

Part II

A “Best Adapted” Health System: Meeting the Challenges

Modern medicine is a negation of health. It isn't organized to serve human health, but only itself, as an institution. It makes more people sick than it heals.

Ivan Illich (1826–2002)
American sociologist

A “Best Adapted” Health System

Part I of this book described the foundational elements that underpin the formation of a *complex adaptive* health system:

- Key aspects from systems and complexity sciences:
 - *Nonlinear behaviour*:
 - disproportional response between inputs and outputs
 - makes outcomes less predictable
 - leads to *self-similar outcome patterns*, each of which is the “best adapted” outcome under a particular set of circumstances
 - *Feedback loops* contribute to the nonlinear behaviour of systems and:
 - result in learning
 - enable adaptation
 - achieve robustness
 - Complex adaptive organisations (or social systems) arise around *shared (or core) values* which “determine” the direction the organisation will follow
 - In a seamlessly integrated complex adaptive organisation *purpose, goals, and values align* within and across all subsystems and organisational levels

- Visualisation techniques help to understand a “*system as a whole*”:
 - A *vortex* is a generic representation of a complex adaptive system and illustrates the self-organising nature of such a system around its focal point
 - *System maps, influence, multiple cause, and sign-graph diagrams* highlight the structural and dynamic interrelationships between the system’s agents
 - The Cynefin framework clarifies the nature and relationship of different dynamics in organisational systems
- Health is a personal complex adaptive state:
 - Health is *experiential*
 - The experience of health is *adaptive* in light of changing internal and external circumstances
 - *Most people are healthy most of the time*
 - *Good health experience* (as in self-rated health) is highly predictive of future morbidity, mortality, and health service use

Part II of this book outlines how these foundational elements can be applied to the redesign of a *complex adaptive health system*.

“**Health systems**” need to be distinguished from “**healthcare systems**”—simply, the focus of the system must shift from *disease* to **health**, and from *disease management* to **health creation**!

Redesign of a *health system* in the first instance then is a shift in *mindset or focus*. A changed focus on the *experience of health* and its *contributing factors* will allow the emergence of a “best adapted” health system based on the reconfiguration of the relationships of its agents and their way of interacting.

Three examples from very different contexts illustrate the emergence of “best adapted” health systems. Each emerged based on its unique focus on *the needs of the people they care for*. Explicitly and/or implicitly each system defined its set of *purpose, goals, and values* statements (reflecting the mindset shift) which gave rise to the definition of its set of “*simple (operational) rules*” (reflecting the way of interacting).

Complex adaptive organisations require a leadership approach that is *committed to uphold* its values and *maintain* its members’ focus on common purpose and common goals.

Leaders of complex adaptive organisation engage with their members to solve common problems—rather than to prescribe solutions. This style of leadership “*shows the way*”, it gives “*direction without directives*”. Leaders lead by *moral authority* rather than *institutional power*.

An important part of leading in complex adaptive organisations is the inevitable need to manage limitations arising from system constraints. The three examples show how leaders have approached system constraints in ways outlined by Goldratt [1]. They:

- Identified the system’s constraints
- Decided how to exploit the system’s constraints
- Subordinated everything else to the above decision
- Elevated the system’s constraints
- If in the previous steps a constraint had been broken, they went back to step one, and did not allow inertia to cause another system constraint

References

1. Goldratt EM (1990) What is this thing called THEORY OF CONSTRAINTS and how should it be implemented? Great Barrington, MA, The Northern River Press