Special Commission of Inquiry into Healthcare Funding

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Commissioner Richard Beasley SC
Special Commission of Inquiry into Health Care Funding

Thank you for providing the opportunity to provide a submission to the Inquiry into Health Care Funding. My submission is based on my observations during a long career in the NSW Public Hospital system.

Summary
The 'core message' of my submission is that irrespective of the total sum of funding available for the health service, there is great potential to improve the efficiency and productivity of the health system, and improve the experience of both patients and staff, without increasing the total funding for the health system.

This can be achieved by:-

- Changing the pervasive culture of division, antagonism and non-cooperation between clinicians and management (both broadly defined) in the healthcare system.
- Changing the internal 'business models' for fund allocation to reward activity and outcomes, rather than 'punishing' managers who do not stay within budgets.
- Developing a culture of clinicians and managers at all levels working together to innovate and change clinical processes to improve productivity, eliminate waste and improve patient and staff experience.

My Background

I am a Senior Staff Specialist Anaesthetist currently working at the John Hunter Hospital in Newcastle. I am nearing the end of my clinical career, having been an intern in 1980. I have worked most of my 43-year career as a full-time clinician in the New South Wales Public Hospital system. During this time I have often been regarded as a clinical leader in my specialty, both locally, nationally, and indeed internationally.

Throughout my career I have had an abiding interest in the benefits to patients and the health system from continuous innovation, and changing the way we do things. I have always believed that there is value in challenging established ideas. In my case, I have been lucky to be involved in a number of successful system-wide innovations. In particular, I led the development of the 'Perioperative System' for managing elective surgical patients. This is now the standard model of care in Australia, and has been emulated internationally. I have been invited to speak at numerous international conferences, consulted for health authorities in other Australian states, the UK, Sweden, New Zealand, Canada, Hong Kong and Denmark, and visited some 150 hospitals in 20 countries to learn and share my ideas and advice about innovations in Perioperative Care.

Earlier in my career, (at Liverpool Hospital) I was also part of the team that introduced the Medical Emergency Team (Rapid Response Team) which has caused a dramatic improvement in patient safety, by improving the care of the deteriorating patient. I have been involved in numerous other positive innovations in improving clinical care and system efficiency.

Apart from my involvement in clinical innovations, I have also held multiple positions within the ANZ College of Anaesthetists, and on the NSW AMA. I am a Ministerial appointee on the New South Wales Medical Council.

I say this to emphasise that I have been a productive contributor to improvements in the NSW Health System over many years. I have an innate passion and commitment to improving the health system, and a history of success in doing so.

Nevertheless, as I approach the end of my career I find myself frustrated by the ongoing problems in NSW Health.

The Gulf between Clinicians and Management.

I am confronted every day by the adverse impacts of the gulfs that have developed between clinicians and management in the New South Wales health system. I say ‘gulfs’ deliberately:- There are gulfs between clinicians and unit management; between unit and middle management; and between middle and senior management. These huge schisms between senior management, middle management and clinicians have led to widespread staff dissatisfaction, frustration, and burn-out across the health system.

In New South Wales there have been some genuine and successful efforts to engage management constructively with teams of clinicians to develop improvements in the way we do things. A particular state-wide example was the Greater Metropolitan Transition Taskforce, which was established by Craig Knowles as Health Minister, and under the inspiring leadership of Dr Kerry Goulston.

In Newcastle, we had programs initiated by CEOs Katherine McGrath and Nigel Lyons, who encouraged genuine engagement with the clinicians. It is of note that 15 years ago, Hunter New England Health was seen as the leading health service in New South Wales. At one stage we were winning so many of the state awards that it was somewhat embarrassing.

Almost 20 years ago the Garling Commission was established, to review all aspects of the New South Wales Health system. The Garling Report made many observations that remain relevant. The report particularly focused on the widespread disengagement between clinicians and management and made multiple recommendations to address this ‘schism’. The Commissioners recommended multiple actions to address this schism, many of which were implemented successfully. The Agency for Clinical Innovation was one example. Unfortunately (for me), the changes made at that time have, perhaps, become de-energised and stale across the State. I think it is now worthwhile re-emphasising the findings, and re-invigorating the initiatives of the

Garling Commission. This is needed to further develop a culture of empowerment and engagement between clinicians and all levels of management.

Unfortunately, in Hunter New England LHD, I believe we have had some 15 years of executive leadership that was antagonistic to, and disengaged from, clinicians. The problems that we have had in the Hunter New England LHD are not unique, although perhaps more noticeable after being the jewel in the crown of the New South Wales Public Hospital system. This fostered suspicion and antagonism between clinicians at all levels of management. The overwhelming sense of not being listened to has become so well-established that many of the junior staff cannot comprehend that there was a time when things were different. I am hopeful that recent changes at the senior level may encourage change, but there is a lot of repair work required to do so.

<u>The adverse effects of internal funding allocation models</u>

I believe that there are many problems associated with the system of healthcare funding (rather than the absolute level of funding) that contribute to current inefficiencies. This includes a relentless emphasis, particularly for unit and middle managers, on financial outcomes ('staying within budget') rather than improving productivity. Internal funding allocation models have been based on historic or block funding rather than activity- or outcome-based funding. Managers have lived in an atmosphere of fear and bullying, and respond with dysfunctional parsimony, unwilling to do or change anything that may result in a budget overrun, even if it will clearly improve efficiency and effectiveness of patient care.

There are numerous examples of this phenomenon. A common example is seen in operating theatres and other procedural services within the hospital. They develop a culture and work practice of working steadily but slowly, to stay within staffing levels and within budget. They receive no extra funding (and thus have no incentive) to increase productivity. Ultimately, this results in semi-urgent patients, admitted to hospital through emergency, having to wait unnecessarily. They may wait in hospital for 2 to 3 days, rather than having their surgery completed so that they can be discharged from hospital. It is a bizarre paradox:- a unit within the hospital will institute policies to save money on their own budget even though the global increased cost to the hospital greatly outweighs the 'saving' that the unit may have made. When the managerial culture is dominated by fear, by excessive authoritarianism, and by lack of reward for productivity, the inevitable results are waste, inefficiency, and a pernicious sense of frustration and demoralization amongst the staff.

<u>The potential for innovation and clinical redesign</u>

Based on my own hospital career, I have a long list of examples of waste, inefficiency and poor-quality outcomes that have resulted from not implementing 'simple' and inexpensive innovations that were identified by clinicians at the coalface. I have a shorter, but nevertheless significant, list of examples where clinician-driven innovation has resulted in great improvement.

I think there is a systemic problem of senior- and middle-management not appreciating just how much chaos and waste occurs at the 'clinical coalface' due to things that would be simple to change. They don't know what they don't know.

I was involved in a broad-ranging quality improvement program in (then) Hunter Health 20 years ago. In this Program we identified multiple improvements that could be made very quickly, without massive increases in funding. One of our techniques to identify improvement opportunities was to carefully mapping out the process that the patient went through, using a patient and clinician (rather than management) perspective. We challenged the purpose and appropriateness of each step in the process. These 'Clinical Process Redesign' initiatives produced great improvements in the efficiency of process. This was one of the contributors to Hunter New England Health's multiple awards at the time. We have not repeated any similar exercise in the last 15 years. I think the senior management has been unaware of just how much 'churn', 'rework', and simple inefficiencies there are at the 'clinical coalface'.

Conclusion

It is easy to focus on the need for extra funding of the NSW Health System. There is no doubt extra funding would reduce some of the pressures on the system. That said, funding is not infinite.

Within current resources, there is potential to improve efficiency, patient care, and the experience of staff. This potential can be achieved by improving the culture between clinicians and managers at all levels; by changing the funding allocation models with hospitals; and by developing a focus on actively seeking and encouraging innovation driven by clinicians working with managers.

I would be delighted to present further to the commission to explore these issues in more detail.
Thankyou for your consideration.

Dr Ross Kerridge