



A new synthesis

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We are on the eve of a revolution in health policy that will forever change our way of thinking about health and healthcare. A few years from now, our vision of the organization and the administration of healthcare services will be transformed.

This is not a revolution born out of crisis, albeit the financial pressure on public and private funders of healthcare is clearly at play. It has not been induced by technological change, even if new means of acquiring and analyzing large amount of data—and consequently, unforeseen possibilities of testing hypotheses and answering puzzling questions—are among the most evident determinants of innovation. It is not a revolution driven by a clique or a conspiracy, although I will mention a few (intellectually) leading figures without whom the movement might have been less decisive.

It will be the third time in my lifetime that I have witnessed such an upheaval. The first revolution took place in the 1970s, a decade or more before I began my training in health administration. During those years, the field that we now know as “health administration” or “health policy”, distinct from medical care or hospital management, emerged as the result of an intellectual breakthrough. It happened when leaders in our discipline realized that instead of just trying to adjust supply to an ever-growing demand, our most important task was to align health services with the population’s health “needs”.

In one of the most influential books ever published in our domain, Avedis Donabedian’s *Aspects of Medical Care*, a simple but luminous equation established the equivalence between “needs”, “resources”, and “services”, thereby inviting a generation of planners and policy-makers to carefully assess health needs before securing resources and organizing services (1). Training programs created in that period were all structured around Donabedian’s trio of concepts, and innumerable proposals were made to facilitate the exact measure of needs or a more rational allocation of human and financial resources, if not a better distribution of healthcare services (2).

The second revolution is not yet over. It started in the 1990s, with the realization that healthcare, far from being driven by evidence, was marred by waste, error, and in all matters related to patient rights and well-being, a good dose of paternalism. *To Err Is Human*, the Institute of Medicine report of 2000, provided the movement with a common language and a common purpose: to “systematically design safety into processes of care” (3). But in fact, the program of research and action associated

with quality and patient safety has its roots in the work of the Institute for Healthcare Improvement, established in 1991, and of Don Berwick, its indefatigable leader and most influential thinker.

While the previous revolution was based on the concept of “needs” as distinct from the mere “wants” of patients (4), the new paradigm makes room for the patient wants, if and once they have been informed by evidence. No one has expressed this credo better than Berwick:

“The truth is, furthermore, that patient-centered care demands that the ways in which a person is cared for ought always to be under his or her control. The patient is the boss; we are the servants. Patients, not others, should direct their own care, and the doctors, nurses, and hospitals should know and honor what the patient wants” (5).

We have not yet reaped all the benefits of this approach. Those of us who participate in health management and policy conferences and who follow the main journals of our trade, are well aware that the most interesting papers and the more important reform initiatives still follow the path traced by Berwick and his colleagues. Integration of care, for example, makes no sense if it is not informed by the patient’s capabilities—from social and cultural skills to actual health status and prognostic—and guided by well-honed tools for shared decision-making.

Why do I believe another revolution is in the making? It is mostly because health policy has not integrated some of the most striking advances in health services and health policy research of the past decade. Four areas of progress in health research are particularly arresting, together with a fifth not unique to health research. These advances are the following: the biosocial stress perspective; behavioral economics; new tools of government; second-order system effects; and as previously mentioned, big data analysis. Each aspect has the potential to radically modify the way we formulate and implement health policy. Taken together, they represent a formidable challenge to conventional thinking about the distribution of health benefits and the allocation of resources.

The idea that social conditions influence our health has been with us forever. In the past five or four decades, many countries and even more international organizations have adopted policies that acknowledge the social determinants of health and the importance of tackling health inequities. But we also know this apparent consensus has not had much impact on the allocation of resources, which still obeys a more traditional logic of immediate medical needs. Progress of research in recent years has given way to the formulation of robust scientific models describing the biological pathways through which social conditions can alter individuals’ physical and mental health (6–8). Situations that health professionals would once have perceived as pure contingencies can now find a place

in the causal model favored by medicine and be addressed accordingly. This is a reality that no public or private system in which organizations are held accountable for their patients' health will be able to ignore for long.

So much has been written on the contribution of behavioral economics to the health sector that there is no need for a long discussion here. Suffice to say that this growing body of work on the economics and psychology of decisions is an opportunity to revisit a number of assumptions on how people make their choices—including choices involving well-informed, well-prepared professionals (9). It is also, quite importantly, a perfect occasion to design more effective institutional frameworks, including health laws and regulations, respectful of the range of incentives, from cupidity to identity, to which people react (10,11).

In the paradigm that currently governs patient safety, most interventions are aimed at health organizations, if not individual care providers. Properties emerge in health systems, however, that are not “reducible” to the conscious behavior of organizations or individuals. One of the major contributions of John E. Wennberg and his colleagues from the Dartmouth Institute for Health Policy is to have observed and documented such second-order effects (12). To take a famous example, if the number of teaching beds in a given catchment area has an impact on a wide range of health-related issues, from high costs to lower health status in the population, any policy that neglects this system-level effect is clearly doomed to fail (13). Improvements in data collection and treatment will make the tracking and analysis of these phenomena much easier and much more common. What is less evident is how to adjust policy discourse and policy practice. How do we explain to the public that limiting access to high-end medical procedures will actually improve their finances and their health? How do we convince doctors?

Policy instruments, or government tools, as they are alternatively designated, have been central to the study of public administration since the beginning of the 1980s (14). During that period, specialists of public policy became interested in the different means, beyond legislation, taxes, and public expenditures, that governments could use to achieve their goals. At the end of the 1990s, thanks to the intellectual leadership of researchers like Lester Salamon, the thinking about instruments included dozens of different tools or tool combinations, ranging from the most traditional to all sorts of sophisticated legal and fiscal devices, from contracts to vouchers (15). It was only the first step toward a conception that now encompasses not only the government sector *per se*, but also the private non-profit and for-profit sector. A larger “tool box” means that policy development does not depend on a bigger, more invasive state but can also consider creative (and confident) policy-making operatives, knowledgeable of the multiple practical options that government can take to achieve worthy common goals.

It is so early in the history of what is commonly called “big data”—the massive data sets documenting the healthcare consumption (or the health related behavior) of millions and millions of individual users—that it is still difficult to predict their long-term impact on health research and, furthermore, on health policy. What is already clear is that they open the way to types of conversation very different from those we have been used to. Instead of dealing with the shortcomings of a client survey, it becomes possible to hunt for patterns in nearly

complete sets of utilization statistics. Instead of arguing for hours the advantage or disadvantage of a public health measure, we can observe its impact, or lack thereof, in real-life conditions and real time, on entire populations (16).

These five streams of research are important for the future of health policy not because they are new and exciting—although in my experience it is easier to convince policy-makers to adopt a new course if you bring them a fresh horse instead of pleading for solutions that have already been examined and ignored. They are important because they all address in some way the most central questions: Where should we allocate our resources to get the best possible impact on people's health? Where should we invest the marginal dollar? Or the marginal euro? Or the marginal rial? Each year we spend more on health, and each year we ask ourselves how this money could be better spent. On new pharmaceuticals? Better paid physicians? New hospital beds? Better prevention? More research? We do not even know who should be answering these questions: our political leaders? Experts? Citizens themselves?

The promise of the next revolution in health policy is that it can bring answers to these questions. And it will succeed if it is able to create a new language in which options can be compared and decisions can be formulated—as Donabedian did in the 1970s. If we look back to his method, it is clear it was based on the careful integration of the best knowledge of the time in a single synthesis. Our task is no different and could bear the same benefits, if not more. Let us work on a new synthesis.

Ethical issues

Not applicable.

Competing interests

The author declares that he has no competing interests.

Author's contribution

PGF is the single author of the manuscript.

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