7 Policy implementation

Overview

It will now be apparent that the policy process is complex and interactive: many groups and organizations at national and international levels try to influence what gets onto the policy agenda and how policies are formulated. Yet policy making does not come to an end once a course of action has been determined. It cannot be assumed that a policy will be implemented as intended since decision makers typically depend on others to see their policies turned into action. This chapter describes this process.

Learning objectives

After working through this chapter, you will be better able to:

- **contrast 'top-down' and 'bottom-up' theories of policy implementation**
- **understand other approaches to achieving policy implementation including those that attempt to synthesize insights from both 'top-down' and 'bottom-up' perspectives**
- **identify some of the tensions affecting implementation between international bodies and national governments, and between central and local authorities within countries**
- **describe some of the factors that facilitate or impede the implementation of centrally determined policies**

Key terms

Advocacy coalition Group within a policy sub-system distinguished by shared set of norms, beliefs and resources. Can include politicians, civil servants, members of interest groups, journalists and academics who share ideas about policy goals and to a lesser extent about solutions.

Bottom-up implementation Theory which recognizes the strong likelihood that those at subordinate levels will play an active part in the process of implementation, including having some discretion to reshape the dictates of higher levels in the system, thereby producing policy results which are different from those envisaged.

Implementation Process of turning a policy into practice.

Implementation gap Difference between what the policy architect intended and the end result of a policy.

Policy instrument One of the range of options at the disposal of the policy maker in order to give effect to a policy goal (e.g. privatization, regulation, etc.).

Principal–agent theory The relationship between principals (purchasers) and agents (providers), together with the contracts or agreements that enable the purchaser to specify what is to be provided and check that this has been accomplished.

Street-level bureaucrats Front-line staff involved in delivering public services to members of the public who have some discretion in how they apply the objectives and principles of policies handed down to them from central government.

Top-down implementation Theory which envisages clear division between policy formulation and implementation, and a largely linear, rational process of implementation in which subordinate levels of a policy system put into practice the intentions of higher levels based on the setting of objectives.

Transaction cost economics Theory that efficient production of goods and services depends on lowering the costs of transactions between buyers and sellers by removing as much uncertainty as possible on both sides and by maximizing the ability of the buyer to monitor and control transactions.

Introduction

Implementation has been defined as 'what happens between policy expectations and (perceived) policy results' (DeLeon 1999). Until the 1970s, policy scientists had tended to focus their attentions on agenda setting, policy formulation and decision making 'stages' of the policy process (see Chapter 1, for an overview of the 'stages', and Chapters 4, 5 and 6, for an account of agenda setting, and policy formulation within and outside government). While the notion of there being formal 'stages' is far from the messy reality of most policy processes, it remains a useful device for drawing attention to different activities and actors. The changes that followed policy decisions had been relatively neglected. However, it became increasingly apparent that many public policies had not worked out in practice as well as their proponents had hoped. A series of studies in the late 1960s of anti-poverty programmes, initially in the USA, led to an increasing focus by practitioners and analysts on showing the effects of policies and explaining why their consequences were often not as planned (Pressman and Wildavsky 1984).

Today, it is common to observe a 'gap' between what was planned and what occurred as a result of a policy. For example, there are numerous case studies of the impact of health policies 'imposed' by international donors on poor countries showing that they have had less than positive results for a range of reasons. For example, El Salvador received loans from the Inter-American Development Bank (IDB) to improve its health infrastructure. However, there was no concomitant closing of old facilities or improvement of existing, dilapidated facilities. As a result, the El Salvador Ministry of Health's maintenance and repair budget could not cope with maintaining the larger capital stock and facilities fell further into disrepair (Walt 1994). Much government reform is currently focused on trying to devise systems that increase the likelihood that governments' policies will be implemented in the way that ministers intended and that provide information on the impact of policies. For example, the Labour government in the UK in the late

1990s emphasized what it called 'delivery' by which it meant the imperative that policies should verifiably make a difference to people's lives. It set a series of quantitative targets with explicit achievement dates and held individual ministries and agencies accountable for their delivery. Similarly, the UN set its Millennium Development Goals in 2000 in order to focus the efforts of its own agencies and world governments on quantitative, timed targets to reduce poverty, malaria and AIDS, and increase access to education by 2015. Unfortunately, it looks unlikely that the goals will be met.

Activity 7.1

Why have programmes driven by overseas donors in low income countries been less successful than expected? What sorts of obstacles face ministries of health in implementing such programmes?

Feedback

The range of reasons has at various times included the following: limited systems in recipient countries to absorb the new resources, lack of government capacity in recipient countries to make good use of resources, the pressure to achieve quick and highly visible results driven by short funding cycles, the importation of alien policy models based on theories tested in other contexts (e.g. in Afghanistan, the World Bank reformed the health system by using its successful experience in Cambodia to introduce a purchaser–provider separation linked to performance-based contracting for services, regardless of the differences between the two countries), differences of view and operating procedures between donors and recipient countries, high costs imposed on recipients by donors' administrative requirements (e.g. the costs of having repeatedly to prepare proposals for fixed-term funding) and a failure to identify opposing interests and/or find ways of changing their positions.

Early theoretical models of policy implementation

'Top-down' approaches

'Top-down' approaches to understanding policy implementation are closely allied with the rational model of the entire policy process which sees it as a linear sequence of activities in which there is a clear division between policy formulation and policy execution. The former is seen as explicitly political and the latter as a largely technical, administrative or managerial activity. Policies set at a national or international level have to be communicated to subordinate levels (e.g. health authorities, hospitals, clinics) which are then charged with putting them into practice. The 'top-down' approach was developed from early studies of the 'implementation deficit' or 'gap' to provide policy makers with a better understanding of what systems they needed to put in place to minimize the 'gap' between aspiration and reality (that is, to make the process approximate more closely to the rational ideal). These studies were empirical but led to prescriptive conclusions. Thus, according

to Pressman and Wildavsky (1984), the key to effective implementation lay in the ability to devise a system in which the causal links between setting goals and the successive actions designed to achieve them were clear and robust. Goals had to be clearly defined and widely understood, the necessary political, administrative, technical and financial resources had to be available, a chain of command had to be established from the centre to the periphery, and a communication and control system had to be in place to keep the whole system on course. Failure was caused by adopting the wrong strategy and using the wrong machinery.

Later 'top-down' theorists devised a list of six necessary and sufficient conditions for effective policy implementation (Sabatier and Mazmanian 1979), indicating that if these conditions were realized, policy should be implemented as intended:

- clear and logically consistent objectives
- adequate causal theory (i.e. a valid theory as to how particular actions would lead to the desired outcomes)
- an implementation process structured to enhance compliance by implementers (e.g. appropriate incentives and sanctions to influence subordinates in the required way)
- committed, skilful, implementing officials
- support from interest groups and legislature
- no changes in socio-economic conditions that undermine political support or the causal theory underlying the policy

Proponents of this approach argued that it could distinguish empirically between failed and successful implementation processes, and thereby provided useful guidance to policy makers. Its most obvious weakness was that the first condition was rarely fulfilled in that most public policies were found to have fuzzy, potentially inconsistent objectives. Other policy scientists were more critical still.

Activity 7.2

Given what you know already about policy in the health field, what criticisms would you level at the 'top-down' perspective on effective implementation? How good an explanation of policy implementation does it offer, in your opinion? How good a guide to policy implementation does it offer?

Feedback

The main criticisms of the 'top-down' approach are that:

- it exclusively adopted the perspective of central decision makers (those at the top of any hierarchy or directly involved in initial policy formulation) and neglected the role of other actors (e.g. NGOs, professional bodies, the private sector) and the contribution of other levels in the implementation process (e.g. regional health authorities and front-line staff)
- as an analytical approach, it risked over-estimating the impact of government action on a problem versus other factors
- it was difficult to apply in situations where there was no single, dominant policy or agency involved – in many fields, there are multiple policies in play and a complex array of agencies

- there was almost no likelihood that the preconditions for successful implementation set out by the 'top-downers' would be present
- its distinction between policy decisions and subsequent implementation was misleading and practically unhelpful since policies change as they are being implemented
- it did not explicitly take into account the impact on implementation of the extent of change required by a policy

In essence, the critics argued that the reality of policy implementation was messier and more complex than even the most sophisticated 'top-down' approach could cope with and that the practical advice it generated on reducing the 'gap' between expectation and reality was, therefore, largely irrelevant. To reinforce these points, Hogwood and Gunn (1984) drew up an even more demanding list of ten pre-conditions for what they termed 'perfect implementation' in order to show that the 'top-down' approach was unrealistic in most situations:

1 The circumstances external to the agency do not impose crippling constraints.

2 Adequate time and sufficient resources are available.

3 The required combination of resources is available.

4 The policy is based on a valid theory of cause and effect.

5 The relationship between cause and effect is direct.

6 Dependency relationships are minimal – in other words, the policy makers are not reliant on groups or organizations which are themselves inter-dependent.

7 There is an understanding of, and agreement on, objectives.

8 Tasks are fully specified in correct sequence.

9 Communication and coordination are perfect.

10 Those in authority can demand and obtain perfect compliance.

Since it was very unlikely that all ten pre-conditions would be present at the same time, critics of the 'top-down' approach argued that the approach was neither a good description of what happened in practice nor a helpful guide to improving implementation.

'Bottom-up' approaches

The 'bottom-up' view of the implementation process is that implementers often play an important function in implementation, not just as managers of policy handed down from above, but as active participants in a complex process that informs those higher up in the system, and that policy should be made with this insight in mind. Even in highly centralized systems, some power is usually granted to subordinate agencies and their staff. As a result, implementers may change the way a policy is implemented and in the process even redefine the objectives of the policy. One of the most influential studies in the development of the 'bottom-up' perspective on implementation was by Lipsky (1980) who studied the behaviour of what he termed 'street-level bureaucrats' in relation to their clients. 'Street-level

bureaucrats' included front-line staff administering social welfare benefits, social workers, teachers, local government officials, doctors and nurses. He showed that even those working in the most rule-bound environments had some discretion in how they dealt with their clients and that staff such as doctors, social workers and teachers had high levels of discretion which enabled them to get round the dictates of central policy and reshape policy for their own ends.

Lipsky's work helped re-conceptualize the implementation process, particularly in the delivery of health and social services which is dependent on the actions of large numbers of professional staff, as a much more interactive, political process characterized by largely inescapable negotiation and conflict between interests and levels within policy systems. As a result, researchers began to focus their attention on the actors in the implementation process, their goals, their strategies, their activities and their links to one another. Interestingly, 'bottom-up' studies showed that even where the conditions specified as necessary by the 'top-down', rational model were in place (e.g. a good chain of command, well-defined objectives, ample resources, and a communication and monitoring system), policies could be implemented in ways that policy makers had not intended. Indeed, well-meaning policies could make things worse, for example, by increasing staff workload so that they had to develop undesirable coping strategies (Wetherley and Lipsky 1977).

Almost 30 years later, studies of 'street-level bureaucrats' still have relevance. For example, Walker and Gilson (2004) studied how nurses in a busy urban primary health care clinic in South Africa experienced and responded to the implementation of the 1996 national policy of free care (removal of user fees). They showed that while the nurses approved of the policy of improving access in principle, they were negative towards it in practice because of the way it exacerbated existing problems in their working environment and increased their workload, without increasing staffing levels and availability of drugs. They were also dissatisfied because they felt that they had not been included in the process of policy change. The nurses also believed that many patients abused the free system and some patients did not deserve free care because they were personally responsible for their own health problems. Such views were presumably at odds with the principles underlying the policy of free care and made nurses slow to grant free access to services to certain groups of patients.

Insights from the 'bottom-up' perspective on policy implementation have also guided a range of studies in health care systems of the way in which the relationships between central, regional and local agencies influence policy. The ability of the centre to control lower levels of the system varies widely and depends on factors such as where the funds come from and who controls them (e.g. the balance between central and local sources of funding), legislation (e.g. setting on which level of authority is responsible for which tasks), operating rules and the ability of the government to enforce these (e.g. through performance assessment, audit, incentives, etc.). Relationships between the centre and the periphery in health systems influence the fate of many policies. Sometimes, as the South African example above showed, policies are diverted to some degree during their implementation. At other times, they are entirely rejected. In New Zealand in the early 1990s, the government introduced user charges for hospital outpatients and inpatients in order, among other things, to remove the perceived incentive for patients to go to hospital rather than use primary care where they faced user

charges. Whatever its intellectual merits, the policy was extremely unpopular among the public, patients, and the hospital managers and staff who had to collect the fees. The user charges were progressively withdrawn until they disappeared about two years after their introduction.

Activity 7.3

Write down in two columns the main differences between the 'top-down' and 'bottom-up' approaches to policy implementation. You might contrast the following aspects of the two approaches to implementation: initial focus; identification of major actors; view of the policy process; evaluative criteria, and overall focus.

Feedback

Your answer should have included some of the differences shown in Table 7.1. While the 'bottom-up' approach appeals to health care workers and middle-ranking officials because it brings their views and constraints on their actions into view, the approach raises as many questions as the 'top-down' perspective. One obvious question it raises is whether or not policy should be made predominantly from the top-down or bottom-up. Another question is how the divergence of views and goals between actors at different levels can or should be reconciled. Specifically, in a democracy how much influence should unelected professionals have in shaping the eventual consequences of policies determined by elected governments?

Table 7.1 'Top-down' and 'bottom-up' approaches to policy implementation

	Top-down approaches	*Bottom-up approaches*
Initial focus	Central government decision	Local implementation actors and networks
Identification of major actors	From top-down and starting with government	From bottom-up, including both government and non-government
View of the policy process	Largely rational process, proceeding from problem identification to policy formulation at higher levels to implementation at lower levels	Interactive process involving policy makers and implementers from various parts and levels of government and outside in which policy may change during implementation
Evaluative criteria	Extent of attainment of formal objectives rather than recognition of unintended consequences	Much less clear – possibly that policy process takes into account of local influences
Overall focus	Designing the system to achieve what central/top policy makers intend – focus on 'structure'	Recognition of strategic interaction among multiple actors in a policy network – focus on 'agency'

Source: Adapted and expanded from Sabatier (1986)

Activity 7.4

Write down any other drawbacks of the 'bottom-up' approach that you can think of.

Feedback

In addition to the value (normative) questions mentioned in the paragraph above, you could have listed:

- If there is no distinction analytically or in reality between 'policy' and 'implementation', then it is difficult to separate the influence of different levels of government and of elected politicians on policy decisions and consequences. This is important for democratic and bureaucratic accountability.
- If there are no separate decision points in the policy process, it becomes very difficult to undertake any evaluation of a particular policy's effects (as you will see in Chapter 9).
- The approach risks under-emphasizing the indirect influence of the centre in shaping the institutions in which lower level actors operate and in distributing the political resources they possess, including permitting them to be involved in shaping implementation.

This list of drawbacks is a reminder that it pays to be cautious when judging one theory superior to another in such a complex field as policy. Most theory in policy science inevitably simplifies the complexity of any particular set of circumstances in order to bring greater understanding.

Other ways of understanding policy implementation: beyond 'top-down' and 'bottom-up'

The approaches debated this far have largely been developed by political scientists and sociologists. However, management scientists and economists have also been drawn to trying to explain why 'top-down' and 'bottom-up' approaches leave gaps between intention and eventual outcome.

Principal–agent theory

From the principal–agent perspective, sub-optimal policy implementation is an inevitable result of the structure of the institutions of modern government in which decision makers ('principals') have to delegate responsibility for the implementation of their policies to their officials (e.g. civil servants in the Ministry of Health) and other 'agents' (e.g. managers, doctors and nurses in the health sector or private contractors) whom they only indirectly and incompletely control and who are difficult to monitor. These 'agents' have discretion in how they operate on behalf of political 'principals' and may not even see themselves as primarily engaged in making a reality of the wishes of these 'principals'. For example, even publicly employed doctors tend to see themselves as members of the medical profession first and foremost rather than as civil servants. Discretion opens up the potential for ineffective or inefficient translation of government

intent into reality since 'agents' have their own views, ambitions, loyalties and resources which can hinder policy implementation. The inherent problem for politicians is to get the compliance of their officials and others who are contracted to deliver services at all levels. The more levels of hierarchy there are, the more principal–agent relations exist as each level is dependent on the next level below or beside it, and the more complex the task of controlling the process of implementation.

The amount of discretion and the complexity of the principal–agent relationships are, in turn, affected by:

- *the nature of the policy problem* – features such as macro versus sectoral or micro (i.e. scale of change required and size of the affected group), simple versus complex, ill-defined versus clear, many causes versus a single cause, highly politically sensitive versus neutral politically, requiring a short or long period before changes will become apparent, costly versus inexpensive. In general, long-term, ill-defined, inter-dependent (goals affected by other policies too), high profile problems affecting large numbers of people are far more difficult to deal with than short-term, specific issues with a single cause and a large technical component. Most public policy debate focuses on the former which are known, understandably, as 'wicked problems' or problems to which there is never likely to be an easy solution. A typical example would be how to simultaneously reduce the prevalence of illegal drug use in prisons while making existing drug use less hazardous to the health of prisoners (e.g. by providing clean syringes or sterilizing equipment). The risk is that the less risky drug misuse is made, the less likely it is that it will be reduced.
- *the context or circumstances surrounding the problem* – for example, the political situation, whether the economy is growing or not, the availability of resources and technological change
- *the organization of the machinery required to implement the policy* – most obviously this includes the number of formal and informal agencies involved in making the desired change and the skills and resources that have to be brought to bear.

As a result of these sorts of factors, officials who typically remain in post longer than politicians often become subject area experts and are able to exercise considerable discretion, for example, in how much they tell ministers and when. Politicians are thus often dependent on the goodwill of their officials to further their own interests and careers.

Activity 7.5

The three sets of factors listed above help explain why some policies are easier to implement than others. Take a health policy with which you are familiar and describe the nature of the problem, the context and the machinery required to implement the policy. Under each of the three headings, try to assess whether the factors you have listed are likely to be make implementation of the policy easier or more difficult.

Feedback

Your answer will clearly depend on the policy chosen. For example, if your chosen policy had simple technical features (e.g. introduction of a new drug), involved a marginal behavioural change (e.g. a minor change in dosage), could be implemented by one or a few actors (e.g. pharmacists only), had clear, non-conflicting objectives (e.g. better symptom control with no cost implications) and could be executed in a short period of time (e.g. drugs were easy to source and distribute), you would be lucky and you would be able to conclude that implementation would be relatively straightforward. Unfortunately, the majority of health policy issues and policies are more complex. Policy analysts are fond of contrasting the challenge of goals such as putting a man on the moon with the stock-in-trade of public policy such as reducing poverty. The former was carried out in a tightly organized, influential, well-resourced organization focused on a single goal with a clear end point. The latter is driven by a large number of causes, involves a wide range of agencies and actors and has inherently fuzzy objectives (Howlett and Ramesh 2003).

The insights of principal–agent and related theories such as transaction costs economics, which focuses on reducing the costs of relating buyers to sellers in markets and public services, led to a greater appreciation of the importance for policy implementation of the design of institutions and the choice of policy instruments in the knowledge that the 'top' needs to be able to monitor and control the 'street level' at reasonable cost. One aspect of this was a growing focus on the actual and implied *contracts* defining the relationships between principals and agents in order to ensure that the principal's objectives are followed by agents. So within the 'core' of central government, in the 1980s and 1990s, in a number of countries, the civil service was reformed to make more explicit what officials were expected to deliver to ministers in return for their salaries, and to put in place performance targets and performance indicators to assess whether their performance in meeting government objectives was improving or not.

In public services the conventional role of government as the direct provider of services was critically reviewed in many countries, with a view to improving the efficiency and responsiveness of services both to the objectives of ministers and the needs of consumers. The catch phrase of the reformers was that government should be 'steering not rowing' the ship of state (Osborne and Gaebler 1992), confining itself to what only it could do best. As a result, some services that had been directly provided in the public sector (e.g. by publicly owned hospitals) were contracted out to private for-profit or not-for-profit providers, thereby making the roles of purchaser and provider more explicit. Table 7.2 lays out the range of substantive

Table 7.2 The spectrum of substantive policy instruments

Family and community	Voluntary organizations	Private market	Information and exhortation	Subsidy	Tax and user charges	Regulation	Public enterprise	Direct provision
Voluntary action			Mixed voluntary and compulsory action				Compulsory action	
Law state involvement in production of services							*High state involvement*	

Source: Howlett and Ramesh (2003)

policy instruments available to government to ensure the delivery of goods and services, each entailing differing levels of government activity and degrees of compulsion. From the early 1980s, policy makers were encouraged to consider the potential of the whole range, in line with the preference in mainstream economics for markets over other approaches to producing goods and services and the fashionable economic theory that the self-interested behaviour of voters, politicians and bureaucrats tends to lead to an increase in taxation, public spending and government activity, often unnecessarily and inefficiently. From an economic point of view, the selection of instruments was seen as largely a technical exercise to improve the efficiency of public services.

Broadly, by the end of the 1990s, market, market-like (e.g. the separation of purchaser and providers within a publicly owned and financed health system) and voluntary instruments had become more prominent in many countries, leading to a more mixed set of policy instruments in sectors such as health. The supposition of reformers was that such arrangements would improve the implementation of centrally driven policy designed to improve the efficiency and effectiveness of public services.

As well as changes to instruments, there were also changes to the processes by which services were delivered, such as the trend to decentralize parts of the decision making function from central to local levels while reducing the number of tiers in the management hierarchy. In many jurisdictions, subordinate agents were given greater control over their own affairs on a day-to-day basis but remained accountable for the attainment of the government's key goals. The theory was that this would free agents to pursue the objectives of their principals, unfettered by unnecessary interference, and allow principals to judge the performance of their agents objectively and remove from agents the excuse that their poor performance was the result of inappropriate interventions by principals. These more autonomous entities are referred to as 'public firms' or 'public enterprises'. Since 1991, NHS hospitals in the UK have operated in this way as 'self-governing' bodies with some, limited freedom from direct ministerial control. In 2004, in England, better performing NHS hospitals were encouraged to apply for 'foundation status' which, in principle, gave them greater freedom to operate entrepreneurially and to keep the rewards of their good performance. Similar reforms have been pursued in low income countries such as Zambia where performance improvements were rewarded with greater freedom from government control (Bossert et al. 2003).

Taken together, these reactions to the perception that traditional ways of public administration had failed to deliver what governments needed came to be known as 'New Public Management (NPM)'. NPM rests (for it is still the dominant approach to public sector management worldwide) on economic critiques of policy implementation and the importation into the public sector of management techniques used in large private enterprises.

Activity 7.6

Extract the main elements of 'New Public Management' from what you have just read about principal–agent theory and related ideas.

Feedback

NPM is a hybrid of different intellectual influences and practical experience, and emphasizes different things in different countries, but the following elements are commonly seen as distinctive in NPM:

- clarification of roles and responsibilities for effective policy implementation by separating 'political' (i.e. advising ministers on policy direction) from 'executive' (i.e. service delivery) functions within the government machinery. For example, this has led to governments setting up agencies to run public services at arm's length from central government (e.g. courts, prisons and health services) with greater operational freedom and attempting to slim down central government ministries providing policy advice
- separation of 'purchase' from 'provision' within public services in order to allow the contracting out of services to the private sector if this is regarded as superior to in-house, public provision, or the establishment of more independent public providers (e.g. turning UK NHS hospitals into 'foundation trusts' at arm's length from direct government control)
- focus on performance assessment and incentives to improve 'value for money' and to ensure that services deliver what policy makers intended
- setting standards of service which citizens as consumers can expect to be delivered

Towards a synthesis of 'top-down' and 'bottom-up' perspectives?

While economists tended to see the choice of the best policy instrument to implement a policy as a technical exercise and were keen to recommend approaches, political scientists studied how governments behaved and with what consequences. For example, Linder and Peters (1989) identified the following factors as playing a critical role in shaping the policy implementation choices of governments:

- *Features of policy instruments* – some instruments are intrinsically more demanding technically and politically to use. They vary on at least four dimensions: resource intensiveness; targeting; political risk; and degree of coerciveness. Ripley and Franklin (1982) suggested that distributive policies (i.e. allocating public funds to different groups) tended to be relatively easy to implement, regulatory policies (e.g. allowing nurses to prescribe drugs previously restricted to doctors) were moderately difficult, and redistributive policies (i.e. policies involving the re-allocation of income or opportunities between socio-economic groups) were very difficult to implement since there were obvious losers from the last category of policy, whereas the costs of the first category were spread across the population less visibly.
- *Policy style and political culture* – in different countries and different policy fields, participants and the public were accustomed to, for instance, different degrees of government control and/or provision. Policies departing from these traditions were more difficult to implement.
- *Organizational culture* – the past operating experience and ways of doing things of the implementing organizations, linked to point 2.
- *Context of the problem* – the timing (e.g. in relation to how well the economy was performing), the range of actors involved, the likely public reaction, etc.

- *Administrative decision makers' subjective preferences* – based on their background, professional affiliations, training, cognitive style and so on.

These factors highlight two general sets of variables affecting policy implementation, namely, the *extent of government capacity* and, therefore, its ability to intervene, and the *complexity of the particular policy field* it is attempting to influence. Attempts to reconcile the 'top-down' and 'bottom-up' approaches have focused on the interplay between these two sets of variables. Crudely, 'top-down' theory provides the focus on government capacity, whereas 'bottom-up' theory offers the focus on sub-system complexity since the former emphasizes how institutional design and socio-economic conditions (context) constrain and shape the process of implementation and the latter emphasizes how the beliefs of participants, their relationships and networks, and inter-organizational dynamics shape and constrain implementation. The best-known attempt to bring together these different strands of theory and research was developed by Sabatier and various colleagues (Sabatier and Jenkins-Smith 1993).

The policy sub-system or advocacy coalition framework

Sabatier's framework is a general approach to understanding the policy process since it rejects the idea of separating 'implementation' from other parts as unrealistic and misleading. Instead, policy change is seen as a continuous process that takes place within policy sub-systems bounded by relatively stable limits and shaped by major external events. Within the sub-system (e.g. mental health policy), 'communities' of actors interact over considerable periods of time. The actors include all those who play a part in the generation, dissemination and evaluation of policy ideas. Sabatier does not include the public in any policy sub-system on the grounds that ordinary people do not have the time or inclination to be direct participants.

The large number of actors and networks within each sub-system are organized into a smaller number of '*advocacy coalitions*', in conflict with one another. Each competes for influence over government institutions. An 'advocacy coalition' is a group distinguished by a distinct set of norms, beliefs and resources, and can include politicians, civil servants, members of civil society organizations, researchers, journalists and others. Advocacy coalitions are defined by their *ideas* rather than by the exercise of self-interested power (see Chapter 9 for more on their role in bringing ideas from research to bear on policy). Within advocacy coalitions there is a high level of agreement on fundamental policy positions and objectives, though there may be more debate about the precise means to achieve these objectives (the concept has much in common with that of a discourse community discussed in the previous chapter). Sabatier argues that the fundamental (or 'core') norms and beliefs of an advocacy coalition change relatively infrequently and in response to major changes in the external environment such as shifts in macro-economic conditions or the replacement of one political regime by another. Otherwise, less fundamental, 'normal' policy changes occur as a result of policy-oriented learning in the interaction between advocacy coalitions within the policy sub-system.

The final element in Sabatier's model is to identify the existence of so-called '*policy brokers*', that is actors concerned with finding feasible compromises between the

positions advocated by the multiplicity of coalitions. 'Brokers' may be civil servants experienced in a particular sub-system or bodies designed to produce agreement, such as committees of inquiry.

Subsequent empirical work has shown that the advocacy coalition model works fairly well in explaining policy change over a decade in relatively open, decentralized, federal, pluralistic political systems such as the USA, but works less well in political systems such as Britain's which are more closed and where there is less interplay between advocacy coalitions. It has also been little used in the context of low income countries where policy making has been traditionally even more closed and elitist. Looking at its utility in specific policy sub-systems, it appears to fit well with sub-systems such as HIV/AIDS policy and other aspects of public health where government typically has to try to reach agreement among conflicting advocacy coalitions, but is far less applicable to the policy sub-systems of 'high politics' such as defence and foreign policy (e.g. decisions to go to war) where policy decisions are normally made within a small and tightly defined elite since the national interest as a whole may be perceived to be at stake.

There a number of different approaches to understanding implementation which transcend the contrast between 'top-down' and 'bottom-up' approaches. Through the concept of 'advocacy coalitions', Sabatier's has the virtue of highlighting the possibility that many of the most important conflicts in policy cut across the simple divide between policy makers and those formally charged with putting policy into practice.

What help to policy makers are the different approaches to policy implementation?

Most of the research discussed in this chapter was not directly devoted to providing practical advice for policy makers, though some fairly simple messages emerge. For example, there is little doubt that policies which are designed to be incremental (with small behavioural change), can be delivered through a simple structure involving few actors and have the support of front-line staff are more likely to succeed than those that are not. However, this is no great help to those charged with bringing about radical policy change in complex systems where conflicts of fact and opinion abound.

Grindle and Thomas (1991) encourage policy makers, whoever they are, to carefully analyse their political, financial, managerial and technical resources and work out how they may be mobilized as well as those of their likely opponents before making decisions about how to bring about change. The key message from their approach is a reminder that the political aspects of the policy sub-system are just as important as aspects of government capacity such as the quality of the technical advice available. Where governments lack capacity and the sub-system is complex, involving a large number of inter-dependent actors, the advice from this perspective might be to use subsidies to encourage particular forms of behaviour rather than attempt direct provision. For example, rather than attempting to employ primary care doctors, the government might subsidize the cost of patients' visits to private doctors.

Given the range of frameworks for analysing policy implementation, each of which has something valuable to offer, Elmore (1985) argues that thoughtful policy makers should use a variety of approaches to analyse their situation simultaneously, both 'bottom-up' and 'top-down'. A key skill is the ability to map the participants ('stakeholders' in modern jargon), their situations, their perspectives, their values, their strategies, their desired outcomes and their ability to delay, obstruct, overturn or help policy implementation (see Chapter 10 for more on this).

As a broad generalization, in the various health policy sub-systems, most governments are ambitious (they want to make a significant impact), but the sub-systems are complex and governments have relatively modest levels of direct control over many of the key actors, for example, they are highly dependent on a range of influential professional groups. This suggests that persuasion and bargaining will often be important parts of any strategy of implementation.

Drawing these threads of advice together, Walt (1998) sets out a strategy for planning and managing the implementation of change in the health sector which is summarized in Table 7.3.

Table 7.3 Strategy for planning and managing the implementation of change

Area or aspect of implementation	*Type of action or analysis*
Macro-analysis of the ease with which policy change can be implemented	Analyse conditions for facilitating change and, where possible, make adjustments to simplify, i.e. one agency, clear goals, single objective, simple technical features, marginal change, short duration, visible benefits, clear costs
Making values underlying the policy explicit	Identify values underlying policy decisions. If values of key interests conflict with policy, support will have to be mobilized and costs minimized
Stakeholder analysis	Review interest groups (and individuals) likely to resist or promote change in policy at national and institutional levels; plan how to mobilize support by consensus building or rallying coalitions of support
Analysis of financial, technical and managerial resources available and required	Consider costs and benefits of overseas funds (if relevant); assess likely self-interested behaviour within the system; review incentives and sanctions to change behaviour; review need for training, new information systems or other supports to policy change
Building strategic implementation process	Involve planners and managers in analysis of how to execute policy; identify networks of supporters of policy change including 'champions'; manage uncertainty; promote public awareness; institute mechanisms for consultation, monitoring and 'fine tuning' of policy

Source: Adapted from Walt (1998)

Summary

Implementation cannot be seen as a separate part of a sequential policy process in which political debate and decisions take place among politicians and civil servants, and managers and administrators at a lower level implement these decisions. It is best viewed as a mostly complex, interactive process in which a wide range of actors influence both the direction of travel as well as the way that given policies are executed, within the constraints of existing institutions. Implementation is a political process shaped by government capacity and system complexity. Experience suggests that this basic insight from the social sciences of the interplay of actors (agency) and institutions (structure) is still imperfectly built into plans for putting policy into practice.

To avoid the gap between policy expectation and reality, policy makers should develop a strategy for implementation that explicitly takes account of financial, managerial and technical aspects of the policy (capacity) and the anticipated resistance and support from all the actors in the sub-system within and outside government.

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