Why health reform?

Steven J Lewis and Stephen R Leeder

ABSTRACT

- Traditional health care is fragmented, marred by quality and safety defects, with a failure to provide evidence-based care, and huge and unjustifiable variations in practice.
- There is abundant evidence that traditional means of delivering health care are obsolete.
- Concerns are deepening about persistent and widening gaps in health status that health care cannot overcome.
- Increased spending on health care has never definitively solved the problems of access, quality, or equity.
- Non-medical determinants of health indicate that the solutions to health problems lie mainly outside health care.
- The current financial crisis may create the urgency and courage to both eliminate the fundamental problems in health care delivery and reduce health disparities.

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The call for sweeping health reform has become an international mantra. Like all mantras, repetition can become reflexive, and one can lose sight of its origins. It is hard to recall a time when governments, research workers and policy analysts were content with things as they are. A Google search finds about 60 000 sources with the exact phrase "health system transformation"; "health reform" pops up nearly two million times. No clear line separates quotidian change from major reform, but transformation entails an irreversible break with the present. The typewriter was a great invention but its day is done.

There is a case against reform. The health status of people living in advanced countries has been steadily improving. Life expectancy has increased, erstwhile rapid killers such as AIDS and several cancers are now chronic conditions, heart disease death rates have halved, and avoidable mortality rates have plummeted.[1] Health technology is ever more dazzling, from high-resolution medical imaging to robotic surgery. There are more effective drugs than ever before. From diagnosis to surgery, health care is steadily less invasive. Health care practitioners are rigorously trained and credentials required to enter practice are on the rise. *Citius, altius, fortius*: faster (technology, recovery, publication); higher (credentials, spending, intervention rates); and stronger (institutions, drugs, methods). Everything's coming up roses, so it's better to finetune here, innovate there, and stick with a model of proven success.

But where the optimist sees paradise, the analyst sees purgatory. Our contention is that the case for reform is compelling, but reform remains very difficult to achieve. One explanation for the lack of progress is that the case is fragmented, and the parts have not been assembled persuasively into a compelling narrative that both unifies and strengthens resolve. In this article, we attempt to create that narrative by weaving together the main strands of the case for reform. We review the evolution of our understanding of health, and health care effectiveness and efficiency; this evidence comprises the intellectual impetus for reform.

The population health revolution

Since the 1970s, biology, epidemiology, geography, sociology and economics have joined to create a fundamentally new understanding of health and the relationship (or lack thereof) between health and health care.[2] For centuries, it has been clear that rich people are healthier than poor people. The famous Whitehall civil servant studies revealed a gradient that added a new dimension of complexity to the determinants of health and the prospects for health improvement.[3,4] Geographers launched a friendly invasion into health territory, illuminating the connection between health and place, and major variability in health status within generally healthy jurisdictions. Health services research workers showed that, even in countries with universal, state-funded health care, non-financial barriers to quality care persist.[5,6] And biologists and geneticists produced the disheartening news that one's life course prospects carry the heavy freight of imprints from the very early years.[7-9]

These findings refuted the presumption that medical wizardry and innovation is the reliable pathway to better individual and population health. They also cast doubt on the relationship between health care spending and health outcomes. Many remained committed to the science and technology road despite apparent failures, such as the "war on cancer"[10,11] and other therapeutic setbacks.[12] For example, renowned physician and essayist Lewis Thomas argued that we are in an era of "halfway technologies"[13] that will, with more investment in material and time, become fully-fledged, brilliant successes. Even if one finds this plausible, the evidence is overwhelming that medicine and science alone cannot compensate completely for the effects of the non-medical determinants of ill health. Some estimate that health care accounts for no more than about 20% of the variance in health status.[14] If better health is the goal, there is good reason to take a hard look at the massive enterprise that is health care.

The intractability of health disparities

There is broad international consensus that reducing disparities is both a moral imperative and the key to improving overall population health.[15] Moreover, while we do not know how to increase the longevity or quality of life among the most advantaged, we do know something about how to enhance the health status of the disadvantaged.

Several countries have done better than most.[16] The northern European social democracies typically have shallower social gradients in health status; not coincidentally, they have shallower income gradients and extensive social support systems. Yet, they too seem to have hit the wall in reducing further disparities — if anything, disparities are widening despite strong political commitment to narrowing them.[17]

Health care can help reduce disparities,[18] or unintentionally exacerbate them. Well-off people often have disproportionately better access to specialists, even under health care financing arrangements that provide universal coverage and that are tax-funded single-payer systems.[19] In two-tier systems like Australia's, even though the publicly insured population formally has equal access to care, in practice, those who are privately insured have better access — precisely what they are paying for.[20,21] Solo or small group primary care practices that are isolated from other sectors and disciplines may

deliver effective episodic care for healthy middle class people, but may not be able to meet the needs of patients with complex health problems and of disadvantaged groups. This is yet another rationale for full-scale reform.

"Flat of the curve" medicine

Within health care, value for money has emerged as a critical issue. The evidence is compelling at several levels.

Internationally, there is virtually no relationship between health status and health spending beyond about US$1000 or so per annum per capita.[22] The upward trajectory in health status flattens out beyond this threshold; in the language of economists, the marginal health benefits from additional health care spending become vanishingly small. Countries such as Costa Rica and regions such as Kerala in India achieve health status not much inferior to that of countries that spend orders of magnitude more on health care. The rich countries are all on the "flat of the curve".

Additionally, there appears to be no relationship between the per-capita number of health care practitioners and health outcomes in high-spending countries.[23] Sooner or later, these provocative findings must lead to hard questions about what we get for what we spend.

Defenders argue that democratic societies, fully aware of these facts, nonetheless invest heavily in health care for three reasons:

- health care is the only available route to improved health for most people in advanced countries because their non-medical determinants of health (income, food, housing, education) are already at high levels, and low marginal returns are acceptable because they are the only returns available;
- much contemporary health care is designed to reassure, and reduce small risks to very small risks — the "just to be sure" magnetic resonance imaging scan, the call-back visit; and
- the focus has shifted from longevity and survival to quality of life, and at this — arthroscopic surgery, joint replacements, medication — modern medicine excels.

Even if one concedes the logic and legitimacy of these arguments, governments recognise that the opportunity cost is massive; there are far more benefits to be had by investing elsewhere. But cutting even marginally effective services risks a middle class backlash. Better to look for outright waste and complete inefficiency in health care — the zero or negative return domains — and here, governments have found a rich lode to exploit.

It's not flat of the curve for nothing

The return on health care investment does not flatten only because health care has a relatively modest impact on population health status, or because it is hard to conceive of how to make healthy people even healthier. It is because a lot of health care is not very good and not very efficient. The large corpus of health services research documenting these uncomfortable truths is compelling evidence for reform.

That health care is not very good at the margins is not newsworthy; that it is not very good in the middle of the curve is quite shocking.[24] All countries that have studied hospital deaths have found that there is a high avoidable death toll in their hospitals.[25-27] This is not a question of halfway technologies, or the inevitable misfortune arising from uncertainty; it is a basic failure to avoid harm. Similar performance in aviation or any other industry would be viewed as both a performance and financial scandal.

The other side of that tarnished coin is waste. Variations in practice are rampant in health care. There are enormous differences in the use and cost of health care among similar populations,[28,29] and some high-performing health systems, such as Jönköping County in Sweden, spend the least and get the best results.[30] It is finally dawning on governments that improved quality costs less. There is no more revolutionary idea in health care than that.

The systems that do best are attuned to, and centred on, the users of services rather than being organised for the convenience of providers. They rely heavily on e-health for both direct care and analysis that informs continuous improvement. They are more serious about prevention and invest in programs — some of which are outside health care — that will defer or pre-empt costs. They have been much more successful in paying for success and not paying for failure.[30]

The authors of government-commissioned reports from around the world have recognised these realities for years. To a large extent, the evidence speaks for itself: the more one looks, the clearer it is that health care delivers neither processes nor outcomes commensurate with the level of spending. No industry — not even a publicly financed health care system revered by citizens — gets an infinitely renewable lease on the flat of the curve.

The evolving political economy

Health care systems do not exist in isolation; they are largely public entities, never far from the centre of political debates. Recent changes in the political and economic terrain are bound to affect health care.

Perhaps the most significant political change is the movement towards greater accountability. Governments are expected to measure, report, and account for themselves more transparently and openly than before. Auditors-General and their equivalents have begun to impose a value-for-money perspective on a sector that has historically been immune to such cold-hearted calculation. The size of health care budgets — approaching half of provincial government spending in many Canadian provinces, and around 25% for the larger Australian states — makes them obvious targets for scrutiny. If the emperor has no clothes, the accountability movement will be the first to publish the photos.

On the economic front, the Reagan–Thatcher neoconservative revolution reduced taxes and devalued and shrank the public sector. Governments deliberately reduced overall revenue growth while investing heavily in health care, particularly in the past decade. In Canada, critics pointed to health care's growing percentage of government budgets as proof of the public system's unsustainability. Some governments agreed, even though the problem was less the health care spending numerator than the total government revenue denominator.[31] However incoherent this discourse, one result was, again, heightened interest in reform.

The size and intensity of the current worldwide economic meltdown is bound to add further fuel to the reform fire. Governments are now forced to be Keynesians again, offering stimulus packages that run up massive deficits. Already there are forecasts of spending restraint. Having spent three decades or so reducing their roles, governments are nationalising banks and taking equity positions in large and failing corporations. Hence, the competition for government dollars is now stiffer, just when the balance sheets look more precarious. In such an environment, business as usual is no longer viable, not even in health care.

Conclusion

The case for major health care reform is persuasive. It rests on three main elements:

- The evidence for the obsolescence of traditional health care delivery is abundant and powerful. Quality and safety defects, the failure to provide evidence-based care, and huge and unjustifiable variations in practice are highly incriminating exhibits. Professions are still largely autonomous and uneasily allied with each other. Fragmentation compromises the continuity and effectiveness of care.
- Evidence confirming the enormous impact of the non-medical determinants of health on health status has diminished confidence that the solution to health problems lies mainly in health care. Understanding the extent and origins of health disparities obliges governments to promise to address them, and heightens concerns about persistent and widening gaps. Health care cannot overcome health disparities; hence, the calls for both health care reform and greater investment in non-health-care sectors. Meanwhile, obesity rates climb and preventable health breakdown abounds.
- No level of spending or rates of increase in spending definitively solve problems of access, quality, or equity. The natural experiment of the past decade has been to test whether it is possible to spend the way to excellence. The experiment failed because we mistook a structural and cultural problem for a financial shortfall. Buying more of the same proved ineffective, and it is now fiscally impossible to extend the experiment. The only option is to reinvent the delivery of care and invest more effectively in the production of health. These realities create a perfect storm. The wonder is not that there is so much call for major reform, but that it has not been pursued more vigorously.

The question is whether the stars are now aligned in favour of true transformation. As Nobel Laureate, Lord Rutherford, said to his laboratory colleagues a century ago, "We haven't got the money, so we've got to think."[32] For the foreseeable future, no country can continue to paper over the cracks in health care with hundred dollar bills. Abundance neither eliminated the fundamental problems in health care delivery nor reduced health disparities. Perhaps relative deprivation will create the urgency and courage to achieve both.

Competing interests

None identified.

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