Te Whatu Ora – What we now have, what are its risks and what should it be done to make it better for patient-care

Alternative heading: How can we get out of this crap?

Ian Powell

Health system commentator and blogger

Former Executive Director, Association of Salaried Medical Specialists

Presentation to New Zealand Branch Annual General Meeting

Australian and New Zealand Oral Maxillo-Facial Surgeons

Queenstown

5 August 2023

In a nutshell the main features of the new health system, which came into force on 1 July 2022, are:

- increased influence of business consultants in design and operation;
- marginalisation of the influence of those with experience in health systems;
- driven by structural rather than cultural change;
- removal of a level of statutory decision-making close to the point where most community and hospital healthcare are provided;
- vertically centralised decision-making setting the foundations for a control culture; and
- threatened by failure to address widespread workforce shortages and increasing health demand.

When it came into office in October 2017 then Prime Minister Jacinda Ardern's government ignored the two main imperatives that required urgent focus – severe workforce shortages, made more difficult by rising health demand and the top-down leadership culture of the Ministry of Health.

Instead it focused on further centralising an already centralised health system through massive restructuring.

The health system that we now have

Te Whatu Ora (Health New Zealand) has inherited a new health system largely devised by business consultants. This is akin to the wisdom panel-beaters designing traffic roundabouts

or Auckland Mayor Wayne Brown writing a book on etiquette. The main beneficiaries are business consultants (or panel-beaters but perhaps not book publishers).

Compounding this fundamental error was the incompetent decision to restructure the whole health system in the midst of the pandemic instead of working to fix these key pressures on the system.

Hospital occupancy

Hospital occupancy is an excellent summary barometer for highlighting the precarious position that political and other decision-makers have now put the health system in.

In 2022 our public hospitals hit 100% occupancy more than 600 times. That is, on average, each day roughly two public hospitals around the country were running at an occupancy higher than they were resourced for.

Hospital occupancy of 100% was occurring back in 2017 but nowhere of this magnitude. Hospitals were in crisis in 2017. In 2023 it would be more appropriate to call it scary crisis+. Carnage might not be overstating it.

Behind high occupancy is 'bed blocking' where patients can't be admitted to the wards from emergency departments because they are already fully occupied. Emergency departments become overcrowded. Diagnoses and treatments are delayed and planned surgery cancelled. The terminally ill are not spared.

The risks that we now have

Crises in health systems are the genesis of risks – to patients (including access and safety), workforce health and safety, innovation, quality, and systems improvement.

Our current crisis won't be addressed until its immediate causes are resolved – severe workforce shortages and rising health demand (particularly acute and chronic illnesses).

However, these causes will not be resolved until there is a substantial culture change within Te Whatu Ora that enables it to focus much more thoroughly on addressing them. The problem is that the new entity is well short of possessing that prerequisite culture.

The 'culture' of Te Whatu Ora's leadership is totally consistent with the restructuring that created it. It is the most vertically centralised national entity that our health system has ever had.

Its prime culture driver is vertical centralisation. It is as destructive as the culture of running the health system as a commercial market was in the 1990s; arguably more destructive.

This, and the distance between its top leadership and from where healthcare is provided, makes its culture top-down. What is needed therefore is a shift to a culture that is engagement based, empowering and relational.

Commissioning and localities

One word more than any other is used to describe the operational role of Te Whatu Ora – 'commissioning'. It is a central part of the Pae Ora Act.

It is a relatively new term in our health system. Under former Director-General Chai Chuah it was used but more by way of title than anything substantively new.

In the National Health Service in England commissioning has been used on and off since the 1990s depending on the particular ideological whim at the time. Each time it has been in fashion it has had a different meaning. Currently it appears to be out of fashion.

In our context commissioning can best be described as funding and planning, both nationally and at a district level. But, in addition to commissioning, Te Whatu Ora is also responsible for the operational delivery of health services that was previously undertaken by the DHBs.

To enable commissioning to be actioned locally, the Pae Ora Act establishes what are called localities who are to undertake locality planning, supposedly central to it.

But these localities have little resemblance to what the Simpson review recommended which was that they function as relational based networks working with and resourced by their relevant DHB.

Now localities are considerably watered down and under the express control of the vertically centralised Te Whatu Ora.

Further, internal Te Whatu Ora restructuring currently underway is leading to a loss of staff working at a district level on the functions of what is now called commissioning. This is directly relevant to localities.

As these functions are shifted 'upstairs', staff who performed them at a district level are losing their positions.

To reinforce this point, the staff at the former MidCentral DHB, who developed the locality approach that excited the Simpson review, now find their positions disestablished. Does irony get better than this?

Replicate this across the country and no wonder that the implementation of localities has stagnated. When even a former head of New Zealand's state services can't get any sense from his inquiry to Te Whatu Ora on the role of localities, no wonder confusion is rampant.

The future of localities is precarious at best. If National leads the next government after October's election they are most likely 'gone by lunchtime'. Should Labour lead it, they are most likely to splutter along in a leadership vacuum.

Unhappy workforce

In the days of DHBs in any particular district, each DHB was the biggest employer, Now Te Whatu Ora is the biggest employer in the country. Unfortunately, arguably it also has the unhappiest workforce.

In part, with the exception of its highest levels, this is because they went to it not by choice but legislative transfer. Most came from the DHBs with a smaller number from the health ministry.

We now have a committed workforce that has been destabilised by substantial restructuring which has been poorly explained and lacks a convincing intellectual construct. It feels disrespected and devalued with the inevitable outcome of demoralisation.

Those closer to the 'clinical frontline' were already fatigued and many burnt out. Those further away from this frontline, but essential to its performance, are devalued, demoralised and many of them in the process of being shown the door.

When Tony Ryall became health minister in late 2008 he initiated a harmful populist slogan of shifting resources from the 'back office to the frontline'. He introduced an arbitrary cap on the number of so-called back office staff.

This neglected the reality that overwhelmingly these demonised back office staff were integrated into what specialists and other health professionals did at the front line.

This included ward clerical staff, booking staff for outpatient clinics, schedulers for operating theatres, information technology, secretaries, and operational service managers. It also included data analysists.

The effect of the upwards centralisation under the guise of rationalisation today under Health New Zealand has parallels with Ryall's demonisation. Devaluing leads to demoralisation.

This has come to a head with the failure of Health New Zealand to provide accurate data that informs the effectiveness of the health system, such as case emergency department admissions.

The cause is the loss of experienced data analysts to the system. The push factor is the destabilising and devaluing restructuring both leading up to and after the formation of Te Whatu Ora. The pull factor is the opportunity to practice their skills elsewhere outside the health system.

Making the health system work better for patient care

So how can Te Whatu Ora make the health system work better for patient care. The first thing to be said it that restructuring the recently restructured system is not the way to go. There is no magic bullet. Given what the workforce has already been put through, it doesn't deserve to suffer more destabilisation.

Pae Ora Act purpose clause: aligning health system internal and external moralities

In order to function effectively health systems require two aligned 'moralities' - internal and external. Internal moralities reside within the ethos of its workforce reinforced by their

professional colleges and associations. This is a rich strength that health systems benefit from.

External moralities define the overall parameters, including distinguishing characteristics, of health systems, beginning with legislation. The Health and Disability Commissioner Act, including its requirement for informed consent, is a case in point.

Legislation governing how the health system should be structured and why is a critical external morality. The starting point is an act's purpose clause. In the case of the Pae Ora Act, its purpose is characterised by its brevity, nebulousness and misplaced focus.

The purpose of the Act is to provide for the public funding and provision of services in order to:

1. protect, promote, and improve the health of all New Zealanders; and
2. achieve equity in health outcomes among New Zealand's population groups, including by striving to eliminate health disparities, in particular for Māori; and
3. build towards pae ora (healthy futures) for all New Zealanders.

The first purpose is uncontestably correct and uncontestably vague on its own. Similarly, so is the third purpose with its apparent bent towards population health.

It is the second purpose which has serious credibility issues. Health inequities and disparities are overwhelmingly driven by social determinants of health such as low incomes, poor housing, limited educational opportunities, and social and community contexts.

While "striving to eliminate" them is one third of the Act's overall purpose, these determinants are outside the control of the health system. Eliminating them requires government actions; legislation and policies. Health systems can mitigate but not eliminate.

By failing to give a clear steer on the purpose of the health system, the clause defaults to allowing a new vertically centralised leadership to emerge in the way it has – control.

Consequently, in order to improve the external moralities of our health system, the purpose clause of the Pae Ora Act should be amended to include the following:

1. Mitigation rather than elimination of health inequities and disparities.
2. Recognition of role of social determinants of health on inequity and disparity, including the role of the Act's health entities to advise government of their ongoing impacts on health status.
3. Placing at a systems level adherence to healthcare provision being patient-centred.
4. Integration between care in communities and care in hospitals, including clinically led and developed pathways between them.
5. The culture within Te Whatu Ora to be relational based on engagement with and empowerment of its health professional workforce.
6. Emphasis on Te Whatu Ora's role to provide national cohesion rather control of healthcare provided locally.
7. Explicit responsibility of Te Whatu Ora for the wellbeing of its workforce.

The rationale for these suggested amendments to some extent has already been discussed and/or is discussed further below.

"If you don't take the temperature you can't find a fever"

Towards the end of last year I got together with my political opposite Heather Roy (former ACT MP, health spokesperson and deputy leader). We agreed to work on a joint paper to Te Whatu Ora on how to make the system we now have work better for patients.

Our approach was that this was not the system we would have designed. A vertically centralised system such as this was unlikely to address nuanced local population needs. Nevertheless the system is what it is

The two of us came from different parts of political spectrum and often had conflicting positions. However, the joint paper was not a compromise document. Instead it was a shared developed consensus based on pragmatism.

The paper was not about funding. However, we did recommend that funding should be seen through an investment lens recognising that bodies such as the International Monetary Fund have concluded that investment in health was good for developed economies.

The paper was titled *Te Whatu Ora: Achieving Patient Centred Care and Wellbeing* followed by a subheading: "If you don't take the temperature you can't find a fever".

The recommended approach was to incorporate the matters discussed below as much as practical by way of policy rather than substantive structural or legislative change.

It was sent to Te Whatu Ora on 16 January, distributed widely throughout the health system, and published in three instalments by *Newsroom*.

1. Patient Centred Care

Our starting point was putting the patient first through what is known as 'patient-centred care'. Health professionals are familiar with this term but usually in the context of treating the individual patient in front of them.

Patient-centred care should also be given a systems purpose, making it the yardstick of decision-making. Every non-clinical decision, before proceeding further, should be assessed on whether it advances or hinders patient-centred care.

2. *Incorporate subsidiarity principle*

Incorporating the principle of subsidiarity in the culture of the health system goes to the heart of ensuring patient-centred care.

Most healthcare innovation, service design, configuration, and delivery is done locally by health professionals. Good clinical sense also makes good financial sense.

An increased level of greater local decision-making is important for continuous quality improvement. It is the core of sustainable systems improvement.

Consequently the subsidiarity principle should be incorporated into Te Whatu Ora's culture, including its strategic and operational functioning.

3. *Integrated care*

The passing of the Pae Ora Act meant a loss of the legislative requirement for integrated care between community and hospital. This was to the detriment of patient-centred care.

Focussing horizontally between care in communities and care in hospitals significantly improves patients' access to and quality of healthcare. It also plays a significant role in constraining acute hospital admissions (keeping people out of hospital).

The internationally recognised pioneering work of the former Canterbury DHB in developing health pathways between community and hospital based care is instructive.

It demonstrated that horizontal integration is where the most significant healthcare improvements can be made from within the health system. This includes mitigating some of the impacts of the external social determinants of health.

Te Whatu Ora needs to recognise this and work hard on integrating community and hospital care as a matter of policy priority.

4. *Culture*

The failure of those responsible for focussing on structural rather than cultural change is ultimately behind the worsened crisis the health system now finds itself in.

Culture is the most decisive driver of system effectiveness. Patient-centred care can't be achieved without the right culture.

No sector in New Zealand has such a large concentrated critical mass of intellectual capital. It is the best resource Te Whatu Ora has to draw upon. Those who do the job know best how to improve it.

It should therefore ensure that decision-making is distributed as close to the workplace as practically possible. This involves workforce empowerment, including what is known as 'distributed clinical leadership' (as distinct from formal clinical leadership positions).

5. *Workforce shortages*

Whether one describes the severity of the workforce shortages as crisis, scary plus+ or even carnage, top priority needs to be done to address it. Te Whatu Ora's recently announced workforce strategy falls well short of what is required.

In the past and for good reason there has been a stronger emphasis on retention than recruitment. There is a relationship between the two; stronger retention benefits recruitment when natural attrition occurs.

But this has changed since salary increases were severely constrained from the 2010s, not by DHBs, but by both National and Labour-led governments. This is compounded by the aging of the workforce.

There is not a single labour market in Te Whatu Ora's health professional workforce. They vary from specialists to nurses to (and between) the numerous critical allied health professional groups.

The reality is that, depending on the occupational group, Te Whatu Ora has to compete domestically in a wider private labour market (such as scientists) or internationally in an Australian labour market (especially in the case of medical specialists compounded by their significantly longer training requirements).

Consequently, it needs to engage directly with the applicable unions to develop recruitment strategies targeted at the specific occupational groups and their different labour markets.

6. External social determinants of health

I've previously discussed the significance of external social determinants of health. They are the biggest driver of health demand and cost, including being the most consistent factor in rising DHB deficits from the early 2010s. Health consequences include increasing chronic illnesses and acute demand.

Te Whatu Ora needs to recognise and act on the importance of mitigating social determinants. It should also advocate for government to make the necessary policies and legislative changes to eliminate them. Neither Te Whatu Ora nor the other new health entities can do the latter.

7. Major capital works

Te Whatu Ora has inherited the legacy of a fiscally irresponsible approach to major capital works, by central government over many years.

This inheritance is hospital rebuilds which are poorly equipped to cope with future demand. Examples in the late 1990s and 2000s include Auckland, Rotorua and Wellington Hospitals.

But in the 2010s it got worse. The Christchurch acute services block business case was submitted by the DHB to the health ministry before the first earthquake in 2010.

By the time of the much delayed opening of the new facility 10 years later, it lacked the capacity to meet even existing healthcare demand. This looks like being replicated at Dunedin Hospital.

The problem is that initially there is a high level of clinical engagement at the hospital level in terms of assessing existing health demand and future proofing it.

This leads to a business case which goes to central government where the process gets delayed, clinical and local operational expertise is marginalised, and arbitrary downsizing is the outcome.

Under the Pae Ora Act major capital works are now at greater risk of this not only continuing but also escalating. This is because there is no longer a local statutory body charged with representing their defined population's health needs.

Te Whatu Ora needs to recognise this and work to ensure that rebuilds are consistent with the clinical and operational expertise which leads to business cases and that this expertise is actively engaged with.

Further, it needs to require that approved rebuilds make good clinical and environmental sense, and are future proofed for anticipated health demand.

The way forward

The way forward to enabling Te Whatu Ora to make our new health system work better for patients is to base it on ensuring patient-centred care as Heather Roy and I advocate.

This presentation today is timely. Since we published our joint paper in January. I've been giving further thought about how this might best be progressed. Here are some thoughts to expand on:

1. Empowering regions and districts.
2. Networks.
3. Role of local government.
4. Polyclinics as part of local integrated care systems.
5. Role of primary care organisations.

1. Empowering regions and districts

The regions and districts within Te Whatu Ora should be empowered to make decisions relevant to the design and provision of local hospital and community services.

Don't restructure again. But drop the top-down control culture inherent in vertical centralisation and go relational.

This should be drilled down further by its regions and districts being empowered to have a proactive engagement culture with its health professionals.

The greatest relevant experience and expertise over how to improve hospital and community health services rests with this workforce.

We need an engagement culture that empowers them to be in the engine-room of decision-making. We need an engagement culture that will better enable improved healthcare within hospitals, between hospitals, within communities, and between communities and hospitals.

2. Networks

While representing salaried specialists and other senior doctors and dentists, I was proud to have been part of popularising clinical networks. I was influenced by innovative developments in Scotland and New South Wales.

A positive feature of the 2000s and 2010s was the emergence and development of a range of these networks – nationally, regionally between DHBs, and between community and hospital care.

They included cardiac and trauma nationally and integrated community and hospital care beginning in Canterbury. Their strength was in part because they were clinically developed and led.

Equally important was that they worked on a relational rather than structural basis. This gave them the necessary oxygen to be innovative rather than constrained by organisational structures.

They could not determine on their own. But their oxygen enabled them to provide independent expert advice unobstructed.

Unfortunately, but consistent with vertical centralisation, Te Whatu Ora is moving to bring these networks directly under its operational structure. This lacks insight. It is most likely to stifle innovation and consequently compromise quality improvement and cost-effectiveness.

Te Whatu Ora needs to drop this move and recognise the value of relational rather than control culture.

3. Polyclinics

Te Whatu Ora should be innovative and plan to provide non-surgical facilities for local integrated care systems; in other words, polyclinics.

These should provide general practice care (particularly in areas of GP shortages), 24/7 urgent care, less complex hospital care (including outpatient clinics and visiting hospital specialists), relevant diagnostic support, and relevant allied health professionals services.

There are several embryos of polyclinics throughout New Zealand which do excellent work. One that comes immediately to mind is the innovative Horowhenua health centre in Levin established by the former MidCentral DHB. I would not yet call it a polyclinic but it is moving in that direction.

I hope to see this picked up and run immediately south of Horowhenua on the Kāpiti Coast where I live.

4. Enhanced role for local government

The Local Government Act requires local government (city and district councils) to improve community wellbeing. Accessible and comprehensive quality healthcare is integral to wellbeing.

Councils are also already responsible for public health matters such as water sanitation and food safety, including requirements to involve medical officers of health employed by the former DHBs.

The Pae Ora Act requires consultation, albeit tokenistic and sidelined, with local government over localities and locality plans. While the future of localities is precarious, it still sits there in the legislation.

Councils need to enhance their role by providing a statutory voice for the health status needs of their populations. Some are already considering this. Te Whatu Ora should encourage this rather than be dismissive.

5. Primary care organisations

The Heather Simpson review envisaged, over time, localities replacing primary health organisations (PHOs). This was in the context of DHBs picking up their organisational functions.

But this was overturned by the abolition of DHBs leaving PHOs continuing in an uncertain limbo.

Over the past four years I have become more engaged with primary care and have developed a much better understanding of the valuable role of PHOs.

While varying and acknowledging there is some limited scope for rationalisation, they do invaluable work. Backed by impressive data, they know their populations' health statuses well.

They have become the most reliable and experienced institutional glue remaining across primary care. Te Whatu Ora should embrace then and support their continuation.

What would Mark Twain say?

New Zealand now has a system largely devised by business consultants were also the main beneficiaries. But insufficient work was done in advance on how the new system might

work. Te Whatu Ora was left to build a plane while flying it or build a house without an architect's plan and resource consent.

The tragedy of the 'health reforms 'is not just that they threw the baby out with the bathwater. They also threw the bath out. If our health system is to be protected and enhanced, the baby at least needs to be retrieved.

It is depressing. However, I would like to share something my father once said to me. First, if you come up with an idea or turn of phrase that you want to impress people with, say Mark Twain said it. His rationale was that no one would ever know! He got that right.

Second, when things seem bad, say that Mark Twain once said that while the glass is always half full rather than half empty, if in doubt put a small drop of whiskey in it. I can't fault this fatherly advice.