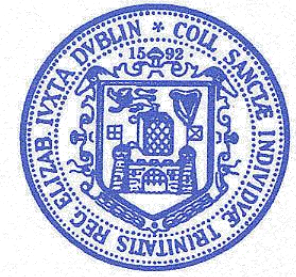


# Overview of the Resilience project: concept, research stages, initial findings

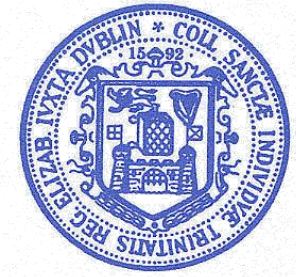
Steve Thomas

Associate Professor and Principal Investigator  
Centre for Health Policy and Management, TCD



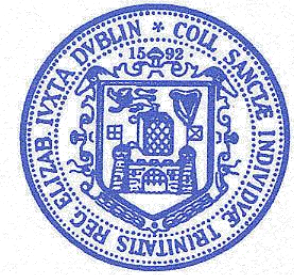
# The Resilience Project

- Resilience of the Irish Health System: Surviving and utilising the economic contraction
- Duration: Oct 2011 – March 2014
- <http://www.resilience4health.com/>
- Initial Collaboration:
  - Centre for Health Policy and Management, TCD
  - Economic & Social Research Institute
  - WHO, Health Systems Strengthening, Barcelona
- Broader Collaboration
  - PIGS and European Observatory



# Knowledge Exchange

- Year 1 Resilience workshop 2012
- Input into the Rapid Response Report 2012
- KEDS event and Policy Roundtable 2013
- Input into Oslo II review
- Extensive dissemination at local conferences and workshops
- Today



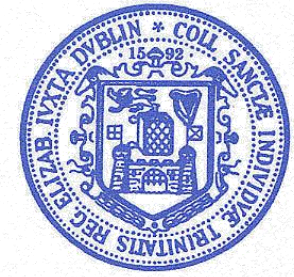
# Peer-reviewed Publications

## Published

1. Steve Thomas, Conor Keegan , Sarah Barry , Richard Layte, Matt Jowett and Charles Normand, A framework for assessing health system resilience in an economic crisis: Ireland as a test case, *BMC Health Services Research*, 13, (450), 2013, p1-8 (**Highly accessed**)
2. Sara Burke, Sarah Barry, and Stephen Thomas. “The economic crisis and the irish health system: assessing resilience” in, editor(s) Hou, Xiaohui, Edit V. Velényi, Abdo S. Yazbeck, Roberto F. Iunes, and Owen Smith, *Learning from Economic Downturns: How to Better Assess, Track, and Mitigate the Impact on the Health Sector. Directions in Development.*, Washington DC, World Bank, 2013,
3. Conceicao Portela, Steve Thomas, Impact of the economic crisis on healthcare resources - An european approach, *International Journal of Healthcare Management*, 6, (2), 2013, p104 – 113
4. Conor Keegan, Steve Thomas, Charles Normand, Conceição Portela, Measuring recession severity and its impact on healthcare expenditure, *International Journal of Health Care Finance and Economics*, 13, (2), 2013, p139 – 155
5. Thomas S, Keegan C, Barry S, Layte R. The Irish health system and the economic crisis. *The Lancet*, Volume 380, Issue 9847, Pages 1056 - 1057, 22 September 2012
6. Thomas S, Burke S. Coping with austerity in the Irish health system. *Eurohealth*. 2012. Vol 18, (1), 2012, p7 - 9

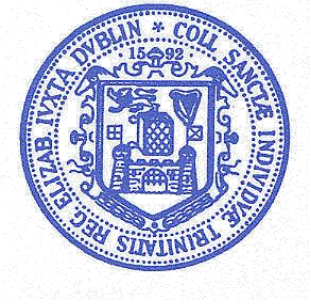
## Forthcoming

1. Steve Thomas, Sara Burke, Sarah Barry , “The Irish health care system and austerity: Sharing the pain”. *The Lancet*
2. Anne Nolan, Sarah Barry, Sara Burke, Steve Thomas, “The impact of the Financial Crisis on Health and the Health System in Ireland” Prepared for WHO and the European Observatory on Health Systems and Policies



# International Presentations

1. "Preparedness Concepts", Preparatory Meeting for WHO High Level Technical Meeting "Health Systems in Times of Global Economic Crisis: An update of the situation in the WHO European Region", 31<sup>st</sup> Jan-1<sup>st</sup> Feb 2013, Barcelona, Spain
2. "Irish Case Study for Oslo II", Preparatory Meeting for WHO High Level Technical Meeting "Health Systems in Times of Global Economic Crisis: An update of the situation in the WHO European Region", 31<sup>st</sup> Jan-1<sup>st</sup> Feb 2013, Barcelona, Spain
3. 'Building Foundations in an Earthquake - The Case of Ireland' 'Workshop on Economic Crisis and Health Systems' Portuguese Association of Health Economics, Universidade Nova de Lisboa, 14th January 2013. Lisbon, Portugal
4. 'From Boom to bust: Ireland, the economic crisis and health policy responses'. Plenary session of the 8th PanHellenic Congress on Management, Economics and Health Policy Athens, 14 December 2012. Athens, Greece.
5. "The Economics Crisis and the Irish Health System: Assessing Resilience" The World Bank and the OECD, 27<sup>th</sup> September 2012, OECD Headquarters Paris, France.
6. "Universal coverage from Ireland's perspective and NHI trends in other countries." Hospital Association of South Africa, 19<sup>th</sup> September, 2012, Cape Town International Conference Centre, Cape Town, South Africa
7. The Economic Crisis and the Irish Health System: Assessing Resilience. Presentation and Organised session at the European Conference on Health Economics conference in Zurich, Switzerland, July 2012
8. "The Resilience of Health Systems: Concepts and Measures," Countries in Crisis Network, 24<sup>th</sup> May 2012, Lisbon, Portugal.
9. "The Economics Crisis and the Irish Health System: Assessing Resilience". European Health Policy Group, Spring meeting 2012, Copenhagen.
10. Portuguese National Observatory, "Economic crisis and the Irish Health system: The story so far." 15<sup>th</sup> June 2011, Gulbenkian Foundation, Lisbon. Portugal

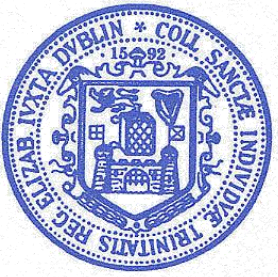


# Project Aims

## Overall Aim:

to identify best practice guidelines and strategies for how the Irish health system can

- withstand the current crisis (in terms of protecting resources for health and managing resource scarcity well)
- benefit from the opportunities that the recession brings to pursue reform and alleviate system bottlenecks.
- build the resilience of the Irish health system in anticipation of future crises



# A **shock** to the system

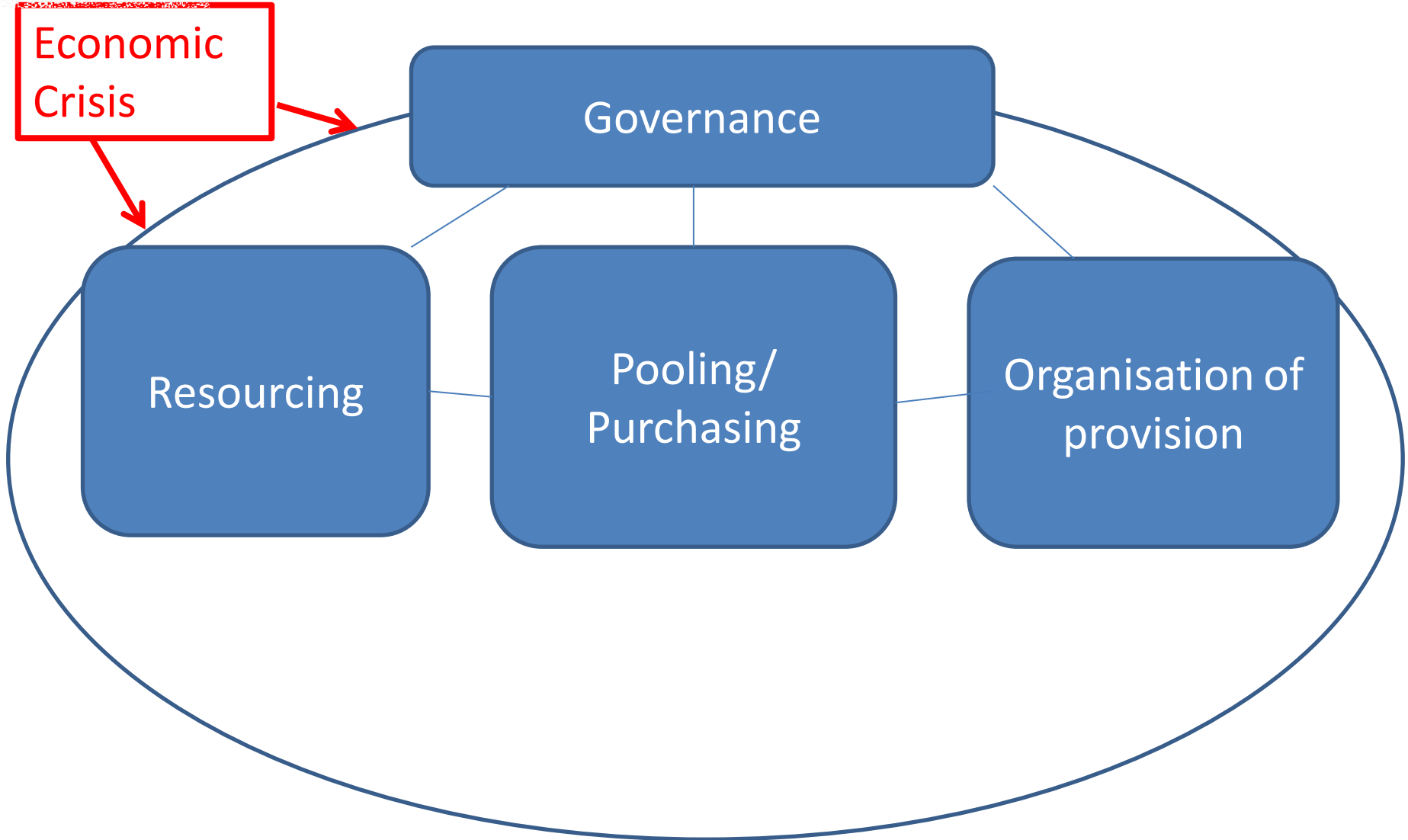
Economic  
Crisis

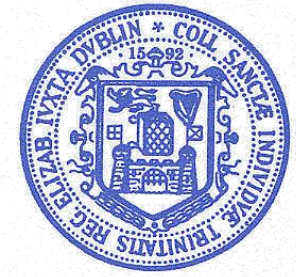
Governance

Resourcing

Pooling/  
Purchasing

Organisation of  
provision

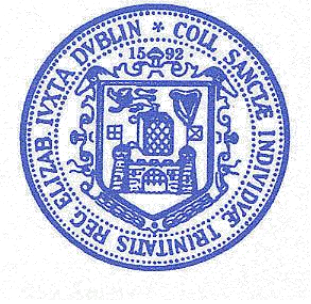




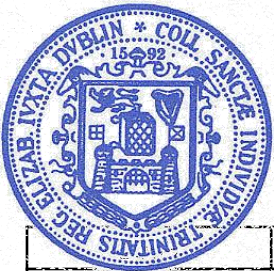
# Health System Resilience

- 1. Financial resilience:** the protection of funds for health care, and particularly that of the vulnerable, in the face of economic contraction.
- 2. Adaptive resilience:** the ability of government and providers to manage the system with fewer resources, through efficiencies, while not sacrificing key priorities, benefits, access or entitlements.
- 3. Transformatory resilience:** the ability or capacity of government to design and implement desirable and realistic reform when the current organisation, structures and strategies are no longer feasible.








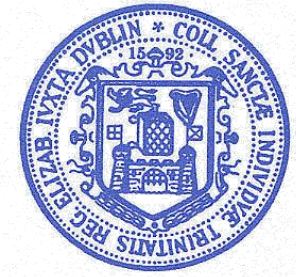


# Phase 1 Results



# Health Policy Timeline

	2009			2010	2011	
Emergency Budget (Oct)	Supplementary Budget (April)	Supplementary Budget (November)	 Budget (Dec)	 Budget (Dec)	New Programme for Government (Mar)	 Budget (Dec)
<p>(i) Without Medical Cards: Increased Charges for IP Beds; Increased ED Charges; Increased Long-Stay Charges; Increased deductibles for drug payment scheme</p> <p>(ii) With Medical Cards: <b>Removal of entitlement for over-70s</b></p> <p>Overall Health Budget for 2009 up by €200 million (1% increase)</p>	<p>Capital spending reduced by 26%</p> <p>Tax relief on nursing homes and hospitals ended</p> 	<p>Extra funds made available to cover extra medical cards needed (€230 million)</p>	<p><b>Savings of over €1 billion</b> (€4bn from total budget):</p> <ul style="list-style-type: none"> <li>• Wage Reductions (5-15%) and lower contract fees (-€659 million)</li> <li>• Introduction of 50c item charge on prescriptions for medical card holders</li> <li>• Cut of €30million in spending on dentistry for those on medical cards</li> <li>• Increase drug reimbursement threshold to €120 per month</li> </ul>	<p><b>Savings of €746 million</b> (€2.2 billion from total budget). Cut of 6.6% to HSE:</p> <ul style="list-style-type: none"> <li>• Voluntary redundancy and early retirement (€123 million)</li> <li>• Cuts in drug spending and fees (€380 million)</li> <li>• Cuts in non-core pay costs, reduced agency and locum staffing (€200 million)</li> <li>• Administration Cuts (€43 million)</li> </ul>	<p>Commitment to UHI single tier system</p>	<p><b>Savings of €543 million</b> (€2.2 billion from total budget)</p> <ul style="list-style-type: none"> <li>• Pay cost containment (reduction in staffing, overtime, agency costs etc.) - €145m</li> <li>• Reduction in procurement costs - €50m</li> <li>• Increased generation and collection of private income- €143m</li> <li>• Demand led Schemes- pharmaceutical reductions, DPS increase from €120-132 per month etc. - (€124m)</li> </ul> <p>+ <b>making good the hospital deficits (€200m)</b></p> 

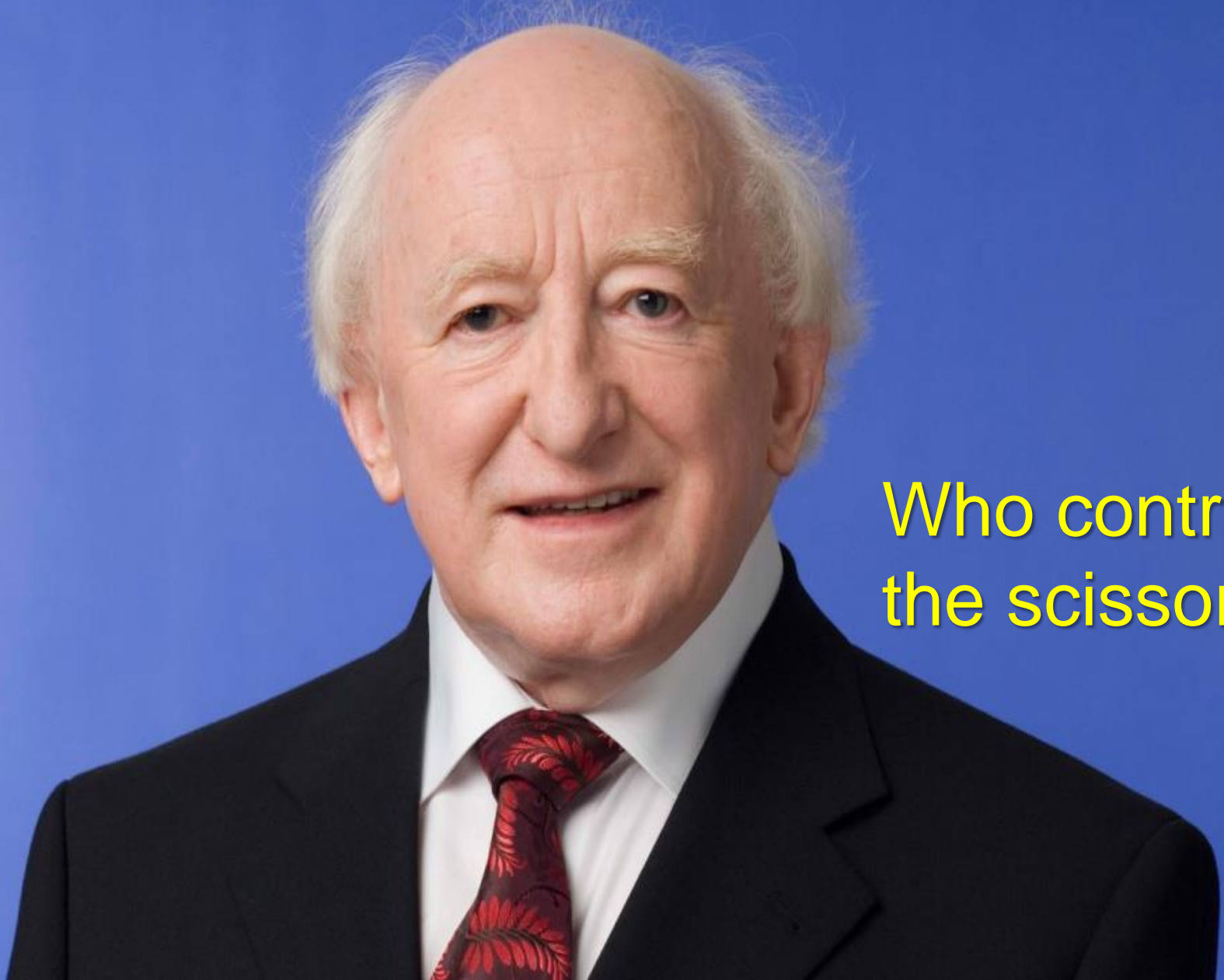


# Phase 1 Results (up to mid 2012)

- Mix of initial panic and recession dividend
- Panic – removal of free care for over 70s, prescription charges, hiking of access payments
- Efficiencies – lower unit costs, increased throughput (more with less)
- Vision – Programme for Government presenting ambitious transformation for universal care

Where to cut now?

Who controls  
the scissors?



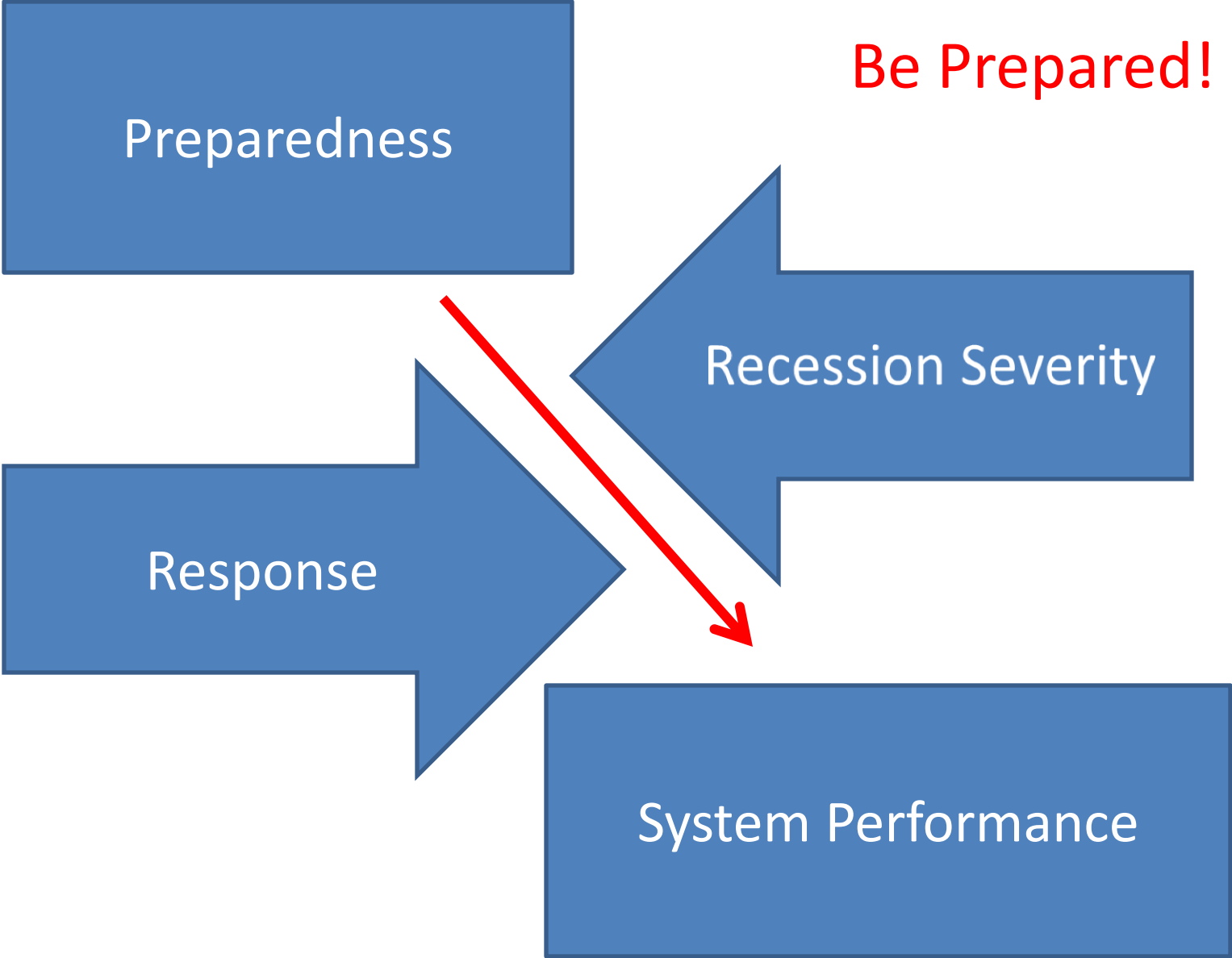
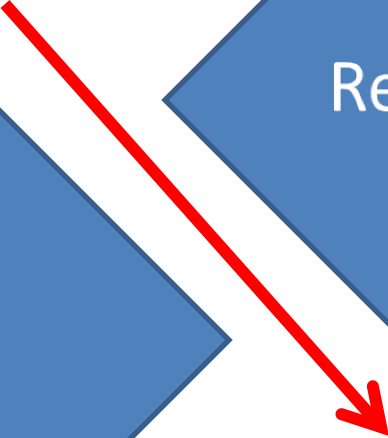
Be Prepared!

Preparedness

Recession Severity

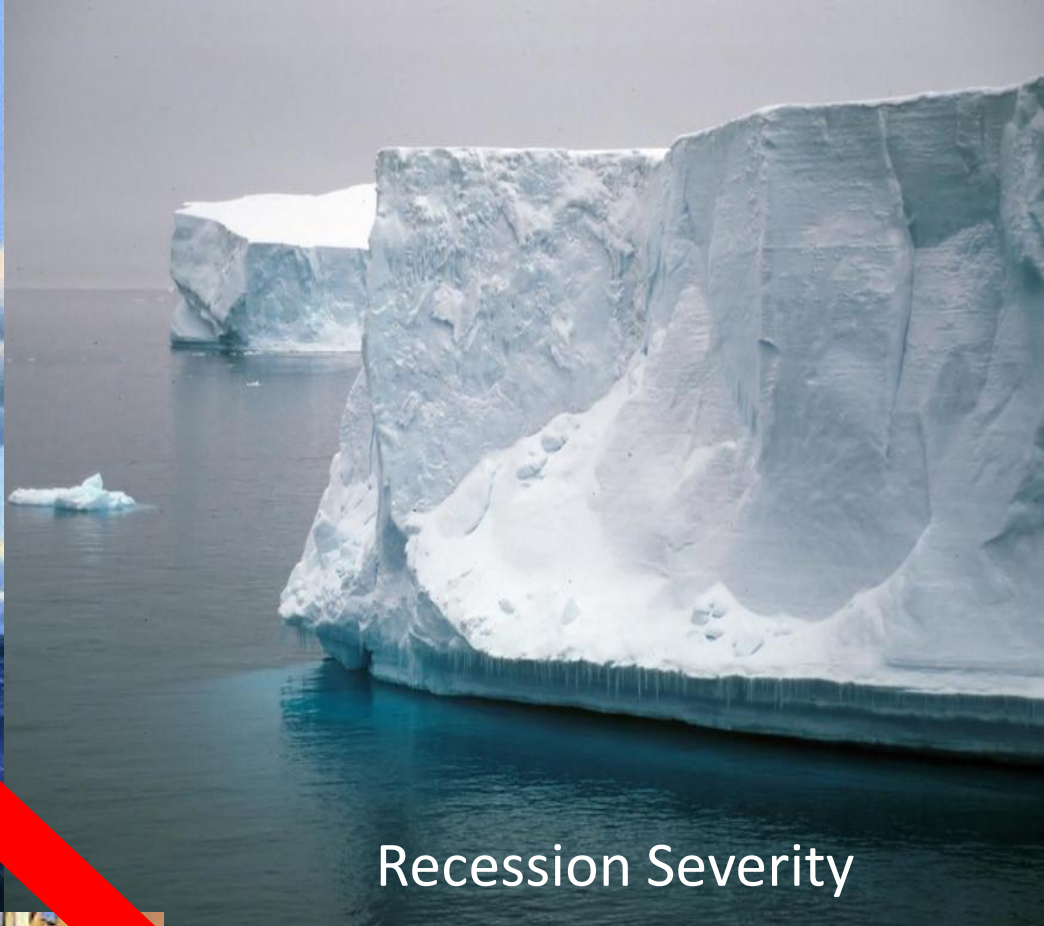
Response

System Performance





Preparedness



Recession Severity



Response

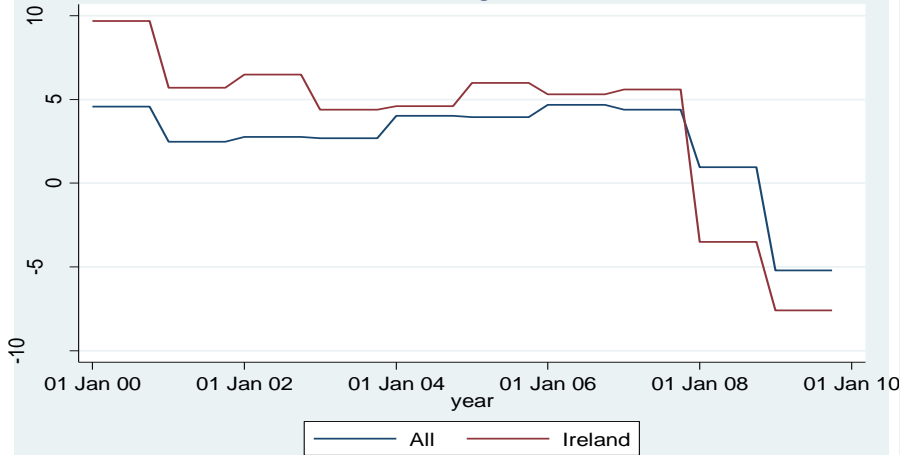


**Outcome?**

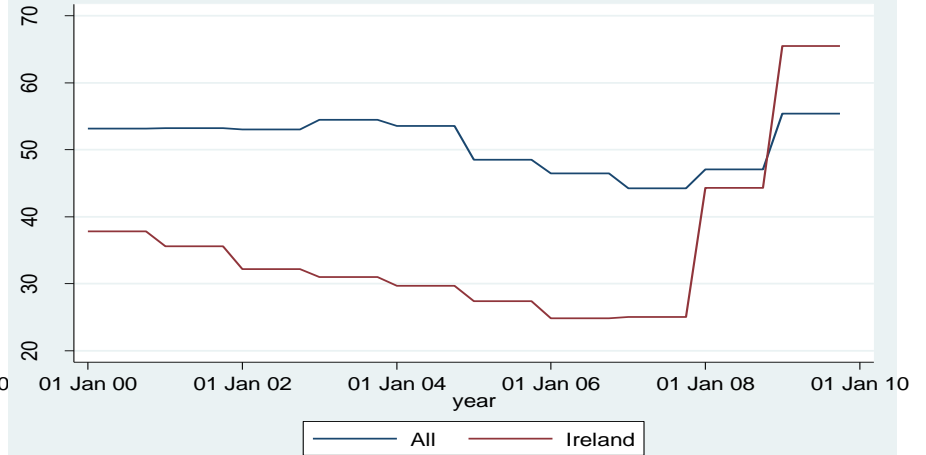


# Key Indicators: The 00s

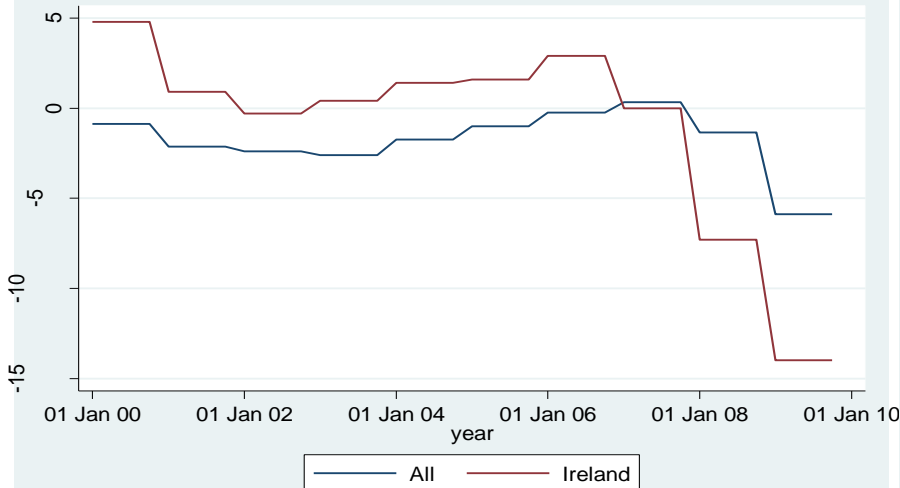
Mean GDP growth rate



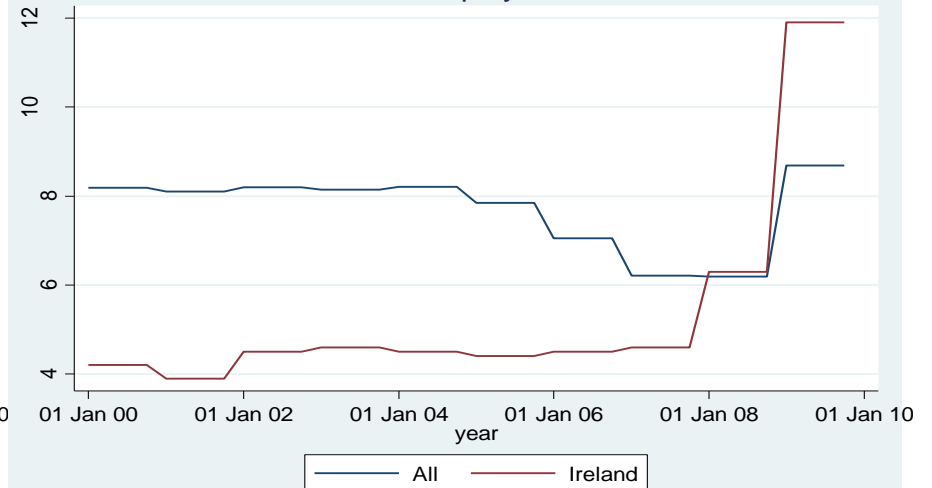
Mean Debt Levels

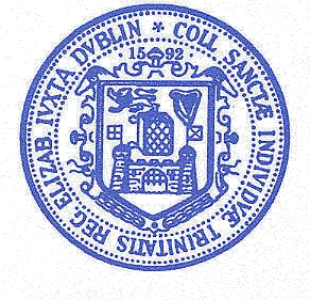


Mean General Government Deficit

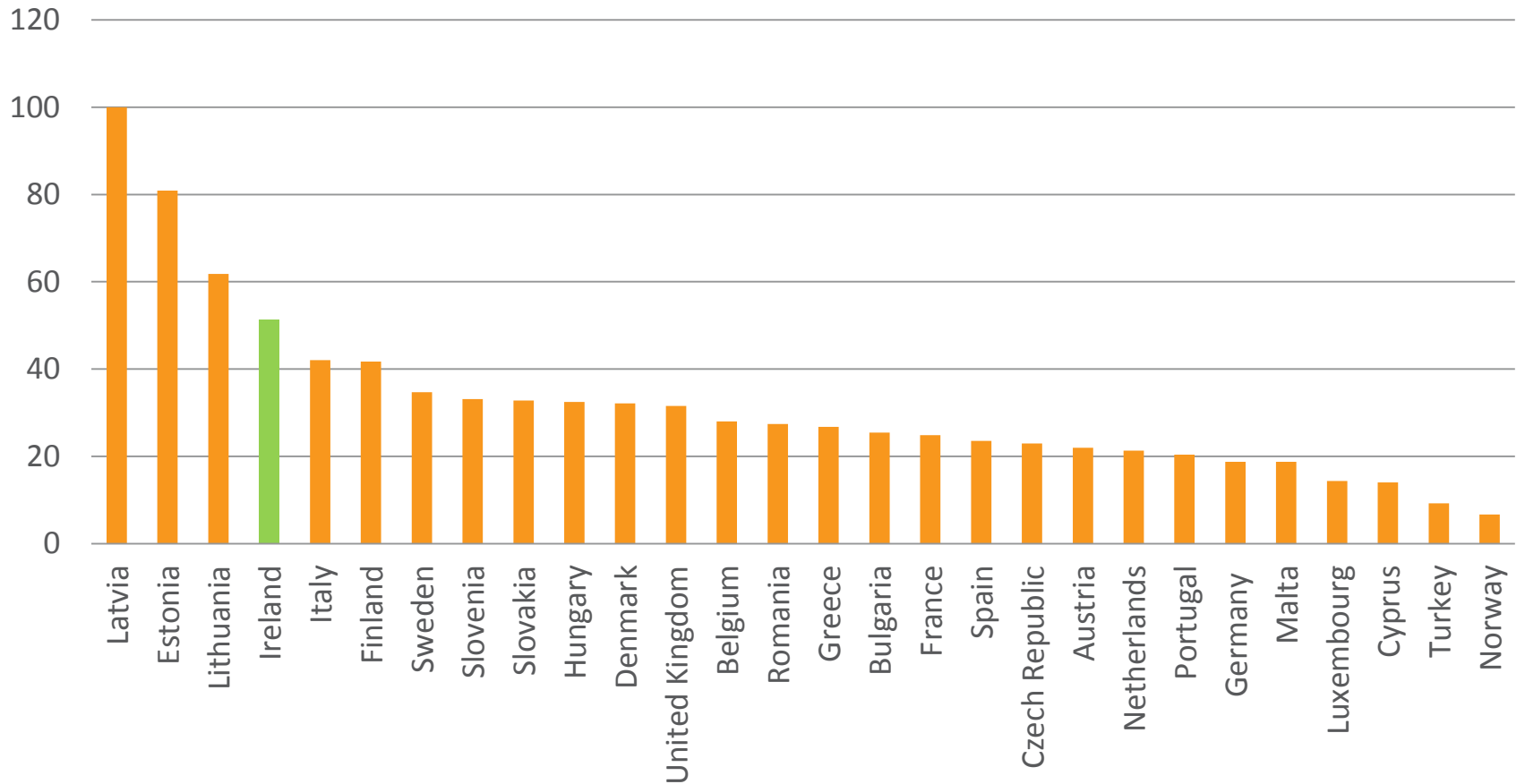


Mean Unemployment Rate

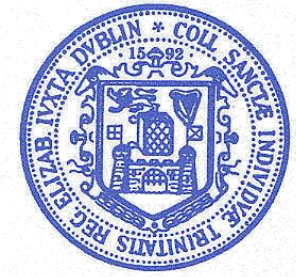




# Recession Severity Results 2008-2009







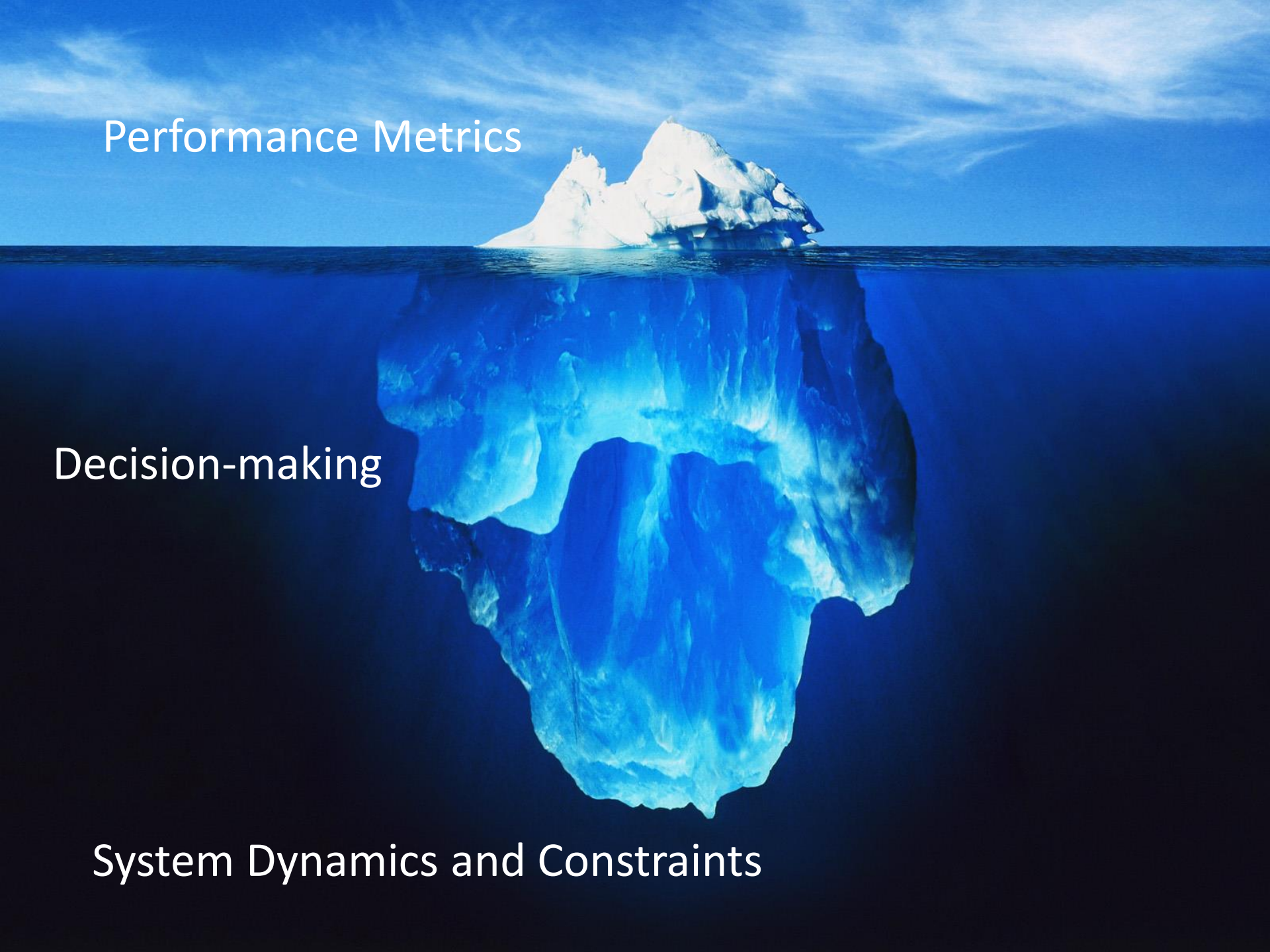
# Key Questions for Phase 2

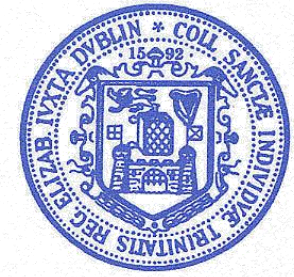
- How does duration of austerity affect performance?
- What are the key issues, choices and constraints facing decision-makers?
- Who is in charge?
- How do we measure transformatory resilience?
- Can we reach universal care?

Performance Metrics

Decision-making

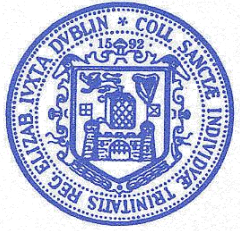
System Dynamics and Constraints





# Today's Programme

- 9.55 Presentation of indicators of health system performance - ***Dr Sara Burke***,
- 10:10 Managing priorities in a recession – findings from a survey of managers and qualitative interviews with service managers – ***Dr Sarah Barry***,
- 10:40 Interviews with senior policy makers (wave 1 and wave 2) –***Dr Sara Burke***
- 10.55 Overall findings and reflections in context of current health reform  
– ***Dr Steve Thomas***
- 11:15 Questions and Answers
- 11:30 Coffee
- 12:00 Health policy responses to the financial crisis: Ireland in the European context - ***Dr Philipa Mladovsky, Research and Teaching Fellow in Health Policy, LSE Health and WHO European Observatory on Health Systems and Policies, London School of Economics***
- 12:40 Questions and Answers
- 1.05 Reflection on the day: ***Leo Kearns, HSE National Lead, Transformation and Change***
- 1:15 Lunch

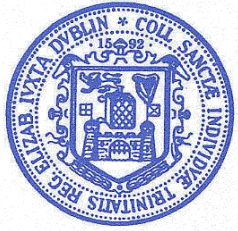


# Indicators of performance: what they tell us and what they don't

Dr Sara Burke

Research Fellow

Centre for Health Policy and  
Management, Trinity College Dublin



# Methods

- Gathered from a range of publicly available data sources
  - HSE Annual Reports & HSE National Service Plans
  - HSE PCRS Statistical Analysis of Claims and Payments 2012
  - HSE monthly Performance Assurance Reports & Management Data reports
  - Some specific requests for information
  - Department of Finance/PER Revised Estimates
  - Health Insurance Authority data
- Health warning re change of definitions
- [Resilience4health website](#)

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# Resilience Project

School of Medicine

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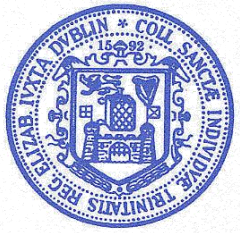
## Indicators

The Resilience project is collecting indicators of health system activity over the last eight years. The indicators are publicly available data from a wide range of different sources. Below are some graphs using the indicators to illustrate what is happening in the health system from the available data.

We also provide the [data in a spread sheet here](#) so that people can do their own analysis from the data. If using the data, we request that you credit the resilience4health.com project in the Centre for Health Policy and Management, Trinity College Dublin. We will introduce new indicators and update the data as new data become available.

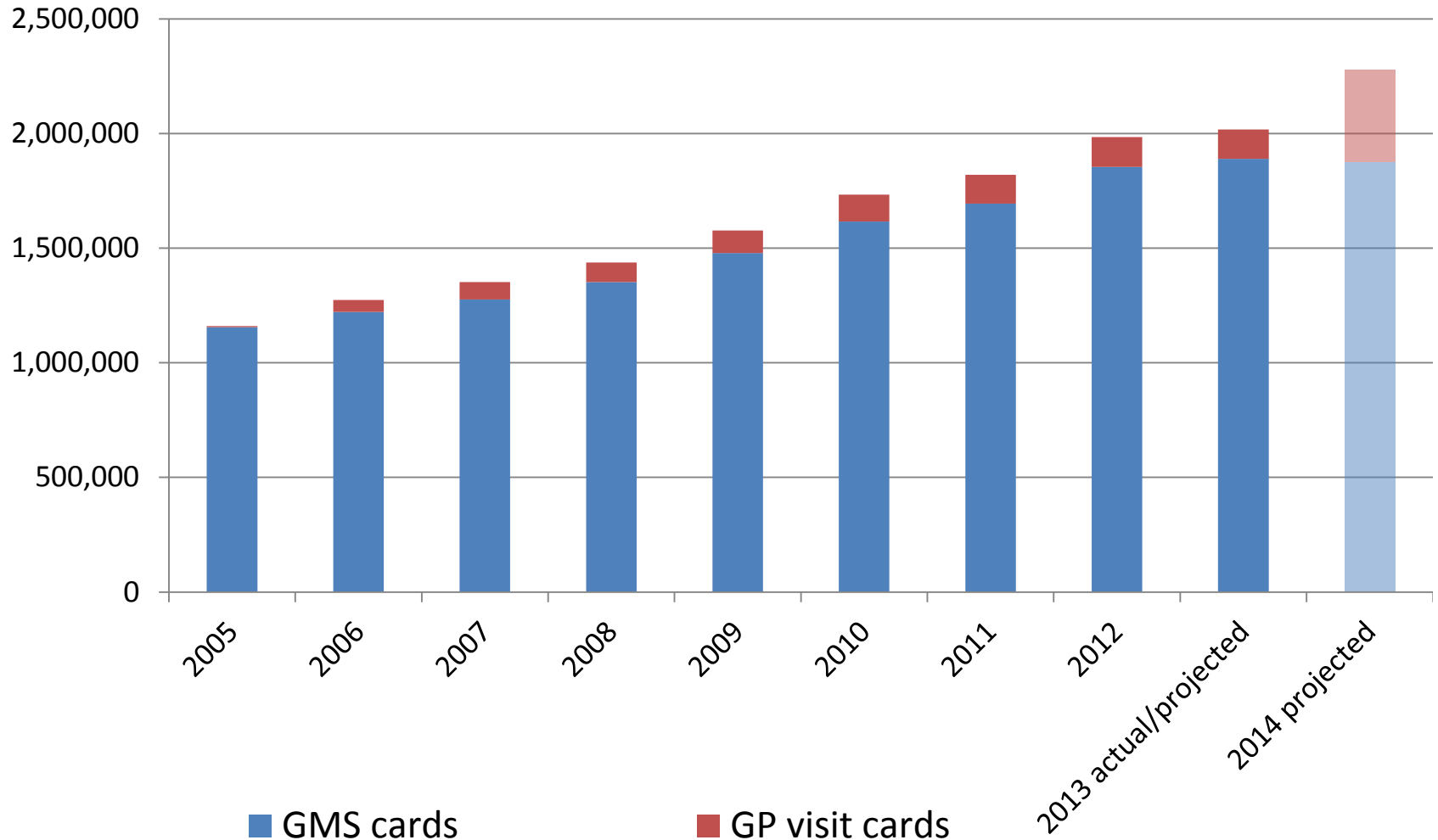
### Graph 1 - Health budget and population growth 2005-2013

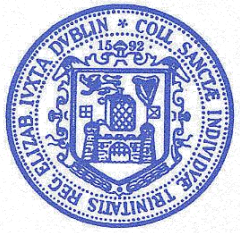
The health budget grew steadily in the 2000s. Despite the onset of the economic crisis in 2007 and 2008, the health budget increased in both those years and was not cut until 2009. This graph shows the increase in the health budget until 2009 and the decline in the health budget since then. This is in contrast to the growth in population, especially the growth in population over 65 years of age, who require greater levels of health and social care. The graph is indexed at 2009 and shows the change in budget and population before and after 2009.



# Resilience indicators

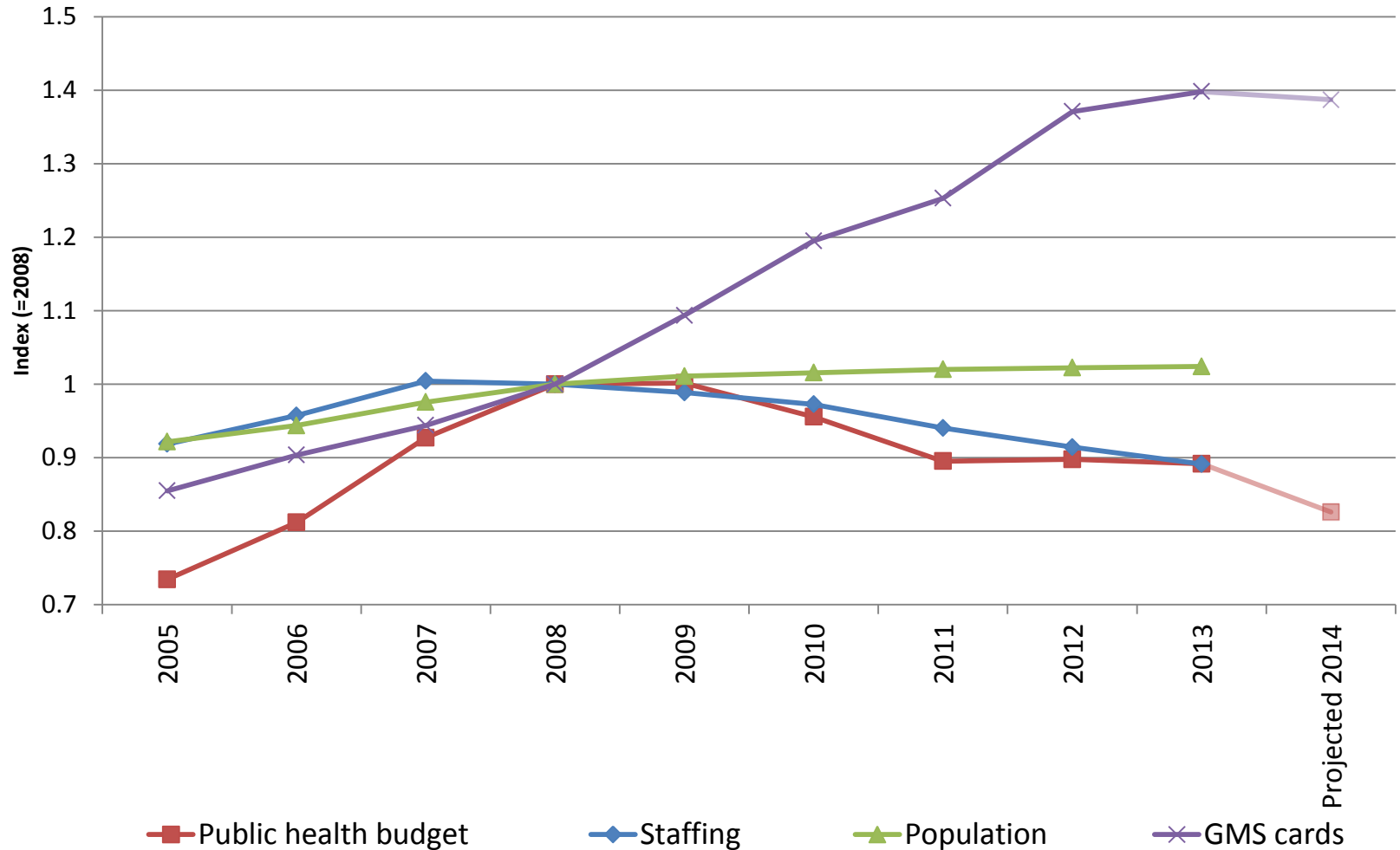
Numbers of medical cards & GP only cards 2005-2014



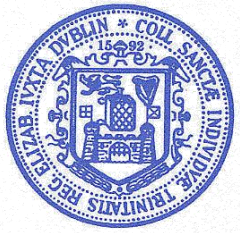


# Resilience indicators

Public health budget, staffing, population and medical card numbers 2005-2014

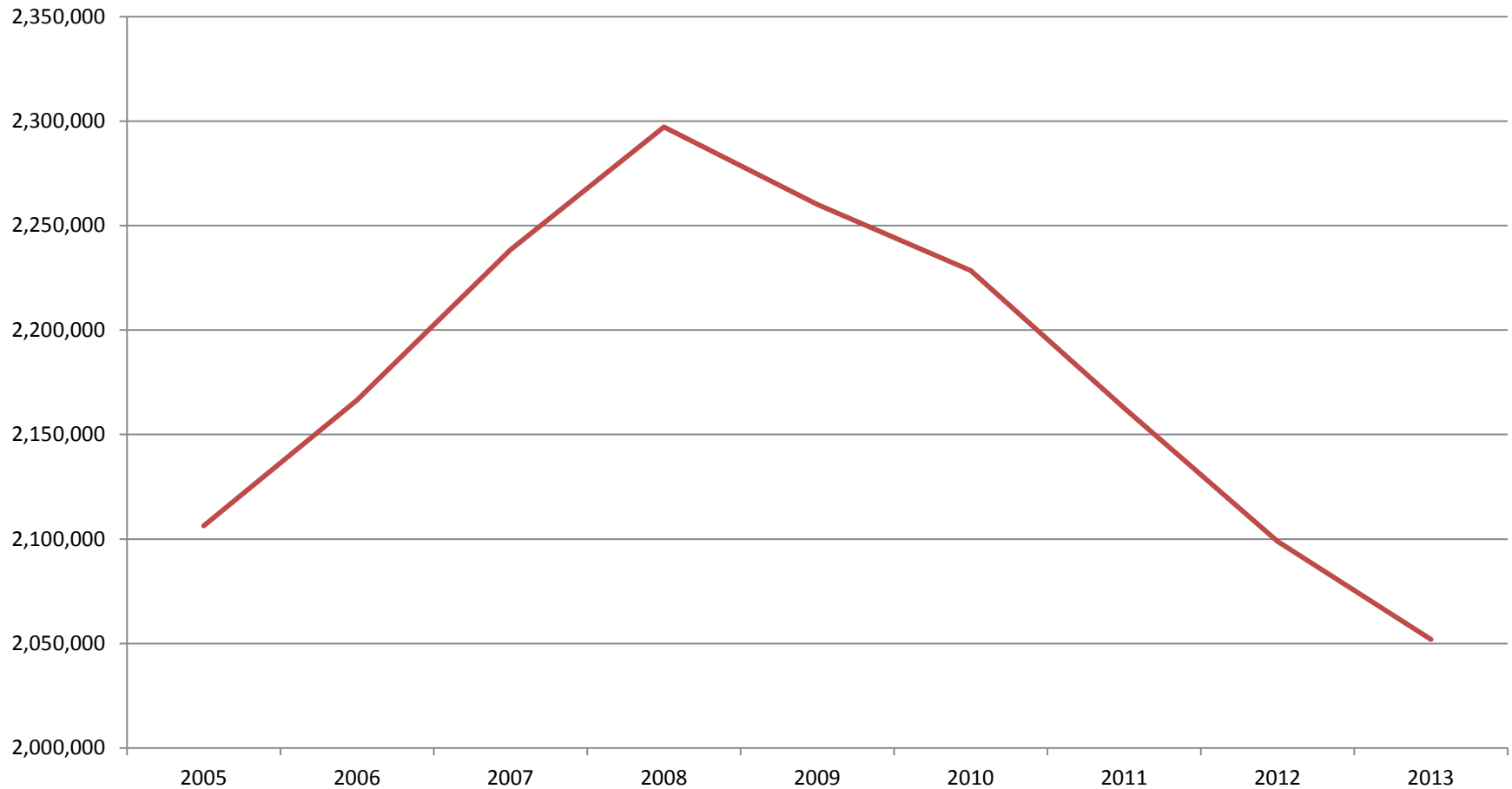




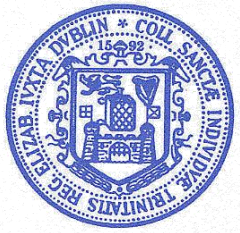


# Resilience indicators

Numbers covered by private health insurance 2005-2013

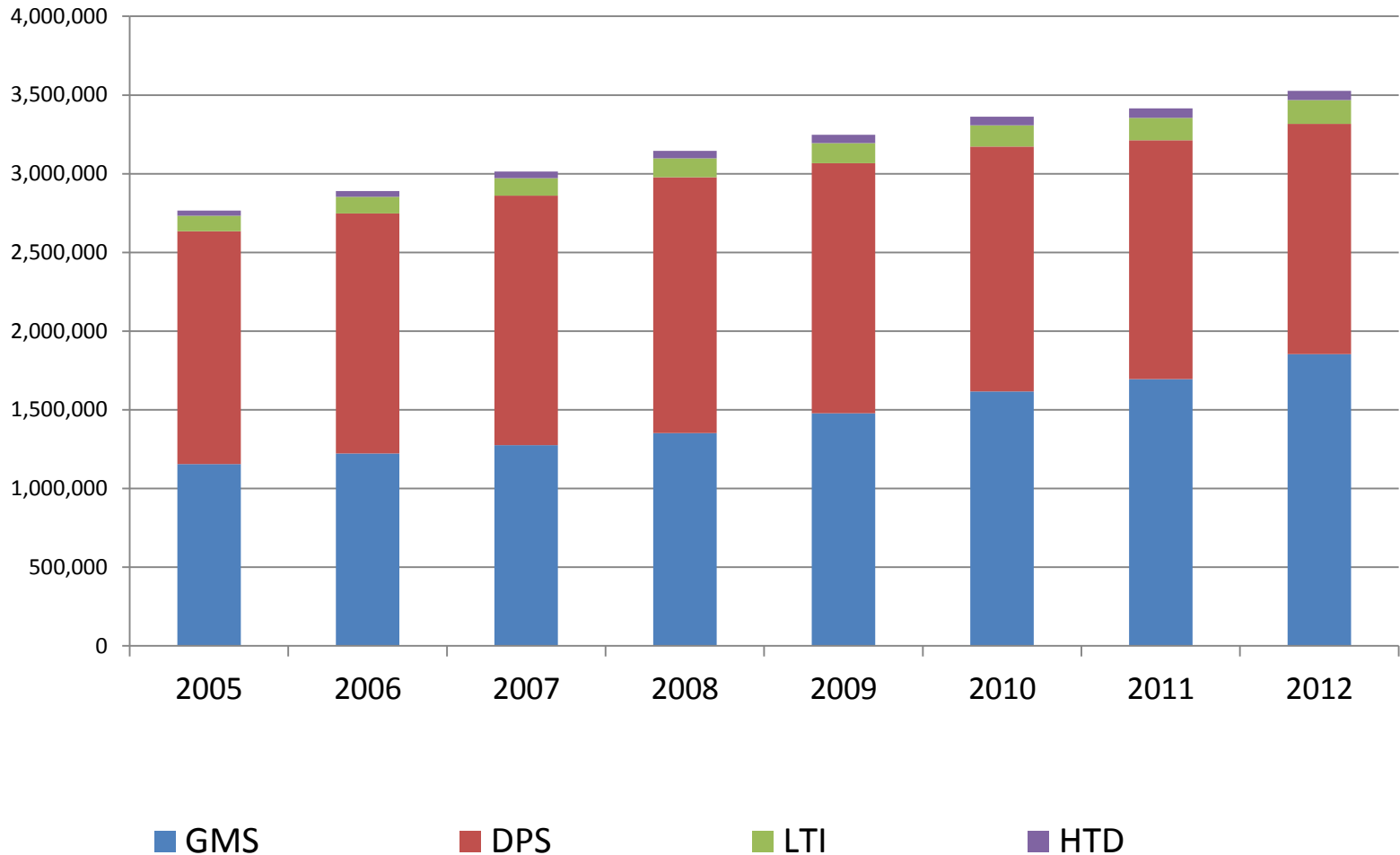


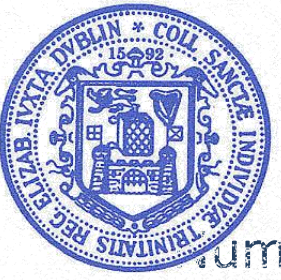
— PHI inpatient cover



# Resilience indicators

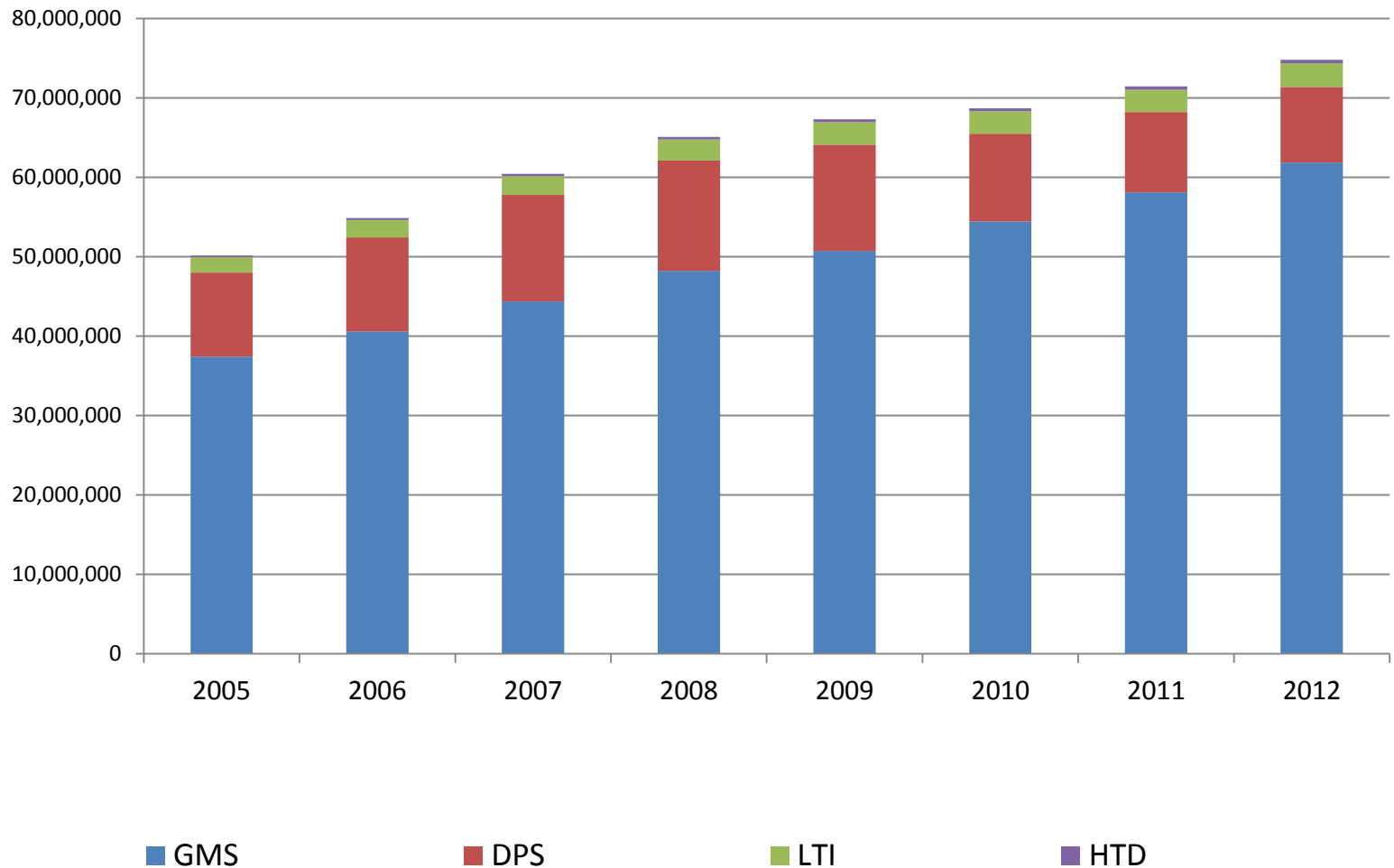
Numbers covered public health schemes 2005-2012

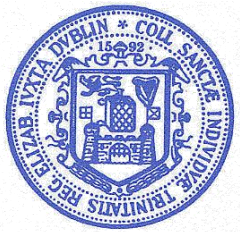




# Resilience indicators

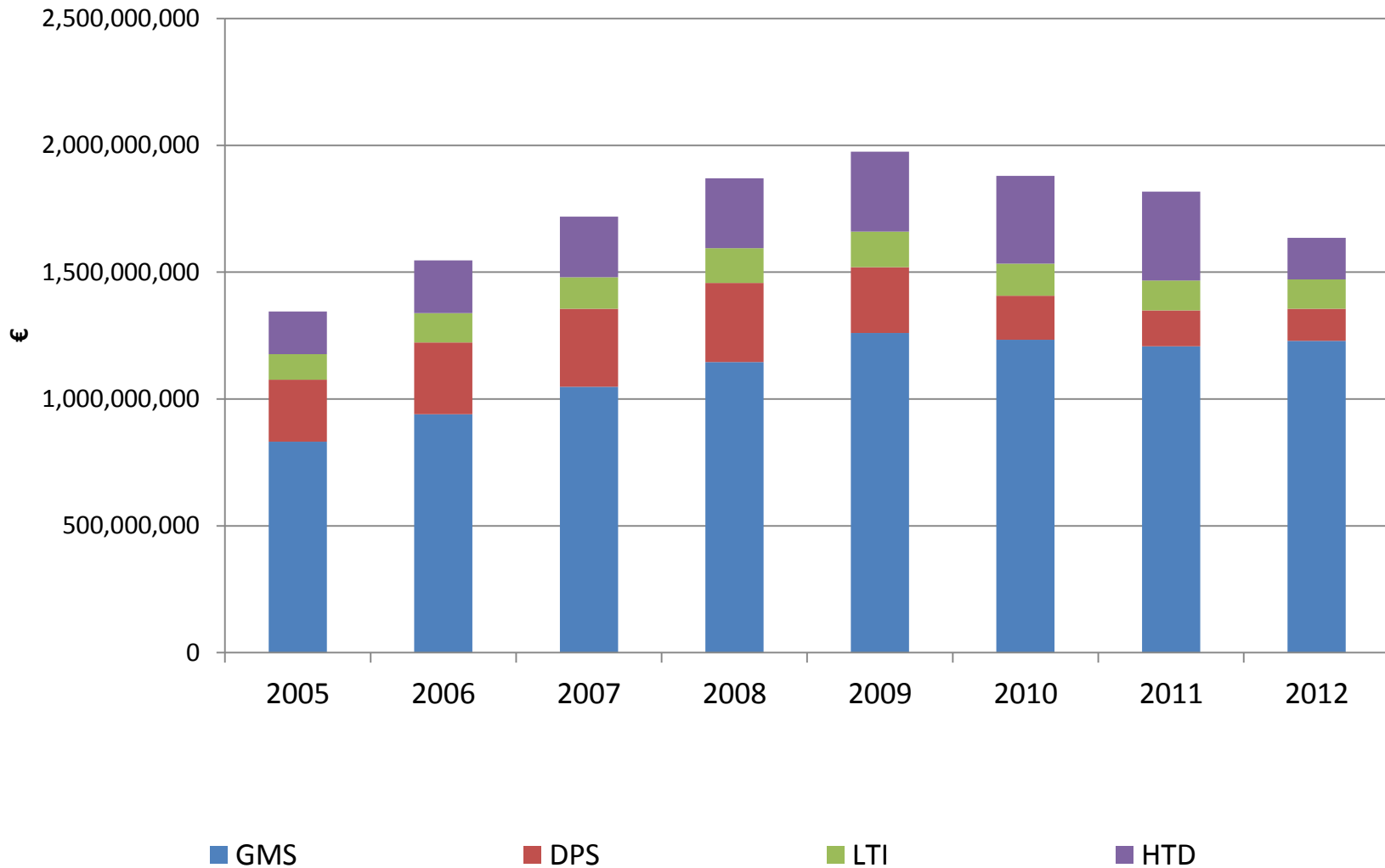
Numbers of items dispensed through public health schemes 2005-2012

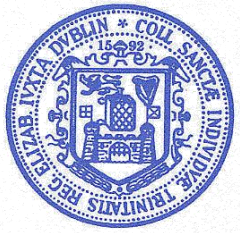




# Resilience indicators

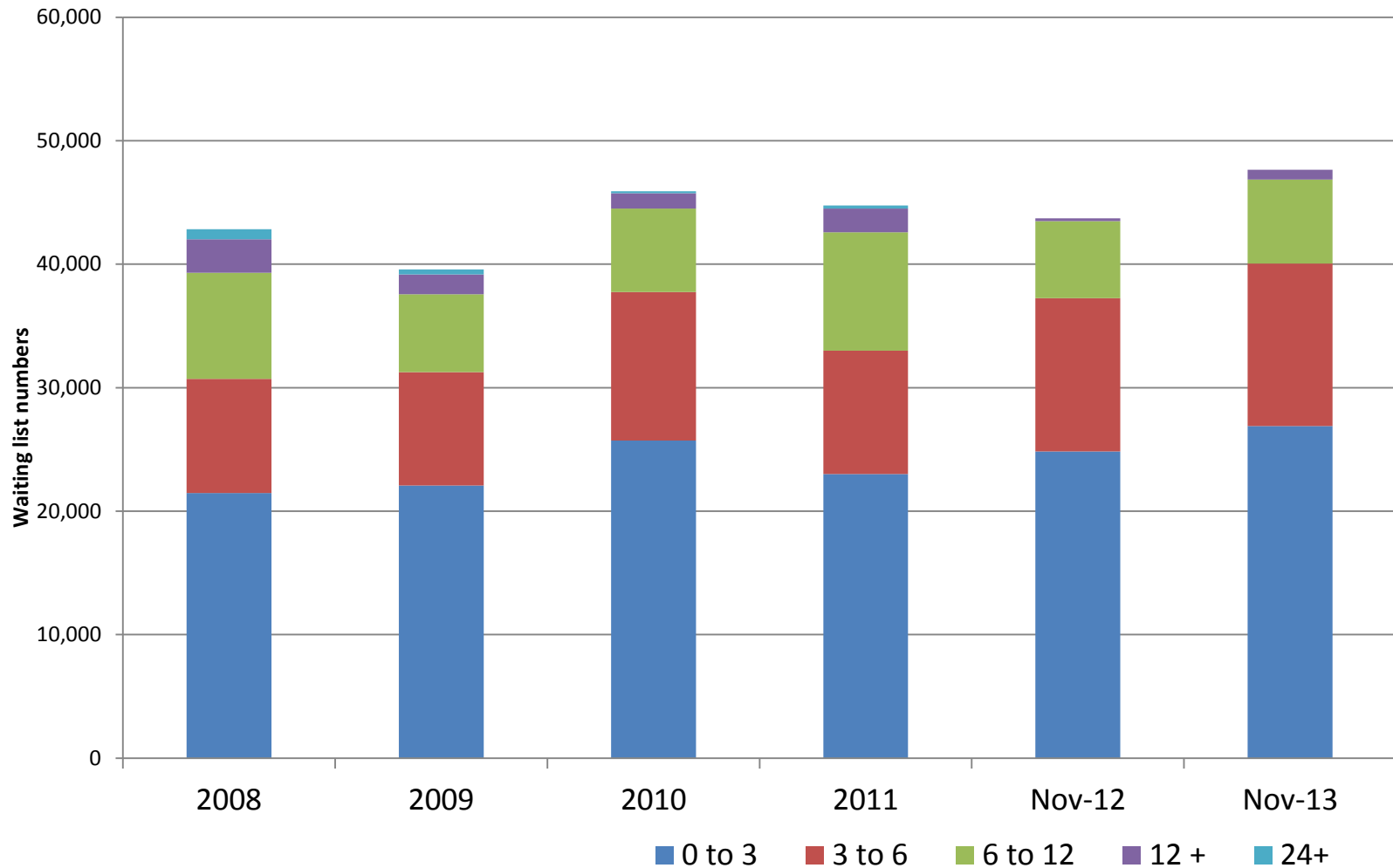
Cost of drugs under public health schemes 2005-2012

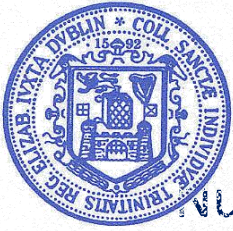




# Resilience indicators

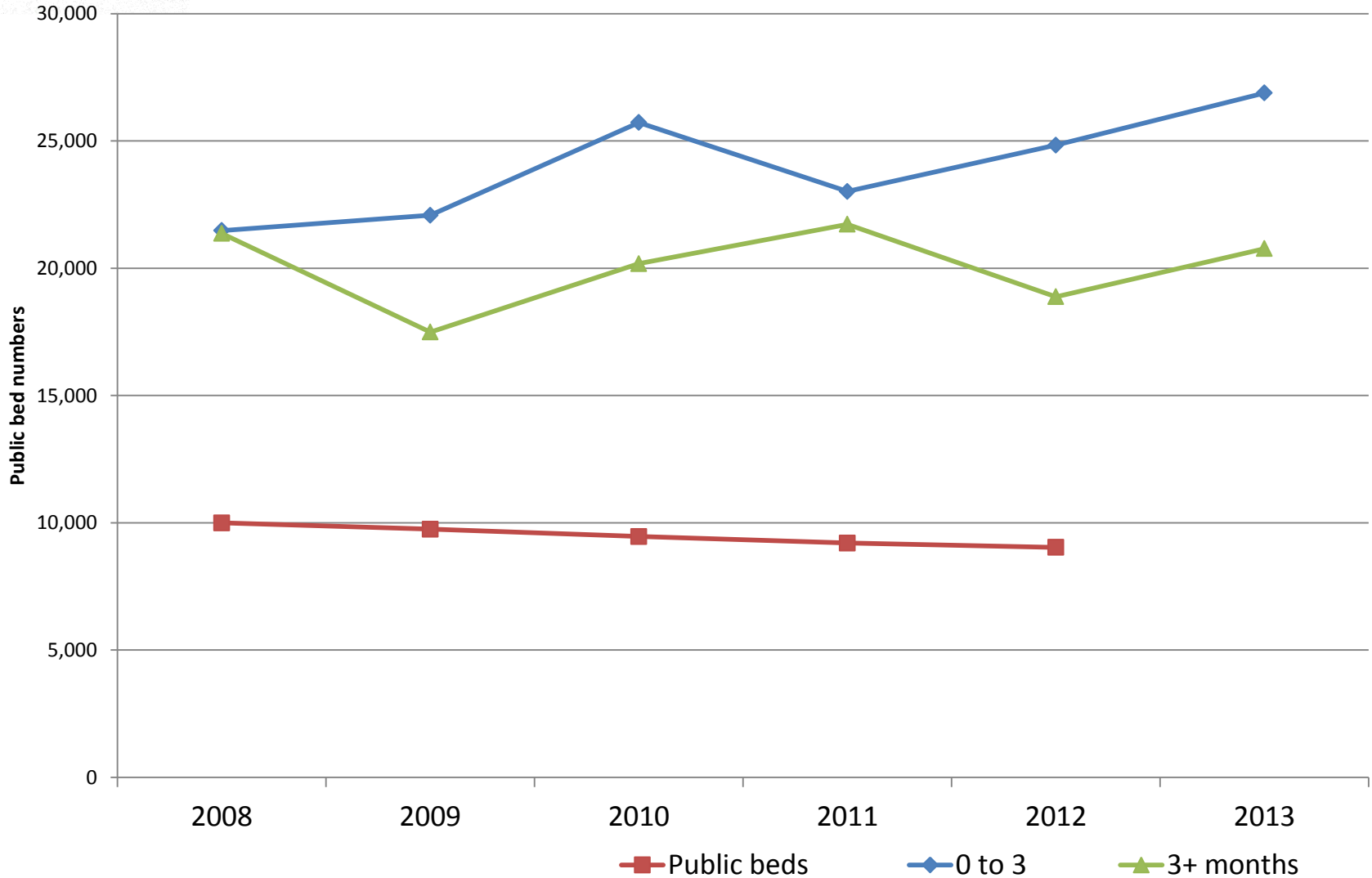
Numbers of adults & children waiting for inpatient & daycase hospital treatment 2008 to 2013





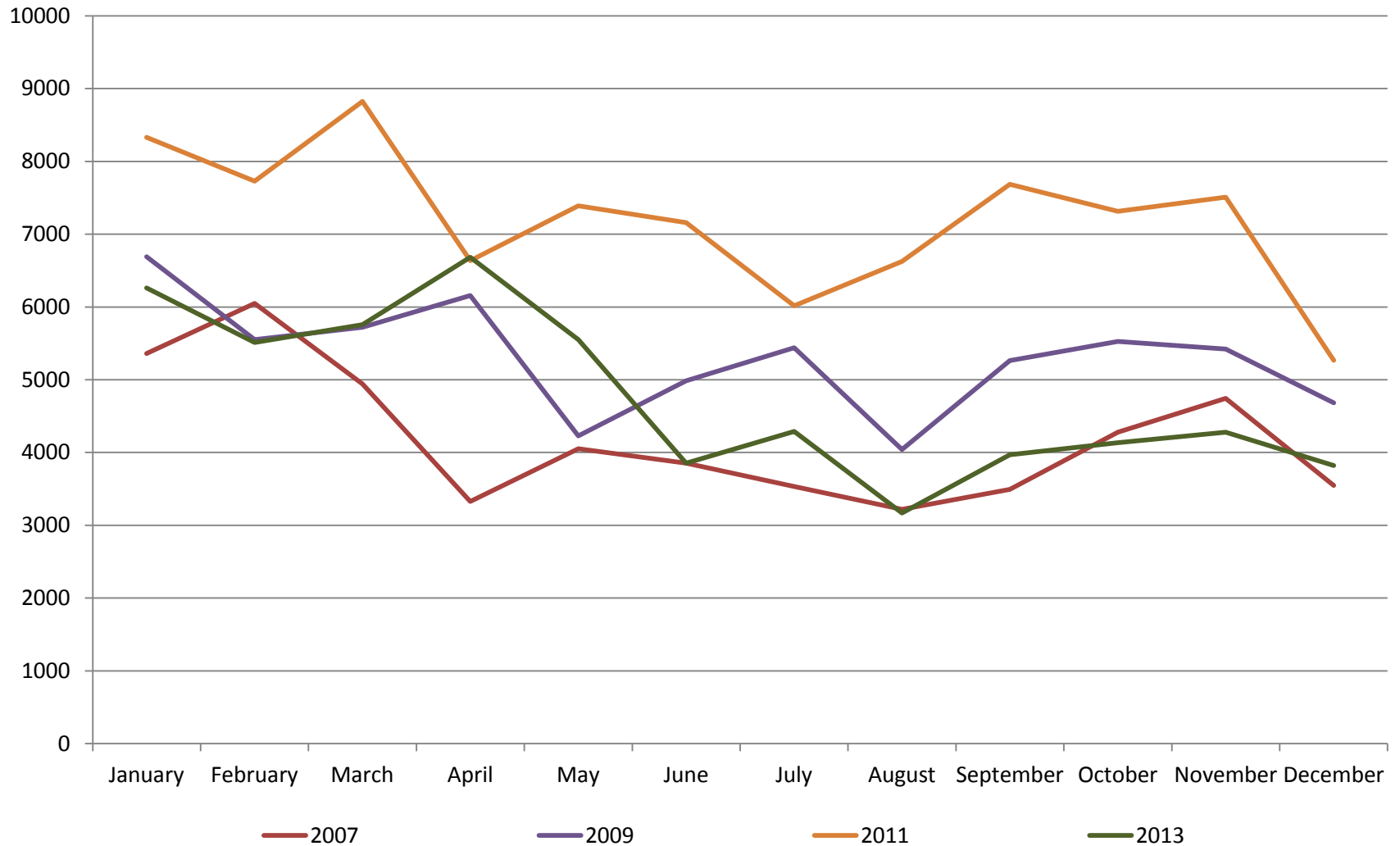
# Resilience indicators

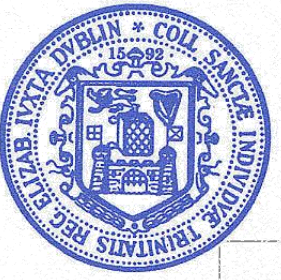
Numbers of hospital beds and numbers waiting 2008-2012



# Resilience indicators

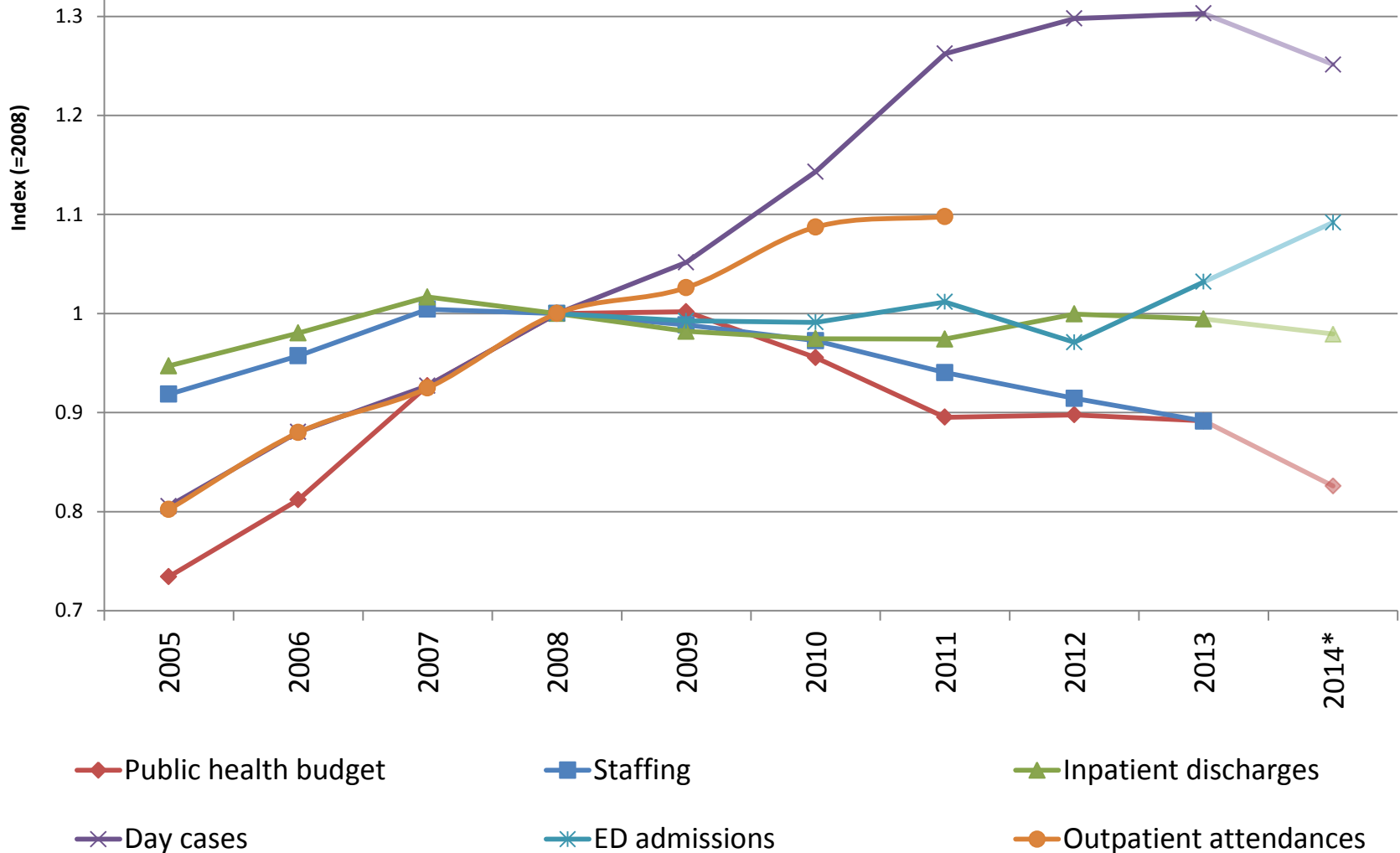
## Numbers on trolleys 2007/9/11/13



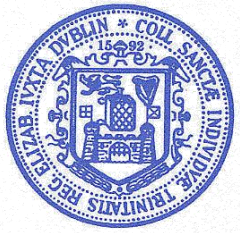


# Resilience indicators

## Change in budget, staff & hospital cases 2005- 14

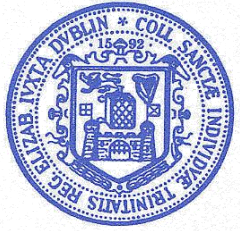






# What the indicators tell us & what they don't

- A relatively resilient system up to 2012
- A system that managed to do more with significantly less money and fewer staff
- A system at tipping point since mid/end of 2012
- Now doing less with less
- Very little data on non hospital services or quality of services
- No data on health outcomes
- A snap shot in time therefore cannot see 'scarring'



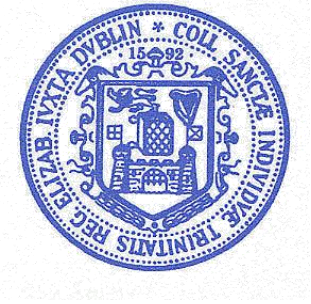
# **Managing Priorities in a Recession**

## **What do senior managers in health do?**

Dr Sarah Barry

Research Fellow

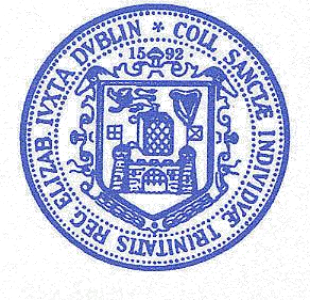
Centre for Health Policy and  
Management, Trinity College Dublin



## Overview

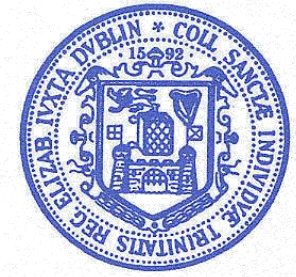
- Step 1 – rationale, context and methods of enquiry
- Step 2 – survey of senior managers' health policy priorities
- Step 3 – interviews with senior health managers
- Step 4 – resilience and transformation?





## Rationale

- Identify core priorities and challenges for senior health service managers
- Identify the ways in which they are meeting these challenges
- Explore how operations management influences the implementation of the current policies of health system reform within a context of economic crisis.

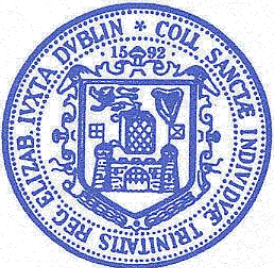


# The Context and Methods of Enquiry 1

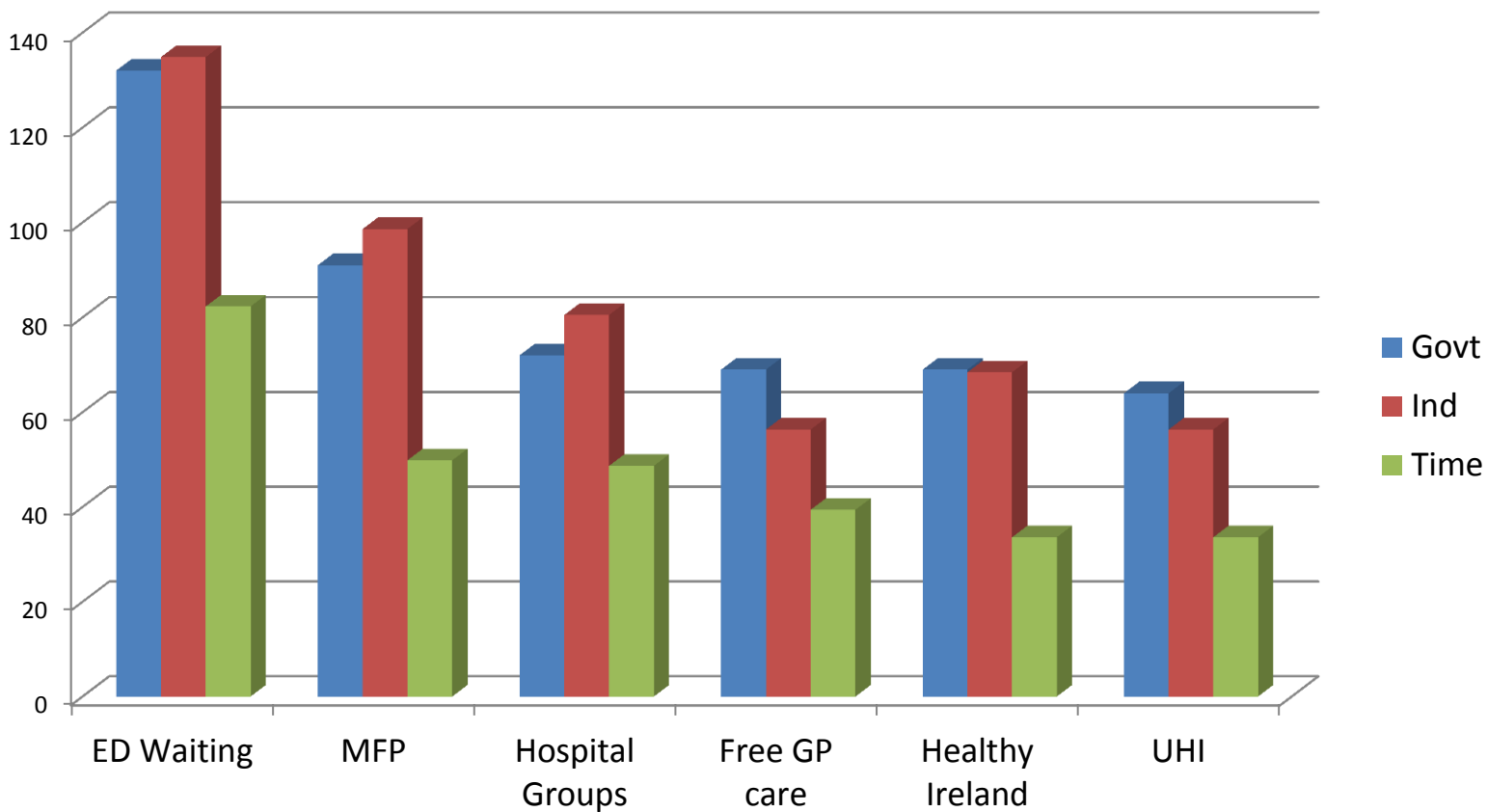
- Methodology – Mixed Method Approach
  - Online survey of 197 HSE service managers to ‘set the scene’
    - 81 responses met the inclusion criteria and were analysed (response rate: 41%)
    - Quantitative analysis of questions which asked respondents to rate and rank the importance of key reforms for government AND themselves; the importance of 5 different drivers of reform; how much time they spent on key reform policies
    - Qualitative analysis of questions asking respondents to identify factors which inhibit and facilitate reform policy implementation; any ‘other comments’ made
  - Semi-structured qualitative interviews with seven senior service managers to ‘explore the detail’
    - 2 Hospital Group CEOs/3 Hospital CEOs/2 ISA Managers = 4 HSE Sector/3 Voluntary Sector interviewed during January and February 2014
    - focussing on management challenges, strategies, outcomes and critical factor changes – content analysis and interpretive framing of the themes emerging

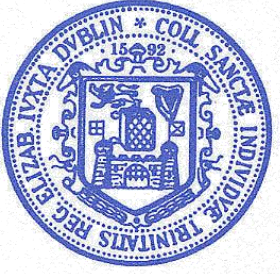
# Health Priorities Survey Nov/2013

- Multiple priorities identified – 19 different themes classified by at least 6 managers as ‘government priorities’
- The top 5 were:
  - Reducing wait times in Emergency Departments
  - Transferring care from the hospital to the community
  - Living within budget/austerity measures
  - Money Follows the Patient
  - Driving down the price of drugs
- These do not reflect the headline priorities of the Programme for Government
- They relate to running the health system more effectively in a constrained environment
- Exception is MfTP – but is as much an efficiency measure as a reform
- **Are the headline reforms getting the focus they require for implementation?**

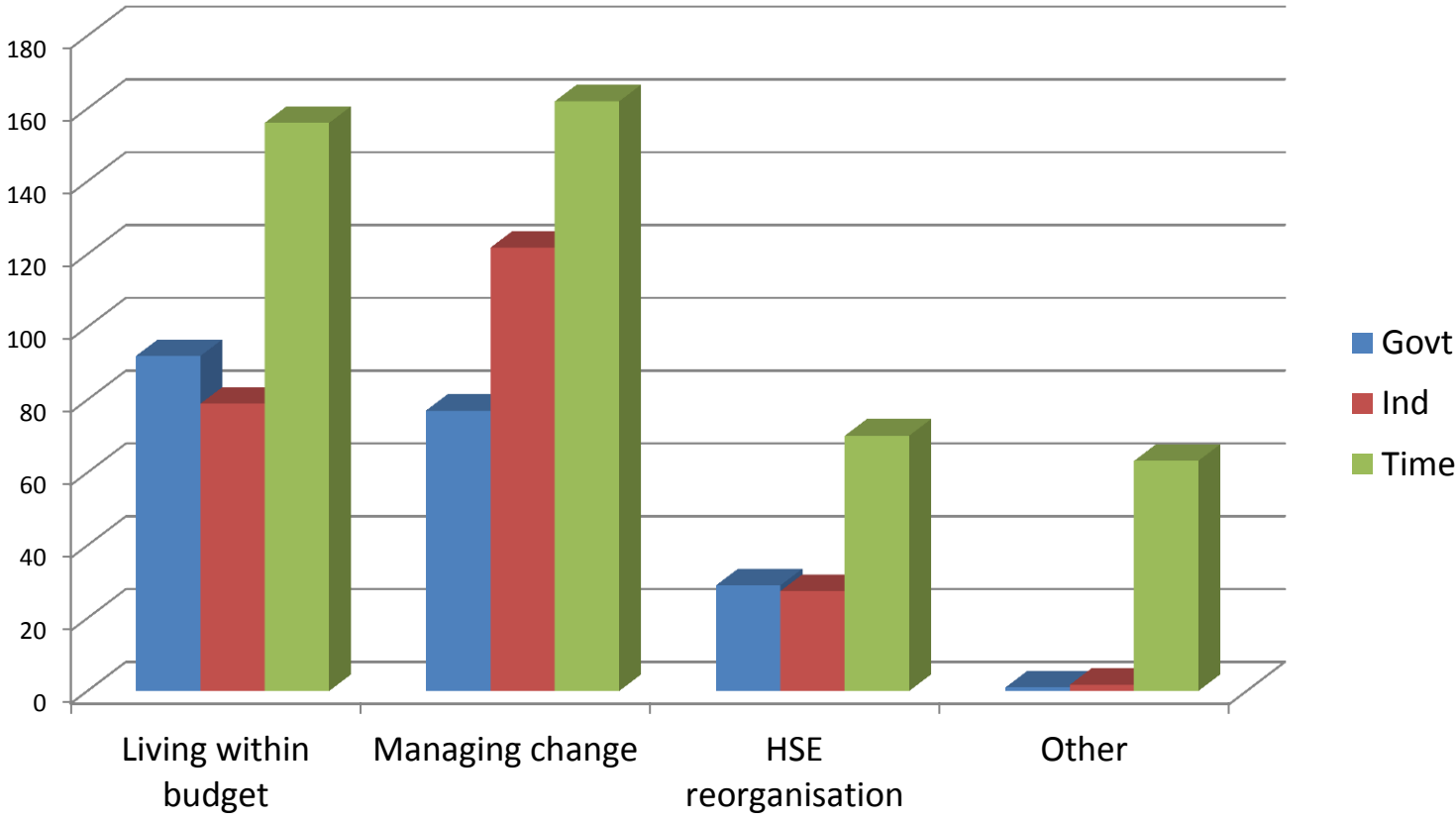


# Senior Managers' Health Reform Priorities in Practice

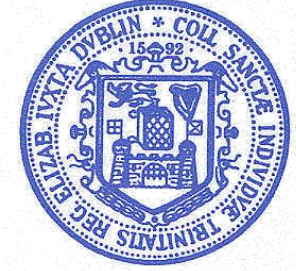




# In Practice, What is Displacing Headline Priorities?

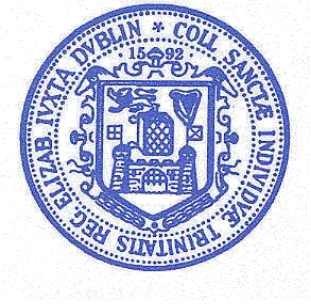






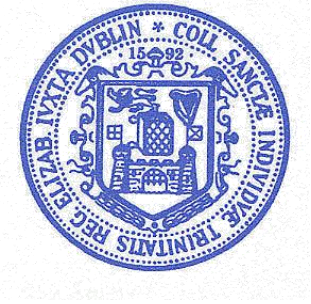
## Drivers of Reform Priorities?

- Managers ranked the importance of government reform drivers in the following order :
  1. Cost saving measures
  2. PfG health commitments
  3. Troika requirements
  4. Requirement to reform driven by EU
  5. Political agenda
- Managers reported that 25% of their time taken up with
  - Living within budget
  - Managing change
- Is the reform process adequately resourced?
- Is progressing reform the job of service managers?



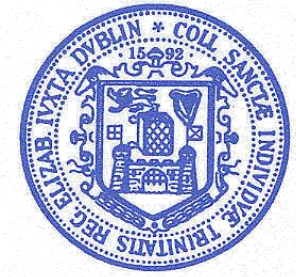
# Policy Implementation Inhibitors

- Lack of resources
  - ‘Balancing services to clients with cost containment’
- Governance/Leadership failure
  - ‘Lack of realistic objectives resulting from woolly strategy’
- Structural weakness
  - ‘Constrained management structure’
- Resistance to change
  - ‘Inability to move staff as required’
- Poor management
  - ‘Difficulty getting top management decisions, fragmented top management structure, lack of integration between clinical care programmes’
- HSE issues
  - ‘Centralisation of HSE’
- Loss of patient focus
  - ‘Ethics – patient must be central to decisions’



# Policy Implementation Enablers

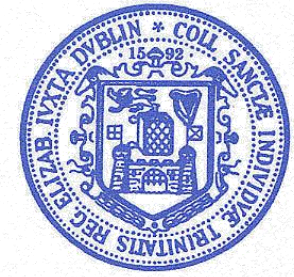
- Re-structuring
  - ‘In time the reorganisation of hospital groups’
- Vision
  - ‘Integrated management who listen to other voices and make the tough decisions’
- Good working relationships
  - ‘Staff willingness to change and be more flexible’
- Some power base enabling change
  - ‘Senior Management Endorsement’
- Local knowledge
  - ‘The fact that I know how to work around the system’



# Health Manager Interviews Jan/Feb 2014

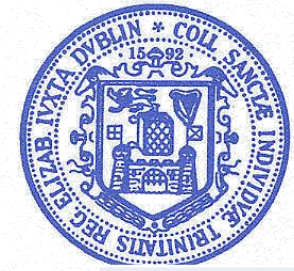
## Some Health Warnings!!

- Time of transition and change – uncertainty and ‘green hills syndrome’
- Topical focus – particular issues through the lens of a ‘bigger story’ in sharp focus at the time of interview
- Complexity – a ‘city of issues’ and not one story
- Initial findings – more in-depth analysis to follow



# Seven Management Stories 1

Respondent	Core Narrative	Quotes
<p><b>Integrated Service Area General Manager</b></p>	<p><b>The divisional structure will further fragment care delivery</b></p>	<p>“We used to work together and we now go to meetings and go <b>‘that’s my money, that’s my money, you’re not getting any of mine and I’m not paying for somebody who’s 68 to do this because they’re in your remit’</b>. So we have, we’ve, we’ve nearly fragmented something that wasn’t.”</p> <p>“My real fear for directorates [is that] I’m in a system that’s already quite fragmented; putting those silos in, silos should really only be a top layer on a whole system, it shouldn’t be the only system because <b>we’ll end up pushing our clients and it’s not going to suit the clients. It may suit the budgets and it may suit management, but it’s not going to suit the clients</b>”</p> <p>“If you put it onto a system that actually isn’t working it will become de facto the only system that exists so it will be a fragmented system”</p> <p>“Those old networks, we used to have, area administration meetings, there used to be general manager meetings, we used to have area management team meetings, some of those structures are, are kind of unbundling a little bit”</p>



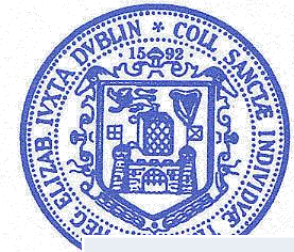
## Seven Management Stories 2

Respondent	Core Narrative	Quotes
<p>HSE Hospital CEO</p>	<p><b>Fragmentation is a threat, and the hospital group is an opportunity, but it is also a challenge to hospital identity</b></p>	<p>“The question in the back of the mind would be will there be more fragmentation, and sometimes then you know, with that you get more layers, layers of everything. So that’s not always, you know, <b>layers of things are not always a positive side because they don’t always produce efficiencies and you know communication can be a challenge</b>”</p> <p>“Now, what happens then if I don’t have the staff to do that, and ... [I say] “as a hospital it’s nothing to do with me, it’s not my problem”, I’m not saying that we’d ever get to that because I don’t actually think in our locality that’s the mentality we have ... that’s not the way we’ve ever worked in the past. But you could say that could be the case in other places that mightn’t have as well-formed [relationships] and maybe wouldn’t bother ... Go to Dublin, [for example] they couldn’t, mightn’t give a hoot on that”</p> <p>“it’s sort of generally accepted that probably <b>services are running at low levels of staffing ... how far can you go without having significant impacts on your service?</b> So that’s been recognised, that’s good because at least then there’s a sense that there is something positive ... and that’s happened through the group structure”</p>



# Seven Management Stories 3

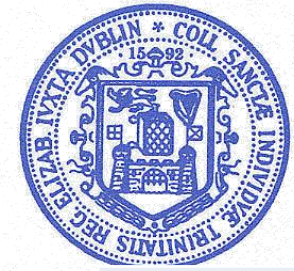
Respondent	Core Narrative	Quotes
<p><b>Voluntary Hospital CEO</b></p>	<p><b>Reduced resources and blocks but organisational development is the right response to the crisis</b></p>	<p>“We’re working with probably a budget of about 25% less than we had five or six years ago ... So the money that has been made available to us has got less but yet we’re doing more work than we did.”</p> <p>“Finance has been quite crude ... <b>in 2012 there was an absolute tsunami of cuts</b>, at the end of 2012 we had overspent by €X million. And it wasn’t that our spend had gone through the roof, our spend had actually come down, but the money that was made available to us, the budget that we were given was way down”</p> <p>“We’ve had the exit strategies, we’ve the pension, the redundancy strategies, early retirement schemes and they certainly have, have been challenging”</p> <p>“<b>Within a hospital you’ve got mixed cultures</b>, you’ve got professional groups, doctors, nurses, healthcare professionals, support staff, trade unions, professional bodies, things like the regulators like HQA, Medical Council, Bord Altranais. So you’ve all that pot of things going on within the organisation and you’re trying to manage pathways through that”</p> <p>“We have invested in our staff, when the economy is in a downturn, staff training is usually one of the areas that’s cut ... <b>But we’ve taken the decision ... to support training ... I think now is a time that people need more support when they’re going through change rather than in a time of plenty</b> ... they actually need tools and skill sets to improve their outputs”</p>



## Seven Management Stories 4

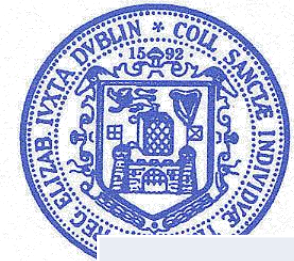
Respondent	Core Narrative	Quotes
<p><b>HSE Hospital Group CEO</b></p>	<p><b>The Group is a response to fragmented care, but not a panacea. There are real barriers to the path of change</b></p>	<p>“Some of the changes ... back to the original surgical changes that were made and the changing of the smaller hospitals in terms of emergency departments and critical care capacity has put this site particularly in a pressure cooker. There is no doubt about it, because the capacity isn’t here”</p> <p>“We have some of the tools [to create change] but that’s back then to a power basis and changing practice and whether we like it or not, <b>I am the CEO, I still have no authority to tell any doctor what to do.</b>”</p> <p>“The macro-economic environment is so fluid ... it’s definitely not, hasn’t, can’t have certainty over a multi-annual [programme. That] is a huge challenge, because <b>you set off to do something and then you arrive at a point where you can’t follow it through</b>, or the implications of following it through will financially put the organisation at risk.”</p> <p>“I think that the HSE and the Department of Health should just get over themselves and merge because it’s hard to know who’s who and what’s what ... I have no idea of what the lines of demarcation between policy and service [are] ... It’s all mixed up and that’s when trouble will come to bear. ... HIQA will be in here next week looking at me from a licensing perspective and fit for purpose from a governance perspective, but <b>how can I be fit for purpose when the pieces that sit on top of me are so mixed up?</b>”</p>





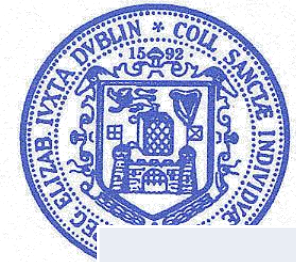
## Seven Management Stories 5

Respondent	Core Narrative	Quotes
<p><b>Voluntary Hospital CEO</b></p>	<p><b>Hospital identity and autonomy are compromised in the group, uncertainty prevails</b></p>	<p>“We’re going through a transition, we’ve lost our ICU, we’ve lost, you know, aspects of the lab, our A&amp;E closed down [and became] an urgent care centre ... we do elective surgery and all admissions are effectively elective. We opened ... beds last year on the direction of the Minister to provide capacity for the region ... <b>we did that and I suppose we’re still in limbo with regard to will we stay open or not</b>”</p> <p>“Our workings with the [Group] trying to find out where we work with regard to that and I suppose <b>the whole governance aspect with regard to that is very, it’s very challenging because there is no roadmap</b> and you know, we were just told we’re reporting to the CEO with regard to finance and we’ve never even received anything on paper with regard to that and it’s just, you know, it’s just a given and that’s it”</p> <p>“The whole financial end of it [is] a very significant challenge for me because you’re really doing, you know, <b>you’re expected to do more and more or the same as last year with less and less, I’d say, where the budgeting system is less than ideal ... because this is February and I still don’t know what my budget allocation is from the Group</b>”</p> <p>“There’s no clear map there , everything is preventing us from working together”</p>



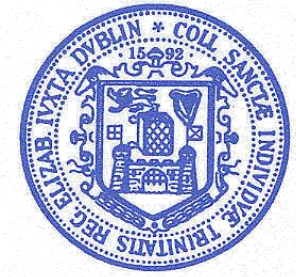
## Seven Management Stories 6

Respondent	Core Narrative	Quotes
<p><b>Voluntary Hospital and Group CEO</b></p>	<p><b>Delivering the service in the face of bureaucracy, under-resourcing and whimsical politicians</b></p>	<p>“Obviously the financial challenge, particularly in 2012. There was some easing in that in 2013 when there was a right-sizing of some of the budgets, that helped us, but <b>2012 was extremely difficult in terms of managing the budget, managing the service plan</b>”</p> <p>“The bureaucracy of the HSE and its structures have been significantly disempowering ... the process of, of the HSE’s HR function take a long time to, to work through the system. And that’s just one area, I mean that’s, across the whole lot of areas there’s standardisation and there’s concentration at the centre and <b>people in hospitals around the country I think are, are just frustrated with that level of, of bureaucracy and centralisation, which is counter to people exercising their initiative and so on at hospital level</b>”</p> <p>“The policy makers have decreed that there are to be no more clerical admin staff appointed to the system. We haven’t had a clerical admin staff member appointed I’d say for the last five or six years . <b>We have no succession planning, we have no investment in management capability. We are in the process now of implementing a huge project, money follows the patient across the whole system. We don’t have sufficient accountants, sufficient IT people, and this is all a direct consequence of successive government policies</b> not to recruit clerical admin, not to invest in them and, and the impact of that is being seen every day. We’re increasingly employing agency staff”</p>



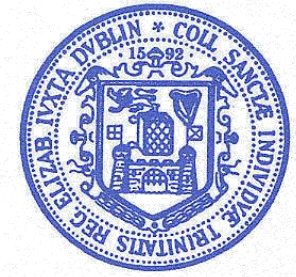
# Seven Management Stories 7

Respondent	Core Narrative	Quotes
<b>Integrated Service Area Manager</b>	<b>The divisional structure has potential to fragment care, need to manage this risk</b>	<p>“I suppose the Department, the funding goals and care group streams and the general rationale would have been that when the money got into the system we would have moved money between care groups ... there was flexibility at a local level. The disadvantage always was that the centre or the national system, be it HSE or the Department, would feel ... the money mightn’t end up for where they would have intended it, but of course <b>on the ground things were changing all the time and that, if you like that vice grip does give the clarity from top to bottom where the funding has gone, but removes any flexibility at all to adjust as you see fit in terms of meeting service demand</b>”</p> <p>“Now <b>it’s about communication, negotiation, building relationships</b> and if relationships are poor obviously people are going to be reticent, and even where they’re good, if your budget’s under pressure there’s a danger that people get caught in that way”</p> <p>“In the meantime you’re restructuring and you’re trying to deal with the financial challenge and keep your HR piece, your headcount and all of those things together ... I think in fairness to people, <b>I have to say our own service managers, there is a lot of resilience there. [Their] greatest anxiety staffing numbers reducing, and their concern is around the safety of the service; they’re always balancing risk ... the risk is always there, the question is how do you mitigate it and minimise it?</b>”</p>



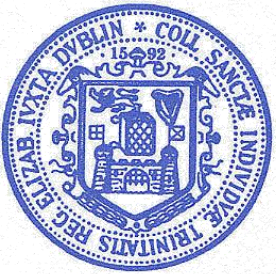
# Manager Strategies in Response to Challenges 1

- Continuous improvement – low cost
- Employing LEAN management methods
- Reliance on established working relationships
- ‘last minute working’ on meeting budget and performance targets
- Using the hospital group structure to leverage greater autonomy on recruitment, service arrangements etc.
- Developing an organisation strategy and finding ways to resource staff training and reflection space
- Negotiation on budget re-balancing with HSE
- Relationship building across professional boundaries
- Staying focussed on core tasks and not getting caught in the political web



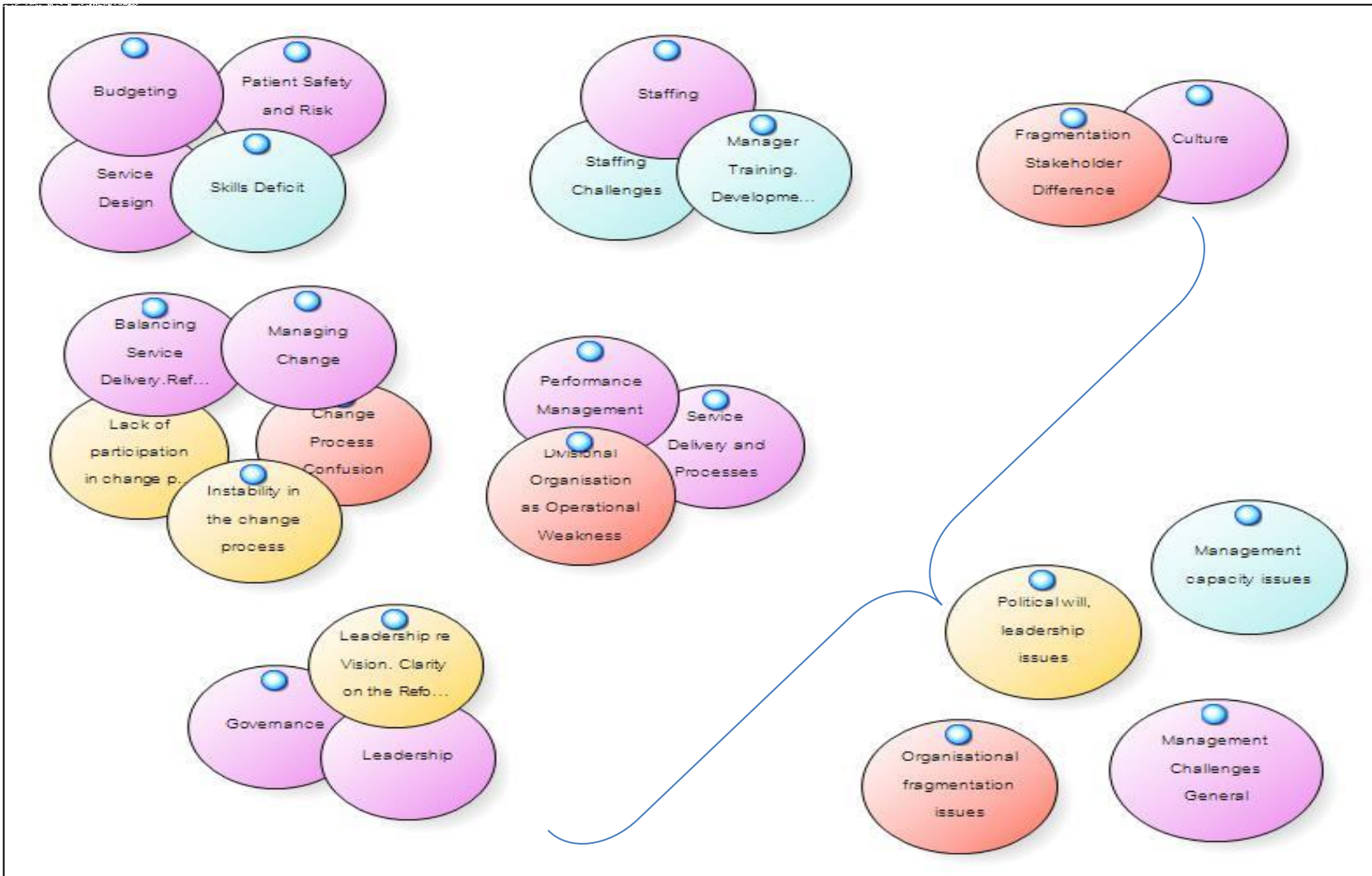
# Manager Strategies in Response to Challenges 2

- Creating space for staff to participate in the change process
- Building the context for team work
- Making local decisions where possible
- Relying on people's professionalism and desire to do a good job, give quality care to patients
- Service delivery strategies to make positive changes (e.g. same-day surgery, patient-wait times)
- Acceptance of change through financial crisis – making the best of the opportunity
- Clarifying what our strengths are within the region
- Innovation in service delivery

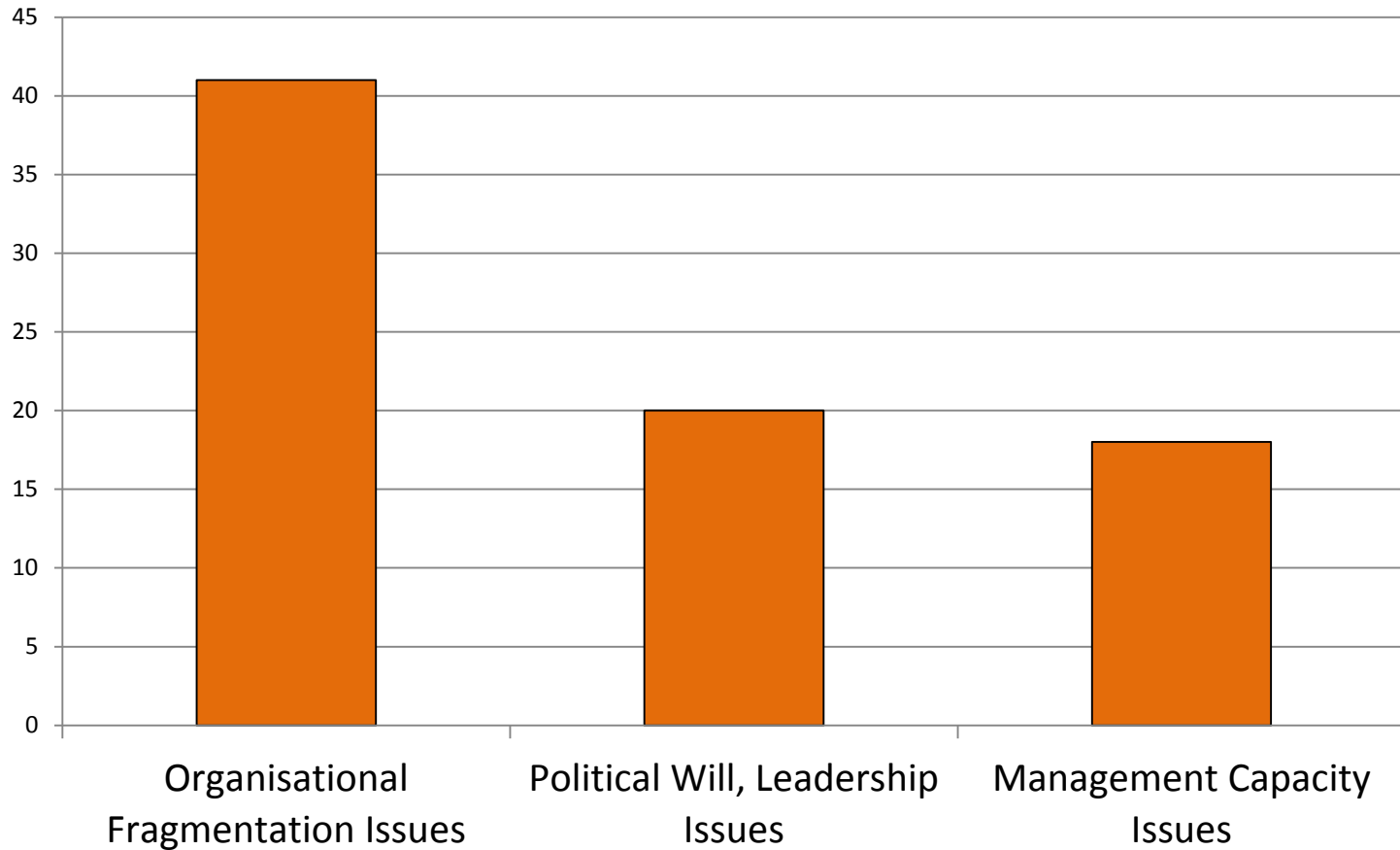


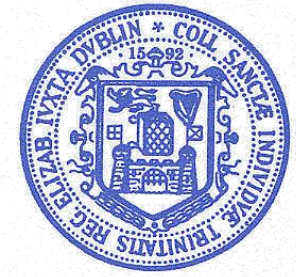
# Health Service Manager Interviews 2014

## Initial themes and grouping

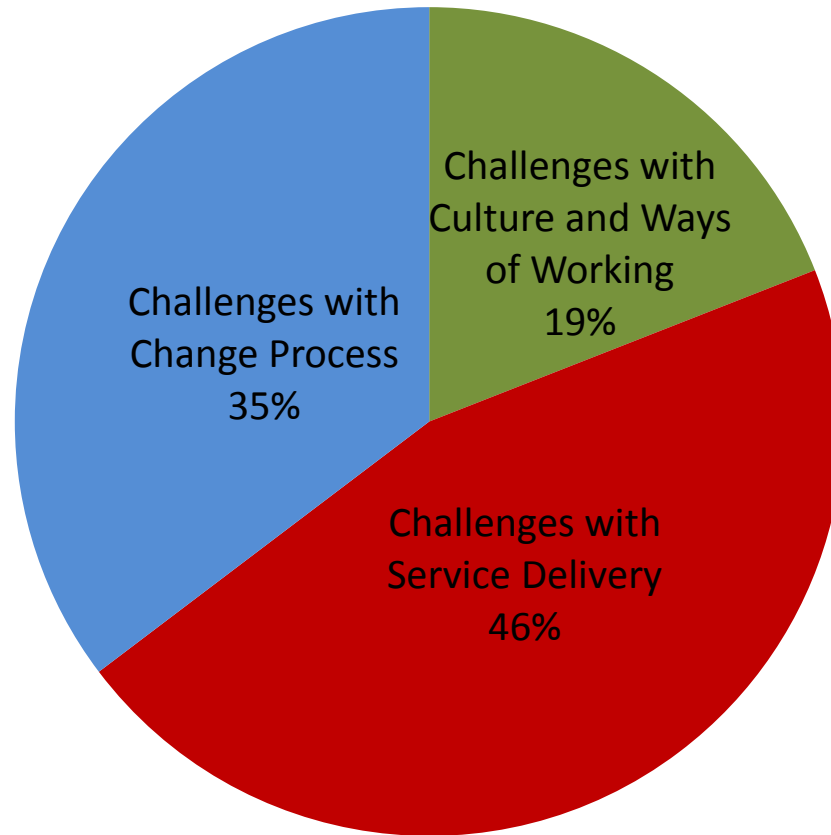


# Resilience Qualitative Wave 1 Themes – Relevance at time of Wave 2

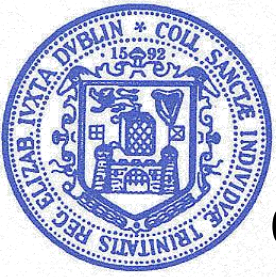




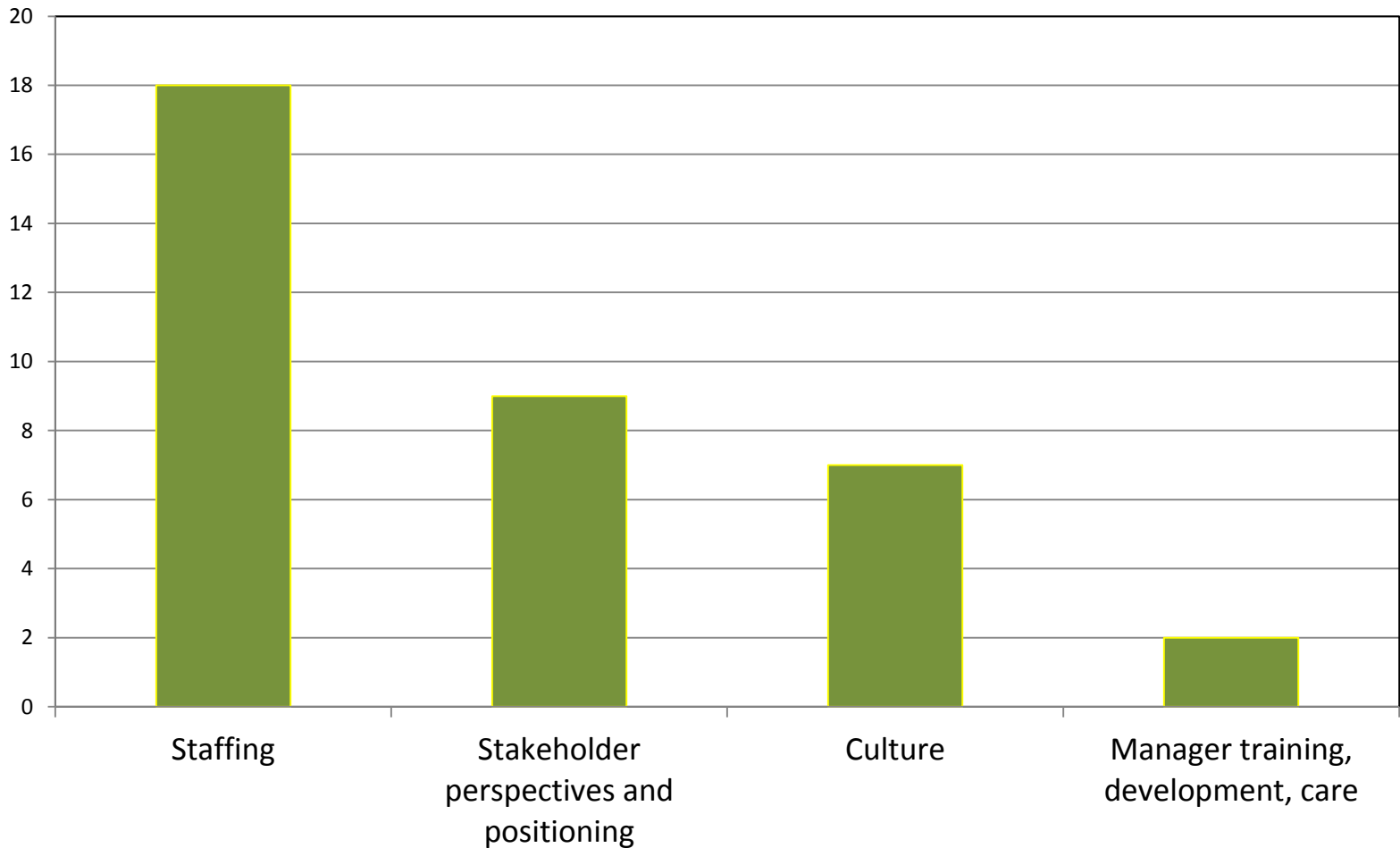
## Overview of Management Challenges – Interviews with health service managers early 2014

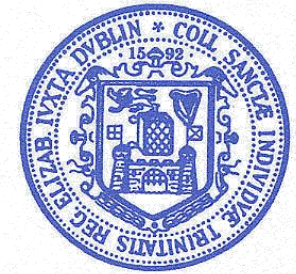




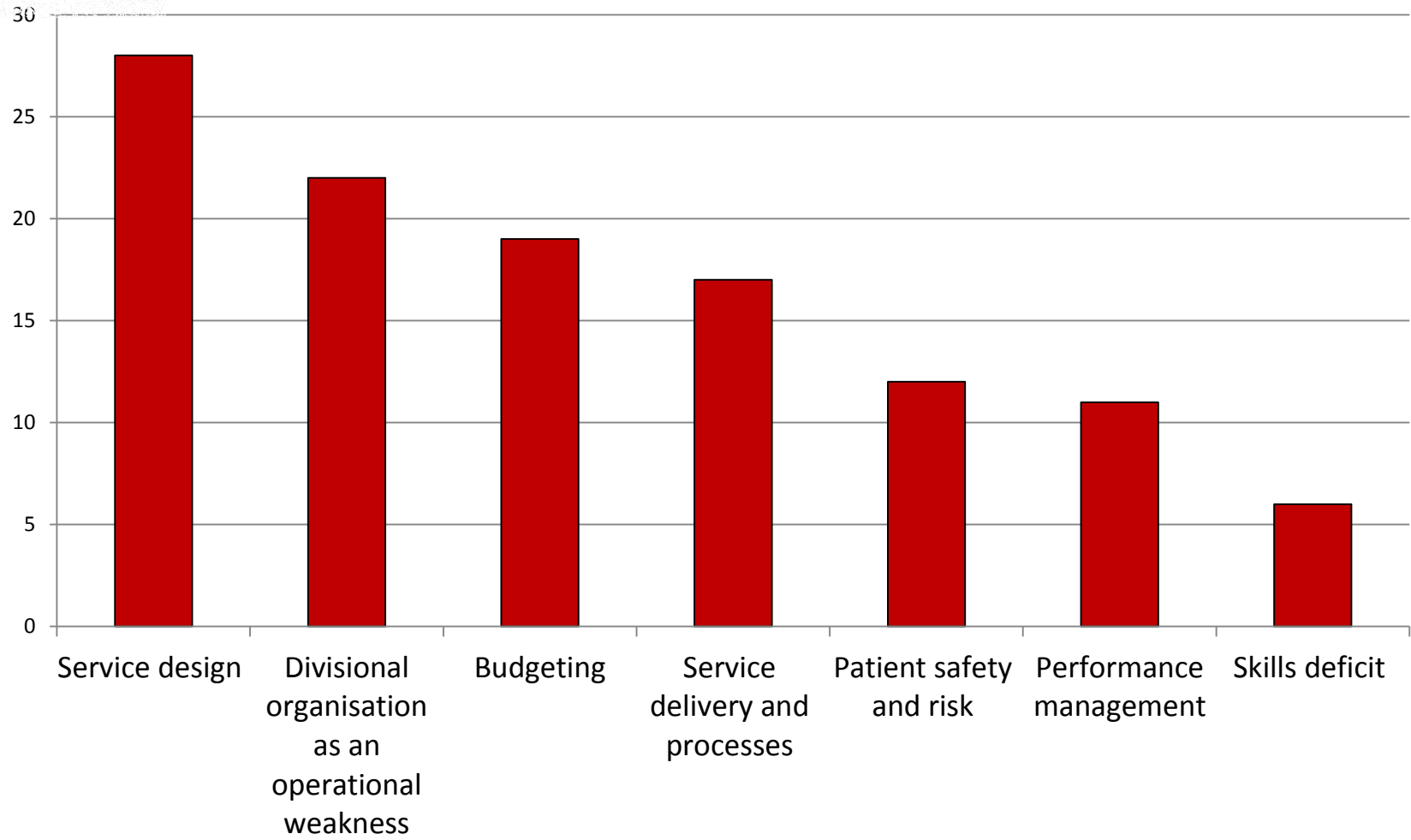


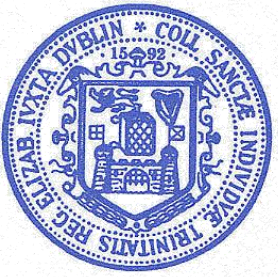
# Challenges with Culture and Ways of Working



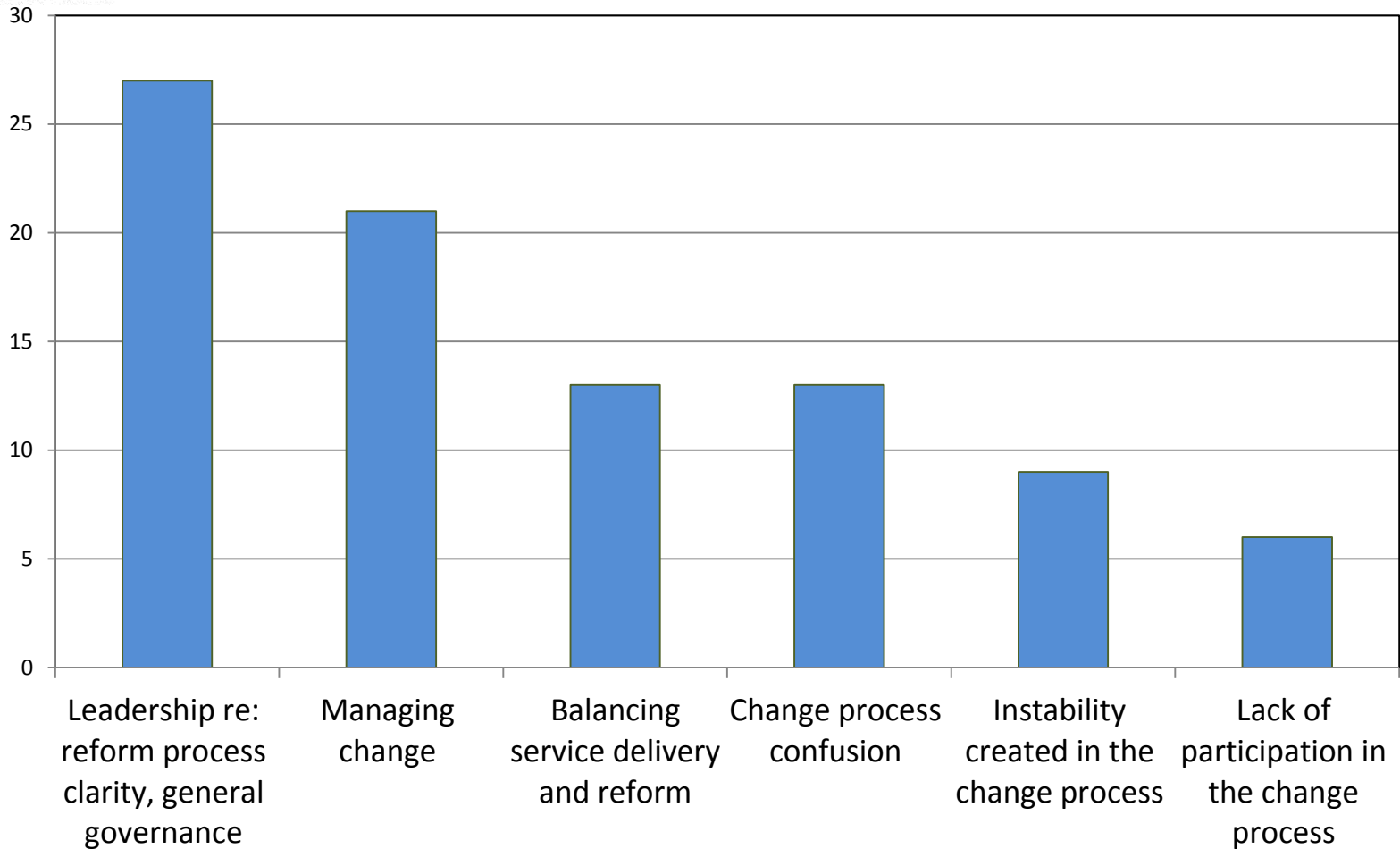


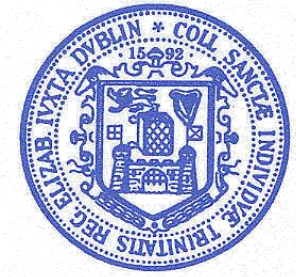
# Challenges with Service Delivery





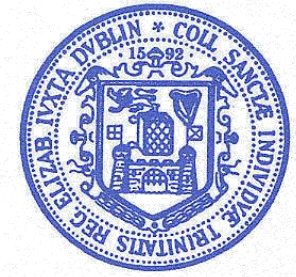
# Challenges with Change Process





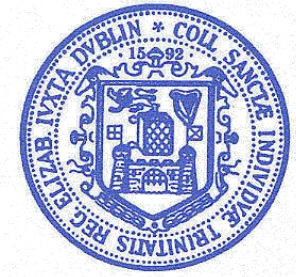
# Resilience AS Culture and Ways of Working

- Managers and staff have been flexible and responsive to the demands of efficiency and on-going structural change with considerable results and outcomes
- Intransigencies and blocks remain – from unions to clinician power, to the bureaucracy within the system and staff recruitment challenges ...
- Opportunities for training, cross-disciplinary engagement, learning and reflection are needed
- Training and support for managers, less of a blame-culture, and high-level encouragement of people within the service would make a difference



## Resilience *AS* Service Delivery

- Health Service Managers are responding to the considerable and complex challenges they face with a range of strategies and some positive outcomes
- There is acceptance of the re-structuring programme but with significant concern about its potential to negatively impact on patients by further fragmenting the care delivery system

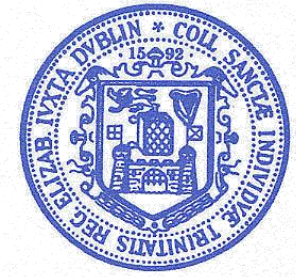


## Resilience *AS* Change Process

- The change process, in terms of the re-structuring of how the service is organised, budgeted, managed and delivered, is biting on the ground ...

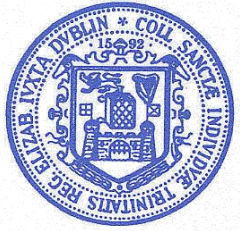
### **BUT**

- With confusion, uncertainty, a lack of clarity, timeliness and communication
- This is inhibiting openness to and the pace of change, the confidence managers feel about it, their ability to bring others along and create new realities



# Resilience AS Policy Implementation

- through Adaptation
  - As reported in phase 1 the system responded well to efficiency drives. Nonetheless, the capital (legislative, social, technical) which upheld this form of resilience seems less available, as reflected in management challenges and other indicators
- through Transformation
  - The demands of delivering a safe, functional, within budget, and efficient system are suffocating the implementation of headline reforms
  - The Programme for Government headline reforms are remote from a service delivery perspective either due to lack of clarity, progress or resources, or lack of importance in the face of more immediate needs



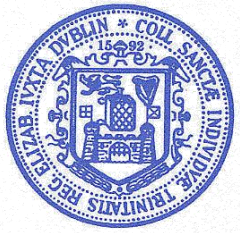
# What do senior policy/decision makers in health think?

Dr Sara Burke

Research Fellow

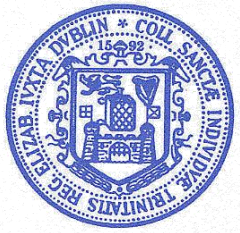
Centre for Health Policy and  
Management, Trinity College Dublin





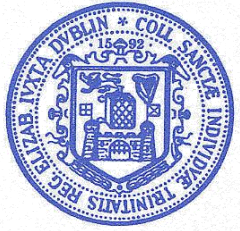
# What do senior policy/decision makers in health think?

- Wave 1
  - the impact of the economic crisis on the health system
  - on-going decision-making including analysis of system reform capacity
- Wave 2:
  - Identifying health reform priorities
  - Managing complexity of reform v resource constraints
- Wave 1 and 2:
  - Barriers/enablers of change/reform



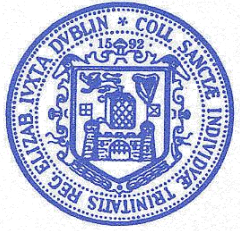
# Methods/approach

- Qualitative interviews with 12 senior personnel from health/finance sector between 2011 and 2014
  - Wave 1: Sept 2011 – Jan 2012 (4), Dec 2012 – Jan 2013 (2)
  - Wave 2: Dec 2013 – March 2014 (6)
- Semi-structured interviews with senior civil servants, health service managers, political advisors
- Recorded, transcribed and analysed
  - Wave 1: content analysis leading to identification of key themes within the resilience framework and organisational learning perspective
  - Wave 2: coded and analysed in NVIVO



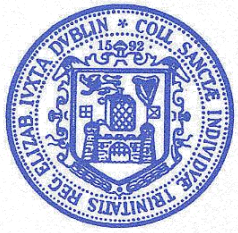
# Interviewees

- Senior Department of Health officials (2)
- Senior Department of Public Expenditure and Reform officials (2)
- Political advisors (3)
- Senior health service management (5)



# Wave 1 findings

- Policy constraint of Troika/financial crisis
- Efficiency drive and effects on services
- Ways of working and the service delivery model
- System capacity for change and reform
- The politicised nature of the system



## Wave 2 findings:

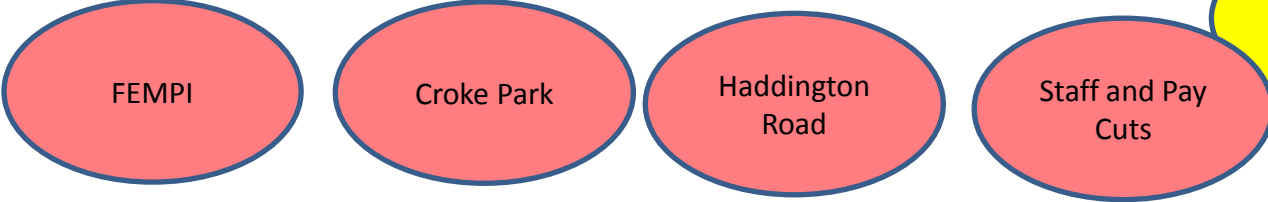
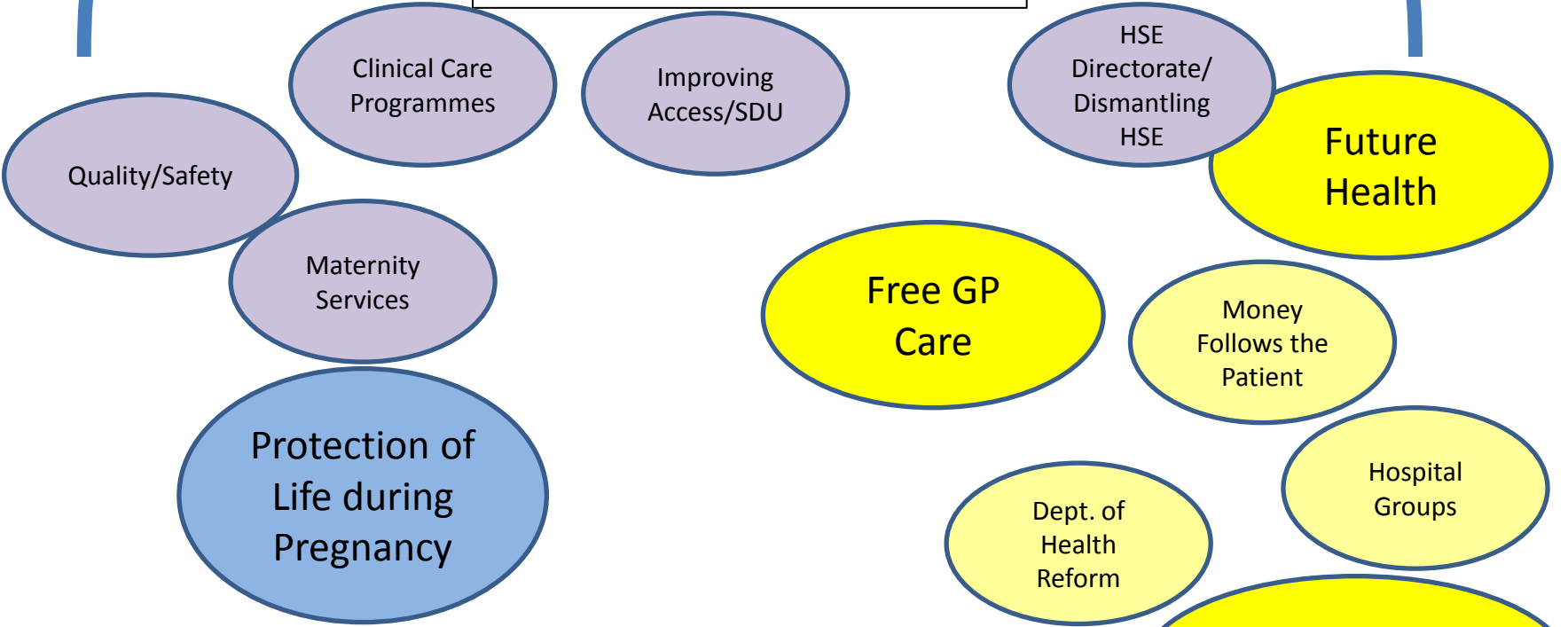
# Identifying health reform priorities

- Improving patient care/quality of care (4), free GP care (1), Universal Health Insurance (1)
- Improving patient care/quality of care
  - Focus on hospital care, quality, clinical care programmes
  - Contrary to budget and service cuts
  - Questioning possibility of doing more with less & improving services
  - Improving access/universal central to quality eg cancer care, waiting times
- Restructuring/reorganising health system
  - Hospital groups, children's hospital, MFTP, HSE break-up
- Future Health and Healthy Ireland

Healthy Ireland

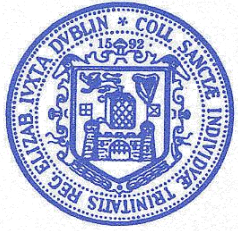
# Health Reform Priorities

Improved Patient Care/Outcomes



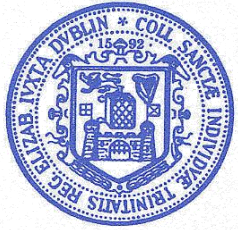
Budget Cuts/Troika/Irish Troika

Reform of Private Health Insurance



# Health reform priorities

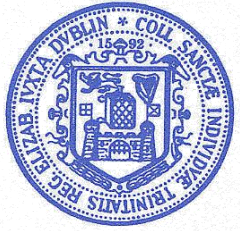
- *The guiding principle was that **we'd have high-quality patient services, patients that were going to be a priority.***
- ***Improved patient outcomes.** That's... what it's all about...*
- *The business of the health service is **caring for patients***
- *I'm not saying it wouldn't have happened otherwise but clearly it [**death of Savita Halapanvar**] was an enormous kind of an earthquake type event, which has changed the way lots of people think about the issue of patient safety, both people inside the system and outside the system*
- *Bringing **governance and ownership of the quality of care right down the operational line...** I think the big process at the moment in terms of **putting responsibility for quality and safety at the core of all operational management,** both nationally and locally*



# Budget cuts v patient care

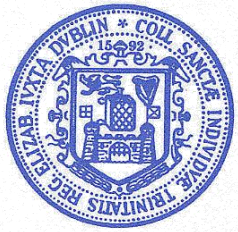
- *at a national level ... we've created the same environment that existed in Mid-Staffordshire, but instead of doing it on a hospital by hospital basis we've done it on a national basis, because we have said the only thing that really matters in discussion is budget, money and head count... and this... is related to the austerity...*
- *one of the real downsides of the whole austerity thing has been that over the last four years, the only measure that has been considered important in the health service is the budget and head count numbers*
- *I really wish that finance and DPER could really truly look at the health services as an investment in our citizens rather than a money pit*
- *that tension between the need for cash extraction and system reform, I don't think we've actually hit the full clash of that yet. I think... that's yet to come and I, and I don't think that's going to be pretty*





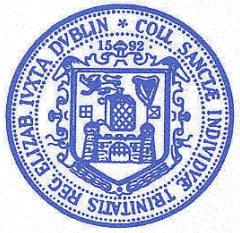
# Wave 2 findings: Drivers of health reform

- Political: change in government, new Programme for Government, James Reilly
- Focus on patient outcomes
  - Minister Reilly, HSE leadership, Savita Halapanavar, Portlaoise
- Economics: budget cuts, troika, Irish troika...
- Incompatibility of the above highlighted in Budget 2014 stand off btw Department of Health & Department of Public Expenditure & Reform (DPER)
- Clarity at the very top of health from 2012/13 on
- Importance of valuing staff, HR, culture to quality



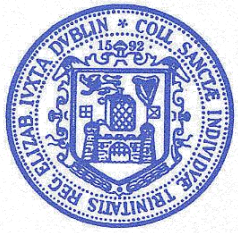
# Drivers of health reform

- *Reform as radical as this would not have come from anywhere else within the system other than from **a change in government** and a different approach.*
- ***there were political imperatives***
- *There were only **four priorities, patients, patients, patients and patients**, and **their safety and the outcomes for them***
- *at a national level the only, **the only discussion or the only strategy we had was around economics...***
- *when **the troika arrive they start talking about top 3 priorities & suddenly health was there alongside the future of banking system, mortgages arrears, was the debt sustainable***
- *then its **the Irish Troika that really runs the government...** the Economic Monetary Council: Taoiseach, Tánaiste, € Ministers*



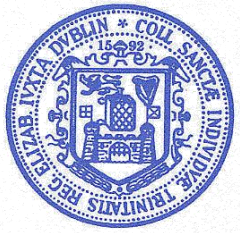
## Wave 2 findings: Managing complexity of health reform

- Dedicated reform groups in Department of Health and HSE overseeing reform & between them
- Greater clarity & coherency at health leadership levels evident mid/end of 2013
- BUT real concerns about the capacity to reform, the complexity, absence of experience in Dept of Health
- Diverted by other issues eg Savita, Protection of Life During Pregnancy, EU Presidency, Portlaoise
- Serious doubt about the delivery of UHI, ability to deliver & improve services in severe jeopardy due to financial constraints and politics



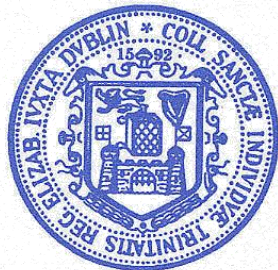
# Revisiting Resilience themes

- Political will/leadership
  - Driving reform & stymying reform, especially political divisiveness (btw Labour & FG, Health & DPER)
- Management capacity
  - Some improvements at the very top in health, questionable that this has seeped down
  - Inherent conflict between budget cuts & quality improvement/patient care
- Organisational fragmentation
  - ‘Reforms’ intent on addressing organisational fragmentation but not yet evident that this is the effect, the opposite, too soon to tell, too complex?



# Transformatory resilience?

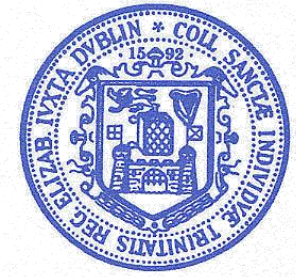
- *the ability or capacity of government to design & implement desirable & realistic reform when the current organisation, structures & strategies are no longer feasibly*
- Questionable evidence of transformatory resilience especially the skills & capability of the system to pull off enormous reform programme with increasing demand for care & ever diminishing resources
- *the challenge of focusing on the important rather than the urgent is a daily battle in health and there's absolutely no getting away with that. It pops up all of the time, the Angola metaphor is an incredibly appropriate one in health*



# An analysis of overall findings and reflections in the context of current health reform

Steve Thomas

Centre for Health Policy and  
Management, TCD



# Conceptual Framework

## **Financial resilience:**

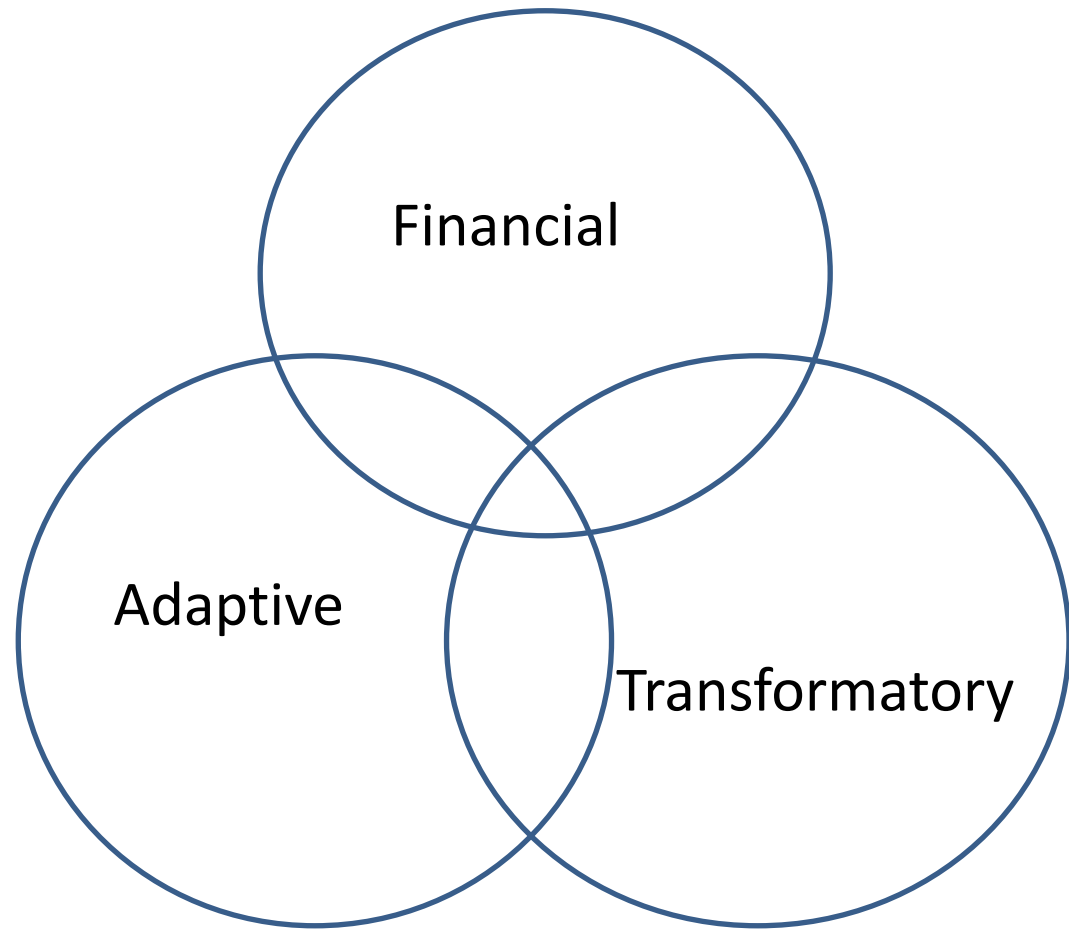
The protection of funds for health care, and particularly that of the vulnerable

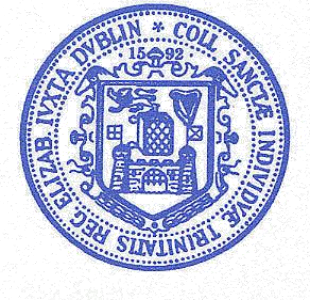
## **Adaptive resilience:**

The ability of government and providers to manage the system with fewer resources, through efficiencies, while not sacrificing access or entitlements.

## **Transformatory resilience:**

The ability or capacity of government to design and implement desirable and realistic reform when the current organisation, structures and strategies are no longer feasible

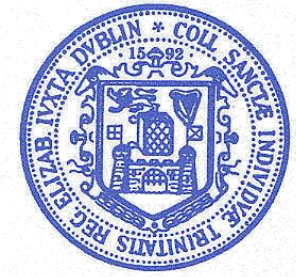




# Scoring framework



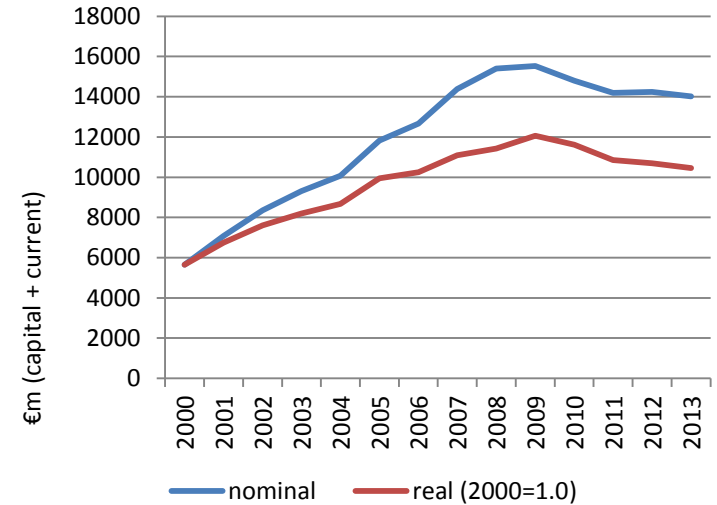


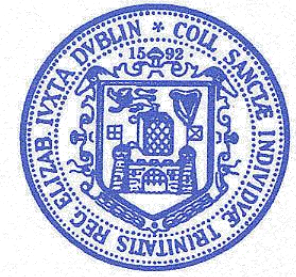


# Financial resilience I

The protection of funds for health care, and particularly that of the vulnerable

- Aggregate
  - OK (some protection of funding initially and in 2012) otherwise general reduction in finances and human resources





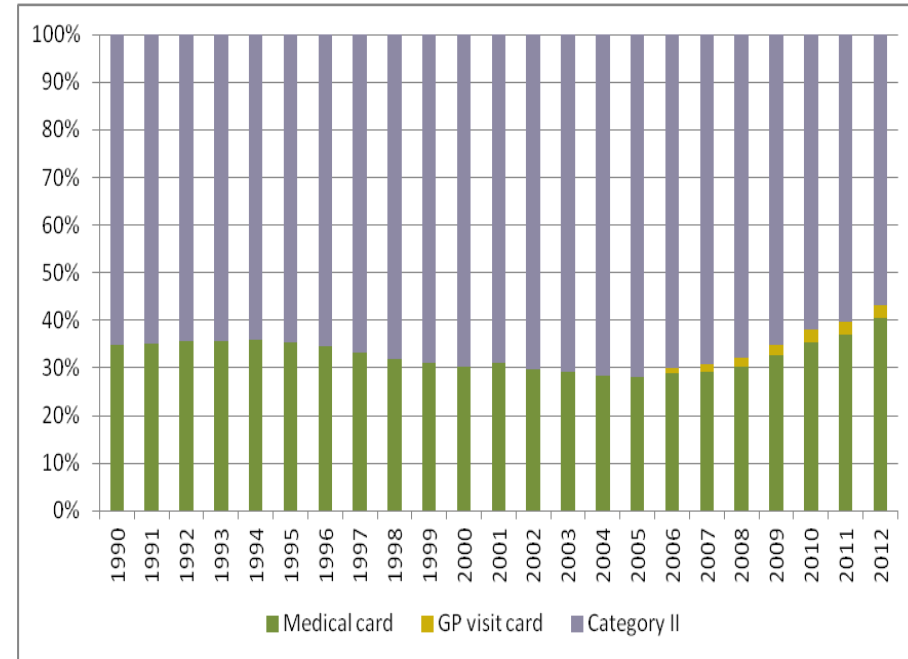
# Financial resilience II

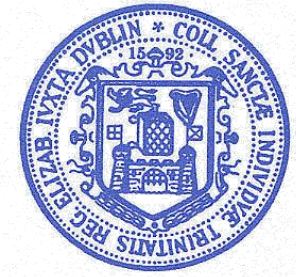
## The poor

Pretty Good – 600,000 more people given medical cards without any change in the thresholds.

Except for:

- the prescription charge + increase and
- removal of dentistry benefits





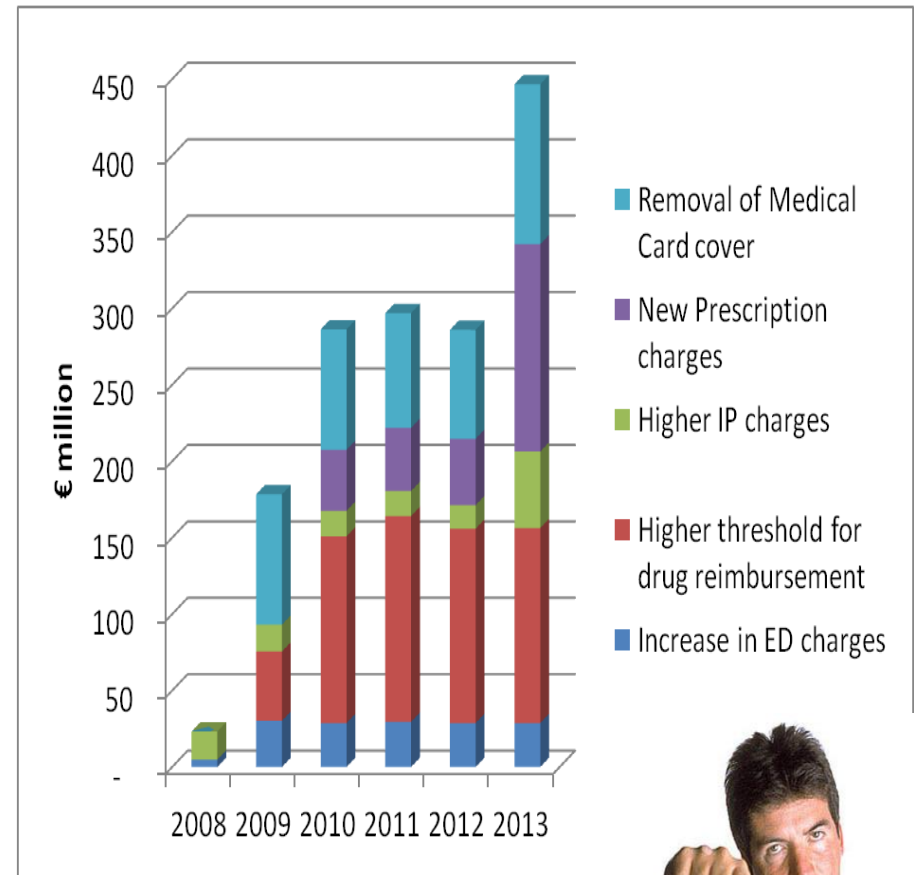
# Financial resilience III

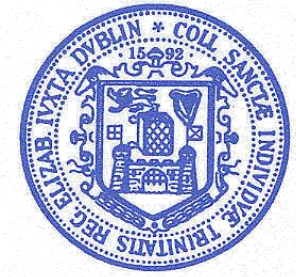
## The old

Not good – removal of automatic entitlement to medical card for over 70s '09 and further clawback '13.

## The sick

Lots of cost shifting on to this category – increased co-pays for IP, EDs, increase thresholds for Drug reimbursements



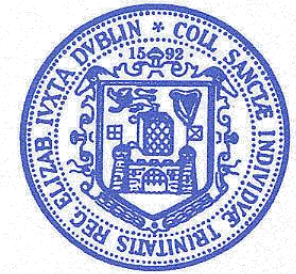


# Adaptive Resilience

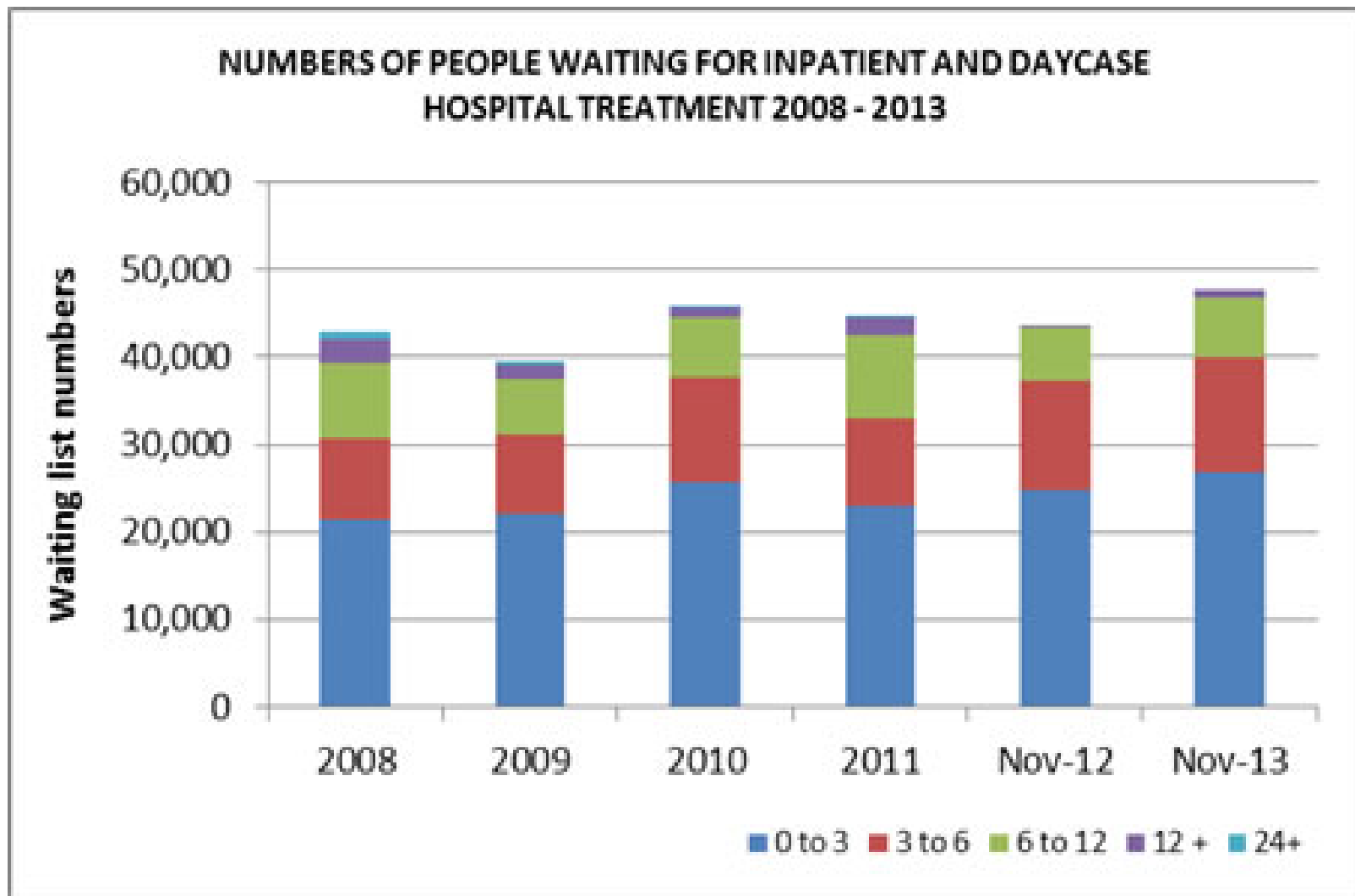
Managing the system with fewer resources

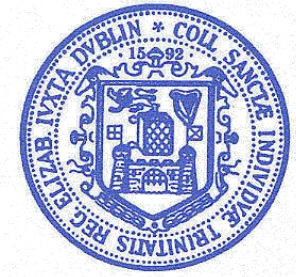
- Quite good..to start with – lots of cost savings through reductions in unit costs (pharma costs down albeit late, salary costs down through Croke Park and Haddington Road, shifting of care to day-case, FEMPI)
- More with less as system “fat” removed
- But...
  - ran out of easy cuts
  - morale problems
- Now less with less



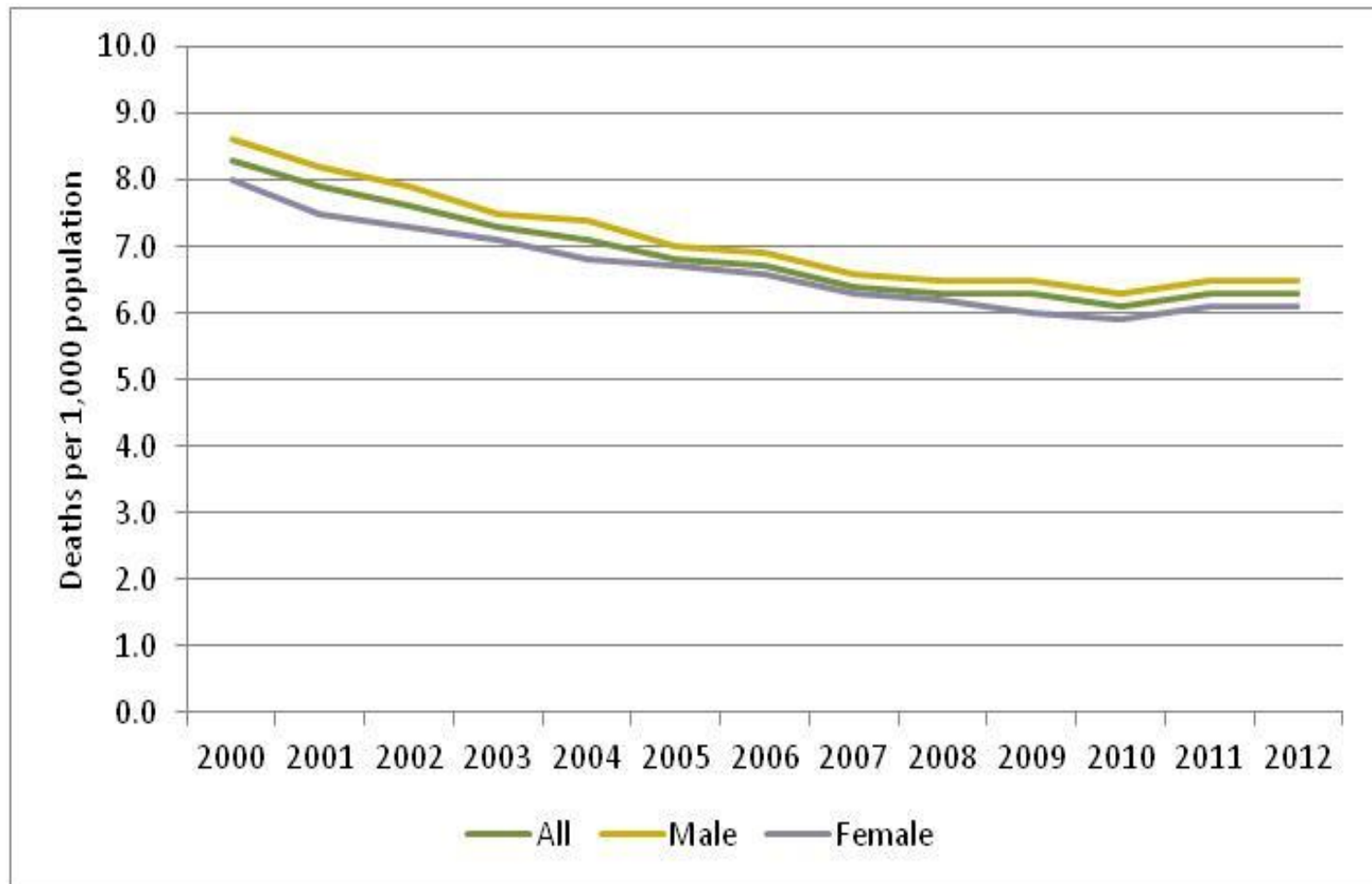


# Increased Rationing

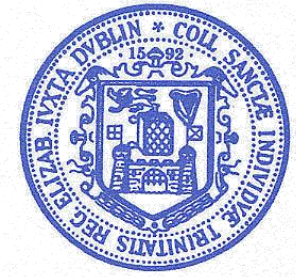




# Total, male and female death rates per 1,000 population, 2000-2012

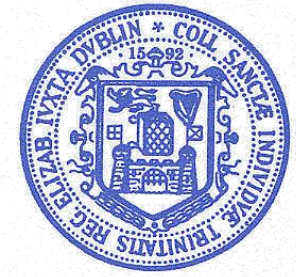


Source: Nolan et al, 2014, CSO



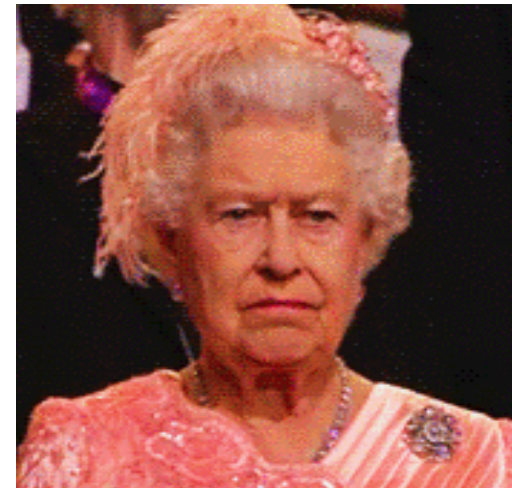
# Transformatory resilience

- A fair attempt at historic reform
  - Great headline
  - Huge policy agenda on paper
  - Evidence of more united health leadership
  - Austerity used as catalyst for reform
  - Still Universal care

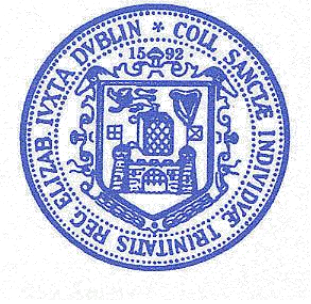


# Transformatory resilience

- But capacity weaknesses
  - Dissonance between health leadership and operational level
  - Dissonance between health and finance
  - Limited progress on headline policies
  - Suggestions that governance capacity absorbed by crisis
  - Urgent trumps the important
- UHI design weaknesses
  - Possibly the worst version for where we are
  - High cost and complex
  - Long-finger, Backburner, Long grass



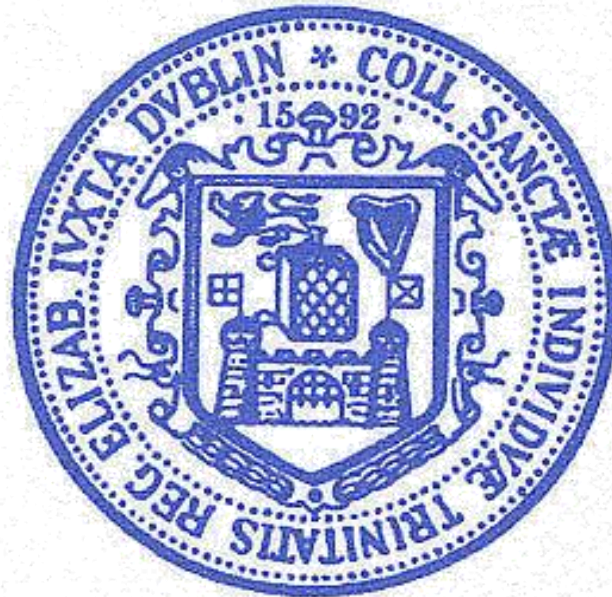




# Reflections

- Depth and duration of crisis
  - Essentially arbitrary budget cuts
  - Medical Card system held together
  - First, useful efficiencies
    - but sapped morale, undermined reform and economic impact
  - Then, cost-shifting and cuts
  - Unknown impact on health quality
- UHI design needs to be reassessed
  - Costing exercise

# The End



# Thank You