

# **What Do We Know About Large System Transformation?**

**Menzies Centre for Health Policy  
Seminar Presentation  
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## Transformation: The Rationale

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- **Quality and safety problems**
- **Equity problems – especially persistent health status disparities**
- **Unhappy workforce**
- **Access problems (long waits)**
- **Poor value for money**



## The Project

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- **“A Systematic Realist Review and Evidence Synthesis of the Role of Government Policy in Directing Large System Transformation”**
- **Funded under CIHR Knowledge and Action for System Transformation program**
- **Rapid cycle project – approx. 6 months start to finish**



## What Is Large System Transformation?

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**“Large system transformation refers to systematic initiatives to create coordinated change in health care across organizations working toward shared priorities within specified boundaries.... [It] encompasses the necessary structural, process and policy changes needed to leverage change... to create transformative synergies across the full range of services and organizations involved currently and going forward.” (from draft project report)**



## Objectives

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- **Identify the most effective examples of large system transformation, and determine the role of provincial government, including policy development and implementation.**
- **Develop a deeper understanding of the strategies and mechanisms that contribute to success in large system transformation.**
- **Identify barriers and challenges to system transformation, and recommend what roles government might play in resolving them.**
- **Identify options for monitoring and evaluation of processes and outcomes for large system transformation initiatives, including the role of government.**



## Have Their Been Successful LSTs?

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- **There are high-performing health care systems**
  - **Kaiser Permanente**
  - **Geisinger Health**
  - **Virginia Mason Hospitals**
  - **Mayo Clinics**
  - **Veterans Health Affairs**
- **If the time horizon is long enough, all health care systems are LSTs**



## So Let's Develop a LST Score

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- $LST = (C_M * S)/T$

Where

$C_M$  = Magnitude of change

$S$  = Scale (% of system affected)

$T$  = Time

- The highest scores (probably) go to:
  - **Veterans Health Administration**
  - **NHS**



## Project Health System Priority Topics

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- **Defined by Saskatchewan decision-makers**
  - **large system transformation generally**
  - **patient & family-centred care**
  - **primary health care redesign**
  - **Lean for healthcare**
  - **surgical wait time and quality improvement**



## Project Method (1)

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- **Realist review – designed to discover not only *what* worked, but *how* and *why***
- **Based on Pawson’s insight that programs are not the agents of change**
- **People and resources in particular contexts make change**
- **Shifts focus from search for surface similarities to search for in-depth explanations**
- **Used theory of *complex adaptive systems***



## Project Method (2)

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- **Review of literature on LTS using extended search vocabulary (ultimately 114 papers)**
- **Surveyed experts from around the world to respond to short, periodic surveys to provide:**
  - **Critical feedback on preliminary findings**
  - **Advice on policy recommendations for government based on their experiences**
- **44 participants in this exercise (45%)**



## Project Principals

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- **Partnership between**
  - **Saskatchewan Ministry of Health**
  - **Research team based in Vancouver with colleagues in US and Ireland**
  - **Expert Panel co-chaired by Trish Greenhalgh (UK - expert) and Steven Lewis (Canada - amateur)**
- **Multidisciplinary team, expert in health services research, systematic reviews, health policy (Allan Best, Stirling Bryan, Craig Mitton PIs)**



## Deliverables

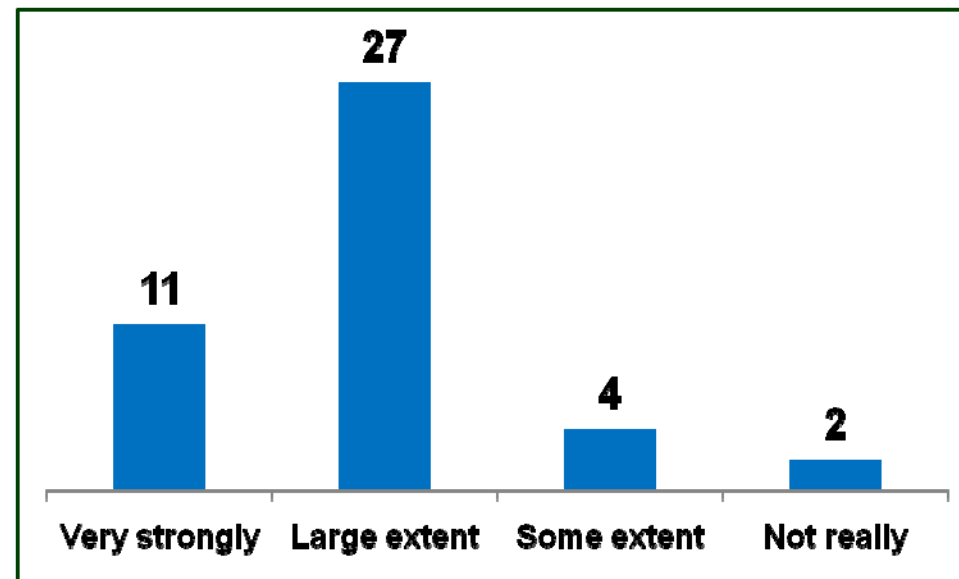
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- **Report on findings**
- **Workshop near end of project to review and validate findings**
- **Ultimately papers on both methods and findings in peer reviewed literature**



## Evidence Statement #1

- *Large system transformation in health care systems requires both top-down leadership that is passionately committed to change, as well as distributed leadership and engagement of personnel at all levels of the system.*





## Recommendations for Governments

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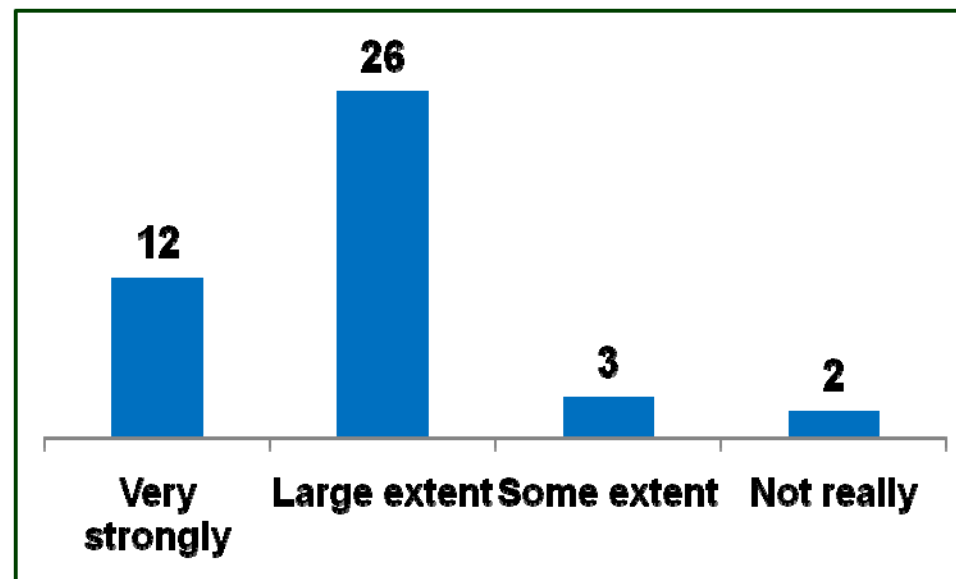
- **Support meso-level changes through policy**
- **Communicate successes widely and often**
- **Emphasize the evidence supporting changes**
- **Expect performance and commit resources commensurate with the task**
- **Insulate change from day-to-day politics**
- **Show courage when there is pushback**



## Evidence Statement #2

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- *Measurement and reporting on progress toward short and long-term goals is critical for achieving effective and sustainable large system transformation.*





## Recommendations for Governments

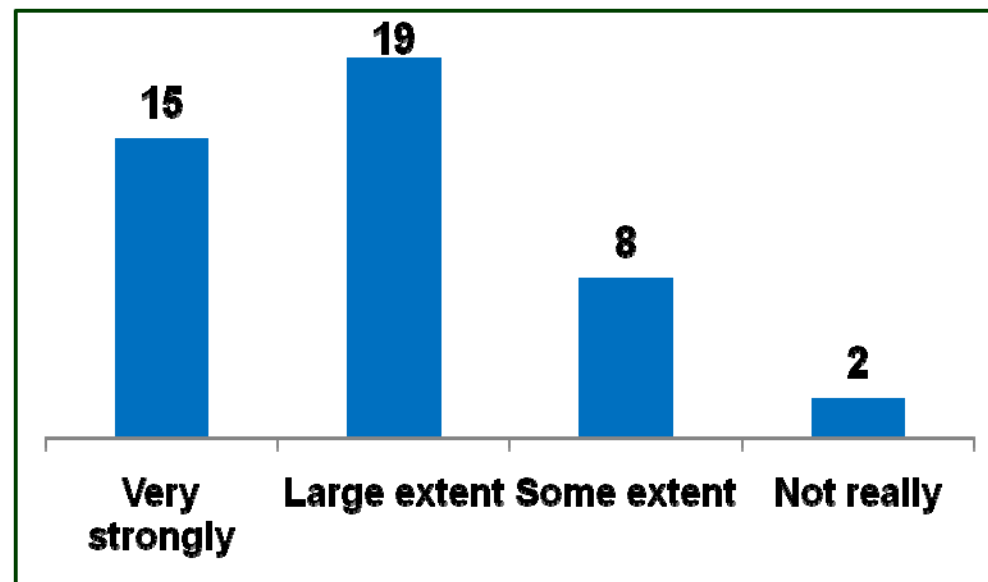
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- **Link measures explicitly to transformation vision**
- **Create independent oversight for measurement**
- **Involve stakeholders in selection of indicators and measures but do not give them a veto**
- **Be prepared to change measures when they generate unintended consequences**
- **Be vigilant about gaming the system**



## Evidence Statement #3

- *Consideration and acknowledgement of historical context will help avoid unnecessary pitfalls, and increase buy-in and support from system stakeholders.*





## Recommendations for Governments

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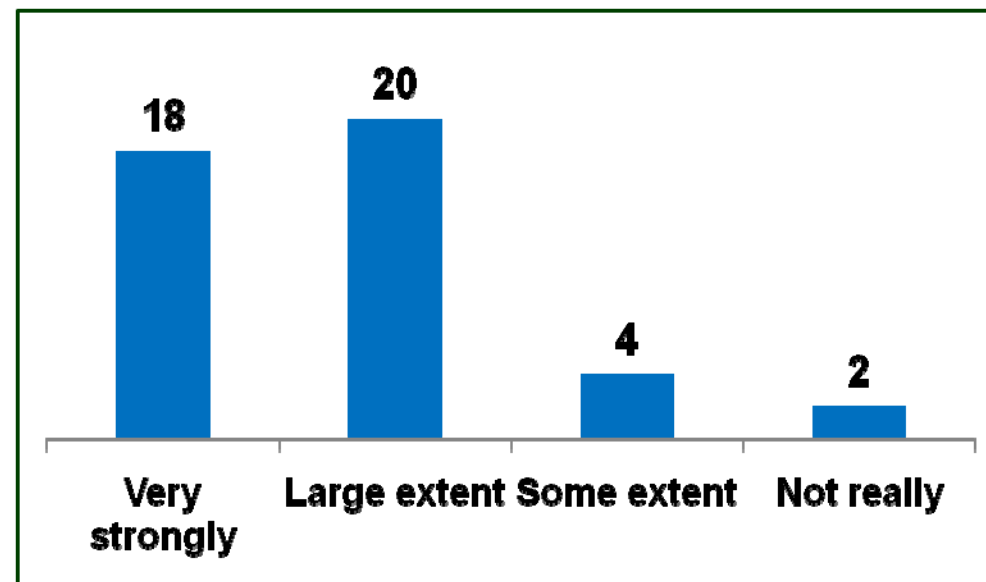
- **Assess organizational readiness and capacity for large scale change**
- **Chronicle past change experiences and use them to inform current activities**
- **Create opportunities to share experiences across jurisdictions**
- **Assess relevance of historical experience to current challenges and avoid the use of history as an excuse to scale back ambition**



## Evidence Statement #4

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- *Large system transformation in health care systems relies on significant physician engagement in the change process*





## Recommendations for Governments

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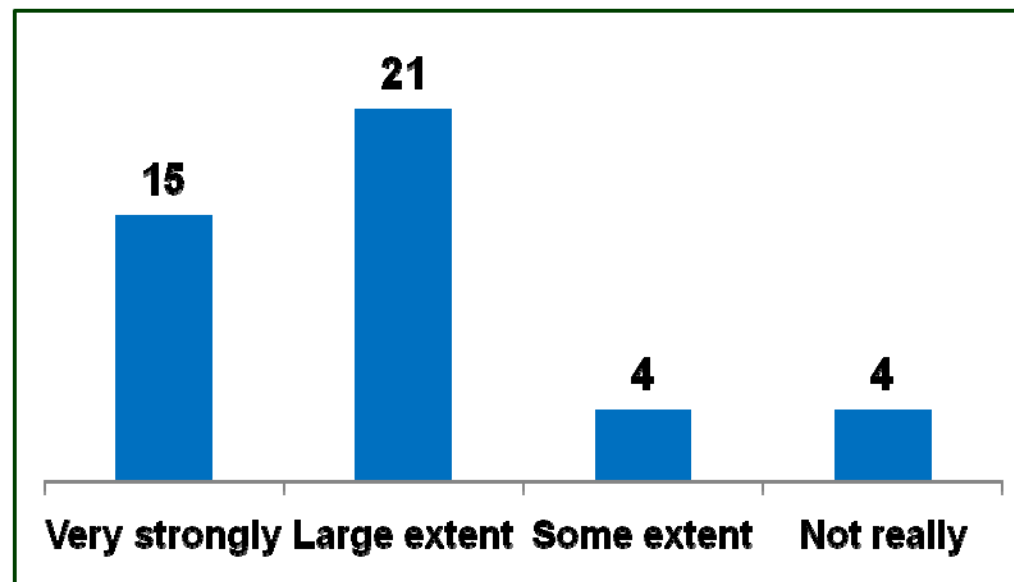
- **Ensure educational institutions include change-oriented curriculum and capacity-building**
- **Engage physicians in policy development at all levels (e.g., UK clinical directors)**
- **Engage professional and regulatory bodies**
- **Align general incentives with objectives of change**
- **Temper expectations of \$ incentives of P4P – there are other ways to reward excellence**



## Evidence Statement #5

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- *Large system transformation that aims to increase patient-centredness requires significant engagement of patients and families in the change process*





## Recommendations for Governments

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- **No respondents could name a single example of a successful effort to truly engage patients in decision-making at a system-wide level**
- **Create independent advisory mechanisms at various levels and fund participation**
- **Adapt UK (NICE) consultation approach**
- **Important to distinguish patient-centredness from appropriateness**
- **Don't overly focus on patient satisfaction surveys**



## Important Enabling Factors

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- **Spread strategies – don't get complacent in pilot phase and have plan for expansion**
- **Coordinate change activities and ensure people are responsible and accountable**
- **Insulate as much as possible from day-to-day politics**
- **Mixed views on need to standardize data across system (36% neutral or negative)**



## Conclusions

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- **Nothing dramatic in the study – it is reflective and useful common sense**
- **No magic elixirs – change is hard work**
- **Policy matters and governments must stay the course**
- **Thoughtless adoption of tools and techniques will not change or represent culture**
- **Misalignment of goals and various forms of incentives at all levels is important barrier to overcome**



## Digging Deeper: Why Change Is So Difficult

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- **Power and legitimacy of professions**
- **Path dependency – tomorrow is largely conditioned by today**
- **Difficulty of identifying the public interest as distinct from the sum of particular interests**
- **Universal systems have greater challenges than closed-ended sub-systems (Kaiser, Geisinger, Intermountain Health, etc.)**



## In Health Politics, Emotion Trumps Intellect

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- **The public understands the virtue of promotion, prevention, and a population health approach on an intellectual level**
- **They are emotionally engaged by wait times, access to technology, fear, anxiety**
- **The emotional factors translate into political commitments**
- **The solution is sustained public engagement – but this is very hard to do**



## Different Classes, Different Utility Curves

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- Health care delivers very little concrete returns at the margins
- A purely utilitarian perspective would reallocate huge amounts of health spending elsewhere
- This would greatly enhance the lives – and health – of disadvantaged people
- But the politically dominant middle class has less to gain and more to lose from reallocation
- And health care professionals are a powerful and large group within the middle class



## **Accountability Is Elusive**

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- **In large and complex systems, it is easy to evade accountability**
- **Physicians have by and large resisted the role of stewardship over public resources**
- **Health care's relationship to physicians and employees is fundamentally different from other industries**
- **Autonomy is a core value, and there is high tolerance for practice variations**



## What's Different In Systems That Do Better?

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- Ability to select key personnel – no automatic right to practice
- Active clinical governance supported by useful information technology
- A major focus on keeping people out of hospital (Kaiser vs. NHS comparisons)
- Walk the talk of primary health care
- Support for clinical leaders
- Consumers active in governance (some – e.g., Southcentral Foundation in Alaska, Group Health in Washington State)



## Final Observations

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- It's easier to change when money is tight
- Competing for the public mind is essential – otherwise the interests will prevail
- It is crucial to launch the discussion about appropriateness (diagnostic imaging, drugs)
- If the “rational” case is to trump the emotional appeals, there will have to be brilliant social marketing



## Contact Information

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