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FIXING HEALTHCARE IN NEW ZEALAND

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There is a group of people that believe the New Zealand health care system could be designed better than it currently is. That group consists of those who have actually used the New Zealand health care system.

In fact, it seems redundant and tiresome to even talk about the subject, let alone take pot-shots at it. We all feel it could be done better. But how?

In terms of design, there is a particular approach that is geared perfectly for health care: experience based design. This discipline focuses design efforts on the sorts of experiences customers have as they interact with a service. Do they feel valued? Do they feel listened to? Is their dignity preserved?

The British National Health Service's (NHS) Institute for Innovation and Improvement has embraced this approach and defined five 'core principles' of experience based design in a health care context:

- A partnership between patients, staff and carers – Experience Design efforts are seen as a joint activity between these three parties
- An emphasis on experience rather than attitude or opinion – observation is critical; what do people actually experience in the setting being considered?
- Narrative and storytelling approach to identify 'touch points' – how do people actually interact with service providers?
- An emphasis on the co-design of services – those who receive services are active participants in the design of those services
- Systematic evaluation of improvements and benefits – when changes are made do they actually deliver desired results?

A simple example of the NHS approach – and one you may have experienced – is being weighed in a health care facility. Those reviewing 'experience design' in British hospitals found that most patients were weighed in full view of other people – patients and non-attending staff. When asked how they felt about being weighed in this manner, patients reported it made them feel 'conspicuous' and 'embarrassed'. Patients simply suggested that weighing be done discretely. This was implemented the next day. No cost, no inconvenience for anyone, but a much happier patient and through this transaction a much happier carer.

The British Design Council says of this approach:

"The biggest untapped resources in the health system are not doctors but users (of the service). We need systems that allow people and patients to be recognised as producers and participants, not just receivers of systems ... At the heart of the approach users will pay a far larger role in helping to identify needs, propose solutions, test them out and implement them, together."

Professor Paul Bate from the University College of London's Centre for Health Informatics and Multiprofessional Education (who names these places?) says that there are only three ways we can approach design of services in health care:

1. Don't listen very much to our users and we do the designing
2. Listen to our users then go off and do the designing
3. Listen to our users and then go off with them to do the designing

Clearly number three is the preferred option. As the business world begins to embrace 'crowd-sourcing' (the practice of putting problems into the public sphere, usually via internet, and seeking solutions from the masses) the benefits are becoming apparent and the health sector seems a logical place to pursue this kind of co-design.

It's very logical, it's not that difficult and it doesn't cost terribly much money. So why isn't it happening already?

And that's the really interesting question here. One finds it difficult to imagine that any but the most arrogant and intransigent health care professional would refuse to accept the benefits of involving patients in designing health care processes that are more positive and dignified experiences.

Yet occurrences of this kind of design in New Zealand are, by all accounts, unusual. Why?

Could it be that the experiences of doctors and nurses themselves are contributing to this reluctance? Are they just so overworked that they don't have the time or headspace to think about whether or not their patients feel embarrassed or ill-informed? Is the problem so institutionalised as to be unsolvable within the existing system?

Dealing with health care professionals as a single homogenous group is, of course, foolish. Ask anyone about the ambulance driver that kept them alive on the way to the emergency room and you will tend to hear a story of admiration and respect. Likewise if you have ever taken a child to an emergency room with a dangerous fever or bad injury, you may remember the experience as harrowing, but one that came with reassurance and calm competence from the doctors and nurses concerned.

Yet as you move further away from the frontlines of the emergency room into the realms of less serious procedures the story starts to become a little cloudier. Ask people about their experiences in hospitals undergoing relatively minor operations or procedures and the responses tend to show a different story.

People often feel dehumanised, disrespected and marginalised. They are not told what is going on, they're treated like a number and they're interacted with as if unimportant.

So here's a designer's hypothesis: could the deliverers of these experiences also be the recipients of these types of experiences? Could it be that the average New Zealand health care professional is treated with disregard by their managers? Could it be that the conditions of employment make the average doctor or nurse feel marginalised and unappreciated?

And could they be passing this experience along to patients without even realising it?

Understanding context like this is a key aspect of service design. Many of us have been in jobs where we felt unappreciated or are treated badly – perhaps as retail part-timers while studying. Oftentimes this means being seen as completely replaceable – low-skilled, low-functioning and low-value. It's no surprise, then, how people in these situations treat customers. Somehow these completely innocent shoppers become our oppressors, participating through their custom in a system that we regard as disenfranchising the worker. They are, in some way, complicit. So we treat them with disregard. Why would we want to give a positive experience to customers so as to benefit those that so woefully failed to give us a positive experience?

It is likely that many in the New Zealand health care sector feel just like this. Doing the basic job is hard enough without making that extra effort to deliver a positive experience for patients. Those in emergency services probably rise above these feelings because if these services are not focused on patient needs, then said patients may die. Those that

are a little further back from the mortality coalface may be more likely to redesign services around their own needs because they feel that no one else (i.e. management) is doing very much to meet these needs.

If this is true, and the observable evidence suggests it is, then it would make sense that setting higher standards, instituting improvement programmes or even throwing money at the health care system will yield little in terms of better customer experiences.

Instead we need to better understand the intrinsic needs of the experience givers before we can meet the needs of the experience receivers.

So why do people choose a career in health care?

No doubt a sizeable proportion see being a doctor or nurse as a calling. Surely this implies a need to be valued, to feel as if they are doing some good, to be appreciated and acknowledged. But does this happen? Is this kind of validation and support a part of the way health care professionals are managed? Do the values of the New Zealand health care system recognise the service of dedicated individuals?

If not, problems will obviously arise. People who don't have intrinsic needs met will start to seek the satisfaction of extrinsic needs. That's why people who are treated poorly tend to demand higher wages and shorter hours. It's also why people who are valued and enjoy the culture of their workplaces tend to care a little less about bonuses and allowances.

Could the New Zealand health care system and the experiences of patients in health care facilities be radically improved by a chain of events that starts with health care professionals being properly valued and acknowledged for the important work they do. Quite possibly.

Happier, more satisfied doctors and nurses will likely be more receptive to management's desires to improve customer experience. Perhaps those that design services around their own needs and power base – yes, this does happen – might start to feel a little different about patients. Maybe co-designing of services and experiences will be more readily embraced in this kind of environment.

Experience based design seems straightforward, but is in fact remarkably complex. In fact, most design activities are more complex than we might think at first glance. Running at a patient experience problem by demanding that health care professionals engage with patients more empathetically is as likely to fail as designing the next killer iPod by simply asking customers what they want and putting all that together into a product.

Any endeavours to improve the experience of patients in the health care system must be cognisant of the experiences of all participants in that system, from the top down.

'Fixing' the health care system in New Zealand may not be about bigger budgets, but about a greater understanding of the emotional needs of ordinary people.