Article

Policy Disaster, Public Policy and the Booking System

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For those interested in the study of public policy (which includes health policy), the booking system is a fascinating example of a 'policy disaster' in the making. A policy disaster occurs when policy fails to perform as promised, or creates systems and processes that counter original intentions; in short, when 'large-scale, avoidable policy mistakes' are made (Dunleavy 1995: 52). Policy disasters are costly: large amounts of money and energy are required to rectify problems, and the legitimacy of the policy in question is undermined as it is attacked by politicians, the media, interest groups and the public. A key characteristic of a policy disaster is that the disaster is predictable, yet those with the capacity to avert the crisis 'systematically choose to ignore an abundance of critical or warning voices in order to persevere with their chosen policy' (Dunleavy 1995: 52). In 'groupthink' mode, and supported by selected policy theory, they implicitly trust in their chosen directions and abilities to pursue these. Eventually, the policy either overrides its setting, perhaps performing poorly, or transmutes into a full-scale disaster requiring extensive rebuilding or abandonment.

Policy disasters do not occur without the 'right' nurturing circumstances. These include:

- Political hyperactivity: This is when decision-making takes place swiftly and with regularity. Politicians may be concerned with demonstrating their decisiveness and ability to oversee change, with showing that they can produce ideas, and that they mean business. Change will often be pursued with little justification other than 'change is necessary, a new system is needed'. Working with existing systems will be ruled out as retrogressive and untenable. Political hyperactivity promulgates a culture of change, meaning that policies are often barely implemented, and administrative systems are rarely stabilised, before further changes are introduced.
- Fast law: Hyperactivity is possible and promoted by 'fast law' political systems in which one political party has the capacity to push through change. This sends a message to government departments and agencies that they, too, should do things hastily and frequently.
- Poorly trained and inexperienced analysts and advisors: While the notion of policy analysis and advice may be emphasised in government, such emphasis is rarely, in contemporary times, given to the training in public policy and government of those appointed to provide analysis and advice. A background in the private sector and training in an unrelated academic discipline are assumed sufficient qualifications for entry into the world of analysing and making decisions about public issues. As such, training largely takes place on the job, while analysts and advisors quickly learn that putting forward a strong case for change is more important than analysing how that change will be implemented, or what its implications might be. Moreover, in a culture of change, staff turnover rates increase as job descriptions are altered (displacing and relocating staff), appointees seek work elsewhere and new employees take their place. Thus, the culture of change creates a culture of inexperience, in turn, limiting institutional knowledge.
- Inappropriate and unproven theory: If there is any 'training' on the job, then it is in the tacit theories (or ideologies) which underpin contemporary public policy and the application of these theories in all decisions. The theories are *liberalism, rationality, institutional economics* and *managerialism*. Combined, they are a potent cocktail providing a prescriptive framework of reference. Such a framework supports the development of technocratic analysts and advisors who have, at their fingertips, a 'toolbox' of ideas to assist policymaking (Fischer 1990). Yet such theories have been in currency for only a couple of decades; their applicability and capacity to produce good results in practical public policy settings has remained questionable and largely unproven (Peters and Savoie 1994, Self 1993, Walsh 1995).

In New Zealand, the climate for a policy disaster has been ripe, particularly so with regard to the health sector. We have seen in health, through the 1990s, a period of change unprecedented in scope, and from which few lessons have been retrieved. The circumstances for a disaster remain prevalent: political leaders have continued to promote continual change; there have been consistently high attrition rates at crucial points across the health sector – from within the key central agencies (the Ministry of Health, monitoring/advisory and purchasing agencies) and at senior management levels within hospitals; and the selected theories that have underpinned public sector and health reform remain ingrained in the decision-making super and sub-structures.

Because these theories have become an overriding factor in the generation and design of policy, the sorts of policies and service delivery environment they create require particular attention. *Liberalism*, as referred to here, is an attack upon government and social democracy. It demands minimal government involvement in the operations of society. Where government is to be involved, then its approach ought to be *laissez-faire*, in other words, as limited as possible, perhaps providing broad directions only and expecting detail to emerge from producers of services (Brooke-Cowan 1997). *Rationalism* re-

fers to the notion of reduction with the aim of 'rationally' identifying the 'one best way' in all undertakings. It seeks the analysis of all possible options that may be likely to achieve desired, often utopian, end-goals so that the best one can be selected. At an operational level, rationalism entails the study and measurement of processes, again to reveal the best way of doing things (Taylor 1947, Lindblom 1959). *Institutional economics* is the application of economics to the study of social issues and public life. Key sub-species include: *public choice theory*, which assumes that people and organisations will all work to maximise their own interests, in turn, distorting the economy; and *agency theory*, which implies that relationships characterise humanity and, thus, may be subject to formal contract (Boston 1991, Stretton and Orchard 1994). The formal contract keeps a check on self-interested behaviour. Finally, *managerialism* is a doctrine stating that the public sector ought to operate like the private sector, with more 'management', 'freedom' and 'entrepreneurialism'. Thus, agencies and individuals should be free to seek their own solutions and be financially rewarded for them, while objectives should be set and pursued, and emphasised over the details of how they will be attained (Hood 1991). It is against such a backdrop that the booking system for non-urgent surgical and medical treatment was first mooted in 1993 (Fraser et al. 1993).

Policy Disaster, Theory and the Booking System

When studying public policy, it is important to go back to first principles as these often provide useful indications of how implementation might proceed (Neustadt and May 1986). If the suggestions of the waiting lists report, which instigated the booking system (Fraser et al. 1993), had been picked up in full by policymakers, then many of the problems now beleaguering its implementation may never have surfaced. Significantly, the waiting lists report was sceptical about the prospects for the booking system if not carefully implemented and supported by the various stake-holders. It noted that it would be essential to nurture a consensus among stake-holders around the tools for assessment. It noted that a priority scoring system could be open to abuse by clinicians and patients in pursuit of higher priority; that inadequate resources could undermine a booking system, especially if providers were unable to provide certainty to those assessed for treatment or honour 'booked' appointments; and that any system ought to be developed on a national basis, with the input of all relevant parties, although it was acknowledged that regional initiatives could be cultivated on a 'pilot' basis.

What happened from (and, indeed, beyond) 1993-96, the years through which priority criteria and the booking system were further developed, set the stage for the booking system 'policy disaster'. Initially, the Core Services Committee and the Regional Health Authorities (RHAs) engaged in joint initiatives for the development of priority criteria. Substantial progress in this was made. However, through this period, the National Government's theory-driven health reforms were also in operation. This was a period of heightened competitive behaviour, of liberalism, rationalism and managerialism and in which those responsible for policy development lacked experience with the new operating environment. Research has shown that RHA employees, in particular, were highly technocratic in orientation (Gauld 1995). In other words, they were programmatically committed and reliant upon theory for guidance, repudiating the perspectives of stake-holders. What was most important were ideas based on the aforementioned theories. In keeping with this, and as was the case with the booking system, policy could simply be implemented without the need for extended and open stake-holder consultation, or the need for pilot testing. 1993-96 was also a period of political hyperactivity, of making policy announcements such as the 1996 pre-election declaration by then Minister of Health, Jenny Shipley, that booking systems would be in place in all hospitals by mid-1998. Unfortunately, as has been the plight of many a health initiative introduced in the 1990s, the booking system has emerged as a policy which required a more eclectic and pragmatic approach to its development and implementation.

The combination of theory-driven policymakers, inexperienced officials and of political hyperactivity has produced a variety of problems which have been left for the National Waiting Times Project Group to work through. These include: (1) the existence of different priority criteria and points scoring systems within each of the 23 Hospital and Health Services, a result of the competitive and *laissez-faire* era in which development took place; (2) different sorts of criteria schemes in use in different specialities, some less reliable than others; (3) funding inequities resulting from the competitive purchasing strategy pursued by the RHAs, and the different sorts of contracts that exist between the purchaser and providers; (4) funding shortfalls resulting in the anomalous 'residual waiting list' in which patients are given neither fair treatment nor certainty, compounded by practices such as 'volume shifting' where providers use elective surgery money for acute and emergency treatment; and (5) increasing, rather than decreasing, numbers of people waiting for specialist assessment or treatment.

Alternative Policy Theories

Anecdote implies that theory remains an important guide for New Zealand's health policymakers. If this is the case, then perhaps the theories upon which policymakers are reliant require substitution if disasters in other areas of health policy are to be avoided. There are a range of theory options available, reference to which would ultimately nurture better, or perhaps more appropriate, policymaking and provide for more successful, or at least incremental, implementation. Of these, two deserve mention. Parts of the following draw upon Tenbensel and Gauld (forthcoming).

First, and in keeping with the notion of the stake-holder (of primary importance in health with its multiple interests, agendas and functional domains), are *stake-holder* theories (Pross 1986). These seek to achieve policy development in the context of multiple and divergent interests, values and beliefs. The emphasis is upon recognising from the outset that conflicting views and approaches to the way in which services ought to be designed and delivered exist, and seeking ways to practically manage these. Arbitration and debate are central to stake-holder theories. Equally important is gaining accurate descriptions and understanding of the various positions and relationships within the stake-holder community, so that agreements over broad directions and the finer details of implementation can be negotiated. This approach induces ownership and commitment from the vari-

ous stake-holders. The likelihood of foreseeable mistakes being made is, in turn, substantially reduced. Secondary to understanding the environment and its inhabitants, and the possible patterns of implementation, is stipulating how policy should be made and implemented. Allusion to stake-holder theories would have alleviated at least points 1, 2 and 3 listed above and the need for the current 'cleanup' efforts. Policy development and implementation using a stake-holder approach may have been less 'efficient' but perhaps more 'intelligent' (Lindblom 1965).

Second, and a more radical yet democratic approach, are *participatory* theories (Fischer 1990). These question the exclusiveness and entrenched nature of the policy community and its established networks. Participatory theories place emphasis on the role of the public and advocate widespread public consultation and input into all aspects of the policy and service delivery processes. Important to participatory theories is not just stake-holder perspectives, which are interest group dominated, but the perspectives of all members of society. Participatory theories are in keeping with a growing literature in medicine calling for the 'patient perspective' (Mooney 1998, Richards 1999). In contrast with the prescriptive technocratic approach, participatory theorists argue for choice from, and debate among, a variety of policy agendas and alternatives. Participatory theories may have alleviated points 4 and 5 listed above. A consequence would have been rising levels of health expenditure, and thus income tax, but this may have been the desire of the wider community.

In Conclusion

The booking system provides a lesson in how not to develop and implement policy. This ought to be heeded in the light of the fact that health policymakers continue to promote restructuring and the introduction of new policy initiatives, many of which spell change at least as widespread and demanding as that of the booking system. While it may be difficult to avoid the circumstances for policy disaster promulgated by political leaders, those responsible for providing policy advice have a duty to inform those working alongside and above them of the various theories available to underpin policymaking and the implications of each. This paper has posited that one set of theories is failing to appropriately guide health policymakers, and that better alternatives are available.

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