Learning from health policy implementation: The interaction of ideas, interests, and institutions

The adage that we must not forget the lessons of the past has never been more relevant than today. These lessons are becoming increasingly important as we witness the blurring of boundaries across the disciplines and as exciting, innovative approaches to theory, evidence, and practice are applied to the flow from knowledge to action.

One of the benefits of a Conference such as this is the opportunity we have to learn from those who work in other disciplines. And nowhere is this need for understanding how others have met policy problems more pressing than in the field of health.

Dolowitz and Marsh [1] observed that:

> There has been a growing body of literature within political science and international studies that directly and indirectly uses, discusses and analyzes the processes involved in lesson-drawing, policy convergence, policy diffusion and policy transfer. While the terminology and focus often vary, all of these studies are concerned with a similar process in which knowledge about policies, administrative arrangements, institutions and ideas in one political setting . . . is used in the development of policies, administrative arrangements, institutions and ideas in another setting.

Unfortunately, one of the problems in understanding lessons from other policy fields is that most of the studies are *descriptive*, but *describing* how policies *change* is far less beneficial than explaining *why* and *how* a desired policy path is achieved.

More and more frequently, researchers are learning that policy implementation is neither a tidy nor a rational process, and that in order to avoid the problems that have plagued healthcare efforts in the past, the complex and interrelated stages of design, planning, implementation, utilization, and evaluation must be understood in detail.

The volume of thoughtful and thoroughly researched information about policy learning, emulating, harmonizing, and converging [2] that is available to us is substantial, for more and more epistemic communities [3] are forming to link these bodies of knowledge. And, in many ways, this is a good thing. The challenge, I believe, is for experts in transdisciplinary studies to link hitherto disparate groups.

As we learn every day, information is rapidly being shared among various groups of policy makers in the healthcare field, not only within national boundaries, but internationally, as well. According to Federico Toth, "[e]ven though each national health system follows its peculiar evolutionary course, mutual exchanges among countries are frequent. To a large extent, policy makers are influenced and inspired by other countries' experience." [4]

In his seminal article "Learning from experience . . . ," McLaughlin maintains that the broad parameters that described the "uncertain relationship between policies and implemented programs" have matured to a point where the lessons learned "frame the conceptual and instrumental challenge" that will integrate "the macro world of policymakers with the micro world of individual implementers." [5]

The link between knowledge and implementation cannot be separated or underestimated. In academia, many now refer to this as the "know-do" gap. In addition to availability of knowledge, successful policy implementation requires a capacity to act—that is, the authority to control the policy process. The ongoing debate between researchers in the social sciences involves discussions about whether policy implementation is more successful when there is a "top down" approach, where those with most authority control the process, or when there is a "bottom up" strategy, where the implementers direct the policy intervention.

Despite such disagreements, we do possess wherewithal to achieve success in policy implementation. For example, in their review of implementation policy literature, Joseph et al. [6] give us an overview of the factors that are

necessary for successful policy implementation. Among them are:

- collaborative planning
- clear and consistent objectives
- accurate causal linkages between objectives and actions
- use of a sympathetic agency with adequate resources and authority to implement the plan
- skilled and committed implementation managers
- public and stakeholder support, and
- a supportive socioeconomic and policy environment.

We might add to this, recognition of the need for standardization of language. The importance of employing standardized language strategies when sharing knowledge is discussed at this Conference by Professor Glickman from the University of Toronto.

The need for standardization of language has also been addressed by John Lavis. According to Lavis, [7] about 30% of research is not actionable because specialists often frame their own research in a jargon which others cannot understand. And the situation is further compounded by the cacophony of sound produced by the lively interplay between other advocates, policy communities, and policy entrepreneurs.

But let's return to the positive. Among the numerous theories that refer to the development and implementation of public policy is the increasingly accepted principle of "evidence-based policy-making." [8] Based on the core idea of "clinical evidence derived from systematic research to guide medical practice," more and more scholars in the realm of public policy have now adopted the concept of using this strategy to shape their research agendas. Among the examples of this tendency that can be cited is the "SUPPORT tools for evidence-informed health Policymaking," an international collaboration that promotes evidence-based policy research. [9]

As a result of all of the volumes published, many researchers are drowning in information. With apologies to the "Rime of the Ancient Mariner" by the English poet Samuel Taylor Coleridge and to the *Economist* journal's recent

article on the superabundance of information, we find that there is "data data everywhere — but let's be careful what we think." What is available in print, on audio, or via the ether may not be correct. As we know, astute statisticians and their allies in different fields often manipulate data to reflect their own position. Consequently, trust is declining in many quarters. For example, in a special report on managing information, a prominent journal related that in a "study by IBM, half the managers quizzed did not trust the information on which they had to base decisions. Many say that the technology meant to make sense of it often just produces more data. Instead of finding a needle in the haystack, they are making more hay." [10]

Fortunately, those of us who are involved in medical research in developed countries such as Canada can look for clarity and precision to the extraordinary contributions made by *The Cochrane Collaboration* and its meticulous reviews of clinical studies and reports.

Elsewhere, the situation concerning data is often different. As I informed the World Congress of Physical Therapy in 2007, one of the major challenges that international organizations such as the UN, WHO, IMF, and OECD have encountered is gaining access to data. Not only has there been a dearth of information in certain areas, but different nations collect different data in different ways. [11] Since then, it appears that little has changed. This teaches us that effective policies cannot be well-designed, implemented, or evaluated if the necessary data is absent, unreliable, improperly understood, or worse, manipulated for whatever reason.

How then can effective policy paths be prepared and followed? The answer lies, in part, in careful analysis of the key elements at play during each stage of the complex and interrelated process. Numerous theoretical approaches are available to promote our comprehension of the knowledge-to-action flow. Political scientists, many of whom embrace transdisciplinary training in fields such as law, medicine, and the social sciences, have provided a number of useful tools designed to facilitate an understanding of health policy development and

execution. For example, some focus on the coalitions that form to influence a particular issue, whereas others describe the societal or ideological imperatives which provoke or promote the need for change.

One particularly useful tool is the Neo-Institutional Framework. Its importance derives from the fact that it combines three essential and complimentary analytical tools: *Historical Institutionalism, Rational Choice,* and *Organizational Theory*.

- *Historical Institutionalism* examines the factors that have affected the structure and behavior of state and societal institutions over time. This type of investigation helps to reveal why differences in power existed and what caused the intended and unintended consequences of policy decisions.
- *Rational Choice* focuses on the actors, their interests, and their political strategies, and seeks to discover what they think is best for them. Among the actors we would find elected officials, bureaucrats, and the various coalitions that form around given political issues.
- *Organizational Theory* examines which factors affect individuals and their environments as well as how people and organizations interact with each other. It seeks to explain why the rules, procedures, and norms of organizations are developed and why those factors change.

Thus, the Neo-Institutional Framework allows us to examine policies from the standpoint of which ideas, interests, and institutions have been involved in the creation of policies; how these factors tend to influence the outcome of those policies; and how they, in turn, are affected by those policies.

The *ideas* that have prompted shifts in health policy often reflect the societal values that are inherent in the nation being examined. For example, the United States—whose deep aversion to taxation by a strong central government, plus its passionate history of states' rights and individualism—has embraced a desire for limited government intervention. On the other hand, Canada—with an ingrained proximity to the Crown and a greater historical focus on government intervention—has endorsed a publicly funded, single-payer

healthcare system.

The *interests* in healthcare matters are those of the patients and healthcare providers, as well as other formal and informal policy communities and networks which strive to influence the policy process, so that it will meet their individual and collective needs. These interests are often the product of informal and fluid links that develop in response to a given policy issue. For example, groups of seniors may form powerful, albeit temporary, coalitions with pharmacists in their attempt to combat a projected change in the provision of prescription drugs.

The *institutions* are the formal and informal organizations in the public, private, and not-for-profit sectors that attempt to affect, that do affect, and that are affected by policy change. These institutions include not only those of federal, state, and local governments, but also unions and professional associations, as well as healthcare, pharmaceutical, and insurance companies. The recent heated debates associated with the healthcare insurance reforms in the United States will attest to the power and influence that large groups of like-minded associations can have on the whole process.

The benefit of the Neo-Institutional Framework as a tool for analysis is that the selected variables used to determine a new policy path may be examined in detail from the standpoint of their role historically, their import to the stakeholders, and their significance within the participating institutions. In so doing, the relative influence, balance, and impact associated with the ideas, interests, and institutions may be anticipated with greater accuracy than might otherwise be the case.

Implementation is a fascinating part of the policy process. It is only one part of the tapestry of policy design and evaluation, and is a dynamic link in a continuum that is neither tidy nor rational. Leslie Alexander Pal once observed that modern governments have “extraordinarily complex bureaucratic structures with overlapping mandates and few centres of control. Moreover, policy-making is often distinguished by crisis response, short time horizons and uncertainty, rather than the leisurely pace of dispassionate assessment implied by the rational model.” [12]

As an illustration of this reality, Contandriopoulos and Brouselle cite Quebec's limited success in implementing the health policy recommendations of three important Commissions in 1970, 1988, and 2000. Using the neo-institutional framework, the authors concluded that:

> . . . while the commissions proposed solutions that were consistent with available scientific evidence, they did not consider the political acceptability of those recommendations. Modifying physicians' employment relations with hospitals or their payment scheme, re-allocating budgets between institutions, shifting resources from secondary or tertiary care to primary care—all may very well be central to tackling the system's main programmatic problems, but they will also immediately trigger radical opposition from key stakeholders. . . . The centrality of interest groups such as physicians' unions, faculties of medicine or teaching hospitals lies in the fact that they are pivotal both in the production and reproduction of (societal) norms and values as well as their political capacity to veto proposals that contradict their preferences. [13]

As we explore the strength and location of decision-making power, the capacity of the various actors to implement policy, and the impact of intended and unintended consequences, we must be prepared to efficiently communicate our findings within and beyond the boundaries of our own discipline and effectively share the lessons that we have learned.

Notes

[1] Dolowitz, David P. and David Marsh. "Learning from Abroad: The Role of Policy Transfer in Contemporary Policy-Making." *Governance*. Vol. 13, No. 1. January 2000, pp. 5-24.

[2] Bennett, Colin J. "What Is Policy Convergence and What Causes It?" *British Journal of Political Science.* Vol. 21, No. 2. April 1991, pp. 215-233.

[3] Haas, Peter M. "Introduction: Epistemic Communities and International Policy Coordination." *International Organization* Vol. 46. 1992, pp. 1-35.

[4] Toth, Federico. "Healthcare Policies Over the Last 20 Years: Reforms and Counter-Reforms." *Health Policy*. Vol. 95. 2010, pp. 82-89.

[5] McLaughlin, Milbrey W. "Learning from Experience: Lessons from Policy Implementation." *Educational Evaluation and Policy Analysis.* Vol. 9, No. 2. 1987, pp. 171-178.

[6] Joseph, Chris, Thomas I. Gunton, and J. C. Day. "Implementation of resource management plans: Identifying keys to success." *Journal of Environmental Management*. Vol. 88, No 4. September 2008, pp. 594–606.

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[8] Behague, Dominique, Charlotte Tawiah, Mikey Rosato, Télésphore Some, and Joanna Morrison. Evidence-Based Policy-Making: The implications of Globally-Applicable Research for Context-Specific Problem-Solving in Developing Countries." *Social Science and Medicine.* Vol. 69. 2009, pp. 1539-1546.

[9] Lavis. John, Andrew Oxman, Simon Lewin, Atle Fretheim. "SUPPORT Tools for Evidence-Informed Health Policymaking." *Health Research Policy and Systems.* Vol 7. 2009, p. 1.

[10] "A Different Game: A Special Report on Managing Information." *The Economist*. 27 February 2010, p. 8.

[11] Jones, Ruth J. E. ""Physical Therapy: Globalization and the Politics of Science." World Confederation for Physical Therapy Congress, Vancouver, BC. 2007.

[12] Pal, Leslie A. *Public Policy Analysis*. Toronto: Methuen. 1987. P. 45.

[13] Contandriopoulos, Damien, and Astrid Brousselle. " Reliable in Their Failure: An Analysis of Healthcre Reform in Public Systems." *Health Policy*. Vol. 95. 2010, p. 151.