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Policy Instruments and Health Reform
The Role for Evidence

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WORKING DRAFT—DO NOT QUOTE OR CIRCULATE

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Instruments for Governance

Governance depends largely upon a choice among policy instruments, "method[s] through which collective action is structured to address a public problem (Salamon 2002, 19)." In fact, without instruments of some sort, decision-makers and managers would not be able to transform political discourse and policy statements into tangible social action (Ringeling 1983; 2002). And while it is true that political discourse and policy statements in themselves are sometimes examples of policy instruments, it is equally true that there is some difference between discourse when it occurs in the course of public problem identification and when used to solve the problem in question — or to conceal it.

Since the 1980's, there has been a growing interest in the use of policy instruments, especially so-called "indirect tools", those government's activities that are conducted outside the realm of public agencies — in his J. Douglas Gibson lecture in 2005, Lester M. Salamon spoke of "the new governance" to describe the complex interplay of government institutions, profit and nonprofit organizations within policy networks (Salamon 2005). Interest in the use of policy instruments cannot be dissociated from major failures in policy implementation (e.g., the war on poverty) as well as the view that "government involvement in almost every aspect of society" (OECD 1985, 121) is undesirable.

While it would be fair to describe the health sector, as we know it, as a good illustration of a "policy network" composed of government institutions, nonprofit and profit organizations, the traditional view is to see it as a battleground for the competing forces of public and private interests. Notwithstanding the formidable difficulties faced by anyone trying to exactly define what is "public" and what is "private" in a system like

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ours (McKillop et al. 2004), this vision of "Government vs. Market" is very much limiting. In fact, a lot of what is going on in the health sector relates to other ways of allocating goods and resources, other ways for making decisions, other ways to provide care to people in need — from authentic altruistic gestures to self-interested cooperation.[1] Is it not time for health administration and health policy to finally come of age and to approach the sector with a better appreciation of the multiple actors and processes which are at play in its functioning?

Most calls to "overcome" the public-private debate have come from advocates of privatized or two-tier health care, but the approach suggested here is in fact quite different. First, it questions whether the current debate even makes sense, at least according to the usual definition of market solutions – one that refers to risk taking and competition; it is all about access of private entrepreneurs to a well endowed public third-party payer, within a sector where most providers are protected against competition. And second, it highlights that there is something valuable to gain from a widening of the perspective to include other forms of collective action, like altruism or cooperation. A better fit between theory and actual practices is already true progress, as for example when the contribution of charitable organizations to the achievement of collective goals is fully recognized. But more importantly, this broader perspective opens the door to an expansion of the knowledge about the tools we use, or can use, with the help of those methods and approaches that have already proven themselves in the development of evidence-based patient or population health.

Nick Black suggests that, because of the social, economic, political, and even cultural nature of policy choices, the notion of evidence must be applied here with precaution, if not with scepticism:

> Clearly, research has only a limited role because governance policies are driven by ideology, value judgments, financial stringency, economic theory, political expediency,

[1] To be fair with the underlying Public Choice framework which I use here (McLean 1987, 9-22), one should also mention *violence* as a possible way of getting or preserving access to scarce health resources — unlikely in the Canadian context, but certainly not unknown overall.

> and intellectual fashion. It would be naïve and unrealistic to expect research to provide evidence to clinch arguments about governance policies (Black 2001, 276-277).

But is this a genuine concern? Evidence — and the research that creates it — are now understood in broader terms than a decade ago, when they were represented as culture, context or even, content free (Walshe & Rundall 2001, 436). As well, more and more people within the expert community share a common "policy orientation", a phrase first used by Harold Lasswell in 1951 to refer to that circumstance in which "authentic information and responsible interpretation can be integrated with judgment" (Lasswell 1951, 4). If *authentic information* requires a methodical (i.e. scientific) approach to fact-finding; *responsible interpretation* only develops with scholarship, in a cultural environment which favours knowledge and discernment; and *judgment* is a matter of practical intelligence, formed as a result of direct experience. The latter is not acquired easily, but it supposes a real acquaintance with the realities of decision-making and the development of personal relationships with some flesh and blood decision-makers, two circumstances that should guard oneself against any excessive idealism…

Now it will not be enough to agree on the existence of a plurality of policy instruments, or to decide on a systematic approach to their evaluation. A further essential step is to ask ourselves about the use of these tools in real life conditions, the crucial question of policy selection and policy design. One very prevalent hypothesis is that choice of instruments is shaped by previous choices in the same area, embodied as they are in institutions and "path dependencies." One other possible explanation is that choice is an outcome of strategic confrontation between major players within a given policy coalition. A third and promising view is that decision-makers act within a defined cognitive frame, made of knowledge, values and expectations and enriched by past experiences. Policy making is not limited to one dimension only and there is a real gain in understanding when one considers the multiple ways a social choice problem is actually framed by the ones who should solve it.

Public Policy Instruments

When associated with the concept of governance, policy instruments may be seen as a "portfolio" of possible means to achieve a given objective through political action. They do so in the least constraining way possible, as brilliantly intuited by Doern and Phidd in their famous taxonomy (1983) – usually exhortation is to be preferred to taxation, regulations will come before prohibition, etc.[2] Expected outcomes of any given option also need to be weighed against the risk of losing support from members of the policy network, the coalition of "governors" composed of public authorities, members of the policy community (i.e., experts and stakeholders), together with some members of the interested public (as voters or direct participants). In many instances, no policy objective would seem more critical to decision-makers than the integrity of the network from which they draw intelligence, resources, and support (de Bruijn and ten Heuvelhof 1998).

One would also like to believe that government choice of instruments is based on appropriateness, i.e. the fit between ends (policy intentions) and means (anticipated outcomes). But what tips the balance in any given circumstance can be as equally shaped by the exigencies of the moment as by rational reflection. If appropriateness is ever to play a role, it is at the deeper level where policy choices are appraised according to social norms and ethical principles; the level where policy measures are seen as "instances of collective expressions of values" to quote from LeGrand (1991, 47). This latter point is particularly cogent in the health policy sector because of the insistence on principles such as equity and efficiency when passing judgment on policy orientations.

Otherwise, definitions for policy instruments are plentiful, most founded on the distinction between decision-making and implementation; for example, Howlett defines instruments as "…techniques at the disposal of governments to implement their public

[2] A typical example is given by the former Commissioner of the U.S. Food and Drug Administration, David Kessler (2001, 392-393), who concluded after years of campaigning against the use of tobacco and of tax increases that "… the solution to the smoking problem rests with the bottom line, prohibiting the tobacco companies from continuing to profit from the sale of a deadly, addictive drug." Kessler even recommended the creation of a public utility to sell cigarettes, under tight control from the Congress.

policy objectives (Howlett 1991, 2).” Other definitions focused instead on the distinction between policy (of which instruments are a constitutive part) and outputs or outcomes.

For our purposes, however, it is important to concentrate on *public* policy instruments, used by governments and similar institutions, as opposed to policy instruments used by other organizations (“business policy tools”) or by individuals in their private life (“instruments used by Sam in the pursuit of his investment policy”). Public authorities are not the only important social actor that attempt to “ensure support and effect social change (Bemelvans-Videc 1998, 4).” Other actors as well are positioned to exert some sort of political influence. But government administration, being about social control and political power, is somehow different. Not only must public authorities persuade or prompt society into the realisation that any given policy is desirable, like any other interest group, but they have sometimes to impose or force a solution upon an unwilling crowd, using a set of tools that only government has at its disposal, like laws and tribunals and mounted police.

In the end, therefore, all public policy instruments are to some degree a combination of persuasion, regulation, and force, though this list is by no means definitive. They are assembled by a government limited in resources like astuteness, legitimacy, or experience, and which is dependent on a network of stakeholders and supporters to achieve its goals. If that government is democratically chosen, moreover, it will also be limited by the electoral cycle. Though this last point is curiously absent from the literature, it is difficult not to be aware of it when looking at actual policy choices: instruments are frequently selected because they bear the promise of results in a given period of time — coincident most often with the moment when the government needs to face the electorate.

Evaluating Policy Instruments

There is no such thing as a “tool box” from which one can choose an instrument ready to be used; instead we must pick several that, in combination, meet our objective. In that regard, standards for selecting and evaluating alternative instruments (or

combinations of instruments) are not very different from standards for evaluating other innovations in health care. The basic questions one must ask are: Are they compatible with the norms and rules that are supposed to guide choices made by decision-makers? and To what degree do observed outcomes correspond with expectations?

An interest in norms and rules may further take the form of concern with general rules of conduct – moral principles usually associated with democratic theory – or with perspectives that are unique to one individual or group of individuals. The fiscal policy of a social democratic government may be judged, for example, from the point of view of its "transparency" (which has been a basic tenet of democracy for centuries) or from the point of view of its consistency with some principle of equality (which might have been part of the ruling party's electoral platform).

An interest in outcomes and expectations is more in line with the tradition of public administration. But it is hampered by many difficulties at the empirical level. It would be utterly naïve to expect to find a direct and simple causal link between a given instrument and what is termed an "outcome". As we maintained at the start, any observable result is the product of a plurality of intermingled factors, of which concrete historical circumstances are among the most influential. It is that which explains why ambitious projects in program and policy evaluation, as seen for example in Donald T. Campbell's dream of an "experimenting society" (Campbell 1988; Forest 1991), have all sunk into oblivion after a few years. Testable hypotheses containing variables, as well as deduced predictions of specific results, might well be unattainable ideals.

As has been seen, an exception to the general lack of formal evaluative knowledge is the identification of concrete attributes through induction. This process could take the form of two distinct processes or procedures:

1. The easiest thing to do is quite certainly to look at incompatibility between intents and instruments, either from a normative (moral) point of view or from an efficacy point of view. This looks like straightforward program evaluation, but it is not. First, the goal is best achieved by multiplying both observations and

observers, i.e. by refusing evidence coming from a single experiment or which is put forward by a group of experts biased by the same tradition or cultural membership. To quote again from D.T. Campbell (1988, 320-321): "…large numbers of independent decision-makers (i.e., scientists) are essential for objectivity in science." Second, compatibility is sometimes a question of degree or even, of mere "quantity"; Alan Williams has argued that a threshold exists in every public health system above which any introduction of a new private or market-oriented instrument affects the global orientation of the system (Williams 1997, 62-64). The debate over the possible introduction, in the Canadian public health system, of instruments like user fees or medical savings accounts is a good illustration of a problem that requires caution in the use of "evidence" (Stoddart, Barer and Evans 1993) and an appraisal of the consequences of any policy initiative on a system that comes perilously close to Williams's threshold.

2. The second thing to do is search for instruments that could help authorities achieve outcomes that are desired by most but which fail to materialize, due to an inability to translate principles into actual policies or models (Okma 2002). One possible route is to look carefully at "failures" and to treat them as the result of a poorly adapted policy frame, rather than as the result of "resistance to change" on the part of the professionals or the public. Primary care reform might become a paradigm in Canada with regards to our collective incapacity to achieve desired outcomes. It could be easily argued that this state of affairs is the result of two concurrent phenomena: (a) an unwillingness to consider alternate policy instruments to achieve reform goals — most proponents of primary care reform conflate the objectives with the process itself; (b) a difficulty with realizing that some hypotheses concerning incentives or resources could be wrong — a new approach to social change might be necessary.

These are only rough outlines. The real task is to identify new policy options, adapted to changing social and economic conditions, and moreover, based on cross-validated evidence: multiple and comparative case studies, open to the judgment of a plurality of point of views.

Framing Instruments

There is a school of thought in policy studies that concerns itself with questions of intent, vision, craftsmanship, interaction with context, etc. and which tries to conceptually integrate these questions into one approach, known as the policy frames approach or, more simply put, as *framing*.

Framing has been defined as "a way of selecting, organizing, interpreting, and making sense of a complex reality to provide guideposts for knowing, analyzing, persuading, and acting (Rein and Schön 1993, 146)." The use of frames is typically a matter of circumstance, context and constraints.

As with other *cognitive* approaches, the orientation of framing is to knowledge in the general sense, with no clear distinction made between "experiential," scholarly or lay types of knowledge; what counts is that as human beings, "we can […] build up a knowledge of the world, integrate our experience into a coherent whole, and develop successful strategies for coping with the situations we meet (Harré and Gillett 1994, 43-44)." This may sound trivial, but important methodological consequences result from this position, notably what regards to the manner one would approach a policy network or coalition. In effect, looking for frames in that context is first and foremost looking for a common language, made up of signs and symbols borrowed from the personal sphere of individuals separated by status and social function, but united by common interest and purpose.

In addition, the orientation of framing around an analytical and *pragmatic* approach, (i.e., Austin 1962: *How to Do Things With Words*) means that discourse is seen as another form of action, and conversely, that action always conveys some form of discursive meaning (Wilson 1990). This again has methodological consequences, this time on the status of political discourse in the list of policy instruments – but as stated previously, only "performative" expressions can be considered truly instrumental.

It should be noted that frames are not instruments. They are "used" however in the process of selecting, organizing, interpreting and making sense of instruments. Some

instruments are incompatible with some frames, even if the instruments pass muster in terms of efficacy, efficiency, legitimacy, and mere legality. In her discussion of the impact of "vouchers" on education reform,[3] Janice Stein has demonstrated how this particular instrument could have "pernicious consequences for equity," while it meets standards for cost-effectiveness (Stein 2001, 98-106). Another recent publication by Christopher Howard (2002) addresses the issue of "tax expenditures"; it shows how this instrument is often questioned on the basis of its legitimacy, even when it is used in the most equitable fashion. We can all think of myriad other examples in health policy, where a heated debate divides those who believe in interventions aimed at reducing risks at the individual level from those who believe in solutions at the societal level, from redistributive fiscal measures to direct public investment in housing or education (Smith, Ebrahim and Frankel 2001, 185).

From a research point of view, it is often possible to proceed inductively from actual instruments back to policy-makers' frames. From a practical point of view, it is possible to help decision-makers select, combine and make generally better use of policy instruments, based on an appraisal of *their* policy frames. In the context of health care reform, for instance, we may recognize four major policy frames, here tentatively labelled following the major approaches to social change with which they share basic assumptions (Table 1). The *organizational* approach is focused on management activities inside health organizations. The *pluralist* approach takes its name from one school of political sociology in the 1960s that insisted on the competition for power between interest groups for its explanation of the policy process. The *cognitive* approach assumes that change comes essentially from the transformation of shared meanings that result in ideologies and world visions. Finally, the *structural* approach emphasizes the transformation of social and economic settings as a condition for change at the level of organizations or individuals.

[3] A direct money transfer from public authorities to parents, that they can use to pay the full or partial cost of the school of their choice.

Table 1 : Four Policy Frames

	FRAME 1 *organizational approach*	**FRAME 2** *pluralist approach*	**FRAME 3** *cognitive approach*	**FRAME 4** *structural approach*
FOCUS	**Internal** (organizations)	**Internal** (groups)	**External** (culture)	**External** (society)
INCENTIVES	**Individuals** (rationality)	**Individuals** (influence)	**Organizations** (values)	**Organizations** (interests)
RESOURCES	**Intangibles** (professional authority)	**Tangibles** (status, supporters)	**Intangibles** (knowledge)	**Tangibles** (money)
LEADERS	**Yes** (entrepreneurs)	**No** (concerned interests)	**Yes** (experts)	**No** (social forces)

These policy frames are characterized by at least four distinct parameters that express how decision-makers conceive of the mechanisms of social change, in other words, their system of beliefs or intuitive "theory" about why and how policy can shape human behaviour (Boudon 1999; Braybrooke & Lindblom 1963). The four parameters are as follows:

1. The *focus* of decision-making could be on factors internal or external to the policy sector, depending on whether or not decision-makers believe the lever they need to introduce change lies within the policy sector itself or in the larger context of social and economic policy, if not demographics. For instance, is an ageing population a health care problem, which can be solved by acting on the supply of services, or a demographic problem, which should be tackled through family policy and other social measures (Palme 1999)?
2. To determine how and why people act, one must define their motivations or *incentives.* These can target organizations or the individuals working in them, and seem to depend largely on assumptions made about human nature and the way it is supposed to condition behaviour. For example, measures that attempted to transform nursing practice in the past decade have wavered between a focus on the individual or on the organization, depending upon whether policy-makers believed that nurses were acting individually, looking for better working conditions or more influence over their environment, or as members of a

particular professional organization, that could only transform itself through cultural change or even confrontation.

3. *Resources* can be intangible or tangible, and include knowledge, money, support, status, and professional or scientific authority (Jenkins 1983). The debate on information technology in health care is structured around the arguments of those who believe that accessing greater quantities of information is the key to better professional practices, and those who are convinced that more information cannot replace adequate funding or proper training.
4. Finally, particular *leaders* or entrepreneurs may be perceived as key to success. It could also be argued that any motivated individual, with sufficient empowerment and information, could fulfill this role. The composition of a regional board might be very different if one thinks that any representative from the community could perform adequately in tasks like health planning or resource allocation, as opposed to thinking that only qualified and politically sound administrators would do the job properly.

All of this suggests that frames provide an alternative to the problem of attempting to build typologies of policy instruments with discrete categories, while not resorting to either an extremely abstract approach (i.e., Hood 1983), or to a purely empirical listing of administrative techniques (i.e., Kirshen et al. 1964). But within an operational context, typologies are of only of limited interest. The next step, therefore, is to provide criteria to determine the appropriateness of different policy instruments in real life conditions. It should be clear that policy frames are part of any serious attempt to assess how a specific instrument, or combination of instruments, would help solve a public problem in a feasible and politically acceptable manner.

Conclusion

Policy frames act as filters or more accurately, as "dams," hampering the natural flow of evidence. Even with the considerable range of tools and approaches available, policy-makers will typically limit themselves to the tools that are immediately compatible

with their own "frames" of reference and which suggest a specific "theory" of problem causation, human behaviour, sources of power and authority, and social change (Andrain 1998). In the health sector, when nobody feels comfortable with the instruments that exist, what an outsider (or a lay citizen) would see as straightforward and simple goals may not be realized for decades – primary care reform, wait times management, and health human resources planning providing us with plenty of examples, if ever needed.

For the "new governance" paradigm called upon by Salamon to take over our approach to health administration and health policy, it will not be sufficient to multiply studies and pilot tests of new policy instruments. In many instances, reform will depend on our capacity to "open the dam" and to introduce changes in the policy frames themselves. While frames themselves could not be tested or contested, most of their constitutive dimensions can be challenged, providing that we have good evidence that an implicit "theory" is wrong or that the instruments it suggests are not producing expected outcomes. The current debate around the influence of financial incentives on physician behaviour is a good example of the case in point, with all sorts of questions asked about individual motivations and structural constraints on professional activities (Marshall & Smith 2003).

Policy-makers make use of many sorts of "evidence." In his superb study of the operations of a Senator's office in the USA, Peterson (1995) has demonstrated that most if not all sources of information are treated almost equally, inasmuch as they reach the desk of the decision-maker and his immediate staff. One source flows from the work of policy analysts and other scientific experts, using the methods of science. A second has its origin in the public communication effort of stakeholders. A third, too easily dismissed by professional analysts and public relation specialists, comes directly from daily contacts between politicians and their constituencies: letters, phone calls, conversations of all extent and style – with polls and surveys being a substitute to real life interactions. It is very unusual for a new policy to get through without the three streams of evidence converging in the first place.

As one could guess, therefore, the problem becomes one of redundancy of information. Multiply the channels of communication and you would multiply the impact. This has important strategic consequences for people who produce or communicate "scientific evidence". The more conversations they enter into, the more interactions they have, the more they will be taken into account and the more they will influence the policy process. This is one sure way to open the dam.

But there is also a risk attached to this strategy. It is likely that in the current climate, decision or policy makers will be attracted to scientific evidence, except in the few areas where the course of action is decided by a network closed to public influence. This however should not be taken for granted. Science and applied research are already perceived by too many people as mere vehicles for ideological or political orientations. The role of scientific evidence in the decision-making process is essential, if only, as stated previously, because of its challenge function. But Max Weber's famous admonition to scientists still holds true. Those who use their position in the world of research to vindicate a particular political standpoint might well be perceived in the end as just any other stakeholder, any other supporter. Rather than serving our collective aspiration to recognition and usefulness, it may well turn to our disadvantage.

[Wednesday, November 9, 2005]

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