Real Reform in Health Systems: An Introduction

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Health care reform seems fundamental to the coherence and the future of the welfare state. Health programs occupy a central place in modern systems of social protection, and it is now quite difficult — albeit not impossible, as exemplified by the United States — to conceive of social justice without including health care in the list of goods that should be provided to all as a right of citizenship. Accordingly, questions about the legitimacy and long-term viability of the welfare state usually aim directly at publicly financed health services. The spiraling cost of providing care and the growing demand for services are pinpointed as major factors contributing to the increase in public deficits and related financial instability.

Before looking to the future, it is instructive to look to the past. Perhaps we should ask ourselves why access to care historically prevailed over access to education, income security, or even clean water.[1] After all, in his master plan for a "comprehensive policy of social progress," William Beveridge (1942: 6) famously identified five "giants" that needed to be confronted. What he called "disease" was only one priority in a list that also included addressing "want, ignorance, squalor and idleness." The triumph of health care was not predetermined, and in fact it took decades for the sector to emerge as a central social service, to use Beveridge's own terminology, with reduced variation from country to country.

1. This question is not just a thought experiment. In Canada, for example, where a significant number of First Nations (Native) Canadians are still deprived of decent housing and basic commodities like running water or modern sanitary installations, it is worth asking, given the relative cost of health care services provided to their communities.

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Whatever the rationale, the bottom line is that all sorts of consequences have flowed from the entrenchment of health care at the core of social policy. Most notable are the constant fiscal pressures resulting from ever-expanding demand and the outsized political influence exerted by the medical profession because of its control over the quality and terms of health services. Rather than aiming to secure the basic needs of the public, as is usually the case with pensions or social insurance, health care policy invariably states that patients should expect the "best" care available, as defined by the providers of that care. It is quite a unique situation, especially when compared with other areas of social protection. In fact, even if health systems have other characteristics, reform and design must always entail some kind of cost-control measures, accompanied by various mechanisms to secure physicians' cooperation.

Not surprisingly, the cost of providing care has escalated swiftly. Over the past two or three decades, questions about the sustainability of the health system have risen in lockstep with this trend in most countries (Chernew, Baicker, and Hsu 2010; Hagist and Kotlikoff 2009). On the surface, sustainability appears to be merely a fiscal matter, amplified by electoral politics — citizens who are told they should pay lower taxes nonetheless demand increased levels of services, including expensive new drugs and technologies (Aaron 2011). However, there are various signs that the problem goes deeper than a budgeting issue and that therefore it will not disappear just by cutting expenses and raising revenues (Orszag and Emanuel 2010; Cornilleau and Debrand 2011). From the diatribes of an Ivan Illich (1976) to the research findings of John E. Wennberg (2010), more and more voices have come to question the "radical monopoly" of the medical profession over health care and the notion that more care is always better.

We may not be at a point yet where people challenge the central role of health care in our society and our culture. The "healthcare imperative," to borrow from the title of a massive report from the US Institute of Medicine (Cortese, McGinnis, and Milstein 2010), is still very much centered on the issue of cost and the preservation of a certain vision of health, essentially defined as an individual and immediate achievement rather than something collective and durable. Nevertheless, there is a growing sense that a new approach is necessary and that our current addiction to expensive and fragmented care is harmful to other key social or economic objectives, to say nothing of the direct burden on patients of uncoordinated care and unnecessary procedures.

Initiatives purported to bring back fiscal discipline are under way

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everywhere, but with questionable success. Rationing, for example, was covertly present in every system, even if it was resisted by physicians and resented by the public (Fuchs 1998). It is now practiced in the open, with the help of a battery of tools and devices ranging from traditional regulation to economic (cost-effectiveness) analysis. But is it working? Not that well, actually, if only because politicians or the courts often reverse unpopular decisions. Third-party payers, whether governments or private insurers, also want everyone to realize that care is never "free." Users are invited to contribute directly to the cost of their care or to contribute more where a patient's contribution is already the norm. Other constraints, such as restricting patients' choice of providers or their access to certain therapeutic options, have been implemented as well. The net impact of these measures on the overall cost of care is dubious because they potentially impinge on necessary as much as unnecessary care with the risk, in the final analysis, of resulting in even greater expense. Predictably, public worries have also prompted political authorities to intervene to soften or even cancel some cost-control policies, especially when they hurt powerful groups or interests such as seniors or the pharmaceutical industry.

What to do? Fiscal strategies fall short because new taxes cannot be raised at a level where it would make a difference, for economic or (mostly) ideological reasons. Cost-control measures are not effective in the long term because benefits cannot be restricted or access limited for long.

Physicians generate a large proportion of health costs and are usually the ultimate judges of quality and appropriateness. Given its dominant position in the health system, it may be more sensible to target the medical profession rather than the general public. Over the years most, if not all, aspects of its behavior have been subjected to some kind of policy initiative. Examples range from prescription patterns to referrals, clinical training, and billing systems. But the results were never as good as expected, either because of so-called professional inertia—the lack of physicians' compliance with rules and regulations (O'Brien 1997)—or, more simply, because the procedures or guidelines were not that well conceived in the first place.

More recently, attempts to impose payment models that focus on a care "episode" or given condition, instead of the traditional fee for service, have been introduced. This approach is grounded in the belief that physicians can be financially induced to approach care with an integrated and long-term perspective, resulting in important savings and high-quality care (Wodchis, Ross, and Detsky 2007). This makes sense, and docu-

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mented experiments show some positive outcomes (Wilenski 2011). However, the results do not look as strong as initially contemplated or at a level that would make a modern health system sustainable. The practical impact of policies aimed at professional behavior is "somewhat more complex" than first expected, to use the euphemism concocted by Adam Oliver and Lawrence Brown (2011).

The American philosopher and political scientist Francis Fukuyama (2006) famously coined the term *historical pessimism* to describe how we have lost hope in the progress of society and public institutions. It is very tempting to apply this concept to our collective experience in health care reform. In country after country we see governments using all the resources at their disposal, from money to expertise and from propaganda to regulation, to try to orient the evolution of health systems. And in country after country, after various intervals of optimism and enthusiasm, reforms are lessened or abandoned.

Some would even say that health care reform is, in and of itself, an important source of stress and that policy interventions aimed at raising productivity or increasing efficiency threaten the very existence of the institution they are intended to sustain. It cannot be denied that the design and reform of health systems sometimes involve real conflicts between worthy social goals. When moving the system from "individual to population health" entails restrictions on access to health care, for example, it most certainly clashes with the more abstract, long-term issue of equity (Brown 2010).

In the end, however, the most important questions might be: Do successful efforts need to include some form of commitment to the stability of the system, in terms of resources, delivery arrangements, and political support? Or is reform — real reform — always disruptive, resulting in a new architecture of programs, resources, and incentives, or even a new set of values and guiding principles?

Beyond Policy Design

A study of health care reform in different Canadian provinces during the last decade of the twentieth century concludes that only a few initiatives eventually succeeded and that even fewer proved sustainable (Lazar 2009). In the Netherlands, a so-called exemplar reform, praised the world over at its inception as the ultimate illustration of a daring and well-conceived effort in health care renewal, is now portrayed by some early advocates as a case of "slow progress" and by its critics as a fiasco (Van der Berg

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et al. 2011; Okma, Marmor, and Oberlander 2011). The British coalition government, unable to resist adding its own mark to what looks like an endless list of experiments and interventions, initiated its ambitious health care reform plan, depicted by D. J. Hunter (2011) as "the triumph of hope over experience." In the United States, the controversial introduction in 2010 of a new regime of mandated health insurance has been followed by major legal and constitutional challenges. The scheme continues to attract critics from all sides, and it is extremely difficult to predict whether the reform will succeed, considering the number of unknown variables.[2]

No wonder pessimism is on the rise, especially when we realize that system-wide failures often reflect hundreds of fruitless efforts at the local level, from health regions to hospitals to individual practices. It does not help that the debate over health reform often is more preoccupied with the minutiae of policy design than with the actual implementation of new practices or new structures. Experts, in particular, tend to argue about schemes and models and to treat events taking place at the "coalface" (the point of actual health service delivery) as mere anecdotes or statistical aberrations, whereas patients and providers would rather consider a reform according to its immediate outcomes. This is not to say that knowledge of the fundamentals of health policy is not essential. But the incomplete understanding of how policy change happens in the real world, at every level of the health system, is a major obstacle to reform, if not the most important obstacle.

Social and organizational change requires that policies be transformed into political decisions, followed by concrete public and private actions, to become realities. Half a century of policy analysis has established that this chain of events is not linear — it can go backward, and when it moves forward it is often crablike, with a slight sideways motion that can generate unforeseen outcomes and upset more parties than planned. Moreover, things may never happen without a mysterious ingredient called "political leadership," especially if change is to overcome resistance from powerful groups and interests. The mutual dependency of politics and policy is well accepted in most areas of public policy (Stone 1989). However, in the health sector it has often been greeted with a certain dose of contempt.[3]

2. For example: What if President Barack Obama is not reelected in 2012? What if the expected savings are never produced? What if the economic situation continues to deteriorate? What if people or firms or insurers find ways around the legislation?

3. Of course, not everyone is taken in by the false dichotomy between politics and policy. Providers working in a sector that is publicly regulated and — at least in part — publicly funded do not have the luxury of ignoring or avoiding politics. Many other groups are in the same situation, including pharmaceutical companies, hospital associations, and patient advocates.

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Calls to politicians responsible for the sector often include the words *courage* or *courageous*, as if they were fearful or incapable of bold thinking. And anything that looks like a compromise, the very essence of democratic politics (Crick 1962), risks being portrayed as a betrayal.

The notion of reform, as well as quasi synonyms like renewal, restructuring, or even rebirth, has strong political and consequently normative undertones. The radical psychiatrist David Cooper (1968) used to say that one person's revolution is another person's platitude, and the many revolutions in health care are no exception. If we were to take the concept seriously, we would qualify as "real" only the few reforms that are effective in achieving substantive change along one or all of the major dimensions of health policy: the governance of the system, its financial arrangements, its delivery arrangements, and the types of programming offered (Lavis, Ross, and Hurley 2002). Moreover, we would expect these changes to be sustained long enough to bring about a transformation in the distribution of power and authority among various groups in the health care system. Reforms should directly affect its "governing coalition"—the compact of health professionals, experts, and policy makers who decide the orientation of the system.

In the end, the health policy framework and the underlying social structure should be enduringly transformed. Not that there are universal pathways to successful health care reform. Every health system has its roots in a particular social and historical context and responds to contingencies that vary widely across national jurisdictions (Tuohy 1999). Public values and the architecture of political institutions seem to play a larger role in a system's capacity for transformation than factors such as the size or structure of the economy, as we are continuously reminded by the American situation, or the soundness of public finances, as per the Canadian experience. Even what we like to call endogenous changes, the powerful drivers of transformation such as technology or professionalization that are present to some degree in every health system in the Organisation for Economic Co-operation and Development (OECD), must make their way through or around the given context of national institutions (Hurst 2010).

In the last thirty years, reform of health care systems has consumed significant amounts of political energy. While providing a convincing account of the progress made by the National Health Service (NHS) in implementing a significant transformation, the British analyst Rudolph Klein (2006) once wrote on the difficulty of keeping faith in the promises of yet another health care reform. He also underlined the political fragility of reform and the difficulty for governments not to be distracted from their plans by short-term considerations and any crises.

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This volume's collection of essays and research papers looks at some options that may strengthen our ability to bring about important and necessary transformations. The articles underscore that it is not that change does not happen; powerful drivers such as technology or demography are at work, and they clearly affect the delivery of health care in myriad ways. But thirty years of reform *by default* have not necessarily produced a viable health system. Decades of fiddling around the edges have yet to produce the substantive improvements required. There remains a real hunger for real reform, even if there are no quick and easy recipes.

In Search of Real Reform

The view that some reforms are more "real" than others surfaced on numerous occasions during the debate around President Barack Obama's reform initiative in the United States in 2009–2010. For the most part the argument was used to designate and promote a different agenda than the one put forward by the administration. Experts advocating for a more radical overhaul of the current American health system were calling for "real reforms," which would get to the "real issues," instead of the compromises and other half measures supposedly urged by the White House or Congress (Ginsburg 2009). While most of these radical options were ignored in the final legislation, the idea of real reform gained traction within policy and academic circles, where it raised awareness of the payoff of innovation.

In this case and in many others, there is some truth to the predictions that implementation of the original plan will never be as effective as conceived. Surely political compromises dilute some "essential" components of an initiative. Should we care? As Larry Brown indicates in his essay for this collection, whether a given plan succeeds in every respect might not be that important: "Real reform is more of a balancing act than the familiar imagery of relentless uprooting and reseeding suggests." Any scenario that provides for a (more) sustainable and (more) equitable health system, in which decision-making power is (more) evenly distributed—to favor patients over "health economists, clinicians, health services researchers, and their soul mates in foundations and government agencies"—should be preferred to the status quo and qualifies as real reform.

Adam Oliver adopts a similar position when he writes that "any reform that has reaped reasonable effectiveness in relation to the theoretically informed intended aims has been 'real' enough." His essay looks at different initiatives imposed on the English NHS in the last two decades in

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light of three developments in the field of behavioral economics. The first proposition relates to the impact of repeated transformations aiming at increased efficiency on the identity of providers and other professionals. To be accepted, a reform initiative that is contrary to people's values must go beyond the practicalities of administration and control, and recognize that fidelity to norms and ideals is a crucial part of what makes institutions work. The second proposition sees loss aversion as a possible lever for policy, notably in the form of "threats" to the reputation of managers or providers who fail to perform according to plans.

The third proposition looks at hyperbolic discounting, the tendency for people to prefer proximate experiences more than distant ones and a limitation on patients' ability to make choices. These insights may be common knowledge outside standard economic theory, but, more important, they all point to the significance of policy instruments in molding successful reforms and the need to conceive such instruments on the basis of actual experience.

The fact that economic theory has repeatedly inspired reform initiatives is less a question for a historian than for a political scientist; it certainly says something about "the mix of control instruments that govern the exercise of power," to quote from the essay by Carolyn Tuohy. Health care reform, as mentioned earlier, is not limited to the administrative dimensions of the health policy framework, as important as they may be. By necessity, it will also affect the distribution of power and influence. One essential aspect of this reality is the actual role played by entrepreneurs, the flesh and blood agents of change in public policy. In recent years the traditional guiding principles of modern health systems widened to make room for assumptions and criteria inherited from other sectors. Public systems have adopted market-inspired initiatives. The private sector is looking for long-term agreements with governments, trading autonomy for security of funding and steady profits. Reforms therefore inevitably create "hybrids," and policy entrepreneurs find themselves quartered between different sets of values and different reference groups.

The capacity of the health system to accommodate a broader range of policy outcomes, inspired by a new breed of entrepreneurs, is surprisingly high. Albeit obliquely, Denis and Forest suggest in their essay that one possible reason is that some health organizations, given a proper policy environment, are particularly resilient. The two key concepts here are the completeness of the organization and the richness of its ecology. Where traditional approaches to health care renewal would want uniformity, inspired by notions of best practice and evidence-based decision making,

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the authors argue that we should be more tolerant of diversity of forms and methods because we need to focus on outcomes. Furthermore, the issue might be less about building the perfect health organization than creating an environment in which good, if hybrid, structures and systems can thrive.

In the last essay of this collection, Michel Grignon explores the notion of resilience at the level of the system itself, using data from OECD countries. What if the resistance to change in fact reflects sincere and widely held public preferences? Reforms do not always provide the benefits they were supposed to bring to users or providers. Sometimes the changes simply make things worse and result in people getting less or lesser care than before. Such innovations may produce only superficial changes, from administrative titles to letterhead, without any improvement in access, quality, or economic performance. In democratic cultures in which public support and consent are essential values, this explains why institutions favor the status quo, even when the context would suggest that change is urgent and necessary.

The Pull of Gravity

A different conjecture, alluded to by Larry Brown, is simply that we do not always know what we want. Options proliferate, following the multiplication of theories and models, up to a point where it becomes very difficult for decision makers to make sense of the evidence and for the public to support one project over another.

After all, an important lesson from Ted Marmor's comparative work is that a multiplicity of arrangements and systems can be derived from the same values or general principles (Marmor, Freeman, and Okma 2005). Even when a government seems to pursue the same objectives over time — using a stable and noncontroversial set of values and guiding principles — each new project might well be in discontinuity with, when not clearly opposed to, previous initiatives. Recent examples in Canada would include repeated reforms of family medicine and regionalization of health care delivery.

Could it be that reforms always come too late? Plans are made based on a perception of the needs and wants of patients and providers and on a certain understanding of the constraints, financial or otherwise, faced by the health system authorities. Yet it is highly possible that the constant borrowing of models from other systems has already made these perspectives obsolete (Schmid et al. 2010). Following Tuohy, for example, we may

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want to call into question the canonical distinction between Bismarck (i.e., social insurance–based) and Beveridge (i.e., tax-based) health systems, now that the two models are open to market-based solutions (Or et al. 2010). The US system, often identified in policy debates around the world as the "ideal type" of a privately driven health system, is in fact a model of intense hybridization, with large sectors of the population serviced by publicly funded or publicly controlled providers. In such a context, policy tools that were fashioned to work in a given systemic environment and that have worked for decades can certainly be found lacking.

Uncertainties about policy design and the impact of policies, as well as limited examples of success, can leave reformers without options. More "political science" and less "policy analysis" may offer a way forward. The former sounds dated and academic, even a little pompous, especially because of its childish insistence on being called a "science" while the latter has everything we like nowadays: practicality, interdisciplinarity, and direct usefulness. The truth, however, is that it is the "gravity of politics" that pulls reforms back, not some iron law named dependency or economic interests or resistance to change, even if these factors play an undeniable role (Kingdon 2010).

Politics is an open system, especially in democratic societies in which voter behavior is unstable and public opinion ever changing. As intimated earlier, without lasting support, great ideas do not pass the numerous hurdles that would transform them into policies. Without popular consent, great initiatives are prone to all sorts of ailments, from classic underfunding to watering down and recall.

It is also important to pay attention to politics for another reason. Politics is not (only) about health care. Contrary to the world into which providers, experts, and other specialized decision makers reside, which looks less like a power triangle than a cognitive prison, citizens and their representatives usually are concerned with a vast number of issues related to other areas of human life. They are constantly thinking and acting in terms of trade-offs. Thus every health reform, even if it is much needed and well praised, must compete with other needs and other programs. Moreover, factors of change, which may take years to touch on health care services, often penetrate other sectors of social life long before health care. It is sometimes more pressing to solve an education issue, cultural challenge, or infrastructure imperative than to bring the latest idea to the health sector.

This perplexes experts who believe in policy and trust in the strength and efficacy of well-conceived proposals. They do not understand why decision makers do not follow through on their beautiful projects, and

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they resent the public for not being educated enough to understand the brilliance of their schemes. During the debate on President Obama's health reform proposals, many experts recommended waiting and taking the time to design a better plan, with fewer compromises and more evidence, convinced that knowledge and acumen would ultimately triumph over the forces of ignorance. But as all the following essays confirm, policy without politics — or, more precisely, policy making without "politicking" — is the public sphere equivalent of daydreaming.

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