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Many health-policy reforms may be guided more by ideology than by rational analysis. Laying bare such ideologies is a key task for professionals.

Health policy – more ideology than rationality?

Rationality is a prerequisite for the medical profession. We may disagree as to *what* is rational in a given situation, and we may also discuss different *types* of rationality. However, nobody doubts the need for rationality *in itself*, including the need to correct medical practice in light of experience.

This is a hallmark, but it may also obstruct our understanding of health policy. Our emphasis on rationality may blind us to the fact that political processes do not need any rational justification whatsoever. For example, many of us will automatically assume that despite everything, reforms in the health sector are based on rational considerations, such as cost-benefit analyses. Even though patient treatment is set to deteriorate, we believe that the reforms are financially appropriate and that society saves money. On the basis of such notions, the reforms may be perceived as immoral, but not irrational.

But perhaps society does not save any money. Perhaps the reforms are not based on rational assessments, but on *ideology*. In the social sciences, the term ideology refers to socially determined perceptions of reality about politics and society, and according to some of the traditions of those disciplines, these have five characteristics (1): *distortion of reality*, meaning that experience has no corrective effect; *self-immunisation*, meaning inherent defence mechanisms against the threat of criticism; *interest dependency*, meaning that the ideology promotes certain vested interests (often disguised as public interests); *an adversely affected party*, meaning that somebody stands to lose from the presence of the ideology; and *system context*, meaning a coherent mindset in which the constituent perceptions confirm each other.

Leading social scientists have argued that Norwegian politics is more ideologically based than what many of us assume (1, 2). In the health field, the establishment of Oslo University Hospital (OUS) is an interesting case in point. Are we here able to recognise the five characteristics of an ideologically driven process? *Distortion of reality* seems to have been present: Oslo University Hospital was formally established in 2009, but a review article published in the UK as early as 2002 documented that hospital mergers provide no efficiency gains or financial savings (3). Equivalent findings had been made in other countries (4), while more theoretically oriented economists warned against efficiency losses (5). It was nevertheless claimed that the process would quickly bring savings of NOK 900 million per year (6), but the end result was a considerable financial

loss during the initial years of operation. What about *self-immunisation*? The demand for loyalty to the merger process (7) and the severe sanctions against those who failed to comply (8) can be interpreted as manifestations of such a phenomenon. Was there any *interest dependency*? At least in financial terms, yes: the bills from various consultancies amounted to NOK 3 billion in total (2). In addition, the process implied a power shift from the professional and political levels to the administrative level (2). Is there *an adversely affected party*? This is difficult to document with any certainty, but there is reason to be apprehensive of the declining quality of patient treatment (9).

Finally, the demand for *system context*. Is the process behind Oslo University Hospital based on a particular set of notions? Many have pointed to the neo-liberal trend towards 'new public management', which is characterised by liberalisation and market orientation (analogous with the private sector), combined with the establishment of bureaucratic control systems (10). Norwegian public administration has been reformed in accordance with these principles ever since the 1980s. Gradually, these reforms have become self-justifying – partly because they may provide an impression of political vigour and partly because enterprises and organisations may have reforms as their main activity or business idea (10). Claiming that reforms are necessary is thus in itself an ideological position.

There is thus much to indicate that the process was ideologically based. This ought to heighten our suspicion of new health-policy reforms, for example the closing of local hospitals. It is frequently claimed that high-quality treatment requires large units, but is this argument based on experience and rational analysis? Or is it a distortion of reality? Empirical studies may suggest that small hospitals have advantages in terms of quality (11, 12). What about the Interaction Reform – will its premises stand up to such critical scrutiny?

Ideological self-immunisation can be dangerous to society and thus also to the objectives that the ideology itself claims to promote (1). Attentiveness to critical voices will better enable us to solve future social challenges. As professionals, we may be well served to develop a critical suspiciousness when it comes to health-policy reforms and call for rational justifications – just as we would do for new programmes for patient treatment.

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