Are we talking reform, REFORM, REFORM or Healthcare improvement in the Australian Healthcare system?

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Of late, 'Reform' has become an Executive Tourette-like utterance in the Australian healthcare sector. However, the nature of the reform, the specific goals and benefits, the risks, and how success will be measured is often poorly described or absent. This short article attempts to create a framework and language to discuss healthcare reform to allow policy and funder decision makers to better plan and communicate their reform agenda.

Even in these times when the Australian Healthcare System, along with all other healthcare systems in the world, is focused on responding to the COVID-19 pandemic, healthcare policy and funder decision makers still wish to, and need to, see the healthcare system reform. There is an extensive literature on reform failures across every industry and health is no exception. Arguably the health industry (as a very complex, adaptive system) is the most challenging of all and reform needs to be expertly planned and delivered.

It is helpful to start with a definition of 'reform'. There are many ways of describing reform and an internet search will bring up many similar definitions, most of which can be summarised as follows:

> Reform: to become better, or to improve or make something better, by making corrections or removing faults.

The definition can apply to an individual, organisation, or system. In this paper, our focus is the Australian Healthcare System.

Reform is a type of change and the change management literature has many categorisations of change. These categorisations generally describe change on both the extent (whole of system to targeted) and impact (small steps to transformational). It is important to note that transformational change is a significant and lasting change to the way a system or organisation operates.

One of the interesting points about the definition of reform, and it's use to describe change in the health industry, is that it gives no clue as to the extent or impact of the intention to make something better.

Any discussion of reform in the Australian Healthcare System needs to be clear about both the extent and the impact of the reform that is to be pursued. For simplicity, we would like to propose three tiers of reform:

1. Bold **REFORM**: where nearly all elements of a system will be different because of the reform (core transformation). Examples of Bold **REFORM** in the Australian Healthcare System include:
    a. the introduction of Medicare;
    b. the introduction of activity based funding in public hospitals; and
    c. the 2011 National Health Reform Agreement that required new organisational structures for state and territory health systems, the

introduction of national health targets, and the increase in the proportion of Commonwealth funding for activity growth in public hospitals.

2. Major REFORM: where significant change is required or sought in many elements of a system (targeted transformation). Examples of Major REFORM are:
    a. the deinstitutionalisation of mental health services;
    b. the introduction of a digital MyHealth Record for all Australians;
    c. the introduction of digital health records in General Practice and public hospitals; and
    d. the creation of Primary Health Networks.

3. Focused reform: where an element of a system looks to make small step-wise improvements or change the way that it operates (targeted and stepped). Examples of Focused reform are:
    a. Specific initiatives to improve operational efficiency: e.g. theatre utilisation process improvements;
    b. Targeted improvements to improve patient flow and models of care; and
    c. the introduction of health screening and vaccination programs.

Using a three-tier approach to reform (**REFORM**, REFORM and reform) allows everyone to understand the extent and impact of the reform being considered.

As a deliberate intervention into a system, it is important to clearly define the components of reform to be able to communicate effectively. There are many ways of categorising the components of reform. The following five-component categorisation attempts to balance the enormous complexity of reform with the need to have a simple way of describing what the reform is attempting to achieve. The five components are:

1. Benefits (B): measurable improvements to be achieved because of the reform.
2. Risk Management (RM): a description of possible events or conditions that could negatively impact on the achievement of the reform, and the successful mitigation of these risks.
3. Change Management (CM): a description of the differences between current and future states across people (structures, capabilities, capacity), processes, and technology to achieve the reform and the defined approach to achieving this.
4. Funding ($): the investment that is required to achieve the reform.
5. Time (T): the allocated time in which the reform will occur so there is a clear start and a clear end to the reform.

All these components interact with each other to achieve reform in the following way: the desired reform can only be achieved when the risks and change are managed to deliver the benefits along with the right level of investment and allocation of time. This can be described as a relationship as outlined below, where reform is possible only when the risks and change are managed successfully to fully achieve the benefits, the level of investment is sufficient to achieve this balance, and the time allocated will allow the reform activities to be fully undertaken.

$$\text{reform} = \frac{b}{rm + cm} + \$ + t$$

The relationship between benefits, risk management, change management, investment and time is the same regardless of the type of reform that is being proposed: **REFORM**, REFORM or reform. The only difference is that, as the extent and impact of the reform increases, the risk and change management requirements also significantly increase thus making it more challenging to achieve the benefits of the reform. This can be described in the following way where risk and change management are increased by a factor of two or three for REFORM and **REFORM** respectively:

$$\text{REFORM} = \frac{B}{RM^2 + CM^2} + \$ + T \qquad \textbf{REFORM} = \frac{\mathbf{B}}{\mathbf{RM^3 + CM^3}} + \mathbf{\$} + \mathbf{T}$$

All successful reform, regardless of whether it is reform, REFORM or **REFORM** starts with a clear description of the reform in an evidence-based way and a clear and measurable description of the benefits, risk management, change management, investment and time requirements. Without these evidence-based and measurable descriptions, the commitment of the people required to lead the reform, and the engagement of the people whose hearts, minds and work are needed to achieve the reform, will be compromised.

The above is self-evident for REFORM and **REFORM**. Big changes carry big risks and governments usually allocate funding for effective change management and risk mitigation. Benefits are also usually clearly specified and measured to justify the funding. It is also worth noting that these reforms also frequently involve financial incentives and/or penalties for key players.

Focused reform is where it gets interesting. We contend that focused reform should not be confused with healthcare improvement as the approach needs to be quite different. Focused reform is usually top down and designed to achieve clear step-change improvement. Like the other types of reform, clearly specified benefits, risks, change management, investment and time is central to success. Healthcare improvement on the other hand is usually more organisationally dispersed, requires clinical acceptance and leadership, occurs incrementally over time, and usually starts from the bottom-up with system support.

Arguably, healthcare improvement is the main path to health system improvement and sustainability as it changes actual clinical practices and treatments. However, it is not amenable to top-down mandates. Braithwaite, one of the most respected researchers and leaders of quality and safety in Australian healthcare, describes this beautifully in his article *Changing how we think of healthcare improvement* (BMJ, 2018). He describes health as a complex, adaptive system and notes that:

- *The key measures of health system performance have frozen for decades—60% of care is based on evidence or guidelines; the system wastes about 30% of all health expenditure; and some 10% of patients experience an adverse event*

- *Proponents of change too often use top-down tools such as issuing more policy, prescribing more regulation, restructuring, and introducing more stringent performance indicators*
- *We must move instead towards a learning system that applies more nuanced systems thinking and provides stronger feedback loops to nudge systems behaviour out of equilibrium, thereby building momentum for change*
- *Effective change will need to factor in knowledge about the system's complexity rather than perpetuate the current improvement paradigm, which applies linear thinking in blunt ways*
- *Yet we should recognise how truly hard this is in the messy, real world of complex care.*

Braithwaite argues for *a new mental model that appreciates the complexity of care systems and understands that change is always unpredictable, hard won, and takes time, it is often tortuous, and always needs to be tailored to the setting.* This type of change is emergent; leverages informal as well as formal systems; uses a range of improvement techniques customised to local settings; and has communication, trust and relationships at its heart.

System wide improvement teams have a key role but their modus operandi is very different to reform; they support a 'learning system' and use data and feedback to drive change at the clinical coal face.

So, if the goal is healthcare improvement, it is important to call it that and use improvement methodologies. If the goal is **REFORM**, REFORM or reform, we need to make sure the investment and time is sufficient to deliver the change, manage the risks and successfully deliver the benefits.

The international guru of benefits management, Steven Jenner, dares us to ask the questions that others don't and to identify the assumptions that masquerade as facts or as Shakespeare asks in Twelfth Night *are we wise enough to play the fool?*

So, the next time you hear someone utter health reform, ask them:

1. Do you mean reform or do you mean healthcare improvement?
2. If you mean reform, do you mean reform, REFORM or **REFORM**?
3. What is your clear and measurable description of the reform, including the benefits, risk management, change management, investment and time requirements?
4. Is the planned investment, time and change management sufficient for the extent and impact of the reform?
5. How will you measure success?