LCLI

Briefing Note

Evaluation criteria for priorities in medicine in the 21st Century: Leading causes of life

Key Messages

Transcending the limits of the science of pathology is the future.
An over-emphasis on needs, deficits, threats and pathology is a fault line.

The 'leading causes of life' is a promising lens for rethinking health.
This shift in language, with its implications for practice and research, offers a compelling framework for innovation.

Community assets for health, tangible and intangible, are key.
Health is a lifespan journey of individuals in communities who hold assets for their health that can and should be leveraged.

Understanding healthworlds helps avoid intervention failures.
The agency of health seekers, linked to their ways of seeing health and illness, is a crucial part of a healthy system.

'Boundary leadership' is crucial to enable innovation across silos.
Such leadership embraces complexity, and is willing to risk for the sake of the health of the whole.

Fully responsive/responsible health systems show 'deep accountability'.
Internal accountability for health services must be linked to external accountability to all relevant stakeholders, which requires trust and trustworthiness.

While huge strides have been made in the last century to understand and combat the various pathologies that threaten human health and life, **we have hardly begun to understand and encourage the processes that enable, sustain and enhance that life and its quality in the first place**.

A framework moving from the "leading causes of death" to the "leading causes of life" is the new, cutting-edge future of health science and practice – we see it in many new programmes that are rethinking health systems and re-imagining health care and its culture around the world. From it flow criteria for evaluating how we build the medical and health care systems of the 21st Century.

Here the "leading causes of life", a **shift in language with practical implications**, is a means to balance the overwhelming stress on needs, deficits, threats and pathology, while inspiring new research and break-through knowledge. Its elements, and related ideas on health assets, healthworlds, boundary leadership, and deep accountability, are outlined below.

Originating in work done in Africa for the World Health Organization[1], these ideas are also being concretely applied to health systems in Memphis[2] and North Carolina, and have fed into the USA Stakeholder Health[3] collaboration. Five key, interlinked 'leading causes of life' are advanced, each backed by substantive existing knowledge[4]:

LEADING CAUSES OF LIFE

Coherence – a meaningful story informing how we make sense of our life journey, and of how we care for it, and for those around us.

Connection – the complex social relationships and connections to one another by which we find life, building communities of various kinds to enable us to adapt to changing threats and opportunities.

Agency – having the will and the resourcefulness to act, expressing the full range of capabilities we have as human beings.

Intergenerativity – being affirmed from one generation to another, encouraged, strengthened and inspired in how we shape our lives by key individuals and valued groups or communities.

Hope – being able to imagine a different, healthier future and finding the energy to do something to try to bring it into being.

Extended Health Systems for Complex Patients in Complex Neighborhoods

Investigating and applying the full implications of a 'life', or generative, perspective on health systems of the future also implies rethinking how we conceive of what we mean by a health system:

- A fully adequate health system will take into account the lifespan journey of health across generations.
- Facilities (hospitals, clinics, etc.) will rethink their mission, practice, and accounting to include, say, the 30 days before, and the 30 days after, patients arrive at their doors.
- Because this clearly exceeds what facilities alone can do, it means entering into trustworthy partnerships with all relevant stakeholders beyond their walls, in communities.
- Then connections, agency, other assets, the healthworlds people live by, and boundary leadership matter.

HEALTH ASSETS

Health assets extend well beyond visible, formal services, and include *tangible* and *intangible* resources and energies in communities that should be made visible and leveraged more effectively for greater individual and population health.

Because formal health systems, private or public, cannot and never will meet all the demands and needs, paying attention to the full range of assets available 'beyond the walls' of the facility, including community strengths, is of obvious consequence.

Crucially, intangible factors are also of considerable import for the effectiveness and efficiency of any service or intervention. Trust is one such; so are credibility, motivation, compassion, mentoring, accompaniment and more. Hard to measure, all nonetheless bear upon whether or not available health care is accessed, regarded as acceptable, or properly utilized, and on their affordability: how direct and indirect costs are carried and shared.

HEALTH-WORLDS

Agency, active engagement in using or leveraging an asset, is essential – and it belongs to provider and health-seeker.

Medical and health care providers and professionals largely see agency as residing with them. Yet durably effective interventions, at individual, community or public level, must also account for the agency of the health seeker. Here the world of the health seeker's individual or communal construction of health and illness and their etiology – their 'healthworld'[5] – often plays a key role in behaviour and choices.

Because the reception of interventions or services impacts on their utility and value, it is unhelpful – perhaps counter-productive – simply to insist on the agency, or power, of the health provider over the health seeker. Trust and credibility are won not by force, but by intelligent encounter.

BOUNDARY LEADER-SHIP

Boundary leadership nurtures innovation and transformation for the sake of the whole and the well-being of all.

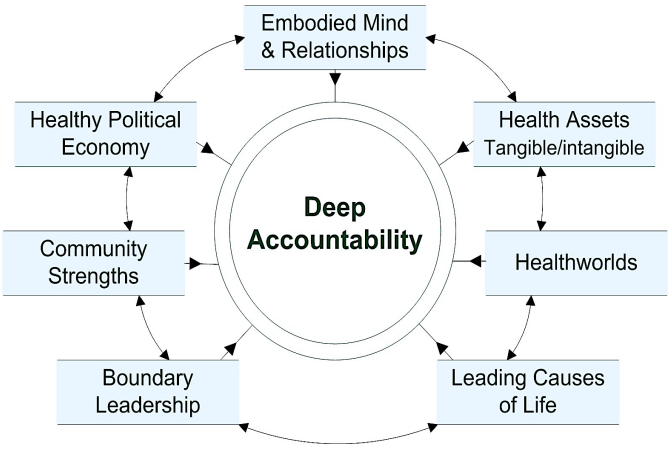
It means embracing complexity, moving beyond inflexible silos of practice and thought, being willing to risk the hopeful, looking for connections and greater coherence, nurturing the agency of others.

DEEP ACCOUNT-ABILITY

Deep accountability, beyond normal internal ('vertical') accountability protocols of health facilities or formal systems, takes proper account of all stakeholders through effective, durable forms of external ('horizontal') accountability.

This includes all involved in the journey of health, taking the complexity of that journey into account. The language of health assets, healthworlds and causes of life, and the patterns and processes they describe, helps describe that complexity. Best understood not in the light of a theory of disease, but in the context of a living person in a social system that is itself alive, it involves a 'blended intelligence' able to work with an ensemble of practices, each distinct but all impacting on the others [6].

An ensemble of interlinked practices



To learn more ...

[1] African Religious Health Assets Programme. (2006). Appreciating assets: the contribution of religion to Universal Access in Africa. Cape Town: ARHAP, Report for the WHO.
[2] Cutts, T. (2010). The Memphis model: ARHAP theory comes to ground in the Congregational Health Network. In J. R. Cochrane, B. Schmid & T. Cutts (Eds.), When religion and health align: mobilizing religious health assets for transformation (pp. 193-209). Cluster Publications.
[3] Health Systems Learning Group. (2013). Strategic investment in shared outcomes: transformative partnerships between health systems and communities. Washington DC: Health & Human Services/Robert Wood Johnson Foundation Leadership Summit.
[4] Gunderson, G. R. & Cochrane, J. R. (2012). Religion and the health of the public: shifting the paradigm. New York: Palgrave MacMillan. For a more narrative discussion, see also Gunderson, G. R. & Pray, L. (2006). Leading causes of life. Memphis, TN: The Center of Excellence in Faith and Health, Methodist Le Bonheur Healthcare.
[5] Germond, P. & Cochrane, J. R. (2010). Healthworlds: conceptualizing landscapes of health and healing. *Sociology*, 44(2), 307-324.
[6] Barefoot Guide #3 (basic, illustrated, covers all concepts): http://www.barefootguide.org/barefoot-guide-3.html