ASMS

ASSOCIATION OF SALARIED MEDICAL SPECIALISTS

TOI MATA HAUORA

# ELEMENTARY, DEAR DAVID

## ADDRESS TO THE HOSPITAL AND COMMUNITY DENTISTRY CONFERENCE

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# ADDRESS TO THE HOSPITAL AND COMMUNITY DENTISTRY CONFERENCE

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 understanding our new Minister of Health Hon Dr David Clark and the pathways he might travel.

## UNDERSTANDING DAVID

Since the coming into being of the Public Health and Disability Act 2000 and before last year's surprise general election outcome, we have had five health ministers – Annette King (six years), Pete Hodgson (two years), David Cunliffe (one year), Tony Ryall (six years) and Jonathan Coleman (three years). Now we have a sixth minister, David Clark.

Who is David Clark? Well, to begin with he's a very nice person. But I had better say more than this for fear of giving him the consequential political kiss of death. He's intelligent, has a good value base and (like myself) was given a placid temperament by his parents (a prerequisite for survival in the health system).

He does have the high-risk attributes of being both a theologian and economist – a potentially deadly combination. The most famous person with these combined attributes is Scotland's Adam Smith who, in the 18th century, skilfully constructed the foundations of classical free market economic theory with his most notable publication being *The Wealth of Nations*. But even the free market driven Smith had a sense of the need for some level of public good. In his ideological construct, this was provided by his notion of an 'invisible hand'.

But the invisible hand of Adam Smith was operating in the economy of the baker, butcher and candlestick maker, not today's modern complex economy and society. The closest New Zealand has come to applying classical free market economic theory in our public health service was in the

ideological binge of commercially competing public hospitals run by state-owned companies in the 1990s under the then National Government. By this time there was no invisible hand. Instead we had a cumbersome iron fist without even a velvet glove.

Fortunately, despite both being Presbyterian, Dr Clark is from a broader church than the church of Dr Smith and has a strong sense of why New Zealand needs and has a universal public health service.

## A MINISTERIAL TREAT

One of the special treats of the Minister of Health is to send an annual Letter of Expectations to the Chairs of the country's 20 district health boards. It is a letter of instruction in which the Minister of the day can tell health bosses who really is in charge. His Letter for the 2018/19 year was the first opportunity to get a fuller sense of the new Minister's direction of travel.

In this Letter Dr Clark has given DHBs a clear signal about the Government's health priorities. There is a welcome Government intention to focus on primary care, mental health, public delivery of health services, and improved equity in health outcomes. These are all worthwhile. Further, the New Zealand Nurses Organisation would have been delighted with his explicit expectation that all DHBs implement the Care Capacity Demand Management programme.

The focus on public delivery of health services represents a significant change in approach from the previous government. This clear signal on public delivery should strengthen confidence in the Government's commitment to public hospitals which have been under threat of privatisation for so long. The signal had already been given by the Minister's earlier decision to stop the controversial and financially precarious Public Private Partnerships promoted by the former Government (surprisingly, however, the Minister opted not to publicise this decision which would have been well-received). The slow learning Taranaki DHB, which had attempted to pressure him

to support its scheme to privatise its hospital laboratory, eventually came to understand the plain language of Dr Clark's letter and ungraciously agreed to back off going down this ideologically and financially irresponsible path.

## PRECARIOUS STATE OF SPECIALIST WORKFORCE IGNORED

However, the Minister's Letter of Expectations does not require DHBs to address the precarious situation of their specialist workforce. This is a significant oversight as hospital specialists are a stressed and stretched workforce, and they have been shouldering the burden of an under-resourced public health system for years to the detriment of their own health.

The following graph illustrates the extent of SMO shortages as identified by clinical leaders in individual DHBs as part of an ASMS survey:

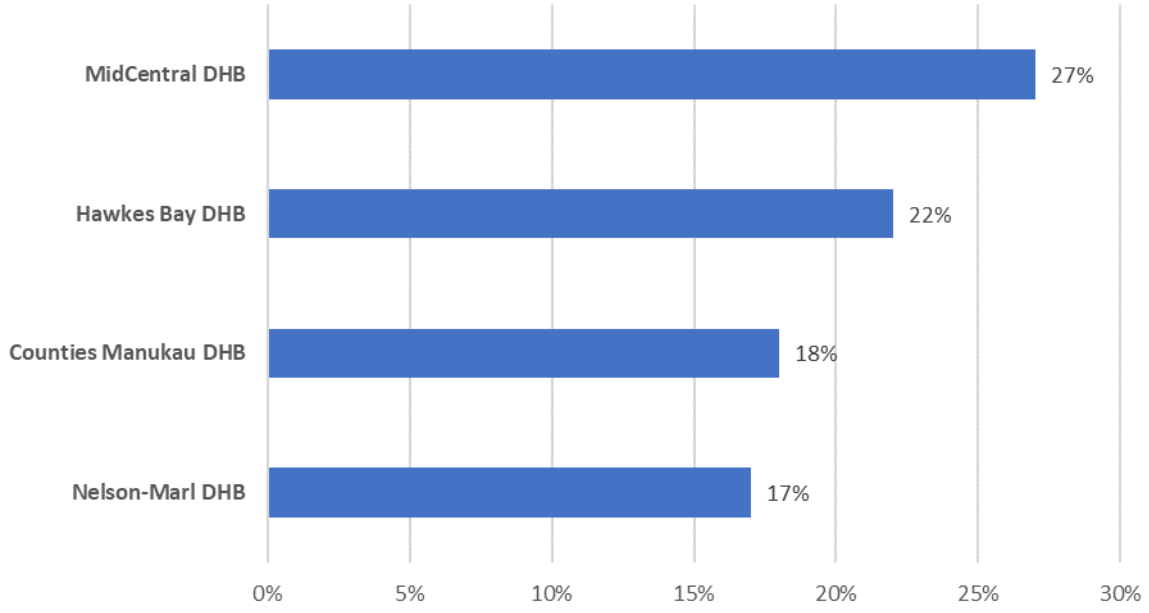


**Figure 1: Estimated staffing shortfall at selected DHBs.**

ASMS published research shows high levels of burnout (50%) among hospital specialists along with presenteeism, including working while infectious, and with 25% of specialists surveyed intending to leave DHB employment in the next five years. The following graph bluntly highlights the extent of this precariousness.

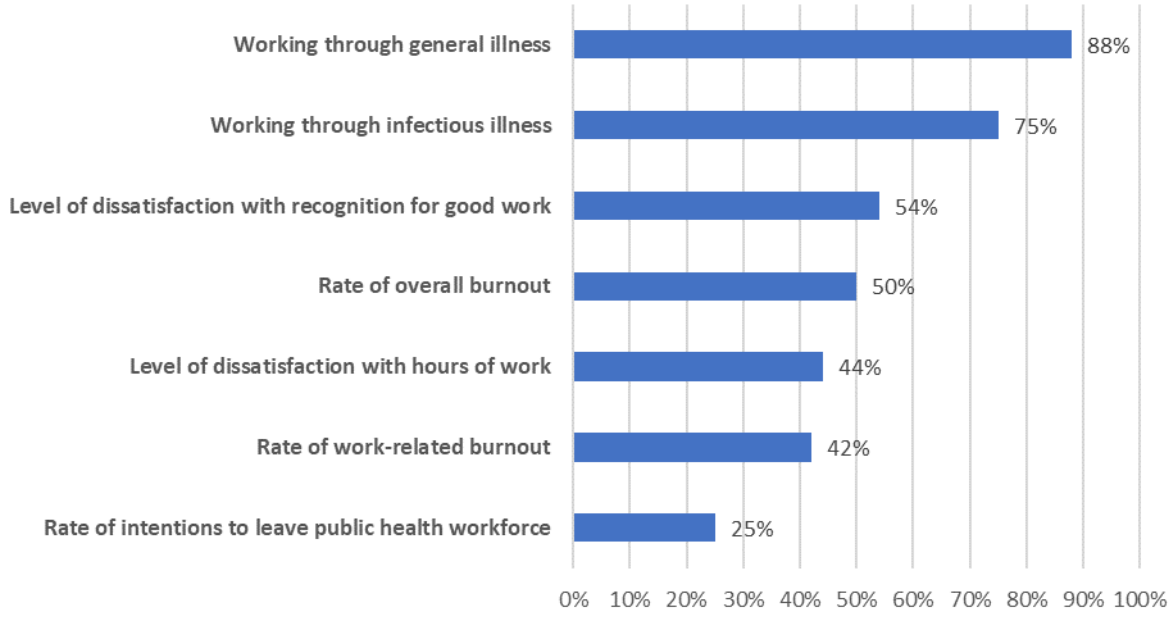


**Figure 2: Indicators of the health and well-being of the senior medical workforce.**

How on earth can specialists be expected to maintain their personal health and well-being and to ensure safe and quality patient care in such a precarious position? If the Minister of Health can require all DHBs to implement Care Capacity Demand Management for nurses, why can't he also require DHBs to ensure staffing levels for specialists that are safe for both themselves and their patients?

## CLINICAL LEADERSHIP BENEFITS ALSO IGNORED

In his Letter of Expectations, Minister Clark unfortunately continues his immediate predecessor's decision to ignore the importance of clinical leadership for DHBs. Distributed clinical leadership (supported by safe staffing levels) is the lynchpin that will help DHBs turn their precarious

situation around. Disappointingly, this has been ignored in the Minister's letter. It's clinical leadership and good engagement that will ensure the ongoing quality and accessibility of patient services, as well as helping to improve the DHBs' financial performance. As the Minister should know, what makes good clinical sense also makes good financial sense.

Health Ministers who ignore clinical leadership are giving DHB bosses a clear signal that it is not that important. It is a body blow to those hospital specialists who have been fighting for it for so many years but have been obstructed by a leadership culture of managerialism in DHBs.

It is also disappointing that Dr Clark does not encourage DHBs to follow the successful approach of Canterbury DHB in the development of health professional-led health pathways between community and hospital care. This approach is based on extensive clinical leadership and developing strong networking relationships across the Canterbury health system. Too many other DHBs have adopted a narrow approach based on limiting formal contracts and commercial 'tool kits'.

## MINISTERIAL REVIEW: NOT A FLUBDUB

David Clark has announced a highly significant and wide-ranging review of health and disability services. The usual and understandable reaction to reviews in the health sector, including by ASMS, ranges from a yawn to a groan (and sometimes, palpitations). This is based on considerable historical experience of so many duds masquerading as reviews. They have been wasteful, corrosive and expensive to the point of fiscally irresponsible. In a word, many reviews have been flubdubs – a noun meaning pretentious nonsense or show.

The review's scope includes district health boards but goes beyond them to include primary health organisations (PHOs) and the wider community sector. The draft terms of reference are broad and open to public consultation, a positive approach which contrasts with past government initiatives.

ASMS has already made a submission on the draft – broadly positive but with some cautions and recommendations for improvement.

## RELATIONAL COMMUNITY AND HOSPITAL CONTINUUM OF CARE

New Zealand's public health system, compared with universal systems around the globe, performs very well. It punches above its weight. But there are difficulties, much of which are due to sustained under-funding in a sector affected by continuing and increasing demand (especially acute and chronic). The Government advises us that it intends to address this during its occupancy of the Treasury benches. It is off to an encouraging start, but one year of reasonable funding does not make up for eight previous years of under-funding.

But there are processes and leadership culture that also constrain the effectiveness of our system. There is too much focus on primary and secondary care as somehow being organically separate, leading to narrow constructs of 'primary-led' and 'shifting services' from secondary to primary care rather like a land grab. The focus is structural, rather than relational. Instead, the emphasis should be relational based on the continuum of care between community and hospital.

The most mature example of this is the several hundred health pathways between community and hospital (broader than just primary and secondary) at Canterbury DHB. These have been developed and agreed through effective clinical leadership (not just doctors) in both community and hospital. As a result, the outcomes are much more robust, despite serious workforce capacity (shortages) issues among specialists at least.

Centred on distributed clinical leadership, good relationship-based networking and patient centred care, they have led to considerable gains both in the quality and accessibility of patient care and in financial performance. This includes the unparalleled experience of bending the curve of increasing acute demand.

This doesn't mean that we don't have disagreements with Canterbury DHB over the quality of engagement; we do. But this experience confirms the importance of this low transaction cost relational approach instead of the alternative high transaction cost contractual and structural approach that dominates our health system. Critical to its success is the leadership culture developing these pathways (distributed clinical leadership), its networking approach and the focus on patient centred care.

The Minister's review needs to focus on improving processes through a relational lens (sometimes called alliancing). This is not just through the networking approach between community and hospital, but also between DHBs sub-regionally, regionally and nationally. Clinically developed and led networks between public hospitals have achieved proven success in Scotland and New South Wales. We have made some progress in New Zealand but are some way short of realising the potential.

For this to happen, however, we need to increase the capacity of the health professional workforce. This includes specialists who face, through leadership neglect from government to DHB, a crisis as they suffer worsening chronic shortages, burnout, presenteeism and retention loss). The review should consider making explicit in the legislation an obligation on DHBs to ensure workforce empowerment and the well-being and health of those they employ.

## AVOID STRUCTURAL RATHOLES

But there are some alarm bells ringing over this risk of falling into avoidable ratholes. Dr Clark has intimated in a couple of public utterances a more structural approach; specifically, the number of DHBs. Further, medical sociologist Professor Peter Davis has argued that we should go back to the short-lived structures of four regional health authorities of the mid-1990s when the government of the day tried to run our public hospitals as commercial businesses competing with themselves

and the private sector. These four authorities controlled the funding for this competitive model that subsequently collapsed under its own ideological absurdity.

I doubt Professor Davis was proposing a return to this failed business model. It would be contrary to his own previously articulated views on this failed attempt to create a commercial market in a universal public health service. But, simplistically, he seems to be advocating for reducing our 20 DHBs to four, presumably based on the four regional groupings of DHBs we know as Northern, Midland, Central and the South Island.

There are several problems with this approach. DHBs are responsible for defined populations. These four populations are too big and dispersed for a DHB to have an effective operational focus in both community and hospital care. It is too big an ask. Look at how difficult the relatively new Southern DHB (the result of a top-down driven merger between Otago and Southland) is finding addressing the health needs of the most geographically dispersed defined population of all our 20 DHBs.

If the objective is to improve integration in the continuum of care between community (why would it not be otherwise), then smaller is better. Where there is more than one general practice voice or PHO in our 20 DHBs, it has proven very difficult to achieve the gains that have been made in Canterbury DHB (which has the added advantage of one GP voice to engage with; Pegasus). Creating four mammoths will severely impede this objective.

Structure is not the determinant of clinical collaboration between DHBs. There are already good examples of this happening now. One that hits me in the eye is the very small West Coast DHB and the very large Canterbury DHB, separated by a huge mountain range. There are longstanding historical roots to this collaboration but in recent years it has qualitatively advanced beyond Canterbury specialists doing lists or clinics on the Coast. Services on both sides of the Alps function

in a more integrative way than before, with an encouraging Transalpine feel emerging. A big brother-small brother relationship would not have allowed this.

This is still a journey, but the road map is good. It is being achieved under two DHBs rather than through a merger (although they share some senior management functions). If it had been a merger, it most likely would have fallen short. What has been important is that by having its own DHB, the West Coast and its SMOs have had a greater voice which has benefited all.

Our current four regional boundaries are somewhat artificial. Largely historical, they do not neatly capture natural clinical synergies between DHBs. For example, while Whanganui DHB has a need to consider a close relationship with its near neighbour MidCentral, particularly vulnerable smaller services and sharing critical mass, in respect of patient referrals its clinical synergies are further north in Auckland and further south in Wellington.

Merging DHBs does not of itself save money, or at least not enough to be worth the considerable hassle and disruption. Didn't the top-down-driven merger of the former Otago and Southland DHBs into the new Southern DHB work well financially with its sustained high level of debt? Does anyone in this room believe that this merger has been a success? The politically-driven failed attempt to merge by stealth the three lower North Island DHBs – Wairarapa, Hutt Valley and Capital & Coast – led only to uncertainty and a level of havoc.

The practical outcome of this review focusing on the number of DHBs will be a distraction from what is really needed to improve our public system. It would create uncertainty over the future for many working in DHBs, particularly the smaller and medium-sized ones, even greater than the poorly judged Health Benefits Ltd initiative of the former Government. The political risk of such an approach, with the next election in 2020, is high. Only policy wonks with their heads in the clouds and their feet well away from the clinical front line would contemplate going down such a short-sighted direction.

## NATIONAL AND LOCAL HEALTH SYSTEMS

A feature of all universal health systems is the tension between their internal local and national systems. All health systems struggle with getting the balance right between what works best locally, regionally and nationally. Arguably, universal health systems are too dynamic to get the balance right. But it is not the struggle that is the issue. Instead it is the quality and robustness of the struggle; the better this quality and robustness, the better for our system overall.

The reality is that we have defined geographic populations with variable diversity of needs as part of a national system. Each depends on and interacts with the other. It is logical, given its defined population, for example, to speak of a Northland health system. Conversely, it is illogical to speak of a northern health system comprising the three quite diverse metro Auckland DHBs and Northland.

In this context, the review would be better placed to consider how the operational role of the Ministry of Health might be better refined to facilitate (perhaps even direct) DHBs to focus on clinically-led relational-based networking within and between DHBs, and across the community-hospital continuum.

## REVIEW MUST NOT BE A RATIONALE FOR PROCRASTINATION OR DELAY

There is also a risk of the Government allowing shorter term exigencies to either be dumped in the bucket of the review's scope or continuing to be ignored. These include the crisis facing the DHB specialist workforce referred to earlier, and the lost opportunities caused by the failure to advance distributed clinical leadership. It is imperative, if the Minister is to be genuinely rather than rhetorically transformational, that he focuses on addressing them post haste.

As discussed earlier, a positive aspect of the Minister's Letter of Expectations to DHBs was the strong, unambiguous commitment to public provision of hospital services (and by direct contrast,

his opposition to privatisation). But there is much more for Dr Clark to front foot on this. With the various services, clinical and diagnostic, that have been privatised over the years, there is a need to plan for returning these to public provision as each contract comes up for renewal. But this should not have to wait until his big review has concluded. It does not need to be part of this review because the policy direction is already established. It should start now.

## FUNDING MECHANISMS

The Population Based Funding formula is a matter that deserves attention but need not wait until the Minister's review. There is general acceptance that a population-based funding system (with appropriate qualifiers) is sound, especially when compared with activity-driven alternatives.

But some sharply focused work is required by those with expertise in this area on fine-tuning the qualifiers, reviewing whether PHO enrolments might be a more robust method of assessing population than the five-yearly census based on smaller numbers, recognising that PBF is unreliable for addressing unexpected cost increases due to natural disasters, and making the whole process transparent instead of the current secrecy.

Major capital works funding could also be addressed more immediately instead of waiting until the review is completed. Its impact on the operational budgets of DHBs is profound and distortionary. The funding of major capital works and operational costs should be separated out. Why not use the expertise that already exists in DHBs, particularly through the chief finance officers, to advise on this? They could look at a national risk pooling system of funding major capital works that takes the pressure off operational funding.

One thing that could be done immediately is significantly increasing the decades old absurdly low threshold ($10 million) for capital works spending for triggering Government approval and Treasury monitoring.

# THE IMPORTANCE OF BEING POLITICALLY STREETWISE

Despite different political foundations, both longer serving health ministers Annette King and Tony Ryall shared a common strength. Both were politically streetwise. Before becoming health ministers, they had had some previous cabinet experience and several years in parliamentary opposition. Politics is not cricket, not that the latter's noble image is beyond reproach these days. To be effective as a senior cabinet minister you don't just require competence and intelligence; you need a good political nose and political antenna. King and Ryall had this; Jonathan Coleman did not. David Clark is a work in progress.

That does not mean that all media critiques of him are justified or correct. In some quarters, being a responsible and conscientious father and husband in accompanying three young children across the Tasman is a hanging offence. I take a different view than this crass opportunist slime attack (I would also take the same view even if it was only one young spirited child).

## TARGETS

Dr Clark is not a work in progress in terms of his objectives or his analytical capability, but he is in terms of its execution. The needless public controversy over health targets in June is a case in point. Dr Clark is right that there are serious concerns with targets, particularly when they are used to assess how well a DHB is performing, and some serious unintended consequences.

Competent journalists such as Audrey Young (*NZ Herald*) and Stacey Kirk (*Stuff*) were wrong when they slammed the Minister for removing public accountability and the public's right to know how well their DHB was performing. Targets never did this. They only focused on those things that could be more easily counted which was often the less complex. They excluded much of what happens in the public health service such as acute surgery, much of ongoing chronic illnesses and

mental health. One DHB performing well on the targets does not mean that it is performing better than one that is not performing well on these targets.

One of the biggest absurdities is that while first specialist assessments are counted, the equally important clinical follow-ups are not. The benefits of timely FSAs disappear if the clinical follow-ups are either not timely or don't happen at all; patients suffer as a result. [Strictly speaking FSAs are not an official health target, but in effect they are].

Further, the media criticism downplayed the extent of unintended consequences, confining it in a minimising way to ophthalmology. First, the impact on ophthalmology was far from minimal. Some patients went blind and many others were put under great risk with all the stress that goes with that.

Second, the unintended consequences went well beyond ophthalmology. It included various forms of gaming, including phantom or hidden lists, virtual compliance and tinkering with the clinical prioritisation of patients on lists. Much of this was around the six-hour target for emergency departments and the three months waiting time for elective surgery following the FSA. Heavily monitored targets for elective surgery are clinically dangerous for patients at a time of chronic under-funding and increasing acute demand (sometimes outstripping population growth).

In my view, the real issue with targets and ESPIs (Elective Services Performance Indicators for first specialist assessments) is not them but the unjustified excessive significance attached to them by the previous Government and the compliance and monitoring costs association with them (financial in the case of ESPIs). They definitely need a reassessment about their usefulness and purpose in terms of whether they make good clinical sense and improve systems. Some may need to go, and some retained perhaps with refinement and a sharper focus on outcomes rather than numbers.

The Health Minister's *only* decision was to discontinue public reporting of the target results. But 'only' is not an insignificant work. The regular reporting of targets is something vigilant journalists look for and when targets are not published, they get curious. Then they discover that reporting has stopped and assume the data has been suppressed.

The Minister believes the targets are a poor indicator of DHB performance and wants to review them, with a view to a new more relevant outcome-focused alternative. No argument here. But he and his advisers should have anticipated the suspicious reaction and front-footed it.

There should have been a proactive, public announcement that the results were no longer being publicly reported because of their unreliability as an indicator of DHB performance, and the whole system was being reviewed. Or (my preference) the results should have continued to be reported publicly but with a strong explicit qualifier from the Minister on their unreliability and that they were under review.

Audrey Young and Stacey Kirk were wrong in their claims of the benefits of the current targets, but they can't be criticised for being wary. Responsibility for this rests with the Minister.

## SET UPS

Another example of the need to be streetwise was the debacle over the state of the buildings at Middlemore Hospital. Senior management privately advised me that they were impressed with the quick positive turnaround when the Minister approved their request for additional funding for the one building they sought it for. So far so good.

But then the Minister was given a bundle of documents and I suspect without sufficient clarity over the smoking gun that was contained within them. No doubt they were then passed on to officials. This was a DHB where the Minister was looking to replace the former Board Chair and

also two other Board current members presumably linked to the toxic environment in the leadership of Counties Manukau DHB.

When a Minister is physically given a bundle of documents in an environment not conducive to political friendliness, political antenna should start detecting something. Sadly, it malfunctioned and the next thing we know there is a public war of words between the Minister and the DHB leadership over whether the former was given documents outlining the poor state of other Middlemore Hospital buildings.

And Minister, never leave a lengthy voice mail message containing too much information on the phone of someone you are seeking to have replaced and be surprised when the transcript ends up in the *NZ Herald* as it did. Treating your political opponents with respect as you did is the right thing to do but don't give them a loaded gun to fire back at you. Never under-estimate revenge as a driver of behaviour – just an opinion.

## OWN GOALS

Recently another competent journalist Andrea Vance had a scoop in the *Sunday Star Times* on the unannounced decision of the Minister of Health not to proceed with a pilot programme involving health professionals seeing suspected mentally ill people in police custody. I can't comment on the wisdom of the Minister's decision. He may be right that the pilot had not been funded and there may have been legitimate doubts about its relative effectiveness as suggested by the Mental Health Foundation.

But again, Dr Clark should have front-footed it with a proactive public statement justifying his decision. He and his advisers should have anticipated that to make such a decision on an initiative that at the very least has the appearance of being laudable (certainly strongly supported by the Police Association for understandable reasons) but not explain why publicly would make such an

attractive scoop for a good investigative journalist. The outcome was that the Minister was placed on the defensive backfoot. Not a good look.

## 'HEALTH STEALTH UNDERMINING GOVERNMENT'

In last weekend's *Sunday Star Times,* I was struck by an article titled 'Health stealth undermining Government' by Press Gallery journalist Stacey Kirk. The word 'stealth' is a guaranteed eye catcher, especially when linked to the health system. Stealth is a dramatic term. Except when used to describe aircraft (especially military), it is usually used in an uncomplimentary manner somewhat akin to a hungry cat; words like sneakiness, covertness, slyness and clandestine come to mind.

The reporter's focus was on the Minister's decisions on the health targets, funding the mental health project for those in police custody, and the apparent dropping of $6.5 million for cochlear implants. She appropriately ignored the slur from some other branches of the media over his exercising of parental responsibility and her political nose steered her away from the staged leaks concerning Counties Manukau DHB.

My view of David Clark is that he is incapable of stealth. He is a principled policy analyst trying to function in the rat-infested political dung heap that sometimes characterises health politics. One could argue that the lack of stealth has contributed to the position he now finds himself in.

The criticisms of Stacey Kirk are of a person unused to this cesspit environment, not someone trying to do things by stealth. If it was stealth, it would have been much more difficult to discover them. Her critique does not consider that the Minister's errors over transparency also apply to good news decisions such as the decision to stop Public Private Partnerships in health; something that would have been well received in the health sector, especially by health professionals, and the public. In fact, had he handled it better his decision to explore possibly moving from targets to

something more useful and outcome-focused, this would have also been well-received in the health sector.

But if a competent journalist like Stacey Kirk draws the conclusions that she has, then it is wrong to shoot the messenger. Even though the word 'stealth' is misplaced, she has a point. More importantly, in the absence of a change of approach from the Minister and his advisers, it is only a matter of time before her analysis becomes the narrative of the 'chattering classes' in the health sector and then the wider public.

The journey from looking like an authentic intelligent and compassionate Minister of Health to a possum in the headlights can be very short if one is not streetwise.

## WHICH WAY DAVID?

Following my address to your conference last year in Christchurch, one of your colleagues commented that one thing that hadn't changed for many years was that we continue to be "screwed". After a slight pregnant pause during which I pondered over the fact that the distinctive hat he was wearing made him look like the lead character in the cult television series *Breaking Bad*, I responded that he might be surprised by how different many ways the specialist workforce could be screwed.

My sense of our new Health Minister is that he is made from a different mould. If he can work on the need to be streetwise and focus on addressing both the main threats and at the same time opportunities, then there will be the turnaround that we have been waiting and campaigning for so many wasted years. The way forward to achieving shared objectives is through focusing on the centrality of workforce, in this case the specialist workforce, and its empowerment. In the words of Sherlock Holmes: "When you're searching for the solution to a problem, don't look at what you can see. Look at what you can't see."

The challenge for David Clark is to give us all confidence that we can advise our *Breaking Bad* lookalike that the public health service has transitioned from specialists being treated as a balance sheet liability who pay for the sustaining of patient care with their own health to a sustainable and empowered workforce in order to achieve the compatible objectives of patient centred care and fiscal responsibility. It's elementary, dear David.