

# DECISION-MAKING PROCESSES FOR EFFECTIVE POLICY IMPLEMENTATION

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## 1. Introduction

The overall aim of the seminar series on turning policy into practice is twofold:

- to distil the lessons from existing evidence and experience about local implementation of policies that are designed to tackle health inequalities
- to assess the quality of the evidence, gaps that need to be filled, and ways that research findings can support implementation.

The seminars will explore how government policy gets or does not get translated into practice and the factors that help or hinder implementation, and identify criteria that lead to success or failure. This background paper is concerned with the implementation of policy and with how decisions do, or do not, get made.

The government insists that the policy framework is clear and unambiguous and that what is required is effective implementation. 'Delivery, delivery, delivery' is the mantra, not lack of sound policy. Indeed, if there is a problem then it is not so much an absence of policy as a surfeit as those charged with its implementation reel under the weight of a constant outpouring of initiatives all jostling for attention and stretched resources, both financial and human.

A first question, therefore, is how far national policy aspirations (including the two national inequalities targets) translate into clear policy guidelines which are meaningful at a local level. This provides the context in which local decision-making takes place.

Unfortunately the transmission of policy into practice is more complex than the government's somewhat naïve or disingenuous stance allows. There are serious and somewhat neglected issues about whether, and how, national policy can be effectively implemented locally and what needs to be in place for this to occur; about whether a plethora of national initiatives from various departments which appear disconnected rather than joined up are dysfunctional or disabling rather than productive and empowering; about who should be taking action locally to implement national policy, eg the NHS, local government, regional agencies or some combination of these.

This leads to a second question concerning the wide range of 'implementation contexts' in which local decision-making takes place and the ways in which they relate to each other if at all.

In a context of considerable uncertainty, policy overload, and major organisational turbulence, the processes for implementing policy and reaching sustainable decisions are likely to become more difficult to put in place successfully. They are also likely to remain vulnerable in respect of further organisational and management changes

that may be on the horizon (eg regional government). They certainly cannot be ruled out. Effecting sustainable policy implementation will become an even greater challenge for both national policy-makers and those locally who have been charged with securing change.

Sustainability is of particular concern for addressing inequalities in health given the accumulation of disadvantage across the life course and the time required to demonstrate changes in health outcomes.

The remainder of this paper maintains that a number of different decision-making models are relevant to implementing policies to address health inequalities. These reflect the complexity of this agenda and the difficulties in reaching decisions where evidence may be uncertain, conflicting, variously defined and differently evaluated. We may understand the nature of the problem and have an idea of its causes. Indeed, this has been the main thrust of inequalities-related research to date. But are we as smart when it comes to finding a connection between diagnosis and prescription and then to acting on it? It is an issue which exercised the Wanless review team in their study of the future demands on the NHS over the next 20 years and the deficits in the public health evidence base about what works and does not work and over how a long period (Wanless 2002).

The first section below therefore considers the search for effective interventions and the state of knowledge on this problematic topic. The section which follows acknowledges the complexity and multi-faceted nature of the inequalities agenda at both national and local levels and identifies the specific issues which need to be understood if effective implementation is to prove possible. This includes the priorities of decision-makers themselves operating in particular local contexts. The position and influence of so-called 'street level bureaucrats' cannot be denied or ignored and is a key determinant of where power ultimately lies and of what gets, and does not get, implemented (Lipsky 1980). A further section highlights the importance of participation in decision-making and of involving those who are to implement policy in its design.

A brief final section identifies some key themes and questions that need to be confronted if there is to be any improvement in decision-making processes for effective policy implementation. If the government is serious about 'joined up' policy then it has to be equally serious about 'joined up' management (Parston and Timmins 1998).

## **2. Effective Interventions?**

Evidence on effective interventions forms part of the decision-making process for addressing inequalities in health. It is rarely a starting point at a local level, however, as priorities for implementation emerge out of the planning process and in response to funding opportunities. Those who seek to prioritise initiatives to address inequalities on the basis of the evidence face a number of challenges.

First, the evidence base for tackling inequalities in health (in the sense of systematic reviews of controlled intervention studies) is scanty. This is the case for interventions designed to reduce socioeconomic health differences; to assess the effectiveness of

health service interventions; to promote the wider public health; or in relation to specific topics (such as housing) which are associated with inequalities in health. This has led to arguments for a more inclusive approach to the evidence base and the importance of drawing on decision-making models which reflect different notions of evidence and different approaches to weighing up evidence in order to reach judgements in situations of uncertainty. These include, for example, impact assessments, public inquiries, and the legal process.

Second, it is argued that focusing on the evidence base and the individualised interventions which typically populate it has the effect of ignoring the more important macro level determinants of health and the degrees to which inequity is tolerated and sustained through policies at national and local levels. Inequalities in health reflect wider inequalities (and therefore decision-making across a wide policy spectrum). At a micro level, too, reliance on the evidence base works against a recognition or assessment of the effects of synergy and also underestimates context-specific aspects of achieving change within local communities.

Third, interventions need to reflect theoretical approaches to understanding social and environmental sources of structured inequalities in health status, how they interrelate, how they are mediated, and how they are constructed over an individual's life history. Just as inequalities in health emerge from an accumulation of different forms of disadvantage across the life course, so *interventions* which are appropriate for tackling these inequalities are often complex, operating on a number of different levels over a long period of time, and involving multiple professions and organisations each with their own values, cultures and priorities. Following a social ecological model of health, Smedley and Syme (2000) argue that for maximum effectiveness, interventions need to be carried out simultaneously across a wide range of sectors. Research is needed into multi level intervention approaches 'to contribute to our understanding of how best to create linkages between levels of influence and how to sequence or co-ordinate interventions across levels' as well as on the increased cost-effectiveness of intervening at additional levels. This has clear links with health impact assessment described further below.

However, unresolved theoretical debates have different implications for the content (and permutations) of interventions. Key among these are:

- the relative contribution of persistent absolute material inequality, relative inequality and psychosocial mediators of socioeconomic inequality to inequalities in health
- 'social capital' and its relevance to inequalities, social exclusion and the wider public health
- the importance of area effects, and the extent to which they exert an effect on inequalities in health independent of individual socioeconomic variables.

Fourth, a focus on identifying new and effective interventions for addressing health inequalities may divert attention from a critical analysis of the ways in which current policies, priorities and ways of working confirm disadvantage or from developing ways of ensuring that new policies are critically and prospectively assessed for their effects on health inequalities. The so-called 'inverse care law' (Hart 1971) remains much in evidence – where the need for treatment increases with the level of

deprivation, the chances of receiving treatment decrease (Wanless 2002). How far, for example, is a concern to narrow the health gap reflected in policies developed by local authorities to promote 'social, economic and environmental wellbeing'? Rolling programmes of equity audit, feeding into systems for clinical governance and for service development along with an 'interrogation' of each programme area along the various dimensions of inequality are ways of tackling these issues.

Health Impact Assessment (HIA) was described in *Saving Lives: Our Healthier Nation* (Department of Health 1999) as decision-making support for healthy public policy. Health Inequalities Impact Assessment was recommended in the Independent Inquiry into Inequalities in Health (Acheson report) (1998) and is considered an integral part of HIA by WHO (Ritsatakis 2000). It is argued that equity is the framework that governs HIA and that the process should be ethical, adopt a sustainable approach and be democratic. Ecological and systems approaches are increasingly important.

The various kinds of impact assessment (economic, social, environmental and health) draw on a range of techniques for quantifying and aggregating risk. Methods have also been developed to try and reflect subjective elements of decision making (through, for example, multi criteria analysis). Although there are different approaches, HIA is multi-disciplinary, spans different organisations, involves stakeholders and renders transparent different approaches to evidence and different perceptions of risk.

Many of the issues facing decision makers in addressing and prioritising an agenda for tackling inequalities in health are presaged in the methodological debates around health (inequalities) impact assessment, and in decision frameworks for assessing complex policies which make explicit trade offs between different priorities and interests. For example, 'ripple methodology', which studies synergies or negations of influence, reflects methods for assessing multiple levels of social and behavioural interventions. This remains a new field and methods for measuring the health of the social environment, costs across whole systems, and health outcomes for particular populations are still being developed.

The evidence base is itself the product of decision-making in relation to methods for synthesis and criteria for inclusion of research studies. It informs part of the decision-making process for addressing inequalities in health but is inadequate (and sometimes inappropriate) for an agenda which is also driven by values of social welfare and equity, and where effectiveness may lie in how decisions are reached as well as an assessment of the evidence which underpins them.

### **3. Effective Implementation?**

The complexity and breadth of the inequalities agenda at both national and local levels are not in doubt. This section briefly explores some of these complexities in relation to decision-making and implementation. It may be useful to consider the various moves to tackle inequalities as resembling a complex adaptive system. Such a system has been described as 'a collection of individual agents with freedom to act in ways that are not always totally predictable, and whose actions are interconnected so that one agent's actions changes the context for other agents' (Plsek and Greenhalgh

2001: 625). In complex systems, unpredictability and paradox are ever present, and some things will remain unknowable.

Furthermore, the interactions within a complex adaptive system are often more important than the discrete actions of the individual parts (Plsek and Wilson 2001). Complexity based organisational thinking is concerned with the whole system rather than with artificially viewing the system in discrete parts or sectors. However, developing a common vision becomes more difficult in an increasingly heterogeneous organisational environment. Moreover, allocating resources according to a whole system is rendered difficult by the existence of separate budgets many of them tightly controlled by central government for a specific purpose or initiative. Pooling budgets to tackle inequalities would entail drawing together resources from across the NHS, local government, regional bodies and possibly the private sector. The mechanisms and systems for such pooling to achieve desired outcomes are not well developed.

### ***Implementing policy***

Since the 1970s studies of policy implementation have become plentiful, in large measure spawned by the desire to explain the 'implementation gap' (Dunsire 1978). The notion of policy failure is of interest to social scientists but does not seem unduly to concern policy-makers who often equate proposing a policy with its effective disposal. Yet as the work by Wildavsky (1973), Pfeffer (1992) and others (eg Gunn 1978) have amply demonstrated, nothing could be further from the truth.

The inability to get things done, to have ideas and decisions implemented, is widespread in organisations today, whether public or private. Some observers consider it a problem that seems to be getting worse (Pfeffer 1992). Indeed, the ability to get policies and/or decisions implemented is becoming increasingly rare.

Policy failure can result from *non-implementation* or from *unsuccessful implementation*. In the former case, a policy is not put into effect as intended (as seemed to be the case in respect of the independent evaluation of the English health strategy which existed from 1992-97, *Health of the Nation* (Department of Health 1998)). Unsuccessful implementation, on the other hand, occurs when a policy is carried out in full and external circumstances are not unfavourable but the policy still fails to produce the intended results or outcomes.

Policy failure can occur as a result of bad execution, bad policy or bad luck. Ineffective implementation will be viewed by policy-makers as bad execution. Or external circumstances may be so adverse that bad luck is identified as the reason for failure. In other words, it was no one's fault. The reason that is less commonly advanced to explain policy failure is that the policy itself was defective in the sense of being based on inadequate information, poor reasoning, or hopelessly unrealistic assumptions.

The point about policy failure is that it suggests there can be no sharp distinction between formulating a policy and implementing it. Yet, as we pointed out at the outset, there is an assumption in government, often implicit, that precisely such a distinction does exist. The line adopted is that the government has produced the

policies and it is now up to those working at the periphery to implement it. Policy failure will therefore be regarded as bad execution and not bad policy. But studies show that it is more likely that what happens at the implementation stage will influence the actual policy outcome in ways that might not have been anticipated or foreseen. Conversely, the likelihood of a successful outcome (defined as that outcome desired by the policy initiators) will be increased if thought is given at the policy design stage to potential problems of implementation. This might suggest the need for a policy impact statement or audit of some kind to identify possible implementation problems or barriers to success. Instead of these being picked up after the event, possibly through evaluation research, an attempt would be made to have some prior warning and understanding of these constraints so that the policy could be modified or adapted in advance of its implementation.

‘Top-down’ versus ‘bottom-up’ perspectives on policy and action are at the heart of discourses on policy implementation (Barrett and Fudge 1981). Policy failure or an implementation gap can occur when policy is imposed from the centre with no thought given to how it might be perceived or received at local level. It is not a case of bottom up approaches to policy and action being preferable to top down. Arguably, a balance between the two is necessary. After all, it could be argued that one reason why progress in tackling health inequalities is slower than it perhaps should be is that central policy-makers refuse for whatever reason to take a stronger line thereby allowing local decision-makers to redirect resources to other activities.

Only those who subscribe to a model of perfect rationality in policy-making would consider that perfect implementation was possible. In fact, implementation involves trade-offs, compromises and operating with often poor or no information.

### ***Some local difficulties***

Views and priorities of local decision-makers illuminate areas of tension and clarify the context in which decisions are made. These views need to be taken into account in order to assess feasibility of implementation in a local setting.

Reflecting policy commitment at a national level to address inequalities, an empirical body of knowledge is emerging on local decision-making in this area. In devising local strategies, decision-makers have to decide, for example, which of the many possible interventions related to specific aspects of the inequalities agenda are to be prioritised; the relative emphasis on disadvantaged groups, areas, services likely to narrow the health gap or wider determinants of health; and the combinations of measures most likely to narrow the health gap (and over what period of time).

Gunn (1978) identified 10 reasons why implementation is so difficult:

- the circumstances external to the implementing agency impose crippling constraints
- adequate time and sufficient resources are not made available to the programme or policy
- the required combination of resources is not available
- the policy to be implemented is not based on a valid theory of cause and effect

- the relationship between cause and effect is indirect and there are multiple intervening links
- dependency relationships are multiple
- there is poor understanding of, and disagreement on, objectives
- tasks are not fully specified in correct sequence
- there is imperfect communication and co-ordination
- those in authority are unable to demand or obtain perfect or total compliance.

How far does the local implementation agenda for tackling inequalities in health reflect these implementation difficulties? A recent (2002) research project, led by Linda Marks, which involved interviewing 36 key decision-makers across Northern and Yorkshire region illuminates some of these points.

First, the inequalities agenda is being pursued in the context of competing priorities arising from a modernisation process which focuses on speed and ease of access (rather than on structured variation in access) and a performance management agenda which does not prioritise inequalities in health. Compounding these competing priorities are barriers of inadequate time and resources, including difficulties of recruitment and retention of staff in disadvantaged areas.

Second, integration of resources in relation to joint targeting of mainstream funds is proving difficult. In particular, targeting mainstream resources towards some disadvantaged areas (and away from others) over a long period of time can be difficult to argue for and sustain within local political systems.

Third, outcomes in relation to interventions for tackling inequalities are typically long term and difficult to attribute to any specific intervention. Process and intermediate indicators or milestones are therefore needed but these may be difficult to measure and their relationship to outcomes uncertain. As one example of this, how are area-based projects to assess their effectiveness in relation to long term health outcomes, when both areas and the populations within them change over time? In addition, decision support systems for those accorded the task of allocating resources across the four kinds of capital (human, economic, social, and environmental) and in balancing long and short term goals are poorly developed.

Fourth, while objectives in relation to specific disadvantaged groups, areas or services may be clear, strategic clarity in relation to narrowing the health gap is hampered by the wide range of priorities seen as relevant to the inequalities agenda. For example, the 36 local decision-makers in Northern and Yorkshire region interviewed for the study reported here identified no less than 35 different priority areas for tackling inequalities in health. Moreover, the potential conflict between utilitarian and egalitarian approaches is often fudged in the commonly expressed twin aims of improving health *and* tackling inequalities in health

Finally, the emerging evidence base is perceived as difficult to access, research studies are difficult to synthesise, and there are concerns over the relevance of research to the local context in which change must take place. Innovative and context-sensitive approaches, along with local rolling evaluations, and 'executive friendly' research summaries are also important for local decision-makers.

#### 4. Not Just a Technical Issue

Decision-making in relation to strategies to address inequalities cannot be separated from issues of transparency, public accountability and public participation notwithstanding increased concern over a widening ‘democratic deficit’ and its relationship to social exclusion.

Enhancement of openness and participation in public decision-making is increasingly supported through common law. Public inquiries are intended to inform decision-makers while facilitating participation in decision-making and ensuring that all relevant issues are taken into account and weighed. Decisions are given legitimacy through participation by the public. Even where it may be difficult to implement policy because there is ignorance over what works it ought to be possible to operate a system of accountability for ‘reasonableness’ which is akin to a set of procedural rights concerning the nature of the decision-making process (Bynoe 1998).

Adherence to the values of openness and participation influences the ways in which decisions are to be reached, effectiveness assessed, and levels of risk agreed. For example, consumer pressures have influenced the scope and the development of techniques for environmental impact assessment. Much health promotion is based on ‘participative ideology’ with an emphasis on choice and control in achieving outcomes rather than on consumers as passive recipients of interventions, however evidence-based. Policies to address social exclusion and promote regeneration are premised on community development and participation and it has been shown that top down approaches to regeneration, for example, are unsuccessful (Bennett *et al* 2000).

Local Strategic Partnerships (LSPs) are bringing together not just the health and regeneration agendas, but also the democratic decision-making structure of local authorities with the different models in business and health organisations. Research into understanding LSPs is needed in order to discover what may need to happen to render them more effective or to disseminate more widely the successes of some and the constraints operating on others.

Understanding implementation, as well as securing its effectiveness, is likely to entail a number of approaches: structural, procedural/managerial, and behavioural. A fourth approach, and perhaps the most fundamental though often ignored or understated, is political. Even if carefully planned in terms of appropriate organisation, management and influences on behaviour, if implementation of a policy takes insufficient account of the realities of power then the policy is unlikely to succeed. A political approach may also challenge the assumptions on which other approaches are based, eg those of behavioural analysts or management consultants. For example, implementation failure often results in laments about the absence of leadership. But it could be that problems of implementation are in many instances problems in developing political will and expertise (Pfeffer 1992). Problems of performance and effectiveness are problems of power and politics – power imbalances, powerlessness, and the inability of some groups or causes to get their ideas or policies taken seriously.

A political approach to implementing policies to tackle health inequalities would seem intrinsic to the complex reality of changing practice and perhaps challenging vested or entrenched interests. Implementation in this policy area is by definition

multi-levelled, multi-organisational and multi-professional. It involves political bargaining and conflict, or at least the potential for such. Therefore, a political strategy for implementation is as important as a strategy for agreeing more technical factors. ‘Unless and until we are willing to come to terms with organisational power and influence, and *admit that the skills of getting things done are as important as the skills of figuring out what to do*, our organisations will fall further and further behind’ (Pfeffer 1992: 12, emphasis added).

The principal message to emerge from studies of the policy process is that policy formulation and implementation are interdependent and that policy initiators should consider them in combination. Implementation should involve a process of interaction between organisations whose members may have different values, perspectives and priorities from each other and from those advocating the policy (Hogwood and Gunn 1984).

Successful implementation involves not just a common agenda and long-term joint commitments across different agencies but a degree of transparency about the model of health being adopted. The breadth of the inequalities agenda is therefore reflected in a wide range of decision-making processes and complex partnerships spanning different decision-making and performance management systems. If policy is to be successfully implemented then those who have responsibility for its implementation should be involved in its design.

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## **5. Some Key Themes and Questions**

A key theme of this short paper has been the nature of policy implementation, especially in a context where policy, and therefore its management and implementation, crosses boundaries between agencies (health service organisations

and local authorities) and sectors (public and private). There exists some expertise about effective management within specific public service organisations. However, less is known about ‘good ways to manage initiatives which cross boundaries between public, voluntary and private sectors, about initiatives which are based in communities and involve networks of different agencies, or about management outside the rules. The skills required to balance stakeholders’ interests, understand complex accountabilities, and manage for social outcomes are as necessary outside the formal public sector organisations as within it’ (Parston and Timmins 1998: 14-15).

If we are seeking to adapt old structures to new processes, then what can research tell us about what needs to happen to ensure that the structures do not remain old and sclerotic? Can they be adapted or are new structures and forms necessary?

If policy, and therefore its implementation and management, no longer fit departmental silos then what structures are ‘fit for purpose’? Are partnerships or networks the future? Where is the evidence, if it exists, that they are effective? And if they are, what accounts for their success and what skills are required on the part of network managers and so on?

Much of the change agenda is not about research in isolation but as a precursor of development. But is there a sufficiently close connection between the research community and the community of managers and practitioners who must make what they can of a messy, turbulent, ambivalent world? Are the two worlds too disconnected to be of value to each other? What might be done to increase the value of the research that is done to practitioners? What gaps in research are there, not so much into the nature of health inequalities and its causes (about which there is probably sufficient knowledge to be getting on with) but into how to bring about change nationally and/or locally?

We hope this provisional, and far from exhaustive, menu of issues and questions will provoke productive discussion in the course of the three seminars and result in a report that is of real value to those wrestling with implementing policy to tackle health inequalities.

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