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Int J Health Policy Manag 2015, 4(12), 837–839

doi 10.15171/ijhpm.2015.145

IJHPM
International Journal of Health Policy and Management

Commentary



Policy Capacity Is Necessary but Not Sufficient

Comment on “Health Reform Requires Policy Capacity”

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Abstract

Policy capacity focuses on the managerial and organizational abilities to inform policy decisions with sound research and analysis, and facilitate policy implementation with operational efficiency. It stems from a view of the policy process that is rational and positivistic, in which optimal policy choices can be identified, selected, and implemented with objectivity. By itself, however, policy capacity neglects the political aspects of policy-making that can dominate the process, even in health policies. These technical capabilities are certainly needed to advance reforms in health policies, but they are not sufficient. Instead, they must be complemented with public engagement and policy advocacy to ensure support from the public that policies are meant to serve.

Keywords: Policy Analysis, Policy Capacity, Policy Advocacy, Public Engagement

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Citation: Gen S, Wright AC. Policy capacity is necessary but not sufficient: Comment on “Health reform requires policy capacity.” *Int J Health Policy Manag.* 2015;4(12):837–839. doi:10.15171/ijhpm.2015.145

Article History:

Received: 15 July 2015

Accepted: 1 August 2015

ePublished: 2 August 2015

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Reforming public policies is a complex process involving many stakeholders from both the public and private sectors. Health policy reform is no exception, as it is a field filled with organized interests representing healthcare providers, insurers, pharmaceutical industry, regulators, patients’ advocacy groups, public health advocates, etc. Compounding its complexity is the broad impact of health policies, affecting virtually everyone in their respective jurisdictions. In this complex environment, the policy capacities of organizations—both public and private—promises to provide some clarity of the issues through rigorous analyses and expert advice. By itself, however, it is not enough to spur meaningful reforms. Instead, policy capacity must be complemented with political skills in public outreach and issue advocacy.

Narrower definitions of policy capacity focus on the expertise, research, and analysis needed to make public policy choices.¹ Broader definitions add managerial and organizational abilities to not only make the choices but also implement and sustain them,² such as research, environmental scanning and forecasting, policy analysis, consultations, communications, program management.³ Forest et al⁴ take this broader view in their prescription for organizations to develop capacity to affect all aspects of health policy processes, from agenda setting through evaluation. Even more, they do not limit their prescription just toward the public sector policy actors that are popularly targeted. Instead, they note that sound reforms in health policy require greater policy capacity in both public and private sector stakeholders.

Their prescription is given within a historical context in which the government’s policy capacity has ebbed and flowed with reforms in public management. Prior to the 1970s, policy capacity was more narrowly focused on the decision-making aspect of the policy process, partly because at that time policy implementation was mostly seen as a bureaucratic process. As

a result, the policy analysis profession flourished and became one requiring specialized skills in analytics.⁵ In the following decades however, that capacity was weakened with the rise of new public management and its reliance on market forces and economic efficiency to guide policy choices.⁶ As new public management has slowly given way to more collaborative and networked approaches to governance, there has been a call to rebuild policy capacity, but in the broader sense described by Forest and colleagues.

This is a welcomed and needed prescription, but it is insufficient to affect policy reforms because it relies on rationalism to guide a process that is inherently political. The drive to redevelop policy capacity is an extension of the rational, positivistic view of policy-making,⁶ in which optimal solutions can be objectively identified, selected, and implemented. It abides by Wilson’s historic plea to separate politics from administration,⁷ paving the way for meritocracy to replace patronage in public policy and administration. And it supports the longstanding view that unelected public servants “have no legitimate claim to influence” policy decisions,³ but instead should only provide objective advice. However, a century and a quarter since Wilson’s article, our collective experiences suggest that such separation is not possible. We have learned that optimal policy solutions are not likely to succeed without political buy-in from key stakeholders.

Take for example the case of the Affordable Care Act of 2010 (ACA) in the United States. In that nation’s market-driven healthcare system the poor and the elderly are unprofitable, so the government acts as their insurer. Even so, prior to the ACA, an estimated 15 million people fell between the gap of private insurance affordability and public insurance eligibility, and millions more were underinsured or chose to be uninsured. The ACA currently seeks to fill this gap by expanding both public and private insurance markets.⁸

Eligibility for public insurance was expanded to adults within 133% of poverty standards. For individuals ineligible for public insurance and not receiving insurance through their employer, new health insurance markets were set up targeting them. Those “exchanges” could be set up by individual state governments, or by the national government for states unable or unwilling to set up their own. Clearly, the ACA is a highly complex policy involving many partners in the public and private sectors including the US Department of Health and Human Services, the Centers for Medicare & Medicaid Services, the states’ insurance commissions, the states’ governors and legislators, and private insurance companies. Further complicating the policy are two overshadowing political dimensions. First, in the federal structure of the US government, the national government and the 50 state governments each have some level of autonomy in the issue. Second, those governments, and the constituents they represent, have their own political interests that might conflict with those represented by the ACA. Thirty-five states opted not to create their own exchanges, a few because they lacked the capacity to do so, but most because they resisted the law, particularly those led by conservative governors or legislatures.⁹ Twenty-eight states, including four that set up their own exchanges, joined in lawsuits against the national government to stop the law altogether. Meanwhile, state and national agencies tried to implement their aspects of the law, under a cloud of uncertainty from the ongoing judicial review, and with varying degrees of success. In the five years since its passage, the ACA has been upheld by the Supreme Court twice, and about 16.4 million formerly uninsured people gained healthcare coverage through the ACA, including 6.4 million in the states who chose not to set up their own exchanges.¹⁰ Even so, Congressional legislators entrenched in their opposition continue to try to repeal or replace the policy. The ACA clearly demonstrates that the political aspects of health policy sometimes dominate the rational ones. Even full policy capacity to guide the decision-making and implementation processes at the national and state levels could not have avoided the pure clash of values and politics brought out by the Act.

To account for and address the political forces involved in health reform, policy capacity must be complemented with competencies in public engagement and policy advocacy. The relevant information and analysis that comes from policy capacity does not inform a purely rational process, despite hopes we might have for it. Instead, it informs a democratic process of policy-making^{11,12} that recognizes the centrality of the public in that process. Acknowledging this role, the practice and profession of policy analysis has evolved, from one explicitly positivistic and rational to one that more critically and acceptingly embraces the relationship between policy analysis and its political contexts and processes.⁵ Thus, truly influential public engagement is needed in our policy processes.¹³ This goes beyond token involvement and moves substantially towards co-production. Such engagement advances policies in two critical ways. First, it legitimizes the resulting policies as outputs of democratic processes, rather than technocratic or bureaucratic processes.¹⁴⁻¹⁷ Second, there is a small but growing body of literature that suggests that it also improves policy outcomes.¹⁸⁻²⁰ Indeed, Parsons

notes that the inclusion of public experiences, knowledge, and values must complement “instrumental rationality” in democratic policy-making.⁶ Policy failures have come from such inputs being “designed out” of the process, rather than being “designed in.” Thus, those building policy capacities of institutions must resist the inclination to sanitize the policy process, and instead embrace its political messiness.

Closely related to public engagement is the need for policy advocacy. For professionals serious about influencing policy decisions and implementation, it is not enough to simply inform the process with sound analysis. There must be advocacy in addition to the analysis.²¹ However, our understanding about this as a professional practice is still woefully underdeveloped. What we do know is mostly anecdotal, based upon the wise advice of seasoned advocates sharing their experiences and lessons. Still, that advice along with the emerging theoretical bases can guide the development of advocacy skills.²²

In the closing sentence of their essay Forest et al⁴ do acknowledge the need for advocacy in policy processes. They make a plea for “...health actors to join the fray and move from their traditional positions of advocacy to a fuller commitment to the development of policy capacity...” Policy capacity is indeed a necessary condition of sound health policy, and such skills and expertise are developed in programs ranging from medicine and public health to economics. But, it is not sufficient. Other limiting factors are the complementary skills and expertise in public engagement and advocacy. Evidence, engagement, and advocacy are all needed; sound analysis developed in the vacuum of objectivity must be complemented with stakeholder support amassed through persuasion.

Ethical issues

Not applicable.

Competing interests

Authors declare that they have no competing interests.

Authors’ contributions

SG was the lead author. ACW provided key input on policy advocacy. Both authors revised and finalized it.

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