Response to "Inertie et Changement"

By AP Contandriopouls

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Introduction

In this paper, Professor Contandriopoulos presents a rich description of health care organizations and systems and those who are involved in them, which I shall call the health field. He argues that change or inertia in the health field depends on the interaction of two processes: 1) the embedding of fundamental values in its organizational structures and 2) the way in which the players in the field internalize and act upon those values. He recognizes that these structures and dynamics of the health field are interdependent and interact with each other and with the values of their context.

Summary of Contandriopoulos' Position

According to Contandriopoulos, the health field is made up of three domains: a system of representation of its values, a governance system for allocating and managing resources and a clinical system for providing care. At the macro level the values of the health field can vary with the dominant value orientations of a society and with the range of views that provide our understanding of the concept of health and its determinants. Once embedded in organizational structures these values are internalized and acted upon by the major players in the field including clinicians, managers, commercial suppliers and politicians. The meso level governance domain consists of management, information and financial systems. The clinical domain is at the micro level, and consists of the provision of services, which are meant to respond to the needs of patients in an integrated way, according to best available knowledge, by appropriate professionals.

Contandriopoulos argues that pressures on the field as a result of the rapid development of new knowledge, clinical and managerial technological innovations, an aging population, and globalization forced the misalignment of the various components of the health field. Once players in the health field could no longer act according to their internalized values the field began to "destructure", and we now find ourselves in a serious crisis, which Contandriopoulos argues can only be overcome by fundamental reform.

He concludes that because of the nature of the interaction between its value-based structures and dynamics, the field tends to be resistant to change. This inertia can be overcome by adopting what he calls a "paradoxical change strategy." Such an approach balances rational planning with emergence, ideal visions with realistic necessity, and embraces various forms of change. He concludes with a series of principle characteristics of his strategy such as the development of more adaptive players, the creation of more responsive information systems, the identification of fresh leadership, and the use of multiple policy levers to foster fundamental reform.

Response to Contandriopoulos

In my response, I will argue that Contandriopoulos has effectively described the health care field as a complex system and has recognized that interventions must be appropriate to this complexity. I will then comment on his ideas about inertia and change in such systems.

I will begin by making a distinction between simple, complicated and complex projects (Glouberman 2001). Simple projects like following a recipe may encompass some basic issues of technique and terminology, but once these are mastered they may be carried out with a very high assurance of success. Complicated projects contain subsets of simple ones but are not merely reducible to them. Their complicated nature is often related not only to their scale like sending a rocket to the moon, but also to issues of coordination or specialized expertise. Complicated projects are generalizable despite their non-reducibility. Complex projects can encompass both complicated and simple subsidiary projects but are not reducible to either since they too have special requirements, including an understanding of unique local conditions, interdependency, with the added attributes of non-linearity and the need to adapt as conditions change. Interventions in such projects often have a paradoxical quality. Unavoidably, complex systems carry with them large elements of ambiguity and uncertainty that are in many ways similar to the problems associated with raising a child. Yet, despite the uncertainty associated with complexity, all three kinds of projects can be approached with some degree of optimism: we do, after all, look forward to raising a child despite the fact that every child is unique and the project is complex.

When one considers this set of distinctions, it becomes evident that Contandriopoulos has demonstrated the complexity of the health field. His rich descriptions of the many values, players and organizations that constitute it and more importantly the multiple perspectives and interactions among them indicate his appreciation of the complexity of health systems. If this is so then there is good reason to agree with Contandriopoulos that

interventions in such systems cannot treat them as if they are merely complicated. For example, interventions within complex systems cannot ignore local circumstance because in such systems there are few if any universal solutions. Successful interventions in one venue cannot be adopted holus bolus in another. Similarly, structural changes often have uncertain dynamic consequences in complex systems because of the non-linear interactions between structure and dynamics. I have argued elsewhere (Glouberman and Zimmerman 2002) that much of the current crisis in the health field in Canada, the UK and the United States is due to the repeated inappropriate application of large-scale complicated solutions to complex problems, which have destabilized these systems.

In what follows, I will try to apply some of these ideas to Contandriopoulos' notion of the inertia of the health field. Contandriopoulos presents two examples to indicate the inertia of the health field: 1) the difficulty in creating integrated delivery systems like the Kaiser plan despite their apparent superiority to the status quo, and 2) the difficulty in changing doctors' pay from fee-for-service to salary despite the clear view of experts that salary would provide more appropriate economic incentives

1. Integrated Delivery Systems Like Kaiser

In the first of these examples Contandriopoulos points out that integrated delivery systems have been shown to provide superior health care performance. He cites an article in the BMJ (Feachem, Sekhiri et al. 2002) that compares the Kaiser plan to the English NHS as an example of the superiority of this structural type over the less integrated NHS. I would argue (along with Contandriopoulos) that the success of the Kaiser plan is due to

local creation of structures, which embed the values of the players in an institutional framework. That is to say that the Kaiser plan has evolved in its own milieu with its own history of roles and relationships of clinicians to each other and to the system. It does not follow that the Kaiser structure will be effective in other contexts. Structural integration must be distinguished from service integration, and the former is never by itself sufficient to guarantee the latter.

Hospital mergers in Ontario, regionalization in the rest of Canada, HMOs in the USA and Primary Care Trusts in the UK are examples of interventions intended to integrate parts of health care systems. They have had very mixed results. In some cases forced structural integration has even weakened them and worsened the coordination of services by destabilizing existing service patterns. Far from displaying the inertia of complex systems, they show how sensitive they are to inappropriate interventions. They are a good example of interventions that do not adequately consider local values, institutions and players: they provide complicated solutions to complex problems and contribute to system destabilization.

Why then has Kaiser continued to be successful and overcome the various pressures described by Contandriopoulos? I would suggest that the answer to this question might not come only from its structure, but also from the underlying stability of the Kaiser plan. Kaiser has not undergone the kind of dramatic restructuring that has occurred elsewhere and which has destabilized existing relationships among providers. A first paradoxical conclusion may well be that adaptation to a changing environment requires stability in

the complex organization that must respond. It may very well be that fundamental stability is at least as critical as fundamental change. It would follow that a first step in reforming Canada's healthcare system is to stabilize it, so that the kinds of changes Contandriopoulos hopes for may become possible.

2. Doctors' Pay

Contandriopoulos' second example also does not demonstrate that health care systems suffer from inertia but rather that introducing interventions which are meant to provide purely economic incentives may not be appropriate in complex systems. Changing the payment mechanism for doctors rests on the assumption that they always seek to maximize their income i.e. that they always function as self-interested rational economic agents. Empirical economists have begun to question the notion that such classical incentives are universally operative. Certainly in the case of doctors, there is substantial evidence that they are not. An OECD study (Organization for Economic Cooperation and Development 1990) has suggested that in most OECD countries, doctors’ earnings fall within a narrow range of between 3 and 5 times the national average income regardless of the method of payment. This corresponds to the widespread conclusion that doctors work to target incomes and expect an upper middle class life style. When changing the mode of doctors' pay threatens the security of their lifestyle, they respond fiercely or find other sources of income. However, when their work situation is stable and secure, other values predominate. Contandriopoulos himself recognizes the deeper values to which doctors respond, including a strong desire to do the best for their patients, to maintain their

knowledge and skills at a high level of proficiency, to use the most up-to-date equipment and procedures etc. These often take precedence over income once target levels are met.

It is significant that doctors in the Kaiser plan receive a relatively stable income that assures them of the lifestyle they expect while NHS doctors who are also on salary, earn significantly less and often must supplement their NHS income with private work. How doctors are paid may not be as significant as how much and how secure that income is.

In much of Canada, the USA and the UK, there have been threats to the stability and level of doctors' income (including attacks on the fee for service structure described by Contandriopoulos.) All have contributed to a growing level of insecurity among doctors who struggle to maintain their target income. For example, the increased debt load on young physicians in much of Canada defers their earning capacity and effectively lengthens their period of apprenticeship. It is hardly an incentive for them to be paid a set salary, which might defer their target income even longer. These attempts at economic control have more than likely also contributed to the growing instability of the system.

Conclusion

Contandriopulos has shown how the health field is made up of complex systems. However, he has not shown that such systems suffer from inertia. I would argue instead that the many interventions in Canada, the USA and Britain in the last decade have shown how sensitive such systems are to change. Forced integration of institutions and containment of physicians' income are good examples of these kinds of changes. I would

conclude that such interventions, though they might be appropriate to complicated systems, serve only to destabilize complex systems and erode public confidence in health care.

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