Creating adaptive health systems: The role of structures and interactions

Jean-Louis Denis FCAHS, MRSC

Professor, Department of health management, evaluation and policy

Canada Research Chair – Health system design and adaptation,

Senior scientist-CRCHUM

Université de Montréal

October 2017

CRCHUM

ESPUM

L'ÉCOLE DE SANTÉ PUBLIQUE DE L'UNIVERSITÉ DE MONTRÉAL

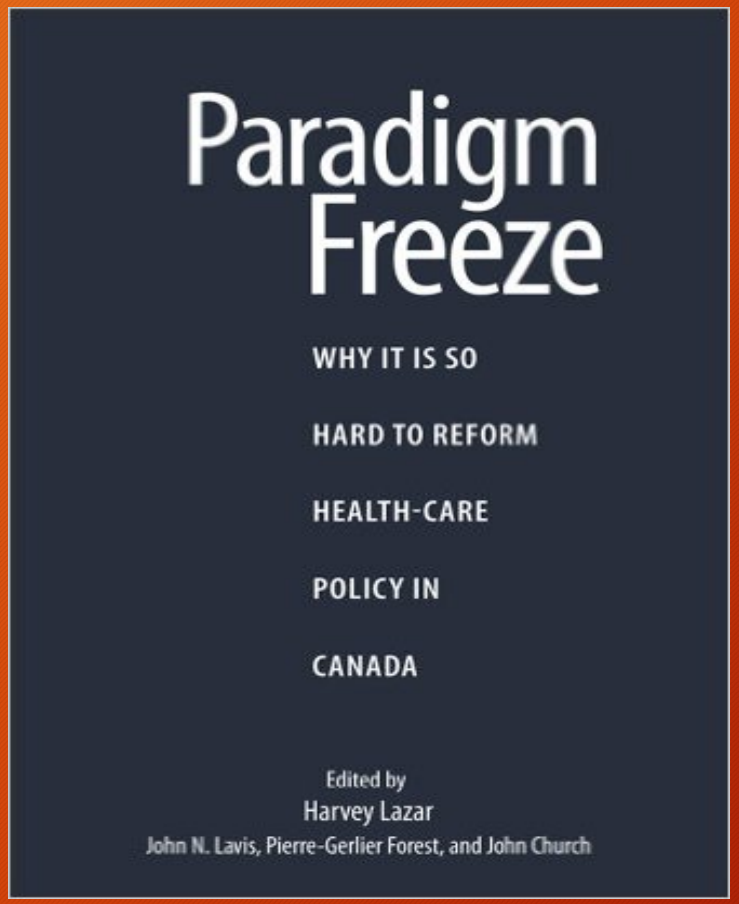
Prospects for transformative changes and large-scale improvement in health systems.

Learning Health Systems + the *Academization* of healthcare are considered the next frontier in health policy & mangement

In Canada, the National Task Force (NTF) defines the mandate of ***AHCs*** as « *(...) engines of health innovation through the interplay between research, education, and clinical practice which accelerates the translation of new knowledge into cost-effective leading practices, new models of organizing and delivering care, breakthrough drugs and/or medical devices that can revolutionize diagnosis, treatment and improve health outcomes* ».[7]

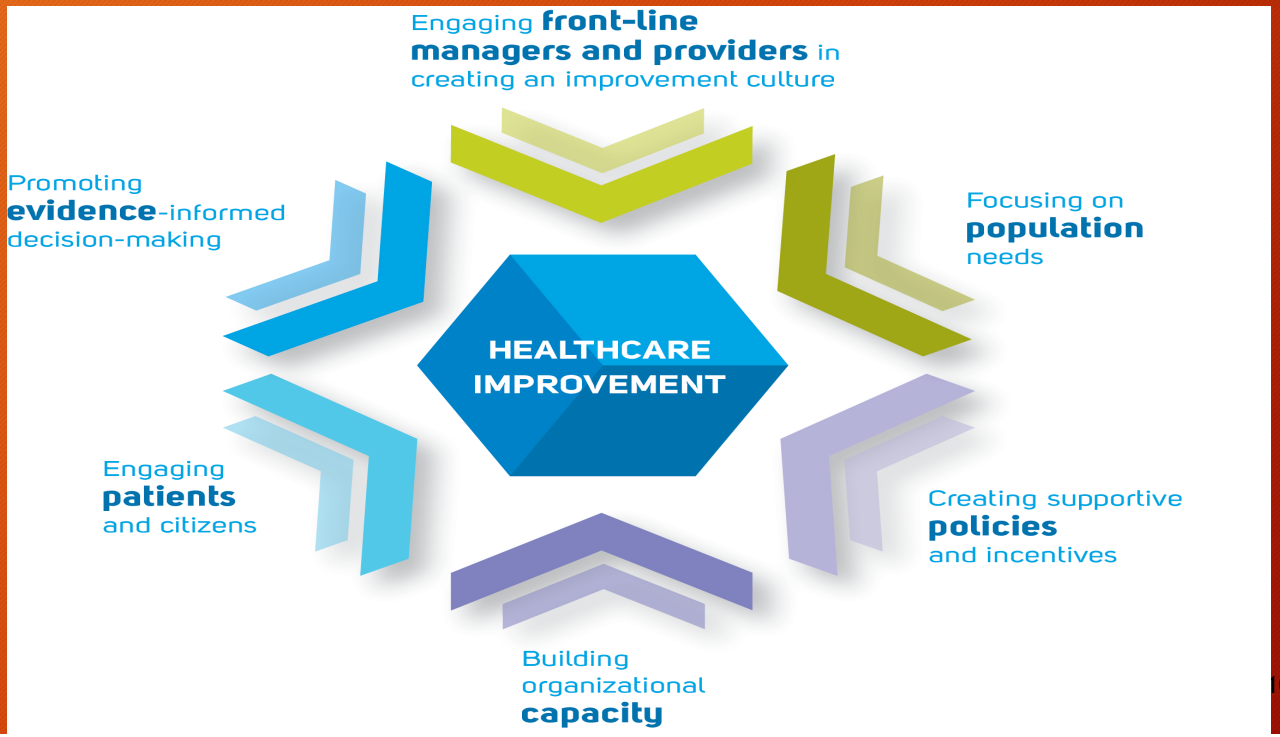
Learning health systems (LHSs)…are entities that develop capacities to "*harness the power of data and analytics to learn from every patient, and feed the knowledge of "what works best" back to clinicians, public health professionals, patients, and other stakeholders to create cycles of continuous improvement*".[9,10]

"We're ready to begin the next phase of keeping things exactly the way they are."


Paradigm Freeze
WHY IT IS SO HARD TO REFORM HEALTH-CARE POLICY IN CANADA
Edited by
Harvey Lazar
John N. Lavis, Pierre-Gerlier Forest, and John Church

“ Embedding within this core organizing dilemma have been continual concerns about quality, responsiveness, and, in some contexts, access regarding wholly publicly service providers. In both primary care and hospital sectors, public and command structures of organizations have lagged (sometimes dramatically) beyond patients and citizens expectations” (Saltman & Duran, 2015:1).

CFHI's SIX LEVERS FOR ACCELERATING HEALTHCARE IMPROVEMENT™



“ *Transformative capacity* ” is defined as a set of resources, levers, and practices mobilized at the three levels of governance of healthcare systems (macro, meso, and micro) to bring about change and improvement. ” (Denis & al., 2015)

Transformative capacities are more distributed and collaborative than usually recognized.

A WORD OF CAUTION!

Maynard, A. (2013) 'Health Care Rationing: Doing It Better in Public and Private Health Care Systems', *Journal of Health Politics, Policy and Law*, 38 (6), 1103–27.

MODES OF REFORMS

"Can I call you back Harry, I think the restructuring has started."

QUALITY IMPROVEMENT COLLABORATIVES

THE MILBANK QUARTERLY
A MULTIDISCIPLINARY JOURNAL OF POPULATION HEALTH AND HEALTH POLICY

Understanding the Components of Quality Improvement Collaboratives: A Systematic Literature Review

ERUM NADEEM,[1] S. SERENE OLIN,[1]
LAURA CAMPBELL HILL,[2]
KIMBERLY EATON HOAGWOOD,[1]
and SARAH McCUE HORWITZ[1]

[1]*New York University;* [2]*Columbia University*

Insights on transformative keys for health systems

- ✓A reform from within
- ✓A commitment to exploit latent capacities for improvement despite political, institutional and structural limitations
- ✓An attention paid to existing basis of mobilization and countervailing powers within and outside health systems:
  - Evidence
  - Patient and citizen engagement
  - Inter-sectoral policies and interventions
  - Regulation and chanelling of professional entrepreneurship
  - Distributed leadership (society, policy, managerial and clinical)

To implement and sustain real reforms

- ✓A *political agenda* aligned with tangible transformative and population health goals
- ✓Attention in reforms to both *operational challenges* and *political contingencies*
- ✓A careful use of structural change to limit the risk of *entropy* (‘’ crowding out ’’)
- ✓More attention on how *local context* and *system’s logics* influence the behaviors of providers and organizations

NARRATIVES OF REFORMS IN CANADA HEALTH SYSTEMS

(with a focus on the Quebec and Ontario experiences)

Research team

Jean-Louis Denis, Université de Montréal
Ross Baker., University of Toronto
Susan Uscher, École nationale d'administration publique
Élizabeth Côté-Boileau, Université de Sherbrooke
Julie-Maude Normandin, École nationale d'administration publique

This research is supported by a grant from the Canadian Institutes of Health Research.

« People can know what they are doing only after they have done it »
(Weick, 1995:24)


North ★ Pole
Polar Ice
Arctic Ocean
Russia
Bering Strait
Alaska (USA)
Arctic Circle
Beaufort Sea
Norwegian Sea
Norway
Greenland Sea
UK
Iceland
Ellesmere Island
Alert
North Magnetic Pole
Kalaallit Nunaat (Grønland) (Denmark)
Resolute
Baffin Bay
Arctic Circle
Davis Strait
Banks I
Victoria Island
Baffin Island
Inuvik
Dawson
Yukon Territory
Whitehorse
Mackenzie River
Northwest Territories
Yellowknife
Great Slave Lake
Nunavut
Baker Lake
Iqaluit
Labrador Sea
Atlantic Ocean
CANADA
Ungava Bay
Newfoundland and Labrador
Nain
Kuujjuaq
Churchill Falls
St John's
Saint-Pierre et Miquelon (France)
Hudson Bay
Fort McMurray
British Columbia
Prince George
Fraser River
Alberta
Edmonton
Calgary
Saskatchewan
Saskatoon
Regina
Churchill
Manitoba
L. Winnipeg
Winnipeg
Sandy Lake
James Bay
La Grande Rivière
Sept-Îles
Quebec
Prince Edward Island
Charlottetown
New Brunswick
Nova Scotia
Halifax
Fredericton
Québec
Montréal
Ottawa
Toronto
Pacific Ocean
Vancouver
Victoria
Kamloops
Thunder Bay
Ontario
Lake Superior
Lake Michigan
Lake Huron
Lake Ontario
Lake Erie
United States of America
LEGEND
National capital
Provincial or Territorial capital
Other populated places
International boundary
Provincial or Territorial boundary
Exclusive 200 nautical mile Economic Zone (EEZ)
Scale
300 0 300 600 900
km km
© 2001. Her Majesty the Queen in Right of Canada, Natural Resources Canada.

ONTARIO CASE STUDY

(PRELIMINARY RESULTS)

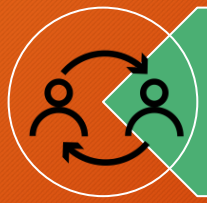
- *In the 1990s, reforms focused largely on **reducing hospital capacity and costs**, with some increase in community based services and primary care but limited emphasis on integrating care across the system.*

- *Reforms in Ontario since 2000 have been shaped by the diagnosis that the **health system operates as a set of disjointed parts, lacking the necessary integration to properly function and perform.***

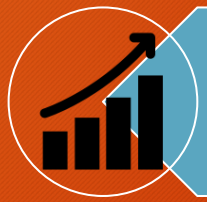
- *The Excellent Care for All Act (2010) and Patient First Act (2016)* aim at orienting the health system toward cost-effective care and high quality patient experiences

ONTARIO
Reform narrative

Phase I (1990-2003): Rationalization and creation of a momentum for change



Phase II (2003-2010): Development of stronger accountability regimes within the Ontario health system.



Phase III (2010-today): The Excellent Care for All Act and the challenge of institutionalizing a culture of improvement

ONTARIO
Two dominant logics

Soft regulation

- Increasing accountability of front line providers
- Growing measurement
- Incentives

Low rules

- Improving quality and system integration
- Focus on alternate mechanisms

A *slow-and-steady* approach for system capability and performance

Ontario
conclusion

The meaning of accountability relations in the system remains unclear (Deber et al 2014) and the impact uncertain. Providers may perceive accountability regimes as more threatening than enabling.

Mechanisms for change and improvement have focused primarily on **generating evidence, modifying financial incentives and creating new organizational forms and models of care.**

Government cannot impose effective local strategies, as these necessarily vary depending on local resources, the relationships between providers, and previous integration efforts.

There is also a sense that the various policies introduced over 15 years of reforms **lack overall coherence**. The pace of change remains slow and variable across organizations.

Recent tensions with government over payment contracts have **reduced physician engagement** in reforms.

QUEBEC CASE STUDY

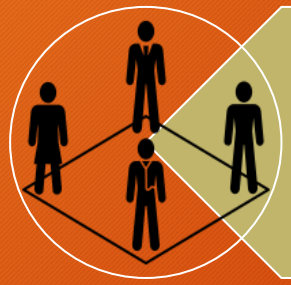
(PRELIMINARY RESULTS)

- *In 1988, **coordination and integration of care were identified as major issues** in the management and governance of the system.*

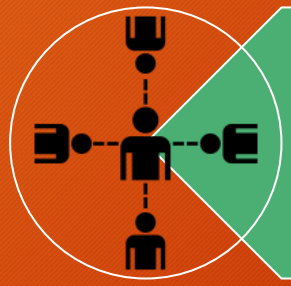
- *Despite some efforts to build regional agencies with local authority, government has sought to **limit the autonomy and independence of healthcare organizations**.*

- *More recently, the Castonguay (2008) report deplores **the lack of clarity around accountability and excessive centralization** as major impediments to system improvement.*

quebec
Reform narrative



Phase I (2003-2014): Creation of local integrated health systems and networks



Phase II (2015today): Consolidation of a centralized approach to governance and organizational restructuring

Quebec
conclusion

Overall, reforms in Quebec's healthcare system have been characterized since 2000 by **repeated massive restructuring and reshaping of governance** in favor of central government or authority.

This represents a clear break with earlier efforts to strengthen the governance of the health system through **regional health authorities, public participation and community care.**

The level of centralization within the system may **impede improvements that require adapting care processes** to local contexts and priorities. It may however send **strong signals** about some necessary changes.

A by-product of repeated restructuring efforts has been an **initial diversion of managerial energies away from supporting front line efforts** to improve care. Organizations and providers **start to see or harness some benefits** from these new regional integrated health systems (CISSS and CIUSSS).

Engaging physicians in reform priorities remains challenging.

LEARNINGS FROM THESE TWO CASES OF REFORMS (ONTARIO ,QUEBEC AND OTHERS)

Quebec & Ontario reforms

- **Two critical policy and political factors:**
  1. The engagement and leadership of the medical profession in the reformative journey
  2. The ability of these systems to reallocate funding around alternative sectors of care (community-based care and non-institutional care)

Four lessons learned:

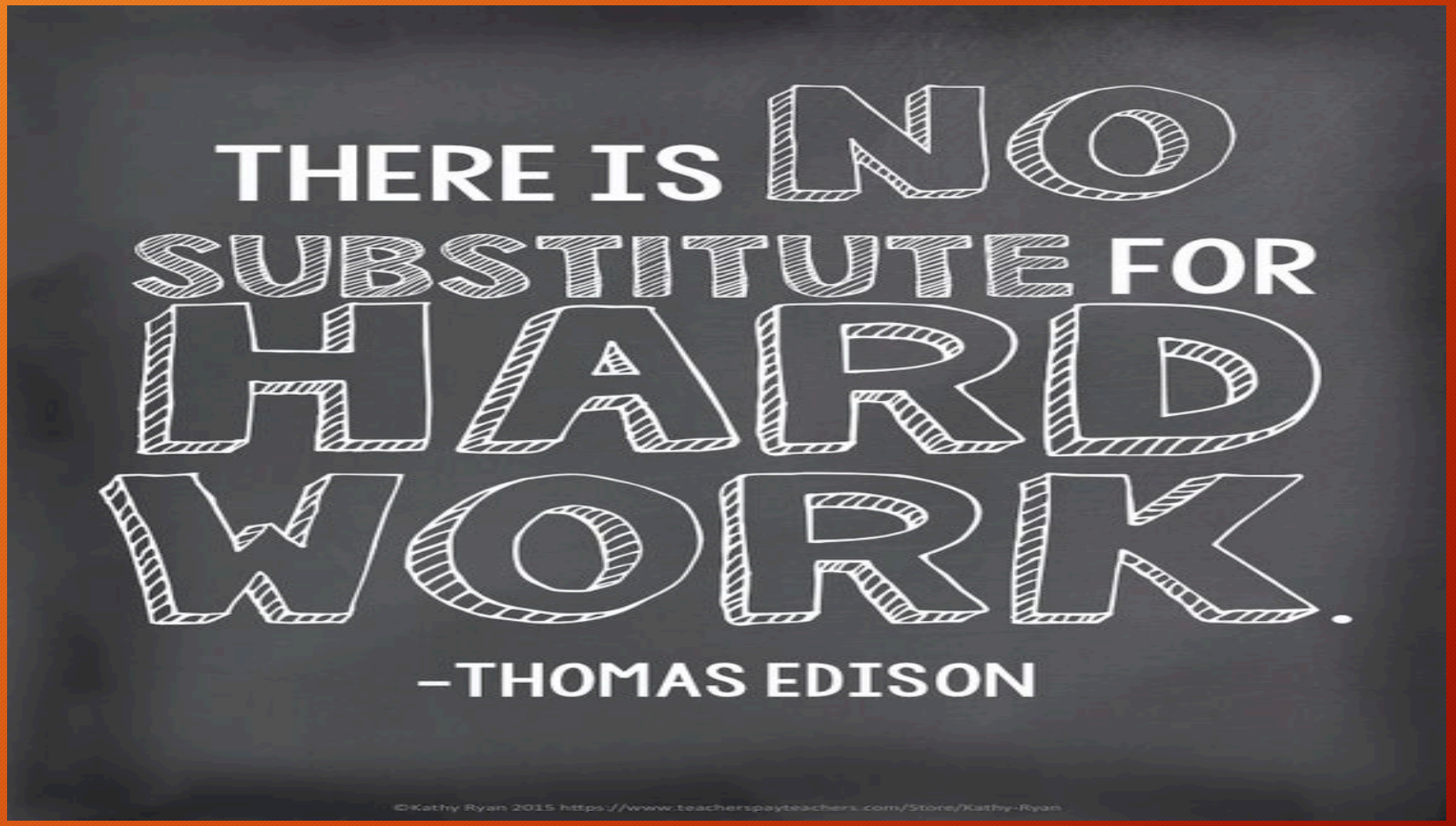
1. Through the experience of reforms, health systems have developed **a variety of strategies and levers** to bring about change and improvements.
2. They face challenges in **using these levers consistently and in a cumulative manner** within a coherent framework to support change and improvements.
3. Learning across different reforms period is not easy to achieve and is **highly dependent on change or continuity in the politics and politicians in power.**
4. The challenge is in **creating sufficient momentum and support** in a system to challenge the status quo and reproductive forces.

Health reforms in Canada

- Temptations for structural reforms and/or re-arranging governance
- Challenges in achieving balance and coherence across a diversity of levers for transformation and improvement
- Growing sensibility to clinical governance
- Growing awareness of the need for capacity development (data, processes to improve care, incentives to support improvement…)
- More attention to values and interests appears important (professionals, patients, citizens)
- Playing wisely with structures and interactions still a challenge

" The ***politics of this redesign*** phase differ from both the "high politics" of welfare-state establishment and the stealth politics and short-term budgetary unilateralism of welfare-state retrenchment. ***In the redesign phase, opportunities for re-allocation and re-investment are seized upon by certain actors within the health care system who see the potential to benefit from them. These may be "policy entrepreneurs" who want to bring a new idea to fruition. Or they may be "organizational entrepreneurs" within the health system itself, who seize upon newly available resources to innovate within the shifting context.*** Alliances between these different types of entrepreneurs, moreover, create yet further impetus for change."

(Tuohy, 2012)


THERE IS NO
SUBSTITUTE FOR
HARD
WORK.
–THOMAS EDISON
©Kathy Ryan 2015 https://www.teacherspayteachers.com/Store/Kathy-Ryan


Enjoy
The Ride
Hekikali