



Waiting lists in Dutch health care

An analysis from an organization theoretical perspective

Patrick Kenis

*Department of Organisation Studies, Tilburg University, Tilburg,
The Netherlands*

Abstract

Purpose – To develop propositions on why public policies towards decreasing waiting list in health care can be expected to be unsuccessful.

Design/methodology/approach – On the basis of a case study of public policies directed towards the reduction of the waiting lists in health care a number of propositions are formulated explaining why this policy has turned out to be ineffective. The propositions are based on theoretical insights from the field of organizations studies about the behavior of organizations and professionals.

Findings – It is demonstrated that public policies on reducing waiting lists in the Dutch health care system are likely to be ineffective because the policy-making strategies used are based on unrealistic assumptions about the behavior of organizations and professionals who are expected to reduce the waiting lists.

Research limitations/implications – Although the propositions are based on established organization literature, empirically they are only based on one case study.

Practical implications – In order to develop effective policy interventions it is important to be realistic about the behavior and strategies of the actors towards which the policy is directed. Moreover, rather than directing exclusive attention to those waiting, it is important for policy makers to address the interdependencies of the organizational field in which waiting lists occur.

Originality/value – This paper gives directions to policy makers who need to deal with complex and interdependent problems.

Keywords Waiting lists, Medical care, Health services, The Netherlands

Paper type Research paper

Introduction

Although The Netherlands is generally considered as one of the showcases of a modern welfare state, it is characterized by the peculiarly phenomenon of long waiting lists in its health care system. At the moment about 350,000[1] persons are on one or the other waiting list for health care services. For example, in mental health care the situation is as follows: patients have to wait 7 weeks for registration, 15 weeks for being informed about the type of help they need, and dependent on the care necessary, 14 weeks for access to extramural care and 29 weeks for access to intramural care.

In order to deal with the waiting lists and the political discussions accompanying them, the former Dutch minister of health decided during her 8-year period in charge to make extra money available in order to reduce the length of the lists. On top of the regular budget for health care about €3 billion was earmarked in 1999-2001 in order to reduce the length of the waiting lists. This extra financial input had, however, no impact. There are still approximately 350,000 persons waiting for some type of cure or care, which is the same number of persons as before.



Waiting lists are in principal something rather simple: a waiting list is an overview of clients which have a valid indication for cure or care, but for which the indicated cure or care did not yet (completely) start (NIZW, 2000). And also the explanation for the existence of waiting lists is rather simple: waiting lists develop when there is a discrepancy between the demand for cure and care and the supply of cure and care (Vissers, 2000). Practice shows, however, that waiting lists are very hard to reduce. The question is why?

The present paper formulates a number of theoretical propositions about why the strategies chosen to reduce waiting lists did hardly produce any result. The propositions are deduced from insights from organization theory. This implies that the answers to the question why waiting lists are difficult to reduce are related to the behavior and structure of organizations in the health care sector. It will be demonstrated that the initiatives, which intend to govern the health care sector in general and the problem of waiting lists in particular, are based on unrealistic assumptions about the behavior and strategies of organizations. On the basis of more realistic assumptions about organizations an alternative strategy to deal with waiting lists is proposed.

The above will be demonstrated on the basis of four propositions:

- (1) Extra resources do not automatically reduce the waiting lists in cure and care.
- (2) Counting and publishing the number of those waiting contributes hardly to the reduction of the waiting lists, but produces a number of unintended negative consequences.
- (3) Not every organization in the field of cure or care has by definition an interest in reducing waiting lists.
- (4) In order to reduce the waiting lists, instead of managing those waiting, it is important to manage the interdependencies of the organizational field.

The propositions formulated here are hypothetical and are the result of a combination of theoretical considerations and empirical indications. Empirical evidence was gathered from official reports, academic journals and articles from the press. The theoretical framework for assessing the information is based on a tradition in organization science which is based on the assumption that things in and around organizations are often not the way they “should” be.

P1. Extra resources do not automatically reduce the waiting lists in cure and care

As stated earlier, a waiting list is the result of a discrepancy between demand and supply. The larger the demand and/or the smaller the supply, the longer the waiting list[2]. A logical way to reduce waiting lists would consequently be to reduce the demand and/or to increase the supply. Within the Dutch system it is, however, virtually impossible to reduce the demand for cure and care since there exist strong formal rights with regard to receiving cure and care (legal rights which can only be changed in the mid- or long-term).

What is possible, is to increase the supply by providing more resources. That is exactly what the ministry of health, welfare and sports (VWS) has been doing in the last years. The Ministry spent in the years 1999-2001 approximately an extra €3 billion in order to increase the volume of the sector (Ministerie van VWS, 2001a, b).

In addition, other resources such as a “waiting-list brigade,” a high level “taskforce,” organizational “platforms” and homepages (www.wachlijstaanpak.nl and www.nietafwachten.nl) were created. Resource endowment for the health sector in The Netherlands is also in general not worse than in many other countries (The Netherlands spends 8.8 percent of its BNP on cure and care, which is about the European average).

Empirical studies carried out in The Netherlands and elsewhere show, however, that the input of extra resources does not automatically lead to a shortening of the waiting lists (Taskforce aanpak wachtlijsten, 2001, p. 20; Breedveld *et al.*, 2000, p. 182; Laeven *et al.*, 2000a, b, p. 6). Research in the UK and Canada arrives at similar conclusions, i.e. spending extra resources does not automatically results in shorter waiting lists (Frankel, 1991; Newton *et al.*, 1996; Wood and Thomas, 1985, p. 89; Yates, 1991). The fact that extra resources do hardly influence the length of waiting lists is something, which comes as a surprise to policy makers. From the point of view of organizational sciences it is much less surprising.

An approach which assumes that an increase in input (i.e. resources for cure and care) will automatically lead to an increase in output (i.e. less people waiting) is based on the theoretical assumption that the output can be governed through the input or, in other words, that output and input are coupled in a logical way. This is by the way an idea, which is generally speaking strongly anchored in our modernist-rationalist way of thinking (Sanderson, 2000, p. 445).

Since, the pioneering work of Herbert Simon we know that such rational assumptions are not consistent with observations of empirical reality. More than 40 years of organizational research in the tradition of Simon (Simon, 1962, 1965; March and Simon, 1958; Cohen *et al.*, 1972; Weick, 1979; March and Olsen, 1984; Brunsson, 1985, 1989) has clearly demonstrated that organizational and policy problems are often characterized by a high level of complexity. This means that a large number of factors are responsible for the outcome of processes, that these factors do influence each other in mutual ways and that we lack knowledge to predict the consequences of action. All this has to do with the fact that we operate on the basis of “bounded rationality.” Limitations in intellectual capacities, time and other resources do not allow making all-embracing evaluations of the different alternative strategies to reach a goal. Given a certain level of complexity of a problem it will become impossible to react in an equally complex way. The consequence is that decisions are often taken which are based on a simplified vision of the problem, which results in inappropriate or even pathological consequences (Kenis, 2001).

Waiting lists seem indeed to be an almost ideal typical example of a problem which is characterized by a high level of complexity. The demand as well as the supply side are constantly influenced by a great number of factors which at the same influence each other mutually and this not always in a linear manner: the need for care or cure, the population structure, epidemiological factors, the way the insurance companies assess future needs, the number of personnel, the efficiency of the cure and care process, changes in the emancipation of citizens, the situation on the labor market, technological developments in the medical sector, existing capacities for child care, etc. But not only is a single waiting list influenced by such factors, other waiting lists (which are on their turn also influenced by a large number of factors) also influence the length of the waiting list: the waiting list for registration at the polyclinic, the waiting list for medical examination at the polyclinic, the waiting list for the hospital, the waiting list for care at home, the waiting list for the nursing home, etc.

Given the complexity of the waiting list phenomenon, as described before, it does not come as a surprise that regulating the input not automatically leads to the expected outputs. The fact that policy makers nevertheless keep believing in such an approach could be explained by two facts: first their underestimation of the complexity of the problem, and/or secondly their overestimation of their own capabilities (Sanderson, 2000, p. 441). Such attitudes not only produce a generally inappropriate reaction to the waiting list problem. It even often produces further breeding grounds for such approaches. Often it is stated that the strategy followed should be enforced in order to get better grip on the system. This is a reaction, which is quite common according to the organizational literature. In cases where problems or situations get out of control, further centralization is often seen as the solution (Chisholm, 1989, p. 6). Especially, in the public sector problems are often seen as a lack of coordination. Almost automatically the reaction is then to strengthen central coordination. Enforcing central coordination does, however, according to what we know from organization science, not necessarily lead to more effective strategies. Even worse, there are good reasons to believe that it often produces negative consequences:

P2. Counting and publishing the number of those waiting contributes hardly to the reduction of the waiting lists, but produces a number of unintended negative consequences

A common answer to complex problems is to chart them by collecting data (Boyne and Gould-Williams, 2001; Chisholm, 1989, pp. 6-9; *The Economist*, 2001a, b). This answer could also be observed in the Dutch health care system. One of the central spearheads in the response to waiting lists has been the development of a central registration and publication of the number of persons waiting for cure and care. A taskforce coordinates this approach for the care sector and the counting in the cure sector is coordinated by the Dutch Association of Hospitals (NVZ). On the one hand, is counting of course an important task since it produces some sort of indication for the problem load and it allows to monitor whether the waiting lists reduce or increase over time. On the other hand, it can be said that the importance, which is attributed to such counting, is based on a number of behavioral assumptions which, again on the basis of what we know from organization science, can be misleading. First, the assumption that counting persons waiting can be done in an accurate way. Secondly, the assumption that the transparency produced by waiting lists induces persons to select those organizations, which have shorter waiting lists. Thirdly, the assumption that adequate information will allow organizations to develop adequate responses to the problem.

All three assumptions are based on good intentions but again contradict with insights from the organizational science literature. On the basis of this literature one could assume that counting has hardly any effect on the length of the waiting lists. Moreover, it could be expected that such counting produces unintended negative consequences.

The first assumption, i.e. that the numbers collected give a clear indication of the demand of cure and care, is probably only partially the case. Even if we assume that the registration system is solid and that all organizations involved put the same energy in the same way in registering those waiting (which is according to some reports doubtful, see, e.g. Breedveld *et al.*, 2000, p. 182) the problem remains that a great number of things can happen in the situation of someone waiting. The change can be the consequence of a worsening or improvement of the patient's situation, the

becoming available of alternative forms of care or cure, changes in the family composition, information about the length of the waiting list, etc. It is not clear which percentage of a waiting list is influenced by such factors but it could be considerable. But in general, it could be stated that the more individualistic society becomes, the more difficult it will be to grasp these demands within organizational frameworks and to map them (Globerman, 1991, p. 256). A reaction to this situation by Dutch policy makers is that the indications will have to be updated more regularly. A polemic reaction to this could be that this could lead to "indication-actualization-waiting-lists."

A second assumption, which lies at the basis of the registration and making public of the number of persons on waiting lists is that these provide instruments to allow clients to take more rational decisions with regard to their cure and care consumption. It is clear that publication of waiting list data can increase the transparency and choice for the consumers. But it is further assumed that they will, on the basis of such information, be mobile towards those organizations which have shorter or no waiting lists at all. This could, consequently, lead to a situation where the average waiting time is reduced. But also this assumption is less obvious than one would like to believe. Clients are not necessarily mobile with regard to their consumption of care and cure. Often they want to be treated in their direct environment since trust in persons and organizations play an important role in the consumption of cure and care (*FEM/de Week*, 2000; Kersboom and Geleen, 2000; Ministerie van VWS, 2001a, b). Moreover, it has been observed that shorter waiting lists produce additional demands, which consequently results in the fact that the length of the waiting lists increases again. This can happen because "hidden demand" becomes visible or through the referral strategies of medical doctors. Two British researchers demonstrated that the referral strategies are influenced by the reported length of the waiting list (Smethurst and Williams, 2001). They statistically confirmed that the longer a general practitioner expected a patient to have to wait, the less the chance was that he would refer the patient. The consequence being that an increased availability of specialists does not contribute to decreasing waiting lists. This because the system adapts in such a way to that a new equilibrium is reached, with the same waiting lists as before. Their explanation for this phenomenon is based on complexity theory, which claims that the characteristics of complex systems cannot in a predictable way be deduced from its separate composed parts, but that they are the results of the interaction between those. They summarize their research as follows: "Hamsters run freely on wheels and a doctor's work may be compared by running on a health service wheel . . . The faster one runs the faster the wheel turns" (Smethurst and Williams, 2001). Similar phenomena have also been observed in the Dutch health care system (Taskforce aanpak wachtlijsten, 2001; School, 2000).

A third assumption, which generally legitimizes the collection of information, is that information can contribute to the solution of problems. This is an assumption about which Simon (1983, p. 3) made the following critical remark: "One kind of optimism, or supposed optimism, argues that if we think hard enough, or rational enough, we can solve all our problems." There are, however, indications that this is not necessarily the case. Such an indication is that information collection is often legitimized with the statement that it will lead to further insights and consequently a solution to the problem, but that the recommendations are most of the time of a rather general nature. For example, a report which presents an impressive and highly detailed collection of waiting list data in the area of care concludes the following: "Central in the solution of

the waiting lists is the extension of capacities in order to provide more care in the sector” (own translation, Taskforce aanpak wachtlijsten, 2000).

Moreover, information about the quantity and type of persons waiting does not, however, automatically contain information on how to reduce waiting lists. According to Wildavsky (1973, p. 132; zie ook Sanderson, 2000, p. 441) “can [there] be no planning without the ability to cause other people to act differently than they would otherwise act.”

Another explanation for the fact that information not necessarily contributes to the solution of a problem, claims that information is often collected for other reasons than contributing to the solution of a problem. Thus, far, there is lack of empirical evidence to proof this thesis but on the basis of organization theory it can at least hypothetically be put forward. In particular, the neo-institutionalist organization theory assumes that what organizations do should not necessary be interpreted as being a contribution to their effectiveness, but rather as a contribution to their legitimacy. This means that organizations do not aim to increase their efficacy, but rather aim at contributing towards the confirmation of certain values and expectations (Meyer and Rowan, 1977; Powell and DiMaggio, 1991). On the basis of such a perspective the hypothesis could be formulated that the reasons way information is collected is in the first place an indication for confirming to certain expectations (i.e. undertaking action). McKeivitt and Lawton (1996) indeed demonstrated in a study in the UK, that the collection of data about results in the first place was a consequence of pressure to confirm to certain expectations rather than to contribute to organizational change or an improvement of services.

What has been illustrated so far is that it could be expected, at least according to organization theory, that reporting waiting lists contributes less to shortening these lists than one would generally expect. The reason being that reporting is often based on a number of unrealistic assumptions.

Not only does counting and reporting not necessarily contribute to a solution of the problem, it could even be hypothesized that it has unintended negative consequences. On the basis of organization theory the following negative consequences could be expected:

Costs

It is clear that a central reporting system generates substantial direct and indirect costs. This, on the coordinating as well on the level of the single organizations, which have to provide the information. The direct costs for the registration of persons waiting for care is for one year approximately €30 million. The indirect costs are very difficult to estimate.

Strategic behavior

A disadvantage of the reporting of waiting lists can be that it produces strategic behavior. It can lead to short-term decisions or can induce the prioritizing of the treatment of simple disorders because they can be treated faster (*The Economist*, 2001a; de Brauw, 2001).

False security

The false precision and rigidity of counts produce a false security and can as such produce failures. As Mintzberg (1987, p. 26) stated: “... setting oneself on a predetermined course in unknown waters is the perfect way to sail straight into an iceberg.”

Misuse

Numbers can by definition be falsified. For political, election campaign or other reasons organization can have an interest in announcing increases or decreases in the length of waiting lists. There are no direct proofs that this has so far been the case in The Netherlands but in other countries (UK and Sweden) with waiting lists in cure and care such incidents have been reported (Pickin *et al.*, 2001).

Legitimacy of policy

Organizations which are, in the first place, confronted with their institutional environment can hardly be assessed on the basis of their outcome (e.g. hospitals, schools, ministries). They will consequently give priority to increasing their legitimacy compared to increasing their effectiveness. On the one hand, it seems thus plausible that the health ministry orders the collection of waiting lists information – especially since as such a signal is given that “something is done.” On the other hand, the type of information which is collected can, however, be used by others as an indicator for the effectiveness of the health ministry (i.e. the number of people waiting for cure and/or care). This leads to a situation where an organization which can hardly be assessed on outcome indicators, is nevertheless by its environment assessed on such criteria and consequently undermines its own legitimacy. That this is the case Netherlands is reflected in many newspaper articles and political commentaries:

P3. Not every organization in the field of cure or care has by definition an interest in reducing waiting lists

A third assumption which is characteristic for the discussion about responding to waiting lists is that waiting are believed to be seen as something negative by the organizations concerned. Although this might be a wishful situation, on the basis of what organization theories learn us, it has to be concluded that this is far from necessarily the case. The fact that waiting lists are the result of an organized and interdependent care and cure field does not yet mean that a care- and cure-field wide norm exists which says that waiting lists have to be eliminated (what Scharpf (1994) calls a “system rationality”). In addition, from a theoretical point of view, there is no necessity why organizations in the care and cure field should see the elimination of waiting lists as one of their central goals. This point has extensively been put forward by those organizational researchers, which use the political metaphor to analyze organizational behavior (Lammers, 1993; March and Olsen, 1984). Such a model describes inter- and intra-organizational systems as a conglomeration of parties. Here norm orientation is not seen as the driving force of organizations or inter-organizational fields.

The fact that groups within organizations or the organizations within organizational fields behave as “parties” is explained in the organizational literature along different lines. It could result from the fact that they have to take different stakeholders into account (Provan and Milward, 1995, pp. 10, 21). Or, by the fact that the earlier described interdependencies constitutes a source of uncertainty, which is reduced through strategic behavior (Chisholm, 1989, p. 43).

In what follows, I will illustrate that the responses to long waiting lists in the Dutch cure and care sector are, in the first place, not characterized by a “system rationality” but rather by “partial interests” (Scharpf, 1994). What shall become clear is that when policy makers assume the existence of a system rationality, which in practice is absent,

however, does probably more harm than good. This point will be demonstrated by describing in short the type of interests different stakeholders can have with respect to the reduction of waiting lists.

Patients

A survey carried out by NIPO shows that 65 percent of the persons asked consider waiting lists in care and cure unacceptable (*Metro*, 2000). Interesting is, however, that those who have probably the highest interest in the reduction of waiting lists are at the same time the least organized group in the care and cure field. Patients have indeed some alternatives in dealing with waiting lists (e.g. treatment in other countries, legal procedures and access to a small number of private clinics). Such alternatives are, however, only realistic to a limited extend, they produce (often substantial) extra costs for the patients and can be expected to increase conflicts of interests in a Dutch context.

Ministry of VWS (Dutch Health Ministry)

It is clear that the ministry itself is a conglomerate of many different interests, but in general it could be said that the ministry as such has an interest in the reduction of waiting lists. The ministry is formally speaking responsible for the quality, the accessibility and the efficacy of cure and care. On the other hand, cost containment is always also seen as one of their main goals. Consequently, it could be stated that the longer the waiting lists are the better the cost containment goal is reached[3]. On the basis of a rational organization approach it seems impossible to reconcile two goals which are so contrary. Approaches inspired by neo-institutional thinking argue, however, that this should not necessarily be a problem: administrations are not in the first place assessed or rewarded on the basis of their output or outcome but on whether or not they have tackled a problem (Kneissler, 1996, p. 144). Or as Lindblom (1959) formulated it: “. . . the test of a good policy is whether it commands sufficient support to be adopted, not whether it will actually achieve some grand objective.”. Or, as stated by the “radical institutionalist” Brunsson (1989, pp. 233-4): “Sin and hypocrisy are necessary to the creation and preservation of high morals” and are consequently important in the survival strategy of political organizations[4].

Medical doctors

The most important aim for doctors is to be able to provide services of high quality to those who need them most. Doctors, who are, as a result of the long waiting lists, not anymore able to provide these types of services will presumably give high priority to the reduction of waiting lists. But there are also good reasons why it is not interesting for doctors to tackle waiting lists. This is, for example, the case for those doctors which so far have no waiting lists and who would have to make sacrifices in their available capacities when others start tackling waiting lists[5]. Another reason why doctors not necessarily have an interest in an active response to waiting lists has to do with the fact that they are in the first place confronted with disciplinary courts which judge them on the patients they have treated and not on the patients they have not treated.

Health insurance companies

Also for insurance companies there can be at the same time reasons why they could be interested in tackling waiting lists and reasons why they should not be interested in doing so. Announcing responses to waiting lists can be interesting for competitive reasons

(given the fact that health insurance companies in The Netherlands are private companies) or in order to anticipate court rulings. On the other hand, it can be observed that insurance companies so far have taken hardly any structural measures to deal with waiting lists. This provoked the following statement by surgeon de Brauw (2001, pp. 36-7): "... when budgets are tight, is the cheapest patient the non-treated patient" (own translation).

Care and cure providers

Also for the care and cure providers it cannot be stated by definition, that they have an interest in reducing waiting lists. Take the example of a hospital as an organization being characterized by diverging interests. This means that it is often the case that each unit works for itself and nobody necessarily is interested in the end result. Surgeon De Brauw (2001):

A unit with empty beds does as a rule not take patients from a unit which is more than fully occupied. The atmosphere in a hospital is characterized by a each for itself-attitude of the different units.

Moreover, the fact that hospitals are not necessarily interested in the reduction of waiting lists is also related to the regulatory regime in which they have to operate. Given the design of the regime, hospitals have no interest in treating more patients. The financing of hospitals in The Netherlands is not based on their primary process, i.e. treatment of patients, but is in the first place based on their facilities and services such as the number of specialists, the costs of the building, the kitchen, the pharmacy, the heating, etc. The consequence of such a regulation is that a hospital has no incentive in carrying out surgeries, which are better for the patient (e.g. in terms of admission duration, pain, and revalidation) when they are more expensive. Since, no real tariffs for the treatment of patients are calculated and since hospitals do not receive a financial compensation for services and treatments a more expensive form of treatment automatically means a larger cost for the hospital. In addition, a hospital does receive part of its budget on the basis of the admission duration which also means that surgeries which result in shorter admission time are less interesting for the hospital. All this means that hospitals not only do not necessarily have an interest in reducing waiting lists but that they often even have incentives to contribute to increasing the length of waiting lists.

The above should not be read as an accusation of egoistic parties but rather as a confirmation of claims made by organization theory, i.e. that organizations and inter-organizational relations are often characterized by different, divergent and incompatible interests on the basis of which it becomes difficult to implement strategies in a predefined manner.

So far it has been argued that organization theory could explain why tackling waiting lists in cure and care is much less straightforward than is generally assumed. The question remains, however, whether organization theory can also contribute insights with regard to how waiting lists could actually be tackled. This questions leads to *P4*:

P4. In order to reduce the waiting lists, instead of managing those waiting, it is important to manage the interdependencies of the organizational field

On the basis of organization theory, solving problems is a matter of coordination[6]. As should have become clear from *P1*, *P2* and *P3* there are different fundamental reasons why coordination in the case of the waiting lists is far from straightforward.

What would be needed, again on the basis of the previous analysis, is a form of coordination, which helps to solve problems in situations, which are characterized by complexity, a large number of organizations and even more interests.

The reasoning by policy makers is often different. Historically, the reaction to this kind of situations has often been that better coordination is needed; this on its turn has often resulted in a plead for reducing fragmentation, to improve the integration of organizations and to improve vertical control (Chisholm, 1989, p. 17; Mayntz, 1993; Kenis and Schneider, 1991). What is striking is that improved coordination is often equated with more centralization: “Where a need for coordination is perceived, the reflexive response is centralization” (Chisholm, 1989, p. 13).

Organization science does certainly not question the fact that a proper response to a problem such as waiting lists requires more coordination. Also is centralization not by definition seen as an ineffective way of coordination (Mintzberg, 1979; Perrow, 1986: Chapter 1). What is, however, questioned in organization science is that improved coordination can only be achieved by improved centralization or that the market is the best coordination mechanism by definition. Also will organization science avoid relapsing in a pessimistic nihilism when confronted with chaos and complexity (Sanderson, 2000, p. 445).

What organization science can contribute, is to produce a diagnosis of the problem in order to propose an effective form of coordination. Different approaches differ with respect to what should be central in such a diagnosis. Diagnosis can be based on a logistic approach (Laeven *et al.*, 2000a; Vissers, 2000), they can be based on the strategic capacities of organizations (Ganz, 2000), they can be based on power differences within and between organizations (Perrow, 1986: Chapter 8), or they can be based on approaches to increase the efficiency of single organizations (Groot, 2001), etc.

What I propose as a basis for the diagnosis of the waiting list phenomenon is an analysis of the interdependency of the organizational field in which waiting lists are produced[7]. The choice of interdependence as a criterion for diagnosis relates to the assumption that inter-organizational systems are more effective when the form of coordination is congruent with the type and degree of interdependency; and this according to the following rule: the more interdependency, the more coordination but never more than absolute necessary (Chisholm, 1989, p. 191).

On the basis of this perspective, the design of coordination mechanisms as an answer to problems, without a diagnosis of the type and degree of interdependence or on the basis of wrong assumptions about these interdependencies, can be a risky and expensive enterprise (see in this respect Simon’s (1973) analysis about dealing with ill-structured problems). This could entail the nucleus for an explanation for the ineffective response to waiting lists, i.e. that the approach to deal with waiting lists is characterized by a discrepancy between the degree of interdependence of the problem and the type and of coordination of the response.

Central coordination in the governance of highly interdependent systems is from an organizational theory point of view for different reasons problematic. Simon (1969, 1973) argued that a high level of interdependency is “deviation amplifying,” which means that a change in one part can reproduce itself throughout the entire system in an uncontrolled manner and thus can produce unintended negative consequences. Central governance implies also that things have to be done which are virtually impossible: having available an action plan on the basis of cause-effect relationships; effective communication to those who have to implement the action plan; and, making sure that

the plan is accepted by those who have to implement it (see *P1*, *P2* and *P3* and Chisholm, 1989, p. 29).

Apart from the fact that central coordination seems not to be effective in situations of high interdependency, it can moreover produce rather negative consequences. Central coordination can artificially increase the interdependency between the different components. The consequence being that ever more coordination is needed among a broader spectrum of interests, which increases the cognitive complexity even more. On the contrary, a diagnosis could help to reduce the complexity of the system, which implies that less coordination, becomes necessary. Simon (1969) claims that even the most interdependent systems are “often nearly decomposable.” Often interdependencies can be reduced in such ways that only loose ties remain and consequently the cognitive complexity of the problem is decreased. This means on its turn that less heavy coordination mechanisms can be used to arrive at a satisfactory level of coordination. Such a perspective means that diagnosis implies in the first place collecting information on the basis of which it becomes possible to assess whether existing interdependencies in decision making can be separated. This means that already the diagnosis of interdependency can increase the chance for effective coordination (Chisholm, 1989, pp. 53-4). Relevant aspects of interdependency in such a diagnosis are: the number of parties in the system, the type of interdependency (bilateral or multilateral), the circumstances under which interdependencies appear and the forms of interdependency (natural, artificial and voluntary interdependency) (Chisholm, 1989, pp. 190-1). On the basis of network analysis such interdependencies could be mapped and analyzed (Kenis and Knoke, 2002; Scott, 2000; Brandes *et al.*, 1999). On the basis of such a diagnosis two things can be done: “decomposing” of the system and consequently research into simpler forms of coordination. Such an approach aims to reduce the cognitive complexity of the problem (*P1*), which implies also that the number of parties which is necessary to arrive at a satisfactory solution, decreases (*P3*). This also means that the potential number of conflicts of interests decreases (Chisholm, 1989, p. 54)[8].

In order to make the above argument somewhat more concrete I present a couple of initiatives which aim at the reduction of the waiting lists and which are, probably unconsciously, based on such an interdependency approach.

One of the often-heard reactions to waiting lists is “getting around the rules.” Getting around the rules is often nothing else than decreasing interdependency. See, for example, the article which appeared in a national newspaper with the title “Health care is ripe for civil disobedience” (own translation):

Patients have to be washed before 10 a.m. and have had their breakfast . . . This produces enormous peaks for the staff. If you explain to a patient that a care institution is a more satisfactory working place if the times in which care has to be provided is managed somewhat more flexible, the client shall readily accept to get his slice of bread a little bit later (*Volkskrant*, 2001).

A similar example is the “brutal way of care assignment in Flevoland”:

Such a care assignment team is a most effective example to tackle waiting list . . . They look for empty places and empty hours, and if the indicated care is not available at that moment, than we check which type of care is available at that moment . . . Only later we are concerned about the budget-line which will cover it . . . (*Nieuwsbrief aanpak wachtlijsten*, 2001).

These are just some examples which demonstrate the more general point, i.e. that dealing with waiting-lists could be less dependent on a “epidemiology” of those waiting than on an “epidemiology” of the interdependencies of the system. In case the assumption about the importance of interdependence is adequate, it seems reasonable to test reforms and initiatives on their interdependency effects. Also considering that it is hardly possible to test new strategies and initiatives on their effects on the length of waiting lists, it seems more appropriate to test new strategies and initiatives on their effects on the interdependency of the health care system.

Findings of this paper might be relevant beyond the field of waiting lists in Dutch health care. It has been regularly observed that the health care systems in particular and any larger policy field in general is very difficult to reform or that tackling problems within such systems often fails. What is demonstrated here, is that more attention should be devoted to the behavior and the structure of organizations in the analysis and management of such cases. Often broader strategies and policies are based on assumptions, which do not comport with the actual behavior of organizations. Given the central position organizations have in such strategies and policies they are thus doomed to fail almost by definition. What is suggested here is that the situation of organizations in general and their interdependency relations in particular have to be understood in order to produce effective strategies or policies.

Notes

1. In a population of approximately 16,000,000.
2. One can distinguish between planning waiting lists and “problematic” waiting lists. With the help of planning waiting lists a provider can tune the stream of clients in such a way that the capacity of the organization is optimally used and the working-load of the personnel is not too much subject to fluctuations (Laeven and van Rooij, 1999). Problematic waiting lists are characterized by the fact that acceptable waiting times are exceeded. Whenever in this text waiting lists are mentioned I refer to “problematic waiting lists.”
3. Especially in the economic literature are waiting lists often seen as a “alternative rationing device” (Martin and Smith, 1999).
4. Brunsson (1989, p. 19) defines political organizations as follows: “This organization has no need at all to produce coordinated action; its only basis for legitimation is that it reflects inconsistent norms. Instead of seeking niches like the action organization and satisfying one need or interest at a time, the political organization reflects a variety of ideas and demands and satisfies the expectations of diverse groups in its environment.”
5. As is illustrated in the following observation by a surgeon: “Also the discussion with other specialists about the redistribution of capacities turns out to be sensitive. The breast reduction operation of a 75-year-old patient by a plastic surgery produces a lot of discussion in my hospital. Is such an operation necessary given the fact that our cancer patients have to wait too long for their surgery?” (own translation, de Brauw, 2001, p. 18)
6. Coordination means “. . . to place things in proper position relative to each other and to the system of which they form parts-to bring into proper combined order as parts of a whole. It means, in essence, to bring about some kind of order . . .” (Chisholm, 1989, p. 13) and coordination describes both a process – the act of coordinating – and a goal. If coordination is considered as an end state, the result of some process, it is defined as “harmonious combination of agents or functions toward the production of a result” (Chisholm, 1989, p. 28).
7. Interdependence can be defined as follows: “Within each set, each decision-maker is in such a relation to each other decision-maker that unless he deliberately avoids doing so (which may

or may not be possible), he interferes with or contributes to the goal achievement of each other decision-maker, either by direct impact or through a chain of effects that reach any given decision-maker only through effects on others" (Lindblom, 1965, pp. 21-2).

8. This is by the way also consistent with a radical-institutionalist point of view, which states that it is not necessarily advantageous that parties are interdependent. Brunsson (1989, p. 230) states, for example, that: "If managers and 'actors' are kept apart, life is easier for both parties" and "... to change products is a difficult organizational action, and action is the weakness of organizations whose main strength is politics."

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Corresponding author

Patrick Kenis can be contacted at: p.kenis@uvt.nl