Health Needs Re-engineering From the Top Down

by Ernie Newman, November 9, 2017

Our health system is broken in so many ways. It is trapped in a 1980s service delivery model, way too complex for a country with 4.5 million people, underfunded, and riddled with waste.

Recently I took part in the annual Health Informatics NZ (HINZ) conference. There is great work being done by masses of competent people. However, nearly all of it is operating only in one DHB, hospital or service area. Silos abound. Inefficiency, with wasted opportunity, is endemic.

The customer interface to health services hasn't changed for a century. We still start, nearly always, by making an appointment with a GP whether or not our issue needs that level of expertise.

Compare that to the customer interfaces in banking, aviation, government services, retail and travel. All those sectors have been re-engineered from scratch to utilise the huge efficiency gains of the digital era. Routine transactions have been automated. Customers who need personal attention are escalated to a real person, of increasing seniority, only if required. All that happened twenty years ago.

By contrast in primary practice for example, there is rarely an automated option. Customers start at the top with a face-to-face appointment with a GP - the most expensive and scarce resource in the system - from where they might be delegated down.

So why does large scale modernisation elude health services? Here's my considered view.

1 The System is Absurdly Complex

Health is a unique blend (I might say hotchpotch) of public and private sectors. Hospitals are run by 20 DHBs. Primary care used to be run by self-employed GPs but has increasingly been corporatised, subsidised by public money channelled through the Ministry, DHBs and primary health organisations. Specialists earn eye-watering sums as private entrepreneurs. Allied services like physios seem to be private. Testing labs are a mystery – I've no idea who pays for my blood test. Pharmacies charge for drugs but the price I pay for a prescription seems unrelated to the cost.

A torrent of taxpayers' money sloshes around the sector under the charge of the Ministry of Health. Some is devolved to DHBs who cycle it around their regions in various ways – spending it directly or through external contractors. Some goes to NGOs, Pharmac and health quangos. Along the way the flow is complicated by ACC, co-payments from patients, private health insurance and incentives. Every level of bureaucracy takes its administrative cut.

That process is so complex that nobody really understands it – witness the fact that the Ministry (more about them later) recently made the public service blunder of the decade in sloshing millions to the wrong DHBs and having to send in pumps to syphon it back.

But with that complexity and lack of understanding comes understandable terror of unintended consequences if we make changes, so we continue using band aids where surgery is needed.

Solution – lets start by developing a vision of a 21st century health system and customer interface, based on the opportunities of the digital era. This cannot be delayed any longer.

2 Political Leadership Has Been Poor

Sorry, but Jonathan Coleman was a disaster as Minister of Health - preoccupied with keeping health off the front page at a time when the challenges it faces mean that is exactly where it

needs to be. His lack of a sense of accountability to the public set him apart from any other Minister in recent rimes. Every depressing time when media reported that numbers of patients had died or gone blind through service deficiency or under funding in health, Coleman was "unavailable for comment." His contribution was to cynically cut back on real funding at a time of massive increases in need due to increasing public expectations, the aging population and record immigration.

No wonder he disestablished the Health IT Board (along with its consumer panel that I chaired) and its parent National Health Board. It was working – albeit slowly but effectively – on the daunting task of coordinating non-interoperable health sector IT functions in a hugely complex environment. At least it delivered on its flagship project of Personal Electronic Health Records for many – I am among allegedly 400,000 Kiwis who have online access to my PEHR but millions more can't yet access them or don't know they exist.

It seems part of a pattern in health – anyone, or any institution that starts making progress gets killed off by the system. Conversely, flurries of activity with no discernible outcome get rewarded.

Yet nothing that I can see was put in place to replace either Board. That begs the mega-billion dollar question – who is now responsible for overseeing the challenging task of changing this complex system to align with the digital age? I have no idea.

Solution – good luck to incoming Minister David Clark, he will need to grasp the nettle and start a process of systemic redesign.

3 The Ministry of Health is Dysfunctional

The prize for the most conspicuous incompetence in the public sector must go uncontested to the Ministry of Health.

The blunder above aside, my observation from working with it over the years is that it is so consumed with perpetually re-structuring or "transforming" itself internally that it doesn't spare a thought for its core task of leading the decades-overdue task of restructuring its sector.

Bureaucratic, ineffective, fiefdom-driven, cumbersome, risk-averse to a fault, and way out of touch with its real purpose – far more attuned to shutting down constructive debate than fostering it. It needs nothing less than demolishing and rebuilding.

Solution – scrap the Ministry and replace it with smaller, smarter units with a very different culture and leadership style.

4 "Clinical Leadership" has Been Overcooked

Clinical leadership is a mantra in health – nothing happens without the docs agreeing - which always requires an evidential base.

That's fine to a point. There are many superb leaders among the clinicians – I've been privileged to work with a number. Doctors generally are smart, committed, outstanding people.

But intelligence doesn't automatically make them great change-agents. Doctors are inherently conservative. Thank God for that when they are wielding the scalpel, but it's a serious drawback when they're contemplating changes to the way of doing things. Dr Lance O'Sullivan told a conference recently that NZ could more than halve the number of GPs if we used them more selectively, to which I can only agree.

Many changes are simple common sense. Clinicians should absolutely be at the centre but so should informed health service consumers, professional administrators, and nurses. No one

group should have power of veto. And as with any occupation, there can be a fine line between professional caution and patch protection.

Solution – doctors should be part of the change but not dominate; an eclectic group including smart health service consumers should lead.

5 Shared Services Companies Are Barriers to Change

Academics and consultants foisted shared services companies onto hesitant DHBs to achieve economies of scale in services like personnel, finance and IT. In theory they are servants of, and accountable to, the DHBs in their region collectively.

The problem is they became the reverse. Once appointed, and with the DHB having lost control of these core functions, they grow like head lice on a five-year-old - they become the master and the hapless DHB the servant. In IT terms that means there is always an excuse to delay, either to wait for other DHBs in their region to catch up, or to dovetail with inconsistent regionally- or nationally-imposed timetables. And of course, there is never any money – see item 1. So nothing changes.

Solution - abandon this failed experiment and give CEOs full control of their destiny.

In Summary

IT specialists are playing a competent and highly constructive role introducing IT-enabled projects but are hampered by two massive barriers. First, inability to take the best pilots and nationalise them. Second, inability to re-engineer service delivery around the potential of the digital age. Technology is best when systems are re-engineered to take advantages of the efficiencies it offers. Superimposing 21st century technology on a creaking 20th century structure and business process denies most of the potential benefits.

But health IT works in glorious isolation from any vision of, or debate about debate about the future structure of health services overall – if one exists. It has been perceived as a service activity to one side, when it should be the mainstream enabler of a sectoral re-build.

There are many extremely capable people leading health IT projects – all power to them within their limited mandates. But back at base many more professionals are jaded, project-fatigued, cynical about pilots that go nowhere, overworked, bitter about underfunding, patch protective, or change-resistant.

The whole health sector nationwide needs to be mobilised and enthused. It needs leadership, energy, commitment, and reallocation of money. Meanwhile time has run out – opportunities are being lost, resources are squandered, the clinic is unattended and the grey tsunami is waiting outside the door.

Welcome, Minister Clark.

Ernie Newman is a Digital Economy Consultant based in the Bay of Plenty. His involvement in the digital economy dates back to 1999-2012 as CEO of TUANZ, the Telecommunications Users Association. Recent assignments in health have involved telehealth and consumer issues for 2 government agencies, 3 District Health Boards and a Pacific Island health organisation.

ernie@ernienewman.com
www.ernienewman.com
0223764363