A values-based health system

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The promise of billions of dollars to treat symptoms of a failing health care system without fundamentally addressing the underlying disease with innovative and revolutionary reform will only inevitably lead to more inquiries and more reports. *Van Der Weyden*[1]

ABSTRACT

- We do not have a health system with collaboratively oriented values.
- Reforms that former prime minister Kevin Rudd initiated, which are now Prime Minister Julia Gillard's to prosecute, do not support such a health system.
- Reformers have consistently ignored present and potential values.
- A plan for reform of the health system must take into account differing stakeholders' objectives and values and incorporate new values.
- This requires an agreement by stakeholders to embrace the common good.
- It will also need strong leadership and a willingness to embrace fundamental change.

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A new paradigm for health care

It remains debatable that the Rudd government's health care reform solutions were revolutionary. The collective proposals fell short of addressing the fundamental causes of health system failure. Despite the efforts of the government in producing weighty reports with hundreds of pages and dozens of recommendations,[2-5] the solutions (according to some) were chiefly mechanistic and structural, although the National Health and Hospitals Reform Commission (NHHRC) report has much useful information and many viable recommendations. At last month's Council of Australian Governments (COAG) meeting, the heads of agreement between the Commonwealth, states and territories authoritatively pronounced on a range of high-level principles, particularly on shared funding, standards of care and performance, and committing to local governance, but it is not clear how reform will be accomplished or what its eventual shape will be.

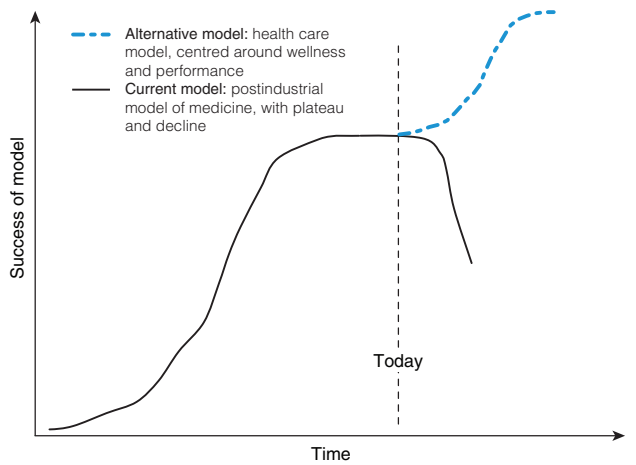
Basic questions remain unanswered, such as, "What is collectively meant by health?" Most in the medical community are busy treating breakdowns in individual patients' conditions, and are thus dissonant about, and distant from, such a question. At what point will we be happy with the health system? What will a well functioning, clearly focused health care service look like?[6-9]

While these questions may be too hard to answer, particularly for incrementalist governments, the end of the innovation life cycle with the current model has been reached. There are, surely, few significant gains to be made in churning out more patients, running more tests, and throwing more dollars at the states and territories to continue to support the existing patchwork we call the health system. No one doubts that people are working hard, but the current incentives, structures and vested interests work against real progress.

We illustrate the point in Box 1. The old paradigm of health care was predicated on industrial thinking and disease management, the mainstays of which are drugs, procedures and biochemical and radiological testing. This needs to shift to a wellness-oriented system focused on performance and outcomes, requiring a radical overhaul.

While we appreciate that the switch to a new growth and innovation model cannot happen overnight, one fundamental aspect of health care could be addressed in the meantime. What is missing from the Rudd government's proposals for health reform, and all others we have read, is a failure to articulate, and argue for, a new values-based system. In a postmodern world of bewildering complexity (the health system is an excellent example of this), we need, more than ever, firm anchors on which to base our reinvention of health care. This reinvention needs to be to a system designed for wellness and performance, rather than for symptom avoidance or salvage of patients when it is too late, and we must realign confidence in and support for the system.

1 Projected success of alternative model of health care versus the current model



Current and proposed values

Consider the values of stakeholders in the system now, which we have observed emerging for some time. They can be seen expressed increasingly through participants' behaviours, practices, attitudes and beliefs. Consider how it might be if they were reframed. In Box 2, the normative values are those toward which the respective stakeholder groups ought to be striving.

In short, while some groups and individuals display normative values some of the time, these instances are much rarer than is preferable. Stakeholder groups are "tribal",[10] favouring their in-group membership over others, and pursue anachronistic or idiosyncratic values. Yet, if human societies eschew the greater good, they run the risk of confronting the "tragedy of the commons" — a well known phenomenon in which the pursuit of

2 Present and emerging versus normative values for health care

Participants, stakeholders	Present and emerging values*	Normative values†
Patients	Expectation of on-demand services and failure to recognise their worth; expectation that health care is a right with few patient obligations; naive belief that health is contingent on beds, procedures and medication	Appreciation of services and recognition that everyone has lifestyle obligations for their own health, society and the health system; recalibration of expectations for optimal or acceptable health
Consumer groups	Undue focus on single issues or specific patient groups; undue criticism of the system, services or individuals	Focus on holistic care; collaboration with those working in the system
Medicine	Provision of episodic, narrowly focused, disease and symptom-based, fee-driven services; acceptance of performance measurement using throughput rather than population health	Focus on putting "care" back into medicine; designing the system for "wellness"; acceptance of long-term outcomes for patients as key indicators of success
Nursing	Tendency to work in rule-governed, hierarchical ways	Tendency to work for outcomes and patients, not structures
Allied health staff	Tendency for professional "positioning" without solving problems of fragmentation and by setting medical roles "above" nursing roles; failure to acquire and exercise power and influence appropriately	Tendency to capitalise on role at the centre of much health care delivery; focus on leadership in inter-professional practice and on addressing silos and acting as an integrative force
All health professionals	Focus on individual benefits ("What's in it for me?"); failure to engage with the "big picture"; following the practice of "excluding disease" as the goal	Focus on contributing to patients, outcomes and families ("What's in it for them?"); development and support of health policy; fostering a culture of innovation and leadership
Education providers	Settling for learning by rote and trial by examination, in monodisciplinary silos	Engagement with holistic, multimethod, interprofessional learning; flexible, life-long learning; and rewarding creativity
Politicians in government	Concentration on politics of health; swayed by short-term media and electoral cycles; focus on politics over policy; pegging quality measures to health care processes or protocols	Full engagement in improvement of care and services; promotion of change based on merit; recognition of policy over politics; shaping policy to engender professional pride and trust
Politicians in opposition	Opposition to every government proposal: the "politics of destruction"	Judgement of proposals on their intrinsic worth; advancement of sound alternative policies: the "politics of construction"
Bureaucrats	Focus on bolstering the current government's short-term political agenda; "keeping the minister off the front page"	Focus on medium- to long-term planning and improvement of population health and services delivery
Managers	Management in hierarchical rather than collegial ways with clinicians; micromanagement; favouring financial management over quality of care	Promotion of partnerships with clinical staff; exhibiting equal concern for financial performance and quality of care
Media	Sensationalising heath care stories; focus on blame rather than cause; distortion and misrepresentation of events; emphasis on the rare, not the common	Provision of more balanced, nuanced accounts of the complexities of health care; promotion of scientific and medical literacy; focus on improvement in communication
Trade unions, associations	Undue focus on member interests at the expense of other interests (including patient interests)	Engagement in "special pleading" only in the light of other stakeholder interests
Universities	Organisation into monodisciplinary faculties; orientation is markedly commercial	Full focus on interprofessional learning principles; focus on creating educational value
Professional colleges	Excessive focus on member needs and "closed shop" behaviours; unwillingness to negotiate boundaries with other colleges and groups	Development of more pluralistic interests; focus on working productively with other colleges and groups; separation of education from accreditation
Funding agencies	Focus on incremental, marginal research gains; fund distribution via inappropriate criteria or political pressures	Support for bolder, more innovative (even radical) ideas; creation of defensible and transparent resource distribution policies
Regulatory bodies	Representation of single professions in separate jurisdictions; protection of practitioners; adversarial approaches to disciplinary matters	Support for interdisciplinarity; representation of needs of patients and professions; conciliatory approaches to disciplinary matters

* Prevailing or increasingly evident values. † Values we should be striving to enact. ◆

sectional interests jeopardises collective wellbeing, as was seen in the recent international banking crisis, and is occurring with deforestation and climate change. We need to reorient the system, aiming to satisfy the needs of the whole community, and taking a less inward, narcissistic focus.

A proposal for embracing the common good

How will a transformation from the present — where stakeholders run things their way, on their terms, and self-interest is increasingly evident — be achieved? How can we reach a more sophisticated view of individuals' and groups' places in society, as productive contributors and partners working towards common goals? There are behavioural examples which reflect the kinds of deeply held tenets that need to be supported: doctors emphasising health prevention, promotion and the long-term health of patients; nurses striving for patient outcomes; managers stimulating genuine teamwork and improved quality of care; and policymakers promoting collaborative, systems-wide efforts.

We believe that many stakeholders are looking for leadership, willing to support it and prepared to embrace change if the appropriate conditions are established. We need new levels of mutual understanding between all the parties, committing them to behave differently toward each other. Then, and only then, will any federally initiated reform plan broaden into something seriously possible, and worth doing.

Can we get to this stage? Are we being excessively optimistic? In a modern psychology classic,[11] Howard Gardner examined how to get people to think differently, and he specified how leaders could induce groups to change their mindsets. He argued that there were seven levers for change, which he called the "seven Rs":

- **reason** involves employing logic and weighing factors so that people are persuaded about the potential change
- **research** is adduced by collecting, analysing and interpreting data to bolster the argument
- **resonance** means that something has to "feel right" to be supported
- **redescriptions** are used to assist in convincing people, that is, the core message is recoded in several forms, because different people respond to different messages
- **resources** and **rewards** are important to support the planned change
- **real world** views of people should be acted on, to try to create a mind shift
- **resistances** (factors which solidify into resistance to change, or disagreement with the proposed change) should be identified, and attempts made to nullify them.

Government plans usually try to grind the gears of reason (the population is in favour of the general logic of health care reform) and resonance (the public suspects intuitively that reform is overdue). The public have noted that the states and territories have been provided with resources and rewards by the federal government in the past round of reform proposals. However, how they will flow to the stakeholder groups to act as incentives for them is not clear, particularly with the reshaped national political landscape since the August 2010 election. The NHHRC's precursor report provided some research (but not randomised controlled data, of course) in support of a revamped health system. More work is likely to be needed by the new government, if they want to pursue reform, to recode their message into redescriptions for various stakeholder groups (after all, how many of us, apart from academics or policy wonks, will, in reality, read lengthy policy reports?). Redescriptions should be designed to overcome various resistances which coagulate whenever reform is proposed. As far as real-world values are concerned, we have made explicit what we believe they are now, or are becoming, and should be encouraged to become, in Box 2.

We must realise that a wellness-oriented health system based on explicit normative values will require a forceful triggering mechanism and a galvanised, critical mass of participants. It might begin with patients demanding a better health system, or some stakeholder groups articulating a shift in perspective, armed with a negotiated blueprint for the future. Local leaders can be catalysts. But it is more likely to be initiated and implemented by a seriously talented, reforming prime minister or health minister. Like or loathe them, those with courage, in the mould of previous reformers such as prime ministers Gough Whitlam (1970s social reforms), Bob Hawke and Paul Keating (1980s macro-economic reforms), health minister Neal Blewett (1980s introduction of Medicare and national HIV/AIDS strategy) and Victorian premier Jeff Kennett (1990s micro-economic reforms and privatisation) are role models. We rarely see such audacious single-mindedness today, and it might be more difficult in a compromise minority government. Will we see bold reformers standing up in the modern era?

What we have seen is a range of measures to put the federal government's current reform proposals into effect (Box 3). While commentators will no doubt feel the package is supportable within the current paradigm, it is unlikely to be a game changer in the way we are advocating.

3 Examples of policy and legislative reform measures[12]

Issue	Measure
Institute national health and hospitals reform	Introduce structural reforms to establish local hospital networks and alter hospital funding arrangements for the federal government to assume responsibility for 50% of the costs of growth in funding; introduce other measures such as a 4-hour rule for emergency departments, and targets and more resources for surgical throughput
Develop "Medicare Locals"	Form independent primary health care organisations with formal links to local hospital networks
Strengthen the Australian Commission on Safety and Quality in Health Care	Establish the Commission as an independent, permanent statutory authority under the National Health and Hospitals Network Bill 2010
Support GP super clinics	Encourage more GP super clinics
Provide prescribing rights for nurse practitioners and midwives	Give nurse practitioners and midwives access to the MBS under the Health Legislation Amendment (Midwives and Nurse Practitioners) Act 2010
Accelerate e-health initiatives	Progress the introduction of e-health measures, including personally controlled e-health records
Establish the National Preventive Health Agency	Address a range of initiatives targeting lifestyle risk factors for chronic disease and tobacco control under the Australian National Preventive Health Agency Act 2010
Reform PBS pricing arrangements	Make a range of alterations via the National Health Amendment (Pharmaceutical Benefits Scheme) Bill 2010
Create a "MyHospitals" website	Provide information about performance, such as waiting times in public hospitals in all states and territories
Develop regional health services	Following discussions with the independent parliamentary members, initiate a regional health package, providing for improved regional infrastructure, health and hospitals, and education

GST = Goods and Services Tax. GP = general practitioner. MBS = Medicare Benefits Schedule. PBS = Pharmaceutical Benefits Scheme. ◆

Conclusion

Despite these measures, we do not have a health system with re-engineered values. Changes that former prime minister Kevin Rudd and health minister Nicola Roxon initiated in the last government, and are now Ms Roxon's and prime minister Julia Gillard's to prosecute, do not support such a health system. Mr Rudd and Ms Roxon have ignored present and potential values, as did prime minister John Howard for 11 years. This is where passion, not technical financial solutions and fundamental change, and not merely structural redrawing of local hospital boundaries, is required.

If there was an inkling that the new government was willing to articulate an argument grounded in values, a plan for implementation as useful as Gardner's, and reform based much more on improving health rather than alterations to the structure,[13,14] people might be more encouraged. Fresh thinking like this is needed in the new parliament. Otherwise, we may risk seeing no real lasting reform, continue to lament lost opportunities, fail to provide the underpinnings to Van Der Weyden's "innovative and revolutionary reform", and encounter, with perpetual deja vu, many more inquiries and reports into our health system. That will be in no one's interests.

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Competing interests

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