Development of sustainable systems in the healthcare sector

- A sector challenged by growing needs from patients, stressed employees and limited economic resources

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Healthcare under pressure

- A rapid growth in demands:
  - More patients (chronics, elderly, multiple diagnosis)
  - New expensive treatments
  - Higher quality expectations
- Public budget constraints (not necessarily cuts)
- Lack of qualified staff
- Competition from a growing private sector
- Frequent criticism from the media

New budget agreement for Danish hospitals

Agreement between the Government and Danish Regions:

- Real growth in budgets of 0.5%
- Required growths in activities of 2.0%
- Large investments in building of new hospitals

The Capital Region of Denmark:

- The 0.5% real growth cancels expected budget cuts of 700 mill. DKK
- The activity growth requires budget cuts of 300 mill. DKK
- A first reaction:
  - Midwifes against budget cuts – it may cost lives (Politiken, 07.06.14)

Examples of challenges from recent Danish political initiatives

- Patient guarantees:
  - Max two month before treatment starts
  - Max one month for a cancer diagnosis
  - Max one month for start of cancer treatment
  - Max one month for start of heart disease treatment
- Structural reforms
  - Closing small hospitals
  - Merging hospitals on separate localities
  - Building new larger ‘super’ hospitals
- The Danish quality model (a certified quality control standard)

Organisational changes of the medical department at Slagelse hospital

1992: The Medical department is merged with the Neurological Deparment to at Medical Area.

2001 The hospitals in the region are scrapped as organisational units and replaced with five centres. The Medical department is included in the Medical Centre distributed on several geographies. Neurology is separated again and moved to another locality.

2005 The Medical Centre is restructured into specialities. The consequences is three ward managements of the former Medical department at Slagelse Hospital.

2007 The center structure is scrapped and several local hospitals are merged into Hospial West. The triple ward structure of the former Medical department is maintained.

2008 Hospital West is scrapped and distributed on Hospital North and Hospital South. The specialised ward structure for medicine is also scrapped and the former Medical Department is reestablished.

2009 Parts of the Medical Department is separated and placed in a new Emergency Department.

Hasle & Jensen, 2012

Growing complexity

Two examples:

- Average days in a hospital bed:
  - 1935 = 30 days
  - Today = 3.5 days
- Possible interpersonal relations in a 20 beds ward:
  - 1935 = 105
  - Today = >4500

Jørgensen, Glostrup Hospital, 2013

Productivity development in Danish hospitals

Danske Regioner et al., 2012
Produktivitetskommissionen, 2013

A possible consequence

Healthcare in a demand and financial trap

Challenges	The present solutions
1. Economic constraints	Some budget increases likely but not following demands
2. Growing patient demands	Demand management little tested, may slow down growth but not likely to stop the increases in demands
3. New expensive medicine and technology	Various forms of procurement methods may slow down cost rise, but cannot stop the growth
4. Traditional restructuring	Mergers, economics of scale and new technology may give economics benefits but documentation of large scale impact limited
5. NPM	Limited effect – tend to increase sub-optimization and cost of control

Conclusion
- more for less seems unavoidable

- Putting a tremendous pressure on
  - The work environment
  - Professionalism
  - Quality
  - Politicians
- There is a need to develop new models
- Do we have or can we develop a Nordic model based on collaboration which meets these challenges?

The Nordic welfare model as a platform for new solutions

Society:

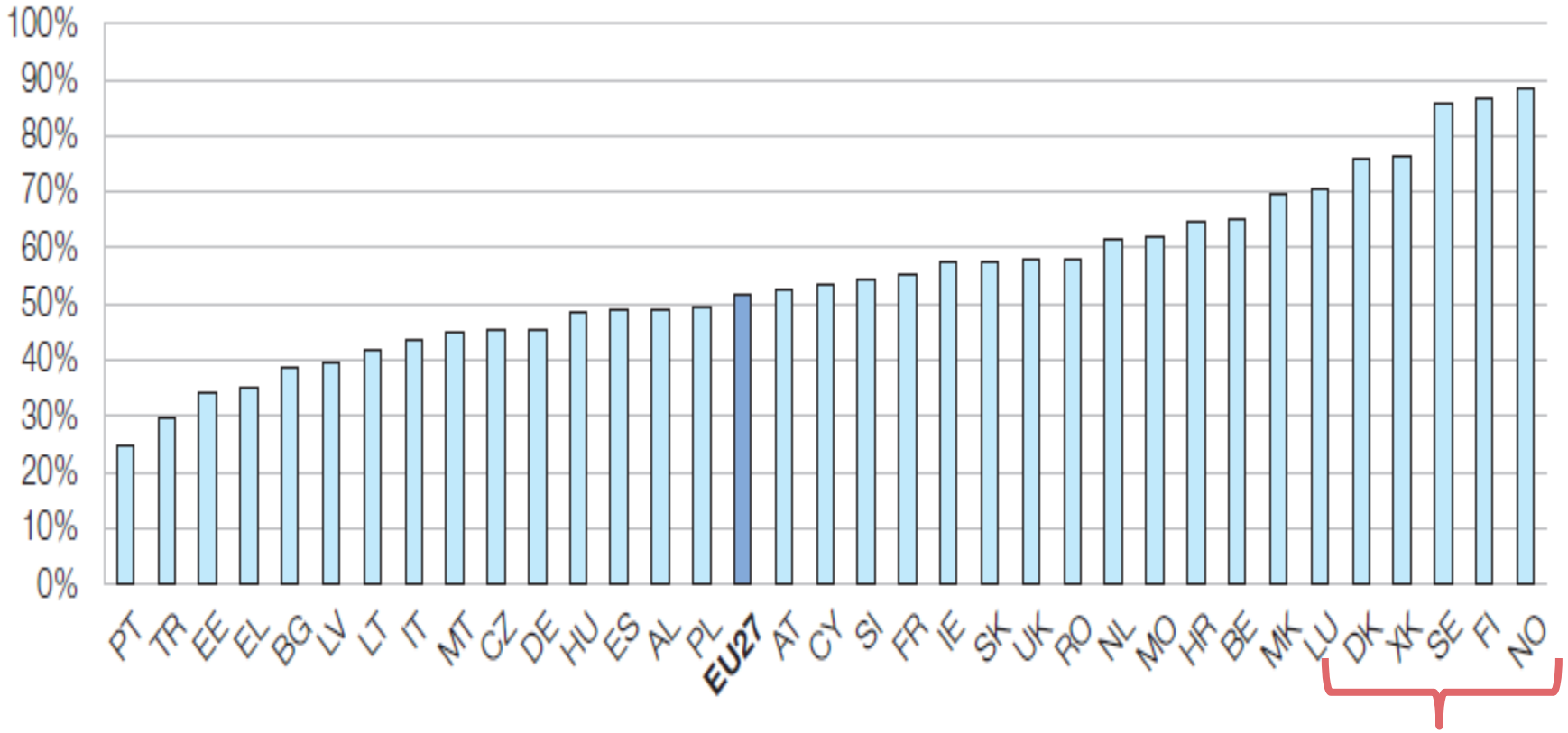
- Free health care for everyone
- Wide coverage of public services
- High and generally accepted tax level
- High social capital

Labour market

- High union and employer association density
- Wide coverage of collective agreements
- Tradition for involvement of employees – directly and through elected representatives

The Nordic model at the labour market may be shaken but still alive

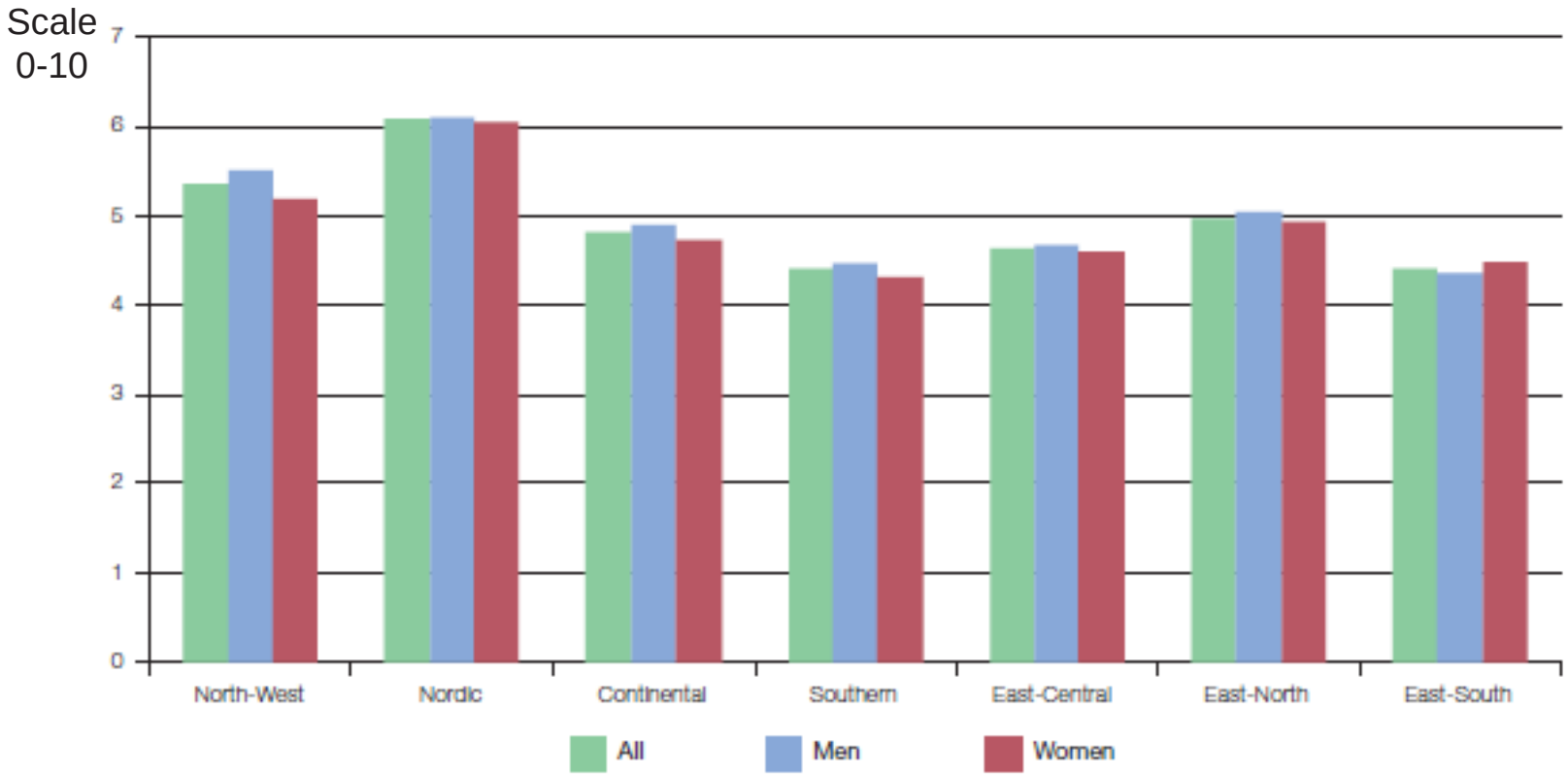
Figure 37: Employee representation, by country (%)



European Working Conditions Survey 2010

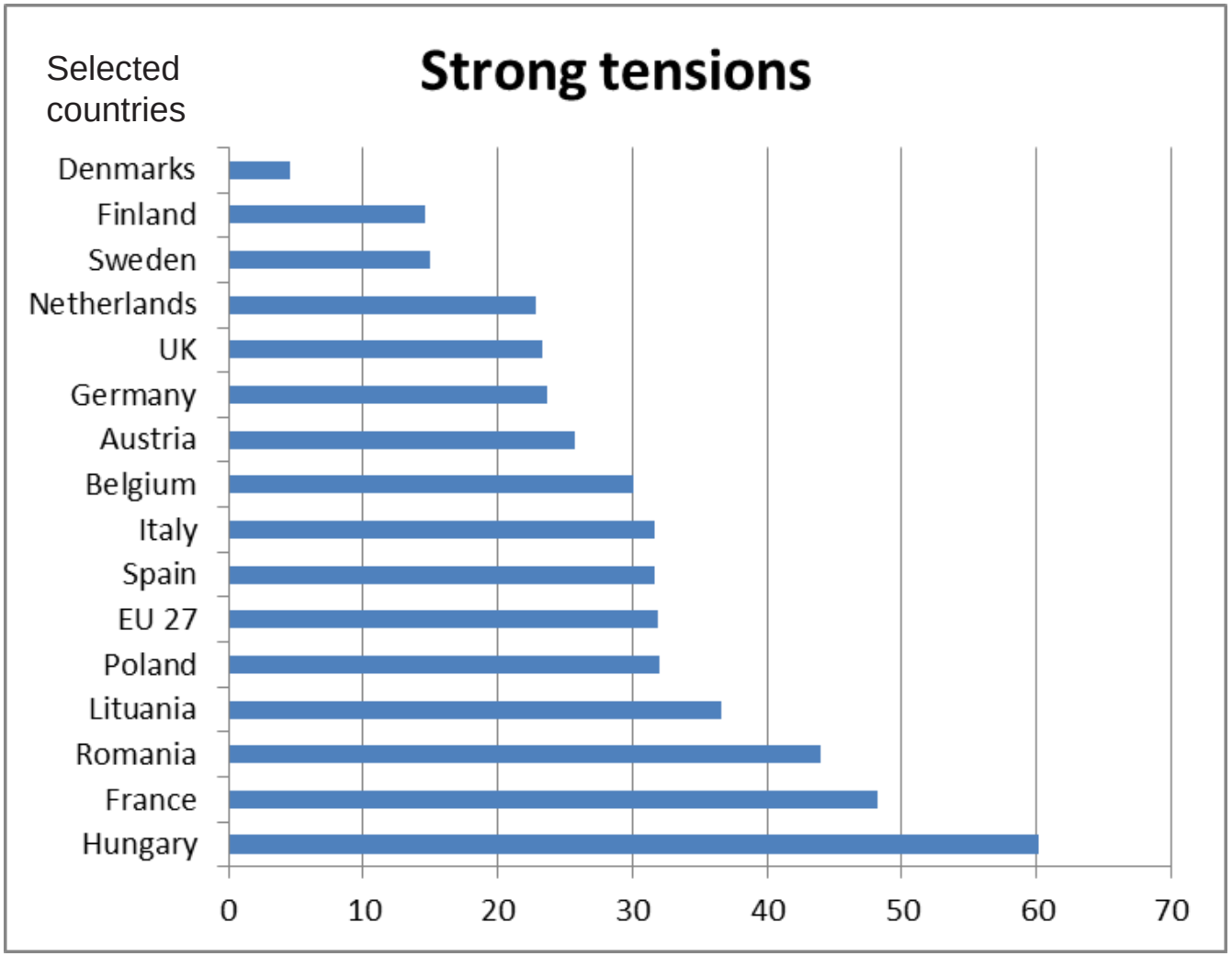
Organisational participation
(influence on decisions at work)

Figure 8: Organisational participation by country group and gender



European Working Conditions Survey 2010

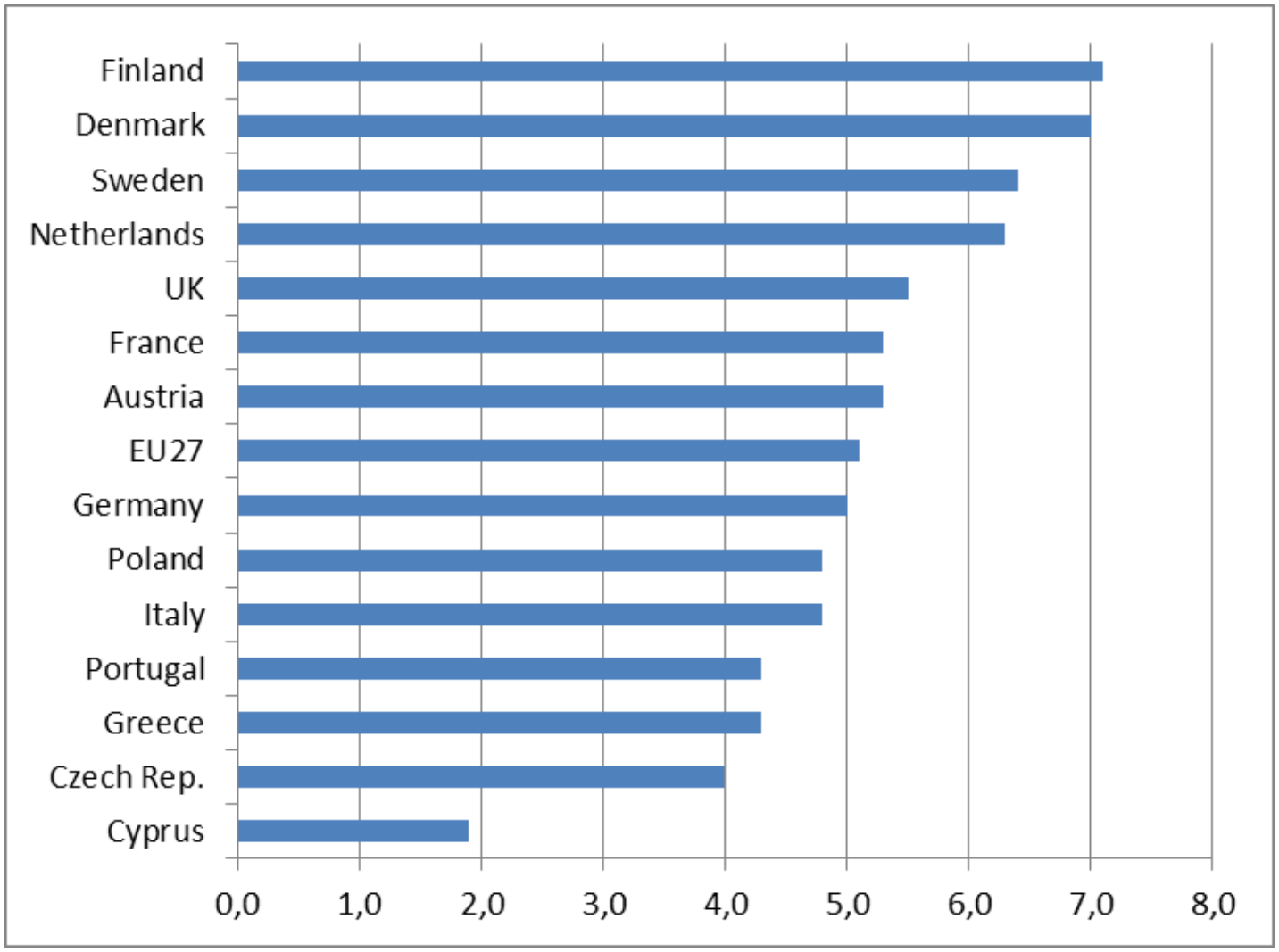
Tensions between employers and employees



European quality of life survey 2012

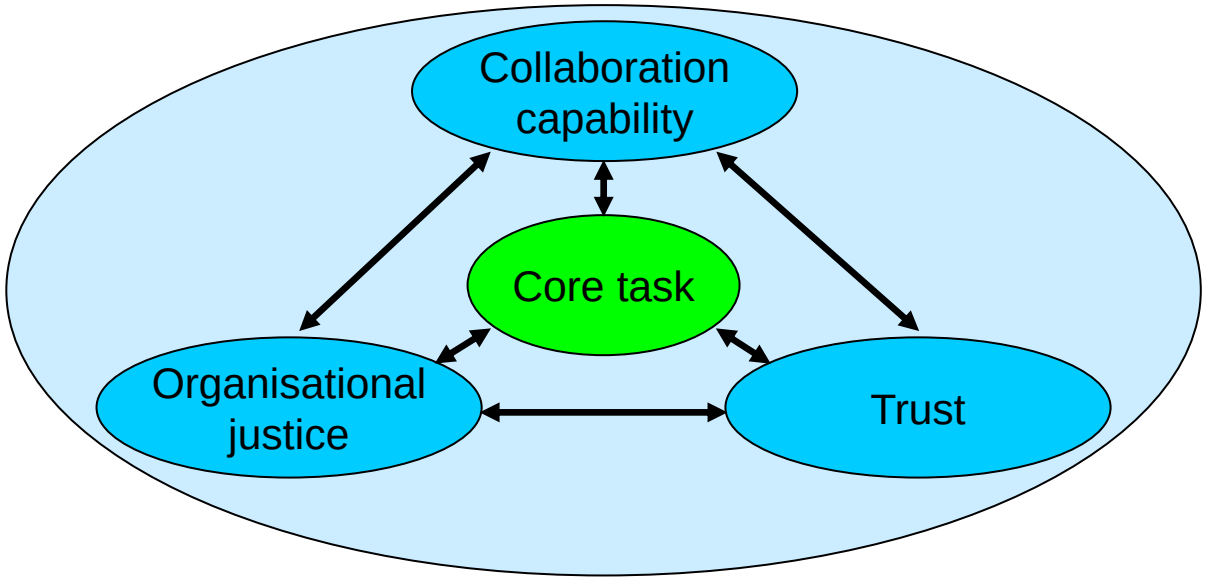
Trust in other people in Europe

Scale 1-10
Selected countries



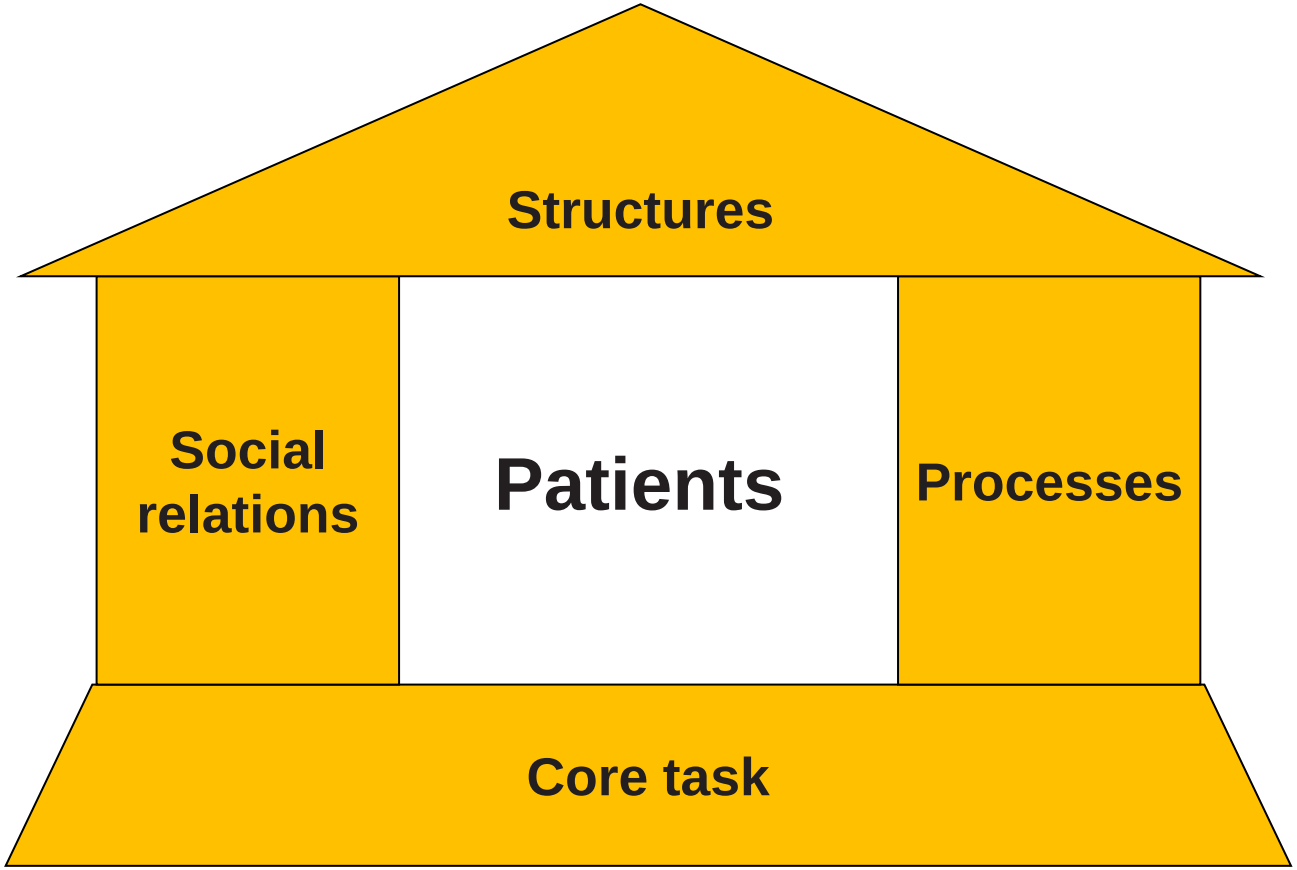
European Quality of life survey 2012

Organisational social capital as a possibility



The capability making the members of an organisation able to solve a joint task

Building a collaborative hospital

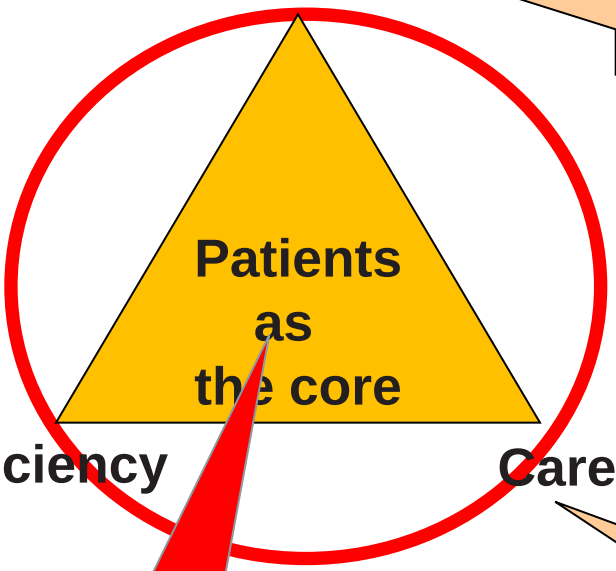


The foundation: the core task

- The core task is neither simple nor unambigous
- Both a staple core and a continuous development of the understanding of the core task
- Different professions and units contribute differently to solution af the core task
- Clarification is both a matter for management and employees
- But also for patients, citizens, politicians and other stakeholders
- Ownership crucial for engagement and collaboration for solution of the core task
- Each individual needs to make sense of his or hers contribution and the have a voice in clarification
- The understanding of the core task is developed through both dialogue and concrete work

Parallel value systems in hospitals

Core task: cure of patients or healthy patients?



Doctors:
Best possible treatment of the individual patient

Managers:
Most possible cure for the money

Nurses:
Best possible fulfilment of the patients needs

And space for the patients' voice

The first pilar: Social relations

- Social relations crucial for joint understanding of the core task and recognition of differencies in understandings
- Not only between professions and organisational units but also with patients
- Social relations secure both efficient operation and well-being
- Relationel coordination and interprofessional learning key tools:
  - Shared goals
  - Shared knowledge
  - Mutual respect

The second pilar: processes

- From: parallel professional and unit tasks based on a resource view
- To: a linked flow of task in a patient care pathway
- Key tools: Lean, productive ward and integrated care pathways
- A simplified understanding of value and waste is a major pitfall
  - But necessary to consider whether activities create value for the patients and the cost-benefit compared to other activities
- An ongoing discussion of lean: beneficial or mean

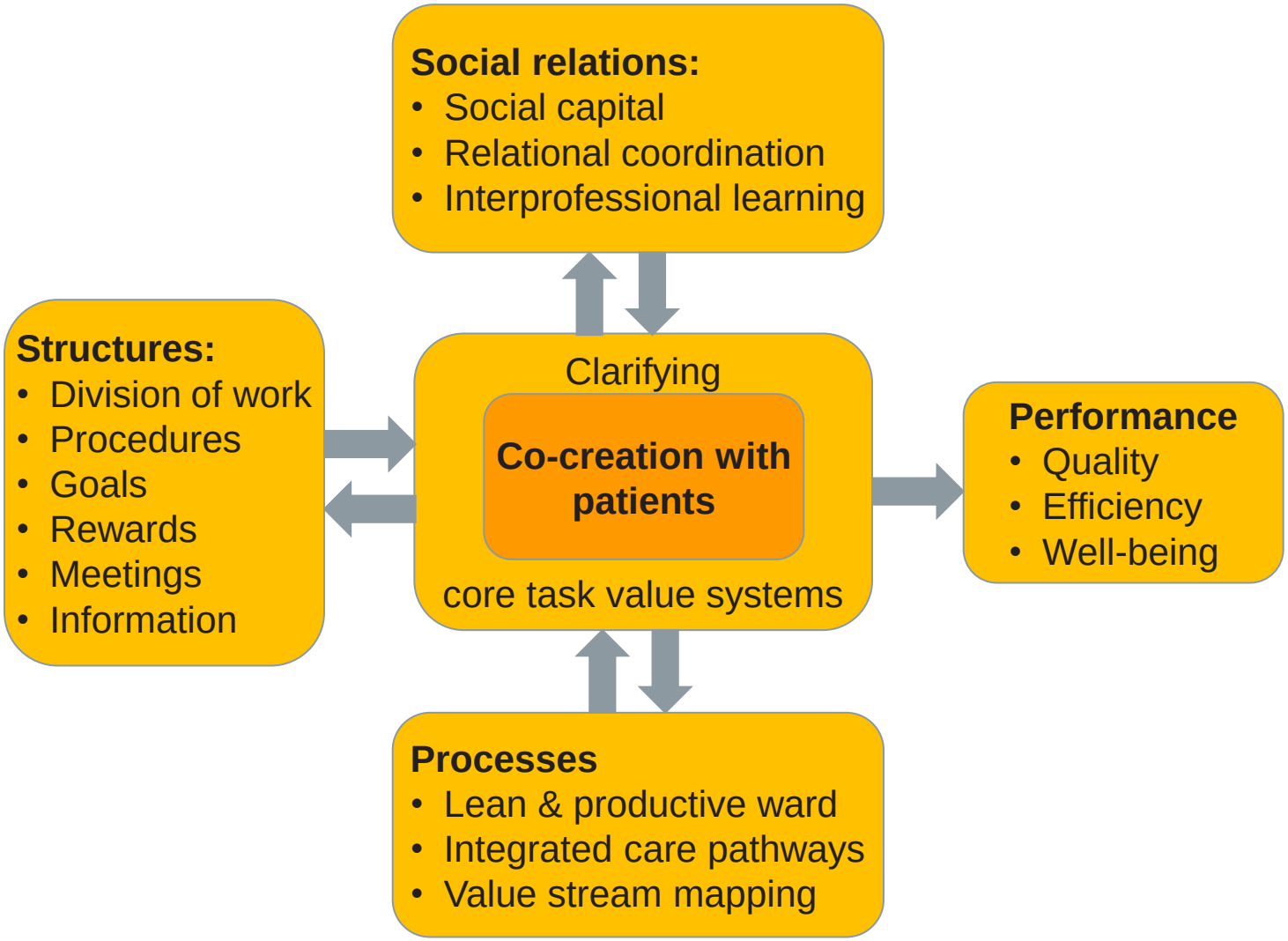
The roof: structures

- The skeleton which makes processes and social relations possible
- Division of work, physical environment, organisational units, rewards, recruitment, meetings, information system etc.
- Support relations and processes:
  - Meetings across professions to support relational coordination and flow by discussing todays tasks
  - Recruitment and competence development to support respect for other professions and orientation towards shared tasks

Rethinking the relations to the patients

- Are we working for or together with the patient?
- All staff at hospitals are focussing on the patient
  - But patient needs are taken for granted and the professional knows best
- Patient involvement is a hot political issue in Denmark
  - Difficult for both staff and patients to tackle
- A new possibility
  - More and more patients engage in their own treatment
  - It requires interprofessional collaboration
  - Co-creation with patients opens for rethinking the system

The collaborative hospital – a Nordic model



Implications for work

A move away from

- providing as much treatment and care as possible for the invidividual as judged by the healthcare professionels

To

- balancing the need of the individual patient and the general patient
  - Longer time with one patient increase the waiting list for the next
- Co-creation with the patient
  - Dialogue about cure objectives and treatment as well as division of responsibilites
- New dilemmas and new possibilities as the core task is the criteria for discussion with management and politicians

Implications for working life research in healthcare

- A critical eye for working life consequences still a corner-stone
  - The transition from traditional professionalism to the new collaborative professionalism will be troublesome
- But a new eye on efficiency is necessary:
  - WLR knowlegde of the needs of humans as individuals and groups can qualify traditional efficiency efforts
  - Integration of work environment and efficiency opens potential for more successful efforts
  - A possibility to move from the sideline to player on the field
  - Requires a move of interest from conditions to the content of work and to the relations with patient

Research needs in the development of a Nordic model for sustainable healthcare

Theoretical questions:

- How to understand the peculiarities of healthcare compared to traditional industrial and bureaucratic organisations?

Methodological questions:

- How to study healthcare which is changing so rapidly and has so great expectations for traditional evidence?

Empirical questions:

- What is the consequences of the rapid restructuring and rationalisation (real life experiments)?
- How to understand the new healthcare professional role?
- What methods to use to integrate efficiency, quality and work environment (interventions)?
- How to co-create with patients?

Thank you for your attention

Further discussions at:

- The 8th NOVO symposium on quality, efficiency and work environment in healthcare, 6-7 November 2014, Technical University of Denmark: http://www.novo-network.dk/
- Research course: Lean and the working environment, 18-21 November 2014 in Copenhagen: http://www.niva.org/start/view-54553-83

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