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.

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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Before we embark on reform related issues, however, two caveats are in order. First, it may be rather simplistic to talk about health reform as an all encompassing and homogeneous social phenomenon without taking into account the large differences between countries. For instance a reform in say the central Asian countries moving out of hierarchical Shemasko systems, may offer an entirely different experience to the changes in some western European countries such as Germany and the Netherlands, with highly pluralistic social health insurance systems. In that regard, Stambolovic’s suggestion to use ‘pluralism’ as a gold standard for measuring reform success, does not work on this latter group of countries.

Second, the term ‘reform’ itself, although it has become increasingly popular, does not have a consistent and universally accepted definition. It includes many different types of health system changes both in terms of content and process. Also the extent to which the term ‘reform’ is adopted by policy makers depends on its distinct political interpretations. Hence, while policy makers in some countries have sought to magnify small health systems changes by labelling them reforms, in other countries, policy makers have chosen not to associate radical overhauls of the health system with the term ‘reform’.

EPIDEMIC OR REGENERATION?

The view of reform as an epidemic of ‘reformitis’ has been voiced by some other disenchanted commentators who see reforms as a type of infectious disease that consumes the ‘tissues’ of the health system. This view does reflect the rapidity with which reform ideas have crossed political and geographical boundaries, however, as Stambolovic recognises, ‘reform’ has some positive connotations that may be missed if we do not acknowledge the regenerative nature as well as the substantial accomplishments of many reform programmes. The widespread dissemination of reform concepts can also be characterized as a form of globalization that breaks down spatial, temporal and cognitive boundaries previously separating countries from each other. However, like globalisation, there are dangers. It will pose ‘threats’ to our health systems when the dissemination of reform policies is not accompanied by evidence about the actual impact of these policies. In this way, it may lead to ideology-rich but knowledge-poor reform programmes.

On the other hand, also like globalisation, exchanging information and evidence across countries has large potential benefits. International differences in health care systems and approaches to reform can provide analysts with a ‘natural experiment’, which, if rigorously examined, can facilitate learning across boundaries. An adaptation of the meta-study format can help researchers to compare primary research on the impact of specific policies within particular countries and to summarise the results in a manner accessible to policy makers. The European Observatory on Health Care Systems, among other organizations has tapped into this potential to produce a series of country analysis and comparative studies (see note). In spite of the obvious methodological difficulties encountered in carrying out such exercises, particularly when attempting to adjust for the nuances of different country health systems and socio-economic contexts, the potential for cross fertilisation and learning across boundaries is huge. Reform can thus become a process of regeneration by learning from each other’s successes and failures rather than a plague that will cause the annihilation of our health systems.

A CLOSER LOOK AT THE EVIDENCE

In spite of a wide variation among countries, it can be argued that the recent wave of reforms in the 90s have not had the kind of results expected by many social actors. This perceived failure may be due to several causes other than the inadequacy of the reform ideas themselves. Reforms are not seeds to be thrown on the ground in the hope that they flourish. In some instances, failure is due to the unrealistic expectations bestowed on what is effectively a social process of change. Or, in some instances, failure may be caused by the barren political and economic contexts within which reform is supposed to take root.

A fresh look at the evidence may reveal some substantial reform accomplishments that should not be ignored, and perhaps a less depressive picture may emerge. The space constraints for this paper do not allow a comprehensive review of the evidence. But to qualify some of the points put forward by Stambolovic. A common mistake made by many commentators is to confuse efficiency (both technical and allocative) with cost containment. They are not the same. It is possible for a particular reform mechanism to increase efficiency without necessarily leading to greater cost containment. For instance a number of technological innovations have increased technical efficiency by offering a higher health outcome per Euro spent and/or allocative efficiency by increasing the overall health of the population, yet have failed to contain overall costs because they addressed previously unmet need and have increased the number of people able to receive treatment. The former not the latter should be the yardstick against which we should measure the impact of reform efforts.

In addition, as the old saying goes ‘one should not throw out the baby with the bath water’. A closer review of the evidence on reforms which have purportedly failed may provide useful lessons to interested policy makers. For instance, Stambolovic quotes Ham to argue, rightly, that priority setting has led to some disappointing results. Yet in the same paper Ham shows that it has also had significant positive effects by concentrating the debate on the use of clinical guidelines and protocols ‘in order to eliminate ineffective procedures and concentrate resources where they will achieve the most health benefit’. He also argues ‘priority setting is not amenable to a ‘quick fix’ (...) a continuing effort is needed over a relatively long time before the results become apparent’.
In the same light, labelling efforts to empower citizens and patients as failure may ignore substantial achievements in this field. While in a number of countries the movement to empower citizens has indeed made little progress beyond rhetoric, in other countries such as Finland or the Netherlands there have been major advances with the passing of patient rights legislation and the adoption of citizen charters backed with legal and financial sanctions.

Furthermore, more recent comparative evidence shows some reform successes in areas such as sustainability of funding mechanisms and restructuring of hospital services and entrepreneurship and regulation in health services.

Most importantly, the evidence clearly shows that the process (not the content) of reform is decisive in explaining success or failure. As Walt argues, there have been substantial difficulties in implementing reforms, which often have less to do with the content of the reform programmes, but instead reflect insufficient attention to the process of implementation. The success of reforms has depended less on the actual content of the reform programmes than on a variety of important accompanying factors including the economic, political and social environment within which the reforms take place, as well as the support – or lack of it – of key actors such as the medical profession.

For instance, reform programmes in a number of countries of Eastern Europe were condemned to failure because of economic recession which in some countries led to financial cuts of the health care budgets of up to 50 per cent; by political instability with frequent political changes of governments and health ministries; and by the insufficient technical infrastructure to implement highly complex reform mechanisms.

AN ALTERNATIVE POST MODERN VIEW

This paper differs from that of Stambolovic on the diagnosis of 'how' reform strategies have performed and 'whether' or 'why' they have failed (or succeeded), yet both papers agree with the basic tenet of adopting a post modern view of reform although the particular form that post modernism should take may differ.

Most commentators would agree with the view expressed by Stambolovic that reforms should be based on the principle of dynamic evolution, lead to real change and transform the system into 'a new level of internal organization and environmental integration'; that is if we manage to implement such level of change. Not surprisingly, those 'reform engineers' who want to 'convert' into catalysts of change may still need to ask 'how' can they successfully 'promote fluctuations that orientate the health systems towards the future (...) break current structures and challenge vested social interests towards real reform change and (...) unlock the largely untapped potential of individuals'. Perhaps an alternative, less conceptual but more pragmatic brand of post modernism may shed some light on the debate. Health reforms have wholeheartedly embraced successive paradigms such as that of the 'markets' as the ultimate solutions for the challenges of the health care system. We are indeed at the end of modern reform rationality, or in other words we have now reached 'the end of the big ideas' and are at the beginning of a brand of post modernism that suggests moving (from the 'big ideas' or enlightened reform models) to the 'mechanics of implementation'. Central elements of this approach are strengthening governance and management of change, understanding the organizational culture, ensuring appropriate accountability lines and improving of human resource capacity or, in other words, 'teaching old dogs new tricks'. It also involves the strengthening of government stewardship as a central function of the health system. This includes providing health information and intelligence coupled with policy vision and regulatory influence.

The conclusion is that this approach is an alternative to, complements or overlaps with that advocated by Stambolovic should be left to those readers more versed in the theory and practice of post modernism.

WHERE NOW?

The key point argued here is that we should not get swept into another big idea, but provide practical support for our policy makers, managers and clinical practitioners involved in the day to day struggle of reforming our health systems. In this light, and in the spirit of non-rational non-prescriptive post modernism, it is worth concluding with a few brief reflections for future reform.

The term 'health care reform' is increasingly unhelpful, because it is interpreted in a myriad of ways. Perhaps it is time to abandon reform as an outlook in favour of more specific approaches that better reflect the nature of health systems change such as health insurance implementation or hospital restructuring.

To characterize reforms as 'epidemics' with broad generalizations about their success or failure does not serve decision makers. There is a need for a more rigorous evaluation of individual reform mechanisms such as a new payment system for physicians or a reorganization of hospital services. We should acknowledge that there will never be 'scientific' or 'rational' reforms. The role of politics, ideology and values in what is essentially a social process is not only unavoidable but necessary. However, we should strive to disentangle the actual evaluation of reform policies against a series of societal objectives from the necessary political debate about the nature and trade offs between these social objectives.

Cross country evaluations cannot substitute for the in-depth assessments at individual country level but can provide practitioners with a very valuable source of evidence which is still largely untapped by the research community.

Finally, honing in on the implementation process is essential if reforms are to be successful. Again, implementation is not exact science and this should not be understood as a series of prescriptive steps which if followed faithfully will lead to success. However there is
increasing evidence about strategies to maximise success. These include the ability to manage external influences; ensure political will; mapping actors agendas and setting up strategic alliances; steering the reform process with appropriate management structures, allocation of responsibility and enabling legislation; setting the appropriate time and pace of change; and building institutional, human and management capacity.\textsuperscript{17}

Sisyphus was condemned by the Gods to rolling a rock ceaselessly to the top of a mountain, whence the stone would fall back of its own weight. Let’s make sure that the eternal search for a single solution or the next big idea does not become our stone. Clearly there will never be one cure-all big idea for the ills of health systems everywhere. Instead we should look to support those on the ground who want to make things work and need the tools and the evidence to do it.

\textbf{NOTE}

See: www.observatory.dk

\textbf{REFERENCES}


\textbf{ANNOUNCEMENT}

\textbf{EUPHA CONFERENCE 2004}

The 2004 EUPHA Conference in Oslo has been changed.

It will now take place on 7 – 9\textsuperscript{th} October.

Please adjust your diaries accordingly.