

RECONFIGURING HEALTH PROFESSIONALISM TOWARDS ADDRESSING MULTIMORBIDITY

By: Thomas Ploch

Summary: Delivering more and better health services with less human and financial resources is key to more sustainable health systems. Health reforms in certain countries tend to focus on enforcing intrusive regulation, management and market mechanisms within health provision whilst preserving the existing nature and type of health professionals, and their way of working. However, it is increasingly acknowledged that the existing health workforce is poorly fit for purpose when it comes to chronic diseases, in particular multimorbidity. Therefore, it would be better to reconfigure the health professions as one way towards more sustainable health systems. The sociology of professions provides clues on how such a reconfiguration strategy could be successfully developed and implemented.

Keywords: *Health Professionalism, Health Policy, Sustainable Health Systems, Multimorbidity*

Background

The future sustainability of health systems is a very pressing issue. Delivering more and better health services with less human and financial resources is the key challenge for health systems across the world. Governments worldwide are struggling to reform their health systems for the better by introducing more intrusive regulation, management, and market mechanisms in health provision. More recently, the economic crisis has forced many governments to impose austerity measures and to cut health budgets seriously.¹

However, evidence fuels the impression that the reforms that have been implemented so far are partial as they

fail to tackle deeper rooted problems arising from fragmentation, which in turn, results from over-specialisation. The piecemeal organisation of the health professions, driven by on-going scientific and technological advances, economic considerations and professional preferences, has distracted health professionals from the new realities of patients suffering from more complex and multiple chronic problems and illnesses, i.e., multimorbidity.^{2,3}

The majority of the health workforce thinks and acts as single-condition experts rather than addressing multiple chronic conditions. As a consequence, patients suffering from multiple conditions must consult a broad range of specialists – one

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for each condition – which is arguably the root of the unsustainable functioning of health care systems. Societies simply run out of human and financial resources to adequately staff and operate these health systems, even when they succeed in achieving high levels of integrated care. Apart from that, it is doubtful whether the mere sum of single contributions leads to optimal health outcomes for patients suffering from multimorbidity.

“make
them better fit
for purpose”

Arguably, one path that can be taken to rise to the challenge of unsustainable health systems is to reconfigure health professions in order to make them better fit for purpose, i.e., multimorbidity-proof. Such a reconfiguration refers to the rethinking of the nature and type of health professions, and how they organise themselves in the 21st century. This article outlines why such a reconfiguring of health professionalism is relevant, what this reconfiguration should entail, and how health policy-makers could successfully nurture it.

Why reconfigure health professions?

The basic need to reconfigure health professionals stems from their minimal adaptation to changing circumstances. Doctors, nurses and allied health professionals essentially work and organise themselves as they did 50 years ago.⁴ The movement from generalist to specialist (i.e., sub-specialisation) that was set in motion a hundred years ago is still the dominant, if not the only way, to gain a foothold as a health professional.

Sociological research provides a good understanding of why this would be the case. In sociology, professions are defined as groups of institutions that permit the members of an occupation to make a living while controlling their own work.⁵ Internal control is a basic characteristic, as professions perform non-routine tasks requiring expertise

based on abstract knowledge and practical apprenticeship that is inaccessible to those lacking the required training and experience. The pursuit of internal control over health labour, i.e., the process of professionalisation, is appealing for occupations as it is associated with more prestige and higher incomes.

Thus far, the professionalisation of health labour seems to be synonymous with sub-specialisation. Newer professions must outperform other (“rival”) occupational groups to obtain the status of a profession. They have to demonstrate the superiority, exclusiveness and the discretionary nature of their knowledge to support their jurisdictional claim for a new health domain alongside, or at the expense of, other professions with a vested interest. This has led to the situation where it seems almost impossible to successfully claim jurisdiction over a health domain superseding (or generalising from) multiple vested ones; the vested professional institutions and academy would not allow for it.

Now the critical issue is that patients suffering from multimorbidity would arguably benefit from health professionals whose expertise is underpinned by more generalised health domains. It would allow them to individually deal with the complex interplay between multiple diseases and conditions within one person without the need to involve many other health specialists. The potential gains in terms of effectiveness and efficiency are huge.

Epidemiological data show that people with multiple chronic conditions already represent 50% of the burden of disease in most OECD countries.⁶ Having multiple, complex and overlapping health problems is associated with poor outcomes in terms of quality of life, psychological distress, longer hospital stays, more postoperative complications, higher mortality and higher costs of care. In the US, for example, two-thirds of all spending in the Medicare program (the programme that insures people over 65 or who are disabled) is for people with more than five chronic conditions.

In other words, any successful effort that addresses the resource use of patients

suffering from multimorbidity, will likely contribute significantly to more efficient health systems. In this context, the reconfiguration of the health professions – essentially innovating the way that health expertise is professionally organised – is worth considering as one policy option.

Three interrelated steps

The reconfiguring of health professions requires a comprehensive agenda; one that focuses on designing out wasted resources that occur from the current way of treating people with multimorbidities, and adapting the professional organisation of health expertise accordingly. Three interrelated steps are suggested.

The first step entails defining and categorising patients and populations according to their burdens of morbidity. New categories are needed in order to classify patients with multimorbidity that provide the basis for gathering and organising health expertise.⁷ For example, what expertise is needed to deliver optimal medical care to patients with multi organ disorders or a frail elderly person with multiple diseases or a teenage girl who smokes, suffers from diabetes and depression, and is pregnant? There are categorisations that explicitly aim to characterise the degree of total morbidity burden from a clinical and epidemiological perspective (see 8). Moreover, primary care, public health, intensive care medicine, paediatrics, occupational medicine, emergency medicine and geriatrics mark fields in medicine where more superseding or “integral” health professions would be advantageous. Nevertheless, which categories will ultimately be used to categorise populations will depend on research studying the potential of the different alternatives to deal with multimorbidity. This research seems now booming, as illustrated by the paper by Barnett et al. in *The Lancet*.⁸

The second step requires that the professional work of doctors, nurses and allied health professionals be organised around the newly defined categories of health needs. This essentially means merging or rearranging specialty domains or establishing new domains and roles. For

Table 1: Strategies to nurture the reconfiguration of health professions

Strategy	Description
Elevating health as the core professional value	Emphasise that health is the business of health care, i.e., the <i>raison d'être</i> of the health professions.
Targeted research funding	Establish an enhanced portfolio of multidisciplinary research (e.g., public health, health services, and sociological research) that provides the credentials for health professions better suited to 21st century requirements.
Targeted technology funding	Invest in the development of health technologies (e.g., eHealth, medical devices, pharmaceuticals) that favour generalisation rather than (sub) specialisation.
Targeted infrastructure investment	Invest in infrastructure (including real estate) that does not block, but preferably initiates and facilitates, the future health professions to incorporate the three capacities.
More flexible professional bodies	Ease the requirements that health professions need to satisfy in order to become a recognised field. This implies that professionalisation not only allows for specialisation but also generalisation.
System and multimorbidity based health curricula	Include expert decision making based on the principles of systems thinking and multimorbidity in the health curricula.
Balanced performance assessment and management	Develop performance-based instruments related to the health outcomes of patient groups, i.e., multimorbidity, that are served rather than for individual diseases.
Supportive payment models	Developing pay-for-population-health-performance schemes that reward health professionals for their contributions in maximising health outcomes.
Policy rich human resource planning	Adjust the models for human resource planning in such a way that they facilitate the desired reconfiguration rather than codify vested health professions.
Support self-organising patients	Use the self-organising power of (multimorbid) patient populations to trigger health professions to adapt to the reconfiguration agenda.

Source: Adapted from ⁶

example, geriatrics might be established more generally as a fully approved medical specialty, thus making geriatricians the frontline staff for frail elderly patients in all countries, which is now not the case. Existing medical specialists (such as internists, cardiologists, and neurologists) would then be aligned to better support the “integral” function of geriatricians.

But a rearrangement of specialty domains and non-physician roles is unlikely to occur by decree; it has to be established from within the health workforce itself, strategically supported and stimulated from the outside and based on a vision of health system design with special reference to the blurring of the interfaces between primary, secondary and tertiary care for people with multimorbidity. Focusing on tasks to be provided by the different professionals and how they best support the integrative function is a critical step in the process of re-aligning skills to better meet new health needs.

The third step is then to reorganise the work of doctors, nurses and allied health professionals practicing in these integral knowledge domains. A major challenge will be to devolve tasks and

responsibilities to the type of health worker most accessible to patients and which is consistent with the achievement of excellent quality and outcomes. This will require a careful reconsideration of sharing or redistributing tasks between different occupations, in particular between doctors and nurses in more advanced roles. Even so, tasks can also be left to the patients themselves – with backup from the professionals – as illustrated by the developments in telemedicine, eHealth, and self-management.

The nurturing of the desired reconfiguration

The challenge of the proposed reconfiguration is daunting. It will run counter to the existing *status quo*, as it rearranges professional domains, resources and incomes. This creates winners and losers and one can expect prospective losers to oppose such change. Nevertheless, the basic idea for change is straightforward: restore the view that ‘health-is-the-business-of-healthcare’, and then emphasise that ‘systems thinking’

and ‘connectivity’ are required capacities for health professionals to actually do so in the 21st century.

Now the critical challenge for policy-makers is to promote such change in practice by moderating the negatives of health professionalism (e.g., unconstrained self-interests, distancing from the client, limited client accountability/responsiveness, professionalism tribalism) while strengthening the positives of professionalism (e.g., a strong educational base, certified expertise/expertise, evidence-based practice, ethical codes).

Therefore, there is a need to nurture leadership from within the health professions, as the health workforce itself is largely responsible for the way in which health expertise is organised and it has the powerbase to lead change. Health leaders must recognise that the proposed reconfiguration is a more promising route towards sustainable health systems and that it better serves to protect the values and principles of health professionalism against the countervailing forces of the free market and bureaucracy.^{8,9} In

concrete terms, policy-makers can draw them in by targeting at least ten key assets of health professionalism (see Table 1).

If appropriately, timely and systematically governed, initiatives could nurture professional self-regulation amongst the health professions, annexing the proposed agenda for reconfiguration. For example, sociological research shows that (medical) professions follow a common pattern when it comes to professional self-regulation. Profession-owned instruments are developed and implemented in order to ease external pressures and their underlying agendas. For instance, the implementation of peer review in the 1990s was a profession-owned response to ease fierce external quality and safety pressures.⁵ Similarly, the sky-rocketing issue of professionalism in health education can be interpreted as the profession-owned response to the upheaval relating to badly-performing individual health professionals.

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Conclusion

The central thrust of this article is that a reconfiguration of health professions is needed to get 21st century-proof health professions, and ultimately more sustainable health systems. The health professions are no longer fit for purpose, since they are based upon the acute single diseases of the past. Due to the successes of modern health care, the burden of disease has shifted towards multiple chronic diseases and conditions, hollowing out the predominant organisation of health expertise into health specialities.

However, the call for a reconfiguration of health professions does not entail the rejection of health specialist activities. After all, during the period 1875–1920, successful sewage systems were not abolished when burdens of disease

shifted from declining infectious diseases towards non-communicable diseases. Nor does it mean the championing of general practitioners and primary care physicians: it is questionable whether these physicians have fully incorporated the three suggested steps into their capacities yet. Besides, it is naïve to assume that general practitioners can do the job on their own. The likelihood of success is probably improved when all health professions rise to the challenge, and thus all become more responsive and accountable to the changing circumstances in health provision.

For health policy-makers, the key message is to stop exploiting the existing single-condition based health professions. By introducing more intrusive regulation, management, and market mechanisms in health care, health policy is codifying the vested health professions in their way of organising health expertise and related processes of health service delivery. This is a counterproductive policy strategy. Rather, health policy-makers could better recognise and use the positive strength of self-regulating health professions. It seems better to start a constructive collaboration; one that leads to the professional adaptation to the multimorbidity challenge. Arguably, such a strategy could turn out to be a more fertile way to achieve the goal of improving how health professions meet the challenges of multimorbidity, and ultimately achieving more sustainable health systems in the 21st century.

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