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Perspective

Lessons for the Australian healthcare system from the Berwick report

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Abstract. There are common key recommendations in the raft of recent reports from inquiries into hospital quality and safety issues, both in Australia and in the United Kingdom. Prime among these is that governments, bureaucrats, clinicians and administrators must work together to place the quality and safety of patient care above all other aims in the healthcare system. Performance targets and enforcement, although needed, are not the route to improvement; what is required is a change in culture to drive a system of care that is open to learning, capable of identifying and admitting its problems and acting to correct them, and where the patient's voice is always heard.

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Every day our healthcare system improves and even transforms the lives of millions of Australians, but too often it falls short and, sadly, sometimes fails miserably to deliver what patients and taxpayers deserve.

Australia is not alone; these are problems regularly confronted elsewhere and tackling them has proven immensely difficult. This paper looks at what Australia can learn – must learn – from the raft of reports that have recently been produced here (Box 1) and in England (Box 2) from inquiries into hospital quality and safety issues.

Why have there been so many inquiries when the problems are so well known? 'When governments are struggling to govern and the media are strident, inquiries proliferate.'[11] The problems have also been so intractable and entrenched that for besieged governments and bureaucrats it is often easier to institute another inquiry in the name of action than tackle the real issues. As the King's Fund pointedly remarked, 'The real challenge is not the diagnosis and prescription for the problem, it is ensuring that the remedy is administered effectively'.[12]

Box 1 Australian reports

King Edward Memorial Hospital Inquiry (Douglas Inquiry), November 2001.[1]
Canberra Hospital Inquiry, December 2003.[2]
Campbelltown and Camden Hospitals Inquiry (Walker Inquiry), July 2004.[3]
Bundaberg Hospital Commission of Inquiry (Davies Inquiry), November 2005.[4]
Royal North Shore Hospital Inquiry, December 2007.[5]
Garling Inquiry Special Commission of Inquiry into Acute Care Services in New South Wales Public Hospitals, November 2008.[6]

The Francis, Keogh and Berwick[8–10] reports from the UK traversed the same territory as the Australian inquiries but were arguably more direct in stating the changes that needed to be made. Many of these recommendations are directly applicable to Australia. For example, the Francis report showed that a focus on reaching national access targets and finances came at the cost of delivering acceptable standards of care and discouraged staff from raising concerns when they recognised that such standards were not being met.

Under the National Partnership Agreements on Improving Public Hospital Services, significant Commonwealth funding is provided to reward jurisdictions that meet national targets for emergency department access and elective surgery. Berwick cautions against the use of quantitative targets; although he acknowledges that they can 'have an important role en route to progress' he also says 'they should never displace the primary goal of better care'.[10] His report finds that the threat to patient safety from the inappropriate use or gaming of performance management targets remains a high risk, particularly in the context of political pressures, increased fiscal constraints, and public concerns and media reports on waiting times for care.[10]

The key recommendation highlighted by all the reports is that what goes on in hospitals is about patients and the quality and

Box 2 National Health Service reports

The Bristol Royal Infirmary Inquiry, 2001.[7]
Mid Staffordshire NHS Foundation Trust Public Inquiry (Francis Report), February 2013.[8]
Review into the quality of care and treatment provided by 14 hospital trusts in England (Keogh Report), July 2013.[9]
A promise to learn – a commitment to act. Improving the Safety of Patients in England (Berwick Report), August 2013.[10]

safety of patient care must be placed by all parties – governments, bureaucrats, clinicians and administrators – above all other aims. Patient care is their fundamental, core duty. That does not preclude efforts to reduce costs, increase efficiencies and restructure and reform systems, but these efforts cannot be at the expense of providing best-quality, safe care.

The breakdown of working relations between clinicians and management is a constant refrain. It seems that this is because they do not have the shared goals outlined above. The Garling report found that intimidation and intolerance of dissent threatened not only morale but also transparency, accountability and trust.[6] As Berwick indicates,[10] that inevitably leads to situations where problems are not reported in a timely and appropriate fashion, meaning there is no growth of knowledge and no ability to correct them or ensure that they do not happen again.

Voluntary reporting from the frontlines of healthcare can capture the complex causal links between events and harms that coded data cannot. When accountability and voluntary reporting is short-circuited by fear or perverse incentives, the only way problems come to light is through whistleblowers and the media. The Berwick report calls for the system to 'foster wholeheartedly the growth and development of all staff, especially with regard to their ability and opportunity to improve the processes within which they work'.[10]

Despite the establishment of bodies such as the National Health Performance Authority, the Australian Council on Healthcare Standards, the Australian Commission on Safety and Quality in Health Care, state bodies such as the New South Wales Clinical Excellence Commission, and the My Hospitals website, Australia struggles to publicly report on the quality and safety of patient care inside hospitals. This reflects a global inability to evaluate progress toward improving patient safety. As Pronovost and Wachter state, 'Sadly, when it comes to our national effort to improve patient safety, we do not know today whether the glass is half full or half empty'[13] and this is despite key reports more than a decade ago that drove the patient safety agenda in the United States.[14,15]

If we are genuinely to have a patient-focussed, safer healthcare system then more must be done to ensure that the patient's voice is heard and heeded at all times, even when it is a whisper. As Berwick points out, this does not mean simply engaging people in a discussion about services; the goal is to achieve 'a pervasive culture that welcomes authentic patient partnership'.[10] A side benefit of achieving this goal will surely be that the community will better understand the decisions, choices and trade-offs that must be made in the provision of healthcare services for all Australians. The Australian Commission on Safety and Quality in Health Care has begun important work in this regard and this needs to be brought front and centre in the healthcare system.

In 2009 the editor of the *Medical Journal of Australia* was moved to comment on the 'pervasive sense of loss – loss of control, loss of direction, and loss of ownership by the hospitals' serving health professionals, politicians, and the community'[16] that the public airing of unsolved problems in quality and safety bring.

In response we should be guided by an Australian paraphrase of Donald Berwick's letter to the people of England.[17] He challenged the people in the National Health Service to abandon 'a culture of fear, blame, recrimination, and demoralisation', to work to make the National Health Service a 'learning system', and to have confidence to speak up everywhere and all the time. Australians too should be able to 'imagine [a healthcare system] where everyone, all the time, was part of that journey, and has the respect and tools to improve'.

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