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Commentary

Unpacking "Health Reform" and "Policy Capacity"

Comment on "Health Reform Requires Policy Capacity"

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Abstract
Health reform is the outcome of dispersed policy initiatives in different sectors, at different levels and across time. Policy work which can drive coherent health reform needs to operate across the governance structures as well as the institutions that comprise healthcare systems. Building policy capacity to support health reform calls for clarity regarding the nature of such policy work and the elements of policy capacity involved; and for evidence regarding effective strategies for capacity building.
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Health reform is a complex and poorly defined process[1] but it seems self-evident that strengthening policy capacity would contribute to success.[2] In their recent editorial, Forest and colleagues[3] argue that health policy advocates need to move beyond making demands and claiming needs, and towards a more enlightened contribution to the definition and resolution of system problems. This, they argue, calls for a fuller commitment to the development of policy capacity.

In this commentary, we explore the dynamics of 'health reform' in order to define the kind of policy work which health reform involves and the implications of this for policy capacity building. We explore also the process of capacity development and argue for a distinction between individual and organisational policy capacity because strategies for developing them are likely to be different. We emphasise the need for robust evidence regarding strategies for capacity building at these different levels.

In thinking through the policy work involved in health reform several features of the change process need to be emphasised. The first of these is context dependence, in contrast to the reductionism which characterises much commentary on health reform. For example, World Health Organization's (WHO's) 'building blocks'[4] (services, workforce, information, products, financing and leadership/governance) invite the policy worker to foreground these analytical components of health systems and leave context in the background. While reducing the health system to building blocks can be useful for some purposes, WHO acknowledges[4] that the decisions which constitute the reform process are deeply embedded in the social fabric and are never restricted to one building block. This tendency to reductionism reflects to some extent the dominant role played by the discipline of economics in much health reform research and commentary. This can be seen, for example, in the engineering approach to incentives which reduces practitioners to objects in the hands of the financial engineers. In contrast to this economism are the contributions of political scientists such as the work of Immergut whose account of health systems development in Western Europe[5] demonstrates how deeply embedded health system change is in the wider social and political context.

The structures of health system governance are a critical part of the field of policy-making for health reform but this tends to be obscured by representations of health reform as mediated by interventions coming from somewhere 'outside'; the agents who drive health reform are seen as somehow not part of the system in which they are intervening. This kind of discourse characterises much of the World Bank commentary, as for example in the Peters et al collection.[1]

China provides an excellent laboratory to study health reform due to the speed and extent of change in comparison with the industrialised world[6] and highlights the usefulness of political science in understanding the political dynamics of change. The development of the Chinese health system over the last 35 years reflects a kind of dispersed 'incrementalism' (as described by Lindblom[7]) with key decisions taken in different sectors (pricing, training, funding, procurement and administration); at multiple levels (central, provincial, municipal and institutional); and across time. The lack of policy coherence across this sequence of decision-making is reflected in perverse incentives[8,9] which are resistant to reform. The capacity of hospital managers to circumnavigate central government policy initiatives[10] corresponds to Lipsky's metaphor of 'street level bureaucracy.'[11] Kingdon's metaphor of 'windows of opportunity' in policy-making[12] is well-illustrated by the impact of the global financial crisis on healthcare funding in China when, because of the need to boost consumption, reduce savings and maintain social stability, the central financial authorities agreed to a huge boost in the funding of rural and urban health insurance (notwithstanding the continuing absence of effective expenditure controls).[13,14]

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Policy work directed to system wide reform needs to address the structures and forces through which the system as a whole is governed and to recognise the incremental and dispersed nature of the policy initiatives through which reform is achieved; dispersed in time, space and sector. When dispersed incremental reforms are not aligned towards a common vision the outcome is a kind of ad hoc incrementalism: one step forward; two steps back. Coherent incremental reform results when a sequence of dispersed incremental initiatives contribute in a complementary and constructive way to driving system wide improvement.

The dynamics which help to align these dispersed incremental initiatives depend in some degree on persuasion rather than being solely driven by law or funding. Two dynamics are important here: first, a powerful vision for change, capable of engendering broad support; and secondly, leadership at various points and levels, capable of inspiring local and specific initiatives that contribute to system wide change.

An understanding of health system governance is critical for theorising health reform and understanding the policy work involved. While health reform may be conceived and driven through the structures of governance, these structures are more frequently the agents of conservation than the agents of change. The structures of governance need to be seen as part of the field of reform; not as the controllers who intervene from the outside but as a network of players who can choose to practise differently. The concept of network governance[15] and particularly the account of nodal governance by Burris et al[16] are useful in this context. These writers posit governance as a network of 'nodes' of influence; including a range of institutions, professional groups, commercial interests and civil society activists. The behaviour of this network is a function of the agency of the nodes, constrained and facilitated by the relationships between nodes and by the broader networks which they comprise. A clear view of these governance structures helps in the development of policy options that could change the dynamics of governance and helps also in projecting and evaluating the different scenarios which might flow from various options.

Driving system-wide health reform involves influencing the governance networks which govern all of the different sites and levels of reform as they evolve over time. Structural change is facilitated by consensus but there is always conflict and the need to change power relations to overcome fixed policy positions. Policy leaders and activist organisations need to build a constituency for reform as well as addressing the fears and apprehensions of those who see their interests as threatened. Change, from within the system, occurs when stakeholders and their constituencies change their evaluation of the problems and the options for reform. Such changes in perception may arise from new information or evidence about causes and strategies. These shifts in perception can lead to new alliances which change the balance of power in relation to various options for reform.

Policy work is complex and it is hard to prescribe capacity building without a clear understanding of the different elements of policy capacity as it applies to health reform. As a first step it is necessary to consider separately the capacity of individual policy analysts, as distinct from the capacity of institutions, organisations and the networks in which they are embedded.

The individual competencies needed for good policy work include a range of knowledge sets, practical skills and personal attributes. The full range of policy competencies is rarely embodied in the same individual which is why team work is important.

Policy practitioners need a sound knowledge of the organisational, political and social context in which they work, a grounding in relevant disciplines, and knowledge of both the historical lineage of the health system in which they are embedded and of systems and developments in other countries.[17,18] These knowledge sets must of course be combined with analytic skills, the practical skills of policy development and analysis, and communication skills.[17,18] Attributes such as creativity, intuition and judgement[17,18] can be just as important as technical skills in a profession that is 'as much an art as a science.'[19] The ability to frame problems and to manage relationships is often seen by policy-makers as more important than the more technical aspects of policy work.[19]

Alongside these individual competencies there is a suite of organisational structures and processes which are necessary for supporting good policy work. These include the generation and management of evidence and information; management of relationships within the organisation, across organisations and with those responsible for implementation; organisational capacities in strategic management, evaluation and monitoring; personnel management and workforce development practices.[17,18] Individual and organisational capacities can overlap, as when professional development policies (an organisational attribute) focus on the competencies of individuals; and in the case of leadership which is an individual competency but one which needs a supportive organisational environment to be fully expressed.

Building health policy capacity is not straightforward. Public sector organisations are characterised by tensions between competing and changing priorities. The requirements for policy capacity can at times conflict with pressures for investing in service delivery, or with priorities driven by political imperatives.[18] For example, the effort involved in building relationships, necessary for successful policy reform, might otherwise be invested in service delivery; relationships with stakeholders can also create political risks for governments.[18] These often quite volatile tensions are an intrinsic part of policy work, and leadership at every level is central to managing them successfully.

We applaud the call by Forest et al[3] for a fuller commitment to the development of policy capacity for health reform. However, there is much more work to be done in terms of teasing out the dynamics of health reform, the policy work which is involved and the capacity building strategies that work.

Ethical issues

Not applicable.

Competing interests

This commentary does not raise any conflicts of interest of either a proprietary or financial nature.

Authors' contributions

Both authors contributed equally to the conception, planning and

writing of this commentary.

References

1. Peters DH, El-Saharty S, Siadat B, Janovsky K, Vujicic M, eds. *Improving Health Service Delivery in Developing Countries: From Evidence to Action*. Washington: World Bank; 2009.
2. World Health Organization (WHO). *Health Systems Financing: The Path to Universal Health Coverage - Plan of Action.* Geneva: WHO; 2012.
3. Forest PG, Denis JL, Brown LD, Helms D. Health reform requires policy capacity. *Int J Health Policy Manag.* 2015; 4(5): 265-266. doi:10.15171/ijhpm.2015.85
4. World Health Organization (WHO). *Everybody's Business: Strengthening Health Systems to Improve Health Outcomes: WHO's Framework For Action.* Geneva: WHO; 2007.
5. Immergut EM. *Health Politics: Interests and Institutions in Western Europe*. Cambridge: Cambridge University Press; 1992.
6. Lin V, Guo Y, Legge D, Wu Q, eds. *Health Policy in and for China*. Beijing: Peking University Medical Press; 2010.
7. Gregory R. Political rationality or 'incrementalism'. Charles Lindblom's enduring contribution to public policy making theory. *Policy Polit.* 1989;17:139-153.
8. Pei L, Legge D. Personnel reform in Chinese hospitals: policy interdependence and the challenge of coherent incrementalism. *China Journal of Social Work.* 2013;6(1):25-39. doi:10.1080/17525098.2013.766623
9. Pei L, Legge D, Stanton P. Policy contradictions limiting hospital performance in China. *Policy Stud.* 2000;21(2):99-113.
10. Ramesh M, Wu X, He AJ. Health governance and healthcare reforms in China. *Health Policy Plan.* 2014;29(6):663-672. doi:10.1093/heapol/czs109
11. Lipsky M. *Street Level Bureaucracy*. New York: Russell Sage Foundation; 1979.
12. Kingdon JW. *Agendas, Alternatives, and Public Policies*. Boston: University of Michigan; 1984.
13. Du L, Killingsworth J, Liu G, Legge D. Macroeconomics and health. In: Lin V, Guo Y, Legge D, Wu Q, eds. *Health Policy in Transition: The Challenges for China*. Beijing: Peking University Medical Press; 2010:350-367.
14. Cao Q, Shi L, Wang H, Dong K. Report from China: health insurance in China - evolution, current status, challenges. *Int J Health Serv.* 2012;42(2):177-195. doi:10.2190/HS.42.2.b
15. Rhodes R. *Understanding Governance: Policy Networks, Governance, Reflexivity and Accountability*. Bristol Pa: Open University Press; 1997.
16. Burris S, Drahos P, Shearing C. Nodal Governance. *Australian Journal of Legal Philosophy.* 2005;30:30-58.
17. Gleeson D, Legge D, O'Neill D. Evaluating policy capacity: learning from international and Australian experience. *Aust New Zealand Health Policy.* 2009;6:3. doi:10.1186/1743-8462-6-3
18. Gleeson D, Legge D, O'Neill D, Pfeffer M. Negotiating tensions in developing organizational policy capacity: Comparative lessons to be drawn. *Journal of Comparative Policy Analysis.* 2011;13(3):237-263.
19. Adams D, Colebatch HK, Walker CK. Learning about learning: discovering the work of policy. *Australian Journal of Public Administration.* 2015;74(2):101-111.