determine. Table 2 summarizes definitions for these key issues drawn from two sets of broadly similar SHA guidance (Schmeer 1999; Roberts *et al*. 2008).

Power is a central concern within an SHA but it is often poorly examined in health policy work (Gilson and Raphaely 2008). The exercise of power can be seen most clearly when stakeholders take public leadership within UC debates, whether of support or opposition. But power is also practised by the less obvious act of keeping issues out of consideration in policy debates (Ministries of Finance might, for example, prevent certain taxation options even being considered within UC design), and by influencing others' views and perspectives on what is or is not appropriate action (Lukes 2005). As noted, for example, some 2009–10 media reporting in South Africa appeared directed at building opposition to new proposals. Power assessments often, therefore, try to take account of all forms of power available to actors by assessing the resources available to each in judging their potential, relative to others, to influence policy decisions (Table 2). Roberts *et al*. (2008) note that the resources can be tangible (such as money, organizations, networks, people, votes, equipment, offices) and intangible (such as information, legitimacy, expertise and access to leaders or the media). However, judging the balance of power among actors is always difficult as different combinations of power are not easily comparable. An SHA requires careful triangulation of perspectives on these issues across interviewees, and testing of initial judgements.

Group brainstorming is one approach to gathering perspectives in an SHA and can support several repeated and fairly quick analyses. However, working with too small a group may exclude or ignore different perspectives, whilst working with a broader group may be difficult to set up and manage. Establishing commonly understood definitions of key issues (as in Table 2) is important, as well as allocating dedicated discussion time to different sets of issues. Key informant interviews are more commonly used (e.g. Schmeer 1999), but have their own difficulties. Just setting up interviews with policy elites can take considerable time, as well as the interviews themselves. As a result only a few interviews may be conducted with some stakeholder groups, and some groups may not be willing to be interviewed at all. The perspectives of some actors may, therefore, be drawn out primarily through engagement with other actors, or from documentary or media sources. It was particularly difficult in South Africa and Tanzania, for example, to set up interviews with the most senior government officials because of their time constraints and the researchers' limited access to them; in South Africa those involved in

Downloaded from http://heapol.oxfordjournals.org/ by guest on April 5, 2016

Table 2 Guidance on assessing power, interests and positions

	Roberts *et al*. (2008)	Schmeer (1999)
Interest	Degree to which stakeholders likely to be affected by policy change. (Degree of interest or concern they have in or about a policy will influence how the stakeholder's resources, and how much of those resources, will be used in the policy debate.)	The advantages and disadvantages that implementation of the policy may bring to a stakeholder or his/her organization. (Also important to consider the level of accurate knowledge the stakeholder has regarding the policy under analysis, in order to identify stakeholders who oppose the policy due to misunderstandings or lack of information.)
Positions	View on the policy issue and position in relation to policy change being proposed, i.e. support or oppose? Also involves assessment of intensity of each group's position on an issue.	Whether the stakeholder supports, opposes, or is neutral about the policy.
Power	Potential capacity to influence policy decisions. Power judgement based on assessment of stakeholder's resources and location in the political system. Interested in power relative to others.	The ability of the stakeholder to affect the implementation of the health reform policy. Judgement of level of force with which the stakeholder might support or oppose the policy is based on the quantity of resources (human, financial, technological, political, and other) available to the stakeholder and his or her ability to mobilize them.

relevant, but confidential, policy processes were also difficult to interview.

'Effective (elite) interviewing [also] requires sound preparation, planning and confidence' (Pierce 2008: 119). Before an interview, analysts should think about what they already know about the respondent and their relevant experience, and determine key issues to explore as well as key insights to test with them. During the interview it is then important to let the conversation flow, adopting an active listening process that gives confidence to the respondent and allows the interviewer to tease out unexpected insights, test her emerging understandings and identify when the respondent's positions and views strike a discordant note with her pre-existing understandings. The texture of the conversation and informal comments may themselves give important clues to critical issues. And it remains important to watch the time and keep focused, nudging the conversation along the pre-prepared lines of inquiry as much as possible and being respectful of the respondent's views.

There are two other challenges to gathering perspectives in an SHA, whether in a group brainstorm or through interviews. The first is the need to try and tease out the personal views of respondents from those that represent the formal position of the organization/group with which they work. Both perspectives are likely to be important, but interviewees' personal views may:

- offer valuable, critical insights on other policy actors (and be based on closer engagement with them than that available to the analyst);
- be a critical driving force of the organization's positioning (e.g. in South Africa, the leader of one health professional organization drove a more public-sector-oriented position at one time than the organization's members themselves held);
- allow the researcher to think through the multiple perspectives a single actor holds (e.g. in South Africa, government health officials might support health insurance reform as an ideal but be concerned about the potential loss of their own health insurance benefits, and the consequences for their families).

The second challenge is how to ask questions about power and interests. It may be politically difficult for actors to answer direct questions about themselves and they may misrepresent their positions. So it is more usual to ask direct questions about other actors and triangulate responses to get an overall composite view. It is also important to try and elicit discursive responses which can be carefully interpreted by the analyst. Stimulating respondents to think about power might, for example, be achieved by including prompts within questions about the political and economic resources of other actors, as well as their alliances with other potentially powerful actors.

Finally, given that an SHA entails judgements on sometimes sensitive issues on the basis of partial information, it is always important to think about how to validate the perspectives gathered. In a brainstorm, the use of visual mapping techniques can assist the process of triangulation. In analysing interview data, triangulation across different interviews and with other evidence (e.g. documentary data, media reports) is important and it may also be helpful to present synthesized judgements back to some respondents to allow reflection on their validity.

Analysts: recognizing your positions and resources

Analysts who conduct SHAs must be self-aware, be they government officials or independent researchers. The SHIELD teams comprised both groups of analysts; in addition, some of us were nationals of the country in which we worked, and some were expatriates working for shorter or longer periods within the country. And some had been engaged in health financing debates in our country for many years, whilst others were new to the field and debates. These differences offered both opportunities and challenges for doing an SHA—in terms of who we know and how we are known, or in terms of the stakeholders to whom we have direct access, the availability to us of third parties who have such access or the value of our organization's reputation in terms of getting such access (Gilson and McIntyre 2008). These factors may influence which people analysts can gather together for a brainstorm or to which respondents they can gain access; they may also

Downloaded from http://heapol.oxfordjournals.org/ by guest on April 5, 2016

influence how respondents perceive the questions they are asked and how they frame their answers.

The differences amongst the SHIELD researchers also influenced our broader understanding of the power plays and nuances in the political context and of UC reform more specifically. Some of us knew too little, and had to be cautious about making too simplistic a judgment about actors' positions and resources. Some of us brought past experience and had to take care to make time-relevant judgements, rather than being biased by earlier insights into the actors of focus (Hyder *et al*. 2010).

Knowing your policy context and making interpretive judgements

In making the judgements necessary within an SHA, it is particularly important to understand the broader policy context in which you work (Hyder *et al*. 2010), and to tease out the understandings and insights that inform your judgements in order to allow these assumptions to be tested, and where necessary, revised.

A range of frameworks and guidelines are available to support greater understanding of the national contextual features likely to influence policy debates. The fairly widely used framework of Leichter (1979) identifies four such contextual factors: situational (irregular, impermanent), structural (more permanent), exogenous (external) and cultural. Table 3 highlights some of the contextual factors of importance in South African and Tanzanian UC debates. It shows that these factors may be important in explaining:

- the particular dynamics of any reform process, such as moments of movement resulting from windows of policy opportunity;
- the power balances among stakeholders;
- stakeholder interests in particular reforms.

Lessons of experience 2: Moving beyond the SHA and using it to support policy change

To prompt thought about the value of conducting an SHA prospectively, we outline two possible uses of SHA: first, as an input into policy proposal design; second, as the basis for developing a 'political management' strategy (Moore 1995) to enhance the likelihood of securing policy change. Both are useful to policy drivers, i.e. those pursuing UC reforms.

Assessing stakeholder responses to UC policy design scenarios

SHIELD analysts in both countries have developed alternative insurance reform scenarios for consideration in policy formulation, starting from the current national health system design.

In South Africa, the scenarios were developed based on the ruling party's proposal to introduce a national health insurance (ANC 2008; ANC 2010). Although the detailed design was not available at the time of writing, the broad proposal was to provide universal coverage to a relatively comprehensive benefit package funded largely through taxes, with additional contributions by the formally employed.[1] The related media debate gave voice to those who preferred earlier policy proposals that had focused on mandatorily extending private health insurance to all formal sector workers and their dependants (Department of Health 1997; Department of Social Development 2002) (see Table 4 and McIntyre and Ataguba 2012 for more details of scenarios).

In Tanzania, the scenarios derived from a proposed regulatory framework for health insurance (Lankers *et al*. 2008) that identified two options for achieving health insurance expansion (Table 5): a single insurer, and managed competition (in which existing schemes would continue to co-exist, but would lie within a more structured and regulated system stipulating minimum benefit packages etc.) (Borghi *et al*. 2012).

In considering the viability of different policy design options it is necessary, first, to consider information about actors' general interests in the reform of focus (drawing on a combination of interview material and wider contextual understanding). As Table 6 shows for UC reform in South Africa and Tanzania, these interests can be quite wide-ranging, although those with specific stakes in the health system appear to have narrower and more focussed interests than those with broader political agendas. Actor concerns are, however, also multi-faceted, often involving some combination of personal, organizational and political concerns.

Across countries, comparison of stakeholder interests (Table 6) and the reform scenarios outlined in Tables 4 and 5, as well as, for Tanzania, information gleaned from interviews, then allowed some judgements about how and why stakeholders would react to the policy proposals. The details of the South African and Tanzanian experiences highlight three sets of lessons about these viability assessments.

First, stakeholder responses to policy proposals are complex and quite variable. Some actors may have a dominant concern across all dimensions of various reform scenarios. For example, donors in Tanzania tend to support a single position on a preferred financing strategy based on the financing model of their own country. The UK's Department for International Development, for example, strongly supported free care through tax funding, over health insurance, whereas the German (GTZ) and Swiss (SDC) aid agencies have strongly promoted health insurance expansion through community and national insurance schemes.

However, for other actors, different dimensions of the same policy option may have contradictory impacts. Given their concerns about the role of private sector companies in health care financing and delivery, the ANC-aligned trade unions in South Africa, for example, are likely to support a reform that collects revenue through a public sector authority and pools this revenue in a central NHI fund administered by a government-controlled body (scenario 3). However, they might also oppose purchasing arrangements that they perceive negatively affect the benefits and access of their members to health care (could be a problem for scenario 3 depending on the benefit package and reimbursement design details). Department of Health officials (at national or provincial level), meanwhile, might support the broad equity goals of scenario 3 and the related intention to strengthen the overall health system, but still be fearful of, and even resist, specific

Downloaded from http://heapol.oxfordjournals.org/ by guest on April 5, 2016

Table 3 Contextual factors influencing stakeholders involved in universal coverage (UC) policy debates in South Africa and Tanzania

Factor	Issue	Influence over UC debates	
		South African examples	Tanzanian examples
Structural	Formal balance of power within political system	Particular form of proportional representation used within national elections, and continued ANC dominance in popular image and minds of majority of population, leaves little political space for a popular/civil society voice in some policy debates. Dominance of the ANC in national elections gives opposition parties little power in national policy debates [though main opposition party forms (2010) government in one province so might use this power base to seek influence in debates].	Dominance of CCM relative to opposition, rooted in its history of political leadership, gives it power to push through its desired policy changes, and leaves little political influence for civil society voices.
	Formal/informal balance of power between government ministries	Strong influence of central Treasury in public policy making and has blocked past health insurance reform proposals. (But new government, elected in 2009, has to some extent limited power of Treasury by bringing new economic policy agents into policy debates and by specific importance it has attached to NHI.)	The Ministry of Finance is powerful because it has control over the budget allocation and can limit the amount that goes to the health sector. It also controls the overall basket fund to which all development partners contribute. But has not played very obvious role in health insurance debates.
	Opportunities for national policy actors outside government to have formal and informal influence over health policy debates directly and indirectly	Continuing economic power of mainstream business interests (given fairly orthodox economic policy frameworks) likely to give them at least covert power in UC policy debates.	n.a.
	Health system—nature and role of private health sector	Monopolistic position of private hospital companies (used primarily by white and wealthy population groups) gives companies power in the health system and strong interests in purchasing reforms. Large number of private health insurance companies (medical schemes), together serving only 16% of the population and each of which must negotiate prices with providers, undermines their power in the system and gives them strong interests in pooling reforms.	Highly fragmented and poorly regulated insurance industry limits power of individual, private schemes, limiting their capacity to bargain on prices with private facilities.
	Health system—structure of public insurance		As both the NHIF and CHF/TIKA are directly connected to the Ministry of Health and Social Welfare, it tends implicitly to support the NHIF position in relation to possible policy reforms, limiting the potential influence of other actors in the sector.
Situational	Window of opportunity for policy change	Changing balance of power within the ANC, culminating in removal of the previous President in 2008 and election of new ANC government in 2009, provided new impetus to move forward with health insurance reform, despite past years of stagnation, due to new policy agenda agreed among powerful ANC players.	Low coverage of CHF/TIKA, growing momentum to expanding insurance coverage from Ministry of Health and donors, combined with political power of NHIF top management, resulted in NHIF taking over CHF management and opening up of NHIF to other segments of the population.
	Competing policy priorities	Health insurance reform only one of several national priorities competing for resources. NHI one of 10 health policy priorities: potential for synergies and contradictions between NHI and other health policy priorities may influence actors' positions on it; key actors' preferences among policy priorities may influence weight given to NHI. For example, as NHI is commonly understood as essentially a financing issue and not about improving general public sector performance, the synergies with priorities such as quality or management improvement are not seen.	Health insurance reform only one of several national and health policy priorities competing for resources.

(continued)

Downloaded from http://heapol.oxfordjournals.org/ by guest on April 5, 2016

Table 3 Continued

Factor	Issue	Influence over UC debates	
		South African examples	Tanzanian examples
	Health policy history and experience	Given small policy field, and long history of engagement amongst limited numbers of actors, individuals have strong influence in policy debates.	Although history of engagement is more limited (since early 2000s), the situation is similar to South Africa. Relatively limited technical knowledge within government regarding insurance design, combined with weak engagement with research community, means that policy goals may not get implemented as intended.
Cultural	Feelings of solidarity	Limited	Existing community networks (informal groups helping each other) improves solidarity and could facilitate insurance expansion.
Exogenous	Donor influence	Less relevant	Health sector dependence on donors gives them influence in national health policy debates, e.g. certain donors supported development of CHF in its early years, and continue to support pilot initiatives to improve performance. DFID advocated for removal of user fees in mid 2000s.

Notes:
ANC = African National Congress, political party in government.
CCM = Chama cha Mapunduzi, political party in government.
NHIF = National Health Insurance Fund.
CHF/TIKA = Community Health Fund.
DFID = Department for International Development.

Table 4 Examples of differences in health care financing reform scenarios: South Africa

	Revenue collection	Pooling	Purchasing
Scenario 1: Status quo	Medical schemes (i.e. private insurance) exist, collecting funds from members. General tax allocations to health sector, for public health services (<12% of government budget in 2010).	16% population covered by medical schemes (increase to 21% in next 15 years as formal employment increases). Rest of population covered by tax-funded services.	Medical schemes purchase mainly from private for-profit providers on a fee-for-service basis, specified package of services (mainly hospital and chronic care). Tax funds used to allocate budgets to public hospitals and clinics, to provide relatively comprehensive services, with some rationing.
Scenario 2: Mandatory extension of medical scheme cover to all formal sector workers & their dependants (SHI)	All formal sector workers and their dependants would have to join private medical schemes. General tax allocations to health sector (would require a smaller share of government budget than at present).	Nearly 40% of the population covered by medical schemes within 15 years. Rest of population covered by tax-funded services.	Same as for status quo. Major difference is that given the smaller size of the population dependent on tax-funded services compared with status quo option, a wider range of services could be provided from public funds, with e.g. less rationing.
Scenario 3: Universal coverage	Increased allocations to health sector from general tax revenue, plus additional dedicated health taxes/mandatory contributions. Medical schemes only provide additional cover for those who choose this (generally higher income groups).	Everyone in country entitled to benefit from services paid for from the single pool of public funds. Medical scheme membership likely to decline to about 10% of population.	Relatively comprehensive package of services (from community level prevention activities to specialist inpatient care, with PHC gatekeeping), and some rationing, purchased from accredited public and private providers; paid using range of mechanisms but avoiding fee-for-service.

Notes:
SHI = Social Health Insurance.
PHC = primary health care.

proposals that may threaten their positional power in the health system (around NHI governance, for example) or proposals that they perceive might threaten their families' health care benefits (the benefit package, for example). And, in relation to scenario 2, lower income employed groups might want to be insured through private insurance, believing the private sector to be more efficient than government, and yet be unhappy with a tiered system in which they get fewer benefits

Downloaded from http://heapol.oxfordjournals.org/ by guest on April 5, 2016

Table 5 Examples of differences in insurance reform scenarios: Tanzania

	Revenue collection	Pooling	Purchasing
Scenario 1: Single insurer	Contributions from NHIF and CHF/TIKA members managed by NHIF. Moves towards cross-subsidization between NHIF and CHF/TIKA. Tax funding to subsidize both schemes, and services provided by public providers. Out-of-pocket payments from the uninsured or for services not covered by insurance.	Two scenarios: Entire formal sector covered by the NHIF, and 52% of informal sector covered by the CHF/TIKA. Other schemes cease to exist. Total population coverage between 62–76% depending on assumptions about rate of growth of formal sector over time; Universal coverage.	The NHIF purchases from government, faith-based and private for-profit providers of all levels of care. CHF/TIKA members have access to all public providers.
Scenario 2: Managed competition	NHIF covers public formal sector; a mix of schemes cover the private formal sector; the CHF/TIKA covers the informal sector. No cross-subsidization between schemes. Tax funding to subsidize NHIF and CHF/TIKA. Out-of-pocket payments from the uninsured or for services not covered by insurance.	Status quo	Formal sector schemes purchase from government, faith-based and private for profit providers of all levels of care. CHF/TIKA as above.

Notes:
NHIF = National Health Insurance Fund.
CHF/TIKA = Community Health Fund.

and less access than more wealthy groups. In Tanzania, meanwhile, despite the NHIF management's strong support for a single insurance model (scenario 1), there are simultaneous concerns about the financial sustainability of cross-subsidization across formal and informal sector members, as well as the acceptability of such an approach to NHIF members. In addition, whilst this stakeholder does not support competition within the health insurance sector (scenario 2), it broadly supports the principle of greater price regulation that is implicit within this scenario.

For other actors, meanwhile, the potential impact of reforms might be concentrated around one particular dimension of any scenario. Providers are a good example of this in both countries. Purchasing reforms will affect them most directly by determining how much they will earn and how long they will wait to be reimbursed for services rendered. In addition, in both countries, the national Treasury/Ministry of Finance seems to be generally concerned about the potential impact of revenue collection reforms on overall taxation levels and so, on the economy more generally. In Tanzania, moreover, the managers of smaller insurance schemes are especially concerned about the mechanism for revenue collection and are keen that UC be achieved through managed competition to ensure that their place within the insurance market is secured.

Second, such assessments highlight specific design barriers to the further development or implementation of policy proposals. The most critical design barriers are those likely to generate sufficient opposition to block further policy development, including those that are seen as problematic by a number of stakeholders and those that perhaps only one relatively powerful actor sees as problematic. For example, in the 2010 South African political climate neither scenarios 1 nor 2 were likely to have enough support to be taken forward, given the lack of re-distribution implied within them, but there was also a possibility that scenario 3, involving a decreased role for private insurance, would be opposed by an alliance of commercial and political actors. In Tanzania, meanwhile, many stakeholders were concerned in 2010 about the cross-subsidization between schemes implied by scenario 1, fearing that the existing insurance schemes were not sufficiently well established to ensure that cross-subsidization was financially sustainable. In contrast, as noted, the NHIF management had voiced some opposition to scenario 2, and this had held back the overall discussions about insurance regulation. In either country, to move the policy process forward these design barriers needed to be considered within an overall political management strategy (see below). One strategy option might be to alter design elements in ways that sufficiently reduce the balance of opposition to a particular set of proposals to allow movement in the policy process. However, policy re-design can be risky. An earlier South African analysis showed that insurance re-design to seek the support of a particularly powerful stakeholder (the National Treasury) resulted in proposals that could not achieve the original objectives of the reform drivers, and were strongly opposed by an alliance of powerful actors (Gilson *et al*. 2003).

Third, all viability judgements are just that: judgements. Even when due care has been paid to validation, they may be inaccurate or, in a rapidly changing policy context, already out of date. Reform drivers must, therefore, always find ways of testing viability judgements as they move forward, and adapting them as necessary. They must also balance the risks of using viability judgements in their decision-making against those of not using them. Experience suggests that recognizing and seeking to take account of stakeholder positions and power is, on balance, the better strategy.

Downloaded from http://heapol.oxfordjournals.org/ by guest on April 5, 2016

Table 6 Stakeholder interests

Stakeholder group	Interests	
	South Africa	Tanzania
Party of government	Contribution to broader political agenda of redistribution and improved 'service delivery' for the majority poor as espoused in 2007.	Government focus on MDG achievement along with national strategy for growth and reduction of poverty (NSGRP) targets. Minister of Health and Social Welfare committed to expanding insurance coverage to 45% by 2015.
Opposition parties	Fit of type of financing reform with economic ideology and policy preferences.	Commitment to increasing resources to health and enforcing exemptions from user fees (CUF, Chadema); free primary health care for all (CUF); development of a community health insurance scheme (Chadema).
Trade Unions	ANC-aligned Unions: The broader political agenda of redistribution secured through change in ANC balance of power in 2007. But also the 'bread and butter' interests of their members (affordable, good quality care).	(Not interviewed, but likely to be concerned about the interests of their members in terms of affordable, good quality care.)
Ministry of Finance officials	Fit of health care financing reform with wider economic policy (e.g. concern for employment and growth impacts) and specific policy instruments (e.g. tax instruments).	Fit of insurance reform with wider economic policy. Concerns about accountability of public funding (resistance to health facility accounts).
Ministry of Health officials	National and provincial departments: contribution to strengthening health system, but also concerns about future roles in health system after NHI implementation and personal impacts on health cover for families.	Concerned with increasing the number of primary facilities and increasing access to health care through greater enforcement of exemptions within the user fee system and expansion of insurance cover. Lobby for additional funding for health from the Ministry of Finance.
Public sector managed insurance schemes	n.a.	NHIF: desire to control the health insurance sector, and consolidate power by absorbing other schemes.
Private health sector actors	*Providers*: purchasing arrangements and opportunities, threats to market growth. *Insurers*: pooling and governance arrangements, and opportunities, threats to market growth.	*Providers*: resistance to capitation funding; desire for increase to reimbursement rates; greater collaboration with government through public–private partnership. *Insurers*: concerns with moral hazard, desire for greater regulation, interest in expanding into informal sector.
Health professionals	*Public*: direct impact on work environment and payment mechanisms. *General*: impact on professional and salary opportunities.	*Public*: chronic health worker shortage, affects motivation and quality of care. Salary concerns.
Business sector	Employment costs. Worker health and productivity.	Same as South Africa.
Social sector – Civil society	Improved health care for poorer and vulnerable groups.	Increase civil society participation in health policy decisions. Specific concerns about equity in the allocation of and funding for human resources for health.
International actors	n.a.	Desire to promote equity in access to care, distribution of funding and human resources in the health sector through the development of a health financing strategy.

Notes:
MDG = Millennium Development Goal.
ANC = African National Congress.
Chadema = Chama Cha Democracia na Maendeleo.
CUF = Civil United Front.

Developing a political management strategy

As noted, a range of visual maps can be used to summarize a stakeholder analysis. Forcefield analysis maps (Varvasovszky and Brugha 2000), for example, provide a comprehensive picture of the balance of support and power around a policy issue at a particular time. Figure 1 presents a forcefield analysis map focused on the broad idea of universal coverage reform in South Africa in 2010. Stakeholders identified in italics had the potential both to support and oppose reform—perhaps reacting differently to different reform dimensions (e.g. ANC-aligned Trade Unions), or because different groups within the overall actor grouping had different perceptions of gains and losses (Department of Health officials).

Such maps can help identify the broad viability of a particular policy direction (or proposal), as well as highlight potential supporters and opponents. Figure 1 suggests, for example, that the balance of power in South Africa in 2010 was probably broadly in favour of UC reforms, but that this could not be taken for granted. In part this was because it appeared that a range of stakeholders had not yet taken a clear position and so, in effect,

Downloaded from http://heapol.oxfordjournals.org/ by guest on April 5, 2016

Power	High Support		Medium (or not mobilized)		High Opposition
High	*Unions aligned with ANC*	ANC National Executive Committee, Health and Education sub-committee Ministries of Economic Development & Labour Presidency	Cabinet – including Minister of Finance	Treasury (Ministry of Finance) officials	
	Minister of Health Some national Dept of Health officials Most provincial Ministers of Health GPs	*Some national Dept of Health officials* Some employers (Banking, Financial) Some health insurers	Large commercial employers Middle-income population groups *Public health managers* *Public providers* *Civil society groups*	Hospital groups Specialist consultants Some employers (small enterprises)	Democratic Alliance (main opposition party) Some health insurers Some Unions (not aligned with ANC)
Low			*Provincial Dept of Health officials* Lower/higher-income population groups		

Note: Names in italics are stakeholders who may both support and oppose different aspects of reforms.

Figure 1 Forcefield analysis map, South African UC reform debates 2010

were not mobilized as supporters or opponents. The map suggests that the policy drivers pursuing UC needed to adopt active stakeholder management strategies with the aim of getting enough sufficiently powerful supporters behind the preferred policy direction to secure the next steps towards policy change.

Schmeer (1999) suggests that stakeholder management strategies should target those stakeholders who are willing to initiate or lead an action for or against a new health policy, or convince others to do so. Roberts *et al*. (2008) suggest that stakeholder management can focus on changing:

- the positioning of policy actors (through deals, promises, trades and threats around the policy issue of focus);
- the distribution of power among key players (e.g. by dividing the opposition or providing resources to supporters to empower them);
- the number of actors actively engaged in the policy process (e.g. by creating friends and discouraging foes);
- actors' perceptions of policy problems, issues and solutions (e.g. by changing how people think and talk about them, and which values are perceived to be at stake).

Given the 2010 South African actor map (Figure 1), it might have been possible to sustain moves towards comprehensive health financing reform by:

(1) Building support through:

(a) Encouraging large employers to become active supporters, by persuading them that the UC proposals would reduce their workforce costs;

(b) Continuing to group together supportive actors with varying levels of power through the policy committees responsible for developing proposals, to build their overall power;

(c) Maintaining the shared vision of the ANC's 2007 'service delivery' agenda (which included NHI), to allow co-ordination among the different interested and powerful actors within the ANC and government, ultimately perhaps even drawing the Cabinet into support.

(2) Offsetting opposition through:

(d) Maintaining the fairly long-standing division within the health insurance industry that results from competition for members between schemes, undermining its overall power;

(e) Convincing the National Treasury, a powerful opponent of reform in 2010, that its objections about the total costs of employment, and impact on employment levels, of the UC scenario did not hold, as the total costs of employment would be less than under the status quo scenario.

In addition, in developing such strategies it is essential to start by being clear about the power (e.g. formal positions, knowledge, rhetorical and interpersonal skills, charisma, connections and networks) of the policy drivers who will implement them (or advocates pressing for change) relative to others, and to think about how they can strengthen that power. It is also important to think about when and how to implement

Downloaded from http://heapol.oxfordjournals.org/ by guest on April 5, 2016

the actor management strategies within a broader political management strategy. The limited published experience around political management and health financing (Glassman *et al*. 1999; Thomas and Gilson 2004), as well as relevant theory derived from experience (Moore 1995; Brinkerhoff and Crosby 2002; Roberts *et al*. 2008), suggest that such strategies must consider:

- which stakeholders to prioritize for engagement: perhaps those who have complementary resources to you or who have enough power to block/resist policy momentum, or who make key decisions relevant to UC reforms, or whom you cannot do without when implementing reform;
- an overarching communication strategy to create support and offset opposition through the symbols, words and messages used around UC proposals, and especially by senior political leaders and policy champions (such as the Minister of Health or President);
- where and when key decisions of relevance to UC will be made—and how to influence those decisions;
- the broader decision-making moments likely to influence the overall movement towards UC, which may either act as catalysts for opposition to UC (parliamentary debates, legislation hearings, provider salary negotiations) or offer opportunities to push ahead with policy (political elections or routine budget cycles);
- the unexpected—as every process of policy change, especially around high politics issues such as UC, is dynamic and contested;
- how to sustain the intensity required to guide these types of reforms over the inevitably long periods of time associated with them [dedicated change teams have sometimes been established, and provide experiences from which to draw lessons (Gonzales-Rossetti and Bossert 2000)].

Policy drivers must also think about the ethical implications of political management. Are actors appropriately categorized within an SHA and their views fairly represented (Mayers 2005)? Do the ends of the strategies justify the means used within them? Whose views determine which ends are being pursued? How are policy drivers held accountable, and by whom, for their strategies (Moore 1995)?

Overall conclusions

The South African and Tanzanian analyses and experiences presented in this paper offer insights about stakeholder analysis and its uses for researchers and policy drivers (those developing and implementing UC reforms). They show that, across the countries, there are some commonalities in the general interests in insurance reform held by particular stakeholders. However, they also show that differences in context and in reform proposals generate differences in the particular interests of stakeholders and their likely positioning on reforms, and in their relative balance of power. It is, therefore, difficult to draw cross-national policy comparisons around these specific issues. Instead, cross-national policy learning is possible around the approach to analysis, the factors influencing judgements (such as critical contextual features), and the implications for, and possible approaches to, political management. Such learning does not entail generalization about which UC reform package offers most gain in any setting, but rather about how to manage the reform process within a particular context.

Funding

This research was funded by the International Development Research Centre (IDRC) (Grant number 103457) and the European Commission (Sixth Framework Programme; Specific Targeted Research Project no: 32289). Preparatory work by Judy Daire was funded through a post-doctoral fellowship under the South African Research Chairs Initiative of the Department of Science and Technology and National Research Foundation.

Conflict of interest

None to declare.

Endnote

[1] In August 2011 the South African government released a Green Paper on NHI for public comment, with proposals that broadly resemble scenario 3.

References

Agyepong IA, Adjei S. 2008. Public social policy development and implementation: a case study of the Ghana National Health Insurance scheme. *Health Policy and Planning* **23**: 150–60.

ANC. 2008. ANC 52nd National Conference Resolutions, 16–20 December 2007, Polokwane. Braamfontein: African National Congress.

ANC. 2010. National Health Insurance: ANC National General Council 2010 Discussion Document. Braamfontein: African National Congress.

Borghi J, Mtei G, Ally M. 2012. Modelling the implications of moving towards universal coverage in Tanzania. *Health Policy and Planning* **27**(Suppl. 1): i88–i100.

Brinkerhoff D, Crosby B. 2002. *Managing Policy Reform: Concepts and Tools for Decision-makers in Developing and Transitioning Countries*. Bloomfield: Kumarian Press Inc.

Bryson JM. 2004. What to do when stakeholders matter: stakeholder identification and analysis techniques. *Public Management Review* **6**: 21–53.

Buse K. 2008. Addressing the theoretical, practical and ethical challenges inherent in prospective health policy analysis. *Health Policy and Planning* **23**: 351–60.

Carrin G, Mathauer I, Xu K, Evans DB. 2008. Universal coverage of health services: tailoring its implementation. *Bulletin of the World Health Organization* **86**: 857–63.

Department of Health. 1997. A social health insurance scheme for South Africa. A policy document. Pretoria: Department of Health.

Department of Social Development. 2002. *Transforming the Present – Protecting the Future: Consolidated Report. Report of the Committee of Inquiry into a Comprehensive System of Social Security for South Africa*. Pretoria: Department of Social Development.

Gilson L, Doherty J, Lakes S *et al.* 2003. The SAZA study: implementing health financing reform in South Africa and Zambia. *Health Policy and Planning* **18**: 31–46.

Downloaded from http://heapol.oxfordjournals.org/ by guest on April 5, 2016

Gilson L, McIntyre D. 2008. The interface between research and policy: Experience from South Africa. *Social Science & Medicine* **67**: 748–59.

Gilson L, Raphaely N. 2008. The terrain of health policy analysis in low and middle income countries: a review of published literature 1994–2007. *Health Policy and Planning* **23**: 294–307.

Glassman A, Reich MR, Laserson K, Rojas F. 1999. Political analysis of health reform in the Dominican Republic. *Health Policy and Planning* **14**: 115–26.

Gonzalez-Rossetti A, Bossert TJ. 2000. Enhancing the political feasibility of health reform: a comparable analysis of Chile, Colombia and Mexico. Health Sector Reform Initiative, USAID. Boston, MA: Harvard School of Public Health/Data for Decision-Making Project.

Hogwood BW, Gunn LA. 1984. *Policy Analysis for the Real World*. Oxford: Oxford University Press.

Hyder A, Syed S, Puvanachanda P *et al.* 2010. Stakeholder analysis for health research: case studies from low and middle income countries. *Public Health* **124**: 159–66.

Lalta S. 2009. Health insurance in Jamaica. PhD thesis, University of London.

Lankers C, Mgonela K, Mtei G, Mushi A. 2008. Suggestions towards a framework for the future development of health insurance in Tanzania. Report prepared for the Ministry of Health and Social Welfare, Tanzania.

Lavis JN. 2009. How can we support the use of systematic reviews in policymaking? *PLoS Med* **6** (11):e1000141.

Leichter HM. 1979. *A Comparative Approach to Policy Analysis: Health Care Policy in Four Nations*. Cambridge: Cambridge University Press.

Lewis J. 2006. Being around and knowing the players: networks of influence in health policy. *Social Science & Medicine* **62**: 2125–36.

Lukes S. 2005. *Power: A Radical View*. New York: Palgrave Macmillan.

Mathauer I, Musango L, Carrin G, Mthethwa K. 2007. Report of the technical support mission for the feasibility assessment and financial projection results for a Social Health Insurance Scheme in Lesotho: exploring possible options. Geneva: World Health Organisation.

Mathauer I, Musango L, Carrin G, Mthethwa K. 2008. Report of the technical support mission for the feasibility assessment and financial projection results for a social health insurance scheme in Swaziland: exploring possible options. Geneva: World Health Organization.

Mayers J. 2005. Stakeholder power analysis. Power tools series. London, UK: International Institute for Environment and Development Online at: http://www.policy-powertools.org/Tools/Understanding/SPA.html, accessed 6 February 2011.

McIntyre D, Ataguba J. 2012. Modelling the affordability and distributional implications of future health care financing options in South Africa. *Health Policy and Planning* **27**(Suppl. 1): i101–i112.

Moore M. 1995. *Creating Public Value Strategic Management in Government*. Cambridge: Harvard University Press.

Pierce R. 2008. *Research Methods in Politics: A Practical Guide*. London: Sage.

Rajkotia Y. 2007. The political development of the Ghanaian health insurance system: lessons in health governance. Bethesda, MD: Health Systems 20/20 project, Abt Associates Inc.

Reich MR. 1995. The politics of health reform in developing countries: three cases of pharmaceutical policy. *Health Policy* **32**: 47–77.

Roberts MJ, Hsiao W, Berman P, Reich MR. 2008. *Getting Health Reform Right*. Oxford: Oxford University Press.

Schmeer K. 1999. *Guidelines for Conducting a Stakeholder Analysis*. Bethesda, MD: Partnerships for Health Reform, Abt Associates Inc.

Surjadjaja C, Mayhew SH. 2010. Can policy analysis theories predict and inform policy change? Reflections on the battle for legal abortion in Indonesia. *Health Policy and Planning* **26**: 373–84.

Tangcharoensathien V, Jongudomsuk P (eds). 2004. *From Policy to Implementation: Historical Events During 2001–2004 of Universal Coverage in Thailand*. Bangkok: National Health Security Office.

Thomas S, Gilson L. 2004. Actor dynamics in financing reform: the contested process of health insurance policy development in South Africa, 1994–1999. *Health Policy and Planning* **19**: 279–91.

Varvasovszky Z, Brugha R. 2000. How to do (or not to do)… Stakeholder analysis. *Health Policy and Planning* **15**: 338–45.

Walt G. 1994. *Health Policy: An Introduction to Process and Power*. Johannesburg: Witwatersrand University Press/London: Zed Press.

WHO. 1993. *Evaluation of Recent Changes in the Financing of Health Services*. Geneva: World Health Organization.

Downloaded from http://heapol.oxfordjournals.org/ by guest on April 5, 2016