ACHIEVING PATIENT-CENTRED CARE OR FLOCCINAUCINIHIPIFICATION BY INGENIOUS PROJECTORS OF PERPETUAL MOTION BELIEVING IN THEIR OWN INFALLIBILITY

[WITH A LITTLE HELP FROM ‘A WORKING MAN’ AND EINSTEIN]

ADDRESS TO THE HOSPITAL AND COMMUNITY DENTISTRY CONFERENCE

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Thank you for the opportunity to address you again. As always my comments are personal observations, although in broad terms at least I believe they are consistent with the Association’s view on the matters discussed. In this address I would like to focus on the theme of whether patient-centred care is to be treated as a slogan or political sound bite, or something worth fighting for and achievable. I am advocating the latter through an interlinked focus on distributive clinical leadership and investment in the district health board specialist workforce.

I discuss the performance of leadership in this address. By this I’m referring to those that make higher level decisions and definitely not to those many hard working and able operational managers whose contribution to the quality of our public health service is considerable.

The Wisdom of ‘A Working Man’

Recently, as an indication of one of my fetishes, I was reading as one does the *New Zealand Spectator & Cook’s Strait Guardian* (22 September 1849). I was struck by a letter to the editor by ‘A Working Man’ on the theorist and leader of early colonisation in New Zealand, EG Wakefield. Responding to an earlier letter by Wakefield, the writer vividly attacked the founder of the New Zealand Company as being like ‘ingenious projectors of perpetual motion’ by believing in his own infallibility when in reality his vision was impractical.

Wakefield was described as believing that large capitalists would “flock” to New Zealand, invest and provide “combined sources of employment” for all the “working class” to “receive full employment at liberal wages”. This would enable workers to save enough to then become landowners. But instead of wealthy capitalists, the colony got mainly “poor adventurers from the middle classes of Britain”. Few workers were able to purchase land. He concluded by describing Wakefield as one of the “greatest humbugs in existence”.

This got me thinking about the leadership within our public health system and many of the policies that drive it. We certainly see the impracticality of particular policies (underpinned by a form of utopianism) - witness the internally contradictory strategic health services plan of Southern DHB which, if you managed to put aside that it possesses neither strategy nor planning, might be quite good. If you could not put this aside, then would ‘A Working Man’
consider this as designed by “humbugs”? I’ll leave our Southern DHB members to advise on that.

If you were a DHB specialist in the lower North Island you would note that what was described as something like “wealthy capitalists” coming to the rescue looks increasing like “poor adventurers” taking control of the Wellington and Hutt hospitals’ laboratories.

But what particularly resonated was the expression “ingenious projectors of perpetual motion by believing in his [their] own infallibility”. This summarises so much of our decision-making in health. As a result of failure to diagnose (due to a failure to engage right at the beginning with specialists) a perceived problem or challenge, an idea emerges which, to borrow from Andrew Little, could best be described as “crap”. Its infallible “projectors” then promote it vigorously and repetitively through “perpetual motion” (and marginalise those with far greater expertise and experience in the subject matter) until such time it becomes perceived reality. This is strikingly descriptive of the decision-making processes in the DHBs I’ve just referred to, but it goes well beyond them.

This is scary stuff particularly when the observation of our former National President Dr Peter Roberts is noted: bad policies do more harm to patients than flesh eating bugs.

**Trans Pacific Partnership Agreement**

Minister of Trade Tim Groser uses of ‘perpetual motion’ in order to create an image of intellectual ‘infallibility’ when defending the controversial Trans Pacific Partnership Agreement (TPPA). Courtesy of WikiLeaks we now know the TPPA would give unprecedented powers to big business interests, including ‘Big Pharma’ and tobacco companies, to interfere in the sovereign decision-making over our public health and medicines policies. It would tie one of Pharmac’s hands behind its back and put the other one in a sling when negotiating over pharmaceutical prices and the use of generics with international companies whose already considerable power will be significantly enhanced by TPPA.

The Government has made a number of concessions which tip the balance of power away from Pharmac and toward the pharmaceutical industry. When taken together, these changes can be expected to exert a major impact on Pharmac’s ability to effectively fulfil its statutory function. The use of investor-state dispute processes against the New Zealand Government under the TPPA could negate the benefits for New Zealanders of any
Pharmac decisions. Australia has closed the investor-state loophole in the TPPA by explicitly excluding their Pharmac equivalent from being subjected to these lawsuits, but New Zealand and Pharmac remain exposed. I did not think it was possible to be outflanked by Tony Abbott on the sanity front.

Mr Groser’s standard response is that those who are critical of the TPPA are (a) ideological and (b) politically irrelevant. His immediate target is Jane Kelsey, whom he dismisses as an activist, neglecting the point that she is a professor of law and an internationally recognised expert. Further, he ignores the fact that critics include a couple of Nobel Prize winning economists, international legal experts (eg, Amy Kapczynski, Yale Law School, *The Trans Pacific Journal of Medicine - Is It Bad for Your Health?*, *New England Journal of Medicine*, 10 June 2015), and senior hospital specialists in New Zealand. But his use of ‘perpetual motion’ and his ‘infallibility’ are unbending. ‘A Working Man’ would easily read the personality type if transported in time from 1849 to today.

**Health Targets**

In another way Health Minister Jonathan Coleman uses ‘perpetual’ motion to defend his government’s record in its stewardship of the health system when questioned about its performance. He often resorts to quoting the results of the Government’s official health targets. Targets can have an important role when they make good clinical sense and lead to systems improvement. But they can only apply to that which is easily countable (a small part of DHB-provided patient services). Further, there is a high risk of unintended consequences such as ‘suspended’ elective lists and ‘virtual wards’ for the six hour target.

Given that these targets largely exclude major areas of health such as acute, chronic, mental health and community care, they tell us nothing useful about the performance of our public health system. But the Minister’s ‘ingenious perpetual motion’ risks reducing the utility of targets to political sound bites. Again, a political style that ‘A Working Man’ would easily recognise and rip into this.

**Looking to Einstein rather than Churchill**

Previously I’ve quoted the observation attributed to Winston Churchill that the Americans could always be relied upon to make the right decision once they had exhausted every other option. I previously argued that perhaps our health bosses, having exhausted the options of business competition and managerialism, would now recognise that the
remaining option was clinical leadership (particularly when distributed throughout the specialist workforce). This was in the context of the *Time for Quality Agreement* between ASMS and the DHBs (2008) and the current Government's advice to DHBs on clinical leadership, *In Good Hands* (2009).

At the time I adopted the cup half full approach. Now I realise that someone has tipped the water out of the cup. Six years later it is evident that clinical leadership is in bad hands. The assessment of our DHB-employed members when recently surveyed electronically is damming (especially when compared with our earlier survey in late 2013). In summary, while 2013 was bad, 2015 was marginally worse. For example:

- In 2015 29% of respondents believed their DHB was genuinely committed to distributive clinical leadership (down from a poor 30% in 2013) while as many as 48% disagreed (up by 1% from 2013). In only two DHBs did the affirmatives exceed 50% (Canterbury and Northland).

- In 2015 27% of respondents believed that the culture of their DHB encourages distributive clinical leadership (down from an also poor 28% in 2013) while as many as 58% disagreed (up by 3% from 2013). In only two DHBs did the affirmatives exceed 50% (Hawke’s Bay and Canterbury).

Rather than Churchill perhaps I should have looked to Albert Einstein for insight into the leadership of our public health service given that he described *insanity as doing the same thing over again and expecting different results*. Or: *the difference between stupidity and genius is that genius has its limits.*

My application of Einstein to what appears to be an enduring feature of our health leadership is that if at first you don’t completely stuff it up, don’t give up; give it another go!

**1990s Ideology minus the Binge**

In its first six years, with much legitimacy and success, the National-led Government did demonstrate that it was, at least in respect of health policy, not the same as the National Government of the 1990s which went on a disastrous ideological market forces binge. Privatisation and contractualism were two of the underpinning foundations of this period. But there are now signs of a return to that ideology, albeit less binged and more astutely planned.
In the related public good area of social housing (a critical determinant of health) there is clearly a contracting out agenda. After failing to create some form of market among New Zealand non-government organisations, seemingly in desperation the Government is seeking support across the ditch in order to maintain ‘perpetual motion’.

**Social Bonds**

The ASMS has not formed a position on the Government’s announcement of social bonds, beginning with mental health, but it is worrying that this policy is not based on proven supporting evidence. But ‘perpetual motion’ is used to promote it in the absence of evidence. The bond holding investors profits would be derived from achieving their goals (‘targets’ by another name).

If the Government’s official health targets are any indication, then it is likely that the social bonds targets will miss most of what is needed in mental health (especially in a service that has less than many other services that can be counted). There is a risk of not only hitting the target without benefiting the patient but even worse – dragging scarce funding away from important patient needs and fragmenting integrated service delivery.

In its social bonds policy the Government seems to be reverting to its discredited 1990s position of contractualism; that is, all you need to do is put things in a contract and your objectives would be achieved. If health professionals confined themselves to working to their contract, the system would fall over.

**Public Hospital Laboratories**

In the ASMS Annual Conference last November, in response to a question about the plan of the Capital & Coast and Hutt Valley DHBs to privatise their hospital laboratories, the Minister of Health said he would be guided by the advice of the doctors (who in this case were primarily pathologists). But despite all the DHB-employed pathologists writing to him recommending that he not approve this plan and despite a similar letter from the Society of Pathologists (New Zealand Committee of the Australian and New Zealand College), he approved it. His argument boils down to the assertion that whatever is in the contract between the private company and the DHBs will resolve concerns. In other words: narrow contractualism.

But:
• Unless corrective action is undertaken, he will have approved the ‘gifting’ to the controversial Healthscope of the most critical part of the laboratory workforce (hospital pathologists) needed to monitor and review the performance of the contract. The DHBs’ lose their most important intellectual capital for this critical task. Instead they are treated like used furniture.

• After the Minister approved the privatisation, the parent company announced that it has sold its laboratory businesses in Australia, thereby cutting off a critical support base and leaving its New Zealand operations to sink or swim.

• When the other private company (Aotea) bidding for the contract pulled out because it believed that what was being required of them was both clinically and financially unsafe, the remaining bidder (Healthscope) privately threatened the same. All of a sudden it had the two DHBs over a barrel and, guess what, as successful hardnosed business operators, the company rolled the barrel over the hapless DHBs. This was only discovered by the ASMS’s use of the Official Information Act.

• There is now alarm among the hospital pathologists that not all the specifications that they required and were agreed may have ended up in the final contract.

This is sweating material for the Minister. It is the price of not practising what one preaches, and giving more stock to hierarchical managerialism than clinical expertise.

The hierarchy of the two DHBs persuaded the Minister to his view through the use of ‘A Working Man’s’ notion of ‘perpetual motion’ to achieve their objective, including marginalising the pathologists and end user specialists as well as making it impossible for Board members to receive any advice that was contrary to their own infallible position. It brings to mind Einstein again:

_Only two things are infinite, the universe and human stupidity, and I’m not sure about the former._

The Minister should have followed another Einstein pearl of wisdom: _The only source of knowledge is experience._
Back to the TPPA

Another related concern is the Government’s preparedness to increase the influence of large overseas businesses into our health system through the TPPA, including through the investor-state international disputes tribunal which will be loaded in favour of so-called free trade criteria.

After previous government denials, this week the Prime Minister (probably because of the existence of eventually discoverable secret documentation) belatedly admitted that the costs of pharmaceuticals will increase as a consequence of the increased monopoly power to extend patents (thereby further delaying cheaper generics) although he then proceeded to downplay the significance.

It is disappointing and disconcerting that the Government is comfortable with the fact that ‘Big Pharma’ and ‘Big Tobacco’ can have more engagement and access to TPPA documents and decision-making processes than health professionals in New Zealand.

Senior doctors and dentists at the ASMS Annual Conference last year voted overwhelmingly in favour of a formal independent health assessment of the TPPA, expressing concern about the potential impact on health care in this country. They also voted for the ASMS to oppose the TPPA on the grounds that health care would suffer from the loss of national autonomy that may result. They are evidently also dismissed by the Trade Minister as politically irrelevant. He has not been so disparaging about ‘Big Pharma’ and the tobacco and alcohol industries.

Government Reviews

Through the Ministry of Health the Government has initiated two reviews that completely their reports to the Director-General of Health by 30 June (within a time frame of three months). One is on Capacity & Capability and the other is on Funding.

As you will probably be aware on Monday and Tuesday this week Radio New Zealand’s Morning Report featured the leaked recommendations of these two reviews. These recommendations were contained in two three page documents shared with alarmed DHB Chairs and Chief Executives. Mysteriously they were not given the explanatory context documentation that attempted to justify the recommendations. So, for example, there was no explanation why the first review recommended that the National Health Committee (new
technologies) be disbanded or that the Director-General of Health should have explicit influence over chief executives’ remuneration.

Broadly there appear at first glance at least (and without access to the context documents) two broad themes:

1. Increasing central government bureaucratic command and control over the operational functioning of DHBs.

2. By a combination of fragmenting the funding of DHBs and eventually opening much (probably most) of it to contestable tendering (including from private providers), trying to create a commercial market in our public health system. The practical effect is the fragmentation of patient service delivery (which does best the more integrated it is) and de-stabilising service planning and development. To put it another way, ‘we stuffed it up in the 1990s so well that we deserve another go’.

These reviews have been poorly constructed and poorly managed. Hopefully sanity in the subsequent political process will prevail although the Minister of Health’s initial response, at least in respect of the funding recommendations, is not encouraging.

**Is the issue $11.75b or $300m?**

Last August the ASMS brought Professor Martin McKee from London to New Zealand as part of our 25th anniversary celebration to speak on the importance of investing in health in developed economies for economic wellbeing. He reported International Monetary Fund analysis showing that for every government dollar spent on health, there was a $4.30 benefit (an even higher benefit of $8.20 was identified for education).

In the New Zealand context at least, ASMS would see the priority for investment being in the DHBs specialist workforce capacity because of its critically strategic leadership role in the design, configuration and delivery of services. We desperately need but do not have a DHB specialist workforce investment strategy.

In the absence of a workforce investment strategy we are forced to focus on the negative picture that the data provides. This is starkly summarised by the following:
• Vote Health in the 2015 budget is an estimated $245 million behind what is needed to cover announced new services, increasing costs, population growth and the effects of an ageing population.
• Between 2009/10 and 2014/15 accumulated funding shortfalls amount to an estimated $0.8 billion, taking into account factors such as cost increases, average wage increases and population changes. This year’s funding shortfall would make it more than $1 billion.

There is a serious lack of a specialist workforce investment strategy in DHBs. Along with technology, the workforce (especially when both are wrapped around by distributive clinical leadership) is the main driver of quality and financial improvement in health systems. Because of this investment deficit, the debate over health funding narrows down to the financial deficit discussed above.

In practical terms, DHBs receives around $11.7 billion funding. This includes an increase of just over $300 million. The consequence of this absence of a workforce investment strategy means the focus is on the inadequacy of the $300 million increase, rather than the effectiveness of the $11.7 billion.

We can be smarter than this

Patients and taxpayers who fund the health system deserve better. In reality we don’t know whether either $11.7 billion or $300 million are adequate or inadequate. We can only conclude that in the absence of this investment strategy, based on the intense pressures at the clinical and diagnostic front lines, both are seriously inadequate.

In November 2010, the DHBs and ASMS jointly concluded in a document known as Securing a Sustainable Senior Medical and Dental Officer in New Zealand: the Business Case [http://www.asms.org.nz/wp-content/uploads/2014/07/The-Business-Case-Nov-2010.pdf] that (a) there was considerable financial waste in DHBs and (b) millions of dollars could be saved by investing in the capacity (numbers) of DHB specialists to enable them to engage in process improvement initiatives (as well as the benefits of a stabilised workforce). This endeavour fell over because of unprofessional conduct by a small number of individuals in the national leadership of DHBs, linked to the settlement of our national collective agreement (MECA) at that time.
Achieving Patient-Centred Care

Let’s come back to patient-centred care. If we continue as we are we will have a leadership aptly described by the word in the heading of this address that I will never be able to pronounce: *floccinaucinihilipilification* which is a rare noun and the combination of two Latin words, each of which refer to something of little or no value. It is the estimation of something as valueless and, appropriately, one of the longest words in the English language.

Patient-centred care can’t be provided without distributive clinical leadership, which is not just about the treatment of the patient but also improving the systems and processes that public hospitals - as the most complex and highly integrated part of our health service - require if the patient journey is to be closer to optimal than sub-optimal.

If we continue down the unpronounceable word path, then patient-centred care becomes a slogan and a sound bite (along with models of care) without practical meaning. But if we go down the path of investing in the DHB specialist workforce capacity (time, numbers and roles) in order to achieve the full benefits (not just partial) of distributive clinical leadership, then we can put meaning into the language of the patient being at the centre of the care process because we would have the wherewithal to do so. The Canterbury Initiative between community and hospital care has achieved so much for patients and taxpayers without sufficient investment in capacity. Imagine how much more could be achieved (including nationally) with this investment.

This is where Health Workforce New Zealand comes in. Late last year in its report, *The Role of Health Workforce New Zealand*, it identified public hospital specialists as vulnerable, and advised that the impact of prolonged labour market shortages on DHB-employed senior doctors was the most important issue for HWNZ’s Medical Workforce Taskforce to address.

Specifically, the report says on page 13:

*While the Taskforce initially focused on the immediate postgraduate period, it has now adopted a whole-of-career perspective. The most important issue currently is the impact of a prolonged period of medical labour market shortages on the workloads, wellbeing and productivity of DHB-employed senior doctors. Other areas under*
consideration, some of which are directly related, include the distribution and long-term retention, including retirement intentions, of doctors trained in New Zealand and overseas. Leadership opportunities in systems improvement and innovation, consistent with the In Good Hands report on clinical leadership, are another focus for the Taskforce.

The challenge for HWNZ is to engage with us to address this priority. Show us that this statement is the light at the end of the tunnel rather than a train coming in the opposite direction.

Let’s make sure that the 1849 assessment by ‘A Working Man’ of Wakefield does not become applicable to today’s health leadership, that we don’t have decision-making by ‘perpetual motion’ based on self-diagnosed ‘infallibility’, that we are not led by ‘humbugs’, and that Einstein’s following observation does not become the defining feature of the leadership of this country’s public health service:

*The world is a dangerous place to live; not because of the people who are evil, but because of the people who don’t do anything about it.*

Ian Powell