The work of policy in Australian health authorities:
A systems approach to aligning capacity and process

Submitted by
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<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>ABS</td>
<td>Australian Bureau of Statistics</td>
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<tr>
<td>APS</td>
<td>Australian Public Service</td>
</tr>
<tr>
<td>ACT</td>
<td>Australian Capital Territory</td>
</tr>
<tr>
<td>AIHPS</td>
<td>Australian Institute of Health Policy Studies</td>
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<td>AIHW</td>
<td>Australian Institute of Health and Welfare</td>
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<tr>
<td>ALP</td>
<td>Australian Labor Party</td>
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<tr>
<td>AMA</td>
<td>Australian Medical Association</td>
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<td>ANAO</td>
<td>Australian National Audit Office</td>
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<tr>
<td>ANF</td>
<td>Australian Nursing Federation</td>
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<tr>
<td>ANZSOG</td>
<td>Australia and New Zealand School of Government</td>
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<tr>
<td>APS</td>
<td>Australian Public Service</td>
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<td>APSC</td>
<td>Australian Public Service Commission</td>
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<tr>
<td>ARC</td>
<td>Australian Research Council</td>
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<tr>
<td>Aust.</td>
<td>Australia</td>
</tr>
<tr>
<td>CE</td>
<td>Chief Executive</td>
</tr>
<tr>
<td>COAG</td>
<td>Council of Australian Governments</td>
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<tr>
<td>Cwlth</td>
<td>Commonwealth</td>
</tr>
<tr>
<td>DCE</td>
<td>Deputy Chief Executive</td>
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<tr>
<td>DDG</td>
<td>Deputy Director-General</td>
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<tr>
<td>DG</td>
<td>Director-General</td>
</tr>
<tr>
<td>DH</td>
<td>Department of Health</td>
</tr>
<tr>
<td>DHS</td>
<td>Department of Human Services</td>
</tr>
<tr>
<td>DP&amp;C</td>
<td>Department of Premier and Cabinet</td>
</tr>
<tr>
<td>ED</td>
<td>Executive Director</td>
</tr>
<tr>
<td>EO</td>
<td>Executive Officer</td>
</tr>
<tr>
<td>EFT</td>
<td>Effective full time</td>
</tr>
<tr>
<td>ERP</td>
<td>Estimated resident population</td>
</tr>
<tr>
<td>FTE</td>
<td>Full time equivalent</td>
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<tr>
<td>GDP</td>
<td>Gross domestic product</td>
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<tr>
<td>GP</td>
<td>General Practitioner</td>
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<tr>
<td>GSP</td>
<td>Gross state product</td>
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<tr>
<td>HDV</td>
<td>Health Department Victoria</td>
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Note: abbreviations have been used in tables and figures where the whole word would not fit. These short forms have not been included in the list of abbreviations.
ABSTRACT

The research examines policy work in three Australian health authorities: ACT Health, Queensland Health, and SA Health

Empirical research to date is limited in that it has focused on policy capacity or policy process as separate rather than interrelated elements in a complex and adaptive system.

The research maintains that the work of policy is complex arising from the multi-causal nature of health problems and the influence of external socio-political factors in a contested policy environment. Inter-sectoral and co-ordinated effort is required in conjunction with adaptive responses in policy process and policy capacity to achieve good policy outputs and outcomes.

The aim of the research is to improve the work of policy in Australian health authorities by developing a better understanding of policy process and policy capacity which in turn should lead to improved population health outcomes.

The research applies a qualitative methodology, based on the perceptions and experiences of policy practitioners and senior managers, using data collected from focus groups, individual interviews and document analysis; and develops and applies a conceptual framework, from both theoretical and applied perspectives, to the analysis of the data in order to develop a better understanding of policy work in relation to policy capacity, policy process, impact of the external environment, and challenges to policy making.

The research presents three key findings:

   The work of policy is identified as diverse in terms of topics and type; and complex in terms of the relationship between capacity and process; subject to different approaches and conducted in many parts of the organisation; influenced by the external socio-political environment; and undertaken by practitioners who are not always clear about intended outputs and outcomes.
The challenges to policy capacity and policy process are identified as recruitment and retention of skilled and experienced policy workers; limited policy-specific skills development; lack of clarity about the purpose of the policy task; inadequate leadership and management of the policy process; inadequate human resources assigned to the task; lack of readily usable data; administrative structures that do not adequately provide for effective communication, information sharing, and shared understanding of priority and commitment to outcomes.

The role of policy leadership is identified as central to aligning the elements of policy capacity and policy process; and requires a slightly different approach and specific competencies in a policy making environment to generic management.

The research, applying a conceptual framework based on a systems approach, provides a comprehensive and practical framework for understanding, explaining and interpreting policy work and has the potential to influence policy practice, leadership and management, teaching, and action research in Australian health authorities.
STATEMENT OF AUTHORSHIP

Except where reference is made in the text of the thesis, this thesis contains no material published elsewhere or extracted in whole or in part from a thesis submitted for the award of any other degree or diploma.

No other person’s work has been used without due acknowledgement in the main text of the thesis.

This thesis has not been submitted for the award of any degree or diploma in any other tertiary institution.

All research procedures reported in the thesis were approved by the La Trobe University Human Ethics Committee, ACT Health Human Research Ethics Committee, Queensland Health Research Ethics Committee, South Australian Department of Health Human Research Ethics Committee, Monash University Human Research Ethics Committee, University of South Australia Human Research Ethics Committee, Queensland University of Technology Research Ethics Committee, University of Queensland Behavioural & Social Sciences Ethical Review Committee, and the University of Wollongong Human Research Ethics Committee.

Signed:

Date: 22 April 2014
FOREWORD

This study has been influenced and shaped by my personal interest in health policy work and my participation in a larger Australian Research Council Linkage project.

**Personal interest in health policy work**

I have a personal interest in health policy and policy capacity as a result of my work as a health researcher, policy practitioner, administrator, consultant and teacher.

For many years I worked as a policy practitioner and program manager in the Victorian Department of Health\(^1\). In this role, I was responsible for developing policy and plans, negotiating with health agencies, professional associations, and other interests, setting priorities, allocating resources, and implementing and evaluating programmes and services. This policy and program management work was undertaken as a team member in specialised policy and research units and divisions.

This experience led to my interest in different aspects of health policy - What is the process for developing, implementing and evaluating policy? How is policy work organised and managed? How are human resources mobilised and deployed? Which stakeholders to engage and how to approach them? How best to engage and communicate with the minister’s office? - and in the capacity of an organisation to organise its resources and infrastructure to produce effective policy i.e. the way in which the organisation assembles and deploys human resources, nurtures and builds specialist teams, develops individual skills, provides access to appropriate information, and provides strong leadership.

Working in the Victorian Department of Health, I also experienced the impact of major reforms introduced to public administration in the 1980s and early 1990s. Some of the key changes introduced in Victorian health administration included a shift in the state’s roles and responsibilities from direct provision to purchasing of health services; significant reduction in government expenditure on programmes and services with

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\(^1\) Note: Over the years, the name of health authorities in Australian jurisdictions has changed. In Victoria from Health Commission Victoria to Health Department Victoria, to Department of Health and Community Services, to Department of Human Services and to Department of Health (as of August 2009).
consequent reductions in health agency budgets, personnel and services; ‘downsizing’ of public administration, resulting in reduction of workforce numbers, removal of policy, planning and research divisions and redistribution and/or loss of functions and specialisation; and introduction of ‘market-type’ practices, including privatisation and corporatisation of public health services, competitive tendering, and outsourcing of functions to external organisations, such as maintenance of data bases and information management.

In experiencing these administrative changes, I became interested in the impact they might be having on the Victorian Health Department:

- how did these changes affect policy capacity? (given the sizeable reduction in workforce numbers, loss of specialisation, loss of policy, planning and research functions, out-sourcing of information systems, and impact of budget cuts on training and development programs); and, if there were negative impacts on capacity; and
- how did this affect the policy making process and the work of policy practitioners?

Being part of the process of public sector reform throughout the 1980s and 1990s in the Victorian Health Department has been important in shaping my interest in organisational policy capacity, policy process and policy outcomes, which, no doubt, has influenced the underlying assumptions, directions and interpretations in my research, particularly in framing the conclusions in terms of suggestions for strengthening policy capacity and process in health authorities.

My views have also been shaped by my experience as a health planning consultant. I have worked as a consultant for nearly 15 years in the areas of public health and aged care, providing advice to Commonwealth, state and local government, non-government organisations, academic institutions and health agencies.

My area of specialisation has been policy formulation, service planning, programme evaluation, and management. In this capacity, I have participated in Commonwealth/state and cross-portfolio negotiations, conducted research and analysis, consulted with diverse stakeholders, assisted in programme implementation, and evaluated programmes and services.
This consulting experience has given me a familiarity with and understanding of the complexities of health policy development, implementation and evaluation in Australia. From a different perspective, my role as an educator of postgraduate and undergraduate students in health policy and administration has nurtured my interest in and commitment to developing the knowledge and skills of students. In the field of education, the curriculum emphasises the development of individual student competencies in the theory and practice of health policy and administration. As an educator, my attention in public health policy has been focused mainly on developing the capabilities of individuals for public health policy analysis and practice.

My career as an educator in public health policy, health researcher, policy practitioner, health administrator and health consultant has given me a strong interest in policy making in government organisations and in particular in the nature of and the challenges to policy work in health authorities: individual and organisational policy capacity, effective and efficient policy processes, and the influences of the external environment.

This experience has created awareness that policy process, capacity, inputs, outputs and outcomes, and the socio-political environment are all interrelated elements in a health policy making environment; and has led to an interest in the application of a ‘systems approach’ to better understanding and interpreting policy making in terms of the relationships between policy capacity and policy process in order to achieve good policy outcomes.

Therefore, my background and experience has shaped my perspectives and biases which have influenced the development of the theoretical framework and research design; and the assumptions, interpretations and conclusions in the analysis and discussion of the data.

**Australian Research Council Linkage project**

This study derives from an action research project, awarded to the Australian Institute of Health Policy Studies (AIHPS), to develop new methods for building health policy capacity in Australia which was managed and coordinated by La Trobe University, in collaboration with the AIHPS Executive Office.²

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² A Reference Advisory Group, comprising members of the partner University and Health Jurisdictions together with an external international researcher, provided direction and support.
The Australian Research Council Linkage project (hereinafter “ARC Linkage project”) identified the need for strong policy capacity in Australia in order to address the complex and challenging health policy issues confronting society. The study also identified a lack of empirical evidence on which to base capacity building initiatives and lack of comparative research examining the ways in which different contexts may shape policy capacity. To address this gap, a collaborative action research project entitled, *Developing New Methods for Building Health Policy Capacity in Australia*, was funded over a three year period.

The aim of the ARC Linkage project was to contribute to strengthening Australia's capacity in health policy development, implementation and evaluation, by developing new methods and approaches for building policy capacity.

To achieve this aim, a two stage process was conducted in three Australian health authorities:

**Stage 1**: Comparative policy capacity assessment at individual, institutional and system levels which involved analysing and comparing information on policy processes and policy capacity across three Australian jurisdictions (The Australian Capital Territory, Queensland and South Australia), identifying current and preferred strategies for capacity development, and confirming target groups to be involved in capacity-building interventions. This stage was to be undertaken by a La Trobe University PhD candidate and has been completed. A PhD dissertation was to be derived from the data collected.

**Stage 2**: Implementation and comparative evaluation of capacity building interventions which involved implementing and evaluating at least three capacity-building interventions identified in Stage 1; subsequently, evaluating these options for wider implementation and incorporation into academic programmes and training. This stage was to be undertaken by a La Trobe University post-doctoral research fellow and is underway.

On completion of both stages, the ARC Linkage project was expected to establish a number of customised interventions that would strengthen policy capacity in health

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3 The PhD candidate was responsible for stage 1 of the ARC Linkage project: data collection and analysis.
authorities in three Australian jurisdictions, to be followed by an evaluation of these capacity-building interventions.

I was selected as the PhD candidate to conduct Stage 1 of the ARC Linkage project comprising the collection and analysis of data on the perceptions and experiences of policy practitioners and senior managers in the health authorities in the three Australian jurisdictions. For my study, I determined a multi-methods approach comprising a review of the academic literature and development of a conceptual framework for the analysis of the Stage 1 data for the purpose of my selected research aim to investigate the interrelationships between the elements of policy work and the importance of aligning strong policy capacity with good policy process to produce good policy outcomes.
CHAPTER 1  GOOD POLICY: A SYSTEMS APPROACH TO ALIGNING CAPACITY AND PROCESS

1.0  INTRODUCTION

The purpose of Chapter 1 is to introduce this study on a systems approach to aligning policy capacity and process in a health policy environment.

This study argues for a holistic ‘systems’ perspective to understanding and interpreting the complex work of policy in a health policy environment providing a greater coherence and integration between the individual elements of capacity and process, review and monitor, and the external socio-political environment. In this approach, the interrelationships between the elements are emphasised, in particular, the importance of aligning strong policy capacity with good policy process to produce good policy outcomes.

Chapter 1 is organised into five sections, commencing with the rationale for conducting the research, and then follows with a summary of the scope of the research, delineation of the research aim and questions, overview of the research design and concludes with an outline of the content of the other seven chapters.

1.1  THE CASE FOR ALIGNING POLICY CAPACITY AND PROCESS

This section presents a case for the importance of an integrated approach to examining the elements of and relationships between policy capacity and policy process that underpin the work of policy. The argument for aligning policy capacity and process acknowledges that health policy is complex and challenging, and as a result the work of policy within the health context requires an integrated approach to be effective and influential.

The health policy environment is complex and challenging

The policy literature generally acknowledges that the substance of policy issues and the policy making process have become increasingly complex and challenging. This has implications for policy capacity and the relationship between policy capacity and process in health policy environments. A number of factors have contributed to the increasing complexity in policy making.
GLOBALISATION OF HEALTH ISSUES AND CONCERNS

Health issues are increasingly a global matter that extend beyond traditional national boundaries, international alignment of health legislation and regulation, disease management, health financing and purchasing, labour recruitment and skills development, applications of new technologies, and medical and public health research. The ‘internationalization of policy work’, with policy occurring increasingly in ‘transnational policy networks’ (Noordegraaf, 2010) and operating in ‘international policy arenas’ (Geuijen, ’t Hart, Princen, & Yesilkagit, 2008) has contributed to a complexity in the policy-making environment involving multilateral negotiations across national boundaries, knowledge of international laws and financing, and the need to strive for ‘international consensus’ on issues in order to protect and promote national interests.

FEDERALISM – A STRUCTURALLY COMPLEX SYSTEM

The national and the state and territory levels of government have specific powers and responsibilities under the Australian federal system of government as defined in the Australian Constitution (Sawer, 1988; Wicks, 2000). However, the two levels of government share responsibilities in the health sector for financing, policy development and planning, and for organisation and delivery of programs and services, such as hospitals, medical services, pharmaceuticals, primary health, and mental health (Duckett, 2007; Palmer & Short, 2010).

The Australian Government has responsibility for the health insurance program, Medicare, which provides universal access to medical services, (specialists and general practitioners), pharmaceutical services, indigenous health, residential and community-based aged care, public dental services, hearing services, private health, health workforce registration and capacity development, biosecurity and emergency response, health system capacity and quality, blood transfusion services, subsidies to family, veterans health and occupational health. The Australian Government also provides financial support for health promotion and for medical and health services research (Palmer & Short, 2010, pp. 10-11).

Whereas, state and territory government are responsible for a range of health services, including hospitals (including geriatric and rehabilitation), ambulance, some primary health, mental health, alcohol and substance-abuse, public health including protection...
from disease, environmental and unforeseen threats, health promotion, some aged care services, and palliative care. The states and territories are also responsible for the licensing and regulation of private hospitals and aged care facilities (Palmer & Short, 2010, pp. 11-13).

This shared responsibility has resulted in complicated financing arrangements in the Australian health system involving multiple funding sources and applications comprising a combination of Australian government, state and territory governments, private health insurers, and individual out-of-pocket and co-payment expenses. These are made evident in Duckett’s (2007) analysis of health expenditure in the Australian health care system: Medicare, Australia’s universal health insurance system, which is funded largely from government sources, with the Australian government responsible for 47 percent of expenditure and state and local government responsible for 20 percent; public hospital funding, which is shared by the Australian and state governments; nursing homes and medical services, which are funded mainly by the Australian government; and private hospital, dental, and other health profession services that are funded by individuals, from either health insurance or out-of-pocket expenditure.

These shared health care responsibilities are discharged in accordance with a number of multilateral and bilateral funding agreements between Australian and state and territory governments such as the Australian Health Care Agreement, Public Health Outcome Funding Agreements, and Home and Community Care Program Agreement, which specify program parameters, roles and responsibilities, funding levels for the period, targets and outcomes to be achieved, and accountability requirements.

Australia’s federal system of government and associated shared powers and responsibilities between the two levels of government has produced a complex and somewhat fragmented system of financing, regulation and service provision. Fenna (2004) notes that Australian federalism has disadvantages in that it creates intergovernmental conflict and the stalling of policy until agreement is reached between different governments; and creates coordination and duplication problems in administration; and blurs the lines of responsibility, providing opportunities for cost and blame shifting from one level of government to another. Duckett (2007) supports this position in reference to the health system, asserting that shared funding responsibilities have resulted in accountability problems, creating underlying tensions and lack of trust,
with each level of government blaming the other for resource shortfalls and shifting costs.

This lack of clarity regarding roles and responsibilities, problems with coordination and accountability, and focus on blame and cost shifting creates an intergovernmental environment fraught with ill will and lack of trust in which national and state policy directions and funding agreements have to be negotiated and agreed to. This unwieldy environment has implications for policy making, the policy capacity required, the management of the policy process, and the interaction with the wider political environment in aiming to achieve good outcomes in regard to policy issues that are subject to intergovernmental relations.

THE HEALTH SYSTEM: PLURALISTIC, MULTIPLE PLAYERS, DOMINANT INTERESTS, AND CHANGING COMMUNITY EXPECTATIONS

Pluralism is a feature of the Australian health system and involves multiple service providers, financed by a mix of public, private and not-for profit or non-government sources; and includes national, state and territory, and local levels of government. Therefore, there are multiple players involved in financing, organising, delivering and coordinating health services in Australia.

In this pluralist system, government is no longer perceived as the sole authority for making policy. Instead there are multiple players, located outside of government (private and non-government sectors), contributing to and shaping health policy (Colebatch, 2009; Hoppe & Jeliazkova, 2006). As a result, the policy process is diffused across multiple players with different values, interests and priorities who contest and direct policy making.

A number of well organised and politically connected interest groups exercise influence on policy development and provision of health services in Australia comprising professional groups, such as medical, dental, and nursing associations; community groups, such as disease and disability advocacy and support groups; industry groups, such as health insurance funds, health sector unions, private health service operators, and food industry and pharmaceutical companies; and research institutes and academic institutions. The medical profession in particular, both senior medical staff in public hospitals and doctors in private practice, have dominated the policy agenda and debate in
terms of public hospitals, health financing and other health reforms (Fenna, 2004; Palmer & Short, 2010).

From the 1970’s, there has been increasing involvement of the community and wider public in health policy issues and concerns. This is partly a consequence of deliberate action by both levels of government to encourage community participation in the public policy making process through a range of consultative approaches; and partly a consequence of a better educated, informed and organised public with expectations of participation in and influence on the policy making process (Advisory Group on Reform of Australian Government Administration, 2010; Canadian Government, 1996; Manitoba Office of the Provincial Auditor, 2001; State Services Commission, 1999).

Health policy making encompasses a broad range of stakeholders and players, dominant and powerful vested interests, and community expectations that influence and increase the complexity of the health policy making process (Colebatch, 2009; Hogwood & Gunn, 1984). As a consequence, policy making is no longer viewed in the literature as a traditional ‘top down’ and ‘authoritative’, government-directed process of decision making. The new complexity in the policy making process arising from the involvement of multiple stakeholders, dominant interests, and changing community expectations, requires that policy capacity and policy process need to be aligned to effectively manage the work of policy.

**HEALTH POLICY: COMPLEX, MULTI-SECTORAL AND COORDINATED**

The nature of health policy is complex, with increasingly complex and challenging health problems and increasingly complex environments within which health policy work occurs, as demonstrated by a few examples of contemporary health policy issues.

*The gap in health status between Aboriginal and Torres Strait Islander and the non-ATSI population*

There are significant discrepancies in health outcomes between the Indigenous and non-Indigenous populations in Australia (Australian Institute of Health and Welfare, 2010, 2011). According to the Australian Institute of Health and Welfare (AIHW, 2010), the life expectancy at birth for Aboriginal and Torres Strait Islander men and women is shorter on average than for non-Indigenous Australians by 12 and 10 years respectively; and overall mortality rates for Indigenous people are approximately twice those of the
non-Indigenous population. The report further revealed that not only do Indigenous Australians die at much younger ages than non-Indigenous Australians they also have poorer health status and significantly higher levels of disability. Remedying this inequity in Aboriginal and Torres Strait Islander population health status requires involvement of sectors other than health and as Duckett (2007, p. 293) points out, requires the ‘broader issues of dignity, identity, and justice’ to be taken into account.

The prevention and management of chronic diseases and obesity
This issue is both multi-causal and multi-sectoral in nature, giving rise to a complex array of issues comprising the role of individual behaviour; the impact of socio-economic status on health outcomes; and a problem that extends beyond the health sector to encompass other policy sectors such as education and recreation. This issue can be examined from several perspectives including individual behaviour and lifestyles; prevention and early intervention or a curative focus; roles and contributions of other sectors and levels of government; and an economic rather than public health perspective given the increasing costs to society arising from these health conditions.

The application of new medical technologies
The Australian community is confronted with difficult ethical issues regarding medical interventions associated with the beginning and end of life associated with the application of new medical research discoveries and technologies which have implications for the creation, termination, and prolongation of life such as assisted reproductive technologies, surrogacy, assisted death, access to organ transplants, and stem cell and genome sequencing. While rationing of services, and making clinical decisions for health care provision on grounds of lifestyle factors and or costs also pose ethical dilemmas.

The alternative models for the funding and provision of public health services
The Australian community is confronted with conflicting goals and values in regard to the funding and provision of public health services in which compromise and trade-offs are inevitable between equity and availability, quality, efficiency and acceptability; and therefore methods of financing the health care system, modes for organising and delivering health services, and distribution of risk between individuals and government or commercial interests (Duckett, 2007, pp. 290-301).
The above examples highlight the complex nature of health policy problems in terms of the contradictions between health system goals of equity and rising costs and financial constraints; the challenges of maintaining social cohesion in the face of widening inequality; the efforts directed at re-orienting the health system from an illness and curative focus to prevention and population health; and promoting better health through healthier lifestyle choices despite the activities of powerful commercial interests promoting consumption of fast-food, alcohol and tobacco.

Rittel and Webber’s (1973) description of ‘wicked’ problems is an appropriate metaphor for the health policy area; a phrase, coined to describe complex, multidimensional problems that are products of the broader social and political environment, characterised by uncertainty and lacking clear-cut solutions, while taking into account ethical dimensions, plurality of values, and interdependence of issues, as opposed to problems examined in a systematic and controlled or ‘tame’ environment. In the broader health and public policy literature, these complex or wicked problems have been referred to as possessing characteristics that are ‘interdependent’, ‘cross-cutting’ and ‘intractable’ (Davis, 2000; Head, 2008; Manitoba Office of the Provincial Auditor, 2001; Peters, 1996).

There is a growing awareness of the multi-factorial and interdependent nature of many health problems and issues and consequently the need to mobilise effort and resources across sectors that can develop strategies and solutions to jointly resolve such complex problems. It is also understood that the underlying causes of and possible interventions for either partial or full resolution of these problems lie outside the traditional health portfolio boundaries to include other functional policy areas of education, employment and industry, justice, housing, transport, urban planning, sport and recreation and agriculture, as well as, the private and non-government sectors. In short, there is an increasing recognition that health policy cannot be solely negotiated and resolved within the confines of the health sector but requires a broader, cross-sectoral and collaborative approach. As Duckett (2007) notes, the policy levers for achieving policy goals are usually located in different sectors.

This cross-sectoral and collaborative approach to health policy is demonstrated in the areas of social determinants of health (World Health Organization, 2003), health promotion and illness prevention (Baum, 1998; Lin, Smith, & Fawkes, 2007; WHO,
1986; 2005), chronic disease management, and the environmental impacts on public health. In each of these policy areas, the emphasis is on the multi-dimensional and interdependent nature of health policy and the need to focus on cross-sectoral and coordinated action in order to achieve improved population health outcomes.

In the policy area of primary health and health promotion, the interconnected and multi-sectoral nature of health is evident, dating back to the 1978 WHO/UNICEF Alma-Ata Declaration ‘Health for All by the year 2000’ in which the foundations of a comprehensive primary health strategy were to address the underlying social, economic and political causes of poor health (WHO, 2005). The primary health care approach to health improvement recognised the relationship of health to broader economic, social, political and environmental factors; situating health within a wider societal context and emphasising the actions of sectors and interests beyond health that influence health improvement.

These early developments in primary health and health promotion in the 1970s and 1980s led to a new public health approach that emerged in Australia and overseas, in which the aim of health policy was the ‘creation of an economy, a society and an environment’ that was conducive to the production of good population health and well being (Baum, 1998; WHO, 1986). The new public health approach promoted the view that healthy public policies were to be found in any sector of government or outside government, and transcended the boundaries of health departments and organisations (Palmer & Short, 2000). This new approach also required a close working relationship between different levels of government, government departments, and private, public and non-government organisations and services, and called for coordination of policy effort across different sectors, including health, housing, education, welfare and industry (Palmer & Short, 2000, p. 223).

Similarly, a multi-sectoral and coordinated approach was also evident in the social determinants of health policy area, which aimed at addressing significant discrepancies in the health of populations within and between countries (WHO, 2005). According to the World Health Organization (WHO, 2003) the social determinants of health are concerned with key aspects of people’s living and working circumstances and their lifestyles. It is the social conditions such as poverty, unemployment, social exclusion, stigmatisation, degree of control over and meaningful work, shelter, education, and access to services,
under which individuals live that impact on and determine an individual’s physical and mental health and well-being. As such, social determinants of health are concerned with the economic and social policies that shape the health of individuals, communities, and jurisdictions as a whole. The social determinants of health recognises the multi-factorial and interrelated nature of policy, in which, determining causation of a problem, identifying strategies and solutions to adequately resolve them, and mobilising broad policy action that involves health and other sectors, is enormously complex and requires long time frames to have a major measurable effect in achieving improved population health outcomes.

Therefore, policy making in this complex environment demands a more sophisticated understanding of causal relationships and interdependencies, structural and systemic issues, and requires capabilities for establishing trust and building support and constituency across different sectors and interests. This complexity in health policy problems and environments requires strong policy capacity, effective leadership and organisational supports, and efficient policy making processes if good policy outcomes are to be achieved.

The need for integration between policy capacity and process for effective policy

To manage current and emerging health policy challenges comprising increasing internationalisation of health issues and concerns, interconnected and intractable policy issues, changing disease patterns and treatment modalities, rapidly changing technologies, increasingly complex health and disability conditions, rising health expenditures and diminished resources, it is essential for health authorities to have strong policy capacity at both individual and organisational levels, that is, a competent and capable policy workforce, strong leadership and appropriate organisational infrastructure and supports. It is important that good organisational capacity in the way of established structures, systems and processes in areas such as policy management frameworks and information systems together with other infrastructure and equipment supports are in place to complement strong individual capacity.

The introduction of public sector reforms (New Public Management) in the 1980s and 1990s in most western democratic countries led to a changing role of the state in purchasing services, privatisation, out-sourcing, debt-management and budget reductions,
and workforce contractions. As a result, some scholars have expressed concerns about a ‘hollowing out’ or diminished government policy capacity from different perspectives, including loss of technical analytical capacity (Howlett, 2007; Howlett & Lindquist, 2004); recruitment and retention of skilled policy personnel (Aucoin & Bakvis, 2005; Lindquist & Desveaux, 2007); structural barriers to effective policy functioning (L. Edwards, 2009); and the need to re-build policy capacity (Bakvis, 2000; Manitoba Office of the Provincial Auditor, 2001). The impact of these reforms on policy capacity has been a sizeable reduction in workforce numbers, a loss of senior and experienced managers and policy practitioners, and a loss in technical specialisation in planning, research, and evaluation. In recent years, there have been concerns expressed by some governments – Australia, Canada, UK, and New Zealand (Bullock, Mountford, & Stanley, 2001; Manitoba Office of the Provincial Auditor, 2001; Ministry of Health, 2010; Peters, 1996; SSC, 1999) about diminished policy capacity and reduced quality of policy advice across the public sector.

Despite the reduction in skilled and experienced policy workers over the last few decades, there is still a need for good policy and strategy to underpin effective government decision making. As fiscal constraints and workforce reductions are unlikely to change, policy units may need to re-focus current policy capacity with new or a different mix of individual skills and training to extract the maximum value from the policy workforce that remains in order to manage the new mix of policy issues arising from public sector reforms. Changes in policy process may also be required to ensure that it remains relevant and effective in conducting quality policy work given the new government business focus and priorities around cost reduction and out-sourcing.

The scholarly and government literature discusses the need for the policy process to remain effective in the context of the new public management. In particular, the different accounts of policy such as ‘networked governance’ (Rhodes, 1996, 1997), ‘policy communities and networks’ (Lewis, 2005; Smith, 1993, 1997), ‘structured interaction’ and ‘social construction’ (Colebatch, 2009), and ‘argumentative discourse’ (Fischer & Forester, 1993), point to a shift in the practice of policy making. The policy making process, has become more complicated acknowledging the increasing levels of participation, collaboration and discourse with non-government interests in influencing and shaping public policy.
In recent years, the challenges to the policy making process have included an increasing emphasis on consulting stakeholders and seeking their input; adopting cross-government ‘joined-up’ and coordinated policy making approaches; a focus on robust and evidence-based policy making; use of new and evolving policy analytical techniques and new information technologies; political and ministerial demands for quality policy advice; and growing community expectations for involvement in the decision making process.

Given the many challenges confronting contemporary policy making, the shift in focus to participatory, collaborative, rigorous and analytical policy making requires strong negotiating, communicating and analytical capabilities combined with strong organisational capacity and leadership. Therefore, the alignment of an effective and efficient policy process with strong individual and organisational policy capacity, in conjunction with the recognition and management of the influence of the external socio-political environment and the function of policy review and monitor as an integral process, should contribute to the achievement of good policy outputs and outcomes.

The need for empirical research to examine the relationship between policy capacity and process

An examination of the policy literature identified a paucity of empirical research regarding the alignment of policy capacity and policy process and a corresponding need for conducting exploratory research that focuses on the relationship between the elements of capacity and process.

In the scholarly literature there is a focus on specific elements of policy work and policy making, usually restricted to an examination of either policy capacity or policy process. The policy capacity literature focuses largely on identifying individual capabilities, organisational limitations, and capacity development strategies, while the policy process literature explores policy making activities and approaches for improving policy advice. Each area concentrates on a single dimension of policy making and tends not to conceive and or interpret the work of policy in a holistic and integrated manner.

An empirical examination of the relationship between the elements of policy capacity and policy process appear to be an overlooked area of public policy, including health policy, research. There has also been a paucity of public policy research examining the interrelationships between the elements of capacity and process within the context of its
relationships to a broader set of factors and influences, including the interaction with the wider socio-political environment, and factors of policy review and monitor, outputs and outcomes.

This study considers the Australian health care system to be complex and dynamic, influenced by increasing globalisation, the federalist system of government, the pluralist nature of health funding and service provision, powerful professional and commercial interests, multiple stakeholders, and changing community expectations, and which is reflected in the multi-dimensional and multi-sectoral nature of health policy.

Therefore, any examination of policy work in health policy environments needs to recognise the requirement not only for strong policy capacity and effective policy process but also for the alignment of these two elements in order to produce good health policy for improved population health outcomes.

1.2 **SCOPE OF RESEARCH**

The scope of this study is limited to public health policy and in particular the effect of policy capacity and policy process on the achievement of good policy outcomes.

This study was conducted in three Australian jurisdictions (The Australian Capital Territory, Queensland, and South Australia); and involved policy staff from their respective health authorities (ACT Health, Queensland Health, and SA Health).

1.3 **AIM OF RESEARCH**

The aim of this study is to contribute to a better understanding of policy work in Australian health authorities by applying a ‘systems’ perspective to the analysis of the perceptions and experiences of policy practitioners and senior managers in ACT Health, Queensland Health, and SA Health; and to demonstrate that aligning policy capacity and process through policy leadership has the potential to lead to more efficient and effective policy making and, as a result, to improved population health outcomes.
Research questions:
To address the research aim the following four research questions are posed:

1. What is the nature of health policy work with respect to capacity and process in Australian jurisdictions?
2. What are the challenges in aligning policy capacity and process in health policy making in Australian jurisdictions?
3. What are the main influences affecting the relationship between policy capacity and process?
4. What are the challenges to leadership in managing the alignment of capacity and process in health policy work?

1.4 Overview of the Research Design
The research design applied to this study involved a mixed-methods approach including document analysis, focus group discussions with middle level policy practitioners and semi-structured individual interviews with policy-oriented senior executives.

The purpose of the focus group discussions and individual interviews was to explore the perceptions and experiences of policy workers of the policy making process in relation to policy capacity, influence of the external environment, organisational barriers to and enablers of policy capacity and policy process, and strategies for building capacity.

1.5 Structure of Thesis
This study comprises eight chapters. An overview of the remaining seven chapters is provided as follows:

Chapter 2 examines the literature in order to gain an understanding of the theory underpinning policy, policy capacity and policy process. It points out the limitations in interpretation applied to policy work in the international and national literature arising from a restricted focus; and argues the need for a broader ‘systems’ approach to the study of policy work presenting a conceptual framework that integrates the elements of policy making, recognising their interrelationships and the influence of the external environment.
Chapter 3 describes the context of this study by presenting an overview of the main demographic, geographic, socioeconomic, political and health administration features of each of the three jurisdictions; and the structure and organisation of policy work in the three health authorities.

Chapter 4 describes the qualitative research design used for this study to address the research aim and research questions comprising methods for data collection, coding and analysis; and concludes by outlining the research design limitations and the ethical considerations.

Chapter 5 describes the nature and type of policy work conducted in the three health authorities; and applies the conceptual framework to the analysis of the data from the focus groups and presents the findings in reference to Research Question 1.

Chapter 6 applies the conceptual framework to the analysis of the data from the focus groups and the individual interviews in order to identify the challenges to aligning policy capacity and policy process in the work of policy in the three health authorities and presents the findings in reference to Research Question 2 and Research Question 3.

Chapter 7 applies the conceptual framework to the analysis of the data from the focus groups and the individual interviews in order to demonstrate that leadership is the strategic means by which to align capacity and process in health policy work and presents the findings in reference to Research Question 4.

Chapter 8 discusses the findings from the analysis of the research data presented in Chapters 5, 6 and 7 in the context of the literature reviewed in Chapter 2 and in accordance with the research design, research aim and conceptual model presented in Chapter 4; and presents the conclusions of the study in regard to a systems approach to aligning policy capacity and process.

1.6 **Research “Cut-off” Date**

In preparing this thesis, a nominated research ‘cut-off date’ of 2010/11 was decided in acknowledgement of the frequency with which health authorities undergo organisational change. No reference material on ‘organisational structures’ later than the ‘cut off’ date have been utilised.
CHAPTER 2 LITERATURE REVIEW

2.0 INTRODUCTION

The purpose of Chapter 2 is to examine the literature in order to gain an understanding of the theory underpinning policy, policy capacity and policy process. It points out the limitations in interpretation applied to policy work in the international and national literature arising from a narrow focus; and argues the need for a broader ‘systems’ approach to the study of policy work presenting a conceptual framework that integrates the elements of policy making, recognising their interrelationships and the influence of the external environment.

The literature available on the theory and practice of policy is extensive and was selected for review according to four criteria: relevancy to the aim and questions of this study (and the context of stage 1 of the ARC Linkage project); research and writings of seminal authors (specifically on theories, models and frameworks); English language literature that was written before 2012 (focusing on the post 1980 period); and primary focus on scholarly and non-peer reviewed government literature from Australia, Canada, New Zealand and the United Kingdom which share a common political tradition based on Westminster-style political systems and with comparable pluralist health care systems comprising a combination of public and private services and funding based on a shared philosophy of universal access to health services.

2.1 WHAT IS POLICY?

[But] policy is rather like the elephant – you recognise it when you see it but cannot easily define it.

(Cunningham, 1963, p. 229)

General nature of policy
The term ‘policy’ has many meanings and has been the subject of extensive debate in the literature.
Policy, in the literature, is broadly interpreted as purposive decisions and actions (Colebatch, 2009; Hill, 1997; Palmer & Short, 2010; Parsons, 1995). For instance, Palmer and Short (2010, p. 23) defined policy as *a set of actions and decisions or statements of intention*. Hill (1997, p. 7) adopts a similar interpretation but emphasises the multiple actions and interconnected decisions that take place over time and are subject to termination.

Colebatch (2009, p. 21) extends Hill’s interpretation to acknowledge that policy incorporates both the perspectives of the practitioner in shaping and applying the policy, and that of the researcher in observing and investigating the policy; and argues that policy is more than a statement or an intention, rather it is a term to describe a wide range of purposes, decisions, processes, actions and practices. Colebatch (2009, pp. 8-9), in defining policy, identifies three essential attributes of policy and their contribution to practice comprising *order* (application of a systematic and consistent approach); *authority* (endorsement by authorised decision makers); and *expertise* (knowledge of the problem and what should be done). These attributes may not be equally present in all points of the policy process and at times may be at variance with each other.

In addition, a number of key characteristics of policy were also identified in the scholarly literature. On the one hand, policy is viewed as an informed choice and as a rational exercise involving a logical and judicious approach to decision making and action (Parsons, 1995, p. 14). On the other hand, the underlying values and norms of individuals, interest groups, organisations and the wider community are recognised as fundamental to policy decisions and actions. The health policy environment is generally acknowledged as being contested (Barraclough & Gardner, 2008; Colebatch, 2009; Lin, 2003), subject to conflict and ‘trade-offs’ between competing interests and demands of multiple participants (government, political parties, special interest groups, non-government organisations, industry and business, research institutions, media), and further exacerbated by problems of scarce financial resources, sustainable development, and economic efficiency.

The policy literature acknowledges that human values are fundamental to understanding and interpreting policy. Lin (2003, pp. 13-16), for example, in recognising competing health policy interests, proposes a ‘competing rationalities’ model that identifies three types of rationality, cultural, political and technical, each group representing specific
values and interests. While Vickers (1965) emphasises the need to recognise that policy analysis and decision making involve concepts such as *values, judgement* and *appreciation*; and that the exercise of judgment, applying human values to appreciating and interpreting a situation is central to policy and decision making.

Although policy is commonly understood as decisions, actions and choices, it is recognised that ‘non-decisions’ or ‘inactions’ were also features of policy, with governments electing not to make a decision or pursue a course of action (Dye, 1976; Fenna, 2004; Ham & Hill, 1993; Hogwood & Gunn, 1984; Palmer & Short, 2010; Parsons, 1995).

Another way of understanding policy is from the perspective of outputs and outcomes which emphasises the relationship between policy development and actual implementation. From this perspective, Hogwood & Gunn (1984, p. 16) interpret policy outputs as “what government actually delivers as opposed to what it has authorised through legislation”. In this interpretation, outputs are viewed as tangible government activities, such as payment of cash and benefits, delivery of goods and services, enforcement of rules, and collection of taxes, arising from a range of policy activity extending beyond the narrow confines of legislative approval. The interpretation of outputs varies as a result of the different factors contributing to their development; the form of policy outputs varies according to the policy area; and outputs may not conform to stated intentions. This broad interpretation of policy outputs matches that presented in this study, with a definition of outputs presented later in the chapter.

While outputs are viewed as “activities of government at the point of delivery”, Hogwood & Gunn (1984, pp. 16-17) interpret outcomes as “what is actually achieved”. In their analysis of outcomes, Hogwood & Gunn focus on policy impacts as a means of establishing whether policy is achieving its stated purpose. However, it is frequently difficult to determine the impact of government activities in practice as there is rarely a direct-line relationship between actual policy delivery and impact and, further, some aspects of the impact may be unintended and or unforeseen (Hogwood & Gunn, 1984, p. 17). This interpretation of policy as outcomes provides a useful perspective for looking at policy; focusing on the impacts of policy, of either what has been achieved in line with stated intentions or occurred unintentionally. This interpretation of policy from the
perspective of outcomes is consistent with that presented in this study, with a definition of outcomes presented later in the chapter.

Although there are numerous definitions and interpretations of the terms policy and public policy depending on context, purpose and application (Buse, Mays, & Walt, 2005; Colebatch, 2009; Ham & Hill, 1993; Hogwood & Gunn, 1984; Lin, 2003; Palmer & Short, 2010; Parsons, 1995), there is general consensus that ‘public policy’ may be defined as policy for which governments are primarily responsible and play a central role in articulating intended goals and objectives, making decisions, and ensuring actions to achieve policy outcomes (Considine, 1994; Hogwood & Gunn, 1984). Dye (1976, p. 1) notes that public policy is “what governments do, why they do it, and what difference it makes”.

The commitment and therefore provision of resources by government in support of policy decisions and actions are critical aspects of public policy (Considine, 1994; Fenna, 2004); in the absence of government commitment, policies will be neither developed nor implemented (Considine, 1994, p. 3).

As stated by Palmer and Short (2010, p. 23), public policy may be interpreted to include policies that affect the public and require public resources, and are therefore developed and implemented in the interest of the people as a whole. In support of the government’s role in public policy, Fenna (2004, p. 2) comments that “what governments do, why, and with what consequences” is a study in politics; in fact,

[...] it is difficult if not impossible to separate policy, and public policy in particular, from the “ebb and flow of politics”. (Buse et al., 2005, p. 7).

The close and intertwined relationship between policy and politics outlined in the above quote is strongly supported in the policy and political science literature (Althaus, Bridgman, & Davis, 2007; Colebatch, 2009; Fenna, 2004; Hill, 1997; Maddison & Denniss, 2009; Parsons, 1995). This situation is expected in the public policy arena, given the close relationship between the political arm of government and public administration (bureaucracy) in the policy making process.

Palmer and Short (2010, pp. 23-25) assert that health policy constitutes a distinct form of policy, separate from other areas of social policy, based on the medical profession’s role,
complexity of health care service provision, consumers inability to distinguish service quality, and the psychological stresses of life and death decision making. Although they recognise the overlap between social, economic and health policy (p. 27). This is acknowledged by Colebatch (2009, p. 4) who in the field of policy studies coined the term ‘adjectival policy’ in recognition of the areas of specialisation (e.g. health, environment, transport and regional policy), each with their own public authority, structures and processes.

It is recognised that there are overlaps between health and social policy, with both considered a subset of the wider field of public policy. For the purpose of this study⁴, a broad interpretation of the meaning of ‘policy’ is adopted, encompassing a broad range of positions, decisions (including decisions not to decide), processes and actions (Colebatch, 2009). In this broad definition, policy can involve different levels of scale, from the goals and aspirations of government to the standardisation of routine practice (Colebatch, 2009).

Types of policy work

Policy work in terms of activities and outputs are identified in the scholarly research as including drafting legislation (Colebatch, 2009; Page & Jenkins, 2005; B. A. Radin, 1997); and preparing Cabinet and Budget submissions (Althaus et al., 2007; Page & Jenkins, 2005). Radin (1997), in describing the emergence of the policy analysis movement in the United States of America, stated that the policy analytic functions of planning, budgeting, regulatory and legislative drafting had by the 1980s become part of standard operating decision procedures in federal agencies. Evaluation as a significant category of policy work is also reported at length in the scholarly literature (Althaus et al., 2007; Page & Jenkins, 2005).

Various typologies are advanced by scholars to classify the type of policy work, influenced by factors such as function, status of policy whether new or existing, and context. Page & Jenkins (2005) used a threefold typology for classifying policy work, comprising ‘production’ (drafting legislation and regulation, monitoring spending, and preparing options and strategy papers); maintenance (monitoring research and spending, ensuring implementation compliance, evaluating programs), and service (offering

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⁴ This interpretation of policy was developed for the ARC Linkage research project, Stage One Report: Preliminary Findings from the Focus Group and Individual Interviews, 18 September 2009.
knowledge and skills to others in advising and briefings). While Scott & Baehler (2010, pp. 13-15) identified three broad domains of policy work comprising strategic, responsive, and operational, influenced by the introduction of either new or maintenance of existing policy, and involved varying degrees of strategic and operational policy.

2.2 Policy Process: A Fundamental Element for Good Policy

Policy process as activities and functions

In this section, the literature on the policy process will be examined from the perspective of ‘activities’ and ‘functions’. Colebatch’s (2009, p. 118) interpretation of the policy process, as “activities or ‘the things that people do’ to produce policy” is adopted for the purposes of this study.

The policy process in the literature is frequently presented as a series of activities and functions to describe the way in which policy is made, identifying a number of specific steps to be carried out. Although used as a tool for explaining the policy process it is recognised that these activities are not always conducted in a sequential manner.

There are numerous scholars who have written about the policy process advancing different interpretations and perspectives in relation to broad activities and functions that describe and explain the process (Althaus et al., 2007; Buse et al., 2005; Colebatch, 2009; Dye, 2008; Hill, 1997, 2009; Hogwood & Gunn, 1984; Howlett & Ramesh, 1995; Lasswell, 1951, 1956; Parsons, 1995). There are many commonalities in the authors’ interpretations of the activities and functions of the policy process.

This study has drawn on aspects of the policy process literature in the development of the conceptual framework for the analysis of the research data, Dye (2008) and Althaus et al. (2007) in particular. Dye (2008) explains the public policy process in terms of six stages. Refer to Table 1.
Table 1: Dye – The six stages in the public policy process

| Problem Identification | Publicising societal problems  
| Agendum setting | Expressing demand for government action  
| Agenda setting | Deciding what issues will be decided, what problems will be addressed by government  
| Policy Formulation | “Nondecisions” – deciding what will not be decided  
| Policy Legitimation | Developing policy proposals to resolve issues and ameliorate problems  
| Policy Implementation | Selecting a proposal  
| Policy Evaluation | Developing political support for it  
| Policy Evaluation | Enacting it into law  
| Policy Evaluation | Deciding on its constitutionality  
| Policy Evaluation | Organising departments and agencies  
| Policy Evaluation | Providing payments or services  
| Policy Evaluation | Levyng taxes  
| Policy Evaluation | Reporting outputs of government programs  
| Policy Evaluation | Evaluating impacts of policies on target and non-target groups  
| Policy Evaluation | Proposing changes and reforms  

Althaus et al. (2007, pp. 32-42), in The Australian Policy Handbook, specify eight stages and their activities as a practical tool to assist policy practitioners as well as to encourage inter-agency co-ordination, comprising issue identification; policy analysis; policy instruments; consultation; coordination; decision; and implementation and evaluation.

The policy process is generally described as a series of activities and functions and with some variation in their number and grouping (Althaus et al., 2007; Buse et al., 2005; Dye, 2008; Hogwood & Gunn, 1984; Howlett & Ramesh, 2003) but with the main activities and functions usually including agenda setting and problem definition, policy formulation, decision-making, implementation and evaluation.

In conclusion, the focus of the policy process literature is on broad activities and functions and does not take into consideration the element of policy capacity nor make explicit mention of policy outputs and outcomes as part of the policy making process. There is limited mention of the dynamic and interactive nature of the external environment that influences the policy making process but may be inferred within the activities and functions, such as, consultation with relevant interest groups or individuals, or the wider community (Althaus et al., 2007). Policy evaluation, rather than being
identified as an integral element in the policy making process itself, is specified as a main function or activity for examining the effects of implementing a policy program (Althaus et al., 2007; Buse et al., 2005; Dye, 2008; Hogwood & Gunn, 1984; Howlett & Ramesh, 2003).

Policy process interpreted as theories, models and frameworks

In this section, the literature on the policy process will be examined from the perspective of theories, models, and frameworks that are applied for interpreting and understanding the policy process; each providing a particular ‘lens’ through which to view the complex set of social processes that comprise policy making.

A selection of the key theories, models and frameworks that describe how policy is formulated, implemented and evaluated and the influence of organised interests in the policy making process is presented in Table 2.

Table 2: Key theories, models and frameworks of policy analysis

<table>
<thead>
<tr>
<th>Author/Year of publication</th>
<th>Theoretical approach</th>
</tr>
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<tr>
<td>Lasswell: 1935, 1951, 1956</td>
<td>World politics and policy sciences approach (application of a rational scientific approach to decision making: objectivity, collection, analysis and interpretation of data, and evaluation of options). The first scholars to formulate a set of ‘stages’ to understand and explain the policy process: intelligence, promotion, prescription, invocation, application, termination, and appraisal.</td>
</tr>
<tr>
<td>Simon: 1945, 1957, 1976</td>
<td>Incrementalism – advocated incrementalism as an alternative to the rational policy process approach; in which, policy is made through a succession of small adjustments. Lindblom is also associated with the ‘science of muddling through’ approach.</td>
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<td>Lindblom: 1959, 1979</td>
<td>Black box of decision-making – provides a model of the political system that conceives the policy process in terms of the relationship between policy making, policy outputs and the wider environment. In this model, inputs in the form of flows of effects from the environment combined with demands within the political system are converted into policy outputs and outcomes.</td>
</tr>
<tr>
<td>Easton: 1953, 1965</td>
<td></td>
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<tr>
<td>Author/Year of publication</td>
<td>Theoretical approach</td>
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<tr>
<td>Cohen, March and Olsen: 1972</td>
<td><em>Garbage can model of decision-making</em> – in which policy is perceived as the outcome of interaction between problems, solutions, participants and choice opportunities as they spin around within the ‘garbage cans’ of organisations and public discourse.</td>
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<tr>
<td>Alford: 1975</td>
<td><em>Structural interest groups</em> – in which policy making is shaped by the interests of professional monopolists, community activists, and corporate rationalists.</td>
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<tr>
<td>Hogwood and Gunn: 1984</td>
<td><em>Rational/stagist model</em> – which views the policy process as a ‘rational’ and orderly sequence of distinguishable stages (e.g. agenda setting, policy formulation and legitimation, implementation, and evaluation), commencing with the policy analysis of Simon (Simon, 1945) and Lasswell (1956) and continuing to the present.</td>
</tr>
<tr>
<td>Baumgartner and Jones: 1991, 1993</td>
<td><em>Punctuated equilibrium model</em> – in which the policy process is characterised by long periods of incremental change, punctuated by brief periods of major policy shifts.</td>
</tr>
<tr>
<td>Kingdon: 1984</td>
<td><em>Three streams model</em> – in which the three separate streams of problems, solutions and politics come together at critical moments, creating windows of opportunity where policy entrepreneurs can match problems and solutions and push issues onto policy agendas.</td>
</tr>
<tr>
<td>Rhodes: 1988, 1996</td>
<td><em>Networked governance</em> – in which policy making processes extend beyond the traditional hierarchical model of government to include networks of organisations and or interests participating in collaborative forms of governance.</td>
</tr>
</tbody>
</table>
| Sabatier and Jenkins-Smith: 1993 | *Advocacy coalition framework* – in which policy making is perceived as the interaction between
<table>
<thead>
<tr>
<th>Author/Year of publication</th>
<th>Theoretical approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fischer and Forester: 1993</td>
<td>Policy discourse approaches – in which the focus of policy-making is on the way in which language and discourse shapes the construction of problems and agendas, as in Fischer and Forester’s argumentative approach.</td>
</tr>
<tr>
<td>Edelman: 1977, 1988</td>
<td></td>
</tr>
<tr>
<td>Colebatch: 2009</td>
<td>Conceptual maps – in which policy work and the policy process is conceived as multiple interpretations: ‘authoritative choice’, ‘structured interaction’ and ‘social construction’.</td>
</tr>
<tr>
<td>Pressman and Wildavsky: 1973, 1979, 1984</td>
<td>Policy implementation models – various models of policy implementation, such as, ‘top down’, ‘bottom up’ and ‘hybrid’ provide different accounts of the implementation process and different reasons for implementation failure.</td>
</tr>
<tr>
<td>Pulzl &amp; Treib: 2006</td>
<td></td>
</tr>
</tbody>
</table>

This overview commences with the early political science and policy studies of scholars like Lasswell (1951), Simon (1957, 1976) and Easton (1953), in the main, advancing ‘rational/stratist’ approaches to understanding and interpreting the policy process; and continues with more recent theories and models on collaborative governance (Rhodes, 1988, 1996), policy networks (Smith, 1993, 1997), and policy discourse approaches (Fischer & Forester, 1993).

The literature in the main is explicit about the role of the external environment in influencing the policy making process, such as, the involvement of professional groups, community activists, and corporate interests in collaborative forms of governance and shaping the policy discourse (Alford, 1975; Colebatch, 2009; Edelman, 1977, 1988; Fischer & Forester, 1993; Lewis, 2005; Rhodes, 1988, 1996; Smith, 1993, 1997); and indirectly reveals evidence about the relationship of policy capacity, policy evaluation, outputs and outcomes, despite these elements not being considered central to the design and development of the theories, models and frameworks.

The focus of this literature review is predominantly the theoretical parameters of the policy making process and to advance theories, models and frameworks that describe and explain, from a particular perspective, a particular aspect of the policy process. Four of these theoretical approaches are examined in detail to determine their suitability as a
conceptual framework for the analysis of the research data: rational and stagist model; conceptual maps framework; institutional rational choice model; and systems approach.

**Rational/Stagist Model**

Commencing with the early studies of Simon (1945) and Lasswell (1951) there have and continue to be numerous policy scholars (Althaus et al., 2007; Dye, 2008; Easton, 1953, 1965; Hogwood & Gunn, 1984; Howlett & Ramesh, 2003; Jenkins, 1978; Lindblom, 1959; Parsons, 1995) advocating a rational and stagist approach to interpreting the policy process.

Underpinning this perspective of the policy process is the rational, scientific basis of decision making, influenced by the application of a rigorous social science approach to understanding causal relationships through collection of facts, analysis and empirical investigation. Within this mode of inquiry, the emphasis in policy analysis is on objectivity and science (rational and technical), with little room for values-based approaches (Parsons, 1995). The ‘rational comprehensive model’ of policy making is neatly summed up by Hogwood & Gunn (1984, pp. 45-46) as comprising the main activities of gathering intelligence, identifying all options, assessing consequences of each option, relating consequences to values, and selecting a preferred option, an approach stressing the importance of objective setting prior to development of suitable options.

Further, the rational/stagist approach views the policy process as a series of distinguishable stages, with a succession of feedback loops between them. Hogwood & Gunn (1984, p. 4), for instance, identified nine stages in the policy process: *deciding to decide; deciding how to decide; issue definition; forecasting; setting objectives and priorities; options analysis; policy implementation, monitoring and control; evaluation and review; and policy maintenance, succession and termination*. While Howlett’s and Ramesh’s (2003) model delineated five main stages of the policy making process, comprising *agenda setting and problem definition; policy formulation; decision-making; implementation; and evaluation*. Although a number of stages are identified in these largely descriptive and explanatory approaches of the policy process, scholars generally acknowledge that in reality the policy process is messy and iterative rather than occurring in neat and sequential stages.
From an Australian perspective, Althaus et al. (2007, pp. 32-42) in *The Australian Policy Handbook*, offer an Australian ‘policy cycle’ model of the policy process and specify eight stages and associated activities. Refer to Table 3.

**Table 3: The eight stages of the Australian ‘policy cycle’ model**

<table>
<thead>
<tr>
<th>Issue identification</th>
<th>the recognition of a problem as needing attention, so that it joins the government’s policy agenda</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy analysis</td>
<td>the assembling of information to frame the issue and understand the problem</td>
</tr>
<tr>
<td>Policy instruments</td>
<td>determining the appropriate tools and approaches to design a policy response</td>
</tr>
<tr>
<td>Consultation</td>
<td>a structured process to seek and respond to views about a policy issue from relevant interest groups or individuals, or the community generally</td>
</tr>
<tr>
<td>Coordination</td>
<td>ensuring that politics, policy and administration work together</td>
</tr>
<tr>
<td>Decision</td>
<td>confirmation of policy by government, usually via formal resolution of cabinet</td>
</tr>
<tr>
<td>Implementation</td>
<td>giving expression to the decision through legislation or a program</td>
</tr>
<tr>
<td>Evaluation</td>
<td>a process to systematically examine the effects of a policy program</td>
</tr>
</tbody>
</table>

In explaining the stages of the ‘policy cycle’ in the Australian context, Althaus, et al. (2007) highlight the importance of political institutions and processes on policy making, reflected in the close interaction between Cabinet, ministers, advisers and the public service. In their policy model, the collective nature of contemporary policy making, involving non-government, business, media and wider citizenry participation, is also recognised; acknowledging a close working relationship between the political and policy making processes.

Hogwood & Gunn (1984, p. 267) also conclude that the political setting has an important influence on all stages of the policy process, and “the relationship between politics and analysis at its best is iterative”. In their view, resource distribution is inevitably politically determined, and policy analysis is never ‘neutral’ but ‘values are at the centre of policy-making’.
The literature on the rational/stagist model reveals a focus on the policy making process; using the specified stages, with corresponding functions and activities, to describe and explain the policy process. In examining the policy process, the literature, either directly or indirectly, refers to policy outcomes in terms of improvements to the life of citizens and well-being of society. Some of the literature refers to producing policy outputs in terms of policy statements and or documents articulating a direction. The literature refers explicitly to the functions of monitoring and evaluation, frequently treated as a distinct stage in the policy process (Althaus et al., 2007; Hogwood & Gunn, 1984; Howlett & Ramesh, 2003). The function of evaluation, as a stage in the policy process, is given prominence as a means of policy review, feedback and adjustment. The rational/stagist literature presents also extensive discussion on the interactions and influence of the socio-political environment on the policy making process, discussed in terms of political and legal institutions and structures, economic frameworks, external interests, media and the wider public. The influence of the political environment on the policy process is strongly acknowledged in this model.

Although the rational/stagist model reduces the conceptual complexities of a frequently messy and iterative policy process and provides a coherent and structured approach for comprehending and explaining the policy making process, it has been criticised by a number of scholars (Lindblom, 1959; Nakamura, 1987; Parsons, 2002; Sabatier, 1999; Sabatier & Jenkins-Smith, 1993).

Lindblom (1959), for example, argues that policy making in practice, for the most part, is more about 'muddling through' rather than a process in which scientific analyses plays an influential part, while Parsons (2002, p. 81) concedes that policy making from this perspective may be perceived as a ‘top down’ approach, a role restricted to government and public administration. Hupe and Hill (2006, p. 27) further criticise the stages heuristic for not being a causal model but for functioning as a ‘general map’ for the analysis of the policy process.

From the perspective of this study the most significant limitation of the literature on the rational/stagist model of the policy process is that it reveals a noticeable absence of reference to any aspect of policy capacity, either individual or organisational. As such, there is no examination of the relationships between the elements of policy capacity,
process, outputs, outcomes, and policy review and monitor as well as the interaction between these elements and the external socio-political environment.

CONCEPTUAL MAPS
In Policy (2009), Colebatch presents a detailed analysis of policy in order to improve our understanding of policy work in Australia from both a theoretical and practical perspective. In this seminal work, Colebatch explores the work of policy, drawing on a wide range of local problems/issues and fictitious examples. Colebatch (2009, p. 45) identifies three major approaches (‘conceptual maps’) for conceptualising policy and the practice of policy.

Authoritative choice – policy is seen as a process of decision-making involving those with legitimate authority (‘vertical’ approach). In this approach, attention is concentrated on the role of ‘authorised leaders’ in policy practice to make the right choices and decisions. The focus on the ‘point of decision’ (p. 45) is central in ‘authoritative choice’.

Structured interaction – policy is seen as a process of negotiation and structured interaction between many recognised stakeholders (‘horizontal’ approach). In this approach, attention is concentrated on the collective role of stakeholders in policy practice, with different agendas and interests, participating in an ordered activity. The focus on ‘who can participate and how they get there’ (p. 45) is central in ‘structured interaction’.

Social construction – policy is concerned with the manner in which participants construct meaning and use processes to shape the policy discourse (‘scene-setting’ approach). In this approach, attention is concentrated on the way in which problems in policy practice are identified and defined, knowledge is assembled, expertise is recognised, forms of reporting and accounting are devised, governing practices are discovered, and appropriate course/s of action achieved. In addition, wider social, community and intellectual interests (referred to as ‘mundane operatives’) play a critical role in developing knowledge, creating the policy discourse and influencing policy outcomes. The focus on ‘how situations are considered as normal or problematic, and whose voices are heard’ (p. 45) is central in ‘social construction’.

The three accounts of the policy making process are not mutually exclusive, and combinations of each may be recognisable in some policy situations. Further, the
different dimensions are not separate but often interact with and complement each other. Colebatch argues that policy practitioners recognise and use all three accounts in policy practice, but two more frequently, being the ‘horizontal’ dimension, through recognising the relevant interests who participate in the process and contribute to framing the policy outcome for example; and the ‘vertical’ dimension, through policy that is being prepared for official approval. Although it may be less frequently recognised by practitioners, the ‘scene-setting’ dimension, which works towards achieving a sphere of ‘shared understandings and values’ for ‘negotiations and decision-making to take place’ is also used. Colebatch notes that practitioners will deploy the most appropriate dimension, depending on the policy situation; and, while all three accounts are recognised in policy practice, practitioners are likely to present the official line of ‘authoritative choice’ in public although acknowledging the significant role of ‘structured interaction’ and ‘social construction’ approaches in practice.

Colebatch acknowledges that in practice the policy making process flows in both directions, using both ‘top-down’ and ‘bottom-up’ accounts of policy making. He contends that policy making is generally a collective process, involving numerous players with different interests and expectations, referred to as ‘policy collectivities’ (p. 38). These ‘policy collectivities’, depending on the policy issue and situation, may involve the following players and interests, including government, bureaucracy, industry groups, commercial and business interests, academics, professional interests, and user groups; each jostling for a prominent position ‘at the table’ in order to exert influence on policy outcomes. Colebatch (p. 120) acknowledges that within this policy-making environment not all participants have equal power and influence, with some more prominent than others: “policy is the work of many hands, but all activity is not the same, nor is it equally significant”.

Colebatch concludes that we need to recognise that there are different accounts of policy making and that a combination of these approaches is used in practice; and that the process of policy making encompasses ‘top-down’, ‘bottom-up’ and combinations of the two approaches - all of which are strongly influenced by the context of a specific situation, varying according to the issue, location and time. He concludes by acknowledging that ‘authoritative choice’ remains the dominant account, and although it is a good account of policy making it is not a true reflection of the real-world situation.
From the perspective of this study, Colebatch’s interpretation of policy practice has a number of limitations.

Colebatch’s doesn’t directly address policy capacity in terms of either individual competencies (knowledge and skills, training and professional development, and leadership and culture) or organisational capabilities (recruitment procedures, information systems, structures and processes, infrastructure and supports) required for policy making. Rather he recognises ‘expertise’ (together with authority and order) as a fundamental requirement of policy activity; regarding specialist knowledge and expertise as central to understanding, framing and addressing an issue/problem. Although Colebatch acknowledges the broad role that policy practitioners play in policy activity, the focus of his thesis is not directed toward examining individual and organisational policy capacity.

Colebatch only indirectly discusses policy outcomes, through identifying and comparing options, ensuring implementation of decisions and achieving desired effects in ‘authoritative choice’ (p. 119); negotiation, coalition-building, the construction of meaning, and the generation and ratification of agreed courses of action’ in ‘structured interaction’ (pp. 119-120). Although Colebatch only infers a relationship between the policy making process and the development of some sort of policy output (document, statement) he does acknowledge that policy outcomes are more than just the development of a formal policy statement but are the implementation of goals to achieve the desired impact on society.

Colebatch also only indirectly discusses the influence of the wider socio-political environment, through the interaction with wider political structures as a result of the prominent role of ‘authorized decision-makers’ (ministers, politicians, Cabinet, parliamentary committees, senior bureaucrats) in ‘authoritative choice’; the involvement, interaction and influence of multiple stakeholders in the policy process in ‘structured interaction’; and the creation of a policy discourse based on developing a shared meaning and understanding for identifying and addressing a policy issue in ‘social construction’. Although recognised by Colebatch as part of the policy making process, the role of evaluation and monitoring (pp. 86-87) is not given any prominence, and is not conceived as being one of a number of interrelated elements in the policy making process with a particular role in terms of reflection and continuous improvement.
In conclusion, within the context of his three accounts of policy activity (‘authoritative choice’, ‘structured interaction’ and ‘social construction’), Colebatch emphasises different aspects of policy process but doesn’t specifically examine the relationship between policy process, policy capacity and policy outcomes.

**INSTITUTIONALISM AND INSTITUTIONAL RATIONAL CHOICE**

This group of theories, referred to as institutionalism, draws on theories from a range of disciplines including economics, political science, sociology and anthropology (March & Olsen, 1984; Ostrom, 2007). The theories focus on the way in which policy is shaped by institutional arrangements.

Institutional rational choice, one type of institutionalism, focuses on how institutional rules and incentives have the potential to change institutional behaviour (Parsons, 1995, p. 224; Sabatier, 2007, p. 8). Ostrom’s Institutional Analysis and Development framework (IAD), developed in the early 1980s, is one such model, which examines the way institutions affect incentives confronting individuals and their resultant behaviour (2007, p. 21).

Ostrom defines the term ‘institution’ to refer not only to an ‘organizational entity’ but to include ‘rules, norms, and strategies adopted by individuals operating within and across organizations’ (Ostrom, 2007, p. 23). Rules are interpreted as ‘shared understandings among those involved that refer to enforced prescriptions about what actions (or states of the world) are required, prohibited, or permitted’ (Ostrom, 2007, p. 36). Norms are understood as ‘shared prescriptions’ that are enforced by participants through internally and externally imposed costs and inducements. In the rational choice model, institutions and their rules determine the nature of interactions between participants and the choices available to actors.

A central concept of institutional rational choice is the identification of ‘action arenas’ or social spaces where ‘actors’ interact with ‘action situations’ to produce ‘patterns of interactions’. Policy outcomes in this model are shaped by ‘patterns of interactions’ that result from the interactions of variables in and between action situations (participants, positions, outcomes, outcome-action linkages, control exercised by participants, information, costs and benefits) and individual or corporate actors in action arenas (Ostrom, 2007, p. 28).
Action arenas are also influenced by three broad categories of variables, comprising rules used by participants to govern the action arena, characteristics of the community or collective unit of interest, and attributes of the physical environment within which the community acts (Ostrom, 2007). A continuous process of evaluation against criteria of economic efficiency, equity, conformance to general morality and accountability, followed by adjustment, further influences the achievement of policy outcomes (Ostrom, 2007).

An important feature of institutional rational choice is the distinction it makes between multiple levels of decision making and the relations among them (constitutional, collective choice and operational); and clarifies the fundamental elements that can be used for analysis of outcomes in any one of the three tiers of decision making. Any one decision-making group or action arena may operate at more than one level of institutional action (Ostrom, 2007, p. 22).

From the perspective of this study the strengths of the institutional rational choice model are the focus on the interactions of multiple variables, from an institutional perspective, in the policy making process; emphasis on policy outcomes, the result of interactions between variables occurring in action arenas and the influence of institutional rules and where the type of outcomes are also variable and contingent on particular action arenas; the prominence given to the function of evaluation of policy outcomes, referring to the continuous process of assessing achievement of policy outcomes against specific equity and economic criteria; the emphasis on the external environment (physical and material conditions, and community attributes) as variables in influencing action arenas and, in turn, policy outcomes. There is no explicit reference made to outputs in the model, although it may be implied.

Although at first glance there may not appear to be explicit reference made to policy capacity as understood by contemporary research, on closer examination, the central role of the ‘actor’ (individual or corporate) in the policy process could be interpreted as being similar to capacity. Ostrom, for instance, refers to an ‘actor’ as the resources brought to a situation (intelligence and capabilities) and the processes actors use for selecting a particular course of action (knowledge and judgement). However, the emphasis in Ostrom’s model is more on the self-seeking behaviours and motivations of actors in influencing the policy process whereas this study examines capacity more from the
perspective of individual and organisational capabilities and infrastructure to support policy making.

While the institutional rational choice model identifies the essential variables that interact in the policy making process, its focus is on the effect institutions have on actors’ behaviours and motivations (incentives and self-interest), a leaning towards the psychosocial aspects of individual behaviour, but doesn’t explicitly examine the relationship between policy process, policy capacity and policy outcomes.

**SYSTEMS APPROACH**

Easton’s (1953, 1965) ‘black box’ model of decision-making is a representation of policy making and its interaction with the political environment: conceptualising the policy process in terms of the relationship between inputs (demands, resources and supports) and process (political system of government decision-making, referred to as the ‘black box’), which is then converted into outputs and outcomes (public policies for goods and services that impact on society); emphasising the importance of ‘regulators’ or ‘gatekeepers’ whose function was to maintain the equilibrium of the system by minimising the likely overload of the system by excessive and or unacceptable demands.

The ‘black box’ model is one of the earliest to explain the policy process from a ‘systems’ perspective, delineating the interrelationship between inputs, process and outputs and outcomes, role of the political system in transforming environmental demands into authoritative decisions and actions, and the role of feedback as a mechanism for coping with stress and, in response, modifying the environment for future policy making. Easton’s approach has appealed to scholars over the years as a logical way of examining the policy process by specifying the relationships between inputs, processes and outputs within the complexities of an open system that interacts with the wider environment. It has been applied within the health sector to numerous areas, including review of health systems, quality of care, health promotion, and program evaluation.

However, the ‘black box’ model has a number of limitations such as a narrow understanding of the complexities of the political system (‘black box’) and its specific activities and functions in the policy making process; and use of terms such as ‘supports’ (i.e. structures, resources and finances) which are interpreted as inputs of the system but
which in contemporary policy terms, are interpreted more broadly as both organisational and individual capabilities or ‘policy capacity’ (a term that emerged in the 1980s). It must be acknowledged that Easton was writing in a different time, and scholarly research was at a different point in its development and orientation.

2.3 Policy Capacity: A Fundamental Element for Good Policy

The Westminster model assumes that the public service will have the internal capacity, competence and skills to support decision making [...].

(Tiernan, 2012, p. 338)

Defining and interpreting policy capacity

The Shorter Oxford English Dictionary (Oxford University Press, 1973, p. 280) defines capacity as: mental receiving power; ability to take in impressions, ideas, knowledge; the active power of mind or talent; and the ability or power to do something.

In these broad definitions, ‘capacity’ is interpreted as both the intellectual talents and capabilities of an individual as well as the ability to organise and deploy resources and supports to achieve an end.

In the scholarly literature, policy capacity as a concept lacks a clear and generally accepted meaning. According to Painter and Pierre (2005, p. 2) policy capacity is “[...] 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 [...]”; while for Polidano (2000, p. 810), policy capacity is “[...] the ability to structure the decision-making process, coordinate it throughout government, and feed informed analysis into it [...]”. Three important themes emerge from these definitions of policy capacity, comprising the ability to assemble appropriate resources (intellectual capability) for making sound decisions (to determine long term directions, assess options,

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5 There is debate in the literature about the meaning and use of terminology, such as, ‘capacity’, ‘capability’, ‘ability’ and ‘competency’ (Bakvis, 2000; L. Edwards, 2009, p. 291 also citing Painter and Pierre, 2005; Gleeson, 2009, p. 66; Tiernan & Wanna, 2006). A number of authors (R. Christensen & Gazley, 2008; Tiernan and Wanna, cited in L. Edwards, 2009, p. 291; Gleeson, 2009) have argued that there is little to be gained from such ‘fine grained distinctions’ because of a tendency for practitioners to use the terms interchangeably.
select appropriate solutions, allocate resources to improve societal outcomes); the need for intelligent and informed analysis for effective decision making; and the ability to coordinate decision making across government.

In their interpretation of policy capacity, Painter and Pierre (2005, pp. 2-3) drew a distinction between policy and other forms of capacity, which they referred to as ‘governing’ capacity. An examination of national and state policy capacity in Canada differentiated three types of ‘governing capacity’.

State capacity is interpreted as the state’s ability to organise social and economic support and consent required to achieve public goals, and drawing attention to the achievement of outcomes as well as policy and administrative outputs.

Administrative capacity is interpreted as the ability to manage efficiently the human and physical resources required for delivering the outputs of government.

Policy capacity is interpreted as the ability to organize the necessary resources to make intelligent collective choices about and set strategic directions for the allocation of scarce resources to public ends. Policy capacity was viewed as the pivot around which the other two revolved, recognizing the critical importance of steering and strategy for effective governing.

In this analysis of ‘governing’ capacity, the relationship between the three components was regarded as analytically discrete but interdependent, with the relationships influenced by a combination of factors including human resource availability and capability, nature of policy episode and sector, participating stakeholders, and existing institutional arrangements.

A number of Canadian policy authors (Canadian Government, 1996; Howlett, 2007, 2009; Oliphant & Howlett, 2010; Peters, 1996; Wellstead, Stedman, & Howlett, 2011) present a slightly different interpretation of policy capacity, applying the more specific terminology of ‘policy analytical capacity’ to describe and interpret it. They use the term in the context of an organisation’s ability to produce robust, evidence-based policy, applying systematic and analytic methodologies in its development and evaluation. For instance, Peters (1996, p. 12) in reviewing the Canadian government’s policy capacity, noted that ‘policy analytic techniques’ were critical in shaping the quality of policy.
decisions, if knowledge was to be utilised effectively within the policy-making process. For some of these authors (Howlett, 2007, 2009; Oliphant & Howlett, 2010; Wellstead et al., 2011), the term ‘policy analytical capacity’ was synonymous and interchangeable with policy capacity and policy research capacity, as they are all used to describe an organisation’s ability to perform policy analysis.

Drawing on a large body of literature (Aucoin & Bakvis, 2005; Davis, 2000; Janicke, 1997; Painter & Pierre, 2005; Parsons, 2004; Peters, 1996), the ARC Linkage project (2012, pp. 3-4) developed a definition of policy capacity which is adopted in this study as being most pertinent to the research aim:

The term ‘policy capacity’ is generally used to describe the conditions for ‘good’ policy making in government. It is a concept that lacks a clear and generally accepted meaning. Definitions in the literature highlight a number of different dimensions of policy capacity, including the ability to make intelligent, collective decisions; the ability to mobilise resources to support policy making; the ability to implement policy; and the ability to coordinate policy making across government.

Capacity is also interpreted as a multi-level phenomenon, with the three levels of capacity highlighted by a recent OECD (2006) paper on capacity development comprising the individual (knowledge and skills); the organisation (structures, processes and cultures); and the wider environment (the environment external to the organisation, including the bigger systems in which organisations are embedded).

and

For the purpose of the ARC Linkage project, policy capacity is conceived as including individual competencies of policy workers (knowledge, skills and personal attributes); and organisational policy capacity (structures, processes and culture that support ‘good’ policy making).

Policy capacity themes
The policy capacity literature in the last two decades has focused predominantly on particular aspects of capacity.

DECLINING POLICY CAPACITY
Declining policy capacity in government departments in Anglophone countries has emerged as a strong theme in both the scholarly and government literature (Bakvis, 2000; Brans & Vancoppenolle, 2005; Canadian Government, 1996; L. Edwards, 2009; Howlett,
This diminution in policy capacity has been linked to the introduction of the ‘New Public Management’ (NPM) reforms in public administration in the 1980s and 1990s in liberal democratic countries, such as, Australia, Canada, New Zealand and the United Kingdom; a shift in the state’s role from directly funding and providing services to a greater reliance on the open and de-regulated market. Briefly, the NPM reforms in these countries have led to increasing privatisation and corporatisation of services, downsizing and contracting-out of public sector services, switch in government’s role from providing to purchasing services, introduction of competitive tendering for services, and a greater emphasis on outputs-based and performance management.

Peters (2005), for example, argued that the introduction of the NPM reforms has had a significant impact on government in terms of the availability and selection of policy instruments and, as a result, the means available to government to influence the societies they govern. While Edwards (2009, p. 300) in examining policy capacity in an Australian rail transport study concluded there was empirical evidence to support the decline in policy capacity following the NPM reforms. Edwards (2009) found substantial structural barriers (lack of technical expertise; Commonwealth-state relations; involvement of private sector operators) now existed, and consequently the roles and functions performed by policy-makers had changed.

Whereas, Howlett & Lindquist (2007, p. 105) argue that changing forms of governance, emphasising ‘participatory and networked’ decision-making of multiple external players, has given rise to changing styles of decision-making. They argue that technical analytical capacity has declined in the Canadian public sector, as a result of a greater emphasis on participatory policy skills of facilitation, negotiation, or advocacy.

In addition, post the international financial crisis of 2008, reduced public sector expenditure in the United Kingdom (e.g. £80 billion decrease in UK Civil Service spending by 2015, and a 23% reduction in personnel from 2010 to 2015) as part of the Cameron Ministry’s ‘modernisation’ reforms (HM Government, 2012), and in some Australian jurisdictions (The Honourable J.J. Snelling MP Treasurer of South Australia, 9 June 2011; The Honourable Tim Nicholls MP Treasurer and Minister for Trade, 11 September 2012) has continued to have a severe impact on the strategic and operational
capacity of government authorities. Although too early to assess, these tighter fiscal management policies are likely to have significant implications on both the policy and operational capacity of government departments.

Therefore, it has been argued, (Colebatch, 2009; Peters, 1996) that the erosion of policy capacity may be evidenced by six outcomes of public sector reform, comprising loss of senior and experienced policy staff and technical specialisation (that is, technical policy analytical capacity); loss of experienced senior managers; outsourcing of information management systems and consequent lack of ready access; reduction in policy, planning and research functions; shift in locus of policy making from public to private and NGOs; growing importance of ‘horizontal dimension of policy making’; and increased politicisation of the public/civil service (technical policy analysis replaced by political ideology).

In contrast, some scholars, such as Davis (2000, pp. 231-235), argue that although policy capacity has altered as a result of NPM reforms it has not necessarily diminished, rather, he suggests, there has been a re-positioning of policy expertise away from government to external non-state actors (non-government organisations, academic institutions and think tanks, civil society), a shift in government priorities, and increased involvement of governments in some policy areas, including the environment and support for cultural activity. Janicke (1997) argues that we have seen the introduction of more skilful policy design and Peters (2005) asserts this has contributed to greater skill in policy instrument selection, both resulting in improved government policy capacity.

**INDIVIDUAL AND ORGANISATIONAL POLICY CAPACITY**

*Individual capacity*


The scholarly and government literature on individual policy capacity has focused on two broad areas: the type of individual competencies and expertise required for policy
practice; and skills improvement through professional development and training (see *Strengthening policy capacity* below).

In the context of individual competencies, Gleeson (2009, pp. 198-199), in her doctoral dissertation, identified three broad categories of individual competencies that contributed to good policy making, comprising ‘knowledge sets’, ‘skill sets’ and ‘personal attributes’. She concluded that individual policy practitioners did not have to possess all these competencies but it was desirable for policy teams to contain a mix of people with different knowledge and skill sets. Similarly, Scott & Baehler (2010) in ‘crafting’ good policy analysis and advice in the Australian and New Zealand context, referred to essential competencies (knowledge, skills and qualities) required by policy analysts, comprising research and analysis; stakeholder facilitation and engagement; understanding of the political and economic environment; knowledge of the public sector context; communication and interpersonal skills; administrative and managerial skills; and personal qualities of judgement, and creativity and innovation in policy design. This is consistent with Page & Jenkins (2005) findings, identifying the type of skills useful for carrying out policy work to include intellectual flexibility and the ability to pick up content on different subject areas, good interpersonal skills, use of networks to obtain information and advice, and knowledge of the policy process.

Furthermore, the UK Cabinet Office (1999) in *Professional policy making for the twenty first century* in developing a descriptive model for professional policy making in the Civil Service, identified nine ‘core’ individual competencies, comprising *forward looking; outward looking; innovative and creative; uses evidence; inclusive; joined up; evaluates; reviews; and learns lessons*. This strong focus on individual competencies by the UK Cabinet Office (n.d.) has continued with the recent introduction of a new *Civil Service Competency Framework 2012 – 2017*, focusing on desired core behaviours, experiences and skills required by Civil Service personnel in order to improve overall performance.

Likewise, in the Australian Public Service, the focus on core competencies at different levels of the Public Service was reflected in *Work Level Standards* (APSC, n.d.) that specifies the typical requirements (key functions and expected characteristics) for each classification for ensuring recruitment of appropriate skills and abilities, and for developing a high performance organisational culture.
Another way of understanding individual competencies is by examining the literature identifying the roles of policy workers, and the activities and styles of policy analysis as discussed by Mayer, van Daalen & Bots (2004) and Hoppe & Jeliazkova (2006). Mayer et al. (2004, pp. 173-183) identify six general policy analysis activities and styles based on policy practice in the Netherlands in developing a conceptual model of policy analyses. Refer to Table 4.

Table 4:  Policy practice in the Netherlands – Policy analysis activities and styles

<table>
<thead>
<tr>
<th>Activities of policy analysts</th>
<th>Policy analysis styles</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Research and analyse</td>
<td>i) Rational style</td>
</tr>
<tr>
<td>2. Design and recommend</td>
<td>ii) Argumentative style</td>
</tr>
<tr>
<td>3. Clarify arguments and values</td>
<td>iii) Client advice style</td>
</tr>
<tr>
<td>4. Provide strategic advice</td>
<td>iv) Participatory style</td>
</tr>
<tr>
<td>5. Democratise</td>
<td>v) Process style</td>
</tr>
<tr>
<td>6. Mediate</td>
<td>vi) Interactive style</td>
</tr>
</tbody>
</table>

These activities and styles interact in an archetypical manner and can be carried out either sequentially or separately, and or in a combined manner, depending on the policy situation, illustrated in the hexagon model presented by Mayer et al. (2004, p. 179).

Hoppe & Jeliazkova’s (2006) study of civil servants in the Netherlands identified five types of policy making roles and functions as perceived by ‘policy functionaries’. Refer to Table 5.

Table 5:  Policy making roles and functions in the Netherlands

<table>
<thead>
<tr>
<th>Types of policy worker</th>
<th>Roles (as perceived)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Process director</td>
<td>perceives themselves as steering, managing and monitoring</td>
</tr>
<tr>
<td>2. Policy philosopher</td>
<td>sees themselves as raising awareness of different positions and implications while maintaining a distance from politics</td>
</tr>
<tr>
<td>3. Policy advocate</td>
<td>promotes the interests and positions of the minister</td>
</tr>
<tr>
<td>4. Neo-Weberian</td>
<td>sees themselves as providing objective and value neutral advice, with a clear separation between politicians and civil servants</td>
</tr>
<tr>
<td>5. Expert adviser</td>
<td>perceives themselves as objective, ‘technocratic’ experts, as equal partners and advisers to politicians</td>
</tr>
</tbody>
</table>
The explication of policy workers roles and activities by Hoppe & Jeliazkova (2006) and Mayer et al. (2004) has influenced the work of other researchers in understanding the range of individual competencies required for conducting policy work.

Finally, the scholarly literature on individual competencies examines it from the perspective of ‘generalist’ or ‘specialist’ knowledge, skills and qualities required for policy work (Aucoin & Bakvis, 2005; Gleeson, 2009; Howlett, 2007; Howlett & Lindquist, 2004; Lindquist & Desveaux, 2007; Page & Jenkins, 2005). In the main, specialist expertise included technical and or subject specialisation to perform particular policy functions (e.g. economics, epidemiology, ethics, law) while generalist skills included workers with general educational backgrounds and broad subject experience capable of applying those skills to conducting policy work. Page & Jenkins (2005) in their UK study of middle-ranking policy civil servants reported that most policy workers purported to be ‘generalists’, with broad educational backgrounds rather than specific technical or subject knowledge expertise. They conclude this lack of subject specialisation and technical expertise, resulting from the UK civil service’s emphasis on movement between portfolios: “people passing through on their way to jobs in the higher civil service”, will have consequences for policy work in the long term (Page & Jenkins, 2005, p. 53).

The need for policy units to assemble a mix of skills and expertise to address complex issues in bureaucracies was also supported by Lindquist & Desveaux, (2007), Howlett & Lindquist (2007), and Tenbensel (2006). Tenbensel (2006) argues that ‘knowledge versatility’ (possessing different knowledge types: epistemic, practical-technical, and phronetic) was important for governmental policy workers in providing the skill set and flexibility to cover the breadth of policy work. Lindquist & Desveaux (2007, p. 124) identify ‘specialist expertise’ and ‘generalist expertise’ together with ‘rare talent’ as the kind of policy competencies required by policy units.

Organisational policy capacity
The scholarly literature on organisational policy capacity, in terms of the conditions of culture, structure and process for good policy making, is usually blended with individual policy capacity, with reference to human resource systems and practices, commenting on workforce issues and proposing strategies for recruiting and retaining policy talent and expertise, with reference to other human resources related issues like career pathways, an
ageing workforce and succession planning (Aucoin & Bakvis, 2005; Lindquist & Desveaux, 1998, 2007); and access to information, the ability to generate and or access quality information and evidence in a timely manner, which is recognised as an important condition for good policy making (Lindquist & Desveaux, 2007). In addition to accessing information, the application of information combined with the use of rigorous analytical techniques was also considered important for good policy making, with emphasis on methods like options analysis, forecasting and futures analysis, and cost benefit analysis (Scott & Baehler, 2010).

However, Gleeson’s (2009, pp. 201-202) empirical study on policy capacity emphasises the relationship between individual and organisational policy capacity. Gleeson, in her case study on building policy capacity in an Australian health authority, identified eight ‘domains’ of policy capacity and within each the ‘enablers’ and ‘barriers’ that either facilitated or impeded policy outcomes (utilising information and evidence; people management in relation to policy development; managing stakeholder relationships; managing intra-departmental, cross-portfolio and inter-governmental relationships; working between policy development and program management; policy evaluation and monitoring; managing the policy process; and leadership), with her findings and conclusions on organisational policy capacity complementing the detailed analysis on individual competencies for policy work.

A number of scholars have emphasised the need to strengthen the medium and long term policy analytical and research capabilities of the organisation (Page & Jenkins, 2005; Scott & Baehler, 2010; Voyer, 2007), which has either been depleted over the years and or is facing new policy making challenges, with the policy process opened to a wider array of stakeholders and faced with multifaceted and interconnected issues. Voyer (2007), for example, argues that the medium to longer term policy analytical capacity of the Canadian federal government needs to be strengthened by improving its research capabilities in terms of developing more forward looking policy; building connections to the external research community; and developing new tools to improve the analytical capacity of departments. Similarly, Scott & Baehler (2010) in advocating a systems approach for improving the quality of policy advice in Australian and New Zealand jurisdictions, proposed a range of rigorous strategies and techniques, appropriate to a given context, for ‘crafting’ high quality policy advice.
A number of international and national government reviews conducted on public administration and more specifically policy advising have utilised a multi-faceted approach to the public service’s capacity to improve the quality of policy advice and policy making (Bullock et al., 2001; Canadian Government, 1996; Manitoba Office of the Provincial Auditor, 2001; Ministry of Health, 2010; UK Cabinet Office, 1999).

These reviews have examined the capabilities of the organisation in a number of areas for modernising public administration and improving the quality of policy advice, including developing a long term and strategic approach; leadership and culture; promoting innovation, reflection and learning; promoting coordination and collaboration across government (‘whole of government’ and ‘joined-up’ approaches); developing relationships with external policy interests and networks; collecting and using evidence; managing human resources (recruitment; succession planning; career pathways); and professional training and development (program for individual development and learning).

In general, these government reviews have focused on the multi-dimensional nature of organisational policy capacity and the relationship to the provision of high quality policy advice and public administration.

**Measuring and Assessing Policy Capacity**

There is extensive debate in the literature about the difficulties inherent in evaluating policy outputs and outcomes in the absence of objective standards by which they can be measured (Bovens & ’t Hart, 1996; Di Francesco, 1999, 2000; L. Edwards, 2009; Uhr & Mackay, 1996). In the absence of agreed standards to measure policy advice, researchers generally have adopted one of three approaches, comprising assessing the quality of ‘outcomes’ of policy advice; measuring the volume of policy advice (the ‘outputs’); and assessing the ‘inputs’ into the policy development process.

For instance, in assessing the impact of public management reforms on declining rail policy capacity in Australia in the 1990s, Edwards (2009) used the third approach, assessing ‘inputs’ into the policy development process. Edwards constructed a definition of ‘quality’ based on practitioners’ understandings and perceptions of the term. From this perspective, she concluded that high quality policy should contain four essential features, comprising strategic and long term; informed by practicalities of
implementation; coherent and with a whole-of-government attribute; and responsive to the elected government’s agenda. While Edwards’ (2009, pp. 291-292) policy capacity inputs were composed of five interrelated components, comprising department’s role; policy network environment in relation to other players involved in the policy process; human inputs – the number of people involved in policy work, educational backgrounds, career experience and skills; information inputs – the range and quality of the data available to inform the decision-making process; and policy levers – the available policy levers that shape or limit the potential policy options and outcomes.

As Edwards noted, the focus of her research is on inputs, there is, however, limited empirical research in assessing policy capacity and the quality of policy advice from the perspective of outputs, outcomes and impacts. In contrast, Polidano (2000, p. 819) attempted to construct an index for measuring public sector capacity in terms of the elements of policy capacity, implementation authority, and operational efficiency as well as the key socio-political and economic factors that exert an influence on policy capacity. Data selected for inclusion in the index were required to meet a number of criteria, comprising data availability and reliability, technical competence in providing policy advice, and political impact on policy continuity. Polidano intended that the development of a country-specific index would enable the assessment and comparison of public sector capacity across countries.

The Australian Public Service (APS) and New Zealand Public Service (NZPS) have attempted to assess the quality of policy advice in their respective public administrations. In the mid-1990s, the Australian Public Service acknowledged the problems associated with managing policy advice, and as a result adopted the Policy Management Reviews (PMR) methodology to evaluate the quality of policy advice. This involved external evaluators conducting an internal qualitative assessment of each government department’s management of the policy process and provision of policy advice.

Di Francesco (2000) on applying the PMR methodology identified a number of concerns, comprising methodological issues relating to assessing impact and indicators to measure success and or failure; orientation of research that focused on process rather than outputs and outcomes; increased central agencies control of policy processes; and review findings not applied.
In New Zealand, the Public Service introduced the *Performance Management Framework* to assess policy advice, focusing on a number of criteria, comprising purpose, logic, accuracy, options, consultation, practicality, and presentation. Ministers were asked every three months to indicate their level of satisfaction with the Secretary’s performance against the criteria. A shortcoming of the approach was a shift in focus from evaluating the quality of policy advice to focusing on appraising the performance of the permanent head of the department.

In light of the above, measuring quality of policy advice in the public sector is difficult:

What is to be measured? (process, outputs, outcomes)
How is it to be measured?
How to attribute responsibility within a changing framework of accountability?

Moreover, a key obstacle to measuring the quality of policy advice has been to reconcile the inherently political nature of the policy advisory process with the need to perform high quality policy work.

**STRENGTHENING POLICY CAPACITY**

*The stronger the policy capacity, the greater the potential for good decision-making and ultimately, good government.* (Manitoba Office of the Provincial Auditor, 2001, p. 3)

A significant component of the literature on strengthening generic and policy capacity has been conducted by government and government-commissioned authorities and as such this study has focused on this body of work. Moreover, the themes of this literature are consistent with the focus of this study on the practical aspects of policy making and the requirement of good inputs and process in order to lead to quality policy outputs and outcomes.

Major reviews conducted in the United Kingdom, New Zealand, Canada and Australia during the 1990s and early 2000s focused on examining the quality of policy advice in government and non-government organisations. These major reviews were largely audits of existing policy capacity levels, concluding with a recommended list of strategies and actions in order to strengthen policy capacity across government departments (Advisory Group on Reform of Australian Government Administration, 2010; Australian National

The proposed strategies and interventions were usually multifaceted in nature, covering the further development of both individual and organisational policy capacity in order to improve the quality of policy advice provided by government departments.

The recommended strategies for ‘leadership and culture’ comprised embedding a strategic vision and direction into organisational culture; and providing leadership training and development, focusing on policy (knowledgeable about the policy process, understanding of policy context, skilled in producing high quality policy outputs, etc.)

The recommended strategies for ‘infrastructure’ comprised establishing inter-departmental and inter-agency policy structures (policy forums); re-structuring to incorporate policy and planning functions; establishing implementation units (Australia and UK); and adequate resources and supports to conduct policy.

The recommended strategies for ‘capability and human resources’ comprised developing policy-specific skills in engaging stakeholders, working collaboratively, collecting and using information and research; providing professional training and development opportunities to improve individual knowledge and skills (e.g. mentoring, rotations/secondments, short policy courses, experiential learning options); and providing effective management of policy-specific human resources (e.g. assembling mix of policy skills, recruitment, succession planning, career pathways).

The recommended strategies for ‘processes and tools’ comprised developing guidelines, tool kits, checklists and protocols for developing policy.

The recommended strategies for ‘evaluate and monitor’ comprised conducting audits of policies and programs; and conducting policy/program reviews.

The conclusions in these international and national government reports are consistent in terms of the proposed strategies, interventions and checklists for strengthening policy capacity. What is unclear from these government reports is whether these strategies and
interventions have been implemented and subsequently monitored and evaluated in terms of achievement of stated objectives.

**Policy Leadership**

> Without leadership, an organization is nothing more than unorganized people, under-utilized resources, and unrealized objectives. Leadership converts the insights of analysis and the capabilities of an organization into policy results. Analysis and organization matter. But when it comes to producing results, it is leadership that counts. (Behn, 1989, p. 494)

**Generic leadership**

Generic leadership, has been studied from the perspective of different academic disciplines, including political science, psychology, sociology, business management, and public administration; and from a variety of perspectives, including leadership styles (Alimo-Metcalfe & Alban-Metcalfe, 2004; Behn, 1989); leader attributes and behaviours (Burns, 1978; Daft, 2010); leader-follower relationships; leadership competencies (Van Wart, 2005); and leadership development (Morse, Buss, & Kinghorn, 2007; Yukl, 2002). Different leadership styles are frequently addressed from the perspective of either transformational change and or routine and transactional management (Bass, 1990; Burns, 1978). More recently, the focus in the leadership literature has been on ‘shared’ and ‘distributed’ approaches to leadership; recognising the capabilities and influence of many leaders beyond the role of an individual ‘heroic’ leader. This leadership paradigm emphases shared responsibilities involving a network of leaders, individual empowerment, collaborative practices, and collective learning (Baker, 2011; Bennett, Wise, Woods, & Harvey, 2003; Bolden, 2011; Conger & Pearce, 2003; Fletcher, 2004; Fletcher & Kaeufer, 2003; Pearce & Sims, 2000; Senge, 2006; Senge & Kaeufer, 2001; Spillane, 2006; Spillane, Halverson, & Diamond, 2001; Uhl-Bien, 2006).

**Leadership in the public sector**

Public sector leadership, (’t Hart & Uhr, 2008b) has been studied from the perspective of the differences in leadership between the public and private sectors as a result of different philosophical perspectives and strategic objectives. As Currie, Humphreys, Ucbasaran and McManus (2008) point out, the aim of public organisations is to create public rather than private goods; while Christensen et al. (2007) note that public sector organisations are accountable to democratically elected political leaders, facing greater public scrutiny with, at times, unclear and conflicting goals, creating a more difficult
environment for public sector leaders. In the Australian context, this is confirmed by Podger’s (2009, pp. xi-xii) account of the demands on a senior public servant by detailing the breadth of responsibilities, close relationship between department head, Minister and ministerial staff, ongoing scrutiny from and potential for exposure by Cabinet, multiple stakeholders, media and public, and the increasing complexity of governance.

The research in public leadership has focused on an ethical dimension of leadership, with qualities like commitment to democratic values, stewardship of resources, and civic responsibility (Rusaw, 2001; Springer, 2007); and capabilities and functions, identifying important public sector leadership competencies (T. Christensen et al., 2007; Currie et al., 2008). Edwards et al. (2003, p. 34), for example, identified the ability to think strategically, motivate staff to share the organisation’s vision, understand the requirements of implementation, and ability to manage interpersonal and inter-agency relationships. Certain themes in leadership have also be examined, including leadership collaboration (Morse et al., 2007; OECD, 2001), and political leadership (Van Wart, 2003); and collective learning-focused leadership, (Dunoon, 2002; Korac-Kakabadse & Korac-Kakabadse, 1998); and leadership development (2009, p. 67).

Leadership in Health – general
Leadership in Health, (Alimo-Metcalfe & Lawler, 2001; Baker, 2011; Fawkes, 2012; Hannaway, Plsek, & Hunter, 2007; Hunter, 2007a, 2009; Plsek, 2001; The King’s Fund, 2011) has been studied in particular from the perspective of leadership and management in clinical, health promotion and administrative health settings. Plsek and Wilson (2001, p. 749), argue that the science of ‘complex adaptive systems’ provides a fresh perspective for addressing the issues confronting management in the health system, whereby adopting a ‘complex adaptive systems’ approach to managing healthcare organisations would give more attention to relationships with staff and stakeholders, positive use of ‘attractors’ to encourage change, and a constructive approach to variation in areas of practice, and with less attention directed to detailed targets and specifications, and a focus on ‘controlling the process’. While Hunter (2009, p. 203) argues for a new public health leadership paradigm also based on a ‘complex adaptive systems’ approach to address a perceived ‘leadership vacuum’ in managing complex health problems. The emphasis on leadership is reinforced in de Savigny & Adam’s (2009) report prepared for the WHO, Systems thinking for health systems strengthening, which identified
leadership and governance as a core element, a ‘health system building block’, underpinning a ‘systems’ approach to achieving effective health outcomes. In the UK, the NHS (Baker, 2011; Hartley & Benington, 2011; James, 2011; Roebuck, 2011; The King’s Fund, 2011, 2012) has given considerable prominence to the notion of strong leadership and management, focusing on ‘shared and distributed’ rather than traditional ‘command and control’ style leadership approaches in ensuring health system performance improvements.

**Leadership in Health - policy environments**

There is very limited empirical and theoretical research on leadership in health policy making environments (Gleeson, 2009; Gleeson, Legge, O’Neill, & Pfeffer, 2011). Gleeson (2009) identified ‘policy leadership’ as a key domain in building organisational policy capacity; further distinguishing it from ‘generic’ public administration leadership. Gleeson maintained that policy leadership in a health authority involved specific features of local level judgment, mentorship, initiative and responsibility, and the ability to mobilise organizational resources to build policy capacity; concluding with the proposition that developing senior and middle and level policy leadership was a strategic approach to strengthening organisational policy capacity.

### 2.4 Key Findings from the Literature Review

**The need for a conceptual framework**

The literature was examined with two objectives. The first was to gain an understanding of the theory underpinning policy, policy process and policy capacity: *policy* in terms of the definitions and interpretations of policy, public policy, and health policy specifically; *policy process* in terms of broad activities and functions; and as theories, models and frameworks; and *policy capacity* in terms of the definitions and interpretations of policy capacity and themes comprising declining policy capacity, individual and organisational policy capacity, measuring and assessing policy capacity, strengthening policy capacity, and policy leadership.

This study identifies a number of limitations in approach to the study of policy making from the review of the literature on policy, policy capacity and policy process, in that the literature focuses on the policy elements of capacity and process and investigates each element separately rather than in an holistic and integrated manner; there is limited attention paid to the policy elements of outputs and outcomes although relationships with
the elements of policy capacity and process are frequently implied; there is minimal reference in the policy capacity literature to the element of review and monitor whereas it is frequently specified as a key activity and function in the policy process literature; there is an acknowledgement of the influence of the external socio-political environment on policy capacity and policy process but only by association, and less explicitly stated, on policy outputs and outcomes; and few authors examined the work of policy from an integrated and coherent perspective acknowledging the interrelationships between the individual elements of policy capacity, process, outputs, outcomes and policy review and monitor; and the interaction and influence of the wider socio-political environment with these elements.

An examination of policy work that does not consider all policy elements in an integrated and coherent way risks not recognising the interdependencies of policy process, policy capacity, policy review and monitor, policy leadership and the external socio-political environment; and the influence each element has on the others in terms of achieving good policy outcomes.

The second objective of the literature review was to develop a conceptual framework for application to the analysis of the research data obtained from the focus group discussions and individual interviews.

The findings of the literature review confirm that a conceptual framework is required that interprets policy work in the context of a ‘policy system’: that policy work has a cyclical rather than linear and sequential nature; that the elements of policy capacity, process, review and monitor, and the external socio-political environment are interrelated elements; that both the external socio-political environment and policy leadership have a significant influence on the individual elements and their relationships; and that the role of policy review and monitor is important as a feedback mechanism that ensures modification and improvement of policy work.

**Applying systems thinking to health**

A system is defined as the interconnections and relationships between the elements or parts, the organisation of these elements to achieve some purpose, and the capacity of the system to respond, adapt and even evolve in the face of external forces. In this context,
“A system is more than the sum of its parts. It may exhibit adaptive, dynamic, goal-seeking, self-preserving, and sometimes evolutionary behaviour” (Wright, 2008, p. 12).

In the field of health, the US Institute of Medicine (Plsek, 2001) in Crossing the Quality Chasm: A New Health System for the 21st Century defined a system in the following way:

A ‘system’ can be defined by the coming together of parts, interconnections, and purpose [...] While systems can be broken down into parts which are interesting in and of themselves, the real power lies in the way the parts come together and are interconnected to fulfil some purpose. (Plsek, 2001, p. 309)

The concept of a systems approach has also become fundamental in the broad fields of health care and public health, including health promotion, program evaluation, and health services research (Butland et al., 2007; Golden & Martin, 2004; Mabry, Marcus, Clark, Leischow, & Mendez, 2010; Mabry, Olster, Morgan, & Abrams, 2008; National Cancer Institute, 2007; Plsek, 2001; Shiell, 2008). In 1966, Donabedian, developed a conceptual model that provided a framework for examining health systems and evaluating quality of care, in terms of the concepts of ‘structure’, ‘process’, and ‘outcomes’. In short, a systems approach, and, the Donabedian Model, according to Frenk (2000), continues to be the dominant paradigm for assessing the quality of health care.

Plsek (2001), amongst others, viewed the health care system as a ‘complex adaptive system’ composed of numerous interrelated microsystems that respond in unpredictable ways, adapting to their environment and resulting in ‘emergent’ behaviour. As such, Plsek argues that most health care system issues in the 21st century lie in the ‘zone of complexity’, with only minimum levels of certainty and agreement. From this and other accounts, the health care system is truly a complex adaptive system.

More recently, WHO (de Savigny & Adam, 2009, pp. 40-42), has advocated a ‘systems’ approach that provides a better understanding of the complexities of the health system, and the application of this knowledge to strengthening health system performance, with the intention of achieving improved population health outcomes. The key characteristics of this ‘systems’ approach to health care is presented in Table 6.
Table 6: World Health Organization – Key characteristics of a systems approach to health care

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Self-organizing</td>
<td>System dynamics arise spontaneously from internal structure. No individual agent or element determines the nature of the system – the organisation of the system arises through the dynamic interaction among the systems agents, and through the systems interaction with other systems.</td>
</tr>
<tr>
<td>2. Constantly changing</td>
<td>Systems adjust and readjust at many iterative time scales.</td>
</tr>
<tr>
<td>3. Tightly linked</td>
<td>The high degree of connectivity means that change in one sub-system affects the others.</td>
</tr>
<tr>
<td>4. Governed by feedback</td>
<td>A positive or negative response that may alter the intervention or expected effects.</td>
</tr>
<tr>
<td>5. Non-linearity</td>
<td>Relationships within a system cannot be arranged along a simple input-output line.</td>
</tr>
<tr>
<td>6. History-dependent</td>
<td>Short-term effects of intervening may differ from long-term effects.</td>
</tr>
<tr>
<td>7. Counter-intuitive</td>
<td>Cause and effect are often distant in time and space, defying solutions that pit causes close to the effect they seek to address.</td>
</tr>
<tr>
<td>8. Resistant to change</td>
<td>Seemingly obvious solutions may fail or worsen the situation.</td>
</tr>
</tbody>
</table>

**Designing a conceptual framework**

A conceptual framework must reflect the complex and dynamic relationships between policy capacity, process, outputs and outcomes as well as their interactions with external social and political factors.

The proposed conceptual framework comprises six elements: external influences; policy capacity; policy process; policy outputs; policy outcomes; and policy review and monitor.

**EXTERNAL INFLUENCES**

External influences are conceived as any external factors that interact with policy capacity, process, outputs and outcomes, including government structures and processes (legislative, policy and financing arrangements of the health system), political parties, electoral cycles, community expectations, stakeholders in the health and government sectors, and status of the economy.
These external influences interact directly with policy capacity, process and outputs and impact on health policy outcomes, as reflected in the framing of policy options and recommendations, designing and subsequent implementation of programs and services, managing stakeholder interests, and allocating resources.

**Policy Capacity**

Policy capacity is conceived as the inputs of policy work: *capabilities*, referring to an organisation’s human resource capabilities in terms of individual knowledge, skills and expertise, including leadership roles and capabilities, underpinned by policy-specific training and professional development; and *infrastructure*, referring to an organisation’s structures, systems, processes and material resources that are important in supporting the work of policy (information systems, human resources management systems, financial systems and resources, equipment and supports, protocols and guidelines for policy making, and programs of training and development).

Policy capacity expressed in terms of leadership and individual capabilities combined with available organisational infrastructure directly influences the policy process, subsequently, affecting policy outputs and outcomes.

**Policy Process**

Policy process is conceived as the activities to achieve particular policy outputs and outcomes, comprising collecting, analysing and applying information and intelligence; engaging and managing stakeholders; coordinating and collaborating within the department, and across portfolios and governments; authorising policy; implementing policy; monitoring and evaluating policy; and preparing written documentation.

Managing multiple activities that encompass the policy process is directly related to and is influenced by the element of policy capacity, and the interrelationship of the two elements in turn influence policy outputs and outcomes. In addition, the policy process together with the element of policy capacity interact with and are influenced by the external social, economic and political environment to impact on policy outputs and outcomes.
POLICY OUTPUTS
Policy outputs are conceived as the product of a set of decisions and actions that lead to tangible results comprising a law or statement of intent.

To be effective, policy needs to be coherent, robust and sustainable, and capable of problem resolution and implementation. Further, an effective policy requires the support of principal stakeholders and the wider community. The quality and effectiveness of policy outputs are therefore influenced by the organisation’s policy capacity (i.e. leadership, individual competencies and infrastructure) and policy processes as well as its interaction with the external socio-political environment, stakeholder interests, and community norms and expectations.

POLICY OUTCOMES
Policy outcomes are conceived as the consequences or impacts of an implemented health policy on society in terms of improved population health and well-being and health system performance.

Good policy outcomes, for instance, include improvements in individual and or population health status, quality of patient care, and efficient clinical practice. In addition, there should be improvements to the overall performance of the health system and the health authority. The quality and effectiveness of policy outcomes are a response to the interaction of and relationship between policy capacity, process and outputs in combination with the impact of the external political, economic and social environment together with health/government sector stakeholder interests and community expectations.

POLICY REVIEW AND MONITOR
Policy review and monitor is conceived as an integral process of reflection, learning and feedback in which policies are monitored and reviewed in order to improve the design, development and implementation of policy through changes in policy capacity and or policy process to ensure that policy remains relevant and effective in a changing policy environment.

This study argues that policy work is not a straightforward and sequential activity rather it is a complex and changeable process. Therefore, the conceptual framework is an
idealised view of policy work, a “mental map”, heuristic in nature, with the possibility for further refinement and development. The conceptual framework systematises the relationship between policy capacity, process, outputs and outcomes and its interactions with the external political, economic and social environment; and incorporates the element of review and monitor, acknowledging the importance of feedback and the cyclical nature of policy work. The conceptual framework provides a different way of thinking and asking questions about health policy, now and into the future; and as a result offers a way of explaining health policy for purposes of teaching, training and development, practice and action research.

A diagrammatic representation of the conceptual framework is presented at Figure 1.
Figure 1: Research model – A systems approach to health policy

EXTERNAL INFLUENCES
- Political, economic and social structures and systems
- Health system
- Participants/stakeholders: health sector and government agencies
- Public needs and expectations

Policy Capacity
- CAPABILITIES
  - Leadership and management
  - Individual competencies
  - Policy-specific training and development

Policy Process
- MANAGING THE PROCESS
  - Consult stakeholders
  - Collect and analyse information and evidence
  - Negotiate and promote
  - Draft and write policy
  - Seek approval and authorisation
  - Implement policy

Policy Outputs
- POLICY
  - Intelligent and coherent
  - Robust and sustainable
  - Capable of solving problems
  - Capable of implementation
  - Community/stakeholder support

Policy Outcomes
- OUTCOMES
  - Improved population health and wellbeing
  - Improved health system performance
  - Sustained development of health system
  - Organisational development and learning

ACT  QLD  SA

REVIEW & MONITOR
- Revise and improve
2.5 Conclusion

In conclusion, the literature review establishes that the approach to the study of policy practice comprises either the examination of particular aspects of policy work or the advancement of various themes, frameworks and theories to explain policy work but is limited in its applicability to this study in terms of providing a conceptual framework for the analysis of the research data.

The literature investigates policy process and capacity separately rather than in an holistic and integrated manner; pays limited attention to policy outputs and outcomes although relationships with the elements of policy capacity and process are frequently implied; makes only minimal reference of review and monitor in the policy capacity literature although frequently specified as a key activity and function in the policy process literature; acknowledges only indirectly the influence of the external socio-political environment on policy capacity and policy process and even less explicitly stated, on policy outputs and outcomes. With few exceptions, only limited attention is paid to the work of policy from an integrated and coherent perspective acknowledging the interrelationships between the individual elements of policy capacity, process, outputs, outcomes and review and monitor; and the interaction and influence of the wider socio-political environment with these elements.

The Australian health care system is complex and dynamic, reflected in the multi-dimensional and multi-sectoral nature of health policy; and influenced by increasing globalisation, federalist system of government, pluralist health system, powerful professional interests, multiple stakeholders, and changing community expectations.

Accordingly, this study proposes a conceptual framework based on a ‘systems approach’ that provides the most appropriate ‘lens’ for viewing the work of health policy which acknowledges the complexity, uncertainty and unpredictability of the health system in terms of social, economic and political challenges such as the interconnected and multi-dimensional nature of health problems and issues, with no clear-cut solutions; the participation of multiple and competing stakeholders in shaping health policy; and the health system’s need for capacity to respond and adapt in a timely manner. The conceptual framework informs the scope and direction of the analysis of findings (Chapters 5, 6 and 7); and the discussion of findings in the context of the reviewed literature and the conclusions (Chapter 8) of this study.
In the next chapter (Chapter 3), the socioeconomic and political context for health policy work in the three jurisdictions is examined in conjunction with the structure and organisation of policy work in the three health authorities.
CHAPTER 3 THREE AUSTRALIAN HEALTH AUTHORITIES: THE SETTING FOR POLICY WORK

3.0 INTRODUCTION

The purpose of Chapter 3 is to describe the context for health policy work by presenting an overview of the main demographic, geographic, socioeconomic, political and health administration features of each of the three jurisdictions; and the structure and organisation of policy work in the three health authorities.

In terms of the research aim, establishing the context for health policy work in each jurisdiction contributes to an understanding of whether context influences the work of policy in terms of capacity and process resulting in a different policy making experience for policy workers as a consequence of the way in which the health authorities have adapted to the different environments in which they work.

Details are provided for each jurisdiction in terms of population, physical size, geography and political structures; each health authority in terms of historical development, organisational structures, strategic directions, major administrative reforms, and operational features of staffing and budgets; and the organisation and conduct of policy work in each health authority (organisational arrangements, staffing, systems and processes, training and development, management, and policy issues of concern).

The data for this chapter were obtained from several sources, including introductory visits, published reports and books, and websites of government and health departments of each jurisdiction. As government organisations are subject to change, the information used in this chapter was current as at the research ‘cut-off’ date (Refer to section 1.6).

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6 The information used in this chapter was current as at 2010/2011.
7 An objective of the ARC Linkage project was to investigate how the context for policy making might influence the work of policy in a health policy environment and whether differences in organisation and process in the health authorities in the Australian Capital Territory, Queensland and South Australia might result in a different policy making experience for policy workers; and to apply the findings in the design and implementation of policy capacity building interventions.
8 Refer to Chapter 4: Research Design for details.
3.1 Overview of Three Australian Jurisdictions

Australian Capital Territory
The Australian Capital Territory is situated in the south east corner of New South Wales with a population of 334,200 (2006) and an area of 2,358 square kilometres. It has the highest population density of 141.7 people per square kilometre, with the population concentrated in the nation’s capital Canberra (Australian Bureau of Statistics, 2007).

The Australian Capital Territory has a number of distinctive socioeconomic characteristics: a large proportion of the population with a high level of educational attainment (ABS, 2008b), a significant proportion of the workforce employed in Government Administration and Defence (Department of Education Employment and Workplace Relations, undated), a high proportion of employed persons per household and high levels of mean disposable household weekly income (ABS, 2009b). As the nation’s capital, Canberra is the seat of Federal Parliament and home to numerous embassies, and international and national institutions.

Queensland
Queensland is a sovereign state with a preliminary estimated resident population of 4,406,800 million (June 2009), comprising approximately 20% of the total Australian population, making it the third most populous state (ABS, 2010). Queensland is a rapidly growing state, and recorded an annual average growth of 2.6% between 2006 and 2009 (ABS, 2009a).

Located in the north-east of Australia, Queensland shares borders to the south with New South Wales, south-west with South Australia and west with the Northern Territory. The State covers an area of 1,730,648 million square kilometres, comprising nearly 25% of the total Australian mainland mass, making it the second largest state in Australia behind Western Australia. Brisbane, the capital city, has the largest concentration of population; with the remaining population largely dispersed into regional cities and towns along the eastern coast, such as Bundaberg, Rockhampton, Mackay, Townsville and Cairns.

South Australia
South Australia is a sovereign state, with a preliminary estimated resident population of 1,622,712 (September 2009), comprising 7.4% of the total Australian population (ABS, 2009a).
South Australia is located in the southern central part of Australia. The state covers an area of 985,335 square kilometres, comprising 12.8% of the total Australian mainland mass. Adelaide, the capital city, has almost three-quarters of the South Australian population; with the remaining population dispersed along the south-eastern coastal areas and the River Murray.

Refer to Section 3.4 identifying the distinctive demographic, geographic, and socioeconomic features of the three jurisdictions (Table 10).

**Political structures**

**FEDERAL SYSTEM OF GOVERNMENT**

Australia has a federal system of government comprising a national government, and the governments of the six states and two territories (ABS, 2008a).

In a federal system, “sovereignty is shared and powers divided between two or more levels of government each of which enjoys a direct relationship with the people.” (Hueglin & Fenna, 2006, pp. 32-33).

The Australian Constitution establishes the legal framework that sets out the division of powers and responsibilities between the federal and state governments. The Constitution protects the autonomy of the states while ceding particular and limited powers to the Commonwealth. However, a Commonwealth ‘paramountcy clause’ (section 109) exists under the Australian Constitution that specifies in the likelihood of conflict between Commonwealth and State legislation the former prevails to the extent of the inconsistency (Fenna, 2004).

Therefore, the distributed powers and responsibilities between Commonwealth and state and territory governments of a federal system provide the context for the financing, coordination and delivery of programs and services in the Australian health system as well as forming a competitive environment within which Commonwealth and state and territory policy development and implementation occurs.

Refer to Section 3.4 identifying the distinctive political features of the three jurisdictions (Table 11).
3.2 The Three Health Authorities

In this section is presented a brief description of each jurisdiction’s health authority in terms of organisational structures and processes, roles and responsibilities, and major administrative reforms of relevance to policy work.

ACT Health

ACT Health is the largest government department in the Australian Capital Territory, with approximately 5,594 FTE employees (excluding Calvary Hospital) and an annual net cost of services budget of $767.1 million in 2009-10 (ACT Health, 2010). Health spending currently accounts for around 30% of total ACT Government expenditure, with an annual estimated growth of 8% (Hawke, 2011, p. 48).

ACT Health has responsibility for promoting, protecting and maintaining the health and well-being of the population by delivering a wide range of health and related services, including hospitals, mental health services, primary health, public health, health promotion, aged care and rehabilitation, cancer services, drug treatment, dental health and women’s health services.

ACT Health has undergone significant administrative reforms since the late 1990's. In October 2000, a number of human services functions and departments were combined to form the Department of Health, Housing and Community Care. Two years later, in June 2002, the ACT health system was restructured with the creation of two separate departments: Department of Health and Department of Disability, Housing and Community Services. In this major restructure, several functions, including disability and therapy services, were transferred from Health to Disability, Housing and Community Services. The Department of Health with slight internal reconfiguration has remained in this form until the present day. However, ACT Health may experience reorganisation and reform in the near future with the Hawke review of ACT government services, proposing the establishment of ‘a single, unified ACT public service organisation’ to coordinate and align public sector effort (Hawke, 2011, p. 4).

Currently, ACT Health has a centralised administration with the Director-General responsible for the management and administration of both clinical and strategic and

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9 In acknowledgement of the frequency with which health authorities undergo organisational change, no reference material on health authority ‘organisational structures’ has been utilised later than 2010/2011.
corporate functions. These functions are divided between two Deputy Directors-General: one, responsible for clinical services (The Canberra Hospital, Mental Health, Justice Health and Alcohol & Drug Service, Capital Region Cancer Service, and Rehabilitation, Aged & Community Care); the other, responsible for strategic and corporate functions (ACT Health, August 2011).

Queensland Health

Queensland Health is a large government department, with approximately 60,000 FTE employees and an annual operating budget of approximately $9.552 billion in 2009-10 (Queensland Health, 2010). Health accounted for the largest proportion (25%) of General Government sector expenditure in the 2010-11 state budget (Queensland Government, 2010).

Queensland Health has responsibility for planning, delivering and funding a range of health and community services including acute care, ambulatory care, primary health, integrated mental health, public health, extended care and rehabilitation, and illness prevention and health promotion programs. The department is the principal provider of health services in Queensland and the only health service provider in some rural and remote areas (Queensland Health, 2010).

Between the 1990s and 2005, Queensland Health experienced a number of significant administrative reforms, including the abolition of independent hospital boards with the introduction of regional health authorities. These Regional Health Authorities were given autonomy over budgets and responsibility for planning and administering hospitals and health services. Subsequently, regional health authorities were replaced by health service districts and zones. In 2005 two Royal Commissions (Morris, 2005), (Davies, 2005) were established to examine alleged surgical malpractices at the Bundaberg Hospital and concurrently an independent review of Queensland Health’s systems was also undertaken (Forster, 2005b). The Forster Review (2005a) and Morris (2005) and Davies (2005) Royal Commissions had far reaching implications for the management, organisation and funding of the Queensland health system, with the introduction of major administrative, workforce and systems changes. At Queensland Health, some of the major reforms included: a restructuring of the Central Office, significant reduction in the size of the corporate workforce, introduction of three new Area Health Services and
Clinical Networks, and a major focus on quality improvements in service delivery and staff training and development.

In 2008, Queensland Health consolidated the number of Health Service Districts and abolished Area Health Services but retained Clinical Networks (Queensland Health, 2009b). Queensland Health is organised into eight administrative divisions, each managed by a chief executive officer/deputy director-general, reporting directly to the Director-General. Administration in Queensland Health is decentralised into 16 Health Service Districts, each managed by a chief executive officer reporting directly to an Executive Director. Health Service Districts have delegated responsibility for administering, planning and coordinating programs and services in their area, including funding and supervising contracts, and providing an interface with health services and community organisations.

**South Australia Health**

SA Health is a large government department, with approximately 1,273.2 FTE employees with an annual net cost services budget of $3.6 billion in 2009-10 (Government of South Australia SA Health, 2010). And, in 2010-11 SA Health accounted for the largest proportion of state government expenditure, approximately 29 per cent (Government of South Australia, 2010).

SA Health has responsibility for planning, delivering and purchasing/funding public hospitals, metropolitan and country health services, primary health, public health, Aboriginal health, extended care and rehabilitation, cancer and palliative care, and illness prevention and health promotion programs. The Chief Executive, SA Health also has responsibility for mental health and alcohol and other drug treatment services, reporting directly to the Minister for Mental Health and Substance Abuse, a new portfolio created in February 2009 (Government of South Australia SA Health, 2010).

SA has undergone significant administrative reforms since the mid-1970s: in 1977, a Health Commission was established combining the separate departments of Hospitals, Mental Health and Public Health; authority was devolved to Sectors in 1981 and then to Regions in 1996; in 1997, three separate departments were amalgamated into a mega-department of Human Services. This was followed in 2003 by The Generational Health Review (Menadue, 2003), which reviewed the health system, including the interface with
the private and non-government sectors, governance arrangements, and the extent of community and clinician involvement in the decision making process.

As a result of the Menadue Review, substantial reforms were introduced to the state’s health services, comprising the formation of three new health regions, with boards of management and responsibility for coordinating regional health services; merging of rural regions into a single entity, Country Health SA; the disaggregation of the mega-Department of Human Services into two smaller departments - Department of Health, and Department of Community Services and Housing; the proclamation of new Health Care and Mental Health legislation in 2007-2008, abolishing hospitals and health services’ boards of management, and replacing them with governance arrangements directly accountable to the department of health; and the introduction of new advisory structures supporting community and clinical participation in service planning.

SA Health is organised into ten Divisions, each managed by an Executive Director/Chief Information Officer, reporting to the Chief Executive. Administration in SA Health is regionalised, with authority delegated to five regions/programs: Central Northern Adelaide Health Service, Southern Adelaide Health Service, Country Health SA, Children, Youth and Women’s Health Service and SA Ambulance Service. The regions/programs are responsible for planning, coordinating and administering health services in either a defined geographical area as is the case of a region or for the state as is the case of a program. All regions and programs report directly to the Chief Executive, SA Health.

3.3 Policy Work in the Three Health Authorities

This section presents an overview of policy work in each of the three health authorities and investigates how policy work is organised, the educational backgrounds of policy workers, and the structure and processes in place to support policy work.

ACT Health

Organisation of Policy Work

Policy work in ACT Health is dispersed across the department, undertaken by a number of divisions and units, including Policy & Government Relations, Professional Leadership, Research & Education, Service & Capital Planning, Performance &
Innovation, Business & Infrastructure, Population Health, Quality & Safety, and Canberra Hospital and Health Services. In addition, The Canberra Hospital and other health services play a key role in the development and implementation of clinical and operational policy. That is, within this structure there are two streams of policy: strategic/corporate and clinical/operational policy.

The Policy and Government Relations Division (ACT Health, 2009a) is organised into eight units comprising Aboriginal and Torres Strait Islander, Aged and community care, Alcohol and other drug, Community and health, Mental health, Primary health care, NGO funding; and Government relations. The Division has responsibility for providing advice to ACT Health and the ACT Government on strategic national and territory health policy in the areas of indigenous health, aged and community care, primary health care, alcohol and other drug, mental health; and for leading the policy development process for policies in tiers 1-3 (ACT Health, 2009b), with input from other divisions, government departments, non-government and private organisations as well as professional and community interests. The Division also has responsibility for negotiating with funding bodies and service providers and managers service agreements with the non-government and government sectors.

STAFFING BACKGROUND
The Policy and Government Relations Division employs approximately 50 staff, with a mix of strategic, operational and clinical policy skills. The division has staff with broad educational backgrounds in humanities, science, economics, law, business management as well as staff drawn from a variety of clinical backgrounds such as nursing, medicine, and allied health. Senior managers in ACT Health reported a preference for recruiting staff with general educational backgrounds because of the variety of policy topics covered.

STRUCTURES AND PROCESSES OF POLICY WORK
ACT Health has a standardised approach for developing corporate and clinical policy that is underpinned by a number of structures and processes comprising a classification system for policy work (tiers), a policy register, a policy management framework, governance structures (Policy Advisory Committee), and templates, guidelines and tools.
Classification system for policy work

Policy work in ACT Health has been classified according to six tiers. Tiers one to three are the responsibility of the Policy & Government Relations Division and Population Health Division whereas tiers four to six are the responsibility of relevant program and clinical areas. Refer to Table 7.

Table 7: ACT Health – Classification system for policy work

<table>
<thead>
<tr>
<th>Tier</th>
<th>Scope</th>
<th>Explanation</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>National</td>
<td><em>National position</em> on a health issue, usually developed in consultation with the Australian Government and other State/Territory Governments (eg AHMAG)</td>
<td>- Policies regarding ACT - Commonwealth Agreements (eg: Australian Health Care Agreement) - National Policies (eg: Mental Health, Tobacco, HACC)</td>
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<tr>
<td>2</td>
<td>Whole of ACT Government</td>
<td><em>ACT Government’s position</em> on territory-wide issues, usually developed in consultation between the Chief Minister’s Department and other ACT Government portfolios</td>
<td>- Caring for Carers Policy - Elder Abuse Prevention Policy - Social Compact: Policy for the Partnership between the ACT Government and the Community Sector</td>
</tr>
<tr>
<td>3</td>
<td>Whole of ACT Health Sector(^{10})</td>
<td><em>ACT Health position</em> on health-sector wide issues, usually developed in consultation between Policy &amp; Government Relations division and other ACT Health areas, non-government organisations, peer groups and consumers</td>
<td>- ACT Health Child Protection Policy - ACT Health Discharge Planning Policy - Nursing Home Patient Placement Policy</td>
</tr>
<tr>
<td>4</td>
<td>Clinical - ACT Health (ACT Health, 2009b, Chapter 21)</td>
<td>Clinical policy is a framework or strategy related to patient assessment, diagnosis, treatment or continuing care, which may occur in a range of settings, including hospitals, clinics or the person’s home.</td>
<td>- ACT Health clinical policy development, eg: Critical care services plan and Ault corrections health services plan.</td>
</tr>
<tr>
<td>5</td>
<td>Whole of ACT Health Non-clinical</td>
<td><em>ACT Health position</em> on corporate or non-clinical issues, usually developed by the relevant area with responsibility and expertise</td>
<td>- Long Service Leave Policy, Study Leave Policy, Leave Without Pay Policy - Chief Executive Financial Instructions</td>
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\(^{10}\) Health Sector includes ACT Health, non-government and private sectors.
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<tr>
<th>Tier</th>
<th>Scope</th>
<th>Explanation</th>
<th>Examples</th>
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</table>
| 6    | Local - Operational          | *Local operational and procedural policies*, usually developed by the relevant area with responsibility and expertise | - The Canberra Hospital (eg: Administrative Policy for Ward 12B)  
- Community Health (eg: Referral Policy between Community Health and Directions ACT) |


Within each of the six tiers policy development is to be undertaken according to the following cycle (ACT Health, 2009b): Stage 1 - Problem Initiation; Stage 2 - Information Collection; Stage 3 - Consideration/Consultation; Stage 4 - Option Analysis; Stage 5 - Decision/Approval/Sign-off; Stage 6 – Implementation; Stage 7 – Evaluation; and Stage 8 - Maintenance, Succession, and Termination. However, it is acknowledged that the policy development cycle will need to be adapted according to the specific policy. ACT Health makes a distinction between the following types of policy documents (ACT Health, 2009c):

- **Policy** - a mandatory statement of required action; systematically developed on the basis of legislation, regulations, standards and/or ACT Health requirements;
- **Standard Operating Procedure** - a procedure that staff should follow in a specific situation to ensure safe, effective and efficient practices; and
- **Guidelines** - a set of guiding principles for best practice where care is provided in partnership with an external stakeholder(s).

*Policy Management Framework* (ACT Health, 2009c)

ACT Health has an overarching Policy Management Framework for the management of policy documents that involve more than one division/service/branch; the development of Standard Operating Procedure by a division/branch; and the development of guidelines where care is provided in partnership with external stakeholders.

*ACT Health Central Policy Register* (ACT Health, 2009b, Chapter 20)

ACT Health maintains an electronic Central Policy Register, a repository of policies developed according to tiers 1-5, accessible to staff and the general public. The review
and revision of policy documents stored on the register is the responsibility of the area that initially developed the policy.

*Policy Advisory Group (PAG)*

ACT Health has a Policy Advisory Group with representation drawn from Divisions/Services and consumers. The Advisory Group oversees the initiation and review of ACT Health clinical and non-clinical policy as well as coordinates policy document management as outlined in the Policy Management Framework.

In addition to the Policy Advisory Group a number of high level committees and groups (ACT Health, 2009c) provide authorisation, advice and guidance on strategic and clinical policy matters. Refer to Table 8.

**Table 8:** ACT Health – Policy advisory committees

<table>
<thead>
<tr>
<th>Portfolio Executive:</th>
<th>endorses ACT Health wide policies, corporate and strategic</th>
</tr>
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<tbody>
<tr>
<td>Clinical Council:</td>
<td>endorses ACT Health wide clinical policy</td>
</tr>
<tr>
<td>Clinical Policy Coordination Group:</td>
<td>discusses and provides advice on ACT Health wide clinical policy, submitting to PAG for approval</td>
</tr>
<tr>
<td>Health Council:</td>
<td>provides advice and guidance on ACT Health wide policy to the ACT Government</td>
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</tbody>
</table>

*Tools and templates (ACT Health, 2009c)*

Templates have been developed and are required to be used for all ACT Health wide policy and Standard Operating Procedure development as specified by the Health Policy Management Framework.


ACT Health uses the ACT Government Community Engagement Manual and a range of tools and techniques to guide the planning, conduct and evaluation of community engagement activity.

**Queensland Health**

**INTRODUCTION**

On 12 December 2011, the Premier announced that Queensland Health was to be abolished by 1 July 2012 and two separate entities established to administer health services in Queensland. External consultants were appointed to prepare a detailed
implementation plan recommending changes to current health administration arrangements, to be tabled in Cabinet by end January 2012 (Bligh, 12 December, 2011). However, the organisation of Queensland Health prior to the proposed changes is presented in this section.

**Organisation of Policy Work**

Policy development, implementation and evaluation is undertaken by a number of divisions and branches of Queensland Health, including Policy, Strategy and Resourcing Division, Health Planning and Infrastructure, Chief Health Officer, Clinical and Statewide Services, Centre for Health Improvement, and Health Service Districts. Within this structure, program and operational policy is conducted by program divisions and Health Service Districts while intergovernmental, legislative and strategic policy is undertaken predominantly by the Policy, Planning and Resources Division.

The Policy, Planning and Resources Division has overall responsibility for policy and planning, including strategic health policy development, intergovernmental negotiations and statewide health service planning in the areas of primary, community and aged care, rural and remote health, women’s health, Aboriginal and Torres Strait Islander health and workforce planning. In addition, the Health Planning and Infrastructure Division has been established to facilitate greater collaboration and integration between health service planning and infrastructure development.

**Staffing Backgrounds**

The Policy Branch of the Policy, Planning and Resources Division employs approximately 30 staff, with a mix of clinical, operational, and policy skills. The staff employed in policy in Queensland Health have diverse educational backgrounds, with qualifications in social science, science, economics, law and health sciences.

**Structures and Processes of Policy Work**

Queensland Health has a standardised approach for developing and implementing policy that is underpinned by an overarching policy framework, structures and processes comprising a Policy Management Policy and decision making and advisory structures.
Policy Management Policy (Queensland Health, 2009a)

Policy Management Policy establishes a cohesive and comprehensive approach to the management of Queensland Health policy. The Policy Management Policy aims to promote a consistent and rigorous approach to policy development, implementation and review, and ensure alignment with Queensland Health policy principles.

To effectively manage policy in Queensland Health, the Policy Management Policy specifies a staged approach from initiation, development, consultation, approval, implementation and review. As part of the Policy Management Policy approach, the following systems and processes were established in 2009-10:

*Policy Register* – established to register current Queensland Health policy documents.
There is a requirement for policy documents to be reviewed every two years. An electronic version of the policy register has been developed for both internal and external use via intranet and internet sites respectively.

*Support documents* – established to specify standard approaches for the development, implementation and monitoring of policy and planning documents. These support documents take the form of either procedures, guidelines, protocols or templates; in some instances, are mandatory, in others, there is room for flexibility in adoption. The *Policy Management Policy Implementation Standard* is an example that establishes minimum requirements or a standard for the implementation of the Queensland Health Policy Management Policy. There are also *protocols* (or specific guidelines) that detail the processes expected to be adhered to by Queensland Health in undertaking policy development and implementation.

*Policy Management Contact Network* – established with representation from all Health Service Districts and divisions to contribute to the policy process.

*Decision making and advisory structures*

The role of the *Executive Management Team* (Queensland Health, 2011a) is to support the Director-General to meet responsibilities outlined in the Health Services Act 1991 and other relevant legislation. The Team is ultimately responsible for endorsing Queensland Health policies, determining strategic directions and priorities, ensuring funding of public health services, and monitoring performance against strategic objectives.
To assist the Executive Management Team, the Integrated Policy and Planning Executive Committee (IPPEC) (Queensland Health, 2011a) was established under the authority of the Director-General and reports to the Executive Management Team. The purpose of the IPPEC is to integrate, coordinate and endorse statewide policy development and implementation, and health service planning within Queensland Health. The role of the IPPEC in endorsing decisions is to ensure policy and plans are implementable within available resources, and based on evidence and rigorous analysis of data and service options (Auditor-General of Queensland, 2009).

In November 2010, an Integrated Policy and Planning Standing Subcommittee of IPPEC was established to assist in maintaining focus on strategic policy and planning in the department. More specifically, the subcommittee is responsible for coordinating the development, review and revision of the Queensland Health Strategic Plan, in line with legislative requirements.

In addition, the following committees provide advice and guidance on strategic and clinical policy matters:

*Health Community Councils (Queensland Health, 2011b)*
Health Community Councils are community advisory bodies established under the Health Services Act 1991 to ensure health services are responsive to their local communities by providing a consumer and community perspective to the provision of public health services. At the end of each financial year, Councils provide an annual report to the Minister for Health.

*Statewide Clinical Networks (Queensland Health, 2011b)*
Statewide Clinical Networks are formally recognised groups, principally comprising clinicians, established to contribute to clinical services planning and implementation, clinical practice improvement and quality and safety enhancements. Currently, a number of Clinical Networks exist in the areas of diabetes, cardiovascular, mental health, maternity and neonatal care, dementia and general medicine.
SA Health

Organisation of Policy Work

In SA Health, policy work is undertaken by a number of divisions and units, including Policy and Intergovernment Relations, Office of the Chief Executive, Aboriginal Health, Public Health and Clinical Coordination, Workforce Development, and Statewide Service Strategy. Regional Offices of Health are also involved in policy development, implementation and evaluation.

The Policy and Intergovernment Relations Division (SA Health, 2008a) has responsibility for providing policy advice to the government and department on intergovernmental and whole of government issues, legislative review, research, monitoring and evaluation, and maintenance of data collection systems.

The Policy and Intergovernment Relations Division is organised into five units comprising Intergovernment Relations, Strategic Planning, Policy and Research, Mental Health Policy, Health Intelligence, and Health ConnectSA.

Staffing Backgrounds

The Policy and Intergovernment Relations Division employs a small number of staff, with a mix of strategic, operational and clinical policy skills. The majority of staff in the policy division have broad educational backgrounds in humanities, science, economics, law and business management. Given the diversity of policy work conducted in SA Health, there is a preference to recruit staff with general educational qualifications and to develop their policy skills through on the job experience.

Structures and Processes of Policy Work

SA Health has a standardised approach for developing and implementing policy that is underpinned by an overarching policy framework, structures and processes comprising a classification system for policy development, a Directive, Guideline and Information Bulletin Standards System, a central registry system, policy advisory structures, and templates.

Classification System for Policy Development (SA Health, 2008a)

Policy work in SA Health has been classified according to six tiers: tiers 1 to 4 are the responsibility of the Department of Health, while tier 5 may be initiated by the health
regions or the department and tier 6 policies are developed by the area in which they will be implemented. Refer to Table 9.

### Table 9: SA Health – Classification system for policy development

<table>
<thead>
<tr>
<th>Tier</th>
<th>Scope</th>
<th>Explanation/Responsibility</th>
<th>Examples</th>
</tr>
</thead>
</table>
| 1    | National               | *National position* on a health issue, usually developed in consultation with the Australian Government and other State/Territory Governments (eg AHMAC) and is the responsibility of either the Policy & Intergovernment Relations Division or responsible division | - Policies regarding SA - Commonwealth Agreements (eg: Australian Health Care Agreement)  
- Australian Immunisation Agreement  
- National Policies (eg: Mental Health, Tobacco, BreastScreen) |
|      | Approval is usually granted by the Portfolio Executive, relevant Minister and or Cabinet |                                                                          |                                                                          |
| 2    | Whole of government    | *SA Government’s position* on state-wide issues, usually developed in consultation between the Minister’s Department and other SA Government portfolios | - SA Strategic Plan  
- State Carers’ Policy  
- Prosperity Through People: A Population Policy for SA  
- Treasury and Finance Policies  
- SA Government Risk Management Policy Statement |
|      | Responsibility Policy & Intergovernment Relations Division in collaboration with other Government departments |                                                                          |                                                                          |
|      | Approval is usually provided by the Chief Executive and Portfolio Executive; and, the Minister if the final policy is to be approved by Cabinet |                                                                          |                                                                          |
| 3    | Whole of SA Health     | *SA Health position* on health-sector wide issues, usually developed by the relevant division within SA Health in consultation with health regions, consumer groups and other relevant stakeholders | - SA Women’s Health Action Plan  
- Code of Fair Information Practice  
- SA Coding Standards  
- Casemix Funding for Hospitals  
- Operational Policy, Guidelines and Standards for |
<table>
<thead>
<tr>
<th>Tier</th>
<th>Scope</th>
<th>Explanation/Responsibility</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Approval is usually required from the Portfolio Executive but sensitive issues may need Ministerial approval</td>
<td></td>
<td>Maternal and Neonatal Services in SA</td>
</tr>
<tr>
<td>4</td>
<td>Legislation</td>
<td><em>SA Government legislative review and development</em> is undertaken by the Policy and Intergovernment Relations Division, with State Parliament responsible for its approval Responsibility of Policy &amp; Intergovernment Relations Division</td>
<td>- SA Health Commission Act 1976&lt;br&gt;- Mental Health Act 1993&lt;br&gt;- Controlled Substances Act 1984</td>
</tr>
<tr>
<td>5</td>
<td>Clinical</td>
<td><em>Clinical policy</em> is designed to guide clinical practice and is the responsibility of Public Health and Clinical Coordination Division Portfolio Executive approval is required</td>
<td>- Birth in Water Policy&lt;br&gt;- Perinatal Practice Guidelines&lt;br&gt;- Ensuring Correct Patient, Correct Site, Correct Procedure</td>
</tr>
<tr>
<td>6</td>
<td>Local/Operational</td>
<td><em>Local operational and procedural policies</em>, usually developed by the relevant portfolio with responsibility and expertise Approval is usually granted by the board of a health region or general manager of a health unit</td>
<td>- Chemical /Hazardous Substances and Dangerous Goods&lt;br&gt;- Quality Management and Performance Improvement&lt;br&gt;- Consent</td>
</tr>
</tbody>
</table>

Source: SA Health Corporate Governance, 2008

SA Health has proposed the Bridgman and Davis’ (2004 p. 26) policy cycle approach for use by policy officers to guide the policy development process: *identify issues; policy analysis; policy instruments; consultation; coordination; decision; implementation; and evaluation.*

*Directive, Guideline and Information Bulletin Standards System*

In 2006/2007, the department established a new Directive, Guideline and Information Bulletin Standards System aimed at improving accountability and access to and retrieval
of policies and guidelines. The system includes the following three-fold classification of policy:

1. **Directives** - refer to documents comprising instructions, instruments or orders issued by the department.
   Directives are mandatory, specify performance measures and procedures that must be adhered to in practice, have an authority conferred by legislation or issued by the chief executive, and refer to legislative requirements or whole of government policies or procedures. Directives are approved by the Ministers or Chief Executive of the Department of Health;

2. **Guidelines** - refer to documents that provide advice or guidance, and reflect best practice standards.
   Guidelines are generally voluntary, and the implication is that the concepts and principles will be used by practitioners and or organisations. There may be sections of the guideline, however, that are mandatory and require compliance. Guidelines are a statement of desired best practice and are considered no less important than directives but there may be greater flexibility in their application. Guidelines must be approved by the Ministers or Chief Executive of the Department of Health; and

3. **Information bulletins** - refer to documents used to distribute information across the Department of Health.
   They are usually brief and written in plain language and can include matters such as: notification of fees and charges, introduction of new or newly amended legislation or regulation, and advice to promote events such as training courses and seminars. Information bulletins are approved by Executive Directors and Directors within the Department of Health, health units and public sector agencies.

The review and management of proposed policy documents to determine its suitability for inclusion in the Directive, Guideline and Information Bulletin Standards System is the responsibility of the Office of the Chief Executive.

**Central registry system**

The department maintains a web-based central registry system for all departmental policy. The Finance and Administration Division is responsible for publishing approved documents on the intranet and monitoring review dates of published documents.
During the course of this study, the department was in the process of developing a system for monitoring and coordinating legislation which aimed to ensure adherence to legislative reform and consistency in implementation.

**Policy advisory structures**

To reduce duplication and improve coordination and integration of policy development and implementation across the health portfolio, the SA Health Policy Review Group was established to review policy proposals and develop recommendations for approval by the Portfolio Executive.

The SA Health Policy Review Group, comprising Executive Directors and Directors from across the department, facilitates the management and implementation of the Directive, Guideline and Information Bulletins Standards System. In particular, the Health Policy Review Group oversees the process for reviewing draft policy to be used through the Directives, Guidelines and Information Bulletins Standards System; makes recommendations to the Portfolio executive on the adoption of new and reviewed policies; identifies training and awareness issues and proposes development of a resource tool kit across SA Health to promote the Directives, Guidelines and Information Bulletins Standards System; and provides advice to Portfolio Executive for the continuing improvement of the Directives, Guidelines and Information Bulletins Standards System.

In addition to the SA Health Policy Review Group the following high level committees and groups provide authorisation, advice and guidance on policy matters:

- **Portfolio Executive** - comprising Chief Executive, Executive Directors of Divisions and Chief Executive Officers of Regions, provides collective leadership for the operation and improvement of the South Australian health system;

- **Clinical Senate** - a peak body comprising 60 leaders from nursing, allied health, general practice, medical specialties, senior SA Health executives and the chairs of the eleven Statewide Clinical Networks established to advise the state government on health reform and system-wide health issues: clinical service planning, service delineation, coordinating and integrating health services, safety and quality, and the use of emerging technology and providing a forum where clinical leaders share their collective knowledge;
- **Statewide Clinical Networks (Government of South Australia SA Health, 2010)** - 11 multidisciplinary bodies in the areas of cancer, cardiology, child health, maternal & neonatal, mental health, orthopaedic, rehabilitation, renal, older people, palliative care and stroke with representation from medical specialties, nursing, allied health, consumers, non-government organisations, indigenous groups, and SA Health established to increase the level of clinical involvement in the planning and coordination of health services: development of statewide clinical plans, health services redesign and redevelopment, integration and coordination of hospital and community-based health services, and workforce planning, training and development; and

- **Health Advisory Councils** - advisory bodies established under the Health Care Act 2008 to advise the Minister on health issues related to specific groups or regions.

**TEMPLATES**
SA Health has adopted a number of templates that outline the structure and key requirements for policy development and implementation that underpin the Directives, Guidelines and Information Bulletins Standards System.

### 3.4 **Comparison of Key Features**

This chapter compares the main demographic, geographic, socioeconomic, political and health administration features of the three jurisdictions.

**Main Features – Demographic, Geographic and Socioeconomic**

The three jurisdictions vary considerably in geographic area, population size and population distribution. Queensland has the largest population and area with a relatively large number of regional cities and towns. South Australia has a large but sparsely populated interior with only one large provincial city (Mount Gambier) compared with 10 provincial cities in Queensland, all larger than Mount Gambier. While only 40% of Queenslanders live in Brisbane, almost 70% of South Australians live in Adelaide. In contrast, the ACT has a very small geographic area and population, mainly located in Canberra, with a smaller satellite city in Queanbeyan over the border in New South Wales.

These differences in population size and distribution have influenced the scale, type and distribution of health services with corresponding implications for health administration,
lines of communication between centre and periphery, relationships between central health administration, service providers and community, the logic and design of decentralisation, mobilising and deploying of resources, training and professional development. South Australia and Queensland have a large network of public and private health services that comprise hospitals, primary health centres, mental health, aged care and rehabilitation, palliative care, and alcohol and drug treatment services. Whereas the ACT has only two public hospitals, one private hospital, one division of general practice and one cancer service compared to 78 and 166 public hospitals and 14 and 17 divisions of general practice in South Australia and Queensland respectively.

The three jurisdictions also vary considerably in regard to socioeconomic indicators. Queensland has the largest economy of the three, relatively strong in mining and construction. South Australia is relatively strong in manufacturing but centred on Adelaide in contrast to the decentralised nature of the mining industry in Queensland. South Australia has a significantly larger health and social care sector than either Queensland or ACT. The ACT economy is dominated by public administration with a strong presence of professional, scientific and technical services. The ACT also has a more highly educated population with higher levels of mean disposable income compared with other jurisdictions.

A summary of the main demographic, geographic and socioeconomic features of the three jurisdictions is presented in Table 10.

Table 10: Summary of demographic, geographic and socio-economic features in ACT, Queensland and South Australia

<table>
<thead>
<tr>
<th>Features</th>
<th>ACT</th>
<th>Queensland</th>
<th>South Australia</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Socio-demographic:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Population (2006)</td>
<td>334,200</td>
<td>4,091,500</td>
<td>1,568,200</td>
</tr>
<tr>
<td>(ABS, 2008a)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estimated area (km²)</td>
<td>2,358</td>
<td>1,730,648</td>
<td>983,482</td>
</tr>
<tr>
<td>(ABS, 2008a)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Density (people/km²)</td>
<td>141.7</td>
<td>2.4</td>
<td>1.6</td>
</tr>
<tr>
<td>Post-school qualifications (%)</td>
<td>61.3</td>
<td>50.4</td>
<td>48.3</td>
</tr>
<tr>
<td>(ABS, 2008b)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Features</td>
<td>ACT</td>
<td>Queensland</td>
<td>South Australia</td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
<td>-------</td>
<td>------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Employment – top 10 industries (% workforce)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Public Admin &amp; Safety</td>
<td>28.6</td>
<td>5.3</td>
<td>5.4</td>
</tr>
<tr>
<td>- Mining</td>
<td>-</td>
<td>9.0</td>
<td>-</td>
</tr>
<tr>
<td>- Manufacturing</td>
<td>-</td>
<td>7.8</td>
<td>9.3</td>
</tr>
<tr>
<td>- Health &amp; Social care</td>
<td>5.3</td>
<td>6.1</td>
<td>6.7</td>
</tr>
<tr>
<td>- Construction</td>
<td>9.2</td>
<td>8.4</td>
<td>6.6</td>
</tr>
<tr>
<td>- Prof, sci &amp; tech (ABS, 2011)</td>
<td>8.6</td>
<td>5.5</td>
<td>-</td>
</tr>
<tr>
<td>Disposable household weekly income (2007-08) (ABS, 2009b)</td>
<td>1,026</td>
<td>810</td>
<td>745</td>
</tr>
<tr>
<td>Summary of key features:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Small geographic area</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Small population</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• High density</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Population concentrated in Canberra/suburbs (ABS, 2008b)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Higher disposable income and higher levels of educational attainment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Larger numbers of government employees</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Large geographical area</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Large population</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Low density</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Population concentrated in Brisbane; remaining population dispersed in regional centres along the coast (ABS, 2009a)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**MAIN FEATURES – POLITICAL STRUCTURES**

The three jurisdictions have different political structures. Queensland and South Australia are independent, sovereign states, governed by a parliamentary structure, a premier as head of government and a governor appointed by and representing the Crown. There is a difference, however, in the parliamentary structure of the two jurisdictions: South Australia has a bicameral Parliament, both an upper and lower chamber; whereas Queensland has a unicameral Parliament, comprising only the Legislative Assembly. Both states also have a third level of government – local government – with clearly defined legislative responsibilities.
The Australian Capital Territory, on the other hand, is a self-governing territory, governed by a unicameral parliament, the Legislative Assembly, and headed by a Chief Minister. However, the Australian Capital Territory does not have full legislative independence as a majority vote of both houses of the federal parliament can override an enactment of the ACT Legislative Assembly. Unlike Queensland and South Australia, the Australian Capital Territory does not have local government and is responsible for both territory and local government functions. As a result, the breadth of territory responsibility extend to maintenance of law and order, transport, environmental health, building regulations, garbage collection, and maintenance of local roads.

A summary of the political structures of the three jurisdictions is presented in Table 11.

Table 11: Summary of political structures in ACT, Queensland and South Australia

<table>
<thead>
<tr>
<th>Features</th>
<th>ACT</th>
<th>Queensland</th>
<th>South Australia</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No Crown appointed Governor or Administrator as assenting to a Bill</td>
<td>Unicameral Parliament (Legislative Assembly)</td>
<td>Bicameral Parliament (House of Assembly and Legislative Council)</td>
</tr>
<tr>
<td></td>
<td>One level of government (Legislative Assembly has both state/territory and local government responsibilities)</td>
<td>Two levels of government (state &amp; local)</td>
<td>Two levels of government (state &amp; local)</td>
</tr>
</tbody>
</table>

In the next section is presented a brief description of each jurisdiction’s health authority.

Main Features – Health Authority and Organisation of Policy Work

In each health authority there are a number of distinct organisational features that have implications for the organisation and conduct of policy work in terms of communication between centre and periphery, relationships between central health administration and regions, service providers and community, mobilising and deploying resources, training and professional development, and monitoring implementation.
Size of health authorities

There are differences in the size of health administration in the three health authorities, a consequence of history, geography, and population size and distribution. Queensland Health (60,000 FTE staff and budget of $9.6 billion) (Queensland Health, 2010) is significantly larger than either SA Health (1,273.2 FTE staff and $3.6 billion) (Government of South Australia SA Health, 2010) or ACT Health (5,594 FTE and $767.1 million) (ACT Health, 2010), and this difference in scale has implications for the organisation and administration of health services across the three jurisdictions.

Decentralised/centralised administration

Queensland Health and SA Health are decentralised administrations, with responsibility for service planning, coordination, implementation and administration devolved to districts and regions respectively. Districts and regions under this arrangement are separate from corporate head office and relatively autonomous in day to day operational matters.

ACT Health, in contrast, has a centralised administrative structure, with responsibility for the management of all public sector programs and services in the Territory (e.g. Canberra Hospital, mental health, primary health, cancer, and rehabilitation and aged care services).

The factors influencing health administration in each jurisdiction are presented next.

ACT Health

Health administration in the Australian Capital Territory has been closely linked with the management of the Canberra Hospital and the former Royal Canberra Hospital. As the only major teaching hospital combined with the close administrative responsibilities between central corporate governance and clinical services, senior clinicians at the Canberra Hospital, play a prominent role and exercise an unusual degree of influence in health administration and policy development in the Territory.

A specific feature of the policy environment in the Australian Capital Territory is the proximity of ACT Health to Commonwealth Government departments and headquarters of other international and national agencies. This has significant implications for policy

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11 The FTE figure excludes Calvary Hospital.
capacity because of the competition for talent and expertise with consequences for recruitment and retention of personnel, investing in training and development, and workforce stability.

Queensland Health
The findings of the two Royal Commissions (Davies, 2005; Morris, 2005) and the independent review (Forster, 2005b) set up in 2005 to investigate surgical malpractice at Bundaberg Hospital and administration of the Queensland health system have had far reaching implications for the Queensland health system in terms of clinical practice, quality and safety, registration and training of the medical workforce, governance and funding of health services. Up to the December 2011 reforms to health services administration announced by the Premier, health administration in Queensland has been characterised by a centralised form of hospital and health services management (Dewdney, 1972); and while the impact of these service delivery and health administration reforms are noted the long term implications for the development and implementation of policy are uncertain.

South Australia Health
Over the last 30 years, regular investigations and reviews have been a noticeable feature of health administration in South Australia (Forbes, 1996) leading to regular restructuring from a centralised to decentralised health administration and vice versa. In addition, each review introduced structural changes to the department of health with the formation of super-large departments (Health Commission, and Department of Human Services) followed by disaggregation into smaller ones (Department of Health, Department of Community Services).

Until recently, South Australia has had a strong tradition of independent, community-representative boards of management responsible for administering health services. At the time of my research, with the introduction of new legislation in 2008, significant administrative changes had occurred including the dissolution of Boards of Management of metropolitan regions and country hospitals.

Organisation of policy work
In all three jurisdictions, policy work is dispersed throughout the organisation as it is undertaken by different divisions and units, including regional offices in Queensland and
South Australia. Each authority, however, has a designated policy division responsible for formulating, developing, evaluating and coordinating departmental policy. These divisions vary in size and resources but conduct similar policy development functions including the provision of advice to the minister and department, intergovernmental relations, legislative review, strategic planning, program review, and coordination of departmental input into whole-of-government initiatives. In addition, ACT Health has direct responsibility for policy development in both corporate and clinical areas in the department.

In the three health authorities, the distribution of policy functions across multiple divisions has frequently resulted in the combining of policy development and operational responsibilities in a policy officer’s workload; recognised as a problem for policy work as operational duties are usually given a priority in health administration. This combination of both operational and policy development work was a more common organisational feature in ACT Health and Queensland Health.

**Educational backgrounds of staff**
Staff engaged in policy development, implementation and evaluation in the three jurisdictions had broad educational backgrounds in humanities, science, economics, the law and business management, with senior managers preferring to recruit staff with general educational backgrounds given the diversity of policy work conducted in health authorities. However, ACT Health and Queensland Health, in particular, appeared to have significant numbers of staff working in policy with clinical nursing and allied health backgrounds. Further, all three jurisdictions placed emphasis on developing policy practitioners skills by ‘on the job’ experience instead of formal academic learning.

**Structures and processes of policy work**
All three health authorities have a range of established systems, structures and processes for managing and coordinating the policy process from formulation to implementation and subsequent evaluation. The policy management framework was explicitly documented in all jurisdictions, comprising a directive defining and interpreting policy, centralised policy registry, policy coordinating and advisory structures, and guidelines and tools for policy making.
A summary of the features of the health authority and organisation of policy work in each of the three jurisdictions is presented in Table 12.

Table 12: Features of health authorities and policy work in ACT, Queensland and South Australia

<table>
<thead>
<tr>
<th>Features</th>
<th>ACT</th>
<th>Queensland</th>
<th>South Australia</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of employees (FTE) in 2009-10</td>
<td>5,594 (excluding Calvary Hospital) (ACT Health, 2010)</td>
<td>60,000 (Queensland Health, 2010)</td>
<td>1,273.2 (Government of South Australia SA Health, 2010)</td>
</tr>
<tr>
<td>Health administration</td>
<td>Centralised</td>
<td>De-centralised (16 health service districts)</td>
<td>De-centralised (5 regions/programs)</td>
</tr>
<tr>
<td>Organisation of policy work</td>
<td>Policy work distributed across a number of divisions:</td>
<td>Policy work distributed across a number of divisions:</td>
<td>Policy work distributed across a number of divisions:</td>
</tr>
<tr>
<td></td>
<td>• Policy &amp; Government Relations</td>
<td>• Policy, Strategy and Resourcing</td>
<td>• Policy and Intergovernment Relations</td>
</tr>
<tr>
<td></td>
<td>• Service &amp; Capital Planning</td>
<td>• Health Planning &amp; Infrastructure</td>
<td>• Office of the Chief Executive</td>
</tr>
<tr>
<td></td>
<td>• Professional Leadership, Research &amp; Education</td>
<td>• Chief Health Officer</td>
<td>• Statewide Service Strategy</td>
</tr>
<tr>
<td></td>
<td>• Chief Health Officer, Population Health</td>
<td>• Clinical and Statewide Services</td>
<td>• Aboriginal Health</td>
</tr>
<tr>
<td></td>
<td>In addition, clinical and operational policy was developed under</td>
<td>Health Service Districts were also involved in developing and</td>
<td>Regions/Programs were also involved in developing and implementing policy</td>
</tr>
<tr>
<td></td>
<td>the Deputy Director-General Canberra Hospital and Health Services</td>
<td>implementing policy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>in collaboration with health services.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Features</td>
<td>ACT</td>
<td>Queensland</td>
<td>South Australia</td>
</tr>
<tr>
<td>----------</td>
<td>-----</td>
<td>------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>A dedicated division responsible for policy development, coordination, implementation and evaluation: Policy &amp; Government Relations</td>
<td>A dedicated division responsible for policy development, coordination, implementation and evaluation: Policy, Strategy and Resourcing</td>
<td>A dedicated division responsible for policy development, coordination, implementation and evaluation: Policy and Intergovernment Relations</td>
<td></td>
</tr>
</tbody>
</table>

A number of differences in geography, demography and political structures are identified across the three jurisdictions. In contrast, similarities are noted in the organisation of health administration and the conduct of policy work.

### 3.5 Conclusion

In conclusion, despite the differences in geography, demography and political structures, there are similarities in the organisation and conduct of policy work in the three health authorities. All three have a dedicated policy division responsible for formulating, developing, evaluating and coordinating departmental policy; and with similar policy development functions including the provision of advice to the minister and department, intergovernmental relations, legislative review, strategic planning, program review, and coordination of departmental input into whole-of-government initiatives. However, in all three health authorities policy work is an activity that is also dispersed throughout the organisation, and is being undertaken by different divisions and units.

In the next chapter the research design is presented (Chapter 4), which takes into consideration the context of policy work as detailed above and the analysis of the literature reviewed in Chapter 2.
CHAPTER 4 RESEARCH DESIGN

4.0 INTRODUCTION

The purpose of Chapter 4 is to describe the research design used for this study to achieve the research aim presented in Chapter 1, comprising methods for data collection, coding and analysis; and concludes with a consideration of the strengths of the research design and the ethical issues.

The research design for this study was influenced by a larger Australian ARC Linkage industry partnership project which was initiated to develop new methods for building health policy capacity in Australia which was awarded to the AIHPS and managed and coordinated by La Trobe University. The AIHPS proposed a study examining and comparing policy capacity in the health authorities in three Australian jurisdictions, the ACT, Queensland and South Australia, based on extending the findings derived from Gleeson’s (2009) single case study of health policy capacity development in Victoria.

The ARC Linkage project was designed to be conducted in two stages. Stage 1 (data collection and analysis) was to collect and analyse information on policy processes and policy capacity in the three health authorities, identify current and preferred strategies for capacity development, and confirm target groups for capacity building interventions. Stage 2 (interventions) was to implement capacity-building interventions with the target groups in the three health authorities (see Foreword for details).

The researcher was responsible for Stage 1 of the ARC Linkage project and the data collected provides the basis of this study. While the ARC Linkage project determined the subject matter and use of focus groups as a data collection method, the researcher determined the details of the project design; and the specific focus of the research aim of this study (see Chapter 1).

4.1 DATA COLLECTION METHODS

The data collection methods used included document analysis and ‘purposive sampling’ involving personnel involved in policy work in the three health authorities. In addition, to test interview schedules and methods, two pilot focus group discussions were conducted with managers and middle level policy practitioners based in Victoria.
DOCUMENT ANALYSIS

The limitations of this form of data collection in terms of accuracy, completeness, credibility, and personal bias in meaning and interpretation (Bowling, 2002, p. 418; Holloway, 2008, pp. 78-79) are acknowledged, and were addressed by checking the source and credibility of information used, while accuracy of meaning and interpretation was checked and verified by personnel in the three health authorities, and revisions made in light of the proposed changes.

PURPOSIVE SAMPLING

The research used purposive sampling for participant selection in the two methods for data collection, namely, focus group discussions and individual interviews. Purposive sampling is defined by Bowling (2002, p. 380) as a ‘deliberate non-random method of sampling, which aims to sample a group of people, or settings, with a particular characteristic.’ The aim of purposive sampling then is to ‘select information-rich cases for studying in depth’ (Liamputtong & Ezzy, 1999, p. 44) in order to increase the researcher’s insight into social phenomena while factors of representativeness and generalisability of results are considered less important (Bowling, 2002; Holloway, 2008; Liamputtong & Ezzy, 1999). The research adopted a homogeneous group sampling strategy for selecting samples; according to Patton (2002, pp. 230-242), the sample is selected to minimise variation and to maximise homogeneity in order to describe the experience or process in as much depth and detail as possible.

The sample selection was configured in two parts: focus group discussions with managers of policy units and middle level policy practitioners; and individual in-depth interviews with senior executives from policy-oriented areas in the three health authorities.

FOCUS GROUPS

Given the limited empirical research available on health policy work, focus groups were selected as an appropriate data collection method to allow for a greater exploration of the topic.

For exploratory research, where little is known about the phenomenon of interest, focus groups are considered an appropriate research technique (Krueger, 1994; Minichiello, Aroni, & Hay, 2008; Stewart & Shamdasani, 1990) and provide a means of seeking in-
depth qualitative information from a small group of individuals around a particular topic, under the direction of a moderator (Stewart & Shamdasani, 1990, p. 10). In this method of data collection, the emphasis is on the interaction between participants to generate data, further acknowledging the active role of the researcher in creating the group discussion for data collection purposes (Minichiello et al., 2008, p. 148; Morgan, 1996, p. 130). Focus groups produce ‘a very rich body of data expressed in the respondents’ own words and context’ (Stewart & Shamdasani, 1990, p. 12); create a particular group dynamic that stimulates discussion and enables exploration of a topic (Minichiello et al., 2008, p. 147); and provide greater insights into why certain opinions are held (Krueger, 1994).

The limitations of this form of data collection in terms of the number of issues that can be discussed, problems associated with group interaction, and ethical issues of confidentiality and anonymity (Hansen, 2006, p. 70) are acknowledged, and were addressed in regard to the group interaction issues through use of a well-designed interview schedule and prompts, the moderator’s ability to carefully guide the discussion, and ensuring open discussion by limiting participation to a relatively homogeneous group in terms of seniority; and the ethical issues through a range of responses including use of ‘Participant Information and Consent Form’ and de-identified transcripts as described in greater detail in section 4.4.

**INDIVIDUAL INTERVIEWS**

The initial ARC Linkage study design proposed focus groups as the method for collecting data from policy practitioners and senior managers. However, it was determined that middle level policy practitioners and managers might be constrained in discussing issues in the presence of senior executives. In response, it was decided on the advice of industry partners to conduct the focus group discussions with middle level policy practitioners and managers and to conduct individual in-depth interviews with a small number of senior executives in each of the three health authorities scheduled to occur after the focus group discussions.

Individual interviews are a widely used form of data collection in qualitative research (Lambert & Loiselle, 2008; Minichiello et al., 2008), often described as a “conversation with a purpose” (Burgess, 1984, p. 102). The in-depth interview technique allows the researcher to obtain a rich source of information on informants’ perspectives, feelings
and perceptions of the phenomenon under study. According to Patton (2002, p. 21), “in-depth intensive interviewing is the major way for qualitative researchers to understand the thoughts, perceptions, feelings and experiences of respondents”.

The semi-structured type of in-depth interview was selected by the research, as it allows informants greater flexibility to report their thoughts and feelings “in their own words and in their own time” whilst providing a tighter structure to collect important information (Holloway, 2008, p. 135). The semi-structured interview format also allows more direction and guidance from the researcher.

The limitations of this form of data collection in terms of interviewer bias, the way the researcher can influence the study both negatively and positively (Holloway, 2008; Lambert & Loiselle, 2008; Minichiello et al., 2008), and interviewees withholding and or embellishing information they choose to present (Lambert & Loiselle, 2008) are acknowledged, and were addressed through the two pilot focus group discussions to confirm and refine the questions and prompts that comprised the interview guide and the manner in which questions were asked by the interviewer; the recording and transcription of all interviews, and through evaluation of responses during data analysis.

Refer to Figure 2 for an overview of qualitative data collection methods.
Figure 2: Data collection methods

Policy capacity and process assessment
Analyse policy capacity and policy process in health authorities in three Australian jurisdictions (Australian Capital Territory, Queensland and South Australia) at the individual, organisational and system levels.

Document analysis

Collected documents on:
- organisational charts
- legislation and regulations
- annual reports
- corporate strategic directions
- reviews
- policies and plans
- protocols and guidelines
- historical documents

Pilots

Number:
Conducted two pilot focus groups with managers of policy units and middle level policy practitioners based in Victoria

Purpose:
- to test interview schedules
- to trial focus group discussion: interview approach, participant interaction, timing, questions and recording methods

Focus groups

Number:
6 (2 per jurisdiction)

With:
- middle level policy practitioners and managers of policy

Collected data on:
- current policy practice in the organisation: perceived strengths and weaknesses;
- external influences;
- policy practitioner competencies; and
- possible strategies and priorities to build policy capacity

Individual interviews

Number:
11 (3 ACT, 4 QLD, 4 SA)

With:
- senior executives in policy-oriented areas

Collected data on:
- current policy practice in the organisation: perceived strengths and weaknesses;
- external influences;
- policy practitioner competencies considered necessary by managers;
- leadership and management; and
- possible initiatives to build policy capacity
Document analysis
The documents analysed comprised both paper and web-based documents.

GOVERNMENT DOCUMENTS
The paper documents included policy documents, government reports, historical records, brochures and organisational resource materials. The documents accessed were published documents and archival material readily available but subject to certain administrative and library conditions.

The documentation obtained from the websites of the three health authorities included historical documents, organisational charts, annual reports, reviews, corporate strategic directions, policies, plans, protocols and guidelines.

These provided information about the context and background of the organisation in relation to historical developments, structures, administrative reforms, distribution and resourcing of policy work; existing policy capacity development initiatives; and specific information relating to investigating the relationship between policy capacity and policy process.

The health authority librarians also provided access to medical and health databases, and provided listings of policies and legislation, policy registers, policy and procedure manuals, and historical documents; and recent policy documents, corporate strategic plans, program plans, and additional information on branch/unit structures, roles and responsibilities.

The documents collected from health authorities were restricted to central or head office and did not include information from either regional offices or clinical settings. This approach was adopted because the central health bureaucracy was the unit of analysis of the study and the originator of the bulk of policy-related documentation; and because practical concerns of time and consistency, availability of and accessibility to documents across jurisdictions influenced the focus of document collection to central offices only.

This documentation was supplemented by material provided by ARC Linkage “industry partners” in each of the three jurisdictions.
The types of documents accessed are detailed in Table 13.

**Table 13: List of documents examined**

<table>
<thead>
<tr>
<th>Documents</th>
<th>ACT</th>
<th>QLD</th>
<th>SA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Organisation charts</strong></td>
<td>2009</td>
<td>2009</td>
<td>2009</td>
</tr>
<tr>
<td></td>
<td>2008</td>
<td>2008</td>
<td>2008</td>
</tr>
<tr>
<td><strong>Legislation and regulations</strong></td>
<td>ACT Health Act 1993</td>
<td>▪ Health Services Act 1991</td>
<td>▪ Health Care Act 2008</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ Mental Health Act 2000</td>
<td>▪ Mental Health Act 2008</td>
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<td>▪ Health Act 1937</td>
<td>▪ Public Health Bill (Draft) 2009</td>
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<td>▪ Health Regulation 1996</td>
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<tr>
<td><strong>Annual reports</strong></td>
<td>2009-10</td>
<td>2009-10</td>
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<td>2008-09</td>
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<td>2007-08</td>
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<td>2006-07</td>
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<tr>
<td><strong>Corporate strategic directions</strong></td>
<td>▪ The Canberra Social Plan (Chief Minister’s Department, 2004)</td>
<td>▪ Toward Q2 – Tomorrow’s Queensland (Department of the Premier and Cabinet, 2008)</td>
<td>▪ South Australia’s Strategic Plan 2007, (Government of South Australia, 2007)</td>
</tr>
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<td></td>
<td>▪ Hawke Review (Hawke, 2011)</td>
<td>▪ Queensland Health systems review, 2005 (Forster, 2005b)</td>
<td>▪ Hospitals Review, 2008 (Paxton Partners Pty Ltd,</td>
</tr>
<tr>
<td>Documents</td>
<td>ACT</td>
<td>QLD</td>
<td>SA</td>
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<td></td>
<td>▪ Health service planning for the future, 2009</td>
<td>▪ Queensland Health Policy Register</td>
<td>▪ SA Health Corporate Governance, 2008</td>
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<td></td>
<td></td>
<td>▪ Policy Implementation Standard</td>
<td>▪ SA Health Policy Register</td>
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<td>▪ Policy Development Guidelines</td>
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<td></td>
<td></td>
<td>▪ Clinical Governance Policy</td>
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<tr>
<td>Policies, guidelines</td>
<td>▪ ACT Health Corporate Governance Statement, 2009</td>
<td></td>
<td></td>
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<tr>
<td>and protocols</td>
<td>▪ ACT Health Policy Register, 2008</td>
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<td></td>
<td>▪ ACT Health Policy Management Framework, 2010</td>
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<td>▪ ACT Government Consultation Manual</td>
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<td></td>
<td>▪ ACT Chief Minister’s Department: A Guide to Better Policy Development</td>
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<td></td>
<td>▪ Guidelines for Developing Non-Clinical Policy, u.d.</td>
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<tr>
<td>Training and development</td>
<td>▪ Learning to Lead Policy Development Workshop</td>
<td>▪ Culture and leadership development program</td>
<td>Health LEADS</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ Clinical Services Capability Framework: Public and licensed private health facilities, Version 2.0</td>
<td></td>
</tr>
</tbody>
</table>
THE SCHOLARLY LITERATURE

Complementing the analysis of government documentation, a comprehensive review of the scholarly literature was conducted:

*International and national electronic databases*


*Library catalogues*

La Trobe University, Monash University, Cochrane and National Library of Australia (‘Libraries Australia’ database); and postgraduate theses databases accessed: ProQuest Dissertations and Theses, and Australasian Digital Theses Program.

*Search engines and directories*

Google, Google Scholar and ANZWERS Australia & NZ; searched hardcopy and online journals, books and reports; and scanned websites such as Australian Policy Online, Menzies Centre for Health Policy – Healthnews, and the United Kingdom’s Policy Network for relevant references and information.

Document analysis provided a rich source of detailed information on the context of the three jurisdictions and the health authorities, complementing the other types of qualitative data collected. As Holloway (2008, p. 77) observed, documents act as ‘sensitizing devices’ and inform researchers of important issues, or as Hansen (2006) asserted, they provide the necessary detail and context to other types of qualitative data.

**Introductory visits to jurisdictions**

At the commencement of stage 1 of the ARC Linkage project, the researcher visited the industry partners in the three State and Territory health authorities to establish a point of communication and liaison. The visit to each health authority extended over a period of two days with industry partners arranging meetings with either individuals or small groups from various divisions and units comprising senior executives and managers of policy-oriented units and policy practitioners to introduce the ARC Linkage project; and obtain background information on the organisation and conduct of policy work.

The information exchanged as a result of the visits included:
• Introduction of research project
• Background information on authority (organisational structure, historical developments, roles and responsibilities, training and development, and recent reviews and plans)
• Individual skills and expertise required for policy work (competencies)
• Strengths and weaknesses in policy capacity and policy process
• Gaps in policy capacity (individual and organisational)
• Current policy capacity initiatives/interventions
• Strategies for building policy capacity
• Data collection and recruitment for focus groups:
  - What divisions/units ought to be involved?
  - What positions/levels ought to be invited to participate?
• Resources

The information obtained from the introductory visits provided useful background information on health bureaucracies, policy capacity issues and the conduct of policy work, and clarified a number of research design issues including sampling frame, recruitment method and data collection. The information provided the background for the organisational structures and operations of the three health authorities described in Chapter 3.

Table 14: Number of meetings and participants in each jurisdiction

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Number of meetings</th>
<th>Number of people</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACT Health</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>QLD Health</td>
<td>9</td>
<td>17</td>
</tr>
<tr>
<td>SA Health</td>
<td>7</td>
<td>12</td>
</tr>
</tbody>
</table>
Pilot studies

FIRST PILOT
In July 2008, the researcher conducted the first pilot with managers of policy units and middle level policy practitioners from the Victorian Department of Human Services and other health-related organisations. The health organisations selected to participate in the pilot shared similar directions, functions and responsibilities as those health authorities involved in the research.

Selecting Participants
A list of potential participants was compiled from names of experienced policy practitioners known to the researcher. All potential participants were telephoned and asked if they would be interested in participating in a one and half hour pilot focus group discussion about policy; further explaining the background, purpose and ethical requirements of the pilot study. Participants were further informed that findings to emerge from the discussion would be excluded from analysis. All seven potential participants agreed to participate in the first pilot interview.

Subsequently, a written invitation was sent to participants who had agreed to participate in the pilot study. The letter was accompanied by an overview of the research project, draft list of interview questions (‘Interview Schedule’), and ‘Participant Information and Consent Form’. Further, the letter asked the participant to prepare for the interview by thinking about the following questions based on their policy experience:

- What are the best and worst policy episodes or projects you have been involved in, that you might be prepared to share with the group?
- What led you to choose these episodes, what might some of the enablers and barriers to good policy capacity and process be, in these particular cases?
- What could be done to address these barriers and build capacity for policy?

On the day, six people participated in the pilot interview, with one invitée unable to attend.

The first pilot study was intended to test all aspects of the focus group discussion comprising recruitment strategy, data collection instruments, conducting the interview, and data processing and analysis. In particular, the researcher wanted to confirm the format of questions (type, wording, number and sequence), focus of questions (exploring specific questions versus general themes), duration of session, sample size and representation,
method of recruitment, facilitation and note-taking, and processing of data (audio-recording, transcripts, field notes).

**Outcome of the first pilot**
After the pilot study was conducted and the interview transcribed and de-identified, a number of revisions were made to the content of the Interview Schedule: interview format, length and question style.

The revisions made to the Interview Schedule, included reducing the range and number of issues, replacing specific questions with broad themes, modifying wording considered too technical for practitioners, and clarifying the conceptual framework underpinning the interview. In terms of the latter, the eight policy capacity domains developed by Gleeson (2009) were selected to provide the conceptual framework underpinning the Interview Schedule and to facilitate the exploration of ideas in the focus group discussions.

To test the revisions made to the focus group Interview Schedule, format and process, identified by the first pilot, the researcher determined that a second pilot study was required.

**SECOND PILOT**
In October 2008, the researcher conducted a second pilot focus group with middle level policy practitioners and managers from the Victorian Department of Human Services.

**Selecting participants**
The process of selection was similar to the first pilot study, with five policy practitioners agreeing to participate in the one and a half hour focus group discussion.

**Outcome of the second pilot:**
Firstly, this pilot interview demonstrated that the overall interview schedule was suitable only requiring minor refinements to headings, sequencing and timing of interview questions. This confirmed the use of the revised Interview Schedule, interview format and method for the focus groups planned for the three health authorities.

Secondly, this pilot identified that it would be useful to explain to participants some of the theoretical concepts of policy work such as organisational policy domains and capacity
building strategies; in response, a number of checklists were developed for use in the focus group discussions. Refer to Appendix 5.

Thirdly, this pilot confirmed the utility of the introductory site visits to the three health authorities that had already occurred to meet with senior executives and middle level policy practitioners and managers in order to introduce the research project, obtain information about the authority and organisation of policy work, discuss current and future policy capacity initiatives, as well as clarify recruitment methods for the planned focus group discussions.

Fourthly, this pilot identified that middle level policy practitioners and managers might be constrained in discussing issues in the presence of senior executives. In response, it was decided on the advice of industry partners to conduct the focus group discussions with middle level policy practitioners and managers and to conduct individual in-depth interviews with a small number of senior executives in each of the three health authorities.

Finally, the decision to conduct individual in-depth interviews resulted in the ARC Linkage project team deferring until Stage 2 the web-based survey\textsuperscript{12} of middle level policy practitioners and managers and senior executives in each of the health authorities that was initially intended for stage 1 of the project.

The outcomes of the pilot studies allowed the researcher to revise and finalise what was thereafter called the ‘Focus Group Schedule’ and ‘Checklists’ for the planned focus group discussions with middle level policy practitioners and managers (Refer to Appendix 5); and informed development of an Individual Interview Guide for the planned individual interviews with senior managers (Refer to Appendix 6).

In the next section will be described the design and conduct of the focus group discussions.

\textsuperscript{12} It had initially been intended to conduct a web-based survey in the first stage of the ARC Linkage research project which would form part of this thesis. The purpose of the survey was to collect a wide range of data on policy capacity in the health authorities of the three Australian jurisdictions: individual capacity and training needs; suggestions for capacity building strategies; assessment of organisational capacity and areas for improvement; and preferences for interventions.
Focus groups
Between November 2008 and May 2009, the researcher conducted two focus group discussions in each jurisdiction with middle level policy practitioners and managers with responsibility for policy development and policy implementation. The discussions were held in a meeting room located in the corporate offices of the respective health authorities and were of two hours duration.

The purpose of the focus group discussions was to explore middle level policy practitioners’ experiences and perceptions of the policy making process; barriers and enablers that influence policy capacity (organisational conditions comprising structures, process and culture) and shape policy outcomes; and strategies that contribute to strengthening policy capacity.

In total, six focus groups were conducted with 33 participants drawn from a range of divisions, branches and units. Refer to Table 15.

Table 15: Number of participants in each focus group

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Focus group participants</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Policy development</td>
<td>Policy implementation</td>
<td></td>
</tr>
<tr>
<td>ACT Health</td>
<td>6</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Queensland Health</td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>SA Health</td>
<td>7</td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

SELECTING PARTICIPANTS
For each jurisdiction, a preliminary list of suitable policy-oriented divisions and branches of the health authority was developed based on an appraisal of the organisation’s structure and relevant corporate reports, as well as, information obtained from informal meetings with middle level policy practitioners, unit managers and senior executives. The list was finalised on the advice provided by industry partners.

13 A confirmatory letter with a formal invitation and background information on the research project and Participant Information and Consent Form (PICF) was sent to 47 people. However, due to work-related demands 14 people were unable to participate. Refer to Appendices 1 and 3.
The ARC Linkage Project industry partners in each jurisdiction then requested senior managers to email staff inviting them to nominate to participate in one of two focus group discussions if they met the following selection criteria: employed in a middle to senior level position, either a policy practitioner or a policy-oriented unit manager, undertaking policy-related functions, such as, development, implementation and evaluation. Potential participants were requested to contact the researcher by email if they wished to nominate to participate in the focus group discussions.

A list of potential participants for each focus group by jurisdiction was compiled. A confirmatory letter with a formal invitation and background information on the research project and ‘Participant Information and Consent Form’ (PICF) was sent to 47 people. The letter also clarified that if total numbers nominating to participate exceeded 12 in each jurisdiction, as required by Ethics approval (LP0776269, refer 4.4 of this Chapter), then researchers would select potential participants on the basis of achieving a distribution across the relevant areas of the organisation.

Further, the letter asked participants to prepare for the focus group discussion by thinking about the following questions based on their policy work experience:

What were the best and worst policy episodes or projects you have been involved in, that you might be prepared to share with the group?

What led you to choose these episodes; and what might some of the enablers and barriers to good policy capacity and policy process be, in these particular cases?

What could be done to address these barriers and build capacity for policy?

Conducting the Focus Group Discussions

The process described hereinafter is identical for all six of the focus group discussions, including use of the ‘Participant Information and Consent Form’ (Refer to Appendix 3); and the ‘Focus Group Schedule’ and ‘Checklists’ (Refer to Appendix 5).

The researcher conducted each focus group discussion as ‘facilitator’ and was assisted by a ‘note-taker’. At the commencement of the focus group discussion, participants were informed about the ethical requirements of the research: signing and returning the ‘Participant Information and Consent Form’; maintaining confidentiality of participant’s
identity and content of information discussed; and seeking permission from the participants to audio-record the discussion. All participants signed and returned the ‘Participant Information and Consent Form’ and gave permission to audio-record the discussion.

Focus group participants were asked to come to the discussions prepared to talk about a particular example from their policy work (either positive or negative) which might illustrate some of the enablers of and barriers to good policy work. At the beginning of the discussions, participants were invited to briefly narrate the policy episode they had prepared, with a focus on identifying enablers and barriers to good policy capacity and policy process in this particular instance. The comments of participants were summarised by the note-taker on butcher’s paper which was displayed around the room so that the narrative could continue to inform a broader discussion directed by the facilitator about external constraints to the policy process.

The session concluded with the group reflecting on strategies that could build policy capacity in the organisation, identifying those of highest priority. Before closing the session, participants were thanked and asked if they would like a copy of the de-identified transcript sent to them.

**Recording the Focus Group Discussions**

The focus group discussions were documented by the note-taker and audio-recorded and transcribed.

The note-taker produced a hand written record of the discussion and as the focus group proceeded also recorded the key points to emerge from the discussion on butcher’s paper. Complementing the note-taker’s record, the facilitator also produced a hand written record of each focus group discussion covering the topics in the Focus Group Schedule and Checklists.

A transcript was prepared from the audio-recording of each focus group discussion, and edited for accuracy of content. The transcripts were then de-identified to conceal personal, program and organisational details. A copy was sent to eight participants as requested.

In the next section will be described the design and conduct of the individual interviews.
Individual interviews

Between February and June 2009, the researcher conducted eleven individual in-depth interviews across the three jurisdictions (3 ACT, 4 Qld and 4 SA) with senior executives from policy-oriented areas in each of the three health authorities. The interviews were semi-structured and of approximately one to one and a half hours duration. Eight of these interviews were conducted face to face and three by telephone. The interviews were audio-recorded and transcribed.

The purpose of the individual in-depth interview was to explore senior executives’ perspectives on policy process and policy capacity in terms of constraints in the policy-making environment; strengths and weaknesses in policy capacity (individual and organisational) and policy process; initiatives to strengthen policy capacity; and leadership roles in and contribution to policy making.

The issues explored in the individual interviews were similar to those discussed in the focus groups although specific questions were asked about the roles and contribution of leadership to building policy capacity and managing the policy process.

SELECTING INTERVIEWEES

A list of interviewees was compiled based on informal discussions with senior staff from partner organisations and suggestions of industry partners. From the list, three to four senior executives were selected from the main policy-oriented areas in each of the three health authorities. Each senior executive was contacted directly and personally invited to participate in the interviews and informed that participation was voluntary.

For those senior executives who agreed to participate in the interview a formal invitation was sent accompanied by background information on the ARC Linkage project and a Consent Form for Individual Interviews. Refer to Appendices 2, 3 and 4 for information sent to participants. In addition, in preparing for the interview, they were asked to think about a range of policy capacity issues at both the individual and organisational levels. A few days prior to the interview, participants were sent a reminder note and the Interview Guide. Refer to Appendix 6.
CONDUCTING THE INDIVIDUAL INTERVIEWS
The process was identical for all eleven individual interviews, including use of the Interview Guide and Consent Form.

At the commencement of the interview, informants were briefed about the ethical requirements of the research: signing and returning the Consent Form and seeking permission to audio-record the interview. All informants signed and returned the Consent Form and gave permission to audio-record the interview. On completion, informants were thanked and asked if they would like a copy of the de-identified transcript sent to them; no one requested a copy.

RECORDING THE INDIVIDUAL INTERVIEWS
The individual interviews were documented by the researcher and audio-recorded and transcribed. The researcher prepared a detailed record after each interview based on the researcher’s hand written notes covering the topics in the Individual Interview Guide.

A transcript was prepared from the audio-recording of individual interviews, and edited for accuracy of content. The transcripts were then de-identified to conceal personal, program and organisational details.

4.2 DATA ANALYSIS
The research data was collected from six focus group discussions involving a total of 33 middle level policy practitioners and managers of policy (hereinafter “policy practitioners”) and 11 in-depth individual interviews with senior executives (hereinafter “senior managers”) from policy-oriented areas in the three health authorities. Overall, the views of a sample of 44 people working in or managing policy areas in the three health authorities were obtained on policy work, policy capacity, policy process and strategies to build policy capacity.

This section describes the framework for analysing the data from the focus group discussions and individual interviews.
Developing policy episodes

The researcher created generic policy episodes from information extracted from the transcripts and the note-taker and facilitator record on the policy example narrated by each participant in the six focus group discussions.

The policy episodes provide a standardised set of data to support systematic analysis and interpretation of the work of policy; and comprise a structure reflective of the conceptual framework in terms of the policy elements of inputs, process, outputs and outcomes. The data extracted from the policy example was grouped to consider issues as follows:

Policy background
- what was the policy?
- what was the reason for developing the policy?
- which level of government initiated the policy?

Policy inputs
- what resources were used to develop the policy?
- who undertook the work?
- who managed the policy?
- what time was allocated for the policy?

Policy process
- how was the policy developed?
- did stakeholders participate?

Policy outputs
- what were the policy outputs?

Policy outcomes
- what outcome was achieved?
- what was the participant’s perception of the outcome?

Other factors
- what other factors influence policy?

Quotes used in the findings chapters are assigned participant codes (to indicate informant’s name (pseudonym/number), informant category (e.g. policy practitioner or senior executive) and jurisdiction (ACT, QLD and SA) to protect the confidentiality of informants. Any references to individuals, programs and services, and organisational settings were removed from the quotes to maintain confidentiality. In addition to these deletions, minor editorial amendments were made to improve readability.
A number of policy episodes were excluded from analysis due to inadequate data describing the episode or referring to another government department and or jurisdiction.

The remaining 23 policy episodes were grouped based on shared features in terms of purpose, processes and expected outputs into five types of policy episode: developing and implementing State and Territory policy and programmes; developing service plans; developing and implementing Commonwealth policy and programmes; preparing Cabinet/Budget submissions; and reviewing legislation. Refer to Table 16.

Table 16: List of policy episodes

<table>
<thead>
<tr>
<th>TYPE OF POLICY EPISODE</th>
<th>NAME OF POLICY EPISODE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australian Capital Territory: Developing and</td>
<td>Developing consent-to-treatment policy (short reference: Consent to treatment)</td>
</tr>
<tr>
<td>implementing State/Territory policy and programmes</td>
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</tr>
<tr>
<td></td>
<td>Developing policy on management of a deceased person (short reference: Management of a</td>
</tr>
<tr>
<td></td>
<td>deceased person)</td>
</tr>
<tr>
<td></td>
<td>Developing policy on the safe handling of drugs at the agency level (short reference:</td>
</tr>
<tr>
<td></td>
<td>Agency safe handling of drugs)</td>
</tr>
<tr>
<td></td>
<td>Developing risk of infection policy for managing the spread of HIV under the Public</td>
</tr>
<tr>
<td></td>
<td>Health Act (short reference: Managing spread of HIV)</td>
</tr>
<tr>
<td></td>
<td>Developing student clinical placement (nursing and allied health) policy (short reference:</td>
</tr>
<tr>
<td></td>
<td>Student clinical placements)</td>
</tr>
<tr>
<td></td>
<td>Developing the territory’s response to a COAG-initiated policy establishing a national</td>
</tr>
<tr>
<td></td>
<td>health workforce agency (short reference: National health workforce agency)</td>
</tr>
<tr>
<td></td>
<td>Reviewing the Mental Health Act 1994 (short reference: Review of Mental Health Act)</td>
</tr>
<tr>
<td>Queensland: Developing service plans</td>
<td>Developing a statewide renal service plan (short reference: Statewide renal service</td>
</tr>
<tr>
<td></td>
<td>plan)</td>
</tr>
<tr>
<td>TYPE OF POLICY EPISODE</td>
<td>NAME OF POLICY EPISODE</td>
</tr>
<tr>
<td>------------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>Developing and implementing State/Territory policy and programmes</td>
<td>Developing policy to implement the new tobacco control legislation (short reference: Tobacco control legislation)</td>
</tr>
<tr>
<td></td>
<td>Developing policy to improve practice standards across the Aged Care Assessment Program (short reference: ACAP practice standards)</td>
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<tr>
<td></td>
<td>Developing policy to improve the storage, handling and disposal of sexual assault adult forensic investigation kits (short reference: Sexual assault forensic kits)</td>
</tr>
<tr>
<td>Developing and implementing Commonwealth policy and programmes</td>
<td>Developing a statewide diabetes type 2 policy in response to a COAG initiative (short reference: Statewide policy on diabetes type 2)</td>
</tr>
<tr>
<td></td>
<td>Developing an indigenous children’s health policy in response to a national strategy (short reference: Indigenous children’s health)</td>
</tr>
<tr>
<td></td>
<td>Implementing new child safety legislation that improves reporting responsibilities of front line personnel (short reference: Child safety reporting responsibilities)</td>
</tr>
<tr>
<td><strong>South Australia:</strong></td>
<td></td>
</tr>
<tr>
<td>Developing and implementing State/Territory policy and programmes</td>
<td>Developing and implementing a triage system to reduce waiting times for emergency dental care (short reference: Emergency dental care triage)</td>
</tr>
<tr>
<td></td>
<td>Developing policy on the extinction of life by a registered nurse or midwife (short reference: Extinction of life)</td>
</tr>
<tr>
<td></td>
<td>Reviewing the state’s health system, structures and services (short reference: Health system, structures and services)</td>
</tr>
<tr>
<td>Developing and implementing Commonwealth policy and programmes</td>
<td>Developing a statewide Alcohol Action Plan in response to the national Drug and Alcohol Strategy (short reference: Statewide Alcohol</td>
</tr>
</tbody>
</table>
The 23 policy episodes were analysed separately in terms of context and background, process, outcome and implications. The findings from the analysis of the policy episodes provide an insight into the nature of policy work and policy process in the three health authorities and supplement the findings from the analysis of the other data categories in terms of the need to align policy capacity and policy process in order to achieve good policy outcomes.\textsuperscript{15}

Five of the 23 policy episodes were selected for preparation as ‘vignettes’ to illustrate the experiences of policy practitioners in the three health authorities in the policy making process and are presented in Chapter 5. Each ‘vignette’ describes and analyses a particular policy episode type focusing on a number of key features: reasons for developing the policy; nature and type of policy; process for development and implementation; challenges confronting the policy process; factors facilitating the policy process; outcomes of the policy; and implications for policy capacity.

\textsuperscript{15} These elements underpin the conceptual framework developed by the researcher, with a detailed description presented in Chapter 2: Literature Review of the doctoral dissertation.
Aggregating and coding the data

The research data comprising the note-taker and facilitator records and transcripts from the focus group discussions and the interviewer record and transcripts from the individual interviews were subjected to categorisation and interrogation using NVivo™ qualitative research software. The combined dataset supported analysis by jurisdiction, by category, by focus group and by individual interview separately or in any combination depending on the research question being addressed.

The ‘coding up’ process (Bowling, 2002, pp. 388-390) applied to NVivo™ was based on the common themes in the research questions, interview schedule, literature and policy capacity domains resulting in a preliminary list of 34 categories: 16 tree nodes and 18 sub-codes (Refer to Appendix 7). The categories were reduced to a more manageable number by combining and deleting those categories that either overlapped or were insignificant.

The categories developed to analyse the research data were as follows:

Table 17: Categories for data analysis

<table>
<thead>
<tr>
<th>Number</th>
<th>Individual interviews (semi-structured)</th>
<th>Focus groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Not applicable</td>
<td>Policy episodes</td>
</tr>
<tr>
<td>2.</td>
<td>External influences</td>
<td>External influences</td>
</tr>
<tr>
<td>3.</td>
<td>Individual capacity:</td>
<td>Individual capacity:</td>
</tr>
<tr>
<td></td>
<td>• knowledge, skills and attributes required in policy staff</td>
<td>• knowledge, skills and attributes</td>
</tr>
<tr>
<td>4.</td>
<td>Policy capacity and process weaknesses</td>
<td>Organisational capacity and process barriers (as per domains)</td>
</tr>
<tr>
<td>5.</td>
<td>Policy capacity and process strengths</td>
<td>Organisational capacity and process enablers (as per domains)</td>
</tr>
<tr>
<td>6.</td>
<td>Initiatives for building policy capacity</td>
<td>Strategies for building policy capacity</td>
</tr>
<tr>
<td></td>
<td>• priorities</td>
<td>• priorities</td>
</tr>
<tr>
<td>7.</td>
<td>Leadership roles in and contribution to policy making</td>
<td></td>
</tr>
</tbody>
</table>

The study design for the individual interviews resulted in the differences in coding: a specific question was asked about leadership roles and contribution to policy making, and
an example of a policy episode was not included in the individual interview. However, it should be noted that leadership was discussed by the focus groups within the context of organisational capacity enablers and barriers.

4.3 **Strengths of the Research Design**

The use of combined qualitative methods, a significant sample size and a wide range of complementary data has produced a comprehensive research design that has enriched the conceptualisation of the phenomenon and enhanced the trustworthiness of findings (Lambert & Loiselle, 2008). This is indicated in the research design synopsis:

*Study Focus:*
  - review of policy work in three health authorities

*Preparatory phase:*
  - discussions with industry leaders (n = 3)
  - introductory visits (n = 36)
  - conducted two pilot studies

*Data collection phase:*
  - document analysis
  - focus groups and individual in-depth interviews (transcripts and field notes)

*Data analysis phase:*
  - applied Gleeson’s (2009) policy domains
  - developed a ‘systems’ conceptual framework
  - applied researcher’s knowledge and experience as a policy practitioner, consultant and teacher

The study focus on the review of policy work in three health authorities has yielded a breadth of data for analysis and interpretation. The application of a mixed methods approach to the research design has yielded rich data, incorporating the perspectives of different groups of participants, and also acts to validate individual participant responses to the extent that they are perspectives shared by other participants; and has reduced the potential for any significant impact on findings arising from researcher bias, in terms of formulation and analysis of questions, or on participant bias in terms of reliance on the subjective assessments of policy work by individual practitioners and senior managers.
4.4 **ETHICS APPROVAL**

Ethics approval for this study was part of the ARC Linkage research project (LP0776269). This involved ethics approval from the university and industry partners identified in Appendix 8.

The main ethical issues arising from this research were voluntary participation in interviews; and confidentiality in terms of participant identification and content of policy information discussed in focus group and individual interviews, and informing and involving partner investigators without breaching confidentiality requirements.

The issue of voluntary participation was managed by asking individuals to nominate if they wanted to participate in focus group interviews and senior managers suggested as potential participants were invited to participate in individual interviews. Prior to the interviews, potential participants were notified in writing and these instructions were restated at the commencement of the interview that participation was voluntary and participants were free to withdraw if they did not feel comfortable about participating in the research.

The second issue was managed by asking participants to maintain confidentiality concerning the identity of focus group participants and policy content discussed in the focus group interview. In addition, the identifying details of participants, unit/branch of department, programs and services were de-identified in transcripts. Finally, in presenting the findings the researcher was also careful to maintain confidentiality of participants, departmental units/branches, programs and services by removing identifying details from quotations, policy stories and examples used in this study.

The third issue of confidentiality in respect to industry partner investigators and recruitment of interview participants, was managed by referring to generic titles of units/branches and positions rather than individuals’ names in my communications with industry partners; invitation emails issued by industry partners were not sent directly to potential participants instead they were directed to managers of appropriate policy-oriented units/branches for distribution to all staff in their area; and potential participants were asked to contact the researcher directly by telephone or email if they wished to participate in the focus group interviews. Finally, any further communication relating to the interviews was conducted between researcher and participant. Similarly, with individual
interviews, the researcher compiled a preliminary list of potential informants from the main policy-oriented areas of the organisation for discussion with industry partners. The researcher then finalised the list of informants and contacted each informant directly.

4.5 CONCLUSIONS

This chapter describes the research design used to achieve the research aim of the study comprising the methods used for data collection and analysis, including sample selection, coding and categorisation of data, and analytical approach, and concludes with a discussion of the ethical issues and the ethics approval for the ARC Linkage research project from which the study originated.

The study adopts a multi-methods qualitative approach to the examination of policy work in the three health authorities, involving document analysis and purposive sampling based on focus group discussions and individual interviews. The analysis of documents supplied by industry partners in the preliminary meetings provided important organisational context to the comments made by participants in the focus group discussions and individual interviews particularly in regard to ‘enablers’ and ‘barriers’. The focus group and individual interview data was aggregated and classified into broad categories and subcategories and also used in constructing policy episodes of the policy practitioners’ policy experiences; and then analysed in accordance with the conceptual framework developed out of the literature review documented in Chapter 2 which applies a ‘systems’ perspective to the understanding of policy making in the three health authorities with the aim of aligning policy capacity and policy process in achieving good outputs and outcomes.

It is acknowledged that the conceptual framework developed for application to the analysis and interpretation of the research data is reflective of the researcher’s personal experience as a policy worker, teacher and consultant but is offered here together with the research findings as a contribution toward the better understanding of policy work in health policy environments.

The findings of the study are presented in Chapters 5 to 7 and have been organised within the conceptual framework described in Chapter 2. Chapter 5 presents the research findings related to question 1, Chapter 6 addresses questions 2 and 3, and the findings related to question 4 are presented in Chapter 7.
CHAPTER 5    UNDERSTANDING THE WORK OF POLICY

5.0   INTRODUCTION

The purpose of Chapter 5 is to describe the nature and type of policy work conducted in the three health authorities; and to apply the conceptual framework to the analysis of the research data and present the findings in reference to Research Question 1: What is the nature of health policy work with respect to capacity and process?

In terms of the research aim, establishing what constitutes capacity and what constitutes process contributes to our understanding of the complex work of policy in a health policy environment; and the application of a systems perspective provides greater coherence to that understanding by emphasising the interrelationships of the elements of policy work.

5.1   UNDERSTANDING THE WORK OF POLICY

The aim of this section is to review the work of policy through presentation of five of the twenty-three generic policy episodes created by the researcher based on the policy examples narrated by focus group participants (see Chapter 4 for details). The particular policy episodes were selected to provide an example from different areas of policy work, from each of the three jurisdictions and from each of the five types of policy episode. Refer to Table 18.

Table 18:   List of policy episode examples

<table>
<thead>
<tr>
<th>No.</th>
<th>Type of policy episode</th>
<th>Name of policy episode</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Developing and implementing State/Territory policy and programmes</td>
<td>A triage system to improve access to emergency dental care</td>
</tr>
<tr>
<td>2.</td>
<td>Developing service plans</td>
<td>A statewide renal service plan</td>
</tr>
<tr>
<td>3.</td>
<td>Developing and implementing Commonwealth policy and programmes</td>
<td>Encouraging nurses to return to the workforce</td>
</tr>
<tr>
<td>4.</td>
<td>Preparing Cabinet/Budget submissions</td>
<td>A national review of maternity leave</td>
</tr>
<tr>
<td>5.</td>
<td>Reviewing legislation</td>
<td>The Mental Health Act</td>
</tr>
</tbody>
</table>
The policy episodes illustrate the characteristics of health policy work in terms of the following framework:

**Nature of policy work:**
- What type of work is considered policy?
- Who are and how do stakeholders influence policy?
- How does the level of government influence policy?

**Capacity for policy work:**
- Who does policy work in Australian health authorities? (educational backgrounds, competencies and experiences)
- How are resources (individual workers and infrastructure supports) organised to conduct policy work?
- How are appropriate skills mobilised to do policy?
- How is information generated and collected?
- What training and development opportunities are provided to develop worker skills?
- What structures, systems and processes are in place to support policy work?
- How is policy work managed in the organisation?

**Process of policy work:**
- How is policy work conducted in health authorities?
- Are there recognisable activities of policy work?
- What are the factors that impede the policy process?
- What are the factors that facilitate the policy process?
- What outputs are produced by the policy process?
- What happened after the outputs were produced?

**DEVELOPING AND IMPLEMENTING STATE AND TERRITORY POLICY**

**POLICY EPISODE: A TRIAGE SYSTEM TO IMPROVE ACCESS TO EMERGENCY DENTAL CARE**

**POLICY BACKGROUND:**
The rapidly increasing waiting list for public dental care was a sensitive and potentially damaging issue for the government. A policy for a statewide triage system to reduce waiting time for emergency dental care was developed. The new ‘triage’ system required

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16 Policy episode narrated by Brian-CF
reception rather than dental staff to undertake the initial assessment to determine an individual’s dental status for ‘emergency’ treatment; using a newly designed computerised system for coordinating and monitoring clients on the waiting list.

A number of complementary initiatives were implemented in order to establish a new triage system to coordinate emergency dental care across the state: development of a standard assessment tool; design and development of a computerised system for coordinating and monitoring the state’s waiting list; training and development of front-end personnel; and promoting the new arrangements to access dental services.

The formulation, implementation and subsequent review of the policy occurred over a ten year period:

There’s a whole lot of things in that process, and it took 10 years, that is to develop the questions, to trial them, to modify them, to get agreement from our clinicians in terms of the so-called ‘gold standard’, to get consumer participation in that process the whole way along, that in fact this is what they wanted to see happen? To ultimately, get a situation where we had an agreement that this is what we would do to write a specification for a computer program, to trial it, to roll it out along with all the education and training that’s required.17

POLICY INPUTS (CAPACITY):
A senior dental officer, with a small number of project and administrative staff were mobilised to complete the project, while guidance and direction was provided by a larger steering group. The steering group comprised dentists, among others, who as experts could understand the technical issues, communicate with professional colleagues and gain their support:

[...] a steering group, comprising wide representation of interests, can provide much-needed intelligence, direction and advice that adds significantly to the capacity of the department [...] and using well respected dental clinicians would enable the dental profession to feel more comfortable in accepting the proposed changes.

17 This quote summarises a few features of the policy process: i) the complex and multi-faceted nature of the policy; ii) the length of time required to complete the tasks; iii) the participation of multiple stakeholders, emphasising the major role of clinicians (dentists); iv) the important role of negotiation in order to build consensus and support; and v) the emphasis on review through testing, revising, and improving.
Over the duration of the project, limited resources were allocated to completing the task. There was some in-house technical expertise provided (dental officer – policy) but, in the main, this expertise was provided by external sources. Although limited financial resources were made available for resourcing the project, funds were made available for designing and developing a computerized system and training of lay staff to undertake the triaging function, ensuring appropriate standards of dental care were met.

**Policy Process:**
The process for developing and implementing the new emergency dental care triage policy involved a number of activities although not necessarily in this order.

*Conducting research*
An external group was commissioned to design and develop clinically appropriate questions to be used by reception staff to assess an individual’s dental health status and assign a waiting list priority. Further, the support of clinicians for the policy was facilitated by using an external group to conduct the research.

*Engaging stakeholders*
Consultation and negotiations with a range of stakeholders were conducted throughout the policy process, including dentists, staff, the professional association and consumers to minimise opposition and gain support for proposed practice changes that were intended for introduction with the new policy:

> [...] because really what they were saying was ‘receptionists can’t make these decisions. We are the only ones that can.’ So the next step was how could we end up with a process where the receptionist’s decision actually matched theirs? And they would start to feel more comfortable.

*Testing and revising*
The assessment questions and computer program were trialled in a number of sites with the aim of identifying problems and assessing performance. The assessment questions and computer program were then revised, as a result of the trial.

*Approving and authorising*
Throughout the process, regular meetings were held between clinicians, the professional association, and Department of Health to negotiate and reach agreement on the policy (e.g. assessment questionnaire, computer program specification, definition of terminology, and
funding). With the parties reaching agreement on all aspects of the policy, approval for the proposed policy was obtained from the Minister.

**Implementing**

Multiple initiatives of the dental care triage policy were progressively implemented, subject to availability of funds: introduction of assessment checklist and a computerised system to monitor and manage the statewide dental waiting list; delegation of initial assessment and triage of waiting list clients to non-dental staff; and conduct of education and training to develop skills of reception staff.

**Monitoring and reviewing**

The introduction of the new statewide dental care triage system enabled monitoring and analysis of dental waiting list activity data. The analysis of statewide client activity data provided useful information on the waiting list population, client demographics, workforce management, and emerging patterns and trends; allowing the policy to be evaluated and modified over time.

**Policy Outcomes:**

\[\ldots\] we have reduced the time we spend on emergency care, or the number of people who spend time on the emergency care list, by about 30 or 40%. The end result is that we have probably contributed to reducing the waiting list by a very, very significant amount of time.

The outcome of the dental triaging policy was considered a success because the emergency dental care waiting list had been significantly reduced by 30 - 40%. Moreover, other reasons contributed to the policy being considered successful: the formulation of the policy had been completed, the process had been skilfully managed and a program and service had been subsequently implemented across the state. The implementation of the program consisted in establishing a triaging system to coordinate emergency dental care across the state; including the design of an assessment questionnaire, development of an electronic data base to manage the statewide waiting list, use of trained non-dental staff to conduct the initial assessment and triage clients on the waiting list, and an arrangement for private dentists to treat people on the waiting list. The implementation of the triaging system resulted in improving access to dental treatment, a significant reduction in waiting times for dental care and an overall improvement in dental care for the community.
Furthermore, the public success of the program was acknowledged with the commendation of a Premier’s Award in the well-being category to the Dental Service in recognition of public health services to the community.

**DEVELOPING SERVICE PLANS**

**POLICY EPISODE: A STATEWIDE RENAL SERVICE PLAN**

**POLICY BACKGROUND:**
The Department of Health made a decision to develop a statewide Service Plan for renal services. A coordinated, statewide renal services planning framework did not exist at the time of the policy initiative. The State Plan was developed in an environment where the culture of health planning was not strong: “[...] until about 18 months ago [planning] had tended to be ad hoc in the department or a little bit hit and miss”.

**POLICY INPUTS (CAPACITY):**
The Planning & Coordination Branch of the Policy, Strategy and Resourcing Division was assigned responsibility for developing the Service Plan. Health service planning is a unit within the Policy Division: “[...] in the statewide planning phase, in many instances, we’ve been developing policy within the planning context”.

The Service Plan was expected to be developed in six months in order to meet the state’s annual budget timelines. This was a “tight timeframe” and inadequate for completing the significant task of developing a statewide Service Plan, with its requirement for rigorous analysis and extensive stakeholder and community consultation.

A senior planning officer from the Planning & Coordination Branch was appointed to coordinate the development of the Service Plan. Consultants were commissioned to provide necessary clinical and statistical expertise that would supplement the planning officer’s skills and to assist in developing the Plan. In addition, as the project progressed, a small team with service planning and clinical expertise was assembled to complete the Service Plan.

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18 Policy episode narrated by Hanna-BF.
19 Reasons for developing the Service Plan were not made explicit in the narration of the policy episode, although gaps and inadequacies in current service provision, distribution and funding and a need to determine future directions and priorities were implied.
On completion, the Service Plan detailed strategic directions, identified priorities, and proposed strategies for the future development and funding of services. The Service Plan presented 64 costed strategies.

**Policy Process:**
The process for developing the statewide Service Plan included a number of activities.

*Collecting and analysing data*
Demographic, financial, service provision and forecasting information was collected and analysed, and different national and international service models for application to the local scene examined.

*Commissioning consultants*
Consultants were engaged to provide specific clinical, statistical and epidemiological expertise to complement the department’s planning and policy skills and expertise.

*Engaging stakeholders*
Stakeholders were consulted including medical specialists, general practitioners, health administrators, professional associations, peak organisations, people from different cultural and linguistic backgrounds, people of Aboriginal and Torres Strait Islander backgrounds and other relevant service providers to elicit comment on the proposal. The consultation process further sought the involvement of consumers and the wider community through the conduct of a number of public forums across the state:

> [...] we held three consultation sessions which were huge sessions in each of the areas and engaged everyone from GPs, through to peak bodies, your key clinicians, your transplant surgeons, your Aboriginal and Torres Strait Islander health workers, so that it was bringing together a number of interests in the one forum [...].

*Writing papers and reports*
Papers and reports were prepared for distribution to stakeholders within and external to the department for comment and advice; revising and finalising the service plan on the basis of feedback.

*Approving and authorising*
The next step required the Service Plan to receive departmental and ministerial approval, and be prioritised against other proposals on the department’s annual budget bids to
Treasury. The Service Plan had not been ranked as a priority and, as a result, additional resources had not been allocated for implementation to proceed.

**Policy Outputs and Outcomes:**
The output from the first stage of the exercise was the development of a Service Plan, detailing strategic directions, identifying key priorities and proposing 64 costed strategies for future action. This stage of the policy was assessed by the participant as a success.

To achieve meaningful outcomes, the Service Plan had to be implemented, and this required government commitment to and support for additional resources to fund new service developments.

The outcome of the Service Plan was unsuccessful as no additional resources were allocated for implementation being considered a low priority on the Department’s annual budget:

> [...] we had a very highly publicised public plan and we got very little money, not even enough to cover the growth in [medical condition] population.

The outcome was disappointing because there appeared to be limited support from the Department for funding service planning outcomes:

> Whilst there’s a commitment to state wide plans in the department, the physical environment at the moment is such that very few get funded [...].

This lack of funding support from the Department was reflected in clinicians and health agencies’ scepticism about the value of embarking on a service planning exercise that would likely result in an unsuccessful outcome, in that no additional resources would be provided for implementation.
DEVELOPING AND IMPLEMENTING COMMONWEALTH POLICY

POLICY EPISODE: ENCOURAGING NURSES TO RETURN TO THE WORKFORCE20

POLICY BACKGROUND:
Encouraging nurses to return to the workforce was a Labor Party policy aimed at addressing Australia’s serious health workforce shortages that was widely promoted in the 2007 federal election campaign. On winning office, the Rudd Labor government agreed to implement their election policy by providing financial incentives to the states and territories to encourage nurses who had left the workforce to return. In principle, the states and territories were committed to the policy as they recognised the financial incentives would be attractive in persuading nurses to return to the workforce, and thus contribute to easing the severe nurse shortage problems experienced by public health services.

The objective of the policy was clear as its purpose was to increase the number of nurses in the public sector health workforce by offering financial incentives to those not currently employed as nurses. The policy consisted of the following elements: an eligible nurse (i.e. a registered nurse not currently in the workforce) interested in returning to the workforce would contact the appropriate jurisdiction and be placed on a list; a first bonus payment would be paid to the nurse on completion of six months employment; and a second bonus payment would follow on completion of 18 months continuous employment.

The policy was initiated by the Commonwealth but refined and further developed in conjunction with the states and territories, which had implementation responsibility.

POLICY INPUTS (CAPACITY):
The Commonwealth Department of Health and Ageing assumed a leadership role in developing and implementing this policy: directing the agenda, managing time, negotiating funding and targets, coordinating policy across jurisdictions, and ensuring accountability arrangements were established. An Intergovernmental Working Group was established by the Commonwealth to ensure representation of state/territory interests and consistency in interpretation and implementation of policy across the nation.

A senior policy officer in the Department of Health was nominated to participate on the Intergovernmental Working Group and assigned responsibility for negotiating and overseeing implementation of the policy. No additional human resources were allocated to

20 Policy episode narrated by Pamela-CF.
assist the senior policy officer implement the policy, although limited financial resources were made available by the Commonwealth to assist the states and territories with implementation.

The states and territories were given six months to implement the national policy; there was significant pressure to meet this timeframe, given government interest and the high public profile of the policy.

**Policy Process:**
The process for developing and implementing the policy involved a number of activities.

*Participating in consultative structures*
An Intergovernmental Working Group comprising Commonwealth and state/territory representatives was established to discuss and negotiate details regarding policy implementation. The Working Group provided a forum for communication and negotiation between the parties for further refinement and implementation of the policy; allowing issues of concern to be identified and solutions to resolve them to be developed.

*Negotiating and reaching agreement*
A significant, if somewhat tense, part of the policy development and implementation process was the negotiation of the agreement between the Australian and states/territories governments. Through these negotiations, agreement was to be reached by both levels of government regarding the policy’s aims and objectives, targets, funding, management and accountability arrangements. These negotiations were to lead to the finalisation and signing of a contract between the Commonwealth and states/territories.

*Implementing the program*
Implementation of the program commenced while Commonwealth and state/territory government negotiations were still in progress to determine terms and conditions of the policy, with establishment of a national telephone line to provide information and advice to nurses, and allocation of Commonwealth funds to states and territories.

**Policy Outputs and Outcomes:**
The intent of this Commonwealth-state policy was supported by the states and territories, because increasing the nursing workforce in Australia “was actually a good idea”. As an election promise by the incoming Labor government, the policy had strong government support and was considered a high priority.
Although the policy direction was sound, the implementation of the policy was poorly planned and conducted. There were numerous problems that the state and territory governments encountered in their contract negotiations with the Australian government: service delivery and funding targets, data requirements, monitoring and accountability, and unrealistic timelines for implementation. A major criticism raised of the Australian government was their lack of knowledge of state and territory legislation, administration, policy and priorities and, as a result, incorrect assumptions on which the policy was based:

 [...] the numbers they expected are completely out of sync with what the reality is, they thought there would be hundreds of them and in fact it’s not, that is, the number of nurses returning to the workforce.

The outputs achieved by this policy included the signing of a contract between Commonwealth and state/territory governments regarding the parameters of the program to be implemented in return for level of funding, and allocation of federal funds for program implementation.

The policy outcome for the jurisdiction was disappointing as it did not achieve the negotiated targets, with a smaller than expected number of registered nurses returning to the workforce. In addition, the long term outcome of the policy was also not viewed favourably by the participant, who stated:

 [...] the point is that even if we increase the capacity of all of the individuals involved in that [policy], it would actually not make a difference really to the outcome [...] but it is the fact that a lot of policy in the public sector is driven absolutely specifically to a 3 year public election marketing program, which bears no resemblance to anything else.

PREPARING A CABINET/BUDGET SUBMISSIONS
POLICY EPISODE: A NATIONAL REVIEW OF MATERNITY LEAVE

POLICY BACKGROUND:
The Health Department participated in the process of preparing a submission for consideration by Cabinet as part of a government response to a national review of maternity leave undertaken by the Productivity Commission. The other state government departments participating in the process included: Premier and Cabinet, Families and Communities, Treasury and Finance, Education and Children’s Services, Economic Development and

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21 Policy episode narrated by Amelia-CF.
Trade, and Immigration. The Department of Premier and Cabinet was assigned responsibility for coordinating the state response.

Further, policy making in the jurisdiction had to take into account the government’s requirement for policy to be developed in the context of the state’s strategic planning framework and shared ministerial responsibility for achieving performance targets, on the one hand, and the traditional Westminster system of ministerial responsibility for individual portfolios, on the other.

As a consequence, cross-portfolio collaboration in policy work requires a different “policy headset and understanding of the processes” of other departments. There were noticeable differences in values, expectations, interests and priorities; participants came from different professional backgrounds, spoke different languages, and perceived their worlds differently:

[...] so you can imagine there is a range of government players in this process from Department of Premier and Cabinet, Department of Families & Communities, Health, Economic Development, Immigration, DECS, Department of Treasury & Finance [...] so each comes to the table with their own perspectives on this issue that it’s supposed to provide a particular perspective on the issue.

Against this background, much time and effort was spent in building a common language, reaching a shared understanding of context and issues, and developing a consensus on direction and proposed strategies to benefit all parties. For instance, the Departments of Education and Health started with different positions in relation to the issue, and both parties had to negotiate, compromise and reach consensus on developing a unified state government position. Working in this capacity also required departmental representatives to be sensitive to and work within the strategic boundaries of their own department’s interests, as well as, within the parameters of interdepartmental structures and processes.

POLICY INPUTS (CAPACITY):

The timeline for completing the policy response was short as an earlier Cabinet date had been missed. Accordingly, a decision was made to curtail some of the necessary policy tasks of collecting and analysing information and evidence, canvassing opinions of relevant stakeholders, and debating issues and options in order to accommodate the limited time frame. Such cross-portfolio policy work is a time-consuming activity, involving:
participation in numerous interdepartmental meetings, telephone conversations and preparation of written communication to follow-up information and issues; negotiations with other parties in order to influence and build support; and preparation of documentation that was acceptable to multiple partners.

At the Department of Health, a senior policy officer was assigned responsibility for participating in and representing Health’s interests in interdepartmental committees and working groups, and developing the coordinated state policy submission.

**Policy Process:**
The process for developing a coordinated cross-portfolio policy submission was influenced by the availability of time and resources as well as a need to work within the parameters of a cross-portfolio environment and involved a number of activities.

*Collecting and analysing data*
Relevant data and evidence was collected, analysed and interpreted, including web-based literature review, to develop a robust Health position. Depending on the particular policy task, there are different types of evidence and information available, “not all of it is ‘pure’”, and specific information is selected to present an argument:

> [...] given the timeline we had, that was basically internet-based research, but you’d get leads to other documents, it was a fairly intensive process of review. I think about 30 or 40 articles, as well as the kind of key ones that have been identified. Of course one has to read them yourself because you can’t rely on other people’s interpretation of those documents, and produce a short summary [...] .

*Participating in consultative structures*
The assigned policy officer participated in interdepartmental committees and working groups to represent the interests of the Department of Health;

*Engaging stakeholders*
The assigned policy officer consulted with different interests within and external to the department to develop a Department of Health position;

*Negotiating and reaching agreement*
The assigned policy officer had to negotiate with and influence other departments to build support for Health’s position, and work towards developing a shared understanding of and consensus between parties; and
Writing papers and reports

The assigned policy officer had to prepare documentation for departmental sign off and collaborate with other departments in preparing a coordinated state government submission.

POLICY OUTCOMES:
The process for conducting interdepartmental policy work was frustrating and time-consuming in relation to the results achieved, with large amounts of time spent participating in committee and working group meetings, heated negotiations, and writing and telephone follow-up.

The high demands on policy officer’s time to produce information and prepare briefs, inability to fully explore and debate issues, the need to constantly explain and defend Health’s position as other departments were unfamiliar with this way of thinking, “there’s a kind of policy conflict there”, lack of authority and control over the process, and short timelines for completing the project “…had contributed to policy failure”.

The dual responsibilities of cross-portfolio work was frustrating for the policy officer involved in this policy initiative: on the one hand, preparing information and proposals, which had to be undertaken within the parameters of departmental structures and boundaries; on the other, the need to adhere to participatory structures and demands of interdepartmental processes.

The output delivered in this policy initiative included the Department of Health’s contribution to a Cabinet submission, which was coordinated by the Department of Premier and Cabinet. The final Cabinet submission was disappointing as it did not adequately reflect Health’s contribution and perspective; further, the Department of Premier and Cabinet in association with the Department of Treasury and Finance appeared to have an undisclosed agenda and predetermined position:
I mean there was also other difficulties because the Department of Trade, the Department of Treasury and Finance have a particular view on this, and that’s not on the table, actually explained because of this conflict and renegotiation or people haven’t actually put it out there to actually debate. It’s been a negotiation that has happened elsewhere between the Department of Premier and Cabinet and Department of Treasury and Finance. So it’s not a decision about what is the best approach based on the evidence as we perceive it, it’s already been pre-determined to an extent.22

REVIEWING LEGISLATION

POLICY EPISODE: THE MENTAL HEALTH ACT23

POLICY BACKGROUND:
The Minister for Health determined on a review of the Mental Health Act, which provides the legislative framework for the treatment, rehabilitation and protection of mentally ill people. This review commenced in 2008-09 and was scheduled for completion in 2012.24

In the jurisdiction, ministerial responsibility for the Mental Health Act is shared between the Minister for Health and the Minister for Justice and Community Safety, with both departments responsible for its administration. This shared responsibility has been in operation for many years; currently the arrangement works well although there had been problems in the past.

POLICY INPUTS (CAPACITY):
The Policy Division was assigned responsibility for reviewing the mental health legislation, with the Executive Director25 responsible for the overall management of the project. One quarter of an effective full-time (EFT) policy officer’s position was allocated to conduct the project, “[…] the in-house process work that has to be done to prop the whole system up is a quarter of the person, or less. I mean, the quarter of the person is the team”. The policy officer was responsible for day to day administration of the project, as well as, organising and conducting consultations with multiple stakeholders, servicing advisory committees, drafting correspondence and policy papers, and liaising with other government departments and external interests. For this exercise, a single, part-time

22 There was no discussion in the focus group about the outcomes achieved on receipt of the submission by Cabinet.
23 Policy episode narrated by Brendan-AF.
24 The underlying reasons regarding the minister’s decision to review the legislation was not made explicit in the interview although it was inferred that there were some limitations and sixteen years had passed since its enactment.
25 The Executive Director, Policy, also chaired the Policy Management Team and Review Advisory Committee (see later section for details).
officer was assigned to the project instead of a team with different skills, as was usual practice in other jurisdictions. However, the Department of Health also commissioned external consultants to assist with the preparation of technical papers, organisation and conduct of individual interviews and facilitation of advisory committee meetings.

**POLICY PROCESS:**
The process for reviewing the mental health legislation involved a number of activities.

*Engaging stakeholders*
Consultations were conducted with a wide range of stakeholders (government departments, service providers, non-government organisations, consumer and community groups, professional interests, and other individuals and organisations with an interest in mental health) to obtain their input (information, opinions and advice) to the process. It was pointed out that all government departments were expected to follow guidelines for community engagement as specified by the Government.

In addition, a number of consultative structures were established to ensure input from a range of stakeholders, including a Policy Management Team comprising senior policy officers from relevant government departments to oversee the management of the project, a Review Advisory Committee representing the interests of key mental health stakeholders including consumers and community, and ad hoc sub-committees established to examine specific issue/s:

*The review of the Mental Health Act has a Review Advisory Committee which is made up of the key stakeholders and that’s - if they all turn up we can have 40 turn up to a meeting and you can’t not have them turn up [...]. I mean, how do you do that governance where everybody has to be there, whether it’s consumers or carers or the chief magistrate or the Head of Department of Public Prosecutions, Chief Psychiatrist, Corrections, and others.*

*Writing papers and reports*
A number of information and technical papers were prepared by either in-house staff or commissioned consultants on specific topics. The department also prepared detailed documentation on the guiding principles, general directions, and implications for service delivery to be included in the proposed Mental Health Bill.
Liasoning with Parliamentary Counsel

The department liaised closely with the Parliamentary Counsel Office in preparing the draft legislation for discussion and debate in Parliament. The Department of Health also continued to liaise with other government departments to ensure the legislation’s enactment.

**Policy Outputs and Outcomes:**

Technical and briefing papers are being developed together with establishment of governance structures, further consultation with stakeholders, and drafting of legislation to be completed during 2012.

The Department would need to give consideration to developing an information kit and conducting information sessions to inform agencies about the implications of the new legislation.  

5.2 **Explaining the Work of Policy**

The aim of this section is to present the findings from the analysis of the research data, comprising the twenty-three policy episodes, transcripts and government reports and organisational structures, in terms of the elements of the conceptual framework: nature of policy work; policy capacity; policy process; influence of external environment; policy outputs; and policy outcomes.

**Nature of policy work**

The analysis of the research data demonstrated the breadth, complexity and multiple purposes of policy work in the three health authorities.

**Range of Policy Topics**

The development and implementation of health policy involves a broad range of policy topics reflective of Health Department responsibilities in regard to service programmes comprising acute health, mental health, public health, primary health, alcohol and drug treatment, palliative care, and aged care; specific population groups comprising indigenous and other ethnic communities, women, and people with disabilities; and operational

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26 As the policy work was still in progress, it was difficult for the participant to comment on the likelihood of the legislation being enacted and the longer term outcomes to be achieved by the review of the mental health legislation. The Government intent was that the changes would lead to health system improvements for people with mental health conditions.

27 The element of review and monitor is referred to in the policy process section.
processes, systems and structures comprising financial management, clinical standards, governance structures, and performance indicators:

*It’s the Policy Division, it has policy responsibilities around particular topics in health and aged care, drug and alcohol, mental health, indigenous, these sorts of things.* (Cameron-AF)

This diversity of policy topics is reflected in the policy episodes which included development of clinical standards and guidelines to improve practice (*Agency safe handling of drugs, and ACAP practice standards*), development of performance measures (*Health system goals and targets*), review of health system structures and processes (*Health System, structures and services, Hospital boards of management*), monitoring and managing potential threats to public health (*Managing spread of HIV*), development of programmes for specific population groups (*Indigenous children’s health*), and submissions for funding (*Statewide policy on diabetes type 2, Statewide renal service plan*).

A senior manager commented on how policy units and policy workers respond to this diversity:

* [...] and that’s part of our skill set is to be adaptive and to become the world’s experts on bizarre things we’ve never heard of before and to be responsive. So unfortunately, policy divisions tend to get this sort of ‘jack of all trades’ fix it sort of responsibility and they can’t afford to say ‘we’re the people who only do this’. So there’s a sort of adaptiveness and willingness to expose yourself to that risk of ‘I need to find out everything there is to know about insulin pumps in the next 24 hours’ [...].* (XI-2)

**RELATIONS WITH OTHER STATE AND TERRITORY DEPARTMENTS AND THE COMMONWEALTH**

The development and implementation of health policy extends beyond the boundaries of health authorities to include relations with other departments at both the Commonwealth and State and Territory level in the sectors of education, employment, finance, housing, immigration, justice, trade and welfare and reflected in the policy episodes which included cross portfolio relations (*Review of the Mental Health Act, Child safety reporting responsibilities, and National review on maternity leave*) and intergovernmental relations (*National health workforce agency, Statewide policy on diabetes type 2, and Statewide alcohol action plan*).
According to one focus group participant:

*Some policy development goes across different portfolios. For this it touched on education as well as the health portfolio. I think that’s important. We’re dealing with different cultures, totally different governance structures, totally different viewpoints.* (Molly-AF)

and

* […] that when a policy comes up […] it often crosses legislation. It’s often inter-jurisdictional. It’s across different portfolios and agencies, it’s quite complex […].* (Molly-AF)

Another participant commented:

* […] and I don’t think we’re sophisticated enough to have very clear up to date knowledge of our populations and the health determinants and the rest that goes with that and that means getting out of the health sector and considering education, housing and employment on the influence of health. So, when we’re establishing policy, sometimes the health policy is going to affect education, housing, business, and this sort of thing. We sort of do that in that there’s been some integration […].* (Gillian-BF)

How a wider than health approach can be effective is summed up in this senior manager’s comments:

* […] we’ve placed responsibilities on other government departments for our chronic disease strategy in recognition of that intersectoral nature and we took our chronic disease strategy to Cabinet and asked the Cabinet to sign off on it as a whole of government document. And, we’re just starting to work our way through now asking the government departments of interest to report to us about how they’re going against the accountabilities that we asked them to take responsibility for. So we’d ask our public transport colleagues what steps they’re taking and they’ve done things like put bike racks on the front of their buses and people get free bus transport if they use a bike […].* (XI-2)

**FOCUS OF POLICY WORK**

The development and implementation of health policy also varies in focus depending on outcomes to be achieved. A policy might apply a strategic focus, at a statewide or long term level, an operational focus, at a programmes and services level, or a clinically-oriented focus at a health agency level. This variation in focus was reflected in the policy episodes which included policy with a strategic focus (**Statewide policy on diabetes type 2**
and Review of Mental Health Act), an operational focus (National mental health standards and Child safety reporting responsibilities) and a clinical focus (Consent-to-treatment and Sexual assault forensic kits).

A senior manager explained how this difference in policy focus is reflected in Division and Branch policy responsibilities:

In Queensland Health, there are different types of policies: operational policies, strategic policies and combinations of the two broad areas with overlap and cross-overs. Operational policy work is undertaken throughout the Department in various operational or program branches and divisions; strategic policy, on the other hand, is the domain of various units and branches in the central or corporate office. Importantly, no single Unit in Queensland Health has overall responsibility for policy work. (YI-5)

However, policy development may start out with a clinical focus and then broaden out as more strategic interests are identified:

[...] in the alcohol and drug program we have a lot of issues with aggressive clients [...]. And there is no policy around what do you do in these situations, what happens, what are the steps? So we actually developed something within our program which was developed by a nurse and an allied health professional [...]. Then as we’re working through that it suddenly becomes evident that mental health obviously has these issues as well, so does the dental health program and in fact, so does The Canberra Hospital. And so what has happened now is that we’ve now just started an ACT Health wide response to aggression and violence policy. (Vanessa-AF)

Sometimes the distinctions between ‘operational’ and ‘strategic’ can become blurred, as a senior manager commented:

We do occasionally start at the strategic plan and work up to the policy and down to the operational bit. That happens from time to time, worth doing. Some of that’s retrofitting, so we’re doing that for mental health, for instance. We’ve got a strategic plan being rolled out in an operational sense [...]. (ZI-9)

In summary, the nature of policy work in the three health authorities can be characterised as being complex and challenging. The range in policy topics varies from programmes, population groups, and systems-procedures-structures each with a particular group of stakeholders and relevant subject matter. Cross-portfolio and intergovernmental relations
involves negotiations with other stakeholders to develop a shared understanding of perspectives in order to reach consensus and agreement on policy outcomes. The focus of policy work varies from the strategic to operational and clinical which provides a particular perspective to the development of policy outcomes.

**Policy capacity**

**INDIVIDUALS RATHER THAN TEAMS**

In most policy episodes, the resources mobilised to complete the policy project included an experienced policy or project officer (*Emergency dental care triage, Statewide renal service plan, Student clinical placements*). While limited and part-time resources were assigned to some policy projects (*Review of Mental Health Act*), despite the broad responsibilities of coordination, stakeholder consultation and negotiation, administration, report preparation and provision of support to advisory and steering committees.

A team of policy personnel, comprising a range of skills, was seldom assembled to conduct specific policy initiatives; a point demonstrated by a participant’s response “[...] No. I mean, the quarter of the person is the team.” Even in large scale, complex policy initiatives (*Review of Mental Health Act, Statewide renal service plan*) it was rare for a team of policy experts to be mobilised at the commencement of a project. In some projects (*Emergency dental care triage, Statewide renal service plan*), however, as the work progressed, a small team comprising a combination of skills was assembled to complete the policy work. Although policy work, in most instances, was conducted on a project basis by an individual officer, it was usually organised and managed as part of a larger branch or unit, say a Policy and Strategy Unit or Intergovernmental Policy Unit.

**GENERALISTS RATHER THAN SPECIALISTS**

The human resources assigned to conduct policy work in the three health authorities were skilled and experienced policy practitioners, with educational backgrounds in social science, health science, science, business and management, economics, and law. They were usually generalists able to perform a variety of policy projects rather than specifically-trained technical specialists.

As one focus group participant noted:
 [...] one of the organisational strengths around why we are able to knock out quite reasonable policy, is because we all actually have to get across [many areas] we are such a small jurisdiction, the breadth of what we’ve got to get across is actually quite broad compared to some of our colleagues in the other States and Territories [...]. So you can bring more to the table in one hit [...]. (Brendan-AF)

As one senior manager reported on the range of topics covered by policy staff:

> It’s better than it was. It’s not fantastic, but there’s a small group of people who do policy who have good policy skills, and they tend to bounce from one topic to another. (ZI-9)

**Clinical Backgrounds**

In addition to the above point about general educational backgrounds, many participants from the three jurisdictions reported that significant numbers of staff working in policy roles had clinical backgrounds, comprising nurses, physiotherapists, speech pathologists and social workers, and came from service delivery backgrounds, frequently motivated by the objective of improving a health problem or working in a health area of personal interest. In some jurisdictions, such as ACT and Queensland, the movement between clinical and administrative positions was relatively easy given the department’s direct responsibility for health services. A number of participants commented that staff with clinical backgrounds, although trained in health sciences, did not have the necessary policy development skills for analysing and interpreting data, negotiating in areas of Commonwealth-state relations and finance, and writing; as summed up in the following statements:

> And all of sudden they find themselves in a position where they have to provide some policy advice and have no idea what to do or how to do it, and often have no idea about numbers either. About how to manipulate information and how to analyse it. Often don’t know how to write. (ZI-9);

and

> [...] people undertaking policy have clinical skills but don’t have the necessary writing and analytical skills required for policy development. (Oscar-AF)
HEALTH POLICY COMPETENCIES
All focus group participants perceived the following individual competencies, characterised as knowledge, skills and attributes, to be important for conducting good policy work. Refer to Table 19.

Table 19: Individual policy competencies

<table>
<thead>
<tr>
<th>Competency</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contextual knowledge</td>
<td>Knowledge of the social, economic and political environment; workings of government and public sector environment; stakeholder interests; public representations of issues</td>
</tr>
<tr>
<td>Content knowledge</td>
<td>Knowledge of the health system: history; programs and services; financing; issues and concerns; stakeholders and networks</td>
</tr>
<tr>
<td>Policy work knowledge and skills</td>
<td>Knowledge of the policy making process: issue identification, information analysis, stakeholder engagement, negotiation and agreement, documentation preparation, implementation, and evaluation</td>
</tr>
<tr>
<td>Communication and interpersonal skills</td>
<td>Ability to listen carefully and understand different perspectives, ability to communicate ideas, ability to engage and build relationships with a range of stakeholders; ability to negotiate effectively and gain support; ability to craft a report - to write clearly, succinctly and communicate complex ideas; and an ability to articulate and discuss concepts and issues</td>
</tr>
<tr>
<td>Analytical skills</td>
<td>Ability to analyse, interpret and apply information, including quantitative data; strong conceptual and analytical skills – clear thinking, logical and critical.</td>
</tr>
<tr>
<td>Political astuteness</td>
<td>Awareness of politically sensitive issues. Understanding the ‘political lie of the land’; being able to anticipate the ‘curve balls’; finding opportunities to influence decision making despite difficult environments</td>
</tr>
<tr>
<td>Personal attributes</td>
<td>Intellectual flexibility, ability to deal with complexity, confidence, resilience, reflexivity, persistence, and pragmatism</td>
</tr>
<tr>
<td>Judgement</td>
<td>Judgement in relation to decisions and actions: use of evidence; consultation with stakeholders; negotiating position; and timing for providing advice</td>
</tr>
</tbody>
</table>
Focus group participants and senior managers were generally in agreement about the importance of the above competencies. Focus group participants emphasised communication and interpersonal skills, contextual knowledge, personal attributes and political astuteness in their descriptions of policy competencies. Senior managers emphasised a combination of political and technical knowledge and skills, health-related expertise, intellectual flexibility, ability to apply knowledge, and good writing skills.

Competencies frequently mentioned included awareness of the political context, including ministers’ and other stakeholders’ positions and priorities; analytical skills, including quantitative skills and ability to access and use information; and communication skills, including writing skills and the ability to effectively engage with stakeholders. Whilst short time frames, lack of resources and political influence were identified as constraints by focus group participants and were also recognised by senior managers, the latter expressed the view that policy workers required competencies to cope with short time frames, vagaries of the political environment, resource constraints and stakeholder opposition. Broadly senior managers were of the view that competencies in project management were required specifically to deal with these constraints in terms of project plans that acknowledged timelines and accordingly determined scope for research, stakeholder engagement and document preparation.

Good writing skills were viewed as an important policy competency by senior managers, as noted in the following comments: “good brief writing” was essential to policy work; the ability to write policy “clearly and succinctly”; the ability to “communicate the message effectively in writing”; and an ability to “distil information and write quickly”.

Analytical and communication skills:

*I very much look to analytical thinking and the ability to gather evidence, first of all. And that ability to communicate with a range of stakeholders, so I think with those two, just to be someone who can devour and synthesise information and evidence on the one hand and then be a very patient and effective communicator with a diverse range of stakeholders are the two key skill sets that I’d look for.* (XI-2)
Communication skills:

*But if we haven’t been communicating very effectively with our stakeholders and with our public and with people who might be protagonists along the way, we’ll find that even with the best evidence and even with political backing and with resources behind us, we might come unstuck in the final analysis because we haven’t been effective in communication.* (XI-2)

Personal attributes:

*It was important for a person working in policy to have ‘perseverance and determination’.* (Molly-AF);

*Working in policy […] it was essential to have a bit of a ‘thick skin’ […].* (Molly-AF);

*[…] the other attribute I would like to add is flexibility to go from one topic to another […].* (Hanna-BF);

and

*I think being resilient is really important, whether you stay or whether you leave the task ‘bitter and twisted’.* (Monica-BF).

Writing skills:

*I look for things like people who can write well […].* (ZI-9);

and

*I think policy people have to be able to write clearly and effectively so people can understand it in the least words possible. I think that this is a very important [policy] skill and its variable.* (YI-7)

In most policy episodes, in-house resources were supplemented by external consultants commissioned for their technical expertise, for example clinical, epidemiology and statistics (*Emergency dental care triage, Statewide renal service plan, Review of Mental Health Act*). Consultants were commissioned to conduct a variety of tasks, including the preparation of technical papers, provision of clinical advice, and conduct of the consultation process with stakeholders:

*We have an external consultant who is doing the writing of the technical papers and some of the face-to-face single consultation processes […].* (Brendan-AF)
In addition to input from external consultants, advisory structures such as steering committees, reference groups, and working sub-committees were established for most large-scale policy projects, with representation from a broad range of stakeholder interests. Although the purpose of these committees varied, they mainly contributed to providing technical/clinical information and advice, stakeholder consensus and support, and direction and guidance adding significantly to the in-house capacity of the department. In one policy episode, the absence of an established working group of key stakeholders, comprising other departments, universities, and non-government organisations, was considered a barrier.

In most of the policy episodes, besides human resources input to conduct the policy work, there were limited additional financial resources made available to purchase information, and other specialised support and equipment for the policy development exercise.

Time may be considered a policy input. In many policy episodes, participants reported that insufficient time was allocated to complete the task to a satisfactory level, which didn’t allow for the necessary range of policy activities to be conducted comprising identifying the problem, consulting and negotiating with multiple stakeholders, collecting and analysing information and evidence, preparing written material, seeking approval, and implementing the program and service. A point confirmed by the following comments by participants:

*One of the other issues here was the timeframes were exceptionally short and we were forever apologising for yet another request to somebody - we need this by midday today - and these requests would be coming down to us from Premiers.* (Monica-BF);

and

*...* when you’re writing a policy if you’re a policy developer then that’s your job and you’re writing a policy but you’re sending it out to people who have a whole host of other jobs of which this is a small part in terms of response time and timeframes can often be very tight and [referring to the difficulties] somebody putting in delayed comments on a draft [...].

(Christine-AF)

However, in a few policy episodes, those involving legislative reviews and designing and implementing systems change, adequate time was allowed for a comprehensive policy development process.
In summary, limited human resources were allocated by health authorities for conducting policy projects, despite their scope and complexity. In most policy episodes, a team, comprising a mix of skills, was less frequently assembled at the commencement of a project, even in large policy projects, such as, review of mental health legislation, and statewide service planning. In many policy episodes, there were limited financial resources made available to support the purchase and development of information, and specialised equipment to complete the policy project.

The policy episodes revealed that capacity, in the form of mobilisation of human resources comprising quantity, mix of skill and expertise, and organisation, and provision of infrastructure and supports, was an important factor underpinning and influencing policy work outputs and outcomes.

Policy process
The policy episodes illustrated that there was no standardised approach to policy work in the three jurisdictions, with differences due to government priority, organisational context, type of policy, availability of time and resources, and the policy’s stage of development. However, a number of similar activities were identified by the participants in narrating their policy episodes, including:

IDENTIFYING A PROBLEM AND PLACING ON THE AGENDA
Participants commented that it was important for policy development to clarify the nature of the problem or issue which at times was not self-evident. The issues identified for policy development originated from a number of sources, including political systems and processes, including election promises, ministerial directives and or cabinet deliberations; government structures and processes, including tabled parliamentary reports (Auditor-General, Productivity Commission); national agenda items arising out of COAG and AHMC; failure to comply with regulations (disclosure of status); adverse events, including deaths, and failures in safety and quality standards; funding, including State Budget and Australian Health Care Agreement; service delivery gaps and problems; consistency in quality and safety standards; and media investigation.

ENGAGING STAKEHOLDERS
Participants considered engaging a range of stakeholders to be an important activity of the policy process. In ensuring input from different stakeholders, participants used various
approaches including submissions, public fora, individual interviews, group discussions and surveys. In many instances, committees and or working groups were established to ensure inter alia representation of stakeholder interests, obtaining clinical and technical expertise, overseeing the management of the policy process, and participation in developing and implementing policy.

Participants commented that they used a variety of methods to engage stakeholders, including focus groups, submissions and online surveys:

*It was pinned largely on broad consultation with practitioners in the system, with consumer groups, with policy makers, planners, it was a very broad consultation exercise which we ran over a [...] lengthy period. And was followed up [...] with focus group type meetings in each area [...]. And then invited formal submissions from all of the stakeholders in the system which was quite a lengthy exercise.* (William-CF)

Another participant commented:

*We used the online tool that was developed by the Department of Communities, getinvolved.qld.gov.au and so that was a mechanism by which we were able to analyse data and results.* (Sarah-BF)

The use of committees and working groups to involve stakeholders in the policy process was raised by many participants, as illustrated in these comments:

*ACT Health did what it would usually do. It pulled together a working group of very busy clinical people who were meant to meet regularly, but couldn’t get there. So it went to a working group model, which in fact was highly problematic because we all know it is very difficult to consult and to get input to something significant by getting people all together in a room at the same time.* (Sandra-AF)

Another participant reported:

* [...] an interdepartmental working group has developed it. So there’s been significant agency buy-in to the development of the policy across government. Obviously way beyond Health [...].* (Belinda-CF)

The establishment of a committee to oversee the implementation process is supported in this comment:
So, having that multidisciplinary committee and then understanding the policy and then developing a district-wide procedure across all those streams, some of them sat in the hospital, some of them sat in community services or mental health services and for managing the information, we have the health information management people as well. That was really quite complicated and also getting a group of educators across the district that would develop the education package that matched the policy [...]. (Gillian-BF)

Cross-portfolio and inter-governmental coordination and collaboration was reported as a strong feature of policy work in the majority of policy episodes. This ranged from participation on formally established inter-departmental committees, task forces and working groups, to individual meetings and exchange of information and advice. The emphasis of State and Territory governments on ‘joined-up’ or ‘whole-of-government’ policy approaches probably reflects an increase in this policy activity.

INVESTIGATION AND ANALYSIS
Participants considered collecting, analysing and interpreting information and evidence to be a routine but important component of policy work. They had a broad interpretation of the required information and evidence that ranged from scholarly literature, government reports, working papers and statistical data, to web-based information. Importantly, participants reported that information and evidence had to be obtained quickly and efficiently.

In selecting and applying evidence and information, participants were influenced by organisational context, type of policy work, and availability of time and resources, resulting in a range of responses comprising reviewing the literature; analysing demographic, health services and financial data; examining policies and models from international, national and state and territory jurisdictions; developing and assessing options, including advantages and disadvantages and costs and benefits; developing strategies and proposing actions; and making recommendations.

The availability of time was a constraint on options for data collection:

 [...] so in terms of the timeline we had, that was basically internet-based research, but you’d get leads to other documents, it was a fairly intensive process of reviewing that. I think about 30 or 40 articles, as well as the kind of key ones that have been identified. Of course, one has to read them
you can’t rely on other people’s interpretation of those documents, and produce a short, short summary of that, which meant that you’d produce a long version and then you’d get down to the nitty-gritty of producing a shorter version. (Amelia-CF)

The selection and analysis of information is driven by the policy output and outcomes to be achieved. As a respondent commented in regard to the development of new clinical guidelines:

...there was a large body of evidence out there on what was best practice and what we were trying to do when we developed those documents was to actually encapsulate what is considered best practice or safe practice, which was not always necessarily what was currently happening. (Lara-AF)

Examining policies of other jurisdictions and then modifying to suit a particular situation was a common practice:

The government solicitor, we went to the university, we went to the staff development unit. Yes, we looked at different states, different jurisdictions, what they did. (Vanessa-AF)

...there was some existing policy but there were loopholes and gaps and so we had to go out to look at other jurisdictions in Australia [...]. (Genevieve-BF)

and

... but you do a lot of scoping of what other people [jurisdictions] are doing [...]. (Cameron-AF)

A senior manager commented that policy making has become much more evidence based with a need to draw on available evidence and information from interstate and overseas which was not a common practice in the past:

Policy development in the department is now more evidence-informed [...] there is more awareness of an attempt to actually find out what the available evidence is on a particular topic and to feed that into the policy development process than there was in the past. (ZI-11)

A number of participants commented on commissioning external expertise to obtain information and evidence for policy development:
what we did was commission a literature review to actually really get the evidence because we knew this was going to be very controversial when we started discussing it with a range of people. [...] We commissioned a literature review to be undertaken by the Centre for [name deleted], which is the only one in the world that happens to sit in Australia, and that was to assist us to understand what the literature said, particularly level 1 evidence or below, to really look at what was out there. That’s really important. (Molly-AF)

While other participants commented that in some policy development initiatives there was no evidence available:

*I had difficulty finding an evidence base I guess in Australia and overseas, because this is quite complicated policy. (Sandra-AF)*

and

*Not all policy has a strong evidence-based research background [...] in a lot of cases you identify a huge gap, that it is [evidence] actually not there and that other states and territories haven’t developed it and often because it’s in the too hard box. (Christine-AF)*

### NEGOTIATING AND INFLUENCING

Participants considered negotiating, bargaining and influencing central to the policy process given the differences in stakeholder interests and priorities. The negotiations required substantial effort in order to develop a shared understanding, gain support and reach consensus between the parties about the policy. The importance of negotiation and persuasion, and the effort required to develop a common understanding, and gain support and consensus is reflected in these comments by participants and senior managers:

*Some of the challenges are to communicate that across the different units, different disciplines, and different agencies. And even culturally some units were, some clinical areas were very reticent to actually give that information up and believe that it could be done centrally as well. So there is a lot of marketing and ‘grovelling’ almost, to say this is the benefit, and this is all going to help us in the end. [...] And to try and bring the [type of] students and agencies on board was also a challenge. (Karen-AF)*

*There’s a whole lot of things in that process, and it took 10 years, that is to develop the questions, to trial them, to modify them, to get agreement from our clinicians [and administrators] in terms of the so-called ‘gold standard’, to get consumer participation in that process the whole way along, that in*
fact is this what they wanted to see happen? To ultimately, get a situation where we had an agreement that this is what we would do [...]. (Brian-CF)

[…] and I guess a key issue for us was steering groups, which was about ownership the whole way through. Good communication with our staff through those steering groups, through management so that people were both engaged and the negativity could be addressed as it occurred, rather than once the policy had been developed and then you are on the back foot all the time. So, I guess really from our point of view in policy development you have got to build relationships with the people who are going to have to do it [...]. (Brian-CF)

and

It's mainly about being the bridge builder and the negotiator between those technical skills and what is the art of the achievable, and that's the other definition of politics isn't it, how one could use an evidence based intervention to get a good public health outcome, but make sure it will get across the line because the stakeholder management and the negotiation and the political acceptability of it has been properly managed. (XI-2)

A senior manager reported that negotiating and liaising were key functions in building support and reaching agreement in policy development, suggesting that negotiation with stakeholders was more a role performed by senior managers than mid-level practitioners:

[…] at the senior level […] you do need the capacity for people to be able to do a lot more of the negotiation and liaison with both internal and external stakeholders, and less of that is required at the middle level. [...] the difficult negotiations are carried out by the more senior people. (ZI-11)

PREPARING A WRITTEN DOCUMENT
Participants reported that the output of the policy process was the preparation of a written document, including briefing notes, discussion papers and reports. However, policy writing was viewed as an iterative process requiring a continuous process of drafting, editing and revising in response to feedback from ongoing consultations and negotiations with multiple stakeholders. Drafting and preparing legislation was more demanding, requiring precision of wording and intent, while working collaboratively with Parliamentary Counsel.

As one participant commented on the iterative process of authoring and authorising:
[...] we’ve got to write a document that works for the whole organisation, not one part of the organisation. So it was just this to-ing and fro-ing and then someone had to make a decision about what was in or out [...] and I think that’s still an issue in ACT Health and perhaps everywhere in terms of how you get sign-off, how you make things not too bureaucratic, that kind of thing, but still end up with meaningful documents. (Briony-AF)

The need to prepare a variety documents as outputs on one policy issue was raised by another participant:

So there was an analysis process and [the output] of that analysis was a policy options document for the Minister [...]. The Minister came back with desired options. Those options were then put into the cabinet policy submission. Cabinet came back a couple of times wanting more detail or further information or knocking back a couple. That process happened three times to actually finalise what the cabinet policy would be, after which an Authority to Prepare Legislation submission was made and then that was passed by cabinet and went through parliament and we had a new Act. (Sarah-BF)

AUTHORISING

Participants reported that obtaining departmental, ministerial and or government approval was important in the policy process. The authorisation of policy depended on type of policy being developed. Legislation required formal structures and processes while other types of policy required less formalised structures and processes. Regardless of policy type, gaining ministerial approval involved ensuring the minister, advisers and senior departmental staff were kept informed of the policy and proposed new developments that could be controversial.

Where policies had strong ministerial and executive support, especially those linked to national policy initiatives, the approval process could be almost automatic:

[...] we could have influenced a bit further to our advantage before it was signed off. Anyway, it was a done deal so it got signed off and we’re now in the process of trying to look at how that might get implemented at a national level. (Maria-AF)

However, in other cases policies could get bogged-down in the approval process for reasons that were not always clear:
The sign-off point in policy is the Portfolio Executive [...] and that can be about 25 or 30 people [...] we’re now in limbo, we’re being told that the policy has to come back but there was no sort of formal direction back from the executive - and it’s causing problems. (Cameron-AF)

Some policy, such as budget submissions and legislation, had to go to a higher level requiring Cabinet submissions for approval and sign-off, as illustrated in this comment:

[...] and in this circumstance the document had to go to Cabinet for sign off, so you can imagine there is a range of government players in this process from Department of Premier and Cabinet, Department of Families & Communities, Health, Economic Development and Immigration, DECS, Department of Treasury & Finance [...]. (Amelia-CF)

IMPLEMENTING

Participants identified the implementation of policy, transforming policy objectives into programs and services, as an important function of the policy process. However, in some policy episodes participants did not perceive such a clear distinction between the functions of policy development and policy implementation rather reporting that the functions overlapped or merged:

[...] you’ve got these people far away from the clinical world making decisions so they are way out there. And then you’ve got people right at the grass roots that are doing the business who know the business best and probably have the best handle on it. And trying to get them to inform that process is very difficult. But on top of that, when the stuff does eventually come down to them, it is so rare that it happens, they are generally left with and they’re told something that is a fait accompli. This is like no one has got an idea of how this is going to look and it is changing as we move. But there is large money attached to it. (Maria-AF)

Participants’ interpretations of policy implementation varied, influenced by the point in the policy process where the narrated episode occurred, that is, either in the earlier phase of policy development or in the later phase of implementation. In the earlier phase, some participants expressed confidence that implementation would follow policy development and authorisation whereas others expressed uncertainty about progress to implementation. In some policy episodes, participants reported that no progress had been made or the policy had not been implemented or, if implemented, its status was not mentioned.
Participants mentioned that to ensure successful implementation it was necessary to have government commitment, resources and agency support as well as an appropriate strategy to manage implementation.

A lack of support for implementation could leave policy instruments in limbo, as reported by one participant:

> And the net result was that those documents were developed within a division and finalised and approved and there was agreement that that suite of documents would be taken up by ACT Health to be driven in terms of implementation and consultation across ACT Health. And to date, that has not occurred. So what we have now is a set of documents that has been developed within a division that are evidence-based that people are referring to with no clear mandate that they are required to comply with. (Lara-AF)

A number of participants reported that limited resources and supports were allocated to enable policy implementation, in particular those linked to national initiatives:

> [...] but a lot of the time national overarching policies are set with no funding attached and the expectation that somehow the states will manage to roll out these quite intensive actions. (Belinda-CF)

On the other hand, commitment to and support, particularly in the form of resourcing, from minister and senior departmental staff, provided a positive and enabling environment for implementation, as reflected in these comments from participants:

> So you could see that there was a political will at the top to change things, with a directive from management at the top to change something about the working processes of people on the ground. (Steve-CF)

> There was a level of commitment that was resourcing. There was an environment across government that encouraged the work which I think was important as well and absolute commitment from the Director General down. (Margo-BF)

and
The policy process has been going on constantly for four years in this area and the national climate and the state climate has been very supportive of this policy direction. So we’ve had all the support for the past four years from both federal and state government. It’s been top priority. So it’s made our job quite easy really. We’ve got everything we asked for. (Louise-BF)

Monitoring and Reviewing
Participants seldom discussed monitoring, evaluation and feedback of findings for subsequent improvement in policy redesign and redevelopment. On the few occasions they referred to monitoring and reviewing policy, it was usually in the context of program management and accountability, such as monitoring performance in order to achieve agreed activity and funding targets. The policy episodes revealed that this policy activity was either not routinely performed as part of policy work; conducted by external consultants and was therefore not a prominent activity performed by policy practitioners; or not reported in the focus group discussions:

[...] what I think is often lacking with a policy development is the ongoing bit which is the implementation, monitoring and review, particularly evidence-based, informing research and evidence-based practice. (Molly-AF)

Testing
Participants discussed in only a couple of policy episodes the conducting of pilots to test the suitability of new and or revised policies with the feedback used to revise policy (Emergency dental care triage).

In summary, the policy episodes demonstrated variability in the policy making process in the three health authorities, with differences due to government priority, organisational context, type of policy, availability of time and resources, and the policy’s stage of development. Nonetheless, there were commonalities in the broad activities that constituted the policy making process comprising problem identification, engaging with stakeholders, investigation and analysis, negotiating and influencing, preparing documentation, obtaining authorisations, implementation, and monitoring, reviewing and testing.

Influence of external environment
The influence of the external environment on policy making was evident in the majority of policy episodes, in the form of interaction with the premier or chief minister, ministers of
health, members of parliament, Cabinet, parliamentary committees, members of political
departments, the minister and ministerial advisers, and liaison with the Parliamentary Counsel Office in preparing draft
legislation for passage through Parliament.

A number of policy episodes referred to frequent requests by the minister’s office to
prepare policy advice after an issue had been raised by the media, interest group or
member of the public. For instance, many participants commented on the role and
influence of the media; and as one reported:

\[... \text{it is important to keep bad news stories out of the paper and get good}
\text{news stories into the paper} \ldots \text{it [bad news] must be kept away from the}
\text{front pages of the [name of daily paper].}\]

Participants also spoke at length about preparing policy briefings for cabinet and for
various parliamentary committees.

The influence of political parties, both in government and opposition, was also reflected in
a number of policy episodes, with many examples referring to pressure to implement
rapidly the incoming government’s election promise and some of the COAG policy
reforms. For instance, the 

\textit{Nurses return to workforce} policy episode had strong
government support and was considered a high priority as an election promise by the
incoming Rudd Labor government.

Engagement of and consultation with a wide range of external and internal stakeholders
was reported in all policy episodes, and was regarded as a routine feature of policy
activity. Depending on the policy issue, external stakeholders consulted included health
agencies, professional associations, non-government organisations, academic institutions,
think tanks, industry groups, community interests, government departments, other
jurisdictions and other levels of government as well as the media. Illustrated in all policy
episodes was the role and influence of external actors in shaping health policy, such as,
hospitals and other health services; professional associations such as the Australian
Medical Association, Australian Dental Association, Australian Nursing Federation,
Australian College of Health Executives, College of General Practitioners, and College of
Physicians; and health interest groups such as Australian Cancer Council, Australian Heart Foundation, Mental Health Alliance, Australian Drug Foundation, and Public Health Association:

[... we held three consultation sessions which were huge sessions in each of the then areas and engaged everyone from the GP sector through to peak bodies, your key clinicians, your transplant surgeons, your Aboriginal and Torres Strait Islander health workers, so that it was bringing together a number of players in the one forum which has its challenges in itself [...].]

(Hanna-BF)

and

The challenges are [...] we have to bring such a large group of stakeholders, different components in building up the policy [...] a number of players, the consumers, justice and legal, the [client group deleted] and their families, other services; also both the NGO sector and the government. (Genevieve-BF)

As stakeholders now have an expectation of participating in the policy making process, a senior manager mentioned the importance of providing opportunities for this to occur:

[...] and it is an important part of a policy portfolio to try and ensure that there are many, many different ways in which people can be heard. Now there will always be people who tell you that they weren’t listened to, if the outcome is not what they want, that’s always the case. But if you can point to it and say this is where we consulted with you here, here and here, you had a chance to respond here and here [...]. (YI-6)

A majority of policy episodes also reported the involvement of other government departments in influencing the policy process, including Departments of Premier and Cabinet, Treasury and Finance and Economic Development. The emphasis by State and Territory governments on ‘whole-of-government’ and ‘joined-up’ government policy making was likely to have assigned a more prominent policy coordination and financial management role to these central departments28.

Similarly, the policy episodes dealing with joint Commonwealth-State and Territory policy, in particular those arising from COAG reforms (Student clinical placement,  

28 In the ACT and Queensland all COAG-related policy work was managed and coordinated by the Chief Minister’s/Premier’s department, with appropriate departments (e.g. Health) invited to participate. In South Australia, strategic policy making was developed in the context of a whole-of-government strategic planning framework, with shared ministerial responsibility for achieving goals and targets.
Statewide policy on diabetes type 2, Nurses return to the workforce, involved participation on intergovernmental committees and working parties represented by State and Australian Government Departments, the latter often including Department of the Prime Minister and Cabinet, Treasury, and Department of Families, Housing, Community Services and Indigenous Affairs.

The potential scope and complexity of participation in cross-portfolio policy coordination projects is illustrated in the National review on maternity leave policy episode:

The Health Department was one of many state government departments involved in the process of preparing a joint departmental submission for consideration by Cabinet and government. The other state government departments participating in the process included Department of Premier and Cabinet, Families and Communities, Treasury and Finance, Education and Children’s Services, Immigration, and Trade and Economic Development. The Department of Premier and Cabinet was assigned responsibility for coordinating the state response. (Amelia-CF)

In summary, many of the policy episodes revealed that the inputs, processes, outputs and outcomes of health policy work interact with and are strongly influenced by the external environment comprising political structures, health system structures and interests, community expectations, and the media.

Policy outputs

For purposes of this study, a policy output is to be understood as the product arising from completion of a policy process. Development of policy statements, policy and briefing papers, Cabinet submissions, annual budgets, establishment of governance structures, documented results of stakeholder consultation, service plans, and legislation may all be considered policy outputs. Other policy outputs reflected in the policy episodes included the signing of a contract between Commonwealth and States and Territory governments, and the preparation of policy guidelines and checklists to assist with implementation.

The achievement of policy outputs typically reflected the effort of policy workers involved in a lengthy process of analysis and research, stakeholder consultation, negotiation, and report writing.

29 An output was considered a success or otherwise based on a participant’s subjective assessment of the policy within a given situation.
In discussing policy outputs it should be noted that participants may not have used the language of outputs and outcomes in the narration of their policy episodes. If they did, their interpretation of these terms was not identical; the interpretation and application of the terms outputs and outcomes could overlap; and a participant’s response could reflect the nature of the policy work he or she was involved in and the stage of a policy’s development, that is initiating, formulating, implementing, evaluating.

As a consequence, in a number of policy episodes, participants did not always have a clear idea of the outputs and outcomes expected from a policy initiative; and policy outputs and outcomes were often discussed with less clarity and certainty than might otherwise have been expected. This lack of clarity about outcomes and the impact this could have on clarity of purpose and process is reflected in the following quote:

*One thing that strikes me from all of this is there is no clear process, we think there is but it varies and it seems to me there are no clear outcomes, that is, what are the building blocks of developing that policy?* (Brian-CF)

In some policy episodes, participants expressed disappointment and frustration at achieving good outputs because of factors affecting policy inputs and process, and the influence of the external environment, namely unrealistic timelines to complete policy work; inadequate human resources, comprising amount and mix of skills; increased demands to participate in intergovernmental and interdepartmental structures and processes that require extensive negotiation, with limited control over process and outcome; ineffectual leadership; and lack of government commitment and support in the way of priority and resources.

This disappointment in achieving effective outputs was noted by a participant:

*And the impact on people at the policy officer level is a diminishing of your work and a lack of valuation of your contribution, and almost a despair in a sense of “what’s the point of doing all of this stuff” when at the end of the day it’s actually all about pragmatics that’s going to be dictated elsewhere.* (Niki-CF)

These emotional reactions to compromised outputs, that is those suspended due to changed political priorities or impaired by lack of resources, shortness of time and lack of clarity about purpose, are indicative of the personal implications of a disconnect between policy capacity and process and effective policy leadership.
As an output, policy instruments\(^{30}\) (APSC, 2009b; Peters, 2005) have a substantial impact on policy process and capacity. Policy instruments, although not discussed as such by participants, were identified in the policy episodes and comprise financial instruments (*Nurses return to the workforce, Statewide policy on diabetes type 2*); regulation and legislation instruments (*Reviewing of Mental Health Act; Hospital boards of management; Tobacco control legislation*); information and education instruments (*Agency safe handling of drugs; Sexual assault forensic kits*). Different policy instruments can provide alternative pathways for achieving health outcomes. The selection of the appropriate policy instrument has a direct bearing on policy capacity and policy process and the achievement of optimal policy outcomes.

In summary, the discussion of outputs in the policy episodes reveals a close relationship between policy outputs, process and outcomes as well as demonstrating the influence of the external environment.

**Policy outcomes**

For the purposes of this study, a policy outcome is to be understood as the result or consequence of a policy output.

In discussing policy outcomes it should be noted that participants did not necessarily use the term policy outcomes and did not necessarily differentiate outputs from outcomes. The uncertainty of participants in regard to identifying policy outcomes is a result of these usually being intangible, long term and not always easy to quantify; and a result of the perception of the participant arising from their role and task in a particular phase off the policy making process, for example information collection and analysis, or stakeholder engagement.

Accordingly, the researcher has characterised the intended outcomes of the policy episodes as being either the improvement of the health and well-being of individuals and the population; improvement in the organisation and delivery of health services in order to

\(^{30}\) The Australian Public Service (2009b) classifies policy instruments as: i) financial: taxes, charges, subsidies, benefits and grants, loans; ii) regulation and other legislation: standards setting, rights and representation, price and market structure regulation; iii) information, education and advice: public education, provision of information, reporting and disclosure; iv) direct intervention: provision of services, commissioning of services; and v) self regulation: codes of practice, voluntary agreements.
improve population health; and development of consistent standards of practice across the service system.

Achievement of policy outcomes is the measure of successful policy work for policy workers; and in the context of this research is a measure of the extent to which policy capacity and process are aligned to achieve good policy outcomes.

The result of the policy work narrated in the policy episodes took a number of forms. The policy initiative was either implemented and expected outcomes perceived to be largely achieved, the intended objectives and priorities of the policy initiative were changed prior to implementation and outcomes perceived as compromised, the policy initiative was implemented but agreed targets were not achieved, or the policy initiative was not funded and implemented so that the outcomes could not be evaluated.

**INITIATIVE WAS NOT FUNDED AND IMPLEMENTED**

The *Statewide renal service plan* policy episode articulated strategic directions, identified priorities, and proposed costed strategies for the future development and funding of services. However, the funding of the Service Plan was considered a low priority in the annual state budget and did not receive additional resources to enable implementation.

The participant perceived the result of the policy work to be unsuccessful:

> [...] we had a very highly publicised public plan and we got very little money, not even enough to cover the growth in [medical condition] population.
> (Hanna-BF)

**IMPLEMENTED BUT AGREED TARGETS WERE NOT ACHIEVED**

In the *National review of maternity leave* policy episode, the participant considered that the final Cabinet submission had not adequately reflected the Department of Health’s contribution; and that the central coordinating department had approached the negotiations with a predetermined position.
[this project] was to look at the health effects of issues related to child birthing and maternity leave. That didn’t actually happen very well because of the policy headset and the process that was used to get an outcome of a submission because there wasn’t the space for debate, to actually allow other people to understand that concept collectively. So I think that was one of the issues I found quite difficult, and in the end I had to sort of just not worry about it because of the time issues, and I think that ends up a lesser product in terms of people not understanding and categorising development in this sort of way [health perspective]. (Amelia-CF)

In the Nurses return to work policy episode, the original targets were based on inaccurate assumptions and not achieved:

[…] it was one of the election promises that the new incoming Rudd Federal government would provide funding through this process to encourage nurses to come back who hadn’t worked for a while. I guess my main thing about that is […] that the numbers they expected are completely out of synch with what the reality is […] they thought there would be hundreds of them and in fact it’s not [...] they have allowed funding for something like 5 to 7,000 over 5 years [...] what we discovered is [the targets] actually came out of [deleted name of jurisdiction] and a couple of people who had a lot of influence and a particular view, but those stats are not borne by any of the other states. So of course none of us can meet our targets, because the initial targets were set on advice from one jurisdiction. (Pamela-CF)

INTENDED OBJECTIVES AND PRIORITIES OF THE POLICY INITIATIVE WERE CHANGED PRIOR TO IMPLEMENTATION AND OUTCOMES PERCEIVED AS COMPROMISED

In the Health system goals and targets policy episode, the participant perceived a lack of success in the development of a statewide Better Health policy through a reduction in goals and targets during policy development:

We came up with proposals around specific goals, targets, performance measures and strategies in relation to each of these topic areas […] went back to this very broad consultative group of people […] then invited formal submissions from all of the stakeholders in the system […] put it into our hierarchy and got told this is all too much and we’d have to go and pick a number of priority areas to hone it down […] We did this huge amount of work and the only really tangible outcome was in one area which was diabetes which was identified as a priority area for the Department and a new structure was developed around that and I think it did put diabetes on the agenda […] I think that was really the only worthwhile outcome from that exercise. (William-AF)
IMPLEMENTED AND EXPECTED OUTCOMES PERCEIVED TO BE LARGELY ACHIEVED

However, in other policy episodes, the outcome was perceived as a success. In the *Emergency dental care triage* policy episode, the policy was fully implemented with funding provided to establish a computerised system to manage the statewide dental waiting list, develop a standard assessment tool, delegate initial assessment and triage of waiting list clients to non-dental staff, and provide staff training and development.

The participant perceived the policy work as achieving a successful outcome by delivering its stated objective in terms of reduction in waiting times:

> [...] but we have reduced the time we spend on emergency care, or the number of people who spend time on emergency care, by about 30 or 40%. The end result is that we have probably contributed to reducing the waiting list by a very, very significant amount of time. (Brian-CF)

In the *Review of Mental Health Act* policy episode, although the process was incomplete at time of interview, the participant expressed confidence in the completion of the review by 2012 as a result of strong governance arrangements in place, extensive stakeholder engagement program, completion of specific tasks by consultants, and strong ministerial and senior departmental officer support. With the process proceeding as planned, the participant believed this should lead to the successful completion and subsequent implementation of the review by that time. Even at this early stage, the department was considering the development of an information kit and the conduct of information sessions to inform agencies about the implications of the new legislation.

> That’s [the process] working very well at the moment, [...] given the work still to be done, the review process should be completed in 2012. (Brendan-AF)

In summary, participants perceived policy episodes as successful if they were implemented and delivered stated policy objectives in terms of bringing about health system improvement or improvement in individual or population health.

5.3 SUMMARY AND CONCLUSIONS

A number of findings emerge from the analysis of the research data in terms of the elements of the conceptual framework: nature of policy work; policy capacity; policy process; influence of external environment; policy outputs; and policy outcomes.
The nature of policy work can be characterised as broad and complex, comprising different types of policy work, diverse subject matter, involving different levels of government, and different points of focus, being strategic, operational, and clinical, with direct implications in terms of project design, comprising output and policy instrument selection, stakeholder consultation, resource allocation, data collection and analysis, and timelines.

Policy capacity can be characterised as comprising individual and organisational inputs in terms of human resources, comprising individual knowledge and skills and mobilisation of amount and mix of resources, and governance and advisory structures, including for instance steering committees and reference groups, and deployment of physical resources, comprising information, infrastructure and other supports, which must be matched to the requirements of the policy project and which may vary during the phases of policy development, involving for instance the support of clinicians for technical papers and the engagement of consultants for community consultations.

Policy process varies in detail depending on a variety of influences including organisational context, type of policy, and availability of time and resources although a number of activities were recognisable across policy episodes, comprising identifying the problem, engaging and managing stakeholders, collecting and analysing information, preparing written documentation, authorising, implementing, monitoring and reviewing; and testing policy. However, monitoring and reviewing, providing feedback for subsequent improvement in policy redesign and redevelopment, and testing, through pilots to validate assumptions, are rarely performed activities but were acknowledged to be as a means to assist health policy units identify weaknesses in capacity and process toward improvement in policy work performance.

Policy work is influenced by the external socio-political environment in terms of interactions with ministers, chief ministers and premiers, Cabinet, parliamentary committees, health agencies, health professional associations, health industry groups, other government departments, other health jurisdictions, different levels of government, media, and community organisations each having a role as ‘actor’ contributing to shaping the nature and course of policy development and implementation; sometimes resulting in a truncation of the policy process to achieve short timelines with potential for compromised policy outputs and changes in policy objectives arising from changes in financial priorities.
or from changes in government leading to policy initiatives not being implemented or implemented in a revised form.

Policy outputs are the product arising from completion of a policy process, and include policy statements, briefing papers, cabinet submissions, annual budgets, legislation, and service plans; while policy outcomes are the result of a policy output, including additional funding, improvement in the organisation and delivery of health services, and improvement in clinical standards. However, the distinction between outputs and outcomes is not well understood leading to a lack of clarity of purpose with implications for policy process involving mobilisation and mix of resources and selection of policy instruments.

These findings confirm the interrelationship between policy capacity, policy process, the external socio-political environment and through this interrelationship the work of policy in achieving good policy outputs and outcomes as proposed in the conceptual framework.

Policy practitioners appear to be well aware of and informed about capacity in terms of individual knowledge and skills, training and development, time, infrastructure and supports; process in terms of how policy work is conducted; and the influence of the external environment in terms of the role of minister and advisers, political structures, inter and intra government relations, health system structures, role of stakeholders, public expectations, and the media.

However, policy practitioners appear to be less aware about the outputs and outcomes associated with policy development and implementation, and the policy activity of review and monitor; and appear to have little appreciation of the relationship between the elements of capacity, process, outputs, outcomes, review and monitor, and external environment that underpin policy work and contribute to good policy making.

In the next chapter (Chapter 6) the complex and dynamic nature of policy work in the three health authorities is examined in terms of the relationships between and challenges to aligning policy capacity and process, and the influence of other elements that may affect the relationship.
6.0 INTRODUCTION

The purpose of Chapter 6 is to apply the conceptual framework to the analysis of the research data in order to identify challenges to aligning policy capacity and policy process in the work of policy in the three health authorities. The conceptual framework conceives policy capacity and policy process as critical elements that underpin and are pivotal to the work of policy; and the two elements and their relationship combined with the other elements as comprising a coherent and integrated ‘policy system’. The findings are presented in reference to Research Question 2 (What are the challenges in aligning policy capacity and process in health policy making?) and Research Question 3 (What are the main influences affecting the relationship between policy capacity and process?).

This study applies Gleeson’s (Gleeson, 2009) organisational ‘policy capacity framework’ derived in her doctoral research, the precursor to the ARC Linkage study31 (Australian Institute of Health Policy Studies, 2009), to identify the challenges to aligning policy capacity and policy process in the three health jurisdictions. The domains of the ‘policy capacity framework’ were selected by the ARC Linkage project research team as an appropriate basis for analysing the organisational barriers and enablers to ‘good’ policy process, and for the preparation of the progress report to the Australian Research Council (AIHPS, 2012) on the findings of stage 1.

The eight domains of organisational policy capacity derived by Gleeson (2009) were as follows:

1. managing stakeholder relationships;
2. utilising information and evidence;
3. managing intra-departmental, cross-portfolio and inter-governmental relationships;
4. working between policy development and program management;
5. policy evaluation and monitoring;
6. managing the policy process;
7. people management in relation to policy development; and
8. leadership.

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31 Refer to the Foreword for information on the Australian Research Council Linkage study awarded to the AIHPS.
In contrast to Gleeson’s approach, capacity domains are conceived here as statements of action and are interpreted to reflect both policy process and policy capacity; and, consistent with the conceptual framework, policy activities are viewed as integrated rather than discrete functions.

The findings are organised according to seven of the above eight policy capacity domains. Leadership, the eighth domain, will be the subject of a more detailed analysis in the next chapter (Chapter 7) in recognition of its vital role in aligning capacity and process.

6.1 CHALLENGES AT THE ORGANISATIONAL LEVEL

Managing stakeholder relationships (Domain 1)

And I think too that we’re increasingly realising that we’re one voice to the Minister and he/she will seek advice from a whole range of different people. But we’re just one little voice, whereas in the past I think the departments have been much more influential with Ministers. (Margo-BF)

In all three jurisdictions, focus group and interview data suggested that stakeholder engagement in policy development and implementation was considered both important and a routine aspect of practice. There was reportedly a particularly high commitment to community consultation in ACT Health and the SA Health due to strong historical commitment to citizen engagement in policy making. In South Australia, a particular tool has been developed to assess, among other things, the impact on the community:

[... ] we developed these tools to assist in policy so that whatever they’re doing in service design, service development, in policy development, in community engagement and consultation that we have this tool [part of name deleted, ... Health Impact Statement] to guide officers in their work and their deliberations so that we take the community’s needs into consideration in the way we conduct our business. (ZI-10)

Each health authority was also reported to have a range of policy directives, processes, guidelines, tools and resources in place to support consumer and community consultation. Structures had also been established for stakeholder involvement in decision making. These included clinical networks, health advisory committees, steering committees, reference groups and taskforces, written submission processes and community and consumer satisfaction surveys. These structures were supplemented by less formal stakeholder communication and interaction mechanisms.
The accounts of policy practitioners in the focus groups suggested that they considered themselves to be generally skilled in engaging stakeholders in consultation, including selection of stakeholders, timing of consultation, choice of methods, handling of feedback and management of expectations and competing interests. The following comments made by policy practitioners in relation to engaging stakeholders are representative of the views frequently expressed in the focus group discussions:

\[\text{It was pinned largely on broad consultation with practitioners in the system, with consumer groups, with policy makers, planners, it was a very broad consultation exercise which we ran over quite a lengthy period. (William-CF)}\]

Awareness about consulting with relevant stakeholders is apparent in the following two comments:

\[\text{So it just depends on the topic [...]. I mean you might have further consultations with key interest groups depending on say the legislation because they have the highest stake. So there’s a hierarchy of stakeholders as well, so you don’t have some, some have higher interests and are more directly affected and are also more influential in the process, so there are differences you know [...]. (Amelia-CF)}\]

and

\[\text{It is important to bring the right stakeholders to the table and to be aware of and skilfully manage different backgrounds, interests and agendas [...]. (Briony-AF)}\]

Whilst another participant commented:

\[\text{[...] we have a very strong network for informing our policy decision making. We’ve had to do that because we’re often given two days to brief the Chief Executive or the Minister on some issue [...]. And so with that group we kind of can get an informed decision. So, we’ve got these networks of different interests quite nicely set up [...]. (Maria-AF)}\]

Senior manager interview findings supported these views, reinforcing that stakeholder engagement was routine policy development practice.

\[\text{Coordination with key stakeholders tends to be a relatively standard practice within the Department. (YI-5)}\]

Other managers commented:

\[\text{Basically, the government puts a lot of emphasis on consultation and that’s done reasonably well. (XI-3)}\]
and

[... engaged stakeholders in order to move beyond resistance, acquire information, develop relationships [...] and bringing stakeholders together does actually help us tease out what the policy means. At times, it is limited or very targeted consultation in order to pull something together quickly [...] consulting with stakeholders is high on the agenda for policy development in South Australia [...]. (ZI-8)

A perspective supported by another South Australian senior manager,

*I think community consultation on policy programme development in South Australia is something we do reasonably well, partly because we have had a commitment to it over a long period and therefore we have developed some expertise in it and partly because it is a small place where it’s relatively easy to engage people.* (ZI-11)

Another comment:

*Policy management framework* integrates both the clinical and non-clinical policies into a single process so that both would go through a common process and essentially it delineates a series of steps such that there’s a systematic approach to evidence-gathering, consultation and clearance of policies that while they diverge at points, at least have a single framework that reviews them and a single set of processes that clears them. (XI-2)

Although structures and processes were in place for enabling stakeholder engagement in policy development and implementation, policy practitioners described many instances where stakeholder engagement was not ideal. Policy practitioners from each participating organisation described difficulties including lack of time and resources for consultation; lack of clarity about the purpose of engagement (and as a result, lack of clarity about the scope of the consultation and which stakeholders should be engaged); and, lack of support from senior managers to conduct consultations.

In regard to the affect of time constraints on stakeholder engagement, a participant noted:

*So although there has been an attempt at consultation we haven’t been able to necessarily go into it because of resourcing and time. And that may depend on the urgency too because if something is absolutely time critical, it is driven from the Prime Minister or the Minister, then the quick decision will be who is best to do this? Get it done quickly, get it down and sign it off.* (Sandra-AF)
This lack of time was supported by a senior manager:

> So there’s the big agenda, and then you have the request either at ministerial or at senior executive level for other smaller pieces of policy. And of course, underneath the big health care plan is a million policy and planning tasks that need to be developed, and they’re never ending. Some will be quite long, and they’ll need a long piece of lead in time, but governments often will want things done in a very short amount of time. They’ve made an announcement and they’ll actually want something on the table in four weeks or eight weeks time. The weakness [in policy] is to deliver to the time line that’s applied by the government, and you actually have to forego some of the steps and the processes, and usually it’s consultation that gets killed off. So, you get limited or very targeted consultation in order to pull something together and run with it. (ZI-8)

In regard to a lack of clarity about scope of consultation, convincing key stakeholders to participate in the process, deciding on which stakeholders to engage, and ensuring fair representation of stakeholder input, was reported by a number of participants:

> The consultation with key stakeholders - who are the key stakeholders? - that was something that came up continually throughout the process, people that we saw as being key stakeholders didn’t see themselves as such - or people that we saw as not having an integral part thought that they should have one, which was interesting and trying to engage people who needed to have some input into that development was difficult again if they didn’t see it as being their purview. The process was just delayed. (Oscar-AF)

> and

> Consultation, I think it’s really important to have a quite clear consultation and communication plan, to respect the diversity. I think it’s very important to be quite clear about what consultation means. [...] when you go out for a consultation, clinicians take it as a wonderful opportunity to speak to those people in corporate office and they’re going to tell you all about what their issues are which may not be related to the consultation so you need to have a strategy in place to deal with those issues which aren’t related but not to fob them off, if I could use that word. I think you’ve got to go in prepared for that because that will happen. (Molly-AF)

There was also a degree of scepticism and disillusionment expressed by participants in the focus groups, particularly in SA Health, about the degree to which stakeholder views were taken into account by senior decision makers; and the degree of government support for the particular policy initiative. Policy practitioners from SA Health gave several accounts
of instances where extensive consultation processes were undertaken, often including public forums, focus groups and written submission processes, but stakeholder views were either not taken into account, or policy development was discontinued for political reasons. This situation left both stakeholders and policy practitioners feeling ‘disenfranchised’ and ‘disillusioned’. As one SA Health participant noted:

[...] all the people who were involved in those topic areas just got dropped off; were then feeling quite disillusioned and disenchanted, and I think that’s a problem that we have in quite a number of areas of our work. We engage people in exercises that come to nothing. (William-CF).

Utilising information and evidence (Domain 2)

The point about policy is that policy is made all the time and it’s frequently made in a very ad hoc and unreflective way. The classic one is something hits the media and the minister says fix it and the department fixes it and they fix it with the first thing that comes to mind. Policy is always going to be like that. (XI-3)

Most policy practitioners reported that the extent to which research evidence and other sources of information were used to inform policy development depended on the available resources and time. They indicated that they relied on their judgement about the type of information or evidence sought and the timing of its deployment. As reported by one policy practitioner: “[...] there are different types of evidence [...] and a lot of judgement in how you use it.” (Amelia-CF). This use of available information within resource and time constraints was reported by a senior manager:

[...] you have no clear evidence to guide your decision making, you have no time to think about it and you’ve got no one out there – you’ve got very few people that can help you. That’s generally the way it works, and you’ve got no money. So given all that, how do you make your best policy? (XI-3)

With these caveats in mind, policy practitioners in all three jurisdictions said they were generally able to commission research, literature reviews, environmental scans and policy analysis from external experts (consultants or academics) when required. Strong relationships with universities and research institutes were reported to be in place across the three jurisdictions. These views were confirmed by senior managers. However, ACT Health senior managers pointed out that the small size of the organisation meant that resources for commissioning research and generating evidence were more limited than in the other jurisdictions.
Most policy practitioners reported having access to the necessary statistical information, government reports and information from other jurisdictions and agencies. In the Queensland Health focus groups, however, a small number of participants commented that there was a lack of data for forecasting, trends analysis and service planning, particularly at the local level. Queensland Health senior managers also reported that information, although available, was not always easy to use, as it was not necessarily extracted, summarised and distributed electronically. This lack of good information systems and data linkage was reported by a senior manager:

[… where there’s been a national effort in improving some of the data […] particularly hospital minimum data sets they are quite good, but in our community health data it is pretty appalling and there is no linkage between any of our data sets. They are not consistent. They’re very much administrative data sets […] but I do think we do need to focus a lot more on improving foundation information which can build good policy. (YI-4)

While information was generally available, there were a number of barriers to access and use of this information reported in the focus groups. These included a lack of expertise in statistical and spatial analysis, forecasting and quantitative analysis. A problem reported by a number of senior managers:

[…] we have a similar problem around data analysis […] the kind of detailed, analytical skills to work with data is still something that’s in short supply. (ZI-9)

and

The ability to prepare information, including data, in ways which is informative, is still a weak skill in our group. YI-6)

Another barrier was lack of time for seeking, collating, analysing and interpreting information, meaning that some policy workers relied on a quick scan of publicly available information on the internet rather than a more thorough search. A problem reported by a number of focus group participants:

[… so in terms of the timeline we had, that was basically internet-based research, but you’d get leads to other documents, it was a fairly intensive process of reviewing information […]. (Amelia-CF)

and
We looked for a policy but there wasn’t one so then it was just ad hoc, what do we have to do? Ringing around people like [Name deleted], staff development unit, the university itself, the policy unit just trying to find out and then working with bits and pieces of information that we had [...]. (Vanessa-AF).

Participants also reported that occasionally urgent ministerial demands for policy made it difficult to properly complete the activities of collecting, analysing and applying information and evidence in developing policy within short time lines. In all three jurisdictions, information collection, analysis, and usage in policy development was frequently customized to suit the available time to complete the project:

[…] so in terms of the timeline we had, that was basically internet-based research, but you’d get leads to other documents, it was a fairly intensive process of reviewing that. (Amelia-CF)

and

One of the other issues here was the timeframes were exceptionally short and we were forever apologising for yet another request to somebody - we need this by midday today - and these requests would be coming down to us from Premiers. So we worked within quite a pressured situation [...]. (Monica-BF)

This lack of time for collecting, analysing and applying information and evidence was supported by a senior manager:

It was a political imperative, so the Minister was being criticised by a lobby group for the fact that he didn’t have a [name deleted] health policy so we were told to give him one, quickly. Yes, a ‘quick and dirty’. Now we’ve probably got a chance to improve that a little bit by trying a bit of a review of that into the work that is being done around the national [name deleted] health policy at the moment so sometimes it can be incredibly, incredibly short. (ZI-11)

Senior managers confirmed the focus group findings and also identified weaknesses in analysing, synthesising, interpreting and applying information and evidence in policy making. This skill deficit is summarised in the following comment made by a senior manager:
[…] we have difficulty from, two fronts. One is just having the people to do that and then secondly those people, having the skills that can be able to analyse and interpret that data, and so that’s certainly a challenge for us and again it’s not just the Commonwealth that takes some of our skilled people, it is agencies like the Australian Bureau of Statistics and Australian Institute of Health and Welfare that you often do get people who have these strong analytical skills and they’re snaffled up by these organisations.

(XI-1)

Managing intra-departmental, cross-portfolio and inter-governmental relationships (Domain 3)

A senior manager’s response to participating in cross-portfolio work:

*I mean in an environment of tightening and declining resources and people not really having enough resources to do their core business it is quite difficult to get people to give space to work with other departments.* (ZI-11)

Working collaboratively across boundaries between units within departments, across state government departments and across levels of government was viewed by policy practitioners and senior managers as an increasingly important feature of contemporary policy work. Particularly notable was the strong mandate for and commitment to whole of government policy making in each jurisdiction. There were structures and processes in place to support collaboration across authorities in each jurisdiction, for example the ACT Government’s Canberra Plan, the Queensland Government’s Toward Q2: Tomorrow’s Queensland and the SA Government’s Strategic Plan. These state and territory plans provided an overarching framework for all government policy directions, while individual authorities were required to develop their policies, strategies and priorities within this context.

Managing inter-governmental relationships, particularly between the states and territories and the Commonwealth Government, was seen to present more challenges. Policy practitioners identified a number of barriers to effective Commonwealth-state relations including governance arrangements that are not well suited to joint decision making, inadequate resources, and lack of leverage of state officials over Commonwealth funded services and programs. An example was the *Nurses return to workforce* policy episode,

which had to be implemented within six months. According to the policy practitioner responsible for its implementation, the policy was poorly fitted to state and territory

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32 Described in Chapter 5: Policy episode type No.3.
financial and personnel management systems and did not have a clearly determined plan for implementation.

Structures for intra-departmental coordination and collaboration may have been largely in place, but policy practitioners in all three jurisdictions raised concerns about a lack of awareness, in some instances, about policy work conducted in other parts of the organisation. In addition, a number of policy practitioners reported a reluctance to participate in intra-departmental policy work for reasons of time, resources and usefulness. This is summed up by a SA Health policy practitioner:

> [...] it’s about process, it’s about time issues, the timing things, and intergovernmental processes that can fail because there is a direction about where they [Department of Premier and Cabinet] want to go [...]. There is a kind of pre-worked decision, pre-existing decision-making about what flavour the submission would be and so that had already curtailed discussion [...].

(Amelia-CF)

Weaknesses in these areas were seen to result in confusion about responsibilities, duplication of effort, missed opportunities, delays in the provision of advice, and sometimes decisions that were made contrary to agreed policy directions. Surprisingly, these issues appeared to be as salient in ACT Health, a small organisation, as in Queensland Health, a much larger one. Focus group discussion on differences in perspective and subsequent tensions between health and other levels of government and state government departments is summed up by the comment of one participant:

> [...] it was around increased national productivity and workplace participation. It wasn’t around health issues [...]. It was a bit of a nightmare. That was one of the issues for us, that we were being driven by a completely different understanding and evidence base [...] and in Queensland Health they are not our drivers. (Monica-BF)

Policy practitioners also suggested that there was a lack of adequate human resources and time for conducting cross-portfolio and intergovernmental policy work. This situation was further compounded by an increase in this type of policy collaboration which generated additional work, including participation in interdepartmental working groups and task forces, negotiations, and provision of information, which was not matched by the provision of additional resources. While senior managers commented on the difficulties they experienced in directing additional resources to meet these cross-portfolio and intergovernmental demands.
 [...] the other thing that’s been really difficult is the fact that you have this Social Inclusion Unit that establishes this particular agenda which all government agencies have to respond to. And, the other thing we’ve got to do is to respond to it without any additional money, you know, got to continually find resources in-house to deal with the issue. (Amelia-CF)

Senior managers reported on the challenges of whole of government policy collaboration within their jurisdictions despite the existence of structures and processes to facilitate this type of policy making. Whole of government collaboration was seen to be undermined by accountability and incentive structures that encouraged the focusing of effort in particular departments. For example, budgets tended to be aligned to individual departments rather than to cross-cutting policy objectives. This is reflected in the following comment expressed by a senior manager:

Once ministers are appointed to particular portfolios, they rapidly develop an alignment with the portfolio, and tend to represent that view – that’s basically what you need them to do to some extent. And, whole of government views then sometimes take second preference or second place to what they see as what’s necessary to survive in the portfolio. You don’t get kudos for whole of government [...] particularly in service departments like this, where you live and die on the basis of what happens within your portfolio and not on what happens outside your portfolio. (YI-6)

Senior managers also suggested that there were shortfalls in the skills of departmental staff, particularly those with clinical backgrounds, with respect to intergovernmental and cross-portfolio policy development. The shortfalls identified included strategic, analytical and negotiating skills for working across boundaries, as well as knowledge of the roles, responsibilities and priorities of other departments:

Where I think we are moving with that sort of [cross-departmental] public policy influence, is to craft our case more cleverly. And I mean that in many different ways, but two ways in particular; one to become more aware and to take into account in our proposals, the needs of other groups, those other priorities, and to look at it. [...] And the other is developing the information base that informs those decisions in a different way. So again the information that we have traditionally collected to inform our decisions, has largely been health-based information, as opposed to information which is actually core to the sorts of issues that other players are going to bring to the table like economics, workforce implications, and development implications. And being cleverer around the information that we use to inform our decisions and try and inform other people’s decisions about these things. And that is requiring us to develop some new skills in our workforce; we don’t have those skills within our workforce and there is a new group of people who will come with that. (YI-6)
Working between policy development and program management (Domain 4)

Policy practitioners and senior managers in all three jurisdictions commented on a perceived lack of continuity, or a disconnection, between policy development and implementation.

This lack of continuity between policy development and implementation was discussed at length in focus groups where there were participants with policy implementation responsibilities. Participants interpreted this lack of progression from policy development to program implementation, perceived as implementation failure, in different ways: the policy was not regarded as a priority in departmental budgets and was therefore not allocated additional resources; did not proceed beyond the consultation process; did not progress beyond the written policy and ‘sat on the shelf collecting dust’; was not endorsed by the minister and did not result in further action; and, finally, the policy did not achieve its intended stated objectives.

This participant’s response highlights a few obstacles to achieving policy implementation:

[…] so policy has to be implementable, it’s nice to have an ideal policy but at the end of the day if we don’t have the workforce, if we don’t have the resources, if we don’t have the commitment, well it’s going to sit on the shelf as per our other documents. (Hanna-BF)

This issue was particularly highlighted in the Queensland Health focus group discussions and to a lesser extent in South Australia. Queensland Health participants described many occasions where policies were not suited to the local context due to failure to consider implementation during policy development (“that clinical and operational people have not been involved in framing the policy”, Hanna-BF), and where there was a lack of resourcing (“often these new policies come out and it’s just implemented with no regard to the resources that are required to actually make that change”, Sarah-BF), infrastructure and dedicated staff to oversee implementation. SA participants expressed concerns about senior decision makers being structurally disconnected from, and not well informed about, implementation:
I think one of the other issues is the lack of the relationship between the nurse who is actually having to deal with the patient’s family, or client’s family and the management up here. There is no association because if that person up here was down there sitting next to the bedside or that was their Mother or Father, that policy would be through like that. (Olivia-CF)

and

[...] my line would be I guess that policy development is consistently, completely disconnected to policy implementation and largely because we function in a management structure that is what I call an old-fashioned command and control, which disconnects decision-making from implementation, from the work itself. (Pamela-CF)

Knowledge and skill deficits were identified as a contributing factor to this disconnection by both policy practitioners and senior managers. Some policy practitioners commented that staff with responsibility for policy implementation did not always have the necessary knowledge and skills to establish a new program or service, and that policy staff in central areas of the authorities did not have sufficient knowledge or understanding of the organisation and delivery of programs and services. Some senior managers also pointed to a lack of ‘on the ground’ practical experience which meant that workers formulating policy did not always consider the operational and practical matters of implementation (such as human and financial resources, time, training and development, and cultural factors) during policy formulation.

Many policy practitioners expressed the view that complex implementation tasks were not always given sufficient time and resources. The lack of designated staff to carry out implementation was a problem identified in all jurisdictions, with implementation responsibilities often ‘added on’ to existing workloads.

Senior managers reported a number of barriers to ensuring effective program implementation, including inadequate policy design and development, poor leadership and management, lack of resourcing of implementing agencies, lack of designated responsibility for implementation, non-compliance and low priority by implementing agencies, lack of mechanisms for monitoring implementation, organisational structures separating development and implementation, and other external constraints. In the ACT, tensions between the health authority and senior clinicians responsible for implementation were seen to frequently result in non-compliance. In Queensland, the large size of the
jurisdiction was considered a barrier to policy implementation; as one senior manager commented, “it is an enormous state and we are highly dependent on a ‘chain of command’ to get to the front line.” (YI-6). Another senior manager from Queensland commented:

A real barrier in Queensland Health is the underdeveloped links between policy development and policy implementation processes. There are many reasons for this, a practitioner’s lack of ‘working on the ground’ experience and therefore limited knowledge about the practical matters of implementation - staff, financial resources, buildings, costs and political considerations. Another problem is that policy practitioners tend to view policy development as a written exercise with little relationship to implementation and action, while some managers do not take on the responsibility for vetting and re-shaping policy to reflect practicalities. [YI-5]

While SA Health shared some policy development and implementation capacity difficulties of the other two health authorities, like inadequate resourcing and insufficient implementation time, poor leadership and management, external constraints and ‘symbolic’ policy making, the relationship between policy development and implementation was viewed more positively by senior managers. In SA there was a stronger emphasis on linking policy development and program implementation functions in the health authority. A number of senior managers in South Australia reported that structural changes had been made to improve the continuity from formulating to implementing policy:

And in part that’s because we’ve engaged the regions in the policy and strategic planning work to begin with. And, a lot of the high level planning, even the medium level planning, is actually done in the Department by our State-wide Services Division as well as my Policy Intergovernmental Relations group. And then we have a Division of Operations where the regions report [...] I don’t think there’s a lack of understanding or appreciation about exactly who’s responsible for what.[...] but the advantage of the State-wide Services people is it picks up the three metro. regions and the country and engages them in the process and then goes on from there. (ZI-9)
The manager continues by saying that the department’s structure was well supported by external expertise:

 [...] sitting alongside to support the department is the Clinical Senate and the Clinical Networks, there are now about ten networks - mental health, cancer, orthopaedics, trauma, paediatrics, rehabilitation, etc. - they produce interesting and detailed work. So, we use these Working Groups for our own internal planning processes. Again, because they are largely clinicians they tend to be very operational, and they lift the work up from time to time. But it’s a useful way of engaging. So we’ve got pretty good structures in place I think to get rid of the worst of the misunderstandings and difficulties in the process. (ZI-9)

This was supported by another senior manager, commenting that recent legislative reforms in SA had contributed to improved compliance and accountability arrangements:

So, under the previous arrangements, we would have policies that we would send out to the regions, but there was no ‘thou shalt ensure that you abide by these directives on the dotted line’. It would be the CE of the Department saying we’ve actually developed this on policy procedure, we would like you to actually put this in place. Now most people would actually cooperate and actually put it in place, but the new system is now very clear in terms of the lines of authority. (ZI-8)

**Policy evaluation and monitoring (Domain 5)**

Policy evaluation and monitoring received very little comment in the focus groups. Evaluation and monitoring appeared to be given low priority by participants. The lack of attention to this issue may reflect the contemporary tendency to ‘contract out’ evaluation of health programmes to external parties, such as research institutions and consultants. When mentioned, evaluation and monitoring was usually discussed in the context of a specific health programme and not perceived as a routine policy function. This lack of emphasis on evaluation by the organisation is reported by this participant:

 [...] we are actually expected to come up with something in six months and run with it, not having done the research, not having done the evaluation, you know they don’t even allow good evaluation. Then before the work has been introduced and allowed to run its natural course, they change it and they want to do something else. (Steve-CF)
Limited references were made about policy evaluation and monitoring in the senior manager interviews. One senior manager in SA Health noted that policy evaluation and subsequent policy refinement and improvement were functions frequently overlooked by the health authority; even major reform programmes were rarely evaluated. In this senior manager’s view, evaluation was mainly linked to accountability requirements:

\[...\] there are no resources allocated to do that so you know there are still major policy and programme changes which are not evaluated. Regrettably it is usually only where there is a contractual requirement, usually in a Commonwealth/state agreement that there is defined money allocated to evaluation. (ZI-11)

Senior managers from other jurisdictions supported the above opinion that there were limited resources allocated to continuing policy and programme evaluation, which is illustrated by this comment:

The resources, structures and processes to support policy evaluation are not so well developed in Queensland Health. (YI-5)

A number of senior managers concurred that policy and programme evaluation in health authorities, in the main, was conducted on an ad hoc basis and usually if agreed to as part of a contractual requirement rather than as a regular activity in the policy making process, represented by this quote:

Yes, that [lack of evaluation] is a gap in my view. (ZI-11)

However, endeavours in a few jurisdictions to address this weakness in evaluation can be observed, with the building of evaluation into the policy management framework and in assigning dedicated specialists to conduct evaluations of programmes:

There are key performance indicators embedded in there that will help to evaluate that policy over time. And indeed, one of the requirements for new policies is that there are key performance indicators included for the evaluation of the policy and a cycle of evaluation that’s proposed. Generally speaking policies have about a three year life, so that there’s a requirement for their review after three years [...]. (XI-2)

Another senior manager commented on the appointment of dedicated resources for conducting evaluation:

[...] but we have an evaluator working alongside the [name of programme deleted] Improvement initiative. Because when we first had that in the former
Department of Human Services, we didn't have evaluation built into it [...]. So we’ve resurrected it, we’ve built evaluation into it and even at our local level work is based on some really important key features like innovation, evidence based work, ensuring that we have community voice [...]. (ZI-10)

Managing the policy process (Domain 6)

Each health authority had recently introduced a range of policy management structures and processes that provided a clear direction for the development, implementation, evaluation and coordination of policy. The directions adopted by the three jurisdictions were similar and comprised guidelines and protocols for policy making, a central policy register, and coordinating structures as outlined in Chapter 3.

Senior managers particularly expected these structures, which had been recently introduced in each jurisdiction, to improve policy coordination and the quality of policy work. While in each case it was seen as too early to evaluate the effectiveness of the new processes at the time of individual interviews, the new structures were expected by senior managers to improve the communication about, and coordination of, policy making across the authorities, improve links between policy development and implementation, improve monitoring and evaluation, and clarify roles, functions and responsibilities:

[...] it [policy management framework] integrates both the clinical and non clinical policies into a single policy process and essentially it delineates a series of steps such that there’s a systematic approach to evidence-gathering, consultation and clearance of policies that while they diverge at points, at least have a single framework that overviews them and a single set of processes that clears them. (XI-2)

and

[the framework] should ensure that if there was one part of the Department or across the portfolio that is considering a policy proposal, then we also get advice of anyone else who might be considering a similar piece of work so we can make sure that we can actually align the various pieces of work and try and synchronise them, or ensure consistency between those pieces of work. (ZI-8)

According to a senior manager, the new policy framework provides a standardised, flexible but mandatory process for policy development:
Yes and probably even more importantly, it can be, in reality of course it can be implemented to greater or lesser degrees, probably what’s not said but what has even more importance is that it’s not to be breached. So in some cases things may not get positively implemented but there is much more responsibility on people to not be seen to be negatively breaching the policy. (ZI-11)

Despite the existence of these formal frameworks for managing and coordinating the policy process, there were many challenges identified by policy practitioners including time delays, lack of support at higher levels and lack of planning for policy development and implementation. Policy practitioners described a lack of clarity about the policy process, and identified various inefficiencies and coordination problems, which sometimes resulted in duplication of policy work in different parts of the organisation:

*The general sense on the ground now is that because they’ve got this new structure in place anything that goes across divisions is going to just take forever.* (Karen-AF)

and

* [...] the other issue is about then you’ve written your policy and where does it then go to get its final sign off? And that depends at what level it is being developed as well. But what is the process for all of that? And that is not necessarily clear to everybody.* (Vanessa-AF)

Some policy practitioners also reported that they found the templates and guidelines that were part of the ‘policy management framework’ too constraining and were deterred from using the process for policy making. Although frameworks were in place, policy practitioners were neither familiar nor comfortable with using effectively the new systems and processes. The administrative requirements were seen by policy practitioners to be onerous: frequently requiring additional time, delaying decision making due to additional approval points, and separating the executive sponsor from his or her policy responsibilities. Some policy practitioners even reported circumventing the new departmental processes in order to avoid the difficulties associated with it.

**People management in relation to policy development (Domain 7)**

Policy practitioners reported that the amount and mix of human resources assembled for policy work was often inadequate, particularly in smaller organisations like ACT Health. In ACT Health, the problem was compounded by the limited number of dedicated full time
policy positions. Other human resource management difficulties included assigning responsibility for policy projects to individual policy and project officer’s rather than small teams comprising a range of skills and expertise. For some large projects (legislative reviews and hospital planning), mainly in Queensland and South Australia, small teams were assembled to complete the policy work. A particular challenge for health authorities, which was more pronounced in the ACT and Queensland, was the inclusion of both policy and operational responsibilities in policy officer positions. As one senior manager reported:

It absolutely is [a problem for policy work]. My team spend so much of their time briefing on the operational side of the business and not actually looking at some of the key pieces of strategic policy work that need to be done and would actually make a really big difference. (YI-4)

Recruiting and retaining policy workers was a significant challenge described by senior managers in all three jurisdictions. Difficulties with recruitment and retention were attributed to the small pool of suitable policy personnel from which to draw:

[...] limited career pathways in health policy; public service restrictions on staffing, remuneration and working conditions; budgetary constraints; competition from other organisations; rapid turnover of policy staff; and the increasing feminisation and ageing of the policy workforce. (ZI-11)

These concerns were seen as more pressing in ACT Health and SA Health compared with Queensland Health, due to the smaller size of the health authorities. ACT Health faced particularly strong competition from other high profile national agencies based in Canberra, with whom they were unable to match remuneration and working conditions. Relatively high staff turnover levels was another human resources management problem experienced, particularly in ACT and Queensland, creating problems such as loss of skill and experience and loss of corporate knowledge and history. Some of the concerns relating to staff turnover are summed up in the following statements of senior managers:

One of the challenges is in the organisation is the retention of people within the organisation, who want to do policy. What you need is you need enough new blood coming in so that you retain some degree of credibility with your policy officers, combined with; but you also need them there long enough that they actually understand and know how to do it. And there’s a learning curve to doing these things. (YI-6)
we’ve got very strong competition from other agencies and limited career path within policy areas because of the small numbers of people. So it’s very difficult to keep people in policy areas for any length of time. That is what I mean by it’s a bit of a movable issue. The capacity is consequently heavily vested in particular individuals and we’re talking about a very small number of them. So key individuals moving on, or the individuals who are in those positions not having much individual capacity, is always going to be a major weakness for us. (XI-3)

A number of senior managers in the ACT Health and SA Health also reported that attracting young people to policy and planning work was difficult because the occupation was not perceived as a recognisable career option with an identifiable pathway and appropriate remuneration. According to one senior manager in SA Health, it was difficult to attract people to policy work as they tended to be unclear about the nature of the work and it was not seen as a legitimate career choice associated with specific training and education: “[...] policy still doesn’t have a good rap. It’s still not seen as a real job in some people’s eyes.” [ZI-9]

In each jurisdiction, a lack of skills in particular areas was identified by both policy practitioners and senior managers. These included specific disciplines and technical skills in epidemiology, economics, statistical and spatial analysis, service planning, program implementation and futures analysis. Senior managers also reported that it was difficult to find skilled and experienced policy practitioners with a combination of strategic, analytical, contextual and operational skills necessary for policy work:

So they might have perhaps good analytical skills, good change management skills, but be missing some components in terms of being able to do the more quantitative analysis or critical appraisal components. So, in that aspect, we tend to have to do a lot of on the job training. (XI-1)

Certainly, critical analysis and I think at times that can be lacking. I have some areas that are very good at it and some other areas that need to keep working at it. Sometimes there is an acceptance that that’s somebody else’s job so they should have got it right and I am just collating it, whereas I am trying to change that culture to...actually we critically analyse and add value to what we see in policy...we don’t just cut and paste and zip it up [...]. (YI-4)

[…] probably something that we are grappling with here is having the skills and ability to develop policy and I’m not entirely sure why that is the case. In my own Branch I have quite a significant number of people who come from health/clinical backgrounds but they do struggle in two respects. They struggle coming into a department, to a bureaucracy, which is quite a
different role [...] a policy role is very, very different to what one of the district roles are, and they struggle in terms of some of those more bureaucratic processes and the way policy is made and who makes those decisions [...]certainly in terms of the writing itself that can sometimes be a problem [...] I spend a lot of time taking the emotion out of the work, out of the writing so you can’t actually say that. This is how you make your point but actually translating to policy writing as opposed to that sort of impassioned clinician-type writing. (YI-4)

and

Our [name of specialist area deleted] staff who are in policy have tended to come from the service delivery end and career path-ed up into policy without having the necessary analytical and writing skills [...]. (ZI-10)

Another senior manager from South Australia makes a similar point, from the perspective of quantitative analytical skills:

[...] the detailed, analytical skills to work with data is still something that’s in short supply. I think in fact this is across the public sectors in general. [...] the other departments have exactly the same problem. (ZI-9)

Professional training and development for policy workers was strongly supported by all health authorities. Focus group participants in each jurisdiction reported having access to professional training and development activities including on-line education, external courses conducted by academic institutions, attendance at conferences, short term placements at and rotations to different work environments, and access to leadership training programmes. They also reported that their managers supported them to pursue professional development opportunities. This was confirmed by senior managers interviewed, who said they encouraged staff to develop their skills. Senior managers also reported that they mentored staff and encouraged their development by including them in senior officer discussions on programs, budgets and intergovernmental matters.

In discussing future professional development strategies, the majority of participants interviewed expressed a preference for developing skills based on a ‘learning by doing’ approach, and ‘tailored’ to their environment; in other words, a practical method of learning that was responsive to the particular problems and difficulties they encountered in policy work. This is reflected in the following quotes by participants:
But I think that absorption actually is one of the organisational strengths around why we are able to knock out quite reasonable policy [...]. (Brendan-AF)

Another comment offered on more practical learning opportunities:

 [...] so targeted sort of interactive learning opportunities around policy topics and processes so that’s really honing in on the policy stuff and it’s best for them to be targeted, we’re happy to support people going and doing higher degrees in policy or whatever but I don’t think it teaches people much. So I’ve got a real reservation about it being nothing more than credentials [...]. (ZI-11)

and

One of the things that I think is part of that experiential thing is getting policy and programme implementation experience. And you know, program implementation linked to policy is like the real rare experience, but that could be the critical experience for many, many people in terms of gaining knowledge and skill about working in public service in policy etc, and the linkage to implementation. (Amelia-CF)

While all three health authorities invested heavily in professional development and training, senior managers commented that this training and development offered by health authorities was not specifically policy focused.

6.2 CHALLENGES OF THE EXTERNAL ENVIRONMENT

In Gleeson’s model the influence of the external environment, comprising political structures and processes, and the health system, is not recognised as a separate domain. However, two of the domains, managing stakeholders, and managing cross-portfolio and intergovernmental relations, implicitly reflect aspects of the external environment. (Refer to Section 5.2).

Focus group participants described their policy work as shaped by a variety of influences and constraints that extended beyond the organisation in which they worked to include wider political and health system factors. Briefly, some of the influences reported by participants as influencing the policy process included premier’s, minister’s and or Cabinet’s requests and directions; elections and the electioneering process; political party demands; and health interest group pressures. Although these influences were mainly associated with political institutions, structures and processes of a parliamentary system of government in a liberal democratic country like Australia, they were often perceived as
beyond the control of practitioners. The capricious nature of the socio-political environment presented the practitioner with numerous challenges to the policy making process. Senior managers also perceived a number of external political and social factors that interacted with and, to varying degrees, influenced the organisation’s capacity for policy work.

The external influences and constraints reported on from focus group and individual interviews in this section include political factors; personal style and interests of ministers and roles and functions of ministerial advisers; Commonwealth-State relations; roles of central agencies and the centralisation of decision-making; whole of government policy approaches; and the influence of the media.

**Political factors**

The influence of political structures, processes and affiliations are evident in the comments made by policy practitioners and senior managers, in terms of political (premier and ministerial) intervention in shaping policy directions and actions; and the power of cabinet and senior political colleagues in ultimately influencing policy directions and outcomes. Perceptions of increasing political influence on and or intervention in policy development and implementation, which included problem and issue identification and determining future directions and actions, were also identified by participants:

South Australia:

*Over the years, there has been a ‘politicisation’ of the public sector which continues to increase, including the Health portfolio. (ZI-11)*

*So something that does get resources, does get supported, does have political traction, does have exposure, and the experience of it, it’s got nothing to do with real policy development and it’s all about pragmatics and it’s all about political strategy. (Niki-CF)*

and

*[…] it’s not a decision about what is the best approach based on the evidence as we perceive it, it’s already been pre-determined to an extent. It is a political decision, and it’s about what do they expect cabinet will also agree to. So there was, I mean there was that pragmatics there as well. You’re still obliged to do this, and that was the other thing, because you’re still obliged to do it despite the fact that you know that there’s those pragmatics there. (Amelia-CF)*
Queensland:

And, more recent policy experience is around the Premier grabbing hold of an issue and then wanting you to find the evidence around it and there’s scant evidence but wanting to run in a certain way, and purely the issue is a political issue to get something up, look like you’re doing something in an area, throwing money at it, building it into something [...]. (Louise-BF)

Australian Capital Territory:

[...] the cabinet process is essentially the highest level policy making process in all governments. It actually is a policy making process, and there are certain types of policy that cannot be done without going to cabinet. That’s the top level, and it’s actually very important, and I think it’s frequently missed in a lot of discussion around policy. (XI-3)

And I think in essence, that remains the case that the government does have the mandate, they’ve been elected by the people, they get to direct the public service and the public service needs to be responsive to them. But that doesn’t mean that that’s to the exclusion of independent advice and that the public service abandons all principles or does everything possible simply to protect the whims of the government of the day. So that’s sort of a constant tension and I suppose it’s a fairly dynamic relationship but you obviously need to both be respectful of what the elected government wants to do, and provide them with accurate information about the risks of what they propose to do [...]. (XI-2)

and

We also have issues identified for us because we are such a small jurisdiction and people will bump into the Minister for Health or the Chief Minister in the shopping centre and have discussions on a Sunday afternoon and you then get a Ministerial about it on Monday morning. That is part of problem identification or issue identification. (Brendan-AF)

Some of the political pressures that policy practitioners were struggling with included competing priorities of political stakeholders and political intervention which sometimes prevented or over-rode (what was seen as) sound policy development; the speed of political decision making; election promises where implementation issues were not considered; lobbying by powerful interest groups and ‘noisy constituents’; and cabinet reshuffles.

Strong public interest in policy and high community expectations for prompt resolution of problems was seen by senior managers to have a significant impact on policy development and implementation in the ACT relative to Queensland and South Australia. A relatively well educated and articulate community and their ease of access to ministers and
parliamentarians given the small size of the jurisdiction could partly explain this situation, according to senior managers. Prominent individuals in the ACT, such as senior clinicians and other experts, were perceived to play an important role in publicly expressing their opinions on government policy and shaping the direction of policy development and implementation.

As these ACT Health senior managers commented:

>You bump into the Chief Minister in the supermarket, politicians feel themselves very close to the community and in a relatively small population, the big fish are big fish. The leaders for business or the leaders of industry or of medicine will be heard, whereas in a large state, they tend to be swimming in a bit more in the sea, they’re one of many voices and it’s a bit more diffuse. It’s a striking thing, as it is not unusual being with a minister at a launch or something and there’d be many occasions where she’s approached by people that she knows who just want to lobby her about something and it’s very sort of casual [...]. (XI-2)

and

>Particularly in a jurisdiction like the ACT where our constituents largely are public servants who all know the processes and are very articulate and well-educated, and are more than happy to put their opinions forward [...]. But it certainly has its challenging aspects as well, in terms of the expectation it creates in the community in terms of consultation that you will do with them, and the say that they expect to have, in terms of generating policy. (XI-1)

In the main, senior managers across the three jurisdictions perceived political events like elections and cabinet decision-making as a routine part of the policy process in a liberal democratic society. As one senior manager from SA Health noted, “four year electoral cycles gives rise to distinct ebbs and flows in the policy environment”. (ZI-11) While another noted: “short electoral cycles are not a constraining factor (unless held under 18 months) as this is the nature of Australian politics”. (YI-6).

A few senior managers, however, in the three jurisdictions commented that elections, particularly the time leading up to one, create a different rhythm and political intensity that increases the pressure on public administration and policy making. During this period, there is increased political activity: promoting particular issues; responding to interest group lobbying; administering resource allocation decisions; and formulating and ensuring policy implementation.
A number of senior managers commented on the effect of elections on policy work:

The agenda and pace of decision-making is influenced by elections [...] they just start getting even more politicised than normal, even more politically sensitive than normal so the politics becomes more of a constraint than normal the closer you get to the election. (ZI-11)

and

I think one of the biggest constraints I believe in Australia is the rapidity of the political cycle. I really think it makes it difficult because we all know that [...] when you come into a new political term, that is your chance to do anything that’s going to cause any sort of controversy with no matter how small a group in the community. I think it’s even harder because they spend the first part of their term actually understanding the system. I think that’s one of our biggest constraints in this country. (YI-7)

While another senior manager reported on the significant changes to policy work that accompany a change of government:

[...] we’ve got an office [referring to the new minister and support staff] that consumes a lot of information and that is probably taking a lot of our time at the moment [...] it is actually getting a new minister and a new office up to speed on a lot of very complex issues. It’s [referring to the new minister and government] a bit of a cultural change for the organisation [...]. (YI-4)

Similarly, a number of focus group participants viewed elections (preparations for and its aftermath) as having a significant influence, mainly an unsettling one, on the policy process:

[...] but it is the fact that a lot of policy in public sector is driven absolutely specifically to a 3 year public election marketing program, which bears no resemblance to anything else. So, yes, that’s sort of the big issue there. (Pamela-CF)

Both senior managers and policy practitioners perceived external political factors, such as elections as somewhat disruptive to the usual routine of the policy making process, creating a degree of unpredictability. While a number of senior managers reported that they recognise the effect these activities have on the policy process but accepted the situation as a feature of the political system.

The level of government interest in and commitment to policy was perceived to have a significant effect on the priority given to policy development by health authorities and consequently for conducting policy and building a policy-competent workforce. Many
senior managers and policy practitioners in all jurisdictions reported that health authorities had a tendency to focus on the operational and service delivery aspects of health care and less on the strategic and policy issues.

For instance, one senior manager in SA Health, who had worked in government for many years, commented on the ambivalence with which policy work was viewed:

“[...] those constraints have been whether governments and agencies are actually interested in doing policy work at all [...] there were times over the last 20 years you would be reluctant to use the word ‘policy’ and it was safer to discuss policy-related work in terms of substitute phrases like ‘operational plans’ [...] you wouldn’t even use the word if you could possibly get away with it, because it was just automatically blacked out. I’ve had a number of ministers with absolutely no interest in policy, and a number of chief executives who give lip service to it.” (ZI-9)

Another senior manager notes:

“At the moment I’m head of a Policy Branch where I would say at least a quarter of my staff are doing programme work”. My team spend so much of their time briefing on the operational side of the business and not actually looking at some of the key pieces of strategic policy work that need to be done and would actually make a really big difference.” (YI-4)

The emphasis given to operational issues in the three health authorities is encapsulated in this senior manager’s comment:

“[…] we are [ACT Health] a service delivery agency. We have five thousand staff, of which realistically no more than 1% would be involved in policy making on any regular basis [...] We run health services as our core business. It [policy] is very much a small component of what we do [...]” (XI-3)

**Role of the minister and minister’s office**

Participants acknowledged the minister’s responsibilities as head of department, and the liaison role performed by their advisers, recognising the relationship as a feature of the parliamentary system of government. The tensions that arise from this relationship is also recognised, and summed up in this senior manager’s comments:

“[…] it’s actually understanding the relationship between departments and ministers. At senior levels, people understand it very clearly. At junior levels – the subtleties of how the Westminster system operates and the nature of how we actually provide advice to ministers, and also the fact that we now really operate – the relationship is mainly with ministers’ advisers.” (ZI-8)
The minister’s relationship with the department was often perceived by policy practitioners in a negative light, more as interference, and is summed up in the quotes below:

*I think the ministerial demands are just exhausting. It is a never ending demand. There is no semblance of any filtering that I can see. Anyway, it is huge. The proximity of the ministerial process here to the actual directions of services is minimal and as a result, the amount of time you spend on ministerial responses as a director at my level, is... a minimum of a day a week in ministerial work - a minimum [...].* (Anita-AF)

Intervention by the minister and their advisers in the development and direction of policy work is supported by another participant’s comment:

*[…] the amount of political interference that goes on in South Australia compared to [another jurisdiction]. And, I have heard that from other people that it’s almost like micro management - we are not allowed to go out and develop without ministerial advisers and ministers [...].* (Steve-CF)

and

*[…] the Commonwealth got very much involved and the then Health Minister got very involved and wanted data collection unfortunately from every state; who these people were? and there were risks actually, there were risks to the whole approach [...] and the Commonwealth Minister wanting these really punitive steps to be taken [...].* (Cameron-AF)

While practitioners may have perceived the relationship between minister and department as ministerial interference, some senior managers however regarded it as part of ministerial responsibility in a Westminster system of government, as reflected in the following quote:

*[…] and in terms of the protection of public health which I suppose, and the promotion of health which is the main ethos of health departments, that’s where responsibility lies. [...] but I suppose if the buck stops anywhere, it’s with the elected government and primarily with the minister responsible. So that’s my kind of conception of policy framework and how it all works.* (XI-2)

The personal style and interests of the minister for health was seen by a number of senior managers as another significant influencing factor, shaping the problems addressed, sources of policy advice sought, resources allocated and decisions made. Senior managers in ACT Health commented that the small size of both the organisation and jurisdiction meant the public had easy access to the minister and chief minister. The personal style and interests of the minister greatly influenced the authority’s ability to get issues on the
agenda, obtain approval for particular policies, consult stakeholders and garner support for implementing policies. The individual style of the minister in influencing the nature of the relationship with departmental officers is evident in this statement:

> And is this partly relating to the style or type of person at the helm I suppose [...] this minister comes with fairly different expectations and different agendas as well? I think any change of minister produces [...] they have a different way of wanting to work and a different level of expectation and need from the department so yes certainly there is a difference [...] (YI-4)

Senior managers in Queensland Health and SA Health also commented on the health minister’s role in ‘championing’ issues and raising them on the agenda, providing resources for policy development, ensuring authorisation, and demanding the formulation and implementation of policy. This was evident in recent years in SA, where the health minister’s interest in pursuing institutional change through legislative reform gave rise to reviews of the Health Care Act, Mental Health Act and Health Professionals Registration Acts.

The increasingly important position of ministerial advisers as a conduit for communication and advice between minister and departmental officers in the health authority not only created tensions which needed careful management but also had an influence on the policy process and outcomes, as reported by some senior managers in SA Health and Queensland Health. The advisers’ increasing role in briefing the minister, filtering departmental policy advice, and controlling access to the minister was reflected in this quote by a senior manager from SA: “a lot of interaction with the minister takes place via their advisers; in fact, the relationship is mainly with minister’s advisers” [ZI-8]. The manager explained that it was necessary to develop a good working relationship with advisers, one which “ensured the provision of advice whilst at the same time ensuring proper authorisation”.

As another senior manager noted:

> Ministerial staff are highly influential. Equally ministerial staff can obstruct, and again just given the nature of what ministers have to consider, they place a great deal of emphasis on, particular longstanding members of their ministerial staff, and so they can be quite influential about the priorities, the importance that are given to particular options which are brought forward or being considered. (YI-6)
Centralisation of decision making

[...] we have this thing like the Minister and DPC or Treasury or whoever it is, there’s a higher authority that dictates it will be thus. (Niki-CF)

and

Treasury see themselves as policy makers now whereas you wouldn’t have seen that before. (Patricia-CF)

Many focus group participants described the increasing role of central agencies in policy making as a constraint. Central agency officials were seen to have more control over the policy development process than in the past, with a more prominent role in identifying policy problems and setting the agenda, determining the process to be followed and time lines for completion, and imposing pre-determined directions; these demands by central authorities were seen to constrain the policy process.

The increasingly major role performed by central agencies is reflected in the following focus group participants’ comments:

I think the ‘top down’ experience is something that’s happened in the last five years and is getting more so, and it’s happening not just within our department but now outside of our department, so Premier & Cabinet, and Treasury now have an incredible influence that I don’t think was there ten years ago. (Winona-CF)

and

Queensland Health, we were not the lead agency on the work. We were reporting through the Department of Premier and Cabinet, so social policy which is a unit in Premier and Cabinet had allocated resources and they then brought us into the discussions, the national discussions so we were participating in the national teleconferences and what have you of the [deleted program name] subgroup. (Monica-BF)

Another participant reports:

[...] it’s about process, it’s about time issues, the timing things, and the intergovernmental processes that can fail because of there being such direction also through DPC about where they want to go. There is also a kind of pre-worked decision, pre-existing decision-making about what flavour the submission would be and so that already curtailed discussion [...]. (Amelia-CF)

In addition to time, resource and process constraints, policy practitioners who had participated in cross-portfolio policy development also commented negatively about the
attitudes and capabilities of central agency personnel responsible for interdepartmental policy coordination, illustrated by the following comments:

That’s been some of my frustration, actually working more recently with people in Department of Premier and Cabinet, that they are very central agency focused and not really perhaps completely across just the day-to-day business. (Margo-BF)

and

It can be a not very pleasant experience working with the central agencies. I’ve had recent experience with COAG from - the Department of Premier’s was the lead agency and their turn around times and very little consultation on things. (Louise-BF)

As another participant commented about the tensions arising from different perspectives and limited knowledge of the subject:

So it was around productivity. It wasn’t around health issues. That is the secret to where this all pivoted because as a health department we fully understood that [deleted program name] is a major health issue […]. It was a bit of a nightmare. That was one of the issues for us, that we were being driven by a completely different understanding, evidence base, and all that type of thing […]. I find they’ve actually got a lack of content knowledge. (Monica-BF)

A number of senior managers in the three jurisdictions confirmed policy practitioners observations that central departments, such as, Premier and Cabinet and Treasury were playing an increasingly significant role in cross-portfolio policy development processes. The more centralised approach to policy work is reflected in the following quote made by a senior manager:

At the moment, particularly if you’re just looking at the federal level, there’s been a more centralised approach to policy and even within the federal government. A lot of that policy generation is largely coming out of the Department of Prime Minister and Cabinet, if not the Prime Minister’s Office. So, I think that does create some constraints in terms of what whole of government perspectives can sometimes make it difficult to, to bring that sort of perspective to policy or planning. (XI-1)

This increasingly prominent role performed by central agencies, according to senior managers, affects the policy development process of line portfolios in terms of priorities assigned, human resources deployed, processes used and its management, and changing roles and expectations of policy work. With central agencies playing a more assertive role
in policy coordination, there are demands on line agencies to allocate policy resources to an activity that may not necessarily be a departmental priority, spend increasing amounts of time on cross-portfolio communication and negotiation by participating on inter-departmental task forces and committees, and preparing large amounts of briefing notes and reports, and manage the relationships and processes with external partners. Constraints, such as lack of clarity about roles and responsibilities, different and at times competing perspectives and priorities, and limited resources to direct to these activities were raised by senior managers:

[...] we sort of try to demand things out of people and other times we want to work collaboratively with them but at other times we say we want to be in partnership with them but I don’t think people actually understand what necessarily their roles are when they sit around the table. I think a lot could be gained by when we set up these forums to actually say what people’s role is, how they fit in and how they will feed into the process because I think participants get equally confused [...]. (YI-4)

A few comments on directing resources to this work:

We are expected to participate in these activities but a real problem with cross-departmental coordination is that no additional resources have been allocated to do this work, as a result there is a reluctance to engage in this type of work. (YI-4)

A comment supported by another senior manager,

There’s a lot of meetings [...]. It’s when you come back to your desk and you actually have to operationalise the work - it’s just lack of resources. So you go along, you talk about it but no one wants to put their hand up because they will end up having to do the job and they don’t have the resources to support it. That’s often the case. [...] but you go along to these meetings and if you have a great idea you end up going home with the rest of the job [...]. (YI-4)

A manager commented on the amount of time required by these cross-portfolio activities:

Unfortunately there are lots of interdepartmental committees, and that’s the other way of working, so there tends to be a plethora of interdepartmental work and it’s a blessing and a curse. (XI-2)

and

[...] a small jurisdiction struggles with the burden of inter-jurisdictional work, whereas in other bureaucracies there’d be a reasonably large team of people who’d be responding to AHMAC or health ministers’ requests, we
don't always have that luxury. Even just our own intergovernmental processes, like the [deleted name] Plan and the [name deleted] Plan suck up a lot of energy, we're constantly getting asked to provide updates on all these plans, usually with very short timeframes. So I think we spend probably more of our time being reactive than we would like. (XI-2)

Some of the constraints identified in this section would also apply to the next section on ‘Whole of government approaches’.

**Whole of government approaches**

*The across government work really does set a lot of our agenda.* (ZI-11)

Senior managers reported that whole of government policy approaches had been adopted in all three jurisdictions. According to senior managers, however, this approach was relatively new in Queensland. The aim of this approach (also referred to as ‘joined-up’ government in public administration) was generally to provide improved policy coherence and coordination across the state and territory’s public sector. To achieve this objective, state and territory governments, to varying degrees, have instituted a strategic policy framework articulating a state and territory-wide vision, objectives and priorities, within which individual departments were expected to align their plans; inter-departmental coordinating structures; accountability frameworks to monitor progress and measure performance against agreed objectives, negotiated targets and allocated resources; and a delineation of roles, responsibilities and functions across the public sector.

All three jurisdictions had structures and processes to facilitate whole of government cross-portfolio coordination and collaboration. In the ACT, this was evident in the application of a territory-wide strategic framework (e.g. Canberra Plan and Social Plan), appropriate interdepartmental coordinating structures, cabinet sign-off for whole of government documents, and a framework for monitoring performance. Similarly, in South Australia, there was a requirement for policy to be developed within the parameters of a statewide strategic framework, namely, the South Australian Government Strategic Plan and the Social Inclusion Unit’s objectives and targets, with established structures and accountability arrangements. As a senior manager commented: “[…] whole of government approaches has been a big issue for us for many years now, and this government you know, sort of six years ago made a big focus around it, social inclusion, and separate structures all set up”. (ZI-9). Queensland also had a strategic framework,
with identified objectives and targets for each government department, established interdepartmental decision making and resource acquisition processes, and performance monitoring requirements.

Senior managers, particularly in SA, commented that whole of government work was time consuming and resource absorbing in terms of time and effort. Since few or no additional resources were provided for cross-portfolio collaboration and because resources were already scarce for undertaking ‘core’ departmental functions there was a tendency by some departments to not give appropriate resources and time to cross-portfolio work:

*I mean in an environment of tightening and declining resources and people not really having enough resources to do their core business it is quite difficult to get people to give sort of space to it [...]*. (ZI-11)

There was also concern expressed by SA senior managers about government’s ability to sustain the policy momentum and interdepartmental structures and processes required to maintain a whole of government approach.

*But again, most of those [cross-departmental] activities have actively reverted to service planning and coordination issues, rather than policy framework issues. And in the early days of all that process there were lots of, almost too many coordinating groups and people meeting. But those groups, where they still go, have entirely buried themselves in how do we deal with this very specific, usually services planning question. And there’s very little in the way of policy leadership around those topics. Even in central agencies.* (ZI-9)

This senior manager continued:

*But its [cross-departmental] gone off the boil a bit, in a way. You can’t maintain that for too long. And every now and again something comes along that gives it a surge. So we’ve been doing for the last year, quite a lot of work around ‘Health in All’ policies concept, taken some material from the New Zealanders and from Europe. And that gave us another surge and when the other agencies realised that we weren’t doing this to try and take over their business but rather to help them do their business. We had quite a surge of interest around that, and that’s kind of regenerated some of that stuff.* (ZI-9)

Queensland senior managers commented that whole of government policy coordination and collaboration posed challenges to policy workers’ competencies and experiences. They reported it was important for departmental policy workers to develop different skills and learn to operate differently, “to develop a different mindset” [YI-6], if they were to succeed in this new collaborative policy making environment. This manager continued:
I think we have traditionally taken the view that we are the experts, and therefore you should do what we say. Where I think we are moving with that sort of public policy influence, is to craft our case more cleverly. (YI-6)

A senior manager from another jurisdiction concurs with the need to emphasise the attitudinal or cultural aspects to policy development in a whole of government, collaborative environment:

I don’t want to over emphasise the extent to which a structural approach is not the answer here [...]. It has to be much more cultural, that it becomes an embedded feature of the way people go about their policy making, that they consider, acknowledge and then act on the cross-agency implications of it. (XI-3)

A number of senior managers from the three jurisdictions were cynical about ministerial and departmental commitment to whole of government policy approaches given a minister’s existing responsibilities and accountability arrangements.

Those ministers have to fight in the budget for their own things. And, ministers are human like everybody else. So they’re a bit loath to go and spend a lot of energy fighting for some money that’s going to be spent by some other minister in some other department, compared to their own pressures. (ZI-9)

This position was supported by another senior manager, who expressed the opinion that a minister’s responsibility and therefore priority was to the portfolio rather than to whole of government activities:

Once ministers are appointed to particular portfolios, they rapidly develop an alignment with the portfolio, and tend to represent that view – that’s basically what you need them to do to some extent. And whole of government views then sometimes take second preference or second place to what they see as what’s necessary to survive in the portfolio. You don’t get kudos for whole of government [...] particularly in service departments like this, where you live and die on the basis of what happens within your portfolio and not on what happens outside of your portfolio. (YI-6)

Commonwealth-state relations

[...] because the COAG thing sets up this sort of like slipstream and everybody just gets sucked into the matter and you don’t get much choice in terms of having any control over it and it’s one of those policy things that drags everybody along. (Monica-BF)
The influence of the Council of Australian Government (COAG) on Commonwealth and state/territory policy was evident in the above policy practitioner’s comment but also in discussions with all jurisdictions.

Commonwealth-State and other inter-jurisdictional issues also created challenges for policy workers. These included national policies which needed to be implemented at state and territory level but without suitable governance, resourcing or capacity for implementation at the local level; lack of leverage of state officials over Commonwealth-funded services; and decision making processes at Commonwealth/COAG level that overrode work already done at the state and territory level.

**Role of media**

According to a policy practitioner:

> *The Courier Mail is a great policy driver in Queensland.* (Louise-BF)

A senior manager commented about the role of the media:

> *The classic one is something hits the media and the minister says fix it and the department fixes it [...] then there’s clearly the pressures of both the media driving the issue which gets on to the front page and how do you respond to getting the topic away from the first page and hopefully away from the papers completely. That dynamic is always going to be there. But how do you best respond from a departmental position?* (XI-3)

As indicated in the above quotes and supported by many focus group participants, the role of the electronic and print media was viewed by many as a strong influence in shaping the policy agenda and the strategic direction of particular issues. While the recent widespread use of social media and other communication technologies have also had a significant impact on government decision making and activities. Participants commented that ministers and governments in all jurisdictions were particularly sensitive to negative publicity of health issues and problems in the national and local media, a situation compounded by greater scrutiny of government activity as a result of the 24 hour media cycle, with departmental officers taking every precaution to minimise risk and avoid adverse reporting by the media.
External stakeholders

Policy practitioners and senior managers shared the view that the minister and government sought information and advice from a variety of external sources including non-government organisations, professional associations, industry groups, and research institutions, as reflected in the following comments:

 [...] you can bet that they’ll also be getting counsel, whether they like it or not, from all sorts of people who are probably opposed to the course of action that you’re wanting to take. So we might be saying to the minister of the day here’s a public health intervention which would be, we think very cost efficient, it would be very efficacious for the community [...]. And you can bet that those very protagonist groups are beating an independent path to the minister’s door and painting a very different picture and saying to the minister this would be a catastrophe, you should never go down this path, and it’ll be doom and gloom for the economy and whatever else.

(XI-2)

Another participant commented:

And I think too that we’re increasingly realising that we’re one voice to the Minister and he or she will seek advice from a whole range of different people. But we’re just one little voice, whereas in the past I think the departments have been much more influential with Ministers. (Margo-BF)

The different and often competing interests of external stakeholders combined with an informed and assertive public has a strong influence on the development and implementation of policy. This is reflected in the comments made by a few policy practitioners and senior managers:

So administering the policy can be adversely affected [names deleted] by the relationship the community have with the Minister in terms of any predetermination. So that makes it very difficult for those managing policy in that area. (Molly-AF)

The influence of the wider public is articulated in this senior manager’s quote:

And I guess this is another constraint that we’re starting to move into in a sense that the government feels increasingly that this is a very demanding community. It’s quite an articulate community [...] and in terms of averages in Australian comparisons it’s a better educated and better rewarded community than many others. So the government feels held to account, it knows that people will be forthright in complaining if they’re not happy and it knows that people want to be consulted about government decision making.

(XI-2)
6.3 **SUMMARY AND CONCLUSIONS**

In this chapter, the views and experiences of policy practitioners and senior managers were examined, within the context of the conceptual framework, according to seven of Gleeson’s eight organisational policy capacity domains, in order to address the issues raised in research question 2 (challenges to aligning capacity and process) and question 3 (influences on the relationship between capacity and process).

The findings that emerge from the analysis of the views and experiences of policy practitioners and senior managers are that the challenges in aligning policy capacity and process are many and varied:

**RECRUITMENT AND RETENTION OF PERSONNEL**
There was difficulty in recruiting and retaining policy workers in all jurisdictions because the pool of available qualified and experienced policy workers was small while the problem was compounded in all jurisdictions (more noticeably in the ACT) by competition for policy and planning skills and experience from other organisations;

**ASSIGNMENT OF ADEQUATE HUMAN RESOURCES**
There were inadequate human resources, in terms of both quantity and combination of skills, assembled to complete a number of policy projects, with an individual or part of an individual’s time assigned to conduct the task. In all jurisdictions, it was less common for a team, comprising a suitable mix of skills, to be assembled to complete the policy. In the ACT and Queensland, the problem was further compounded with policy practitioners having dual responsibilities for both policy and operational functions;

**LIMITATION IN POLICY WORKER SKILLS AND EXPERIENCE**
There was a lack of skill and expertise to conduct particular areas of policy work, such as analysing, interpreting and applying quantitative information; negotiating across sectoral boundaries; and evaluating and implementing policy and programs. The problem was exacerbated by a shortage of policy practitioners with specific qualifications and technical skills in epidemiology, statistical and spatial analysis, economics, ethics, service planning and futures analysis;
LIMITED POLICY-SPECIFIC SKILLS DEVELOPMENT
There was limited policy-specific skills development provided in the professional training and development programs of the three jurisdictions, instead relying on academic courses, external seminars and short courses, and learning by observing experienced senior staff. All three jurisdictions expressed a desire for customised, workplace-based professional development opportunities that emphasised experiential learning approaches. Some of the capacity building strategies suggested included: mentoring, coaching and shadowing; policy development training by increased use of placements, rotations and secondments; policy discussion and debate; and increasing exposure to senior decision makers;

ORGANISATIONAL STRUCTURES AND BUSINESS PROCESSES
The existing structures and processes in health authorities were inhibitors to effective communication and information sharing, shared responsibility and commitment to outcomes, and acknowledging authority; frequently resulting in increased administration and extended timelines;

ACCESSIBLE AND COMPREHENSIVE DATA
There was a lack of synthesised, readily available and ‘easy to use’ data for a range of policy and planning purposes, such as, forecasting, determining trends, benchmarking and service planning. Although a range of health and related data is collected by health authorities (e.g. utilisation of health programs and services, finance, workforce, demography) it is not accessible to practitioners for policy work;

COMMITMENT TO POLICY REVIEW AND MONITOR
While the function of review and monitor was recognised as an important process of continuous feedback, reflection, adaptation and improvement, it is not routinely conducted by policy practitioners in the health authorities; and not considered a core function of the organisation. If conducted, it was a task often contracted out to external consultants and usually in the context of performance monitoring and accountability to the Commonwealth and or State and Territory government;

INFLUENCE OF THE EXTERNAL ENVIRONMENT
The influence of the external environment exerts multiple constraints on policy capacity and process, and, in turn, on policy outputs and outcomes. Some of the constraints of the external environment discussed in the interviews included:
• intervention from minister and advisers with requests and or instructions to resolve a constituent’s problem with a program or service, modify policy options and directions, and or allocate resources to a particular project;
• demands of elections and the electoral cycle in terms of preparing for an election and a possible change of government, accommodating new policy directions and resource allocation as a consequence of a changing government, and ensuring a new government’s electoral promises are fulfilled;
• demands of health industry interest groups and stakeholders who exert pressure through lobbying and negotiation to influence and change a policy position and or obtain additional funding; and conduct extensive campaigns to acquire government support for their cause;
• pressures exerted by intergovernmental and cross-portfolio coordinating arrangements (structures and processes), with central agencies (Department of Premier and Cabinet, Treasury, Department of Prime Minister and Cabinet, and Commonwealth Department of Health and Ageing) placing unrealistic demands on practitioners for additional data, briefings, and resources; limited knowledge and expertise of central agencies on policy issues, programs and services; and developing policy direction that frequently ignored the information and advice provided by line agencies;
• pressure from media arising from the availability and wide use of different forms of print, visual and social media and the twenty-four hour news cycle which places government decisions and actions under constant media scrutiny; and that policy problems and inconsistencies, funding shortfalls and service gaps may be exposed at any time. Given the heightened public awareness and publicity a media investigation generates, there are increasing pressures on policy practitioners and managers in government authorities to ensure potential policy problems are kept out of the news, and to reduce the risk of negative publicity for Government, Minister and Department; and
• demands of an informed, organised and articulate public who are aware of their rights, and willing to take action against government policies and issues with which they are dissatisfied.

This range of external influences (ministerial intervention, elections, demands of central departments, commonwealth-state relations, role of the media, and health industry interest groups) that generated unexpected shifts and a degree of volatility in the environment, strongly influenced the policy making process. These external influences imposed
constraints on policy capacity and process, creating significant challenges for practitioners in developing and implementing policy.

**Effective Leadership**

Inadequate leadership and management in health authorities was identified as a barrier to aligning policy capacity and process in terms of determining the parameters of the task, providing clear direction, mobilising appropriate resources, providing guidance and support, advocating and promoting policy at higher levels of the organisation, managing effectively the policy process, protecting staff from other demands, and overseeing effective policy implementation and evaluation.

These findings confirm the interrelationships proposed in the conceptual framework between policy capacity and process, the influence of the external environment, and the need for a process of review and monitor. Action to address the challenges to policy capacity and process must be mindful of the political context in which policy work occurs and accommodate the influences of the external environment including ministerial intervention in allocation of resources, and authority to implement; demands of short term electoral cycle; intergovernmental and cross-portfolio coordination; health industry stakeholder demands; twenty-four hour media surveillance; and public and community expectations. In addition, if health policy is to be effective, a continuous process of review and monitor is the mechanism by which policy adapts to internal and external challenges and continues to be relevant in order to meet current community expectations and future service need.

In the conceptual framework, policy work is proposed as an integrated system in which policy capacity, process, outputs, outcomes, review and monitor, and the external socio-political environment are interrelated elements. However, it is the elements of policy capacity and policy process that underpin and are pivotal to the work of policy; and the extent to which they are aligned and influenced has a direct bearing on the achievement of policy outcomes.

The above findings reveal that many of the barriers and constraints identified in aligning policy capacity and policy process are either directly or indirectly the result of inadequate leadership and management in the three health authorities. The most critical barrier to effective leadership is the failure to promote and advocate policy work at the highest level
of the organisation leading to the development of a policy-supportive organisational culture.

Policy leadership has a central role in aligning capacity and process and emerges as instrumental in achieving good policy outputs and outcomes. Strong leadership also has the ability to better manage organisational and external environmental constraints to achieve effective policy outputs and good population health outcomes.

In the next chapter (Chapter 7), the challenges for leadership in aligning capacity and process in health policy making environments are examined.
CHAPTER 7 LEADERSHIP: ALIGNING CAPACITY AND PROCESS IN POLICY WORK

7.0 INTRODUCTION

The purpose of Chapter 7 is to apply the conceptual framework to the analysis of the research data to demonstrate that leadership is the strategic means by which to align capacity and process in health policy work; and to present the findings in reference to Research Question 4 (What are the challenges to leadership in managing the alignment of capacity and process in health policy work?).

The role of leadership and management in aligning capacity and process is examined by defining leadership and management, identifying its challenges, and delineating its roles, responsibilities and competencies to achieve effective health policy.

In the previous chapter (Chapter 6) the findings revealed that many of the barriers and constraints identified in aligning policy capacity and policy process either directly or indirectly were the result of inadequate leadership and management in the three health authorities.

In this chapter, leadership and management are identified as the strategic means to effectively align policy capacity and process in order to achieve good policy outputs and improved population health outcomes.

Leadership in the health sector (Alimo-Metcalfe & Lawler, 2001; Baker, 2011; Fawkes, 2012; Hannaway et al., 2007; Hunter, 2007a, 2009; Plsek, 2001; The King's Fund, 2011), has been studied from a number of perspectives including management in clinical, health promotion and administrative health settings. Plsek and Wilson (2001, p. 749), argue that the science of ‘complex adaptive systems’ provides a fresh perspective for addressing the issues confronting management in the health system: adopting a ‘complex adaptive systems’ approach to managing healthcare organisations should emphasise relationships with staff and stakeholders, positive use of ‘attractors’ to encourage change, and a constructive approach to variation in areas of practice, with less attention directed to detailed targets and specifications, and a focus on ‘controlling the process’; with Hunter (2009, p. 203) arguing for a new public health leadership paradigm based on a ‘complex adaptive systems’ approach to address a perceived ‘leadership vacuum’ in managing
complex health problems. Empirical and theoretical research on leadership in health policy making environments is very limited (Gleeson, 2009; Gleeson et al., 2011). Gleeson (2009) identified ‘policy leadership’ as a key domain in building organisational policy capacity; further distinguishing it from ‘generic’ public administration leadership. Gleeson maintained that ‘policy leadership’ in a health authority involved specific features of local level judgment, mentorship, initiative and responsibility, and the ability to mobilise organizational resources to build policy capacity; concluding with the proposition that developing senior and middle and level policy leadership was a strategic approach to strengthening organisational policy capacity.

Despite different academic perspectives and research foci, the central role of leadership and management to an organisation’s performance and achievement of outcomes is confirmed.

This study builds on and extends the concept of ‘policy leadership’ for effective policy and the achievement of good policy outcomes; and confirms leadership as a critical component of policy capacity that determines the direction and culture of an organisation, central to the effective management of resources and the policy process, and an important conduit to the external socio-political environment. See Figure 3.
The diagram illustrates the central role of leadership and management in a health policy environment in the achievement of good policy outcomes.

Leadership and management roles provide the conduit for departmental communication with ministers on policy work: responding to government policy initiatives for development and implementation; and, proposing departmental initiatives for government endorsement.

Leadership and management roles provide the organisational context for policy development and implementation: confirming desired policy outcomes; determining the policy outputs necessary for these outcomes; ensuring that policy capacity and policy process are aligned toward the efficient achievement of the policy outputs; and providing an environment conducive to the continuous review and monitor of policy work as a process for feedback, learning and improvement.
7.1 **PERCEPTIONS OF LEADERSHIP AND MANAGEMENT IN HEALTH POLICY ENVIRONMENTS**

This section analyses the perceptions of policy practitioners and senior managers on leadership in policy environments in order to develop a better understanding of the broad features of leadership and management that are considered necessary for policy work in Australian health authorities.

**Defining Leadership**

This study uses a broad definition of leadership, which, in the context of the state and territory public service, is interpreted as senior executive and senior management positions, with prescribed authority through their defined roles and responsibilities for providing high level, specialist advice, managing and directing staff, and controlling resources. Therefore, in the state and territory public service, leaders are empowered by their position.

Further, the researcher recognises two levels of management comprising senior management, referring to the top echelons of the public service, the senior executive service, with responsibility for managing a large sphere of human and financial resources; and middle management, referring to a combination of classification levels (e.g. middle and senior administration) and position titles (e.g. managers, program managers, coordinators and team leaders), with responsibility for supporting senior management and supervising and supporting subordinate staff. In addition to supervising staff, middle managers are still engaged, to some extent, in conducting policy work. Within this context, both senior and middle managers are involved, to varying degrees and with some overlapping functions and responsibilities, in providing leadership and management. This broad interpretation of public service leadership and management is applied to leaders and managers in dedicated policy and other policy-oriented divisions in the three health authorities.

**Perceptions of policy practitioners and senior managers**

A policy practitioner, in the following quote, commented on the importance of receiving intelligent direction and guidance from a manager:

> [...] you hope that your boss will provide that good guidance and feedback on the job. (Maria-AF)
The importance of receiving sound advice from a manager is summarised in this comment:

*I would say, if in fact my boss doesn’t understand enough about where I am at, then it’s doomed in any case.* (Brian-CF)

Policy practitioners in the three jurisdictions expressed frustration with managers who *‘didn’t know what they wanted’*; waiting until the draft policy report or statement had reached an advanced stage before offering constructive comment and direction. This lack of clarity about direction, frequently required practitioners to substantially reorient and restructure a policy, whilst recognising that a slightly different process (purpose of task, possibly less stakeholders consulted, different information and evidence analysed, and different options investigated) could have been used and or time saved. They expressed a preference for a leader who could provide intelligent input into policy making; who would be able to discuss and provide advice on concepts, available evidence and research, appropriate methodologies, political and health system sensitivities, potential impacts of strategies, and ministerial preferences.

Policy practitioners emphasised the importance of having a senior manager, sometimes referred to as an ‘executive sponsor’, in policy work who could provide guidance on a project’s direction, scope, approach, and strategic options but also take responsibility for the development and implementation of policy. They further perceived the ‘executive sponsor’ as being able to advocate for and defend the policy at higher levels of the organisation:

*So having a clear framework and methodology and an executive sponsor can assist you when you come across some of those barriers ... it was having the executive sponsor and we had to go up through that channel and then it came back down. The directive was given: thou shalt contribute to this policy.* (Molly-AF)

Another policy practitioner commented:

*I guess, there’s a leader being a good leader in which case performance appraisal and mentoring is important, but there’s also leadership of policy initiatives. So, making sure there is an owner and there is a sponsor and there is someone who will take responsibility and lead that initiative.* (Sarah-BF)

The ability to protect and support policy staff from wider organisational demands, enabling them to carry out their policy work was perceived as an important feature of
senior leadership by participants in the focus groups. Freeing staff from other duties, including operational responsibilities, while ensuring cooperation and timely support from other parts of the organisation, and providing the necessary time and space for practitioners to complete the policy task:

\[\text{\ldots} it \text{ is important to have a director who protects staff from additional responsibilities, so we have the time to get on with the policy work.} \] (Vanessa-AF)

This is supported by another policy practitioner:

\[\text{\ldots} it \text{ is about allowing the people they employ for their skills and knowledge and context to be able to actually flourish and do the work that they're actually good at doing and not be caught in the factory. So providing that space for them to engage is important.} \] (Niki-CF)

The significant features of leadership perceived by participants comprise:

- providing staff with clear direction and guidance;
- providing staff with the necessary resources and infrastructure to carry out their work while protecting them from the demands and pressures of the internal and external environment;
- managing uncertainties and risks in the external socio-political environment;
- managing effectively the policy making process;
- promoting and advocating at higher levels of the organisation the work of staff;
- enabling staff to work autonomously and exercise their judgement, recognising their intelligence and skills: to trust staff to work autonomously rather than telling them what to do; and
- mentoring staff to further develop their knowledge and skills.

The importance of good leadership is well summed up by a participant, in the following comment: “\textit{definitely good leadership is required as a high priority in policy making; good leadership and good communication are important in shaping good policy\textit{}}”. (Olivia-CF)

**Perceptions of senior managers**

A few senior managers expressed the opinion that policy making in health authorities was more about exercising influence than possessing real power as they had to rely on their ability to manoeuvre and persuade to gain support at senior levels of the organisation to achieve successful policy outcomes. They explained, the focus in health authorities was
on managing and delivering health programs and services, and a policy manager had to compete against this strong operational bias on budgets and resources. In short, policy did not have the same standing and value as service delivery. As a senior manager from ACT Health reported:

*The point of difference is the difference between influence and control. That’s the primary point of difference […]. Policy development works via influence rather than control […]. (XI-3)*

Another senior manager commented:

*I would have said one of our big problems was that policy work is not valued […]. I think you go in surges in governments, and in bureaucracies, where policy work is not seen as having a great deal of priority […]. (ZI-9)*

Many senior managers reported that it was important for senior managers to be clear about a policy’s direction for development and implementation, and to be able to provide intelligent input into directing and shaping policy work, reflected by the following quotes:

*A leader must be clear about their own direction and the direction in which a policy should head, and they need to communicate that clearly to people they are leading[…] what’s the policy direction you want to take?, what’s the rationale for it?, what are the three or four areas for reform strategies?[…]. (ZI-9)*

and

*I see a leader’s job is to lead and inspire […] my job is not to be down in the trenches fighting the war but rather to have that ‘helicopter view’ and make sure that we are all heading towards the direction the department wishes to go. (YI-4)*

In addition to intellectual input and direction, a number of senior managers noted that it was important for leaders in policy environments to provide policy practitioners and unit managers with the necessary support (acquiring resources, providing input into shaping decisions and actions, and promoting a position) to perform their duties, as expressed in this quote:

*To be able to listen as well as support and I suppose again because I am in this generic area I often get other senior directors ask me if I will come along and support them and I provide that kind of backup and give them that confidence to do the job that they are doing […]. (YI-4)*
Their job is to tell me what resources they need and my job is to support them in getting that. (YI-4)

Besides providing intellectual, emotional and material support, it was also necessary for policy leaders to create a supportive and conducive environment for policy making; based on respect for the policy practitioners’ knowledge and skills, open communication and trust, and enabling staff to work autonomously:

It is important to create a culture for good policy: open communication, trust, empowerment and support. It is also necessary to keep staff informed and involved. (YI-7)

In reference to policy practitioners’ capabilities and working styles, a number of senior managers reported:

[…] it is necessary to give policy staff explanations and reasons for doing things but a manager in a policy area needs to ‘negotiate and argue’ with policy staff rather than ‘tell them what to do’. (ZI-9)

and

[…] which is peculiar or idiosyncratic about policy staff in terms of how one needs to lead them because they all are…of course I’m making an assumption but from my experience with people…they are all well-educated, they are certainly well read, they know a lot about maybe their area, and they tend to have quite a good understanding of the wider environment whether it’s health specific or something wider, so they come at quite a different level in terms of their skills and ability. (YI-4)

Senior managers reported that policy practitioners were usually highly qualified, came from diverse educational backgrounds and disciplines, and exhibited a range of competencies (strong analytical skills, sound interpersonal and written skills, knowledge of the policy process and health system, and politically astute) and were considered to be highly professional and experienced in policy work, and capable of working autonomously.

Most senior managers placed emphasis on developing the policy capacity of individuals. A position strongly supported in the following comment:
I think the really practical approach is the way, what we do is, we actually encourage, we try and arrange to take some of the younger and newer staff along to some of the meetings and things but it’s hard to explain, the best way for them to learn is probably by observation [...]. (ZI-11)

The significant features of leadership perceived by senior managers comprise:

- using influence to gain organisational support for policy;
- providing intellectual input and direction to guide policy making;
- providing a supportive environment based on trust and respect for practitioners’ skills and experiences; encouraging them to work autonomously; and
- supporting policy staff by mentoring and encouraging them to participate in professional development and training opportunities to further develop their skills.

Given the different needs and requirements of the two groups, they emphasised slightly different aspects of leadership: focus group participants emphasised a supportive environment in which leaders provided intellectual input and direction, mobilised adequate resources and allowed sufficient time to complete tasks, supported their work at higher levels of the organisation, and managed the policy process efficiently and effectively. They further perceived it was important for policy leaders to recognise their skills and experience, allowing them to operate autonomously.

For senior managers, it was important to provide a supportive environment for policy practitioners to conduct their work, unimpeded from external pressures and demands. They respected practitioners’ skills and professionalism, and strove to provide an environment that enabled staff to exercise initiative and judgement, and work independently. In addition, senior managers strongly supported the continuing professional development of policy staff by actively encouraging them to participate in a range of training and development opportunities. However, although senior managers discussed particular aspects of the policy process in the individual interviews, such as engaging stakeholders, analysing information, and implementing policy, they did not refer directly to the role of actually managing the policy process.

Although different in their needs, both groups placed value on similar leadership features including provision of intellectual input and direction into policy making, provision of a supportive environment that respects staff knowledge and skills, responsibility for mobilising adequate resources and allowing sufficient time to complete the policy, and
encouraging development of staff skills by mentoring and participation in professional development opportunities.

7.2 CHALLENGES TO LEADING AND MANAGING IN HEALTH POLICY ENVIRONMENTS

The findings reported in Chapters 5 and 6 demonstrated that the alignment of policy capacity and process will achieve more effective policy outputs, which leads to the achievement of good policy outcomes, such as, improved population health and health system performance. In particular, the findings in Chapter 6 identified that leadership and management perform a vital role in aligning policy capacity and process for effective policy making in health authorities.

In the previous section (7.1) the perceptions of policy leadership by senior managers and policy practitioners were identified.

In this section the challenges confronting policy leadership in terms of the barriers and constraints identified in the focus groups and individual interviews are presented; and complement the findings in section 7.1 and provide further insights into the role of policy leadership in aligning capacity and process for effective policy making.

The findings are presented in three parts. The first part examines the barriers to leadership from the perspective of policy practitioners, while the second and third parts examine the barriers and constraints to policy leadership predominantly from the perspective of senior managers.

Policy practitioners’ perceptions of leadership barriers and constraints

The challenges to leadership reported by policy practitioners from the focus group discussions are grouped and presented according to lack of direction and guidance from senior managers; inadequate support from senior managers for policy work; and lack of clarity about leadership roles and responsibilities.
LACK OF DIRECTION AND GUIDANCE FROM SENIOR MANAGERS

In narrating their policy episodes, a number of participants in the three jurisdictions reported that senior managers when assigning policy projects for development were not always clear about the direction, process, output and or expected outcomes of the policy. They pointed out that some senior managers offered little intellectual assistance in developing policy in terms of providing direction, clarifying problems, selecting options, framing arguments, and developing strategies to resolve problems and issues.

In some instances, senior managers were neither sufficiently informed nor familiar with the policy being developed, and, at times, were disconnected from the policy exercise. Although reasons were not made explicit for these limitations, there may have been structural reasons for this disconnect, with decentralised administration in Queensland and South Australia, and the separation of policy and operations functions in health administration in the three jurisdictions.

In these policy episodes, participants reported a lack of strong leadership as demonstrated below:

\[
[...] we work on the policy on our own, there is no clear direction and guidance from senior staff for doing the ‘nuts and bolts’ of policy work – how to do policy development and who to consult – we are missing the start of the ‘policy cycle’[...]. (Vanessa-AF)
\]

Another participant reported:

\[
[...] there’s a number of examples of that, this is a pretty significant one, but certainly fantastic work that sort of goes nowhere because of the organisation’s leadership [...]. (William-CF)
\]

Participants also noted that some senior managers did not always manage the policy making process well in terms of overseeing the process, and ensuring policy tasks were appropriately scheduled and completed in a timely manner. In a number of cases, participants commented that senior managers could have managed the policy development process in a more efficient manner, possibly applying a planned ‘project management’ approach, as stated in the quote below:
And if you applied a project model to policy development then you would have a research base, you would have your consultation worked out, you would have a time line, you would have deliverables along the way. And we don’t do that. (Sandra-AF)

**INADEQUATE SUPPORT FROM SENIOR MANAGERS FOR POLICY WORK**

Many policy practitioners commented on the lack of support from senior managers for carrying out their policy work, including:

- not assembling the appropriate quantity and mix of human resources and infrastructure supports to complete the task properly;
- not providing sufficient time to complete the policy;
- not informing staff of sensitive issues and unexpected changes arising from the external environment;
- not communicating in advance with senior colleagues from other areas to inform them and facilitate the work of junior staff;
- not advocating and promoting the policy at higher levels of the organisation, across departments and sectors; and
- not appreciating the effort and contribution of staff in achieving policy outcomes.

In addition, participants reported in a number of policy episodes that the absence of a senior manager or ‘executive sponsor’ with direct responsibility for a policy project meant there was no senior person with the necessary authority to negotiate and advocate for a policy at higher levels of departmental decision making. As one participant noted, without a senior manager supporting and promoting a policy it could easily “…fall off the radar because they are really inundated with other pressing policy development questions.” (Lara-AF)

As this participant stated:

…” but the executive sponsor is terribly important because when you particularly have unresolved issues they’re the ones with the authority to actually help mobilise the issue. (Molly-AF)

**LACK OF CLARITY ABOUT LEADERSHIP ROLES AND RESPONSIBILITIES**

Across the three jurisdictions, a number of participants commented that, in some policy episodes, they weren’t always clear about either the senior manager who had overall leadership responsibility for their project, or the clarity of their roles in relation to
developing and implementing policy. This, they perceived, could be attributed to a number of factors including multiple layers of management in a large hierarchical organisation, vacant management positions the result of staff turnover, and responsibilities for functions distributed across two or more areas. This is reflected in the following quote:

*There were a number of staff changes so there was never really any clear leadership as to who owned it, who was driving it, who was doing the work on it, who needed to be consulted and what that consultative model was about.* (Sandra-AF)

In reference to the lack of centralised coordination and inadequate policy leadership, which was partly explained by the size of the organisation and jurisdiction, and devolved administrative responsibility, a participant from Queensland stated that “Queensland Health was like a cottage industry”. (Hanna-BF)

In summary, policy practitioners generally had a negative perception of leadership in their health authorities. Senior managers were considered as not discharging effectively and efficiently the roles and responsibilities that policy practitioners perceived as necessary for a supportive policy work environment. Senior managers needed to provide better direction and guidance in the form of intelligent and strategic input, more active participation in the management of the policy process to ensure efficient execution, more effective mobilisation of appropriate resources including sufficient time to undertake required tasks, better articulation of leadership roles and responsibilities, and better advocacy and promotion of the work of policy in the organisation.

**Policy capacity: Challenges to leadership**

The policy capacity challenges to leadership reported by senior managers from the individual interviews are grouped and presented according to senior leadership capacity (limited skilled resource base, recruitment, staff turnover, focus on operations and programs, and absence of policy-specific leadership training and development); and organisational and staff capacity (recruitment and retention of skilled policy staff, lack of specific policy skills and expertise, and lack of policy-specific leadership training and development).
SENIOR LEADERSHIP CAPACITY

On the issue of senior leadership capacity in health authorities, senior managers in the three jurisdictions reported the limited numbers of skilled and experienced senior leaders from which to draw for senior policy roles. At this level, it was difficult to find senior managers with specific capabilities (knowledge, skills and expertise) for managing in health policy environments.

As one manager stated:

[...] a leadership weakness in Queensland Health is that there are too few good leaders in general and certainly in policy; these positions are spread too thinly in the organisation, which presents a real problem when these senior leaders leave. (YI-5)

Given the limited size of the talent pool, recruiting suitably trained and experienced people into senior leadership positions in policy environments was difficult, often requiring health authorities to seek expertise further afield, from other jurisdictions. Staff turnover of senior management policy positions was another problem mentioned by senior managers in Queensland and the ACT, the result of short term contracts combined with the demands of leadership and more attractive opportunities elsewhere.

In relation to the problem of loss of corporate knowledge as a result of senior staff turnover, one senior manager noted:

We have to recognise it. I don’t think we’re going to change that. I think there’s going to be continuing rapid movement of people and we can’t use people then as our source of knowledge and history and policy development. (YI-7)

In Queensland and the ACT, the emphasis has been on operational, clinical and pressing quality issues, consequently, the focus on policy leadership has not been so strong. According to one senior manager, Queensland Health’s leadership focus in the last few years has been directed mainly on setting up systems and processes to improve practice:

I think at the moment for the past few years Queensland Health has been so consumed with getting things right out on the ground that they probably are not putting as much into the policy leadership as they would like to and I think that has changed. (YI-4)
The situation of senior policy leadership in all three jurisdictions was compounded by the absence of policy-specific leadership training and development, which provided professional development opportunities for senior managers to hone their policy leadership skills. Although all three jurisdictions conducted comprehensive leadership training programs, the focus of these programs was on developing generic rather than policy-specific leadership skills.

**Organisational and Staff Capacity**

The challenges for senior policy leadership in relation to individual and organisational policy capacity as reported by senior managers included the recruitment and retention of skilled policy staff, lack of specific policy skills and expertise, and lack of policy-specific leadership training and development.

*Recruiting and retaining skilled policy staff* was a problem for all jurisdictions, as there were few skilled health policy practitioners available yet demand was high for their skills. The competition was strong from other organisations, particularly in the ACT, with all health authorities trying to attract, at times, ‘poaching’ good policy personnel from other government departments and the non-government sector:

*I think good policy people are hard to find, which takes me back to the recruitment issue. It takes a long time to actually develop that skill, and people sometimes – because at an individual level, (a) they don’t have the skill, or (b), they’re either too high level without addressing some of the detail, or they’re so involved in the detail that they’ll miss the strategic stuff.* (ZI-8)

In the ACT, recruitment and retention of skilled policy staff was compounded by the health authority’s proximity to other large research and policy organisations like the Australian Bureau of Statistics, National Health and Medical Research Council, Australian Institute of Health and Welfare, and Commonwealth Department of Health and Ageing; organisations that were able to offer better remuneration and career paths, and stimulating work environments. As a senior manager from ACT Health reported:

* [...] we’ve got very strong competition from other agencies and limited career paths within policy areas because of the small numbers of people. So it’s very difficult to keep people in policy areas for any length of time.* (XI-3)
A number of senior managers across the three jurisdictions reported a lack of skill and expertise in particular areas of policy, including analysis, interpretation and application of data, and quantitative analytical skills in general.

As a senior manager from SA Health commented, “my big problem is finding the right people to do the work ... people with good data analytical skills are in short supply” (ZI-9). While senior managers in both Queensland and ACT Health also reported similar policy skill deficiencies in staff’s use and application of evidence and information, with one Queensland manager reporting:

> The ability to prepare information, including data, in ways which is informative, is still a weak skill in our group. (YI-6)

This lack of analytical and quantitative policy skills was exacerbated, to some extent, by the fact that many policy personnel, particularly in Queensland and the ACT, had health science and clinical backgrounds (nursing, physiotherapy, dietetics), and did not necessarily possess strong policy analytical and evaluative skills, and expertise in data analysis and policy writing.

Another capacity issue of concern reported by senior managers in the three jurisdictions was the lack of leadership training programs, with a policy focus, for middle level staff (e.g. ASO 4 and 5 levels in South Australia) to develop their policy leadership and management skills. They emphasised that policy courses were available for middle level and junior staff to extend their policy making skills however, of particular concern, was the lack of leadership training opportunities in all three jurisdictions for senior and middle level managers to develop their leadership skills to manage effectively in a policy environment.

The importance of focusing leadership training and development at the middle management group (supervisors, coordinators and team leaders) was pointed out by one senior manager:

> [...] as these staff are in direct contact with managing and supervising teams, and are well situated to mentor and pass on their skills and expertise to a range of personnel, including newly recruited and inexperienced staff. (YI-5)
Policy process: Challenges to leadership

The policy process challenges to policy leadership perceived by senior managers will be examined with respect to the following policy making processes:\footnote{Refer to 6.1: Challenges to aligning policy capacity and policy process for a detailed discussion of the first three points which are policy capacity domains. The fourth point, managing the writing of good policy, is not a policy capacity domain.}:  

- managing intradepartmental, cross-portfolio and intergovernmental relationships;  
- managing policy development and program implementation relationships;  
- managing monitoring, review and improvement relationships; and  
- managing the writing of good policy.

MANAGING INTRADEPARTMENTAL, CROSS-PORTFOLIO AND INTERGOVERNMENTAL RELATIONSHIPS

 [...] across government work really does set a lot of our agenda. (ZI-11)

Senior managers in all three jurisdictions acknowledged that ‘whole-of-government’ or ‘joined-up-government’ approaches were part of contemporary public administration, with established structures and processes to facilitate cross-portfolio coordination and collaboration. For example, in South Australia, the South Australian Strategic Plan sets the strategic framework and priorities for whole of government, while the Canberra Plan is the overarching strategic plan for the ACT. Despite these structures, senior managers identified a number of challenges to managing cross portfolio coordination and collaboration.

The commitment and priority given to cross portfolio functions is compromised by existing accountability and incentive structures as ministers/chief executives are responsible for their own departments (staff, budgets, performance) and are less willing to become involved in cross departmental matters they are not directly responsible for:

\begin{quote}
Those ministers have to fight in the budget process for their own things. And ministers are human like everybody else. So they’re a bit loathe to go and spend a lot of energy fighting for some money that’s going to be spent by some other minister in some other department, compared to their own pressures. (ZI-9)
\end{quote}

An opinion supported by another senior manager:
Once ministers are appointed to particular portfolios, they rapidly develop an alignment with the portfolio, and tend to represent that view – that’s basically what you need them to do to some extent. And whole of government views then sometimes take second preference or second place to what they see as what’s necessary to survive in the portfolio. You don’t get kudos for whole of government […] particularly in service departments like this, where you live and die on the basis of what happens within your portfolio and not on what happens outside of your portfolio. (YI-6)

The constraints of whole of government agendas and activities on departmental priorities and resources were also identified, with a number of senior managers reporting it absorbed considerable amounts of resources and time, to which, they were reluctant to direct scarce resources. This position is summed up by a senior manager:

*I mean in an environment of tightening and declining resources and people not really having enough resources to do their core business it is quite difficult to get people to give space to it [cross-portfolio work]. (ZI-11)*

They further acknowledged difficulties for government in sustaining this approach in the long term given time and resources required and ministerial accountability arrangements. There was a perceived problem, particularly in South Australia, that cross portfolio coordination had become more of an exercise in service planning and administrative coordination, and less of dealing with large visionary and strategic issues. Although all jurisdictions participated in whole of government activities, the process was viewed by senior managers as being onerous because it was not part of routine public service practice. As a senior manager noted:

*It has to be much more cultural, so that it becomes an embedded feature of the way people go about their policy making, that they consider, acknowledge and then act on cross-agency implications. (XI-3)*

The shortfalls in knowledge and skills of departmental staff, particularly those with clinical backgrounds, with respect to cross-portfolio and intergovernmental policy work was identified by a number of senior managers. As a senior manager in Queensland Health noted:

*Health has to become a lot ‘smarter’ by crafting our case more cleverly; broadening our perspectives from health alone to include wider social and economic considerations; developing a different skill set; using an information base that is wider than health to inform decisions and develop options […]. (YI-6)*
This senior manager also acknowledged that the whole of government approach in Queensland was a relatively new mode of public administration, and, for policy staff, collaborative decision making was a new practice, demanding strong negotiation and interpersonal skills, flexibility of mind in understanding other players’ perspectives and priorities, and the ability to manage the collaborative process.

**MANAGING POLICY DEVELOPMENT AND PROGRAM IMPLEMENTATION RELATIONSHIPS**

 [...] the disconnection between policy development and implementation is a very real problem and I think it would still be fair to say that there are many policies that are developed because there is a perceived need to have a policy but there isn’t really any commitment to implementing it but there is a perceived need to have one. (ZI-11)

According to senior managers, departmental arrangements such as policy frameworks, central policy coordinating mechanisms, and accountability structures, exist in the three jurisdictions to improve relationships and communications between central and regional administration and health agencies, and to facilitate continuity between policy development and program implementation.

Despite these structures, senior managers identified a number of challenges to managing the process of transitioning from policy formulation to program implementation:

A barrier to ensuring continuity of policy from formulation to programme implementation was a lack of consideration, in some policy cases, given by senior managers to implementation issues when a policy was being developed. In this quote, a senior manager from Queensland Health noted that in a number of instances, consideration had not been given to the practicalities of implementation:

[in developing policy] very little consideration was given to the practicalities of financing, human resources, capital, etc; compounded by the disconnection of the budget cycle to other ongoing policy and program issues. This is poor oversight by managers, who should have taken this into account [...]. (YI-5)

Senior managers, particularly in Queensland and South Australia, also referred to decentralised administrative structures combined with large jurisdictions and organisations as factors hindering the transition from policy development to implementation. As a few senior managers pointed out, with decentralised offices and
services located at great distances from head office, there were implementation problems of communication and compliance with which to contend:

*We are highly dependent on a chain of command to get to the front line, and the timeliness of that sometimes defeats us. Sometimes it’s just the actual practicality of getting it; if you take somewhere like Mornington Island for example [...]. (YI-6)*

Finally, a few senior managers commented that a number of barriers existed to implementing policy that were beyond the control of senior managers, namely, changed government priorities and perceived legal or political risks, which stymied a policy’s movement to implementation. While, a small number of managers also mentioned that ‘symbolic’ policy, where a government had little intention of pursuing implementation, was another barrier to policy implementation.

**MANAGING MONITORING, REVIEW AND IMPROVEMENT RELATIONSHIPS**

*We don't have a lot of luxury of being reflective and proactive and I mean we do have a planning cycle, we have a business plan and all of that but we don't spend a lot of time contemplating what could be or what the next ideal policy development process would be, we’re too busy on the hop. (XI-2)*

Despite the established structures for policy development, implementation and evaluation, senior managers reported that evaluation and monitoring were neglected activities in the policy making process. Senior managers identified a number of challenges for senior management in policy evaluation and monitoring.

If a policy or program was evaluated, it tended to be conducted for accountability and performance purposes, usually to meet funding and accountability requirements to the Commonwealth or state and territory governments, rather than encouraging a culture of reflection, feedback and improvement.

Another barrier reported by senior managers was the limited resources allocated by health authorities for conducting policy and program evaluation:
There is still an oversight regarding evaluation of policy and programs in the department, although the situation has improved in recent years. In SA Health, inadequate resources are devoted to the task and some programs, including those with a significant reform orientation, are not evaluated. (ZI-11)

and

[...] resources and processes to support policy evaluation are not so well developed in Queensland Health. (YI-5)

MANAGING THE WRITING OF GOOD POLICY

I think people have to be able to write clearly and effectively so people can understand it in the least words possible. I think that is a very important skill and it's variable. (YI-7)

The majority of senior managers in the three jurisdictions placed a strong emphasis on good writing as a core requirement of policy work; requiring that it be logical, succinct, strongly argued and well structured. As they commented, in the final analysis, policy work was underpinned by high quality written communication in the form of briefing notes, reports, strategic directions, Cabinet submissions, and drafting legislation. A number of senior managers expressed concern over the detailed and lengthy documents produced and the inadequate quality of some of the written material, the latter often reflecting a lack of time and resources. Whilst others expressed concern over the content of the writing in terms of sound analysis of available evidence and information, identification and consideration to options recognising environmental constraints and implementation implications, and framing concise recommendations and directions. This is aptly summed up in the following quote:

[...] they need good writing skills, with the ability to express their thinking clearly and succinctly; that is, absolutely critical in dealing with politicians and political advisors. (YI-6)

The roles and responsibilities, and competencies that were considered important for leadership and management in health policy environments are presented in the next section.
7.3 LEADERSHIP AND MANAGEMENT REQUIRED FOR HEALTH POLICY ENVIRONMENTS

In this section the roles, responsibilities and competencies required for effective policy leadership in health authorities identified in the focus groups and individual interviews are presented, compliment the evidence provided in sections 7.1 and 7.2, and provide further insight into the role of policy leadership in aligning capacity and process for effective policy making.

The findings are presented in two parts. The first part examines the roles and responsibilities of policy leadership, while the second examines the competencies required for effective policy leadership.

Perceived roles and responsibilities of policy leadership

In Australian health authorities, there are many levels of management and leadership from senior executive to middle level leadership positions, the latter including team leaders, coordinators, managers, supervisors and practitioners. However, in large, hierarchical bureaucracies, roles, functions and responsibilities for each leadership level may overlap and are not always distinctive. This is evident in the classification systems and capability frameworks of the Australian and states’ and territories’ public services (ACT Government, n.d.; APSC, 2009a; n.d; Queensland Public Service Commission, 2008; State Services Authority, 2007).

While the public service classification systems of the three jurisdictions are different, some similarities exist between senior executive service and middle level positions across the three jurisdictions. For purposes of this research, ‘senior managers’ are interpreted as holding positions in the highest levels of the senior executive service (executive directors and deputy directors-general), with middle managers occupying a range of subordinate positions. The research acknowledges this wide range in senior and middle management positions in the health authorities in the three jurisdictions and subsequent difficulty in delineating precise roles and responsibilities of the different leadership levels.

The perceptions and expectations of senior managers and policy practitioners in relation to roles and responsibilities of the levels of leadership are presented below:
Providing Strategic Direction

*In a leadership position in policy it is important to think strategically and to be able to see the ‘big picture’. (ZI-9)*

The strategic function of senior leadership was considered to be a major responsibility in policy making environments. Both senior managers and policy practitioners felt it was important for policy leaders to be able to clearly articulate the strategic direction of a policy. Policy practitioners expressed the view that this strategic direction should come from senior management although, quite often, this clarification was not forthcoming.

Senior managers shared the view that senior management was responsible for articulating the policy’s strategic direction, although it was frequently left to middle level managers to determine:

> [...] the senior leadership level requires strategic skills and ability for high level negotiation and liaison, while the focus at the middle management level is on ‘getting the evidence and doing the background work. (ZI-11)

This was supported by another senior manager:

> I would think their skills as you go further up the food chain in an organisation the level at which you’re applying those skills is often more strategic or needs to take in a broader perspective in terms of whether it be a more across government, across agency, or an across government perspective. (XI-1)

Managing and Supporting Staff - Resources, Time and Space

The majority of senior managers interviewed emphasised the importance of providing a supportive environment for policy practitioners to conduct their work by mentoring and encouraging them to participate in professional development and training opportunities to further develop skills; providing flexible conditions for experienced workers to refresh skills and interest; and protecting staff from internal and external demands and pressures. They also placed value on developing an environment based on trust and respect for practitioners’ skills and experiences; encouraging them to work autonomously. They did not discuss at length, however, the mobilisation of necessary human resources and infrastructure supports (information, equipment) to do the job.
In terms of protecting staff from other demands, a number of senior managers in the three jurisdictions, particularly Queensland and the ACT, noted that it was important to relieve staff of their operational duties and enable them to concentrate on policy work, because their program delivery issues crowded out policy work. As a Queensland Health senior manager reported:

" [...] there is a preoccupation with ‘getting things right on the ground’ [...] staff are currently so overwhelmed by operational responsibilities and ‘fighting fires’ that it is hard to make space for policy thinking. (YI-4)"

The majority of senior managers in the three jurisdictions placed strong emphasis on providing training opportunities and encouraging middle level and junior staff to further develop their skills and capabilities. Although senior managers supported a range of professional developmental opportunities for skills enhancement, they strongly favoured experiential and work-based learning over theoretical training. They supported mentoring, shadowing and rotation programs where less experienced staff were given the opportunity to learn and hone their skills from more experienced and skilled senior staff:

" [...] managers have a working relationship with each of their staff, and the one-on-ones is so important as well as team meetings, and everyone must have an opportunity to have one-on-ones with their manager to actually discuss the things that they need to discuss, and managers can actually provide such valuable mentoring opportunities. (ZI-8)"

Senior managers emphasised in the interviews the importance of mentoring less experienced and junior staff and reported investing considerable time and effort in this role. As one senior manager commented, this approach enables middle level staff to develop their confidence and to learn from observation by participating in high-level meetings with senior staff:

" [...] a lot of it relies on them being exposed and I actually think it’s about listening and learning and mentoring, so for them to listen and learn and for the more experienced staff to mentor them. (ZI-8)"

Policy practitioners reported the need for senior managers to provide support and protection to enable them to carry out policy work. They perceived mentoring and professional support, mobilisation of human resources (range of skills and amount) and infrastructure supports (information, equipment), and making available adequate time to complete the project, as important responsibilities of senior management. Many also reported that they appreciated the role senior managers performed in shielding them from
external risks and uncertainties, yet allowing them to work independently, recognising their intelligence and skills.

**MANAGING THE POLICY PROCESS**

Senior managers did not comment specifically on managing the policy process, although they referred indirectly to it in the context of other dimensions of policy work such as cross-portfolio collaboration and implementation; and in the context of recently established structures and processes that were designed to improve coordination and management of the policy making process such as a policy management framework, policy advisory group, executive management team, policy register, and guidelines and protocols. One senior manager reported on the introduction of a policy management framework:

> [...] to integrate the policy process into a single process so that both clinical and non clinical policies would go through a policy management framework that was common and essentially it delineates a series of steps such that there’s a systematic approach to evidence-gathering, consultation and clearance of policies [...] (XI-2)

Another senior manager reported on the introduction of a policy register:

> [...] about 18 months ago, a web portal was established [part of the policy directives framework] so there was a single place for across the portfolio to be able to access those documents. One of the challenges which we continue to face is that you will still find pieces of policy work, that different parts of the organisation will be developing policies to address similar problems, and we still haven’t quite got the system right to actually ensure that we join the dots. [...] we can now make sure that we actually align the various pieces of work and try and synchronise them, to ensure consistency between those pieces of work. (ZI-8)

In contrast, focus group participants did make comment about the roles and responsibilities of senior managers in managing the policy process efficiently and effectively. Many participants were critical of the performance of senior managers.

For instance, senior managers were often either not involved in the day to day management of the process or not aware of the detail of the policy issues requested by the minister. Determining or ‘teasing out’ the detail in terms of direction, scope, evidence and information, consultation approach, focus of negotiations, and drafting documents was usually left to middle-level managers:
At our level, we’re the ones doing the discovering and the uncovering of the policy work, so in a lot of ways, we are the ones that are forced to think it through in a lot of detail that leadership doesn’t do, so expecting leadership to inform you about something from a comprehensive point of view, is probably unrealistic. (Patricia-CF)

A number of participants suggested that senior management in health authorities should deploy a project management approach rather than a ‘hit and miss’ approach to managing the process efficiently, as illustrated by these quotes:

[…] those sorts of things also have to be sorted and managed as well because there’s a number of views and all sorts of things are in the mix and it’s quite complicated. Again, that process has to really work well so that those things can be well managed and you know, we probably need a project management plan a bit like there was for [Act ] to make sure it works out well […]. (Amelia-CF)

and

And I think the project management framework is a really good framework to consider when we’re making that recommendation about the policy process. (Vanessa-AF)

As one participant noted, I think the ability to mobilise a collaborative policy management team to develop and coordinate policy would be a good idea in a large organisation:

[…] a small group of people [to those working in policy] who wouldn’t necessarily do all the policy groundwork but will form a policy team and provide support - when a major issue comes up and major policy is being developed. For example, the team could get involved in developing legislation, liaising with departments and preparing Cabinet submissions, working with the Parliamentary Council’s Office in drafting legislation, and the whole Parliamentary process of getting legislation through. (Cameron-AF)

MANAGING CHANGE

Senior managers in all jurisdictions shared the view that a function and responsibility of senior leadership in both policy and operational environments of health authorities was to steer and oversee change, for example, major organisational restructuring and or policy and program re-orientation and redevelopment, frequently arising from changes in the external social, economic and political environment. As a senior manager noted, it was important “to bring people along that journey” in a change environment. (XI-1). Another senior manager reported that one of the roles for a senior manager “was to act as an agent of change and to improve a particular situation” (YI-6).
A number of senior managers pointed out, change was a normal feature of contemporary public administration: policy re-orientation arising from change of government, organisational restructuring, and policy and program changes in response to wider impacts of fiscal constraints, public sector downsizing, work practice changes and introduction of new technologies. And, all public sector leaders, including those in policy environments, had to deal with a constantly changing environment.

Senior and Middle Level Managers: Differences in Roles and Responsibilities

The data from focus groups and individual interviews revealed differences in the roles and functions of senior and middle level managers in Australian health authorities. Senior managers, in general, perceived the roles of middle level policy leaders and managers as “hands-on and doing the job, of taking responsibility for and completing the policy task” (YI-6). In support of this position, a senior manager from SA Health suggested that at this level the role was more about the technical and analytical skills of policy work: “getting the evidence and doing the background work, consulting with major stakeholders and preparing written reports” (ZI-11).

Some senior managers also noted that in policy negotiations, middle level managers were not expected to assume responsibility for shaping the strategic direction of policy; advocate for it at higher levels of the organisation and with external stakeholders; participate in ‘sensitive’ negotiations and discussions with the minister and government; and assemble and deploy human and financial resources.

In summary, senior managers in the three health authorities generally perceived the role of middle level managers as practical rather than strategic, expecting them to take responsibility for managing the routine aspects of policy work including staff supervision and performance monitoring. In addition, senior managers noted that middle level managers were well placed to teach and pass on their knowledge and skills to less experienced and junior staff.

Based on analysis of information provided by industry partners during the introductory site visits, comprising departmental and policy branch organisational structures, policy unit and personnel roles and functions; analysis of the focus group and individual interview data; and examination of capability frameworks and workforce classifications documentation in the three jurisdictions, the different roles, responsibilities and
relationships of the two broad levels of leadership (senior and middle level management) in health authorities are presented in Table 20.

Table 20: Features of leadership – Senior and middle level management

<table>
<thead>
<tr>
<th>Features</th>
<th>Senior manager</th>
<th>Middle manager</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to and direction from minister/government</td>
<td>Regular access to and direct communication with minister/government</td>
<td>Infrequent access to minister/government; communication with ministerial advisers</td>
</tr>
<tr>
<td>Position/relationship</td>
<td>Conduit between political leaders (minister, premier, cabinet) and middle management</td>
<td>Conduit between senior executive leaders and subordinate staff</td>
</tr>
<tr>
<td>Roles and responsibilities</td>
<td>Provide advice and strategic direction to minister and government</td>
<td>Provide advice to support senior executive management</td>
</tr>
<tr>
<td></td>
<td>Responsible for delivering departmental goals and objectives</td>
<td>Responsible for delivering branch/unit objectives and outputs to meet departmental goals</td>
</tr>
<tr>
<td></td>
<td>Interpret information and direction received from minister and government; delegate request for action to middle management</td>
<td>Provide daily management and supervision of subordinate staff doing policy work: interpret and provide information to staff</td>
</tr>
<tr>
<td></td>
<td>Manage divisional staff: mobilise human resources; acquire financial resources; re-assign responsibilities</td>
<td>Responsible for conducting policy work - ‘hands-on’ role in shaping and crafting policy work</td>
</tr>
<tr>
<td></td>
<td>Shield subordinate staff from organisational and external demands</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mentor and support staff</td>
<td>Mentor less experienced/junior staff</td>
</tr>
<tr>
<td>Sphere of control</td>
<td>Large span of control: staff, budgets, infrastructure and resources</td>
<td>Narrow span of control: staff, budgets, equipment</td>
</tr>
<tr>
<td></td>
<td>Access to a wide range of information</td>
<td>Restricted information provided to middle management</td>
</tr>
<tr>
<td></td>
<td>Wide span of influence because of status and networks</td>
<td>Span of influence restricted to smaller area</td>
</tr>
<tr>
<td>Features</td>
<td>Senior manager</td>
<td>Middle manager</td>
</tr>
<tr>
<td>--------------------------</td>
<td>--------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Relationship to external stakeholders</strong></td>
<td>Promote organisational interests and issues</td>
<td>Develop the trust and respect of key stakeholders</td>
</tr>
<tr>
<td></td>
<td>Build stakeholder support</td>
<td>Engage and maintain a close working relationship with a range of stakeholders to obtain information and seek advice</td>
</tr>
<tr>
<td></td>
<td>Diffuse/minimise stakeholder disagreement and opposition</td>
<td></td>
</tr>
</tbody>
</table>

Although capability frameworks and workforce classifications and associated remuneration levels define difference in roles, functions and responsibilities of the two levels of leadership in policy environments, the findings from the focus groups and interviews indicate an overlapping of roles and responsibilities between different levels/positions of senior and middle level leadership within the health authorities.

In general, senior managers in policy leadership roles exercise a wider span of control compared to middle level managers but senior manager policy positions are few in number. Whereas, middle level manager positions are larger in number compared to senior manager positions but their sphere of influence is constrained to their area of work and staff for whom they have responsibility. The sphere of control and nature of relationship to external stakeholders varies between the two broad categories of leadership in the health authorities.

Senior managers had direct access to and provided information and advice to the minister and government while communicating their wishes to middle level managers, thus performing an intermediary role between the political arm of government (Minister, Premier, and Cabinet) and middle level management. As senior managers, they were responsible for determining the strategic direction of the organisation, and delivering organisational goals and objectives. In this capacity, they had significant responsibility for managing people, finances, procurement of goods and services, information, marketing, and responsibility for the formulation, implementation and review of policy work, as well as, mentoring and encouraging professional development of middle level policy staff. Senior managers, positioned between the political arm of government and middle level management, perform a valuable ‘conduit’ role of interpreting policy direction and communicating information, and are well positioned to protect subordinate staff from wider demands and pressures.
Middle level policy managers, with less frequent access to ministers and government but regular communication with ministerial advisers, relied on senior managers for direction and information and were positioned to communicate and inform subordinate staff. In this intermediary role between senior managers, on the one hand, and subordinate staff, on the other, they were able to: provide a ‘hands-on’ role in shaping and crafting policy work; supervise subordinate staff and ensure delivery of branch/unit objectives; and mentor and develop less experienced/junior staff. They were well positioned to ‘work up and down’ the organisation, supporting the senior level of management, on the one hand, while supervising and supporting subordinate staff to deliver departmental objectives and policy outputs, on the other. Middle management had a significant responsibility in delivering quality and effective policy outputs and in supervising and developing individual policy capacity.

**Competencies required for policy leadership**

The senior managers and policy practitioners in each jurisdiction reported a similar range of competencies (knowledge, skills and personal attributes) as important for leaders in health policy environments; ensuring effective policy leadership in aligning policy capacity and process to underpin good policy making in Australian health authorities.

The competencies identified for good leadership in health policy environments are presented in Table 21.

**Table 21: Categories of policy leadership competencies**

<table>
<thead>
<tr>
<th>Categories</th>
<th>Leadership competencies in health policy environments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Context and content</td>
<td>Knowledge and understanding of the wider political environment and in particular the health system</td>
</tr>
<tr>
<td></td>
<td>Ability to manage stakeholder relationships and interests</td>
</tr>
<tr>
<td>Strategic</td>
<td>Ability to have clarity of vision and direction, and the means for achieving long term goals</td>
</tr>
<tr>
<td>Technical</td>
<td>Knowledge of policy making process</td>
</tr>
<tr>
<td>People management</td>
<td>Ability to manage policy people by understanding their strengths and weaknesses, developing trust, informing and involving staff, supporting and developing staff capabilities</td>
</tr>
<tr>
<td>Change management</td>
<td>Ability to initiate and manage effectively in a change environment</td>
</tr>
<tr>
<td>Personal skills</td>
<td>Strong interpersonal and communication skills; strong analytical and critical appraisal skills</td>
</tr>
<tr>
<td>Personal attributes</td>
<td>Range of personal attributes including: ethical, acumen, decisive, agile, resilient and flexible</td>
</tr>
</tbody>
</table>
KNOWLEDGE OF THE HEALTH SYSTEM

 [...] it is hard to see someone leading in a field they know nothing about [...] . (X1-3)

A number of senior managers in the three jurisdictions noted it was important for a policy leader to have credibility to be able to gain the respect of his or her senior colleagues. This credibility was derived from possessing a knowledge and understanding of the wider political environment and the health system: services and programs; Commonwealth/State relations; legislation; financing; workforce; stakeholder interests and networks, and existing structures and governance arrangements:

In any leadership role it is important to have credibility which comes from a knowledge and understanding of the environment within which one works. (YI-6)

Another senior manager reported:

[...] senior executives in health departments must have a strong knowledge of the health industry, have experience in different jurisdictions, understand Commonwealth-state/territory responsibilities and relationships, and generally have a sound understanding of the wider political environment. (YI-5)

KNOWLEDGE OF THE WIDER SOCIO-POLITICAL ENVIRONMENT

In addition, an important capability of senior leadership was to possess a sound knowledge of the wider social, economic and political environment, including a good understanding of changing community needs and expectations, of government decision making structures and processes, Commonwealth/State reforms and developments, economic conditions, inter jurisdictional and departmental developments and relationships, the ability to manage stakeholder relationships and interests, an understanding of the media’s role and impact; and how these may all interact to affect the work of policy in terms of priorities and funding.

Further, senior managers need to be capable of translating the wishes and demands arising from the external political environment (premier, ministers, cabinet, stakeholder and community interests) into manageable and achievable organisational activities and outputs, linking (acting as an interface) the wider socio-political context to the work of policy practitioners and production of policy.
It also became evident from the focus groups and interviews that the ability to develop and maintain productive relationships with major stakeholders - AMA, ANF, Unions, and industry, special interest and consumer groups - was viewed as an essential leadership capability in a health policy environment. Senior leaders were expected to maintain a high level of involvement with stakeholders, and take the lead in negotiations, developing strategies, and conflict resolution.

The following comment expressed by a senior manager highlights the importance of developing relationships with stakeholders in developing and implementing health policy:

> [...] a policy will only be successful depending on the journey that you take the stakeholders through, there is a need to build a relationship with stakeholders in order to facilitate ownership of and commitment to the policy. (ZI-8)

**ABILITY TO THINK AND ACT STRATEGICALLY**

Both senior managers and policy practitioners reported that a senior manager in a policy making environment needs to have clarity of vision and direction, and the means for achieving long term goals:

> If you can’t ever tie it back to basic objectives and values, then you’ll have no chance of ever providing the leadership because people will disengage because they won’t see the point of what you’re trying to achieve and they won’t see how it aligns with what they’re trying to achieve. (XI-3)

As this quote by a senior manager revealed, it was important for senior leaders to have a clear understanding of the organisation’s strategic directions and, importantly, to have the ability to harness staff’s effort in achieving outcomes.

The sentiment was much the same although expressed differently in the following comments made by another senior manager:

> A policy leader must be clear about their own direction and the direction in which a policy should head. (ZI-9)

and

> I mean the really critical stuff in policy is being able to think very strategically, which is true for leaders, anyhow. But to be able to take the ‘big picture’ view on topics, and to understand the connections outside your own agency [...]. (ZI-9)
Another senior manager noted that in any senior leadership role in health policy, it was important to *provide direction*, and to have a ‘*helicopter view*’ of the situation.

The focus group discussions revealed that policy practitioners expected senior managers to have the ability to clarify the department and government’s strategic directions and articulate potential difficulties as well as offering guidance in positioning their policy work to achieve a favourable outcome. For instance, their discussions indicated they looked to senior managers to provide intelligent input and to stimulate their thinking around policy issues in terms of identifying and clarifying the nature of the problem for investigation; identifying relevant and current evidence and information; discussing key stakeholders to consult (or avoid), their interests and likely expectations and or demands; discussing feasible options and the framing of arguments; and informing staff of sensitive issues at the higher level and with particular stakeholder interests.

The ability of senior leaders to provide intelligent input into the design and development of policy was affirmed by senior managers in the three jurisdictions. Whilst not reporting in detail about the actual provision of intellectual and strategic input into assisting staff, senior managers acknowledged the importance of this role in shaping policy, by clarifying the nature and extent of the problem, proposing an appropriate process, suggesting broad directions and options for developing policy, and raising awareness of resource constraints, implementation considerations and environmental impediments. A point emphasised by a senior manager, a policy leader had to have “*a capacity for logical thinking*” and, as such, “*analytical thinking capacity was the most important leadership skill in a policy environment.*” (ZI-11)

**Knowledge of the Policy Making Process**

Senior managers acknowledged that in a policy environment it was important for senior managers to have specific knowledge of and skills in the policy making process.

It was important to understand the complexities of the policy making processes, including identifying the policy problem; collecting, analysing and synthesising evidence and information; managing diverse stakeholder interests; preparing written documentation; negotiating and acquiring consensus and support; obtaining agreement; framing options and strategies; and clarifying policy outputs and outcomes. Although less frequently
discussed, possessing an understanding of programme implementation, evaluation and feedback were also recognised as important policy making skills for senior managers.

Further, policy practitioners reported that senior managers had to be aware of, and understand, the vagaries, tensions and constraints of the wider policy environment (e.g. political changes and demands; competing stakeholder interests; economic fluctuations; and changing community expectations), with a capacity to respond appropriately. For instance, a number of policy practitioners commented, it was easier to work with senior managers who had a 'nuts and bolts’ understanding of policy work, including, how to develop policy, who and how to engage stakeholders, how to frame options and recommendations, time required for extensive negotiations, impediments to developing policy, and the requirements of implementation.

A senior manager, in support of possessing sound knowledge of the policy process, noted it was necessary for senior policy managers to oversee the design and development of policy that was “‘implementable’, giving consideration to the practicalities of financing, human resources, and capital while being aware of the annual budgetary cycle and other environmental constraints”. (Y1-5)

ABILITY TO MANAGE PEOPLE
This senior manager competency almost states the obvious, that any senior management role in public administration would need to be competent in managing people in subordinate positions as well as those higher up in the organisation (as in upwards management). And, managing people involves overseeing responsibilities of recruitment, mentoring, coaching, performance management and support of less experienced staff.

Leadership in a policy environment, at first glance, appeared not to be very different from generic leadership; however, policy practitioners reported the importance of senior managers being able to provide support in developing their work and mentoring for developing and extending their skills. For instance, they believed senior managers should be able to provide support and protection for policy staff, allowing them time and space to complete their policy work. As there were numerous demands on a policy worker’s time from more pressing policy requests or, in many instances, from operational and program management responsibilities, being shielded by senior management to fulfil their policy development responsibilities was an important attribute of a senior manager.
A position supported by a number of senior managers, with one stating:

“...staff are currently so overwhelmed by operational responsibilities and ‘fighting fires’ that it is hard to make space for policy thinking, one of the jobs I am trying to do is create more space for strategic policy by restructuring the division.” (YI-4)

The ability of senior managers to mentor and develop skills of less experienced and junior staff was also regarded as an important aspect of managing people in policy environments. The importance of mentoring and developing skills was consistent with the views of most senior managers, illustrated by the following comments:

“...it was important for policy practitioners to learn by ‘seeing and doing things’, taking them to meetings and senior level negotiations was a practical and useful way to develop their skills.” (YI-4)

and

“I think the really practical approach is the way, what we do is, we actually encourage, we try and arrange to take some of the younger and newer staff along to some of the meetings and things but it’s hard to explain, the best way for them to learn is probably by observation [...].” (ZI-11)

In addition to supporting and developing individual capacity, managing in a policy environment required senior managers to have the ability to recognise and respect the skills and professionalism of policy practitioners, develop trust and confidence in their capabilities, whilst encouraging them to work autonomously and be supportive of others. A few senior managers noted that in a policy environment it was important for senior leaders to create a supportive culture for good policy making: mentoring and supporting staff, sharing information, open communication, and involving and empowering staff based on respect and understanding.

ABILITY TO MANAGE CHANGE

“[leadership] is absolutely essential, particularly if you’re talking about major change. Major change does not occur in government without good leadership.” (YI-6)

Senior managers in the three jurisdictions reported that managing and driving change (acting as an agent of change) within health authorities was a significant responsibility of senior management.
Major change, whether it be at the wider environmental, organisational or policy and program levels, was a significant and ongoing feature of the public sector, and something that senior leaders, including those in policy environments, had to manage skilfully. A definition of leadership adopted by one senior manager in Queensland Health was about being capable of introducing and overseeing major policy and organisational change.

While another senior manager reported, in managing change it is important as a leader to “build a shared understanding about what the organisation is trying to achieve and take people along with you on the journey” (ZI-8):

> [...] it’s probably as much to do with the change management component. I just think so much of managing in terms of successful policy and planning is managing change well [...]. (XI-1)

**PERSONAL SKILLS AND ATTRIBUTES**

Senior managers reported that, amongst a range of skills and personal attributes, strong interpersonal and communication skills were important for senior managers in policy environments. Communicating clearly was considered an essential capability for senior managers in charge of policy as they were required to: listen carefully and probe deeply (need to listen to different perspectives even to those who oppose you), articulate and promote policy ideas and issues, negotiate effectively and persuasively, and write logically and succinctly. In a senior policy leadership role, it was important to establish effective relationships with a range of stakeholders across government, health, business, research, and community in order to build consensus and support for policy. The importance of interpersonal skills in building rapport with stakeholders was strongly expressed in the following quote by a senior manager:

> A leader [in policy] needs to develop good relationships with a range of people, break down resistance and take people with you [...] consult and hear different views, and be aware of environmental sensitivities, the thing that’s really important is building those relationships because that’s what establishes your networks. (ZI-8)

This position was supported by another senior manager:
but if we haven’t been communicating very effectively with our stakeholders and with our public and with people who might be protagonists along the way, we’ll find that even with the best evidence and even with political backing and with resources behind us, we might come unstuck in the final analysis because we haven’t been effective in communication [...] because policy does require building consensus or some agreement, even if it’s reluctant agreement, this is the best we can do and we agree it’s the way we’ll do things. (XI-2)

Another senior manager from Queensland Health (YI-7) reported that it was necessary for senior leaders to create a culture for good policy work by not only promoting policy work in the department but by creating a positive work environment based on respect that empowers and trusts people; collaboration that encourages sharing information and knowledge; transparency that promotes open communication and action; and accountability for achieving outcomes.

In addition, both senior managers and policy practitioners mentioned a number of other personal skills and attributes that were considered important capabilities for senior leaders in a policy environment: ethical, decisive, agile, resilient to withstand constant pressures and demands, and flexible enough to respond promptly to new information and change. The following comment by a senior manager summed up the situation well: an important leadership skill for a policy environment is being “increasingly quick on your feet” (ZI-11).

7.4 SUMMARY AND CONCLUSIONS

The main findings that emerge from the analysis of the challenges (barriers and constraints) confronting leadership in health policy environments are presented as follows.

A slightly different approach or leadership style is required in health policy environments compared to operational and programme management environments given the differences in nature of policy work, capabilities of policy workers, collegial approach to policy making, and the relationship to and influence of the external socio-political environment.

The challenges (barriers and constraints) confronting leadership in health policy environments are perceived differently according to the role of ‘players’ in the policy making process.
Senior managers perceive the challenges as recruitment and retention of skilled staff, lack of policy specific training and development, lack of staff with appropriate skills (quantitative, evaluative and analytical), resource implications of cross-portfolio relations, skills required for cross-portfolio relations, policy designs that acknowledge the practicalities of implementation, political agendas for policy development with no intention to implement.

Policy practitioners perceive the challenges as a lack of direction and guidance in the form of intelligent and strategic input and efficient management of the process, inadequate support including the mobilisation of appropriate resources, provision of sufficient time, and inability to advocate and promote policy, and a lack of clarity regarding leadership roles and responsibilities.

The roles and responsibilities of senior leadership in policy environments are perceived by both senior managers and policy practitioners as a strategic function, influencing and shaping policy development, creating space and time for policy staff, mentoring staff, and managing change; and of middle level managers as a ‘hands-on’ role in shaping and crafting policy work, supervising subordinate staff and ensuring delivery of branch and or unit objectives, and mentoring and developing less experienced and or junior staff.

Certain competencies are considered crucial for effective health policy leadership including knowledge of the health system, of the wider socio-political environment and of the policy making process; ability to think and act strategically, to manage people, to manage change; good interpersonal and communication skills; and personal attributes comprising being ethical, decisive, agile, resilient to withstand constant pressures and demands, and flexible enough to respond promptly to new information and change.

In conclusion, the findings demonstrate that leadership and management in policy making environments have distinctive features, identified by a particular policy leadership approach, roles and functions, and competencies; and together with an analysis of the perceived challenges, highlighted the central role that leadership plays in better managing individual and organisational capacity and process in order to achieve good policy outputs that lead to improved population health outcomes.

Senior leadership and management is an essential ingredient in achieving good policy and requires the capacity to identify and respond to changes in the external and organisational
environment, to assemble and deploy appropriate human resources and supports, to manage effectively the policy making process, to develop policy staff’s capabilities, and to develop a culture that is committed to and supports good policy.

The findings confirm the strategic role of policy leadership in aligning policy capacity and process in the context of policy work in the three health authorities and supports the conceptual framework in which policy work is proposed as an integrated system in which policy capacity, process, outputs, outcomes, review and monitor, and the external socio-political environment are interrelated elements.

In the next chapter (Chapter 8) the findings outlined in Chapters 5, 6 and 7 are discussed in support of a ‘systems’ approach to the understanding of policy work and the importance of effective policy leadership in the alignment of policy capacity and process toward the achievement of good policy outcomes.
CHAPTER 8 THE WORK OF POLICY: A SYSTEMS APPROACH TO ALIGNING CAPACITY AND PROCESS

8.0 INTRODUCTION

The purpose of Chapter 8 is to discuss the findings from the analysis of the research data presented in Chapters 5, 6 and 7 in the context of the literature reviewed in Chapter 2 and in accordance with the research design, research aim and conceptual model presented in Chapter 4; and to present the conclusions of this study in regard to a systems approach to aligning policy capacity and process.

The chapter comprises two parts. In the first part, the findings from Chapters 5, 6 and 7 are discussed within the context of the literature reviewed in Chapter 2 and presented under three headings that reflect the research questions posed in Chapter 1. In the second part, the conclusions of this study are presented within the context of the research aim posed in Chapter 1.

8.1 DELINEATING THE WORK OF POLICY

The nature of policy work in health policy environments

(Research question 1)

Trends in policy making

Broad stakeholder engagement has become an important part of the policy process in the three health authorities. Policy practitioners are aware that the public policy environment is contested, with multiple stakeholders influencing and shaping the policy process. There are many well organised interest groups in the health sector comprising professional groups, such as medical, dental, and nursing associations; community groups, such as disease and disability advocacy and support groups; industry groups, such as health insurance funds, health sector unions, private health service operators, and food industry and pharmaceutical companies; and research institutes and academic institutions espousing different values, interests and priorities, with a strong interest in influencing the policy process.

Narrow stakeholder engagement has always been a feature of health policy work arising from a practical consideration to obtain specialist clinical and technical advice, say in the development or revision of practice guidelines, often through technical reference groups or
working parties. However, broad stakeholder engagement has arisen from a strategic consideration to canvas opinion on complex and potentially politically contentious issues associated with sector reform, say revision of legislation, new funding arrangements and associated operational implications. Government has become increasingly concerned to be perceived as ‘listening to the community’ in policy development with a requirement that the bureaucracy consult widely to ensure stakeholder ‘buy-in’ on policy issues.

The requirement for interdepartmental, intergovernmental, and inter-sectoral public policy coordination is now a common feature of the policy process in the three health authorities. This has arisen from the ‘whole-of-government’ and ‘joined-up’ government approaches implemented as part of public management reforms in the three jurisdictions. As a result, the findings revealed the increasingly prominent role performed by central agencies, such as Department of Premier and Cabinet, and Department of Treasury, in cross-portfolio policy coordination. This has resulted in a new emphasis in the policy making process on cross-agency functions such as partnerships, coordination and collaboration, policy co-production and joint financing.

The study findings on trends toward multiple stakeholder involvement and cross-portfolio, cross-government and cross-sector coordination in policy making are consistent with the government literature from other Australian and overseas jurisdictions. The government literature refers to the increasing importance of the public sector to work collaboratively across organisational and sectoral boundaries, with other government portfolios and organisations external to government in order to address socially complex or ‘wicked’ problems. This has been documented by the Australian Government (Advisory Group on Reform of Australian Government Administration, 2010; APSC, 2007b; Management Advisory Committee, 2004), the Canadian Government (Canadian Government, 1996; Manitoba Office of the Provincial Auditor, 2001; Peters, 1996), the New Zealand Government (Ministry of Health, 2010), and the UK Government (Bullock et al., 2001; UK Cabinet Office, 1999).

In Connecting Government, the Management Advisory Committee (2004, p. 1) articulates that improving whole of government work is a priority for the APS, calling on all APS agencies to review their structures and practices. To promote a comprehensive whole of government approach, the Management Advisory Committee suggests a number of improvements, including developing a supportive culture and skills base; establishing
appropriate governance, budget and accountability frameworks; sharing information and communications infrastructure; improving government’s engagement with individuals and communities; and building capacity to respond quickly and effectively to emerging issues and future crises.

The study findings on the increasing emphasis on engagement with stakeholders and on inter-departmental and inter-organisational collaborative policy making support the theories and arguments advanced in the scholarly literature. A number of scholars have commented on the involvement in public policy making of multiple actors with different values and interests, in particular from beyond the traditional confines of government.

In ‘networked governance’, Rhodes (1988, 1996) introduces the concept of a fragmented or ‘differentiated polity’ of British government, in which many sub-central government institutions beyond Westminster and Whitehall play a key role in governing. Rhodes (1996, p. 652) argues that a new process of governing is emerging, one in which relatively autonomous ‘self-organizing, interorganizational networks’ complemented the role of markets and bureaucracies as governing structures for authoritatively allocating resources, exercising control and coordination, and delivering services.

In ‘structured interaction’ and ‘social construction’, Colebatch (2009), outlines two accounts of the policy process involving negotiation and structured interaction between many recognised stakeholders. In these accounts, policy making is interpreted as a collective process involving numerous players with different interests and expectations, participating in an ordered manner to construct meaning and shape the policy discourse.

In ‘policy networks and communities’ Lewis (2005) mapped social networks of interpersonal connections to identify actors and networks of influence in health policy; identifying ‘organised medicine’, academics, senior bureaucrats and the nursing union together with the Minister for Health and the minister’s chief of staff as central players in the health policy process. Lewis concludes that networks are an important metaphor for understanding the power connections that are crucial in influencing health policy.

The participation of multiple actors in the policy process is well summed up by Peters (2005, p. 87) stating that ‘governance is increasingly a multi-actor phenomenon’ that involves not
only the roles and resources of government but also the participation and resources of the private and non-government sectors in governing.

The trends in policy making comprising a requirement for broad engagement with stakeholders and management of stakeholder interests and implementation of ‘whole-of-government’ and ‘joined-up’ government approaches have introduced a complexity to the work of policy in health authorities with direct consequences for policy capacity and policy process.

Types of policy work
Policy work in the three health authorities was diverse. The range of policy making activities was broad including the review of legislation and programs, development of cross-portfolio submissions as part of state and territory budget cycles, briefings for Cabinet, development of health service plans, and formulating and implementing a range of Commonwealth and state and territory policies and programs. The focus of policy work was wide, including strategic (statewide and long term), operational (programs and services), and clinically-oriented policy (health agency), and involved different levels of government. The range of policy topics was broad reflective of health authority responsibilities comprising acute health, mental health, public health, primary health, alcohol and drug treatment, palliative care, and aged care; and specific population groups comprising indigenous and other ethnic communities, women, children, and people with disabilities; and operational processes, systems and structures comprising financial management, clinical standards, governance structures, and performance standards.

The study findings on the diversity of health policy work are consistent with the theories and arguments advanced in the scholarly literature. Various typologies to classify the different features of policy work are proposed in the scholarly literature, influenced by factors such as function, status of policy whether new or existing, and context. Page & Jenkins (2005), for instance, used a threefold typology for classifying policy work comprising production (drafting legislation and regulation, monitoring spending, and preparing options and strategy papers), maintenance (monitoring research and spending, ensuring implementation compliance, evaluating programs), and service (offering knowledge and skills to others in advising and briefings). Whereas Scott & Baehler (2010, pp. 13-15) identified three broad domains of policy work comprising strategic, responsive,
and operational, influenced by the introduction of either new or maintenance of existing policy, and involved varying degrees of strategic and operational policy.

Specific features of policy work are also discussed in the scholarly literature including drafting legislation (Colebatch, 2009; Page & Jenkins, 2005; B. Radin, 2006) and preparing Cabinet and Budget submissions (Althaus et al., 2007; Page & Jenkins, 2005). Radin (2006, p. 26), in describing the emergence of the policy analysis movement in the United States of America, stated that the policy analytic functions of ‘planning, budgeting, regulatory and legislative drafting’ are part of standard operating decision procedures in federal agencies. Evaluation as a significant category of policy work is also reported at length in the scholarly literature (Althaus et al., 2007; Page & Jenkins, 2005).

While the activities, topics and focus of policy work in the three health authorities presented in this study serve merely to reflect the differences in the policy episodes discussed in the focus groups, they are reflective of the typologies and specific features of policy work identified in the scholarly literature. This diversity has direct implications for policy capacity and process in terms of mobilisation of appropriate resources and policy development tasks.

**Organisation of policy work**

Policy work was dispersed in the three health authorities and was the responsibility of different divisions and units. All three authorities had a central policy unit which varied in size, structure and resources but tended to carry out similar functions. However, policy work was also conducted in program management, and operational divisions and units and in regional administrative offices in Queensland and South Australia, while in ACT Health, health services were also involved in policy work. This distribution of policy work in the three health authorities is attributed to a separation of policy functions. Policy development in relation to issues of major strategic importance, intergovernmental policy work, legislative review, provision of policy advice to program areas, strategic planning, research and analysis, program review, and coordination of departmental input to whole-of-government initiatives are the responsibility of central policy divisions. Program and service-related policy development and implementation are the responsibility of operational divisions and regions.
The distribution of policy work within the three health authorities is a feature of policy work shared with other jurisdictions. The government literature discusses dispersion of policy making capacity and responsibilities from the perspective of administrative efficiencies. For instance, in New Zealand, it was recommended to concentrate policy functions and human resources in order to improve the quality of policy advising in the Ministry of Health (2010); and in the UK it was recommended that specialised units be established to concentrate talent and expertise to conduct certain policy functions (Bullock et al., 2001).

In the scholarly literature, the distribution of policy work is inferred within the study of policy capacity and policy process instead of specifically examining the organisational arrangements for policy making in bureaucracies. For example, the empirical research on policy making capacity of Page & Jenkins (2005) examined the characteristics and competencies as well as activities of middle ranking officials in policy bureaucracies in the United Kingdom. The research acknowledged that many people were engaged in conducting policy activities, referred to as a ‘cast of thousands’, with different responsibilities and functions dispersed throughout many parts of the bureaucracy but did not directly examine organisational arrangements for policy making. This is also evident in the work of other scholars, including Dobuzinskis, Howlett & Laycock (2007).

The distribution of policy work in the three health authorities has direct consequences for policy process and capacity in terms of separation of policy functions and dedication of policy making resources.

**Structures and processes supporting policy work**

Health authorities in the three jurisdictions have well established systems, structures and processes for developing, implementing and evaluating policy, including: a policy development classification system, policy management framework, centrally coordinated policy register, established policy advisory and decision making structures, monitoring and accountability mechanisms, and guidelines, protocols and templates for policy development and implementation. In addition, there are guidelines, tools and accountability mechanisms for ensuring effective stakeholder engagement, program implementation, and cross-portfolio coordination and collaboration.
Despite these established organisational structures and processes, practitioners reported a number of challenges to conducting policy work comprising onerous administrative requirements, frequently requiring additional time and delaying decision making; frameworks that policy workers were neither familiar with nor comfortable using; and multiple approval levels that delayed the process.

The government literature has emphasised the need for improving policy making in public sector bureaucracies by specifying systems, structures and processes for developing, implementing and evaluating policy, including advisory committees; guidelines, protocols and templates; and mechanisms for stakeholder engagement. At the time of this study, a number of reviews of ‘health systems’ and ‘health processes’ had been completed in the three Australian jurisdictions and recommendations implemented. Examples are the ACT Health Review (Michael Reid and Associates, 2002), the Queensland Health Systems Review (Forster, 2005a), and the South Australian Generational Health Review (Menadue, 2003) which have contributed to procedural initiatives such as the ACT Health policy register and ACT guidelines for developing non-clinical policy; Queensland Health policy register and Queensland Health policy development guidelines; and SA Health policy register.\footnote{Refer to Table 12, Chapter 3.}

In New Zealand, the recommendations of the Review of Expenditure on Policy Advice Committee (2010) are intended to improve the quality of policy advice through the development of a multi-year policy work programme agreed to between ministers and chief executives, and development of a range of systems to support policy advice and analysis comprising management information systems and tools to manage policy work, regular review of policy advice functions, development and use of a quality management process, and the need for clear guidelines on inter-agency consultation to improve effectiveness for decision making. Similarly, the Canadian Government (Canadian Centre for Management Development, 1996) has institutionalised a programme of annual strategic planning sessions for ministers to come together to identify and prioritise issues of importance to the country that enables a more systematic approach to policy work, with a similar arrangement proposed for deputy ministers.
The structures and processes supporting policy work are intended as enablers enhancing policy capacity but need to be appropriate to the policy task, clearly articulated and understood by policy workers if they are not to be barriers to efficient policy process.

**Capabilities of policy workers**

Staff working in policy and planning areas in the three health authorities have diverse educational backgrounds, including social science, health science, science, economics, law, and business management. Senior managers in the three health authorities prefer to recruit staff with ‘general’ rather than ‘specialised’ skills, who are capable of performing a variety of policy work, as the authorities have responsibility for a wide range of policy functions. However, a number of staff, particularly in ACT and Queensland Health, have clinical backgrounds in nursing, physiotherapy, social work and psychology. The majority of policy practitioners do not have specific policy and planning qualifications but developed their skills by ‘on the job’ experience, learning from experienced staff, and participation in professional training and development opportunities.

The competencies (knowledge, skills and attributes) considered important by both practitioners and senior managers for individual’s conducting policy work were knowledge of context and content, knowledge of policy making process, good communication and interpersonal skills, strong conceptual and analytical skills, political astuteness, and personal attributes of judgement, intellectual flexibility, ability to handle complexity, confidence, resilience, reflexivity, persistence, and pragmatism.

The study findings on policy worker capabilities are consistent with the government literature from other Australian and overseas jurisdictions identifying policy practitioners’ competencies.

The review of Australian Government administration aimed at reforming the Australian Public Service recommended, amongst others, enhancing policy capability as a major area for improving public administration in order to meet the complex and contested policy challenges of the future. The suite of skills emphasised for good policy analysis included data generation and analysis, engagement of multiple stakeholders, project management, and a focus on policy implementation, evaluation, and strategic thinking (Advisory Group on Reform of Australian Government Administration, 2010; Australian National Audit
The Canadian Government in *Rethinking policy: Strengthening policy capacity*, (Canadian Centre for Management Development, 1996, p. 25) states that good policy development is demanding and requires good communication skills, intellectual engagement, intellectual honesty, the capacity to leave personal opinions aside in analysing options and proposing solutions, recognizing that there is never a single option. The need to work horizontally across government departments and sectors to tackle complex issues, to build consensus amongst stakeholders that is in line with societal values, and to develop policy that is ‘feasible, implementable and sustainable’, were additional skills required for good policy making.

Amongst a number of options for improving the quality of policy advice, the New Zealand Ministry of Health (2010, p. 13) proposed that policy personnel with specific capabilities be recruited to overcome current knowledge and skill gaps: understanding of and familiarity with the ‘machinery of government’ and the ‘tools of the policy trade’, such as writing Cabinet papers and an understanding of the legislative process; knowledge of the policy process; and strong written skills, with the ability to collect and apply evidence and information. The report also specified skills in health economics. There was a further expectation that senior policy analysts would supervise and mentor junior and less experienced staff. Although specifying a background in health economics, there was an emphasis on recruiting staff with strong generic policy skills who were capable of ‘applying a range of analytical frameworks’ and ‘contributing to a variety of policy issues’.

The UK Cabinet Office (1999), in ‘Professional policy making for the twenty first century’, identified that the ‘traditional’ policy-making skills of drafting clearly and concisely, chairing meetings effectively, synthesising and absorbing large amounts of information quickly and accurately will be required, as well as, skills in understanding the organisational and political context; managing complex relationships; good communication and presentation skills; grounding in economics, statistics and relevant scientific disciplines; project management skills; managing risks; and continuous learning and improvement.
The UK House of Commons Public Administration Select Committee (2007), in their report, ‘Governing the future’, emphasised the need for competencies in strategic thinking (horizon scanning, developing scenarios, futures analysis) and the recruitment of personnel from a wide range of backgrounds in order to improve governing in the UK.

In summary, the government documentation emphasised a similar set of competencies for policy practitioners as the study findings, with a preference for workers with a wide range of educational backgrounds but with particular skills in economics and statistics.

The findings are also consistent with recent empirical research discussed in the scholarly literature. For instance, Lindquist & Desveaux (2007), in their study of the Canadian public service identified specialised policy knowledge on specific technical issues pertinent to a policy domain, ability to generate and or access data, generalised policy knowledge, systems knowledge, process skills for negotiating and managing stakeholders, and the ability to protect and preserve public service norms of probity, loyalty, confidentiality, discretion and anonymity. They found additional competencies of timeliness, quality control, flexibility, sustainability and loyalty were important for policy analysis. These individual competencies were similar to those identified by Gleeson (2009) in her study of the Victorian Department of Human Services, comprising knowledge of the health system and its dynamics; knowledge of the departmental and public sector environment; knowledge of the policy process; conceptual and analytic skills; strategic and political skills; intuitive judgement; communication and interpersonal skills; project management skills; writing skills; data analysis and research skills; skills in accessing, appraising and filtering information; evaluation skills; and personal disciplines for ethical practice.

However, Gleeson’s greater emphasis on competencies in project management and on comparative and historical knowledge was not as evident in the study findings. Scott & Baehler’s (2010) delineation of desirable competencies for producing quality policy advice comprising research and analytical skills, facilitation and engagement of stakeholders, understanding of political and economic environment, knowledge of public sector context, communication and interpersonal skills, administrative and managerial skills, judgement, creativity and innovation in policy design, reinforces those identified by Gleeson (2009) and Lindquist & Desveaux (2007).
Although Lindquist & Desveaux (2007) emphasised specialised policy knowledge and technical skills pertinent to a policy domain, the findings of this study are more consistent with Page & Jenkins (2005, pp. 52-53) findings that place greater emphasis on the general rather than specialised knowledge of a substantive area and specific technical skills, which they termed an ability to ‘pick things up’ quickly - the cues that help frame decisions and actions in policy work, and to deal with a variety of changing topics and subjects; referred to as a competency of ‘intellectual flexibility’ in this study.

Gleeson (2009) further argued that individual policy practitioners did not have to possess all these competencies but it was desirable for policy teams to contain a mix of people with different knowledge and skill sets. Similarly, Tenbensel (2006, p. 209) argues that ‘knowledge versatility’, covering the range of epistemic, practical-technical, and phronetic knowledge types, is important for governmental policy workers, providing the skill set and flexibility to cover the breadth of public policy work. While Page and Jenkins (2005) provided empirical evidence that British policy-making was typically carried out by ‘generalist’ rather than ‘technical specialist’ policy makers, and often with limited training in policy analytical techniques.

Taken together the scholarly literature provides a list of competencies that mirrors those identified by practitioners and senior managers which includes research and analysis skills, stakeholder facilitation and engagement skills, communication and interpersonal skills; administrative and managerial skills; knowledge and understanding of the political and economic environment, and of the public sector and health system contexts; and personal qualities of judgement, creativity and innovation, agility, resilience, confidence and perseverance.

The preference for policy practitioners to possess generalist or broad policy knowledge and skills provides for a flexible and adaptive workforce but places great emphasis on ‘on-the-job’ learning in terms of the particular skills required in policy work; and emphasises the need for mentoring by more experienced staff as part of structured organisational knowledge sharing and skills development. The preference for policy development by individual policy workers rather than teams limits the intellectual capital that can be applied to a policy task in terms of policy capacity. Although when clinical and technical knowledge is required it is either procured through consultancies or co-opted through technical reference groups and working parties.
Process of doing policy work

There was no consistent approach to conducting policy work in the three health authorities, with differences in the process related to government urgency and priority, organisational context, type of policy, availability of resources and time, and a policy’s stage of development. For instance, in some episodes, extensive public consultation was considered unnecessary while, in others, information collection and analysis was limited.

However, a number of similarities in process were identified across the policy episodes, comprising identifying the nature of the problem; engaging relevant stakeholders, those external to the department as well as other departments and levels of government; collecting and analysing appropriate information and evidence; negotiating and reaching agreement with key stakeholder interests; preparing written documentation in the form of briefing notes, discussion papers, and reports; obtaining ministerial and or departmental approval; implementing policy into programs and services; monitoring and reviewing policy; and testing policy to assess its suitability for wider implementation. The episodes illustrate that these activities are not conducted in distinctive stages, more often overlapping and merging, with the policy making process moving between multiple activities; and that testing policy was infrequent and undertaken in the form of a ‘pilot’ as an initial stage of implementation and that reviewing policy was limited specifically to programme evaluation undertaken to satisfy funding and accountability requirements.

The study findings on the processes of policy work are consistent with the views expressed in the scholarly literature. The policy process activities identified are consistent with the ‘stages heuristic’ or ‘policy cycle’ steps in the scholarly literature, as well as confirming that not all activities are performed in each policy making episode, and the activities may not occur in a sequential manner.

Buse, Mays and Walt’s (2005, pp. 13-14) analysis of the policy process builds on the ‘stages heuristic’ of previous scholars, articulating the following main stages and activities: problem identification and issue recognition; policy formulation; policy implementation; and policy evaluation. Likewise, in their ‘policy cycle’ model, Althaus et al (2007) identify eight stages in the policy process that provides a framework to assist Australian policy practitioners organise and coordinate policy work. Despite the delineated phases, they argue that policy making is a fluid process that rarely proceeds in a ‘linear fashion through the policy cycle’ (p. 40). Althaus et al. continue (2007, p. 41) that
“a policy cycle cannot capture the full ebb and flow of a sophisticated policy debate, nor does it accommodate fully the value-laden world of politics. Experience shows that the normative sequence is easily disrupted. The “policy dance” is sometimes seemingly random movements rather than choreographed order.”

Although Hogwood & Gunn’s (1984, pp. 4-5) nine stages are applied as a useful framework to describe and analyse the policy process, they assert firstly that it is not a definitive list and can be adjusted from time to time, secondly, the dividing lines between the various activities are artificial and policy-making is unlikely to be performed in the implied “logical” order, and thirdly, it is misleading to view analysis in terms of a straightforward sequence through each stage rather the processes of analysis is frequently iterative. Hill (2009, p. 8) also acknowledges the stages approach as a practical means of providing an appropriate structure for describing and explaining the policy process, recognising that “every process is continuously seen as interacting with every other process” in the actual world of policy-making. Hill further argues that an orderly and staged approach to policy making is compounded by the realities of the policy process with its grounding in politics and distribution of power, influence of economics, impact of organisations, and involvement of multiple actors beyond that of government.

Although not arguing for the policy process to be viewed from a rational and sequential approach, Rasmussen (1999) in examining the views of senior provincial public servants concerning ways to strengthen policy capacity in Saskatchewan, concluded that improving the policy-making process, particularly the interface between cabinet and the departmental bureaucracy, was important. Improvements in communication could be made by designing processes that provided greater opportunities for departments to participate in, and be apprised of, cabinet’s strategic policy and goal-setting agenda (Rasmussen, 1999, p. 338).

In contrast, Gill & Colebatch (2006) contend that the actual policy process, as articulated by policy workers, bears little resemblance to the sequential policy cycle approach of official texts. Rather, that policy work in Australia is largely unstructured and does not fit neatly into the rational, objective, ‘authoritative choice’ account of policy making. On the basis of an empirical study of policy workers’ experiences in gender and education policy, they conclude that all three perspectives (authoritative choice, structured interaction, and
social construction\textsuperscript{35}) are in use by policy makers, in different ways and to varying extents (Gill & Colebatch, 2006, p. 241).

**Expected outputs and outcomes of policy work**

Policy practitioners were not always clear about expected outputs and outcomes from a policy project. This is understandable given the complexity of policy problems, often interpreted as ‘wicked’ and ‘intractable’ (Rittel & Webber, 1973) and difficult to resolve, and a policy process that is non-linear and unpredictable. The factors identified as contributing to this situation were the project-specific and short term nature of policy work; the long time lines required for formulating, negotiating, drafting, approving, implementing and evaluating policy; staff specialisation and turnover such that a practitioner may not work on a project from policy development to program implementation; and policy outcomes that are usually less tangible and frequently require long periods of time to be realised; and the fact that practitioners did not hold a common interpretation of the terms policy output and policy outcome.

Despite a lack of clarity about outputs and outcomes, there was a consensus among practitioners that policy work has a particular orientation which is reflected in the way issues are examined and analysed, specific activities conducted, written documentation produced, and decisions implemented; and that the policy process has a particular objective, whether called output or outcome, in terms of production of written documents comprising statements of direction and intent, legislation, reports and guidelines that are intended to achieve improvement in health systems and/or health services. The lack of clarity regarding policy outputs and outcomes demonstrates the difficulties in navigating the complexities of the policy process.

The study’s explicit treatment of the expected outputs and outcomes of policy work, as perceived by policy practitioners, is not so clearly depicted in the scholarly literature. The public policy literature focuses specifically on aspects of either policy capacity or policy process, with less attention paid to policy outputs and outcomes; although a relationship between the elements of policy capacity, process, outputs and outcomes is usually inferred (Colebatch, 2009; Gleeson, 2009; Scott & Baehler, 2010). Although her focus was on policy capacity development, Gleeson (2009) recognised the importance of the relationships between organisational context, policy process and policy outcomes.

\textsuperscript{35} This refers to Colebatch’s three accounts on policy.
Similarly, Scott & Baehler (2010) in emphasising improvements in policy practice acknowledged that good process produces quality outputs and outcomes; however, the relationship between the elements of process, outputs and outcomes is implied rather than made explicit. However, Colebatch (2009) did advance the view inter alia that policy outcomes are more than just the development of a formal policy statement but also the implementation of goals to achieve a desired impact on society.

Any lack of clarity about the distinction between policy outputs and outcomes will have a negative effect on the process of policy development and implementation as well as on the inputs (mobilisation of resources and infrastructure) to complete the task. The intent of the policy, the outcome, must be clear in order for the required outputs to be identified and most appropriate policy development process determined.

### 8.2 Elements and Relationships Underpinning Policy Work

The elements of policy work and their interrelationship  
(Research questions 2 and 3)

**Policy capacity**

In this study, policy capacity has been defined as a combination of individual capabilities, understood as inputs in the form of individual knowledge, skills and expertise; leaders’ roles and capabilities; underpinned by policy-specific training and professional development; and organisational infrastructure, understood as an organisation’s structures, systems, processes and material resources that are important in supporting the work of policy, such as information systems for collecting and disseminating information, human resources management systems, financial systems and resources, equipment and supports, protocols and guidelines for policy making, and programs of training and development.

In this context, the potential of the individual and organisation to adapt and respond to change in the wider social, economic and political environment is also interpreted as capacity.

The findings identify the following challenges to policy capacity:

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36 Refer to Chapters 5 and 6 for a detailed analysis of the relevant findings.
Recruitment and retention of policy workers was a significant challenge in all jurisdictions. The pool of suitably qualified and experienced policy workers from which to draw was small, particularly in the ACT; and attracting young people to policy and planning work was difficult for reasons of low profile, poor remuneration and limited career development opportunities. Rapid ‘turnover’ of skilled and experienced policy staff, and loss to the health sector was a notable problem in the ACT and Queensland.

Mobilisation of appropriate human resources (amount and mix) was a challenge. Many policy projects were under-resourced. In most policy episodes, an individual worker was assigned the task, which was often added to their regular responsibilities. Rarely was a team, comprising a suitable mix of skills, assembled to complete the work. Insufficient resources was also mentioned as a barrier to conducting evaluation, participation in intra-departmental and cross-portfolio collaboration, and, at times, stakeholder consultation and analysis of information and research.

A lack of skill and expertise in particular areas of policy work was a challenge, including analysing, interpreting and applying quantitative information; negotiating skills for working across boundaries; and evaluating and implementing policy and programs. There was also a shortfall of specific technical skills, which made it difficult to recruit staff with expertise in epidemiology, economics, statistical and spatial analysis, service planning, and futures analysis. Further, a number of staff working in policy had clinical backgrounds, and their knowledge and skills were not always suitable for working in an analytical and strategic policy environment.

A lack of synthesised data in an ‘easy to use’ format for a range of policy and planning purposes was a challenge, including forecasting, determining trends, benchmarking and service planning, although a range of health services data was reported as available in all jurisdictions.

A lack of policy-specific skills development was a challenge in all jurisdictions. Limited policy-specific skills development is provided in professional training and development programs, instead relying on academic courses, and learning by experience from senior staff.
Inadequate leadership and management was a barrier to effective policy work. Leadership and management skills were required for determining the parameters of the task; providing clear direction; mobilising appropriate resources; providing guidance and support; advocating and promoting policy at higher levels of the organisation; managing effectively the policy process; protecting and supporting staff from other demands; and overseeing effective policy implementation and evaluation.

The study findings on policy capacity are consistent with specific policy capacity problems identified in the public administration and scholarly literature, such as shortage of qualified and skilled policy personnel, inadequate policy analytical skills, high staff ‘turnover’, and difficulties in attracting personnel due to limited career development opportunities, poor remuneration, and competition from non-government and private sectors.

Aucoin & Bakvis (2005, pp. 194-195) argue that public service reforms over the past two decades have had negative consequences for public service capacity, making it a less attractive place for people to work and pursue a career. This has made it difficult for the public service to recruit and retain ‘the best and the brightest’. They argue that a top priority of a professional public service must be to recruit and retain its share of talented and high-quality staff, and to invest in developing its own leaders.

Acknowledging the difficulties in recruiting skilled and experienced policy analysts and the need to strengthen the policy capacity of Canadian bureaucracies, Lindquist & Desveaux (2007) advise that policy units need to use a mix of recruitment practices to attract and retain high quality policy staff, including the establishment of a centre of excellence in the public service, introducing means to retain rare talent, and establishing a program of research.

The recruitment problem in Canada was partly the result of a limited supply of trained and experienced policy personnel, evidenced in the Manitoba Office of the Provincial Auditor’s (2001, p. 31) claim, ‘they would like to hire more policy staff or give their existing staff more time to develop policies but the demands of government for policy outstrips the available supply of resources’. At the federal level, the report continues, they lacked sufficient policy resources, the result of a shortage of policy staff, to collect and
analyse data, undertake background research studies or alternatively the resources to hire the services of consultants to conduct such work.

In addition to a shortage of supply of policy personnel, a lack of skill and expertise in specific policy areas was identified by a number of jurisdictions. In regard to policy skill gaps, the New Zealand Ministry of Health (2010, p. 13) identified a lack of understanding and or familiarity with ‘machinery of government’ and the ‘tools of the policy trade’, such as writing Cabinet papers and understanding the legislative process, as well as a lack of skills in particular specialist areas, especially in health economics. The Manitoba Office of the Provincial Auditor (2001, pp. 30-37) also identified gaps in policy capacity in the specialised fields of economics and international trade agreements, as well as, the need for improvement in analytical and critical thinking, computer skills for data manipulation, survey design and evaluation skills.

The lack of ‘strategic thinking’ and ‘futures planning’ skills were also identified as a policy capacity weakness by a number of jurisdictions. For instance, the Advisory Group on Reform of Australian Government Administration (2009, p. 24) noted that a significant challenge for the Australian Public Service is the short-term focus of policy work to the neglect of strategic, long-term policy thinking, stating: “the capacity of APS agencies to focus on long-term issues is often overwhelmed by ‘day-to-day demand’ and ‘the immediate pressures of program and service delivery take priority over long-term policy development.” This limitation in policy capacity was acknowledged by Prime Minister Rudd in 2008 in an address delivered to the Australian Public Service, and identified the need to enhance the strategic policy capability of the Australian Public Service as a government priority (2009a, p. 17).

Similarly, the New Zealand Ministry of Health (2010, p. 5) identified that policy making in New Zealand had a tendency to be reactive, with less of a focus on acting strategically. In the case of the United Kingdom, the House of Commons Public Administration Select Committee (2007) revealed weaknesses in civil service policy skills in the areas of strategic thinking: horizon scanning, scenario development, and futures analysis. This was supported by the Manitoba Office of the Provincial Auditor (2001, p. 31) who concluded that there was insufficient time for conducting in-depth analysis to “develop long-range and forward-thinking proactive policies”, with government departments focussing their attention on more immediate policy needs and ‘responding to emerging pressure points’.
The Advisory Group on Reform of Australian Government Administration (2009, p. 24) identified another policy making capacity gap in the Australian Public Service, being a lack of knowledge and skills in connecting the “higher level of policy formulation to the attainment of practical outcomes on the ground”, that is, skill in understanding both development and subsequent implementation of policy.

The findings raised in this study on the lack of quality data, that could be accessed easily was generally consistent with that in the government literature. The Review of Expenditure on Policy Advice Committee (2010, pp. 45-47) identified that the availability and consistency of data was inadequate across much of the policy advisory system and was a barrier to good policy development. They argued that unlike other countries, access to public databases, models and tools was severely restricted in New Zealand, and recommended improvements to the current management and dissemination of data and information. Despite the availability of a few excellent longitudinal data sets for understanding individual and household behaviour, the information was not accessible and in a format that could be easily used. The Manitoba Office of the Provincial Auditor (2001, p. 38) identified similar problems regarding access to quality data, and concluded that there was a need for improving the availability of and access to data across the public service.

The study findings on the lack of policy-specific skills development were consistent with the scholarly and government literature. In the area of formal skills training and development, Howlett & Lindquist (2007, p. 104) acknowledge that professional training and education curricula will need to be redesigned to reflect changes in contemporary policy knowledge and skill comprising a shift in emphasis from ‘rationalism, client advice and argumentative skills’ to encompass ‘process management, interactivity and participation’. According to Howlett & Lindquist (2007) this new policy skill set emphasises ‘facilitation, negotiation, or advocacy.’ While this shift in emphasis is an important acknowledgement in formal policy training and education curricula, the government literature however places a strong emphasis on practical and ‘hands-on’ learning opportunities as an effective method of skills development for mid-level and senior policy staff. This is evident in the practical approach recommended by the Australian Public Service Commission (2007a) to understanding behavioural change and new policy challenges; that learning could be achieved based on other agencies’ experience including international agencies.
The Better policy making report in the UK (Bullock et al., 2001, p. 10) supported a similar approach, that is, identifying the sharing of best practice knowledge in policy making across agencies and improved networking with others working in policy as an effective means of improving policy skills. The Victorian Department of Human Services (2008, p. 7) in Towards Better Policy suggested an increased engagement with professional associations, improved sharing of information, and further development of links between the department and external experts as important ways for developing policy skills.

The inadequacies of leadership and management as a barrier to effective policy making that were identified in this study are consistent with the government literature. The New Zealand Review of Expenditure on Policy Advice (2010, pp. 41-42) stated there were “gaps in the policy advice leadership capability at the highest levels of the public service”. The report concluded that policy leadership was variable across the public sector, leaders were strong on operational and technical matters but frequently lacked substantive policy skill, and in response recommended policy advice leadership skills should be given more emphasis in the selection of chief executives and policy leaders. More specifically, the New Zealand Ministry of Health (2010, p. 15) found that senior management had not provided clear policy direction and priority setting in the last few years, and there was a need to develop a stronger management culture with better delineation of roles and responsibilities, clearer priority of policy issues, and improved project management.

In the review of policy development capacity within Canadian government departments, the Manitoba Office of the Provincial Auditor (2001, p. 29) recognised the importance of good leadership direction and support, together with good process and products (policy documents), as an important component of effective policy development capacity. The review found that while senior management generally perceived their role to include process management (interpreting for staff direction from the centre and the minister; giving direction and feedback; managing relationships within and external to the department) and resourcing policy staff they did not play a significant role in quality control of the policy document produced.

Although the study findings revealed policy capacity problems relating to frequent staff ‘turnover’, particularly in some jurisdictions, and difficulties in attracting policy personnel due to limited career development opportunities, poor remuneration, and competition from
non-government and private sectors, these were not significant issues identified in the scholarly and government public administration literature.

**Policy process**

In this study, policy process has been defined as the conduct of activities to achieve particular policy outputs and outcomes comprising collecting, analysing and applying information and intelligence; engaging and managing stakeholders; coordinating and collaborating within the department, and across portfolios and governments; preparing written documentation; authorising policy; implementing policy; and monitoring and evaluating policy.

The findings identify the following challenges to the policy process:

Lack of clarity had implications for the purpose and selection of participants in stakeholder consultation, outcomes to be achieved from cross-portfolio negotiations, the choice and content of policy instruments, and the design of implementation plans.

Existing structures in health authorities were often barriers to communicating and sharing information, sharing responsibility, acknowledging authority, and a shared priority and commitment to outcomes. This is evidenced by the lack of awareness of policy work conducted in different parts of the organisation; the gap between policy development and program implementation with different parts of the organisation responsible for each function; and templates and guidelines developed to assist the policy management process which were either not understood, overly complex or considered too constraining.

Inadequate management of the policy process was a barrier in specific areas, such as managing stakeholders, cross-portfolio coordination, implementing policy, and evaluation and monitoring, despite the institutionalisation of structures and processes. This was evidenced in the confusion about roles and responsibilities, duplication of effort, and delays in provision of appropriate advice in the area of cross-portfolio and intergovernmental policy collaboration. Some of the concerns reported that could be interpreted as poor management of the policy process included disillusionment in conducting extensive stakeholder consultations that were not reflected in the final policy, lack of continuity between policy development and program implementation, lack of commitment to evaluation and monitoring, and lack of appropriate resources and time for completing policy tasks.
Influence of the external environment

The external environment comprising political systems and structures, state of economy, health system issues, stakeholder interests, and public expectations, significantly influence the policy making elements of capacity, process, outputs and outcomes and hence the work of policy.

Policy development and implementation are influenced by the political context in which health policy occurs. The electoral process can result in changes in policy direction arising from a change in government. The increased intensity of political activity in the lead up to an election can test policy making capacity with short time frames within which to provide advice; and longer term implications arising from election promises where implementation issues have either not been considered or fully developed. Changes in priorities can occur as a consequence of Cabinet reshuffles and appointment of a new minister; or as a consequence of lobbying by powerful interest groups. The level of government commitment to a policy has a significant effect on priority for development and implementation and can be influenced by the minister championing health policy issues in Cabinet particularly in regard to priority for funding; by media attention in publicising a policy issue; and unexpected crises requiring the department to respond urgently with policy advice on an issue.

The centralisation of decision making arising from the coordination of national policy on health by the Australian Government and from Departments of Premier & Cabinet or Chief Minister’s Office exercising greater control over policy development and implementation, by imposing pre-determined directions and defining policy outputs and outcomes, under ‘whole of government’ and ‘joined-up’ government influences both policy process and capacity in terms of participation in cross portfolio coordination and collaborative policy development and implementation.

Policy making is influenced by the context within which it operates and, as such, is influenced by political structures, institutional arrangements, organisational culture and structure, individual capabilities, available resources, economic conditions, and wider community interest. Therefore, the external environment significantly influences the elements of capacity, process, outputs and outcomes and hence the work of policy.
The study findings on the influence of the external environment on policy work is consistent with the public administration literature which recognises the importance of external stakeholders, inter-departmental and intergovernmental coordination, as well as, changing community needs and expectations on the policy making process and the need to adapt and respond promptly.

The UK Government’s (Bullock et al., 2001, p. 14) emphasis on ‘inclusive’, ‘joined-up’ and ‘outward-looking’ decision making, some of the key features proposed for modernising the policy-making process in the twenty-first century, illustrates the important role of external influencing factors, such as stakeholders, other departments, other institutions, and other countries. For instance, to be more outward-looking in the policy process, the report states that government will need to take into account influencing factors in the national, European and international situation, particularly drawing on experience in other countries. In joined-up and inclusive decision making, emphasis is placed on working closely with other departments to achieve the government’s strategic objectives, acknowledging the ‘cross-cutting’ nature of issues and the need for organisational structures to manage the process. This type of decision making recognises the need for inter-departmental communication and problem solving; careful consideration given to the views of individuals or groups affected by a policy; and the close involvement of operational staff and those responsible for implementation to facilitate implementation on the ground.

The Australian government review of administration (Advisory Group on Reform of Australian Government Administration, 2010) identified a number of challenges that the public service had to contend with, including public policy complexity and the need for cross-agency and cross-jurisdictional cooperation; increasing public expectations and demands; technological changes; and globalisation of information and issues. The review concluded that reforms proposed for Australian public administration will need to focus on a whole-of-government and across APS approach if the challenges of the future are to be met. Although referring to public administration in general this has implications for public sector policy making.

The study findings place significant emphasis on the influence of the external environment on policy work, which is mirrored in the scholarly public policy literature on policy
capacity and policy process (Buse et al., 2005; Colebatch, 2009; Easton, 1965; Hill, 2009; Janicke & Weidner, 1997).

In studying the policy process, Hill (2009, p. 8) states that ‘any discussion of the public policy process needs to be grounded in an extensive consideration of the nature of power in the state.’ In this analysis of the policy process, Hill acknowledges the interrelationship and influence of politics but also emphasises the close links with economics and the sociology of organisations. This is supported by Buse et al., (2005, p. 1) in their study of health policy, who assert that ‘all [policy] activity is subject to politics’, which in turn requires a sound understanding of the relationship between power and policy making: how power is exercised by different groups; how political systems and governments transform power into policies; how power is distributed; and how power affects decision making processes. Similarly, in Easton’s (1965) systems model of policy making, the influence of the political environment is considered as fundamental to understanding the policy process. In this ‘black box’ metaphor, the political system of government decision-making is central in transforming inputs into policy outputs and outcomes (public policies for goods and services that impact on society), and in regulating and modifying the environment for future policy making.

Similarly, Janicke & Weidner (1997, pp. 12-13) in their case study analysis of environmental policy and management across 13 countries assert that successful environmental policy is influenced by several important factors: the importance of public awareness and environmental knowledge; the existence of an “epistemic community”; the role of the media and environmental reporting; a leading paradigm of policy actors; and an institutional framework with open and participative politico-legal structures, and a capacity for consensus and strategic action. More importantly, Janicke & Weidner (1997, p. 4) link technical environmental policy with economic conditions, concluding that the structure of policy problems as well as the capacity to respond is strongly influenced by economic performance and the wider international context by stating that “successful environmental protection is brought about by a complex interaction of influences and not by a single, isolated factor, nor a favourite instrument, nor a single type of actor, nor a particular framework condition or institution.”

The role and influence of multiple stakeholders in policy making is evident in Colebatch’s (2009, p. 35) three accounts of policy: authoritative choice, referred to as the ‘vertical’
dimension, where the dominant account is the role of government; structured interaction, referred to as the ‘horizontal’ dimension, where the dominant account includes the active participation of stakeholders outside government (e.g. international participants, other levels of government, and other agencies), and social construction, referred to as the ‘scene-setting’ dimension, where the dominant account recognises the role of different participants in developing shared understandings and values in relation to a policy issue. According to Colebatch, features of these different accounts can be found in practice in all policy, although the mix varies according to the policy situation. In these accounts of policy, ‘policy collectivities’, comprising a range of participants from different settings and with different interests, emerge to actively participate in and influence the policy process.

Jayasuriya (2005) reaches similar conclusions about changing models of public governance and the role of players other than government in the process in reviewing policy capacity. Jayasuriya (2005, p. 34) argues that in the era of globalisation a new form of regulatory state has emerged, which diffuses public governance functions across a range of sites and actors (“decentred state”), and in this environment of ‘networked capacities’ and ‘metagovernance’ a relational model of policy capacity is required.

Policy review and monitor

Few comments were made by participants about the function of review and monitor in the policy process as it is given low priority and often ‘contracted out’. When participants did mention the function of review and monitor it was usually in the context of accountability and not policy feedback and improvement.

There is a discrepancy between the study findings and the representation of monitoring and evaluation in the public administration literature and scholarly literature on policy process and policy capacity.

In the public administration literature, evaluation and monitoring were given significant attention. The Manitoba Office of the Provincial Auditor (2001, p. 27), in reviewing the policy development capacity of Canadian government departments, found that they did not have a systematic approach to evaluation of policies; evaluations were generally conducted on an ad hoc basis, usually in response to emerging problems, negative media coverage and complaints, or where federal/provincial agreements were in place. Other review findings identified that most departments did not consider it necessary to have a systematic
evaluation of policies as it was an ‘ineffective and inefficient use of scarce resources’, instead favouring a selective approach where certain policies are evaluated as deemed necessary. The usual constraints to policy evaluation were identified: cost of data collection and analysis, lack of staff time, lack of in-house expertise to conduct evaluations, and long time frames to see the measurable impact of a policy. The review concluded that senior management in a number of government departments reported that policy evaluation can be a ‘waste’ since policy change rarely occurs (Manitoba Office of the Provincial Auditor, 2001, p. 28).

In Australia, the Advisory Group on Reform of Australian Government Administration (2009, p. 21) also identified there were no systematic processes in place, with measurable benchmarks, for assessing the quality of policy advice in the public service. The Advisory Group found that a number of departments did not routinely obtain qualitative feedback from Ministers or conduct peer review of performance. They concluded that a prevailing culture cautious of taking risks and less supportive of innovative and creative policy making, combined with the absence of a process for systematic review of policy capability were barriers to the provision of high quality policy advice, and recommended a programme of regular review of strategic policy and implementation capability be introduced across the APS. This was supported by the Productivity Commission (2010, pp. 8-9), stating: ‘Evaluation sometimes seems an afterthought to the policy implementation process and, on occasion, appears geared only to enable proclamation of success or failure rather than policy improvement. It is rare to find funding for and design of high-quality evaluation at early stages to guide policy implementation and refinement.’

In better policy-making in the United Kingdom, Bullock et al. (2001, p. 8) report “relatively few policy-makers reported using a reviewing or lesson learning approach”, in response they recommend review, evaluation and learning as three of the nine features for modernising policy-making. They propose (p. 14) that existing and established policy is constantly reviewed to ensure relevance and effectiveness, that systematic evaluation is built into the policy making process, and a learning approach is applied to policy making.

In the policy process literature, evaluation is strongly represented, frequently specified as a critical function and notable stage in the rational and stagist approach to the policy process (Althaus et al., 2007; Buse et al., 2005; Dye, 2008; Hogwood & Gunn, 1984; Howlett & Ramesh, 2003; Scott & Baehler, 2010). Althaus et al. (2007) identify evaluation as an
essential step in the Australian ‘policy cycle’ that enables government to assess the effects of and subsequently adjust and redesign a policy as appropriate. Also, acknowledged is the cyclical nature of evaluation, which allows re-examination of the problem and reconsideration of the policy’s objectives and policy instruments.

Similarly, the policy capacity literature (Brans & Vancoppenolle, 2005; Gleeson, 2009; Howlett & Lindquist, 2004) also refers to evaluation and monitoring. For example, Brans & Vancoppenolle (2005), in reviewing the New Public Management reforms on government policy-making, identify evaluation as one of the five main dimensions in the policy-making reform agenda of a few liberal democratic countries; arguing that the evaluation function is becoming increasingly important as a result of an emphasis on performance management, learning and policy improvement.

Despite the emphasis in the scholarly literature on monitoring and evaluation, it was either less frequently reported or not performed routinely by practitioners, perhaps due to factors such as low organisational commitment and priority, resulting in limited allocation of resources; perceived as a non-core organisational function; focus on performance monitoring and accountability rather than organisational learning, reflection and improvement; and low in-house technical capabilities with the functions frequently contracted out.

8.3 LEADERSHIP: A CENTRAL ROLE IN MANAGING THE ELEMENTS AND INTERRELATIONSHIPS OF POLICY MAKING

The role of policy leadership in managing the elements of policy work (Research question 4)

In this study leadership and management are understood, within the context of state and territory public services, as senior management positions with prescribed authority through their defined roles and responsibilities for providing high level, specialist advice, managing and directing staff, and controlling resources. Therefore, as specified in the relevant public service classification system, a leader and manager is empowered by his/her position in the state and territory public service.

In the context of staff in senior management positions in dedicated policy and other policy-oriented divisions in the three health authorities, the study identified two levels of
management, being senior management, which refers to the top echelons of the public service, the senior executive service, with responsibility for the management of large human and financial resources; and middle management, comprising a combination of classification levels (e.g. middle and lower ranking senior administrative) and position titles (e.g. managers, program managers, coordinators and team leaders), with responsibility for supporting senior management and for supervising and supporting subordinate staff. In general, middle level managers not only supervise the day to day operations of and mentor junior policy and project staff, they also perform the function of conducting policy work. That is, both senior and middle level managers are involved, to varying degrees and with some overlapping functions and responsibilities, in providing leadership and management.

The study findings indicate that, while there are similarities between generic and policy leadership, the approach required to leadership and management in health policy environments is different to that in health operational environments. The difference in leadership and management approach is attributable to the nature of policy work, the capabilities of policy workers and the collegiate approach to policy making, and the relationship to and influence of the external socio-political environment.

The study findings demonstrate that many of the barriers and constraints to policy capacity and policy process that underpin the work of policy were either directly or indirectly the result of inadequate leadership in the three health authorities, including lack of commitment, in turn, low priority and funding; failure by senior managers to promote and advocate policy at the higher level of the organisation; inadequate resource and infrastructure mobilisation to complete policy development; inadequate clarification of policy scope; lack of direction and guidance; limited formal mentoring and development of less experienced staff; and lack of development of a policy-supportive organisational culture.

Leadership is perceived as a vital component of organisational policy capacity and an essential factor in managing effective policy making through the alignment of policy capacity and process. Leadership has an essential role in establishing the organisation’s strategic direction; influencing organisational culture; mobilising resources and infrastructure; managing processes efficiently and effectively; interacting with and managing the external environment; and managing and supporting staff. In addition, the
study findings differentiate health policy leadership from generic public administration leadership, delineating a specific style, certain roles and responsibilities, and particular skills and competencies required of leaders in a health policy environment.

**Importance of leadership/health policy leadership**

The study findings on the importance of leadership in public administration and specifically policy environments is supported by the scholarly and government literature, which substantiates the pivotal role that leadership performs in steering an organisation’s direction, managing its resources and overall performance for the achievement of good outcomes.

This is evident in ‘t Hart & Uhr (2008a) who analyse public sector leadership in Australia and New Zealand from different perspectives, such as democracy and leadership, the practice of public leadership in various settings, and political leadership, drawing a distinction between political, administrative and civic leadership, and emphasise the important role performed by public sector leadership in general. However, leadership is not reviewed from the specific perspective of health policy leadership in public sector bureaucracies.

More specifically, in a health context, contributors (Brommels & McCallum, 2007; Hannaway et al., 2007) in Hunter (2007b) discuss the importance of public health management by examining concepts of health management, skills and frameworks for health managers and practitioners, and training and development for health improvement outcomes; and combine a theoretical and practical approach, in the latter using examples and case studies, to explore management challenges in public health policy. In a later study, Hunter (2009, pp. 203-204) on health management, argues that there is a ‘health leadership vacuum’ and central government policy-makers are stuck in an ‘outmoded managerial paradigm’, calling for a new public health leadership paradigm that focuses on ‘complex adaptive systems’ for improving health and wellbeing. Under this new paradigm, leaders will need to be more aware of the complexity of public health problems, so called wicked problems; skilled in systems thinking; and politically astute to ensure health improvement outcomes.

Hunter’s focus on a systems perspective of health management, which acknowledges complexity of the health policy context and political astuteness, to some extent matches
the findings of this study, as both recognise complexity and conclude that leadership and management are important for improved policy work leading to better health outcomes. However, from the perspective of this study, health policy leadership should be viewed as a ‘specialised’ field separate from generic leadership in public administration, with a specific style, certain roles, and particular skills and competencies; and the systems perspective, as described in the conceptual framework, has as its focus the central role of leadership and management in aligning policy capacity and process in order to achieve good policy outputs and outcomes.

The importance of leadership and management in health is reinforced by the spate of reports and reviews on the United Kingdom’s National Health Service (Baker, 2011; Hartley & Benington, 2011; James, 2011; Roebuck, 2011; The King’s Fund, 2011, 2012). The King’s Fund (2011, p. 1) report, entitled The future of leadership and management in the NHS: No more heroes, states that strong management and leadership is required if the NHS is to meet the quality and financial challenges now facing the health care system: “The bottom line is that an organisation as large and complex as the NHS cannot be run without high-quality management and leadership. This will happen only through a commitment of time and resources and a willingness to value the role of managers whatever their background.” The report concludes that a ‘shared and distributed’ rather than traditional ‘command and control’ leadership approach is more suited to ensuring health system performance improvements in the NHS; consistent with this study’s findings, arguing for a more collegiate and team-based policy leadership approach that recognises the nature of policy work, and the skill and experience of many middle and senior managers.

The government literature on public administration in a number of countries has also emphasised the importance of leadership and management in establishing the organisation’s strategic direction; influencing culture; mobilising resources and infrastructure; managing processes efficiently and effectively; interacting with and managing the external environment; and managing and supporting staff.

As early as the 1990s, the UK Cabinet Office (1999, p. 5), in modernising the government agenda for the 21st century, stated that change in policy making will need to be led from the top and the involvement of ministers as well as top managers and policy makers will be essential for success. The White Paper set out a major programme of change for the public
sector as a whole, including work practices through ‘joining up’ and partnerships, wider use of technology, changes to organisational culture, and changes to the policy making process. In another paper, Mulgan and Lee (2001) identified management as one of a number of factors in a typology of policy failure. The reasons listed for policy failure attributable to inadequate management and leadership, included an inability to obtain an adequate amount of resources and assemble the appropriate mix of skill; inadequate planning; setting wrong targets; poor policy design; the inability to achieve stakeholder support and reduce public opposition; ineffectual management in overseeing the specification and management of contracts; inadequate information technology systems to deliver information to monitor progress; and no review and feedback of information into the implementation process.

The New Zealand Ministry of Health (2010) recognised the important role leadership performed in producing quality policy advice; asserting that leadership plays a major role in determining the culture of an organisation (in valuing and promoting good policy analysis, encouraging open and honest communication, and clarifying directions and priorities) thereby improving the quality of policy advice. Strong leadership, the Ministry (2010, p. 15) concludes is responsible for bringing about changes in organisational behaviours and expectations. The New Zealand Review of Expenditure on Policy Advice (2010, p. 41) reinforced the role of leadership in creating a culture that supports good policy development and produces quality policy advice.

**Leadership challenges: policy capacity and policy process**

Policy practitioners identified a number of challenges (barriers and constraints) to policy leadership in managing both the policy process and policy capacity comprising lack of direction and guidance in the form of intelligent and strategic input; inadequate management of the policy making process in terms of appropriate overseeing and scheduling; inadequate support from senior managers in mobilising appropriate resources, allowing sufficient time for completing tasks, advocating for and promoting their policy work; and lack of clarity regarding leadership roles and responsibilities despite strongly structured organisations.

Senior managers identified the policy capacity challenges as comprising limited skilled resource base of senior managers, loss of senior leaders from staff turnover, limited focus on policy leadership with an emphasis on operational leadership, and the absence of
policy-specific leadership training and development for senior managers. For policy leadership, the policy capacity challenges were identified as comprising recruitment and retention of skilled policy staff; lack of specific policy skills and expertise in data analysis, service planning, forecasting, epidemiology and cross-portfolio negotiations; and lack of policy-specific leadership training and development.

Senior managers identified the policy process challenges for policy leadership as comprising:

- the relationships with other government and department portfolios in terms of a lack of commitment and low priority given to cross portfolio functions that are also compromised by existing accountability and incentive structures as well as a reluctance to re-direct scarce human resources;
- the interface between policy development and program implementation affected by multiple factors including the lack of consideration given to implementation issues when formulating policy, structural impediments arising from decentralised administrative structures and jurisdictional size as well as changed government priorities that were beyond the control of senior managers;
- the neglected activities of monitoring, review and improvement in the policy making process that are conducted mainly for accountability and performance purposes, with few resources allocated, and as a consequence a culture of reflection, feedback and improvement is not encouraged; and
- the quality of policy writing in terms of style, content, structure and framing of concise recommendations and directions.

Leadership and management required for health policy environments

The main roles and responsibilities of senior leaders as perceived by senior managers and policy practitioners are summarised as providing strategic direction; managing and supporting staff by creating space and time as well as opportunities for professional development; managing the policy process; and managing change. However, a distinction was made between senior and middle level managers’ roles in health authorities, the latter perceived by senior managers to perform a practical and ‘hands-on’ rather than strategic role, while managing the routine aspects of policy work including staff supervision, mentoring and performance monitoring.
Complementing the above roles and responsibilities of senior leaders, the competencies considered important for both senior and or middle level leadership and management as perceived by policy practitioners are summarised as knowledge of the health system; knowledge of the wider socio-political environment; ability to think and act strategically; knowledge of the policy making process; ability to manage people; ability to manage change; and a number of personal skills and attributes comprising strong interpersonal and communication skills, ethical behaviour, decisiveness, agility, resilience and flexibility.

The study findings on the challenges for policy leadership and the alignment of policy capacity and process in policy work indicate that four pre-conditions are required for leadership and management as the means for aligning capacity and process in health policy work:

1) **Supportive organisational culture**: the need for leadership and management to either develop and or enhance further an organisational culture that is committed to and supportive of good policy making; valuing the contribution of policy to the achievement of organisational goals.

2) **Knowledge of policy making**: the need for senior and middle level leadership and management to possess a sound knowledge of policy making and the skill to apply this knowledge to a range of policy problems. This knowledge entails an understanding of policy work in terms of process, outputs and outcomes, and the influence of the external environment.

3) **Systems framework applied to policy making**: the need for senior and middle level leadership and management to apply a conceptual framework based on a systems approach to understanding, explaining and interpreting policy making in terms of the elements of and relationships between capacity, process, outputs, outcomes, review and monitor, and the external environment.

4) **Responding assertively, proactively and reflectively**: the need for leadership and management to act more assertively in the conduct of the policy making process.

The adoption of the first three leadership and management pre-conditions provides the foundation for performing efficiently and effectively the fourth. The areas in which policy leadership needs to take a more ‘directing role’ are identified in Table 22.
Table 22: Leadership and management – Responding assertively

<table>
<thead>
<tr>
<th>Function</th>
<th>Leadership and management response</th>
</tr>
</thead>
<tbody>
<tr>
<td>i) Delineating the scope and strategic direction of policy:</td>
<td>The need to determine assertively and proactively, the:</td>
</tr>
<tr>
<td></td>
<td>• scope of policy;</td>
</tr>
<tr>
<td></td>
<td>• strategic direction of policy; and</td>
</tr>
<tr>
<td></td>
<td>• impact of policy on implementation.</td>
</tr>
<tr>
<td>ii) Clarifying intended outputs and outcomes at the time of developing and implementing policy:</td>
<td>The need to determine assertively and proactively, the:</td>
</tr>
<tr>
<td></td>
<td>• policy products to be delivered and when (advice, written material); and</td>
</tr>
<tr>
<td></td>
<td>• long term outcomes to be achieved.</td>
</tr>
<tr>
<td>iii) Managing the policy process efficiently and effectively:</td>
<td>The need to determine assertively and proactively, the:</td>
</tr>
<tr>
<td></td>
<td>• selection of an appropriate process;</td>
</tr>
<tr>
<td></td>
<td>• efficient application of established structures and processes;</td>
</tr>
<tr>
<td></td>
<td>• selection of key stakeholders to consult;</td>
</tr>
<tr>
<td></td>
<td>• evidence and research to be applied;</td>
</tr>
<tr>
<td></td>
<td>• role and responsibilities in cross portfolio and intergovernmental negotiations;</td>
</tr>
<tr>
<td></td>
<td>• demands of the external environment;</td>
</tr>
<tr>
<td></td>
<td>• requirements for transitioning from policy formulation to implementation;</td>
</tr>
<tr>
<td></td>
<td>• role of review and feedback to ensure learning and improvement; and</td>
</tr>
<tr>
<td></td>
<td>• importance of strong analysis and writing.</td>
</tr>
<tr>
<td>iv) Managing individual and organisational capacity:</td>
<td>The need to determine assertively and proactively, the:</td>
</tr>
<tr>
<td></td>
<td>• human resources required to conduct the task (mobilise appropriate mix and amount of resources, allow sufficient time, deploy resources flexibly as projects change, ensure skills development); and</td>
</tr>
<tr>
<td></td>
<td>• infrastructure required to complete the task (assemble information, software, equipment).</td>
</tr>
<tr>
<td>v) Managing the external socio-political environment:</td>
<td>The need to recognise the influence of the external environment and implications on the policy making process and respond in order to position the organisation favourably to ensure that policy is developed efficiently and effectively.</td>
</tr>
</tbody>
</table>
Skilled and capable policy leadership at both senior and middle management levels is strengthened by the adoption of the four pre-conditions and are essential for aligning capacity and process for good health policy making.

The focus of the public administration literature has been mainly on examining policy making and the quality of policy advice: assessing policy capacity; evaluating specific aspects of process; and recommending strategies and mechanisms to strengthen policy capacity to improve policy making.

The Australian National Audit Office (2001), in its review of departmental quality management systems for policy advising, found that there was scope for strengthening management systems for providing policy advice by implementing consistently a range of procedures which were undertaken only implicitly, comprising promulgating appropriate guidance on all elements of the policy process; conducting and documenting key management activities including risk assessments, timetables, information requirements and consultation plans; documenting key discussions and decisions; establishing explicit criteria for evaluating the quality of advice both for obtaining ministerial feedback and assessing the performance of policy advising staff; developing a culture of continuous improvement by periodically capturing and applying feedback of a range of stakeholders and lessons learned by the policy team; developing a strategic perspective on policy advising requirements in corporate and business plans by identifying where policy development may be required to meet future needs or to respond to current problems; and awareness that maintaining staff skills was a key risk to capacity to deliver quality policy advice and that this risk should be reflected specifically in corporate and business plans to ensure appropriate recruitment and staff development programmes.

While the focus of such reviews has been on policy making, other government literature on public administration and the scholarly literature have referred to leadership and management as one of a number of factors contributing to improved policy making in the public sector.

**Leadership skills and competencies/roles and responsibilities**

There is a large body of government literature on generic leadership roles and responsibilities, and competencies in public administration. This is evident in the following Canadian and Australian public sector leadership capability frameworks:
In *Public Service Leadership: Emerging Issues*, a report for the Australian Public Service Commission, the National Institute for Governance (2003, p. 4) adopt a definition of leadership that encapsulates the individual competencies and qualities required for effective leadership in an organisational context:

> The capacity at both the individual and institutional levels to: identify and define organisational goals and desired outcomes; develop strategies and plans to achieve those goals and deliver those outcomes; and guide the organisation and motivate its people in reaching those goals and outcomes. This requires energy, commitment, persistence, integrity, intelligence and a capacity to inspire from the leader and the encouragement of these attributes from the organisation.

The report observes that while it is possible for an individual to be a good manager, through effective management of resources to deliver already determined outputs, without necessarily being a good leader, it is unlikely that an effective senior manager would be able to operate without at least some attributes of leadership. Similarly, a good leader does not necessarily need to be a highly accomplished manager of resources, projects or programs, but is unlikely that such an individual would be able to effectively identify and define organisational goals and desired outcomes without having a reasonable understanding of managerial possibilities and constraints in implementation.

The report poses the public administration leadership challenge as being to develop, resource and maintain leadership capacity that can organise thinking and analysis around the policy problems of contemporary government: applying skills of strategic planning, analysis and forecasting to both policy matters and the organisational and performance issues of program design and delivery; and motivate staff and organise resources, structures and systems effectively to achieve strategic objectives and outcomes. However, the report acknowledges that such a range of abilities and experience is rarely found in a single individual. It becomes a matter of deploying these capacities across the leadership cohort, as an organisational leadership capacity. In this sense policy leadership capacity needs to be developed in the system as a whole.

More specifically, the Canadian Public Service (Treasury Board of Canada Secretariat, 2006) leadership competencies profile details leadership skills, abilities and characteristics, and behaviours needed by managers in the public service to meet current and future challenges. In addition to determining suitable competencies and behaviours, it establishes
desirable leadership values and ethics, and provides the standard against which executive candidates are assessed.

This approach to leadership skills and behaviours is mirrored in the Australian Public Service (APSC, 2009a), Integrated Leadership System, which expands the Senior Executive Leadership Capability framework that is based on five core capability clusters, and provides a set of tools to assist in professional development, capability planning and agency succession management. Accompanying this is the Leadership Pathway that identifies and describes leadership capabilities and behavioural elements for leaders at each stage of their career path.

Although these Australian and Canadian capability frameworks are comprehensive in terms of detailing leader competencies, characteristics, behaviours, and roles and responsibilities by level they are designed to focus on leadership in general and are therefore limited in the attention given to policy leadership and health policy leadership in particular. They do, however, provide a framework for understanding and identifying the competencies, characteristics, standards of behaviour, and roles and functions required of each level of middle and senior public service management.

There is limited public administration government literature reporting specifically on public sector policy leadership competencies. The New Zealand Review of Expenditure on Policy Advice (2010, p. 37) stated there is no concrete body of work defining policy manager and leader competencies to which public service leaders can refer; senior executives (many chief and deputy chief executives of core public service agencies) are unable to address policy questions because of a lack of policy experience; and managerial oversight of the policy programme is ineffectual, resulting in poor quality policy. In response, they recommended the recruitment of chief executives and policy leaders with appropriate policy-related competencies, skills and attributes.

In regard to the scholarly literature, Van Wart (2005, p. xiii) presents a comprehensive review of public sector leadership from the perspective of leader competencies and a comparative review of the theoretical literature. In this analysis of leadership, a ‘leadership action cycle’ model breaks down the leadership process into five major elements: leadership assessments; leader characteristics; leader styles; leader behaviours and leader evaluation and development. Van Wart (2005, pp. 123-124, 153) then
identified a range of leader characteristics and practical competencies required by, and
traits considered suitable for public sector leaders: practical competencies were
communication, social, influence, analytical, technical, and continual learning skills; traits
included self-confidence, decisiveness, resilience, energy, need for achievement,
willfulness to assume responsibility, flexibility, service mentality, personal integrity, and
emotional maturity.

Van Wart’s (2005) focus is the broad field of public sector leadership whereas the study
examines leadership from the perspective of policy environments in health bureaucracies.
Notwithstanding the different contexts, a number of policy leadership competencies
identified in the study (knowledge of context and content, strategic, technical, people
management, change management), are similar to those (communication, social, influence,
analytical, technical, and continual learning) identified by Van Wart. The competencies
that differed, for example ‘social’, were found in another category in the study’s findings,
namely, personal skills - ability to communicate and interact with people. Similarly, the
personal attributes (ethical, acumen, decisive, agile, resilient and flexible) identified by
this study could be interpreted as equivalent to Van Wart’s (2005, pp. 123-124) traits of
self-confidence, decisiveness, resilience, energy, need for achievement, willingness to
assume responsibility, flexibility, service mentality, personal integrity, and emotional
maturity. Although Van Wart identifies a larger list of traits for leadership in public
office, the attributes identified in this study are similar to Van Wart’s, with some either
assumed (service mentality, self-confidence) or subsumed (energy, need for achievement)
in another category.

The study also identified the main roles and responsibilities of policy leadership including
providing strategic direction, managing and supporting staff, in terms of appropriate
resources and adequate time, managing the policy process, and managing change;
acknowledging that the emphasis placed on roles and responsibilities for policy leadership
were perceived differently by senior and middle level managers. While Van Wart did not
have a specific category for roles and responsibilities under the ‘leadership action cycle’
model, some of the elements identified by the study under this heading could be found in
Van Wart’s category of ‘leader behaviours’; for example, managing change was
recognised as managing innovation and creativity’, managing ‘personnel change’ and
managing ‘organizational change’; and managing the policy process was included in Van
Wart’s task-oriented and people-oriented behaviours categories.
Gustafson (2008, pp. 107-109) in his biographical study of New Zealand political leaders, applied Burns’ transformational and transactional leadership categories, to analyse types and styles of leadership. He identified a number of qualities and styles possessed by individual leaders, including vision and direction; reliance on ‘one’s instincts’ and not just informed intellect; an ability to balance knowledge versus feel for public opinion; understanding of people as well as policies and processes; adept at using rhetoric, bargaining and manipulation; and recognising the need for change but balancing that with stability and security. Adding that leadership in public office is about ‘co-production’ of interacting with others and harnessing their capabilities ‘to get things done’.

Whilst recognising that Gustafson is referring to individual leadership qualities and styles required in a political environment (senior politicians) there are some similarities to those leadership features required in high office in a bureaucratic environment, namely, vision and direction, recognising the need for change, and the need to interact with others to achieve outcomes. Some of the features are consistent with the study findings although there are a few differences, which are more appropriate to a political role, such as, a reliance on public opinion to influence decision making, balancing the need for change with voter satisfaction, and skills in using rhetoric, bargaining and manipulation.

**Leadership skills and competencies – policy-specific**

The only scholarly work known to the author that examines ‘policy leadership’ in health policy environments is Gleeson (2009) and Gleeson et al. (2009). Gleeson’s (2009) empirical research distinguished ‘policy’ leadership from ‘generic’ public administration leadership, arguing that ‘policy leadership’ in a health authority involved local level judgment, mentorship, initiative and responsibility, and the ability to mobilise organisational resources to build policy capacity.

Although Gleeson’s research is not primarily about policy leadership competencies, rather identifying the strategic importance of developing senior and middle level policy leadership as a means for strengthening organisational policy capacity, the study supports and extends Gleeson’s work, confirming the different qualities that distinguish generic from policy leadership arising from the nature and orientation of policy work, the collegiate approach to policy making, the need for awareness of the external environment, and the need to ensure a culture of learning and improvement; and identifying the differing
roles, responsibilities and competencies required of senior and middle level management in policy environments.

While the study findings support Gleeson’s efforts at differentiating ‘policy’ leadership from ‘generic’ public administration leadership, and the proposition that developing senior and middle level policy leadership is essential to strengthening organisational policy capacity, it goes further in arguing that policy leadership and management in health environments perform a vital role in managing policy capacity and process in order to achieve quality policy outputs that lead to good health outcomes. The findings reinforce the important role that policy leadership and management perform in aligning capacity and process by defining policy leadership; identifying barriers and challenges to leadership and management in aligning capacity and process; identifying roles and responsibilities of management and senior and middle level leadership; and determining competencies required for policy leadership.

Although the scholarly and government literature examine competencies for ‘generic’ public sector leadership and management, it does not deal specifically with ‘policy’ leadership. The government literature has dealt mainly with reviewing public administration in general, with a limited focus on policy making and the quality of policy advice in particular: assessing policy capacity; evaluating specific aspects of process; and recommending strategies and mechanisms to strengthen policy capacity to improve policy making. While the scholarly literature on leadership and management is diverse, depending on the focus of the research: leadership qualities and behaviours; leadership styles; leadership biographies and case studies; leadership development; and leadership in different settings and sectors, comprising political, administrative, non-government, health, education and the environment.

The study endeavours to fill this gap by identifying appropriate competencies required for effective ‘policy’ leadership and management in Australian health authorities by taking a different approach to both the government and scholarly literature by differentiating between ‘generic’ and ‘policy’ leadership and management in health policy environments; distinguishing between the perspectives of senior managers and middle level policy practitioners on the challenges and barriers to leadership and management; and distinguishing between the competencies, and roles and responsibilities of senior and middle level leadership and management.
The study argues that policy leadership is a vital component of organisational policy capacity and an essential factor in managing effective policy making through the alignment of policy capacity and process. The study identifies the barriers and challenges to policy leadership and the roles and competencies for effective policy leadership; and argues that policy leadership has an essential role in establishing the organisation’s strategic direction, influencing organisational culture, mobilising resources and infrastructure, managing processes efficiently and effectively, interacting with and managing the external environment, and managing and supporting staff toward the development of good policy outputs to achieve good policy outcomes.

8.4 CONCLUSION: A SYSTEMS APPROACH TO UNDERSTANDING POLICY WORK

The study concludes that adopting a ‘systems’ approach to policy work in which the health policy environment is conceived as comprising multiple interrelated elements contributes toward development of a more comprehensive understanding of health policy making in Australian health policy environments.

The conceptual framework applied by this study has examined policy work in health authorities in terms of:

- the elements underpinning health policy, comprising
  - policy capacity, understood to include individual capabilities and organisational infrastructure and supports;
  - policy process, understood as the activities of policy work;
  - policy review and monitor, interpreted as the functions of feedback, reflection and improvement;
  - policy outputs, understood as a tangible product and or completion of a process;
  - policy outcomes, understood as the result or consequence of a policy output;
  - the external environment understood as socio-political structures, health system structures, and stakeholder interests.

- the interrelationship of the elements of capacity, process, outputs, outcomes, review and monitor, and the external environment.

The application of a ‘systems’ perspective to the work of policy in a health context acknowledges the complexity, uncertainty and unpredictability of the health system in terms of social, economic and political challenges such as the interconnected and
multidimensional nature of health problems and issues, with no clear-cut solutions; the participation of multiple and competing stakeholders in shaping health policy; and the health system’s capacity to respond and adapt in a timely manner.

The study proposes adoption of a ‘systems’ perspective by Australian health authorities in policy practice, leadership and management, and staff development and training to improve knowledge and understanding of the work of policy in a health policy environment toward achieving better policy outcomes; in conjunction with ongoing action research to improve policy practice.

Looking to the future: Applying the research model

FURTHER ACTION RESEARCH

The research model lends itself to further testing and empirical research of policy work in Australia and other countries in order to better understand the elements of and relationships between capacity, process, outputs, outcomes, review and monitor, and the influence of the external environment.

This will enable testing of the relationships between the elements of health policy work in Australia and other countries, and or relationships between specific policy elements (e.g. policy capacity and the socio-political environment). The research should have an applied focus, with the findings to inform the practice of policy work.

It is proposed that a number of joint action research projects could be established investigating the application and testing of a systems perspective to health policy development, implementation and evaluation in complex and dynamic environments. The research should involve, in addition to academic institutions, health policy organisations with responsibility for policy development and implementation.

The ‘systems’ approach provides a framework for proposing a number of research questions to extend the findings of this study in the specific areas of policy leadership and the policy development and implementation relationship.

Policy leadership

1. Could the leadership competencies for, roles, responsibilities and styles of generic and health policy leadership be tested and confirmed?
2. Could a systems approach be applied to promote a culture and environment for good policy development, implementation and evaluation?

*Policy development and implementation relationship*

3. Could the nature and type of the relationship between policy development and implementation be identified?

4. Could the challenges to aligning the functions of policy development and implementation be identified?

5. Can it be established that the function of policy review and monitor has a vital role in ensuring the alignment between policy development and implementation?

The ‘systems’ approach contributes to a better understanding of the work of health policy in Australian jurisdictions, and the findings arising from the above action research will provide additional support for the usefulness of the research model.

**TEACHING**

The ‘systems’ approach, represented by the research model, enhances our theoretical understanding of policy work and could be perceived as a useful framework for curriculum development in the teaching of public health policy.

In the ‘systems’ approach to health policy, students are provided with a conceptual framework for developing an understanding of the elements of and relationships between capacity, process, outputs, outcomes, review and monitor, and influence of the external environment; and an appreciation of the different elements that constitute policy work, some of which are overlooked in existing courses, such as, policy capacity, review and monitor, influence of the external environment and achievement of outputs and outcomes.

These educational opportunities, based on a ‘systems’ approach, has the potential to provide future practitioners with an enhanced theoretical knowledge of policy work which may lead to improved policy making practice in Australian health authorities.

**LEADERSHIP AND MANAGEMENT**

In recognition of the central role that leadership and management plays in producing high quality policy outputs and effective policy work it is important for senior and middle managers to have a sound knowledge and understanding of the complexities of policy
work and the underpinning elements and relationships. As a result, multiple approaches are proposed, on the one hand, enhancing existing organisational structures and processes and, on the other hand, putting forward a new approach to leadership and management.

The ‘systems’ approach to policy making could be built into the organisation’s leadership training and development programmes in Australian health authorities, with a policy-specific focus embedded within each programme. A leadership development programme, using a ‘systems’ approach, should include: basic ‘systems’ thinking, principles and application; the work of policy in terms of capacity, process, outputs, outcomes, review and monitor, and the external environment; as well as, systems, structures and processes that underpin policy decision making and action. Leadership development of both senior and middle levels is considered equally important, with development of both levels leading to enhanced knowledge and understanding of policy making processes and outcomes, and improved leadership overall.

A ‘systems’ approach for enhancing leadership and management should be incorporated into the organisation’s systems for performance appraisal, continuous quality improvement and other accountability mechanisms; recognising that effective policy leadership in Australian health authorities is best realized by a team-based and shared approach to achieving good policy outcomes. This could be attained by establishing Policy Leadership Teams, comprising different levels of senior and middle management, within which there are multiple positions with different functions and responsibilities. In recognition of the nature of policy work and staff’s educational backgrounds, knowledge and skills, and their ability to operate autonomously, most would benefit from a team-based leadership style to organising and conducting policy work.

The Policy Leadership Team approach creates, within a supportive environment, a nucleus of policy leadership that has the potential for increasing the organisation’s focus on policy making and the achievement of high quality policy and lead to improved population health outcomes.

Adoption by the Policy Leadership Team of a ‘systems’ perspective to the work of policy, in terms of the interrelationships between capacity, process, outputs, outcomes, review and monitor, and the external environment, has the potential to enhance the quality of policy
making by acknowledging the pivotal role of leadership in aligning the elements that underpin and influence policy work.

The combination of the above approaches to policy leadership and management has the potential to establish an organisational culture and environment that support efficient, effective and high quality health policy.

**Practice of Policy Making**

A number of new initiatives could be introduced and or built on existing structures and processes that provide policy practitioners with information about a ‘systems’ approach to understanding policy work as well as a range of opportunities for professional development that will assist them in the practice of policy making.

In the study, the emphasis is on the provision of professional development opportunities for policy practitioners, based on experiential rather than theoretical learning principles. Experiential learning was also adopted as the basis for stage 2 of the ARC Linkage project to explore a number of professional development interventions.

One professional development opportunity would be the appointment of a mentor, experienced senior policy manager, who applies a ‘systems’ approach to conducting policy work, with the practitioner learning by participation and observation. Another approach would be the conduct of small group-based learning opportunities, such as learning sets, communities of practice and forums, which examine and discuss real-life policy examples to enhance their policy making skills. The introduction of these professional development opportunities, embedded within the systems, structures and processes of the health authority, has the potential to foster a continuous learning and development culture essential to good policy practices.

These learning and development opportunities will provide practitioners with an improved understanding of policy work in terms of the underlying elements and their relationships that will lead to better policy making practice.

The research model conceives health policy work as a complex and integrated system in which policy capacity, process, outputs and outcomes, monitor and review, and the external environment are interrelated elements; and provides a comprehensive and
practical framework for understanding, explaining and interpreting the complexity of policy work and has the potential to influence policy practice, leadership and management, teaching, and action research in Australian health authorities.
Appendix 1: INVITATION TO PARTICIPATE IN FOCUS GROUPS

[DATE]

Dear [NAME],

You are invited to participate in a focus group interview for a research project titled ‘Developing new methods for building health policy capacity in Australia’.

The project is an initiative of the Australian Institute of Health Policy Studies (AIHPS) and is funded by an Australian Research Council - Linkage Grant. Partner organisations include seven universities (led by La Trobe University) and three Australian health departments (ACT Health, Queensland Health and Department of Health South Australia). The project aims to strengthen Australia’s capacity in health policy development, implementation and evaluation, by developing new methods and approaches for capacity development.

The details for the focus group discussion are as follows:

- **Date:** Thursday 27th November
- **Time:** 2.00 - 4.00 pm
- **Venue:** Staff Lunch Area 1, Level 2, Adelaide CitiCentre, 11 Hindmarsh Square
- **Facilitator:** Alison Hughes (PhD Candidate)
- **Note-taker:** Deborah Gleeson (Research Fellow)
- **Refreshments:** will be served at the session.

The purpose of the focus group interview is to develop practical strategies and interventions for building future policy capacity based on your personal experiences of policy development and implementation.

We would appreciate it if you could spend a few minutes thinking about the following issues prior to participating in the focus group interview:

- Select a policy episode or project you have been involved in, that you would be prepared to share with the group
- What was good (or not so good) about the policy process?
- What was it about the a) context and/or b) knowledge and skills of people that contributed to a good (or not so good) policy process?
- What sort of practical initiatives/interventions would you like to see to develop policy capacity?

We do not expect you to ‘know the answers’ to these questions but hope that you will bring some of your own experiences to share with the group as we think together about how the policy making process can be improved.

Attached is an overview of the research project and a participant information and consent form. Please read the participant information and consent form prior to the interview. A copy will be provided for you to sign on the day. On the second page of this letter are two
checklists which may assist you in thinking about policy capacity in your organisation and how it can be improved.

If you would like clarification and/or further information please contact either Deborah Gleeson on 0423 209 029 (email d.gleeson@latrobe.edu.au) or Alison Hughes on 0419 300 862 (email hughes33@bigpond.net.au)

Regards

Deborah

Deborah Gleeson
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Ph. 9479 3262
Mob 0423 209 029

Alison

Alison Hughes
PhD Candidate
School of Public Health
La Trobe University VIC 3086
Mob 0419 300 862
Appendix 2: INVITATION TO PARTICIPATE IN INDIVIDUAL INTERVIEWS

[Title]
[Address]

[Date]

Dear [Name]

You are invited to participate in an individual in-depth interview for the research project titled 'Developing new methods for building health policy capacity in Australia'.

The project is an initiative of the Australian Institute of Health Policy Studies (AIHPS) and is funded by an Australian Research Council - Linkage Grant. Partner organisations include seven universities (led by La Trobe University) and three Australian health departments (ACT Health, Queensland Health and Department of Health South Australia).

The project aims to strengthen Australia's capacity in health policy development, implementation and evaluation, by developing new methods and approaches for capacity development. The need for strengthening health policy capacity is widely recognised, however there is currently little empirical evidence on which to base health policy capacity building initiatives.

The details for the individual interview are as follows:

- **Date:** 28 May 2009
- **Time:** 3.00 – 4.30 p.m.
- **Venue:** ACT Health, Canberra City (Level 3/your office)
- **Interviewer:** Alison Hughes

Attached is an overview of the research project, and Participant Information and Consent Form 2: Individual Interviews. Please read the participant information and consent form prior to the interview. A copy will be provided for you to sign on the day.

The purpose of the individual interview is to capture the perspectives and opinions of senior managers in the Department of Health on a range of policy capacity issues at both the individual and organisational levels. Some of the issues the research is interested to explore include:

- the major external influences on policy making
- the existing policy capacity of the Department, at both individual and organisational levels
- the knowledge and skill sets that senior managers seek and/or would like to further develop in their policy staff
- the role of leadership for good policy making, implementation and evaluation
leadership for policy making: is it different or distinctive from generic leadership?
the barriers to and facilitators of policy capacity in the Department
the way/s in which you addressed the barriers (using an example) to build policy capacity
the practical strategies/interventions required by the Department to strengthen policy capacity by a) developing policy knowledge and skills of the individual and b) developing organisational capacity.

To get a feel for the topics to be covered in the interview, you may be interested in reading a literature review paper written by members of our research team entitled 'Evaluating policy capacity: learning from international and Australian experience' published in Australia and New Zealand Health Policy: http://www.anzhealthpolicy.com/content/6/1/3

It is intended that these interviews will provide different perspectives on policy capacity from those of middle and lower-senior level policy staff obtained from focus group interviews. Information from these interviews will be combined with data obtained from focus group interviews, a web-based survey, and national workshop to assist the research team in identifying practical strategies and interventions for strengthening policy capacity in health jurisdictions.

Alison Hughes, PhD candidate, La Trobe University will conduct the interview. If you would like clarification and/or further information please do not hesitate to contact Alison on either telephone: 0419 300 862 or email hughes33@bigpond.net.au

Yours Sincerely

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Appendix 3: PARTICIPANT INFORMATION AND CONSENT FORM FOR FOCUS GROUP AND INDIVIDUAL INTERVIEWS

Title of Project: Developing New Methods for Building Health Policy Capacity in Australia

Principal Researchers:
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Ms Alison Hughes
Doctor of Philosophy Candidate
Principal Supervisor: Professor Vivian Lin
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Ph. 03 9479 3262
This Participant Information and Consent Form is seven (7) pages long. Please make sure you have all the pages.

Please read this Participant Information carefully. Once you understand what the project is about and if you agree to take part in it, you will be asked to sign the Consent Form. By signing the Consent Form, you indicate that you understand the information and that you give your consent to participate in the research project. You will be given a copy of the Participant Information and Consent Form to keep as a record.

**Aims**

Strong policy capacity is essential if the health sector is to effectively address a range of complex problems. In order to build capacity for good policy making we need to know more about the elements of policy capacity and what types of capacity building strategies would be likely to work.

This project aims to:

(i) evaluate and compare health policy capacity (ie. the organisational and practitioner capacity to develop, implement and evaluate health policy) in three Australian state health jurisdictions; and

(ii) evaluate a series of different strategies to enhance health policy capacity (eg learning sets, short courses, mentoring and organisational development).

These strategies will contribute to future capacity building and inform health policy training, with the aim of contributing to more effective health policy in Australia.

**Participants**

The project will be conducted within three State health departments (ACT Health, Queensland Health and the South Australian Department of Health). Approximately 150 people will participate in this project.

You are invited to participate in this research project because you are a policy practitioner (someone who is engaged in policy work) in the health sector. Your insights into organisational and practitioner health policy capacity will be valuable for this research.

You may have been identified for potential participation in this research by a supervisor, however your relationship with your supervisor will not be adversely affected in the event of your decision not to participate. If you decline to participate, you will not suffer any negative consequences in the workplace such as unfair discrimination in the workplace or unfair dismissal.

**Funding**

This project has been funded by the Australian Research Council as a Linkage Project.

**Procedures: Stage 1 Focus group interviews**

If you agree to participate in this research project, you will be asked to participate in a focus group interview of approximately one to one and a half hours’ duration. Focus groups will discuss current policy practice, organisational capacity for policy work, policy practitioner competencies and training needs, different approaches to capacity development and possible target groups for capacity building interventions. The focus group interviews will be audio recorded and transcribed.
Possible Risks
Possible risks include breaches of policy confidentiality or breaches of individual confidentiality. Such breaches could result in negative consequences such as embarrassment or distress.

These risks will be minimised by de-identification of the data before it is seen by any employee of the State health departments (researchers or members of the project reference group). Focus group participants will be asked to agree to maintaining confidentiality of any matters discussed during the focus group interviews.

All research data will remain confidential, however participants are advised that they need to be mindful of their duties of confidentiality with respect to specific policy or workplace issues within their organisation.

You can suspend or even end your participation in the project at any time.

Use of the data
If you give us your permission by signing the Consent Form, we plan to communicate the results of the project through State health department publications and seminars; through journal publications and presentations at appropriate meetings and conferences; and through seminars, websites and publications of the participating universities. Data used for reporting and publications may be in hard copy or electronic form. The results of this research may also be incorporated into a PhD student’s thesis.

During the project, the data will be stored in a locked filing cabinet in the office of the student researcher and/or the senior research associate (in the School of Public Health at La Trobe University). Data will be de-identified before storage. The student researcher and/or senior research associate will have sole access to the filing cabinet. After the completion of the project, the data will be stored in the research data archives of the School of Public Health for seven years from the date of publication. At the end of this period the data will be destroyed.

You may request a copy of your personal data collected in the course of the research by contacting Ms Deborah Gleeson on (03) 9479 1750 or Professor Vivian Lin on (03) 9479 1717.

A plain English summary of the results from the study will be made available to you at the end of the project. You will be contacted by the researchers to arrange this. This summary will also be distributed through your department.

Any information obtained in connection with this project and that can identify you will remain confidential. It will only be disclosed with your permission, except as required by law.

Data will be de-identified before being viewed by members of the research team who are also employees of State Health Departments. De-identification will involve removing names and any other details from the data that might reasonably identify you personally. Participants in focus groups will be asked to strictly maintain the confidentiality of any information shared in the groups.

Whilst every effort will be made to protect your anonymity, due to the small number of people participating in some parts of this project it is possible that you may be identifiable as a participant. If this becomes a concern to you at any stage during the project you may withdraw and ask that data arising from your participation is not used.
In any publication, information will be provided in such a way that you cannot be identified.

**Possible Benefits**

The benefits of this research are likely to accrue to members of society in the future as a result of more effective policy development.

However possible benefits to the participants include professional development as a result of the opportunity to reflect on your practice. Some participants may have the opportunity to participate in professional development activities that offer personal and professional benefits such as the acquisition of new skills.

We cannot guarantee or promise that you will receive any benefits from this project.

**Further Information or Any Problems**

Any questions or complaints regarding this project may be directed to Deborah Gleeson of the School of Public Health, La Trobe University on (03) 9479 1750.

If you have any complaints or queries that the investigator has not been able to answer to your satisfaction, you may contact the Secretary, Human Ethics Committee, Research and Graduate Studies Office, La Trobe University, Victoria 3086 (ph. 03 9479 1443, email: humanethics@latrobe.edu.au).

Any complaints received by the researchers will be directed to the La Trobe University Human Ethics Committee in the first instance but the ethics committee at each participating institution will also be notified.

If you prefer, you may contact the ethics committee at one of the participating institutions in your State as follows:
South Australia

Executive Officer, Department of Health Human Research Ethics Committee
Research, Policy and Ethics Unit
Department of Health
Level 10, City Centre Building
PO Box 287
Rundle Mall
Adelaide SA 5000
Ph. 08 82266367

Ms Vicki Allen
UniSA Ethics Officer
Research and Innovation Services
University of South Australia
Mawson Lakes Campus
Mawson Lakes Boulevard
Mawson Lakes SA 5095
Ph. 08 8302 3118, Fax: 8302 3921
Email: Vicki.allen@unisa.edu.au

Queensland

Queensland Health Research Ethics Committee
HREC Administrator
Level 18, 147-163 Charlotte Street
GPO Box 48, Brisbane Qld 4001
Ph: 07 3234 0034

Research Ethics Support Officer
Research Ethics Office
Queensland University of Technology
Office of Research
GPO Box 2434
Brisbane 4001
Ph. 07 3138 5123

Ethics Officer
Office of Research and Postgraduate Studies
University of Queensland
Cumbrae-Stewart Building (#72)
BRISBANE QLD 4072
Tel: 07 336 53924

ACT Health

ACT Health Human Research Ethics Committee
Research Office
11 Moore Street
Canberra City ACT 2601
Ph. 02 6205 0846
Participation is Voluntary

Participation in any research project is voluntary. If you do not wish to take part you are not obliged to. You have the right to withdraw from active participation in this project at any time and further, to demand that data arising from your participation are not used in the research project provided that this right is exercised within four weeks of the completion of your participation in the project. You may also request that your data be destroyed.

There are no disadvantages, penalties or adverse consequences for not participating or for withdrawing from this research. Your decision whether to take part or not to take part, or to take part and then withdraw, will not affect your relationship with your employer or colleagues.

If you decide to withdraw from this project, you are asked to complete the “Revocation of Consent Form”. Please notify a member of the research team before you withdraw.

This project will be carried out according to the National Statement on Ethical Conduct in Research Involving Humans (June 1999) produced by the National Health and Medical Research Council of Australia. This statement has been developed to protect the interests of people who agree to participate in human research studies.
Consent Form: Focus group interviews

Project Title: Developing New Methods for Building Health Policy Capacity in Australia

I (the participant) have read and understood the participant information sheet and consent form, and any questions I have asked have been answered to my satisfaction.

I agree to participate in the focus group interviews for this project, realising that I may physically withdraw from the study at any time and may request that no data arising from my participation are used, up to four weeks following the completion of my participation in the research.

I realise that whilst every effort will be made to protect my anonymity, it is possible that I may be identifiable as a participant in this research.

I agree that research data provided by me or with my permission during the project may be included in a thesis, presented at conferences and published in journals on the condition that neither my name nor any other identifying information is used.

Name of Participant (block letters):
Signature Date

Name of Investigator (block letters):
Signature Date

Name of Student Supervisor (printed)………………………………………………
Revocation of Consent Form

Project Title: Developing New Methods for Building Health Policy Capacity in Australia

I hereby wish to WITHDRAW my consent to participate in the research proposal described above and understand that such withdrawal WILL NOT jeopardise any treatment by, or relationship with, my employer.

Participant’s Name (printed) ..............................................................

Signature ............................................................... Date
Appendix 4: **Overview of Australian Research Council - Linkage Research Project**

Developing New Methods for Building Health Policy Capacity in Australia

**Project Summary**
INTRODUCTION

The Australian Institute of Health Policy Studies (AIHPS) has been funded by an Australian Research Council - Linkage Grant from 2007-2010 to undertake a collaborative action research project to develop new methods for building health policy capacity in Australia.

The project will be managed and coordinated by La Trobe University, in collaboration with the AIHPS Executive Office. A multidisciplinary team of investigators from partner University and Health Jurisdictions will participate in the research project:

<table>
<thead>
<tr>
<th>NAME</th>
<th>ORGANISATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professor Vivian Lin</td>
<td>La Trobe University</td>
</tr>
<tr>
<td>(Principal Investigator)</td>
<td></td>
</tr>
<tr>
<td>Associate Professor David Legge</td>
<td>La Trobe University</td>
</tr>
<tr>
<td>(Principal Investigator)</td>
<td></td>
</tr>
<tr>
<td>Professor Kathy Eagar</td>
<td>University of Wollongong</td>
</tr>
<tr>
<td>Associate Professor Marylou Fleming</td>
<td>Queensland University of Technology</td>
</tr>
<tr>
<td>Professor Wayne Hall</td>
<td>The University of Queensland</td>
</tr>
<tr>
<td>Professor Robyn McDermott</td>
<td>The University of South Australia</td>
</tr>
<tr>
<td>Professor Brian Oldenburg</td>
<td>Monash University</td>
</tr>
<tr>
<td>Dr Deidre O'Neill</td>
<td>Australia and New Zealand School of Government</td>
</tr>
<tr>
<td>Mr Ian Thompson</td>
<td>ACT Health</td>
</tr>
<tr>
<td>Professor Andrew Wilson</td>
<td>Queensland Health</td>
</tr>
<tr>
<td>Dr David Filby</td>
<td>Department of Health (South Australia)</td>
</tr>
<tr>
<td>Ms Deborah Gleeson</td>
<td>La Trobe University (Research Fellow)</td>
</tr>
<tr>
<td>Ms Alison Hughes</td>
<td>La Trobe University (PhD Candidate)</td>
</tr>
</tbody>
</table>

*Note: The above listed team together with an external international researcher will comprise the Reference Advisory Group [Refer to section on Project Approach].

PROJECT OVERVIEW

Aims and Objectives
The project aims to strengthen Australia's capacity in health policy development, implementation and evaluation, by developing new methods and approaches. The need for strengthening health policy capacity is widely recognised, however there is currently little empirical evidence on which to base health policy capacity building initiatives.

The project will describe and compare health policy capacity in three state/territory health jurisdictions (ACT Health, Queensland Health and Department of Health South Australia) as a basis for developing, implementing and evaluating new capacity-building strategies. More specifically, the objectives of the project are to:

- describe and analyse existing health policy capacity in each of the three state/territory health jurisdictions;
• evaluate and compare health policy capacity (i.e. the organisational and practitioner capacity to develop, implement and evaluate health policy) in three Australian state/territory health jurisdictions;

• evaluate a series of different strategies to enhance health policy capacity in the three state/territory health jurisdictions; and

• design and develop a capacity building framework and customised strategies responsive to the specific needs of each state/territory health jurisdiction.

WHAT DO WE MEAN BY POLICY CAPACITY?

The term ‘policy capacity’ is generally used to describe the conditions for ‘good’ policy making in government. It is a concept that lacks a clear and generally accepted meaning. Definitions in the literature highlight a number of different dimensions of policy capacity, including:

- the ability to make intelligent, collective decisions;
- the ability to mobilise resources to support policy making;
- the ability to implement policy; and
- the ability to coordinate policy making across government (Aucoin & Bakvis, 2005; Davis, 2000; Janicke, 1997; Painter & Pierre, 2005; Parsons, 2004; Peters, 1996)

In the past, efforts to build capacity were often focused on training individuals. Capacity is now, however, understood to be a multi-level phenomenon. A recent OECD paper on capacity development (OECD, 2006) describes three levels of capacity: the individual (knowledge and skills); the organisation (structures, processes and cultures); and the enabling environment (the environment external to the organisation, including the bigger systems in which organisations are embedded). In this project we are interested in exploring policy capacity in terms of the enablers of, and barriers to, good policy process at each of these levels.

A study of policy process and policy capacity currently underway in the Victorian Department of Human Services (Gleeson, n.d.) identified the following domains of organisational and individual policy capacity:

<table>
<thead>
<tr>
<th>Organisational capacity</th>
<th>Individual competencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supply of and capacity to generate information and evidence</td>
<td>Knowledge sets</td>
</tr>
<tr>
<td>Adequate supply of highly skilled policy personnel and appropriate skill mix in policy units; supported by personnel management and workforce development practices</td>
<td>Knowledge of context, including the health system and its dynamics, and the public sector environment</td>
</tr>
<tr>
<td>Coordination within and between departments and between different levels of government</td>
<td>Knowledge of a range of disciplines</td>
</tr>
<tr>
<td></td>
<td>Knowledge of the policy development process</td>
</tr>
<tr>
<td></td>
<td>Knowledge of systems and developments in other countries</td>
</tr>
</tbody>
</table>

Skills sets
• Closer links between policy development and implementation
• Formal and informal relationship with internal and external stakeholders, including capacity for timely and comprehensive consultation
• Systematic and integrated processes for monitoring, evaluation and review
• Policy leadership (overall direction and policy frameworks); strategic management of the policy process; and a supportive institutional culture

• Conceptual skills, including: analytic skills; strategic and political skills, and judgement (with respect to politics, policy and people)
• Generic skills, including: communication and interpersonal skills, relationship building and management, project management skills, writing skills and research and data analysis skills

**Other attributes**
• Commitment to outcomes

The current project will investigate the applicability of these domains in different organisational and system contexts.

**PROJECT APPROACH**

The research project will utilise the following mix of qualitative methods, and will be conducted in two stages, over a three year period.

**Stage 1:** *Comparative Policy Capacity Assessment at Individual, Institutional and System Levels* involves analysing and comparing policy processes and policy capacity in each participating health jurisdiction (Qld, SA, and ACT), identifying current and preferred strategies for capacity development, and confirming target groups to be involved in capacity-building interventions. The focus of comparative policy capacity assessment in this stage will be directed at individual, institutional and system levels.

Stage 1 includes the following methods:

❖ **Focus group interviews** with managers of policy units and middle level policy analysts in each health jurisdiction to explore a range of issues: current policy practice, organisational policy capacity, policy practitioner competencies, perceived gaps/weaknesses and strengths/benefits, possible target groups for capacity building interventions, areas for policy capacity improvement, and approaches/strategies for future capacity development. The focus group interviews may be supplemented by individual interviews with senior managers.

❖ **Literature review** including literature on the policy process, policy analysis and policy capacity as well as relevant policy documents from each of the participating jurisdictions.

❖ **Web-based survey** of health policy practitioners and decision makers in each participating health jurisdiction (depending on the outcomes arising from the focus group interviews). Referred to Stage 2.

❖ **National workshop** will provide the means of assessing capacity development needs and developing possible interventions. The workshop will be aimed at project personnel.
and policy practitioners from each of the three levels involved in policy capacity assessment: senior executives, managers of policy branches and middle-level policy analysts.

Stage 2: Implementation and Comparative Evaluation of Capacity Building Interventions involves implementing and evaluating at least 3 capacity-building interventions identified in Stage 1 and then formally evaluating these as options for wider implementation and incorporation into academic programs/training. These capacity-building interventions will reflect the needs of individual jurisdictions and could include strategies such as short courses, mentoring and shadowing, learning sets (small facilitated groups of learners who support each other in their learning), and team-based leadership development and organisational development strategies.

❖ For the duration of the project, a Reference Advisory Group comprising one representative from each of the academic and health jurisdiction partner organisations of the Australian Institute of Health Policy Studies and an international researcher will provide expertise, guidance and a point of reference for the research project.

OUTCOMES

A number of outcomes are expected from the research project, including:

• report/s presented to the Australian Research Council
• published articles in peer-reviewed journals and chapters in books
• development of customised capacity-building interventions and strategies for implementation in the three health jurisdictions
• a PhD thesis

REFERENCES


Appendix 5:  Focus Group Schedule

Held on 20th November 2008

1. [INDIVIDUAL] Briefly outline a policy episode or project (either positive or negative). As the episode is being narrated, the key points/ideas will be written down on butchers paper under the following headings:
   - Policy Episode/Project
   - External Environment
   - Organisational Context
   - Individual knowledge & skills
   - Strategies for building capacity

   [Each Episode: Points x Heading on Butchers Paper]

2. [GROUP] Discuss policy capacity, in terms of the policy making environment, organisational conditions (structures, processes, cultures), and knowledge and skills of policy workers. When talking about these cases and from these examples:
   - What are the general principles about the sorts of conditions which are needed for good policy making?
   - What are the ‘enablers’ and ‘barriers’ to good policy making?
   (Checklist 1: Domains of organisational capacity)
   (Checklist 2: Individual capacity – competency fields)

   [Group: Identify key points on Butchers Paper]

3. [GROUP] Discuss the sorts of practical strategies (initiatives/ interventions) that would build policy capacity in your organisation. In the context of domains and propositions outlined in Checklists 1 & 2.
   (Checklist 3: Range of capacity building strategies)

   [Group: Identify strategies on Butchers Paper]

4. [GROUP] Discuss and identify the priority capacity building strategies for your organisation

   [Group: Determine priorities of strategies on Butchers Paper]
### Domains of organisational capacity [Checklist 1]

<table>
<thead>
<tr>
<th>Domain</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to, and use of, information and evidence</td>
<td>Ability to commission research; internal information systems; effective stakeholder relationships</td>
</tr>
<tr>
<td>People management</td>
<td>Access to professional development opportunities; appropriate skill mix; recruitment and retention; succession planning; career paths for policy personnel</td>
</tr>
<tr>
<td>Stakeholder relationships management</td>
<td>Relationships management skills and processes; communication channels</td>
</tr>
<tr>
<td>Intra-departmental, cross-portfolio and inter-governmental collaboration</td>
<td>Structures and processes for collaboration; incentives; communication fora</td>
</tr>
<tr>
<td>Links between policy development and implementation</td>
<td>Processes for engaging implementers in policy development; continuity of staffing</td>
</tr>
<tr>
<td>Policy evaluation and monitoring</td>
<td>Evaluation skills; culture; technical support; procedures</td>
</tr>
<tr>
<td>Management of the policy process</td>
<td>Norms and protocols; project management skills; project management tools and supports</td>
</tr>
<tr>
<td>Leadership</td>
<td>Skills for policy leadership; learning culture</td>
</tr>
</tbody>
</table>

### Individual capacity – competency fields [Checklist 2]

| Knowledge sets | Knowledge of the health system and its dynamics  
Knowledge of the departmental and public sector environment  
Knowledge from different disciplines  
Comparative and historical knowledge  
Knowledge of the policy process |
|----------------|------------------------------------------------------------------------------------------------------------------------------------------|
| Skill sets     | Conceptual and analytic skills  
Strategic and political skills  
Intuitive judgement  
Communication and interpersonal skills  
Project management skills  
Evaluation skills  
Writing skills  
Data analysis skills |
| Other attributes | Commitment to outcomes  
Other - resilience, persistence, creativity, problem solving; sense of humour |
### Range of capacity building strategies [Checklist 3]

<table>
<thead>
<tr>
<th>INDIVIDUAL</th>
<th>ORGANISATIONAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mentoring/Shadowing</td>
<td>Support a ‘learning culture’</td>
</tr>
<tr>
<td>Short courses (formal skills development e.g. ANZSOG, Research Institutes)</td>
<td>Human resources development: policy capacity</td>
</tr>
<tr>
<td></td>
<td>• Induction programs</td>
</tr>
<tr>
<td></td>
<td>• Leadership/management</td>
</tr>
<tr>
<td></td>
<td>• Personal coaching</td>
</tr>
<tr>
<td></td>
<td>• Other</td>
</tr>
<tr>
<td>Rotations/Placements</td>
<td>Graduate training programs</td>
</tr>
<tr>
<td>Recruitment of staff</td>
<td>Public Fellowships</td>
</tr>
<tr>
<td>Investment in training – range of opportunities</td>
<td></td>
</tr>
<tr>
<td>Personal coaching</td>
<td></td>
</tr>
</tbody>
</table>
Appendix 6: INDIVIDUAL INTERVIEW GUIDE

1. What are some of the major constraints in the policy-making environment?
   - external environmental factors (political process, Ministerial intervention, central departments, whole-of-government agendas, etc)

2. Do you have weaknesses in policy capacity in the department?
   - expand on what they are (e.g. short timeframes; disconnection between policy development and implementation; stakeholder consultation)
   - at the individual level
   - at the organisational level (e.g. resources, relationships with stakeholders, generating information, etc.)

3. What are you currently doing or plan to do about policy capacity gaps/weaknesses in the department?
   - address the weaknesses outlined above (question 2)
   - at the individual level
   - at the organisational level

4. What are the most important initiatives in the department that still need to be done to strengthen policy capacity?

5. What sort of leadership will contribute to building policy capacity in the department?
   - what are the features of good policy leadership? (is it the same at higher/middle levels?)
   - in light of the above dot point, are there missing areas of policy leadership in the department?
   - how could such leadership skills be further developed?
# Appendix 7: Data Analysis Categories

## Categories derived from note-taker’s summaries

1. **External influences and constraints on policy making:**
   - State level political influences
   - Commonwealth-State issues
   - Role of central agencies

2. **Competencies important for policy work:**
   - Contextual Knowledge
   - Content knowledge/subject expertise
   - Knowledge of policy development process
   - Communication and Interpersonal Skills
   - Analytical skills
   - Judgement
   - Personal Attributes (flexibility; reflexivity; persistence; confidence; ability to deal with complexity; pragmatism; resilience)

3. **Organisational conditions that facilitate good policy work (Enablers)**
   - used policy domains from Gleeson study

4. **Organisational weaknesses with respect to policy capacity (Barriers)**
   - used policy domains from Gleeson study

5. **Suggested strategies for capacity building:**
   - People (including professional development; people management)
   - Process and structure (e.g. tools for policy development; guidelines for implementation)
   - Leadership and culture

## Categories derived from facilitator’s summaries

1. **Policy episode:**
   - Nature and type of policy work
   - Policy process

2. **External Influences on policy making:**
   - Political environment
   - Commonwealth-State matters
   - Central/other departments
   - External agencies

3. **Individual Capacities:**
   - Personal competencies (knowledge, skills and attributes)

4. **Barriers to organisational capacity:**
   - Generation and use of evidence and information
   - Engagement and management of stakeholders
   - Coordination and collaboration across governments and departments
   - Policy development and implementation
   - Leadership
   - Monitoring and evaluation
Enablers of organisational capacity:
(used policy domains – as above)

Suggested strategies for building capacity:
- Proposed directions (professional development, leadership development, organisational structures and processes, etc.)
- Priorities for strategy development

### NVivo Tree nodes and sub-codes

<table>
<thead>
<tr>
<th>NVivo Tree nodes and sub-codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Barriers to organisational capacity</td>
</tr>
<tr>
<td>2. Coordination and Networks</td>
</tr>
<tr>
<td>3. Enablers to organisational capacity</td>
</tr>
<tr>
<td>4. Episodes (narrated policy story)</td>
</tr>
<tr>
<td>5. External environment influences</td>
</tr>
<tr>
<td>6. Implementation</td>
</tr>
<tr>
<td>7. Individual capacity</td>
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<tr>
<td>8. Ambiguity</td>
</tr>
<tr>
<td>9. Communication</td>
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<tr>
<td>10. Confidence</td>
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<td>11. Flexible</td>
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<td>12. Hopelessness</td>
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<td>13. Influence</td>
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<td>14. Judgement</td>
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<tr>
<td>15. Persistence</td>
</tr>
<tr>
<td>16. Reflexivity</td>
</tr>
<tr>
<td>17. Institutional structure, processes and culture</td>
</tr>
<tr>
<td>18. Leadership</td>
</tr>
<tr>
<td>19. Organisational capacity:</td>
</tr>
<tr>
<td>20. Human resources management</td>
</tr>
<tr>
<td>21. Attainment of critical mass</td>
</tr>
<tr>
<td>22. Information systems &amp; management</td>
</tr>
<tr>
<td>23. Research, evidence &amp; knowledge production</td>
</tr>
<tr>
<td>24. Monitoring &amp; evaluation</td>
</tr>
<tr>
<td>25. Leadership</td>
</tr>
<tr>
<td>26. Project management</td>
</tr>
<tr>
<td>27. Coordination and collaboration</td>
</tr>
<tr>
<td>28. Policy development/implementation process</td>
</tr>
<tr>
<td>29. Policy capacity</td>
</tr>
<tr>
<td>30. Policy practice</td>
</tr>
<tr>
<td>31. Policy process</td>
</tr>
<tr>
<td>32. Stakeholder engagement and management</td>
</tr>
<tr>
<td>33. Strategies for building capacity</td>
</tr>
<tr>
<td>34. Tensions</td>
</tr>
</tbody>
</table>
# Appendix 8: Ethics Approval from University and Industry Partners

<table>
<thead>
<tr>
<th>Institution</th>
<th>Ethics Committee</th>
<th>Approval Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>La Trobe University</td>
<td>La Trobe University Human Ethics Committee</td>
<td>07-131</td>
</tr>
<tr>
<td>University of Wollongong</td>
<td>University of Wollongong Human Research Ethics Committee</td>
<td>HE07/354</td>
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<tr>
<td>Queensland University of Technology</td>
<td>University Human Research Ethics Committee</td>
<td>0800000096</td>
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<tr>
<td>The University of Queensland</td>
<td>The University of Queensland Behavioural &amp; Social Sciences Ethical Review Committee</td>
<td>2007001688</td>
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<tr>
<td>The University of South Australia</td>
<td>University of South Australia Human Research Ethics Committee</td>
<td>P321/07</td>
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<tr>
<td>Monash University</td>
<td>Monash University Standing Committee on Ethics in Research involving Humans (SCERH)</td>
<td>2007002192</td>
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<tr>
<td>ACT Health</td>
<td>ACT Health Human Research Ethics Committee</td>
<td>ETH.11/07.1005</td>
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REFERENCES


