

Progressing health reform through collaboration and community engagement

In the recent Chris Selby Smith Oration at the 2017 Shape International Symposium, the orator, Stephen Leeder presented on 'the desirability of zero tolerance for procrastination' [1] and that oration is published in this issue for you to read and reflect on. His words resonated with the audience at the time and raised the question for us as to why health reform and innovation in healthcare are so difficult to achieve. After all, we are continually being asked to adapt reform and address the challenges inherent in the system.

We have immeasurable data and the literature is replete with debate about how we address specific challenges, but we seem to respond with the oft used refrain of 'admiring the problem' but often not taking any positive action to address. We have a highly developed health system that we regard as complex and difficult to change. Alford [2] has for some time reminded us to ask when considering the challenges, whose interests are being served. The structural interests are 'well in play' in health systems and not necessarily serving the interests of communities and, Dwyer [3] was right to question us as to 'what problem are we attempting to resolve'.

Despite good comparative performance generally at the national and aggregated data level the challenges are described as the financial sustainability of the health system with increasing demands on the 'public purse'; [4] inappropriate care and technology use; [5] overuse and underuse in healthcare [6] cost and utilisation of drugs [7] and healthcare variation, generally. [8] We could and should add to this list of challenges, the mostly unseen social gradients of socio-economic determinants of health (SEDoH) rightly identified by Leeder [1] in his drive from the Hills District to Mount Druitt in Sydney in the diminished life expectancy between suburbs along the way. Similarly, variability and poorer life expectancy can be expected on a much longer drive through rural NSW, along the New England Highway to the Queensland border and beyond. Yet these disparities fail to gain much attention from our policy makers and health providers. They are largely unseen but provide a disproportionate cost to our health system and demonstrate a lack of concern over access and equity in our health system.

We live in a federated nation of states and territories established more than a century ago. An arrangement that persists and has not changed much in structure, delivering to us some nine or so Ministers of or for Health, Assistant ministers and an array of bureaucracies at each level to be concerned with a population of some 24 million. Compare this with other nations that have a national system, one Minister and a handful of agencies that manage services in an innovative context to in excess of a population of 60 million! [9] Rapport and colleagues remind us that our federated approach in Australia has led to 'increased bureaucracy, imposed solutions, many policies and protocols' [10] as also described by Sturmberg. [11] Health policy development in Australia is essentially internalised within the bureaucracies and negotiated through an overarching Australian Health Ministers Advisory Committee (AHMAC) and the Council of Australian Government (COAG). Despite the promised review of the Federation, progress and improvement will most likely be incremental.

Despite the bureaucracies, healthcare is essentially a human service. [12] People, health professionals and communities working in cooperation with each other. In earlier times but less than fifty years ago this connection was much stronger with communities establishing hospitals, aged care facilities. Government interest and the process of slowly taking control [13] only emerged when government recognised the cost and financial implication of the growth in community controlled services. Currently the emphasis of this control has moved the focus from community participation and ownership to the 'business model' of healthcare where the prior connections have become a casualty of the focus on the 'economic bottom line'. This focus on 'bottom line mentality' is said to have done much to 'erode public trust' amongst other things. [13, p.149]

We the citizens and our communities substantially fund the health system; this implies that we have a collective responsibility for the moral stewardship of the resources. [13] The impact of the bottom line, efficiency focus and the bureaucratic domination of health systems have seen community engagement reduced to an 'advisory role'. Part

of the solution of course is for health organisations to have 'a broader focus on corporate citizenship' and a greater focus on a 'triple bottom line of ethics, community and wellbeing as well as the concern for economic profits' or balanced budgets. [13, p.149]

There are compelling reasons for improved community and stakeholder engagement in healthcare systems. It should be a compelling feature of democratic societies where people are meant to 'have a right to a direct and meaningful voice about issues and services that affect them.' [14, p.14] The value of community engagement is evidenced in policies such as localism and in the principle of subsidiarity [15] and essentially suggest that services should be delivered and managed locally to meet local needs and decision-making should be made at the lowest level of government that can effectively be achieved. In addition in health systems now facing an array of non-communicable diseases (NCD) within an ageing society no one 'person, organisation or sector working alone' can solve these challenges. [14, p.15] If communities are not engaged then it is difficult to suggest that others have the capacity to solve those problems on their behalf.

Others suggest that community can be defined as a group of people, geographically defined with shared social identity that may also include entities such as local government, local health and community- based organisations, business and other groups. [16] One of the 'defining characteristics of primary healthcare from that of general care is community engagement.' These authors go on to suggest that 'in the interest of equity, it is imperative that the most vulnerable community members are part of the decision-making process' [17, p. 399] and that 'collaborative processes empowers individuals and builds social relationships between people can be health promoting in and of itself – even if it does not solve any community health problems.' [14, p.34] These authors suggest that a highly participative collaborative process suggests a community health governance (CHG) model.

Healthcare 'has an important role in addressing the social determinants of health' even though 'the main determinants of health inequity lie outside the healthcare system.' [18, p. 182] Social capital is an important talisman for addressing the social determinants. The human resource component of social capital must be adequately embedded in communities for them to not only survive but also thrive in healthier contexts. Often the health professionals employed and living within a community provide much of the social capital and its leadership both within the community and

within the organisation in which they are employed. Where services are delivered from a distant location and staff visit or 'fly in and out' there is a distinct loss of community social capital.

Values and culture contribute to social capital within communities and organisations and some suggest that we should focus on a culture of health more so than healthcare. [19] Others suggest that we need to build social capital 'to strengthen the ethics and safety of our cultures, teamwork and patient care' and that health systems need to have a 'goal of creating reliable networks' for this purpose. [13, p.136] Strengthening social capital within organisations require groups and networks, trust and solidarity, collective action, cooperation, information, communication, social cohesion and inclusion. [13, p.146] These authors and others suggest that social capital and participatory, collaborative community engagement 'individual empowerment, the bridging of social ties and synergy within organisations and communities' to strengthen and enhance capacity in community problem solving. [14, p.17] These approaches suggest the emergence of action at the local level is preferable rather than top down directive control and is said to require a different kind of leadership and management from that required to deliver health services.

Given our propensity to procrastinate and just admire the problem, where do we go from here? The complexity of the issues and the challenges presented in this editorial do to some extent explain our hesitancy to act. However, the continued practice of the delivery of a standard range of services, often described in terms of a 'hub and spokes' approach, particularly in primary healthcare, is not going to produce improved health outcomes. We need to understand and accept that health needs and priorities vary across communities and geographic regions. Access to services is equally variable as is the availability of a skilled workforce, increasingly so in regional, rural and remote areas.

However, in my view, the important first step is to recognise that we need to change our approach. We need to change our view of communities from that of recipients of services we determine they need to one that gives them an equality of status as a stakeholder and a partner with those charged with funding and/or delivering health services. This then empowers communities to be part of the solution to addressing the challenges they and the data correctly identifies. This inclusive approach might then lead to increased purpose to the social movements inherent in communities that see them fundraising for charitable purposes and actively participating in healthy lifestyle

activities described in the media daily of 'fun runs, group walks, bike riding, community gardens' This is the social capital that we should build on for planning, improvement and development of healthier communities and relevant services.

Rather than procrastinating it would be good to see some pilot projects advanced that might test out how localised emergent practices can be advanced that also cross organisational boundaries in innovative ways!

DS Briggs

Editor

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