Building a Culture of Health

Commentary and published research on the value of healthcare has become more evident in recent times. There has been a noticeable shift from the focus on efficiency of health systems and practice to a greater focus on what effectively works, or more so, what doesn't work. Health delivery systems struggle with increased demand on existing services and other health priorities remain underserviced. What do we need to do to better examine and understand what delivers value to people, communities, the health system and at the same time improves health outcomes?

Most recently Hillis and colleagues addressed the 'increasing concern about the sustainability of healthcare in the Organisation for Economic Co-operation and Development (OECD) countries' with their focus on the variation in the cost of surgery. [1, p. 153] They accurately described expenditure per capita, the rise in out of pocket (OOP) expenses with most of the funding being public expenditure and the challenges of private health insurance, with significant rises in OOP and insurance premium costs.

These authors use a definition of value 'as the health outcomes achieved per dollar', describing the importance of measurement to that definition and go on to provide examples of costs, using hip replacement surgery as an example. [1, p.153] They describe variation in costs within the public sector and between it and the private sector in their example. They conclude that the variability provides opportunity to further reduce length of stay without reducing quality and potentially save money and hence, increase value. Importantly they call for greater transparency and accountability through reinforcing an earlier call to make reports more publicly available. [1]

Balaji Bikshandi, [2] a specialist intensive care physician, draws on Tantalus from Greek mythology to provide a wider perspective to the debate about value in our health system. Leaving Tantalus's difficulty of attaining low hanging fruit and water aside he suggests that 'modern scientific medicine is confronting a litany of similar phenomena', to that faced by Tantalus. He evidences 'antibiotics to address infections presenting us with antibiotic resistant bacteria, prosthetic devices presenting an array of new problems, pharmaceuticals with adverse reactions and interactions, even automated alarms leading to alarm fatigue and being recognized in some specialties as a significant safety issue'.

Adam Elshaug, a Professor of Health Policy and a 2010-11 Commonwealth Fund Harkness Fellow in Health Care Policy and Practice, recently responded to questions about 'combatting overuse and underuse in healthcare' [3] based on his and others contributions to a special issue of The Lancet on this topic. [4] He suggests that the problem of use and underuse of healthcare may be worse than that currently envisaged and he suggests that 'we might be going in the wrong direction'. [3] He then emphasises the fact that worthy inexpensive interventions go unused or underused while some 'high cost services of little or no value are commonplace'. Elshaug then goes in the direction of Bikshandi and his reference to Tantalus [2] about the difficulty of addressing continuing use of unnecessary 'tests, treatments and procedures'. [3] Elshaug addresses the disconnect of research evidence and the public health agenda. Public education and empowerment are proffered as useful directions, the variability in quality of guideline production is a challenge, the potential of technology as part of a solution is before us and reform to payment systems is also in the future. Importantly, he is optimistic about the future because the problem is now well known and cannot be avoided by adherence to the status quo. [3]

These challenges described above are not new but perhaps better understood. We could discuss pharmaceutical use, for example, both costs and utilsation and find fertile ground there about not just cost but over utilisation. [4] There is a lack of equity of access to more appropriate care and prescribing becomes the treatment of choice. If you want to delve further into the world where we could do better, delve into the analysis from an OECD study that explores healthcare variation in Australia. [5] Variation matters and some of it is readily explained. Unwarranted variations raise questions about quality, equity and efficiency in healthcare. [5]

It is not just about the way clinicians work but is more systemic than that. Look at population health planning in the primary health networks and the link between socioeconomic determinants of health and the analysis by local government area is compelling in identifying geographic locations of poor health outcomes of discrete communities, within a national health system that is generally, highly regarded. [6] All of us who work in a health professional context need to be active about how we might shift the focus from addressing process performance in a healthcare focus to address wider perceptions about system wide health outcomes. [6,7] Importantly, addressing the issues discussed may well require us to determine how we value health ahead of a more current focus on valuing healthcare. [9,10]

Fortunately, the Robert Wood Johnson Foundation (RWJF) has been exploring the potential in this change of focus from valuing healthcare to valuing health since its adoption of 'developing a culture of health.' [10] This culture is built on 10 underlying principles, describes action areas and associated drivers, together with data measures and has recently been further described in an issue of Health Affairs. [10,11] Chandra and colleagues suggest that this approach requires 'shared values around health and social and emotional wellbeing', a focus on health not healthcare, the alignment of 'core values for cultural change'. [12, p. 1959]

The RWJF approach is compelling and requires cross sector collaboration. The approach highlights the need for managers and leaders to be prepared to be boundary riders and that in the United States, at least cross sector networks 'are a common way to tackle complex issues, including population health…'. [12, p.1960] Hogg and Varda [13] suggest that there is increased interest in integrating social and medical care and Glen and colleagues [14] described value being achieved in multisector networks with a reduction in health disparities. Weil emphasises:

> That if there is one notion that captures what is needed to create a culture of health, it is that existing boundary lines must be crossed. Whether it is the public and private sectors, the health and social sectors, or the silos that exist within the health care system, a new culture requires combined efforts that remove the barriers that each has placed around its work. [11,p.1947]

This is the fundamental challenge for Australia and many other countries that are still focused on just addressing the 'self-inflicted Tantalus' outcomes of a healthcare system focus that continues to present us with the problems that this internalised focus has delivered! The challenge for Australia is how to cross sectors within the health sector let alone lifting our vision and culture to multisector approaches focused on health.

Government policy aligning PHN and LHD boundaries could be taken as permission to act. Perhaps we should adapt a RWJF framework to say to the health, education, social care and local government sectors that they should move to cross sector collaboration?

Government could require these sectors to demonstrate in their funding allocations and published performance reports that their respective sector and organisational entities have a vision and strategy that articulates collaboration in advancing health and wellbeing as part of an ongoing and systematic process. [14] Health outcomes could include measure around how many collaborations are active, including their breadth, quality and the extent of resource commitment made by all partners and how communities are included in those collaborations.

The current complexity of Commonwealth-State relations in healthcare should not be allowed to continue to be used as an excuse for inaction. Perhaps we should start with understanding the difference between valuing health ahead of the current focus on valuing healthcare might be a start. Reading about the culture of health at http://www.rwjf.org/en/how-we-work/building-a-culture-of-health.html is a good starting point, further informed by the references in this editorial.

Secondly, it is already within the realm of Primary Health Networks (PHNs) in Australia to make contracted funding arrangements that require partnerships and collaboration with other providers and communities. Perhaps Local Health Districts (LHD) could follow that approach by subcontracting out those services they deliver that might be better delivered in primary health and community contexts to providers who are also prepared to collaborate and partner. Perhaps PHNs and LHDs could achieve this change in culture together. Perhaps State and Territory and Commonwealth Agencies could adopt a policy position that values health.

The author would be interested in your thoughts on a change of direction and culture.

Dr DS Briggs
Editor

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