

POLICY CAPACITY FOR HEALTH SYSTEM REFORM

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Abstract

In the past decade Canada and its provinces have conducted several reforms of their health-care systems. Through various public policies, governments have tried to improve their health systems and population health status. Growing demands for health services in the face of resources constraints raise the question of the capacity of governments and others actors to develop and implement effective public policies to face health-system challenges. Policy capacity refers to the resources and conditions to make policy work. Policy capacity has been defined as the capacity of government and other “public” actors to plan, develop, implement, and evaluate purposeful solutions to collective problems (Denis et al., 2014). Policy capacity goes beyond policy analysis; it encompasses to policy design, policy know-how, and the ability to align policy work with context. In this review, we identify and analyze the various dimensions of policy capacity to support effective policy-making.

First, we note that the policy analysis aspect of policy capacity extends beyond the use of rational approaches based on formal knowledge, analytical skills, and evidence. Policy analysis relies also on “soft” skills and competencies (management of anticipations or communication) in support of the utilization of research-based evidence. It also pays attention to the context in which policy work is performed. Research on policy design suggests that policy-making is a social exchange process. Negotiations of policy objectives, controversies based on normative values and interests, trust among various groups concerned with a policy, capacity to enrich public debate, and level of policy literacy in a population all influence the ability to generate policy alternatives. Another theme of this review is that policy know-how matters. Policy-makers work in a complex environment where political, policy, and organizational contexts shape opportunities and constraints. Policy-makers must be able to mobilize a variety of stakeholders and create supportive networks through a collaborative policy process. They need to be conscious of the limits of experience and the importance of learning from various policy sectors. Policy actors outside governments can be a rich source of knowledge and innovation. Policy-making takes place in evolving contexts where relations between governments and jurisdictions become more and more important. Globalization, economic cycles, technological advances, ideologies, and new trends in public administration all influence the demand for policy capacity. This review seeks to provide a better understanding of the requirements of policy capacity in term of skills, competencies, and conditions required for productive policy results. It also indicates how organizational support is crucial for the development, implementation, and monitoring of policies.

Introduction

Health systems in most developed countries face a broad range of issues, including spiralling health-care costs, increasing demands, an ageing population, increasing use of new technologies, rising incidence of chronic diseases, and difficulties of access to health care. Health policy-makers and governments must face these challenges and respond to demands for adaptation and improvement without losing consistency and performance

(Denis & Forest, 2012). Effective public policy in terms of design and implementation is essential to transform and improve health systems. Sound policies reduce the need to constantly make decisions. For example, a policy that allocate a percentage of the health budget to research will reduce the need to take ad hoc and frequent decisions in this matter. Policy also minimize the need to be political on a day-to-day basis by having to discuss issues without clear or pre-determined parameters. Public policy can be defined “as a course of action or inaction chosen by public authorities to address a given problem or interrelated set of problems” (Pal, 2006, p.2); it deals with “public problems, not organizational routines or structure” (Pal, 2006, p.5-6). Policy capacity is required to design, implement, and evaluate effective policies. Moreover, a receptive political environment of effective strategies is necessary to make policy happen.

Health policies can be defined as plans or actions that are taken to achieve health system goals; some of these are specific (e.g., reducing mortality rates, improving health conditions related to chronic disease, etc.), others more general (e.g., equity, efficiency, quality, access). Health policies can be designed to reflect change in economic and social conditions, shifting values, community and citizen expectations, and political beliefs (Davis et al., 2000). As the health environment is constantly changing, a comprehensive approach to health policy issues has become essential (Forest & Denis, 2012). Regardless of the type of health system, health policies concern a wide range of activities, from provision and financing of health-care services to funding and coordination of public health functions, and regulation of health providers, technology, drugs, and insurance plans. As a consequence, health policy-making tends to mobilize a wide range of expertise, disciplines, and actors.

The aim of policy-makers in the best situation is to identify the right problems to address and the desirable goals to achieve, and to choose the most effective policy instruments to resolve priority problems. In most situations, they will perform these tasks in response to political orientations and imperatives. In this report, we analyze the variety of resources and conditions (i.e., policy capacity) that policy-makers can draw on to make policy work. The need for well-developed policy capacity is increasing in contemporary states and governments: “The policy capacity of the modern and lean state is not the same as that of the states of the 1960s and 1970s” (Painter & Pierre, 2005, p. 2). Policy capacity today has become a primary ingredient for transformative change (Forest et al., 2014).

Capacity to conduct solid policy analysis is crucial. Policy analysis has evolved from the analytical side of “what governments do, why they do it, and what difference it makes” (Dye, 2005) to the inclusion of broader governance processes and policy advocacy by non-traditional policy actors (Coveney, 2010).

The need for policy capacity cannot be assessed if it is detached from the context of health-care systems where goals must be achieved in environments of increasingly scarce

resources and where demand and supply of health-care services are growing. Ability to make policy trade-offs and choices on very sensitive issues is part of the day-to-day work of policy-makers. In addition, growing recognition of the importance of the social determinants of health implies that policy-making takes place within an increasingly broad set of actors and policy sectors (Gleeson et al., 2009; Painter & Pierre, 2005). Within the formal structures of government are a myriad of informal networks and relationships that link officials to each other across departments, sectors, and governments and to others such as political staff, different levels of government, and a wide range of interest groups (Johns et al., 2007). This pattern has been observed in recent literature on the “health in all policies” (HiAP) movement (McQueen et al., 2012). These actors may have dissimilar experiences and normative beliefs that can contribute to the emergence of polarized policy networks (Petridou, 2014). For example, they may have different views on genetically modified foods, quality of care, and proper welfare policies (Olive, 2012, p. 64-65). Policy-making is thus in essence controversial.

These changes underline the importance of more collaborative approaches to policy-making (Raine et al., 2014, Weissert, 2004) combining the work of government officials with the participation of third parties, interest groups, or non-traditional policy actors (academic institutions, citizens, health professionals associations, researchers, employers, insurers, foundations, NGOs, think tanks, non-profit or profit firms (e.g., Big Pharma, managed care industry) (Peterson, 1995; Raine et al., 2014). Little is known about the impact of such a diversified set of actors on policy-making (Johns et al., 2007, p. 18). In addition, broader access to information and data can stimulate the development of policy capacity within and outside governments.

The context of health-care reforms offers a unique opportunity to address the challenges of policy capacity. Within Canada, almost all provinces have recently initiated substantial revision of their health-care systems (health-care provision, hospital closure, regionalization, drug reimbursement plans, etc.) within the context of the principles embodied in the Canadian Health Act. In the United States, the significant health-care reform embodied in the Affordable Care Act of 2010 (ACA) underlines the importance of policy capacities at both the federal and state levels (Callaghan & Jacobs, 2014). History shows that health policy-making and health planning must be realized in increasingly complex policy environments (Callaghan & Jacobs, 2014; Gleeson et al., 2009; Weissert, 2004; Corrigan & McNeil, 2009). Among the elements contributing to these evolving policy environments are: the struggle between political ideologies, the changing role of the public sector in health policy-making, and the promotion of new policy approaches, including the question of the type of knowledge that has to be taken in account in the policy process and the intersection between policy and politics (Gleeson et al., 2009, p. 2-15; Maybin, 2014; Stone, 2008). Resources, both financial and human, allocated by a government to the policy-making process are also an important element to consider, one

that undoubtedly affects the changing scope and the capacity of policy-makers to perform their tasks. In a context where the perceived trustworthiness of governments continues to decline, the playing field occupied in governance by non-government stakeholders becomes more important, leaving more room for policy decisions taken through the interaction of collaborating non-government and government actors (Painter & Pierre, 2005; White, 2003; Kehoe & Ponting, 2003). In such situations, policy capacity is no longer the monopoly of governments but is distributed and dispersed in networks. In addition, some predominant voices in policy-making (e.g., medical associations) may see their power decrease, while the influence of others groups (e.g., patient voices) may increase (Peterson, 2001).

In response to changes in the policy environment, the concept of strategic capacity of government emerged in the mid-1990s, creating greater awareness of the need to redesign institutions to enhance policy-making effectiveness (Parsons, 2004, p. 44). Research done in the Canadian context indicates that public policies have often failed to achieve their intended objectives partly through a lack of adaptation of the policy-making process (Peters, 1996; Anderson, 1996; Bakvis, 2000; Wellstead & Steadman 2010, Baskoy et al., 2011; Levasseur, 2013). Our analysis of policy capacity aims to look more deeply at evolving contingencies in policy-making and their implications for the development and deployment of such capacities. Concerns have been expressed about the capacity of governments to integrate proper knowledge and information in policy-making and about their ability to move from good policy ideas to real policies in action (Painter & Pierre, 2005; Parson 2004, Wells 2007; Steinhouse, 2014; Bakvis, 2000; Anderson, 1996; Gleeson et al., 2009; Polidano, 2000).

Below, we analyze the issue of policy capacity and identify its components and characteristics for the effective design, implementation, and assessment of health reforms. We also look at strategies to support an appropriate supply of policy capacity. We first review various definitions of policy capacity. The following sections bear directly on various components/dimensions of policy capacity: the second section considers the role of policy analysis in policy capacity; the third section deals with policy design as a core capacity and a specific component of policy analysis; the fourth section reports on policy know-how to make policy work. The fifth section relates the development of policy capacity to the broader context of political regimes and institutions.

I Definitions of Policy Capacity

Policy capacity is an increasingly important concept in the public policy literature. The idea of government policy capacity is a complex phenomenon that is not easily conceptualized (Peters, 1996; Painter & Pierre, 2005, p. 255). Policy capacity can be

simply defined as the capacity of government and other “public” actors to plan, develop, implement, and evaluate purposeful solutions to collective problems (Project proposal NSHSRF, Denis et al. 2014).

The published literature presents varying conceptualizations of the notion of “policy capacity.” One view proposes a set of definitions that are narrowly focused. A second is associated with a more extended definition of policy capacity.

Scholarly work that adheres to a more restricted definition conceives policy capacity as capacities for the design of policies. With such a narrow definition, policy capacity is regarded as the ability of a government to think through the challenges it faces. In this view, intellectual efforts and extensive deployment of knowledge accruing from expertise as well as experience define policy capacity as separate from administrative and implementation capacities (Baskoy, 2011). Attention revolves around the intelligent use of knowledge along with necessary analytical skills to shape public policies (Painter & Pierre, 2005). Policy capacity is associated with technical state capacity defined as “the intellectual and organizational resources owned by a state, such as internal or external expertise or experience, that may be brought to bear on the policy-making process so as to design coherent, viable and politically feasible policies” (Baskoy, 2011, referring to Cummings, 2004, p. 688). Policy capacity is thus viewed as a way of improving the ability of governments to understand and manage complex realities and to steer strategically with the aim of improving policy coherence (Parsons, 2004, p. 44).

A more extended version of policy capacity goes beyond the technical and political sensitivity involved in well-designed policies. For example, Davis (2000) proposes to incorporate outcomes as a fundamental element of policy capacity: “It’s the ability of governments to decide and implement preferred courses of action, which makes a difference to society and its economy” (Parsons 2004, p. 44). Polidano (1999) also proposes a more extended definition, referring to the capacity of governments to take informed decisions and have them implemented. Going even further, the Canada Privy Council Office considers that policy capacity should also include policy enforcement (Baskoy, 2011 referring to CPCO, Deputy Minister Task Forces, 1996). The inclusion of a concern for the feasibility of policies leads these authors to recognize the distributed nature of policy capacities across various levels of governance (federal, state, local government) and across wide networks of traditional and non-traditional policy actors (Baskoy, 2011; Peters, 1996).

Painter and Pierre (2005, p. 2) refer to “governing capacity” and identify three types of capacities that intervene in the realization of policies: policy capacity, administrative capacity, and state capacity. They define policy capacity as “the ability to marshal the necessary resources to make intelligent collective choices about and set strategic directions for the allocation of scarce resources to public ends.” Administrative capacity “refers to

the capacity to manage efficiently the human and physical resources required for delivering the outputs of government”; state capacity “is a measure of the state’s ability to mobilize social and economic support and consent for the achievement of public-regarding goals.” Policy capacity can thus be conceived here as an umbrella concept including a wide range of capacities to support the whole policy cycle. It incorporates capacities (1) “endogenous” to government (policy expertise, professional staff, financial resources, and some degree of organizational continuity) and (2) exogeneous “related to the nature of state-society exchange” to achieve policy goals (Painter & Pierre, 2015, p. 10). This extended approach is motivated by an ideal of creating a policy process not captured by parochial interests. In this report we adhere to a broad definition of policy capacity that is not limited to analytical skills of policy workers within government.

II Methodology

The literature search was conducted through electronic databases focusing on policy capacity within the field of health, public policy, and public health policies, for the years 1995 to 2015. First, a list of keywords was developed using those proposed in the research protocol as a starting point. Keywords were refined after an exploratory phase of the research including discussions among members of the research team. Research of scientific publications on policy capacity was conducted using the following databases: SAGE, Academic Search Complete (EBSCO), Oxford Journals, ABI/INFORM Complete (ProQuest), the Cochrane Library, JSTOR (Medicine and Allied Health), Longwoods Publishing (Health Policy/Healthcare Papers), Oxford Journals, Springer, and Wiley Online Library.

This search produced an initial total number of 4,962 references. From this group, 2,492 were extracted using the following combination: policy AND health in publication title, abstract or key words. These references were retrieved, and a new selection was made using as exclusion criteria papers that relate to developing countries; health promotion; prevention or public health programs or programs that relate to specific pathologies; implementation and evaluation issues related to health programs (smoking, obesity, cancer, HIV); and capacity at the community and/or individual level with no linkages to policies. We also paid specific attention to reviewing material on policy capacities in selected jurisdictions – namely, Canada, France, the United States, England, Netherlands, Australia, and New Zealand. The objective was to look at common and divergent dynamics across comparable jurisdictions or contexts. Only articles written in French and English concerning specific jurisdictions were selected. At the end of this process, abstracts of 425 references were selected and retrieved. From this group, 186 were retained for in-depth analysis, and then the most relevant references were retained. Snowball technique was also

used to add key works in the field, for an additional total of 10 references. In the end, 76 references were retained and fully analyzed for the report.

III Policy Capacity as Policy Analysis

This section focuses on policy capacity as policy analysis. Policy analysis is broadly defined as “the disciplined application of intellect to public problems” (Pal, 2006, p. 15). Health policy analysis (HPA) has been defined in various ways, including as “a multidisciplinary approach to public policy that aims to explain the interaction between institutions, interests and ideas in the policy process” (Walt et al., 2008, p. 308); as “an interdisciplinary field that investigates how health policy is made, what it is, what it might become, and what its effects are” (Abelson & Giacomini, 2008, para. 2); and as the “generic name for a range of techniques and tools to study the characteristics of established policies, how the policies came to be and what their consequences are” (Collins, 2005, p. 192-193). In general, HPA is intended to allow policy actors to learn from policy failures and successes so as to inform the future design and implementation of policies (Gilson & Raphaely, 2008; Walt et al., 2008). Our review of works on policy capacity as policy analysis refers to these various dimensions.

As underlined by Maybin (2014) in her critique of the knowledge requirements for making policy work, policy analysis has traditionally been conceived as “authoritative, expert knowledge claims in order to inform decisions” (Maybin, 2014, p.1). From this standpoint, the whole policy cycle can be conceived as a rational-technocratic process of “gathering intelligence on some policy problems, to develop recommendations for action, which may then be implemented and subsequently evaluated to inform the next policy” (Maybin, 2014, p.1). The use of logical principles and rigorous methodologies are thus viewed as the main ingredients of policy capacity (White, 2003). Policy analysis consists of addressing substantive issues (social problems) with facts and ideas uncontaminated by sectoral interests (Wildavsky, 1979).

We have identified in the literature two main streams related to the building of policy capacity as policy analysis: (1) works on the content of knowledge and analytical skills to support policy-making, and (2) works inspired by the evidence-based policy movement. We review below each of these orientations to identify their contribution to the development of policy capacity and to identify its potential and challenges.

1. Knowledge and Analytical Skills

In its most rudimentary form, policy capacity consists of attracting and retaining the best and brightest policy workers (Gleeson et al., 2009). High quality research appears crucial to stimulate and sustain the interest of politicians and policy-makers for research-based evidence. These people should be well trained to conduct applied and policy-relevant research. Capacity to perform policy evaluation and large-scale policy experimentation, analogous to the notion of the “experimenting society” developed by Campbell (1973), is considered central to policy capacity. Because of its objective of promoting rational trade-offs in the policy-making process, considerable space is given here to methodological capacity such as quantitative techniques for modelling, trend analysis, and cost-effectiveness research (Canada Privy Council, 1996), to solid disciplinary knowledge in law, economics, and social science (Gleeson et al., 2009), and to gathering data to document problems and monitor policies. In addition, an intimate knowledge of policy experiments in other contexts or jurisdictions is conceived as part of policy workers’ knowledge base. Hunter (2015) strongly advocates that political science should be a fundamental part of policy capacity to support the implementation of policies that challenge predominant interests.

A study by Gleeson, Legge, and O’Neil (2009) on policy capacity in jurisdictions including Canada, England, Australia, and New Zealand, while recognizing the importance of analytical skills and proper disciplinary knowledge, incorporates in policy capacity more “soft” skills or process-oriented knowledge. Parsons (2004, p. 54) emphasizes similar considerations, insisting on the need for new capacity: “If the state is to ‘build’ a new capacity to control and weave a coherent fabric out in an incoherent world, then the policy-making process has to be a lot smarter.”

Gleeson and colleagues (2009) define two broad categories of capacities: individual and organizational capacity. At the individual level, they identify “soft” elements that relate to the management of anticipations, communication, and briefings, including the construction of credible policy narratives and the ability to transfer international policy experiments within specific jurisdictions and contexts. Coordination, networking, and the ability to support implementation are listed as key to organizational capacity. In addition, organizational capacity is related to the creation of favourable context for the use of evidence in policy setting. We return to this issue in our assessment of the contribution of evidence-based policy to policy capacity.

In summary, generic analytical skills and disciplinary knowledge are seen to make up only one aspect of policy capacity. There is a growing recognition of the importance of in-depth and specialized knowledge about policy sectors. For example, the work by political scientists on programmatic elites (Genieys & Hassenteufel, 2015) in France suggests that new state elites develop around their “identification with specific program of public

actions” (9), such as the ability to mobilize policy instruments to promote rationalization in the social policy sector. Knowledge is considered here to be intimately linked to familiarity with specific policy instruments and to their potential application within key policy sectors. More broadly, these works depart from an approach that would aim mostly at training the best policy workers around a set of pre-conceived analytical skills and disciplinary background. The ability to learn from experience and to accumulate knowledge on critical policy issues is considered key for policy capacity.

As we underlined earlier, the ideal of policy analysis is to inform policy choices by means of rational reasoning and rigorous inquiry. It is in this context that the provision of tools to support policy-making is seen as a policy capacity resource.

Hankivsky and colleagues (2012: 11) have identified different techniques in health policy for the conduct of policy analysis from a “simple step by-step linear approach” (Bardach, 2000; Collins, 2005) to more specialized tools largely organized around more complex conceptions of the policy-making process and/or “problem” definition (Bacchi, 1999). Collins’ (2005) analytical tool for policy-makers is organized around a set of logical steps: (1) definition of the context; (2) statement of the problem; (3) search for evidence; (4) considerations of different policy options; (5) anticipation of outcomes; (6) application of evaluative criteria; (7) assessment of the outcomes; and (8) selection of a specific policy. Collins also offers a simplified version of the policy-making process for policy-makers with limited available time, resources, and/or experience (Collins, 2005). Competencies and skills must be developed to support each phase of policy development.

Beyond the conduct of a rational analysis (magnitude of problem, cost-effectiveness of plausible solutions), some tools explicitly incorporate considerations of the complexity of the policy-making process. Attention is paid to the fragmented or distributed interests and values in the policy sector and their consequences for the design and implementation of policies. For example, Blanchet & Fox (2013) propose a rational analysis of the distributional impact of a policy to create a single-payer health-care system in Vermont. A prospective political analysis based on the survey of stakeholders (supporters and detractors) is integrated in the technical design of policy. Their analysis reveals a notably heterogeneous view on how various stakeholders react to or assess policy options and attributes. According to the authors, such analysis can increase a policy’s viability by adjusting its design to the mosaic of interests, values, and preferences.

A similar approach is taken by Campbell and colleagues (2011), who develop an analytical approach in policy design to take into account anticipations of the consequences of a policy (see next section on policy design). A paper by Oliver and Singer (2006) on the role of health services research in legislative analysis within the context of the California Health Benefits Plan (CHBP) also proposes a matrix for policy design that incorporates elements of political feasibility. These different tools and analytical approaches see a core capacity

in a more systematic assessment of the distributional impact of policies. They aim to anticipate challenges related to a policy's implementation and long-run viability. Even from a rationalist or instrumentalist viewpoint, there is a growing acceptance of the importance of the broader context in which policies must be legitimized and implemented.

Overall, in this sub-section on policy capacity as policy analysis, we observe two major trends in the literature. One is related to the emergence of a broader conception of knowledge and analytical skills required for effective policy work where soft skills or competencies are considered as important as formal analytical skills and disciplinary knowledge; the second is related to the incorporation of anticipations and policy feedback in the design of policies, revealing an increasing focus on implementation and feasibility issues.

2. Evidence-Informed Policies

While the previous sub-section focuses on policy capacity in terms of knowledge, analytical skills, and tools, the literature on evidence-informed policies aims at defining the conditions that facilitate the use of rational analysis and research-based evidence in policy development and ultimately in political decisions. Most of the work falling into this category looks at organizational capacity and arrangements to create a favourable context for the use of evidence in policy-making. An underlying assumption here is that a lack of attention to evidence stems from problems in the availability of evidence for policy-makers and to the cultural and spatial distance between the research community and the policy world, including the day-to-day pressures faced by policy workers and from the limited benefits they often attribute to extensive analysis. This, however, may not be the main issue: a more critical challenge may be encouraging effective communication and exchanges between the policy world and politicians.

Studies on evidence-based policies search for elements that will transcend these limitations. For example, Lavis and colleagues (2008) conclude on the basis of eight case studies in international health that extended relationships between researchers and policy-makers provide a favourable context for increased use of research-based evidence; however, adopting and implementing an evidence-informed approach requires resources, including time. The authors recognize that conflicts of interest can always threaten the viability of an evidence-informed approach to policies, but the balance of opinion is in favour of adopting and implementing deliberate strategies to promote such an approach. Ross et al.'s (2003) study of Canadian decision-makers in health care observes similar enabling factors for research use within an organizational context. A recent report by AHR (2015), based on a set of commissioned papers and forums with experts, concludes that research use in policy is enabled by (1) developing closer linkages between research and

policy and practice, (2) framing research to increase its usefulness for policies (e.g., paying attention to the increasing role of states within the United States), and (3) communicating research more effectively. The authors call for innovation and investment in each of these areas to increase research utilization

More broadly, long-term partnerships and the dedication of specific resources are needed to promote the utilization of research-based evidence to inform policy. Recent developments in this area rely on the advantages provided by web-based technologies and the evolution of research synthesis methodology to increase the availability and accessibility of research-based evidence for policy-makers. The site created under the leadership of John Lavis at McMaster University is a clear illustration of an initiative to reduce the burden on policy-makers of using evidence by increasing its availability and accessibility.

Lomas and Brown (2009), using the case of the Ministry of Health and Long Term Care in Ontario, have documented the resources and processes involved in the creation of a policy advisory system (Craft & Howlett, 2012) to better connect research, evidence, and policy-making. Their study, based on interviews, hands-on experience with the policy context, and reviews of documents, looks at the stewardship role played by civil servants in strengthening the use of evidence to inform policies and anticipate policy issues. The authors identified three core functions of a policy advisory system: (1) helping to set and anticipate policy agendas, (2) informing new policy development, and (3) monitoring and modifying existing policies. Each of these functions can be supported by a specific set of tools, resources, and processes. For example, for setting and anticipating policy agendas, government can rely on arms-length institutions like the Institute for Clinical Evaluative Sciences (ICES), the support of a cadre of career scientists, and various platforms to promote the use of evidence by civil servants and policy workers. Recognizing the need for on-time evidence to support policy development, the ministry establishes evidence priorities and relies on commissioning research and various exchange mechanisms to ensure the supply of evidence for the policy process. To monitor policies, the ministry invests in the quality and availability of data sets, internships in research and evaluation at the ministry, and the support of ad hoc evaluation studies. A paper by Hoch (2012) on the program for evidence-based care in oncology is another example of an initiative in Ontario to support the use of evidence for health policy-making.

A Scottish collaboration in evidence-informed policies provides yet another example in this area (Frost et al., 2012): a deliberate strategy was developed and implemented within a network of internal policy workers and external researchers to promote the use of evidence in shaping public health policies and to ensure a supply of needed evidence. In a US context, Oliver and Singer (2006) describe and analyze the experience of the California Health Benefits Plan (CHBP), where a collaborative model was developed between policy-makers and university-based researchers to provide research-based evidence and analytical

support on request. The authors note that both supporters and detractors of the program positively assess the contribution of researchers. This case study suggests that policy capacity for research use can be distributed and that governments need not internalize all the expertise they need to ensure proper capacity.

Some additional recent work deals with the organizing principles to support the development and use of specific types of research in health policy. An AHR report (2015) on the impact of economic evidence on policy-makers concludes that attributes like transparency and clarity in the research process and transparency in the decision-making process increase the attention paid to economic evidence in policy-making. Chalkidou et al. (2009) have developed a systematic analysis of how different jurisdictions (Britain, France, Germany, and Australia) organize to implement comparative effectiveness research (CER, a new term for health technology assessment and evidence-based policy-making) in health systems. Their analysis and case history identify specific organizational principles to ensure an adequate supply of CER and procedural principles and success criteria to support CER's use in health policy-making. Based on a review of policy documents and websites and on hands-on experience with agencies promoting CER as a mechanism to support policy development, the authors first underline that CER is a demand-driven activity and consequently should be clearly aligned to policy-makers' demands and expectations. Second, they note the difficulty of sustaining CER capacity through time where, for a variety of reasons, each of these organizations was discontinued or significantly reorganized. This observation is reflective of the significant political challenges involved in the promotion and use of scientific evidence for health-care policy. In the authors' words, these agencies face "intense controversy, negative press, and rapid transformation" (Chalkidou & al., 2009, p. 356). Third, they note that one of the factors in the evolution of these agencies/units is the incorporation of prospective evidence-generation, meaning that they no longer rely only on existing studies to inform policies.

In studying challenges of implementing CER as a privileged source of advice for policy development, Chalkidou & al. (2009) identified three ingredients for success. First, a strong political endorsement, especially at the early stages of the entity's life, seems crucial for the legitimation of these agencies and of their roles. A second success factor is early engagement with key and concerned stakeholders to anticipate controversial issues, along with sustained communication throughout the process of assessment, with opportunities to dispute research results and associated decisions through appeals and judicial challenge. The authors emphasize the importance of not avoiding confrontation within the policy advice process. Thirdly, they note the importance of consistently showing "a demonstrable commitment to quality and evidence-based best practices in order to gain professional approval. Methodological rigor and the involvement of well-respected clinical and nonclinical researchers have helped legitimize each entity's role in its respective system" (Chalkidou & al., 2009, p. 364). In summary, these ingredients of success reflect an attempt

to incorporate and take account of controversies within the analytical process in order to increase the use of evidence and eventually its influence in policy-making.

While this stream of work on the principles and strategies used by agencies to gain credibility in the policy arena is informative of the attributes of organizational capacity to support evidence-informed policies, it does not provide a clear assessment of the “real impact” on policy. It underlines the challenge of the capacity to sustain agencies that carry a mandate for evidence-informed policies. Somewhat analogous to our analysis of the tools to support policy-making (previous sub-section), there seems to be a difference between a commitment to take into account the variety of interests, values, and preferences and the ability to implement a policy. In addition, this work pays limited attention to how formal analysis, even stakeholder consultation, is used in the policy process and in determining policies. How is such formal knowledge combined with other considerations or alternate forms of knowledge in policy-making and in political orientations? Moreover, formal analysis can be used to promote or legitimize adopted policies, not only to support their formulation. Finally, as Brown (2012) indicates, the proliferation of data, tools, and advice may bring more confusion than to clarity in the policy-making process.

In a recent paper on the policy advice system, Craft and Howlett (2012) address the issue of how content knowledge can be taken into account in an environment more and more characterized by “fluid, pluralised and polycentric advice-giving reality.” They note that some studies underline the roles of political advisers in brokering, coordinating, and integrating endogenous and exogenous sources of policy advice. This emphasis may be a realistic reflection of how evidence can travel in the complex world of policy-making. Evidence is taken from a broad diversity of sources and is promoted by a wide range of actors and interest groups. For example, Peterson (1995) provides a detailed account of how members of the US Congress relate to various sources of knowledge, and how so-called scientific knowledge mixed with a set of interests and values is mobilized in partisan politics. Peterson’s analysis suggests that there is no absolute division between the apparently irrational world of politics and the apparently rational world of science. The author explores the use and intricacies of three forms of knowledge to deal with what he calls political and programmatic uncertainty: ordinary knowledge, distributional knowledge, and policy-analytical knowledge. Politicians cannot base their decisions solely on analytical knowledge. They are influenced by ordinary knowledge – that is, the experience of a given policy issue in daily life that is communicated by the population to elected representatives. Also important for our study of policy capacity, Peterson observes that a sound policy decision will always take into account its distributional consequences – meaning its political consequences for supporters and detractors as well as the political survival of elected representatives concerned with a given issue.

Ideologies and values infiltrate and guide policy decisions. In some circumstances, values can be used as a substitute for policy development and decisions. Ideologies may also

provide a context in which some policy options will be more acceptable than others. Alternatively, politicians and policy-makers may ask for existing evidence around a given phenomenon (e.g. evidence regarding the behaviours of physicians when introducing a form of payment by capitation). However, in a highly risk-adverse environment – attention paid to evidence may be limited. The development of a culture of measurement and experimentation may foster more attention to research-based evidence.

According to Peterson, a good policy decision will be informed by a synthesis of the three sources of knowledge noted above. In addition, he observes that in contemporary politics a large supply of information comes from these various sources. Policy-making may not be totally aligned with research-based evidence, but it is based on multiple information sources. Peterson also notes that research-based evidence is a distributed capacity and is used by numerous interest groups and lobbyists. While scientific evidence does not determine policies, it contributes to improving the quality of debate. This model of knowledge use is somewhat similar to Weiss's enlightenment model of knowledge utilization. To achieve a fair consideration of analytical evidence in the policy process, Peterson argues, three factors are important: (1) the congruence of messages gained from the three forms of knowledge, (2) the incentives politicians have to use research-based evidence, and (3) individual competencies in research use. Politicians must be in a position to rely on evidence in the context of their work. The role of agencies and technically competent policy workers is to provide support in making sense of research evidence and to help incorporate analytical knowledge with other legitimate sources of knowledge.

3. Implications for the Development of Policy Capacity as Policy Analysis

In his classic paper on policy capacity, White (2003) proposed a classification of the concept in three dimensions: technical, institutional, and political capacity. Technical capacity corresponds to the rational approach of policy analysis based on logical principles and rigorous methodologies. The other two dimensions refer to capacities in dealing with the uncertainty of institutions and politics. Political and institutional capacities provide the context in which rational analysis can be performed and acted upon. In the education and debate section of the *British Medical Journal*, Black (2001) has suggested that we should proceed with care in the promotion of evidence-based policy. His short paper outlines a set of considerations that make the use of evidence in policy arenas and in politics very challenging. Our review of works on policy capacity and policy analysis suggests that researchers have started to recognize the importance of context in shaping the utilization of scientific knowledge in health policy. Policy workers can rely on a set of tools and on knowledge of context to help them promote a more realistic assessment of the evidence-based policies agenda.

Growing recognition of the role of context in shaping policies and greater attention paid to the day-to-day life of the policy process have reopened the question of the knowledge requirements for policy capacity (Maybin, 2014). Policy capacity as policy analysis initially advocated for the power of reason and analytical skills over political forces in policy-making. The division between analytical knowledge and skills and others forms of knowledge in policy-making can be affirmed intellectually but does not reflect the reality. These considerations have induced an evolution in works on policy capacity as policy analysis. The focus is now less on arguments in favour of specific disciplines and techniques and more on “soft” skills and competencies (including cognitive ability to make sense of complex situations) to support the utilization of research-based evidence in policy-making. Work on evidence-based policies has paid a great deal of attention to how to create enabling contexts for the use of evidence in the development of policies. While such work provides plausible organizing principles to support research use, it is much less explicit on how alternative forms of knowledge get into the policy-making process and on how to enhance our understanding and assessment of the conditions that can promote the use of research-based evidence not only in policy-making but also in political decisions.

Another line of inquiry rests on the growing attention given in policy capacity to the whole policy cycle. Considerations in policy design of the distributional impact of policies through policy feedback and prospective political analysis are illustrative of an ambition to use formal analysis to better understand the politics of health-care policy. The ability to take into account issues of feasibility and implementation is thus considered central to the development of policy capacity. In addition, the need for knowledge management and organizational intelligence is revealed by a growing demand for capacity to monitor and evaluate policies on an ongoing basis.

Finally, as suggested by the literature on the policy advice system, policy capacity is a distributed phenomenon where a variety of actors (including non-traditional policy actors and interest groups) dispute the monopoly by technocrats and policy workers on analysis and advice. One key policy capacity in this situation is to coordinate, ensure coherence, and make sense of multiple sources of advice that in the end may create more confusion than enlightenment (Brown, 2012).

Policy capacity as policy analysis departs from a simplistic promotion of rational analytical techniques. Work in this sector provides insights into how to create more favourable contexts for the application of rationality and analytical skills in developing policies. The emphasis on context suggests that efforts to build policy capacity should be deployed at the individual and collective levels. By focusing more and more on what is needed to make policy work, the rationalist perspective in its more extended version opens the door to work on policy know-how and to more process-oriented forms of knowledge covered in the next sections. A shortcoming of much of the work on evidence-informed policies is a lack of attention to the dynamic between policy-making and politics.

III Policy Capacity as Policy Design

Recent work on policy design as a component of policy analysis considers policy-making as a sophisticated form of social exchange. Policy design is simultaneously an investigation stream and a practice orientation for those engaged in the policy domain (Considine et al. 2014). The concept emerges from the work of Schneider and Ingram (1998; 1993), two policy experts interested in the dialectics of policies and target populations, who expanded on considerations derived from the emerging field of policy implementation (e.g., Linder & Peters 1984). Policy design is extremely attentive to the social construction of policies, the complex negotiation around resources and objectives that take place throughout a policy lifecycle. For example, in her careful analysis of the public debate that preceded the adoption of the Affordable Care Act, Campbell (2011) insists on the importance of “policy feedbacks” – i.e., how “the creation of constituencies and the forging of understandings about the nature of their benefits” come to shape attitudes and subsequent political events (Campbell 2011, 966). In his empirical study of the building sector in Australia, the Netherlands, and the United States, van der Heidjen (2014) compares the *content* and *process* of experimentations in engaging builders in sustainable development, concluding on the need of taking into account all related participation costs before advancing to policy success.

Policy design also integrates normative considerations: the institutions that are responsible for policy development and implementation are more likely to perform effectively when and if they are able to accommodate proper policy dialogue, framed by a set of commonly held values. Traditional policy analysis tends to treat values as an external factor – something that is left to the political decision-makers to determine or, in more recent years, a kind of very high-level framework expressing basic constitutional “principles” *à la* John Rawls (Linder & Peters 1992). Policy design insists on the need to integrate discussions of values and moral considerations in the very early stages of the policy process, to ensure that stereotypes, rationales, and underlying assumptions have been examined and if appropriate, revisited (Schneider & Ingram 1997; Schneider & Sidney 2009). Needless to say, this requires a degree of reflexivity and sophistication not often present in policy organizations.

In fact, policy design came about in part in reaction to a literature that continued to view policies as merely the translation of interests or ideas into public decisions instead of the result of complex and changing social exchanges. As Keiser and Meier note, the conditions for policy success stated in most policy textbooks are never to be found:

[A] policy is more likely to succeed if it has clear, coherent goals within an unambiguous context, if ample resources are provided to the implementing

agency, if the policy itself is constructed with the best available policy knowledge, if it exploits preexisting bureaucratic loyalties, and if the policymakers recognize its possible impact on local factors that affect implementation (Keiser & Meier 1996, 338).

By contrast, policy design insists on the need for trust as a precondition of policy success and, consequently, on the importance of building institutions that have the capacity to foster and sustain trust. Consent is a precondition of policy success, and consent in a democracy is always contingent on trust: “Citizens are likely to trust government only to the extent that they believe that it will act in their interests, that its procedures are fair, and that their trust of the state and of others is reciprocated” (Levi 1998, 88). According to Box (1998, 20-21) this overarching principle depends on conditions like *scale* or *subsidiarity* (i.e., decision-making and policy implementation must be kept as close as possible to those affected); *accountability* (i.e., decisions about public services and their operation should be based on stated expectations and verified performance); *transparency* (i.e., the “best” public decisions result from public access to information and free and open discussion); and importantly, *rationality* (i.e., values, assumptions, and reasons for choices made need to be clearly expressed).

From a capacity viewpoint, therefore, one distinctive element of policy design as a core element of policy analysis is a clear invitation to develop processes to constantly inform and interact with the public. Accordingly, policy staff must have the preparation and skills required to deal with the expression of “political voice” and social movements (Schneider & Sidney 2009). Staffers need not only the usual familiarity with office holders and influential stakeholders but also willingness to interact with “groups whose voices are marginalized in political processes and in daily life” (Blacksher et al. 2012, 14). Put differently, good policy design is dependent on the capacity for open and far-reaching public deliberation. This process can take place upstream, before powerful interests and dominant groups frame issues, or downstream, to make sure real policy choices are made with direct input from affected populations (Solomon & Abelson 2012).

The need to provide more and better-quality policy alternatives is widely recognized in the policy world (Linder & Peters 1988; Öberg et al. 2015). Many recent developments in policy design result from experimentation aimed at generating more policy options and/or at making sure that valuable options are not discarded too early in the policy process (Knill & Tosun 2008). From that perspective, policy capacity is less the capacity to formulate the “right” solution to a given public problem than the ability to engage (or to support the engagement of public officials) in communities of “argumentation, informed debate, public deliberation, justification, and criticism” (March & Olsen 1995).

IV Policy Analysis as Policy Know-How

Policy capacity is the “fitness” of those engaged in the making of policy to achieve their goals. Capacity as fitness has several elements: one is intellectual ability and preparation (knowledge and information) sufficient to grasp what is at stake in a given policy issue and in getting from goals to results. Another element is judicious selection and practice in mastery of the tools of policy-making – for instance, cost effectiveness analysis (see section II of this report). But ability and equipment are not the whole story. Smart and well-informed policy-makers, deploying sophisticated analytical tools, may still fall short of their aims if they lack adequate understanding of how the policy system works and how to move it most productively in the desired direction in the particular case(s) at hand.

This section takes a pragmatic approach to policy capacity, focusing on the practices of those involved in making policy work (Maybin, 2014). This practical capacity (know-how) would seem to depend heavily on experience, that is, on having “been around” the halls of government enough to understand the policy cultures that attach to different institutional settings, enough to gauge “how things are done around here” (Geertz, 1973). Know-how in policy affairs embraces but is not exhausted by insights into the working of governments. Long-serving government officials may have such know-how, but so too may in-and-outers, lobbyists, and members and staff of coalitions that seek to shape policy (Peterson, 1995).

A basic component of policy know-how, however, is recognition that (and how) one size does not fit all. If, as Schattschneider (1975), Lowi (1972), and other “arenas” theorists are right that “policy determines politics,” then political dynamics would be expected to reflect the characteristics of the policies at issue. Consequently, policy-making in health care will be different in important ways from policy-making in other sectors. Policy know-how will mean, at least partly, having an in-depth knowledge of a sector and its context specificities. This proposition has a possibly disquieting implication, namely, that know-how acquired in one policy arena might be misleading and have to be discarded or much modified in seeking to advance a different “type” of policy. Policy know-how may therefore become less dependable and transferrable as the activities of governments grow more differentiated and as new players get into the act. A key element of know-how, then, is the development of collaborative capacity to transcend limits and constraints by making room for the capacities and capacity-building activities of non-traditional actors. (Sullivan et al. 2006). Policy-making will have to be supported by a network of policy workers specialized in various areas but working closely together. The development of inter-sectoral policies to improve the health of the population is an ideal setting for the deployment of collaborative policy capacity.

A crucial ingredient in policy know-how, then, is a well-developed sense of context (discussed in the next section) – how different policies engage different departments and bureaucratic units, different parliamentary committees (and districts), different interest groups, different elements in party coalitions, and different non-traditional organizations, multi-sector coalitions, and hybrid organizational entities (Denis, Ferlie, & Van Gestel, 2015). The sheer variety of policy contexts suggests that know-how is as much about unlearning (ignoring, discounting, forgetting, bracketing) the lessons learned in one context as it is about learning and applying lessons learned as one moves among contexts.

Policy know-how is often said to derive from knowing how to navigate the complex corridors of political power. An iconic US case in point is President Lyndon Baines Johnson, “master of the Senate” (Caro, 2002) and the successful initiator of dozens of Great Society programs in the mid-1960s. Johnson knew how to apply the various tools of persuasion – pressuring, bullying, cajoling, horse-trading, and so on – to the legislators (and outside influentials) whose support he needed to advance his ambitious agenda. On this count he is often compared favourably to Barack Obama, who has had limited success in winning over his Republican opponents in Congress. Here too, however, the importance of context is a critical question: how far did Johnson’s victories – enactment of Medicare and Medicaid, for example – derive from his copious policy know-how, and how far are they explained by the large new liberal Democratic majorities in the House and Senate with which the voters supplied him in the elections of November 1964? (Johnson’s efforts to pass Medicare in a more conservative Congress the year before were unavailing.)

Policy know-how depends not only on the personal qualities of policy-makers, the organizational setting in which policy plays out, and the characteristics of distinct policy arenas but also on the complexity of the challenges to which policies give rise. Some types of policy – for example, job training and the reform of police practices – must take into consideration the behaviour of service providers in “street level bureaucracies” (Lipsky, 2010). Information and monitoring come hard, so policy know-how entails a high degree of “local knowledge” (Geertz, 1973). Complexity is also of course built into the very structure of federal systems. Health policy-makers in Ottawa have no easy time grasping how federal health-care dollars are blended with those of the ten provinces and with what outcomes (see, for example, recent reports of the defunct Health Council of Canada). The US Affordable Care Act relies heavily on the 50 states to expand Medicaid, build health insurance exchanges, and enforce new regulations on private health insurers. The implementation of the law has called into question the capacity of many states to shoulder these tasks (quite aside from the question of their will to tackle them at all). Relying on states and provinces as vehicles of reform has its limits (Sparer, 2004; Weil, 2008; Greer & Jacobson, 2010), and a reasonable division of labour depends less on constitutional explication or theoretical ingenuity than on policy know-how that recognizes where to look and what to look at within the labyrinths of federalism. Organizational capacity is critical

to sustaining the commitment of policy-makers and reformers to innovative improvements in policy (Huber & McCarty 2004). But understanding which elements of capacity are crucial to a given task in a given setting is more art (know-how) than science. Policy know-how cannot and should not be located at a single level of governance.

Developing know-how can entail a sometimes uncomfortable stretching of perspectives. For instance, reformers in public health departments who seek to promote health by changing the built environment in ways that create new options for walking and biking must deal with and in some measure come to share the language and culture of traffic engineers in departments of transportation and of public works. And the implications of these languages and cultures for health-promoting changes in the built environment will likely differ substantially among states/provinces and communities. The importance of this kind of know-how can be asserted in a classroom, but the know-how itself must be acquired in the field. A “Berlitz” level of exposure yields a modicum of know-how, but the real thing requires immersion in the work of policy-making in distinct settings. No wonder that participants in conferences, sponsored by reform-minded foundations and government agencies for the benefit of state/provincial and local officials, so often report that the learning of greatest value they acquired came from peer-to-peer discussions – that is, exchanges of know-how. Policy know-how develops in policy networks (Rhodes, 2006).

Complexity also challenges know-how in seemingly circumscribed policy areas that have little to do with federalism and local bureaucracies. Making and reforming payment policies in Medicare (US or Canada) turns largely on balancing restraint in spending with previous and continuing “accommodations” with physicians (Tuohy, 2012). In this case, know-how consists of a “realistic” reading of what economic models of payment, constantly in flux, imply for keeping the peace with physicians who may speak with distinct organizational voices. The bearer of policy know-how in this case presumably has “been around” the worlds in question – of economic advisers and modellers, physician leaders (and perhaps dissidents), budget makers, and professional politicians – and can, by translating among them, move from proposal to resistance to negotiation, refinement, and enactment.

Maybin (2014) in her study of civil servants in England’s Department of Health identified elements of policy know-how to make policy happen. Among them, she insists on the importance of constructing connections with powerful individuals, organization, and ideas. She also notes the importance of linking a policy to powerful political agendas and policy instruments. Policies are more and more involved in environments where programmatic proposals such as reducing the size of the state and leaving more place for market-like mechanisms spread across policy sectors. To make policy work, one way is to connect with such powerful and sometime fashionable policy drivers. Consistency between inter-related policies has an impact. In an analysis of the reform of public health in the United Kingdom, Evans (2004) demonstrated that a formal commitment to public health, several policy

documents to establish the philosophy behind the reform, and the designation of the issue as a political priority were not sufficient. The public health reform had been undermined by dilemmas, tensions, and contradictions due to the priority given to health services, the lack of consistency between public health priorities and the major health-care reform, the lack of funding, and the lack of mechanisms to achieve the objectives.

Finally, the work involved in building consensus among a variety of stakeholders and interests cannot be ignored and should be done early in the process to prevent blockages. Such know-how is surely devoutly to be wished in policy-making. And yet, as noted above, mastery of the arts of the possible may enshrine a dominant medical logic and discourage tenacious promotion of progressive population health management models that may have been formally adopted (Evans, 2004). If reform is in order, know-how should be not only about when and how to negotiate and settle but also when and how to nudge and push. The political dimension of reforms cannot be ignored, and policy and managerial leadership (Thompson, 2008; Corrigan & McNeill, 2009) must be developed to resist and counteract powerful interests that are at stake (Hunter, 2015).

In policy analysis, a field in which the term “social learning” is tossed about on all occasions, one wonders how the term applies to know-how. Perhaps the most robust form of policy know-how is negative learning: nothing is more instructive than watching a disaster unfold, dissecting its unhappy contributing causes, and then resolving to do things differently. The ACA is a vivid case in point: its progenitors derived crucial know-how from anatomizing the collapse of the Clinton plan of 1993–94. From this exercise they learned to involve Congress early and often in the process, avoid rhetoric that could be construed to signal an intended “government takeover of the health-care system,” accede to the submerged character of the US state (Mettler, 2010) by bargaining with and co-opting powerful interest groups at the outset, and saying nothing about managed care. Was the successful passage of the ACA a testament to the know-how of Washington insiders who had served in the Clinton administration and returned, chastened and enlightened, to the action under Obama, whereas the Clinton effort was led by brilliant novices (Ira Magaziner, Hillary Clinton) lacking policy know-how? Or did the miscalculations of the Clinton plan speak for themselves, allowing policy-makers to see what not to do next time, with no special policy know-how required?

Finally, the content of policy know-how may vary with the situation of policy-makers in the political structure and/or in its environment. Neustadt (1962), for example, was referring, in essence, to policy know-how when he famously contended that presidential power is the power to persuade. Maybin has explored the strategies of mid-level civil servants in the British NHS as they try to advance their ideas on the agenda of their superiors. Sardell (2014) has sketched how the application of policy know-how enabled the Children’s Defense Fund and its organizational allies to build congressional support for what became the Children’s Health Insurance Program. Genieys and Hassenteufel show

how policy elites in France's social security regime worked to protect solidarity amid fiscal strains by developing both the sectoral expertise and the durable networks needed to "handle" budget makers (Genieys & Hassenteufel, 2015).

Policy know-how in promoting and securing policies does not necessarily translate into successful implementation of policies, however. Thus, Klein's 60-year analysis of the National Health Service (2013) repeatedly finds reformers in London wondering what is going on out there among providers and local authorities and whether, in this uncommonly "unitary" system, policy innovations achieve anything like unity of behaviour and result. May and Winter (2009) point out the importance of acquiring more knowledge about how political and management signals influence (or fail to influence) the behaviour of agencies and actors charged with implementation of policies.

A general theme that runs across these mini-cases and considerations is that policy know-how is a capacity to read and interpret the meaning of interlocking political and organizational contexts. Who has power at what stages of the policy process? What do power holders want and what can they not accept? What are the levers a change agent has for winning their support – for example, the bully pulpit, threats, bribes, offers of public offices, pork-barrel projects, support for re-election, evidence, and ideological appeals, to name but several among many. Certain players in and around government seem to have this kind of capacity for judging situations; others have less of it, and there are no formulas either for augmenting the numbers of the "gifted" or for ensuring that they are in the right places at the right times on the right policy challenges. These considerations underline the fact that policy capacity is a collective enterprise. Policy capacity is spread across individuals, groups, organizations, and levels of governance. No single person will assemble all the competencies, knowledge, and abilities to support solid policy analysis of complex policy issues and to make policy work through extensive know-how of issues, context, and politics.

V Policy Capacity as Context

The context surrounding the elaboration, decision, and implementation of public policies has implications for the work of policy-makers. In this section, we present an overview of the contextual factors influencing policy-making and its consequences for policy capacity.

1. Globalization, Economy, Technology, Ideology and Trends in Public Administration

The world goes through major transformations induced by global phenomena influencing societies. Below, we discuss how globalization, economic cycles, technological advances, ideologies, and new trends in public administration influence the needs for policy capacity.

1.1 Globalization

Globalization, whether a new phenomenon or not, is associated with growing global governance based on policy coordination between public authorities and private actors seeking to achieve common goals or to solve collective problems through standards, rules, programs, and global or transnational policies (Baylis & Smith, 2005, p. 773). This definition implies that globalization has an impact on states' power, but how and how much? Researchers' views differ greatly on the effects of globalization on the power of states and their capacity to drive policies.

First, globalization's effects differ depending on policy domain: international institutions and treaties and non-state actors may constrain state power in some sectors (e.g., monetary policy) more than others (e.g., women's rights). This situation influences the cost (resources, energy) associated with specific policy choices (Keating, 2000) and leads governments to rely on more indirect instruments instead of highly interventionist ones (Davis & Keating, 2000). Second, the impact of globalization is less important for powerful states that have more ways to assert their interests in international agreements than for less powerful states (Hobden & Wyn Jones, 2005). Third, global governance offers new opportunities for states through their access to several political levels of intervention (local, national, regional, international) to defend their interests (Princen, 2007, p. 13), through sharing of policy issues with other jurisdictions, for example, managing cross-border issues (immigration, trade) and through learning and policy sharing across jurisdictions to deal more effectively with common problems (health and urbanization) (Busch & Jörgens, 2005; Stone, 2008).

1.2 Economy

States' economic resources influence their policy capacity. Researchers have investigated the impacts of economic fluctuations (recession, growth) and the pressure in recent years to reduce government budgets on policy-making. An important part of this literature focuses on the effects of the downsizing of the state on the evolution of policy capacity. Pressures to reduce government budgets, to decrease the size of public services and the number of programs, to limit the intervention of governments, and to increase the presence of market-like mechanisms are associated with a decrease in policy capacity (Pierre &

Painter, 2005). An analysis (Baskoy, Evans, & Shields, 2011) of policy capacity in Canada underlined a significant association between the decline of policy capacity and factors such as losing institutional memory due to reduction of human resources, and fiscal imbalance. These impacts, however, may differ from one sector to another. For example, the health sector may to some extent pass through a period of budgetary cuts without important reduction in policy capacity because this issue remains at the top of the political agenda (O'Reilly, Inwood, & Johns, 2006). Furthermore, the reduction of spending by the state may also have such indirect effects as the erosion of confidence by private and public partners and increased public disillusionment about the government's ability to intervene and take charge – a crucial component of policy capacity (see section on policy design) (Davis, 2000, p. 238).

1.3 Technology

Information technologies (e.g., Internet, computers, global TV networks) influence the development of policy capacity by facilitating the collection and diffusion of information and the coordination of policy-making and may impact on the public's policy literacy and expectations (Davis, 2000). In the health sector, new technologies and innovations are pushing policy-makers to consider whether it is necessary to regulate new developments such as assisted reproduction, GMOs, and nanotechnology. Also, emerging and new technologies increase the “costs of health services beyond any predictions of future cost that are based on current approaches to care and technology” (Provincial and Territorial Ministers of Health, 2000, p. 40). Policy-makers have to deal with increasing demands by the public for the best possible treatment and with the willingness of providers and professionals to benefit from new equipment.

1.4 Ideologies, beliefs, norms, and policy paradigms

As noted in the section on policy design, socio-cognitive models play an important role in policy-making. They are based on a broad set of concepts (culture, ideology, beliefs systems, policy paradigms, frames, or discourses) that tend to overlap in part, without being interchangeable (Burns, Calvo, & Carson, 2009, p. 14). In all cases, “conceptual models structure and constrain where and how policy alternatives are developed, what kinds of rules and actions are seen as appropriate and legitimate, and which kinds of actors are considered to be the appropriate and legitimate authorities for dealing with the issue” (p. 20). In this sense, socio-cognitive models undermine the propensity to view the public policy process as an entirely rational exercise. Ideologies, beliefs, norms, and policy paradigms of government, policy elites, coalitions, or populations influence all stages of the policy cycle.

For example, the cynicism and skepticism of citizens about the capacity of governments to provide high-quality services for the middle class bring about policies to limit direct

spending and services and to rely more on tax expenditures (Campbell, 2011; Davis, 2000). Also, concerns among the public have pushed governments to intervene into new policy areas such as the environment or LGBT rights (Davis, 2000). This is not a one-way relationship (Campbell (2011). For example, Schneider and Ingram (1993) explain how social constructs characterizing target populations (advantaged, contenders, dependents, and deviants) affect policy perception and political participation of citizens and also influence the policy orientation of decision-makers.

In fact, ideas, discourse, and rhetoric play an important role in convincing political actors to support a policy or not. As Stone (1997) said, “the struggle over ideas” is “the essence of policy-making in political communities” (p. 11). For example, Olive et al. (2012, p. 650) demonstrate that normative beliefs could partly explain state policy enactments not only for morality policies (abortion, gay rights) but also in other fields like the environment.

As an interest group, physicians have particularly attracted the attention of researchers. Their role is important, because “physicians have considerable political capital and have also traditionally been influential in shaping public opinion around health care reform” (Rabinowitz & Laugesen, 2010, p. 1346). Some authors argue that the “supremacy” of health-care professionals has declined in the Netherlands (Trappenburg, 2005), while in Australia others see few signs of decreased influence (Lewis, 2006). In the United States, Rabinowitz and Laugesen (2010) identify the lobbyist activities of physicians organized by specialty societies (e.g., pediatrics, cardiology) who behave like “niche” issue experts, while broader physician organizations may defend the economic self-interest of their members.

1.5 Trends in public administration: New public management and transparency

Public administration is frequently transformed by trends and fashions that propose to improve the efficiency of government, the services for citizens, etc. The impact of the New Public Management on policy capacity, with an increased withdrawal of the state and rationalization of expenditure, has been underlined elsewhere. In a demonstration of the evolution of policy capacity in Canada under the Mulroney and Chrétien governments, Bakvis (2000) draws three conclusions. First, the public administration did not lose many resources over time, but the deployment of these resources evolved (e.g., less use of royal commissions, increased political will to control the administration). Second, there is constant questioning of the balance between two organizational principles: centralized management to concentrate policy knowledge, and decentralization and horizontal structures to bring information from different perspectives. Third, innovations may be implemented to manage information and deal with complex issues, but these transformations lack institutionalization.

One possible effect of a withdrawal (in discourse or practice) of the state is that policies are more and more a product of a submerged state – that is, a conglomeration of existing government policies that incentivize and subsidize activities engaged in by private actors and individuals (Mettler, 2010, p. 803). In a submerged state, the public tends to underestimate the actual role of government and consequently to see poor capacity in governments (Mettler, 2010). This point of view is shared by Campbell (2011), who maintains that taxpayers will identify themselves as beneficiaries of the state if they receive visible benefits through direct funding or services, but that this may be less the case if they receive less-direct governmental efforts such as tax breaks. To counter this effect, Mettler (2010) recommends revealing to the public how existing policies function, and making the active role of government more visible.

Another trend in recent years is the increased participation of stakeholders and citizens in the policy process. Ministries are sometimes less directly involved in the implementation of reforms, and leave more space to joint self-administration between stakeholders (Kim & Simon, 2009). Partnerships with external organizations involved in a given sector may contribute to develop their community, organizational, and individual capacities and to ensure better coordination of resources, structures, and interventions to manage complex policy issues (Driedger et al., 2007).

Different types of instruments may facilitate the participation of new actors. For example, virtual policy networks could regroup individuals to develop ideas and transfer information on specific issues (McNutt, 2010). A good example of more formal instruments is the Canadian Strategy for Cancer Control, a “multiple partnership arrangement” to facilitate “communication between governments, non-governmental agencies, health professionals, and cancer survivors and families” (Prince, 2006, p. 468) based on a deliberative federalism. This approach has helped to solve two problems affecting the efficiency of interventions for cancer. First, it has decreased the fragmentation of information by facilitating the integration of knowledge across organizations. Second, this structure was adapted to manage a growing challenge with many related issues and had a better capacity to deal with a high level of new knowledge on cancer.

Developing a diversified coalition poses some challenges (Raine et al., 2014). First, the diversity of actors must be balanced to ensure effective participation and the representation of relevant interests. Second, the involvement and roles of each partner need to be effectively defined. Third, tools should be developed to give members access to internal resources and to disseminate information among them and to other relevant actors. Despite the great benefits of a collaborative process, this approach needs to be sustained by specific capacities such as strategic capacity, governance capacity, operational capacity, practice capacity, and community capacity (Sullivan, Barnes, & Matka, 2006) – new competencies that must be acquired by public administration and its partners. A collaborative network

process raises the question of whether government should focus mainly on its own policy capacity or should also pay attention to the policy capacity of its different partners.

In conclusion, public administration has experienced significant transformations in recent years that necessitate reflection on the development of policy capacity. While we are unable to determine if these changes have decreased or increased policy capacity, we generally agree that adaptation is necessary to align policy capacity to this new context.

2. Institutions That Limit or Empower Actors

Institutions are “a relatively enduring collection of rules and organized practices, embedded in structures of meaning and resources that are relatively invariant in the face of turnover of individuals and relatively resilient to idiosyncratic preferences and expectations of individuals and changing external circumstances (March and Olsen, 1989; 1995; 2006, p. 3). According to March and Olsen (2006), institutions influence the capabilities of actors by empowering or constraining them. We review three types of institutions that influence the policy capacity of actors: political regime, division of powers between levels of government, and organizational culture.

2.1. *Political regime: Differences between presidential and parliamentary systems*

White (2003) views the leadership that governments exercise to change policies as based on technical capacity (knowledge), institutional capacity (adequacy of the institutions and power), and political capacity (will to act according to current political circumstances). He defines institutional capacity in terms of whether a government has adequate instruments, powers, and resources to act. Each institutional arrangement has its strengths (fiscal capacity, coercive power, etc.) and weaknesses (procedural restriction, organizational distance, etc.). The challenge is to select a problem to solve “for which the government special powers are particularly relevant and the weaknesses less germane” (p. 224).

The limits imposed by the presidential system in United States and the system’s great division of power, which could slow down and complicate the process, have been highlighted above. For example, the behaviour of political parties constrains the power to reform policies by passing new laws. Rigby et al. (2014) observe that intraparty conflicts limited the power of the Democratic Party during the Obamacare episode, while their party’s control over the two houses allowed them to dominate the policy agenda and the legislative process. From another point of view, Morgan and Jacquin (2014) contend that the political fragmentation between Democrats and Republicans is not just a source of blockage but can actually promote the adoption of reforms because political parties are more disciplined and homogeneous. In short, the political system influences the ability of governments to pursue their goals. A US presidential system based on checks and balances may complicate reforms, especially in the negotiation process, while a British

parliamentary system like that in Canada facilitates decisions because the executive branch controls the legislature in majority government. However, the American system has some advantages that increase policy capacity, such as major search services (expertise) inside government departments and within the legislative branch in the offices of elected officials and committees, and outside, as in think tanks.

2.2. *Division of powers in federal regimes*

The constitutional division of powers between federal and provincial/state levels influences the capacity for action by governments, since it established their respective fields of action. For instance, policy coordination between federal and provincial/states governments is, theoretically, defined as more centralized in the United States than in Canada, but “hierarchical administrative federalism in the United States does not always produce the degree of coordination one might anticipate while a decentralized non-hierarchical system in Canada can achieve surprising degrees of coordination” (Bakvis & Brown, 2010, p. 484). In fact, the authors argue that despite the use of contrasting institutions, mechanisms, and practices, policy outcomes are often similar in both countries in health care (in term of national coordination and the regulation of private markets), environment, and infrastructure provision (Bakvis and Brown, 2010). Consequently, it is necessary to understand not only the rules of intergovernmental relationships but also how they are applied in practice and changed over time (e.g., Sparer, France, & Clinton, 2011). For example, according to Graefe and Bourns (2009), a change of perspective on intergovernmental relationships about health policy developed in Canada through three royal commissions (1937–40, 1961–64, and 2001–02). The authors argue that over time, concern for protecting provincial powers has decreased in favour of a vision asserting that what “works for Canadian citizen as a whole” must be done. This view contrasts with that of O’Reilly et al. (2006), who argue that intergovernmental relationships in health care focus on fiscal transfers and technical aspects rather than on long-term policy planning in part because provinces want to protect their power.

In the United States, several authors proposed that, to restart the reform process following its failure under Clinton, states should take the initiative to improve the health system with the financial support of the federal government (Aaron & Butler, 2008; Nathan, 2007; Weil, 2008; Weissert & Scheller, 2008). This view was attractive because states had developed their power, authority, and administrative capacity by a professionalization of the civil service, better relationships with research institutes, and increased leadership by governors (Sparer, 2003; Thompson, 2008). In Canada, provinces are also increasingly important as drivers of change, particularly in sectors such as domestic trade (Berdahl, 2013). According to Greer and Jacobson (2010), states have the capacity to develop policy based on local knowledge, value pluralism, and democratic process. But this position

presupposes that ideas and information reach decision-makers, that they have the capacity to transform local values and needs into policy, and that states can sustain their innovations with financial and bureaucratic resources. Moreover, the political will of the governor may not be sufficient. For example, in Wisconsin at the end of 1990s, despite a window of opportunity and a reformist governor, reforms remained incremental because their scope was limited by national constraints, lack of money from the federal level, and important advocacy groups (Sparer, 2004).

Patterns of intergovernmental relations have also affected the ability of government to develop public policies. Analyzing health reforms in 50 states, Callaghan and Jacobs (2014) find that state decisions are influenced by party control over the policy process, the trajectory of established policy (path dependency), and the state learning process during the intergovernmental bargaining. According to them, states that consider Washington's decision as a starting point for negotiation instead of a final decision will develop the skill and confidence to interact with the national government; they will produce a better understanding of the federal program by acquiring knowledge and experience and will be able to adapt programs to their particularities for better implementation. In both Canada and the United States, provinces/states with economic means and trained professionals in sufficient numbers tend to enjoy better policy capacity than others.

2.3. Tailoring the reform to organizational culture or making the necessary changes

In an analysis of reforms in public health in Quebec, Bernier (2006) observes that a key element of success was based on the culture change put in place over a long period of time by an institutionalization process and the mobilization of public health stakeholders. In Bernier's view, public health strategies should be tailored to specific administrative arrangements and administrative cultures rather than the adoption of exemplary models. Also, Kim (2008) demonstrates that the interactions among political institutions create conditions in which government agencies will respond to political requests, but also that agencies can push their own preferences in policy outcomes.

To implement a policy effectively, bureaucracies need to have not only policy expertise (Lavis et al., 2008) but also administrative capacity. Huber and McCarty (2004) develop a model of delegation to understand how the policy-making process is influenced when bureaucracy lacks the ability to accomplish intended actions. They conclude: (1) low bureaucratic capacity diminishes the ability of politicians to achieve their goals because bureaucratic "incompetence diminishes their incentives to implement the policies politicians describe in legislation"; (2) politicians will delegate less to low capacity administrations; and (3) "politicians in such polities are trapped in a situation where they have little incentive to reform not only the bureaucracy, but other institutions as well." Huber and McCarty's proposed model illustrates the two key perspectives about the role

of the public servant for implementation: the “top-down” perspective suggests constraining discretion by imposing controls, incentives, and rules (Elmore, 1979; Wenger & Wilkins, 2009), while a more “autonomous” perspective emphasizes that the administration could use its knowledge and autonomy to improve the application of the policy (Durose, 2011; Moore, 1987; Rowe, 2012).

On the ground, meso-level managers are deeply involved in the translation of policy to their specific context. An analysis of the implementation of the Quebec health system reform emphasizes that managers will use “institutional works” to adjust their organization to the new policy. Four types of work could be used: (1) *structural work*: efforts to establish formalized roles, rule systems, organizing principles and resource allocation models to support the new policy; (2) *conceptual work*: new belief systems, norms and interpretive schemes consistent with the new policy; (3) *operational work*: concrete actions shaping the everyday behaviours of front-line professionals directly linked with the new policy; and (4) *relational work*: building linkages, trust, and collaboration between people involved in reform implementation (this work underpins the other three) (Cloutier et al., in press). The task of governments is to support capacities within organizations to perform this work in order to implement and sustain reforms.

In conclusion, the capacity to understand the limitations and benefits imposed by institutions is an important part of policy capacity. However, it would be wrong to believe that these institutions remain immutable; those wishing to exercise greater leadership would be well advised to develop their capacity by leveraging both internal resources and external partnerships.

VI Implications for the Development of Policy Capacity

In this report, we have explored various streams of scholarship related to the complex and critical notion of *policy capacity* – the combination of knowledge, skills, organizational resources, and experience necessary to the development and implementation of policies. Our wide-ranging review of the scientific literature shows that policy capacity is still an emerging concept, yet one that is essential to the understanding of the policy performance of decision-makers. In the health sector, with its rapidly changing economic, social, political, and technological context, the success or failure of policy initiatives is increasingly dependent on the aptitude of public authorities to mobilize and retain an adequate level of specific policy resources. Policy capacity includes not only the relevant information on a given issue and the technical ability to develop appropriate solutions but also the human and financial resources to monitor their implementation and the social and political capital needed to achieve positive outcomes. All these aspects of policy capacity

are of course to the whole policy cycle from the initial identification of a problem to the decision to pursue or abandon a particular course of action.

Policy capacity is first understood as an individual characteristic, like leadership or expertise. The literature insists widely on the need for those who perform policy work to acquire strong analytical abilities and good technical knowledge, which is common sense. Disciplines like economics, law, or political science are mentioned, mostly because so many policy analysts are recruited from these fields. The literature also suggests that some familiarity with tools such as cost-effectiveness analysis or statistical modelling is important. Because of the practical nature of policy work, however, formal training is just one step toward acquiring the proper skill set. Most would agree that the real test of capacity is to apply one's knowledge to the resolution of a specific problem or to learn how to adapt one's solutions to the concrete political and social conditions in which policies are defined, adopted, and appreciated. At the individual level, therefore, policy capacity presumes some degree of intellectual agility and a good dose of direct experience, over and above the proper academic credentials. Needless to say, people who combine all these characteristics are few.

Context is overwhelmingly important. The literature is insistent that formal knowledge and analytical skills are important but never sufficient. Policy work is always done in a given context, made up of social and economic conditions, political and institutional realities, and historical and cultural constraints. This context may vary according to the policy sector. It is also informed by previous policy choices, which may decide the political acceptability or feasibility of a given policy alternative. A certain number of "soft skills" are required for the policy context to be acknowledged and further integrated in the policy process. The literature mentions "system thinking," or the ability to build and manage networks, for example. As well, interest in the context of policies suggests that policy capacity, like other social competencies involving interpretation and judgment, cannot be limited to individual characteristics but must involve collective learning.

Policy capacity is therefore *both* substantive and relational. Capacity also resides, for example, in policy networks, whether they operate like traditional sectoral networks of bureaucrats, experts, and stakeholders or more like complex, hybrid systems such as those supported by various health reform organizations in Canada and the United States. The important point is that capacity need not reside entirely within the state bureaucracy. Investing in knowledge networks, and consequently in policy learning, is in fact an efficient way to build policy capacity. This is particularly true of federal or quasi-federal states, in which one can use other jurisdictions as "laboratories" for policy experimentation. Another essential aspect of network building is to create knowledge pathways between the administration and civil society. Experts in policy design have insisted for some time on the importance of ensuring proper participation of stakeholders and the public in policy decisions.

Individuals evolve in institutional settings that are more or less enabling. Literature on evidence-informed policies, policy design, and policy know-how insist in various ways on organizing principles and resources to support policy work. Formal collaboration between governments and academic and research institutions has in some cases ensured a supply of high-quality expertise in support of policy-making. The ability to commission research, achieve prioritization of needs, and set up deliberations around research results and derived policy options appears to be an essential ingredient of policy capacity. However, the most difficult challenge resides in the connections between the production of knowledge, good policy work, and what happens in the political arena. Understanding the needs and expectations of politicians is fundamental to connecting the knowledge around a policy issue with other legitimate sources of information. Skilful policy workers help politicians to discover convergences in various sources of information; they may take on the roles of brokers, coordinators, and integrators to support politicians in managing multiple sources of credible and legitimate information. This is why we have insisted on the importance of policy anticipation and feedback as essential ingredients of strong, resilient policy design.

The public's preferences and aspirations may help in changing policy conversations and the views and behaviour of politicians, yet political realities cannot be ignored. Studies of policy know-how clearly underline the tactical side of policy capacity, where careful analysis of the positions of various groups and of their ability to influence is taken into account. Being equipped to face controversial issues and to reframe policies to win more supporters appears essential. However, as we have suggested, policy work performed with and through networks inside and outside governments may help in mitigating political forces around a given policy issue.

These considerations around policy capacity suggest that there are no absolute recipes. Individuals placed in enabling contexts will be able to develop, expand, and sustain policy capacity in its various dimensions. Policy work is teamwork, and it is how knowledge, skills, and experience can be adequately combined. Public authorities and decision-makers can develop and sustain policy capacity using a formal strategy to combine internal and external capacity. Examples of such arrangements are found in Canada in the Centre for Health Policy in Manitoba, ICES in Ontario, and INSPQ in Quebec. One needs to note that policy capacity development is influenced by broader context such as political regimes and institutions. In a federal regime, policy capacity is, de facto, distributed across levels of governance. Institutions, depending on their ability to intervene, will be more or less inclined to tackle a given policy issues. Finally, the so-called general population is important to making policy happen, and capacities should be in place to bring the public closer to policy-making.

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List of Key Words Used in the Initial Search Process

1. Capacity building experiences AND healthcare / health reform
2. Policy AND capacity building
3. National capacity AND health services or national capacity AND healthcare reform/ health reform
4. Building capacity AND policy work AND healthcare reform/ health reform
5. Policy advice AND health / health reform
6. Innovation AND policy capacity
7. Policy leadership AND Health reform
8. Political leadership AND Health reform
9. Bureaucratic expertise AND Policy capacity AND health or Bureaucratic expertise AND health reform
10. Policy capacity AND exchange knowledge or practice knowledge
11. Policy capacity AND policy makers
12. Policy capacity AND researchers
13. Policy analysis AND health reform
14. Public health AND strengthening capacity / building capacity
15. Policy advice AND health policy or policy advice AND health reform
16. Sustaining capacity AND health policy or health reform
17. Developing capacity AND health policy or health reform or policy development AND capacity
18. Mobilizing capacity AND health policy or health reform
19. Health policy making-process AND capacity
20. Policy based-evidence AND health policy
21. Intersectorial collaboration AND health policy or policy network AND capacity
22. Intersectorial governance AND health policy or health reform or policy capacity
23. Virtual policy networks; policy layering, alignment of policy

List of additional keywords:

1. Federalism AND health reform
2. Federalism AND health care
3. Federalism AND health reform AND capacity
4. Federalism AND health care AND capacity

5. State policy AND capacity AND health
6. Leadership capacity AND health reform
7. Leadership capacity AND health care
8. Decentralisation and health reform
9. Decentralisation and health care
10. Horizontality AND health reform
11. Horizontality AND health care
12. Multi-level governance AND health reform
13. Multi-level governance AND health care
14. Joined-up governance AND health reform
15. Joined-up governance AND health care
16. Agenda-setting AND capacity AND health
17. Policy formulation AND capacity AND health
18. Decision-making AND capacity AND health
19. Decision makers AND capacity AND health
20. Policy design AND capacity AND health
21. Policy tools AND capacity AND health
22. Policy implementation AND capacity and health
23. Policy evaluation AND capacity and health