AN EXPLORATORY STUDY OF POLICY COHERENCY MODEL IN A TEXAS STATE-LEVEL HEALTH POLICY SETTING

BY

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CHAPTER 1

Introduction

Over the last eighteen plus months, the author has written three papers on Texas health care. Each paper, written for a different Public Administration class, covered separate but interrelated aspects of Texas health care. With each paper the craziness of Texas health care policy became more apparent. For example, why is it?

- there are over fourteen different state agencies involved in public health care in Texas; or
- there is no uniformity in health data reporting from one state agency to another.

The further the inquiry went the more the entire system appeared to be fragmented and out of control. To get a better understanding of the system, standard models, i.e., the rational model and the group model, were investigated. When applied, however, both the rational model and the group model appeared to miss essential elements of the system or structure. Hence, Robertson and Judd's policymaking model was brought to my attention. I began to wonder if this model could be used to describe Texas health care policy. At the about the same time, the following passage from James Q. Wilson's book, Bureaucracy: What Government Agencies Do and Why They Do It (1989) came to my attention. This further peaked my interest.

> Policy making in Europe is like a prizefight: Two contenders, having earned the right to enter the ring, square off against each other for a prescribed number of rounds; when one fighter knocks the other one out, he is declared the winner and the fight is over. Policy making in the United States is more like a barroom brawl: Anybody can join in, the combatants fight all comers and sometimes change sides, no referee is in charge, and the fight lasts not for a fixed number of rounds but indefinitely or until everybody drops from exhaustion. To repeat former Secretary of State George Schultz's remark, "its never over" (Wilson, 1989).

Thus, the basic theme for this paper evolved.

Research Purpose

In, The Development of American Public Policy: The Structure of Policy Restraint (1989), David B. Robertson and Dennis R. Judd, present a policymaking model which provides vision different from current standard models. The explanations provided by Robertson and Judd, although concentrating on national policy, give useful insights into state level policymaking. Their model takes into account the notion of structure on policymaking, whereas, most standard models concentrate on the decision criteria and tend to ignore the influences of structure. Their model describes the decentralized health and human services structure and explains the effects it has on policymaking in Texas. Also, Robertson and Judd's model incorporates the ideas of coherence and fragmentation in policymaking process. By focusing on concepts ignored in other models Robertson and Judd provide useful new insights into health policymaking in Texas.

This paper will demonstrate Robertson and Judd's model can do a good job, if not better than other models, of characterizing healthcare policy in Texas. At the very least their model incorporates ideas previously ignored--coherence and fragmentation--which are critical concepts underdeveloped in other models.

The purpose of this research paper is multifold. First, it examines, assesses, and makes preliminary attempts to apply Robertson and Judd's policymaking model to healthcare policymaking in Texas. Second, it describes Robertson and Judd's policymaking model and compare it with other standard models. Third, it extends Robertson and Judd's policymaking model to state-level policymaking. Fourth, it presents examples to illustrate the usefulness of Robertson and Judd's policymaking model. Finally, research questions to be investigated include--Can Robertson and Judd's policymaking model be operationalized? If so, can Robertson and Judd's policymaking model be used to describe Texas healthcare policy?

Texas Healthcare

The provision of healthcare in Texas is big business. It is estimated that almost 31 billion dollars was spent on healthcare in Texas during 1989 (Texas Statewide Health Coordinating Council, 1990:3). Public health policies made at the state level affect almost

every aspect of the provision this healthcare. Any disunity in the state level policymaking process and structure can result in the inefficient delivery of good healthcare to almost seventeen million Texans. Consequently, the importance of coherent health policies at the state level can not be overemphasized. Overall, relevant research in this area can establish the feasibility of extending the application of Robertson and Judd's policymaking model from national to the state level. Specificly this research can give useful insight into Texas healthcare policymaking which might ultimately result in better healthcare delivery to all Texans.

Chapter Summaries

There are five remaining chapters in this applied research paper. Chapter 2 will concentrate on a review of the literature. Within the conceptual framework the relevant aspects of the policymaking process will be developed. These aspects include policymaking stages, policy capacity, structuralism, models, comparison of models, assessment of health policy in light of models, and health policy. A matrix comparing the rational model, group model, and Robertson and Judd's model using characteristics common to at least one model will be developed. The strengths and weaknesses of each model will be analyzed. Chapter 3 will develop, describe, and discuss the methodology used in this research paper, its

strengths, and weaknesses. Case study techniques were selected as the main method of research. Original source documents such as planning documents, legislative abstracts, etc. will provide the basic evidence for analysis. Chapter 4 will briefly describe the setting to which Robertson and Judd's policymaking model will be applied -- Texas. Aspects of Texas included in the discussion are its: demographics, health issues, health organization, and legislation which affect health policies. In Chapter 5, the information presented and developed in preceeding chapters will be used to extend Robertson and Judd's policymaking model. In turn, an attempt will be made to apply Robertson and Judd's model to the healthcare policy structure in Texas. Chapter 6 will be devoted to a summary, recommendations, and closing remarks.

CHAPTER 2

Literature Review

As stated in Chapter 1, David B. Robertson and Dennis R. Judd (1989) have developed a policymaking model which provides a different view from current standard models. Robertson and Judd (1989) view the policymaking process and structure in the United States from a historical and comparative vantage. Throughout their book Robertson and Judd compare the policymaking process and structure with other Western industrialized nations, i.e., England. Their work in this area basically stands alone much like James Q. Wilson's work concerning bureaucracies. Although their work concentrates on national policy, the explanations provided by Robertson and Judd give useful insights into state level policymaking. Their model takes into account the notion of policymaking structure; whereas, most standard models concentrate on the decision criteria and tend to ignore the influences of structure. Also, Robertson and Judd's model incorporates the ideas of coherence and fragmentation in the policymaking process.

The purpose of this chapter is to develop a conceptual framework. The conceptual framework will provide the basis from which Robertson and Judd's policymaking model can be: (1) described and compared with other standard models; (2) possibly extended to

state-level policymaking; and (3) examined, assessed, and possibly preliminarily applied to healthcare policymaking in Texas.

Conceptual Framework

Robertson and Judd (1989) state as their thesis:

> ... that America's policymaking structure always has fragmented and limited the development of effective and equitable policymaking effort in the United States. The unevenness and disorder of contemporary American public policy reflects the incapacity of our government institutions to design and implement coherent policies. Policymaking incoherence--notably institutional fragmentation and rivalry within and among all levels of government--has not changed very much; instead, new agencies and programs seem to have increased rather than reduced policymaking incoherence. The story of American public policy is in large measure a struggle by policymakers to develop and implement effective programs within the context of an elaborate and resiliently incoherent government structure (Robertson and Judd, 1989:viii).

The expressed purposes of this paper coupled with Robertson and Judd's thesis dictate the logic of this chapter. The relevant aspects of the policymaking process included here are structuralism, models, comparison of models, assessment of health policy in light of models, and health policy.

Various Aspects of Policymaking Process

From a review of the literature it is obvious that the policymaking process is a complex ordeal within the federal system of the United States. This view

is echoed by Robertson and Judd (1989) when they state "... such features of the American policymaking structure as federalism and checks and balances complicate the American policy process..." (Robertson and Judd, 1989:6). Robertson and Judd (1989) provide the following summary of the development of policymaking in the United States:

> Policymaking has developed in four stages: a period of dividing policy responsibility among government institutions (1787 to the 1870s); state government activism (from the 1870s to 1933); national activism (from 1933 to 1961); and national standards (1961 to the present). In each stage, government grew more capable of making policy, but at each stage institutional fragmentation imposed significant obstacles to enacting and implementing equitable and efficient programs (Robertson and Judd, 1989:viii).

Below definitions are presented. They include policy maker, the stages of policymaking, and policymaking capacity.

Definition of Policy Maker. Carley (1980) gives the following general definition of policymaker.

> Policy maker is one individual or a group of individuals who make explicit or implicit single decisions or groups of decisions which may set out directives for guiding future decisions, initiate or retard action, or guide implementation of previous decisions (Carley, 1980:1).

A more politically specific definition is provided by Ripley (1985). "Policy makers are those in officialdom (political appointees in the bureaucracy, perhaps a few senior civil servants, and members of Congress at the

national level in the United States) who make policy statements, which are general lines of intention" (Ripley, 1985:26-27). Policymakers are involved at every stage of the policymaking process.

Stages of Policymaking Process. To paraphrase Robertson and Judd (1989:4), policy outcomes are hard to define and analyze. Deriving the results of policies is messy process. However, distinct stages of the this process can be identified. Although, often blurry and oversimplified, John Kingdon (1984) has identified four stages.

> Public policymaking can be considered to be a set of processes, including at least (1) the setting of the agenda (the list of subjects or problems to which government officials, and people outside of government closely associated with those officials are paying some serious attention at any given time), (2) the specification of alternatives from which a choice is to be made, (3) an authoritative choice among these specified alternatives, as in a legislative vote or a presidential decision, and (4) the implementation of the decision (Kingdon, 1984:3).

Ripley (1985) elaborates on this version of this process and adds evaluation of both implementation and results to the stages (1985:22-23). He states that there are six sets of activities involved in the political process. These are:

> (1). Agenda Setting--The agenda setting stage refers to the processes by which problems get selected for government action. In principle there are many problems 'out there' to which

government can pay attention. But, in fact, only a subset--even though large--is on the governmental agenda at any given time (Ripley, 1985:23).

(2). Goal Setting--The goal setting stage refers to the political and intellectual processes by which items on the governmental agenda are considered in some rough sense and one or more goals or broad aims are attached to each item. These goals are likely to be quite vague, and there may also be competing or logically inconsistent goals. Broad social and political forces are at work as the polity edges toward setting goals for itself on its current agenda items (Ripley, 1985:24).

(3). Alternative Development and Selection--Once broad goals are arrived at, governmental agencies (both legislative and executive) can begin searching for ways to achieve these goals. This involves the development of different alternatives in the form of general approaches to the problem, specific program designs, and administrative structures (Ripley, 1985:24).

(4). Implementation of the Selected Alternative--Once an alternative has been selected and the word made flesh through the establishment of some kind of program (usually by statute), many concrete activities have to take place in order to implement the good words of the statute (presumably pursuing some of the general goals that turned out to be politically attractive enough to achieve relatively broad support). The job of implementation is primarily that of bureaucrats (at various territorial levels in the case of most domestics policies in the United States) (Ripley, 1985:24-25).

(5). Evaluation of Implementation--The evaluation of implementation is a relatively new intellectual activity. As always, there are also political elements to evaluation (Ripley, 1985:25).

(6). Evaluation of Results (Impacts)--Evaluation of results is complicated and tricky (Ripley, 1985:25).

Robertson and Judd (1989) state that "the stages in the policymaking process are far less easily distinguishable in practice than in theory because actual policymaking is an untidy affair in which the boundaries between these stages are hard to draw" (Robertson and Judd, 1989:5). The success of a policy is also dependent on policymaking capacity.

Policymaking Capacity. Robertson and Judd (1989) provide an indepth account about policymaking capacity. They state that "A government's policymaking capacity can be defined as its ability to entertain a variety of responsees to social and economic problems, to enact or reject authoritative solutions, and to implement its decisions" (Robertson and Judd, 1989:9). Indicators of government capacity include:

> First, the scope of government authority, taxes and expenditures, and the level of its commitment and resources to formulate and implement policy on a continuing basis (Robertson and Judd, 1989:9).
>
> Second, is its ability to raise taxes and fund policy initiatives. ... However, arbitrary rules may inhibit the growth of taxes and government spending. Most American state constitutions require that state expenditures not exceed state tax receipts in a budget year, and the states impose similar limits on city governments. Such pervasive and automatic restrictions on capacity do not exist in other nations (Robertson and Judd, 1989:9-10).
>
> Third, policymaking institutions differ in the workload they are capable of undertaking. American governments in the early eighteenth

> century possessed very little capacity to implement policies of any kind because legislatures met infrequently and officials were usually untrained amateurs. Over time, Congress and state legislatures, the president and state governors, and bureaucracies at all levels of government have grown larger, and more professional. ... The policymaking capacity of the executive branch, and particularly of the executive agencies, has indisputably outpaced the capacity of other government institutions at all levels (Robertson and Judd, 1989:10).

Given that all other factors are equal, there is a direct relationship between the above indicators and public policymaking capacity. That is, as governmental capacity such as scope and taxes increase, public policymaking capacity increases. However, even though there is an increase in policymaking capacity does not necessarily mean that the resulting policy effort will be coherent. In fact, policy incoherence constrains policy development nearly as much as the lack of policymaking capacity (Robertson and Judd, 1989:10).

Although feasible, Robertson and Judd (1989), maintain policy coherence is the "exception rather than rule" (Robertson and Judd, 1989:14).

Assessing and explaining Robertson and Judd's policymaking model involves two interrelated issues. First, the underlying role of structure as it influences outcome must be examined. Secondly, in order to evaluate their contribution it is necessary to compare their model with others. Hence, criteria to assess policy models will be developed.

Structuralism

Lawson (1985) states that "..., structuralism is ... about behavior" (Lawson, 1985:54). Unlike behavioralists who focus on "political" behavior, "the political scientist who focuses on structures asks how political structures structure our behavior in general" (Lawson, 1985:54). Behavioralist examine how psychological factors shape political behavior and structuralists emphasize the way political organizations and institutions function as social forces that shape all kinds of behavior (Lawson, 1985:54).

Further, Ronald Cohen (1969) succinctly defines structuralism as "... concerned with the relations of parts to one another and the conditions which are correlated with such relations to effect their change and/or stability" (Cohen, 1969:47).

The principles of struturalism will be used in analyzing Robertson and Judd's policymaking model and the underlying role of structure as it influences outcome.

Models

"The policy process is complicated, and the analyst must seek to simplify it. The generic form of simplication used by social scientists, including political scientists, is a model" (Ripley, 1985:31).

General. Dye (1989:20) states that conceptual models used to study policy try to:

1. simplify and clarify our thinking about politics and public policy;
2. identify important aspects of policy problems;
3. help us to communicate with each other by focusing on essential features of political life;
4. direct our efforts to better understand public policy by suggesting what is important and what is unimportant; and
5. suggest explanations for public policy and predict it consequences.

Models simplify a set of complicated processes. They can take many different forms, ranging from the purely mathematical to the purely verbal. All, however, have the same purpose: "to render what is incredibly complex and idiosyncratic in any individual case into a set of relationships that are both simpler and more recurrent. Model makers aim at both understandable patterned description and, sometimes without thinking about it, an explanation (what causes what)" (Ripley, 1985:31).

Ripley (1985) asserts that "Models are not neutral. Models are the product of the mind of the person constructing the model. ... the general vision of political life is both empirically and theoretically derived..." (Ripley, 1985:32-33).

In addition, Ripley (1985) cautions that, unfortunately, models of the policy process are "likely to

make the world of policy too ordered, too predictable, and too rational" (Ripley, 1985:33). Regardless, of the form of the model used, it needs to be realized that:

- o The chronology implied in any model of the policy process is only rough at best. Stages may occur 'out of order,' simultaneously, or in other ways that are not tidy chronologically.
- o The boundaries between different stages are blurred and not readily discernible to either participants or analysts in completely clear or consistent ways" (Ripley, 1985:33).

Ripley (1985) goes on to say that there is a tension between the elegance of a model and the untidiness of reality. The "analyst must not be so struck by the values of order as to force reality into a model in which it might not fit" (Ripley, 1985:55).

Further, Dye (1989) states that policymaking models do not compete in the sense that "any one of them could be judged 'best'" (Dye, 1989:20). Rather, each provides a separate focus on political life and us to understand different aspects of public policy (Dye, 1989:20). To be useful, a model must provide a separate, although not necessarily a mutually exclusive, view from other models. Assessment of the usefulness of Robertson and Judd's policymaking model will be made with respect to other standard models of policymaking. The rational and group policy models have been selected for comparison purposes. Next a general discussion of each model will be developed. Finally, characteristics used for comparison purposes will be examined.

Rational Model. A rational policy is one that achieves maximum social gain. Maximum social gain is defined by Dye (1987:31) as:

> Government should choose policies which result in gains to society which exceeds costs by the greatest amount, and governments should refrain from policies if the costs are exceeded by gains.

Two items must be kept in mind when using this definition of maximum social gain. First, if a policy's costs exceed its benefits, it should not be adopted. Second, when selecting among policy alternatives, the policy that is selected should be the one that produces the greatest benefit over cost (Dye, 1987:31-32). Thus, a policy is rational when the "difference between the values it achieves and the values it sacrifices is positive and greater than any other policy alternative" (Dye, 1987:32). The factors that must be considered and the method used to analyze these factors are critical in the selection of a rational policy. Dye (1987) gives the following summary of that procedure.

> To select a rational policy, policymakers must (1) know all the society's value preferences and their relative weights; (2) know all policy alternatives available; (3) know all the consequences of each policy alternative; (4) calculate the ratio of benefits to costs for each policy alternative; and (5) select the most efficient alternative (Dye, 1987:32).
>
> This procedure assumes that it is possible to determine and weight the value preferences of society as a whole. Complete understanding of societal values is essential. Information about

> alternative policies is also required. This information enables the "predictive capacity to foresee accurately the consequences of alternate policies, and the intelligence to calculate correctly the ratio of costs to benefits. Finally, rational policymaking requires a decision-making system that facilitates rationality in policy formation" (Dye, 1987:32).

Carley (1980) provides a similar set of sequential activities for the rational process. He states that, working definitions of rationality are generally expressed by five sequential activities undertaken by an idealised "rational man":

1. A problem which requires action is identified and goals, values, and objectives related to the problem are classified and organised.

2. All important possible ways of solving the problem or achieving goals and objectives are listed--these are alternative strategies, courses of action, or policies.

3. The important consequences which would follow from each alternative strategy are predicted and the probability of those consequences occurring is estimated.

4. The consequences of each strategy are then compared to the goals and objectives identified above.

5. Finally, a policy or strategy is selected in which consequences most closely match goals and objectives, or the problem is most nearly solved, or most benefit is got from equal cost, or equal benefit at least cost (Carley, 1980:11).

According to the above description the rational policymaking process is either explicitly or implicitly characterized as normative i.e., value driven, integrative i.e., takes into account all areas, and adaptive i.e.,

continuously evaluative. It also implies that to be effective this process must be coherent regardless of the level at which it is performed.

The following advantages of rational techniques in choice assisting are offered by Carley (1980):

1. Rational analysis promotes a systematic, orderly approach to the study of policy problem.

2. Rational analysis assists in problem definition, or locating a decision space, which is the first and often the most important step in policy analysis.

3. Rational analysis assists in satisfying the information needs of all the parties to a policy decision ...

4. It is only through rational analysis that efficiency can be measured.

5. Rational techniques, coupled with an aggressive public participation model of policymaking, can help to extend and deepen the involvement of various interested parties in the policy process.

6. Finally, rational analysis promotes explictness in presentation of data basic to a problem and casual linkages and transcidence postulated in the analysis (Carley, 1980:31-33).

Due to the many barriers against it, rational decision making in government is a rarity. Several important barriers to rational decision making asserted by Dye (1987) are paraphrased below: (Dye, 1987:34-35)

> Usually no agreement can be made on <u>societal</u> benefits. Generally, only conflicting benefits to specific groups and individuals are enacted. In fact, many of these conflicting benefits and costs cannot be compared or weighed.

> Policy makers are motivated to make decisions based on their own self interests--not based on the goals of society. They merely try to satisfy demands for progress by stopping at the alternative that "will work" and not searching until the "the best way" is found. They have no motivation to maximize the net social gain. In addition, the large "sunk costs" in existing programs keep policy makers from reconsidering previous decisions.
>
> Cost, availability, and time required to collect information are major barriers to finding all policy alternatives and their consequences.
>
> The predictive capacities of the social, behavorial, physical and biological sciences are not advanced enough to enable policy makers to understand the full benefits or costs of each policy alternative. Even with the most advanced computerized analytical techniques, policy makers do not have sufficient intelligence to calculate accurately costs and benefits when a large number of diverse political, social, economic, and cultural values are at stake. Hence, without knowing the full consequences of various policy alternatives policy makers are forced to adhere closely to prior policies to reduce the possibility of unanticipated consequences. Finally, the fragmented policymaking process in large bureaucracies makes coordinating decisions difficult. Coordinated input from all of the various specialists necessary to make a competent decision is generally lacking (Dye, 1987:34-35).

Carley (1980) notes that academic discussions about the rational process are really idealized. He asserts that nobody is truly arguing for full-grown comprehensive rationality and that in the real world all that can be attained is "limited or partial rationality--only some alternatives and some consequences are related to some objectives" (Carley, 1980:15). The magnitude of the problem is reduced because (1) decision makers ignore

consequences which are of no interest; (2) decision makers 'learn' from past decisions and thus adjust the scope of their concern accordingly; and (3) 'satisficing'. When decision makers satisfice they pursue sufficient, satisfactory goals rather than 'one best' goal" (Carley, 1980:15). Wade (1977) and Knott and Miller (1987) give similar definitions for 'satisficing' (Wade, 1977:165) (Knott and Miller, 1987:181).

Further, Carley (1980) asserts rational techniques assist choice and hence even with their limitations offer advantages as a partial solution to policy problems (Carley, 1980:31).

Group Model. Group theory is a widely used and controversial approach to political analysis. The intellectual basis for group theory lie in the doctrines of 'pluralism' developed by a number of nineteenth- and early twentieth-century English philosophers (Young, 1968:79).

The concept of the "group" is the keystone to the group approach. Bentley (1908) describes a group as follows:

> ... means a certain portion of the men of a society, taken, however, not as a physical mass cut off from other masses of men, but as a mass [of] activity, which does not preclude the men who participate in it from participating likewise in many other group activities (Bentley, 1908:211).

Earl Latham (1956) viewed groups as "private governments" which perform basically the same environmental functions for their members as public governments (Latham, 1956:239).

Latham (1956) describes public policy from the group theory viewpoint:

> What may be called public policy is actually the equilibrium reached in the group struggle at any given moment, and it represents a balance which the contending factions or groups constantly strive to tip in their favor.... The legislature referees the group struggle, ratifies the victories of the successful coalition, and records the terms of the surrenders, compromises, and conquests in the form of statutes (Latham, 1956:239).

Latham (1956) continues that the above could not happen "... without some participation in the struggle by the legislators, who themselves constitute a group. Administrators carry out the terms of the treaties the legislators have negotiated and ratified" (Latham, 1956:239).

David Truman (1971) asserts that group interaction is the central core of politics. Individuals with common goals and interests unite to press their demands on government (Truman, 1971:37).

Truman (1971) defines an interest group as "'a shared-attitude group that makes certain claims upon other groups in the society' (Truman, 1971:33); and such a group becomes political 'if and when it makes a claim through or upon any of the institutions of government'" (Truman, 1971:37).

Young (1968) provides a similar idea of an interest group. He states that, "Another critical aspect of group lies in the notion of interest--a shared attitude concerning a claim or claims to be made by one group upon certain other groups in a social system. ... the interest of a group is taken to be the sum of its policy-oriented and directional activities" (Young, 1968:81).

Dye (1987) states that group theory describes political activity as a group struggle. Policy makers constantly respond to group pressures forced upon them by the competing demands of influential groups. Politicians try to form a majority of support by coalescing groups. By doing so they have some say so as to what groups are included in their majority coalition. The larger the politician's constituency, the greater the diversity of constituency interests. This large diversity in constituency interest groups allows the politician more latitude in selecting the groups to form a majority coalition. Thus, based on size and diversity of constituencies, members of the House have less flexibility than senators. In turn, the president has more flexibility than members of Congress in selecting the groups which form a majority coalition. It must be kept in mind that executive agencies go through basically the same process as politicians with their group constituencies (Dye, 1987:28). Obviously, the outcome

results of this process is that all decisions are the product of compromise.

Further Dye (1987) adds that, "The entire interest group system--the political system itself--is bound in equilibrium by several forces" (Truman, 1951:14-44) (Lowi, 1969:68-97) (Dye, 1987:28).

First, the United States has a latent group which is large and fully supportive of the constitutional system. Although this group is not always visible it can rise up to squelch any group that attacks this system and threatens the equilibrium (Truman, 1951:14-44) (Lowi, 1969:68-97) (Dye, 1987:28).

Second, normally individuals belong to more than one group. This overlapping group membership helps to maintain the equilibrium by preventing any one group from moving too far from prevailing values. Groups moderate their demands to avoid offending their members who have other group affiliations (Truman, 1951:14-44) (Lowi, 1969:68-97) (Dye, 1987:28).

Finally, no one group forms a majority in the United States. The checking and balancing resulting from group competition helps to maintain equilibrium in the system. These "countervailing" centers of power function to check the influence of any single group and protect the individual from exploitation (Truman, 1951:14-44) (Lowi, 1969:68-97) (Dye, 1987:28).

A criticism of group theory is provided by Truman (1971). He maintains that group theory ignores the "individual and a sort of totally inclusive unity designated by terms such as 'society' and 'the state'" (Truman, 1971:47-48). Further, Truman (1971) states that any try at a group interpretation of the political process inevitably ignores some greater unity designated as "society or the state" (Truman, 1971:49). Society or the state in this context incorporates individuals, institutions, laws, culture, history, etc.

Robertson and Judd's Coherency Model. Robertson and Judd (1989) emphasize the importance of policymaking structure on outcomes. In addition, policy is formed within a historical/cultural context. Hence, policy makers can not ignore the roots of public policy or the ways that other nations handle similar problems. Because policy makers tend to ignore these context they have engaged in "a myopic quest for marginal change that too often yields results that satisfy virtually no one" (Robertson and Judd, 1989:ix). Failure of United States public policy can be traced to the losing of goal allocated resources in the maze of institutions and governments. Each of which is pursuing conflicting goals and priorities (Robertson and Judd, 1989:ix).

The notion of policy coherence has been developed by Robertson and Judd (1989). In their discussion Robertson

and Judd (1989) emphasize policy coherence as the critical standard or norm. They use examples of incoherent policy to test and illustrate their thesis. For the purposes of this paper the notion of policy coherency will be discussed first followed by policy incoherence.

The idea of coherency in public policies is intuitively a concept with which people can easily identify. On one side of the coherency spectrum, one expects an integrated and comprehensive set of programs and procedures that serves the public fairly and with respect. They describe policymaking coherence as "...the degree to which the various policymaking institutions align their efforts in a consistent policy direction" (Robertson and Judd, 1989:10). Further, Robertson and Judd (1989) define "coherence as a function of the number of government units involved in policymaking and the ability or motivation of these units to alter or stop policy in the agenda-setting, formulation, enactment, and implementation stages" (Robertson and Judd, 1989:10). It should be noted that later in this discussion this statement will be used as a cornerstone to explain and expand Robertson and Judd's policymaking model.

On the other side of the coherency spectrum, an incoherent policy is a totally fragmented and confusing set of programs. The procedures under an incoherent

policy serve the public poorly or not at all. Robertson and Judd (1989) emphasize the influence of fragmentation on policy design. They maintain that fragmentation within government increases the likelihood that policy design will be illogical and prone to failure. Governmental fragmentation results in poor policy design because it:

(1) increases veto points;

(2) allows formal and informal changes in policy goals; and

(3) produces the need for expedient compromises (Robertson and Judd, 1989:11).

This last statement forms the second cornerstone of Robertson and Judd's policymaking model.

According to Robertson and Judd (1989) our forefathers favored limited government. Hence, they structured a system with fragmentation and incoherence built in.

> The framers of the American constitution understood that fragmentation tends to impede policymaking capacity. The fragmentation of American national government was a deliberate effort to make positive, decisive governmental action difficult (Robertson and Judd, 1989:12).

The notion that fragmentation increases the number of veto points is a designed feature of our federalist system.

> The checks and balances established by provisions for two houses of Congress, a separate executive branch and a presidential veto, and a federal court system all weakened the national government's ability to act decisively on behalf of popular majorities or well-organized political movements (Robertson and Judd, 1989:12).

Fragmentation also enhances incoherence because it allows for conflicting formal and informal policy goals as well as changes in the goal. The impact of conflicting or changing goals is usually not easily discernible until after the fact. "... less obvious tradeoffs also undermine policy coherence by creating policy designs that are logically inconsistent--such as the Model Cities Program of 1967, with ambitious goals for urban revitalization in a few 'demonstration' cities, but, ultimately, a dispersal of funds to all too many cities (pork-barrel politics) for the funds allocated" (Robertson and Judd, 1989:11).

The authors also point out that fragmentation produces the need for expedient compromise. Swapping one policy goal to protect another is a way of life for public officials. Regardless of the true public need, officials strategically pass bills that place cherished publicly funded projects (pork barrel) in a given geographical region. This is done either to gain support for or to increase the size of the coalition necessary to attain the desired goal (Robertson and Judd, 1989:11).

Policy incoherence in the United States is enhanced by the high degree of autonomy maintained by state governments under the federalistic system. In many instances the fragmented national system is reflected at

the state government level. For example, the division of authority is pronounced. In fact, many states elect their executive branch leaders, such as lieutenant governors and attorney generals, separately from one another. Nationally originated programs which are implemented by the states is an example of pass through fragmentation. Social programs in which the states are allowed to establish benefit levels, eligibility requirements, etc. are typical examples of pass through fragmentation. (Robertson and Judd, 1989:11). Other examples of pass through fragmentation are federally assisted state programs such as Aid to Families with Dependent Children (AFDC), established under the Social Security Act. Under this type of federal funding AFDC coverage and benefits vary substantially across the states (Robertson and Judd, (1989:212-225). On the other hand, Federal programs such as the old age insurance program (social security) under the Social Security Act are funded differently. The social security program is paid for by employees/employers and administered by the federal government. Under this program coverage and benefits are standard nationwide (Robertson and Judd, 1989:212-225).

As to the effects of dividing responsibilities within the policymaking structure are divided among several institutions at the national level. This same

fragmentation exists in the states. Additionally, most policies such as the ones associated with environmental program are decentralized through the federal system. An example of this are the pollution abatement regulations resulting from the Clean Air Act of 1970 and Air Quality Act of 1967. Pollution abatement in the United States is complicated by jurisdictional fragmentation because pollution generally does not confine itself neatly to just one jurisdiction. It is further exacerbated by the dual nature of the federal court system which is aligned to existing jurisdictional lines. The combined effects of the above factors have created cross-pressures that have garbled federal environmental regulations (Robertson and Judd, 1989:327-328).

This fragmentation slows the securing of public capacity needed to achieve equitable and efficient policies nationwide. In fact, government efforts can be so diverse and uncoordinated that it is questionable if any welfare, health, civil rights, or other 'policy' exists at all. Most of the time, American policy seems very incoherent--that is, lacks national consistency, order, and uniformity (Robertson and Judd, 1989:3-4).

Robertson and Judd (1989) predict that national policy implementation will continue to be slow and fragmented as long as there is state influence in Congress; institutional fragmentation at all levels of

government; and delegation of federal responsibilities to states, local governments, and private institutions (Robertson and Judd, 1989:ix).

According to Robertson and Judd (1989), fragmented policy systems can occasionally produce coherent policy. They affirm "two circumstances in which coherent policy can emerge from an incoherent policymaking structure" (Robertson and Judd, 1989:14).

> First, a powerful national mass movement mobilized in support of a policy remedy can simultaneously pressure all institutions in a fragmented system to align in support of uniform policy. Such movements facilitated the passage of the old age insurance title of the Social Security Act of 1935, the Civil Rights Acts of 1964 and the Voting Rights Act of 1965, and the Clean Air Act and other environmental statutes of the early 1970s. Even in these cases, however, coherent policy once enacted was often slowed or undermined when implemented through the fragmented political structure" (Robertson and Judd, 1989:14).

> Second, the favored political interest, business, may under some circumstances fight for uniform national standards. On these occasions business sought to eliminate variations in state laws. For example, national standards achieved by the railroads in the 1880s and more recently in the 1980s the trucking industry's push for national standards allowing double-bottom trucks (Robertson and Judd, 1989:14).

Robertson and Judd's model (1989) differs from other models because it uses a more inclusive notion of public policymaking structure. They emphasize the independent effect of government structure on policy outcomes as well as its "influence on the way policy demands are expressed" (Robertson and Judd, 1989:7).

There are two important ways that government affects public policy, independent of 'inputs' or outside pressures:

> First, is its policymaking rules, i.e., how laws are made, what jurisdiction an agency has, etc. These offer both opportunities for or barriers against accomplishing specify policy outcomes. These game rules greatly influence government officials' goals, strategies and tactics (Robertson and Judd, 1989:7).
>
> Second, these rules of government effect every aspect of our lifes. They affect the way that groups and citizens interact with one another and with government. This negates the common view that the government is a neutral umpire in social and political conflicts. Governments set the rules of assembly, i.e., when citizens can organize into groups and demand policy change. Political demands will be aimed at the institutions or levels of government most capable of responding. If they are unresponsive or ineffective in answering the demand it will be moved to the next higher governmental level (Robertson and Judd, 1989:7).

Changing these game rules and patterns of organizational behavioral are difficult once they are established. By capitalizing on these phenomena public agencies are able to resist change. By developing routines and constituencies supportive of their original purposes they are able to fend off new problems or changes in priorities (Robertson and Judd, 1989:8).

Comparison of Models

Each model was described in the above sections. In the next section, the three models will be compared using variables or factors common to at least one. Model

comparison will enable sharper focus. Table 2-1 summarize the findings (Literature which supports Table 2-1 is developed in Table 2-2). The criteria used for comparison purposes include the models basic thesis and its treatment of the role of structure, decisions, information, politics, implementation, bureaucracy, goals, coherence, process, individual, and institutions. Health policy is also compared.

National Policy. Each model approaches national and health policies from a different but not necessarily a mutually exclusive viewpoint. Achieving a national policy of maximum social gain (Dye, 1987:31) as professed by the rational model is in direct conflict with a group model policy. A group model policy is one which results from the struggle of different interest groups (Dye, 1987:26) (Truman, 1951:33). Whereas, Robertson and Judd's model indicates that neither the rational nor the group model policies will be effective and equitable because of the fragmented policymaking structure (Robertson and Judd, 1989:viii).

Structure. The rational model does not take the influence of structure into account. Whereas, the group model addresses the internal structure of the groups as a measure of the group's influence. For example, the more

coherent the internal structure the higher the influence of the group (Dye, 1987:28). Robertson and Judd (1989), on the other hand, focus heavily on the effects of fragmentation of the policymaking structure. Robertson and Judd (1989) examine how structure affects outcomes and the division of responsibilities.

Decisions. The decision is a central focus of the rational model. Social gain is maximized through rational decision process. Decisions are dictated by the rational analysis of all alternatives (Shields, 1991:18) (Dye, 1987:32) (Carley, 1980:31-33). Decisions are also important in the group model. Here, however, decisions play a different role. Decision points provide a forum for compromise. The ultimate compromise generally reflects the goals of the most effective interest group at that time (Dye, 1987:28) (Young, 1968:89). Truman (1951) further states that public policy at any given time is the equilibrium reached in the group struggle. This equilibrium is determined by the relative influence of interest groups (Truman, 1951:33) (Lowi, 1969:68-97). Dye (1987) adds that changes in group influence can be expected to result in changes in public policy (Dye, 1987:27). Robertson and Judd (1989) focus on the decision chain rather than the "decision". They maintain that the fragmented policymaking structure leads to increased numbers of veto points in the decision chain. It also,

enhances the need for expedient compromises by decision makers (Robertson and Judd, 1989:11).

Information. Information costs are considered to approach zero in the rational model. In addition, individuals will adjust quickly to new information and move quickly to "optimize" its use (Shields, 1991:18). The role of information is not addressed by the group model. Whereas, Robertson and Judd's model implies that information flow is restricted by either the fragmented system or motivation of government units (Robertson and Judd, 1989:8-12).

Politics. The rational model seldom addresses the role of politics explicitly. It assumes a nonpolitical administrator (Knott and Miller, 1987:3). The group model, on the other hand focuses on politics. Here the struggle of groups to influence public policy is a central fact of politics in group model tenets (Dye, 1987:27) (Latham, 1956). On the other hand, to Robertson and Judd politics perpetuates the fragmented policymaking system and protects interests of particular policy participants (be they an individual or agency) (Robertson and Judd, 1989).

Implementation. Neither the rational nor the group models address the role of implementation. Robertson and Judd (1989) profess that implementation is

one policy stage at which governmental units have an opportunity to alter or stop a policy (Robertson and Judd, 1989:10). This is one of the strengths of the model since it addresses an area which is not covered by the other models.

Bureaucracy. The rational model implies bureaucracy should: (1) consider all policy alternatives, and (2) select the alternative which provides the maximum social gain (Dye, 1987:32) (Weber, 1946:196-244). A rational bureaucracy is mainly organized to "resolve the problem of a misty future: their routines, programs, information gathering and process techniques assist in that purpose" (Wade, 1977:165). Wade (1977) continues:

> ... bureaucracy, by its very nature, may afford a particularly fruitful area for academic explication through rational-choice models. Not only may organizational goals be relatively unambiguous and reasonably stable, but the relatively self-conscious nature of an organization's role-structure, information-processing system, and authority matrix do tend in the direction of purposeful and rational action. Indeed, the major criticism of bureaucracy--its stifling of individual spontaneity, its enforced discipline, its perverse "efficiency"--stems precisely from this realization (Wade, 1977:166).

Anthony Downs (1966) in Inside Bureaucracy applied the rational model to the context of a bureaucracy. Although maximum social gain may be a goal. This goal may interfere with a "rational" bureaucrat who is maximizing his income or agency budget. The rational model, thus may

examine how the bureaucracy departs from a social maximum. The reason, however, is still couched in the terms and ideas of a "rational" actor (Downs, 1966).

To group theorists, bureaucracies enact compromise decisions that arose through group struggle (Dye, 1987:28) (Latham, 1956:239) (Young, 1968:89) (Truman, 1971:37). In the Robertson and Judd model the bureaucracy is central to the policymaking process. The governmental units which have the possible ability or motivation to alter or stop policy are part of the intergovernmental bureaucracy (Robertson and Judd, 1989:10).

Goals. Rational models typically assumes stability in institutional goals. Changes in knowledge or reduction in risk, however, may lead to the choice of new alternatives in pursuit of those goals (Wade, 1977:164). There is some instability in individual goals according to Wade (1977). Although such instability may be more apparent than real. For example, Maslow's need hierarchy seems to summarize the nature of first-order enduring and innate goals. Second-order goals (e.g., job mobility, income) may be shifted to more efficiently achieve first-order goals. Such shifts are only partly recognized by rational choice models (Wade, 1977:165).

Under the group model, groups goals are paramount. Young (1968) summarizes this view.

> Goals and goal attainment are essential to the group approach to society. According to the model groups are compelled by both their interests and claims upon other groups in the system. They must participate in the group struggle that constitutes society. Hence, goal attainment is the motivating force of the entire process (Young, 1968:89).

Robertson and Judd (1989) profess that goals are unstable. The system of fragmentation enhances the possibility of formal and informal goal changes (Robertson and Judd, 1989:11).

Coherence. It seems as if the rational model is a prescription for better policy. Hence, if the rational model is conscientiously applied, by implication, policy coherence will follow (Dye, 1987:32). Under the group model, policy coherence is not addressed; rather, it focuses on group coherence. Internal group coherence is important because it is indicative of a group's influence (Truman, 1971:14-44). Policy coherence is a focal point of the Robertson and Judd model. It is an ideal standard or norm (Robertson and Judd, 1989:viii).

Process. The decision making process is central to policymaking under the rational model (Dye, 1987:32). The process or steps to achieve rational outcomes are well articulated by proponents of this model. In the group model, the process of concern is interest group interaction. Interest groups try to influence the

decision process to their advantage during each stage of policy development (Dye, 1987:26-28) (Latham, 1956:239). Robertson and Judd (1989) are interested in how process and structure interact and either compliment or conflict with coherence. For example, a process imbedded in a multi-stage/multi-governmental structure will probably result in incoherent policy (Robertson and Judd, 1989:10).

Individual. The rational model assumes that people act rationally and individual follow their self interest (Shields, 1991:18). Individuals, under the group model are not considered because the individual only acts as part of, or on behalf of, group interests (Truman, 1971, 14-44) (Dye, 1987:27). Robertson and Judd's model does not address the individual.

Institutions. The role of an institution, according to the rational model is to make rational policy decisions (Dye, 1987:31-35). The rationally based concepts of the Progressive governmental reform movement which included separation of politics and administration, professional dominance of agency administration, and use of hierarchy and rules to enforce institutional professionalism. Simon (1945) contended that the long-term effects of these reforms would lead to institutional dysfunctions of rigidity cycle, trained incapacity, goal displacement, and dual system of authority (Simon, 1945:79-109). Knott and

Miller (1987) theorically added to Simon's work and elaborate extensively on the current effects of those dysfunctions:

> Knott and Miller (1987) assert that the classical reform model is no longer parsimonious because it supports two sets of assumptions as to the institutional role of the individual. The two opposing explanations are (1) individual cognitive limits, and (2) rational individuals-irrational institutions (Knott and Miller, 1987:166-187). Individual cognitive limits explanation is that organizational design is fine, but, something is wrong with the individual's behavior or problem-solving capacity. This allows superficial decisions to be made and accommodates satisficing with "make do" solutions. The rational individuals-irrational institutions explanation is organizational rules force individuals to behave in a certain way if they want to "succeed". For example, an employee gives what seems to be on the surface an irrational response, but, which may not be irrational from an organizational viewpoint. Knott and Miller (1987) maintain that the current model fails because it does not take into account the impacts of politics, institutional design, and basic human needs on outcomes.

Under the group model, institutions are treated as another interest group (albeit an unique interest group). Consequently, the model focuses on their interest group behavior within the larger policymaking process (Latham, 1956:239). Buchanan (1977) points out that institutions are unique type of group because they link "government to the governed" (Buchanan, 1977:110).

Robertson and Judd (1989) view institutions as the governmental units of the bureaucracy which have the possible ability or motivation, to alter or stop policy

(Robertson and Judd, 1989:10). In addition, Robertson and Judd (1989) address the pressures policymaking structure institutions face:

> These institutions are affected by both external social and political pressures. The irresistible pressures which can be placed onto government by changing economic conditions, popular beliefs, political party coalitions, and interest group power can force even the most rigid institution to change its priorities (Robertson and Judd, 1989:8).

Health Policy. Essential to the rational model is the ability to define the problem. Good health or good healthcare--is the goal of the rational model as applied to health policy (Dye, 1987:152). The group model predicts that compromise among interest groups, such as the American Medical Association and unions, explains health policy. The observed policy outcomes and focuses have fluctuated as the influence of a given group at a given time fluctuates (Dye, 1987:26-28). Here again, Robertson and Judd profess that a incoherent health policy is expected given the limitations imposed by a fragmented policymaking structure (Robertson and Judd, 1989).

Assessment of Health Policy in Light of Models

When assessing health policy in light of these three models, it is obvious that each model has it strengths and weaknesses. The following presents the strengths and weaknesses with regards to the health policy process. Each model is addressed separately.

TABLE 2-1

MODEL COMPARISON

Characteristic	Rational	Group	Robertson & Judd's Model
Basic Thesis National Policy	Achieve Maximum Social Gain	Interaction Among Groups Is Central Fact of Politics to Produce a "Fair" Equilibrium	Achieve Coherency in Public Policy
Structure	Does Not Address	Focuses on Internal Group Structure	Focuses on Influence of Fragmentation of National and to Some Extent State Structures
Decisions	Dictated by Rational Analysis of Alternatives	-Compromise -Pressure Group Influemce	Coherent Decisions Almost an Impossibility in a Fragmented system
Information	-Costs Approaches Zero -Individual Will Adjust Quickly to New Information and Move Quickly to 'Optimize' On It	Does Not Address	Implies Fragmented System Restricts Flow Either Through System or Government Unit Motivation
Politics	Explicitly Nonpolitical	Groups Struggle to Influence Policy	Politics Perpetuate Fragmented System to Protect Self Interests

TABLE 2-1 continued

MODEL COMPARISON

Characteristic	Rational	Group	Robertson & Judd's Model
Implementation	Does Not Address	Does Not Address	One Policy Stage at Which Government Units Have Opportunity to Alter or Stop a Policy
Bureaucracy	Implies a Bureaucracy Should: -Consider All Alternatives -Select Alternatives Which Provides Maximum Social Gain	-Enactment of Compromise -Bureaucracy Is a Group	Central in Policymaking Process It Is Made Up of Units Which Have The Possible Ability or Motivation to Alter or Stop a Policy
Goals	-Typically Assumes Stability of Organizational Goals -Individual Goals Are Subject to Some Instability	Group Goals Are Paramount	Fragmentation Allows Formal and Informal Goal Changes
Coherence	Implies Coherence Through Rationality	-Group Coherence Indicative of Group Influence -Policy Coherence Not Addressed	Policy Coherence Is the Ideal Standard

TABLE 2-1 continued

MODEL COMPARISON

Characteristic	Rational	Group	Robertson & Judd's Model
Process	Decision Process Is Central to Policymaking	Group Influence Each Stage of Policy Development	Policy Process Is Central to Government Units Motivation or Ability to Influence Policy Outcome
Individual	-Assumes People Act Rationally -Individual Follow Self Interests	Individual Not Considered, Only Acts As Part of, Or On Behalf of, Group Interests	Does Not Address
Institutions	To Make Rational Policy Decisions	Form of Interest Group Consequently Act As Such In Policy Process	Possible Ability Or Motivation to Alter Or Stop Policy Somewhere In Policymaking Process
Basic Thesis Health Policy	Dilemma in Policymaking Good Health or Good Medical Care	Interest Groups Both Inside and Outside Health Try to Influence Health Policy	Fragmented Policymaking Structure Has Limited Development of Effective and Equitable Health Policies

TABLE 2-2

SUPPORTING LITERATURE TO MODEL COMPARISON (Table 2-1)

Characteristic	Rational	Group	Robertson & Judd's Model
Basic Thesis National Policy	Dye (1987)	Dye (1987) Truman (1951)	Robertson & Judd (1989)
Structure		Dye (1987)	Robertson & Judd (1989)
Decisions	Shields (1991) Dye (1987) Carley (1980)	Dye (1987) Young (1968) Truman (1951) Lowi (1969)	Robertson & Judd (1989)
Information	Shields (1991)		Robertson & Judd (1989)
Politics	Knott & Miller (1987)	Dye (1987) Latham (1956)	Robertson & Judd (1989)
Implementation			Robertson & Judd (1989)
Bureaucracy	Dye (1987) Wade (1977) Downs (1966) Weber (1946)	Dye (1987) Young (1968) Truman (1971) Latham (1956)	Robertson & Judd (1989)
Goals	Wade (1977)	Truman (1971) Young (1968)	Robertson & Judd (1989)
Coherence	Dye (1987)	Truman (1971)	Robertson & Judd (1989)
Process	Dye (1987)	Dye (1987) Latham (1956)	Robertson & Judd (1989)
Individual	Shields (1991)	Dye (1987) Truman (1971)	
Institutions	Dye (1987) Knott & Miller (1987) Simon (1945)	Buchan-an (1977) Latham (1956)	Robertson & Judd (1989)
Basic Thesis Health Policy	Dye (1987)	Dye (1987)	Robertson & Judd (1989)

Rational Model

Strengths	Weaknesses
o Achieves Maximum Social Gain	o Definition of Problem
o Use of Cost/Benefit Analysis	o Purposely Separates Politics from Process
o Examination of All Alternatives	o Assumes People Act Rationally
	o Implies Policy Coherence Equates to Rationality
	o Individual Follow Self Interest
	o Does Not Address the Role of Structure
	o Does Not Address the Role of Implementation

Group Model

Strengths	Weaknesses
o Politics Is Recognized as Central to Group Struggle	o Does Not Address the Role of Policy Structure
o Acknowledges the Important Groups, i.e., AMA, Unions, etc which Influence the Current Health Policy Process	o Does Not Address the Role of Policy Coherence
	o Does Not Address the Role of Information
	o Does Not Address the Role of Implementation
	o Compromise Decisions Are the Type Made
	o Group Goal Is Paramount

Group Model continued

Strengths	Weaknesses
	o Individual Not Considered
	o State or Society Not Considered

Robertson & Judd's Model

Strengths	Weaknesses
o Recognizes that Policy Coherence Is Almost An Impossibility Due to Fragmented System	o Does Not Address the Role of the Individual
o Policy Coherence Is Ideal Standard	
o Recognizes the Importance of the Role of Structure on Health Policy	
o Recognizes Institutions As Main Actors In All Stages of the Health Policy Process	
o Recognizes the Importance of the Role of Implementation on Health Policy	

From the above compilation of model strengths and weaknesses it appears that each model provides a different view of the health policy process. It is obvious that Robertson and Judd's policymaking model provides, at least, as good an insight into the health policy process as the other standard models. Therefore, Robertson and Judd's model deserves further investigation.

Health

A review of the literature reveals that both the rational model and the group model have been used to describe aspects of United States health policy in the past. Each description provides a slightly different view of the same basic issue--public support of healthcare in America. The ensuing discussion gives a general outline of the health issue and governmental strategies to solve that issue. Subsequently, a rational model and a group model view on health is presented.

General. According to James A. Morone (1991), "Today, the American health policy agenda is especially crowded with issues competing for attention. Perhaps the most important are rising costs, uninsured citizens and accountability for the medical system as a whole" (Morone, 1991:273).

Lawrence D. Brown (1988) states that sometimes technical medical breakthroughs have become routine practice without relevant costs-benefits analyses being properly applied. Preoccupation with curing has led to neglect of caring. Of the two, curing or caring, caring maybe the more important when one considers the number of ailments which have no organic source or just get better by themselves. Individual preventive responsibility and the collective societal environmental responsibility has

gained renewed attention. Both approaches emphasize nonprovider and preinstitutional sources of healthcare. In fact, some have concluded that "policy makers should invest fewer resources in exotic basic research and more in exhorting or inducing the population to honor Mother's insights--"Eat a good breakfast! Sleep eight hours a day! Don't drink! Don't smoke! Keep clean! And don't worry!" (Brown, 1988:3).

Further, Brown (1988) describes the four main policy strategies and four primary objectives used by the United States federal government (and central governments of comparative countries) to intervene in the healthcare system.

First, the government uses a subsidy strategy if its objective is to influence the supply of healthcare services and resources, especially hospitals and personnel. This subsidy strategy has taken the programmatic form of grants to the National Institutes of Health, the Hill-Burton program, and various programs assisting medical schools and medical students (Brown, 1988:2).

Second, the government uses a financing strategy if its objective is to influence the demand for healthcare among all or part of the population. Usually the financing strategy is in the form of publicly created health insurance program which is financed all or in part

by public funds. Medicare and Medicaid are major program forms under this strategy (Brown, 1988:2).

Third, the government uses a reorganization strategy if its objective is to alter the organization of the healthcare system. This is done by building new organizations to (1) serve special subgroups of the population such as veterans; or (2) advance some larger goal such as health maintenance organizations which are intended to contain health costs (Brown, 1988:2).

Fourth, the government uses a regulatory strategy if its objective is to influence the behavior of healthcare providers. The regulatory strategy approach is especially apt when government wants to influence the use, price, and quality of services; and the size, location, and equipment of facilities. Major regulatory programs include Peer Review organizations and the Prospective Pay System (Brown, 1988:2-3).

"... these strategies have emerged in roughly chronological sequence, the later ones intended in part to address and correct the problems of those that preceded" (Brown, 1988:3).

Rational Model. Decisionmakers and decisionmaking bodies address policy goals. In the case of healthcare this could be described as attaining the maximum social gain in health matters for the people. Clearly, this type

of policy goal is consistent with and characteristic of the rational policymaking model (Dye, 1987). However, several obstacles are encountered when using the rational model to explain American health policy. The main obstacle to a rational explanation is defining the problem. Is our national goal to be good health, i.e., lower infant mortality/longer life span, or good medical care, i.e., accessible medical care/new facilities, for the people? It must be understood that good medical care does not necessarily mean good health. Factors that effect good health such as heredity, lifestyle, and physical environment are generally beyond the control of doctors and hospitals. However, throughout the years America's health policies have focused on the idea that better medical care means better health (Dye, 1987:152).

The most basic level of choice a country faces is between health and other goals. The realization of health as a "right" for every citizen is always less than complete because resources that could be used for health are diverted to other goals. This is true in all countries regardless of (1) economic system; (2) the way medical care is organized; and (3) the level of affluence. In fact, no country is as healthy as it could be or does as much for the sick as it is technically capable (Fuchs, 1974:17). As to the "right to health", most Americans

feel that everyone should be be guaranteed as much healthcare as they need. In fact, 73 percent of the American public favors a constitutional amendment to ensure this "right" (Rochefort and Pezza, 1991:249).

Resource limitation constraints in health results in the absence of amenities; delays in receipt of care; and minor inconveniences; and loss of life. The grim fact is that no nation is wealthy enough to avoid all unavoidable deaths especially accidental deaths (Fuchs, 1974:17).

The same is true of deaths from other causes--many of them are preventable if we want to devote the resources. However, the yield may be small when compared to the costs, as in the case of organ transplants. Within the limits set by genetic factors, climate, and other natural forces, every nation chooses its own death rate by the value it places on health in relationship to other goals (Fuchs, 1974:18).

Further, Fuchs (1974) defines the term "optimum" level from a medical and social aspect. To the medical professional the health optimum level is the highest level technically attainable, regardless of cost. On the other hand, the economist is concerned with the social optimum. Where, social optimum is defined as the point at which the value of an additional increment of health equals the cost of the resources needed to obtain that increment. For

instance, the first few days of hospital stay after major surgery might be extremely valuable for preventing complications and assisting recovery. However, at some point the value of each additional day decreases. When the medical value of an additional day's stay falls below the cost of that day's care, the patient should be discharged. Assigning costs to the process reminds us that those resources could be used to satisfy other goals (Fuchs, 1974:19). Fuchs closes his argument with, "If better health is our goal, we can achieve it, but only at some cost" (Fuchs, 1974:19).

In, Health Care Economics (1988), Paul J. Feldstein demonstrated that the principles of economics can be applied to medical care issues. The use of economic criteria enables the policy maker to determine whether particular policies increase or decrease efficiency and equity in medical care. Additionally, economics can highlight the choice a society can make when its resources are insufficient to achieve everything it desires (Feldstein, 1988:593).

Feldstein (1988) contends that by analyzing the elasticity of supply of medical services,

> ... it is possible to forecast more accurately the effect on prices and expenditures of demand-increasing programs and to evaluate the performance of the providers of medical care. If analysis reveals that the supply of medical services is determined solely by the nature of the production function for producing those

> services, and further, that the providers are attempting to minimize their costs, then very few changes will be possible to improve the performance of the industry. The increase in medical prices and the type of output being produced could be altered without serious and harmful effects on the industry and patients. If, however, the production function is artificially constrained by legal restrictions, and there are few incentives for the providers to minimize their costs of productions, it would be possible to improve the performance of the medical sector (Feldstein, 1988:149).

Additionally, Feldstein (1988) asserts that the market performance within a given industry can be improved two ways. First, the actual market can be restructured to resemble a competitive industry with decentralized decisionmaking, and greater reliance can be placed on competitive pressures to gain economic efficiency. Second, more focus can be placed on centralized decisionmaking and regulation to gain the desired outcomes of a competitive market. Under either of these approaches there needs to be a comparable set of performance measures for each market. Without these desired performance measures, the differences between the advocates of increased regulation and proponents of greater use of market pressures will be stated in value judgments rather than in measurable terms which reflect the most efficient way to achieve a given outcome. In the health field, restructuring the delivery of medical services proposals are often based upon a general set of values. The problem

with using general values is that they do not provide a clear definition of performance outcomes for the health industry. If the health industry is evaluated using performance measures that are different from traditional economic efficiency measures, those measures should be clearly enunciated. Also, the implicit values underlying them should also be clearly explained (Feldstein, 1988:151-152).

The determination of optimal output in a market, i.e., medical care demand, the manpower markets, or the health education markets, is based upon the concept of marginal benefits and marginal costs. When the marginal benefits of a service are equal to the marginal costs of producing that service, the amount of that service is considered to be "optimal". If the marginal benefits are either less than or greater than the marginal costs of producing a service, consumption in that market is considered economically inefficient (i.e., resources are misallocated--not placed in their highest-valued uses). Efficiency in consumption, therefore, is one criterion by which the output of different medical care markets can be evaluated. The other criterion is efficiency in production--whether the output is produced at minimum cost. Economic efficiency in consumption and in production are criteria used to evaluate the performance

of different markets. In medical care, the criterion of efficiency in production is more widely accepted than is the criterion of efficiency in consumption, i.e., need criterion. Applying the criterion of efficiency in consumption to each medical care market should sharpen the debate as to whether consumers' or health professionals' perception of marginal benefits prevail (Feldstein, 1988:79-80)?

To be able to determine whether or not the quantity (and quality) of medical care consumed is optimal, one must understand the demand for medical care as well as the demand for health insurance. As discussed previously, the optimal rate of output of medical care will be achieved when the price of that care (which is presumed to equal the costs of producing that care under a competitive system) is equal to the marginal benefit of that care. The type of insurance coverage that has existed in the United States (service benefit coverage) and the tax treatment of health insurance premiums are two reasons why prices in medical care to consumers have been (and still are) distorted, thereby resulting in consumption of a nonoptimal amount of the medical care (Feldstein, 1988:135).

In fact, the market has failed in medical care to produce the optimal amount of output--price equaling

marginal cost--according to Feldstein (1988). This situation or outcome raises the question--is government intervention in medical care justified? One reason for this failure would be the lack of a "natural" monopoly in the provision of a particular medical service. In a natural monopoly the economics of scale are so large that given the size of the market, it would be less expensive to have one firm produce that service. The situation in which natural monopolies exist in the health field field are rare. Relatively good substitutes exist for most medical services at the local level. Economies of scale in hospitals are slight. Because few medical services have the characteristics of a natural monopoly, the natural-monopoly argument has not been an important justification for government intervention or subsidies in medical care (Feldstein, 1988:514-515).

The existence of externalities is another possible reason for market failure in medical care. Externalities occur when an action undertaken by an individual (or firm) has secondary effects on others, which may be favorable or unfavorable. Externalities result in a nonoptimal amount of output being produced, because an individual or firm considers only their own benefits and costs when making a production or consumption decision. If costs or benefits are received by others as a result of someone's private

decision, the level of output produced in the market will be based either too small a level of benefits or too small a level of costs of production (Feldstein, 1988:515).

The existence of externalities legitimizes a role for government in healthcare. The proper role of government is twofold. First, it must determine the exact nature and size of external benefits and costs. The measurement of externalities is a difficult task, both conceptually and empirically. Second, is to determine how the externalities will be financed--who will be compensated and who will be taxed (Feldstein, 1988:516).

Several types of situations in the health and medical fields give rise to externalities. The first type is "consumer protection". Given the technical nature of medical care and the patient's lack of knowledge regarding diagnosis, treatment needs, and the provider's competence, consumers might benefit from the establishment of certain minimum standards and the provision of information. Thus, consumer protection would become an externality and hence a legitimate role for the government (Feldstein, 1988:517).

The second type of externality that occurs in the health field is associated with public health programs. Vaccination programs, clean water supplies, air pollution abatement, and medical research are examples of

goods that result in large external benefits. These types of programs have been the subject of many cost-benefit studies (Feldstein, 1988:519).

Another externality with regard to personal medical services is "externalities in consumption". When healthier and wealthier individuals do not want to see persons less fortunate than themselves go without necessary medical care and are willing to contribute to their medical care, an externality in consumption exists. Theoretically, each person who receives an external benefit should contribute according to the size of the external benefit. Unless there is some form of nonmarket decisionmaking, it will not be possible to collect from all the persons who receive an external benefit. Under circumstances of externalities in consumption, in-kind subsidies are efficient (Feldstein, 1988:517-518). This discussion of in-kind subsidies leads into the primary subject under the group model, national health insurance (NHI).

Group Model. Feldstein (1988) provides the following theoretical economic framework about national health insurance (NHI):

> National health insurance may be viewed as an in-kind demand subsidy based on the argument that there are externalities in consumption. If the nonpoor wish to subsidize the poor, this will result in a demand for government subsidies. The degree of subsidization will differ depending upon the values held by the nonpoor with respect to redistribution of

> medical care services. One set of values may be termed minimum provision, meaning that no person in society should receive less than a certain quantity of medical care in case of illness. A second set of values might be called equal financial access to medical care. If these values were the basis for the externalities in consumption, they would suggest an NHI plan that would equalize the financial barriers to all persons; in other words, the price of medical services would be the same for everyone. The third set of values that people may share with respect to redistribution of medical care services goes beyond equal financial access to require equal treatment for equal needs--in other words, equal consumption of medical services regardless of economic or other factors affecting utilization. The different demands for government subsidies reflect varying sets of values that are believed to exist in the population. The first set of values would require the smallest level of subsidization; the third set of values would be the most expensive to achieve (Feldstein, 1988:527-528).

Minimum provision according to Feldstein (1988) may be achieved in one of two ways. First, those persons whose consumption of medical care is below the minimum may be subsidized to bring their consumption up to the minimum. Second, a subsidy can be provided to everyone so that at the resulting new, lower price, no one person's consumption would be below the minimum specified by society. Both approaches would achieve the goal of minimum provision. The approach that provided a subsidy to the lower-income group only would be less costly, hence more efficient, than a scheme that reduced the price to everyone (Feldstein, 1988:528-529).

If society's values with respect to redistribution of medical care were that all persons should have equal

financial access to medical care, this access could be accomplished two ways. First, a free medical care system or low prices for all persons can be established. Second, a system of subsidies that vary according to income level can be instituted. It is unlikely that the external demand for subsidization, based on equal financial access, would include the value judgment that the demands of higher-income persons should be increased beyond levels that they currently spend and be financed through higher taxes (Feldstein, 1988:529).

The third values that give rise to a demand for medical care subsidies is equal medical treatment for equal medical needs. Since the demands for medical care vary for more reasons than just financial ones, merely making the price of medical care free to all will not result in equal consumption. Thus, a free medical care system would not be able to achieve that set of values defined as equal treatment for equal needs. The value likely to be achieved through a free medical care system would be equal financial access which could be achieved at lower cost by a system of subsidies that varied by income level. The only way equal treatment for equal needs could be achieved would be by differential income level subsidies. For example, lowering the price of medical care to zero for both low- and middle-income groups would still not increase their utilization to where it equalled

that of the high-income group. Only if the low- and middle-income groups were subsidized further, through a system of negative prices, could their utilization be equal to the high-income group (Feldstein, 1988:530).

It is unlikely that legislation would be passed that would actually pay people to increase their use of medical care. Instead, a negative price would be paid by means of a direct in-kind subsidy to low-income groups (Feldstein, 1988:530).

Feldstein (1988) asserts that advocates of a free medical system are opposed to competition as a way of determining the most efficient system and set of providers. Thus, reliance would have to be placed upon government to manage the medical system and to bring about greater efficiency in supply. Previous attempts by government to regulate or manage the supply of a medical care good or service lend little credibility that government will become an efficient and innovative manager in the near future. It is more likely that the current medical care system would be frozen in existing patterns. In the past, the government has not been able to close Veteran Administration, Public Health Service, or any municipal hospitals, on grounds of efficiency because of political pressure from employee groups and the constituencies of these facilities (Feldstein, 1988:532).

Feldstein (1988) concludes his theoretical NHI discussion by stating:

> For each of the set of values examined--minimum provision, equal financial access, and equal treatment for equal needs--it was shown that these values can be achieved more efficiently if the subsidy varies by income level rather than if changes are sought through a system that either results in an equal price reduction to all or makes medical care free to everyone, regardless of income level (Feldstein, 1988:533).

Feder (1980) focuses on the NHI issue from a group influence point of view. Feder (1980) states that, "The debate about compulsory national health insurance has extended over fully one-third of America's life as a nation. Teddy Roosevelt first made national health insurance an issue in the Bull Moose campaign in 1912. Since then and with varying degrees of intensity, the issue has held a place on the national political agenda" (Feder, et al., 1980:1).

The legitimacy and desirability of government intervention in healthcare are the key issues in the NHI debate. It involves such fundamentals as the redistribution of income, status, and influence, and the legitimacy of highly valued political beliefs. Because the stakes are so high, NHI generates an ideological intensity matched by few other issues in American politics (Feder, et al., 1980:7).

The antagonists in the NHI debate are well defined and well known. Over time they have remained basically stable. One side wants to shift medical care financing

from the private to the public sector. The same side believes that private financing has produced intolerable inequities in the distribution of medical services. The large industrial unions such as the Union Automobile Workers have traditionally led this coalition. The coalition also includes a variety of liberal religious, service, charitable, and consumer groups. The members of the coalition are united in their belief that NHI is a crucial missing element in the array of social welfare programs enacted in the 1930s (Feder, et al., 1980:7).

On the other side of the debate is an equally broad coalition. It ranges in membership from medical and hospital groups to the U. S. Chamber of Commerce and the Young Americans for Freedom. This coalition views government financing as synonymous with government control which equates to impersonal and inadequate medical care. At most these groups have favored limited federal involvement. The arguments and the alignment in the NHI debate have remained much the same over time (Feder, et al., 1980:7-8).

Below, Robertson and Judd (1989) supplement Feder's (1980) comments by amplifying the role of American unions in policymaking, in particular health policy.

> American unions are not as influential in the U. S. policymaking process as the unions in West European nations... American political scientists tend to view unions as participants in

> a pluralist system in which interest groups slug out their differences in a constantly changing battle for policy influence. In the pluralists' view, trade unions compete with other interest groups, and seldom win everything they seek or leave the government arena entirely empty-handed (Robertson and Judd, 1989:66).
>
> Health policy in the United States seems to confirm this observation. The American Medical Association (AMA) has been a powerful lobbying group throughout this century, and its opposition to national health insurance proposals has been more single-minded than doctors' interest groups across the Atlantic. America's unions have been too weak to offset the influence of the AMA. Lacking a labor movement powerful enough to demand the expansion of public health insurance effectively, no American political party seriously pursued the issue at the national level until the 1940s. Only the Democratic landslide in the 1964 elections produced enough political momentum to overcome opposition by doctors and other interest groups to the health insurance programs [Medicare and Medicaid] adopted in 1965 (Robertson and Judd, 1989:66).

Bette S. Hill and Katherine A. Hinckley (1991) provide the following apt summary of characteristic political behavior of health interest groups:

> Interest groups make a variety of strategic decisions, though no typology of them has ever been developed. We know for example, that different groups select different arenas in which to work; some concentrate on the federal courts, while others choose state legislatures. They also make different decisions about which issues deserve top priority for their attention. But one pair of interlocking strategic decisions is absolutely central: How a group defines the issues, and what stance it takes on them (Hill and Hinckley, 1991:226).

Summary

From the preceding review of literature several

important items become apparent. The policymaking process, even though it can be broken down into separate and distinct stages, is in reality a very messy, complex, and indistinct process. Models are used to simplify this highly complicated process. Each model provides a different, not necessarily mutually exclusive view of the policymaking process. In addition, each model has its own strengths and weaknesses. A comparison of Robertson and Judd's policymaking model with two standard models revealed that it provides, at least, as good an insight into the health policy process as the other standard models. Therefore, Robertson and Judd's model deserves further investigation. The next chapter will develop the methodology to be used in this investigation.

CHAPTER 3

Methodology

Methodological Application

This applied research project is an exploratory study. It concerns the description, assessment, and applicability of Robertson and Judd's new model to Texas healthcare policymaking. In the literature review the cornstones of Roberstson and Judd's were described. In addition, the literature review demonstrated that the policymaking process is very messy, complex, and indistinct. Models are used to simplify this complicated process. Each model provides a different, not necessarily mutually exclusive, view of the policymaking process. A comparison of Robertson and Judd's policymaking model with two standard models revealed that their model provides, at least, as good an insight into the health policy process as the other standard models.

The best way to investigate Robertson and Judd's policymaking model is the case study method. A case study is very appropriate for exploratory research (Yin, 1989:15-16). Since this study's unit of analysis is the health policymaking structure of the state of Texas, it can not be categorized as a typical case study. However, the techniques which compose the case study method are appropriate for this investigation. These techniques include:

- Documentation technique for collecting evidence (Yin, 1989:85);

- An adaptation of the explanation-building strategy, i. e., hypothesis generating, to analyze the evidence (Yin, 1989:113); and

- Linear-analytic structure technique for paper presentation (Yin, 1989:138).

The case study and each of the techniques above are briefly discussed next.

Case Study

In general, case studies are the preferred strategy: (1) for "how" or "why" types of questions; (2) when the investigator has little control over events; and (3) when it centers on a current event within some real-life context (Yin, 1989:13).

Yin (1989:23) defines a case study as an empirical inquiry that:

- o investigates a contemporary phenomenon within its real-life context; when

- o the boundaries between phenomenon and context are not clearly evident; and in which

- o multiple sources of evidences are used.

There many different aspects of case studies. The case study research strategy: (1) is used in many settings to include policy, political science, and public administration; (2) contributes uniquely to our knowledge of individual, organizational, social, and political phenomena; and (3) allows an investigation to retain the

holistic and meaningful characteristics of real-life events such as organizational and managerial processes (Yin, 1989:13-14).

This study of Texas healthcare policy structure addresses how and why questions. For example, how can Robertson and Judd's model be operationalized in a Texas healthcare policymaking setting; and why is Texas healthcare policy structure crazy? To answer these questions the Texas healthcare policymaking structure will be examined. It is anticipated that Robertson and Judd's model will provide a broader insight into the health policy structure in Texas. This broader insight will contribute uniquely to our knowledge in this area, especially with respect to the real-life organizational and political phenomena in Texas. The key to a creditable case study is sound data collection.

Documentation

Documentation, archival records, interviews, direct observations, participant-observation, and physical artifacts are the primary sources of evidence for data collection for case studies (Yin, 1989:85).

Documentary information is relevant to most case study topics. Data of this sort can be found in many different forms and should be the focus of explicit information collection plans. The following illustrates the wide variety of available documents (Yin, 1989:86):

- o letters, memoranda, and other communiques;
- o agendas, announcements and minutes of meetings, and other written reports of events;
- o administrative documents--proposals, progress reports, and other internal documents;
- o formal studies or evaluations of the same "site" under study; and
- o newsclippings and other articles appearing in the mass media.

According to Yin (1989) corroboration and amplification of evidence from other sources is the most important use of documentary evidence. Documents can also be used as the basis to make inferences. These inferences should be treated not as definitive findings but as clues deserving further investigation because they could turn out to be false later (Yin, 1989:86-87).

The potential for over-reliance on documents is a criticism of the use this type of evidence. A casual investigator might mistake the information contained in the documents being investigated as the unmitigated truth. To avoid this pitfall the investigator must keep in mind that the document was written for a specific condition, purpose and objective other than the study in question. In fact, the key to analyzing documentary evidence critically, i.e., not be misled by its surface contents, is to try to constantly identify the circumstances under which the document was written and adjust accordingly (Yin, 1989:87).

This research paper will use original source documents: books, planning documents, legislative abstracts, healthcare oriented technical publications, special studies, and scholarly articles. Review of these types of documents will provide information about the legal underpinnings and institutional structure of health policy in Texas. In addition, since this is exploratory, research documentation review is needed to find potential variables. For example, a review of the Texas Health and Human Services Coordinating Council's Biennial Report 1987-88 revealed that there were sixteen different state institutions organized under six different organizational configurations involved in providing health and human services in Texas. Analyzing the evidence collected requires an analytic strategy.

Explanation-Building Strategy Adapted

A general analytic strategy is important in conducting a case study. Its main goal is to: (1) treat the evidence fairly; (2) produce compelling analytic conclusions; and (3) rule out alternative interpretations (Yin, 1989:106). There are two general analytical strategies used in case studies. One relies on theoretical propositions as a basis, and the other begins with a descriptive approach (Yin, 1989: 108). These general strategies underpin pattern-matching, explanation-

building, and time series modes of analyses (Yin, 1989:109).

In fact, explanation-building for this study was begun in the literature review. Three alternative models (rational, group, and Robertson and Judd's) or explanations for policymaking were presented. It was shown that when health policy is assessed in light of these three models, that each model has it strengths and weaknesses. For example, achieving maximum social gain in health policies is a major strength of the rational model, whereas, purposely separating politics from the health process is one of its major weaknesses. One of the group model's major strengths is that the important influence interest groups have on health policy is acknowledged; whereas, not addressing policy structure is one of the weaknesses. The recognition that coherence in health policy is almost an impossibility because of the fragmented system is one of the major strengths of Robertson and Judd's model; whereas, not addressing the influence or role of the individual is a major weakness. Through this model assessment it was also shown that Robertson and Judd's policymaking model provided as good an insight into the health policy process as the rational and group models. Additionally, this model evaluation demonstrated that Robertson and Judd's model warranted a critical examination and assessment (explanation).

Explanation-building is a special type of pattern-matching. The goal of explanation-building is to analyze the case study data by building an explanation about the case. This research paper will use an adaptation of explanation-building strategy--hypothesis generating. It uses a similar procedure as explanation-building, i.e., stipulation of casual links. However, the goal of the hypothesis generating adaptation is not to reach a study conclusion, rather, its goal is to develop ideas for further study (Yin, 1989:113). Next, the method of presenting the research paper will be discussed.

Linear-Analytic Structure

Yin (1989) presents six illustrative structures for case study compositions. These structures are: linear-analytic, comparatives, chronological, theory-building, suspense, and unsequenced. It is felt that the linear-analytic structure is the best way to present this exploratory research paper because the logic flow used in the paper's development is closely matched. Basically, this form of presentation involves the issue or problem being explored, the methods of exploration, the findings from the exploration, and the conclusions (for further research) (Yin, 1989:138). For example, this paper's order of presentation is: (1) statement of research problem (purpose) is made; (2) the problem's conceptual framework is developed; (3) the way the problem is

investigated is developed; (4) the investigative setting is presented; (5) model extension and assessment is made; and (6) a summary and recommendations (to include a future study area) are provided.

Summary

The methodology used for this research paper is the case study. The paper concerns the description, assessment, and applicability of Robertson and Judd's policymaking model (a new model) to Texas healthcare structure. Original source documents will provide the basic evidence for analysis. It is anticipated that by using the case study methodology, at the very least, the new model will be extended. In addition, the examples of application will illustrate the usefulness of the new model. The next chapter presents the setting in which this methodology will be applied.

CHAPTER 4

Setting

Introduction

The provision of healthcare in Texas is big business. It is estimated almost 31 billion dollars was spent on healthcare in Texas during 1989 (Texas Statewide Health Coordinating Council, 1990:3). Public health policies made at the state level affect almost every aspect healthcare provision. Any disunity in the state level policymaking process and structure can result in the inefficient delivery of good healthcare to almost seventeen million Texans. Consequently, the importance of coherent health policies can not be overemphasized. This chapter will briefly describe the state policy geographic location to which Robertson and Judd's policymaking model will be applied -- Texas. Aspects of Texas included in the discussion are its: demographics, health issues, health organization, and legislation which affect health policies.

Demographics

Texas is best known for its size and wealth. Texas is the second largest state in the United States with a total land and water area of about 276,000 square miles. The state is as large as all of New England, New York, Pennsylvania, Ohio, and Illinois combined. The longest distance from north to south in the state is 801 miles;

whereas, the longest east-west distance is 773 miles. The largest of Texas' 254 counties is Brewster County which covers 6169 square miles or an area equal in size to Connecticut and Rhode Island combined. At the opposite end of the scale is Rockwall County with only 128 square miles (Texas Department of Health (TDH), 1987:3).

Based on the 1986 census estimate, the population of Texas has increased about 17.3 percent since the 1980 Census (Table 1) growing to over 17 million in 1987 (TDH, 1987:3).

In 1987, whites composed 66 percent of the state's population, whereas Hispanics represented 23 percent and blacks 11 percent. The estimated populations of the individual counties in Texas in 1987 ranged from almost three million in Harris County to 114 in Loving County. About 54 percent of the state's population resides in only ten counties (Bexar, Cameron, Dallas, El Paso, Harris, Hidalgo, Jefferson, Nueces, Tarrant, and Travis) (TDH, 1987:3). The diversity in population density throughout the state is a major obstacle to the accessibility of healthcare (Texas Statewide Health Coordinating Council (TSHCC), 1985:11). Variation in the state's population density is the basis for many problems in the delivery of healthcare. The selected data presented in Table 4-1 partially illustrate several of these problems.

TABLE 4-1

SELECTED TEXAS HEALTHCARE DATA

YEAR	OF THE 254 COUNTIES
1984	41 Had No Hospitals
1984	33 Had No Nursing Homes
1984	11 Had No Physicians
1984	5 Had No Registered Nurses
1984	12 Had No Pharmacists
1987	129 Had No Public Hospitals or Hospital Districts

Source: Siegel, C. H. Texas Health Care Data: 1987 (Special Project Report). (Austin, TX: University of Texas, Lyndon B. Johnson School of Public Affairs, 1987) pp. 69-71, 84.

Since the early 1980s, Texas has been plagued with economic decline. Now, many authorities feel that the Texas economy has "bottomed out", and the state's economy has entered into a long period of slow recovery (TSHCC, 1988:3-4). The effects of this economic decline such as high unemployment and poverty level, have a direct impact on the provision of healthcare in both public and private healthcare delivery systems in Texas.

Table 4-2 below depicts the state's median income in 1985 as compared to U.S. poverty income guidelines. Note that the median income increases with family size until it peaks at a family size of four. After the median income peaks at a family size of four, it declines falling below the U.S. poverty income guidelines for a family size of eight.

TABLE 4-2

1985 SPECIAL TEXAS CENSUS
STATE MEDIAN INCOME COMPARED TO
1985 U.S. POVERTY INCOME GUIDELINES
(dollars)

FAMILY SIZE	MEDIAN INCOME	U.S. POVERTY INCOME GUIDELINES
1	9,600	5,250
2	20,880	7,050
3	27,600	8,850
4	30,600	10,650
5	25,670	12,450
6	20,400	14,250
7	18,000	16,050
8	13,440	17,850

Source: Siegel, C. H. Texas Health Care Data: 1987 (Special Project Report). (Austin, TX: University of Texas, Lyndon B. Johnson School of Public Affairs, 1987) p. 16.

Table 4-3 below provides (based on 1984 and 1985 data) percentage listing of healthcare funds in Texas and the United States brokendown in two ways--source of funds and expenditures of funds. Indications are that in sources of dollars Texas lags behind the United States as a whole in receiving money from Federal, State and third party payers. In-turn, this situation highlights the high percentage of funds that came from consumers in Texas (about 42 percent) which is indicative of a large number of uninsured or underinsured patients. In fact, "The number of people under age 65 (in Texas) without health insurance coverage increased by about 46 percent between 1979 and 1987" (Texas State Health Coordinating Council,

1990:36). On the other hand, in healthcare dollars paid out, Texas pays about 4.6 percent more for physicians services and about 2.3 percent less for nursing home care than the United States as a whole.

TABLE 4-3

THE HEALTHCARE DOLLAR

WHERE IT CAME FROM:

SOURCE	TEXAS PERCENT (1985)	U.S. PERCENT (1984)
Federal Funds	23.9	29.0
State and Local Funds	11.1	13.0
Private Insurance	23.2	31.0
Consumer and Other Funds	41.8	24.0
Philanthropy		3.0
Total:	100.0 ($25.21 Billion)	100.0

WHERE IT WENT:

EXPENDED ON	TEXAS PERCENT (1985)	U.S. PERCENT (1984)
Hospital Costs	40.8	41.0
Physicians Services	23.6	19.0
Nursing Home Costs	5.7	8.0
Administration and Government Public Health Activities	8.8	
Other Health Costs	21.1	20.0
Research, Construction, Adminstration, etc		12.0
Total:	100.0 ($25.21 Billion)	100.0

Source: Siegel, C. H. Texas Health Care Data: 1987 (Special Project Report). (Austin, TX: University of Texas, Lyndon B. Johnson School of Public Affairs, 1987) pp. 36-37.

Table 4-4 below displays the 1985 ten leading causes

of death in Texas. Diseases of the heart and malignant neoplasms accounted for over 54 percent of the deaths in Texas in 1985. Additionally, the data presented in Table 4-4 lend further evidence to the health goal dilemma agrument with nine out ten of these causes of death falling into those categories which hospitals and physicians have very little, if any, influence over (Dye, 1987).

TABLE 4-4

TEN LEADING CAUSES OF DEATH IN TEXAS, 1985

CAUSE	PERCENT
Diseases of the Heart	33.9
Malignant Neoplasms	20.3
Cerebrovascular Diseases	7.4
Accidents and Adverse Effects	6.0
Bronchitis, Emphysema, Asthma, and Allied Conditions	3.2
Pneumonia and Influenza	3.0
Suicide	1.9
Homocide	1.9
Diabetes Mellitus	1.6
Certain Conditions Originating in the Perinatal Period	1.2
All Other Causes	19.6
Total	100.0

Source: Siegel, C. H. Texas Health Care Data: 1987 (Special Project Report). (Austin, TX: University of Texas, Lyndon B. Johnson School of Public Affairs, 1987) p. 24.

Selected health data 1985 comparisons are presented in Table 4-5. Both in the expenditures for Aid to Families with Dependent Children (AFDC) and MEDICAID Texas ranks very low, 46th and 45th respectively. On the other

hand, Texas ranks eighteenth in Food Stamp Issuance. This disparity in these rankings is not completely unexpected because the Food Stamps Program is entirely federally funded; whereas, AFDC and MEDICAID are funded about equally from federal and state funds. Additional insight into these relatively poor rankings can be obtained when consideration is given to the fact that Texas' Comptroller estimates that Texans get about $2.4 billion less each year in federal funds than deserved. The Comptroller further contends that of the $2.4 billion about 80 percent can be obtained by changing Texas state policies (Texas State Comptroller, 1990:1).

TABLE 4-5

SELECTED HEALTH DATA COMPARISONS--1985

AREA	TEXAS RANK	AVERAGE PER PERSON TEXAS	AVERAGE PER PERSON UNITED STATES
Aid to Families with Dependent Children	46	$57.26	$118.83
MEDICAID Expenditures	45	$90.13	$166.44
Food Stamp Issuance	18	$46.25	$45.00

Source: Siegel, C. H. Texas Health Care Data: 1987 (Special Project Report). (Austin, TX: University of Texas, Lyndon B. Johnson School of Public Affairs, 1987) pp. 46-47, 49.

Major Health and Human Services Issues

There are a multitude of health and human services issues facing the state of Texas. The health issues belaboring Texans cover the entire range of concern from

local to statewide. Provided below are the issues which were included in the 1989-90 and 1991-92 Texas State Health Plans (Texas State Health Coordinating Council, 1988/1990). These issues attempt to address statewide problems. These listings give the major health area of concern followed by the priority issue within that area. It appears, when comparing the issues presented in the two plans, that there has been a major shifts in issues. However, upon closer inspection one finds that all of the 1989-90 issues have been either expanded, combined, or refocused into the 1991-92 issues.

To illustrate a degree of disunity in some health areas, terms in the official issue statements such as "inconsistent" are underlined. Thus, even official assessment of Texas health policy reflects the problem of incoherence.

1989-1990 Issues

-ENVIRONMENTAL HEALTH--Diversity of environmental health problems and the lack of unified direction for all environmental health issues.

-SCHOOL HEALTH--Inconsistent public policy for school issues.

-ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS)--The increasing incidence of AIDS.

-TRAUMA AND EMERGENCY MEDICAL SERVICES--An effective and efficient trauma care system for the state of Texas.

-SHORT-TERM INSTITUTIONAL CARE--Financial stress of Texas acute care hospitals.

-LONG-TERM INSTITUTIONAL CARE AND ALTERNATIVES--The quality of care provided in long-term care facilities licensed by the Texas Department of Health.

-DISABILITY AND REHABILITATION--Fragmentation of the disability and rehabilitation delivery system.

-MENTAL HEALTH AND MENTAL RETARDATION--Aftercare and community-based mental health and mental retardation services.

-ALCOHOL AND DRUG ABUSE--Prevention of alcohol and drug abuse through education at all school levels.

-HEALTH PROFESSIONS--The uneven distribution of primary care physicians and nurses resulting in an inadequate supply in rural and inner-city areas.

-MATERNAL AND CHILD HEALTH--Access to prenatal and maternity care for low-income pregnant women in Texas.

-PROFESSIONAL AND MEDICAL LIABILITY INSURANCE--The impact of unaffordable professional and medical liability insurance on access to healthcare.

-THE HEALTHCARE NEEDS OF THE HOMELESS IN TEXAS--The health and social problems of an increasing number of homeless Texans.

1991-1992 Issues

-TEENAGE HEALTH--Teen pregnancy rate, prevalence of substance abuse among teenagers, and teen suicide.

-HEALTHCARE PROFESSIONS--The availability of physicians, nurses, and certain allied health care personnel for the delivery of primary healthcare in rural areas, and the professional qualifications of some allied healthcare personnel not credentialed by Texas state agencies.

-RISING HEALTHCARE COSTS--Rising healthcare costs impacted by changing healthcare capabilities and demands, inadequate reimbursement mechanisms, and the medical liability insurance system.

-ACCESS TO CARE--The declining access to quality, continuous, and appropriate healthcare due to the availability of facilities, equipment and services, transportation constraints, and financial barriers.

-MEDICAL CARE REIMBURSEMENT--Availability and affordability of health insurance, availability of care through county Indigent healthcare programs, and optimum use of the Medicaid program to expand health services for low-income Texans and to maximize the receipt of federal funds.

-PREVENTION AND CONTROL OF DISEASES AND INJURIES: Promoting individual responsibility for maintaining personal health and well-being.

-ENVIRONMENTAL HEALTH--Waste Management in Texas the 1990s.

-CHRONIC AND DISABLING CONDITIONS--Fragmentation of services to persons with chronic and disabling conditions.

-MENTAL HEALTH AND MENTAL RETARDATION--Access to community-based mental health and mental retardation services for all citizens, availability of appropriate community-based mental health services for children and adolescents, and adequate funding for public mental health and mental retardation services.

A Macro Description of the State's Current Health and Human Services Organization

Primary health and human services in Texas are provided by a variety of different organizational structures to include four departments, seven commissions, and three councils. In addition, there are eleven other agencies that provide and administer significant services

relating health and human services. The list below was adapted from data provided by the Texas State Comptroller (TSC, 1991:HS 6):

Primary Health and Human Service Agencies

Departments:
- Aging
- Health (Including Chest Hospitals)
- Human Services
- Mental Health and Mental Retardation

Commissions:
- Alcohol and Drug Abuse
- Blind
- Deaf
- Employment
- Juvenile Probation
- Rehabilitation
- Youth

Councils:
- Cancer
- Early Childhood Intervention--Interagency
- Health and Human Services Coordinating

Secondary Health and Human Service Agencies

1. Texas Agricultural Extension Service
2. Office of the Attorney General
3. Texas School for the Blind and Visually Impaired
4. Department of Commerce
5. Department of Community Affairs
6. Texas School for the Deaf
7. Texas Education Agency
8. Commission on Human Rights
9. Council on Offenders with Mental Impairments
10. Veteran's Commission
11. Medical Schools

There is no single organization that establishes state health policies. Consequently, agreement on goals by state health and human services organizations must be

achieved in what is essentially a confederation atmosphere. Overall state health and human services organizations work well together until a problem with available resources arises. This scarce resource situation results in each organizational head retreating to his/her kingdom and preparing to protect his/her own. The results of this protectionist posture is a breakdown of the communications and decision making apparatus of the confederation.

Legislation

Three Federal laws, one state law, and the Texas State Constitution have influenced the shape of health policy process in Texas.

National Health Planning and Resources Development Act of 1974 (NHPRD)

This act essentially abolished the Comprehensive Health Planning Agencies, Hill-Burton, and Regional Medical Programs as individual programs (Whitacre, 1990). NHPRD Act of 1974 (PL 93-641) created a single program of state and areawide health planning and development which combines the best features of the existing programs. The functions performed under this act are for the purpose of improving health of the area's residents; increasing the accessibility, acceptability, continuity, and quality of health services; restraining increases in the cost of

providing services; and preventing unnecessary duplication of health resources in the area (NHPRDA, 1974:7843-7844). Additionally, the enabling legislation for PL 93-641 established, funded, and required a comprehensive health planning effort at the state level.

Omnibus Budget Reconciliation Act of 1981 (OBR)

The legislative history OBR Act of 1981 gives interesting insight as to the reasons why Federal funding for state health planning and development agencies would be eventually phased out under the Health Programs Act of 1986. The basic reasoning stated:

> Health planning programs represent efforts to impose complex national health regulatory programs on States and localities. Moreover, it has not proven to be effective in controlling costs on a national basis, and it inhibits market forces needed to strengthen competition and provide less costly services. For competitive forces to restrain costs, free entry into healthcare market is essential. Otherwise, high-cost providers can monopolize healthcare markets (OBR, 1981:902).

Health Programs Act of 1986 (HP)

Federal funding for state health planning and resource development was finally stopped in 1987. The authority for the this stoppage was contained in the HP Act of 1986. Provisions of this act repealed Sections 300m to 300m-6, Title 42, USCA. In Texas, the stoppage of federal funding under HP Act of 1986 resulted in the

abolishment of the Texas Health Facilities Commission (along with it went the certificate of need (CON) process) and the abolishment of the State Health Planning and Resources Agency. The Texas State Health Plan, however, is continued on a limited basis within the Texas Department of Health under the authority of the 1975 Texas State Health Planning and Development Act (TSHCC, 1988).

Texas State Health Planning and Development Act of 1975 (TSHPD)

To be in compliance with the provisions of NHPRD Act of 1974, the Texas legislature passed the TSHPD Act in May 1975 (Vernon's Texas Civil Statutes, Article 4418h). This state law initiated two state agencies--the State Health Planning and Development Agency under the Texas Department of Health and the Texas Health Facilities Commission. Their purposes were to administer the state's health planning and certificate of need (CON) programs, respectively (IFHP, 1983:2).

Texas State Constitution

Each health and human services organization in the the state acts independently of the other, i.e., each is a kingdom to itself. As can be seen from the interpretive commentary on the Texas Constitution of 1876, given below, independency of state agencies was done by design by the framers of that constitution (Texas Constitution, 1876:726).

> Texas, like every other state, has created a separate executive department in keeping with the doctrine of separation of powers, but unlike some states, the executive department established is decentralized in that there is a diffusion of executive authority within the executive department itself. The governor, to be sure, is the chief executive officer, but executive authority is distributed by constitutional mandate among six other officers, all but one of which are elected by popular vote. Futhermore, they are largely independent of the governor in exercise of their powers. This in effect establishes a plural executive, and was done to weaken the executive branch, for such an arrangement makes for a separation of powers within the executive department itself...
>
> The framers of the Constitution of 1876 were in no mood to return to the principle of the Constitution of 1845 and vest all the executive power in the governor, for after reconstruction experiences they were determined to cut down still further on the governor's power so as not to see a future renewal of his despotic control over state administration. Hence, they adhered to the executive department principle and decentralization of authority, and further made all the officials but the secretary of state independent of the governor and dependent only to the electorate by taking away the governor's appointive power.

Summary

The above discussion has provided the last pieces of information needed to set the stage for application of Robertson and Judd's policymaking model in the next chapter.

CHAPTER 5

Model Extension and Application

In this chapter the information presented and developed in preceeding chapters will be used to extend Robertson and Judd's policymaking model. In turn, an attempt will be made to apply Robertson and Judd's model to the healthcare policy structure in Texas.

Brief Review of Robertson and Judd's Policymaking Model

In Chapter 2 it was shown that Robertson and Judd's policymaking model revolved around the two concepts of policy/structure coherency and policy/structure fragmentation. Robertson and Judd (1989) make two explicit statements related to these two concepts. These are:

> First, coherence is a function of the number of government units involved in policymaking and the ability or motivation of these units to alter or stop policy in the agenda-setting, formulation, enactment, and implementation stages (Robertson and Judd, 1989:10). Note that full definitions of these policymaking stages were given in the literature review by John Kingdon (1984) and Randall Ripley (1985).
>
> Second, the degree of fragmentation within government increases the likelihood that the policy design will be illogical and prone to failure because: (1) it increases veto points; (2) it allows formal and informal changes in policy goals; and (3) it produces the need for expedient compromises (Robertson and Judd, 1989:11)

These statements form the cornerstones of Robertson and Judd's model. After the initial presentation of these

concept statements, Robertson and Judd (1989) do little to elaborate on them. Each cornerstone provides a basis for extending the model.

Model Extension

Functional Equation

Robertson and Judd (1989) state that coherency is a function. This function is composed of several factors, e.g., the number of government units involved in policymaking. Expressing coherency in functional terms allows these terms to be translated into and shown as a functional equation. Table 5-1 displays the coherency concept in a functional equation format. Displaying the concept in this manner makes it easy to see that: (1) the only constant in the equation is the number of government units involved in the policymaking process; and (2) the ability or motivation of these units to stop or alter policy can occur during any one policymaking stage, all stages, or any combination thereof. This second observation combined with the reality that the stages of policymaking are not distinct can complicate interpretation of the model.

Policy Design Success

An examination of the fragmentation cornerstone of Robertson and Judd's model reveals several interesting,

TABLE 5-1

COHERENCY MODEL FUNCTIONAL EQUATION

COHERENCY = f (NGUIP + A/MUI/SAP[ASS] + A/MUI/SAP[FS]
+ A/MUI/SAP[ES] + A/MUI/SAP[IS])

or f (NGUIP + A/MUI/SAP[ASS] + A/MUI/SAP[ES]
+ A/MUI/SAP[IS])

or f (NGUIP + A/MUI/SAP[ASS] + A/MUI/SAP[IS])

or f (NGUIP + A/MUI/SAP[ASS])

or f (NGUIP + A/MUI/SAP[FS] + A/MUI/SAP[ES]
+ A/MUI/SAP[IS])

or f (NGUIP + A/MUI/SAP[FS] + A/MUI/SAP[IS])

or f (NGUIP + A/MUI/SAP[FS])

or f (NGUIP + A/MUI/SAP[ES] + A/MUI/SAP[IS])

or f (NGUIP + A/MUI/SAP[ES])

or f (NGUIP + A/MUI/SAP[IS])

WHERE:

NGUIP = NUMBER OF GOVERNMENT UNITS INVOLVED IN POLICYMAKING
A/MUI/SAP = ABILITY OR MOTIVATION OF UNITS INVOLVED TO STOP OR ALTER THE POLICY
[ASS] = AGENDA SETTING STAGE
[FS] = FORMULATION STAGE
[ES] = ENACTMENT STAGE
[IS] = IMPLEMENTATION STAGE

SOURCE: INTERPRETED FROM ROBERTSON & JUDD, 1989:10.

although somewhat hard to visualize, notions. These ideas include:

- o degree of fragmentation within government
- o policy design
- o policy design illogic or conversely logic
- o policy design failure or conversely success
- o veto points
- o formal and informal changes in goals
- o expedient compromises

After extensive consideration of these ideas it became apparent both "fragmentation" within government and "policy logic" were cornerstone concepts in the Robertson and Judd model. It also became apparent that both "fragmentation" and "logic" can be placed on a continuum. Further, the relationship between these concepts is a predictor of policy design success. Both "logic" and "fragmentation" were operationalized by a 0 to 100 scale, where, 0 = no logic or 0 = no fragmentation and 100 = total logic and 100 = total fragmentation. These concepts are graphically illustrated in Table 5-2. Here the probability of policy success is classified. When fragmentation is low and logic high the probability of success is high, i.e., "policy success". Conversely, when fragmentation is high and logic low the probability of success is low, i.e., "unsuccessful policy". Policies that fall outside these extremes are classified as

"successful if". Thus, they are contingent on one or more factors resulting from the fragmentation within government being controlled. For partial policy design success one or more of the following factors must be controlled: the number of veto points; volatility of formal and informal policy goals; and/or the need for expedient compromise.

Model Application to Texas Healthcare Policy Structure

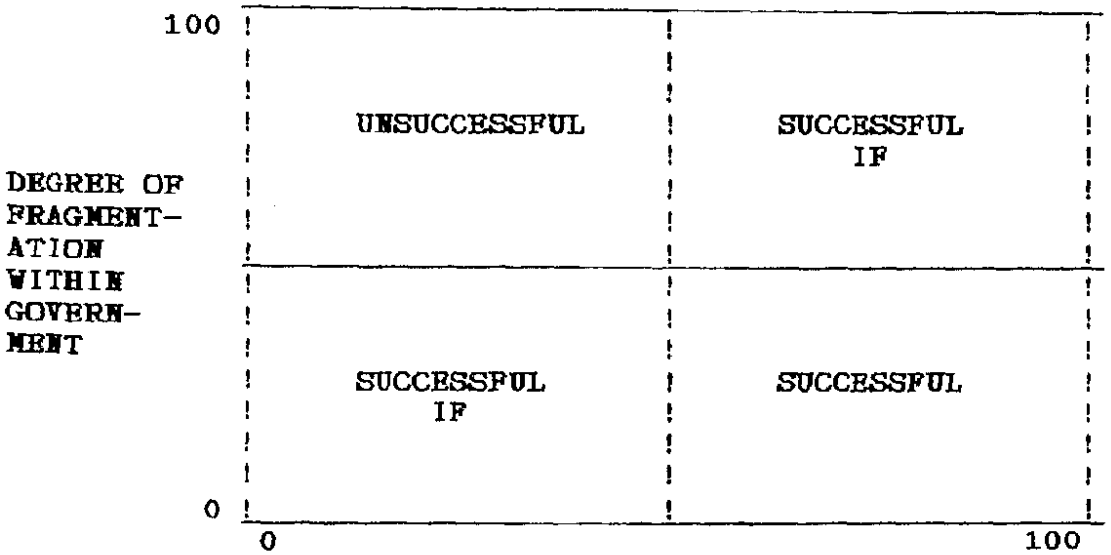
Problematical Factors

The coherency of the policy process in Texas is problematically affected by several interrelated factors which include legislation, funding, administration, coordination, authority to implement and planning. During a personal conversation with Robert S. Smith, Staff Planner, Bureau of State Health Data and Policy Analysis of the Texas Department of Health, the above factors were discussed, and insight into the problems associated with each factor was gained. Application of the Robertson and Judd's model to Texas revolves about these problematical factors.

Each factor will be discussed in general along with examples, followed by the policymaking stage(s) in which that factor is most likely to be of concern to Texas health and human services agencies. Aspects of the model's coherency and fragmentation concepts will be integrated into these discussions.

TABLE 5-2

POLICY DESIGN SUCCESS MATRIX.



DEFINITIONS:

SUCCESSFUL--POLICY DESIGN TOTALLY LOGICAL & PRONE TO SUCCESS.

UNSUCCESSFUL--POLICY DESIGN TOTALLY ILLOGICAL & PRONE TO FAILURE.

SUCCESSFUL IF--POLICY DESIGN CAN BE PARTIALLY SUCCESSFUL IF ONE OR MORE OF THE FOLLOWING RESULTS OF FRAGMENTATION WITHIN GOVERNMENT CAN BE DECREASED OR REDUCED:

- THE NUMBER OF VETO POINTS;
- THE FORMAL AND INFORMAL CHANGES IN POLICY GOALS; AND/OR
- THE NEED FOR EXPEDIENT COMPROMISES.

SOURCE: INTERPRETED FROM ROBERTSON & JUDD, 1989:11.

In Table 5-1 coherency was defined as an equation. Critical variables in the equation are defined as the number of government units involved in policymaking and the ability to motivate at each stage of the policymaking process. Table 5-3 represents an initial attempt to operationalize variables in the coherency equation as applied to the Texas health policy structure, extending the model in light of legislation, funding, administration, coordination, authority to implement and planning.

First, the number of government units involved in policymaking must be considered. In the case of Texas, the number of state health and human services agencies having a direct interest in healthcare policy can vary from one to fourteen. The large number of interested health and human service agencies in Texas is due to the decentralized nature of the state's executive branch which was explicitly designed by the Texas state constitution. Hence, there is no single organization that establishes state health policies. Consequently, goals in state health and human services organizations must be achieved in what is essentially a confederation atmosphere. The establishment of a unified goal is difficult to achieve in such a confederated context.

Legislation. As discussed in Chapter 4, the three federal laws and one state law that have influenced the

shape of health policy process in Texas are:

- National Health Planning and Resources Development Act of 1974 (NHPRD) (PL 93-641)
- Omnibus Budget Reconciliation Act of 1981 (OBR) (PL 97-35)
- Health Programs Acts of 1986 (HP) (PL 99-660)
- Texas Health Planning and Development Act (THPD) (Vernon's Texas Civil Statutes, Article 4418h)

In addition, the state's constitutional explicit design of a decentralized executive branch has had a profound impact on the policymaking process and structure.

During the agenda-setting and formulation stages legislation plays a minor role. Legislation becomes very important during the enactment stage. Enactment of any state policy requires the passage of the legislation which evolved out of the formulation stage. In some cases, state laws are passed in order to comply with federally enacted legislation or federally assisted programs. Examples, include the passage of the Texas Health Planning and Development Act (THPD) by the Texas legislature in May of 1975. THPD was enacted to comply with the provisions of NHPRD Act of 1974 and federally assisted Medicaid. In-turn, the guidelines set down in the enactment legislation establish the way the policy will be implemented during the implementation stage. Also, during the implementation stage, the courts will, if necessary, interpret the legislation.

Funding. As presented in Table 4-3, indications are that Texas lags behind the United States as a whole in receiving money from Federal, State, and third party payers sources (58 to 73 percent). In-turn, the high percentage of funds that came from consumers in Texas (about 42 percent) is highlighted. Texas consumers pay such a large portion of the total healthcare bill because a large percentage are uninsured or underinsured patients. In fact, "The number of people under age 65 (in Texas) without health insurance coverage increased by about 46 percent between 1979 and 1987" (TSHCC, 1990:36). Also, about 24 percent of the Texas healthcare dollar in 1985 came from federal sources such as MEDICARE or federal state assistance such as MEDICAID.

Funds appropriated for Federal health programs are further subdivided among the difference titles under each of these programs. Subsequently, regulations and guidelines dealing with fund administration are written. Ideally, the next step is to translate these Federal regulations and guidelines into policies in a coherent setting at the state level. Finding a coherent setting is the problem in Texas, consequently, different state agencies are allowed to administer different functions under the same title of a given health program. For example, under Title XIX of the Social Security Act (MEDICAID): the Texas Department of Health is charged

with licensure and certification of nursing homes which accept MEDICAID patients; the Texas Department of Human Services is charged with the determination of MEDICAID eligible recipients and administration of the healthcare delivery method; and the Texas Department of Mental Health and Mental Retardation is charged with the care for MEDICAID-eligible mentally retarded persons (THHSCC, 1989:296, 396, and 469). Clearly, the above programs are fragmented. Under this fragmented state policy structure, each of the above agencies determines and implements its own policies with respect to Title XIX of the Social Security Act. If these policies were established in a coherent setting, it would facilitate coordination in implementation.

Environmental health is another example of policy/program fragmentation. There are seven state agencies. These include Texas Departments of Agriculture and Health, Texas Railroad and Water Commissions, Texas Air-Control and Water Development Boards, and the Texas Low-Level Radioactive Waste Disposal Authority administering this program (TSHCC, 1988:9). Here again, each agency develops separate policies and methods of implementation. The fragmentation problem within the environmental area was addressed by the 71th Texas Legislature resulting in the "consolidation" of all programs under one agency.

In one manner, means, or form, sources of funding are important to any policy. Funding resources, i.e., local, state, or federal are initially established during the agenda-setting stage of policymaking. From that stage on, it becomes a matter of refining the exact way the funding will be handled.

Administration. Each of the health and human services agencies provide service statewide on an area basis. Most of these agencies divide the state up into geographic regions. It would seem that if coherent policymaking existed in Texas, there would be some semblance of uniformity in the geographic regions among state health agencies. Further, working on the assumption that each of the twenty-four Councils of Government (COG) regions in Texas is a cooperative geopolitical entity. One would logically think that all of the health and human service agencies' geographic regions might encompass more than one COG region but would not split a COG region. Such is not the case. In fact, if one were to examine the geographic regions of the Texas Department of Mental Health and Mental Retardation, one would find that not only do the Mental Health Council Regions (MHCR) and Mental Retardation Council Regions (MRCR) violate COG boundaries, but MHCR differs from MRCR as well.

Like funding, administration is important to any policy. For example, can an existing agency handle the

policy administration or is a new agency needed? Policy administration, i.e., local-level or state-level, is initially established during the formulation stage of policymaking. From that stage on, it becomes a matter of refining the exact way the policy will be administered such as writing appropriate rules, regulations, and procedures.

Coordination. Changes in both federal and state legislation such as the abolishment of the Texas Health Facilities Commission and the certificate of need (CON) process in the mid 1980s resulted in the state's return to a laissez faire environment. Institutions are aggressively pursuing independent and usually uncoordinated approaches to hypertechnical services i.e., CAT scans. The absence of an effective communication network in healthcare makes the coordination of some of these services difficult to manage (TSHCC, 1986:11). Efficient coordination and planning efforts, both public and private, are necessary to utilize resources to the fullest extent. Such coordination and planning can serve to eliminate wasteful duplication of investment in expensive capital equipment and to promote shared services among neighboring facilities. Also, equipment and service coordination could result in relieving much of the pressure on medical and healthcare cost. High levels of

capital and physical plant investment can often be avoided when investment plans are coordinated on a regional basis (TSHCC, 1985:13-14). The idea of coordination on a regional basis is aptly supported by the concept that although the health problems are local, the solutions to those problems are regional (Reeves, et al., 1984:23).

Within the state, the Texas legislature has mandated that the Texas Health and Human Services Coordinating Council (THHSCC) coordinate and perform the eight functions listed below (THHSCC, 1988). The underlined words in each of the eight functions illustrate that THHSCC's mandate is adequate. But, THHSCC has, in reality, little authority to coordinate and/or implement without going to the Governor and/or Legislature.

- Establish and maintain a central data base covering public and private sector health and human services.

- Conduct and contract for studies of significant health and human services issues.

- Serve as the primary state resource in coordinating and planning for health and human services.

- Analyze federal, state, county, municipal, agency, and public/private sector relationships to coordinate efforts to plan and deliver health and human services.

- Provide a central information and referral source concerning health and human services.

- Review existing and proposed actions and policies of federal agencies to determine the health and human services impact on the Texas and recommend to the Governor and the

Legislature alternative actions and policies consistent with state health and human services policy.

-Provide advice to agencies, organizations, and governmental entities concerning the analysis of needs and the development, evaluation, and coordination of health and human services.

-Conduct regular and comprehensive reviews and analyses of health and human services policy and make recommendations to the Governor and to the Legislature.

The use of terms such as establish and maintain; serve as the primary state resource; analyze; provide; conduct and contract; and review and recommend in THHSCC's mandate further illustrate that no one state agency is charge of healthcare policy.

The coordination factor is normally established during the agenda-setting stage and solidified during the formulation stage of policymaking. However, as has been shown or implied in the examples provided throughout this part of the paper, in Texas, coordination of healthcare policy does not rest with any one state agency. In fact, it is a rarity that a given policy's coordination responsibility rests with just one state agency.

Authority to Implement. Assuming that Reeves, Bergwall, and Woodside (1984) are right and that health problems are local, but solutions to those health problems must be regional, Texas fails miserably. For example, the

solution of making healthcare accessible to a person living in one of the forty-one counties of Texas (Table 4-1) without a hospital does not lie at the local level. It lies at a regional level. This solution is based on the assumption that the regional health agency is given the authority to coordinate and implement the necessary services needed to assist that person. To paraphrase Reeves, et al. (1984:23), when regions are involved in more than one geopolitical entity, in Texas' case-Councils of Government, then these regional agencies lack the direct authority to implement policies at the regional level. It appears that authority to implement in Texas closely parallels the statement by Reeves, et al. Even the authority given to the Texas Health and Human Services Coordinating Council is subject to political approval.

The authority to implement a policy, like coordination, is generally established during the agenda-setting stage and crystallized during the formulation stage of policymaking. Authority to implement healthcare policy does not normally rest with just one state agency in Texas.

Planning. The Texas State Health Plan is developed biennially by the Texas Statewide Health Coordinating Council (TSHCC). The plan stated purpose is:

> ... as a guide to help Texas decision-makers development health policies and programs and in

> determining the resources needed to conduct those programs. ... to provide direction for refining and implementing the essential health programs for Texas. It identifies major statewide health concerns, recommends strategies to resolve these concerns and analyzes the need for various types of health facilities and services. ... to assure equitable access to needed healthcare services--at affordable prices--for all citizens of Texas (TSHCC, 1990:1).

Overall, the Texas State Health Plan is a professionally-prepared document. It incorporates input from the public. Four major groups/agencies (Texas Statewide Health Coordinating Council [SHCC], Bureau of Health Data and Policy Analysis of the Texas Department of Health [BHDPA-THD], Texas Health and Human Services Coordinating Council [THHSCC], and State agencies [SA]) have responsibilities in the plan development. Briefly, the responsibilities of each include:

- -TSHCC--biennially develop the Texas State Health Plan; policy development and guidance in plan development; adoption of the final state health plan; and plan implementation.
- -BHDPA-TDH--conducts the initial policy analysis; identifies priority concerns to be addressed in the plan; works closely with 16 state agencies designated to implement the plans of the plan related to state government and coordinates with the private healthcare sector; and holds public meetings on the plan in Arlington, Beaumont, Laredo, San Antonio, and Austin.
- -THHSCC--reviews the draft plan.
- -SA--determine the costs of implementing plan recommendations; and report whether implementation costs are included in the agencies' biennial appropriations requests to the legislature (TSHCC, 1988:1-2).

Dr. Zetzman, Chairman, TSHCC, stated in the plan's transmittal letter to the Governor that, "Every effort has been made by the Council to produce a plan that fosters a positive, concise approach and one that has the potential for implementation during the next biennium" (TSHCC, 1990). Given, the fragmented nature of the Texas healthcare policy structure, the question is: What potential for implementation does this plan have?

As indicated above, state-level health and human services planning is one of the few items which is written and coordinated by one council. State-level planning becomes very important during the implementation stage after the policies have been formulated and enacted.

Texas Policy Design Success

In Table 5-2 the relationship between "fragmentation" within government and "policy logic" concepts in the Robertson and Judd's model are graphically illustrated. It became apparent that when both "logic" and "fragmentation" are operationalized on a 0 to 100 scale, these concepts are predictors of the probability of policy success. The following discussion is an initial attempt to apply these policy success predictors to the Texas health policy structure.

In, Breaking The Mold: New Ways To Govern Texas (1991), John Sharp, Texas State Comptroller, provides the

TABLE 5-3

POLICY COHERENCE MATRIX

FACTORS CONSIDERED	NUMBER OF GOVERNMENT UNITS INVOLVED IN POLICYMAKING	ABILITY OR MOTIVATION OF UNITS TO STOP OR ALTER POLICY DURING DIFFERENT STAGES OF POLICY DEVELOPMENT			
		AGENDA-SETTING	FORMULATION	ENACTMENT	IMPLEMENTATION
LEGISLATION	Varies Between 1 to 14 Different State Health and Human Service Agencies			X	X
FUNDING	Varies Between 1 to 14 Different State Health and Human Service Agencies	X			
ADMINISTRATION	Varies Between 1 to 14 Different State Health and Human Service Agencies		X		
COORDINATION	Varies Between 1 to 14 Different State Health and Human Service Agencies	X	X		
AUTHORITY TO IMPLEMENT	Varies Between 1 to 14 Different State Health and Human Service Agencies	X	X		

SOURCE: PARTIALLY INTERPRETED FROM ROBERTSON & JUDD, 1989:10.

TABLE 5-3 continued

POLICY COHERENCE MATRIX

FACTORS CONSIDERED	NUMBER OF GOVERNMENT UNITS INVOLVED IN POLICYMAKING	ABILITY OR MOTIVATION OF UNITS TO STOP OR ALTER POLICY DURING DIFFERENT STAGES OF POLICY DEVELOPMENT			
		AGENDA-SETTING	FORMULATION	ENACTMENT	IMPLEMENTATION
PLANNING	Varies Between 1 to 14 Different State Health and Human Service Agencies				X

SOURCE: PARTIALLY INTERPRETED FROM ROBERTSON & JUDD, 1989:10.

following apt summary of Texas' health and human services structure:

> The administration and delivery of health and human services in Texas is among the most complex and costly responsibilities borne by the state. Next to education health and human services is the largest function of Texas state government. While 14 separate state agencies primarily deliver programs in this area, a total of 25 agencies are routinely involved in some aspect of service delivery (TSC, 1991:43).
>
> Each of the 14 primary health and human services agencies is governed by a separate board, commission or council that has agency and policymaking responsibilities. Because there is no incentive for agency boards or agencies to work together, planning and policymaking often occur in a vacuum, all too often resulting in either unnecessary duplication of services or the failure to provide needed services. Often, policymaking is reactive in nature--responding to acute service needs in a crisis-oriented manner, rather than through a progressive planning process. The reactive nature of the planning and policymaking process is best illustrated by the state's failure to emphasize cost-effective, prevention-based programs (TSC, 1991:43).
>
> Although the focus of the review of the health and human services function has been limited to only the most pressing problems, the problems that have been identified are largely attributable to the fragmented approach that is taken in developing, administering and delivering health and human services. This fragmentation produces well-documented agency-wide problems such as a failure to maximize federal funds, inconsistency in rate-setting and contracting and a failure to coordinate transportation services. However, accountability across agencies is hindered by a lack of common program definitions, outcome measures and regional boundaries that normally would allow for cross-agency comparisons and analyses of existing and needed services (TSC, 1991:43).

The wide-range effects of governmental fragmentation highlighted above indicate that Texas' health policy structure fits neatly into the "unsuccessful" portion of the policy success design matrix (Table 5-2). More specific information which supports this conclusion is provided below. This evidence includes indications of duplication of program efforts and a comparison of Texas' health and human services structure to the health and human services structures of the ten most populous states.

Supporting Evidence

Cash assistance, counseling, job placement, residential care, in-home help, basic healthcare, and protection from abusive situations and persons are among the many services provide by the Texas health and human service agencies through 300 different programs and activities. Various regional delivery systems are used by the agencies; the number of geographic regions used by the agencies varies from six to eleven (TSC, 1991:HS 3). Table 5-4 displays twelve various health and human service functions. Beside each function is indicated the number of agencies and programs associated with that function. The table shows that there are many areas of program duplication. For example, twelve of the fourteen primary agencies provide education and/or training services; nine are responsible for providing rehabilitation services; and

nine agencies include some type of information/referral services. Also, Table 5-4 shows that no function is provided by less than four of the health and human service agencies (TSC, 1991:HS 7).

TABLE 5-4

Fourteen Primary Health and Human Service Agencies Summary of Programs by Function and Agency, 1991

Function		No. of Agencies	No. of Programs
1.	Protective Services	4	15
2.	Education/Training	12	56
3.	Rehabilitation	9	23
4.	Medical Services	4	56
5.	Employment Services	6	17
6.	Income Assistance	4	26
7.	Independent Living Assistance	4	17
8.	Mental Health Services	7	28
9.	Case Management	5	14
10.	Certification/Licensing	5	14
11.	Information/Referral	9	17
12.	Residential	8	20
	Total Programs		**303**

Source: The Texas Health and Human Services Coordinating Council, Health and Human Services in Texas: A Reference Guide. (Austin, TX, January 1991).

The health and human service agency structures among the states are very diverse. These structures range from a comprehensive umbrella type of structure to structures that deliver services through independent agencies. Also, PL 93-641 enabling legislation required that states establish separate agencies for the programs encompassed

within the law, thereby, contributing to the fragmentation of state programs. Using agency structure definitions developed by the Council of State Governments (CSG), these organizational structures can be categorized into three different groups. These definitions are (TSC, 1991:HS 9):

> **Umbrella or comprehensive**: an agency that administers a number of the following seven major human service programs along with public assistance/social services: public health, mental health, mental retardation or developmental disabilities, youth institutions, vocational rehabilitation, and employment services;
>
> **Partial umbrella or semi-comprehensive**: an agency responsible for at least major human service programs but not more than three; and
>
> **Non-umbrella or non-comprehesive**: administers human service programs by several separate agencies without a central agency responsible for all or most service programs.

Using the above definitions, the health and human service agency structures of the ten most populous states may be characterized as follows (TSC, 1991:HS 9):

> **umbrella agencies**: California, Florida, North Carolina and Pennsylvania
>
> **partial umbrella**: Michigan and New Jersey
>
> **non-umbrella**: Illinois, New York, Ohio, and Texas.

The organizational approach used in other states varies. Table 5-5 compares the number of state health and human services agencies in the ten most populous states. Table 5-5 also shows the number of major programs administered in each state's primary health and human

service agency. The table shows that the average number of agencies in other states is five, compared to Texas' fourteen. Out of a potential seven major service programs administered under a umbrella/comprehensive structure, California is currently administering six programs; and Florida and North Carolina follow with five service programs. At the opposite end of the spectrum, Texas, Illinois, New York, and Ohio administer each major program from a separate agency (TSC, 1991:HS 9-10).

TABLE 5-5

Number of Health and Human Service Agencies and Programs By State, 1991

State	No. of HHS Agencies	No. of Programs*
California	2	6
Florida	2	5
North Carolina	3	5
Pennsylvania	4	4
New Jersey	5	3
Michigan	5	2
Illinois	8	1
Ohio	9	1
New York	10	1
Texas	**14**	1
Average (non-Texas)	5	3

*Out of a potential of seven major health and human services programs.
Source: American Public Welfare Association, 1990/91 Public Welfare Directory: A Resource Guide to the Human Services. (Washington, D.C., 1990)

This supporting evidence clearly shows duplication of program efforts within the Texas health and human services

structure. The non-comprehensiveness of the Texas' structure became apparent when it was compared to the health and human services structures of the ten most populous states. Coupling this information with the governmental fragmentation summarized previously further confirms the high probability of failure of Texas health policies.

Summary

In this chapter it was shown that two concepts critical to the Robertson and Judd model "coherency" and "fragmentation" are possible to operationalize and apply to a state level context. On the one hand, the functional equation extension of the coherency cornerstone highlighted that the number of government units involved in the policymaking process is the only constant. Also, the influence of government units can occur during any one policymaking stage, all stages, or any combination thereof. On the other hand, the policy design success matrix interpreted from the fragmentation cornerstone visually established both extremes of policy design. Also, established was the fact that there can be varying degrees of policy design success if fragmentation within government can be controlled. Additionally, it was confirmed that the Texas' health policies had a high probability of failure.

It has been shown that Robertson and Judd's model does a good job of explaining the Texas healthcare policymaking structure. The model takes in account the number of state agencies involved in policymaking; that these state agencies can influence the policy during any developmental stage; and that there is a direct relationship between the state's governmental fragmentation, policy illogic, and policy failure. The expalnations provided by Robertson and Judd's model go far in answering why there is such craziness in the Texas healthcare structure. A summary of this paper and recommendations are the subject of the next and last chapter.

CHAPTER 6

Summary and Recommendations

Summary

Briefly, the question that initiated this paper began with the astonishment over the crazy healthcare policy structure in Texas. Wilson's (1989) barroom brawl analogy fits all to well. Robertson and Judd offered a model that took into account the craziness, formulating a new policymaking model/concept. Research questions in this paper included: Is this new policymaking model worth further investigation?; Does the model provide better insight into the policymaking situation?; and Can the model be applied to the Texas healthcare policy structure?

In this paper, it was found that the policymaking process regardless of which level it is performed is a confusing. Models are used to help simplify the policymaking process. Each model provides a different, but not neccessarily mutually exclusive, view of the process. Consequently, each model has its own strengths and weaknesses.

It was found after a comparison of Robertson and Judd's model to the rational and group models that Robertson and Judd's model is worth further investigation. It was shown that both the concepts of "coherency" and "fragmentation" (the model's cornerstones) could be

illustrated differently without changing Robertson and Judd's original intent. It was also shown that Robertson and Judd's model can explain much of why the healthcare policy structure in Texas is crazy. It was noted that the indistinction between the policymaking stages complicates, i.e., limits, the use of Robertson and Judd's model. For that matter, it complicates the use of any model.

Recommendations

Robertson and Judd's model highlighted that the State's constitutionally decentralized state executive branch has resulted in a multitude of loosely confederated health and human services organizations. It is clear that the current state confederation of health and human services organizations lead to "fair weather" policymaking processes and a detrimental fragmentation of health and human services. This disunity has from statistical data presented in Chapter 4 contributed to somewhat poorer health conditions in Texas than the United States as a whole.

A recommended solution to the evidenced fragmentation of the state healthcare policymaking structure is to consolidate health and human service agencies under one organization. Under this type of organization, policymaking is centralized, and the individual health service agencies are placed into strictly a policy implementation (operator) role.

From a policymaking process viewpoint advantages to a centralized organizational structure include the following:

- -It unifies the policymaking process.
- -It clarifies the information flow process from the agency relationship viewpoint.
- -It unifies funding.
- -It provides for uniformity of administration.
- -It simplifies the information flow process with the legislature, the private sector, and the consumer.
- -It places the service providing agency into an operator mode rather than that agency being in both a policy maker/operator mode.
- -It provides the opportunity for the service providing agency to adapt from it's current production, i.e., pyramidal, structure to a more service oriented, i.e., organic, structure.
- -It increases the potential for implementation of any state health policy.
- -Most of the structures required to implement a centralized organization currently exist within the state.

Disadvantages of a centralized structure include the following:

- -It requires that the Texas Constitution be amended to change from a decentralized executive branch to a centralized executive branch.
- -It requires the political will and commitment to do so, i.e., all political forces act in an unbiased manner.

From an organizational efficiency viewpoint, the proposed structure has more advantages than disadvantages. From a political feasibility viewpoint, however, the chances of this structure being adopted in Texas in the foreseeable future are almost nil.

It has been demonstrated that Robertson and Judd's model can be aptly applied to a decentralized executive branch state situation, i.e., Texas. Possibly, a future study in this area would be to investigate the applicability of Robertson and Judd's model to a state with a centralized executive branch.

In closing, it became clear in this paper that coherency in policies and policymaking is the key to providing an integrated and comprehensive set of programs and procedures that serve the public fairly and with respect. Obviously, process coherency can help change the situation from, as James Q. Wilson (1989) states it, a "barroom brawl" to a "prizefight".

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