Doctor, mind your decision space

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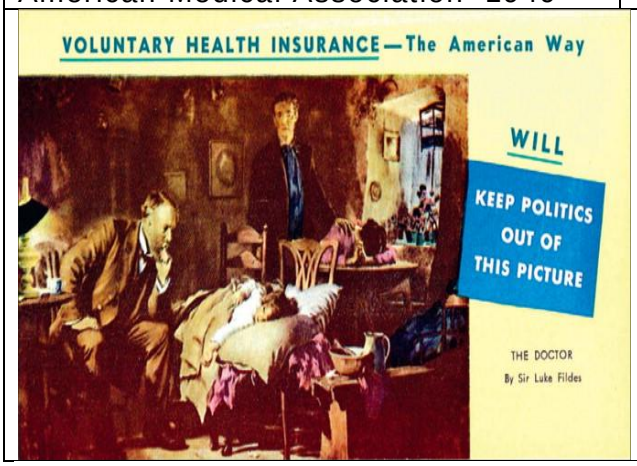
Abstract

The exercise of power by professional groups and corporations helps shape the nature of the health system and the outcomes that it is likely to achieve. Tracing developments in New Zealand and by making comparisons with global developments, this paper discusses the current shift in and likely impacts of increasing corporate power in the New Zealand primary care system. In particular, it will discuss the likely impact of these changes on population health and health equity.

When Luke Fildes painted this image of the doctor and a sick child in 1891, he was depicting the devotion and care that had been shown by the attending physician to his son who died of TB 14 years earlier. The thoughtful, compassionate and focused doctor; the seriously ill child; the watchful, stoical father supporting the distraught mother. The lamp illuminating the strength of the doctor's focus on and compassion for the sick child.

The painter was describing his own personal experience, not making a political statement about the role of the physician. He would, I suspect, have been surprised to find that over the next century this image was used to signify what is regarded as most precious about the doctor–patient relationship by both the political left and right of medicine. The image featured during the 1949 American Medical Association Campaign: "Keep Politics Out of this Picture"

A Painting for all Seasons	
American Medical Association 1949	The Lancet 1998
	

The implication was that if universal health insurance were introduced, the richness of this beautiful relationship would be lost.

Then, 50 years later, in 1998 the same image featured in the Lancet during the 50th anniversary celebrations of the National Health Service in the UK[1], showing the compassionate doctor, but this time with the implied protective arm of the state allowing the beautiful relationship to be maintained.

Unfortunately, the evolution of health care systems in countries of both the political left and the right has fundamentally changed this relationship.

The same sick child is likely to be in a setting like the one below:

1891	2013
	

We see the evolution of technologies – the doctor's bag has grown exponentially, along with the patient's chances of survival. However, that in turn

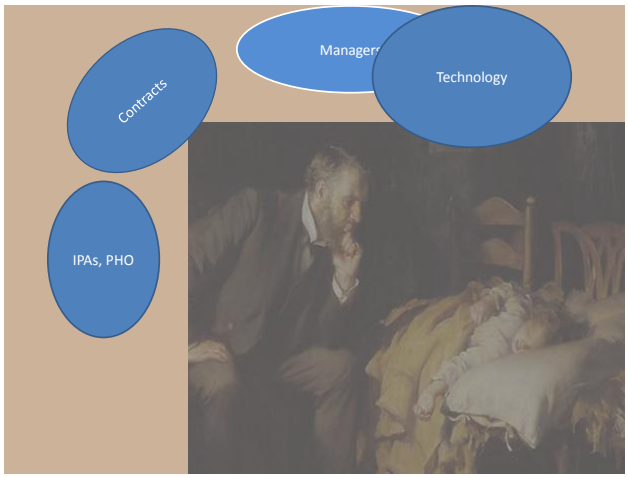
has drawn attention away from the quality of the relationship. The focus of the health workers in the room in 2013 is largely on the machinery.

The change in the intensity of the bond between doctors and patients is also influenced by the way health care systems are organised, as both the AMA and the NHS (Lancet) use of “The Doctor” intimate. There has been considerable reduction in the realm over which the clinicians make decisions.

Mangerialism:

The greater use of generic management skills, replacing the old triumvirate (Superintendent, Matron, Administrator) rose to prominence in the 1990s with high hopes:

> *Service management is seen to be a major paradigm shift in health services organisation and could be of international significance in its potential for achieving medical accountability for cost containment and quality assurance, and for coordinating care across agency and disciplinary boundaries.*[2]



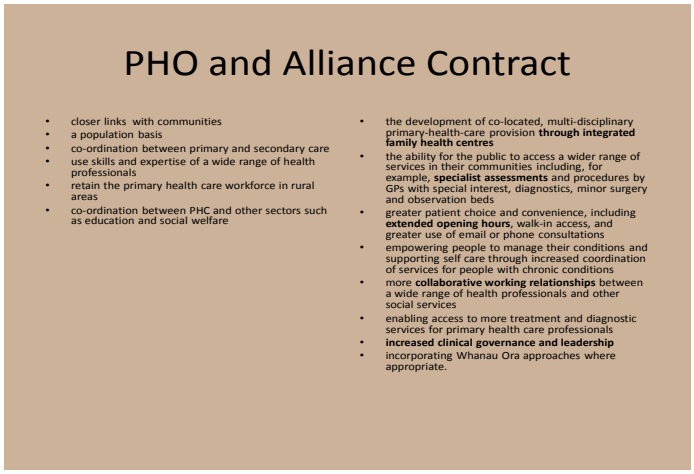
Contracts:

In the bad old days, GPs operated under what is best described as “John Wayne” contracts: “a doctor’s got to do what a doctor’s got to do”. Money was passed over for “The Provision of General Medical Services”. This arose mainly because the doctor was in the best position to make the most of the decisions, and no one else in the system had the information available to suggest otherwise. Such decision latitude did not last, as the profession’s internal control mechanisms did not lead to an equitable delivery of services, nor did it deliver quality and safety consistently. Change was also assisted by information that was previously locked in the doctor/patient interaction being readily available to many others; the decision space for doctors has since then been reducing.

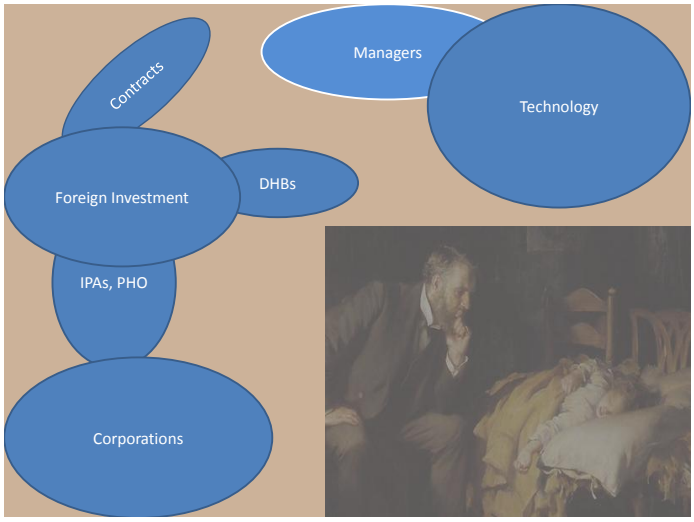
The organisational moves that have supported this shift are many and varied. The formation of IPAs – on the one hand hoping to preserve that decision space:

> *“that the independence of general practice should be preserved”;* (7 1990, NZGPA.)

but by their very formation reducing that independence, as they morphed into PHOs being seen as a mechanism of directing the primary health care activity of their member practices. The PHO contracts and now the alliance contracts have increased the specificity of what is required at the level of the practitioner and how they run their practice.



But it’s not only government-inspired changes that are impacting on the relationship.



Alongside the technology, managerialism and contractualism inspired developments has been equally dramatic change occurring in the ownership of the primary health care sector. Entirely new organisational forms are developing outside of, but intimately linked with, the recognised structures of PHOs and practices.

http://www.nzdoctor.co.nz/media/1751476/p11_changing_landscape.pdf

Keeping track of the changing players and influences in the sector is increasingly difficult. Directors and owners span multiple organisations, from PHOs to practice ownership, on one hand adding to the apparent institutional diversity, but in reality concentrating control of the sector into the hands of a few.

PHOs have been encouraged to consolidate into mega organisations, such as Procare, which serves 800,000 people or 18% of the population, compared with

the biggest DHB (Waitemata at 7.6%). If the next move is to shift secondary care purchasing to these organisations, then it will rapidly reach that important status in the New Zealand health sector – too big to fail.

Further to that we also now have the prospect of foreign investment into the primary care sector.

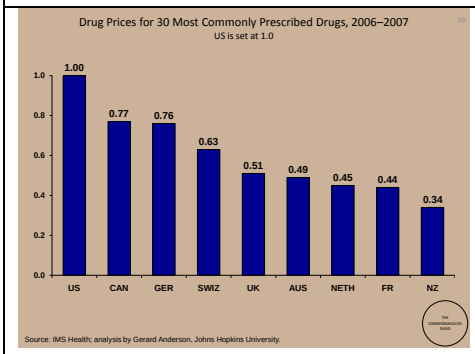
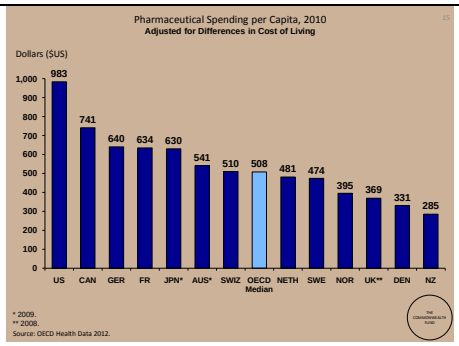
Peak is the poster child of this development, with 48% holding by a Malaysian company, Qualitas Healthcare International.

Consider for a moment if this trend of foreign investment continues, and the ownership and control and profits from the New Zealand health sector move off shore.

Fortunately, we already have some experience of how to deal with this. The pharmaceutical industry is an example of how global companies work in health. Each of the major companies involved has annual revenues well in excess of our total annual health expenditure. The model has been successful in providing the developed world with drugs, but less successful in providing drugs for conditions that impact mainly on the poor in developing countries[1].

[1] For discussion of impact of patent protection on availability of third world medicines: http://www.msfaccess.org/content/trans-pacific-partnership-threat-affordable-medicines-millions

Drug budgets and their growth are a major headache for most countries. However, New Zealand has developed the world's most effective drug purchasing agency, PHARMAC. It manages to get a better price for drugs than other similar countries.

PHARMAC pays less for commonly used drugs	PHARMAC has the lowest OECD Drugs Budget
	

Despite the pressure governments in the OECD are under for efficiency and spending cuts in their health systems, over the last decade no other OECD country has been able to match New Zealand's efficient drug-buying performance. This, of course, is no surprise as it is not in the interests of the major pharmaceutical companies for efficient purchasing mechanisms to be adopted more broadly and they use a variety of tools to protect their markets.

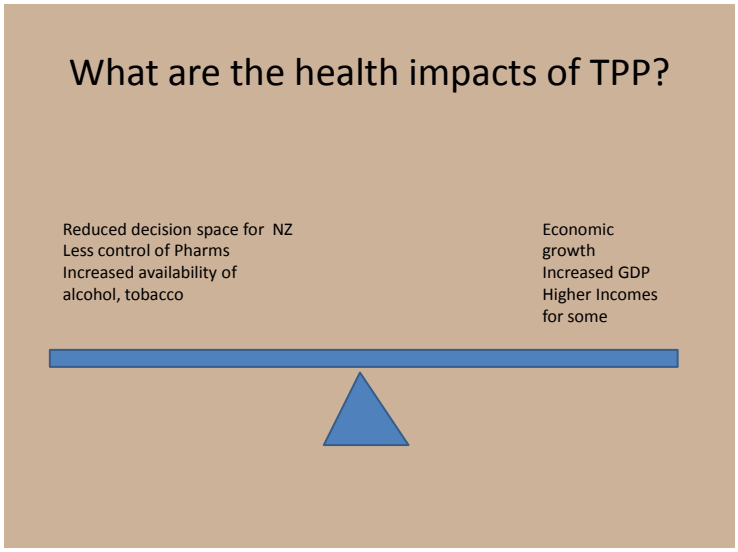
An example of how a globalised industry fights back against countries trying to make markets work is being played out now in the Transpacific Partnership agreement, the TPP. This agreement, which includes New Zealand, will represent 40% of world trade. Central to the negotiation from the New Zealand perspective is the US insisting on changes to the rules by which PHARMAC operates – not because of the amount of money involved (which is miniscule in terms of volume) but because of the danger the pharmaceutical industry sees if the NZ purchasing model is adopted more widely. New Zealand, of course, would like to sell more milk to the USA, so what is being considered is trading

off the New Zealand government's financial and policy control over a major health system building block, Pharmaceuticals, for more milk sales.

Unfortunately, these negotiations are secret. The decisions made will not be discussed openly in Parliament; in fact, we as citizens won't be told about them until two years after the agreement has been reached. At stake is giving away some sovereignty; global investors are given the right to initiate dispute settlement proceedings against foreign governments in their own right under international law.

The negotiations are not being played out on a level playing field – US industry negotiators such as the pharmaceutical industry have access to the negotiating text, but other stakeholders, such as New Zealand patients, do not.

So it's something of a leap of faith; potential benefits include economic growth and increased GDP, higher incomes for some, better living conditions and better health for some.



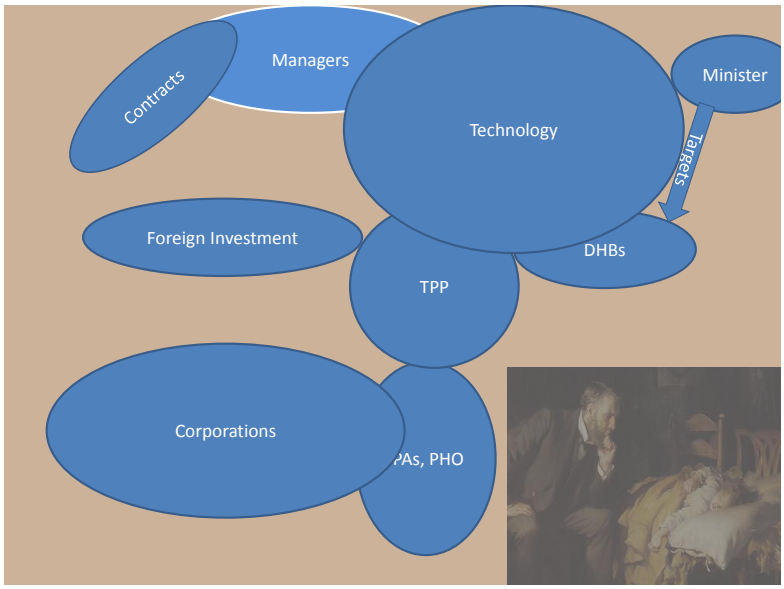
The risks are reduced access to affordable medicine, increased availability of health-damaging products such as processed foods, alcohol, and tobacco; restricted 'policy space' for health; and indirect effects through the social determinants of health: income, jobs, environment,[3] etc.

In relation to pharmaceuticals, the likely outcomes are higher costs of pharmaceuticals, reduced control of the government over drug policy, fewer restrictions on Direct To Consumer advertising, and longer periods before patent drugs can be produced as generics, further delaying the diffusion of drug technologies to the developing world.

However TPP rules are likely to be applied to other global health services, not just pharmaceuticals. So the future rules by which international companies will operate may well be applied to other parts of the health sector, reducing government's decision space, and subsequently that of clinicians.

We need to know how much milk that is worth.

Targets



It is impossible to be fully comprehensive about all the new players operating in the health sector. Entire new entities have formed, such as the health IT sector, now beginning to assert itself in the decision-making space, not to mention an increasing share of health care expenditure. Much of the current discussion about the primary/secondary care interface is dominated by IT system capabilities. Diagnostics and laboratories have undergone similar transformations.

These capabilities take us into a whole new world – ministers (from successive governments) have become besotted with targets – technology has enabled ministerial insight into the very heart of health services, and offers the opportunity to micro-manage these interactions like never before. This is truly transforming the system, but not in the way you might imagine. Technology, and its enabling of the use of precise targets, has narrowed the decision space of district health boards to the point that they are losing a sense of oversight of the sector at the local level, losing their focus on equity, and are redefining themselves as, in the words of Capital and Coast DHB[4]:

The current discussion going on in the sector about the performance and incentive framework for primary care seems to indicate that this same approach is about to be applied to primary care:

> *PHO and provider performance will be measured using a small number of indicators. The intent is for there to be a **'line of sight'** in terms of what DHBs, PHOs and practices are required to achieve and report on, thereby providing a 'whole of system' view*[2].

This 'line of sight' is implying that the Minister of Health will be able not only to observe but direct the work of general practice. The evidence is lacking that ministerial 'Line of Sight' either provides a whole of system point of view, or improves system-wide performance. Performance approaches that focus on narrowly defined targets describe and highlight narrowly defined targets – and have nothing to do with (in fact may adversely impact on) whole system performance, as has been noted in CCDHB.

Imagine you were in charge of a supermarket chain. You sent out an instruction that the entire chain is to focus issues such as:

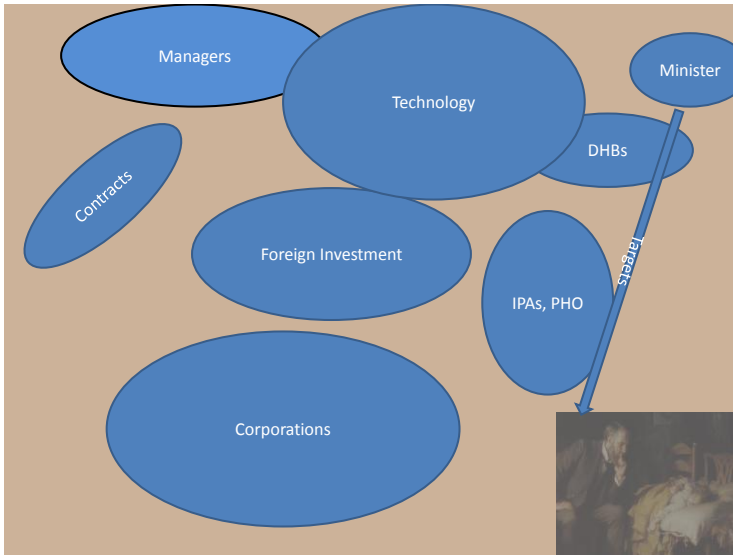
- the amount of time customers are waiting for the checkout
- the sale of bananas.

[2] Development of the integrated performance and incentive framework PHO service agreement Version 1 May 2013

This focus is appropriate for the checkout manager's targets and the fruit division, but hardly adequate means by which to run a complex business.

I have painted a rather grim picture – the erosion of 'decision space' is impacting on the clinician, the DHB, the government. Occupying that space are increasingly powerful PHOs, practice ownership companies, IT companies and foreign investors, who in future may, through trade agreements be able to erode that space further.

I have discussed the use of targets as an attempt to exercise control, while undeniably popular with the public, are largely peripheral to the system that they hope to influence. The introduction and focus on targets is more an exercise in displacement behaviour than effective management of the sector. The days when the relationship between health workers and their patients were centre stage are now a mere shadow; clinician decision space is shrinking fast.



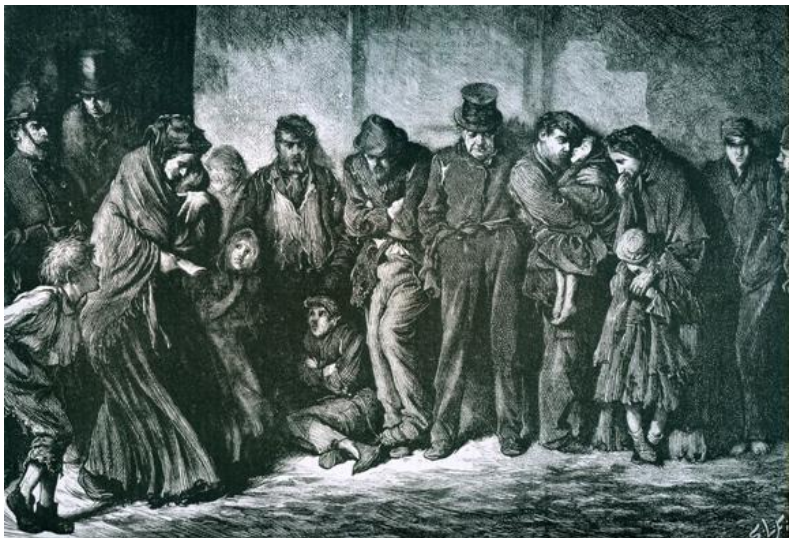
Is there another way?

I am not suggesting bringing back the leech. Quite the opposite; we need to embrace modernisation and technological development, but strengthen our ability to make it work for all. Part of this is confronting the fact that these systems are very complex, behave in unexpected ways, and can often surprise us. The evidence for the systems following an ideological blueprint, such as neoliberal economic fundamentalism or idealised socialism is weak. We are in a period of global reflection, old paradigms are looking rusty, new paradigms are

yet to clearly emerge. However, system complexity is something we can all agree on, and we need to explore ways to work better with it.

Firstly, it would help if we were a lot clearer about our societies' objectives, both in a general sense and in the health sector.

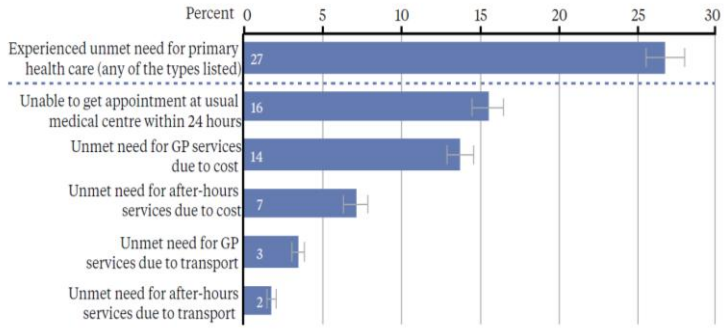
Fildes had another painting that he did a decade earlier than "The Doctor", which caused a major controversy in its time.



Entitled "Applicants for admission to casual ward", it depicts the desperation and struggle of the poor – as they wait to be admitted. Sadly this picture has been slow to change, especially here in Aotearoa.

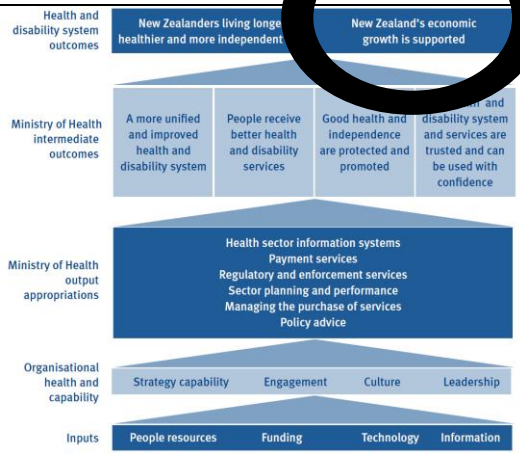
The New Zealand health sector continues to struggle to address inequities. The fact that in the recent New Zealand health survey almost 1 million New Zealanders experienced unmet need for primary health care services in the last year is a national disgrace.

Unmet need for primary health care in the past 12 months, by type



Note: Respondents could report multiple types of unmet need.
Source: 2011/12 New Zealand Health Survey (15 years and over)

The health sector needs clearer leadership in this regard:

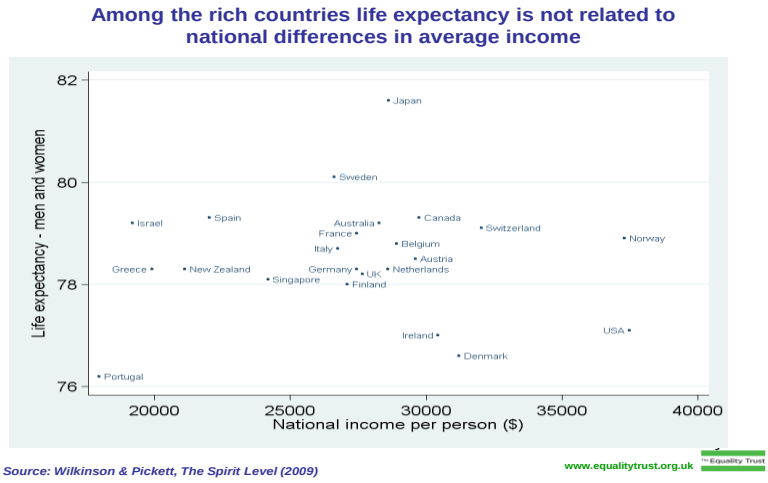
2009 Statement of Intent	2011 Statement of Intent
	

Between 2009 and 2011, reduced inequalities and equity of access were down-played as a major goal for the health sector, and were replaced with the term "New Zealand's Economic growth is supported". Many countries have demonstrated that they can grow their health sector by reduced government expenditure and increased private expenditure, including out of pocket payments, but this has been at the expense of equity and in some cases quality.

The informal word in the sector was that the government had decided that we had enough equity for the time being, and felt it was more important to focus on economic growth – the argument being that economic growth will itself lead to

better health outcomes, through mechanisms such as more jobs, higher living standards etc.

However, the relationship between economic growth and life expectancy is a lot less certain.



As Wilkinson has demonstrated, it is more to do with the distribution of wealth than the amount. Growth of the economy loses its relationship with life expectancy for high income countries. Do we want to mimic the economic growth of the USA, doubling the size of the economy, but reducing our life expectancy?

We do need to re-assert the fact that as a society we still value fairness – Jack's as good as his master, and should at least be able to get to the doctor when he has the need.

We need to build on the leadership shown by the NZMA in this area, with its clear position on health equity[3]:

- *Recognises that the health system itself is a determinant of health*
- *Believes that all health professionals should be supported and encouraged to act, advise and advocate for action on social determinants of health.*

[3] www.nzma.org.nz/sites/all/files/ps_healthequity.pdf March 2011

This recognition by the NZMA is a significant turning point in the equity debate in New Zealand, and has been further reinforced by the action the association has taken in support of the priority being given to the welfare of children. It could be further reinforced at the practical level with actions such as those being proposed in the Working for Health Equity Report, where the UK General Practitioners made a commitment to:

> *Focus on social exclusion as a clinical priority – ensuring access to PHC for people in deprived areas, for asylum seekers, refugees, homeless, people in vulnerable housing, travelling communities, offenders and sex workers.*

These changes herald a new awakening of the profession towards the use of ethics and their organisational power to protect patients and their rights.

To papraphrase Freidson (2001) it heralds a move away from managerialism and consumerism, which has legitimised and advanced the individual pursuit of material self-interest and the standardization of professional work, “the very vices for which professions have been criticized, preserving form without spirit”.

I had a premonition of the future economically robust health care sector when I went to get the light fixed in my car the other day. I was met by a ‘Sales Representative’ in a smart suit, not a mechanic in greasy overalls. While my presenting problem was a dodgy light switch, he did his best to sell me a new set of wheels, (we have some Pirelli’s in your size available now) an oil and grease (yours is not due yet, but let’s do it while you are here) a new cam belt, etc etc. It was very clear that ‘Sales’ had overtaken ‘Service’ as the driving motive of the organisation. The mechanic had been replaced by the salesman.

What enormous scope there is for this approach in medicine. In some countries, unfettered health care markets have already produced this brave new world. Upper income women in Bangladesh have a 50% caesarean section rate, while low income women have a 2% percent caesarean rate. Unfettered medical markets will reliably over and undersupply services in relation to need.

Simplified targets, new structures, frequent ‘restructuring’, are inadequate responses to the system’s complexity.

Complex systems, with multiple structures and relationships, can be influenced by a shared value set – valuing the fairness of the system, the right of all people to health care, as demonstrated by the NZMA's lead. New players, including foreign ownership and international trade laws, need to be subordinate to those values. Until they are, we should not be giving our sovereignty away – not even for milk money.

We need consistency in the values underpinning the system over time – addressing equity and prevention are generational challenges and are not going to be achieved if the policy directive is dropped or downplayed every time there is a change in government. Having reached a societal consensus that equity or prevention is important, we must sustain it and not allow it to be undermined for short-term political opportunism.

We need to recreate space for respectful informed evidence based discussion about the nature of the challenges we face and the potential solutions to them. I back the creativity and ingenuity of this country and its health workers, provided they are given the information, the support and the decision space to act. We are underutilising the brains and creative ability of the sector, including the DHBs, as we increasingly centralise decision making and build bigger organisations. The artificial construct of "back room functions" hides the integrated nature of health systems – it undervalues a large part of the health workforce, while trade offs are being made between efficiency and equity. Focusing on IT led "efficiencies" are notoriously difficult to pull off as our education colleagues remind us. Prof Greenlaugh[4] in the context of describing the greatest (failed) IT investment in history noted:

"It is a mathematical axiom that as a system gets more complex, it becomes less predictable because fixed inputs cease to produce fixed outputs. Different parts of the system adapt locally, insofar as they are able, to local influences and available information, leading to organic rather than linear change… The more complex the system, the more likely efforts to ensure that implementation is "properly managed" (by imposing centrally-driven milestones, inflexible business processes and mandatory reporting of progress) will backfire. ."

[4] http://www.computerweekly.com/blogs/public-sector/2010/06/trisha-greenhalgh-on-the-summa.html

Change needs to be led by people, not technology. We may well be in for a period of protracted zero or low growth, while at the same time we need to respond to an emerging epidemic of NCDs through unchecked obesity: we need to transform the sector and unleash its creative potential and ability to solve problems.

Finally, we need to revisit the conditions in which clinicians can focus on their primary role, responding appropriately to the needs of those under their care.

Relationships based on openness, trust and good communication enable the partnership with patients to address their individual needs.

To do this, we can no longer ignore the political and economic forces that are impinging on this relationship – but engage with these forces in a way that ensures our ethical responsibilities to care are not compromised.

My colleagues at Massey have been looking at this relationship for Māori with cancer.

One of the interviewees put the issue succinctly:

Why relationships matter

"When I was going through some treatments you get people coming around introducing themselves and you are like well hold on, I am not really worried about you right now, I have got to focus on myself.....

..... so come and see me when I am at home, when I am all alone, when there is nobody there to help me"

Relationships may not be a target, but they do matter. [5].

1. Warner JH. The Doctor in early Cold War America. The Lancet. 2013;381(9876):1452-3.
2. Malcolm L. Service management: New Zealand's model of resource management.. Health Policy 1990;16(3):255-63.
3. Gleeson D, Friel S. Emerging threats to public health from regional trade agreements. The Lancet. 2013;381(9876):1507-9.
4. Matheson D. From Great to Good; how a leading New Zealand DHB lost its ability to focus on equity during a period of economic constraint. Wellington Massey University 2013.
5. Slater T, Matheson A, Davies C, Tavite H, Ruhe T, Holdaway M, et al. “It’s whanaungatanga and all that kind of stuff” -Māori cancer patients’ experiences of health services in the Wellington Region .In press.