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Coláiste na Tríonóide, Baile Átha Cliath
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Towards Dynamic Resilience in Health System Performance and Reform - Resilience to Reform (RESTORE)

Realist Literature Review: The legacy of successive health system shocks Nov 16th 2021

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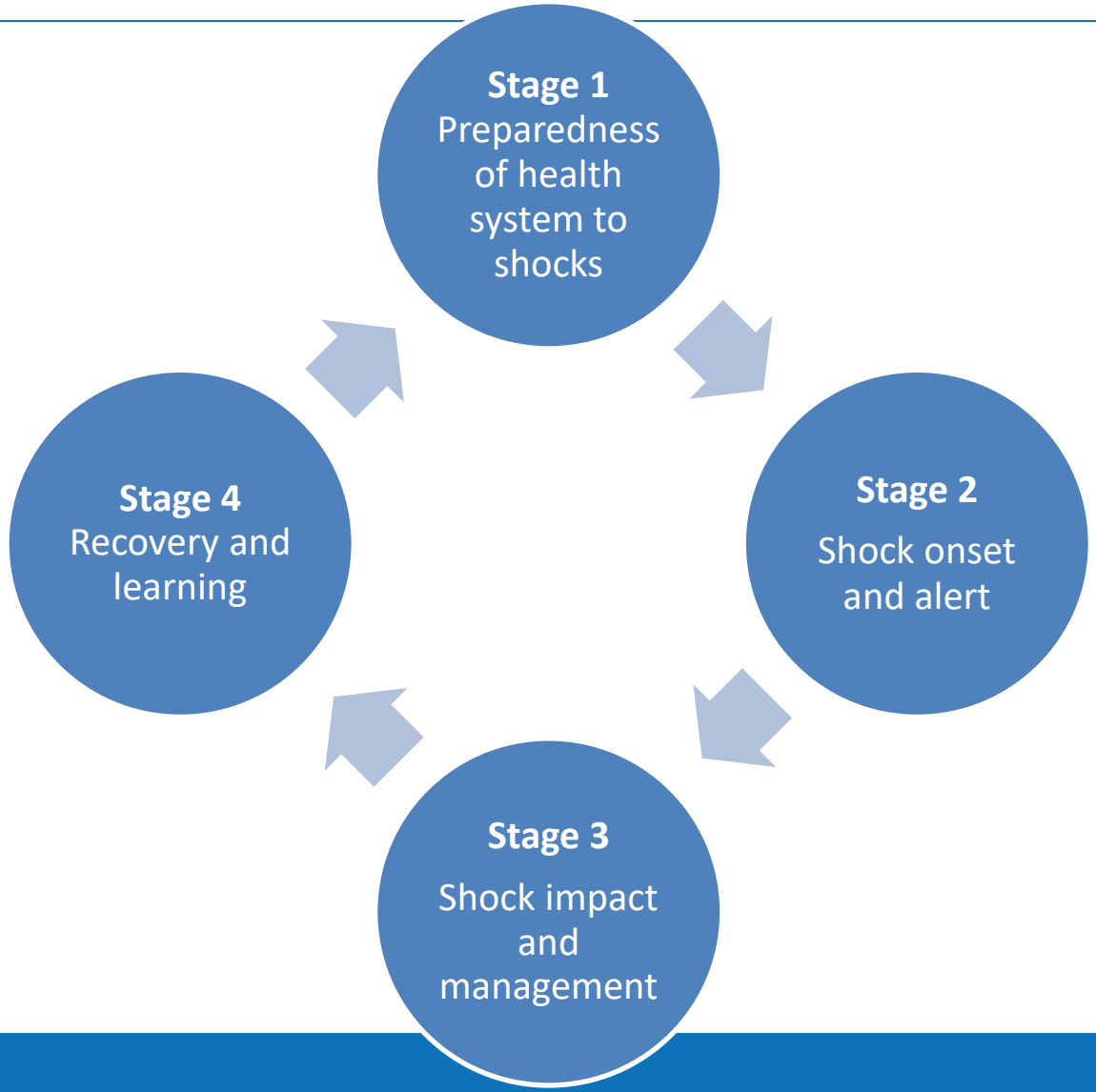
HRB Health Research Board

RESTORE: Resilience to Reform

A realist review to determine how health system austerity responses to the 2008 financial crisis impacted health system resilience for subsequent shocks

- Literature focuses on definitions and conceptualisations
- Shock cycle
  - Absorption and adaption
  - Little focus on the transformative stage
  - Less again on legacies – preoccupied with everyday shocks (fire-fighting)
- Important to understand the factors that strengthen or weaken broader measures of resilience



What is a realist review & what is it not

- A realist review is **not** a systematic review
  - Although it is systematic and transparent
- It is about building theory
  - Explanatory rather than judgemental
  - How? Why? For whom? To what extent? In what circumstances
- Realist Reviews examine the causal relationships between seen and unseen factors
- Looks for mechanisms (M)
  - Usually hidden
  - Sensitive to variation in context (C)
  - Generate outcomes (O)
- Iterative process building CMO configurations (CMOCs)
- Relentless chasing of the 'why?

Progress to date

- Protocol published (26.06.21)
- Realist Review training completed
- Developed a range of statements to further develop our initial theory
  - Reviewed by full team members (x 2)
  - Members of Advisory Group
  - PPI representatives & Sara Van Belle
- Developed a search strategy based on initial theory (2007 onwards)
- Statements helped develop inclusion / exclusion criteria for screening

"**If** [salaries are reduced; workload is increased; staff are lost]

then there will be [less flexibility; lower productivity; poorer performance; less willingness to innovate; lower quality of care]

because [staff demotivated; disengaged; burnt out]"

- Access
- Decision making
- Innovation
- Public dissatisfaction
- Political instability
- Population health
- Short-termism
- New Public Management

1,081

Title /Abstract Double Screen

- 1044 from library databases
- 44 grey literature
- 7 duplicates
- **600 excluded**

481 Full texts screened

(10% double screened)

- **303 excluded**
- 107 Not relevant
- 92 No primary data for CMOC
- 48 Not available in English
- 24 Abstract only
- 16 Full text not available
- 7 Not rigorous
- 1 Book review only
- 8 Lit/Systematic reviews

178 studies moved forward

- 101 quantitative
- 34 qualitative
- 43 mixed methods

- 93 aligned with IPT
- 22 further informed IPT

- Impact on training opps
- Inappropriate skill mix
- Weakened mental health = more vulnerable to next shock
- Non-compliance with medication
- ….

Helped sort and categorise the evidence, and provides data on impact (outcomes)

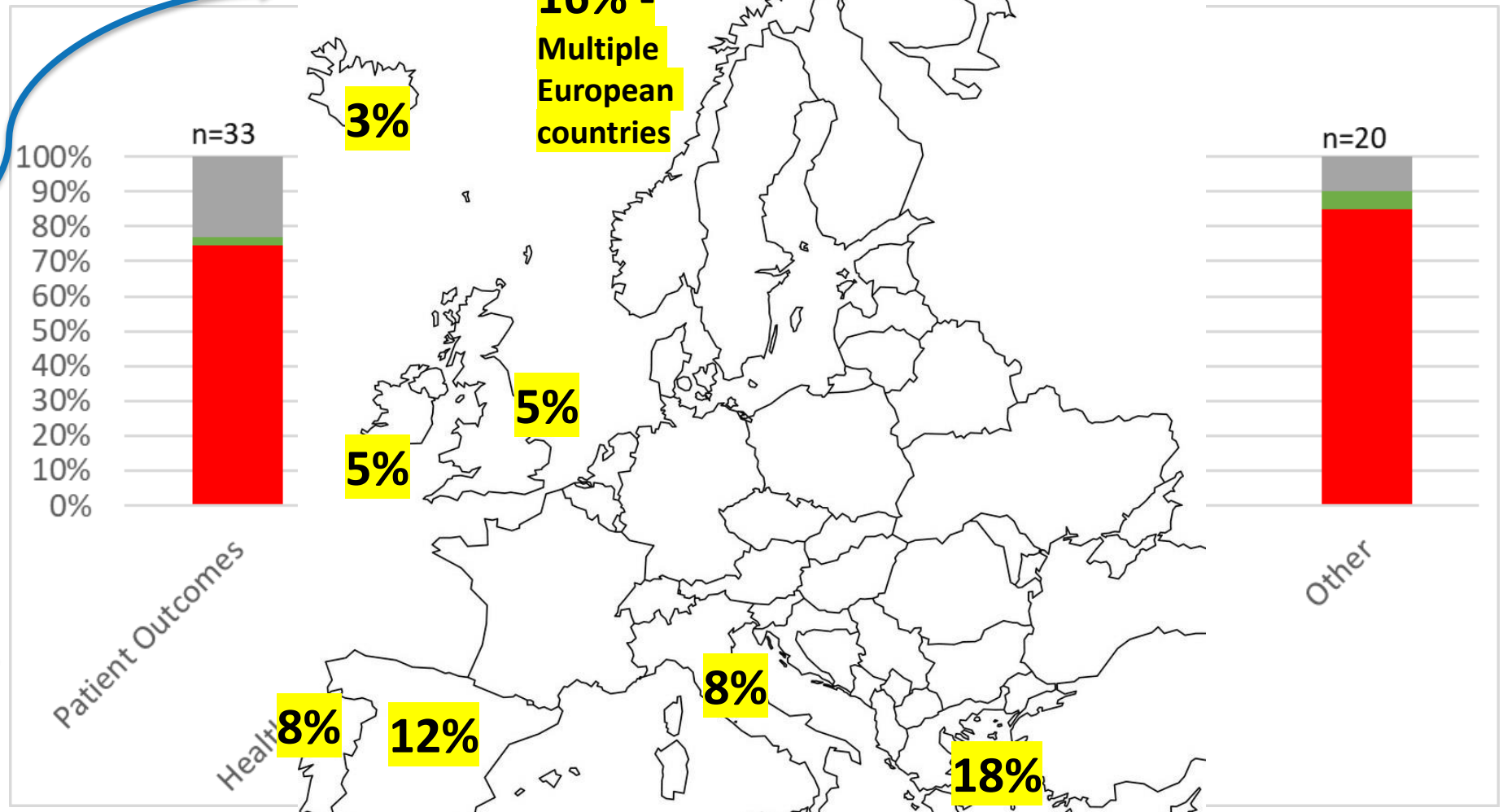
- Pt. outcomes
- OOPs
- Health care €€€
- Workforce
- Access

Quantitative outcomes

- Evidence for context and outcomes
- Setting the scene at a macro level for review & analysis
- Allow for informed ‘abstraction’ regarding health system pressures

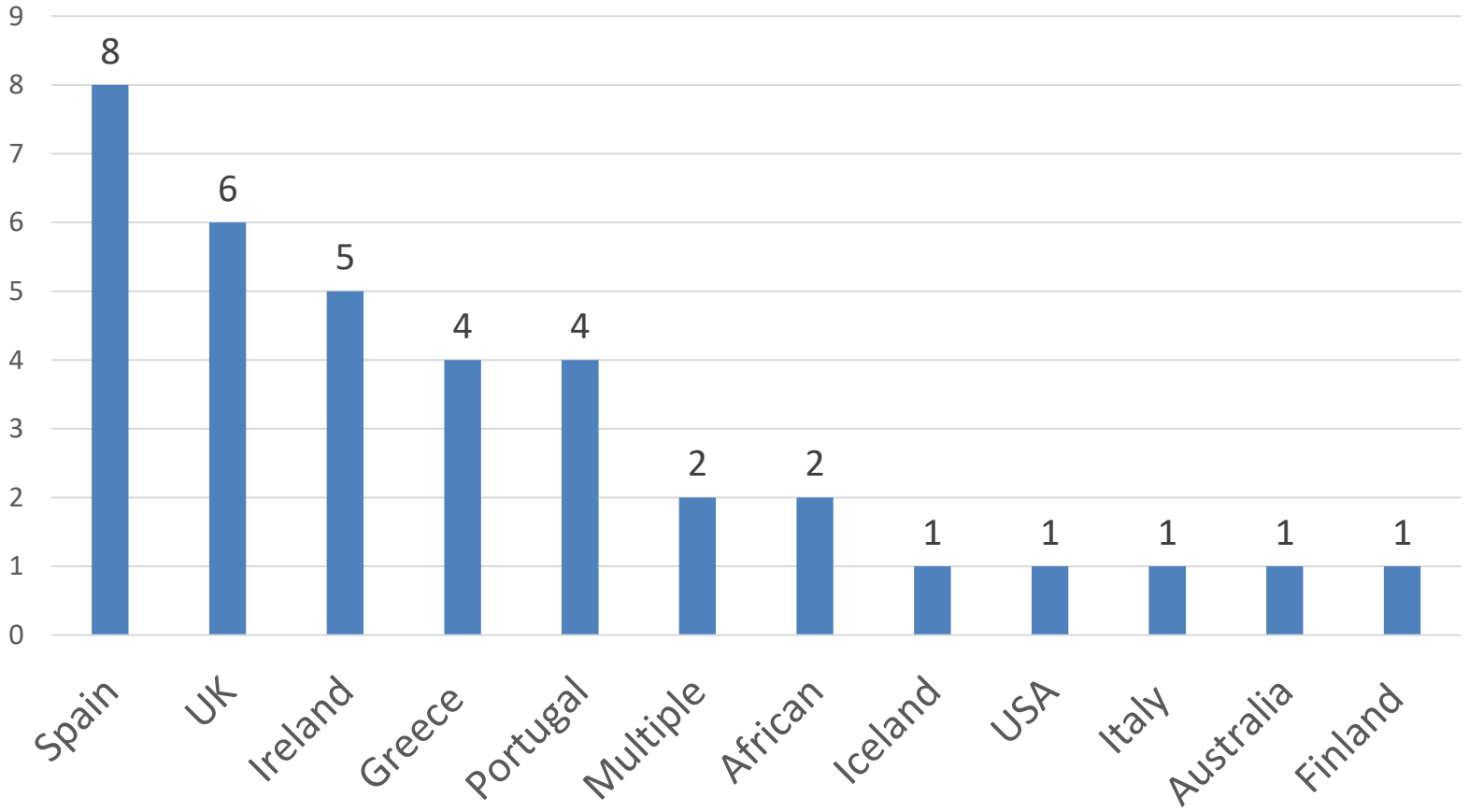
Descriptive analysis:

- Year
- Title
- Publication type
- Time period
- Geography
- Aim
- Design
- Methods
- Data source
- Outcomes Quant/Qual
- Outcomes Categorised
- Impact of Economic Crisis



Coding and Initial analysis

- **36 studies coded across 5 key categories**
  - Workforce / Decision Making / Access to care / *Impact / Service delivery*



Five broad CMOCs emerging from the analysis

1. **Top-down governance -** lack of ownership and buy-in from those delivering care and a distrust of the decision-making agenda.
2. **Perceived value shift** - a diminished view of the profession, apathetic and burnt-out.
3. **Powerless and detached-** a resistance to change and conflict between front line workers and policy decision makers / management.
4. **Working the system (access) -** strain on frontline workers, increases ER use but more stable health outcomes than originally predicted.
5. **Health-seeking behaviour change -** led to reduction in primary care usage, increased emergency care, medication mismanagement, delayed treatment

So what's this telling us about resilience?

Continue to build and refine theories with a view to inform and build resilience within the health system for future shocks

- When workforce under immense pressure – Trust paramount
  - decision making, political agenda, implementation of innovations/reform, patients
- Understanding what drives and motivates the workforce
  - Tensions revealed
  - Values / respect / solidarity
- Street level bureaucrats
  - Propensity and opportunity to influence policy implementation
  - Co-production, buy-in, ownership

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Thank you

4 broad CMOCs emerging from the analysis

1. **Top-down governance:** Health systems decision-making was highly influenced by outside agents (e.g. TROIKA) within the broader austerity agenda, while the lack of transparency about these outside influences, poor communication from policy-makers and management and lack of co-production with frontline staff, led to a lack of ownership and buy-in from those delivering care and a distrust of the decision-making agenda.
2. **Perceived value shift:** In context of restrictive fiscal policies (staffing, consumables, treatment options, available time with patient), a perceived value shift is evident for health professionals, from patient-focused to economic, with long-term consequences resulting in a diminished view of the profession, apathetic and burnt-out.
3. **Power game:** With the introduction of information systems to track activity and spending, health professionals perceive a loss of autonomy and decision making power, leading to a sense of powerlessness and detachment and ultimately a resistance to change and conflict between front line workers and policy decision makers / management.
4. **Working the system (access):** A sense of professional / moral duty or ethical decision making, solidarity with patients or fellow health professionals led to health professionals circumventing policy to deliver care (legal, informal referrals, treat regardless of ability to pay), but ultimately lead to strain on frontline workers, increases ER use but more stable health outcomes than originally predicted.
5. **Health-seeking behaviour change:** With the introduction/increase in OOPs, health-seeking behaviour change, compounded by health illiteracy, led to reduction in primary care usage, increased emergency care, medication mismanagement, delayed treatment