What Do Effective Consumer-Centred Health Services Look Like? Providing a positive and beneficial approach to the consumer:health system interface, through the Five 'I's Framework

Charlotte Korte, Sue Claridge, Denise Astill and Katherine Gibbons

Health Consumer Advocacy Alliance, PO Box 32 445 Devonport, Auckland 0744, New Zealand
info@consumeradvocacyalliance.co.nz | http://consumeradvocacyalliance.co.nz

Abstract

Recent health reforms in Aotearoa New Zealand have led to an increased focus on the importance of engaging effectively with consumers, including how health care professionals and health consumers should work in partnership for health and well-being. Despite this apparent placement of health consumers/patients at the heart of the health system, the centuries old patriarchal approach to health care, which places health professionals at the heart of the health care model has been difficult to repeal. The experience of many people in our health system is one of discrimination and bias; lack of or poor communication; delayed diagnosis or misdiagnosis; incorrect, inadequate or incompetent treatment; breaches of their rights; and treatment injury and adverse events. What is required is a paradigm shift in the approach to health care, one that focuses on: more collegial relationships among health professionals; the concept of whakawhanaungatanga; interdisciplinary and integrated care guided by integrity, transparency and accountability; and assigning the health and well-being patients/health consumers the utmost importance. This paper provides the background to the modern health care and health system setting in Aotearoa New Zealand, and proposes a new model of health care services provision – the Five 'I's Framework; an holistic and integrated approach to health care with ethics at its heart. The Five 'I's Framework provides a focus on cohesive integration that is applicable to all health care settings and services. It is a new model that focuses on both consumers and health professionals, and aligns with the principles and philosophies of Māori models of health.

Key Words: interdisciplinary, integrated, interrelated, intergenerational trauma, trauma informed practice, health equity, consumer engagement, consumer-centred, co-design, collegial relationships, whakawhanaungatanga, transparency, health system reforms, health care model.

Background

In 2018, the Aotearoa New Zealand Health and Disability System Review expert panel was charged with recommending "system-level changes that would be sustainable, lead to better and more equitable outcomes for all New Zealanders and shift the balance from treatment of illness towards health and wellbeing."[1]

In 2020, the final report of the review made a substantial number of recommendations, which together represented a major overhaul of the way in which our health system is structured and managed. Among many other changes, these health reforms led to an increased focus on the importance of engaging effectively with consumers. This consumer focus includes the way in which health professionals should empower their patients to take an active role in managing their own health; and how health care professionals, and health consumers (patients)* and health consumer advocates should work in partnership. What does this really mean, how does it fit into

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* The terms 'health consumers' and 'patients' are used throughout this paper. All patients are health consumers, but not all health consumers are patients or regard themselves as patients, especially in the context of normal life events such as pregnancy, and those working as consumer advocates.

practice and is our health system a place where consumers can achieve this? Will improving interactions with and between colleagues and patients help to alleviate the intractable problems we face in the health sector today? How do we ensure that consumers are equal partners in the co-design process, with consumer well-being the shared priority?

Many health consumers/patients feel like they are lost in a health system in which they are forced to go around in circles, constantly repeating their experience of living with often complex health issues, and reporting their symptoms to different health practitioners. Patients often feel as if they are not having their health needs met, are not being listened to properly, and that they are not considered as a 'whole' human being.

Countless media articles,[2, 3, 4] anecdotal evidence, and clinical research[5, 6, 7, 8, 9] show many women's health issues are simply not being addressed appropriately. Men, who are often reluctant to attend doctors' appointments, or even talk about their health needs, are also struggling in our overstretched and overburdened health system. Our hospital system is being portrayed as a "health system sinking deeper into crisis, with emergency departments overflowing, patients experiencing long delays for treatment, and nurses leaving in droves for Australia."[10]

The recent overhaul of the health system in Aotearoa New Zealand was a chance for health entities and individual health practitioners to reflect on how we deliver health care services in this country; to define and characterise the critical issues that our health professionals face; and ascertain what is contributing to, and negatively impacting on consumers in our health system today.

Past failures of our health system to address the needs of health consumers are, in part, owing to a failure to engage properly and listen to people. The failures begin at the 'coal face', in primary care appointments with patients, and continue all the way through the sector right up to the development of policy. At the highest level, health entities and our legislators are making important decisions that affect all New Zealanders, often without adequate consumer engagement. The benefits of improved consumer engagement include a greater understanding of the factors contributing to ill-health and thus more effective prevention strategies.

A patient-centred health system is one in which consumers are at the heart of, and are involved in, all aspects of health care: legislation/regulation, policy, development, design, implementation, research and service provision.

"Patients and families should be involved at every level of health care, ranging from policy-making and planning, to performance oversight, to fully informed consent and shared decision-making at the point of care."[11]

The Code of Expectations for Health Entities' Engagement with Consumers and Whānau/Te tikanga mō te mahi tahi a ngā hinonga hauora ki ngā kiritaki me ngā whānau (Code of Expectations) sets out the expectations for how health entities must work with consumers, whānau and communities in the planning, design, and evaluation of health services in Aotearoa New Zealand.[12] The code is required by the Pae Ora (Healthy Futures) Act 2022 and was established by Te Tāhū Hauora | Health Quality & Safety Commission (HQSC) with consumer engagement and consultation. Its development was an attempt to promote the need for, and to improve, consumer engagement by providing a more formal framework. The Pae Ora legislation states that "Health entities must act in accordance with the code." (Subpart 6, Section 60).[13]

Under the Pae Ora (Healthy Futures) legislation, health entities include Health New Zealand/Te Whatu Ora, HQSC, The Māori Health Authority/ Te Aka Whai Ora, Pharmac and the New Zealand Blood Service (Part 1, Section 4).[13]

Manatū Hauora | Ministry of Health, the Health and Disability Commission (HDC), and the Accident Compensation Corporation (ACC) are not identified as health entities required to act in accordance with the Code of Expectations under the legislation.

The Health Consumer Advocacy Alliance believes that this must change; that all health entities, regardless of any legislative restrictions,* must act in accordance with the Code of Expectations. It is not sufficient for these entities to just say they will act in good faith and with intent to align with the Code of Expectations in their Statement of Intent. Legislation and policy that govern those entities must also be amended to ensure they comply with, and demonstrate how they will meet, the standards set out in the Code.

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* the justification provided to date for some health entities not being required to act in accordance with the Code of Expectations under the legislation.

Amending current legislation as part of formal reviews is one way to do this, such as the review of Health and Disability Commissioner Act 1994 being undertaken this year, or the addition of secondary legislation. Generally, matters of significant policy and principle are included in an Act, while secondary legislation usually deals with minor or technical matters of implementation and the operation of the Act. However, the distinction is not always "clear-cut, and some matters may be appropriate for both primary and secondary legislation. Secondary legislation often involves some policy, but this should be at a lower level than the policy in the Act."[14]

If Aotearoa New Zealand truly wants transformative change in the health system, then all health entities must revise their thinking, and be willing to implement tangible change to ensure that health consumers are truly at the heart of the health system at all levels. Health entities must think 'outside the square'; they must find novel ways to make changes to ensure their policy and internal processes are consumer-centric, and that recommendations for action are solution-based.

It has become evident that there are significant shortfalls in the health reforms in Aotearoa New Zealand. These shortfalls, and the current state of our health system, are contributing to health professionals being unable to "provide safe and timely care".[10, 15, 16, 17]

At the primary health care level there are too few GPs;[18] many are retiring, leaving the profession or choosing to relocate overseas.[19] This places an even greater burden on remaining GPs and the entire system.[20] When people cannot receive timely care from their GP they are often forced to seek urgent care services,[21] especially at accident and emergency departments in our hospitals[22, 23, 24, 25] placing further pressure on those services.[26] Since the reforms have been implemented, consumers and health professionals have been speaking out about their concerns and have publicly shared their fears about patient safety.[27, 28, 29] Both patients and health professionals are questioning whether these "changes move us any closer to equity in outcome for Māori, or a sustainable health system."[30] The health workforce crisis is widening the equity gap, and a 2022 survey of more than 900 doctors in Aotearoa New Zealand across 30 subspecialities of medicine found that "we are at risk of catastrophic collapse of the health-care workforce".[31, 32]

However, at a much deeper level, it is how consumers are treated on an individual basis that needs more scrutiny, regardless of whether our health system is performing at an optimum level (or not) and if these reforms were worth it.

The Consumer Experience in Our Health System

During public consultation on the Pae Ora (Healthy Futures) Bill in 2021, feedback from health consumers in many written submissions revealed that women are less likely to be listened to by health professionals, and often passed around to different doctors and specialists, with little consistency or continuity in care. However, this issue does not just pertain to women, and the way in which health consumers from all demographics are being treated needs to change.

Health consumers face a wide range of negative and harmful experiences in their interactions with health services providers, including but not limited to:

- racism;[33, 34, 35, 36]
- gender bias;[37, 38]
- disrespect and loss of dignity; being patronised or their concerns dismissed;[2, 39, 40, 41, 42, 43]
- diagnosed with somatic[*] or functional disorders; accused of being drug seekers, attention seekers or malingerers;[43, 44, 45, 46]
- lack of, or poor, communication;[39, 42, 43]
- misdiagnosis or delayed diagnosis;[39, 42, 47, 48]
- insufficient or misleading information about their condition and/or treatment;[39, 43]
- breach of informed consent rights[43, 49, 50] including in teaching hospitals;[51, 52]
- incorrect, inadequate or incompetent treatment, insufficient follow-up or referral, incorrect prescriptions or medication error;[39, 42]
- treatment injury, adverse events.[43, 53, 54, 55]

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[*] Somatisation is defined as "a maladaptive functioning of an organ system, without underlying tissue or organ damage, or where the symptoms are disproportionate to the underlying structural cause." Somatic disorders can also be called functional disorders or factitious disorders. Such diagnoses are often used when a patient's symptoms cannot be readily explained by an identifiable disease, often when patients present with complex health issues and the health practitioner is unable to make a concrete diagnosis.

Dr Tedros Adhanom Ghebreyesus Director-General of the World Health Organization states that "If it is not safe, it is not care."[56]

The increasing number of complaints received annually by the Health and Disability Commissioner (HDC)[†] and the complaints Nationwide Health and Disability Advocacy Service are indicative of the negative and harmful interactions and inadequate care that consumers experience in the provision of both public and private sector health care services. In the year to June 2022, the HDC received 3413 complaints (the Advocacy Service received 2971 complaints),[49] compared with less than half the number of complaints a decade earlier when they received 1,564 in the year to June 2012.[57] The most common primary issues in complaints made to the HDC over the last four years include: inadequate/inappropriate treatment; missed/incorrect/delayed diagnosis; inadequate/inappropriate examination/assessment; failure to communicate effectively; disrespectful manner/attitude; delay in treatment; unexpected treatment outcome; and inadequate/inappropriate care.[49]

The lack of informed consent has also typically been a significant cause for complaint with the former HDC Anthony Hill writing that "The issue of informed consent, which lay at the heart of the Cartwright Inquiry and is the cornerstone of the Code of Health and Disability Services Consumers' Rights (the Code), continues to be raised in complaints to HDC."[49] Consent is an issue that is prominent in complaints to the HDC virtually every year.[58]

Overt gender bias and racial discrimination only serves to exacerbate existing inequities and disparities for women, Māori and Pāsifika, and disabled people.

For example, the Accident Compensation Corporation Aotearoa (ACC)[*], Aotearoa New Zealand's national no-fault injury insurance scheme, recognised inequities and discrimination for women, Māori and Pāsifika in a series of briefings, obtained by *Radio New Zealand* under the Official Information Act in 2021.[59] The results of their analysis were consistent with international research that "has found that women, indigenous people, and people of colour are all more likely to be seen as exaggerating, malingering or drug-seeking when accessing healthcare."

Injured New Zealanders are reliant on their health care provider lodging a thorough and adequate claim form to ACC. Once accepted, patients are considered 'covered' by ACC for their injury and can receive treatment from a range of health practitioners.

ACC's data analysis confirmed that "clinicians' lodgement decisions may be impacted by scheme complexity and gender bias, and women were more likely to have claims for injury compensation declined."[59] The likelihood of claims being denied can be exacerbated by the way in which health professionals complete the forms, resulting in inherent inequities and barriers within the ACC process. Without private health insurance, reliance on our stretched and overwhelmed public health system means that patients can wait for months, sometimes years to receive help. Such delays can contribute to the onset of new co-morbidities that may not have presented if they had been seen earlier.

The reality is consumers need to be better served by health professionals and health entities.

The History of Consumer Engagement in New Zealand

There are several rationales that justify the benefits of consumer engagement; "citizen participation rights, empowerment of consumers, enhancing accountability, legitimating decision made by managers and health professionals, and to achieve more responsive and acceptable services and improvement in the quality of health care".[60]

The concept of formalised consumer engagement, or consumer representation is not new. From the mid-1990s there had been an increasing number of calls for public and private agencies in the health and disability sectors to engage with consumers and to involve consumers in their decision-making and/or governance.[60] Subsequently, in 2004, a discussion document written

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[†] The Health and Disability Commissioner promotes and protects people's rights as set out in the Code of Health and Disability Services Consumers' Rights. This includes resolving complaints about infringements of those rights by health and disability services providers in a fair, timely, and effective way. Resolution of more serious complaints may involve investigation by the HDC.

[*] The Accident Compensation Corporation is a Crown entity responsible for administering the Aotearoa New Zealand's no-fault accidental injury compensation scheme, commonly referred to as the ACC scheme. The scheme provides financial compensation and support to citizens, residents, and temporary visitors who have suffered personal injuries. It very largely removes the ability of New Zealanders to seek redress against a defendant through the courts when injury is suffered.

by Sandra Coney for the New Zealand Guidelines Group (NZGG) was published: *Effective Consumer Voice and Participation for New Zealand: A Systematic Review of the Evidence*.[60]

This review of consumer engagement found that "To date in health care consumer participation has largely been occurring on terms by non-consumers".[60]

This finding is consistent with the centuries old concept of a patient; a person who, in the medical context, is one who 'patiently' allows "things to be done to them", as opposed to being a health consumer whose relationship with health care providers is equal, one of partnership. With the traditional patient-doctor relationship there is a distinct lack of equality, an imbalance of power, and the medical/health system was entirely able to ignore people's views and concerns.

In Aotearoa New Zealand, health consumers didn't have any formalised rights until after the Cartwright Inquiry and Report.[61] This Inquiry, and the recommendations that came from it, led to the establishment of the Health and Disability Commissioner in 1994[62] and the development of Code of Health and Disability Services Consumers' Rights in 1996.[63]

To date, there has been more than three decades of effort to establish an effective consumer voice within the health system in this country.

From the 1980s to 1993 a number of Consumer Health Councils (CHCs) were formed under area health boards "to help address gaps in community engagement in the health sector."[64] It is difficult to ascertain whether these councils were effective as little is known about the establishment, structure, roles and functioning of these councils, or their developmental history. From the scant documentation available publicly, most appear to have been abolished by early 2000.[64]

In 2005, a National Consumer Group was established after a national hui in October of that year (hosted by HDC) but was ultimately disbanded.[65]

More recently, starting in 2008 with the establishment of the Canterbury DHB Consumer Council, the concept of new CHCs at most public hospitals was to "address the existing gaps in community engagement in the health system". The aim of public hospitals developing these communication pathways with their communities was to become more patient-focused in decision making.[64]

Ongoing independent evaluation of any new consumer engagement structures is vital. The Health Consumer Advocacy Alliance recommends a review of CHCs to ascertain whether there is consistency nationally, if these CHCs are efficacious and contribute to improving the health system and health outcomes for New Zealanders, or if they are merely tokenistic. Conversely, are we better to utilise newly appointed consumer representatives who are more connected with their communities than round table consumer councils?

In 2013, the Ministry of Health released their *2013 to 2016 Statement of Intent*, in which then Minister of Health, Tony Ryall, said that the New Zealand public health service was driving an "integrated approach that puts the patient and user at the centre of service delivery."[66] The document went on to advise that that it will "ensure patients and carers are at the centre of service delivery"; that they are planning a "health system that is people-centric and more convenient. A high-quality health system… that meets people's health needs and their legitimate expectations."[66]

Long-time consumer advocate and consumer representative, Jo Fitzpatrick, commented on the *2013 to 2016 Statement of Intent* in her plenary address at the Legacy of Cartwright seminar marking the 25th anniversary Cartwright Report:[67]

"The rhetoric is rampant but is it reflected in reality? So much in health is about us. Without us, the whole enterprise becomes somewhat pointless! With today's emphasis on patient-centred care, patient portals, patient journeys and patient-directed care pathways, has the power in medicine shifted towards consumers as partners in care?"[67]

In 2023, consumer advocates and consumer representatives have to wonder if consumer representation has, in reality, come very far. The Government recently again promised New Zealander's that health system reform would be consumer, whānau/family and community centred. The Pae Ora (Healthy Futures) Act 2022[13] demanded the Code of Expectations (see page 2), but how consumer-centric is our new health system?

What is needed is a paradigm shift in the way in which health consumers engage with health care providers and the health system, and the way in which health care practitioners work and communicate with each other as well as their patients.

Hans Wiegant, Co-ordinator of the Patients' and Residents' Councils in Mental Health Care in The Netherlands said, "If you try to make changes in [...] health care, without involving the people concerned, nothing will actually change."[68]

The Positive Impact Collegial Relationships Have on Patient Care

There is clear evidence demonstrating that patient-centred care improves patient experience and creates public value for services.[69] How health professionals work together impacts on health outcomes and the treatment that patients receive. “In healthcare, mistakes that are potentially harmful or fatal to patients are often the result of poor communication between members of a team.”[69]

The need for teamwork with multiple disciplines working together in health is increasingly highlighted in health care services, research, education, and policy. However, how practitioners engage with, and/or provide information to each other, is a key factor, and a barrier that consumers face when seeking help.

Recent decisions by the HDC following investigations highlight the dire results of poor practitioner relationships in the provision of health care, including, one in which lack of communication between treating clinicians and failure to review clinical history prior to surgery, resulted in the death of the patient.[70]

The importance of maintaining healthy working relationships with colleagues and peers is recognised throughout the medical profession. Collegial relationships are vital for maintaining standards of professionalism and for ensuring accountability for safe practice. Health professionals “often find it difficult to identify their own learning needs,”[71] which in turn impacts on professional development and the care that patients receive. Respect for each other’s expertise, a willingness to listen, understanding others’ perspectives when working together is easier than it sounds.

Health care professions experience a high level of bullying in the workplace[72, 73, 74] and the Aotearoa New Zealand health sector is no exception.[75, 76, 77, 78] When health care staff do raise issues of concern, the lack of appropriate response by senior management and/or senior medical personnel not only allows unprofessional conduct to continue, but harms both patients and vulnerable staff lower in the hierarchy.

For example, in 2019 it was revealed that a theatre nurse at North Shore Hospital in the then Waitematā District Health Board, had laid a complaint with the HDC regarding “junior doctors, midwives and paramedics observing or performing obstetric and gynaecological surgeries on patients under anaesthetic who have not consented to it.”[79]

Over a period of six years the nurse observed numerous instances in which patients informed consent rights were being breached. These breaches were typically in women’s health, and often involved a teaching situation with trainee and not fully qualified doctors. The nurse repeatedly brought these breaches to the attention of doctors and surgeons in the course of her work, and formally raised her concerns with her charge nurse and unit manager, hospital and Waitematā DHB management, and then the chair of the WDHB Board, but to no avail.[80]

Eventually, under the Protected Disclosures Act 2000*, the nurse ‘blew the whistle’ and laid the complaint with the HDC, yet at work she was increasingly under threat from the senior medical staff with whom she worked.[80] Her position became so tenuous that North Shore Hospital stood her down; her safety at work could not be guaranteed by hospital management and she was being bullied and threatened by the doctors and surgeons she had to work with; ultimately, she was forced to resign.[80]

There is clear evidence that the hierarchy, or ‘perceived’ hierarchy of the health system, engenders a tendency for health professionals to avoid conflict with peers, to avoid open discussions about errors or problems and/or avoiding honesty when things go wrong.[81, 82] Such an environment existed in National Women’s Hospital at the time that Dr Herbert Green was involving women in his research on cervical cancer without their knowledge or consent,[61, 83] and this may have had a critical impact on the continuation of the unethical research. “Explanations for this avoidance have tended to concentrate on psychological and cultural factors, with relatively less attention paid to organisational influences.”[84] These organisational structures and systems must also be scrutinised, and deficiencies addressed.

What inhibits or enhances consumers’ access to healthcare services is not restricted to geographical location, affordability, personal domestic limitations (such as childcare arrangements, transport and ability to take time away from work), or accessibility issues for those

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* The Protected Disclosures Act 2000 has since been replaced by the Protected Disclosures (Protection of Whistleblowers) Act 2022

living with disabilities. Often it is the fear, especially in our indigenous and minority populations, that comes with just getting through the door. Reflecting as individuals, what can we personally do to remove barriers, rebuild trust and channels of communication, and get health consumers through the door?

Effective working relationships assist in mitigating or reducing inconsistencies in healthcare delivery; they enable improved provision of appropriate and accurate information; and in delivering quality services.**Error! Bookmark not defined.**

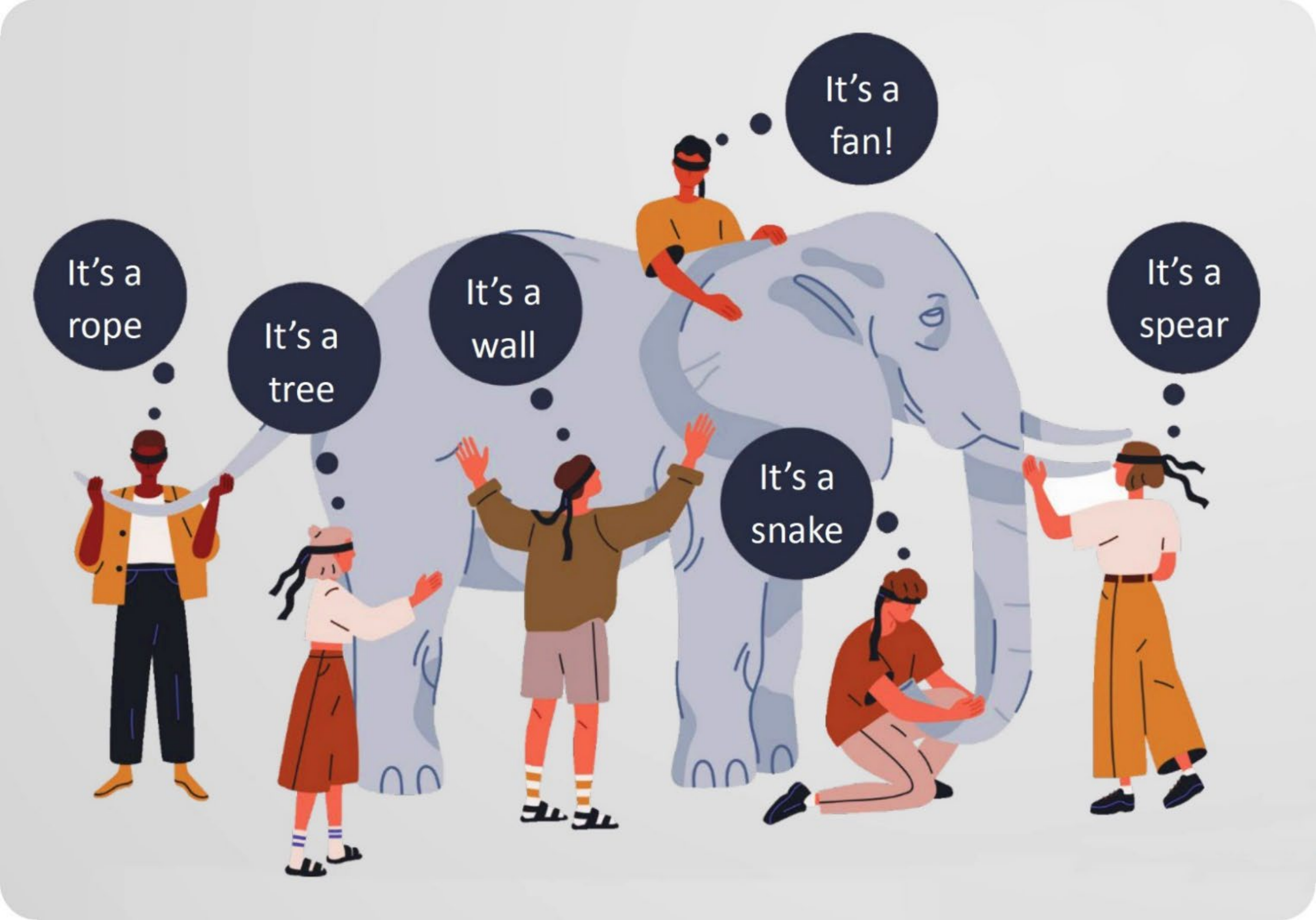
Learning how to first develop effective and constructive relationships with colleagues is as important as enhancing relationships with patients. How the 'team' works together makes a critical difference to the health care services provided to patients, and ultimately to their wellbeing and health outcomes. Effective collaboration is key, and the way in which clinicians work together impacts on whether the services and treatment provided is consistent, seamless, and quality care.

Whakawhanaungatanga = the process of establishing relationships and connections, relating well to others.[85]

While whakawhanaungatanga is a central concept in the provision of Māori-centred health care,[85] it is relevant to all health entities, health providers and individuals — both in Aotearoa New Zealand and internationally. It can and should be applied in all health care settings; the aim of whakawhanaungatanga in the health care setting is to deliver a clinically relevant and responsive service.[85, 86] "Critically, whakawhanaungatanga not only requires the person and their [whānau/ family] to share information about aspects of themselves, but it also requires that the healthcare practitioners disclose and share information."[85]

The interdisciplinary approach — a relational holistic approach to care with a significant focus on collaboration — is where all clinicians work together in a synthesised and harmonised manner. "Research indicates that medical care based on interdisciplinary cooperation is associated with increased patient safety, lower hospitalization rates, and reduced rates of complications and medical errors. Furthermore, it enhances the co-ordination of care and improves patient access to medical services".[87]

The interdisciplinary approach is seen as more effective than multi-disciplinary care, in which many clinicians are dealing with their own bit of the 'elephant'[88] (see below), working alongside each other but in silos. Adopting this approach will help to change health culture, enhance patient safety, and improve health outcomes.



Fragmented Patient Services vs Integrated, Holistic Care

While much is made of multi-disciplinary care, it still offers a fragmented approach, involving "team members working independently to create discipline-specific care plans that are implemented simultaneously, but without explicit regard to their interaction."[89]

In contrast, the key focus of the interdisciplinary approach is on "communication across disciplines, care providers and with the patient and their family/carers," with the aim of meeting the goals and needs of patients.[89]

Health consumers no longer want to be treated as a number or seen as the problem they present with; they need a safe environment where they know they will be listened to and taken seriously, and in which they feel they have equal importance in the relationship with the health care provider, and an active role in decision making.

"Well-integrated and coordinated care that is based on the needs of the patient can contribute to reducing delays to provision of care and duplicating assessment."[89]

Beneficial outcomes of interdisciplinary care and teamwork can be experienced at three levels (health care professionals, patients, and health care organisations) and these outcomes have an impact on staff satisfaction, quality of care, control of costs, well-being and retention.[90]

"The most effective teams share responsibilities and promote role interdependence while respecting individual members' experience and autonomy."[89]

Heather Derrick, of Michigan State University, in research on the benefits of interdisciplinary care, found that results of studies on interdisciplinary team care "show a clear benefit of the practice in decreasing length of stay, decreasing the [incidence] of adverse drug events, and improving staff communication with one another."[91] Additionally, patients' had improved perceptions of being respected by nurses and doctors and feeling like their needs were understood.

The interdisciplinary approach is consistent with, and integral to the Five 'I's Framework, developed by the Health Consumer Advocacy Alliance in 2022, which focuses on integrated healthcare.

The Five 'I's Framework

The Five 'I's Framework was developed by a team of four health consumer advocates with a combined 55 years of health research and advocacy work across a variety of consumer health issues in Aotearoa New Zealand. It was developed in response to the many concerns that New Zealanders have in accessing health care that places them at the heart of the health practitioner-patient relationship. The Five 'I's Framework is focused on patient wellbeing, safety, and improved health, and promotes a relationship in which respect, dignity and communication are central and is guided by principles of integrity, transparency and accountability.

The Five 'I's Framework (see page 9) is an holistic and integrated approach to health care with ethics at its heart. The core tenets are:

Interdisciplinary: Medical professionals from a range of disciplines working together with the aim of organising and co-ordinating health treatments and care services. Providing an environment that supports co-operation, respect and collaboration between colleagues and health practitioners to provide seamless, continuous care.

Integrated: A healthcare approach that takes account of the whole person, including the social determinants of health, their past, present and future. Holistic practice that considers the interconnectedness and interrelationship of the different parts of the body as well as mental, spiritual and physical wellbeing, while utilising all appropriate therapies.

Interrelated: Building and fostering relationships with team members. Valuing and validating personal and individual strengths to achieve desirable patient outcomes, effective communication and provision of quality care. Information sharing across the team and with consumers/patients.

Intergenerational: Actively promoting, valuing, fostering and encouraging intergenerational communication with patients/consumers and whānau. Understanding the impact of intergenerational trauma, adopting a trauma informed approach to health care.

Inclusive: Validating identity, diversity and culture. Being aware of unconscious bias. Ensuring accessibility for all to a range of community services that support mental health and wellbeing. Meeting the needs of individual consumers/patients and whānau, providing patient centred care.

The Five ‘I’s Framework

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Interdisciplinary
Medical professionals from a range of disciplines working together with the aim of organising and co-ordinating health treatments and care services. Providing an environment that supports co-operation, respect and collaboration between colleagues and health practitioners to provide seamless, continuous care.

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Validating identity, diversity and culture. Being aware of unconscious bias. Ensuring accessibility for all to a range of community services that support mental health and wellbeing. Meeting the needs of individual consumers/ patients and whānau, providing patient centered care.

Charlotte Korte, Kat Gibbons, Denise Astill and Sue Claridge: “The Five ‘I’s Framework”, Consumer Advocacy Alliance, Copyright © 2022

The Health Consumer Advocacy Alliance
Experts by Experience

The Five ‘I’s Framework is applicable to all health care settings and services. In practice the Five ‘I’s Framework involves:

- Providing an environment that supports co-operation, open discussion and transparency, and respect between colleagues and health professionals.

  Problems should be challenged, and issues should be navigated in a safe space, in a respectful way. If for any reason this is not possible, outside help should be sought to ensure that problems are resolved in this manner.
- Questioning if there are specific barriers for consumers seeking help within a practitioner’s own practice. Gaining an understanding of the impact of intergenerational trauma to better understand how unconscious bias can affect provision of treatment and health care services, by choosing to actively listen and learn from patients and their communities.
- Seeing and treating the patient in a holistic manner, as a ‘whole’ person rather than the health problem they present with, as opposed to the prevailing reductionist approach, where the complexity of individual health needs can be ignored.
- Learning how others embrace mental, spiritual, and physical well-being in treatment, so their patients and their whānau are at the centre of care. Creating opportunities for staff so they are aware of, recognise, and acknowledge the holistic approach, and the importance that reflection has in changing practice to improve healthcare outcomes.

This framework aligns with four Māori models of health, *Te Whare Tapa Whā,*[92] *Meihana model,*[93] *Te Pae Māhutonga*[94] and *Te Wheke model,*[95] which underpin an holistic approach to healthcare and encompass spirituality as a key element and core foundation. For many Māori, the major deficiency in modern health services is taha wairau, the spiritual dimension; none of the elements illustrated within these models can be separated from the socioeconomic circumstances and social determinants that lead to such significant disparities in health. By understanding our health system’s flaws and inadequacies, and its strengths, we can embrace a more holistic approach to care. We can learn a lot from looking at health care through a different lens, such as the Māori models of health and the Five ‘I’s Framework.

Adopting the Five ‘I’s Framework and using an interdisciplinary, trauma informed approach to care would be beneficial for both patients and health professionals.

Conclusion

Despite recent health system reforms in Aotearoa New Zealand and promises from the Government and health entities that our health system would be people-centred, and that consumers would be engaged with at all levels, the consumer experience still leaves much to be desired.

To properly address the evident inequities, disparities, discrimination and bias in our health system, and to substantially improve health outcomes, requires a paradigm shift at all levels of health care services. We must replace the centuries old patriarchal hierarchy in medicine, where patients were 'informed' what was best for them. Consumer awareness is higher, patients want to be fully informed about all risks and benefits before making treatment decisions, and to be actively involved in creating treatment and care plans.

New Zealanders want a health system that delivers quality, safe and equitable care, where healthcare services are accessible, affordable, and culturally appropriate. Communities living in areas of high deprivation want to have access to the same high-quality health care services that all New Zealanders expect. Services provided should improve patients' health and wellbeing, not leave them worse off, feeling dismissed, ignored and mis-treated.

More focus is needed on creating collegial relationships and positive interactions between healthcare providers, and health professionals must work in a safe supported environment. Patients accessing health care services now tend to have far more co-morbidities and health complexity, so it is essential that health providers work collaboratively to chart care services. Using a cohesive relational, holistic approach to service provision will enable patients to receive optimal care.

A significant focus on collaboration and strengthening staff relationships not only benefits health consumers but also the workforce, in terms of improved staff satisfaction. Research has shown that using an interdisciplinary approach to health care, helps to reduce adverse events, decrease hospital stays, reduces barriers for patients accessing health care services, and improves health and wellbeing.

The Five 'I's Framework offers that paradigm shift; a focus on cohesive integration that is applicable to all health care settings and services. It is a new model that focuses on both consumers and health professionals, and it aligns with the principles and philosophy of Te Aka Whai Ora, for ensuring patients are at the centre of care.

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