

Proposed privatisation of hospital laboratories: weighing the risks of unintended consequences

Wairarapa, Hutt Valley and Capital & Coast DHBs

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Introduction

Privatisation of hospital laboratory services is being considered in a proposal from the Wairarapa, Hutt Valley and Capital & Coast District Health Boards (DHBs). If approved it will be the biggest privatisation of public hospital services in the 25-year history of the Association of Salaried Medical Specialists (ASMS).

The proposal aims to 'integrate' hospital and community laboratory services to improve efficiency and save money. Two options are presented:

1. a partnering arrangement between a private laboratory and DHBs (including the possibility of a new company being set up for this purpose), or
2. a single, private laboratory provider.

Potentially both options involve forms of privatisation of publicly provided services which, if either proceeds, would be the first privatisation of a public hospital service since 2008. Both options are riddled with high risk unintended consequences in respect of the clinical needs of the 'end users' of these services and fiscal prudence.

This is especially significant because the work of laboratories is critical to the safe and effective delivery of patient care and treatment across the public health system. More than 70% of all diagnoses involve pathology tests, and pathology plays a vital role in infection control and monitoring disease. The options significantly underestimate and would undermine the importance and benefits of a highly integrated relationship between hospital laboratories and the 'end users' in their hospitals. The objective of integration in the context of the prime purpose of hospital laboratories is at serious risk of being disintegrated.

The financial risks of privatising the hospital laboratories, either directly to a private company or through a joint venture with a private company, well exceed the cost of investing in the establishment of the recommended shared data repository.

Privatisation of either form would create a major obstacle to developing and supporting a desperately needed laboratory workforce strategy. It would risk losing current employees and also make recruitment to this already vulnerable, skilled workforce more difficult in a competitive labour market.

This paper examines the proposal, the stated problems it is attempting to fix, the evidence to support it, and the risks of unintended consequences – including a high risk of destabilising the region’s laboratory workforce. The ASMS also presents a proposal based on a partnership approach and clinical leadership 1 to build on the existing strengths of the regional laboratory service, while avoiding the risks.

Time-line of events

2010

Capital & Coast Health, Hutt Valley and Wairarapa district health boards embarked on a '3DHB Programme' to gradually improve integration of services between the three DHBs.

December 2012

To advance the '3DHB Programme', the three DHBs' planning and funding units were amalgamated to form a Service Integration and Development Unit (SIDU).

Mid-2013

The three DHBs commissioned SIDU to develop a strategic framework to improve integration of laboratory services. They established a steering group to oversee development of the strategic framework for laboratory services. The group was chaired by SIDU Director and included SIDU staff, an independent pathologist, a private laboratory expert, a general practitioner, chief medical officer and chief operating officer.

July/August 2013

A 16-person laboratory working group was formed 'to provide direction to the development of the strategic framework'. It included clinicians and management representation from community and hospital services and an SIDU staff member. The steering group oversaw the working group's activities.

28 August 2013

The working group's report, Laboratory Services Strategy, was published. It includes an overview of the current state of laboratory service provision across the three DHBs, recommendations, and options for possible configurations of the region's laboratory services.

September 2013

The three DHBs endorsed the Laboratory Services Strategy and agreed the future configuration of laboratory services should seek to achieve, among other things, 8% savings.

October 2013

SIDU, on behalf of the three DHBs, sought expressions of interest (EOI) from the private sector in providing community-referred laboratory services, and broader proposals seeking to integrate hospital and community-referred laboratory services.

March 2014

Providers shortlisted through the EOI process were invited to participate in a Request For Proposal (RFP) stage, beginning with a 'competitive dialogue' exploring different partnership models. Details were not publicly disclosed.

August 2014

The RFP was issued. Documents were not publicly disclosed.

August 2014

Implementation of a new shared laboratory data system (Laboratory Information System - LIS) for CCDHB and HVDHB hospital laboratories was announced. The system has potential to be expanded to become a regional shared data repository.

3 September 2014

The three DHBs released an Integrated Laboratory Services Proposal and Consultation Document. The proposal presented two options; potentially both options involve forms of privatisation of publicly provided services. Two weeks were allowed for feedback.

24 September 2014

The RFP submissions were closed.

September-November

An appointed panel, which includes clinicians and management representatives, has been evaluating the RFP submissions.

Early December

DHB Boards are due to consider recommendations from the evaluation panel and the steering group.

Executive Summary

1. Privatisation of hospital laboratory services is being considered in a proposal from Hutt Valley, Wairarapa and Capital & Coast DHBs. The proposal suffers by not being led by those with clinical and operational experience in hospital laboratories. The process, contrary to the requirements for clinical leadership, has been a top-down directive with the scope of activities and decision-making determined by the DHBs' Service Integration and Development Unit (SIDU).
2. The proposal's stated main aim is to 'integrate' hospital and community laboratory services to improve efficiency and save money. Two options are presented: (1) a partnering arrangement between a private laboratory and DHBs (including the possibility of a new company being set up for this purpose), or (2) a single, private laboratory provider. Potentially both options involve forms of privatisation of publicly provided services.
3. The proposal comes when the DHBs' own documents show laboratory services across the three DHBs are not 'broke' and do not need 'fixing'. Services are reported to be working well from the perspectives of both patients and clinicians. The available data showing trends in costs versus laboratory test volumes also point to increasing efficiency. Conclusions include:
 - There are no pressing issues in service delivery.
 - Turnaround times for most tests are short.
 - Hospital specialists have good access to pathologists and microbiologists to directly discuss results.
 - There are no major barriers to accessing laboratory sample collection centres.
4. The main concern is that information technology integration is partial only. The clear message is that 'overwhelmingly' most of the areas where services could be improved revolve around the ability to access test results at the point of physician consultation and that this could only be fixed if a shared data repository is introduced. This was seen as the 'lynch pin' of integration.
5. The main underlying reason for the proposal appears to be to cut services costs. However, there is no information as to how that might be achieved, the evidence that either of the two options would improve the

effectiveness and efficiency of services is not presented, and there is a lot of uncertainty about what the proposals mean in practice.

6. The proposal fails to recognise the crucial integration of hospital laboratories with their 'end users' in the public hospitals who critically depend on their service. This includes the full range of surgical and medical hospital specialties (more than 70% of clinical decision-making depends on the work of hospital laboratories).
7. The risks of unintended consequences of the DHBs' proposal are considerable. Greater structural or organisational integration with a private community testing company risks fragmenting the current high successful level of integration with hospital 'end users'. This would have a negative impact on the quality and effectiveness of patient care across the system and lead to extra costs downstream. A loss of integration with the university community at the Wellington School of Medicine is also likely. It is particularly disturbing that the DHBs have omitted any discussion on the impact their proposal would have on the integration between hospital laboratories and other hospital services, which raises a serious question as to whether in fact they have even thought about it.
8. There is strong evidence internationally that attempts to impose top-down organisational integration do not achieve service integration but instead can be counter-productive, creating workplace tension and conflict.
9. The hospital laboratory workforce is particularly vulnerable, including in respect of aging and shortages. There is a real risk that this top-down proposal will trigger resignations in a service that already faces challenges in recruitment and retention.
10. International evidence shows integrated care is possible only if it comes from the 'bottom up' through the development of specific 'micro-level' interventions by a small number of providers. Organisational integration then comes as a consequence rather than a cause.
11. Services across the health system also depend on maintaining integration with laboratory services for their role in infection control – a role that is crucial both in terms of preventing ill health and avoiding potentially huge health care costs. Thus, the laboratory bears the cost of setting up good systems, but if not done, overall cost of care will be ultimately a lot higher.
12. The process for developing the proposal does not meet the engagement obligations of the DHBs under the national multi-collective employment

agreement covering senior medical and dental officers (MECA, Clause 2), in particular the requirement for managers to support employees (senior medical staff) to provide leadership in service design, configuration and best practice service delivery. This engagement obligation is derived from the engagement principles of the *Time for Quality* agreement between the Association and the DHBs (which is also incorporated in the MECA). It also fails to meet the expectations of the Government's policy advice on clinical leadership, *In Good Hands*. To the extent that there has been clinical engagement leading to this proposal:

- it has not involved clinical leadership as envisaged in the above policy documents
 - it has been severely restricted by its narrow allowable scope
 - it has been forced by the process to be reactive rather than proactive (that is, instead of specialists leading with management supporting it has been management-led with specialists restricted to commenting on a limited range of matters determined by management).
13. The Association recommends that the DHBs review their process in order to (a) confirm that hospital laboratories will continue to be publicly provided and their staff DHB-employed and (b) work with the Association to establish a process for clinical leadership in the development of a more integrated relationship between the hospital laboratories and between them and the community testing provider based on enhanced collaboration. This would include directing particular attention to addressing the needs of HVDHB's laboratory services to ensure integration with hospital clinical services is maintained and a level of certainty about the future direction of the laboratory is re-established following recent restructuring. It would also include development of a shared data repository. This approach, which is in line with international evidence for achieving greater integration, would not involve transferring skilled hospital laboratory staff to a new employer (and possible loss of staff in the process) and would have a stabilising rather than destabilising impact on staff.

Background

Laboratory Services Strategy

Over the past few years, the Hutt Valley, Wairarapa and Capital & Coast DHBs have worked closely together to improve collaboration and better integrate service delivery across the region, with the aim of tempering growing financial and clinical pressures. As part of that, they decided to jointly review the way laboratory services are provided in the region and develop a plan to guide further integration of laboratory services and related procurement.

One of the first things they did was establish a laboratory working group to advise them how to proceed. This group comprised senior managers and clinicians from both public and private service providers but was subject to close oversight and stage-by-stage approval of a steering committee, which in turn worked under the Service Integration Development Unit (SIDU) and was chaired by the Director of SIDU. (SIDU is an amalgam of the three DHBs' planning and funding units.)

Information for the development of the strategic framework was gathered through site visits, patient focus groups and stakeholder interviews, all conducted by SIDU staff or a contracted research organisation.

The SIDU-approved working group's report, *Laboratory Services Strategy*, was published in August 2013. It included an overview of the current state of laboratory service provision across the three DHBs, recommendations, and options for possible configurations of laboratory services across the region, discussed in this paper. The *Laboratory Services Strategy* report did not seek feedback.

In September 2014 the DHBs produced a proposal and consultation document, allowing two weeks for feedback. The proposal's main aim is that hospital and community laboratory services are 'integrated... into a seamless service for referrers and patients, as this is where the largest clinical and financial gains will be made'. It comprises just two options:

1. a partnering arrangement between a private laboratory and DHBs; and
2. a single laboratory provider.

It is clear from the consultation document that the second option would involve a private provider. Potentially both options involve forms of privatisation of publicly provided laboratory services and transfer of the staff of this critical service to a third party. If either form of privatisation proceeds,

it will be the first privatisation of a public hospital service since 2008. It is counter to the direction taken by, for example, the three Auckland DHBs, and Waikato and Canterbury DHBs when they reviewed their community testing contracts in recent years.

Current state of laboratory services

Hospital laboratories

Capital & Coast DHB (CCDHB) currently operates two hospital laboratories, based in Wellington Regional Hospital (main laboratory) and Kenepuru Hospital (satellite laboratory). Hutt Valley DHB (HVDHB) operates one hospital laboratory at Hutt Hospital.

CCDHB and HVDHB hospital laboratories have undergone a process of organisational integration in the past couple of years, with the two laboratories becoming known officially as OneLab on 1 March 2014. Like the current DHBs' proposal, this 'integration' has followed a 'top-down' approach which has had a negative impact on morale at Hutt Hospital's laboratory, coincided with resignations of senior staff, and created uncertainty about the future direction for the laboratory.

In the Wairarapa, hospital laboratory services are contracted to Medlab Central, part of the Australian-based multinational company Sonic Healthcare Ltd, which operates from the Wairarapa Hospital laboratory and Medlab's laboratory at MidCentral DHB.

Community laboratories

CCDHB and HVDHB community-referred laboratory services have been provided by New Zealand company Aotea Pathology under a five-year bulk-funded contract since October 2006. This contract was extended in November 2011.

Medlab Central has been providing hospital and community-referred laboratory services for WDHB under a five-year bulk-funded contract since 2007. This contract was extended in July 2012.

Both agreements were due to expire on 31 October 2014 but have been extended to 31 October 2015.

Assessment of services

The working group summarised the current state of service provision as follows:

The current state of service provision is relatively strong. There are no pressing issues in service delivery. Growth in testing volumes has slowed considerably although there have been material price increases in laboratory costs. There are further areas of refinement, for instance,

in laboratory standardisation (all of which would be resolved by a data repository), but much has been done. There is partial IT integration only.

Laboratory Services Strategy, 2013¹

Patient focus groups ‘provided very positive feedback on the current provision of laboratory services in the region. Patients described the services as responsive and meeting the patients’ needs’.

Physicians interviewed for the project were ‘generally happy’:

Turnaround times for most tests are very short. Laboratory results received are mostly accurate. Physicians described the access to pathologists and microbiologists to directly discuss results as very good. They can ring up the laboratory for backup and ask laboratory scientists and pathologists for additional interpretation of a result and advice.

Laboratory Services Strategy, 2013

The views of the various stakeholder groups were summed up:

Overall, stakeholders reported that the current provision of laboratory services in the region works reasonably well. However, certain services need to be ‘fine-tuned’ to achieve efficiency gains...Overwhelmingly, most of the issues revolve around the ability to access test results at the point of physician consultation. The working group considered that this could only be fixed if a data repository is introduced.

Laboratory Services Strategy, 2013

[Since the publication of the *Laboratory Services Strategy* a shared data system has been established for CCDHB and HVDHB hospital laboratories. This new system, which cost around \$4 million to develop has potential to be expanded as a central regional data repository. This investment could be wasted, however, if a new company decided on different system.]

Collection centres

The availability and efficiency of sample drop-in sites largely determine the level of patient access to laboratory services. The adequacy of this particular service is in effect a measure of the government policy of providing services ‘closer to home’. The *Laboratory Services Strategy* found ‘no major barriers’. The network of collection centres ‘looks appropriate’, with a question to be investigated in the Hutt Valley about more centres being needed in high deprivation areas.

Cost of services

Hospital laboratory funding information is not provided in the *Laboratory Services Strategy*. Only nominal figures are given for the Aotea and Medlab 'contract values' for delivering community-based services.^a When these are converted into real terms, taking into account inflation and demographic changes, funding for community laboratories across the three DHBs increased by 1.16% from 2008/09 to 2013/14.^b However, that figure includes additional costs from 2011/12 onwards for the reinstatement of private specialist-referred testing (PSRT). (In 2006 CCDHB and HVDHB ceased paying for private specialist referred tests, saving \$1.4 million a year on average, but reinstated payments following a review of the policy by the Ministry of Health.) When the reinstatement of PSRT is excluded from the funding trends, real funding decreased by 4% between 2008/09 and 2013/14.²

Information on volumes of community-based tests is provided from 2008/09 to 2011/12. Over that period total test volumes (Schedule A & B tests) increased by 5.4%, while real funding increased by 0.4% (or dropped by 5% when PSRT reinstatement is excluded).^c

Appendix 1 provides further details on real funding calculations and community test volumes.

Workforce

While the working group's assessment of current services is a general tick of approval, its *Laboratory Services Strategy* reveals the laboratory workforce is particularly vulnerable. The strategy does not provide details on specific professions but indicates 38% of the total laboratory staff is aged 50 years or older and 16% are approaching retirement. Those proportions are likely to be higher still for the local pathologist workforce.

Unpublished data from the Medical Council's 2012 medical workforce survey show 57% of pathologists practising in New Zealand are aged 50 years or

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- a Note: Table 12 of the *Laboratory Services Strategy* contains an error, where the contract value for Aotea Pathology for 2010/11 has been omitted. The published figures for 2010/11, 2011/12 and 2012/13 are in each case the figures for the following year. The effect of the error has been to inflate the nominal growth rate over five years from 15.7% to 19.2%.
 - b Medlab's costs for Wairarapa community tests are estimates assuming community testing costs remained approximately 50% of Medlab's total hospital and community laboratory contract, as indicated in the working group's report (page 43).
 - c Medlab's volumes are assumed to be constant at 2,750 per year, based on an estimate of between 2,500 and 3,000 per year provided in the working group's report (page 42).

older; 23% are aged 60 or older. The data also show that medical specialists tend to reduce the number of hours they work as they get older.

As at October 2014 there were three vacancies for pathologists at CCDHB, including a clinical leader position. Official vacancies, however, tend to be a conservative indicator of workforce needs because they are influenced by budget constraints. Medical registration data show there were 29 pathologists with annual practising certificates living in the Wellington and Hutt areas as at October 2014, about 10 of whom work between Aotea Pathology and either CCDHB or HVDHB. Assuming all were practising, that amounts to approximately one pathologist for every 15,800 people - a ratio that has been described as 'a severe workforce crisis'.³

The pathology workforce comprises a number of small specialties which are especially vulnerable. For example CCDHB currently has just one half-time chemical pathologist, and immunology is covered by one permanent specialists working in a 0.2 full-time equivalent position, with a locum working a similar number of hours. Potentially, the loss of a single specialist can therefore have a significant impact on service delivery.

In addition, there is an international shortage of pathologists, who, like laboratory scientists, are on Immigration New Zealand's Long-Term Skills Shortage List – defined as 'occupations where there is an absolute (sustained and ongoing) shortage...both globally and throughout New Zealand'.

This is especially significant for New Zealand because international medical graduates (IMGs) comprise almost half of the pathology workforce and global competition for pathologists has been increasing and will continue to for the foreseeable future. Australia, for example, expects the demand for pathologists to outstrip supply for at least the next decade.⁴ As the *Laboratory Services Strategy* acknowledges, 'Pathologists and laboratory scientists are in an international market and many countries pay higher salaries than New Zealand'. Pathologists are not easy to come by.

The working group recognised the need for strategies to keep the current aging workforce working longer. It does not suggest what that might involve, nor is such a strategy mentioned in its recommendations.

Capital deficit

The *Laboratory Services Strategy* also reveals an urgent need for capital investment in local laboratory services, including investment in IT systems. While capital spending issues are not discussed in any detail, concerns about a lack of capital investment are reflected in various parts of the report.

For community laboratory providers, current contract terms of five years were considered too short to allow laboratories to take a long-term approach on capital intensive investments.

Staff interviewed from hospital laboratories also expressed a need to invest in equipment, infrastructure and staff. The report identifies 'capital constraints' as a constraint on integration.

Lack of funding was identified as a barrier to the urgent establishment of a shared data repository accessible to all relevant clinicians across the region, which the working group regarded as a top priority to address the service 'fine-tuning' needs identified in their report, and was regarded as a 'lynch pin' of integration.

The working group summarised the issue:

Capital expenditure is essential to develop and maintain reliable laboratory infrastructure. Barriers to capital expenditure include the length of community provider contracts, and spending for hospital laboratories being complicated by the needs of the wider hospital system.

Laboratory Services Strategy, 2013

Funding

Both the workforce shortage and capital deficit are linked to budget constraints, which lead to the 'complications' referred to above.

Says the *Laboratory Services Strategy*: 'Collectively, the three DHBs will receive a total of \$1,536,012,708 in 2013/2014, an increase over last year of \$15 million. Despite this increase, the three DHBs will have to improve efficiencies ... to achieve a break even position across their collective catchment for 2013/2014'.

When demographic changes and cost increases are taken into account, it is a real funding cut of approximately \$36 million.

Such 'efficiencies' are necessary because \$15 million amounts to less than a 1% increase in funding across the three DHBs. When demographic changes and

cost increases are taken into account, it is a real funding cut of approximately \$36 million.^d

This funding cut is part of the broader funding cuts to DHBs nationally, when measured in real terms. An analysis of government health funding trends, taking into account increased costs and demographic changes, estimates Vote Health operational funding fell by a conservative half a billion dollars between 2009/10 and 2014/15. Further cuts are forecast between now and 2018.⁵

^d Based on an inflation rate of 1.6%, average wages increases of 1.25%, and a population and aging adjustment of 1.54%. The latter is estimated by the Ministry of Health as the average funding adjustment needed across New Zealand to cover population growth and the aging effect. The three DHBs are assumed to need an average adjustment.

Future challenges and opportunities

The future poses big challenges for laboratory services, but also opportunities that could have a substantial impact on the effectiveness and efficiency of patient care across the whole health system.

Challenges

The *Laboratory Services Strategy* says changing demographics will significantly affect demand for laboratory testing. The Capital & Coast population is expected to increase by 0.8 per cent per year, with growth highest in Wellington City, followed by Kapiti Coast District. While the Hutt Valley and Wairarapa populations are not expected to grow in the next 15 to 20 years, all three DHBs will experience significant aging. The region's population aged 65 to 84 years is expected to grow by nearly 80% from 2011 to 2031 - from 51,000 to 91,000 people. The population aged 85 and over is estimated to double, increasing from 7,400 to 15,000 people.

Forecasting laboratory service demand is difficult, however. On the one hand, on top of the growing demographic pressures, an increasing incidence of cancer combined with the increased complexity per case and genetic technology may increase demand for anatomical pathology beyond that expected through an aging population alone. Further, the clinical pathologist's role is expanding into wards, ongoing clinical audit, adverse occurrence screening and critical incident monitoring. For anatomical pathology specifically, pathologists are becoming increasingly involved in reviewing complex cases as part of a multidisciplinary team. Not least, there will be greater requirements for increased training places and therefore an increased training role for pathologists.⁶

Opportunities

On the other hand, investment in laboratory services has proven valuable not only in improving patient care but also in producing the much sought-after 'efficiencies'. Technology capable of performing repetitive actions at relatively high speeds has been developed to improve quality, consistency and efficiency. The results of tests on samples that previously took hours to process can now be reported in a matter of minutes. Automation in the laboratory has had a significant impact in the blood sciences and is becoming increasingly significant in microbiology and histopathology.

A recent review of pathology quality issues in the United Kingdom summarises some of the benefits to patients and services of investment in laboratory technology:

New technology for blood culture analysis dramatically reduces the time taken for the isolation of organisms from positive blood cultures. This enables more rapid and focused antibiotic treatment to be given, resulting in better patient management, improved outcomes, and reduced lengths of stay in hospitals.

Advances in screening techniques, genetic testing and new technologies are often cited as key contributors to the predicted increases in longevity. Perhaps the most significant innovation is the development of genetics and molecular technologies into mainstream medicine, which will have substantial impact on the health of the population, clinical practice and the management of patients.

An understanding of how an individual's genes can inform decisions about appropriate therapy is likely to have major positive effects on patient outcomes. The use of companion diagnostics in personalised medicine, where pharmaceuticals will be supplied only to those patients who are shown to be likely to benefit from treatment, will avoid possible harm and inconvenience to patients.⁷

To ensure laboratories are capable of making the best and safest use of new technology, it is essential their staffing includes a high level of experienced scientists.

Infection control

Infection control is an important function of laboratory services both in terms of preventing ill health and avoiding potentially huge health care costs. As the *Laboratory Services Strategy* points out, increasing numbers of patients need complex care which is now often delivered in community settings as well as in hospitals. Patterns of infection are becoming blurred – community

infections are becoming established in the hospitals and vice versa.

Investment in laboratory services has proven valuable not only in improving patient care but also in producing the much sought-after 'efficiencies'.

Globally, antimicrobial resistance is now recognised as one of the key threats to human health. Some researchers are saying it 'could be far worse than ebola'.⁸ Although rates of antimicrobial resistance remain

relatively low in New Zealand, this situation can rapidly evolve. In addition, there are emerging infection risks from novel organisms. Recent examples include H7N9 influenza, and Middle East respiratory syndrome-Coronavirus.

The working group comments:

Identification of new trends and tracking of patterns potentially leads to improvement in individual patient care, but also may benefit the population as a whole through improved empiric antibiotic choices, better resource allocation and utilisation, bed usage, infection prevention, length of stay and pharmacy costs and also may have public health impacts with early detection of potential outbreaks.

None of these benefits or cost savings are likely to be reflected in laboratory costs, which will ultimately be higher than if no surveillance were done. Thus, the laboratory bears the cost of setting up good systems (large initial outlay and ongoing maintenance) and a relatively small amount of additional testing (ongoing costs) but if not done, overall cost of care will be ultimately a lot higher from both a personal, financial and resource usage perspective.

Laboratory Services Strategy, 2013

In summary, laboratory services are at the heart of the public health system and hospital laboratories are at the heart of public hospitals.

More than 70% of clinical decision-making depends on the work of laboratories and, as discussed above, the extent to which laboratories invest in their services can have a major impact on people's health, the effectiveness of health treatment and cost-efficiency. Under-investment, on the other hand, can lead to poorer health outcomes, inefficiencies that flow on through the health system, and potentially substantial costs.

Indeed the extent to which governments invest in public health services generally has been shown to have significant benefits to a country's economy. A major international study evaluating the economic effects of different types of government spending found \$1 invested in health produces \$4.3 in the economy.⁹

DHBs' proposed reorganisation of laboratories

Summary of current laboratory services and actions required

To summarise the state of current laboratory services at Capital & Coast, Hutt Valley and Wairarapa DHBs:

- The current state of service provision is relatively strong. There are no pressing issues in service delivery, although the 'top-down' process of 'integrating' CCDHB and HVDHB hospital laboratories has, according to various anecdotal reports, been regarded by HVDHB laboratory staff as a step backwards in terms of effectiveness of service delivery at Hutt Hospital. This could have been avoided if the DHB had adhered to genuine clinical leadership (rather than disengage their relevant health professionals) and had understood better the importance of the relationship between the laboratory and its 'end users' in the rest of the hospital.
- Some 'fine-tuning' is needed to achieve efficiency gains. 'Overwhelmingly', most of the issues revolve around the ability to access test results at the point of physician consultation, which could be fixed with the establishment of a data repository.
- Demand for services is increasing and is likely to become more complex, though the impact of that demand is difficult to measure accurately due to the confounding effects of new technology.
- While the volume of laboratory tests is increasing, the cost of services, based on incomplete data, appears to have remained virtually level in real terms over recent years.
- The laboratory workforce is aging and key professions, such as pathologists, are in demand internationally.
- DHB funding pressures and relatively short-term contracts for private providers have created barriers to capital investment in laboratory services. The establishment of a data repository will require capital funding which is not currently available. While some progress has been made with the recent implementation of a shared data system for CCDHB and HVDHB hospital laboratories, it is not known whether a new company or management would retain this system.

From the above points, two key actions can be identified as necessary to secure efficient and sustainable laboratory services, which are able to respond to growing demands:

1. Investment in capital including, as a priority, funding for a data repository.
2. Urgent development and implementation of a strategy to retain current staff and to promote recruitment to ensure there are sufficient staff to meet service demands, especially as staff retire. This is most likely to involve further investment.

DHBs' response

To recap on the DHBs' proposal:

Despite the *Laboratory Services Strategy* indicating current laboratory services in the three DHBs are generally functioning well and require only some 'fine-tuning', the DHBs decided laboratory services must be reorganised into an integrated whole, both regionally and across hospital and community services, in order to meet 'ongoing financial challenges' and to manage demographic and service pressures. In September 2014 the DHBs produced a proposal and consultation document, allowing two weeks for feedback, with the main aim of integrating hospital and community laboratory services 'into a seamless service for referrers and patients, as this is where the largest clinical and financial gains will be made'. It comprises just two options:

1. a partnering arrangement between a private laboratory and DHBs; and
2. a single laboratory provider.

It is clear from the consultation document that the second option would involve a private provider. Potentially both options involve forms of privatisation of publicly-provided services and transfer of the staff of a critical service to a third party.

Disturbingly, the DHBs' documents contain virtually no discussion on the impact their proposal would have on the existing integration and critical reciprocal relationships between hospital laboratories and other hospital services. This, along with a poor level of engagement with hospital specialists and staff with clinical and operational experience in hospital laboratories, raises questions as to whether this has even been considered by the proposers.

Current laboratory services in the three DHBs are generally functioning well and require only some 'fine-tuning'.

Will the options presented in DHBs' proposal address the identified laboratory service needs?

The following sections examine the case put up by the DHBs and consider whether the proposed options are likely to (a) achieve the stated aim of essentially doing more for less, and (b) address the two key issues of the capital shortfall and securing the workforce capacity to meet ongoing service demands.

Since the proposed options depend on achieving a level of integration to reduce the cost of services, an important question is whether 'integration' per se has been shown to reduce service costs. According to the literature, the answer is uncertain, but there are risks of unintended consequences.

ORGANISATIONAL INTEGRATION

Integrated health services are considered a solution to the challenge of maintaining the accessibility and integrity of health care around the world. One common aim is to achieve better economies of scale and therefore greater cost-effectiveness, as is the case with the DHBs' proposal. However, researchers have struggled to find high quality, empirical studies providing evidence on how integrating health services can improve cost-efficiency of service delivery. Part of the problem is that there is no universal definition or concept of integration, and there is a lack of standardised, validated tools that have been systematically used to evaluate integration outcomes. This makes measuring and comparing the impact of integration on systems, providers and at patient level challenging.^{10 11 12}

The literature does not contain a one-size-fits-all model or process for successful integration, nor is there a firm empirical foundation for specific integration strategies and processes.¹³

Moreover, because of the complexities of health systems and the multiple contextual factors that have to be weighed up, integration of health services has proved an elusive goal for many policy-makers around the world. As one commentator put it, there is an online graveyard of policies and programmes that, over the years, sought to bring about integrated health care.

New Zealand's Ministerial Review Group, in discussing primary and hospital integration, observed that despite 'significant investment' from most of the major OECD countries, no jurisdiction has discovered the ideal model for integration.^{14 15}

One recent study which provides a summary of published reviews on the economic impact of integrated care approaches (and found the evidence

inconclusive), questions whether ‘integration’ should be considered an intervention or whether it should instead be interpreted and evaluated as a complex strategy that involves multiple changes at multiple levels.¹⁶

The literature is clear that organisational integration does not necessarily lead to integrated care at the patient level (which is one of the main goals of the DHBs’ organisational integration proposal).¹⁷

A study examining the experience of mergers and integrated care in Quebec concluded: ‘Policy-makers and health care organisation executives often believe that organisational integration leads to, or even equates with, integrated care. This assumption doesn’t hold true in practice’. The study found that merging organisations could not facilitate integrated care unless all players wanted this to happen and were involved in an appropriate way to deal with service problems. Otherwise they triggered conflicts and mistrust.¹⁸

Empirical studies in Sweden and Britain show that conflict of values, mistrust and opposition from various stakeholders are chronic features of top-down forced mergers, particularly when they are seen as simply attempts to cut costs.^{19 20}

Another major study, which draws lessons from seven international case studies on integration, found that while there were potentially some advantages in having a unified organisation – for example, single budgets and clear lines of accountability – the evidence from the case studies indicated a great deal of time and effort is required to merge organisations, and they were more vulnerable to ‘top down’ interference, which was identified as a barrier to integration. The study, echoing other international studies, suggests integrated care is possible only if it comes from the ‘bottom up’ through the development of specific ‘micro-level’ interventions by a small number of providers. ‘Organisational integration then comes as a consequence rather than a cause, and may not occur at all.’²¹

Empirical studies in Sweden and Britain show that conflict of values, mistrust and opposition from various stakeholders are chronic features of top-down forced mergers, particularly when they are seen as simply attempts to cut costs.

Where integration does appear to have produced benefits (in terms of quality of care and patient satisfaction, rather than any economic effects), it has tended to involve programmes initiated by clinicians and often focused on particular patients groups or specialties, such as through clinical networks. Big are seldom better and imposed decisions rarely bring cooperation among potential partners.

While intuitively integrating services ought to improve economies of scale and therefore cost-effectiveness, it may not necessarily be cost saving – which is an underlying aim of the DHBs' proposal – if, for example, improving quality and safety and maintaining good access to services in the face of increasing demand are taken into account.

Further, as the literature shows, attempts to achieve economies of scale and greater cost-efficiency through a top-down directive can be counter-productive, especially when it is driven by a cost-cutting agenda. It can only be achieved by allowing genuine clinical leadership to drive the process. Unfortunately this has been badly lacking to date.

Canterbury DHB's incremental moves to better integrate hospital and community services over the past six years or so is, according to one analysis, one of 'a small stock of examples' where integration appears to have resulted in some measurable positive changes.²² More services are now provided in the community, and acute admission rates have dropped while average length of stay and readmission rates for both elective and acute surgery have also fallen. Moves to better integrate services, however, 'have not demonstrated that it is possible substantially to shrink the hospital'. Furthermore, 'amid the welter of initiatives that Canterbury has taken, it is impossible to unpack their individual impact... [and] there is very limited cost/benefits analysis available for the various programmes'.

Notably, the process at Canterbury involved a number of different initiatives developed and implemented 'from within, by empowering clinicians and others who are prepared to take responsibility for changing the way things work, instead of seeking to drive change through external stimuli...'. Clinical leadership was 'not focused on just a few heroic individuals in formal leadership roles', but was shared and distributed as a collective responsibility.

Examples provided in the *Laboratory Services Strategy* of better integration of laboratory services (eg, Canterbury DHB) indicate the models can produce benefits after difficult starts, though no data or referenced evaluations are provided to validate this or enable a full assessment of the models. Nor is it possible to identify which components of the respective models may have had most impact on service improvements, including those programmes that do not necessitate organisational mergers.

Organisational 'integration' involves upfront costs; it is a 'marathon', not a sprint... and it is highly challenging to implement.

Anecdotal reports suggest the quality of some community-based services may have suffered, including reduced access to microbiologists and insufficient

data gathering to ensure good quality infection control. Lack of transparency on some financial details raises questions as to the cost-effectiveness of the Canterbury model. What is clear from the examples, and indeed from the literature, is that organisational ‘integration’ involves upfront costs; it is a ‘marathon’, not a sprint (in fact it is commonly viewed as a continuing process); and it is highly challenging to implement, even when it is a ‘bottom up’ process, let alone when it is an imposed directive.

PRIVATISATION

The other main feature of the DHBs’ proposal is the option to privatise the service. There is little evidence available on the cost-effectiveness of private laboratory services compared with public services, due in part to variations in the services provided, the way data are collected and measured, and a lack of openness due to commercial sensitivity of some basic information.

Lack of transparency has been identified as a major problem in attempting to evaluate private health service providers as well as public-private partnerships (PPPs^e) in health services, including joint ventures such as that proposed by the DHBs. Lack of transparency has also limited informed debate on how laboratory services are delivered.^{23 24}

The available evidence, however, does not support private provision over public provision. And if organisational integration of health services has proved difficult regardless of whether it is in the private or public sector, attempts to integrate public and private health organisations, adding an extra layer of parallel for-profit requirements, can significantly complicate the process.^{25 26}

Public-private partnership projects (especially those with integration of clinical services) will fail in most countries unless there is buy-in by the clinicians, and by the wider political environment. This issue is still more emphasised when transforming an existing state facility into a private sector one, and if the public and private sector ... staff management practices differ significantly.

Report to the European Union, February 2014²⁷

e Public-Private Partnership (PPP) refers to forms of cooperation between public authorities and the world of business, which aim to ensure the funding, construction, renovation, management or maintenance of an infrastructure or the provision of a service.

A catalogue of safety, quality and financial issues arose following the establishment of a joint venture between the multinational Serco and two NHS hospitals, Guy's and St Thomas's, (GSTS) in London in 2009. A GSTS performance review in 2010 noted an increase in clinical incidents, 'some of which could have had serious consequences for patients' and remained of 'some concern'. In 2011, however, the not-for-profit research group Corporate Watch detailed 400 clinical incidents.

Clinical failures were matched by a slide in finances. GSTS accounts show it lost 5.9 million pounds in 2011 owing to higher than expected laboratory costs.

In May 2013 senior managers admitted they had underestimated the challenges of running the service and acknowledged clinicians' frustrations. A report by the Care Quality Commission the following month said GSTS was not compliant with the regulation to ensure staff were properly trained and supervised.²⁸

Lessons from a failed attempt at change

The following excerpts from a ministerial review of the Auckland laboratories' transition illustrate issues that arose, which reflect those identified in the literature when organisations are merged.^a This did not involve privatisation but instead, in large part, involved a failure to effectively and actively engage with skilled hospital laboratory staff including pathologists.

Throughout the transition communication with stakeholders was not as effective as desired, even though considerable efforts had been expended on consultations. There was a fundamental lack of understanding of the strong clinician backing of the outgoing provider, DML.

This is clearly a business in which the professional component of highly qualified staff adds greatly to the ability to perform, and the DHBs' expectation that the DML staff would simply switch allegiances and join LTA [Labtests] borders on fantasy.

At a minimum, a stronger presence of laboratory specialists in the planning team would have been helpful...

There should be a clear guiding vision for the change. People should be able to see what the future will look like, after the change.

In this case, the DHBs had championed this change mainly on a platform of cost savings. As legitimate as that argument is, given the accountability duties of DHB leaders, it resonated poorly with the external stakeholders.

Changes in service provisioning that affect a wide group of stakeholders must be anchored in a coherent and well-communicated long-term strategy and not solely rely on short-term financial parameters.

This community laboratory services transition was initiated by well-intentioned people who used a narrow platform of short-term/mid-term financial considerations to embark on a complex change of relationships. This niche-view approach created a 'we don't know what we don't know' myopia as to foreseeable consequences that arose too late to be effectively addressed.

^a G Milne, J Mueller. Auckland Region District Health Boards: Review of transition to new community laboratory services provider, 30 September 2010.

In New Zealand, safety and quality issues arose soon after the private company Labtests (owned by Healthscope, one of the bidders for the DHBs' services), took over community laboratory services in August 2009 from another private provider, Diagnostic Medlab Ltd, which had a long-established relationship with the DHB. Within weeks the Health and Disability Commissioner was receiving complaints 'thick and fast' about Labtests' services, indicating he was concerned about public safety.²⁹ Labtests was evidently unable to cope and ended up shifting the high-cost, unprofitable anatomic pathology back to the DHB, while keeping the highly mechanised, high-volume, high-profit work.

A similar creaming of low-cost profitable work has occurred in Northland, with the DHB being left responsible for high-cost anatomical pathology.

The Auckland case highlights the extent of the fallout that can occur when laboratory staff are suddenly expected to switch allegiances to another organisation.

In the Auckland case, one private company was taking over from another (and involved a long and expensive legal battle costing the Auckland DHB millions of dollars). It is particularly pertinent to the Wellington region DHBs proposal, however. First, all Wairarapa laboratory

staff, who currently work for a private provider not included in the DHBs' proposal, will have their service taken over by another private provider. Secondly, the Auckland case is another example of an under-estimation of the task of taking over a complex service, and recognising the importance of engagement with clinicians on the ground, even without the additional challenges of attempting to integrate with another organisation. It also highlights the extent of the fallout that can occur when laboratory staff are suddenly expected to switch allegiances to another organisation (see box).

Similar issues arose with regard to MidCentral's organisational integration of laboratory services, as noted in the *Laboratory Services Strategy*: 'Cultural differences in staff from the community and hospital laboratories were very difficult to manage in a combined workforce. Years were required to build up a shared culture'.

There is a dearth of good quality evidence on the cost-effectiveness of public-private partnerships (PPPs) such as that proposed by the DHBs. However, an independent 'expert panel' set up by the European Commission to provide advice on effective ways of investing in health, reviewed a range of PPP models internationally and found no evidence they were any more cost-effective than the traditional forms of publicly funded and provided health care.³⁰

On the contrary, 'various reports show that PPPs have been more expensive in the long term'. The panel's analysis points out that while PPPs may offer a private financial source to accelerate investment, PPPs do not eliminate a public budget fiscal constraint. Eventually the state has to pay, and this can be at a higher cost for taxpayers because generally the public sector can borrow more cheaply than the private sector.

The expert panel suggested that in order to compare the cost-effectiveness of projects procured via PPPs and those procured via conventional regimes, answers to a number of basic questions were needed:

- Will the cost of borrowing be lower?
- Will the total cost of construction and/or management of the facility be lower, when compared to traditional public procurement (assuming the same functions)?
- Will functions improve at the same or lower cost, compared to traditional public procurement?
- Will health service productivity be higher, for example measured as cost per hospital episode or physician visit?
- Will cost-effectiveness in terms of cost in relation to health outcome be improved?

The *Laboratory Services Strategy* notes that laboratory service outsourcing or joint venture arrangements 'have generally been successful', and the report's observation that, 'so far, no DHB has chosen to bring the service back home', similarly implies success, though the basis of that conclusion is unclear since there appears to have been no thorough evaluation of such arrangements and certainly none that address questions such as those listed above. The lack of evaluation and data, combined with the prospect of facing upfront costs and disruption in any service provider change, would undoubtedly influence any DHB's decisions regarding possible changes to laboratory service provision.

The *Laboratory Services Strategy* omitted any reference to the three Auckland DHBs, and Waikato and Canterbury DHBs, which have all reviewed their community testing contracts in recent years and did not decide to outsource their hospital laboratory services.

How does the DHBs' proposal sit with the literature on integration?

The DHBs' proposal is an example of a type of approach that tends *not* to achieve integration at the service level, and the risk of unintended consequences is high, including the risk of triggering a destructive working environment. Specifically:

1. It is a top-down directive

The proposal originates from a process initiated by the three DHB boards. The process itself was tightly controlled by the DHBs' Service Integration Development Unit (SIDU), which set up a laboratory working group to advise on the development of a strategic plan, though, as the working group's charter states, 'The scope of our activities and decision making is determined by SIDU'.

SIDU also set up a steering group, which included SIDU staff, and was chaired by the Director of SIDU. The steering group oversaw the work of the working group. Its role included:

- approval and amendment of 'management recommendations for project and project tolerances'
- approving completion of each stage of the working group's work
- approving project changes with 'board approved tolerance'
- ensuring 'the project continues to be fit for purpose, remains viable and meets the appropriate standards'
- managing risk
- providing advice to the project team
- advising on contract arrangements arising from a Request For Proposal (RFP).

The latter suggests outsourcing of services was decided upon before the process began.

The working group's brief included commenting on five possible service configuration options and five ownership and management options. It is not clear whether the group itself produced the options or whether the options were presented to the group. 'The working group was not asked to make a recommendation on the preferred option', which the Association takes to mean: the group was specifically asked not to make a recommendation.

The working group did, however, make some service recommendations, including the establishment of a shared data repository as an urgent and top priority. The group saw this as invaluable in reducing medical error, avoiding waste and duplication of tests and improving the quality and timeliness of care to patients, and was an essential for improving service integration. Bizarrely, and perhaps as a consequence of the close management and stage-by-stage approval of the steering group, the two options presented in the working group's *Laboratory Services Strategy* are both rejected in the same report.

Rather than a process of clinical leadership and engagement, including a full clinical analysis of the best options to meet the clinical identified needs... the emphasis has been on management and ownership.

The three DHB boards endorsed the *Laboratory Services Strategy*, despite the document raising many unanswered questions, and thereafter all decision-making has been made at board level, leading to the current proposal.

2. Lack of clinical engagement and clinical leadership

Rather than a process of clinical leadership and engagement, including a full clinical analysis of the best options to meet the clinical identified needs and identifying ways to promote service-specific innovation, the emphasis has been on management and ownership. The process has also taken a speculative approach. Rather than clinicians and managers working in partnership to determine the best way forward, the current proposal has effectively handed that task to two unnamed private providers to resolve through a secretive commercial process.

It is an indication of the three DHBs' failure to commit to clinical leadership and engagement generally, as reflected in the Association's survey of DHB-employed members on distributive clinical leadership late last year, which gave very low rankings to CCDHB, HVDHB and WDHB. The handling of this laboratory process will only reinforce this failure.

The process leading to the DHBs' current proposed options, beginning with the development of the *Laboratory Services Strategy*, falls well short of the engagement obligations of the DHBs under the national multi-collective employment agreement (MECA, Clause 2), including the requirement for managers to support employees (senior medical staff) to provide leadership in service design, configuration and best practice service delivery. This is derived from the *Time for Quality* agreement between the Association and the DHBs, in particular the engagement principles. It also falls well short of the standard set by the Government's policy advice on clinical leadership, *In Good Hands*. (Both documents are provided in Appendix 2 & 3.)

Those two core documents underpin government policy on clinical leadership. The policy has been adopted not because clinical leadership is a desirable aim, but because it has been proven overwhelmingly as *essential* to achieving the best quality and cost-efficient services. This is reflected in the Minister of Health’s Letter of Expectation for 2013/14.

Given the high clinical and financial risks involved in the boards’ proposed options (as well as political risk for the Minister), and the potentially far-reaching consequences for many services provided by the DHBs, as discussed in the following sections, the case for a clinical leadership approach in this review of services could not be stronger.

Between the publication of the *Laboratory Services Strategy* in August 2013 and the release of the consultation document in September 2014, the range of service and ownerships options presented in the former were reduced to the two options in the latter, though it is not clear why these two options were chosen above the others. These options were not determined on the basis of engagement with affected specialists.

3. Proposal primarily about cost-cutting

The *Laboratory Services Strategy* shows that while current services require some ‘fine-tuning’, they are not ‘broke’ and do not need ‘fixing’, especially by the radical nature of the two options proposed. As with other health services generally, laboratory services face mounting demand and demographic pressures, though there is little in either the strategy or the proposal and consultation document that shows the proposed options would meet those challenges any better than the current service arrangements.

The proposal seeks to achieve 8% savings across laboratory services, though it is unclear precisely how this figure was arrived at and how it might be achieved.

The main driver for this proposal appears to be the need for DHBs to ‘live within our means’ as budgets are cut in real terms.

The *Laboratory Services Strategy* and the proposal and consultation document make confusing and unsubstantiated claims about the costs of services.

The proposal asserts ‘the cost of laboratory services continues to increase at an unsustainable rate in many areas’ which, as discussed earlier, is not borne out by the (incomplete) data released by the DHB.

The proposal seeks to achieve 8% savings across laboratory services, though it is unclear precisely how this figure was arrived at and how it might be

achieved, and over what timeframe, without compromising service quality and access.

The literature repeatedly warns that attempts to integrate health organisations as a cost-cutting measure will not work, especially when the health professionals involved have had no say in how services are to be provided and how the cuts are to be achieved.

4. The process has raised more questions than answers and there is no clear vision of what services will look like

The *Laboratory Services Strategy* presents a range of service configuration options, including pros and cons for each option. There is no evidence of options having undergone any detailed analysis; hence the assessment of each is based on assumptions and guesswork. No attempt has been made to compare options, other than a comment that an 'enhanced status quo' would achieve lower savings than the other options. It is unclear how this conclusion was arrived at.

The document also describes five possible configurations for ownership and management of laboratories.

Again, no preferences are put forward (as mentioned above, the working group was not asked to make a recommendation on preferred options) and the lack of any detailed information or supporting arguments about the options prevents any meaningful assessment of comparative merit. And as with the options on possible service configurations, there is no advice on which of the ownership and management options might best suit the implementation of a data repository or complement the developing national IT and laboratory services strategies.

The *Laboratory Services Strategy* was unable to suggest a way to implement its 'Priority 1' for a shared data repository, and barely discusses 'Priority 2' recommendations for an 'alliance' structure (though there are indications it will be challenging). The boards' endorsement of the strategy was given without any indication as to how they might be achieved.

The strategy notes hospital laboratory providers interviewed during the process agreed there was potential for closer integration of services. 'However, perspectives on what closer integration and future configuration of services across the region should look like differ significantly'.

If they had expected some clarification from the DHBs on this fundamental question, they would be disappointed.

The questions of 'how to?' and 'what exactly?' were shifted to a prospective private 'interested party' to resolve in the subsequent call for expressions of interest 'from private sector providers in tendering for the provision of community-referred laboratory services across the three DHBs, as well as seeking suggested approaches for achieving closer integration with hospital services'.

As mentioned earlier, discussion on how the boards' proposal would affect the crucial integration of hospital laboratories and other hospital services is noticeably – and alarmingly – absent.

By the time the proposal and consultation document was released in September 2014, the working group appears to have dropped away, presumably having completed its advisory task (notwithstanding that many questions remain unanswered) and it is not clear what has become of its recommendations. They are not mentioned in the consultation document.

As with the *Laboratory Services Strategy*, key aspects of the proposal are mystifying. As the proposal and consultation document itself acknowledges: 'At this stage in the process, we cannot detail exactly what the future laboratory services will look like...'

Not least, some of the terms in the consultation paper are ambiguous. 'Partnering arrangement' may mean a 'joint venture' where the DHBs retain their staff, or it may mean creation of a new company jointly owned by the DHBs and a private company with the possibility of DHB staff having to shift their employment to the new company. The term 'joint venture' may be applied to either arrangement.

In summary, the *Laboratory Services Strategy* indicates that none of the possible options it has identified for reconfiguring laboratory services across the three DHBs are straightforward. All carry risks. The lessons learnt from other laboratory service changes are to proceed with caution and understand that gains are not realised easily, and take years to achieve.

Risks in the DHBs' proposed options

Loss of staff

The greatest risk of the boards' proposal is to an already vulnerable laboratory workforce and the potential consequences for wider DHB services as well as laboratory services. The literature is clear that attempts to integrate organisations imposed from the top are not only doomed to failure but can create a toxic work environment.

As the *Laboratory Services Strategy* noted with regard to MidCentral's organisational integration of laboratory services: 'Cultural differences in staff from the community and hospital

laboratories were very difficult to manage in a combined workforce. Years were required to build up a shared culture'. The document does not detail the effects of these tensions but it is well recognised that such environments are not conducive to efficiency and are more likely to prompt resignations.

'At this stage in the process, we cannot detail exactly what the future laboratory services will look like...'

Furthermore, the current proposal discussed here is of a much greater scale and is occurring at a time where there are greater services demands and workforce and demographic pressures than were experienced in the 1990s, when Palmerston North Hospital laboratory was privatised.

It is also occurring when the hospital laboratories of CCDHB and HVDHB are continuing a process of developing greater integration, which began more than two years ago. This has been another ill-considered 'top-down' process which has coincided with some senior staff resignations at Hutt Hospital's laboratory and has created much uncertainty among remaining staff. The key challenge now involves navigating the development of a collaborative public hospital laboratory service that ensures the relatively smaller Hutt Valley service does not become a mere satellite to Wellington Hospital laboratory or compromise the critical integration that is needed between Hutt Hospital's laboratory and the rest of the hospital's clinical services. That, in turn, involves ensuring the needs of the HVDHB 'end users' (hospital specialist services, etc) are the decisive factor shaping the configuration of their hospital laboratory.

At a simplistic level it is not difficult to see why working with a private laboratory (Aotea Pathology in particular) might be preferable when contrasted with the fear among Hutt Valley laboratory staff of being absorbed

by CCDHB. But privatisation, either through a private company or the joint venture would not resolve this, because the Wellington Hospital laboratory would still be the largest site. In this situation the private company or joint venture would be strongly motivated to maximise its profits which, in turn, would incentivise it to centralise (rationalise) as much as possible on the largest site.

In part, this fear is also influenced by the good relationship that HVDHB laboratory has with Aotea Pathology (CCDHB also has a good working relationship with the latter). But, first, this assumes that Aotea Pathology is successful against Healthscope, which is in doubt because of the greater resource base of the latter. Second, the stakes are very high for Aotea Pathology because to fail is essentially to go out of business. Consequently its incentive to be both a loss leader and to recoup through profit maximisation will be very strong.

The risk of a negative impact on the work environment across the three DHBs is exacerbated in several ways.

First, it is clear that saving money is a major reason behind the proposed options. The experience, as indicated in the literature, especially when the changes have come from a top-down process, results in a cynical and disengaged staff. Further, the drive to reduce costs will occur when there are additional upfront costs required for the structural integration (note that the MidCentral 'enterprise' posted a net loss in the first three years) and DHB budgets generally are forecast to continue to reduce in real terms in the coming years, while demand increases. All of which signal increasing pressures on staff to do more for less.

Secondly, as discussed earlier, the laboratory workforce is aging and it is likely a significant proportion of the pathologist workforce in particular is approaching retirement age. Medical Council data indicate a sharp drop in the number of medical specialists before they reach retirement age, and a report prepared for Health Workforce New Zealand observed that older doctors are tending to work fewer hours.³¹ The *Laboratory Services Strategy* noted the need for measures to encourage the laboratory staff to stay on longer. Clearly, a difficult workplace will run counter to that need.

Thirdly, if DHB staff had to shift to a new employer, under the Employment Relations Act they would move under the same terms and conditions, but they would not remain covered by their union's employment agreement. Specialists, for example, would not stay under the ASMS-negotiated MECA covering their core terms and conditions of employment and their terms and conditions of employment would only have limited protection. Their ability to

collectively negotiate a suitable collective agreement would be noticeably diminished. For example, had this joint venture or private arrangement been in place before the settlement of the current MECA, affected specialists would not be eligible to receive the additional step added to the salary scale; given the age demographic of the workforce discussed above this is particularly significant. This would weaken the ability of the joint venture or private company to retain and recruit specialists in a competitive labour market with specific references to the publicly provided comparable hospital laboratories in the larger three Auckland, Waikato and Canterbury DHBs.

There is also a question about the employment arrangements of specialists who work for both a DHB and the university. This includes specialists whose primary employment may be with the university but who also work part-time for the DHB, or vice versa. These staff are not acknowledged in the DHBs' documents but clearly their employment situation, including maintaining their current access to laboratory work, would add further complications to any changeover to a new employer.

Any real or perceived disadvantages from a change in employment arrangements may well prompt resignations or a reduction in work hours.

Fourthly, the international shortages of some professions, such as pathologists, will mean these staff will not be short of alternative employment options whatever stage of career they are at, should the workplace environment become difficult.

Given the small size of the pathology workforce in the region, especially when considering the even smaller pathology specialties such as immunology and chemical pathology, any loss of a few staff could have a major impact on the effective delivery of services and could well have a domino effect if replacements were not found quickly.

The DHBs' proposal fails to take into account the need to maintain strong integration between the hospital laboratories and secondary and tertiary services.

In addition, scientists and technicians who, like medical specialists, are part of an aging workforce and are difficult to recruit, also have attractive opportunities outside the health sector such as the crown science entities and the wine industry.

Impact on other health services

The DHBs' proposal fails to take into account the need to maintain strong integration between the hospital laboratories and secondary and tertiary

services. This is a serious flaw in the proposal and appears to have come about in part because of the absence of a local hospital-based pathologist on the decision-making groups. Any measures that impede the effectiveness of that integration, whether due to organisational changes or lack of resources, would compromise patient safety and quality of care across the system, including among many others:

- delays in cancer diagnosis with patients not being able to get access to the required treatment in a timely fashion
- compromises in infection control, leading to further spread of the illnesses, with patients suffering and the healthcare system having to cope with more sick people
- risks to safety in blood transfusion, affecting surgery and the management of emergency trauma cases
- bed blockages in wards and emergency department when pathology results are delayed
- delays in diagnoses for patients' who have diabetes or have had heart attacks or kidney failure, leading to delays in appropriate treatment
- variations in the quality of laboratory results and reporting across the country
- under-testing with regards to antimicrobials which in turn will hamper data collection and production of meaningful data on antimicrobial resistance.

Lost opportunities

While there has been much debate about the need to move beyond silos in health care delivery, the DHBs' proposal evidently takes a silo approach to funding its laboratory services, despite the strong dependency of hospital services on a well-functioning laboratory service.

Wise investment in laboratory services can produce significant benefits for patients across the health system. Image technology in histopathology, for example, is predicted to revolutionise workflow and reduce lead times of interpreting test results. New technology for blood culture analysis enables more rapid and focused antibiotic treatment to be given, resulting in better patient management, improved outcomes, and shorter stays in hospitals. The development of genetics and molecular technologies into mainstream medicine will have a substantial impact on the health of the population, clinical practice and the management of patients.

New laboratory technologies are evolving rapidly with potentially significant benefits for patients and the effectiveness and efficiency of health care. At present, however, many of these innovations can be more time consuming than traditional methods and some depend on staffing and IT that is currently lacking in New Zealand. Any attempt to reduce funding of laboratory services therefore must take account of the impact not just on laboratory services but on other clinical services, including lost opportunities to provide 'better, sooner, more convenient' and more cost-effective care. The *Laboratory Services Strategy* makes a similar point with regard to the vital role laboratories play in infection control – a role which incurs costs for laboratories but which provides significant health and economic benefits across the whole health system.

The risk of creating a short-sighted silo approach to hospital laboratory investment would be greater still should hospital laboratory services be privatised. There would be little incentive for a private provider on a fixed-funding contract making investments in order for the benefits to be gained by the DHB service.

Opportunities to further integrate hospital laboratory services with secondary and tertiary specialist clinical services may also be lost if the laboratory were privatised. For example, there is growing realisation that pathology and laboratory medicine should be considered and perhaps managed alongside imaging and endoscopy as part of a wider diagnostic service. A growing number of hospital trusts in Britain now have a diagnostics directorate or division with responsibility for all these services. Such an approach is believed to improve patient care.³²

Loss of accountability

Lack of disclosure of information is a common finding – and frustration – of researchers attempting to assess the effectiveness of policies that have involved privatising or outsourcing public health services. In addition to information being restricted due to 'commercial sensitivity', joint ventures with private providers have been found to lack robust evaluation requirements. The DHBs' proposal does not appear to include any plans to evaluate its effectiveness. Taxpayers may be left in the dark as to whether the boards' decision has given them value for money or is in fact costing them more.

The consultation document itself acknowledges significant risks specific to each option, some of which are related to the above discussion.

Partnership option

Risks include:

- more complex to operate due to potentially different goals and interests of DHBs and private provider
- more difficult to implement due to melding of laboratory processes and structures
- risks shared by all partners; for example, in a capped price contract, if demand rises, then increased costs are borne by provider
- accountability clearer than an alliance but there is still potential for non-delivery of some key outcomes in the strategy
- joint venture with DHBs requires approval from the Minister, which adds complexity to the process
- employment arrangements for an already vulnerable workforce may change for the worse, depending on the partnership model.

There will be additional risks, depending on the yet-to-be-determined detail of what is being proposed. The consultation document points out, for example, that under a partnering arrangement services can be subcontracted to other providers, which entail risks related to lack of control and a loss of key competencies and capabilities. A partnering arrangement may also mean the formation of a new jointly owned company, with current DHB employees being required to shift to the new employer.

This proposal is not the same as the ‘alliancing’ approach adopted by Canterbury DHB, referred to in the consultation paper. The Canterbury ‘alliancing’ was less structural and more relational, and hospital laboratory staff continued to be employed by the DHB. There was no privatisation.

Single (private) provider option

Risks include:

- longer-term market risk, with competition reduced for the next procurement process and the ‘locking in’ of a private provider
- reduced competitive pressure may lead to a loss of efficiency over time; continuing with a capped funding mechanism focuses the provider on cost containment. This can be offset by ensuring quality payments are linked to key performance indicators based on service quality, but how well that is measured remains a question

- more difficult to get transparency of costs and therefore understand value for money
- no governance role for DHBs in laboratory service; contract management role only
- consideration needs to be given to facility ownership at end of contract, which requires detailing in the provider contract agreement
- potential loss of hospital culture for hospital laboratories.

In addition, the risk of loss of staff would be even greater than in the partnership option, given it would most likely involve more radical changes.

Further, both private company bidders have a strong incentive to price the contract artificially low in the knowledge that once the DHBs have become dependent upon them they could renegotiate the contract.

The risk of there being no governance role for the DHB in the laboratory services is a critical issue as it effectively puts quality and patient safety in the hands of private providers with less public accountability.

The range of tests offered by the private provider may be substantially shortened if they are deemed not cost-effective. They may then be out-sourced to reference laboratories or will simply not get done.

With regard to the 'locking in' of a private provider, there are very significant downstream risks.

As soon as a public service becomes dependent on a private provider's facilities and capital investment (in this case including the development of data systems), it is difficult to get out of the arrangement, and the public service provider loses control of how services are planned and delivered. The experience in the United Kingdom has shown it can be very costly, with large sums of money being spent on private contractors rather than on patients. The private sector has been shown to be only willing to get involved in developing and providing public services if it can eliminate any risk to itself.

As soon as a public service becomes dependent on a private provider's facilities and capital investment it is difficult to get out of the arrangement.

The underlying aim of cutting costs when there is reduced public accountability raises questions about effective monitoring for quality and safety. Private laboratories are not required to report serious adverse events to the Health Quality & Safety Commission, for example. This was highlighted in a

Ministry of Health breast biopsy errors report, which recommended that they should be required to do so.³³

In the short term, when money is needed to invest in facilities and technology, the private option may appear tempting but ultimately private companies want a return on their investment, so that will be an extra cost to the system. It is risky to insert profit maximisation into the running of hospital services and clinical support facilities which are so interwoven in the provision of patient care. It also creates confused accountabilities between private provider and the DHB for staff whose work directly or indirectly affects both.

For both options, the Auckland DHB experience, as outlined in the *Laboratory Services Strategy*, provides important lessons:

- The complexity of services should not be underestimated, as all contracts are to some extent imperfect specifications of what happens. What is written and what is custom and practice, as well as the detail of who does what and where, may differ.
- Getting it wrong is expensive – and there is no back-up if this proposal is implemented and fails.

Benefits of the DHBs' proposed options

The only potential benefit of any form of privatisation over the Association's recommended approach (p 44) would be that private investment hypothetically may make up for a lack of public funding to make progress in improving these services, which appears to be the key (under-stated) issue. But, as explained above, that would be a short-term benefit only and would be outweighed by the downsides, both short-term and long-term, especially as both private companies will be incentivised to make loss leading bids, placing them under pressure to recoup this down the track, thereby increasing the risk for the quality and range of service and support currently provided by the hospital laboratories.

In the single provider option, logically there ought to be more streamlined decision-making. Whether this would be the case in practice, however, is unclear as it depends on the detail that has yet to be determined. Again, this potential benefit would be far outweighed by the disadvantages. Any potential benefits of integration between hospital and community testing would most likely be offset by the increased obstacles to integration between hospital testing and secondary and tertiary DHB 'user' specialists.

All of the other 'advantages' listed under the consultation document options (some of which appear more aspirational than real), are matched or bettered by the potential advantages of a partnership approach that does not involve privatisation in any form and which in addition carries substantially less risk.

Conclusion

Laboratory services across the three DHBs are working well from the perspectives of both patients and clinicians. The available data showing trends in costs versus laboratory test volumes also point to increasing efficiency. Fine-tuning of services is needed, most of which could be accomplished with the establishment of a shared data repository. The recent establishment of a shared data system for CCDHB and HVDHB is an important step towards this goal.

In view of these findings, the DHBs proposal to radically restructure services, including possible privatisation, is difficult to fathom. The main aim appears to be an attempt to reduce service costs. However, the DHBs have produced no evidence to show their proposal would be any more cost-effective than the current service arrangement. Indeed the literature evidence overwhelmingly suggests the board's top-down approach and lack of a clear vision of what its proposal means in practice would not only fall short of what is intended, but would also carry substantial risks of destabilising an already vulnerable laboratory workforce.

The proposal risks undermining the integration between hospital laboratories and their 'end users' in the public hospitals who critically depend on their service. This includes the full range of surgical and medical hospital specialties. Greater structural or organisational integration with a private community testing company risks fragmenting the current high successful level of integration with hospital 'end users'. Further, there is an ongoing change dynamic in the relationship between hospital laboratories and their 'end users' through interdisciplinary teams.

It is particularly disturbing the DHBs have omitted discussing these matters in this whole exercise, which raises a serious question as to whether in fact the impact of the boards' proposal on the critical integration between hospitals and other hospital services has even been taken into account.

A more constructive approach, avoiding these risks, would be to use clinical leadership to further develop collaboration across all laboratory and clinical services, including development of a shared data repository. This approach would not involve any form of privatisation but would be in the range of possible scenarios in the DHBs' proposed Option 1.

Recommendation

That the DHBs review their process in order to (a) confirm that hospital laboratories will continue to be publicly provided and their staff DHB-employed, and (b) work with the Association on a process to establish strong clinical leadership in the development of a more integrated relationship between the hospital laboratories, and between them and the community testing provider, based on enhanced collaboration. This would include directing particular attention to addressing the needs of HVDHB's laboratory services to ensure integration with hospital clinical services is maintained and a level of certainty about the future direction is re-established. It would also include development of a shared data repository. To reiterate the working group's rationale for such a data repository (p 8 *Laboratory Services Strategy*):

The working group thoroughly canvassed both the need for and implementation of a shared view of laboratory results and came to the view that, from the perspective of the working group, a data repository is the best way forward. Ideally this will be linked with e-ordering of laboratory tests.

The working group does not want to sort out this matter at a detail level. However, the working group makes it very clear that implementation of this data repository is critical for primary and secondary integration, for reduction in patient harm, reduction in waste through duplicated testing and needs to happen much faster than currently planned.

And further on page 68, the *Laboratory Services Strategy* explains: 'Overwhelmingly, most of the issues revolve around the ability to access test results at the point of physician consultation... This could only be fixed if a data repository is introduced.'

Immediately concentrating attention on introducing a data depository and in the meantime looking at renegotiating and fine-tuning current contracts with the aim of improving integration over time is the clear message sitting behind the *Laboratory Services Strategy*.

Appendix 1

TABLE 1: INFLATION ADJUSTMENTS

% adjustments	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
CPI		1.7	3.1	1.0	0.7	1.6
Population & aging adjustment		1.79	1.72	1.45	1.42	1.54
Total annual adjustment		3.52	4.87	2.46	2.13	3.16
Inflation index	100	103.52	108.56	111.23	113.60	117.19

Sources:

CPI: Statistics New Zealand. Note: the CPI is an estimate of 'trimmed mean inflation', calculated by Statistics New Zealand, to neutralise the effect of the rise in GST in October 2010.

Population and aging adjustment: Ministry of Health.

Note: Total annual percentage adjustments are obtained by multiplying the population & aging adjustment by the CPI. For example, 2010/11: $[(100 + 3.1) \times (100 + 1.72)\%] - 100 = 4.87$.

TABLE 2: CONTRACT VALUES FOR COMMUNITY REFERRED TESTING (\$)

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	% change
Aotea	21,638,489	22,214,326	22,806,302	24,231,252	25,044,688	25,803,648	19.2
Medlab	1,628,500	1,669,000	1,711,000	1,753,500	1,779,627	1,779,627	9.2
Total	23,266,989	23,883,326	24,517,302	25,984,752	26,824,315	27,583,275	18.6
Real \$	23,266,989	23,071,219	22,584,103	23,361,280	23,612,953	23,537,226	1.16
Inflation index	100	103.52	108.56	111.23	113.60	117.19	

Source of Aotea & Medlab data: Laboratory Services Strategy.

Note: Aotea Pathology's contract value from 2011/12 includes referrals from private specialists.

Note: Medlab's funding is half of the total figure, which included hospital referred testing. The Laboratory Services Strategy Report (p 43) indicates the share is about 50/50.

TABLE 3: VOLUMES OF COMMUNITY-REFERRED TESTS

DHBs	2008/09	2009/10	2010/11	2011/12	Change
CCDHB/HVDHB					
Test A	2,048,257	2,055,036	2,094,191	2,167,729	5.8%
Test B	47,076	48,781	46,884	38,589	-18.0%
WDHB					
Test A	165,259	170,744	168,117	176,883	7.0%
Test B	2,750	2,750	2,750	2,750	-
Total	2,263,342	2,277,311	2,311,942	2,385,951	5.4%

Source: Laboratory Services Strategy.

Note: Medlab's volumes are assumed to be constant at 2,750 per year, based on an estimate of between 2,500 and 3,000 per year provided in the Laboratory Services Strategy (page 42).

Appendix 2

Time for Quality

This agreement was developed between the Association of Salaried Medical Specialists (ASMS) and the 21 District Health Boards (DHBs) with the support of the Minister of Health.

Time for Quality sits within the Tripartite Process involving the Government, the District Health Boards and the Council of Trade Union affiliated health sector unions.

Reports of the Commonwealth Fund and OECD indicate that the New Zealand health system is in relatively good shape and compares well internationally. Other indicators highlight problems, including systemic failures, and disconnect in sections of the system.

We recognise we have a collective responsibility to improve the quality of healthcare delivery. We are committed to building on the current system, to transform it along a path to become a system of excellence.

We acknowledge that, central to our collective responsibility, the patient and citizen receives care of optimal quality, that is financially sustainable, and that encourages and supports trust and confidence in the health system, now and into the future.

We recognise that in some cases, a contributor to areas of underperformance in the sector is under-utilisation of the experience and expertise of health professionals which is, in part, due to the poor state of relationships between health professionals and management. This means we are not working to best effect and is something we need to work together to transform. It is essential if we are to achieve a health system of excellence. The community we serve has a legitimate expectation that we have the expertise, resource and will to do better.

We will jointly seek to achieve this transformation by making an explicit commitment to a health professional partnership founded on:

1. Recognition and acknowledgement of the problem.
2. Legitimation of a new view through principles of engagement.
3. A work plan of active steps.

Principles of Engagement

- Health professional–management partnerships are founded on teamwork and respect.
- Managers will support health professionals to provide leadership in service design, configuration and best practice service delivery.
- Managers will support health professionals to ensure recognised competency and credentialing standards are met.
- Managers and health professionals affirm that quality care drives the system to optimise patient outcomes.
- Managers and health professionals will collaborate to meet both the ‘patient test’ and the ‘whanau test’, which means the patient experience is optimised for the patient and in a culturally appropriate way.
- Managers and health professionals explicitly agree that decision-making and responsibility will be devolved to the appropriate level.
- Managers and health professionals accept that there will be some services that can more appropriately be delivered regionally or nationally to effectively meet patient needs.
- Health professionals will support managers to operate services within the resources available.

Work Plan of Active Steps

- Acknowledge that participation of health professionals in quality development and service improvement is a core aspect of their roles.
- Facilitate participation of health professionals and managers in conversations nationwide, within existing DHB budgets, as a symbol of commitment.
- Use the Ministry of Health Sector Capability and Innovation Directorate to host these conversations on behalf of the sector.
- Through these conversations, identify and animate projects for nationwide improvement, with an initial focus on five areas.
- These five projects will be a combination of high risk and high gain areas (examples may include national Cystic Fibrosis services, national Paediatric services, and national Intensive Care networks).

- Give life to the partnership so it becomes 'business as usual', through the spreading and sharing of progress made across the system.

Signed by:

Jeff Brown
President

ASMS
On behalf of 21 District Health Boards

Dennis Cairns
Chair

Witnessed by:

Hon David Cunliffe
Minister of Health

Appendix 3

In Good Hands

Transforming Clinical Governance in New Zealand

“Healthcare that has competent, diffuse, transformational, shared leadership is safe, effective, resource efficient and economical.”

- Task Group, 2009

This report outlines transformative changes to clinical leadership that must occur, specifies some measures of that transformation, and identifies the challenge of nurturing clinical leadership.

Purpose of this Task Group Report

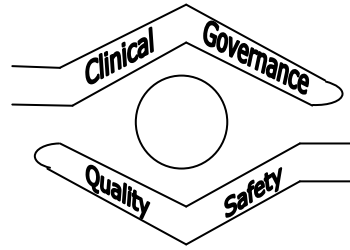
Throughout the New Zealand health system there has been increasing disengagement between clinicians and managers. Many clinicians have felt less and less able to influence decisions on the delivery of health care, while being held increasingly to account for the results of those decisions, or at least responsible for the outcomes. Many clinicians have decided to abrogate the responsibility for managing the health system at many levels, and just to get on with the clinical work. Many managers, left to make decisions without clinical expertise, feel less and less able to influence the clinicians who deliver the healthcare and who determine the quality and safety, and cost, of that care.

Clinical networks in primary care, developed in recent years, report effective partnerships between managers and clinicians at the network level, but poorer engagement with DHB management and governance structures.

Recognising the detrimental effects on quality and safety from increasing disengagement, all 21 DHBs and hospital specialists signed up to “Time for Quality” - an explicit commitment to a health professional partnership and principles of engagement.

This report “In Good Hands” develops that commitment to greater clinical engagement in order to improve the quality of care in our health and disability services. The Ministerial Task Group on Clinical Leadership was convened by the Minister of Health to:

- describe how we can establish strong clinical leadership and governance in the health system.



- describe and develop aspects of leadership required for good clinical governance
- develop examples of how processes for clinical governance can be established

Summary of Report

- “In Good Hands” defines clinical governance.
- It discusses components and attributes of leadership that can identify leaders, both formal and informal, and can be used to measure their performance.
- It advises transformation to structures within DHBs to achieve better quality and safety through clinical governance.
- It recommends that DHBs be required to report on outcomes of such transformation.
- It recommends action to foster and train leaders.
- It recommends sharing successes.

Definition of Clinical Governance

Clinical governance is the system through which health and disability services are accountable and responsible for continuously improving the quality of their services and safeguarding high standards of care, by creating an environment in which clinical excellence will flourish.

- Scally, Donaldson, 1998 (adapted)

Clinical governance is the system. Leadership, by clinicians and others, is a component of that system.

Introduction – the Problem

Decisions around the planning of health care now demand a balance between clinical, community and corporate governance. This balance is increasingly important as services develop population health focus (area, region, nation) as well as individual patient care, and integrate the patient journey through primary to tertiary services (and back) across specialty silos.

A lot of effort has gone into corporate governance, and reporting corporate outcomes, and processes are being established for community governance. However, clinical governance, and reporting on clinical outcomes, has not been the prime focus of many DHBs, especially in their hospitals. Primary care clinical networks have shown that successful clinical governance requires distributed leadership (at practice, network, and national levels), and much of primary health care governance is “in good hands”.

The challenge for the rest of the healthcare system is to transform clinical governance into an every day reality at every level of the system, to ensure the whole system is in good hands.

Principles

A process for the New Zealand healthcare system to transform towards clinical governance needs to be based on the following six principles.

-
1. Quality and safety will be the goal of every clinical and administrative initiative.
 2. The most effective use of resources occurs when clinical leadership is embedded at every level of the system.
 3. Clinical decisions at the closest point of contact will be encouraged.
 4. Clinical review of administrative decisions will be enabled.

5. Clinical governance will build on successful initiatives.
 6. Clinical governance will embed a transformative new partnership which will be an enabler for better outcomes for patients.
-

Components of Clinical Leadership

Extensive expertise in other health systems explores components and attributes of effective clinical leadership. The NHS Leadership Qualities Framework lists 15 qualities or competencies. The Canadian model (CanMEDS) listing 7 domains of performance is common to, and forms the basis for, accreditation of undergraduate and postgraduate, and vocational medical education programmes, and continuing professional development programmes, throughout Australia and New Zealand, and internationally.

These competencies, outlined in the Appendix, can form both a guide to identify and develop future leaders, and a framework for measuring and reporting on clinical leadership.

Structure of Clinical Governance in the New Zealand Health System

“If clinicians are to be held to account for the quality outcomes of the care that they deliver, then they can reasonably expect that they will have the powers to affect those outcomes. This means they must be empowered to set the direction for the services they deliver, to make decisions on resources, and to make decisions on people.”

- Professor of Surgery, the Lord Darzi, Parliamentary Under Secretary of State, Department of Health UK.
NHS Next Stage Review Final Report, 2008

The structure necessary to operationalise the Time for Quality agreement and the Quality Improvement Strategy for the best care of citizens/patients within the New Zealand health system encompasses the whole spectrum of care, from primary to tertiary and national services.

The following adjustments are imperative for the successful transformation of healthcare and effective clinical governance.

1. **DHB Boards** must establish governance structures which ensure effective partnership of clinical and corporate management. DHB Boards must be required to report on clinical outcomes and clinical effectiveness, via a nationally consistent framework. Quality and safety must be at the top of every agenda of every Board meeting and Board report.
2. **The Chief Executive** must enable strong clinical leadership and decision making throughout the organisation. Assessment of Chief Executive performance must include clinical outcomes, clinical effectiveness, and the establishment of clinical governance.
3. **DHB Governance** will promote and support clinical leadership and clinical governance at every level of the organisation. DHBs must report on clinical leadership and clinical governance through their District Annual Plans, their Statement of Intent, and scorecard reports to the Ministry. This reporting includes, but is not limited to, the functions of their Clinical Board.
4. **Clinical governance** must cover the whole patient journey, including horizontal integration across the sector and across primary and secondary/tertiary services. Tangible examples of clinical governance, which DHBs must report on, include:
 - a) Clinicians on the Executive Management Team as full active participants in all decision making

- b) Effective partnership between clinicians and management at all levels of the organisation with shared decision making, responsibility and accountability
 - c) Decisions and trust devolved to the most appropriate clinical units or teams, which are many and varied, including clinics, offices and practices, wards and departments, hospitals and networks, regional and national bodies.
5. **Clinical leadership** must include the whole spectrum from inherent (eg surgery, clinic, bedside, theatre relationships) through peer-elect (eg practice, ward, department arrangements) to clinician-management appointment (eg clinical directors, clinical board). DHBs must report on the establishment, and effectiveness, of clinical leadership across the spectrum of their activities, aligning management to clinical activities.
6. DHBs and the health system must **identify actual and potential clinical leaders**, and foster and support the development of clinical leadership at all levels. To this end DHBs must together establish strategies to:
- a) Provide on the job training to strengthen the competencies and attributes of clinical leaders
 - b) Measure the achievement of leadership competencies in their workforce
 - c) Link with Universities, Colleges, and professional associations to coordinate funding, access to internal and external training, and support for coaching and mentoring of leadership at all levels.

Clinical engagement is about more than simply appointing people to particular positions or forming committees. It is about recognising the diffuse nature of leadership in healthcare organisations and the importance of influence as well as authority. Within health professions a range of leaders also exist who may not be official leaders in the eyes of the organisation; however they may be influential for other reasons amongst their peers, for example academic appointments, positions in professional organisations such as Colleges and Societies, or elected representation.

“Leadership is emphasised as a mechanism for effecting change and enhancing quality - with opportunities for this more likely to arise ... at a

local than a national level. [It] requires a new obligation to step up, work with other leaders, both clinical and managerial, and change the system where it would benefit patients."

- Darzi, High Quality Care For All, 2008

Empowerment of clinicians is the best means of realising this obligation, and will be accompanied by a willingness to accept responsibility and accountability, including for best use of resources.

Reporting on the Transformation

Quality and safety will improve when DHBs, and their Chief Executives, are required to report clinical outcomes, and the establishment of clinical governance within their healthcare organisations, as part of their routine "bottom line" and their own performance measures.

The Task Group recommends that, at a minimum, DHBs must::

1. Report on clinical outcomes and clinical effectiveness, in a nationally consistent manner.
2. Ensure that quality and safety are at the top of every agenda of every Board meeting and Board report.
3. Assess their own and Chief Executive performance on measures that include clinical outcomes and the establishment of clinical governance.
4. Report on clinical leadership and clinical governance through their District Annual Plans and scorecard reports to the Ministry.
5. Demonstrate clinician involvement at all levels of the organisation including the Executive Management team.**
6. Demonstrate devolvement of decision making and responsibility to the most appropriate clinical unit or team.**

**The mechanisms for reporting on 5. and 6. must include clinicians themselves.

**An example is existing Joint Consultative Committees.

7. Identify actual and potential clinical leaders, and foster and support the development of clinical leadership at all levels.
8. Coordinate funding, access to internal and external training, and support for coaching and mentoring of leadership at all levels.

Nationally Consistent Reporting

The health safety and quality literature clearly states that measurement is a very effective tool for driving change. The existing well established and validated international leadership metrics should be applied to the New Zealand healthcare industry.

The Task Group recommends that a small group be tasked with developing an initial national framework for reporting on clinical outcomes, clinical effectiveness, and clinical leadership within DHBs. This evidence-based framework should be part of existing reporting mechanisms such as “balanced scorecards” to the Ministry, and should be validated for accuracy by clinician groups within DHBs.

The initial framework should be reviewed and updated regularly as part of a national process to improve the quality and safety of health and disability services.

“...where change is led by clinicians and based on evidence of improved quality of care, staff are energised by it and patients and the public more likely to support it.”

- Darzi, High Quality Care For All, 2008

Sharing Successes

DHBs, through clinical networks and other networks, should share the successes of effective clinical governance. Some current examples of these successes include:

- Quality Improvement processes eg Cornerstone in primary care
- PHO accreditation - Te Wana programme for Healthcare Aotearoa
- Regional quality and education programmes through primary care networks
- Hospital medical department credentialing in MidCentral and Counties Manukau
- Regional cancer networks
- Joint Consultation Committees – local DHB and national
- Newborn Life Support Course – nationally consistent training in resuscitation
- TelePaediatrics – videoconference network linking child health professionals

- New Zealand Incident Management System – training and standards

The Task Group is aware that many other examples of clinical leadership have led to major improvements in quality and safety. Supporting and sharing these successes requires transforming leadership throughout the entire system, including not just DHBs but also at Ministry level and national advisory groups.

“Starting from isolated pockets of excellence and innovation, clinical leadership still has a long road to travel. But it is an essential road for both clinicians and their patients. A deep commitment to patient care and to traditional clinical skills will always remain the core of a clinician’s identity. To achieve the best and most sustainable quality of care, however, a commitment to building high-performing organisations must complement these traditional values. All the evidence suggests that patients will see the benefit.”

- Mountford and Webb, 2009

Ministerial Task Group on Clinical Leadership

In Good Hands – Transforming Clinical Governance in New Zealand

February 2009

Appendix

Components of Clinical Leadership

The NHS Leadership Qualities Framework was the result of consultation including feedback from hundreds of clinicians and managers in the NHS.

A brief overview of the 15 qualities of the NHS Leadership Qualities Framework is.

Cluster One: Personal Qualities

1. Self Belief – The inner confidence that you will succeed and can overcome obstacles to achieve the best outcomes for service improvement
2. Self Awareness – Knowing your own strengths and limitations and understanding your own emotions and the impact of your behaviour on others in diverse situations
3. Self Management – Being able to manage your own emotions and be resilient in a range of complex and demanding situations
4. Drive for Improvement – A deep motivation to improve performance in the health service and thereby to make a real difference to others' health and quality of life
5. Personal Integrity – A strongly held sense of commitment to openness, honesty, inclusiveness and high standards in undertaking the leadership role.

Cluster Two: Setting Direction

1. Seizing the Future – Being prepared to take action now and implement a vision for the future development of services
2. Intellectual Flexibility – The facility to embrace and cut through ambiguity and complexity and to be open to creativity in leading and developing services
3. Broad Scanning – Taking the time to gather information from a wide range of sources
4. Political Astuteness – Showing commitment and ability to understand diverse groups and power bases within organisations and the wider community, and the dynamic between them, so as to lead health services more effectively

5. Drive for Results – A strong commitment to making service performance improvements and a determination to achieve positive service outcomes for users.

Cluster Three: Delivering the Service

1. Leading Change Through People – Communicating the vision and rationale for change and modernisation, and engaging and facilitating others to work collaboratively to achieve real change
2. Holding to Account – The strength of resolve to hold others to account for agreed targets and to be held accountable for delivering a high level of service
3. Empowering Others – Striving to facilitate others' contribution and to share leadership nurturing capability and long-term development of others
4. Effective and Strategic Influencing – Being able and prepared to adopt a number of ways to gain support and influence diverse parties with the aim of securing health improvements
5. Collaborative Working – Being committed to working and engaging constructively with internal and external stakeholders.

Each of these competencies may exist or develop to variable strengths in an individual, and not all individuals will necessarily be equally strong in all attributes. Individuals will complement each other to achieve overall clinical governance by shared leadership.

Other countries have developed frameworks which share the common theme that clinical leadership in health is essential, and must be developed throughout the system.

NHS Leadership Qualities Framework



CanMEDS roles framework

- Medical Expert (the central role)
- Communicator
- Collaborator
- Health Advocate
- Manager
- Scholar
- Professional

The Canadian model of the domains of performance (CanMEDS) is common to, and forms the basis for, accreditation of undergraduate and postgraduate and vocational medical education programmes, and continuing professional development programmes (eg MCNZ guidelines), throughout Australia and New Zealand, and internationally.

For other clinicians this model can be adapted, with the central or principle domain (for doctors - medical expertise) changed to nursing, or physiotherapy, or other allied health expertise, surrounded by the same six roles (communicator, collaborator, etc). The same six domains are applicable to associated professional groups within the healthcare industry, surrounding a central or principle domain specific to their profession eg managers requiring expertise in management of the health industry. Similarly for human resource practitioners, information technology practitioners, and even financial advisors, accountants, and lawyers.

The Canadian Health Leadership Framework (see appendix) is essentially similar to the NHS Leadership framework. New Zealand needs to adopt, not invent, its own.

“Leadership is not advanced management ... most ... corporations today are over managed and under led ... they need to develop their capacity to exercise leadership.”

- John Kotter, Professor of Leadership, Harvard Business School.

In fact, leadership is required within all professional groups in healthcare. There are different styles of leadership in different industries but there are

qualities, particularly in healthcare, which research has found to be common to effective leadership.

Qualities which cumulatively form a leadership style:

- specific technical skills
- charismatic inspiration
- cooperation
- networking
- empathy
- a dedication that consumes much of a leaders' life.
- credibility
- optimism
- a sense of purpose or mission
- ability to generate trust
- an ability to delegate and to nurture

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