

Transformation of Analytical Capacity in Health Policy Governance: A Comparative Analysis of Canadian Administrative Practice and Lessons for Developing Countries

Yogi Anugrah Nurrochim¹, Alfahrizal Andrian², Ilham Muhammad³

^{1,2,3,4}Universitas Maritim Raja Ali Haji. Tanjungpinang, Indonesia

Correspondence: yogianugrah12@gmail.com¹



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ABSTRACT

The transformation of analytical capacity has become central to health policy governance because governments must convert increasingly complex data, scientific evidence, and stakeholder knowledge into timely and defensible decisions. This article examines how analytical capacity is developed in Canadian health governance and identifies conditions under which selected practices may be adapted in developing-country settings. A structured qualitative literature review and comparative lesson-drawing design was applied to 40 scholarly sources published between 2016 and 2026. The analysis integrates policy-capacity theory with evidence-informed policymaking and learning-health-system perspectives. Analytical capacity is operationalized through four interdependent dimensions: technical and data capability, institutional arrangements, human-resource capability, and organizational culture. The findings show that Canada's experience is characterized by a dense evidence infrastructure, specialized analytical organizations, knowledge-translation platforms, investment in professional expertise, and growing efforts to improve data stewardship and interoperability. However, Canadian practice also demonstrates important constraints arising from federal fragmentation, uneven data access, interjurisdictional coordination costs, and the gap between the availability of evidence and its actual use in policy decisions. The comparative analysis therefore rejects mechanical policy transfer. Transferable lessons are conditional on institutional readiness, data governance, workforce capability, leadership commitment, and mechanisms that connect evidence production to formal decision routines.

Keyword: Analytical Capacity, Policy Capacity, Health Data, Governance



INTRODUCTION

Health policy governance increasingly depends on the capacity of public institutions to interpret data, assess evidence, anticipate risks, compare policy alternatives, and learn from implementation. The expansion of digital health systems, administrative databases, real-time surveillance, health technology

assessment, and artificial intelligence has increased the volume of potentially useful information, but it has not automatically increased the quality of public decisions. Evidence must be assessed, translated, combined with contextual knowledge, and embedded in administrative routines before it can influence policy. This distinction is central to the contemporary literature on evidence-informed policymaking, which emphasizes that policy decisions are shaped by institutional rules, political priorities, organizational incentives, professional judgment, and public values rather than by research evidence alone (Head, 2016; Cairney, 2016; Cairney et al., 2016).

Analytical capacity refers to the competences and organizational resources required to generate, access, interpret, and apply policy-relevant knowledge. It is related to, but narrower than, overall policy capacity, which also includes operational and political capabilities. Governance failure can occur when a government possesses data and formal analytical units but lacks the organizational routines, political support, or implementation capacity required to act on analysis (Howlett & Ramesh, 2016; Wu et al., 2018). In health governance, this distinction is especially important because decisions must frequently reconcile epidemiological evidence, fiscal constraints, professional standards, equity considerations, public expectations, and intergovernmental responsibilities.

Canada provides a useful administrative case for examining these dynamics. Its health system combines universal public financing principles with substantial provincial and territorial responsibility for organization and delivery. This creates strong incentives for intergovernmental learning and policy experimentation, but it also produces coordination challenges, differences in data infrastructure, and institutional fragmentation. Recent Canadian scholarship shows that policy capacity is mobilized through commissions, analytical agencies, performance systems, professional expertise, and interprovincial policy learning, while remaining strongly conditioned by federal arrangements and political feasibility (Marchildon et al., 2020; Béland et al., 2021; Denis et al., 2022).

The Canadian case is also analytically valuable because evidence infrastructure is not confined to central government departments. National collaborating centres, universities, health-data organizations, provincial agencies, research institutes, and learning-health-system initiatives participate in the production and mobilization of evidence. Such a plural advisory environment can widen access to expertise, but it also requires strong coordination and clear pathways through which analysis enters authoritative decisions (Craft & Wilder, 2017; Dubois & Lévesque, 2020; Husson et al., 2021).

Despite the growing literature on policy capacity, evidence use, digital health, and learning health systems, these strands are often discussed separately. Studies of policy capacity emphasize competencies and institutional resources; knowledge-translation studies focus on the evidence-policy interface; digital-health scholarship emphasizes data infrastructures and interoperability; and learning-health-system research examines continuous feedback between data, practice, and improvement. The result is a conceptual gap: insufficient attention is given to the causal sequence through which technical infrastructure, institutional arrangements, professional skills, and organizational culture combine to produce usable analytical capacity in health governance.

This article addresses that gap by integrating these literatures into a single analytical framework and by using Canadian administrative practice as a reference case for structured lesson drawing. The novelty lies in treating analytical capacity not as a stock of technical expertise but as a governance capability produced by

interactions among data systems, institutions, people, and organizational norms. The article asks three questions: (1) What dimensions constitute effective analytical capacity in health policy governance? (2) Through what mechanisms have Canadian administrative practices strengthened or constrained these dimensions? and (3) Which lessons are potentially transferable to developing-country settings, and under what institutional conditions?.

Table 1. Integrated analytical-capacity framework for health policy governance

Dimension	Core indicators	Primary governance mechanism	Illustrative evidence base
Technical and data capacity	Interoperable data; data quality; secure access; analytical tools; timely reporting	Converts dispersed information into comparable and decision-ready evidence	Enticott et al. (2021); Shaw & Sekalala (2023); Wolfson (2024)
Institutional capacity	Analytical units; legal mandates; coordination arrangements; evaluation routines; advisory networks	Stabilizes evidence production and connects analysis to formal policy processes	Craft & Wilder (2017); Dubois & Lévesque (2020); Kuchenmüller et al. (2022)
Human-resource capacity	Policy analysts; epidemiologists; data scientists; health economists; knowledge brokers; leadership skills	Enables interpretation, synthesis, communication, and contextualization of evidence	Lawrence et al. (2020); Newman et al. (2022); Migone & Howlett (2023)
Organizational culture	Leadership demand for evidence; learning orientation; evaluation; openness to revision; cross-sector collaboration	Determines whether analytical outputs influence decisions and support adaptation	Head (2016); Husson et al. (2021); Friedman (2022)

Source: Author synthesis from the reviewed literature, 2026

The analytical framework combines three bodies of scholarship. First, policy-capacity research distinguishes analytical capacity from operational and political capacity and locates capacity at individual, organizational, and system levels. This perspective helps explain why technical expertise alone is insufficient: an analyst may possess strong skills while the organization lacks access to data, or an organization may generate high-quality analysis that is not incorporated into political decisions. Contemporary work has also moved toward more explicit measurement of governmental analytical capacity and the distribution of policy professionals across administrative systems (Lawrence et al., 2020; Migone & Howlett, 2023).

Second, evidence-informed policymaking scholarship emphasizes that evidence use is an institutional and political process. Evidence can reduce uncertainty, but policy actors must also manage ambiguity about problem definitions, values, priorities, and acceptable solutions. Consequently, the quality of the evidence-policy relationship depends on sustained interaction, brokerage,

trust, organizational routines, and explicit processes for appraisal and evaluation (Cairney & Oliver, 2017; Oliver & Cairney, 2019; Oliver et al., 2022). In health systems, formal institutionalization of evidence use requires governance arrangements, standard procedures, leadership, resources, partnerships, and a culture that treats evidence as a normal component of policy work (Kuchenmüller et al., 2022).

Third, learning-health-system research broadens analytical capacity from one-off policy analysis to continuous learning. A learning health system links routinely generated data, scientific evidence, professional knowledge, evaluation, and feedback so that policy and service systems can adapt over time. Reviews show that successful learning depends on data access, organizational infrastructure, multidisciplinary collaboration, and the ability to convert analysis into actionable decisions (Enticott et al., 2021; Nash et al., 2021; Pomare et al., 2022; Friedman, 2022). Based on this synthesis, the article operationalizes analytical capacity through four interdependent dimensions: technical and data capacity, institutional capacity, human-resource capacity, and organizational culture. These dimensions are assessed not as independent variables but as mutually reinforcing conditions. Table 1 presents the indicators used in the comparative analysis.

RESEARCH METHOD

This study uses a qualitative structured literature review combined with comparative lesson drawing. The design is appropriate because the research question concerns how administrative arrangements generate analytical capacity and which mechanisms may be transferable across institutional settings, rather than estimating a single causal effect. The review period was limited to 2016–September 2026 so that the evidence base reflects contemporary developments in policy capacity, evidence-informed policymaking, digital health, health-data governance, and learning health systems.

Sources were identified through combinations of the terms policy capacity, analytical capacity, evidence-informed policymaking, health policy governance, health data governance, interoperability, learning health system, Canada, policy transfer, and developing countries. Searches were conducted across major scholarly discovery platforms and publisher databases, including Google Scholar, PubMed, ScienceDirect, SpringerLink, Wiley Online Library, and relevant journal platforms. The revised corpus consists of 40 scholarly sources that met three criteria: publication within the specified period, direct analytical relevance to at least one dimension of the framework, and sufficient methodological or conceptual detail to support comparative interpretation.

The selection process prioritized peer-reviewed journal articles and scholarly books. Sources were excluded when they duplicated another item, addressed health services without a governance or analytical-capacity component, or offered claims that could not be connected to the analytical framework. Two studies from the Journal Governance Society archive were intentionally included to strengthen the discussion of governance and public-health policy in the Indonesian context: Imani et al. (2024) and Santosa et al. (2025). These sources are not treated as direct equivalents to Canadian evidence; instead, they support the cross-context discussion of governance capacity, strategic analysis, and the institutional adaptation of policy lessons.

Analysis proceeded in three stages. First, each source was coded deductively against the four analytical-capacity dimensions. Second, Canadian

evidence was synthesized to identify recurring administrative mechanisms, including specialized analytical institutions, data integration, knowledge-translation platforms, intergovernmental coordination, professional capacity development, and continuous evaluation. Third, the identified mechanisms were assessed through a lesson-drawing lens by separating the functional principle of a practice from the institutional form through which Canada implements it. This distinction is important because policy transfer is more credible when jurisdictions adapt underlying functions to local administrative conditions rather than copying organizational forms. Source triangulation was used to reduce dependence on any single literature stream. Claims about analytical capacity were compared across public-administration, health-policy, evidence-use, data-governance, and learning-health-system scholarship. The study does not claim statistical representativeness. Its validity rests on conceptual consistency, explicit source selection, cross-source comparison, and cautious interpretation of transferability.

RESULTS AND DISCUSSION

1. Analytical Capacity as a Governance Capability

The literature consistently indicates that analytical capacity is more than the ability to perform statistical analysis. It includes the institutional authority to obtain information, the professional capability to interpret it, and the organizational routines through which analysis becomes relevant to decisions. This broader view addresses a recurring problem in evidence-based policy debates: governments may increase the supply of research while leaving the demand, interpretation, and use of evidence unchanged. Head (2016) and Cairney et al. (2016) show that better evidence does not eliminate political judgment; instead, analytical institutions must help decision-makers manage both uncertainty and competing interpretations of policy problems.

For health governance, the implication is that analytical capacity should be evaluated as a chain rather than a single asset. Data must be available and trustworthy; organizations must have authority and routines to analyze it; professionals must be able to interpret results; and leaders must create demand for evidence and permit revision when new information challenges existing assumptions. This chain provides the basis for the causal model developed in Figure 1.

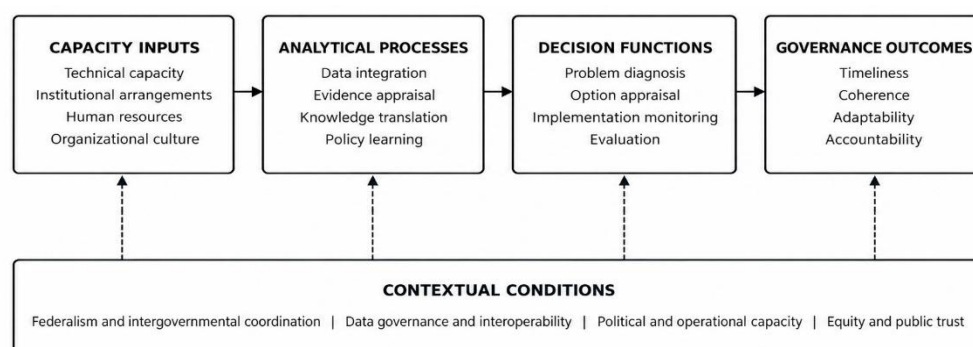


Figure 1. Causal pathway from analytical-capacity inputs to governance
Source: Author synthesis (2016–2026).

The policy-capacity perspective clarifies why imbalances matter. Analytical competence without operational resources can generate recommendations that cannot be implemented, while analytical and operational capacity without political

legitimacy can produce technically sound but politically unsustainable reforms. Howlett and Ramesh (2016) therefore treat capacity deficits as a core source of governance failure. More recent work similarly emphasizes that effective policy design depends on the alignment of capacities across system, organizational, and individual levels (Mukherjee et al., 2021; Capano & Lepori, 2024).

2. Canadian Administrative Practice: Data, Institutions, and Evidence Infrastructure

Canada's health governance combines decentralized delivery with national principles and a substantial network of organizations that produce, standardize, synthesize, and mobilize knowledge. The health-system review by Marchildon et al. (2020) demonstrates that provincial and territorial governments retain central responsibility for service organization, creating variation in governance and administrative practice. This structure supports experimentation and policy learning, but it also means that system-wide analytical capacity depends heavily on coordination across jurisdictions.

A significant strength of the Canadian case is the presence of intermediary evidence organizations. Canada's National Collaborating Centres for Public Health were designed to identify knowledge gaps, synthesize evidence, build networks, and support public-health decision-makers. Their role illustrates how analytical capacity can be distributed across a governance system rather than concentrated in a single ministry (Dubois & Lévesque, 2020). The National Collaborating Centre for Methods and Tools further demonstrates how curated evidence, competence building, rapid reviews, and coordinated synthesis can reduce duplication and increase access to decision-ready knowledge during periods of high uncertainty (Husson et al., 2021).

The Canadian policy environment also relies on specialized expertise and advisory arrangements. Craft and Wilder (2017) argue that contemporary policy advisory systems must be understood as networks whose effectiveness depends on access, compatibility, and the way advice is connected to decision authority. In health policy, Lawrence et al. (2020) operationalize policy capacity through expert assessment, while Denis et al. (2022) show that Canadian health reforms mobilize analytical, operational, and political capacities in different combinations over time. These findings challenge any assumption that analytical capacity can be separated from broader reform leadership and implementation conditions.

At the same time, federalism creates coordination costs. Comparative analysis of the COVID-19 response found that governance structure shaped the degree of data integration and resource coordination across Canada and other countries (Desson et al., 2020). Béland et al. (2021) similarly show that health financing and federal arrangements influence the distribution of authority and crisis response. Canadian experience therefore provides a balanced lesson: decentralization can support local adaptation, but analytical capacity must include mechanisms for common standards, interoperable data, and intergovernmental learning.

3. Technical and Data Capacity: From Data Availability to Interoperability

Technical capacity is the most visible dimension of analytical transformation, but the literature shows that it is also the dimension most likely to be overestimated. Digital records and large datasets do not automatically become useful policy evidence. Analytical value depends on data quality, standard definitions, secure access, interoperability, metadata, governance rules, and the

ability to link information across organizational boundaries. Learning-health-system research demonstrates that the practical value of data comes from repeated cycles of analysis, feedback, and improvement rather than from data accumulation alone (Enticott et al., 2021; Nash et al., 2021).

Canada continues to face important interoperability challenges. Wolfson (2024) notes that health data are distributed across multiple organizations and databases and argues for practical indicators that assess whether patients, providers, and analysts can access the information required for care and system evaluation. El Sabawy et al. (2024) similarly frame interoperability as a policy and governance issue, not merely a technical problem. These studies show that analytical capacity depends on rules and incentives that prevent data blocking and enable legitimate use across systems.

Recent data-governance literature further emphasizes that accessibility must be balanced with privacy, public benefit, and trust. Shaw and Sekalala (2023) argue for health-data justice as a governance norm that addresses who benefits from data use and how power is distributed. McGrail and Kelly (2025) show that standardizing health-data stewardship across Canada requires shared principles, collective responsibility, transparency, attention to privacy and Indigenous data sovereignty, and a cultural shift toward responsible sharing. McGrail and Buckeridge (2026) extend this argument by emphasizing timely, meaningful, and comprehensive access as an explicit condition for decision-making and system improvement.

Digital policy therefore requires a multidimensional governance framework. A cross-national analysis that includes Canada identifies regulation, financing, delivery integration, workforce support, IT systems, data sharing, and patient involvement as interdependent components of digital-health policy (Srivastava et al., 2023). The analytical lesson is that investment in digital infrastructure should be accompanied by institutional standards, professional capacity, public trust, and explicit decision-use cases.

4. Human-Resource Capacity and the Professionalization of Policy Analysis

The transformation of analytical capacity depends on people who can move between technical analysis and policy reasoning. Required competencies include quantitative and qualitative analysis, evaluation, epidemiology, economics, data science, risk assessment, communication, and the ability to translate technical findings into feasible policy options. The growth of sophisticated analytical tools increases rather than reduces the need for professional judgment because officials must evaluate model assumptions, data limitations, distributional consequences, and implementation constraints.

Evidence from Canadian governments indicates that policy analytical capacity can be examined through the distribution and roles of policy professionals. Migone and Howlett (2023) propose measures that move beyond anecdotal assessments and map policy professionals across Canadian governments. Lawrence et al. (2020) similarly demonstrate that health-policy capacity can be translated into observable factors and indicators through expert validation. Together, these studies support a shift from viewing capacity building as generic training toward assessing the specific competencies required at individual, organizational, and system levels.

Cross-context evidence is important because analytical work is shaped by administrative traditions. Newman et al. (2022), studying West Java, find substantial policy-analytical activity while cautioning against assumptions that

analytical practice can be understood solely through Western administrative models. This finding is directly relevant to lesson drawing from Canada: developing-country reform should strengthen analytical professionalism without assuming that Canadian institutional forms can be transplanted unchanged.

5. Organizational Culture, Knowledge Translation, and Learning

A recurring finding across the literature is that evidence use depends on organizational culture. Policy organizations may possess analysts, databases, and research partnerships while still treating evidence as peripheral to political or managerial routines. Sustainable analytical transformation therefore requires leaders to request evidence, standard procedures for appraisal and evaluation, incentives for collaboration, and tolerance for revising policies when results are disappointing. Parkhurst (2017) describes this as a governance problem concerning the appropriate use of evidence, while Parkhurst et al. (2018) emphasize the need to study the political and institutional conditions under which health-policy evidence is selected and interpreted.

Knowledge translation provides the connective tissue between evidence producers and decision-makers. Sarkies et al. (2017) found that strategies promoting evidence-informed management and policy decisions work through multiple mechanisms, including access to evidence, interaction, facilitation, and organizational support. Partridge et al. (2020) similarly show that knowledge-translation platforms can support evidence-informed policymaking when they are embedded in networks and respond to decision needs. However, Oliver and Cairney (2019) caution that engagement requires an understanding of policy processes rather than simple dissemination, and Oliver et al. (2022) find that many research-policy engagement initiatives remain poorly evaluated.

Learning-health-system scholarship converts this insight into an organizational model. Pomare et al. (2022) show the rapid expansion of the learning-health-system field, while Friedman (2022) emphasizes the alignment of science, informatics, incentives, and culture. Canadian empirical work during the COVID-19 period similarly demonstrates the value of rapid evidence cycles and system learning. Cassidy et al. (2022) identified both assets and gaps when applying a learning-health-system framework to pandemic planning in a Canadian health centre. These experiences suggest that analytical capacity is strongest when evidence generation, implementation, and evaluation are treated as a continuous cycle rather than separate administrative activities.

6. A Causal Explanation of Analytical-Capacity Transformation

The revised framework allows the Canadian evidence to be interpreted causally. Technical capacity expands the availability and comparability of information. Institutional capacity establishes authority, routines, and coordination mechanisms that determine whether information enters policy processes. Human-resource capacity enables interpretation and translation, while organizational culture creates demand for evidence and legitimizes learning. These inputs affect governance outcomes through intermediate analytical processes: evidence appraisal, knowledge translation, policy learning, option assessment, implementation monitoring, and evaluation.

This mechanism also explains why isolated interventions frequently underperform. Building a data platform without interoperable standards can reproduce silos at a larger scale. Establishing an analytical unit without access to administrative data limits its practical influence. Training analysts without formal

decision pathways can produce technically strong reports that remain unused. Conversely, institutionalizing evidence use without adequate professional capacity can turn appraisal into a procedural requirement rather than substantive analysis. The interaction among dimensions is therefore more important than the presence of any single element (Kuchenmüller et al., 2022; Mukherjee et al., 2021). Table 2 summarizes major Canadian practices in terms of the mechanism through which they contribute to analytical capacity and the conditions required for transfer.

Table 2. Canadian analytical-capacity practices, mechanisms, and transfer conditions

Practice	Analytical-capacity mechanism	Main governance value	Persistent challenge
National/provincial evidence networks	Connect researchers, practitioners, and policy officials; synthesize evidence	Reduces search costs and improves access to decision-ready knowledge	Fragmented demand and uneven uptake
Specialized analytical agencies and policy units	Concentrate expertise and institutional memory	Improves appraisal, evaluation, and continuity of advice	Risk of separation from political and implementation realities
Interoperable health-data initiatives	Enable cross-organizational analysis and performance monitoring	Supports timely diagnosis and evaluation	Privacy, standards, data silos, uneven infrastructure
Learning-health-system routines	Create feedback loops between data, practice, and policy	Supports continuous adaptation	Requires sustained participation and organizational learning culture
Intergovernmental policy learning	Allows jurisdictions to observe, compare, and adapt reforms	Supports experimentation and contextual learning	Coordination costs and uneven provincial capacity

Source: Author synthesis from Canadian and comparative literature.

7. Comparative Lesson Drawing for Developing-Country Contexts

The principal comparative finding is that Canadian practices are transferable as functions, not as institutional templates. The function of a national evidence network is to connect knowledge producers with decision-makers; a developing country may perform this function through a ministry unit, university consortium, public-health institute, or intergovernmental platform. Similarly, the function of interoperability is to permit authorized information exchange and comparable

analysis; the institutional solution may differ depending on legal systems, digital maturity, fiscal resources, and administrative decentralization.

Evidence from low- and middle-income settings reinforces the importance of contextual adaptation. Witter et al. (2019) show that cross-country health-system learning is shaped by the reasons for learning, the actors involved, and the mechanisms through which lessons are interpreted. Walls et al. (2017) demonstrate that evidence can take different forms and perform different roles within policy processes, while policy learning is affected by political and institutional context. Consequently, importing a technically sophisticated Canadian model into an environment with fragmented authority, limited analytical staff, or weak data standards could increase complexity rather than capacity.

The Indonesian context illustrates both the need and the opportunity for adaptation. Imani et al. (2024), in the *Journal Governance Society*, use a structured analytical approach to identify strategic strengths, weaknesses, opportunities, and threats in Indonesian public-health policy and point to infrastructure, access, and digital-health opportunities as important policy dimensions. Santosa et al. (2025) emphasize adaptive, networked, and multi-level governance as part of a contemporary governance framework. Read together with Newman et al. (2022), these studies suggest that strengthening analytical capacity in Indonesia should combine professional policy analysis with governance arrangements that fit decentralized institutions and local administrative practice.

Table 3. Comparative adaptation matrix

Canadian reference feature	Common transfer constraint	Adaptation principle	Risk of mechanical transfer
Dense network of evidence institutions	Limited institutional specialization and fiscal capacity	Start with a small number of mandated analytical hubs linked to priority decisions	Creation of parallel units with unclear authority
Large administrative and clinical datasets	Incomplete digitization, inconsistent standards, data-quality gaps	Prioritize minimum datasets, standards, and stewardship before advanced analytics	Technology investment without usable data
Specialized professional workforce	Shortage and uneven distribution of analysts	Build multidisciplinary teams and combine training with career pathways	One-off training without organizational retention
Intergovernmental policy learning	Weak coordination across national and subnational levels	Use common indicators and regular comparative review mechanisms	Centralization that suppresses local adaptation

Canadian reference feature	Common transfer constraint	Adaptation principle	Risk of mechanical transfer
Learning-health-system orientation	Weak evaluation routines and limited feedback loops	Institutionalize rapid review, monitoring, and post-implementation learning	Data collection without policy revision

Source: Author comparative synthesis, 2026

A realistic adaptation strategy would therefore prioritize sequencing. Initial reforms should establish a minimum analytical infrastructure: agreed data definitions, access rules, a small multidisciplinary analytical team, and a routine mechanism for presenting evidence to decision-makers. A second phase can strengthen institutional networks, digital integration, and knowledge-translation functions. More advanced stages can develop learning-health-system capabilities, cross-jurisdictional comparison, and predictive analytics. This staged approach reduces the risk that investments in technology outpace the institutional and human capacities required to use them.

8. Policy Implications

First, governments should treat analytical capacity as an institutional system rather than a technology project. Investments in digital platforms should be accompanied by governance rules, professional roles, and explicit decision pathways. Second, data stewardship and interoperability should be treated as public-governance functions because access, standards, privacy, and public trust determine whether data can legitimately support policy decisions. Third, professional development should target multidisciplinary policy work and should be linked to stable organizational positions so that analytical capability is retained rather than lost through staff turnover.

Fourth, evidence use should be embedded in recurrent administrative routines. Policy proposals can require an explicit evidence statement, major programs can include pre-defined evaluation questions, and senior management forums can routinely review monitoring results. This institutionalization reduces dependence on individual champions and helps normalize learning. Fifth, intergovernmental and cross-sector learning should be designed around comparable indicators and transparent interpretation rather than simple ranking. The purpose of comparison is to identify mechanisms and contextual differences that explain variation, not to assume that a practice effective in one jurisdiction will produce the same result elsewhere.

Finally, analytical capacity should be evaluated by use and consequence, not only by inputs. The number of analysts, datasets, dashboards, or reports is an incomplete measure. More meaningful indicators include whether evidence is accessed in time for decisions, whether options are compared transparently, whether implementation data trigger corrective action, whether evaluation findings alter programs, and whether analytical processes improve accountability.

CONCLUSION

This study shows that analytical capacity in health policy governance is best understood as an integrated governance capability created by the interaction of

technical infrastructure, institutional arrangements, professional expertise, and organizational culture. The Canadian case demonstrates the value of specialized evidence organizations, knowledge-translation networks, professional policy analysis, data-governance reform, and learning-oriented administrative practices. It also demonstrates that analytical capacity remains constrained when federal fragmentation, non-interoperable data, coordination costs, and political or organizational barriers limit the movement of evidence into authoritative decisions.

The theoretical contribution of the article is an integrated causal framework that connects analytical-capacity inputs to evidence-processing mechanisms and governance outcomes. Its empirical contribution is a synthesis of recent Canadian administrative practice showing that strong analytical capacity is distributed across organizations and depends on relationships among government, research institutions, health organizations, and data stewards. Its practical contribution is the distinction between transferable functions and non-transferable institutional forms. Developing countries can learn from Canadian experience, but adaptation should be sequenced according to data maturity, institutional authority, workforce capability, fiscal resources, and governance structure.

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