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In his new book, Dealing with Messy Policy Problems*, to be published in April 2009, political science professor Steven Ney of the Singapore Management University offers insights on how to make sense of complex, messy and often overlapping policy problems. Ney's book uses Cultural Theory, inspired by Mary Douglas, as an analytical model to dissect and understand the various policy debates related to climate change, transport, ageing and health. It provides a close look at how policy makers attempt to deal with messy policy challenges by adopting different "frames", defined as "coherent sets of ideas and beliefs".*

The interactions between the different frames, or policy domains, inevitably lead to agreement and disagreement. However, Ney contends that having conflicts is not a bad thing. In fact, it is a necessary part of the process of finding solutions to complex policy issues. The key lies in the ability to listen and adapt to differing views. Ney spoke to Knowledge@SMU on policy issues relating to the crisis in global health care.

Knowledge@SMU: What exactly is the global health crisis?

Ney: The global health crisis is the type of slippery policy issue that eludes attempts to define it. Although these types of messy policy issues -- including problems such as climate change or pension reform -- generate a lot of research and data, there is much about them that we really just do not know. For example, how will the HIV/AIDS epidemic affect Africa in the long-run? Some scientists argue it will be a curse; others argue that it will be a boon to African economies. Both arguments are equally plausible, if not necessarily equally appealing. Which one is right? There is no way of knowing.

And because these issues are so uncertain, policy debate about them tends to generate considerable conflict about what the problem is, who is to blame, and what is to be done. In the book, I use a theory, devised by the late Dame Mary Douglas and developed by Michael Thompson, to make sense of the conflicts around messy policy problems.

Refracting debates, such as the global health crisis, through the theoretical lens of Cultural Theory tells us a number of things about policy conflict. First, the analysis suggests that, in the absence of scientific certainty, parties to these debates rely heavily on something Douglas called 'cultural bias' to make sense of the issue.

Policy-makers are called to act on issues such as health care, transport or demographic ageing, and need to have some idea about how these issues impinge on the world. These cultural biases provide templates for policy actors to interpret the flood of often contradictory data that surround messy policy issues, and to decide what to focus on and what to ignore. Through this process of selection and interpretation, policy actors build plausible but partial accounts of what is going on, for instance, with the global health crisis.

Second, since the different interpretive templates are based on fundamentally divergent values and beliefs, policy debate produces incompatible stories about the problem. When policy actors tell these stories in the public sphere, the result is going to be conflict about the nature of the messy policy challenge.

For the global health crisis, the analysis unearthed three such incompatible stories.

One account, told by organisations such as the World Bank or the pharmaceutical industry, sees it as a problem of inefficient public institutions, lacking individual responsibility and poor medical innovation. The dominance of the state as health care provider -- and all the inefficiency and corruption this implies -- has corroded individual responsibility for health choices and strangled medical innovation. In poor countries, politically influential middle-classes 'hog' scarce public health care resources, thereby crowding out the truly needy. In rich countries, public health care systems encourage individuals to abdicate responsibility for their health to the taxpayer. All this leads to an irresponsible waste and misallocation of resources that, given the right system of market incentives, could be put to much more effective use.

Another story conceives of the global health crisis as the result of prevailing global inequities. In this view, propounded by the many civil society organisations critical of globalisation such as Oxfam, ATTAC, or the People's Health Movement , the problem is that a few have far more than they could ever need, while the majority must make do with far less than they need to live. Around the globe, the poor suffer unnecessarily from diseases for which effective cures could be made available. What is needed, they contend, is a profound change of our ways so that health care becomes a social right, not a traded commodity.

The last story, told by organisations such as the WHO or national medical associations, is about the stewardship of

health systems. Effective health care provision, so the argument goes, is an immensely complicated task that requires considerable expertise, skill and judgement. It is about balancing public and private sectors, individual responsibility and public health duties, medical authority and patient rights, or health wants and health needs. On this view, the main problem is that many health systems in the world lack the institutional coherence and management capacity for balancing these factors. What is needed, then, are strong institutions in the public sector staffed by capable medical experts.

Knowledge@SMU: Your book is an attempt to make sense of the complex and messy policy issues. But what come next?

Ney: The important thing to remember is that none of these accounts gets it completely wrong. However, none of them gets everything absolutely right either. So, conflict is inevitable. Traditionally, policy scientists have believed that this sort of value-driven conflict gets in the way of rational policy solutions. Conflict was something to be avoided or expunged. One way of doing this was to resolve disagreements by furnishing more facts ; here, science was to tell us the right solution to our problems. Another way was to exclude contending parties from policy-making; here, policy-making sovereignty was to implement rational solutions without distraction.

But, as the book shows, these traditional modes of conflict resolution don't really work for messy policy problems because of the significant scientific uncertainties involved. Adding more facts to the already torrential stream of data merely fans the flames of contention. Paradoxically, the more facts and data there are, the more policy actors need to select and focus on what they consider to be salient.

To do this, in turn, policy actors rely on their cultural biases to guide them. Since each story focuses on an important part of the solution that the others ignore, excluding any one view from policy-making may lead to very unpleasant surprises. The global financial crisis is one example. Arguably it has been brought about by an unswerving belief in the self-regulatory capacities of global capital markets. Believers paid little attention to widening global inequities, on the one hand, and poured scorn on anyone arguing for more moderation and regulation.

The upshot of my argument is that messy problems require messy or, as Michael Thompson and Marco Verweij put it, clumsy solutions. In order to come to grips with these important policy challenges, we need to embrace conflict. Only the critical engagement between parties telling contending stories enables us to learn how to deal with complex and uncertain issues. Clumsy solutions include proposed solutions from all competing accounts of a messy policy issue. Paradoxically, then, value-driven conflict is the key to unravelling messy policy problem because it is the most effective vehicle for public or policy-oriented learning.

Knowledge@SMU: What do you think is the greatest challenge health care policy makers face?

Ney: I think the greatest challenge is ageing. Ageing brings about a specific set of problems for health care systems. And, significantly, ageing is a messy challenge that is likely to affect different health systems in very different, largely unpredictable ways.

In countries with high-performance health care systems, we have predominantly focused on the cost pressures associated with ageing, and for good reason. Higher life-expectancy – essentially the outcome of high-quality health care – has meant that we face far more complex health challenges. Instead of dealing with diseases such as cholera, measles, TB, or malaria for which there are few known causes, health systems today deal with diseases such as cardio-vascular problems, a range of cancers or diabetes for which there a very many potential, mostly unknown, causes. Moreover, the older we get, the more chronic diseases we accumulate (something called multimorbidity), the more medical attention we will require. This is likely to be very costly.

The debate about how best to approach these complex challenges is, predictably, intense. Some argue we have to radically change our unhealthy lifestyles imposed on us by a consumerist society to avoid contracting diseases such as diabetes or heart disease. Others argue that we need to create strong financial incentives for people to look after themselves. Others still contend that disease is largely unpredictable, which is why we need health systems staffed with knowledgeable health professionals to react appropriately when disaster strikes.

Knowledge@SMU: Do you see any health care system model that is better than others?

Ney: There is no one best model of health care. Health care systems have evolved within specific socio-economic and cultural contexts over many decades. They are attuned to the political, economic and socio-cultural conditions in these countries. As a result, health care systems have developed in very different ways in different parts of the world. Countries like the UK, Canada or Sweden rely on public sector health care provision. People in Japan, South Korea, Germany, France and, to a lesser extent, Singapore depend on a system of semi-public insurance institutions to fund and regulate health care providers in the public and private sector. Yet, despite very real institutional differences, so called high-performance health care systems produce very similar broad brush health outcomes. With one prominent exception, namely the US, all high-performance systems provide high-quality health care to almost everyone in the population. Admittedly costs and modalities differ. In countries such as Germany or Japan, the patient has far more choice of provider than, say, the UK or Canada. This choice, however, comes with a price-tag.

Knowledge@SMU: Should the government play a bigger role in health care?

Ney: The size of a government's role in the health care system is not nearly as important as the quality of the state's involvement. In the real and rather messy world of health care provision, governments have a crucial role in the management, provision and regulation of health care. No one really disputes this except for rhetorical effect. The real and hotly debated question is, what should governments be doing in health care systems?

For example, if we look at health systems in the developing world -- say Indonesia, the Philippines or Bangladesh -- we can see a massive involvement of the state in health care. But public sector health systems in these countries find it difficult to provide even basic health services all the time.

Alternatively, the Canadian health system features a very high level of public sector provision and regulation of health care. However, much of the day-to-day health system governance is done by so-called 'arms-length' Regional Health Organisations. These institutions are public but largely independent of the political system. This type of public system strengthens the autonomy of health professionals to provide the best health services they can.

back to top (#top)

back to top (#top)