P05 / Mechanisms of policy change in health and social care reform

Topic : HEALTH POLICY

Chair : Carmen Huckel Schneider (University of Sydney)

Second Chair : Jennifer Smith-Merry (University of Sydney)

Third Chair : Sara Allin (University of Toronto)

GENERAL OBJECTIVES, RESEARCH QUESTIONS AND SCIENTIFIC RELEVANCE

In a post-covid era, many countries are revisiting health and social care systems with a shift in focus from technical to distributive efficiency for equity, access and resilience. Reforms are wide reaching, from governance and financing to new models of workforce participation, role shifting and system integration.

The aim of this panel is to delve into the mechanics of health and social care systems reform, by exploring mechanisms of change across system layers.

Policy sciences have long been interested in theories of policy change in a bid to better understand the context in which reforms are charted and how they lead to desired outcomes. Several strands of scholarship focus on ‘mechanisms of change’ as the key unit underlying causal relationships through attending to the underlying building blocks of policy design and its unique implementation process and outcomes (van der Heijden et al., 2021). In contrast to realist evaluation approaches which aim to assess whether policies achieve their stated objectives within stable policy processes through theorising causation, less attention has been paid to discerning the discrete mechanisms of change which operate across the trajectory of system reform – at various levels of government and transcending locations of authority and modes of control (Tenbensel, 2020, p.117). Against the constant tinkering with policy design by government to optimise the achievement of policy goals, a mechanistic approach is an opportunity to delve into how policy reform operates through a focus on ‘realistic causation’ (Capano & Howlett, 2021, p.142) of what will occur when change is applied to policy tools and instruments wielded by government, and to account for the foreseeable, or unforeseeable, impacts or consequences of reform.

Policy change – including the design, tools and instruments used by government, interactions and relationships that shape the achievement of policy goals – is a core issue at the centre of devising effective solutions in interconnected and complex policy systems. In this panel we aim to explore how policy reform produces behavioural changes during and after implementation, such as first- and second-order changes at the individual, group and sub-system levels (Capano & Howlett 2021), to better understand the dynamics of reform involving complex assemblages of actors, institutions and organisations with disparate motivations and interests.

We aim to bring together and deepen this scholarly work to explore the potential, and the realisation of, a mechanisms of change approach to policy reform in health or social care contexts.

Capano, G., & Howlett, M. (2021). Causal logics and mechanisms in policy design: How and why adopting a mechanistic perspective can improve policy design. Public Policy and Administration, 36(2), 141-162. https://doi.org/10.1177/0952076719827068

Tenbensel, Tim. (2020). How do governments steer health policy? A comparison of Canadian and New Zealand approaches to cost control and primary health care reform. Policy Sectors in Comparative Policy Analysis Studies. (pp.115-131) Routledge.

van der Heijden, J., Kuhlmann, J., Lindquist, E., & Wellstead, A. (2021). Have policy process scholars embraced causal mechanisms? A review of five popular frameworks. Public Policy and Administration, 36(2), 163-186. https://doi.org/10.1177/0952076718814894

CALL FOR PAPERS

In this panel we explore health and social care system reform taking a mechanisms of change approach.

Papers should explore policy reform through a lens which focuses on identifying the mechanisms which

create change. We are interested in papers which focus on the health and/or social care sectors, including (but not limited to) primary care, health system integration, mental health, disability, aged care and health equity. We are particularly interested in papers addressing the following themes:

Examples of health and policy system reform characteristic of post-Covid shifts towards allocative efficiency, equity and system integration.
Comparative approaches to policy reform involving causal mechanisms
Comparison of reform elements as way to identify, describe and explain the nature of reform and construct models to explain observable outcomes and their variance
Exploring how reform leads to behavioural changes within health or social care systems at the individual, group and sub-system levels
What opportunities does a mechanisms of change approach offer compared to other theories of change methodologies
Challenges associated with taking a mechanistic approach in complex causal chains of policy reform
We invite empirical, normative, theoretical, as well policy-in-practice papers that illuminate change mechanisms in health policy or social care contexts or to health or social care issues.

We welcome papers from disciplines that include (but are not limited to) health or social care policy, public policy, public administration and management, interpretive policy analysis, political science, political economy and comparative public policy.

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Session 1

Wednesday, July 2nd 13:45 to 15:45 (A5)

Reforms in India’s Mental Health Policy for Integration into Primary Healthcare

Anindita Dey (Indian Institute of Technology Jodhpur (India))

Alok Ranjan (Indian Institute of Technology-Jodhpur)

Isha Sharma (Indian Institute of Technology, Jodhpur)

Globally, mental disorders are being considered as one of the major causes of the burden of disease, with depressive disorders being the second highest cause in Years Lived with Disability (YLD) in 2021. According to India’s National Mental Health Survey, 2016, 10.6% of people over the age of 18 had mental illness, with the lifetime prevalence being 13.7%. The proportion of mental illnesses in India's overall disease burden nearly doubled between 1990 and 2017, and one in seven Indians had a mental illness in 2017, ranging in severity from mild to severe. Whereas two-thirds of individuals with a recognised mental illness never seek medical attention from a healthcare provider, leading to a high treatment gap of 84.5%. The existence of treatment gaps is the result of a complex interaction between several factors: the availability of mental health services, costs, mental health literacy, stigma, community involvement, and traditional healing practices. All these factors are highly impacted by policies designed. Indian policies have evolved from addressing mental illness at the institutional level to mental health services at the community level through primary health care.

India policies have focused on integration of mental healthcare into primary level since 1996 with District Mental Health Programme (DMHP) under the National Mental Health Programme (NMHP). Recently in 2018 Mental health care has been included as part of Comprehensive Primary health care (CPHC) under Ayushman Bharat Health and Wellness Centres (AB-HWC), renamed as Ayushman Arogya Mandir) at community level.

This study aims to analyse the Indian policies reform in the role of primary health care in mental health care services from the 1980s to the present with respect to different approaches applied and how the role of different cadres in mental health care has been framed over time.

This study employs major policy and document analysis with respect to mental health care and its integration with primary healthcare in chronology with content analysis. Along with this, comparing India’s policies with global frameworks.

It has been found that there is evolution in the framework of involving primary health workers in mental healthcare from identification of cases to providing services like counselling services by community health workers. Recent policy primarily focuses on human resources capacity building, along with introduction of new cadre at the community level i.e. Community Health Officer (CHO) along with a dedicated training manual for each cadre where mental health has been included with neurological and substance disorders. Additionally with technological driven initiatives like Tele Manas. Overall, India’s mental health policies are aligned with WHO’s Mental Health Gap Action Programme (mhGAP). Further refinement in mental health policies is needed to meet the increasing unmet need of mental health, more specifically after Covid-19 severe impact on mental health.

The Occlusion of Rights for Services: Analysing the Shifting Contours of Narratives, Subsystems, and Decision-making for Disability Policy in Australia

Betsi Beem (University of Sydney)

The development and ratification of UNCRPD set the stage for disability policy transformation in Australia. The centrality of the social model of disability, with its attention to social attitudes and environment as disabling to people with impairments, directed governments to think more broadly about mechanisms to diminish marginalisation. This research examines the two Australian policies, National Disability Strategy 2010-2020 and its subsequent updates and the National Disability Insurance Scheme (2013) and its reform in 2024. The former is a comprehensive, whole-of-government (Federal, state, local) policy framework aimed at improving the lives of people with disability (PWD) in Australia with broad reaching, potentially transformative systemic change based on a human rights framework. The latter, a complementary policy that focuses on providing funding for individualized supports to people with disability, aimed at improving their independence, participation, and quality of life.

A social constructivist framework (Schneider & Ingram, 1993), predicts that “dependent” populations (positive construction, low political power) will have low control and undersubscribed benefits, i.e. policy design results in those that are largely symbolic. Numerous studies have identified that PWD are socially constructed in this quadrant (Kreitzer & Smith, 2018) and that benefits are systematically undersubscribed (Stone, 1984)

The NDS received less attention and budgetary resources, affirming predictions generated through the Schneider and Ingram (1993) framework. However, the NDIS, narrowly targeted at service provision, is the largest social welfare program in Australia since Medicare)- ostensibly delivering real benefits (financially and inclusion in decision making) to persons with disabilities, contrary to the model’s prediction. However, its implementation has been uneven and has, in many ways, occluded more systemic rights-based change, furthermore, recent reforms (2024) indicate erosions of gains.

Using network-framing analysis that combines both quantitative network and qualitative framing analyses (Browne et al., 2017), it analyses the dynamic contours of the policy subsystems engaged disability policy in Australia. It attends to who is engaged in the policy process, their relationships, and contributions to narratives in shifting venues as the locus of power and decision-making shifts from state to federal as bureaucracies are formed and dismantled; as provision, payments responsibilities shift between public and private; as benefits and costs are redistributed; and peak bodies are reconfigured. The longitudinal approach that tracks these changes and the interplay of venues , narratives, and subsytems sheds light on the effects of policies on target population engagement (Schneider and Ingram 1993).

Browne, J., de Leeuw, E., Gleeson, D., Adams, K., Atkinson, P., & Hayes, R. (2017). A network approach to policy framing: A case study of the National Aboriginal and Torres Strait Islander Health Plan. Social science & medicine (1982), 172, 10-18. https://doi.org/10.1016/j.socscimed.2016.11.011
Kreitzer, R. J., & Smith, C. W. (2018). Reproducible and Replicable: An Empirical Assessment of the Social Construction of Politically Relevant Target Groups. PS: Political Science & Politics, 51(4), 768-774. https://doi.org/10.1017/S1049096518000987
Schneider, A., & Ingram, H. (1993). Social Construction of Target Populations: Implications for Politics and Policy. The American Political Science Review, 87(2), 334-347. http://www.jstor.org/stable/2939044
Stone, D. A. (1984). The disabled state. Temple University Press.

Rebuilding Adult Social Care: comparing Australian and British social experiments

James Gillespie (University of Sydney)

Social care – its availability, finance, quality and workforce – is in crisis. This paper compares Australian and British policy responses. Since the 1980s both were part of ‘market citizenship’ experiments (Calafati 2022). Funding remained public while collective provision was privatised. Competition and consumer demand would drive investment and quality. Instead, by the 2020s the supply of social care provision continued to lag steadily rising demand and was marked by precarity, low pay and chronic labour and skill shortages. New Labo(u)r governments in 2022 (Australia) and 2024 (UK) commenced reform. Both increased public funding to widen access – but also made labour standards (starting with pay) central to the renewal of care quality.

This paper compares policy drivers, instruments and early outcomes. It does so by testing the Capano and Howlett (2021) model of causal mechanisms in policy design. This model highlights the centrality of ‘activators of change’ and the different mechanisms they chose for achieving change.

Both reform agendas were critical of the market liberal variant of neo-classical economics. In this narrative the labour intensive service sector was seen as an intractable productivity problem, drawing workers away from the allegedly more productive areas of production and private services like finance and ICT. Australia saw a general defence of the value of ‘care’. While still in opposition, the British Labour Party flirted with more fundamental critiques of conventional growth models.

Reform was driven by novel social coalitions. Their emergence is analysed using Perera’s (2025) institutional model of coalition formation. Actors in both cases were not primarily from within government but a complex mix of politicians, academic social policy activists, trade unions and other civil society organizations. These are good examples of what Thelen (2014) calls new social coalitions for a new politics of solidarity.

First and second order mechanisms are identified. Fiscal policy (i.e. increased government expenditure) has been crucial in both cases as an enabler. But the changes involved more than increasing levels of government expenditure. Contrasting models of minimum wage fixation and regulation have been the crucial mechanisms for lifting service quality. Australian reforms were driven by investigative Royal Commissions and the imaginative use of formal wage setting institutions, such as the Fair Work Commission to push government from outside (Buchanan 2024). Britain has followed a more formal parliamentary direction through establishment of the Adult Social Fair Pay Agreement.

Conclusions. The paper assesses how different social alliances and choice of mechanisms have shaped differing outcomes in wages, conditions and workforce quality and quantity. It highlights how creative use of fiscal and industrial relations can begin to change the trajectory of reform in the social care sector.

Buchanan J et al 2024, Journal of Industrial Relations, 66, 654-84.

Calafati L. (2022). Political Quarterly 93(4) October/December 2022 640–648

Capano, G., & Howlett, M. (2021). Public Policy and Administration, 36(2), 141-162.

Perera, IM (2025) The Welfare Workforce: Why mental health care varies across affluent democracies, Cambridge UP.

Thelen, K (2014) Varieties of liberalisation and the new politics of social solidarity, Cambridge UP

Meeting Long-term Care Needs of Older Adults in Ageing Societies: case of Lithuania

Virginija Poskute (ISM University of Management and Economics)

The care of older people traditionally was taken by family members and local communities in most Western countries. Development of public and social policies formalized long-term care (LTC) arrangements in some of the countries, however informal networks still play a significant role in the provision of care for older people in all countries. Rapidly ageing societies and decreasing availability of informal care (changing family models: more single people, higher divorce rates, fewer children per family, etc., migration within and outside of a country) in many countries, call for action in ensuring access to long-term care at older age. The importance of ensuring quality, affordable and accessible care services is acknowledged by the European Commission which issued the European care strategy (EC, 2022) recently.

The article aims at analysis of LTC challenges in satisfying LTC needs of older people in a country primarily relying on informal care – Lithuania. The empirical data covering topics such as accessibility and affordability of services at older age, sustainability of the system and collaboration of formal and informal sectors in providing LTC is collected via semi-structured interviews with key LTC stakeholders in the country. Among the stakeholders are representatives of the Ministries responsible for the LTC organization (Social Security and Labour and Health), municipalities and municipal organizations responsible for the LTC delivery, institutions responsible for supervision of the LTC delivery, private and public LTC providers and representatives of older people and their informal carers as well as representatives of formal care professionals (nurses and social workers). The data is collected within the EU Horizon Let’s care project.

Preliminary research findings show that there are two types of challenges for the LTC system in Lithuania: organizational-level and policy-level related. Organizational challenges indicate insufficient collaboration among LTC stakeholders, inefficient use and lack of available LTC resources (human and financial) and insufficient use of technologies. Policy-level challenges are related to the sustainability of the system in longer term: there is no broader discussion on LTC strategy on policy level so far; division of responsibilities for LTC organization and delivery among the two ministries (Social security and Labour and Health) often result in fragmented or overlapping services from the two systems; very limited inclusion and support for informal carers in the country.

Efficient LTC requires integration of services provided via social and health care sector, informal care, home

care or residential care to satisfy needs of those needing services and those who care for them in a person-centred way. Policy recommendations based on the study findings in Lithuania can be applied to all countries with reliance on informal long-term care for older people.

The article analyzing the access, affordability and availability of LTC for older people and ensuring the system's sustainability is a part of the panel's intended discussions on social protection system response to emerging and current needs and potential inequalities at older age. Affordable and accessible long-term care requires collaborative efforts by many LTC stakeholders integrating social and economic dimensions, which is also the panel's topic.

Trajectories of primary care reform in Canada and Australia: a mechanisms of change approach

Joanna Mason (University of Sydney)

Carmen Huckel Schneider (University of Sydney)

Stefanie Tan (University of Toronto)

Sara Allin (University of Toronto)

Primary care is the essential first line of contact for just, sustainable, accessible, comprehensive and coordinated patient-focused care. However, its complex financial and economic organization – characterized by public, centralized funding and private service provision by independent general practitioners/family medicine specialists – poses a major barrier to health system reform. Primary care professionals have significant power and autonomy as gatekeepers of change while governments are left with weak and indirect policy instruments to influence professional practice. Under these conditions, reform to primary care policy has largely been limited to incremental and small-scale change, with little progress towards more ambitious or transformative reform goals which would improve the functioning or sustainability of the health system or secure improvement to patient care or clinical outcomes.

How reform success can be achieved is a pertinent question which has been of enduring interest to policy scholars and policy practitioners. Frequently studied and explained through the lens of popular policy process or policy change theories such as Punctuated Equilibrium and Multiple Streams, there is a growing trend to understand the successful attainment of policy reform as a design challenge that pays attention to underlying causal mechanisms in selecting an appropriate configuration of policy tools and objectives which will act in predicable and desired ways in relation to reform goals and aspirations (van der Heijden et al., 2021). In other words, there is an increasing impetus to attend to causal mechanisms as a scientific approach to analysing and informing reform which links policy inputs and outputs through constructing plausible explanations of how change is secured.

This paper illustrates the application of a mechanisms of change approach to primary care reform using results from a comparative study of policy reform and governance in Canada and Australia. With a focus on how primary care physicians engage with reform and the policy tools/instruments which are deployed and calibrated during reform events and the policy goals/targets pursued by government, this paper features findings from a scoping review and intensive case studies of reform across a 20-year time period. Narrowing in on the interrelationship of policy reform and governance in primary care, this paper delves into the dynamic behaviour of central primary care actors to chart causal processes and discern mechanisms of change – featuring the primary care workforce and their business models, the professional associations which represent them and the government policymakers who are tasked with optimizing primary care delivery and patient outcomes. A central component of this research is to take a fresh look at how the policy and governance design elements which structure reform are bundled or clustered across discrete events, contexts and primary care systems despite the appearance of seemingly unique and individual reform trajectories.

van der Heijden, J., Kuhlmann, J., Lindquist, E., & Wellstead, A. (2021). Have policy process scholars embraced causal mechanisms? A review of five popular frameworks. *Public Policy and Administration*, 36(2), 163-186. https://doi.org/10.1177/0952076718814894

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Session 2

Thursday, July 3rd 08:00 to 10:00 (A5)

Influences of multi-level governance in Australian integrated care

Alexandra de Souza (University of Sydney)

Carmen Huckel Schneider (University of Sydney)

Background

Australia's health system is a complex mixed model with responsibilities sitting across federal, state, and local governments, and the private sector. The federal government has responsibility for primary care and the universal health system, Medicare, the state and territory governments have responsibility for hospitals with the private sector being the main provider of primary care services. These privately provided primary care services are fee-for-service with rebates available through Medicare. Through the differing responsibilities and points of authority, the Australian health system experiences significant fragmentation.

For decades, partnerships between Australia's federal, state, and private actors have been trialled through integrated care initiatives in an attempt to bridge the divide and reduce fragmentation all with varying degrees of success. NSW Health's Collaborative Commissioning was implemented to change how the health system functions through providing flexible funding and support for the development of regional partnerships between the state funded Local Health Districts, and the federally funded Primary Health Networks. This programme of work allowed these partnerships to design and implement a care pathway for a priority cohort within the region.

Why did we do this?

This research aims understand the nature of partnerships between state, federal, and private health system actors within integrated care initiatives and to draw out important learnings that can support future health system reform.

Approach

Fifty four semi-structured interviews were conducted with health system staff and stakeholders across four of the regional partnerships under Collaborative Commissioning. Participants included those involved in the planning and management of the care pathway, and those with project oversight. Transcripts were thematically analysed to gain insights into partnership strength of ties, implemented governance structures, and contextual influences.

Results

Findings highlight a variety of partnership governance structures including hierarchical and collaborative. Based on the strength of the existing relationships between the actors involved, these governance structures either functioned effectively or became complex and over-governed. The program of work that was intended as the output of each partnership faced repeated contextual challenges. We categorised these challenges according to communication between partners, ongoing impacts from the COVID-19 pandemic, and understanding of roles between the partners, trust, partner strengths, and understanding of project goals.

Implications

Partnerships are necessary within a health system where responsibilities are shared across federal, state, and local levels. Researching the influence of governance in integrated care will allow for insights into the

how and why a partnership functions. Consideration for what tools are available to govern the dynamic of public actors managing initiatives that influence how private actors provide care is essential to facilitate a robust understanding of the influential factors associated with governance. Without this, partnerships may continue to be ineffectual leading to a waste of public resources, reduced accountability and transparency, and repetition of past mistakes.

The political economy of priority-setting: A synthesis of frameworks for the prioritization of universal health coverage in low and middle income countries

Ashley Fox (Rockefeller College, University at Albany)

When and why do governments adopt universalistic health reforms? This perennial question has motivated numerous inquiries into the adequacy of national health spending and its determinants. In this paper, we conduct a scoping literature review of conceptual and analytical frameworks for assessing priority setting in government health policy. We first motivate the study by reviewing different theories explaining the expansion of the welfare state in high-income countries as well as theories about why specific issues advance on the agenda. We identify both the relevant factors and the short-comings of these explanations for LMIC contexts. Next, we report the results of a more targeted search of research on health agenda setting in LMIC contexts. We report our findings about which frameworks/models have been most cited and influential as well as provide a critical assessment of knowledge gaps. We then present a synthesized framework for advancing health on the agenda in LMICs and a ‘how to’ guide on the application of the framework. Our synthesized framework emphasizes the importance agentic and idiosyncratic factors coming together at the right moments (critical junctures) and alignment with existing structural, institutional and actor-oriented factors. We illustrate the framework with examples from case studies of Thailand, Mexico, Indonesia, Ghana and Egypt.

Political Sources of Health Inequities: Mechanisms of Policy Change in Disability Policies

Ahmet Tar?k B?y?kl?o?lu (Bilkent University)

Assistive technology (AT) is crucial for the 1.5 billion people worldwide who live with disabilities. Yet only ten per cent have access to these devices. This disparity is particularly evident in prosthetics provision, where veterans with disabilities in the US can access high-technology prosthetics free of charge, while civilians must bear substantial out-of-pocket costs even for conventional devices. Far and away from the US, similar inequities exist in Türkiye, despite the country’s widely different institutional and socio-political context. What mechanisms enabled veteran interest groups to secure and maintain privileged access to prosthetics in both the US and Türkiye, and how did these mechanisms produce so similar policy outcomes across so widely different institutional settings?

This paper examines how veterans' organizations successfully framed their disabilities as more deserving of social rights than those of civilians through a comparative case study of the US and Türkiye. The historical trajectory of these inequities stems from specific policy transformations: the 1940s in the US and the 2000s in Türkiye, when veteran advocacy reshaped disability policy frameworks. Today, the Veterans Affairs in the US spends USD 914 million annually on prosthetics research and USD 2.5 billion total on research, development, and provision of prosthetics, reflecting the institutional legacy of these changes. Similarly, in Türkiye, the Social Security Institution maintains a tiered system that privileges veterans' access to advanced prosthetics while limiting civilians to more basic options.

The paper relies on the insights of analytical sociology on causal (social) mechanisms. The paper relies on Coleman's boat framework linking macro phenomenon to another macro phenomenon by tracing their micro foundations. The paper demonstrates that, first, a set of “situational mechanisms” in both the US and Turkiye where policy windows opened without much resistance produced similar outcomes. Second, veterans' belief formation served as an “action formation mechanism” that led to their disabilities being viewed as more deserving. Third, similar “transformational mechanisms” in both countries where key influential policy actors refrained from resisting reforms subsequently shaped the design of these inequitable disability policies. The analysis reveals how first-order, second-order, and third-order changes in policies combined to create durable systems of inegalitarian health policies. Despite couched in different welfare regimes and different political systems, both countries developed remarkably similar patterns of privileged access for veterans.

By taking a causal mechanismic approach, this paper illuminates the causal processes that led disability policies to shift toward inegalitarian outcomes in these two different countries at different points in time. The findings contribute to our understanding of how mechanisms of change operate across diverse institutional contexts to produce and maintain systematic inequities in healthcare access, particularly in the distribution

of vital medical technologies.

The role of instrument constituencies in policy change: the case of primary care in France

Anne Moyal (Ecole des Hautes Etudes en Santé Publique / Sciences Po Paris)

Patrick Hassenteufel (Université Paris-Saclay)

The last two decades have seen the recognition of “latent” problems (Cefaï 1996) affecting ‘Bismarckian’ health insurance systems. It is the case for the progressive decline in medical demography, more specifically regarding GPs, leading to territorial inequalities in access to primary care –a phenomenon dramatized by the expression "medical deserts" in France (Hassenteufel et al. 2020). At the same time, we are witnessing the development of a new repertoire of policy instruments that make primary care professionals – first and foremost GPs– the cornerstone of the healthcare system, with the aim of improving the articulation of available healthcare resources: gatekeeping mechanisms, multi-professional healthcare centers, territorial networks integrating hospital and ambulatory care, etc.

In France, a small group of GPs has been supporting an alternative conception of medicine since the 1970s (open to collective practice, integrating the psychosocial dimensions of health and questioning the fee-for-service remuneration of liberal medicine) and defending the specificity of general practice when it has long been devaluated in relation to hospital and specialty medicine (Hassenteufel 2010). These GPs have been promoting and developing new multi-professional and coordinated organizations of ambulatory care, first through healthcare networks and now multi-professional healthcare centers –called MSP for Maisons de Santé Pluriprofessionnelles (Moyal 2024). They are now involved in the territorial integration between hospital and ambulatory care creation of territorial professional health communities –called CPTS for Communautés Professionnelles Territoriales de Santé.

Through an empirical analysis of the emergence and implementation of primary care policies in France, we shed the light on the key role of a new “instrument constituency” (Beland et Howlett 2015; Voß et Simons 2014) between part of the medical profession and the established “programmatic” or “Welfare elite” (composed of political actors and specialized civil servants that share reform ideas and objectives in the field of health and social policy (Genieys et Hassenteufel 2015; Hassenteufel et Genieys 2021) driving major public policy change in the primary care sector. Besides, we make the hypothesis that the Covid-19 crisis contributed to reinforcing this instrument constituency as it questioned the organization of the health care systems criticized for its hospital-centrism and sheds new light on the difficulties of care accessibility and continuity.

References:

Beland, Daniel, et Michael Howlett. 2015. « How Solutions Chase Problems: Instrument Constituencies in the Policy Process ». Governance 29(3): 393?409.

Cefaï, Daniel. 1996. « La construction des problèmes publics. Définitions de situations dans des arènes publiques ». Réseaux. Communication-Technologie-Société 14(75): 43?66.

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Hassenteufel, Patrick, et William Genieys. 2021. « The Programmatic Action Framework: An Empirical Assessment ». European Policy Analysis 7((Suppl.)): 28?47.

Hassenteufel, Patrick, François-Xavier Schweyer, Thomas Gerlinger, et Renate Reiter. 2020. « Les “déserts médicaux” comme leviers de la réorganisation des soins primaires, une comparaison entre la France et l’Allemagne ». Revue française des affaires sociales (1): 33?56.

Moyal, Anne. 2024. « Implementing Primary Care Reform in France: Bargaining and Policy Adaptation. The case of MSPs ». Journal of Health Politics, Policy and Law 49: 1015?50.

Voß, Jan-Peter, et Arno Simons. 2014. « Instrument Constituencies and the Supply Side of Policy Innovation: The Social Life of Emission Trading ». Environmental Politics 23(5): 735?54.

(Virtual) Title: What are the limitations of using the term ‘mechanism’ when building explanations of policy change?

Tim Tenbensel (University of Auckland)

Across recent policy studies literature, a widespread consensus has emerged regarding the central

importance of "mechanisms" in explanations of policy change. This consensus covers policy design researchers (Capano & Howlett), proponents of punctuated equilibrium theory (True, Baumgarter and Jones), multiple streams analysis (Herweg et al) the advocacy coalition framework (Pierce et al), historical institutionalist scholars (Thelen & Mahoney, Kay), realist evaluation (Pawson), critical realists (Danermark), and those advocating theoretical pluralism (Weible, van der Heijden).

The common ground between these approaches is the aim to open the black box of causality and explain how and why changes in X (eg an institutional arrangement, a specific policy instrument) result in changes in Y (a policy outcome).

For most traditions noted above (with the notable exception of the two realist camps), the choice of the word 'mechanism' is pragmatic rather than ontological – it is a term that creates the prospect of a common foundation for theory-building across theoretical and research approaches. Policy academics advocating the investigation of mechanisms of change aim to support theory-building through more general propositions, and enable more authoritative, practical and clear advice for policy practitioners.

However, the word 'mechanism' works primarily as a metaphor, and like any metaphor, it has its uses and its drawbacks.

Building on sociologist Andrew Abbott's 2006 critique, I explore the limitations of the mechanism metaphor for making sense of health policy, drawing on examples of health service targets and pay-for-performance as policy instruments, comparative health policy, and policy implementation research.

I argue that the drawbacks of the mechanism metaphor entail practical implications for both theory-building, and for providing advice to policy actors, which need to be acknowledged more explicitly, and I suggest some alternatives that avoid these limitations.

Abbott, A. (2007). Mechanisms and relations. Sociologica, 1(2), 1-22.

IMPLEMENTATION DYNAMICS AND THE IMPACT OF THE HEALTH SUB-DISTRICT STRATEGY ON MATERNAL AND NEONATAL HEALTH OUTCOMES IN UGANDA (2000-2024): A REALIST EVALUATION

Aloysius Ssennyonjo (Makerere University)

Background

Towards the end of the 20th century, fundamental changes in the public sector globally, labelled as New Public Management (NPM), led to significant reforms. In Uganda, the Health Sub-District (HSD) strategy was introduced in 2000 as part of the Health Sector Strategic Plan (HSSP I) to decentralize the health sector and improve health service delivery, particularly for maternal and neonatal health.

This study highlights key findings in the evaluation of the HSD strategy, pointing out facilitators and barriers in the implementation process over the years, as well as recommendations and critical reflection on the emerging lessons, causal pathways and prospects of implementing the HSD strategy in Uganda. This evaluation assessed the impact of the HSD reform on health systems performance, with a focus on maternal and neonatal mortality, while examining the mechanisms through which these impacts were derived. It also sheds light on the various system dynamics and contextual factors that have had a bearing on the overall implementation and the over-the-years progress in the impact of the HSD strategy on improving maternal and neonatal health outcomes in Uganda, from its inception to the year 2024. Also, it subsumes major developments in the recent past in the health sector that have further contributed to improvements in MNCAH health outcomes.

Methodology

The evaluation employed a mixed-methods approach, including literature reviews, key informant interviews (KIIs), and stakeholder validation workshops. Primary data collection spanned from March to October 2022. Secondary data collection continued till June 2024. Complex adaptive systems and realist evaluation methodologies informed the approach. Drawing on both qualitative and quantitative methods, the study developed context-mechanism-outcome configurations and initial program theory which were refined after analysing the HSD implementation dynamics and performance over time.

Key findings

The HSD strategy has evolved significantly since its inception, adapting to changing contextual conditions and health system dynamics. Key features included decentralized management, capacity development, supervision, quality assurance, human resource management, and logistic support. Fitting its design to the prevailing context and purpose of strengthening local health systems offered the promise of a successful

intervention. Leveraging supportive global, national and local factors such as funding availability, strong public-private partnerships, and policy champions at the Ministry of Health (MoH) increased the opportunities for success. However, its effectiveness has been constrained by various system dynamics and contextual implementation challenges. Despite health system improvements, constraints such as inconsistent leadership, political dynamics, and varying levels of local government engagement affected the uniformity and sustainability of the HSD strategy's impact. Effective data management systems and tools like health management systems capture particular aspects of the HSD performance, undermining the evaluation of impacts. Addressing these challenges through targeted interventions and policy adjustments can optimize the HSD's contribution to overall health system performance. Unconventional approaches to impact evaluation, such as realist impact evaluation and process tracing, are necessary for conducting a focused exploration of policy interventions for health since they operate in a complex and dynamic sphere. The HSD strategy has had direct and indirect causal pathways to maternal and neonatal health improvements in Uganda. Overall, there were notable improvements in maternal and neonatal health outcomes in the country over the years. The maternal mortality ratio reduced from 336 to 189 deaths per 100,000 live births, and the neonatal mortality rate decreased from 27 to 22 deaths per 1,000 live births between 2016 and 2022.

Key recommendations

1) There is a need to reconsider whether the HSD is still fit for context and purpose in the prevailing conditions in Uganda.

a) Reconsider the viability of the constituency at the HSD level, considering the political dynamics such as patronage and competition over resources underpinning their creation and splitting.

b) The MOH should review the criteria for designation as HSD and withdraw the HSD status where it is no longer viable, such as instances of single HSD districts. Upgrading facilities and designation of HSD facilities should be based on service volumes and population dynamics instead of geographical location. At the minimum, the HSD structure should be reserved for districts with big populations, as was the case in the initial design.

c) Align the HSD to politico-administrative structures with corresponding political leadership and ongoing national development agenda such as program-based planning and parish Development model (PDM).

2) Articulate the theory of change and performance management framework and adopt a viable M&E system to track the progress of the HSD strategy or similar reforms. The M&E system should capture quantitative data to facilitate a quantitative impact assessment of the HSD strategy.

3) Mainstream outcome and impact monitoring at the HSD level beyond outputs and inputs. Further development and integration of data management systems to adopt HSD-relevant indicators are required to track the HSD strategy implementation and effects effectively. The Sector should leverage the district league table concept, and annual health sector performance review reports to assess the performance of the HSDs that could remain in practice.

4) Complexity-aware evaluation approaches such as realist evaluation should be adopted to examine the impacts of complex health system interventions. Systems thinking would enrich the conceptualisation of the causal processes and better account for the dynamic change processes and uncertain outcomes.