World Health Organization
REGIONAL OFFICE FOR Europe

European Observatory on Health Systems and Policies
a partnership hosted by WHO

Policy brief

What are the conditions for successful health policy implementation?

Lessons learnt from WHO's regional health policy Health 2020

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6 August 2019

What is a Policy Brief?

A policy brief is a short publication specifically designed to provide policy-makers with evidence on a policy question or priority. Policy briefs:

• Bring together existing evidence and present it in an accessible format
• Use systematic methods and make these transparent so that users can have confidence in the material
• Tailor the way evidence is identified and synthesised to reflect the nature of the policy question and the evidence available
• Are underpinned by a formal and rigorous open peer review process to ensure the independence of the evidence presented.

Each brief has a one-page key messages section; an executive summary giving a succinct overview of the findings; and a review setting out the evidence. The idea is to provide instant access to key information and additional detail for those involved in drafting, informing or advising on the policy issue.

Policy briefs provide evidence for policy-makers, not policy advice. They do not seek to explain or advocate a policy position but to set out clearly what is known about it. They may outline the evidence on different prospective policy options and on implementation issues, but they do not promote a particular option or act as a manual for implementation.

Acknowledgements

This report was drawn up by the European Observatory on Health Systems and Policies, at the request of the WHO Regional Office for Europe. Matthias Wismar and Bernd Rechel conceptualized the study and provided overall guidance. Gemma Williams conducted the scoping review of scientific and grey literature. Cristina Hernández-Quevedo, Bernd Rechel, Erica Richardson and Anna Sagan drew up the textboxes on country examples, based on the information provided by country experts. Bernd Rechel and Matthias Wismar compiled the overall report.

We are especially grateful to the national experts for sharing their knowledge and expertise through interviews or completing a structured data collection template. These include Johanna Ahnquist, Natasha Azzopardi-Muscat, Anna Bessö, Zinaida Bezverhni, David Hunter, Meder Ismailov, Nils Janlöv, Pavlo Kovtonyuk, Andrei Matei, Vesna-Kerstin Petric, Marge Reinap, Nataliya Riabtseva, Roberta Siliquini and Marcela Tirdea.

We would also like to express our gratitude to the Standing Committee of the WHO Regional Committee for their helpful and constructive comments on earlier drafts of this report.

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Key messages

This policy brief explores the conditions that need to be in place for successful health policy implementation in the context of Health 2020. It is based on a scoping review of the literature, as well as semi-structured in-depth interviews with experts in selected WHO member states.

The policy brief identifies six key conditions for successful health policy implementation in the context of Health 2020:

1. Ensure contexts are appropriate and receptive
2. Get the timing right
3. Transfer appropriate policies and innovations
4. Ensure good governance
5. Work with other sectors
6. Move from exploration to full implementation

Identifying how these conditions can be used to maximum effect in specific national contexts and policies will help health policy-makers to increase the chances of success for the policies they develop and aim to implement. Crucially, putting policies in place is only the first step towards full implementation. Successful health reforms generally take several years to prepare and adopt, and they often take far longer to implement. A certain degree of pragmatism will also be needed, using evidence as best as possible and allowing for feedback and refinements throughout the reform process. This includes sticking to principles of good governance. They fulfil a double purpose, ensuring the required leadership for the reform process and allowing for effective implementation to take place.

Executive summary

The European health policy Health 2020 has inspired policy action in many member states. What is less clear, however, is the status of implementation and what conditions need to be met for successful health policy implementation. This is the gap this policy brief aims to fill.

It explores the conditions that need to be in place for successful health policy implementation in the context of Health 2020, drawing on a scoping review of the literature, as well as semi-structured in-depth interviews with experts in selected WHO member states.

The scoping review has shown that:

- Existing literature on the status of Health 2020 implementation is largely derived from WHO or WHO-affiliated reports, so a certain bias in reporting cannot be excluded
- There has been a marked increase in the number of countries aligning national polices and strategies with Health 2020 values and principles, alongside developing accompanying implementation plans and accountability mechanisms to monitor implementation progress.
- Encouraging progress has been made in terms of the number of countries embedding actions to tackle the social determinants of health within national policies.
- The adoption of whole-of government approaches to policy making is also becoming more common, although planned intersectoral or multisectoral actions are often not translated into action or are only partially implemented.
- Implementation and enforcement of effective inter- or multisectoral policies can be enhanced through the engagement and action of individuals, civil society, researchers, government and industry stakeholders.
- All actions should be underpinned high quality data and evidence and supported by good governance, a clear mandate to reach out beyond the health sector and sufficient resources and capacity.

The country case studies allow for the following conclusions:

- In the exploration stage of policies, Health 2020 only played an explicit and acknowledged role in two of the nine countries covered, Malta and Slovenia.
- Several of the case studies point to the importance of national ownership and broad consultation and engagement with other ministries, all levels of government, the public, NGOs and other stakeholders.
- In the installation phase, a key facilitator of implementation was the inclusion of government funding in regular budgets and the availability of technical and policy capacity. Limited funding was identified as a barrier.
- In the initial implementation phase, robust monitoring and evaluation to inform further implementation emerges as another ingredient of successful implementation.
- Only few countries have reached the stage of full implementation, so it is still early for drawing lessons.
- Successful reforms and their implementation require not only technical expertise, but, more importantly, political will, ownership and buy-in. This requires broad engagement, with policy-makers, health professionals and the public, through communication before, during and after implementation to highlight the benefits the new policies bring.
- National coordination of involved stakeholders can play a crucial role in supporting implementation at the local level.
- Dedicated funding streams, including where appropriate additional funding, and a clear roadmap for implementation with dedicated focal points, administrative support and systems for monitoring and evaluation are other ingredients of successful implementation.
- Another lesson is that reform agendas can be either too ambitious, when they are all-encompassing in the absence of sufficient resources, but also fail to be ambitious, when solutions to problems only emerge once reforms started.

Overall, six key conditions for successful health policy implementation can be identified:

- Ensure contexts are appropriate and receptive
- Get the timing right

- Transfer appropriate policies and innovations
- Ensure good governance
- Work with other sectors
- Move from exploration to full implementation

These conditions provide guidance to health policy-makers on how to increase the chances of successful policy implementation, but will need to be carefully adapted to fit with national contexts and policies. Not all conditions are equally relevant to all contexts and it will not always be possible to meet all requirements of effective or “perfect” implementation. Two of the challenges are the complexity of policies themselves, dealing with “wicked problems”, and the number of stakeholders involved. Crucially, it is important to recognize that putting policies in place is only the first step towards full implementation. Successful health reforms generally take several years to prepare and adopt, and they often take far longer to implement. A certain degree of pragmatism will also be needed, using evidence as best as possible and allowing for feedback and refinements throughout the reform process. This includes sticking to principles of good governance. They fulfil a double purpose, ensuring the required leadership for the reform process and allowing for effective implementation to take place.

Introduction

Health 2020 has inspired policy action in member states and many are referring to it in national policy documents. Others have adopted policies that do not refer to Health 2020 but pursue some of the same objectives. What is less clear, however, is the status of implementation and what conditions need to be met for successful health policy implementation. This is the gap this policy brief aims to fill. It identifies six key conditions for successful health policy implementation.

- Ensure contexts are appropriate and receptive
- Get the timing right
- Transfer appropriate policies and innovations
- Ensure good governance
- Work with other sectors
- Move from exploration to full implementation

Aims and objectives

The overall aim of this study was to identify conditions for successful health policy implementation, drawing on the experience with implementing the European health policy Health 2020 at the national and sub-national level. It aimed to provide an illustrative overview of how policy-makers can increase the chances of successful health policy implementation, providing examples of lessons learnt so far and challenges encountered, including key contextual and governance factors.

Background

Health 2020 was adopted by WHO member states in 2012. It has two strategic objectives and is based on four priority areas for policy action (Figure 1).

Figure 1 Strategic objectives and priority areas in Health 2020

At the 63rd session of the Regional Committee in 2013, WHO Europe Member States approved a set of core indicators to monitor progress towards achieving six key targets of Health 2020. The targets monitor progress in Europe towards: reducing premature mortality rates; increasing life expectancy; reducing health inequities; enhancing the well-being of the population; universal coverage and the right to health; and national targets or goals set by Member States (WHO Regional Office for Europe 2017). The monitoring framework largely consists of quantitative indicators that measure progress towards meeting targets, although a number of qualitative indicators are included to capture the development of policies aligned with Health 2020 values and principles and implementation status (WHO Regional Office for Europe 2017). Qualitative indicators measured include:

- indicator (11) 3.1.e: national and/or subnational policy addressing the reduction of health inequities established and documented
- indicator (18) 6.1.a: establishment of a process for target-setting documented;
- indicator (19) 6.1.b: evidence documenting establishment of:
    - (a) national health policies aligned with Health 2020
    - (b) an implementation plan and
    - (c) an accountability mechanism

Data for qualitative indicators are routinely collected through questionnaires administered to Member States, first at baseline in 2010 and subsequently in 2013 and 2016 (WHO Regional Office for Europe 2017). Other data for indicators are taken from official WHO sources or other non-WHO agencies including UNESCO and UNDP. All data are routinely published on the European Health Information Gateway (Division of Information 2018) and are periodically reviewed in a number of WHO reports.

Alignment of national policies and strategies

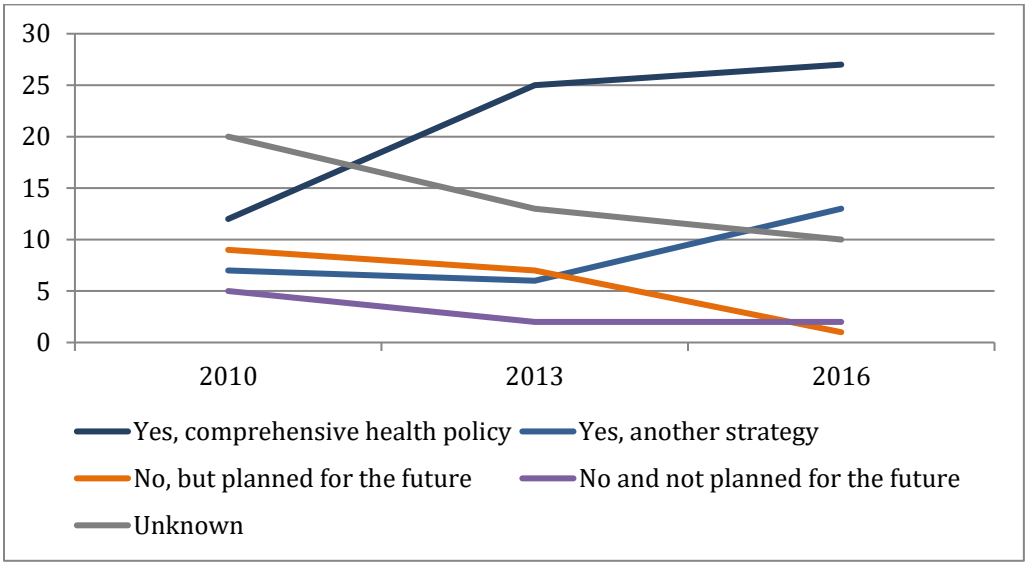
A WHO monitoring report published in 2017 provided an update on Member States' progress towards implementing Health 2020 values and principles (WHO Regional Office for Europe 2017). The report focused on analysing qualitative policy indicators within the Health 2020 core indicators that measure the implementation status of Health 2020 itself and the development of accountability mechanisms for WHO and national stakeholders.

Findings from the 2017 monitoring report show that, overall, implementation of Health 2020 values and principles at the national level have improved since baseline measures were taken in 2010. For instance, the number of countries with policies addressing health inequalities and their social determinants rose from 88% of reporting countries in 2010 to 98% in 2016, with 43 of the 53 member states responding to the questionnaire in 2016 (WHO Regional Office for Europe 2017). According to the monitoring report, efforts to reduce health inequalities in 2016 most frequently focused on providing a healthy start in life and improving the health of disadvantaged groups, with over 90% of the 43 reporting countries addressing these issues in health policies and strategies. Overall, the diversity of measures to address health inequalities incorporated in national policies and plans has increased since 2010, with 80% of countries now considering a range of measures advocated by Health 2020 including developing a healthy workplace, human rights, social resilience and empowerment, improving the physical environment, reducing poverty and economic

disadvantage and providing universal health coverage (WHO Regional Office for Europe 2017).

There has also been a marked increase in the number of reporting countries that have aligned national policies with Health 2020 in terms of developing a comprehensive national health policy or strategy that incorporates efforts to improve universal health coverage, reduce the major causes of the burden of disease, tackle the social determinants of health and well-being and to strengthen health systems. Data show that the proportion of reporting countries with national policies aligned to Health 2020 rose from 58% in 2010 to 93% in 2016 (see Figure 2) (WHO Regional Office for Europe 2017). The most common approaches for aligning plans in 2016 were identified as improving universal health coverage and patient-centred care (88% of the 43 reporting countries), improving health governance and adopting a whole-of-government approach (86%), tackling health inequalities and the social determinants of health (86%) and addressing major health challenges and threats (86%) (WHO Regional Office for Europe 2017). Fewer countries had considered adopting a whole-of-society approach and increasing social capital and empowerment, with these measures only considered in 60% of reporting countries (WHO Regional Office for Europe 2017).

Figure 2: Evidence documenting establishment of national policies aligned with Health 2020



Notes: 2010: data for 31 countries; 2016: data for 43 countries

Source: Health 2020 indicators, European Health Information Gateway (WHO Regional Office for Europe 2018b)

Importantly, the 2017 WHO monitoring report concludes that progress in terms of alignment of national policies has been accompanied by a substantial increase in the number of countries developing accompanying implementation plans and accountability mechanisms to monitor implementation progress. For instance, in 2016, 67% of reporting countries had adopted an implementation plan for national policies and strategies aligned to Health 2020 compared to 28% in 2010 (WHO Regional Office for Europe 2017). Furthermore, 70% of reporting countries in 2016 had established accountability mechanisms to monitor implementation progress through, for example, setting targets, presenting progress reports to parliament or conducting independent evaluations, a marked increase from 21% of reporting countries in 2010 (WHO Regional Office for Europe 2017).

Tackling the social determinants of health

In a review of commitments and strategies on actions on the social determinants of health, Donkin et al. (2018) identify that a number of countries have scaled-up activities to address health inequalities following the publication of Health 2020 (Donkin, Goldblatt et al. 2018). These include the development of a new health plan in Lithuania and a new health strategy in France that committed all government departments to be responsible for the impact of their actions on public health and health inequalities. In addition, Norway, Hungary and Poland have published analytical reports on health inequalities, while Sweden has established a commission on health inequalities to inform the development of future strategies (Donkin, Goldblatt et al. 2018). The authors also note that eight countries in the WHO European region have requested WHO support to integrate equity into their policy process, with six Member States working with WHO to develop strategies to address the social determinants of health (Donkin, Goldblatt et al. 2018).

Yet, while most countries have undertaken efforts to tackle the social determinants of health, the review highlights that health departments cannot reform many key elements, such as economic policies, that are necessary to reduce health inequalities. As such, the review recommends that more is done to incentivise other sectors to take health and well-being outcomes into account when developing policies, while all Member States that have not yet adopted a Health-in-All policy approach should do so to encourage a cross-government approach to improve health (Donkin, Goldblatt et al. 2018).

Public participation in health policy-making

Health 2020 emphasizes that active public participation should be integrated into policy-making to ensure that individuals and communities shape decisions that affect their health and well-being. In a think-piece on engagement and participation for health equity developed for WHO, Boyce and Brown (2017) provide illustrative examples from some Member States that have embedded

participation and engagement into intersectoral policies designed to improve health and health equity through the active engagement of community stakeholders (Boyce and Brown 2017). Examples highlighted include the Kyrgyz Community Action for Health Programme, the Lithuanian National Health Plan, the Scottish health strategy “Equally well”, the Slovene Programme MURA and various Swedish municipal social sustainability plans (Boyce and Brown 2017). The think-piece also explores the creation of supportive environments and resilient communities, a Health 2020 priority area. It is shown that resilient communities have been considered in mainstream policies in some Member States, most notably in Sweden (Boyce and Brown 2017). Nevertheless, resilient communities remain relatively neglected as a policy consideration across Europe and active participation is often not incorporated into countries’ policy-making processes.

Conceptual clarifications

Implementation can be defined as “the carrying out of a basic policy decision, usually incorporated in a statute but which can also take the form of important executive orders or court decisions” (Mazmanian and Sabatier 1983). It has long been recognized that it is not enough to adopt health policies, but that they also need to be implemented. This process of implementation is far from automatic. Many health policies have only been partially or not at all implemented. The resulting gap between policies and implementation has drawn attention to factors that favour implementation. A range of elements have been identified, although the importance of country- and case-specific contextual factors has also been highlighted.

Conditions for successful implementation identified in previous work

Sabatier and Mazmanian (1979) identified a number of legal and political variables and synthesised them into six necessary and sufficient conditions for effective implementation (Sabatier and Mazmanian 1979):

- clear and logically consistent objectives;
- adequate causal theory of actions and outcomes;
- an implementation process structured to enhance compliance;
- committed and skillful implementing officials;
- supportive interest groups and legislature;
- no undermining changes in overall socio-economic conditions or conflicting public policies.

Similarly, Hogwood and Gunn (1984) drew up ten (theoretical) preconditions for "perfect implementation" (Hogwood and Gunn 1984):

1. The circumstances external to the agency do not impose crippling constraints
2. Adequate time and sufficient resources are available
3. The required combination of resources is available
4. Policy is based on a valid theory of cause and effect
5. The relationship between cause and effect is direct
6. Dependency relationships are minimal
7. There is an understanding of, and agreement on, objectives
8. Tasks are fully specified in correct sequence
9. Communication and coordination must be perfect
10. Those in authority can demand and obtain perfect compliance

However, critics of the "top-down" approach to implementation exemplified by the conditions identified by Sabatier and Mazmanian (1979) and Hogwood and Gunn (1984) have pointed out that it is very unlikely that all 10 conditions would be met in practice. Consequently, this approach has been criticized as being neither a good description of policy implementation nor particularly helpful to real-world policy-makers (Buse, Mays et al. 2005). Furthermore, the variety of conditions identified for successful implementation has been rather descriptive and highly contextual. Overall, the literature has proposed about 300 potential variables that

can affect the success of policy implementation, but without being able to specify a model for implementation that could be generally followed (Cerna 2013).

In contrast to the “top-down” approach, the “bottom-up” perspective on implementation emphasizes that implementers play a crucial role in implementation. More often than not, they are active participants in a complex interactive process, often changing the policy that is being implemented (Walt 1994). A seminal study on national anti-poverty programmes in the United States in the 1960s focussed attention on the fact that national policies are not necessarily implemented at the local level (Pressman and Wildavsky 1973). The authors concluded that implementation should not be conceived as a process that takes place after, and independent of, the design of policy. One of the most influential studies in the development of “bottom-up” approaches was done by Lipsky (1980) on “street-level bureaucrats”, i.e. front-line staff including social workers, teachers, local government officials, doctors and nurses. He showed that these workers had discretion in how they dealt with clients, reshaping policies for their own ends (Lipsky 1980). This work helped to re-conceptualize implementation as a more interactive, political process.

Some useful lessons have also emerged from specific research and policy examples of implementation. A 2010 OECD report identified the following traits of successful health reforms (OECD 2010):

- sound public finances;
- an electoral mandate for reform;
- effective communication;
- policy design underpinned by solid research and analysis;
- appropriate institutions to make the transition from decision to implementation;
- allowing time for successful structural reforms;
- leadership;
- undertaking several attempts;
- engaging opponents of reform rather than trying to override their opposition;
- compensating those who lose from the reform.

Similarly, Thomson et al. identified the following requirements for effective policy implementation (Thomson, Figueras et al. 2014):

- ensure reforms are underpinned by capacity, investment and realistic timeframes;
- ensure reforms are in line with national policy goals, values and priorities;
- ensure transparency in communicating the rationale for reform and anticipate resistance to changes that challenge vested interests;
- improve information systems to enable timely monitoring, evaluation and the sharing of best practice;
- foster strong governance and leadership at national and international levels;
- address gaps in coverage;
- strengthen health financing policy design;
- invest in measures to promote efficiency.

Methods

This background paper is based on a scoping review of the literature, as well as semi-structured in-depth interviews with experts in selected WHO member states. The scoping review aimed to identify work undertaken so far on implementation of Health 2020. It is based on a search of PubMed and Scopus using the search terms “Health 2020” and “implementation”, limiting results to 2010 onwards and English language articles. We also searched the website of the WHO Regional Office for Europe and Google Scholar to identify grey literature.

The interviews aimed to cover a selection of countries across the WHO European region, covering Western, Northern, Southern and Eastern Europe, the Baltics, the former Soviet countries, and a selection of both small and big countries. Interviews followed a structured data collection form (see Annex) that elicited information on the different stages of policy implementation, key contextual factors facilitating or hindering implementation, and key lessons learnt so far. In some cases, national experts preferred to complete the template rather than being interviewed. The information gathered through the template through either interviews or self-completion was used to construct narrative boxes on

selected policies that were included in this report. We validated the content of the boxes with the national experts before including them in the report. Ten policies from 9 countries were included in the report (Table 1).

Table 1 Overview of policies explored in the case studies

Country	Policy and timeframe
Malta	2014-2020 National Health System Strategy
United Kingdom	n.a.
Estonia	National Health Plan 2008
Republic of Moldova	National Health Policy for 2007-2021 and Health Care System Development Strategy 2008-2017
Sweden	2015 Patient Act
Sweden	National Action Programme on Suicide Prevention
Ukraine	Health financing reform
Italy	2017 Vaccination Law
Kyrgyzstan	National health reform programmes “Den Sooluk” (2012-2018) and “Healthy People, a Prosperous Country 2019-2030”
Slovenia	National Health Plan 2016-2025

Findings

In the context of Health 2020, we identified six key conditions for successful health policy implementation:

- Ensure contexts are appropriate and receptive
- Get the timing right

- Transfer appropriate policies and innovations
- Ensure good governance
- Work with other sectors
- Move from exploration to full implementation

These are explored in more depth in the following sections.

Ensure contexts are appropriate and receptive

Early theories of “effective” or “perfect” implementation already emphasized the importance of contextual factors for policy implementation, including the general economic, social and political conditions of a country (Cerna 2013)(Cerna 2013). This means that policy implementation looks different across countries, involving other actors, agencies and contexts. In general, implementation is characterized by complexity and tends to involve multiple actors and levels of policy that are not easily comparable across countries. In view of the overriding importance of contextual factors, it is difficult to come up with any single or simple model for meeting the challenges of implementation. Simply speaking, there is no ‘one-size–fits-all’ approach to policy implementation (Cerna 2013).

A study on the implementation of health financing reform in transition countries, for example, identified a number of contextual factors that have facilitated or limited reform options and the path of policy implementation: the specifics of the inherited health system; the fiscal shock associated with the early transition period; changes in relative prices due to integration in the world economy; the degree of severity in economic collapse in the early transition period; and, finally, changes in the political context (Kutzin, Cashin et al. 2010).

The receptive contexts for change framework

One of the frameworks for guiding successful large-scale change or transformation is the receptive contexts for change framework developed by Pettigrew et al. The framework comprised eight factors relevant to achieving successful strategic change (Pettigrew, Ferlie et al. 1992).:

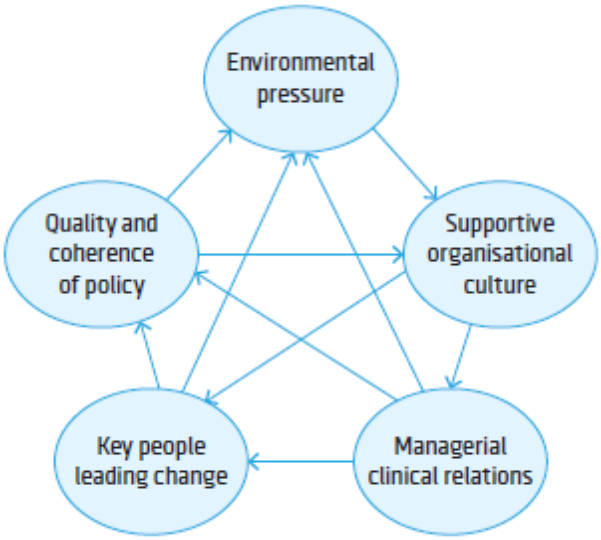
- key people leading change;
- supportive organizational culture;
- the quality and coherence of policy;
- environmental pressure;
- managerial and clinical relations;
- cooperative inter-organizational networks;
- a fit between the change agenda and its locale;
- the simplicity and clarity of organizational goals and priorities

An analysis of a health reform programme in the North-East of England, the North-East transformation system (NETS), found that programme implementation was shaped by all eight factors of the receptive contexts for change framework, but that four factors were especially important: environmental pressure, quality and coherence of policy, key people leading change, and supportive organisational culture. It concluded that achieving whole systems change is particularly vulnerable to the overall political context (Hunter, Erskine et al. 2015).

The 2016 WHO report on “Health system transformation: making it happen”, based on an expert meeting on implementation of health system transformation in Madrid in December 2015, provided a further adaptation of the receptive contexts for change framework, adding the fifth dimension of managerial and clinical relations and thus using five of the eight factors originally outlined by Pettigrew (

Figure 3).

Figure 3 The receptive contexts for change framework



Source: (WHO 2016), as adapted from (Pettigrew, Ferlie et al. 1992)

The five interrelated features of receptive contexts for change can be helpful to identify supportive contextual conditions for successful health policy implementation.

Environmental pressure

Environmental pressure relates to the external factors that can impact policy implementation, including the buy-in from stakeholders and the general public. It can for example be useful to conduct a stakeholder mapping exercise to identify relevant stakeholders, their resources and relationships, and opportunities and obstacles (WHO 2016). The national context will be particularly relevant to the relative importance of European health policies such as Health 2020 (Box 1).

Box 1 Lacking reference to Health 2020 in the United Kingdom

Health 2020 has not had much evident traction in policy-making across the UK and is not referenced in policy documents. There have been many policy

initiatives in public health and health system reforms, but these have been quite fragmented and not taken the type of intersectoral approach advocated in Health 2020. For example, the government reorganized health care and public health in England from 2012, but these reforms were formulated much earlier, and their ideological focus was not aligned with the Health 2020 approach.

The reasons why Health 2020 did not have the same visibility or possible impact in the UK as other initiatives (such as implementation of the SDGs) are various. However, some are connected to the political environment in the UK when Health 2020 was launched. The UK government initiated a programme of austerity in 2010 that entailed significant cuts to social assistance and local government spending and a commitment to small government. This has hollowed out the public realm and increased poverty in ways that have put more pressure on the health system and hinders whole system approaches to address the social determinants of ill health (OHCHR 2018).

There are also potential wider socio-political or geographical factors that pushed Health 2020 down the agenda in the UK. As a high-income country with a relatively large population and a long history of health and social research, the UK has extensive technical capacity. As such it is not reliant upon, and does not routinely look to, global agencies for technical assistance or policy learning.

Quality and coherence of policy

Early scholars of implementation already stressed the close relationship between policy design and implementation. Pressman and Wildavsky furthermore emphasized the need for simplicity in policies (Pressman and Wildavsky 1973). A number of characteristics of policies affect implementation. Implementation is more likely where policies (Walt 1994):

- Have simple technical features;
- Require only marginal change;
- Can be implemented by one actor;

- Have clearly defined goals and one major objective;
- Can be implemented quickly;
- Have no clear cost or burden to the population or powerful interest groups;
- Do not require major resources or technical skills.

However, the challenge is that many public policies deal with long-term, ill defined, interdependent and high-profile problems – also known as “wicked problems” that defy easy solutions (Buse, Mays et al. 2005). It is therefore important to look at the system as a whole and avoid offering partial solutions (WHO 2016).

Key people leading change

It has been shown that, when acknowledged leaders accept innovation, other follows. The success of the implementation will depend on identifying strategies that help to change behaviour, having codes of practice that establish expected standards of service provision, and inventing incentives for change (EXPH 2016). Strong leadership is critical but does not necessarily mean top-down leadership. In most places strong leadership means distributed leadership (WHO 2016).

Supportive organizational culture

A supportive organizational culture can help greatly in health policy implementation. For health care organizations, it can be helpful to focus narratives on patient needs. Engaging health workers and drawing on their values and non-monetary incentives helps to create and nurture a supportive organizational culture (WHO 2016).

Managerial and clinical relations

Related to the previous point, managerial and clinical relations are also part of a receptive context for change. Sometimes professional cultures are the biggest and most resistant silos. They can be addressed using team-working, integrated care networks, systemic thinking and population health approaches. Enabling

frontline bottom-up innovation is another way of engaging clinical staff in health policy implementation (WHO 2016).

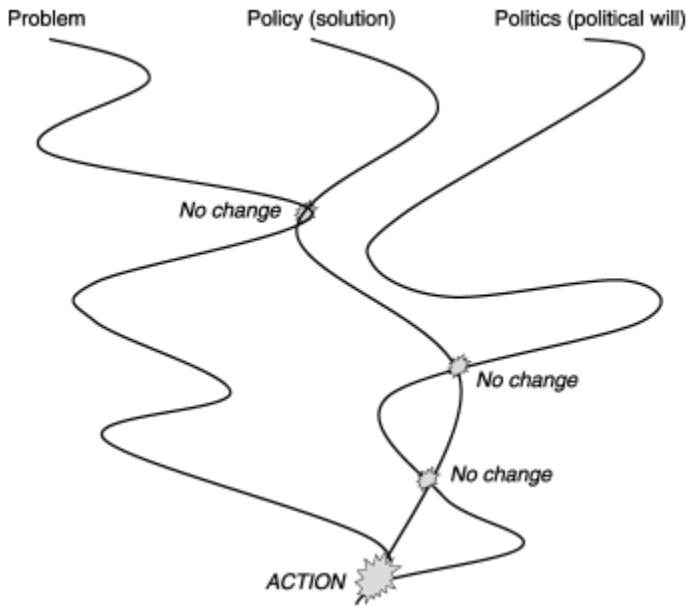
Get the timing right

Timing is crucial for successful health policy reform and implementation. This includes a consideration of the political, social and economic context and any circumstances that might favour change. Electoral cycles are of particular relevance, in view of the limited duration of governmental mandates. Ideally, health reform proposals are already part of electoral party platforms and based on comprehensive analyses (EXPH 2016). It is not enough to win an election or command a parliamentary majority: it also matters a great deal if the government has made the case for reform to the voters ahead of an election. Passing appropriate legislation in the early stages of the process can significantly facilitate reform, although having legislation in place does not guarantee automatic implementation (EXPH 2016). Often, it is best if ministers intervene at the start of their mandate if they want to ensure lasting change (WHO 2016).

Kingdon's model of policy windows and streams (Kingdon 1984) is helpful to understand what it takes to effect policy change. Kingdon focuses on the role of policy entrepreneurs outside and inside government who take advantage of agenda-setting opportunities, described as "policy windows" to put items on the formal government agenda. The model suggests that policy change emerges from three independent processes or "streams": the problem stream, the policy stream, and the politics stream (**Figure 4**). The problem stream refers to the perception of problems as issues requiring government attention. The policy stream consists of the analysis of problems and proposed responses or solutions. Finally, the politics stream is comprised of events such as changes of government or campaigns by interest groups. The model suggests that policies are only taken seriously by governments when the three streams come together, creating "policy windows". Until then, problem assessment, policy development, and politics can move in parallel and be relatively unconnected. For example, there may be solutions, but the problem is not yet generally perceived as such

(Buse, Mays et al. 2005). When “stream convergence” occurs, a problem is clearly defined, a solution has been developed and is waiting to be implemented, and the public perception for both problem and solution is favourable. A “policy window” opens through which the item can be put on the agenda (Aluttis, Krafft et al. 2014).

Figure 4 Kingdon’s three stream model of agenda-setting



Source: (Buse, Mays et al. 2005)

The question remains how policy windows can be created. This can happen through predictable or unpredictable events. Predictable events are elections and changes of decision-making personnel. Unpredictable events are usually disasters or crises (Aluttis, Krafft et al. 2014). For example, the BSE crisis led to the introduction of the EU’s health policy mandate, and WHO’s International Health Regulations were only reformed after the threat of the SARS epidemic (Wismar and Martin-Moreno 2014). Similar “focusing events” that draw widespread attention and publicity to a problem can be natural disasters or

industrial accidents. They change the dominant issues on the agenda of certain policy domains and lead to interest group mobilization (Birckland 1998).

An issue related to timing is the sequencing of reform steps. An analysis of the implementation of health financing reforms in transition countries concluded that the correct sequencing of reform actions was a crucial condition for success (Kutzin, Cashin et al. 2010). In the context of health financing reform in transition countries, this meant first establishing the policy objective of addressing structural inefficiencies, and then establishing and strengthening the agency responsible for pooling funds and purchasing services, which would then create opportunities to drive broader health financing reforms (Kutzin, Cashin et al. 2010). A study on health reforms in Central Asia corroborated the importance of the sequencing of health reforms and the combination of health care restructuring with new economic instruments. While in Kyrgyzstan the introduction of a state-guaranteed benefit package and patient co-payments was embedded in a wider reform of health care financing and delivery, in Tajikistan the new scheme was not accompanied by new mechanisms of health financing or an emphasis on primary health care. This meant that although most services under the basic benefit package were to be delivered at primary care level, the budget was still directed at the operating costs of hospitals (Rechel, Ahmedov et al. 2012).

Transfer appropriate policies and innovations

Health 2020 has played an important role in the identification, transfer and up-scaling of policy and service innovations. Health 2020 also provides a framework for countries through which they can identify innovations for priority areas where there is dire need for innovations (Box 2). The priority areas are articulated in a way that different innovations fit together and contribute to health system performance, financial sustainability and the social determinants of health. Health 2020 offers a platform that helps disseminate these innovations, so that all countries in the WHO European Region benefit from them.

Health 2020 has a couple of new and innovative aspects, in particular with its priority areas and the emphasis on leadership, governance and partnerships. At the same time it shows continuity with the Alma Ata declaration and the various editions of the European Health for All policy, which also provided a platform for exchange for more than 40 years, showcasing innovations that were successful in some countries of the WHO European Region allowing other countries to benefit from it.

Box 2 Priority areas of Health 2020

- Priority area 1. Investing in health through a life-course approach and empowering people
- Priority area 2. Tackling Europe's major health challenges: noncommunicable and communicable diseases
- Priority area 3. Strengthening people centred health systems, public health capacity and emergency preparedness, surveillance and response
- Priority area 4. Creating resilient communities and supportive environments

Innovations are important because they can make a key contribution to health system performance, the social determinants of health and financial sustainability. There are many definitions of innovation but all of them have in common that they emphasize the improvements innovations bring. These are improvements e.g. with regard to access to services, the continuity of care, the comprehensiveness of care the patient experience, medical quality and outcomes and efficiency (Nolte 2018). They also may bring improvement with regard to the social determinants of health. Recent examples are the use of digital health solutions for care integration (Thiel, Deimel et al. 2019) or the contribution of health to other policies such as education (McDaid 2016).

As there are many relevant outcome dimensions, in some cases synergies may be at play, improving for example medical quality and efficiency at the same time.

But innovations may also produce trade-offs between those outcome dimensions. Improving the comprehensiveness of care by adding new and costly medication to the healthcare basket may come with severe consequences for the financial sustainability of health systems. This is a reminder that in the transfer of innovations the receiving country needs to analyze with great thoroughness and accuracy what improvements a transferred innovation would bring and if it really relates to a perceived gap or problem in the country of reception.

The perceive gap to be closed in a country or the objective it pursues with the transfer of an innovation is a central issue. Only if we fully understand what the objective of the innovation in the country of origin was, can we understand whether it will match the objectives pursued with the transfer to the country of destination. There is a long list of transferred innovations that have not lived up to the promise because of this mismatch. The transfer of the DRG is an often-cited example. The countries transferring and adopting the DRG system often pursued different objectives compared to the country of origin. As a consequence, results of the transfer often fell short (TO-REACH 2019).

But even when the objectives of an innovation match in both the country of origin and destination there is a second issue crucial to the success of the transfer. We need to understand under what circumstances an innovation transferred can work. This usually refers to the regulatory context, the preparedness of the health workforce, payment systems that allow money to fund the innovation and last but not least the acceptability both in terms of culture and politics (TO-REACH 2019).

Often, we see innovations in the same country in form of a pilot or a local model of service provision. The results seem positive, the local stakeholders are adamant about the improvement the innovation brings. The problems of scaling-up are not so different from the transfer, though many contextual factors seem to be the same. But very often successful local models of service provisions are answers to local problems and again, the objective pursued in one locality does not necessarily match the needs of the whole country. Problems may also arise in the transfer from affluent to deprived regions and from rural to urban areas,

where it cannot be taken for granted that the innovation will produce similar positive results for the whole country as in the original locality.

Health 2020 has an important role in bringing policy and service innovations to the forefront and facilitating their transfer across the WHO European Region. But it has in addition another important role in terms of the transfer of procedural innovation. This is particular the case for the emphasis on leadership, governance and partnerships. Health 2020 promotes governance across different governmental departments since transferring innovations for health systems, public health and the social determinants of health is an intersectoral activity. But they also require very often the engagement with non-state actors or civil-society organizations including associations of health professionals, patients, informal careers and many others. The important and indispensable contribution civil society can make in transferring innovations from elsewhere e.g. in tobacco control, fighting TB, dealing with the refugee crisis are well documented (Greer, Wismar et al. 2017). Civil society can make an important contribution in choosing the matching innovations and implementing them effectively.

The intimate knowledge of local context and sectoral issues and the legitimacy with regards to its constituency makes civil society organizations an extremely important partner in decision making on and implementation of the transfer of policy and service innovations (Greer, Wismar et al. 2017).

This is even more the case with regards to the need to manage the transfer of innovations. Innovations are by definition disruptive, which distinguishes them from the more continuous, small-step service improvement. An innovation requires changes in behavior and routines to produce the desired results. People should do things differently. Skill-mix innovations for example may require professionals to work in teams and communicate with other disciplines and coordinate among themselves. Advanced prescribing in nurses may require changes in attitude as the adoption of routine medical tasks could be alien to some nursing cultures. And the same is true for the patients who are often expected to play a larger role in the management of their condition.

Consequently, innovation requires additional training. This can be perceived as disruptive not just on a system level but individually for the health professions, the patients and citizens and therefore requires attention.

Ensure good governance

A number of observers have pointed out the need for strong governance or leadership for policy reforms to succeed and policies to be implemented (EXPH 2016). The study on implementing health financing reform in transition countries concluded that "what matters most for health financing reform, as with policy reform more generally, is effective, consistent stewardship. Concretely, this refers to the public policy leadership and coordination that government brings to bear on the design, implementation, governance and monitoring of health financing reforms. […] Strong stewardship is required, with a reform roadmap and guiding principles that can be adapted as new realities are encountered during implementation" (Kutzin, Cashin et al. 2010). This was also apparent in primary health care reforms in Estonia and Bosnia and Herzegovina (Box 3).

Box 3 Governance issues in primary health care reforms in Estonia and Bosnia and Herzegovina

In primary health care reforms in Bosnia and Herzegovina, and Estonia governance challenges positively or negatively affected the realization of the intended policy. In the Bosnian case, lack of accountability, transparency, low participation and organizational integrity played a central role. In the Estonian case, the governance issues of strong integrity and participation are argued had a positive effect on realizing the policy outcomes.

The Estonian case was an example of successful adoption and implementation of a complex policy innovation, with rapid spread across the country, resulting in revolutionary change in the health system. The Bosnian case was moderately successful in the degree of change achieved, facing considerable challenges in scaling up the FM-centred PHC model outside pilot sites, while both the old and

the new system co-exist in patchy developments across the country. Estonia managed to rapidly implement revolutionary reforms in health financing by adopting a completely different system compared to the pre-existing Semashko model. The new financing arrangements rolled out rapidly and were characterized by the gradual integration of sophisticated resource allocation formulas and performance payment mechanisms for service providers. Bosnia and Herzegovina also adopted substantial structural changes in financing and performance payment systems, but these were delimited primarily to the pilot sites. Estonia has adopted more radical structural changes in service provision, such as the introduction of numerous guidelines and protocols, has enhanced the clinical role of FPs, and has implemented unified service provision in PHC, achieving a considerable shift in service provision from secondary to primary care. Bosnia and Herzegovina, in contrast, has adopted moderate changes in service provision.

Source: (Kyratsis 2016)

A recent framework for analysing and improving health system governance suggests five key attributes of governance (Greer, Wismar et al. 2016): transparency, accountability, participation, integrity and capacity (see also Box 1). These attributes help to identify the governance elements required for effective implementation. Three of these attributes have received particular attention in the study of policy implementation: participation, capacity and transparency.

Participation

Participation means that affected parties have access to decision-making and power so that they acquire a meaningful stake (Greer, Wismar et al. 2016). A key point here is that "good governance" involves "shared governance" among different levels of public sector government (national, regional and local) as well as buy-in from private sector actors, health workers and the general population

(Saltman and Duran 2015). Successful reforms have usually been accompanied by consistent coordinated efforts to persuade voters and stakeholders of the need for reform and, in particular, to communicate the costs of non-reform. Real engagement with stakeholders also involves listening to their concerns, and may result in the modification of reform proposals (EXPH 2016). The new national health policy in the Republic of Moldova is an example of a policy that was based on broad consultation with stakeholders, including from other sectors (Box 4).

Box 4 National health policies in the Republic of Moldova

Health 2020 has been embraced in the Republic of Moldova and has proved useful in pushing forward intersectoral working to strengthen population health and as a tool for guiding the technical agenda. Health 2020 has provided an overarching framework for action as both objectives and all four priorities are reflected in national policy documents; although the National Health Policy for 2007-2021 and Health Care System Development Strategy 2008-2017 predate it.

Recent reforms in public health, primary care, and the hospital sector have included the development of a health workforce strategy and the implementation of public health policies to address key health determinants (such as alcohol and tobacco consumption). The key challenge to implementing health policy has been political instability that has led to frequent changes of government and leadership.

Nevertheless, in the Republic of Moldova intersectoral working has been achieved by promoting an understanding of health as a 'social good' that is relevant for all ministries and the establishment of technical working groups for civil servants working at lower levels of government with the active participation of researchers and civil society representatives. Consultations have been broad and take place early in the development phase so a wide range of stakeholders can comment and help shape the final policy. Using the best available evidence, as well as communication and transparency have been important parts of the policy-making process, but so too has rigorous monitoring and evaluation of

policy impact. Monitoring and evaluation mechanisms have provided the evidence base to inform next steps.

Having Health 2020 as an umbrella has also facilitated health diplomacy with Transnistria which is not under the control of central authorities in Chisinau due to the ongoing frozen conflict. As part of an EU funded confidence building project, Health 2020 enabled WHO staff to broker a high-level roundtable meeting in Copenhagen bringing representatives from both banks of the Nistru river together. They used Health 2020 as a framework to harmonize health systems and public health policies and to foster the rapprochement in capacities on both sides for the benefit of population health. Having Health 2020 as the point of reference for guiding the technical reform agenda in the Republic of Moldova has therefore allowed health policy to transcend some of the challenges born of the frozen conflict.

The role of the general population has been highlighted in several studies on health reforms and implementation. Broad public support for reform can be an effective catalyst for change, just as lack of it can be a major barrier to it (EXPH 2016). In the study of health reforms in Central Asia, the involvement of the general population and of health workers has been an element of successful reforms and was missing in reform attempts that failed. This might not be surprising in many countries but is so in the political context of Central Asia, which is generally characterized by the strong role of the executive and the powers vested in the presidency. It seems that even in less permissive political environments, health reforms depend on the buy-in of health workers and the general population (Rechel, Ahmedov et al. 2012). Similarly, a review of Canadian experiences with primary health care reforms found that successful large-system transformation required distributed leadership, engaging front line workers and providers, and engaging end-users (Best, Greenhalgh et al. 2012). In Spain, one principle of health reforms was citizen involvement, with public forums to get input into health system innovations. There was also flexibility at

the regional and local level, where national health care strategies were implemented and coordinated, allowing for adaptations where necessary. Finally, health reforms benefited from bipartisan, sustained commitment by Spain's political leadership to providing universal access to high-quality health care for all (Borkan, Eaton et al. 2010). The case of Slovenia illustrates how important it is to involve stakeholders from the very beginning (Box 5).

Box 5 Slovenia's National Health Plan 2016-2025

Slovenia adopted the "National Health Plan 2016-2025 – Together for a healthy society" in 2016. The document was inspired by Health 2020 and reflects both strategic objectives and all four priority areas. Key priorities include strengthening primary health care, investing in preventive services and focusing on the most vulnerable groups of the population to reduce inequalities in health. Development of the health plan was based on broad consultation with all relevant stakeholders.

The economic crisis contributed to a better understanding that changes are needed to strengthen the health system in Slovenia and assure its sustainability. The government was urged to implement a fiscal consolidation package to control expenditure through structural reforms, including in the health sector. The implementation of primary health care reforms was facilitated through EU funding.

After the national health plan was adopted, its implementation through legislative changes and investments faced several challenges. One was strong opposition and lobbying from the private sector against proposed changes in financing (abolishment of voluntary health insurance). There were also difficulties due to approaching elections and weak support from the prime minister and the minister of health. To some extent, the implementation of change in primary health care was hindered by negotiations on standards and norms for professionals working in primary health care. Adoption of a primary health care development strategy, one of the key priority measures proposed in the national plan for 2016, did not happen. Nevertheless, implementation took place at the primary care level

through the introduction from 2011 onwards of pilot model practices into the system and by assuring EU funding for additional piloting in primary health care, focusing on vulnerable groups and key risk factors through a community approach.

In strengthening primary care, implementation has been led by the Ministry of Health, in cooperation with the National Public Health Institute. The intention, however, was to empower Health Care Centres (at the primary health care level, with no referral) to act as a leading partner in mobilizing local communities for health, reducing inequalities and addressing the needs of all population groups, including the most vulnerable.

As foreseen in the National Health Plan, the model practices have developed into a standard family physician practice and are financed through contributions by the Health Insurance Institute. As for the EU-funded project, the roadmap is clear and predictable. To assure sustainable funding and move from project-based initiatives to system reform, a national strategy for the development of primary health care would need to be adopted and financed.

By 2018 almost all family practices (those within public Health Care Centres and those privately financed through contracts with the Health Insurance Institute) have strengthened their capacities by employing extra nurses to deal with preventive services and navigate chronic patients through the health system.

The Slovenian experience of implementing the National Health Plan provides a number of lessons. One is that involving key stakeholders from the start is crucial. Local strategies and action plans are valuable tools in this regard and contribute to sustainability based on identified responsibilities and financing. Local communities with a variety of stakeholders have enormous potential in mobilizing individuals and organizations to identify and include those left behind. They allow a combination of top-down and bottom up approaches in developing and delivering programmes for those in need and should go beyond institutional boundaries in health and social care.

A generally high level of political consensus on issues relating to health policy has also been noted in Malta as an important factor that has permitted successive governments to move forward relatively smoothly with the implementation of health policies (Azzopardi-Muscat, Buttigieg et al. 2017). A review of the experience of health reform in Israel argued that the course of the reform depended to a large degree on the strengths and interests of different stakeholders in the health system and their roles during the implementation phase. Imbalances among stakeholders in the health system caused several aspects of the reform to stray from the original plan (Horev and Babad 2005). It also found that the success of the reform depended on a political constellation that allowed at least one stakeholder to play the role of an unbiased public representative that will speak up for the consumer vis-à-vis the government and act as its trustee (preferably an independent authority), with no conflict of interests to muddle its judgment (Horev and Babad 2005). The implementation of primary health care reforms in South Africa was facilitated by a number of factors, including dialogues with the community (Box 6).

Box 6 Features of implementing primary health care reform in South Africa

Implementation of the primary health care outreach team strategy in South Africa was characterized by the following features: 1) A favourable provincial context of a well-established district and sub-district health system and long standing values in support of PHC; 2) The forging of a collective vision for the new strategy that built on prior history and values and that led to distributed leadership and ownership of the new policy; 3) An implementation strategy that ensured alignment of systems (information, human resources) and appropriate sequencing of activities (planning, training, piloting, household campaigns); 4) The privileging of 'community dialogues' and local manager participation in the early phases; 5) The establishment of special implementation structures: a PHC Task Team (chaired by a senior provincial manager) to enable feedback and

ensure accountability, and an NGO partnership that provided flexible support for implementation.

Source: (Schneider, English et al. 2014)

The 2016 WHO report argued for a balance between top down and bottom-up implementation. Large-scale initiatives require a balance between centralized strategic planning and coordination, and autonomy and empowerment at the local level to generate innovation and more sustainable engagement. Investing in the skills and resources at the point of clinical care is vital but needs to be supported by an overarching body that can provide high-level strategic alignment, large-scale coordination, consistent provision of standardised and specialized resources and training, and the removal of obstacles that are beyond the ability of local departments (WHO 2016). In Estonia, the national health policy was developed following extensive engagement with other ministries, all levels of government as well as NGOs and other stakeholders (Box 7).

Box 7 National Health Plan in Estonia

The National Health Plan in Estonia was approved in 2008, and it is the main strategic document to shape progress in the health sector. It was developed and began implementation before Health 2020 was launched, but the Plan is rooted in the wider WHO approach, so it fully aligns with the objectives and priorities of Health 2020 and it shares the same elements. This means the documents are conceptually synchronised, but the National Health Plan has full country "ownership".

Country ownership was also reinforced by the way in which the National Health Policy was developed, with intersectorality at its core. The development phase included extensive engagement with other ministries, a range of elected representatives and all levels of government down to the county level as well as NGOs and other stakeholders. This is the usual approach to strategy-making in

Estonia and it contributes to their sustainability over the longer-term across any political changes. Strategies and the operational plans to implement them are also part of the budget process so are a well-embedded feature of policy-making.

The National Health Plan 2008 was revised in 2012 to address shortcomings in the official reporting mechanisms. Initially different stakeholders were responsible for providing inputs and data collection both to the Plan and to the condition-specific strategies for which it provided an umbrella. Consequently, the Plan was revised to reduce duplication in monitoring and defragment data flows, thereby improving the efficiency of the feedback loop.

Estonia is currently in the process of developing the new National Health Policy for 2020-2030, so the country is seeking to apply the lessons learnt from implementing its forerunner. Firstly, there is greater focus on the whole system, both health care and public health. The vision for health care is being made more specific and has been elaborated in more detail to make it easier to implement while also treating health care and public health as a whole system. Secondly, the new National Health Policy has built on the successes of the previous inclusive development process but hopes to establish platforms to continue engagement through the elaboration of operational programmes as well as implementation and monitoring.

A stakeholder analysis and political mapping exercise can help policy implementation by identifying who holds power on issues, visualizing relationships between stakeholders, and identifying resources, opportunities and obstacles among key influencers, allies and constituencies (WHO 2016). One of the lessons of health reform in the United States is that special interest groups pose a continued obstacle to change. The Obama administration worked successfully with some health care organizations and groups, such as major hospital associations, to redirect excessive Medicare payments to federal subsidies for the uninsured. Yet others, like the pharmaceutical industry, opposed any change to drug pricing, no matter how justifiable and modest,

because they believed it threatens their profits (Obama 2016). Even in the case of no apparent opposition to a new policy, implementation can lack behind if there are no clear structures, roadmaps and accountability (Box 8).

Box 8 Swedish Patient Act of 2015

In Sweden, the Patient Act entered into force on 1 January 2015. Although the Act (and related official documents) makes no direct references to Health 2020, the policy appears to support the strategic objective of Health 2020 of "Improving leadership for participatory governance for health" and the policy priority of "Strengthening people-centred health care systems".

The aims of this Act were to strengthen and define the position of patients and to promote patient integrity, self-determination and participation. While it introduced new provisions, the Act has for the first time gathered all relevant regulations into a single legislative act. Thereby, the Act clarified the obligations of actors within the health system towards the patients (there are no explicit patient rights in Sweden; instead, health care providers and other actors within the health system have certain obligations vis-à-vis patients) and presumably strengthened their position.

The Act introduced the following key changes: (1) clarified and expanded the obligations of health care providers relating to the provision of information to patients; (2) enhanced the possibilities of receiving a second medical opinion by patients; (3) extended the choice of publicly financed primary care and outpatient specialist care to all such providers in the country; (4) placed the child's own best interest at the centre of any decisions regarding health care for children.

The policy was initiated by the government and had a wide support among patient organizations, with no apparent opposition. Its implementation was bestowed upon the local government (21 county councils) and private health care providers. The government has commissioned the Agency for Health and Care Services Analysis to monitor and follow up on the implementation of the Act. At the time of writing (January 2019), the policy has been fully implemented. However, the policy does not appear to have achieved its goals: early analysis

shows that ‘patients’ position’ and ‘patient-centeredness’ have not improved since the reform.

The reasons for this may include lack of a clear roadmap and dedicated (additional) funding for the implementation of the reform as well as lack of national administrative support and information sharing in the early stage of the implementation. Related to the latter, there was no consensus among health care providers on how to interpret the reform. Further, the reform requires a change of attitudes and culture and such changes do not happen instantaneously. Nevertheless, the reform increased the *awareness* of the importance of patient-centeredness among all stakeholders within the health care sector.

Capacity

Successful implementation of health policies also requires policy capacity. While capacity is needed for evidence review and policy formulation, it also affects all other stages of the policy process, from the strategic identification of a problem to the actual development of the policy, its formal adoption, its implementation, and even further, its evaluation and continuation or modification (Forest, Denis et al. 2015). Policy capacity focuses on the managerial and organizational abilities to inform policy decisions with sound research and analysis, and facilitate policy implementation with operational efficiency (Gen and Wright 2015).

A review of health policies in Europe argued that government effectiveness is perhaps the most important factor in determining whether a health policy can be implemented. Governments in Europe vary greatly in their ability to carry out core functions, such as collecting taxes or organizing health care or education systems. A related issue is trust in government. It will be more difficult to persuade the public to act on messages set out by governments if they distrust them. An institutional infrastructure to develop policies that are appropriate to the national context is also essential (McKee and Mackenbach 2013). The case of Malta (Box 9) illustrates the importance of having a dedicated focal point for implementation.

Box 9 The National Health System Strategy in Malta

The 2014-2020 National Health System Strategy for Malta (Parliamentary Secretariat for Health 2014) was developed to implement the European health policy Health 2020 as well as an ex-ante conditionality for the European Commission Funding Programme of 2014 – 2020. The National Strategy was adopted in 2014 and is expected to run until 2020; a mid-term review was performed in 2018. The work on the design and planning of the National Strategy started in 2012, just after the adoption of Health 2020 by WHO member states. Therefore, Health 2020 was used as a guidance document to elaborate the National Strategy in Malta, with all elements of Health 2020 (that is, the two strategic objectives and the four priority areas for policy action) being reflected as much as possible, both in the pillars and in the objectives included in the National Strategy.

The development of the policy was led by the Chief Medical Officer in Malta and the key proponents were public health doctors. Therefore, the policy was primarily technically driven by civil servants. There were no opponents to the National Strategy. While the National Strategy was launched for consultation in 2013, the technical nature of the document led to little discussion and debate. Political leadership within the Ministry of Health changed from the time the strategy was drafted for consultation until its actual adoption. This might have been one of the reasons for the lack of political ownership of the document which remained viewed as a highly technical strategy. The mid-term review revealed that barriers to implementation included limited funding as well as the absence of a dedicated focal body/person/high level committee specifically tasked to work on the National Strategy's implementation. This is partly because when the actual plan was brought up, it had more than 600 measures, and it was found very ambitious and overwhelming. Since then, the focus has been more on specific strategies and areas within the National Strategy, including: cancer, diabetes,

more recently, AMR, and a number of specific projects (e.g. on infrastructure or the operational reform project).

The implementation of the National Strategy includes a mix of top-down and bottom-up approaches, depending on the specific project. Funding comes from the general government budget funding for health care but is not specific to the strategy. There is sufficient (technical and policy) capacity for the implementation of the National Strategy; however, the lack of a specific point of responsibility does not facilitate the optimal organization of this implementation.

The mid-term review (2018) assessed the different measures included in the National Strategy. Some of the issues included in the National Strategy have been tackled (e.g. the development of cancer services, the expansion of services in primary care, waiting times, large investments to increase the number of doctors and nurses). However, the sustainability of the health system as well as shifting the focus from hospital to community services have not been developed fully. The sustainability of the National Strategy is very much linked to the sustainability of the health system itself, which is an ongoing issue, although the performance of the health system has improved over time.

A 2020 – 2030 National Health Strategy is currently under development. This is expected to be more specific, focused on concrete issues (e.g. health inequalities, health workforce, innovation) and linked to specific priorities such as mental health. The new Strategy is expected to be shorter, less technical and more political in its approach.

Several lessons can be taken from the Maltese experience on the implementation of the 2014 – 2020 National Strategy. Firstly, the success in the implementation of a national strategy requires both political and technical ownership: while the political ownership facilitates the visibility of the strategy as well as the availability of resources for its implementation, the technical ownership ensures the continuity of the policy despite political changes. Secondly, strategies that are too technical in their approach, may result in a lack of engagement from the different stakeholders, including the civil society. Finally,

an ambitious agenda may result in little impact due to the lack of resources for its implementation: “less is often more”.

In health reforms in Central Asia, continuity was facilitated by incorporation of capacity building into reform programmes, as in Kyrgyzstan, with its Health Policy Analysis Project that has now been transformed into the Health Policy Analysis Centre. The Centre has provided a range of reports and surveys on the reform process which fed back into health policy-making. In other countries, such as Tajikistan, a lack of local capacity-building has been identified as one of the factors impeding reforms (Rechel, Ahmedov et al. 2012). In addition to national capacity, it is also essential to have clear objectives, a roadmap for implementation and scope for adapting reforms as necessary (Box 10).

Box 10 Lessons from implementing health financing reform in transition countries

The main conclusion from nearly 20 years of policy reform experience is that coherent and successfully implemented reform strategies require clear identification of specific policy objectives, based on analysis of critical health system performance problems, and careful choice of a combination of well-aligned policy instruments that respond to the identified problems. Having a clear roadmap with guiding principles for reform, linked to processes to generate evidence for monitoring progress, makes it possible to adapt implementation to accommodate changes over time, while retaining the overall goals and integrity of the reform process. Consistent but adaptable implementation of the roadmap, in turn, requires political will and some degree of continuity. What appears to mark the more successful reformers (such as the Czech Republic, Estonia, Kyrgyzstan, the Republic of Moldova and Slovenia) has been full implementation of their reforms and progressive development of their institutions once decisions had been made with regard to the main direction of change.

Source: (Kutzin, Cashin et al. 2010)

Transparency

Transparency means that “institutions inform the public and other actors of both upcoming decisions and decisions that have been made, and of the process by and grounds on which decisions are being made” (Greer, Wismar et al. 2016). In the area of policy implementation, transparency in communicating the rationale for reform can help to reduce resistance to changes. This is particularly important when policies directly threaten the incomes of patients, health workers, providers and the suppliers of drugs, devices and equipment (EXPH 2016). Transparency also requires good information systems and technical skills to allow for effective monitoring and evaluation of the whole reform process (EXPH 2016). This includes transparent reporting on the use of funds and the performance of the health system against defined policy objectives (Kutzin, Cashin et al. 2010).

Evidence from the European Health Report 2018 makes it clear that, although much progress has been made towards meeting Health 2020 targets, more remains to be done across the region to achieve equitable, sustainable and universal health systems that improve health and well-being (WHO Regional Office for Europe 2018a). Recognising the need for accelerated action, the report notes that improved and harmonized health information is needed that can be ‘actively applied’ to the development of evidence-informed health in all policies (WHO Regional Office for Europe 2018a). Progress towards this aim is already being supported by the European Health Information Initiative (EHII) that aims to support development of an integrated, harmonized health information system for the entire European Region and WHO’s Evidence-informed Policy Network (EVIPNet) which acts as a “neutral and trusted intermediary between researchers and policy-makers” (WHO Regional Office for Europe 2018a).

The report suggests a number of further ways in which the quality of evidence informing policy can be enhanced. It is recommended, for example, that the experiences of local communities should be better explored to inform research

and evidence, while qualitative data should be used more to investigate complex Health 2020 concepts such as community resilience, empowerment, the life-course approach and the whole-of-society approach (WHO Regional Office for Europe 2018a). Intersectoral cooperation at both the international and national levels should be intensified and reporting requirements streamlined to reduce the burden on Member States by approving a Joint Monitoring Framework (JMF) containing a common set of indicators for Health 2020, the 2030 Agenda and the Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020 (WHO Regional Office for Europe 2018a). It is, however, noted that against the need for greater evidence to inform policy are rising concerns regarding transparency and privacy over health information. Resolving this conflict will be key to ensure evidence-based policy can continue to inform progress towards improving the health and well-being of populations in Europe.

Accountability

Accountability involves explanation and sanction. It is a relationship between an actor (such as an agency) and a forum (such as a legislature) in which the actor must inform the others of decisions, must explain decisions, can be mandated and can be sanctioned (Greer, Wismar et al. 2016). While this aspect of governance has not been studied much in implementation research, it is obvious that it affects policy implementation. The case of Ukraine illustrates the role of leadership for participatory governance, but also the need for an ambitious reform agenda (Box 11).

Box 11 Health financing reform in Ukraine

Health 2020 was not an explicit reference point for health financing reform in Ukraine, but it aligns with the strategic objective of improving leadership for participatory governance for health, and the process has been heavily informed by technical assistance from international partners including WHO.

Profound health financing reform in Ukraine has been high on the political agenda since 2004. In 2014, political changes opened another window of opportunity, and a Strategic Advisory Group of national and international experts in health financing were brought together to develop a long-term vision for health reforms in Ukraine. However, it was only in 2016 that there was sufficient political capital to allow the implementation of reforms to shift the health system decisively away from an input- to an output-driven model that supports primary care. The reforms have included the establishment of an independent purchasing body (NHS Ukraine) which now contracts with all primary care providers. The next step is to extend contracting to specialist care and hospital care

The health financing reforms have progressed according to an extremely ambitious timetable. The reforms were signed into law by the President in December 2017, to come into force from January 2018. This allowed just one year for the establishment of NHS Ukraine (in March 2018) and the introduction of contracting in primary care in June 2018. The key challenge through 2019-2020 is to embed the reforms so they are sustainable through changes of government.

One of the key lessons from the experience in Ukraine is that health reform is primarily a political issue. Strong leadership for participatory governance for health is needed not just to choose the most appropriate technical solutions, but also to work with politicians, health professionals and the general population to ensure the support of key stakeholders. Communication is central to achieving this and communicating what can be gained from successful reforms is not a single event but an ongoing process – before, during and after implementation. Communicating with the general public requires feedback mechanisms, and in Ukraine they monitored popular expectations, evaluated the impact of information campaigns, and sought to address concerns by adjusting the reform programme before implementation.

However, the key lesson learnt in Ukraine was to try the impossible. It was only by trying that solutions to seemingly irresolvable problems could be found; and overall, it was better to be criticized for making mistakes than for inaction.

Integrity

Integrity "has many synonyms and related terms: predictability, anti-corruption, ethics, rule of law, clear allocation of defined roles and responsibility, formal rules, stability. It means that the processes of representation, decision-making and enforcement should be clearly specified" (Greer, Wismar et al. 2016).

Work with other sectors

The WHO Regional Office for Europe has recently undertaken a mapping exercise to document good practice examples of multisectoral and intersectoral actions that have been implemented by Member States to support health and well-being for all (WHO Regional Office for Europe 2018c). The study detailed initiatives in 36 countries with the aim of understanding why actions were initiated, how they were implemented, and lessons learnt for health policy development and implementation. Although case studies covered a number of different policy areas, they most frequently focused on areas of broader national or regional health policies, the prevention and control of NCDs and health promotion in schools.

The most common motivators for implementing multisectoral and intersectoral actions across the region were identified as the health sector being unable to address health and well-being challenges on its own; to improve coherence across sectors; and to mobilize increased resources for improving health and well-being (WHO Regional Office for Europe 2018c). Implementation of case study actions occurred most often at the national level (in 20 of the 36 case studies), with eight actions supporting coherent implementation at the national,

regional and local levels and only four actions incorporating an international component (WHO Regional Office for Europe 2018c).

The report concluded that successful adoption of multisectoral actions required political support from ministers and ministries responsible for health and well-being, good governance, a clear mandate to reach out beyond the health sector, sufficient resources and capacity, and any actions to be underpinned by data and evidence. Strong cross-sectoral collaboration and engagement with WHO and civil society were also deemed to be important facilitating factors for implementation. Emphasizing the many co-benefits to other sectors from improved health and well-being was found to be important to enhance buy-in and support from stakeholders outside of health. The quality of cross-sectoral collaboration at the interpersonal level was also seen to be a facilitator of successful multisectoral action, including the early engagement of collaborators, effective working methods, trust, and open communication (WHO Regional Office for Europe 2018c).

Barriers to implementation were also explored. A lack of political will and commitment, insufficient resources and coordination, not emphasizing co-benefits, and changes in governments or ministers presented challenges to implementation and the sustainability of actions (WHO Regional Office for Europe 2018c). Further still, failure to distribute associated funding for actions across relevant sectors and the health sector's "perceived superiority" also impeded implementation. The authors conclude by recommending that policy-makers, civil servants and technical experts are provided with training on how to coordinate and structure multisectoral and intersectoral work in practise and suggested that tools and toolkits for planning, implementation and monitoring could be developed to foster development and implementation of multisectoral and intersectoral action (WHO Regional Office for Europe 2018c). The case of Sweden's National Action Programme for Suicide Prevention illustrates that a plan for implementation should be a key part of every policy, with defined ownership and responsibility for coordination, support and follow up (Box 12).

Box 12 Sweden's National Action Programme for Suicide Prevention and the platform for coordinated implementation

Sweden adopted a National Action Programme on Suicide Prevention in 2008. It involves evidence-informed actions in 9 strategic areas such as health care, urban planning, transport, education, social services, first responders, as well as research and civil society. Participation was a key part of the development of the Action Programme, when several hearings and reference group workshops were held, as well as interviews with local and regional practitioners. Since it was a national policy, the public was mainly represented through national NGOs, and local governments were represented at the national level through the Swedish Association of Local Authorities and Regions.

Since 2015, the Public Health Agency of Sweden has been commissioned by the government to promote implementation of the Action Program. The Agency's role is to develop coordination and monitoring of suicide and suicide preventive work, and to develop and disseminate knowledge support to a wide range of stakeholders.

To support the implementation of the policy, the Public Health Agency has created a national collaboration group of agencies, and a national interest group comprised of researchers and representatives of the non-profit sector (NGOs). These groups now make up a platform for knowledge dissemination, knowledge transfer and national coordination. The members of the platform meet regularly to discuss common concerns and to exchange knowledge and ideas pertaining to the Action Programme.

There are several benefits of national coordination in the area of suicide prevention. When agencies and other relevant organisations meet and coordinate their work, they can take advantage of each other´s expertise and endorse the dissemination of knowledge among different target groups. Because different agencies seldom work toward the same target groups, national coordination also facilitates the identification of knowledge gaps and the prioritising of areas of action, based on different target groups' needs. The coordination platform promotes cooperation on common concerns and collective

action to be taken. It creates synergies between national stakeholders and prevents duplication of efforts.

A key lesson from implementing the National Action Programme is that a plan for implementation should be a key part of every policy, with defined ownership and responsibility for coordination, support and follow up. In this case, the policy was formed and passed by parliament without a specific plan for implementation from the beginning. There was no defined ownership and no organization or agency given the responsibility to coordinate activities or support implementation and there was no defined plan for follow-up. Funding was not initially in place, and separate actions were taken sporadically, instead of having a clearly defined organizational structure for implementation.

It can be concluded that Implementation of national policies, such as suicide prevention strategies, can benefit from platforms that support coordination between government agencies from different sectors, researchers and NGOs, particularly when it comes to promoting evidence-informed preventive actions. Furthermore, building lasting structures for implementation from national to local level takes time, even when there is adequate funding, especially within a complex field such as mental health and suicide prevention, which involves many sectors of society.

In a report assessing whole-of-government and whole-of-society policy approaches globally, Kickbusch & Behrendt (2013) observe that existing holistic policy approaches focus on communication, cooperation and coordination but often neglect the final step of collaboration and integration where risks, rewards and responsibilities for a common goal are shared (Kickbusch and Behrendt 2013). Furthermore, although whole-of-government approaches have strengthened central coordination bodies in many countries, cooperation often works better at the local level, due to improved transparency, accessibility and responsiveness (Kickbusch and Behrendt 2013). The authors conclude by noting that there is often a gap between what is planned and what is eventually implemented. To support successful implementation it is necessary for countries to establish sustained commitment from stakeholders at all levels, to ensure

good communication, adequate resources, shared and innovative accountability arrangements, clarity regarding tasks and responsibilities and a common understanding of goals and objectives (Kickbusch and Behrendt 2013).

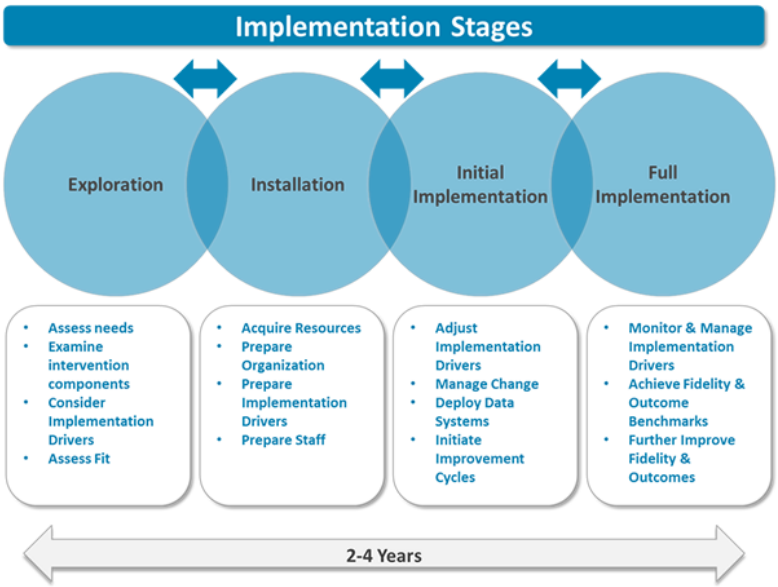
A WHO report on the experiences of small countries in intersectoral action for health (WHO Regional Office for Europe 2016), covering eight countries with a population of less than one million, found that small size (in terms of geography and population) could be an advantage, as it is easier to forge political will and consensus. The case stories identified a number of mechanisms that facilitated intersectoral action for health, such as passing new legislation or enforcing already existing legislation, using intersectoral working groups and promoting working relations with minimal bureaucracy. Facilitating factors included having high-level support and firm government commitment and mechanisms such as international commitments and global/regional policy frameworks. Challenges reported were lack of funding, resources and time. Lack of a common language and difficulty in showing the financial benefits of investing in disease prevention were also mentioned (WHO Regional Office for Europe 2016).

A review of which intersectoral governance structures can facilitate intersectoral action (McQueen, Wismar et al. 2012), identified a range of instruments, including cabinet, parliamentary or interdepartmental committees, ministry mergers, joint budgeting, delegated financing, and engagement of stakeholders, the public, and industry. Several of these instruments are directly related to implementation. Interdepartmental committees provide a mechanism for departments from multiple sectors to report on and coordinate implementation. Mega-ministries can serve as another mechanism for implementation and management. Joint budgeting arrangements can support implementation with regard to the implementation of joint services. Co-financing via delegated financing can foster ownership and sustainability, resulting in creative approaches to planning, implementation and management (McQueen, Wismar et al. 2012).

Move from exploration to full implementation

Implementation is not a singular event, but a process that takes several years, and that involves multiple actors and stages (Figure 5), as well as specific governance structures and contextual factors.

Figure 5 Implementation stages



Source: Frank Porter Graham Child Development Institute, 2012, Stages of implementation [https://sisep.fpg.unc.edu/news/sisep-enotes-may-2012, accessed 23 May 2019]

The idealized "stages" of the implementation process involve exploration, installation, initial implementation and full implementation (Figure 2). In the exploration stage, an assessment is being made whether to proceed with the policy or not. In this phase, stakeholders are starting to be engaged. After a decision to proceed has been made, the installation phase puts in place activities and financial and human resources to prepare implementation. The next stage is initial implementation of the new policy, when first challenges become apparent and may need to be overcome by policy adjustments. Full implementation can

begin once the new ways of working have become part of everyday practices and procedures.

Full implementation of comprehensive reforms takes time, partly due to refinements and repeated attempts. Successful health reforms generally take several years to prepare and adopt, and they often take far longer to implement. By contrast, many of the least successful reform attempts were undertaken in a haste, often in response to immediate pressures (EXPH 2016). Consistency in the direction of reforms is also crucial. As was observed in Central Asia, countries that demonstrated a consistent commitment to comprehensive reforms fared better than those that followed a more erratic approach (Rechel, Ahmedov et al. 2012).

Table 2 Policies explored in the case studies

Country	Policy and timeframe	Did it exist (was planned) before Health 2020?	Which elements of Health 2020 are reflected?
Malta	2014-2020 National Health System Strategy	No	All
United Kingdom	n.a.		
Estonia	National Health Plan 2008	Yes	All
Republic of Moldova	National Health Policy for 2007-2021 and Health Care System Development Strategy 2008-2017	Yes	All
Sweden	2015 Patient Act	No	Improving leadership for participatory governance for health and Strengthening people-centred health care systems

Sweden	National Action Programme on Suicide Prevention	Yes	Improve health for all and reduce the health divide
Ukraine	Health financing reform	No	Improving leadership for participatory governance for health
Italy	2017 Vaccination Law	No	Improving health for all and Addressing major health challenges
Kyrgyzstan	National health reform programmes “Den Sooluk” (2012-2018) and “Healthy People, a Prosperous Country 2019-2030”	Yes and no	All
Slovenia	National Health Plan 2016-2025	No	All

The country case studies showcase the experience of nine countries in implementing ten policies related to Health 2020 (Table 2). Given the small number of cases and countries, it is difficult to make generalizations. However, the examples still provide illustrative evidence of some of the challenges and facilitators of successful implementation which may be useful for other countries.

In the **exploration stage** of policies, Health 2020 only played an explicit an acknowledged role in two of the nine countries, Malta and Slovenia. In Malta, work on the design and planning of the National Strategy started in 2012, just after adoption of Health 2020, which became a guidance document for the National Health System Strategy. The National Health Plan 2016-2025 in Slovenia was also inspired by Health 2020 and it is mentioned in the foreword of the document. In the other seven countries, work on the policies reviewed in the case studies either started well before Health 2020 was adopted (such as in Estonia, Sweden or the Republic of Moldova) or did not make explicit reference to Health 2020 (such as in Sweden or Ukraine), although policies may still

embody key values expressed in Health 2020. High-income countries such as the United Kingdom may also be less likely to look to WHO for technical guidance than countries with fewer resources.

Several of the case studies point to the importance of national ownership and broad consultation and engagement with other ministries, all levels of government, NGOs, the public and other stakeholders. Such engagement (as in Estonia) greatly increased the chances of successful implementation, while the lack of engagement and political ownership (such as in Malta) undermined it.

In the **installation phase**, a key facilitator of implementation was the inclusion of government funding in regular budgets and the availability of technical and policy capacity. Limited funding was identified as a barrier.

In the **initial implementation** phase, robust monitoring and evaluation to inform further implementation emerges as another ingredient of successful implementation. In Malta, the large number (over 600) of measures originally used to gauge progress were found to be too ambitious and overwhelming. There was also a lack of a dedicated focal point responsible of implementation. In Italy, the success of the new vaccination law could only be gauged when data on vaccination coverage became available.

Only few countries have reached the stage of **full implementation** at the time of writing (January 2019). In Sweden the 2015 Patient Act seems to have failed to achieve its goals, while in Italy the seemingly successful policy is under threat of being revoked following a change of government. Kyrgyzstan has come to the end of its national health reform programme "Den Sooluk" and has now embraced a new programme of reform. In Italy, efforts to improve vaccination coverage have shown promising initial results (Box 13).

Box 13 The 2017 Vaccination Law in Italy

The Law 119/2017 on "Urgent dispositions concerning vaccine prevention (*Disposizioni urgenti in materia di prevenzione vaccinale*)" is one of the policies

implemented in Italy in line with the European health policy Health 2020. The 2017 policy made 10 vaccinations mandatory (and free of charge) for children aged 0 to 16 years, including: polio, diphtheria, tetanus, HBV, pertussis, haemophilus influenzae b, measles, mumps, rubella and varicella. For children aged 6 to 16 years, missing or incomplete vaccinations will result in sanctions such as a fine. Children aged 0 to 6 years with missing or incomplete vaccinations can be refused school enrolment, in addition to the fine.

The development of the 2017 Law was led by the Ministry of Health. Key proponents were the Ministry of Health, in agreement with the Ministry of Education, universities and research institutes, the Ministry of Justice, the Ministry of Economy and Finance, and the Ministry of Regional Affairs. Key opponents were the *No Vax* movements, which included movements against vaccinations and movements against mandatory vaccinations, and some political parties (mainly, *Movimento 5 stelle* and *Lega*). Given the perceived urgency of implementing the 2017 Law (in view of a 2017 measles epidemic in Italy), no particular efforts were made to ensure participation of civil society. However, the Law was discussed with the regional governments and representatives of health professionals. The design of the National Vaccination Plan was based on broader engagement: the Plan had many contributors organized in two working groups, which included the Ministry of Health, the regional governments, the Italian Medicines Agency, scientific societies, and practitioners' associations. Some regional governments had already started to discuss (e.g. Piemonte) and approve (e.g. Emilia Romagna) similar policies at the regional level. On the other hand, supporters from the opposition parties, the No Vax movement and the Free Vax movement held many public demonstrations to express their discontent with the Law. Moreover, some regional governments led by the opposition party tried to oppose the Law, e.g. the regional government of Veneto brought the Law to the Constitutional Court.

The implementation of the 2017 Law has been led by regional health services and follows a top-down process. The Law does not specify a roadmap for implementation, even if the main goal was to increase the vaccination coverage

as soon as possible. The Law set a specific milestone after 3 years, which allows the Ministry of Health to remove 4 vaccines (MMR and varicella) from the mandatory ones, depending on vaccination coverage. No specific funding was set out by the Law, as all vaccinations were already included in the Essential Level of Care (LEA) (that is, the national benefits package) and hence are covered by the National Health Fund. No new governance structures were set up to facilitate implementation across sectors and levels of government.

The initial implementation of the policy required a great organizational effort, to both vaccinate the unimmunized children and to clarify rules for school admission. The policy was not adjusted following its initial implementation. The policy requires parents to show a certification of complete immunization to proceed to school admission, which has been used as a monitoring tool of the policy. In September 2018, the competent control authority decided to check a sample of 55 700 self-certifications, which revealed 55 frauds.

The Law was not fully implemented until September 2018. It was approved at the end of July 2017, and there were difficulties to fully implement the mandatory plan at the beginning of the school year 2017-2018. The first data released after the mandatory vaccination law correspond to 2017 and show an increase in vaccination coverage for all vaccines. As the compulsory vaccination programme did not start until the second part of 2017, the efficacy of full implementation can only be evaluated when 2018 data become available. While full implementation has been reached and no particular efforts are required to maintain the policy, more human resources at the local prevention departments may ensure the sustainability of vaccination services. The public debate around this Law seems to have strengthened beliefs in the benefits of vaccination among the medical community and the general population, but it has also been met by a vocal anti-vaccination movement. Some political parties tried to exploit this situation to increase their electoral support.

During 2018, a new parliament has been elected and a new government formed. Leaders of both parties that became the leading force of government (*Movimento*

5 stelle and *Lega*) announced during the election campaign and through their social media accounts that they intended to modify the 2017 Law. Moreover, the Minister of Health of the new government made some conflicting statements about the Law's implementation, raising additional uncertainties.

Yet, making vaccinations mandatory has proven its efficacy in achieving, in a short period of time, adequate levels of immunization coverage, with an increase that varied across regions from 1% to 4.5%. Further efforts are required to raise awareness of the benefits of vaccination.

Big bang or incremental change?

One of the questions of policy reform and implementation is whether to opt for "big bang" or incremental change. The ability to introduce rapid reforms depends mainly on the configuration of the governance structure and on political will, but it is also influenced by contextual circumstances such as the state of the economy and the degree of support from key stakeholders. Radical changes based on ideology may not be politically and technically sustainable in the long run and an incremental approach may lead to more socially sustainable policies than the wholesale changes introduced in "big-bang" reforms (EXPH 2016).

The early researchers on implementation emphasized that most policy change in Western societies is incremental, based on a method of successive limited comparisons, where policy-makers choose directly between alternative policies that differ in relatively small degrees. The resulting "empirical comparison of marginal differences" draws on knowledge of consequences based on (similar) previous policies. The "method of successive limited comparisons" has also been termed the "science of muddling through" (Lindblom 1959).

Incremental policy changes in successive steps tend to be smoother and more effective than fundamental "big bang" reforms due to the "limits of rationality" of governmental implementers (Lindblom 1959). Rapid implementation also

contradicts "good governance" principles as applicable to public agencies (Pressman and Wildavsky 1973).

A study on two decades of health reform in Central Asia concluded (Rechel, Ahmedov et al. 2012) that it paid to pilot reform elements before rolling them out nationwide, a conclusion that has also been reached in other countries of Central and Eastern Europe and the former Soviet Union (World Bank 2003). An example is the step-wise introduction of a benefit package in Kyrgyzstan, which allowed consensus to be built on reforms and for their refinement where necessary (Rechel, Ahmedov et al. 2012). In Spain, the use of multiple demonstration projects to develop best practices for the redesign of clinical processes and to share lessons learned throughout all Autonomous Communities was an important aspect of the transformation of the health system. The ultimate goal was to generate knowledge with which to improve health organizations, as well as facilitating collaboration among organizations and the general public (Borkan, Eaton et al. 2010).

However, there are some examples of countries embracing “big bang” health reforms. One is the United Kingdom’s reforms of the NHS in 1991 when the government introduced the principle of an internal market in the face of near unanimous opposition (Klein 1995). Sometimes, a crisis situation can provide a window of opportunity to introduce large-scale reforms. An example is Cyprus, where the economic crisis provided an opportunity to introduce a General Health Insurance Scheme (GHIS), originally proposed by the Cypriot government in 1992 and eventually approved by the Parliament in 2001. In 2012, following recommendations by the European Commission, the Cypriot Cabinet decided to recommit to the reform (Cylus, Papanicolas et al. 2013).

The best approach thus depends on the particular circumstances of the country in question, but it is possible to build flexibility into the implementation process even in the case of “big bang” reforms. For example, one could combine a political “big-bang” approach for the passage of legislation, followed by incremental implementation inside health sector institutions. Two different

situations may occur. The first one is when an initial impetus triggers a snowball effect, making it easier to progress through the reform. The second situation is when upon start of a policy reform, barriers and obstacles begin to mount. In this case, persistence is the key to implementing the reform, so rather than a 'big-bang', a continuous reform effort, with increasing force put into it, is necessary (EXPH 2016).

Organizational maturity has been identified in the 2015 WHO experts meeting as a key factor for determining which change to opt for. It argued that in some immature or stagnant contexts, there is a need for 'context-busting' initiatives, such as top-down enforced rules and 'big bang' approaches. However, while sometimes effective, it conceded that this may also have unintended side effects, including staff disengagement and poor morale, and reform fatigue (WHO 2016).

Financial resources

For effective policy implementation, additional resources are generally required (Cerna 2013). This includes political, financial, managerial and technical resources (Walt 1994). Many health policies require actions by skilled workers, both in the health sector and beyond. Consequently, the effective implementation of many health policies will only be possible if they can build on the presence of a trained workforce. Health policies also require functioning information systems (McKee and Mackenbach 2013). Even when reform measures are aimed at containing costs or generating savings, their results are not likely to be felt in the short term. In most cases, additional resources are needed to establish information systems, management training, hire new personnel, purchase equipment, or drive changes in organizational structures (EXPH 2016). When no additional resources are provided, this can undermine intended reforms (Box 14).

Box 14 National health reform programmes in Kyrgyzstan

Kyrgyzstan has adopted several national health policies that embody key values of Health 2020. The "Den Sooluk" National Health Reform Programme for 2012-

2018 was adopted in 2012, continuing previous health reform programmes. “Den Sooluk” aimed to improve population health through expanding and improving the coverage of health services in four priority areas: cardiovascular disease control, maternal and child health, tuberculosis, and HIV/AIDS. The programme aimed to strengthen public health, individual health services, health financing, human and health care resources, and strategic management. The "Den Sooluk" programme was developed under the leadership of the Ministry of Health with the support of WHO and other development partners involved in the country’s sector-wide approach (SWAp).

The government, the Ministry of Health, and development partners began developing a new strategy in 2016. This new strategy was to be part of a larger cross government exercise to develop a 20-year strategy for the country (the National Development Strategy of the Kyrgyz Republic for 2018-2040), reflecting the Sustainable Development Goals (SDGs) agenda. Extensive discussions were held throughout the country at various venues, including with other ministries and departments, deputies and regional authorities. Kyrgyzstan also joined the Global Partnership on Universal Health Services Coverage 2030 and signed the Universal Health Services Coverage 2030 Compendium during its participation in the UN General Assembly in September 2018.

In 2018, the new health reform programme “Healthy People, a Prosperous Country 2019-2030” and its 5-year action-plan for 2019-2023 were adopted. Implementation is a top-down process, with overall coordination and monitoring carried out by the Ministry of Health. A new approach compared to past strategies is that the domestic budget will be a key source of financing, with the health sector from 2019 onwards being one of the first sectors to shift towards programme budgeting. This is to be complemented by development assistance, but promises to make the health reform programme more sustainable.

Key conditions for successful implementation of the new health reform programme will be a strong system of monitoring and evaluation at national, regional and departmental levels, wide engagement and consultation with

government bodies and civil society, and the development of leadership and management capability, particularly for mid-level managers.

A related question is whether, when and how to compensate those who will lose out a result of reforms. Concessions to potential losers need not compromise the essentials of the reform: it is often possible to improve the prospects of particular groups that will be affected by a reform without contradicting its overall aims. Failure to compensate may reinforce opposition to reform, but excessive compensation may be costly or may simply blunt the effects of the reform (EXPH 2016). The case of Iceland illustrates the difficulties of strengthening a key agency in the health system (Box 15).

Box 15 Challenges of implementing health reforms in Iceland

The current financial crisis has had some impact on the implementation of health reforms (a reform under the 2008 Health Insurance Act, introducing purchaser-provider arrangements and a commissioning agency, the Icelandic Health Insurance). However, the struggles facing the relatively new Icelandic Health Insurance agency have less to do with the financial crisis than with resistance inside the system. One factor is the reluctance to transfer resources, in the form of financial and human resources, expertise and skills, to the new agency from other parts of the health system (as planned when the legislation was drafted and agreed in parliament). Consequently, operationalizing parts of the agency's responsibilities has been repeatedly postponed by parliament on the grounds that the agency lacks the necessary resources to undertake its designated tasks. In particular, the full implementation of the agency's commissioning function is currently in a 'catch-22' position and the necessary political leadership to bring the plan forward has been absent.

From a system and governance perspective, this reform raises some questions. Firstly, a policy aiming to strengthen operational functions at the agency level

does not necessarily or automatically translate into strengthening of policy functions at the system level. This is due to the well-established knowledge that policy outcomes also depend on implementation processes in which competing views and professional interests may affect the balance of influence and allocation of resources necessary to see such policy priorities through. Moreover, while policy performance relies on similar operations, such as information gathering, data analysis and dissemination, merging different policy functions into one agency can also reduce their visibility, which again can facilitate the shifting of resources from one policy function to another, and run the risk of destabilizing the balance of influence and effectiveness between them.

Source: (Sigurgeirsdottir, Waagfjoreth et al. 2014)

Discussion

Based on a scoping review of the literature and in-depth interviews with experts in selected European countries, this policy brief has explored the conditions that need to be in place for successful health policy implementation in the context of Health 2020. Six conditions emerged as the most important ones:

- Ensure contexts are appropriate and receptive
- Get the timing right
- Transfer appropriate policies and innovations
- Ensure good governance
- Work with other sectors
- Move from exploration to full implementation

Identifying how these conditions apply to specific national contexts and policies will help health policy-makers to increase the chances of success for the policies they develop. The literature on policy implementation emphasizes that there is no one-size-fits all approach, so adapting these findings to country contexts will be key. The relative importance of conditions will differ between countries and

policies and also depend on the general national context in which health policies are being adopted and implemented. The importance of intersectoral working will naturally also differ in line with the specific policies that are being put into place. Crucially, putting policies in place is only the first step towards full implementation and the formal adoption of policies should not be taken as proof of implementation.

The country case studies identify a number of other relevant key lessons. One is that successful reforms and their implementation require not only technical expertise, but, more importantly, political will, ownership and buy-in. This requires broad engagement, with policy-makers, health professionals and the public, through communication before, during and after implementation. Political instability such as through changes of government, on the other hand, can undermine the implementation of health policies. National coordination of involved stakeholders can play a crucial role in supporting implementation at the local level. Dedicated funding streams, including where appropriate additional funding, and a clear roadmap for implementation with dedicated focal points, administrative support and mechanisms for monitoring and evaluation are other ingredients of successful implementation. Another lesson is that reform agendas can be either too ambitious, when they are all-encompassing in the absence of sufficient resources, but also fail to be ambitious, when solutions to problems only emerge once seemingly futile reforms started.

While this policy brief provides an illustrative overview of conditions for successful health policy implementation, its limitations need to be borne in mind. There is a dearth of peer-reviewed academic literature on the implementation of Health 2020. Our case studies helped to fill some of the gaps, but they only cover a relatively small selection of countries and policies. While not claiming to be comprehensive, we added information from the literature on health policy implementation more generally that illustrates how successful implementation of Health 2020 would look like. There is a clear need for more comprehensive research on which health policies are being developed and implemented, by whom, and facing which barriers and facilitators. It is generally (although not

always) clear which health policies have been formally adopted, but often it is much less clear (even in the countries themselves) which are being implemented. The complex interplay between national and international health policies, which can both inform or ignore each other, is also poorly documented, but of particular relevance to health policies at the European level, such as Health 2020.

Conclusions

This policy brief has identified a number of elements of relevance to the effective implementation of health policies and reforms, illustrated by examples of the national implementation of WHO's European health strategy Health 2020. However, it is clear that not all conditions are equally relevant to all contexts and it will not always be possible to meet all requirements of effective or "perfect" implementation. Two of the challenges are the complexity of policies themselves, dealing with "wicked problems", and the number of stakeholders involved. A certain degree of pragmatism will be needed, using evidence as best as possible and allowing for feedback and refinements throughout the reform process. This also includes sticking to principles of good governance. They fulfil a double purpose, ensuring the required leadership for the reform process and allowing for effective implementation to take place.

The scoping review allows for the following conclusions:

- Existing literature on the status of Health 2020 implementation is largely derived from WHO or WHO-affiliated reports, so a certain bias in reporting cannot be excluded
- There has been a marked increase in the number of countries aligning national polices and strategies with Health 2020 values and principles, alongside developing accompanying implementation plans and accountability mechanisms to monitor implementation progress.

- Encouraging progress has been made in terms of the number of countries embedding actions to tackle the social determinants of health within national policies.
- The adoption of whole-of government approaches to policy making is also becoming more common, although planned intersectoral or mutlisectoral actions are often not translated into action or are only partially implemented.
- Implementation and enforcement of effective inter- or multsectoral policies can be enhanced through the engagement and action of individuals, civil society, researchers, government and industry stakeholders.
- All actions should be underpinned high quality data and evidence and supported by good governance, a clear mandate to reach out beyond the health sector and sufficient resources and capacity.

The country case studies allow for the following conclusions:

- In the exploration stage of policies, Health 2020 only played an explicit and acknowledged role in two of the nine countries covered, Malta and Slovenia.
- Several of the case studies point to the importance of national ownership and broad consultation and engagement with other ministries, all levels of government, the public, NGOs and other stakeholders.
- In the installation phase, a key facilitator of implementation was the inclusion of government funding in regular budgets and the availability of technical and policy capacity. Limited funding was identified as a barrier.
- In the initial implementation phase, robust monitoring and evaluation to inform further implementation emerges as another ingredient of successful implementation.
- Only few countries have reached the stage of full implementation, so it is still early for drawing lessons.
- Successful reforms and their implementation require not only technical expertise, but, more importantly, political will, ownership and buy-in. This requires broad engagement, with policy-makers, health professionals and

the public, through communication before, during and after implementation to highlight the benefits the new policies bring.

- National coordination of involved stakeholders can play a crucial role in supporting implementation at the local level.
- Dedicated funding streams, including where appropriate additional funding, and a clear roadmap for implementation with dedicated focal points, administrative support and systems for monitoring and evaluation are other ingredients of successful implementation.
- Another lesson is that reform agendas can be either too ambitious, when they are all-encompassing in the absence of sufficient resources, but also fail to be ambitious, when solutions to problems only emerge once reforms started.

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Annex: Template for country case studies

Please complete the below table as far as possible. The aim should be to capture the most important aspects of policy implementation, including key actors, governance structures and contextual factors. This information should then be used to write a short (300-450 word) summary of the policy and key lessons learnt from its implementation.

Exploration stage	
Who was leading development of the policy?	
Who were key proponents?	
Who were key opponents?	
Have there been efforts to ensure participation (of the general public, civil society, local government, the private sector)?	
What were the key contextual factors facilitating implementation (e.g. change of government, federal structure of the country, funding constraints)?	
What were the key contextual factors hindering	

implementation (e.g. change of government, federal structure of the country, funding constraints)?	
Installation phase	
Who is leading implementation?	
Is implementation a top-down or bottom-up process?	
Is there a clear roadmap for implementation, with clear targets, funding allocations and milestones?	
Where does funding come from?	
Were new governance structures set up to facilitate implementation across sectors and levels of government?	
Initial implementation	
Is there sufficient (technical and policy) capacity for implementation?	
Was the policy adjusted following initial implementation?	

How is implementation being monitored and evaluated?	
Full implementation	
Has the stage of full implementation been reached?	
Have the goals of the policy been achieved?	
Is it sustainable?	
What other results did the policy have?	
Are there plans to continue the policy beyond its current timeframe?	
Overall lessons learnt	
What are the key lessons learnt?	