

The appropriate limits placed upon what people can expect from health care



by **Jan-Kees Helderman**

In '*Speaking Truth to Power*', the American political scientist Aaron Wildavsky argued that the 'pathology' of healthcare policy is that the past successes of medicine are likely to lead to future failures in healthcare policy. For, as life expectancy increases, only partly as the result of medicine, a nation's healthcare system is faced with an older population whose ailments are more difficult to treat, sending the costs of treatment ever higher while each improvement in health and medicine becomes more expensive than the last. It is the '*doing better – feeling worse*' syndrome which, in the end, Wildavsky argued, will also undermine solidarity, since: '*the rich don't like waiting, the poor don't like high prices, and those in the middle tend to complain about both.*'

Wildavsky wrote this 1979, and he reflected of course on the US healthcare system, but his pathological law should also hold for European healthcare systems. The two fundamental sources of the challenge that I wish to bring forward are, first, the rise of cognitive, normative and strategic uncertainty that comes along with the emergence of new social risks that do not fit adequately within an actuarial-based social insurance arrangement because of their unknown magnitude. And secondly, the cognitive, normative and strategic uncertainty that comes along with accelerating innovations in medical science. Because of these uncertainties, we are doomed to juggle with different frames of knowledge and justice when it comes to health. By not recognizing this, we brought ourselves trouble.

By emphasizing *Complete Health* as the 'gold standard' of our healthcare systems and our welfare state, we caused public spending on healthcare to spiral to unsustainable levels, crowding out investments in other socially valued domains, such as education. In our desperate attempts to contain rising healthcare expenditures, we have put all our hopes on rationing and efficiency enhancing measures, facilitated by utilitarian decision-making frameworks and supported by the randomized controlled trials of evidence based medicine. But, unfortunately, the frameworks that we still use to govern our health systems are of little help in making the social optimal choice between curative treatments on the one hand and investments in prevention or investments in capacitating social services on the other hand. The problem is that these frameworks not only deny the contextualized interdependencies of health related risks to other social risks, but also the fact that it becomes more and more difficult to make the right moral choices with respect to health within one coherent and consistent set of philosophical and conceptual arguments.

The only way out of this dilemma, I suggest, is that we modify our standard of what good health is or ought to be, and this also asks for another approach to the way we govern our health systems. In their groundbreaking article in the British Medical Journal (BMJ), our Dutch colleague Macheld Huber and her co-authors suggested an alternative approach towards health. Health is not to be defined as complete wellbeing, but instead as: "*The capacity to adapt and self-manage when dealing with the social, physical and mental challenges in the life course.*"

This 'health-as-a-capacity' approach, as I call it, has more potential to re-align the domains of public health and medical care with other domains of the welfare state. It blurs in many ways the boundaries between medical care, public health and other social systems. In contrast to the Complete Health standard, this approach is both dynamic and situational in the sense that it emphasizes health as being a dynamic balance between opportunities and limitations, shifting through the life-course and affected by external social and environmental conditions. This then

opens up new areas for investments and interventions (outside the medical sector) that may contribute in a positive way to our health but that are currently not recognized for this. And by successfully adapting to an illness, people not only feel better, but they are also able to work or to participate in social activities and feel healthy despite limitations. In this way, reciprocity is brought into the interrelatedness between health and its social and physical determinants.

One can find already many examples in contemporary social policy discourses, in various contexts, that emphasize the importance of investing more in citizen's capacities to adapt and self-manage, instead of relying on curative treatments and insurance. It relates for example to the Health-in-All-Policies programme of the WHO and its plea for a Whole-of-Society Approach. In the European context, it has clear affinities with the 'social investment welfare state' approach. On a more philosophical level, there is a clear link with the Capability approach. And when it comes to governance, it fits within a more pragmatist and experimentalist approach towards health governance, emphasizing the need to invest in a governance infrastructure of monitoring and forward-looking accountability that facilitates mutual learning about the wicked problems that we necessarily have to deal with.

To be sure, health-as-a-capacity is in many ways surrounded with ambiguity and ambivalence, its socio-political and policy consequences can hardly be overseen yet. The challenge is how and to what extent this health-as-a-capacity approach can be further developed *within* a policy-making context. I hope that in the next ten years, HEPL is one of the platforms where we can explore and discuss the consequences of this new approach towards health.

About the author

Dr Jan-Kees Helderman is Associate Professor within the Nijmegen School of Management, Radboud University Nijmegen, the Netherlands. He is also Associate Editor of the **Health Economics, Policy and Law** journal.

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