Chapter 4 Policy implementation

Problems relating to the implementation of policy have been recognised only recently, that is, in the USA and the UK only from the 1970s onwards. There used to be a general assumption that once senior decision-makers had formulated a policy and communicated it to their own and, if appropriate, other agencies, implementation would follow almost automatically – that is, the policy or policies would be acted upon and put into effect. More recently, in the light of analysis *of* various policies, it has become increasingly recognised that having and announcing a policy is not enough to guarantee (a) that the policy will be fully implemented and (b) that it will be effective in achieving its intended objectives.

Hogwood and Gunn (1984), for example, argue that such failures have been observed in a wide range of fields, for example urban regeneration, land development, employment initiatives, the control of pollution and industrial restructuring. To this list, it is almost inevitable that we can add examples from the arena of health and health care services. Certainly, in the UK, stated policy intentions have not always been fully implemented, and the government's objectives have consequently either been thwarted or only partially successful. Harrison *et al.* (1992) have pointed out that attempts within the British NHS to shift resources towards the 'Cinderella' services for the mentally ill, mentally and physically handicapped and elderly people have not been accomplished. Similarly, the relatively recent initiative in the UK to redirect care into the community and out of hospital and other institutional settings has yet to fulfil its promise of effective support organised across professional boundaries.

The implementation gap

In certain circumstances, health care policies may only be partially implemented, may suffer delayed implementation, may

not be implemented or, once put into effect, may produce completely unintended consequences. A useful framework for clarifying this concept of a 'gap' is to consider the extent to which a stated policy has achieved its stated objective or objectives. In the case of the UK care in the community initiative referred to above, all the mechanisms for putting the policy into effect were set up, legislation was passed, and health, social care and housing organisations – public, private and voluntary – started working more closely together. Yet there continue to be problems centred on the gap between intention and effect. What appears to have happened is that the whole community care enterprise is inadequately funded, and agencies 'in the field' were left by the government in power at the time to find whatever funds they could. Underlying the UK government's community care policy was a drive to reduce public expenditure on care services (Hunter 1993, Lewis and Glennerster 1996).

The above analysis is rather superficial, but it does draw attention to the fact that policy-making has to take into account, at that stage in the process, the important question of how the policy can be successfully implemented. This means that the policy process cannot be depicted visually as a neat stage-by-stage process, along the line suggested by Simon's rational model (see Chapter 3), 'implementation' being identified as a separate and later stage following on from the actual decision. The issue of implementation has to be attended to by policy-makers at the time when a possible response to a certain issue is under discussion.

The work of Pressman and Wildavsky

An influential piece of research into implementation was carried out by Pressman and Wildavsky (1973). They investigated the relative failure of the Economic Development Agency (EDA) in the city of Oakland in California, USA to achieve its key objective of providing jobs for ethnic minority groups. The EDA sought to achieve this by financial aid schemes for public works and local businesses. The results were very disappointing. A great deal of money was spent, few jobs were created yet there was no apparent participant conflict or resistance to contend with.

Pressman and Wildavsky found that the main obstacle to success was that, although the ends were agreed, the means to

achieving them relied on too many different agencies at central and local levels, all of which were working to different timescales. No single group had control over the total situation. In short, there was poor co-ordination.

Pressman and Wildawsky defined 'policy' as 'a hypothesis containing initial conditions and predicted consequences. If X is done at t1, then Y will result at t2'. Implementation is the process of interaction between the setting of goals and actions geared to achieving them. The conversion of the hypothesis into action these authors called a government 'programme'. Initial conditions are the passing of legislation and the securing of funds. Implementation will, they argue, become less effective as the links between all the various agencies involved in carrying out the policy form an 'implementation deficit'. The chain of command has to be capable of assembling and controlling resources, and the system able to communicate effectively and control those individuals and organisations involved in the performance of tasks (Parsons 1995). Pressman and Wildawsky later modified their original analysis towards a less 'top-down' model of the implementation process, but they initiated a flow of literature that focused on the complex nature of policy implementation.

The 'top-down' model of policy implementation

This model assumes that the process of implementation follows from decisions made at the top tier of any organisation. These decisions then have to be implemented by personnel lower down the hierarchy. Hood (1976) and Gunn (1978) adopted the thesis of Pressman and Wildawsky that stressed a quasi-military approach to ensuring that policies were implemented as intended and that, as a result, the targeted goals were attained. Hood detailed five conditions for the achievement of *perfect implementation*:

- The system in which implementation is to take place needs to resemble an army-type organisation with clear lines of authority and responsibility.
- Precise tasks and objectives are laid down.
- People carry out their specified tasks as given.
- Communication between different sections of the organisation(s) needs to be perfect.
- There are no problems created by constraints of time.

Gunn added to these items, and later, in his collaborative work with Hogwood (Hogwood and Gunn 1984), a list of eight prerequisites for perfect implementation was compiled:

1. There must be clear objectives.
2. There must be no ambiguity about the purpose of the policy.
3. Those who have to implement the policy must have the necessary commitment and skills.
4. The policy must have the support of key interest groups.
5. Sufficient time and resources are made available.
6. There are relatively few links in the implementation chain.
7. Communication between all parties is excellent.
8. There is no resistance to the policy.

These eight conditions for perfect implementation in the 'top-down' model of the policy process may be summed up under three broad headings:

1. *Change*. Has the extent of change been made clear and accepted by all interested and powerful groups affected by the policy?
2. *Control*. Can the policy-makers control the resources required in order to implement the policy and also control and, if necessary, direct all participating groups and agencies?
3. *Compliance*. Does the top level of decision-makers have complete confidence that those people who have the task of putting the policy into effect will do so without resistance?

Critiques of the top-down rational control model

This top-down prescriptive or normative model resembles the comprehensive-rational model of the policy-making process delineated by Simon, which was described in Chapter 3. It assumes that, providing the organisational mechanisms are in place and geared towards the accomplishment of clearly defined and meticulously communicated objectives, the stated policy will be fully put into effect and will, therefore, be 'successful'.

There are, it is suggested, two flaws in this model:

1. It appears to assume that human beings will tend to behave like automatons, as if we need only to set up the correct

computer program and process it by making sure that all the correct keys are pressed in the right order. Human beings, for whatever reasons, do not always behave predictably. Therefore, even if there were perfect control and compliance, there remains – at various strata within organisations – a degree of autonomy to act in ways that might not fit exactly with the policy-makers' assumptions. Lipsky (1980), as we shall see, has been influential in challenging the somewhat authoritarian rational control model of policy implementation.

2. Even if the policy has been implemented 'perfectly', the anticipated consequences may not automatically follow. What Hogwood and Gunn (1984) have described as a 'blemished theory of cause and effect' as a potential obstacle to perfect implementation is not strictly about implementation as the *process* of putting policy into operation; it has more to do with the *consequences* of a particular policy during or after the process of implementation. We return to the points made in the previous chapter about competing rationalities. In other words, the logical cause-and-effect relationship can rarely be uncontestable. Given certain, sometimes unforeseeable circumstances, a policy – even if perfectly implemented – might result in one of several possible outcomes depending on a variety of factors.

Some interesting hypothetical and actual examples of this kind of disjunction between intended and eventual policy impact illustrate the complexities involved in policy implementation.

Problems with forecasting the consequences of policy

In an article entitled, 'Laws that backfire', Bartholomew (1994) related the incident in which an aeroplane crashed in Sioux City, USA killing 111 people including a baby. The baby, like other children under the age of 2, was being carried by his parents. In the outcry that followed, politicians, parents and consumer groups demanded legislation to make baby seats compulsory. Everyone, including air crews and the airlines, agreed. Legislation was planned to implement this agreed action.

However, some academics examined other possible effects that such legislation might have. They reasoned that many couples travelling within America with their small children are

relatively short of money. If they were obliged to pay for an extra seat, many would choose the cheaper alternative option of road travel. Since cars are far more likely to be involved in an accident than are aeroplanes, the likelihood of babies being killed would rise rather than fall if this policy were introduced.

This possibility of the effect being the reverse of that intended has also been noted, according to Bartholomew, by charities who provide free food to underdeveloped countries. The economic effect on local farmers has, in some cases, been negative because it annihilates their profits so that, instead of being encouraged to plant more, they are induced to plant less. In the field of social housing, the UK government of the day introduced legislation in 1967 that decontrolled rents in the privately rented sector. The intention was to stimulate a declining private sector to increase its market share. The logical argument was that, by enabling private landlords to set their own rent levels, more income would be generated, which would, in turn, be reinvested in acquiring or building new homes for rent. As it turned out, the Rent Act of 1967 led to an as yet irreversible decline in private renting as a form of housing tenure. Many landlords used the legislation to set rent at prohibitive levels so that sitting tenants who could not longer afford to remain were evicted and the houses and flats were then sold.

The 'bottom-up' model

This approach has been described as a process of consultation and negotiation that takes place between those at the 'top' and those implementing policy, and as an approach that might at times be the only means by which resistance and suspicion on the part of individuals and groups with entrenched interests might be overcome and the policy successfully implemented.

A useful contribution to recognising the influence or potential influence of lower-level 'actors' in the implementation process is that of Lipsky (1980), who coined the expression 'street level bureaucrats' to describe those people who lie at the interface between the organisation and members of the public. People such as school teachers, nurses, social workers and social security officers all play a crucial role in the kind of service that people receive. According to supporters of the bottom-up model of policy implementation, these relatively low-level personnel

may have more discretion to act in the way they think appropriate than they are given credit for. Consequently, they may mediate policy imperatives in the light of competing pressures such as limited resources.

Professional and administrative practices might not actually sabotage or even undermine policy but they may certainly slow down the process of implementation. Health and social care policies, for example, that rely heavily on interprofessional collaboration might not be very effective 'on the ground' because, intentionally or unintentionally, a range of practitioners often find it difficult to work together, particularly in preplanned teams.

Baggott (1998) has remarked that joint planning between health authorities and local authorities in Britain failed to achieve a 'seamless service' in relation to implementing community care policy and legislation because of the contrasting organisational cultures and structures. As a result, certain needs were defined in different ways. For example, the majority of health authorities regarded care of the elderly mentally ill as a duty of the psychiatric services, whereas local authorities preferred to view them as clients catered for by generic services for the elderly. Compounding the problem of implementation at 'street level' are the professional rivalries between health service and local authority staff, the different planning timescales, differences in accountability and management structures, and the fact that, in many instances, the geographical jurisdictions of the two types of authority were not co-terminous.

Some potential problems in implementing health and health care policies

If we now consider some specific policies that have been put forward in order to improve the health status of nations and individuals, we can link the discussion back to the subject matter of previous sections. The statements of intent published by the WHO in a variety of documents illustrate at least two of the problems inherent in implementing policy.

First of all, the WHO definition of 'health' is so broad that the attainment of even clearly articulated objectives under this general policy 'banner' would be problematic. How, for example, could various governments agree on what constitutes 'social

well-being' among their populations? Policy as 'mission statements' cannot be successfully implemented because they are rhetoric or 'symbolic' rather than declarations specifying explicit and mutually agreed objectives.

Second, the policy of moving the main responsibility for maintaining and improving the health of any nation from government to each individual raises the question of how any government can exercise *control* over people who do not act with *compliance*. Does the government use the carrot or the stick in order to ensure that the policy will be fully implemented and the targets achieved?

In its strategic policy document *Affordable Health Care* (1993), for example, the Singapore Ministry of Health stated that 'we owe it to ourselves individually to keep fit and healthy' and that 'our health care financing is based on individual responsibility' (p. 1). As we noted in Chapter 1, this sentiment is echoed by the DoH in drawing up its Green Paper for England entitled *Our Healthier Nation* (1998), although this document acknowledges the responsibility of the government to tackle health-related social, economic and environmental problems and widening inequalities in health status within the population.

The document that preceded this in 1986 and its later version in 1992, *The Health of the Nation* (DHSS 1992), was also predicated on the *a priori* imperative of personal responsibility for maintaining a healthy lifestyle. Many of the targets set out in the 1992 document under 'Diet and Nutrition', 'Smoking' and 'HIV/AIDS' rely for their achievement on the willingness of people to alter their habits, to become much more moderate in their smoking and drinking, to take more exercise, to forego the consumption of foods that contain saturated fat and, for drug misusers, to avoid sharing injecting equipment.

The overall policy of improving the nation's health status by, at least in part, informing people about the potential health hazards of certain lifestyles in the hope of achieving something approaching moral reform, brings into high relief the issue of compliance. It also raises questions about a government's relative commitment to those dimensions of policy-making spelt out in Chapter 1. In order to make the attainment of certain targets a more realistic enterprise, policies could be devised that banned smoking, drinking alcohol and eating fatty foods with attendant draconian penalties for people who broke the law by supplying and consuming such products. The financial benefits that would

accrue in terms of a reduced demand upon expensive health services would clearly be offset by (a) the loss of revenue for the government through taxes on potentially health-damaging products; (b) the pragmatic concerns about the political wisdom of invoking such restrictive measures; and (c) the moral argument that – providing they do no harm to other citizens – individuals should be free to damage their own health if they so choose.

In essence, *The Health of the Nation*, as a policy document, exemplifies the inherent tension that exists between the rational control model of implementation and Lipsky's concept of street-level bureaucrats. For even though the government at that time set up a comprehensive structure of monitoring that was designed to oversee and ensure complete implementation, that is

- A ministerial Cabinet committee to co-ordinate strategy
- Three working groups
- A network of regional co-ordinators to assist with the implementation process and to disseminate information about best practice
- The establishment of focus groups for each of the key health target areas

putting appropriate mechanisms in place does not mean that the 'human factor' can be easily controlled.

This last point is clearly illustrated by comparing a policy that has the backing of legislation, and consequently the imposition of penalties for breaches of that law, and policies that mainly rely on the goodwill and compliance of staff and members of the public. Seat belt legislation and no smoking policies in the workplace and in some public areas both involve the deprivation of individual 'rights'. From time to time, police forces in many countries carry out an enforcement of the compulsory wearing of seat belts by fining drivers and/or passengers on the spot or bringing them to court, where the guilty receive a fine. In the UK, a number of public houses and bus companies have tried to impose a policy of no smoking in at least a part of the premises or vehicle. Personal experience has, however, shown that non-compliance on the part of customers has failed to invoke sufficiently punitive responses from 'street-level' staff who – in wishing to avoid conflict – more often choose to ignore behaviour that is in open defiance of the stated policy.

Another problem of implementation is that organisations – governments included – often work with different objectives at any one time. For example, a government might simultaneously be following a policy of increasing emphasis on health promotion and education with respect to the use of life-threatening drugs by young people, and a policy of stricter punitive measures against parents who are apparently not exercising proper control over their children. There will not only be issues here about what proportion of resources these two initiatives should be granted in relation to each other, but also the question of how the government can identify the extent to which each policy is or is not helping to reduce the incidence of drug use among young people. This is related to the area of policy evaluation, which we shall deal with in the next chapter.

Even when policies appear to be fully implemented on a continuing basis, the intended result may not happen. Hogwood and Gunn (1986) would call this the problem of a blemished cause-and-effect theory. That is to say, the underlying logic 'If we do X, then Y will follow' is flawed in some way. As we have noted earlier, a policy will sometimes turn out to have an effect opposite to that intended, even though it has been properly implemented. In many cases, the reason for such an unexpected outcome is the human factor. An example to add to those already given is that the provision of health care services free at the point of need would arguably so enhance the general health status of a population that the demand for such services would decrease over time; a healthier population would make fewer demands for services, and gradually the funding of these services would decrease. Yet we know that this logic – although not unreasonable in theory – has proved wrong in many countries: the provision of services has served only to stimulate demand.

Summary

Top-down and bottom-up models of policy implementation are not, in themselves, completely adequate facsimiles of how policy is put into practice. As Elmore (1978) has stated, no single model captures the full complexity of the implementation process.

A quotation from a book written by Walt (1994) aptly sums up the main issues concerning implementation as part of the policy-making process:

> implementation cannot be seen as part of a linear or sequential process, in which political dialogue takes place at the policy formulation stage, and implementation is undertaken by administrators or managers. It is a complex, interactive process, in which implementers themselves may affect the way policy is executed, and are active in formulating change and innovation. (p. 177)

The provision of services free at the point of need has indeed considerably helped to reduce the risks and prevalence of many diseases. It has greatly contributed in many countries to extending life expectancy and reducing the infant mortality rate. Yet the system has been a victim of its own success. People's expectations of health standards have increased, and – as we shall note in subsequent chapters dealing with health care planning – the demand for expensive health care interventions seems to be insatiable.

Items for discussion

1. With reference to any aspect of health care services, consider the reasons – hypothetical or actual – why a policy does not appear to have achieved its objectives.
2. Discuss the relevance of the concept of street-level bureaucrat to any health care setting with which you are familiar.

Chapter 5 Policy Evaluation

Governments and health care agencies use a variety of methods to check whether their 'performance' meets certain standards. This concern with such matters as 'quality control' is a recent phenomenon in the history of the health care services. In the field of education, however, there has been, in several countries, a series of formal evaluations designed to assess the impact of innovative teaching/learning programmes on particular sets of students (Cronbach 1963, 1982, Mathison 1992).

The term *formal evaluation* is the one that applies to the main contents of this chapter. This differs from various other methods of attempting to measure performance, which are dealt with more extensively by Phillips *et al.* (1994). Formal evaluation is a form of social science research that often attempts to discover whether a specified form or programme of interventions has achieved its objective(s). A useful framework to apply to the process of formal evaluation is the system model, in which an organisation's activities may be characterised as a quasi-production process involving the linked components:

- *Inputs*: for example funding, staff and values
- *Process*: the manner in which services are provided, including procedures, communication and, generally, the nature of interaction between people
- *Outputs*: the goods and services provided
- *Outcomes*: the impact of inputs, process and outputs on key stake-holders involved in the health care system.

This last-named item – outcomes – has come to be a dominant concern within health care organisations and for governments in many countries, and we will devote part of Chapter 8 to the issue of health care outcomes.