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Review article

Stakeholder analysis: a review

RUAIRÍ BRUGHA[1] AND ZSUZSA VARVASOVSZKY[2]
[1]Senior Lecturer in Public Health, London School of Hygiene and Tropical Medicine, London, UK and [2]Health Policy Advisor, National Health Insurance Fund, Budapest, Hungary

The growing popularity of stakeholder analysis reflects an increasing recognition of how the characteristics of stakeholders – individuals, groups and organizations – influence decision-making processes. This paper reviews the origins and uses of stakeholder analysis, as described in the policy, health care management and development literature. Its roots are in the political and policy sciences, and in management theory where it has evolved into a systematic tool with clearly defined steps and applications for scanning the current and future organizational environment. Stakeholder analysis can be used to generate knowledge about the relevant actors so as to understand their behaviour, intentions, interrelations, agendas, interests, and the influence or resources they have brought – or could bring – to bear on decision-making processes. This information can then be used to develop strategies for managing these stakeholders, to facilitate the implementation of specific decisions or organizational objectives, or to understand the policy context and assess the feasibility of future policy directions. Policy development is a complex process which frequently takes place in an unstable and rapidly changing context, subject to unpredictable internal and external factors. As a cross-sectional view of an evolving picture, the utility of stakeholder analysis for predicting and managing the future is time-limited and it should be complemented by other policy analysis approaches.

Introduction

References to stakeholders and the use of stakeholder analysis as a tool have become increasingly popular in the management, development and health policy fields during the last decade. This popularity reflects a recognition among managers, policy makers and researchers of the central role of stakeholders (individuals, groups and organizations) who have an interest (stake) and the potential to influence the actions and aims of an organization, project or policy direction (Mason and Mitroff 1981; Crosby 1992; Walt 1994). Through collecting and analyzing data on stakeholders, one can develop an understanding of – and possibly identify opportunities for influencing – how decisions are taken in a particular context. Although stakeholder approaches and concepts have been articulated within business management from the early 1930s (Clarkson 1995), the widespread use of the term 'stakeholder' in common parlance is a relatively recent phenomenon, especially in the field of politics (Anonymous 1996). References are frequently found to stakeholder 'approaches', 'frameworks' and 'issues' (Clarkson 1995); 'stakeholder-focused criteria' (Thomas and Palfrey 1996); 'stakeholding' and 'stakeholder society' (Thompson 1996); 'stakeholder-agency theory' (Hill and Jones 1992); 'stakeholder power matrices' and 'bunching' (Winstanley et al. 1995); and 'stakeholder values' and how to involve stakeholders in decision-making (Gregory and Keeney 1994).

Stakeholder analysis aims to evaluate and understand stakeholders from the perspective of an organization, or to determine their relevance to a project or policy. In carrying out the analysis, questions are asked about the position, interest, influence, interrelations, networks and other characteristics of stakeholders, with reference to their past, present positions and future potential (Lindenberg and Crosby 1981; Freeman 1984; Blair et al. 1990). This review identifies some of the different historical roots of stakeholder analysis, in that many of its features are found in the development and policy literature which predate by decades the use of the term. However, the paper does not attempt to comprehensively review the wider and extensive literature on stakeholders or interest groups and how they influence policy, organizations or project decision-making processes. It focuses on studies, principally in the management and development literature, which have explicitly used a systematic approach to stakeholder analysis, identifying key features which distinguish it from the broader literature on stakeholders. Recent applications in the policy field are also discussed. Initially, a literature search of the Health Star, BIDS and MEDLINE databases was conducted, using the keywords 'stakeholder' and 'stakeholder analysis'; further searches were made on important authors.

The review evaluates the utility of, and different approaches to conducting, a stakeholder analysis in relation to the different purposes for which it has been used. As Crosby (1992) pointed

out, 'stakeholder analysis encompasses a range of different methodologies for analyzing stakeholder interests and is not a single tool.' The purpose, time-dimension of interest, the context in which the analysis is carried out, and the degree to which an issue has been clearly defined and the stakeholders identified, each has a bearing on how one conducts it. The paper is aimed particularly at those who are considering using it for the analysis, development or implementation of public health policy, which frequently involve a complex range of stakeholders, often in diverse cultural contexts. The practical steps and methodological approaches to carrying out a stakeholder analysis are outlined in a separate paper, '*How to do (or not to do) . . . a stakeholder analysis*', later in this volume (Varvasovszky and Brugha 2000).

Background

Policy roots

Policy analysts have long been aware of the importance of interest groups in the policy process; and the need to characterize and categorize levels of interest and power which influence, and therefore impact on, particular policies. Political scientists have viewed decision-making and implementation as determined by how power is structured, differentiating between: *elitism*, where power is concentrated in the hands of an influential few (Laswell 1958; Bachrach and Baratz 1962); *pluralism*, where power is distributed throughout various groups in society (Lindblom 1959; Dahl and Lindblom 1976); *Marxism*, where power is distributed among classes and the state is the instrument of class power; *corporatism*, where the state has the power to overcome the conflict between labour and capital; *professionalism*, where power is concentrated in the hands of professional elites who may give preference to their own interests over those of the public they serve; and *technocracy*, where decision-making is by technocrats, using principles of scientific rationalism.

Policy network and community approaches have focused on the patterns of formal and informal contacts and relationships which shape policy agendas and decision-making, as opposed to the interplay between and within formal policy-making organizations. This approach takes the view that networks and communities structure people's interests in the policy process (Smith 1993). Kingdon (1984) conceptualized the policy stream as being dominated by policy entrepreneurs who are willing to invest resources of various kinds in the hope of a future return in the form of policies they favour. Benson (1975, 1982) argued that, to understand inter-organizational relationships, the network of interests within a policy sector had to be understood. He proposed three main elements: (1) administrative networks, where agencies are dependent on each others resources; (2) interest group networks, which support shared interests within the policy sector; and (3) the rules which limit or enable action at the administrative and interest network levels. A criticism of the network and community approaches is that they say little about the policy-making process itself (Ham and Hill 1984).

In 1959, Lindblom outlined an incrementalist model to explain the policy-making process, characterized by 'negotiation, bargaining and adjustment between different interest groups (or partisans)' (Walt 1994). Gergen (1968) also recognized the role of actors as potential 'leverage points' in the process of policy formulation and the need to obtain information on them. Hall's 1975 model for policy agenda-setting included the concept of levels of support, along with legitimacy and feasibility, for explaining what got on the agenda (Walt 1994); and Kingdon (1984) referred to visible and hidden participants, within the politics stream, each of which could actively promote policy options or solutions. Walt (1994) highlighted the fact that many different groups, including non-governmental organizations (NGOs), may be involved in both policy formulation and policy implementation; and that policy makers need to mobilize support and resources in favour of policy reforms.

Stakeholder analysis, as one approach to conducting policy analysis, was adapted from the organizational and management literature in the 1970s and 1980s, drawing on the earlier work of policy scientists who were concerned with the distribution of power and the role of interest groups in the decision-making and policy process. Here, policy actors are considered not only as interest groups but also as active or passive players on the policy scene who are also affected by the policy. Stakeholder analysis, in the light of policy science approaches, provides a conceptualization which assists in the analysis of interests and influence with a specific focus on policy actors. It focuses on the interrelations of groups and organizations and their impact on policy, within a broader political, economic and cultural context.

In the last decade, in industrialized countries with democratic political structures, the views of civil society citizen groups have increasingly been sought (see Introduction). There has been a noticeable shift from a rational policy-making model towards a greater recognition of the importance of actors or stakeholders and their 'political will' in policy formulation and decision-making (Weiss 1977; Walt 1994; Grimble et al. 1995; Reich 1995; Holzknecht 1996). Much of the focus of health policy research has been on retrospective or concurrent analyses of the processes of health policy formulation in different contexts (Grindle and Thomas 1991; Walt and Gilson 1994). The approach is often more intuitive and less systematic than the structured prospective stakeholder analyses conducted by development managers and organizations (see Management roots). Varvasovszky and McKee's (1998) policy analysis and exploration of future alcohol policy directions and the influence of stakeholders in Hungary is one example of a more systematized approach with a prospective perspective.

Management roots

According to Preston (1990), stakeholder theories for managing an organization originated in the early 1930s in the United States, where the General Electric Company identified four major interest groups it had to consider: customers, employees, the general public and shareholders. If the legitimate needs and expectations of the first three groups, categorized as the company's primary stakeholders, could be met, the shareholders would benefit (Preston 1990). A stakeholder approach reflects the realization that the interests and influence of these

individuals or groups, both within and outside the organization, need to be taken into consideration in evaluating threats and opportunities for change, in strategic planning and selection of strategic options, and in successfully implementing and managing change (Mason and Mitroff 1981; Lindenberg and Crosby 1981). In organizational and strategic management, as outlined by Freeman (1984), the rationale for paying attention to stakeholders is that they are – by definition – in a position to influence the wellbeing of an organization or the achievement of its objectives; managers therefore require strategies for mobilizing, neutralizing or defeating them, depending on their potential to support or oppose the interests of the organization (Bernhart 1992).

Within US health care management since the late 1980s, stakeholder analysis has evolved as a systematic approach with clearly defined steps and applications for scanning the current and future organizational environment (Blair and Whitehead 1988; Blair and Fottler 1990; Blair et al. 1996a). The aim is to generate knowledge about the relevant actors so as to understand their behaviour, intentions, interrelations, agendas, interests, and the influence or resources they can bring to bear on the decision-making processes. Explicitly, it recognizes that different levels of importance are accorded to each stakeholder, when evaluated using these criteria; and it attempts to quantify levels of importance (Blair and Whitehead 1988; Fottler et al. 1989; Blair et al. 1990). When used as a management tool, where the analysis is mainly prospective, it is usually outlined as a series of well-defined stages or steps.

Development roots

Lindenberg (1981) highlighted the political dimension of development and the need for development managers to first undertake a systematic political analysis so as to understand the positions and importance of the different actors. He adapted Lasswell's (1958) definition of politics, 'the study of the process of Who Gets What, When and How [to] . . . the even more pragmatic: "What Do I Want? Who Has It? and When and How Can I Get It?"' (Lindenberg 1981). His outline of the steps in the political analysis process included many of the features of what was later termed stakeholder analysis: making an inventory of the actors who might have a role in decision-making; collecting information about them to gauge their importance – managers could thereby eliminate 'marginal' ones and 'concentrate their attention on those actors they believe will make the final decisions, as well as those who will have the most influence on the principal decision makers'; quantification of the actors' levels of influence (high, medium or low), and their interest and support for a specified outcome; assessment of their capacity and willingness to mobilize resources towards a particular goal; and the 'mapping' of actors, both in terms of the relationships between them, their potential for developing alliances with each other, and in their relationship to the desired outcome (Lindenberg 1981).

Confusion and clarification

Reich's (1994) political mapping tool is a notable recent development in the policy literature in that it represents a systematic approach to increasing the political feasibility of implementing a specific policy, similar to the use of stakeholder analysis as a project implementation tool. Reich describes political mapping as a six-stage process, the third of which is stakeholder analysis, at which stage information is collected about the objectives and underlying motives of major organizations and individuals with regard to the health policy decision in question and what priority they give to it. In political mapping, mapping organizational networks with regard to the policy, assessing transitions in the organizational and political environment, and then selecting strategies for change are each seen as subsequent steps in which the information generated by a stakeholder analysis is used (Reich 1994). That there is some uncertainty, and possibility for confusion, in the use of terminology is apparent in a recent reference to the development of an 'interest mapping' tool for use by policy makers, which is described as 'a combination of stakeholder analysis and political mapping approaches to profiling interest group positions . . .' (PHR 1998).

With the growth in the popularity of the term, an increasing number of studies report that a stakeholder analysis was conducted. In many cases (Ashbury et al. 1995a; Ashbury et al. 1995b; Chowdhury 1996; Evans 1996; Morrisey et al. 1997; Palmer 1998), these studies have been restricted to eliciting the views of stakeholders or involving them in decision-making, without a systematic analysis of stakeholders' roles, relationships, interest and influence in the decision-making process. This use of the term for studies which have often included only one or two features or steps of a stakeholder analysis risks causing confusion. The diversity of applications and references to the use of the tool indicates a need to identify the characteristic features and alternative approaches to conducting such an analysis. These are largely determined by its purpose and how the information will be used: to achieve an organizational advantage, implement a project or policy, or analyze how policies have developed and predict their future directions. These different purposes require focusing on one or more different time dimensions and stages of events – past, present, near or distant future; and they determine who should be considered stakeholders and how they are categorized. In addition, the methodological approach to collecting and analyzing data is determined by the cultural context and the level at which it is conducted. This can range from the local level in project implementation, to the international, for global policy analyses [see *How to do (or not to do) . . . a stakeholder analysis*, Varvasovszky and Brugha 2000 (this issue)].

Organizational and health management

In health management, stakeholder analysis has usually been advocated as a tool for an (insider) organization to achieve specific advantages and goals in its dealings with other organizations, through identifying potential allies and building alliances or attenuating potential threats (Blair et al. 1996b). It may be carried out to inform strategic planning for a specific short-term objective, or as a periodically conducted exercise in scanning the external or internal organizational environment, focusing on the present or more distant future. Frequently, the organization – rather than a specific venture

– is the focus of the analysis; and the purpose is to predict changes in the relative importance of stakeholders, identify new or upcoming ones and decide on what strategies to use in managing them. A notable example is the five-year prospective study of medical practice executives, 1994–99, reported by Blair et al. (1996a). The study aims to identify the 'optimal fit' for organizations in their dealings with stakeholders, predict what the 'optimal fit' will be in the future; and, by assessing the outcome at the end of the period, to evaluate the utility of stakeholder analysis as a predictive tool.

Similar applications from the United States include: to identify the most important future medical group practice stakeholders who will play a major role in shaping these delivery networks (Dymond et al. 1995); to improve the management and performance of Health Maintenance Organizations (Topping and Fottler 1990); and to assist physician executives in coping with uncertainties facing their organizations in their dealings with other stakeholders (Blair et al. 1989). Stakeholder analysis has also been used to assess the likelihood of success of specific projects or collaborations, e.g. joint business ventures between hospitals and groups of physicians (Blair et al. 1990). In collaborating with a group of neurologists to set up a magnetic resonance imaging (MRI) centre, an hospital would aim to achieve the dual benefit of financial and collaborative success; and it might be willing to risk or incur short-term financial losses so as to retain the good will of, and attract hospital admissions from, these independent specialists. In US hospital management, the analysis has a strongly prospective and often long-term time dimension, involving stakeholders in a relatively stable, if evolving, context. Organizations which expect to be in long-term inter-dependent relationships with important stakeholders can use the tool to build collaborations and thereby foster a more favourable future environment (Reeves 1994). In organizational management, stakeholder analysis can have other purposes: Frost (1994) describes how it was used by the mining industry in Australia to understand ethical issues and develop an ethical framework in its interactions with other stakeholders who have an interest in the primary resource sector.

Clarkson (1995) defines stakeholders as 'persons or groups that have, or claim, ownership, rights, or interests in a corporation and its activities, past, present, or future.' He categorizes them as *primary* stakeholders, who are essential to the survival and wellbeing of the organization (shareholders, employees, customers and those with regulatory authority or other forms of power over the organization), and *secondary* stakeholders, with whom the organization interacts but who are not essential to its survival (Freeman 1984; Clarkson 1995). They are also categorized according to their organizational location: internal ones (operating within the bounds of the organization), interface ones who interact with the external environment, and external stakeholders (usually other organizations) who may either contribute to, compete with, or have a special interest in the functioning of one's organization (Fottler et al. 1989; Blair and Fottler 1990). They are frequently considered in adversarial terms, i.e. as opportunities for collaboration or as threats (Blair and Fottler 1990).

In health management, *identification* of an organization's important stakeholders is usually the first step in a stakeholder analysis (Hatten and Hatten 1987; Blair et al. 1990). This is frequently done through structured surveys of a known group of key stakeholders, where inclusion of others as important stakeholders is determined by what percentage of respondents mention them (Fottler et al. 1989; Blair et al. 1996a). The increasingly structured approach to stakeholder analysis in the US health management literature reflects the stability of the context, familiarity with the organizational environment, and a resultant pragmatism: 'Hospital executives do not have time to consider all possible stakeholders so it is important for them to focus on the most important ones' (Fottler et al. 1989). However, Frost (1994), in writing about environmental and resource management from the perspective of a mining company in Australia, cautions about making premature judgements and excluding apparently minor stakeholders who can subsequently exert disproportionate leverage on decisions.

Through structured surveys, respondents may be asked to score the level of power of stakeholders, e.g. on a 10-point scale, and to indicate whether the power of each is increasing, reducing or stable. Potential limitations of this approach, as noted by Fottler et al. (1989), are that the pre-selection of respondents may result in important stakeholders being omitted due to sampling biases favouring particular types; respondents' opinions about who are important stakeholders are given equal weight, which may not be justified; and it treats stakeholders – both respondents and those identified through the survey – as clearly defined entities. Whereas, even in the more clearly defined organizational environment of the United States, and often more so in developing country contexts, stakeholder respondents are often individuals with multiple formal and informal organizational and individual interests and allegiances. The structured quantitative approach to data collection also reflects the cultural context, where the use of self-completed questionnaires is normal and acceptable. Blair et al. (1996a) view this move from qualitative to quantitative approaches as requiring further evaluation (data collection methods are considered in *How to do (or not to do) . . . a stakeholder analysis*, this issue).

When used as an organizational management tool, stakeholder *mapping* or assessment is usually the next step. How these maps are constructed depends on the purpose of the analysis. In scanning the organizational environment, they can be used to display an organization's key relationships, placing the organization at the centre of the map (Fottler et al. 1989; Blair et al. 1996a). Maps can be used to display the strength of these relationships and the potential for coalitions with, and between, important stakeholders. Alternatively, if the aim is to analyze stakeholder positions around a programme or organizational objective, this is placed at the centre of the map. Stefl and Tucker (1990), in conducting a stakeholder analysis to assist in designing a health care administration academic programme, mapped internal stakeholders (programme faculty, students and applicants), interface stakeholders (university administration) and external stakeholders (external funders, potential employers, professional bodies and accrediting bodies) in relation

to the proposed programme. Particular dimensions which could affect the outcome were listed – values/beliefs, power, cooperative potential, and issues likely to be of particular concern to individual stakeholders. Their interests and likely positions with regard to the programme were mapped on a matrix grid, and actions for mobilizing the support of each were identified.

Increasingly, in US health care management, stakeholder analysis is used by organizations as a tool for long-range strategic planning and stakeholder management (Blair and Fottrell 1990). Based on the responses from 686 group practice executives in 1994 and 1995, Dymond et al. (1995) summarized their predictions of how control of resources and relative power were likely to shift from individual physicians and hospitals to integrated delivery networks (IDNs) and health maintenance organizations (HMOs) over the subsequent 5 years; and hence the need for affiliations or alliances with these IDNs, and for negotiation skills so as to develop and handle complex contracts with HMOs, if group practices were to survive. In 1994, 82% of group practice executives considered individual physicians, and 18% considered IDNs, to be currently among the five key stakeholders; 49% of the same respondents predicted that physicians, and 82% that IDNs, would be among the top five by 1999 (Blair et al. 1996a). Interestingly, the percentage of respondents which expected patients to be among the top five key stakeholders, at the end of the same period, dropped from 90 to 62%. Stakeholder *diagnosis* and *strategy formulation* are the final stages in organizational stakeholder analysis and management. Diagnosis is about assessing the potential of stakeholders as threats and as opportunities for cooperation with one's own organization, which are classified as high or low. The aim is to identify the appropriate strategy or 'optimal fit' for managing each category of stakeholder (Blair and Fottrell 1990).

Development projects and programmes

In project planning and implementation, the support or opposition of parties involved in or affected by the project is an important factor in determining its success or failure (Montgomery 1974; Brinkerhoff 1991). A stakeholder analysis can be used to inform project planning, implementation or evaluation (ODA 1995; MacArthur 1997); the latter can be conducted during or after project completion. Primary stakeholders include intended project beneficiaries, and others who are positively or negatively directly affected by the project; while secondary stakeholders are intermediaries who can influence project outcomes (ODA 1995). In strategic planning (and in policy implementation), criteria for inclusion are the potential of stakeholders to strengthen or weaken the authority and political support of the decision maker, or to influence the direction and outcome of the decision under consideration (Crosby 1992). As in the case of health management, the perspective is prospective and pragmatic, and is additionally constrained by available resources.

In planning and managing development programmes, the usual starting point is defining the goal and identifying the issues of interest or different aspect of the project to be implemented (Lindenberg 1981; Brinkerhoff 1991; Bernhart 1992). Lindenberg (1981) recommended first articulating the different dimensions of a development problem (location, magnitude, possible causes), setting objectives and desired outcomes, followed by identification of the actors who might have an influence on the achievement of the outcomes. Bernhart (1992), for the planning of a population control programme, recommended an evaluation of how different components of such programmes have evolved, followed by an identification of important management issues and possible strategic responses (e.g. adolescent-targeted services, abortion, revenue generation, regulation, public-private competition). Once the key issues and components of a programme have been identified, stakeholder analysis is used to identify who will be concerned by or affected by these issues, followed by an assessment of their levels of interest and influence.

A stakeholder analysis conducted after the design and before the implementation of a women's and children's health development project in India concluded that the project should be cancelled (Kumar et al. 1997). The funder and the state government and bureaucracy could not reach agreement: the former believed that involvement of NGOs was essential to the success of the project, while the latter two did not want to see donor funds being transferred to the NGO sector. Other stakeholders who supported the project (NGOs, media and local political groupings) did not have sufficient influence to tip the scales in its favour. The authors, probably with some justification, thought that this was a successful use of the tool.

Policy

Stakeholder analysis is one of a number of different but closely related policy research or strategic tools now found in the health policy literature, including political analysis (Lindenberg 1981), policy mapping and political mapping (Reich 1994), and more recently interest mapping (PHR 1998). In that there are features common to all of them – e.g. mapping of stakeholder power, interest and influence around a policy issue – there is a need to identify and clarify differences. The purpose of the analysis and time dimensions of interest determine the approach and how the tools are used. Holzknecht's (1995) analysis of stakeholder clashes in the rainforests of Papua New Guinea (PNG) demonstrated how powerful foreign and internal commercial interest groups were able to subvert government, emasculating national policies for the protection of natural resources and the rights of indigenous communities. This *analysis of policy* had a strong retrospective dimension, covering the previous 20 years, and concluded with recommendations for achieving 'the sustainable and equitable management of natural resources in PNG' (Holzknecht 1995). As has been the case in many references to the use of the tool for policy analysis, the methodological approach was not described.

Varvasovszky and McKee (1998) conducted a stakeholder analysis of policies around alcohol in Hungary; it sought to understand the process of public health policy making in a

situation of political, economic and social transition. The aim was to produce results which would inform and assist policy makers in making policy choices, i.e. an *analysis for policy development*, taking into account the interest and influence of a wide range of stakeholders in the development of a national alcohol policy. As a piece of research, the purpose was to understand the policy-making process, a past and present time dimension; with a view to predicting and possibly influencing policy development, a prospective dimension. The purpose (interest) of the analyst was to conduct a piece of sound research, with a view to it contributing to the development of effective public health policy. The analysis aimed to identify the most acceptable, and therefore feasible, policy directions for achieving broad public health goals. *How to do (or not to do) . . . a stakeholder analysis*, later in this volume, describes how this analysis was conducted.

Reich (1994), in his description of political mapping, includes stakeholder analysis as one of the steps. Political mapping has a strongly prospective time dimension where, frequently, it is a *tool for policy implementation*, i.e. where it is used to assist a policy maker – the client – in implementing a specific policy. In its purpose, it is similar to the use of stakeholder analysis as an implementation tool, as described in the organizational management and development literature. In discussing the politics of health sector reform policies, Reich shows how it can be used for problem identification, policy formulation, and identification of implementation strategies '. . . that can improve the political feasibility of health policy; and overall enhanced impact of health policy, by improving the chances that a policy will achieve its intended effects' (Reich 1995). Frenk (1995), in his 'Comprehensive policy analysis for health system reform', describes the use of a range of technical tools for identifying the optimum (most efficient) policy proposals for reforming the health system: burden of disease assessments for identifying and quantifying the problem; evaluation of the evidence on the effectiveness and cost-effectiveness of the available interventions; analyses of health systems performance and available finances, to determine the technical feasibility of the different interventions; followed by a community survey and political mapping exercise to assess the political feasibility of the different options.

Conclusion

Stakeholder analysis has developed as a tool with quite different purposes in its application in the fields of policy, management and project implementation. It is often outlined as a series of steps. Identification of the different dimensions of the analysis, in relation to its different purposes (see Figure 1 in *How to do (or not to do) . . . a stakeholder analysis*, this issue), is an alternative way of illustrating its key features. In policy, its scope can range from broad with a strong retrospective dimension, with the aim of understanding the policy context and processes; to working towards a more immediate, often well-defined and focused policy implementation goal; to prospectively outlining more long-term and broadly focused policy directions. The important distinction in its use as a policy tool is whether it seeks to facilitate the implementation of a specific pre-determined policy or policy direction, as used within political mapping (Reich 1994; Frenk 1995); or as an historical and concurrent analysis to evaluate how policies have developed and the feasibility of different policy options and directions. In the latter, the analysis is often conducted by an independent analyst or researcher, within a broad public health or ethical framework (Holzknecht 1995; Varvasovszky and McKee 1998); whereas, in the former, the analysis is conducted by, or on behalf of, a policy maker.

Descriptions of health policy as 'fuzzy' (Kroneman and van der Zee 1997) highlight the need for policy analysis tools. As a tool, or set of tools, for analyzing policy, stakeholder analysis is only one of a number of approaches for understanding policy-making processes and how policy issues get onto the agenda. Policy development is not circumscribed, in the way organizational relationships and project implementation often are, and, in the context of increasing globalization, is increasingly influenced by external agents and factors (Walt 1998). National policy development can be influenced by processes of 'policy convergence' or 'policy transfer', which might not emerge in a stakeholder analysis (Bennett 1991; Dolowitz and Marsh 1996). For example, in the case of Hungary where the analysis showed limited potential for the development of a comprehensive public health-promoting national alcohol policy (Varvasovszky and McKee 1998), non-mobilized, high influence, low interest stakeholders such as Ministries of Finance and Industry might become mobilized high-interest actors, if the European Union (EU) made such policies a prerequisite to EU entry.

The usefulness of the tool, along with other non-linear policy analysis approaches, is that stakeholder analysis highlights the importance of actors and interest groups in the policy-making process. Its particular strength, and one of its principal limitations, lies in its prospective dimension whereby it can be used to predict and provide information to influence the future. Observations are made cross-sectionally over a limited period of time. However, the policy environment, the context of the analysis, stakeholder interests, positions, alliances and influence are subject to change; and stakeholder perceptions of the past also change. The political context of policy-making is frequently unstable, especially in many developing countries, and can be subject to sudden, unexpected transformations. A stakeholder analysis by one of the authors to facilitate the development of public–private sector malaria control strategies in an urban area of India had to take into account the impact of three different Municipal Commissioners – the principal local policy maker – on the project over the course of one year (unpublished data). Similarly, leadership uncertainty, due to imminent elections in the Dominican Republic in 1995, obstructed the implementation of reform strategies developed over a period of years through a political mapping process (Glassman et al. 1999). Therefore, if the time-frame of a prospective analysis is too long or study results are not applied in a relatively short period of time, especially in complex and potentially unstable settings, the relevance of the analysis for informing stakeholders on how to manage the future decreases rapidly.

The use of structured data collection approaches, e.g. modified Delphi tools, in the health management literature, where respondents are asked to quantify the current and future

levels of importance and influence of the different stakeholders, is a useful adjunct to the more intuitive qualitative approaches usually used in policy analysis. However, the development of health policy is a complex process, the nuances of which may often not be adequately captured using overly structured approaches. If a stakeholder analysis approach is used, analysts needs to retain a critical stance in interpreting the responses of actors. The quality of the analysis will be determined by the understanding and ability of the analysts, and therefore their judicious use of such tools.

Cultural contexts where respondents are not familiar with this approach, or have unspoken agendas which deter them from making forthright responses, can limit its usefulness. However, where stakeholder representatives can be encouraged to state the positions and declare the interests of their organizations – and share these with other important stakeholders – a more coherent dialogue between interest groups and a more transparent process of policy development may be facilitated. The cross-sectional nature of the analysis, the provisional nature of the information obtained and the unpredictability of future events are inherent limitations of stakeholder analysis; recognition of these limitations increases its utility for understanding and influencing the policies and politics of health.

References

Anonymous. 1996. Blair raises the stake: Labour's leader says he wants to turn Britain into a 'stakeholder economy'. What might this mean? *The Economist Newspaper* Jan 13; **338**: 7948.

Ashbury FD, Iverson DC, Shephard PJ. 1995a. Issues for interpreting external stakeholder feedback on restructuring NCIC's research programs. *Canadian Journal of Oncology* **5**(1): 328–37.

Ashbury FD, Iverson DC, Shephard PJ, Hachey C. 1995b. Charting the NCIC's future: stakeholder support for identified options. *Canadian Journal of Oncology* **5**(1): 314–27.

Bachrach PS, Baratz MS. 1962. Two faces of power. *American Political Science Review* **56**: 1947–52.

Bennett CJ. 1991. Review article: what is policy convergence and what causes it? *British Journal of Policy Studies* **21**: 215–33.

Benson JK. 1975. The interorganizational network as a political economy. *Administrative Science Quarterly* **20**: 229–49.

Benson JK. 1982. A framework for policy analysis. In: Rogers DL, Whetten D (eds). *Interorganisational coordination: theory, research and implementation*. London: Anglo-German Foundation.

Bernhart MH. 1992. Strategic management of population programmes. Policy research working papers, population, health, and nutrition; population and human resources department. Washington DC: The World Bank.

Blair JD, Whitehead CJ. 1988. Too many on the seesaw: stakeholder diagnosis and management for hospitals. *Hospital and Health Services Administration* **33**(2): 153–66.

Blair JD, Fottler MD. 1990. *Challenges in health care management: strategic perspectives for managing key stakeholders*. San Francisco, CA: Jossey-Bass.

Blair JD, Buesseler JA, Stanton SY, Whitehead CJ. 1989. Stakeholder issues for the physician executive. *Physician Executive* **15**(3): 9–14.

Blair JD, Slaton CR, Savage GT. 1990. Hospital-physician joint ventures: a strategic approach for both dimensions of success. *Hospital and Health Services Administration* **35**(1): 3–26.

Blair JD, Rock TT, Rotarius TM, Fottler MD, Bosse GC, Driskill JM. 1996a. The problematic fit of diagnosis and strategy for medical group stakeholders – including IDS/Ns. *Health Care Management Review* **21**(1): 7–28.

Blair JD, Fottler MD, Whitehead CJ. 1996b. Diagnosing the stakeholder bottom line for medical group practices. Key stakeholders' potential to threaten and/or cooperate. *Medical Group Management Journal* **43**(2): 40, 42–8, 50–1.

Brinkerhoff D. 1991. *Improving development program performance*. Boulder, CO: Lynne Reinner Publishers.

Clarkson MBE. 1995. A stakeholder framework for analyzing and evaluating corporate social performance. *Academy of Management Review* **20**(1): 92–117.

Crosby B. 1992. *Stakeholder analysis: a vital tool for strategic managers*. Washington DC: USAID.

Dahl R, Lindblom CE. 1976. *Politics, economics and welfare*. 2nd ed. New York, NY: Harpers.

Dolowitz D, Marsh D. 1996. Who learns what from whom: a review of the policy transfer literature. *Political Studies* **XL1V**: 343–57.

Dymond S, Nix TW, Rotarius TM, Savage GT. 1995. Why do key integrated delivery stakeholders really matter? Assessing control, coalitions, resources and power. *Medical Group Management Journal* **42**(6): 26–38.

Evans D. 1996. A stakeholder analysis of developments at the primary and secondary care interface. *British Journal of General Practice* **46**(412): 675–7.

Fottler MD, Blair JD, Whitehead CJ, Laus MD, Savage GT. 1989. Assessing key stakeholders: who matters to hospitals and why? *Hospital and Health Services Administration* **34**(4): 525–46.

Fottler MD, Blair JD, Rotarius TM, Youngblood MR. 1996. Strategic choices for medical group practices. *Medical Group Management Journal* **43**(3): 32–6.

Freeman RE. 1984. *Strategic management: a stakeholder approach*. Boston, MA: Pitman.

Frenk J. 1995. Comprehensive policy analysis for health system reform. *Health Policy* **32**(1–3): 255–77.

Frost FA. 1995. The use of stakeholder analysis to understand ethical and moral issues in the primary resource sector. *Journal of Business Ethics* **14**: 653–61.

Gergen KJ. 1968. Assessing the leverage points in the process of policy formulation. In: Bauer R and Gergen K (eds). *The study of policy formulation*. New York, NY: The Free Press, pp. 181–204.

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

Gregory R, Keeney RL. 1994. Creating policy alternatives using stakeholder values. *Management Science* **40**(8): 1035–48.

Grimble R, Chan MK et al. 1995. *Trees and trade-offs: a stakeholder approach to natural resource management*. London: International Institute for Environment and Development.

Grindle M, Thomas J. 1991. *Public choices and policy making*. Baltimore, MD: John Hopkins Press.

Hall et al. (1975), in Walt G. 1994. Setting the policy agenda: who influences what? (Chapter 4). *Health policy: an introduction to process and power*. London: Zed Publications.

Ham C, Hill M. 1984. *The policy process in the modern capitalist state*. Brighton, Sussex, UK: Harvester Wheatsheaf.

Hatten KJ, Hatten ML. 1987. *Strategic management: analysis and action*. Englewood Cliffs, NJ: Prentice-Hall.

Hill CWL, Jones TM. 1992, Stakeholder-agency theory. *Journal of Management Studies* **29**(2): 131–54.

Holzknecht H. 1996. Policy reform, customary tenure and stakeholder clashes in Papua New Guinea's rainforests. *Rural development forestry network paper 19c*. London: Overseas Development Institute (ODI).

Kingdon J. 1984. *Agendas, alternatives and public policies*. Boston, MA: Little Brown & Co.

Kronemann MW, van der Zee J. 1997. Health policy as a fuzzy concept: Methodological problems encountered when evaluating health policy reforms in an international perspective. *Health Policy* **40**: 139–55.

Kumar Y, Chaudhury NR, Vasudev N. 1997. *Stakeholder analysis: the women's and children's health project in India*. Technical Report No. 13. Bethesda, MD: Partnerships for Health Reform, Abt Associates Inc.

Lasswell H. 1958. *Politics: who gets what, when and how*. New York, NY: Meridian Books.
Lindblom CE. 1959. The science of muddling through. *Public Administration Review* **19**: 78–88.
Lindenberg M, Crosby B. 1981. *Managing development: the political dimension*. Hartford, CT: Kumarian Press.
Mason R, Mitroff I. 1981. *Challenging strategic planning assumptions*. New York, NY: John Wiley & Sons.
Montgomery J. 1974. *Technology and civic life: making and implementing development decisions*. Cambridge, MA: MIT Press.
Morrisey J, Johnsen M, Calloway M. 1997. Evaluating performance and change in mental health systems serving children and youth: An interorganisational network approach. *Journal of Mental Health Administration* **24**(1): 4–22.
ODA. 1995. *Guidance note on how to do a stakeholder analysis of aid projects and programmes*. London: Overseas Development Administration.
Palmer J. 1998. Prioritization in community health planning: Combining methods to achieve implementable priorities. *Journal of Health and Human Services Administration* **21**(1): 109–34.
PHR. 1998. *Interest mapping for MoH reform in Ecuador*. Bethesda, MD: Partnerships for Health Reform, Abt Associates Inc.
Preston LE. 1990. Stakeholder management and corporate performance. *Journal of Behavioural Economics* **19**(4): 361–75.
Reeves PN. 1994. Strategic planning revisited. *Clinical Laboratory Management Review* **8**(6): 549–55.
Reich M. 1994. *Political mapping of health policy; a guide for managing the political dimension of health policy*. Boston, MA: Harvard School of Public Health.
Reich M. 1995. The politics of health sector reform in developing countries – 3 cases of pharmaceutical policy. *Health Policy* **32**(1–3): 45–77.
Smith MJ. 1993. *Pressure power and policy: state autonomy and policy networks in Britain and the United States*. Hemel Hempstead, Herts, UK: Harvester Wheatsheaf.
Stefl ME, Tucker SL. 1994. Applying stakeholder analysis to health care administration education. *Journal of Health Administration Education* **12**(2): 119–44.
Thomas P, Palfrey C. 1996. Evaluation: stakeholder-focused criteria. *Social Policy and Administration* **30**(2): 125–42.
Thompson P. 1996. Editorial commentary: stakeholding as state strategy. *Renewal* **4**(2): 3–11.
Topping S, Fottler MD. 1990. Improved stakeholder management: the key revitalizing the HMO movement? *Medical Care Review* **47**(3): 365–93.
Varvasovszky Z, Brugha R. 2000. How to do (or not to do) . . . a stakeholder analysis. *Health Policy and Planning* **15**: 338–45.
Varvasovszky Z, McKee M. 1998. An analysis of alcohol policy in Hungary. Who is in charge? *Addiction* **93**(12): 1815–27.
Walt G. 1994. Can interest groups influence government policy? *Health policy: an introduction to process and power*. London: Zed Publications.
Walt G, Gilson L. 1994. Reforming the health sector in developing countries: the central role of policy analysis. *Health Policy and Planning* **9**: 353–70.
Walt G. 1998. Globalisation of international health. *Lancet* **351**(9100): 434–7.
Weiss C. 1977. *Using social research in public policy making*. Lanham, MD: Lexington Books.

Biographies

Ruairí Brugha is a Senior Lecturer in International Public Health, with a background in clinical work, public health practice and research in Africa and Asia. His current research interests are in the public health role and potential of private for-profit health care providers in developing countries, and in policy and health systems research.

Zsuzsa Varvasovszky is a health policy advisor at the National Health Insurance in Hungary, with a background in public health and policy research. Her current interests are in health care policy and management issues particularly in countries with unsettled policy environment.

Correspondence: Ruairí Brugha, MB, MD, Senior Lecturer in Public Health, London School of Hygiene and Tropical Medicine, Keppel Street, London WC1E 7HT, UK. Email: ruairi.brugha@lshtm.ac.uk

Zsuzsa Varvasovszky, MD, PhD, Health Policy Advisor, National Health Insurance Fund, 1137 Budapest, Váci út 70/a, Hungary. Email: zs.varvasovszky@mail.matav.hu