A major new alliance in Australian health care: the Australian Consensus Framework for Ethical Collaboration in the Healthcare Sector

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Abstract:

The “Australian Consensus Framework for Ethical Collaboration in the Healthcare Sector” (ACF) is an Australian initiative aimed at countering dysfunction and growing mistrust in the health sector through the development of a cross-sectoral consensus framework. The development of this framework arose from Australia’s involvement in the Asia Pacific Economic Cooperative (APEC) and has since become the largest of its kind internationally, with over 70 signatories representing professional bodies, industry organisations, hospital and health services associations, regulators, and patient and advocacy groups. In this article, we describe and critique the framework and outline its implementation.

By global standards, the Australian health system is well organised and highly effective, as evident in positive health outcomes, a comprehensive system for health education, a strong health workforce, a productive health and biomedical research sector, and robust processes for the regulation and subsidisation of health technologies. Nonetheless, the system is facing a number of persisting and newly emerging challenges resulting from the fragmentation and complexity of healthcare delivery,^{e.g.1} growing costs of health technologies and services,^{e.g.2} chronically under-served populations,^{e.g.3} demographic changes,^{e.g.4} an increase in complex, chronic diseases,^{e.g.5} and increasing stresses on the workforce.^{e.g.6} In addition, like health systems internationally, the reputation of the Australian system is impacted upon by publicity surrounding episodes of research^{e.g.7}, professional^{e.g.8} and corporate^{e.g.9} misconduct, and failure on the part of health services^{e.g.10} and regulatory bodies^{e.g.11} to protect patients from harm or exploitation.

The evolving COVID-19 pandemic is quickly revealing both the strengths and weaknesses of the Australian health sector. The speed with which public resources have been allocated to healthcare¹² and public—private alliances have been formed,¹³ and the obvious commitment of health professionals to caring for patients with COVID-19¹⁴ have no doubt been a source of public confidence and pride. But problems such as lack of personal protective equipment (PPE) for healthcare workers,¹⁵ breakdowns of basic quarantine measures¹⁶ and variation in the implementation of public health advice across different jurisdictions¹⁷ have reignited public concerns about the organisations responsible for the design and delivery of healthcare.¹⁸⁻²³

COVID-19 has also highlighted the critical necessity of collaboration for social benefit in the health sector. This is because an effective response to COVID 19 requires that testing equipment is manufactured and delivered, PPE is available to all who need it, hospital facilities including intensive care beds are available in both the public and private sector,

there is an adequate healthcare workforce, research into vaccines and therapeutics are fast-tracked and supported, and public health measures are evidence-based and enforced. All of these components of the response to COVID-19 require extensive planning and coordination; they also require that the organisations that make up the health care sector are perceived to be legitimate (or to have so-called “social licence”²⁴).

Importantly, the causes of loss of trust and social licence in health systems are morally and politically complex, and involve organisations spanning public, private and non-government sectors. Their solution therefore relies on organisations collaborating for common good and mutual benefit. This, however, raises its own challenges because organisations can have widely divergent interests. Here we describe an Australian initiative to counter the growing dysfunction and mistrust in the health sector through the development of a cross-sectoral collaboration—the *Australian Ethical Health Alliance* (AEHA).

The development of this collaboration arose from Australia’s involvement in the Asia Pacific Economic Cooperative (APEC). APEC is a multilateral economic and trade forum established in 1989 to leverage the growing interdependence of the Asia-Pacific region. Its 21 members, which include the United States, Russia, China, Australia, Canada, Indonesia, Japan and Singapore, aim to promote sustainable economic growth and prosperity and accelerate regional economic integration.

Since 2010, the APEC Business Ethics for APEC Small and Medium Sized Enterprises (SMEs) Initiative has driven the development of several “consensus frameworks” for ethical collaboration within healthcare sectors. Following the development of frameworks in Canada, Vietnam and Peru, the development of an Australian framework began in 2017. Australia’s approach quickly diverged from that of other countries based on the recognition that consensus frameworks should encompass the whole health “ecosystem” (beyond the business sector) and include clinical, consumer, health service and regulatory organisations alongside industry and government.

The Australian Consensus Framework for Ethical Collaboration in the Healthcare Sector

Australia’s consensus framework, which has since become known as the “Australian Consensus Framework for Ethical Collaboration in the Healthcare Sector” (ACF) [**Boxes 1 and 2**] was launched in 2018 following endorsement by the Federal Government. The ACF consists of a set of guiding principles, to which organisations can become signatories, and which are designed to:

- Promote collaboration and interaction among healthcare sector organisations and those who work within them that benefits patients, consumers, communities, populations, healthcare systems and the healthcare sector.

- Encourage better dialogue, trust and respect between and amongst organisations in the healthcare sector.
- Enhance the integrity and trustworthiness of organisations in the healthcare sector.
- Promote public confidence and trust in healthcare sector organisations by demonstrating a shared commitment to integrity and ethics.

The decision was made to focus the framework on mid-level guiding principles rather than on rules or on a single ethical theory. While principle-based approaches to ethics have been criticised for being insufficiently grounded in moral theory, non-generalisable from context to context, and insufficiently action-guiding, it was felt that a principle-based approach would provide the best means of articulating the values necessary for building trust and collaboration in the healthcare sector. This is because principles arise from commonly shared values and so facilitate communication face of disagreement and difference. Principles are also recognised by a wide range of stakeholders as having moral force, and can usefully *guide* action.^{25, 26}

The selection of principles took into account the consensus frameworks that had been developed by other countries and other APEC codes of ethics such as those guiding business ethics in the pharmaceutical sector.²⁷ It also took into account normative principles that have been articulated in medical ethics²⁵ and public health ethics²⁸, as well as within influential codes of ethics, including those guiding global public health, bioethics²⁹ research,³⁰ medical practice,³¹ public administration³² and global business.³³ The selection of principles also drew heavily on philosophical ideas about procedural justice and fairness, particularly those of John Rawls as articulated in Daniels and Sabin's "accountability for reasonableness" (A4R) framework.³⁴ This framework articulates principles that must be satisfied in order for decision-making and policy development to be perceived as legitimate, even by those who are adversely affected by their outcomes.

The principles were initially developed by a writing group, which included two bioethicists and representatives from industry, professional, regulatory and consumer organisations. The principles were then refined iteratively by the broader group of 50 framework signatories including consumers, health care professionals, hospitals, businesses and government representatives. This broad representation ensured that the framework would have legitimacy in the sector, and that it would reflect concern for individuals, communities and organisations in industry, government and NGO sectors. After several rounds of consultation, 15 principles were articulated.

To assist with their implementation, the principles were divided into "substantive principles" [**Box 1**][—]which articulate the kinds of "external" goods, that organisations should strive for[—]and "procedural principles" [**Box 2**][—]which articulate how organisations

should act in in developing policy, collaborating and communicating with the public and other stakeholders.

Although the principles were initially focused on mechanisms of collaboration among organisations within the health sector, they are in fact much broader than this, and can be thought of as a set of considerations that can assist organisations to enhance their real and perceived trustworthiness by showing that they are committed to the right goals (substantive principles) and to the right ways of achieving these goals (procedural principles).

Box 1: Substantive principles

Those working together and/or making collaborative judgements and decisions should give due consideration to:

- *Benefit and welfare*: Acting in ways that advance the health, wellbeing and interests of patients, consumers, communities, populations, healthcare systems and the healthcare sector, and that avoid or minimise harm.
- *Justice*: Fair distribution of access, opportunities, and privileges, with an emphasis on addressing socio-political and economic inequality. Justice also refers to fairness in the processes that allocate resources and resolve disputes
- *Respect for patients, consumers, communities, colleagues and organisations*: All interactions and activities are respectful of the dignity, worth, rights, beliefs, values, preferences, customs and cultural heritage of all involved.
- *Solidarity*: A collective commitment to sharing costs and benefits for the good of a group, community, nation or global population.
- *Effectiveness, efficiency, safety, sustainability*: Continuous commitment to improving outcomes in healthcare through promotion of responsible innovation, generation and utilisation of evidence, economic cooperation, reduction of waste, and productive utilisation of limited resources.

Box 2: Procedural principles

Collaborations and interactions should be characterised by:

- *Honesty*: Those engaged in collaborations are truthful in all their interactions.
- *Integrity*: Those engaged in collaborations are alert to competing and conflicting personal, professional and organisational interests and to the management of bias.
- *Reflexivity*: There is ongoing critical reflection on the values, principles and evidence underpinning collaborative judgments and actions.
- *Transparency*: The processes of collaboration, and the values, principles and evidence upon which decisions are made, are open to scrutiny.
- *Inclusiveness and shared understanding*: All relevant stakeholders should participate in collaborations in order to learn from one another and work together respectfully to generate mutually agreed outcomes.
- *Responsibility and accountability*: Those involved in collaborative processes take responsibility for, are able to explain, and are accountable for, their actions and decisions.
- *Reasonableness*: Those involved in collaborations act, and make decisions, on the basis of rationales that are widely accepted as relevant and fair.
- *Testability*: The judgments and decisions made by those engaging in collaboration are open to

independent verification and revision.

- *Revisability*: There are procedures in place for appeals and for revising collaborative judgments and decisions in the light of challenges to them.
- *Oversight*: There are mechanisms in place to ensure that the principles described above are given due consideration.

The framework was formally launched in Tokyo on 20 July 2018. At the time of its launch, the framework had been endorsed by 55 organisations representing industry, government, the professions, consumer groups, regulatory bodies and health providers. In signing up to the framework, these organisations commitment to work to align their own policies and processes with the consensus principles and take the principles into account in their activities including education and training, research, advocacy, purchasing and resource allocation, and policymaking. By early 2019 the number of signatories had risen to over 70 organisations (listed below), making the ACF the largest of its type in the world. At this point, the Australian Ethical Health Alliance (AEHA) was established to support the implementation of the ACF. The AEHA has since developed an implementation program that provides organisations and signatories with the resources that they need to develop and modify their policies and processes in alignment with the ACF. At present, it is envisaged that signatories to the ACF will report regularly to the AEHA and share their experiences and resources on a newly established website: www.ethicalhealth.org.au.

What can be achieved by cross-sectoral ethics initiatives?

Although the ACF has attracted unprecedented support from across the Australian health sector, it is open to different types of critique. In addition to the limitations of principle-based ethics described earlier, there are serious questions about whether frameworks of this type have “real world impacts”. For the reality is that ethical statements *of any kind* are not enforceable, and there is no guarantee that organisations that become members of AEHA and sign up to the ACF will institute any substantive changes in organisational behaviour. Indeed, agreement on general ethical principles may obscure more substantive value conflicts and, in some cases, be used as “tokens of legitimacy”³⁵ or as “ethics theatre”²⁶ to mask wrongdoing at an organisational or systemic level. In this regard, it is noteworthy that organisations are beginning to express an interest in membership whose values do not appear to align with the ACF, and the organisation is now grappling with how to assess and monitor the commitment of organisations to acting in accordance with the principles outlined in the ACF.

Another, more practical, challenge associated with statements such as the ACF is that they need to be aligned with existing regulations, codes and policies and into activities involving organisational members. This challenge (which may have discouraged some organisations from signing up to the ACF) may add to the complexity of organisational governance and

place extra demands on those responsible for such governance. Finally, even if codes are aligned with organisational policies and procedures, they are unlikely to translate into changes in attitudes or actions unless they are scaffolded by ethical leadership and by a culture that embeds ethics at all levels of the organisation.³⁶

Despite these challenges and limitations, the ACF has the potential to strengthen the rigour and impact on behaviour of organisational codes, guidelines and policies—particularly those that currently have limited ethical infrastructure. The ACF also provides a common language and “network of concepts”^{26:369} that can form the basis of organisational activities involving their members (e.g. ethics education initiatives) and discussion among organisations with otherwise disconnected ways of thinking and communicating. Perhaps most importantly, the ACF may engender explicit discussion of issues that are often avoided—such as those centred on what organisations with political, commercial and professional agendas owe to the communities they are intended to serve. In so doing, the ACF might help to enhance the perceived trustworthiness and social licence of organisations within the healthcare sector. At a time when ethical issues regarding public and private resource allocation, the duties owed by and to the health workforce, fast-tracking of research, and tensions between “economic” and “health”-related social goods are coming to the fore the weight given to ethical principles by the existence of the ACF could foment further reflection and encourage reform.

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Author contributions

All authors contributed to the development of the ACF. WL and IK wrote the first draft of this article. All authors were involved in critically revising and editing it. All authors have approved the submitted version and agree to be accountable for all aspects of the work.

Organisations that have become signatories to the ACF

Arthroplasty Society of Australia
Assistive Technology Suppliers Australia
Audiology Australia
Australasian College of Cosmetic Surgery
Australasian College of Dermatologists
Australasian College of Health Service Management
Australasian College of Phlebology
Australasian College of Sport and Exercise Physicians
Australasian Leukemia and Lymphoma Group
Australasian Sarcoma Study Group

Australasian Sleep Association
Australian and New Zealand Association of Oral and Maxillofacial Surgeons
Australian and New Zealand College of Anaesthetists
Australian and New Zealand College of Paramedicine
Australian and New Zealand Melanoma Trials Group
Australian and New Zealand Sarcoma Association
Australian and New Zealand Society for Geriatric Medicine
Australian and New Zealand Society for Vascular Surgery
Australian and New Zealand Society of Cardiac and Thoracic Surgeons
Australian and New Zealand Urogenital and Prostate Cancer Trials Group Ltd
Australian College of Emergency Medicine
Australian College of Nursing
Australian Dental Association
Australian Hand Surgery Society
Australian Healthcare and Hospitals Association
Australian Knee Society
Australian Orthopaedic Association
Australian Orthopaedic Association Medical Legal Society
Australian Orthopaedic Foot and Ankle Society
Australian Orthopaedic Trauma Society
Australian Paediatric Orthopaedic Society
Australian Pharmacy Council
Australian Private Hospitals Association
Australian Society of Anaesthetists
Australian Society of Clinical Immunology and Allergy
Australian Society of Ophthalmologists
Australian Society of Otolaryngology Head and Neck Surgery
Australian Society of Plastic Surgeons
Australian Traditional Medicine Society
Breast Cancer Trials
BUPA
Complementary Medicines Australia
Consumer Healthcare Products
Consumers Health Forum of Australia
Cosmetic Physicians College of Australasia
Day Hospitals Australia
Gastroenterological Society of Australia
Medical Technology Association of Australia
Medicines Australia
Musculoskeletal Australia
National Prescribing Service (NPS) Medicinewise

National Rural Health Alliance
Neurological Society of Australia
Painaustralia
Praxis Australia
Private Healthcare Australia
Royal Australasian College of Dental Surgeons
Royal Australasian College of Physicians
Royal Australasian College of Surgeons
Royal Australian and New Zealand College of Obstetricians and Gynaecologists
Royal Australian and New Zealand College of Ophthalmologists
Royal Australian and New Zealand College of Psychiatrists
Royal Australian College of General Practitioners
Royal College of Pathologists of Australasia
Shoulder and Elbow Society of Australia
Skin Cancer College
Society of Hospital Pharmacists of Australia
Spine Society of Australia
The Thoracic Society of Australia and New Zealand
Universities Australia
Urological Society of Australia and New Zealand

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