Principles for Australia's Health System

Executive Summary

The Royal Australasian College of Physicians provides the following submission to the NHHRC, addressing the Principles for Australia's Health Care System:

People and family centred:

The health system should:

- Focus on health care team management of chronic disease;
- support and encourage ambulatory and community based programs;

Equity

The health system should:

- Address socioeconomic determinants of health;
- Foster a whole of government approach;

Shared responsibility

The health system should:

- promote community and health care teams working across many settings;
- Provide ready access to evidence informed health information at all levels of care;

Strengthening prevention and wellness

The health system should:

- Be supported in the coordination of prevention strategies by a National Public Health/Prevention Institute;
- Give consumers capacity to be involved in prevention strategies;

Comprehensive

The health system should:

- Integrate generalist physician care within primary and ambulatory care;
- Co-locate physician practices and community health care organisations;

Value for money

The health system should:

- Address inequalities which are a significant barrier to care;

- Promote evidence based early interventions that save health costs;

Providing for future generations

The health system should:

- Invest significantly in new medical technologies which reduce health costs;
- Invest in evaluation of new models of care;

Recognise broader environmental influences which shape our health

The health system should:

- Consider environmental factors in a global context;
- Focus on environmental influences on population health;

Taking the long term view

The health system should:

- Address workforce issues to ensure adequate future services;
- Invest in information technology infrastructure for the future;

Safety and Quality

The health system should:

- Deliver patient centred care within multidisciplinary teams;
- Invest in quality training across the whole health system , and place value on hospitals as training and education facilities;

Transparency and accountability

The health system should:

- Ensure industry sponsorship and promotion is appropriately regulated;
- Encourage physician autonomy and better prescribing practice;

Public voice

The health system should:

- Engage the population on health promotion and management issues;
- Build health literacy and help patients to help themselves;

A respectful and ethical system

The health system should:

- Assist health care professionals in managing their relationships with industry;
- Develop procedures for managing conflicts and dualities of interest;

Responsible spending on health

The health system should:

- focus on prevention and better management of chronic illness;
- Improve access to all services through innovative spending on health care models;

A culture of reflective improvement and innovation

The health system should:

- Be effectively engaged in innovate decision making and promotion of clinical effectiveness;
- Adequately fund training and development of the health workforce.

People and family centred

The College recognises the many challenges to providing a family centred care approach for physicians who predominantly provide tertiary level health care following referral. The role of general physicians in primary and ambulatory care is to be encouraged. The literature suggests that patient attitudes and behaviour are increasingly based on personal choice and are less dependent on tradition and social connections.[1] We also know that the family structure has changed over the past two decades, families are now less cohesive, family members are more autonomous and parenting has become less controlling. [2]

One aspect of patient and family centred care concerns sharing the management of an illness between patient, family and physician. This approach has a good base in the evidence based literature especially for chronic conditions such as diabetes, asthma and arthritis.[3] [4] The literature acknowledges that patient-centred care results in increased adherence to management protocols, reduced morbidity and improved quality of life for patients.[5] For a patient centred approach to function effectively, and result in improvement of population health, there has to be a commitment to community-based services and programs.

In 2004 to demonstrate the Colleges' commitment to developing a culture of people and family centred care the College conducted a three day workshop for leading physicians on how to move from an individual approach to caring for people with chronic conditions to a multi-disciplinary approach.[6]

Equity

The Royal Australasian College of Physicians (RACP) has identified health inequities as one of the most pressing health problems facing Australia today.[7] The College believes that it is the responsibility of the Federal Government to provide clear and non-partisan leadership with the following recommendations that are supported by a growing body of world-wide evidence.

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[1] Ester P, Halman L, Moor R de. Value shifts in western societies. In: Ester P, Halman L, de Moor R, eds. *The individualizing society: value change in Europe and North America*. Tilburg, Netherlands: Tilburg University Press, 1993:1-20.

[2] Swaan A de, In care of the state: health care, education, and welfare in Europe and the USA in the modern area. Cambridge: Polity Press, 1988.

[3] Wagner EH, Austin BT, Von Korff M, Organizing Care for Patients with Chronic Illness *The Milbank Quarterly*, 1996; 74 :(4): 511-544.

[4] Grumbach K, Chronic illness, comorbidities, and the need for medical generalism Annals *of Family Medicine* 2003; 1:4-7.

[5] Bauman AE, Fardy HJ, Harris PG. Getting it right: why bother with patient-centred care? *Med J Aust.* 2003 Sep 1; 179(5):253-6.

[6] Cottrell Report 2004 - Managing Chronic Conditions 2004. Available at http://www.racp.edu.au/page/health-policy-and-advocacy/workforce

[7] RACP, Inequity and Health A Call To Action Addressing Health *and* Socioeconomic Inequality *in* Australia, 2005.

The link between socioeconomic status and significant influences on morbidity and mortality has been the subject of a considerable body of research in Australia. [8] [9] Such research provides the basis for the argument that socioeconomic status has an influence over the differential experience of subgroups in society of rates of disability, chronic disease and the use of the health system.[10] [11]

Australia's overall good health is *not* shared by all Australians.

It can be argued [12] [13] that the highest health risk and determinants of health are systemic, located within complex, social institutions and organisations including families, communities and workplaces. On every indicator of social and economic disadvantage people suffer poorer health.

For Government:

- That the Federal, State and Territory Governments make immediate commitments, both strategic and financial, to improving the quantity and quality of health care services in the poorest and most disadvantaged communities;
- That the Department of Prime Minister and Cabinet at the Commonwealth level and the Premiers' Departments at the State level be nominated as the accountable department for 'whole of government' responses to health inequities;
- That the Department of Prime Minister and Cabinet and the Premiers' Departments, as part of their leadership role, commission equity-focused Health Impact Assessments for all significant developments that could affect health inequities;
- That the Australian, State and Territory Governments consolidate a coordinated universal approach to early childhood promotion, prevention and early intervention activities to ensure that all children get a fair start in life. The Directors-General/Secretaries of all relevant Government departments such as Health, Community Services and Education should be made accountable for the achievement of key performance indicators related to the health, development and wellbeing of all children;
- That the Federal, State and Territory Governments should adopt targets to close the gap in educational opportunities between different social groups. All

[8] National Health Strategy, *Enough to make you sick. How income and environment affect health.* National Health Strategy Research Paper No 1. September 1992. ISBN 0 642 18377 5
[9] Legge D, *The evaluation of health development: the next methodological frontier?* ANZ J PH 1999; 23:117-118
[10] Report by the Social Exclusion Unit, *Bringing Britain together: a national strategy for neighbourhood renewal*. Presented to parliament by the Prime Minister. http://www.cabinet-office.gov.uk/seu/1998/bbt/nrsum.htm
[11] WHO. *The solid facts. Social determinants of health*. Eds Wilkinson R and Marmot M. 1998. ISBN 92-890-1287-0
[12] Syme SL. T*o prevent disease: The need for a new approach*. Sited in Blane D, Brunner E, Wilkinson R. (1996) Health and Social Organisation: Towards a health policy for the 21st Century. Internet Journal of health promotion. 1998. URL:http://www.monash.edu.au/health/IJHP/verona/1
[13] Putnam RD. (1993) *The prosperous Community: Social capital and Public Life*. Blane D, Brunner E, Wilkinson R. (1996) Health and Social Organisation: Towards a health policy for the 21st Century. Internet Journal of health promotion. 1998. URL:http://www.monash.edu.au/health/IJHP/verona/1

Directors-General of Education should be made accountable for the achievement of key performance indicators.

For the Health Sector:

- That all health care organisations, at national, state, regional and local levels, develop an explicit plan of action to reduce health inequities for the populations they serve and in the services they deliver.
- That all health care organisations make such plans publicly available and report annually on progress. This will require the development of new and more appropriate information systems.
- That all health care service delivery and training organisations recognise the need for cultural competency in healthcare service delivery and include specific training at all levels of education and professional development.

Shared responsibility

Shared responsibility implies a sense of mutual obligation from both the health system and the consumer to each contribute towards improving well-being. One of the best approaches to shared responsibility is where management includes the community and involves a team of health professionals working together across many settings. Consumer care needs are integrated by increasing consistent communication between professionals about the management in individuals and their families. The success of integrated care requires that people I have access to, and be able to afford, quality medical care and treatment.

Consumers of health have the capacity to contribute to their health and well-being and require access to reliable evidence informed medical information. In the United Kingdom the "Map of Medicine" offers high quality, evidence based clinical information to health care professionals.[14] This portal serves as a single healthcare knowledge source to speed the delivery of evidence based best practice across healthcare organisations. The Map of Medicine currently includes clinical information from 28 specialties organised over 390 pathways and equivalent to over 6000 printed pages. Pathways include clinical knowledge across the patient journey from diagnosis to treatment, providing a single resource across primary and secondary care settings.

Information for consumers is important in determining the best strategy for their current health problem. Consumers may have difficulty in determining the real value to them of a particular health service. Patient information often resides with numerous service providers, with no one (provider or patient) in possession of the complete picture of current patient care, health status, recent tests performed, test results etc. This not only results in duplication, but also limits the capacity of consumers to participate intelligently in decisions about their own care and in the practice of effective self-care.[15]

To provide the best environment for a shared responsibility the College recommends:

- Develop a model similar to "the map of medicine that has the following features:

[14] http://www.mapofmedicine.com/what_is_the_map.php
[15] Segal L, The importance of patient empowerment in health system reform *Health Policy* 1998; 44: 31–44.

- designed to improve consumer care, and is a vital component of a Healthcare IT program that will ensure appropriate clinical actions are triggered directly from the interface;
- supports healthcare planning;
- easy to localise and represent pathways for health or social care;
- enables demand management including getting the right information to health professionals to achieve correct referrals;
- facilitates coordination between health and social care;
- provides knowledge support, guidance and searching for the latest evidence;
- supports professional training and development.

- The adoption of an empowerment model that can contribute to efficiency by ensuring the market is driven by the (well informed) preferences of consumers.
- Health services to provide the mix of services that best meets the needs of consumers (in terms of their contribution to health and well-being).

Strengthening prevention and wellness

An integrative approach incorporating lifestyle modifications, such as changes in diet and nutrition, physical activity and exercise, adopting stress management methods, and strengthening social networks to lower an individual's risk of specific diseases can improve overall health. Assisting people to reduce their harm through smoking tobacco and consumption of high risk or risky alcohol having particularly important roles.

When consumers are given the capacity to take steps to prevent chronic conditions such as cancer (as opposed to treating it once people have developed the disease) this has shown to have a large impact on cancer mortality rates.[16] Current cancer interventions have produced only a small decrease in mortality rates where seven million deaths from cancer worldwide in 2001, were attributable to nine modifiable risks factors, all of which are preventable and controllable. In other words, preventing the disease could cut mortality rates by one-third.

Comprehensive

Health systems which include strong primary medical care are more efficient, have lower rates of hospitalisation, fewer health inequalities and better health outcomes, including lower mortality.[17] [18] [19]

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[16] Danaei G, Vander Hoorn S, Lopez A, Murray C, Ezzati M. Causes of cancer in the world: comparative risk assessment of nine behavioral and environmental risk factors. *The Lancet*. 2005; 366; November 19.

[17] Forrest C, Whelan EM. Primary care safety-net delivery sites in the United States: a comparison of community health centres, hospital outpatient departments, and physician's offices. *JAMA* 2000; 284: 2077-2083.

[18] Starfield B. Is strong primary care good for health outcomes? In: Griffen J, editor. The future of primary care. London: Office of Health Economics, 1995.

[19] Shi L, Starfield B. The effect of primary care physician supply and income inequality among blacks and whites in US metropolitan areas *Am J Public Health* 2001; 91: 1246-1250.

During 2006–07, there were 90.6 million attendances with general practitioners billed to Medicare, and 80 per cent of the Australian population visited a GP at least once in the year.[20] [21] The burden of chronic diseases and their risk factors is large and increasing, with an increasing proportion of the population having more than one chronic illness or risk factor for chronic illness.[22] The scale of these emerging health problems cannot be managed effectively by specialist services working in isolation from generalist primary care services.[23]

Accordingly the College believes that any reform of the Australian health system must involve efforts to strengthen and integrate generalist physician care with primary medical care.[24]

There is an under-valuing of the generalist skills required to assess a broad range of health problems and manage them in a patient-centred way.[25] The erosion of support for the generalist role is partly due to over specialisation within health care and a failure of education. This has increased the trend towards specialties and sub-specialists, despite the evidence of increased costs and decreased coordination.

One approach the College is investing in is to bring together physician practices with Aboriginal Community Controlled Health Services. These facilitate a basis for greater integration between physician practice and primary health services.

Value for money

Persistent socio-economic inequalities within particular populations in Australia, combined with a greater severity of market failures affecting lower socio-economic groups, seem to have contributed to significant inequalities in health outcomes which, unless tackled, will present a significant barrier to many in society becoming "fully engaged". To undertake the challenge of reducing health inequalities within the health system and to deliver the largest possible improvements in the delivery of these services with finite resources depends on building a body of knowledge about which interventions are the most cost-effective. The economic evaluation of interventions in the delivery of health requires designing rigorous evaluations of health interventions.

To ensure value for money the College recommends:

- Guarantee equity is addressed within existing frameworks of economic evaluations;

[20] Britt H, Miller GC, Charles J, Bayram C, Pan Y, Henderson J, et al. General practice activity in Australia 2006–07. General practice series no. 21. Cat. No. GEP 21. Canberra: Australian Institute of Health and Welfare. 2008.
[21] Medicare Australia, Medicare Australia 2005–06 annual report. Viewed 1 June 2008, <www.medicare.gov.au/about/about_us/annual_report/ 05_06/statistics/mcare22.shtml>.
[22] Australian Institute of Health and Welfare, Diabetes: Australian facts 2008. Diabetes series no. 8. Cat. No. CVD 40. Canberra: AIHW 2008.
[23] Browne G, Roberts J, Gafni A, et al. Economic evaluations of community-based care: lessons from twelve studies in Ontario. *J Eval Clin Pract* 1999; 5: 367-385.
[24] Harris MF, Harris E, Facing the challenges: general practice in 2020 MJA 2006; 185 (2): 122-124.
[25] Ramachandran A, Asnastasopoulos C. Death of the generalist. *Aust Doctor* 2006; 3 June: 1.

- Promote interventions that are evidence-based, though the lack of conclusive evidence should not, where there is serious risk to the population's health, block action proportionate to that risk;
- Promote the right of the individual to choose their own lifestyle must be balanced against any adverse impacts those choices have on the quality of life of others.

Providing for future generations

The College recommends a change in thinking by physicians and an increased focus on critical appraisal of the effectiveness of health care technologies and the structure and financing of health care systems. Physicians should be obliged to provide leadership in determining value for money in the choice of health care for specific patient populations and how that care is delivered.

The College believes that new medical technology, especially hospital care and pharmaceuticals that underpins more than a third of the growth in health costs over the past decade is responsible for the rapidly increasing health costs. [26] The College recognises that it is individual physicians, who are gatekeepers in prescribing new medications, drive this expenditure, with patients contributing less than 20 per cent of total health spending in the form of the Medicare levy and health insurance premiums.

Future research is needed to explore Australian specialist-physicians' views, attitudes and barriers to participation in future research to promote a positive attitude to research. A study of physicians and their attitude to research found that strategies for providing the necessary time, resources and opportunities for research while reducing the workload for trial participation were needed.[27]

The College believes the following research topics need to be explored in more detail:

- How to recognise and develop strategies to address institutional racism;
- What are the best investments that strengthen communities so that they can support their families and children effectively;
- How best to equip physicians to practise in a new way and thrive in new organisational environments that require a rapid response to reshape curricula and training programmes;
- How do Colleges maintain a sustainable development of the 21st century health workforce;
- How are changes in the external environment affecting the physician workforce;
- What are the implications of new emerging models of service provision and modes of practice for the physician workforce; and
- what challenges do these emerging models present for the development of the current health workforce and the training and development of new physicians.

Recognise broader environmental influences which shape our health

[26] Scott IA, Is modern medicine at risk of losing the plot? MJA 2006; 185 (4): 213-216.
[27] Caldwell PHY, Craig JC, Butow PN, Barriers to Australian physicians' and paediatricians' involvement in randomised controlled trials *MJA* 2005; 182 (2): 59-65.

When considering the broader environmental problems the College recognises that environmental issues are broader than just climate change. The environmental challenges are also about obesity, tobacco smoking and ageing. These issues have to be considered within a global context.[28]

The greatest share of health problems in Australia is attributable to the social conditions in which people live and work, referred to as the social determinants of health. People in lower socioeconomic groups die younger and suffer more serious illness than those in higher groups. At any point on the social scale, people have, on average, better health than those below them on the scale and worse health than those above them. This is partly due to individual lifestyle factors: for example, people in lower socioeconomic groups are more likely to smoke tobacco, to smoke more, to consume alcohol at a high risk or risky way, to exercise less and to have a poorer diet.

Increasing proportions of Australians are overweight or obese, with as many people in the world overweight as underweight. Increasing obesity is a serious public health as well as economic problem. Its associated greater risks of high blood pressure, heart disease, osteoarthritis, type 2 diabetes, some cancers and other health problems consume considerable proportions of healthcare budgets.[29] Health inequalities often reflect social inequalities, but with overweight there is also a male-female difference in the relationship between overweight and socioeconomic status.

The challenge for physicians particularly public health and community paediatricians is to strengthen community leadership, address social and environmental causes of ill health, and link with primary care (a) to improve the health of populations and (b) to combine perspectives in commissioning services. Current threats derive from organisational philosophies. For example, focusing on market development does not allow for population based functions and so neglects the main influences on health. One way forward is a network model of organisation in which small teams collaborate with each other to the common good. For example, successful commissioning authorities would have the public health leadership of the director of public health and the support of the chief executive, treasurer, and representatives of primary care, including a medical adviser from the family health services authority.[30]

The College believes that there needs to more information available

- improved 'nutritional literacy" in schools;
- treatment strategies must involve lifestyle modification, with a reduction of energy intake and an increase in physical activity
- regulating the nature and amount of food advertising directed at children;
- providing high-quality recreation areas, safe cycle paths and safe street lighting in local neighbourhoods;
- improving public transport;
- providing economic incentives for production and distribution of vegetables and fruit; and
- developing town planning policies that promote active or public transport over private motor cars.

[28] Leeder SR, Raymond SU, Greenberg HM The need for leadership in global health *MJA* 2007; 187 (9): 532-535.
[29] Eckersley RM Losing the battle of the bulge: causes and consequences of increasing obesity *MJA* 2001; 174: 590-592.
[30] Watkins SJ, Education and debate For Debate: Public health 2020 *BMJ* 1994;309:1147-1149

Taking the long term view

The College's vision for 2020 is for a first class health service delivering first class care to people in Australia. The gap in inequalities would have closed particularly for Aboriginal communities, people will have access to affordable health care with limited waiting times. Food and housing would be improved; there would be investment in information technology with physicians spending more time focusing on developing partnerships and working in multidisciplinary teams.

For this to occur changes are required in the skills mix to meet the shortfalls in health workforce. Over the next two decades people will be living longer, people will be enjoying a greater quality of well being and there will be a sharp decline in smoking and obesity, and a widespread public involvement in health care. There will be an immediate investment in information technology with the modernisation of primary health.

Safety and quality

Over the past decade there has been intense scrutiny over adverse events in particular medication errors and a rigorous media and consumer call for more professional accountability in relation to physicians and their relationship with the pharmaceutical industry. Improving safety and quality of health care for physicians requires the delivery of a patient-centred care within multi disciplinary teams, and the use of evidence-based and ethical practice, quality improvement approaches and information technology (IT).[31]

The College's new education curriculum has moved away from the traditional model of classroom teaching to more case studies, role plays, professional mentoring, hypothetical scenarios, seminars, videos, project work, log books (MyCPD), teaching by patients (real, standardised or simulated) and carers and peer review. The College is reviewing possible roles for the patient as educator. It sees the patient's role in physician education as a valuable potential resource particularly in discussion groups, problem-based learning groups, simulations and interactive seminars on topics such as management of chronic diseases, risk communication and adverse events. Patients are increasingly involved in the assessment of communication skills and could also be used in assessing risk communication. [32]

The College's therapeutics expert advisory group is developing an on line teaching module to fit into the education curriculum with the National Prescribing Service (NPS). The aim of this module is to highlight the principles of quality use of medicines (QUM) and will focus on the following key areas:

- the life-cycle of pharmaceuticals in Australia and the role of the pharmaceutical and health technology sector;

[31] Walton MM, Elliott SL, The Safety and Quality Of Health Care: Where Are We Now? Improving safety and quality: how can education help? *MJA* 2006; 184 (10 Suppl): S60-S64.
[32] Rees C, Sheard C, McPherson A, Communication skills assessment: the perceptions of medical students at the University of Nottingham *Med Educ* 2002; 36(9):868-878.

- the role of objective information and prescribing data in QUM, including obtaining and assessing relevant evidence;
- the influence of the pharmaceutical and health technology sector on clinical practice;
- understanding product promotion and marketing techniques; and
- what kind of interaction is ethically appropriate, with reference to RACP's Ethical Guidelines in the Relationship between Physicians and the Pharmaceutical Industry.

Transparency and accountability

The College believes that the issue of physician-industry interaction is one of the most complex and pressing within our health care system. Because of their position in the health system, physicians are actively targeted by the pharmaceutical and other industries seeking to promote and sell products.

There now exist a number of systematic reviews of the published literature that clearly show the impact of industry sponsorship and promotional activity on physicianly practice. Among other things they show:

- that frequent contact with industry representatives is associated with changes in prescribing practice, with a trend towards newer and more expensive drugs;[33]
- that sponsorship of educational and conference travel results in a many fold increase (4.5 to 10) in the prescription of the industry sponsor drug; [34]
- that receiving gifts from industry is strongly associated with the belief that industry representatives have no effect on prescribing practices; [35]
- that accepting and using samples are associated with awareness, preference and rapid prescription of a drug; [36] [37]
- that up to 25% of all clinical trial investigators have industry links [38] and that such links introduce systematic bias into research outcomes.[39]

Through a series of targeted education initiatives, to encourage physician autonomy and better prescribing practice by improving the critical appraisal skills of physicians in their interactions with the pharmaceutical and health technology industries

[33] Wazana A. (2000) Physicians and the pharmaceutical industry: is a gift ever just a gift? *JAMA*, January 19 283 (3) 373-380.
[34] Wazana A. (2000) Physicians and the pharmaceutical industry: is a gift ever just a gift? *JAMA*, January 19 283 (3) 373-380.
[35] Wazana A. (2000) Physicians and the pharmaceutical industry: is a gift ever just a gift? *JAMA*, January 19 283 (3) 373-380.
[36] Wazana A. (2000) Physicians and the pharmaceutical industry: is a gift ever just a gift? *JAMA*, January 19 283 (3) 373-380.
[37] Groves KE, Sketris I, Tett SE (2003) Prescription drug samples--does this marketing strategy counteract policies for quality use of medicines? *Journal of Clinical Pharmacy & Therapeutics.* 2003 Aug; 28(4):259-71.
[38] Bekelman JE, Li Y, Gross CP. (2003) Scope and impact of financial conflicts of interest in biomedical research: a systematic review. *JAMA.* Jan 22-29; 289(4):454-65.
[39] Lexchin J, Bero LA, Djulbegovic B, Clark O. (2003) Pharmaceutical industry sponsorship and research outcome and quality: systematic review. *BMJ*, May 2003; 326: 1167 - 1170.

Public voice

Following the 2020 Summit there is now a good opportunity to engage the population on the issue of their own health and the balance between an individual's right to choose and the impact that individual behaviour has on the well-being of others. In particular the College would like to address the issue of environmental tobacco smoke and how this affects children.

In the UK there has been a call for a new focus on moderating demand by investing in effective health promotion and disease management with the active involvement of individual patients and local communities. Achieving this involves promoting the concept of self care or self management with the patient as the expert. By encouraging patients to adopt healthy behaviours and to diagnose and treat minor ailments, involving them in treatment decisions, and supporting them in active self management of chronic conditions.

Drawing on a survey of 8672 adults selected at random in Australia, Canada, New Zealand, the United Kingdom, and the United States the study focused on patients' experience in primary care. It found that 43 per cent of Australia patients reported that their doctor always tells them about treatment choices and asks for their ideas and opinions.[40] A growing body of evidence shows that patient engagement in treatment decisions and in managing their own health care can improve patients' experience and often results in more appropriate and cost effective utilisation of health services and better health outcomes.[41]

The College believes that the key to greater patient engagement lies in building health literacy and ensuring that physicians help patients to help themselves. In addition to the potential for achieving greater efficiencies in resource use, and promoting involvement, empowerment, and a sense of ownership of their health care could be the best way to ensure that people adopt healthier lifestyles. For public health policy to be realised, paternalism must be replaced by active encouragement of patients to participate in their own care.

A respectful and ethical system

The College in its third edition of *Guidelines for ethical relationships between physicians and industry* [42] aim to assist health care professionals in managing their relationships with industry to develop more accountable and transparent strategies when dealing with complex ethical dilemmas. The College believes it is vital that patient care and science are unaffected by industry affiliations of health care professionals. The guidelines recommend that health care organisations develop procedures for managing dualities or potential conflicts of interest situation before they escalate into major ethical issues.

Accordingly the College recommends that:

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[40] Schoen C, Osborn R, Huynh P T, Doty M, Davis K, Zapert K, et al. Primary care and health system performance: adults' experiences in five countries. *Health Aff* 2004;10.1377/hlthaff.w4.487.

[41] Coulter A. *The autonomous patient*. London: Nuffield Trust, 2002.

[42] RACP, Guidelines for ethical relationships between physicians and industry 3rd Edition 2006. http://www.racp.edu.au/page/publications-and-communications

- every organisational or practice setting a group of individuals should be identified with responsibility for ensuring that processes exist for identifying issues and developing policies relevant to relations with industry in that particular setting. This function may be taken on by a pre-existing body such as an Ethics Committee or a Conflict of Interests Committee may need to be established.

- Details of membership of this group and the outcomes of its deliberations should be publicly available.

- The group, or those delegated by it, should have responsibility for deciding how to respond to complaints, inquiries and changing circumstances.

Responsible spending on health

The College believes that responsible spending on health means focusing on prevention and better management of chronic illness. This will require targeting populations with the greatest need, especially Indigenous communities, establishing better links between primary, acute and rehabilitative services, and developing innovative ways of delivering health care to rural and remote communities. [43]

The College also believes that by improving access to all services through better emergency care, reduced waiting, increased booking and more patient choice will improve the patient journey through hospitals.

- Improved outcomes in cancer, CHD, mental health and older people;
- Improving life chances for children;
- Improving the patient experience;
- Reducing health inequalities;
- Contributing to the cross-government drive to reduce drug misuse.

A culture of reflective improvement and innovation

New forms of leadership are required for the health system to be effectively engaged and involved in innovative decision-making and promoting clinical effectiveness. One strategy tried in different countries is shared governance and shared leadership that ensures the delivery of health services are jointly owned and organised. This includes consumer involvement at the very beginning of the patient journey – a part of the clinical process redesign. [44] Allowing staff to have the capacity to be involved in the redesign is a challenge that requires effective planning, preparation and commitment. Establishing the process of shared governance requires effective leadership, implementation of a suitable framework, multidisciplinary working and examination of the organisation's structure and culture. Shared governance is a system of management and leadership that empowers all staff in decision-making processes. [45]

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[43] Armstrong BK, Gillespie JA, Leeder SR, Rubin GL, Russell LM, Challenges in health and health care for Australia *MJA* 2007; 187 (9): 485-489.
[44] Phillips PA, Hughes CF, Clinical process redesign – can the leopard change its spots? *MJA* 2008;188: 6: S7
[45] Geoghegan J, Farrington A, Shared governance: developing a British model *British Journal of Nursing* 1995; 4 (13), 780–783.

The core business of the College is to train future physicians and to assist these trainees become leaders in medical innovation for the future. Shared governance therefore is an important component of the clinical governance agenda, vital for effective leadership and creation of a learning organisation such as the College. It will provide a framework for physicians as they move into careers health care to work together and to develop multi-disciplinary approach to service delivery. Shared governance is widely recognised as having benefits in empowering practitioners from a variety of settings.[46] [47] [48]

[46]Heard SR, Schiller G, Aitken M, Fergie C, McCready Hall L, Continuous quality improvement: educating towards a culture of clinical governance *Quality in Health Care* 2001; 10:70-78.
[47] McSherry R, Kell J, Developing practice network Practice development or service improvement: are they the same? Practice Development in Health Care 2007; 6: (4): 245 – 248.
[48] Girvin J, Leadership and nursing. Part 2: styles of leadership *Nursing Management* 1996; 3 (2), 20–21.