An epidemic of health care reforms is spreading through the world. The basic reason behind the epidemic is the concept of these reforms. Namely, at the time in which Modernity (the main context of mechanicism) has worn out its potentials, they are based on the principles of mechanistic paradigm. Epidemic could fade away if health care reformers would abandon their role of engineers and turn to catalist role. In that role they could work on reforms which would rely on principles of evolution. The first result of this reform orientation would be creation of the germ of pluralistic health care systems.

Keywords: health care reforms, principle of evolution

Health care reforms now seem so frequent that one could speak of the development of an epidemic. Of course, ‘reform’ has a positive connotation and ‘epidemic’ a negative one, so it is unusual to speak about epidemic of reforms. Still, if one looks closely into the dynamics of health care reforms, the analogy with chronic disease becomes apparent. Health care reforms tend to last for years, highly qualified experts are engaged and vast amounts of money are spent. This massive enterprise does not, however, lead to a ‘cure’, but rather to new interventions to keep the health care system going.

Why do health care reforms simply reproduce themselves rather than bring about effective change? Because they are mostly based on principles of social engineering. Thus, health care experts, as engineers of reforms, are striving to change health systems while maintaining the status quo. They want to improve efficiency, effectiveness and equity, but at the same time they are reluctant to challenge the fundamentals so that they protect those dominant interests that have made health care systems the way they are.

Health care reform engineers seek to establish a balance, ‘between various market-oriented mechanisms in allocating resources and managing institutions, on the one hand, and a complicated mix of public sector decentralization, as is state vigilance, and greater citizen empowerment, on the other’ hoping that ‘the balance of forces in tension can lead to new solution’. Of course, the reality makes no concession to the mechanistic principle of balance.

THE REALITY

The primary goal of the engineers of health care reforms was to improve efficiency, effectiveness and equity, their main criteria for assessing the quality of health care systems. However, when assessed in relation to the ability of systems to respond to significant pressures for reform (the tendency of health expenditures to increase faster than national resources, pressures caused by aging of the population and increased public expectations) success has been extremely limited.

Policy makers have sought various strategies to contain costs without reducing quality of care. However, factors such as increasing demands for care, the interests of the pharmaceutical and medical technology industries, and an unwillingness of the medical profession to place public above their professional interest, proved stronger.

Markets failed to provide the expected efficiencies and undermined equity.

Setting priorities, in the circumstances of ‘infinite demand and finite resources’, essentially meant rationing, reflecting the value systems of those who wielded the greatest political clout.

Cost sharing reduced access by the poor, with harmful effects on their health status, while failing to achieve cost containment.

Attempts to reduce expenditure on medicines were blocked by the conflict governments faced in industrial and health policies and the ability of companies to introduce new, more expensive drugs, few of which offered therapeutic potential.

Another issue is aging of the population. The most logical way to confront the pressure arising from aging was to reduce aggregate population demand through effective public health measures. However this was obstructed by an array of concealed, but successful resistance. Decision makers, with short time horizons, did not like interventions acting over a long time frame.

Medical professionals opted for measures that concentrated predominantly on individual demand because they offered more direct benefits.

The tobacco and food industry successfully prevented the implementation of many effective policies.

Introduction of high technologies also failed, as it was poorly managed and frequently led to increased costs but little clinical benefit.
The promises of 'the outcomes movement', with activities ranging from 'evidence-based medicine' and 'outcomes research' to 'technology assessment' and 'quality assurance' failed to live up to its potential. It was hampered by a range of phenomena: on the one side by technological imperative and the habit of main-stream medical science to neglect studies that produce 'unpleasant' findings; on the other side by the dominant medical paradigm itself within which the mechanistic treatment of patients reduced patient satisfaction. The empowerment of patients through their participation in clinical decision making was inhibited by dependency on medical professionals. Put simply, the asymmetry of information between provider and consumer, as well as the structural relationships, gave physicians an undue influence over patients' decisions. The codification of patients' rights was of little help. The much vaunted right of patients to choose whom they will see was illusory. Social attitudes surveys indicated that the public was not convinced that its views counted, and that patients frequently failed to make use of officially increased choice. Finally, citizens' (and patients') political participation was blocked by professional domination aided by the technical complexity of health-related issues.

THE OUTCOME

The logical consequence of these factors was that the outcome of reforms was predictable. In reality, their main goal was improving efficiency. Consequently, important policy objectives such as strengthening prevention and health promotion, as well as pursuit of equity, have not been high on reform agendas. Thus, health care reforms stayed far away from policies that would generate health gain for the population as a whole or to sustain equity within the health system. Leading engineers of health care reforms are aware that the current method of reforming health care is not effective. They accept that no payment system will ever achieve the much vaunted right of patients to choose whom they will see. Social attitudes surveys indicated that the public was not convinced that its views counted, and that patients frequently failed to make use of officially increased choice.

A DIFFERENT QUESTION

Notwithstanding their awareness of these issues, engineers of health care reforms are pursuing the rationality of goals, accepting value of goals as given. That is why the leading question for engineers of health care reforms is 'How?'. However, the process of health care reform could be approached from the rationality of values. In this case everything else could be put in doubt. The leading question would then be the question 'Why?'. In that case many things would appear different, including the three phenomena identified above as pressures for reform. So, if we would ask ourselves: 'Why has the aging of the population played a significant role in triggering the current wave of reform?', we would discover that aging of the population is not a pressure for reform because the old people are more ill than young ones, but because the dominant model of health care does not have effective answers to a whole array of chronic diseases that have a higher prevalence among old people.

Then, if we would ask ourselves: 'Why expenditures on health care absorb an ever greater part of GDP?', we would discover that health expenses are increased less by innovations (which are rare), but more by a medical professionals' need to disguise their therapeutic impotence behind technological power. Finally, if we would ask ourselves 'Why do citizens and patients have increased expectations?' we would see that these expectations are not related to their wish to control health care. Increased expectations are mostly connected with a general belief that health care is somehow inadequate.

Our age is an age of achievement, as well as the global spread of the concept of human rights. Both of these phenomena are permeating all kinds of human relations. Thus, the dominant model of health care, with its authoritarian and manipulative attitude, coupled with limited effectiveness against the main causes of human death and suffering is hopelessly obsolete. Pondering on these issues reminds us that contemporary health care is the product of modernity and that it suffers the same flaws; i.e. that contemporary health care, with contemporary medicine at its core, should not be the norm to which human society is aiming. Instead, they are something that we should transform, if we want to diminish suffering and promote life.

The epidemic of health care reforms thus appears as a defensive mechanism aiming to prolong the survival of the dominant system of health care. A different type of reform, which would not be a part of the epidemic, would have a post-modern orientation. That means that it would not be based on the principle of balance, but on the principle of evolution.

OVERCOMING THE PRESENT

Evolution tends towards increasing complexity. In non-linear systems, such as health care, complexity is increased by fluctuations produced by the system or its environment. While fluctuations remain below the critical threshold, the system returns to its initial state. But when the system can no longer contain the fluctuations it is transformed to a new level of internal organization and environmental integration.
Thus, a necessary evolution (and within it a real reform) would not be promoted by the simultaneous production and reproduction of both the existing and potential form. Strengthening of status quo would only suffocate necessary fluctuations.

Neither would fluctuations be amplified by a “balance of forces in tension”. Behind the ideal of balance is an ideology of enforced structural stabilization.

Similarly, ‘managing uncertainty’ offers little help. Fluctuations are not promoted by a capacity to control future events, but by a capacity to devise systems that could accommodate these events in whatever form they may take.

This is why engineers of health care reforms seeking to abandon the production of epidemics should change their role to that of a catalyst. A catalyst promotes fluctuations: by an orientation to future opportunities rather than past certainties, by engagement in the continuous search for new relationships and techniques, and by unlocking the largely untapped potentials of cultures and of individuals.

Initially, the catalytic role would not be all encompassing but sporadic. Instead of organizing the whole system it would concentrate on the creation of psychosocial spaces within which system fluctuations would be reinforced by means of positive feedback.

There, the emphasis would be on development instead of control, on relationships instead of manipulation, on openness instead of structure.

The first evidence of a successful exit from the epidemic would be the development of pluralistic health care systems. The present emphasis on predictability, balance, structural rigidity and hierarchical control (characteristic of machine-like structures) is leading engineers of health care reforms in an other direction: toward reproducing the myth of Sisyphus – the ancient hero who was the symbol of futile attempts to block evolution.

REFERENCES


Health system reforms and post-modernism

The end of the big ideas

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In his paper, Professor Stambolovic gives a rather gloomy picture of recent health system reform experience. Health care reforms have indeed failed to deliver the ultimate cure for all the ills of the health system but a more thorough and constructive assessment of the evidence may lead to a more complex and instructive picture. In addition to a brief commentary on the nature of the reform ‘epidemic’ this response puts forward an alternative post-modern view of reform together with some pragmatic suggestions for the way forward.