Introduction

For most of the twentieth century, health care has been the world's largest local, or "cottage," industry. Communities all over the world have built hospitals. Societies have trained doctors and nurses, and funded health-care services — services that are highly prized by citizens. We seek relief from our pains and we search out cures for our illnesses.

It is not surprising, therefore, that health care is a priority for public and private spending in all nations. Governments, communities, and employers have organized systems to finance health-care services. But it has been only in the last decade or so that serious efforts to organize integrated systems of care delivery have gained momentum. This shift from systems of finance to systems of delivery is profound. It is an unprecedented change, both in its direction and in its speed.

The long-established medical guild is under siege as doctors are

questioned about everything they have long regarded as sacred. So too, the ate mows, who feel set upon as their profession is restructured, hospital *by* hospital, nation by nation. The old ways of both physician and nursing care are being altered forever.

Health-care delivery Is undergoing rapid changes, evolutionary and revolutionary. Much has been written about the nature of these changes, country by country. Among the emergent new approaches are the integrated delivery systems in the United States, Crown health enterprises in New Zealand, and purchasing authorities in the United Kingdom. However, very little has been written about the actual experience of these new organizations. Is the integration of health services working? What are its early consequences — for patients? For providers? For communities?

Even less has been written about the powerful societal forces driving these changes. Studying health-system change without understanding these forces misses the dynamic motion that underlies the upheaval. It is like trying to teach sailing without discussing *winds.* As a young student, I taught sailing during my summers, to small children and sometimes to their parents. The first essential lessons in sailing are not about the boat but about the winds. No sailor can function without understanding the many clues to the directions of winds: the wind on the water, the wind in the rigging, the patterns of clouds, the shape of the land Knowing the true wind, with its shifting, changing force
and direction, is a challenge with which all sailors must contend. Without knowledge of the winds, one is merely an "accidental" sailor — and will never really be in control of the boat.

Of course, understanding the boat is essential as well. To leave the metaphor and come back to health care, this means understanding the vessels that provide it — institutions and organizations that have often been built over long periods of time and are deeply rooted in the values of the communities they serve.

Those responsible for managing the great changes in health care face a highly complicated, challenging task. Health-care systems are some of the most complex organizations we have devised as a species. They

Are buffeted by strong winds of change. Like sailors, their managers must understand the winds blowing against their rigging if they are to contend with them successfully. Without this understanding, they are no better off than the accidental sailor.

There is no shortage of accidental health reformers. U.S. President Bill Clinton might be the most prominent; his proposed reforms were not rooted in an understanding of the forces driving change — nor did they reflect American values well. The reforms inevitably failed.

Clinton fundamentally misunderstood the power of the coalitions that support the current U.S. health-care system. Although health-insurance coverage for all Americans had political appeal, opponents of the model proposed by Clinton were easily able to portray it as overly bureaucratic and governmental. No matter how unfair this characterization might have been, it stuck. A consumerist public with rising expectations of quality and speed in health services did not believe these demands would be met by the Clinton approach, quality and speed not being virtues most Americans associate with their government.

Much of the one-time efficiency the Clinton reforms sought has now been achieved by health maintenance organizations. The goal of universal coverage has drifted further from the achievable as more Americans than ever — some 40 million — lack any health coverage at all, and tens of millions more have inadequate insurance. This situation persists after the longest period of economic prosperity in American history.

Across the industrialized world, health systems — which consisted largely of hospitals and doctors — were fuelled by more and more funding in the four decades following World War 11. Through the 1950s to the mid-1980s, billions and billions of dollars poured in. Growth in health spending averaged well above 10% — higher than inflation, higher than population growth. The late 1980s and 1990s marked a sudden change in the approach to health financing in industrialized countries. Hospital funding has been frozen or reduced. Now, health managers and planners must reshape health-care delivery organizations to be lighter, more dollar efficient, and yet of higher quality and more responsive to consumers.

Like early naval architects working to design ships that could sail closer and closer to the wind, health leaders must design health services to be delivered closer and closer to the populations they serve. Like the square-rigged galleons of centuries past, the stand-alone general hospital is increasingly an anachronism.

The winds of change do not blow steadily, but shift as they bump up against existing health systems. They blow in more than one direction at a time — at times they are in conflict, and at other times they reinforce each other. Sometimes they are gentle breezes, and sometimes they are howling hurricanes. At times, existing health-delivery systems must claw their way to windward, fighting for each inch of room to deliver services. At other times, the winds are behind them; these favourable winds will waft lighter, leaner delivery systems swiftly into the future.

Not all change is for the better. There are always casualties in a period of reform. In all countries, the disruptions of reform are creating problems for patients and providers. It is a turbulent era in health care as the winds of change blow both good and ill into our health-care systems even as they profoundly alter how we think about health and how we deliver health care.

These winds are global. They do not abate at national borders. They do not respect tradition or the centuries-old values of physicians and nurses. They do not bend to the will of politicians.

What are these powerful forces? What are the north, south, east, and west winds blowing through global health systems, compelling their rapid transformation? I have identified four important forces of change, as follows;

0. powerful new ideas, including a paradigm shift in health policy from providing individual health care services to managing costs to endeavouring to manage the health status of populations;

• a consumer revolution — What the public wants is quality, speed, affordability, and appropriateness, as well as accessibility; what it needs is shaped by demographics;

e. the technological transformation of health-services delivery, driven

by silicon-chip-enhanced information management, *new* drugs, the biotechnological revolution, and changing clinical practice; and

- financial pressure from employers and from governments to deliver more services, more efficiently — driven by global competitive pressures.

Let us consider each of these forces briefly.

Powerful New Ideas

There are both radical new ideas and radical old ideas at large in the world of health today. The idea that health intervention should be as much or more about enhancing health status than curing disease is not new, but it is a paradigm that has gained tremendous force in the major industrialized countries in the past two decades. in 1974, Marc Lalonde, then Canadian Health Minister, issued a key report that made an effective case for broader determinants of health. Over the next two decades, other industrialized nations followed the Canadian lead. Each in its own fashion has embraced this approach; its implementation, however, both in Canada and elsewhere, has been less rapid. The old ways of health show resistance to even the strongest forces.

Vast investments in new drugs and technologies have yielded great advances — yet diminishing returns. The potential of this realm remains great, yet unlocking it has proven elusive. As diseases such as cancer remain stubbornly resistant to cure, our attention has turned sharply to prevention. With regard to cancer, for example, the linking of many causal factors, particularly smoking and diet, to various forms of cancer has given health advocates the momentum needed to move the system toward this new paradigm. Health promotion has gained millions of allies.

The idea of measuring health by the life expectancy of a population, and particularly its disability-free years of *life,* has also gained great momentum in the world health community. No one is suggesting that we abandon accounting for how we treat illness and cure disease.

However, we are witnessing a much greater focus on the health of a population, the epidemiology of disease, and the search for root causes that can be altered. Chief among these are income level (health rises with wealth), lifestyle choices, and the safety of the general environment. The World Bank report of 1993 marked a watershed in the movement toward investing in improving health rather than in simply treating illness.

In the United States, the health-care debate of the 1990s was dominated by the concept of managed care — and the reality of its implementation. Health maintenance organizations have been the controversial vehicles for this massive experiment. Has managed care stalled at managed cost? Did it achieve a one-time saving by removing excess capacity only to fall victim to its own success?

There are other powerful ideas shaping health policy, particularly the notion of competition as a means of improving efficiency, and the idea of more integrated approaches to care delivery. Each of these ideas will be explored in greater deaf in Chapter 1.

Changing Public Expectations

Changing public expectations are the second powerful driver of reform. The era of provider domination in health has endured for several centuries. But this tradition, which was based largely on information monopolies, is giving way to the age of the empowered consumer. Consumers can reach out through the Internet to drkoop.com, fire up a CD-ROM, read one of hundreds of new books, or simply turn on the television to obtain information on a scale unimaginable less than a decade ago. We can now know what it is that our bodies are confronting. We can know our risk factors.

Public expectations combine with changing demographics as a force for change. Our health needs change as we age — and we are aging, all of us, one year at a time. This the best educated generation, ever.

We are confronted in every other wall(of life by a rapid increase in the pace of activity. We no longer have the patience to line up in our bank

branches — automated teller machines have proliferated. At gas stations, we have self-service pumps. Automated-checkout machinery has sped up the supermarket experience. Fifty channels on television — soon to be five hundred. Five million Web sites on the Internet — soon to be fifty million. In every walk of life the consumer's desire for speed has brought about a transformation, be it fast food or fast entertainment.

There is also greater demand for quality. The revolution that swept through the car industry several decades ago has, in the last several years, come to health-care delivery. Chapter 2 explores the wants and needs of today's new consumer as they relate to health care, specifically the changing public expectations regarding quality, speed, and appropriateness.

New, Chip-Driven Technology

Perhaps the most profound of the societal forces driving change in the delivery of health care worldwide is technological change — specifically, the corning of the digital age_ The ubiquitous silicon chip, which has transformed our ability to obtain, store, and manage information, is affecting health care in a myriad of ways. Other technological advances have had an important effect, too — for example, our vastly enhanced ability to scan and image the human body in much less intrusive ways and with much less risk to patients than ever before. And new wonder drugs, although at a greater cost for each than previously. But it is the

!icon chip, and its unprecedented effect on our ability to manage information, that is at the centre of the technology revolution in health care. Chapter 3 reviews this interplay of technology and change.

Financial Pressures

Finally, there is the fiscal crisis — the big squeeze. As government debt and deficits reached unsustainable levels across the industrialized countries in the late 1980s and early 1990s, health-care cost containment .became a central issue — one that became even more pressing in several

nations as fiscal situations tightened with recessions.

The form that cost containment has taken differs according to the nation and its particular system. In most countries, where financial responsibility for health-care services rests with the state, the government has brought about change and rationalization in how these services are delivered and managed. In the United States, where responsibility for health insurance rests primarily with private employers, this rationalization has been largely a marketplace phenomenon. Chapter 4 reviews the relationship between money and its restriction, affected health care, and discusses the recent move toward reinvestment of funds as we enter the twenty-first century.

These are the four powerful winds blowing through global health care: new ideas and a different vision of health; a more demanding and knowledgeable public; advances in technology — in particular chip-based technology; and a desire for greater affordability and value for money. These forces are bringing about phenomenal and rapid change **in** health-care delivery as we know it. They offer the potential for great constructive change, as well as the certainty of a significant disruption of the existing order.