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Commentary

A new synthesis in search of synthesizing agents

Comment on "A new synthesis"

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Abstract

In a recent editorial in this journal Pierre-Gerlier Forest foretells a coming revolution in health policy based on the synthesis of four conceptual innovations and one technological breakthrough. As much as I agree with the intellectual story told in this editorial I present a more skeptical view of the effect of paradigm shifts on healthcare systems on the ground. I argue that ideas triumph when times are ripe and times are ripe in health policy when payers and providers can find a compromise between the need to value what providers do and their professional autonomy. I also argue that autonomy is a product of the market: patients value autonomy and prefer doctors to insurers.

Keywords: Clinical Governance, Standardization, Professional Autonomy, Paradigm Shift, Agents of Change, Revolution in Healthcare

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In an editorial in this journal Pierre-Gerlier Forest (1) foretells a revolution in health policy and, consequently, in healthcare, a revolution that is four-pronged but revolves around the intellectual emergence of a central concept of "integration" (more on this later). Not only "integration of care" which, as Forest rightfully writes "makes no sense if not informed" by something else (in his words, "patients capabilities"), but integration of all that contributes to population health. The revolution pushes providers to not work in isolation or at arm's length from "society"—this is the biosocial stress perspective—or policy-makers—thanks to a combination of new tools of government and a better understanding of medical decision-making through behavioral economics—or, as importantly, in isolation from each other—thanks to the realization that problems in the healthcare system are not those of individual providers, but systemic in essence. This is an idea-driven revolution in which a series of intellectual innovations, helped by the advent of better technology (big data) gives birth to a new paradigm, which itself transforms the way things happen on the ground. Last, PG Forest is not only the chronicler of the revolution, but also one of its actors and proponents, certainly more of a Camille Desmoulins than an Edmund Burke.

The story as told is compelling and not easy to dismiss. In this commentary, I will play the devil's advocate, trying to curb enthusiasms for the coming revolution. To do this, I will not use the standard argument (rather posture) of the conservative curmudgeon stating that what looks like new and innovative is really old tricks under a new name. I will not, because I sincerely believe that all four advances contributing the revolution are, indeed, new and revolutionary. In the realm of ideas and concepts, these are path-breaking and have an obvious ability to change our perceptions of the way health systems work (or do not work as they should). Serious exploration and measurement of the effects of social hierarchies on health (and health inequalities) is a new field of research, now free from ideological imprecations from the left (hierarchies must kill because they are bad) or stubborn denials from the right ("there is no such thing as society"), health economists are more likely to investigate behavior than other economists and to apply behavioral tools to the understanding of medical or health-related decisions, and health services research is accumulating findings that will change the way we understand evidence-based medicine and policy.

My line of argument is that paradigm shifts do translate on the ground if and only if actors and structures are willing to adopt them or, at least, if one group of determined agents of change are willing to take the risk and bear the cost of waging the revolution. A good example to the contrary is Ignaz Semmelweis's discovery of the simple prophylaxis of puerperal fever through hand washing in 1847. Not only his discovery was not taken up until long after his death, but it can be claimed he lost his reason and his life for having discovered an inconvenient truth.

To follow the metaphor used by PG Forest in his editorial, the first revolution that took place in the 1970s around the notion that healthcare resources should satisfy some objective needs rather than all that the doctor ordered and the patient wanted was certainly helped by Donabedian's concepts but would certainly not have been feasible if payers had not won the initial battle to cover healthcare costs. Private insurers (Blue Cross) faced the same uphill battles as public ones when trying to create something called "the financial risk associated with healthcare" because doctors (and pharmaceutical companies to a lesser extent) knew very well that such coverage would ineluctably end up as inquisitive intrusion in the "clinical encounter". The counter-revolution of the day urged that the

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best health insurance was technological innovation. However, once insurers had won the day they desperately needed a conceptual framework to help them manage the risk and bend the infamous cost curve. Doctors were right to be scared and they had seen Donabedian coming decades ahead of time.

Similarly, evidence-based medicine (the second revolution in healthcare according to PG Forest) has become orthodoxy not only by virtue of being articulated but, again, because it served the purposes of "statistical buyers of care" (either single-payers in public schemes or private insurers in competition), and accompanied the transformation of social medicine into managed competition in the US healthcare system. Medical groups practicing a cost-efficient medicine for the working and middle classes, often eager to help the poor, became health maintenance organizations competing for coverage of big corporations. This is the result of Richard Nixon shrewdly using well-meaning and efficient doctors and nurses as a Trojan horse into the citadel of universal health insurance. To counter social insurance, the movement toward health maintenance, and as a result, evidence-based medicine was launched.

What these two revolutions and the one in coming have in common is a societal evolution: healthcare is less a personal service resulting from the clinical encounter (and idiosyncratic interactions between providers and patients) and more of a product that can be evaluated (at least statistically). The main outcome of such an evolution is clinical governance: providers are held accountable, possibly even liable, not only for undesirable events, but also more broadly for improper use of resources that could have been put to better use elsewhere (opportunity costs liability). This standardization and, some would say nostalgically, commodification of healthcare has been a trend in almost all healthcare systems, whether public or private. Simultaneously and logically connected, providers of this more and more standardized product are paid on the basis of outcomes rather than merely for what they do. A growing proportion of doctors in most countries now receive a growing proportion of their income on a capitated basis rather than fee-for-services, and primary care teams in which individual remunerations are based on contribution to activity rather than on unionized wages or professional fees flourish in many part of the world. It can even be said that hospitals have moved from a general obligation to provide what hospitals are meant to provide (under global budget) to being paid for producing something that can be tracked and measured (treatment of a given case based on prices per diagnosis-related groups).

The next revolution will change things on the ground if some agents of change want clinical governance to extend to population health. The intellectual tools are ready to be used but the question is whether economic and social conditions are ripe to see their use on a scale that would trigger a revolution. The question is: will doctors and other professionals fight back or will they have to accept more clinical governance at the population level this time? My guess is that we will see some more of the same evolution toward standardization and accountability taking place, but also the same lines of resistance opposed by doctors and nurses (and drug companies). My description of the evolution above made it look like some kind of inexorable Behemoth mercilessly crushed physicians' autonomy and the mystery of clinical encounter. The truth is, of course, that professionals managed to save a lot from the onslaught of standardized medicine: in healthcare it is still labor hiring capital and the autonomy of the profession running the show. Doctors may be more accountable and liable than fifty years ago, but they keep a massive advantage over agents of standardization, a not-so-secret weapon: their patients' trust. For all the noise about "internet medicine", it is still the case that patients want their family doctor (not a doctor in a walk-in clinic) to make clinical decisions, even though these decisions must now be in accordance with statistical evidence known by the patient. What the patient knows they do not know, because it is not in the publications, is the fine-grained, almost idiosyncratic information on how this particular illness will evolve or is supposed to evolve in their particular case. As a result, patients (and tax-payers as patients in the making) are always going to go with their doctor against their payer. The managed care backlash of the late 1990s in the US clearly showed that patients with chronic illnesses or in need of regular care rejected closed panel medicine, mostly because they did not want to lose the right to see "their" doctor: if an insurer were to exclude my family doctor from their panel I would quit my insurer and follow my doctor. The lesson, therefore, seems to be that we embrace standardization in medicine but we remain attached to personal relationships, and we are ready to pay for it. We are going to move toward more clinical governance, certainly in the direction described by PG Forest, but professional autonomy of doctors and nurses will set limits to it.

Ethical issues

Not applicable.

Competing interests

The author declares that he has no competing interests.

Author's contribution

MG is the single author of the manuscript.

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