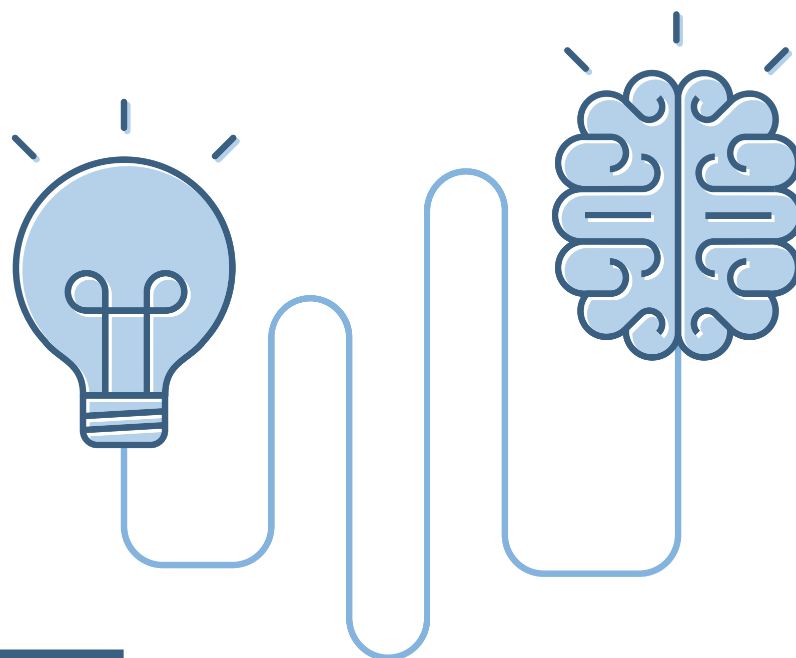
Comisiwn
Bevan
Commission

Exploiting the Welsh
Health Legacy Series: 1

A New Way of Thinking:

The Need for a Prudent Model of Health & Care



www.bevancommission.org
@BevanCommission

SUMMARY

This paper is the first in the series called 'Exploiting the Welsh Health Legacy' which calls for a joined up, prudent and social model of health and care - moving away from the more traditional medical model of care.

"A New Way of Thinking: The Need for a Prudent Model of Health and Care" sets out the case for change and looks to identify a model and approach which best suits the needs of people in Wales. A model which prevents ill health and preserves and supports all aspects of wellbeing, in which everyone has a responsibility.

We have looked at how this could be achieved by looking at health and care through a different lens - a prudent lens. This proposed new model is based on the Bevan Commission's concept of Prudent Healthcare and the application of its principles in practice. It recognises the shared responsibility of society starting with the individual. This new model promotes innovation, new ways of thinking and working and explicitly places the responsibility of improving population health and wellbeing across society as a whole. It takes into account the wider social determinants of health and helps people achieve their maximum wellbeing.

With the challenges and threats to the future sustainability of health and health services in Wales, the notion of prevention and to some extent early intervention is a recurring theme in policy documents. Enabling individuals to lead healthier and more resilient lives is a clear andaccepted goal as is promoting wellbeing rather than just treating ill health. However, the balance of resource and effort to date to reflect this goal is questionable. Similarly, the prominence of wellbeing rather than health reflects the move to focus on the individual rather than an individual's health problem.

We believe this demands a social model in which everyone has a responsibility for health and must reflect and strongly address the determinants of ill health and the many other different factors which frustrate the attainment of people's maximum wellbeing.

The desired goal of healthcare is to eliminate or minimise the impacts of ill health and disabilities through effective and timely treatment and to enhance optimum functional recovery, as prudently as possible. It is about enabling people to do as much as possible as measured by functionality.

Unfortunately, the health service is not well-equipped for the latter and raises questions around its validity as the only vehicle to deliver it.

The "achievement of health and wellbeing with the public, patients and professionals as equal partners through co-production" is an overarching basic tenet to be applied alongside the other three Prudent Healthcare principles. This cannot be achieved within the confines of a strictly biomedical model which fails to include unique human attributes and the socio-economic determinants of ill health. We seek to develop a health and care model which engenders a culture of ownership by all parties in decision-making and in gaining mutually agreed goals - an important characteristic of co-production and key prudent health principle. It can promote health literacy and provide a framework for better clinical assessment, joint management of health, social and domestic matters, empowerment and enablement.
Conventional healthcare is, of course, important, but healthcare alone is not paramount in achieving good health and wellbeing.

We have to recognise that improving health and wellbeing is not solely the responsibility of the NHS, but also should involve everyone. Our new way of thinking promotes the development of a health model which places responsibility for gaining good health beyond the NHS treatment service. A prudent model will need widespread sign up and active support from the public sector, industry, the third sector and the public itself. Achieving our aspiration rests a great deal on changing understanding, attitudes and behaviours.

Conventional healthcare is, of course, important, but healthcare alone is not paramount in achieving good health and wellbeing.

INTRODUCTION

The success of science, technology and medicine has driven unparalleled advances in our understanding of disease, disability and dying, resulting in increased longevity across the board.

Whilst our understanding has significantly increased, we still fail to address the basic, ever increasing inequalities, which occur, and the unfair impacts that society, not science, has upon this. Failing to recognise and addressing such a basic issue in an ever-advancing technological and scientific environment is likely to compound the widening gap between those who are more able to enjoy a long and healthy life and those who cannot.

There is a real danger that we look for complex scientific advances such as genomics and epigenetics and other ground-breaking developments, at the expense of the basic things we already know or that ought to be done, but which may not be as attractive in pursuing excellence and resource. To be able to improve and sustain health and wellbeing for the people in Wales we must look for a new solution and be brave enough to pursue it.

We must not hang onto the old ways of thinking and working, neither must we look for new and attractive answers that ignore the basic principles of Prudent Health and Care.

We must be bold and take a different lens, a prudent lens, to find a model and approach that best suits the needs of people in Wales, preventing ill health, preserving and supporting wellbeing and providing a society that supports and enables us all to achieve these.

CONTEXT

In response to these challenges the Bevan Commission outlined its approach and thinking through Prudent Healthcare which it defined as "healthcare which is conceived, managed and delivered in a cautious and wise way characterised by forethought, vigilance and careful budgeting which achieves tangible benefits and quality outcomes for patients"
Bevan Commission 2014).

This was supported by four prudent principles, namely:

PRINCIPLE 1

Achieve health and wellbeing with the public, patients and professionals as equal partners through co-production:

When people and professionals work together as equals, responsibility to find the best solutions to improve health and well being is shared. The aim is to avoid illness and treatment where at all possible by working with people to help them gain greater control over their own health and wellbeing and that of their families and friends. There is a need to move from education to motivation, from passive acceptance to proactive engagement, using wider societal solutions to better health and to turn good intentions into actions.

PRINCIPLE 2

Care for those with the greatest health need first, making the most effective use of all skills and resources:

Prudent Healthcare provides us with a way of matching need and resource most fairly. The intention is to ensure that all the skills and resources available are maximised ensuring allocation to where needs are greatest, at both and individual patient and population level.

PRINCIPLE 3

Do only what is needed, no more, no less; and do no harm:

No intervention should be carried out unless it is agreed, between the clinician and the patient, that the intervention would be better than not adopting that intervention at all. The aim is to deliver healthcare that fits the needs and circumstances of the person and actively avoids ineffective, harmful or wasteful care that is not to

their benefit. This goes beyond the 'do no harm' approach to one in which an intervention must do more measurable good especially from the individual's perspective, than not introducing it.

PRINCIPLE 4

Reduce inappropriate variation using evidence based practices consistently and transparently:

Patients should be able to access high quality health care easily and consistently across Wales. The performance of the different parts of the health service in Wales should be further examined, identifying and spreading effective practice and discontinuing ineffective practice where it is being undertaken. Making comparative data and information easily accessible will help to make comparison of practice in one area with another possible and thereby help local systems share best practice.

With approximately 80% of the NHS resources tied up within its workforce the Bevan Commission then sought to understand the extent to which employees of the NHS were able to respond to the prudent healthcare agenda.

'A Workforce Fit for Prudent Healthcare' (Bevan Commission 2015) explored workforce solutions that were aligned with prudent health and care for NHS Wales, where all skills and resources are used to best effect.

In trying to set out solutions it became evident that it was difficult to determine this without a clear model of health and care in Wales. This paper therefore seeks to address this by developing a new, more prudent model, recognizing that it is not the NHS that makes health, it helps to mend ill health, not make it and not always in the most prudent ways. For health and wellbeing to be sustainable for our future generations, we need a clear, rebalanced and more prudent model for health and well-being, which brings together the medical, social and psychological aspects of people's lives, more appropriately and more fairly.

KEY MESSAGES FROM CURRENT POLICY

Since devolution the responsibility for both the health service and the health of the people of Wales has moved to the Welsh Government. Successive and distinctive policies have been developed that seek to address some of the well-known challenges and legacies of ill health that face Wales and create sustainable future services. These are summarised below;

Together for Health (2012) is a five-year plan based around community services with patients at the centre, and places prevention, quality and transparency at the heart of healthcare to enable a health service capable of world-class performance. It seeks to do this through service modernisation, addressing health inequalities, better IT systems and information strategy, improved quality care for patients, workforce development, instigating a 'compact with the public' and a changed financial regime.

The Social Services and Wellbeing (Wales) Act (2014) looks to give people a stronger voice and control over the support needed to remove barriers to their own wellbeing. It focuses on earlier intervention; increasing preventative services within the community and helping people maintain their independence.

The Wellbeing of Future Generations (Wales) Act (2015) is about improving the social, economic, environmental and cultural well-being of Wales. It will make the public bodies listed in the Act think more about the long-term, work better with people and communities and each other, look to prevent problems and take a more joined-up approach. It sets the goals which need to be achieved in Wales to secure the nation's wellbeing and marks out Wales as the first country to place wellbeing at the heart of legislation and government policy.

The Public Health (Wales) Bill (2015) brings together a range of practical actions for improving and protecting health. It focuses on shaping social conditions that are conducive to good health, and where avoidable health harms can be prevented.

The move towards more person centred care per se has become the favoured mantra of politicians and senior policy-makers in health for 20 years or longer.

Person-centred care is not just about giving people whatever they want or just providing information. It is a way of thinking and doing things that sees the people using health and social services as equal partners in planning, developing and monitoring

care to make sure it meets their needs. This means putting people and their families at the centre of decisions and seeing them as 'experts', working alongside professionals to get the best outcome (Health Information Network 2016).

The Health Foundation (2014) has identified four principles of person-centered care:

- Affording people dignity, compassion and respect;
- Offering coordinated care, support or treatment;
- Offering personalised care, support or treatment;
- Supporting people to recognise and develop their own strengths and abilities to enable them to live an independent and fulfilling life.

The Bevan Commission believes that this still tends to focus upon doing things to people and for people and not with people, as promoted within the prudent health principles. The Kings Fund (2014) notes that 'despite its prominence it still feels to many that 'putting patients first' is more of an aspiration than an implicit value or behavior; the reality lags behind the rhetoric'.

International examples of patient centred care that incorporate approaches from the social model perspective include; The Esther Network, Sweden (Davies 2007), Participatory Democracy in Healthcare, Brazil (Cornwall 2007) and the Nuka System of Care, Alaska USA (Hussey & Gottleib 2014).

DETERMINANTS OF HEALTH

The most powerful determinants of (ill) health are social gradients (Marmot 2004) and the linked problem of regional deprivation (Aylward and Phillips 2008). There is a 10-fold difference in Incapacity Benefit rates between the least and most deprived communities in local authorities across England and Wales (Waddell and Aylward 2010). Death rates and life expectancy in Merthyr Tydfil compared with Ceredigion are respectively almost 50 per cent higher and around 11 years less (Welsh Government 2013). A person's past social experience becomes written into the body's physiology and pathology (Blane 1998) and lack of autonomy in life is an enduring influence leading to poor health, worklessness and frustrated wellbeing.

Class difference in mortality, morbidity and economic inactivity are consistent features of the entire human life-span (Black 1998) reinforcing the need for a wider social model for health and healthcare to ensure we address these challenges. The following key themes were set out by Professor Sir Michael Marmot as a key elements necessary to redress the balance:

- Education and training;
- Putting the patient in the broader perspective;
- NHS as employer;
- Working in partnership;
- Advocacy.

With the challenges and threats to the future sustainability of health and health services in Wales, the notion of prevention and to some extent early intervention is a recurring theme in these policy documents. Enabling individuals to lead healthier and more resilient lives is a clear goal, promoting well-being rather than just treating ill health. However the balance of resource and effort to date to reflect this goal is questionable.

Similarly, the prominence of wellbeing rather than health reflects the move to focus on the individual rather than an individual's health problem. This demands a social model which must reflect and strongly address the determinants of ill health and the many other different factors which frustrate the achievement of the people's wellbeing.

Each life stage presents different health needs and diverse challenges that will require an approach that aims to address these in the most meaningful and integrated way. Life-long determinants of health experienced in childhood including the social, environmental and behavioural factors impact upon health and care needs in later life. For the elderly population with multiple conditions restricting their activities, the societal impact is crippling and therefore requires multifaceted orientated strategies.

CONCEPTUAL MODELS OF HEALTH, ILLNESS AND DISABILITY

Conceptual models of health, illness and disability are a practical approach to moving from theory to reality (McLaren 1998, Llewellyn and Hogan 2000) and a means of aiding understanding, management and research about what is required to deliver prudent health and healthcare for the people in Wales.

Conceptual models help crystallize thinking, improve understanding and recognise the impact of human, social, environmental and economic implications. They can help develop joint decision making, facilitate co-production of solutions and engineer new interventions. Importantly they play a critical

role in clarifying and formulating desired tangible outcomes and a sound framework for effective measurement and evaluation (Waddell and Aylward 2010). Inevitably each model has its own strengths and weaknesses.

The current predominant biomedical model still provides the basis for our current health care system, reflecting the medicalisation of our population ("I have a health problem and need to see a doctor or other health professional who will make me better"), reinforcing the medicalisation of the health service, ("we have all these patients waiting for procedures, and I am measured on waiting times and throughput") and the medicalisation of our policy makers ("having more doctors and nurses would sort out the problems in the NHS").

The desired goal of healthcare is to eliminate or minimise the impacts of ill health and disabilities through effective and timely treatment and to enhance optimum functional recovery, as prudently as possible. It is about enabling people to do as much as possible as measured by functionality (CQ5D). Unfortunately the health service is not well equipped for the latter and raises questions around its validity as the only vehicle to deliver it.

The "achievement of health and wellbeing with the public, patients and professionals as equal partners through co-production" is an overarching basic tenet to be applied alongside the other three prudent principles. This cannot be achieved within the confines of a strictly biomedical model which fails to include unique human attributes and the socio-economic determinants of ill health (Engel 1980, Peters 1996) and is Cartesian dualist, reductionist and deterministic (Waddell and Aylward 2010).

Social models and the role of personal and psychological factors provide a better understanding of health, wellbeing, sickness and disability. They also impact upon broader complex issues such as social exclusion, deprivation, capacity for work and developing interventions aimed at facilitating return to optimal health and the achievement of wellbeing. A social model of human illness that takes account of the person, their health problems and their social context has profound implications for healthcare, and social policy.

The biopsychosocial model first described by Engel (1977) provides both a philosophy for clinical engagement and a set of practical tools (Schultz et al 2000, Borrell-Carrio et al 2004) for engagement between health care professionals and patients. This engenders a culture of ownership by the participating parties in decision-making and in gaining mutually agreed goals, an important characteristic of coproduction and key prudent health principle.

At a practical level the focus on personal matters and the social milieu advances a better understanding by all parties of illness, sickness and disability. It promotes health literacy providing a framework for better clinical assessment, joint management of health, socio-domestic matters, empowerment and enablement. The dominance of aetiology pathogenesis and organic nature of the health condition in medical models is tempered in biopsychosocial models by focusing on joint management between the patient and the health care professional (and other key players) moving from predominantly clinical outcomes to personal and social outcomes. A biopsychosocial model acknowledges that people may have a condition affecting their health, but the extent to which the health condition affects their ability to cope is affected by their wider social circumstances e.g. employment, education and skills, housing, relationships, environment and lifestyle, as well access to effective rehabilitation following illness.

If we are to maximise the wellbeing and functioning of the population then we must recognise that the activities of all aspects of the public life and the public sector which serves them are equally important. The close links between social exclusion, disadvantage and poverty and that the challenges faced by people with disabilities and illnesses do not lie solely within a recognised health condition or diagnosis. They are also impacted upon by the social and economic circumstances of the individual and the way society and the healthcare system is organised and delivered. Conventional healthcare is, of course, important, but healthcare alone is not paramount in achieving good health and wellbeing.

One proposed new definition of health is articulated as "the ability to adapt and self-manage in the face of social, physical and emotional challenges" (Huber et al 2011). It also describes it as "ability to cope" as distinct from the WHO definition as "a state of complete physical, mental and social wellbeing and not merely the absence of disease" (WHO 1948).

In Scotland the definition of health developed for the working age population focuses on "maximising the function of each citizen" (Scottish Executive 2004) and recognises that this is a multiagency as well as individual responsibility.

It follows from the above that any new definition which relates to health also has to recognise explicitly that improving health and wellbeing is not solely the responsibility of the health service, but also should involve the wider public and third sector as well as employers and the citizen. The biopsychosocial model of health places responsibility for gaining good health beyond the NHS treatment service.

A wider biopsychosocial model of health and healthcare must provide all the essential elements which encourage, promote and support the ability of the citizen to maintain health, adapt, enable self-management and secure the environment and freedom for people to do that as circumstances change. Thus the individual and their needs prompt treatment or rehabilitation when necessary, rather than being directed by the system or services available. Equally important is the need to help them address what matters most to them including the issues that may exist in their personal lives, social circumstances and environment.

MEDICAL MODEL V SOCIAL MODEL

'Medicine has to some extent become a victim of its own 'life-saving' success and as a result it presents us with uncomfortable moral and ethical dilemmas (Elliot 2011). It drives a medical model of care which places the 'power' with the professionals delivering care rather than the individual receiving it. Blaming health professionals for this, while fashionable, is inappropriate.

The health service is sometimes wrongly perceived and often misunderstood by the population at large, as well as by politicians, as the primary actor with responsibility for improving the health of Wales. For instance general practitioners are meant competently to recognise a person's holistic health and social problems in a 7 -10 minute consultation, while dealing with the medical complaint. The health service is regularly criticised for not doing enough to reduce the unnecessary admissions to hospital with the inevitable bed blockage, by supporting people in their homes. This is as much a local authority function and it is often where such boundaries cross that the confusion lies and the patient is lost in the process.

A social model perspective provides a different viewpoint and way of looking at and understanding health and care needs. It embeds an holistic approach on how we view people as individuals with a wide range of different needs and circumstances. It is complex and multi-faceted and does not lend itself to being discretely identified but presents as bundles of complex health and social care provided by a range of different agencies (local government, NHS and the third sector) and often changing over time.

A social model will take account of these wider factors and enable individuals to achieve their maximum potential physically, mentally and socially. This recognises societal responsibility, starting with each individual, but ensuring that all of the public sector, the third sector and indeed the private sector, are all focused upon this common purpose, through a prudent approach to health and wellbeing.

This should ensure the effective delivery of health and wellbeing for all, through employment, education and skills, housing and health and care services when needed. This will require real joined up thinking in practice as well as across policy, organisational and professional boundaries where, for example, rehabilitation after illness and injury involves leisure services, health and social care services, employability support and advice and carer support and self-care.

This common purpose includes a healthy and supportive physical environment, where good housing, work and community resources fully maximise the potential of the individual, their health and their economic success.

LEGACY BARRIERS TO CHANGE

We have seen a continued failure by government to join up health, social care, employment, housing, welfare and education. This, combined with ingrained professional attitudes are powerful barriers to achieving the approaches seen in a social model, as are the views of the public, who can be equally inhibiting and at times irrational.

In theory, when asked, the public may want to have more say over services, but in practice few actually get involved (Public Services Trust 2010). It is often only in a crisis situation that mobilises large-scale public involvement, which can result in corresponding political action. The challenge therefore remains as to how we ensure that that we effectively rebalance the relationship between the citizens and the state in a meaningful and prudent way.

When things go spectacularly and publicly wrong, as they did in the cases of GP Harold Shipman or the Mid Staffordshire NHS Foundation Trust, the instinctive policy and political response, for understandable reasons, has been seen to being to enhance safety and protection through increased regulation, rather than to liberate and empower. Creating the conditions in which people have more say has not been the dominating narrative (Kings Fund 2014). The public may want a greater say but still expect the state to come to their rescue.

Finance will always be an important consideration and we all have a responsibility to ensure that we get the very best we can from the total resources available to us. Spending public resources wisely, prioritised according to greatest need is difficult,

especially when we also have to consider the balance between prevention, early intervention, treatment and care, from the young to the elderly. While there is inevitably an emphasis on finance and financial regimens, this differs between macro level in health and the micro individual budgets seen within social care. Theseare driven by the different ways in which these sectors of care are financed, organised and delivered.

While more joined up and integrated working is also often highlighted in policy, and indeed by the Commission, the disparity in the way different elements of care are financed and delivered are major barriers that must be overcome to ensure care is based upon the individual's health and social care needs and is fair and sustainable for everyone, irrespective of their position in society.

In summary, what we see is good will and sound aspirations based upon predominantly medical outcomes in a somewhat complicated and fragmented backdrop of policies and legislation What we need is a better balanced combination of all models; one simple and clear model which sets out what is required and how everyone can contribute, redrawing the relationship between the citizen and the state and rebalancing rights and responsibilities.

A COMMON PURPOSE & VISION FOR WALES

A Prudent Model of Health and Care

Engaging with and gaining the support of all partners in this shared vision will be crucial to its success. A Prudent Model of Health and Care will need widespread sign up and active support from the public sector, private industry, the third sector and the public itself, if we are to achieve better health and wellbeing for people in Wales.

The transformation and integration of thinking, service design and service delivery should also form key features of a future model which should be places for ongoing innovation, research and learning, where evaluation of effectiveness using data and public/ patient outcomes are intrinsic to their collaborative working.

Achieving its aspirations for a social, prudent model for health, rests a great deal on changing understanding, attitudes and behaviours across many constituencies. This will not be easy to achieve and will be a generational challenge.

Some practical actions to aim for include:

- Sign up and practical support for maintaining health and wellbeing from employers, employees from the public and private sector;
- Focus a concerted effort on the wellbeing during the early years of life and robustly tacklingadverse childhood experiences;
- Achieve young people's maximum potential with more targeted support for those at greater risk such as 'looked after' children;
- Seamless and consistent transition from school to skill development with specific targeted approaches to support those at greatest risk of falling through the system into NEETS;
- Health improvement/employment and housing programmes addressed in an integrated way and targeted at those most disadvantaged;
- Maximise recovery and rehabilitation when sick or injured with the objective of achieving optimal functioning of body and mind;
- The elderly should have free access to leisure services and other programmes designed topromote and maintain physical and social function.

CONCLUSION

Given the fact that the wellbeing of the population in Wales has to be a multiagency concern and the desired objective in which everyone should share responsibility, it is strongly recommended that the new model to achieve health and wellbeing should be based on the concept of Prudent Health and Care and the thorough application of its principles.

In Wales, we propose a new Prudent and co-operative Model of Health and Care which promotes innovation and thus a new way of thinking and working is the best way to achieve the desired outcomes for the health and wellbeing of the people of Wales.

One which explicitly places the responsibility to improve health and wellbeing across society as a whole in an integrated way and fully exploits the, as yet, untapped resources and ambitions of NHS Wales.

Health is about enabling and where necessary supporting each citizen to maximise their wellbeing and functioning so that they can do as much as possible, for as long as possible, or as long as they want to in both their working and personal lives.

REFERENCES

Aylward M & Phillips CJ (2008):
Report for Edwina Hart AM, Minister for Health and Social Services,Welsh Government

Bevan Commission (2014):
Prudent Healthcare Principles. Available at www.bevancommission.org

Bevan Commission (2015):
A Workforce Fit for Prudent Healthcare. Available at www.bevancommission.org

Black C. (2008):
Working for a Healthier Tomorrow: Dame Carol Black's Review of the Health of Britain's Working Age Population. London: TSO. Available at: www.workingforhealth.gov.uk/documents

Blane D, Montgomery S & Berney L. (1998):
Social Class Differences in Lifetime Exposure to Environmental Hazards. Sociology of Health and Illness. 20:532-536

Borrell-Carrió F, Suchman AL & Epstein RM. (2004):
The Biopsychosocial Model 25 years Later: Principles, Practice, and Scientific Inquiry. Ann Fam Med 2: 576-82

Cornwall A. (2007):
Deliberating Democracy: Scenes from a Brazilian Municipal Health Council. Brighton: Institute of Development Studies

Davies J. (2012):
Person Driven Care. Cardiff: 1000 Lives Improvement. Available at: www.plus.rjl.se/info_files

Elliot J. (2011):
Moving beyond the medical model Journal of holistic healthcare. Available at: www.martinsey.org.uk/pdf/moving.pdf

Engel GL. (1977):
The Need for a New Medical Model: A Challenge for Biomedicine. Science 196:129–36

Engel GL. (1980):
The Clinical Application of the Biopsychosocial Model. Am J Psychiatry. 137: 535–805

Health Foundation (2014):
Person Centred Care Made Simple. Available at: www.health.org.uk/publication

Health Information Network. (2016):
What is Person Centred Care and Why is it Important. Available at www.hin-southlondon.org

Huber M, Knottnerus JA, Green L, van der Horst H, Jadad AR Kromhout D, Leonard B, Lorig K, Loureiro MI, van der Meer, JWM, Schnabel P, Smith R, van Weel C & Smid H (2011):
How Should We Define Health? BMJ ; 343. Available at www.doi.org/10.1136/bmj.d4163

Hussey R. & Gottleib K. (2014):
Redesigning Healthcare: Learning from the Nuka System of Care to Inform the Development of Healthcare in NHS Wales. Cardiff: 1000 Lives Improvement

Kings Fund. (2014):
People in Control of Their Own Health and Care: The State of Involvement. Available at www.kingsfund.org.uk

Llewellyn A & Hogan K. (2000):
The Use and Abuse of Models of Disability. Disabil Soc 15: 157–65.

McLaren N. (1998):
A Critical Review of the Biopsychosocial Model. Aust N Z J Psychiatry 32: 86–92

Marmot M. (2004):
Status Syndrome. London: Bloomsbury.

Peters DJ. (1996):
Disablement Observed, Addressed and Experienced: Integrating Subjective Experience into Disablement Models. Disabil Rehabil 18: 593–603

Public Services Trust. (2010):
What Do People Want, Need and Expect from Public Services? 2020 Public Services Trust at the RSA.

Schultz IZ, Crook J, Fraser K & Joy PW. (2000):
Models of Diagnosis and Rehabilitation in Musculoskeletal Pain-related Occupational Disability. J Occup Rehabil 10: 271–93.

Scottish Executive. (2004):
Healthy Working Lives: A Plan for Action. Edinburgh: Scottish Executive. Available at www.scotland.gov.uk/Resource

Waddell G & Aylward MA. (2010):
Models of Sickness and Disability Applied to Common Health Problems. Available at www.webility.md/praxis/downloads

Welsh Government. (2012):
Together for Health. Available at www.gov.wales/docs/dhss/publications

Welsh Government. (2013):
Chief Medical Officer for Wales Annual Report 2013-14 Healthier, Happier, Fairer. Available at www.wales.nhs.uk/documents

Welsh Government. (2014):
Social Services and Wellbeing Act (Wales). Available at www.gov.wales/docs/dhss/publications

Welsh Government. (2015):
Public Health Bill (Wales). Available at www.senedd.assembly.wales

Welsh Government. (2015):
Wellbeing of Future Generations (Wales) Act. Available at www.gov.wales/docs/dsjlg/publications

World Health Organisation. (1948):
Preamble to the Constitution of the World Health Organization. Available at www.who.int/about/ definition/en/print.html

Comisiwn
Bevan
Commission

The Bevan Commission is an independent and authoritative think tank made up of international experts who challenge current practice and work with others to find solutions to create a sustainable health and care system **fit for the future**.

This publication can be referenced as:
Bevan Commission (2017) Exploiting the Welsh Health Legacy:
A New Way of Thinking: The Need for a Prudent Model of Health & Care

www.bevancommission.org
@BevanCommission