LINKING SYSTEM DESIGN TO SYSTEM PERFORMANCE: *A SYSTEMS DYNAMICS PERSPECTIVE*

By

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Organizational scientists working in complex, high risk/high consequence activities like healthcare, airlines, nuclear and chemical industries have been demonstrating a variety of innovative ways in which "system performance" can be dramatically improved through improved system design. For example, the type of macro and micro process designs in the airline industry -- combined with their willingness to "learn from their best mistakes" -- has enabled them to achieve 9-Sigma quality status, compared to 2 to 3-Sigma for most hospitals in North America. The difference in the outcomes are embedded in the design -- in both sectors.

By "design", organizational scientists mean functional design (*what is done*); structural design (*who does what*); and, work process design (*how work is done*). These functional, structural and work process designs are designed into the macro system level provincially; at the local level within LHIN boundaries; and, at the micro level within health service delivery organizations like hospitals and Community Care Access Centres.

Today, in the province of Ontario, we are on the verge of a fundamental transformation of our entire healthcare delivery system with the introduction of new structures (*Local Health Integration Networks*); new terms for resource allocation (*Service Accountability Agreements*); new accountabilities for outcomes/results (*patient safety targets, wait-list targets*, *financial targets*, etc.); and, emerging new systems, structures and processes for accountability (*Accountability Agreements* with CEOs and with senior/middle managers/Chief-of-Staff & Medical Chiefs) linked back to the strategic directions provided by the Board.

This amounts to a fundamental redesign of the system -- from top to bottom.

Large scale change is now occurring on all levels in the system -- at the provincial level, with the integration of the MOHLTC silos; at the community level, with the

establishment of LHINs; and at the service delivery level, with major change initiatives being introduced across the system -- including the downsizing of 42 CCACs into 14 and the impact of those traumatic changes on the delivery of community and home care services and on patient flow in the hospital system.

To determine whether all this change is going to produce some positive results, (e.g. patient safety, customer satisfaction and leveraged use of resources), we need to step back and reflect on how the humans in the healthcare delivery system are actually going to react to all this change.

Will Health Minister George Smitherman produce the results he intends, or, will the delivery system continue on its downward performance spiral?

Causal-Loop Diagramming

We need to step back from the "crisis du jour" to sort out the patterns that have emerged from our past system change efforts and reflect on the way incremental health system reform has been managed over the years.

"What can we learn from the 'best mistakes' of the past?"

So, what can we learn from the "best mistakes" of the past?

Causal-loop diagramming is a technique in systems dynamics (a branch of systems thinking) that enables people to see the *"relationships-of-effect"* within a complex adaptive system -- such as our healthcare delivery system -- without the "tags of blame".

While too often we can get lost in all the complexities of the service delivery system, the causal loop diagram on the adjacent page attempts to tell a simple and dramatic story: the macro design of our healthcare delivery system that has evolved within governmental silos over the years, and the thinking and behaviour (culture) of provincial politicians and public servants always have a direct and significant impact on how the service delivery system actually functions/performs.

How will the thinking/behaviour/performance of the healthcare delivery system be different now that LHIN's have been added to the mix of ingredients in the macro design box on the adjacent page labelled **"Provincial Government"**.

What are the unfolding new dynamics that are being generated by the changes in this box? And, how are these dynamics driving the system in new directions?

Organizational scientists tell us that our existing service delivery system is perfectly designed to produce the outcomes/results that we are currently achieving. So, if we are dissatisfied with the status quo, and want better results, we'll need a very different macro design than the one we have had – with design assumptions that need to be embedded at the service delivery level of the system as well.

We know from years of experience that "tinkering on the edges" of the system simply won't do anything meaningful. Fundamental, deep, transformational change is required. Clearly, that's what Minister Smitherman is attempting to achieve with his more integrated and more aligned approach to comprehensive healthcare reform.

But are LHINs an example of tinkering, or of deep transformational change?

We don't really know yet. The strategy is certainly sound, the Minister is very sincere, but how will the implementation be managed and led?

That's the key question. Successful change requires a coherent and integrated strategy that will shift how people in the system think and behave.

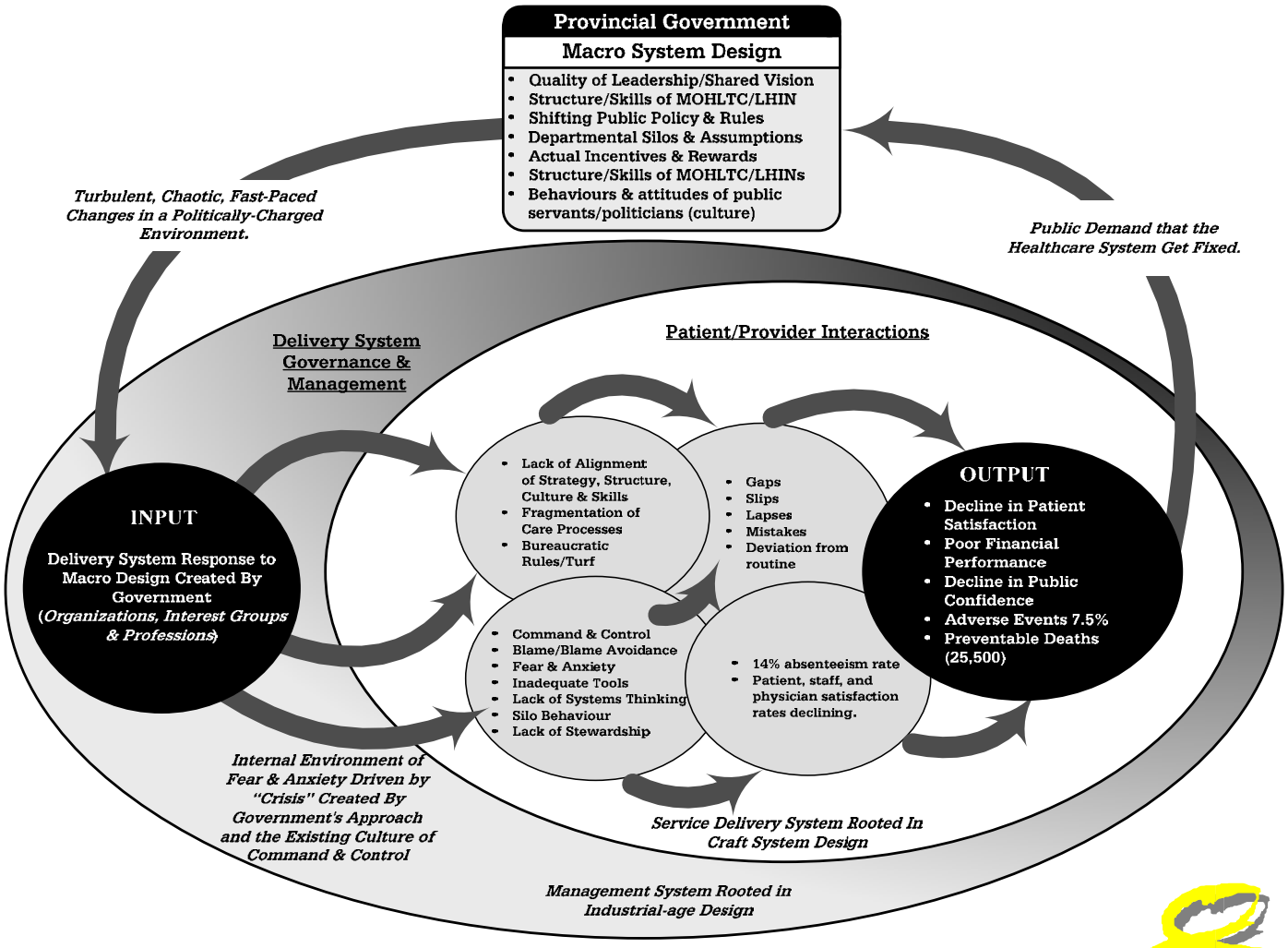
Every now and then we get Ministers of Health who really get this point -- they learn very quickly what the nature of the system is, and they intuitively know how to shape its direction. Previous Health Ministers Larry Grossman (PC), Murray Elston (LIB), Elinor Caplan (LIB), and Francis Lankin (NDP) each fit that mould.

However, while each of these Ministers were able to tamper with the basic DNA of the system to some extent, none had a holistic view of what to do -- and most only had twenty-four to thirty-six months as their time horizon for action.

Complex Adaptive Systems Dynamics

The Escalation Causal Loop Archetype:

What Causes Adverse Events in our Hospitals?



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So even the best of the system's past leaders were driven to a great extent by short-term political self-interests.

Because senior public servants and Ministers aren't usually around for very long, they don't tend to understand how their particular contribution can be so devastating to the healthy functioning of the delivery system over the longer haul.

They often suffer from performance anxiety and feel the need to be seen to be "in control of the file". Optics, or what Peter Senge calls *"the illusion of control"* drives people's thinking and behaviour at the top of our public healthcare system.

Unfortunately, real people are harmed and even die because of short-sighted political and bureaucratic decisions that were rooted in the mental blinder known as *"the assumption of control"*.

Unintended Consequences

The diagram on page four is our attempt to highlight some very profound issues that never really get openly addressed -- because the system has been designed to avoid them, to cover them up.

These are the system's *"undiscussables"*.

The first undiscussable is that incoherent policy signals from Queen's Park has, over the years, created extraordinarily dysfunctional dynamics across the entire delivery system.

Local governance boards, CEOs, senior managers, middle managers and front-line service providers in the healthcare services delivery system are all dramatically affected by politics, public policy and the personal behaviours of the people who occupy the box that contains the macro design -- the basic DNA of the healthcare delivery system.

The diagram shows an arrow leaping out of the government-of-the-day and dramatically impacting on the governance and management components of the healthcare delivery system -- which is further compounded by the dynamics of vested interest group politics in what is a very short-term political decision-making system.

Short-term optics -- rather than long-term results -- have traditionally been the true focus of the system.

The behaviour of the governance and managerial leadership at the community level, and the behaviour of vested interest groups at the provincial level (OHA/OMA/etc.), does indeed have a dramatic impact on a whole range of system outcomes, including:

- staff/physician and patient satisfaction rates;
- quality-of-care/patient safety;
- the number of adverse events; and,
- financial performance -- in an environment of total confusion (i.e. the government often says it values "good management", but in fact only rewards bad management).

"Even the best of the system's past leaders were driven to a great extent by short-term political self-interests."

Historically, those Ministers who have made a positive contribution to the functioning of our healthcare system were those who were "natural systems thinkers". They had an intuitive understanding -- a gut feel -- for what organizational scientists call a "*complex adaptive system"*.

Politicians and bureaucrats who are in a big hurry to be "seen to be doing something", usually tinker with structure -- without any real understanding of the actual system dynamics that are at play in the service delivery system.

Causing real and significant harm inside our healthcare system is called *"an unintended consequence"* of political and bureaucratic decision-making.

That's the risk that these new LHINs face today: are they supposed to create certain optics for the government before election day, or, are they really going to play a constructive role in helping their communities

determine how to improve quality and coordination of services -- at the customer level?

System Design Changes

Today, even the most cynical of observers are giving credit to the McGuinty/Smitherman government and their senior public servants for what appears to be highly strategic and very leveraged health system design changes that are intended to change the basic DNA of the delivery system for the better.

By challenging the system to solve its own problems, the Ministry has operated as a "disruptive catalyst" that is beginning to spark positive change in the delivery system through "expert panels", "innovation expositions" and "innovation funding" for those on the leading edge of change.

Rather than pretending that they have the answers, Queen's Park is finally saying that "the answers are in the system".

This is a major and welcome shift in attitude.

"Causing real and significant harm inside our healthcare system is an unintended consequence of political and bureaucratic decision-making."

At the local level, LHIN's have the potential to play a very positive role in health reform -- but they could also do harm, or allow harm to continue if they don't make the shift from command & control to a facilitative role in their network.

Nobody ever means to cause harm in the delivery system. However, historically the top people in the Ministry don't have to "own the consequences" of their actions because usually by the time the harm is done, they have moved onto something else -- and the system has moved on to the next flavour-of-the-month.

But, how many of our 23,750 annual preventable deaths (Baker/Norton) actually have a *relationship-of-effect* with short-term political and bureaucratic decisions and their impact on those who manage and govern the system at the community level -- and their impact on service delivery at the customer level?

Evidence tells us that it is the existing combination of perverse incentives, centralized control mechanisms and siloed/fragmented structures that – in combination -- have contributed to making our healthcare delivery system increasingly dysfunctional. The existing relationships are rigid, command and control, highly political and adversarial in nature.

When the system is under stress, our normal habit is to blame people (*"those high-priced CEO's"; "those incompetent bureaucrats"; "those angry doctors"; "those pushy LHINs"; etc.*), rather than seeing, understanding and acknowledging the role played by the actual design of the system.

Designing Complex Systems

The fact is that human behaviours are caused by the way we have designed the system at both the macro and micro levels.

Edward Deming (the father of TQM/CQI) said that 93% of all problems in systems can be traced to their macro designs -- that is, to the design of the systems/structures and processes.

While 3.5% to 7% of the time the problem is "people", we unfortunately seem to find people to blame and shame most of the time.

In his ground breaking report, ***"Patient Safety and the Just Culture"***, David Marx identified what he called the four "evil behaviours" related to people. These are *human error*, *negligence*, *intentional rule violations* and *reckless conduct* (see diagram next page).

If we accept these categories, Deming would say that these would be the cause of the problem 7% of the time – at the most. He would say that if you want to achieve results, you need to look at the functional, structural and work process designs to discover where 93% of the problems have their roots.

In ***"Human Error: Models and Management"***, J. Reason rejects the person-centred approach for the system approach as he explains that "errors are seen as consequences rather than causes, having their origins not so much in the perversity of human nature, as in 'upstream' systemic factors". Reason says that "when

an adverse event occurs, the important issue is not who blundered, but how and why the defenses failed".

By stepping back and exploring our circumstances from a higher level, we can see a larger and more complete picture of reality.

What emerges from tracing the *"relationships-of-effect"* in our complex healthcare delivery system in our page four diagram is what is known as an "*Escalating Causal Loop"* -- the same dynamics that continue to fuel the Israeli/ Palestinian conflict.

That is: the repeating dynamics ensure that everyone is going to lose -- unless there is a fundamental and transformational change in the system.

This particular *systems dynamics archetype* means that the same pattern will repeat forever -- unless someone changes the dynamics by changing the macro design of the system.

So, the key "lessons learned" has been that until and unless the basic DNA is changed, "system reform" efforts will continue to be an exhausting waste of time and effort.

"Unintended Consequences"

The truth is that over the past 20 years of healthcare reform in Ontario, we have been able to make a number of critical mistakes which we don't have to repeat anymore.

So, how will we incorporate these "lessons learned" as we move forward with the implementation of the McGuinty government's health system reform agenda?

Lots and lots of activities could be undertaken by very sincere people that may never produce any meaningful results or improvements for patients, taxpayers or service providers.

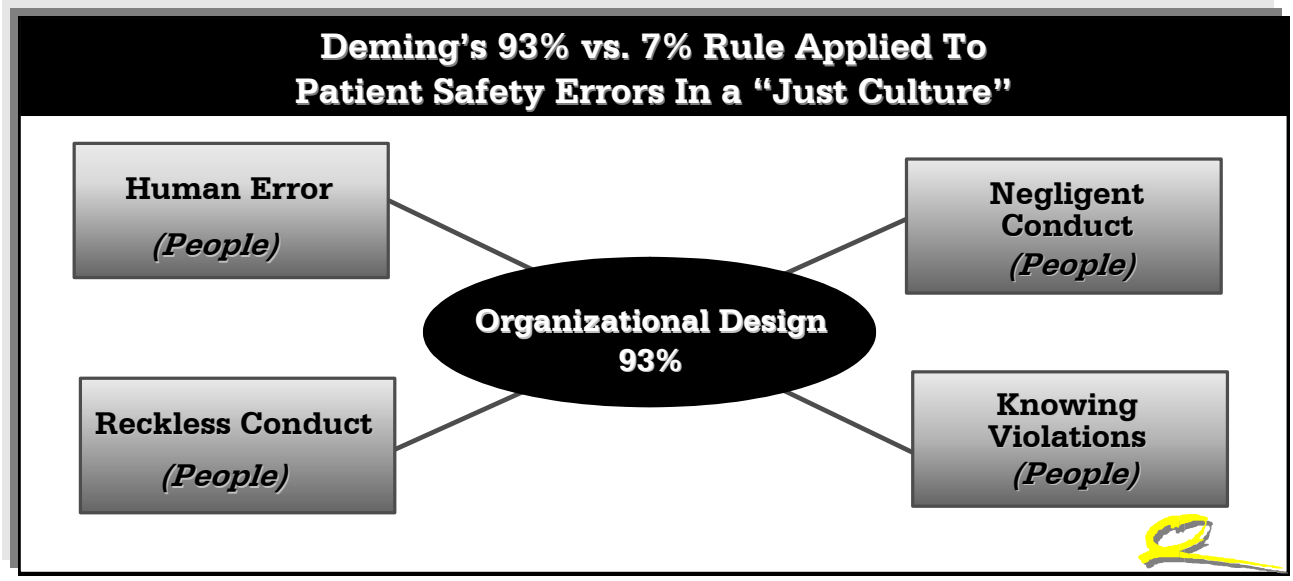
We could easily end up investing the same amount of time and effort in another round of "visioning exercises" and "planning exercises" with the LHINs as we invested in the hospital mergers and bed closures that were initiated by the MOHLTC through their *Healthcare Restructuring Commission* a few years ago.

We are asking a simple question: "Won't we just produce the same results that we obtained from all those previous efforts at health system reform if we don't fundamentally change what we're doing -- and how we're doing it"?

Did the hospital mergers and acute care bed closures from ten years ago ever lead to decreased costs and improved quality -- as was promised?

No. They did not. They created a whole series of other "unintended consequences" -- like the predicted back-ups in emergency departments because elderly people were blocked in acute care beds due to our historical under-investments in community care services.

Will the current round of CCAC mergers lead to decreased costs and improved quality? Since the



evidence on mergers tells us that 80% fail to achieve their intended outcomes, why would anyone think we will achieve great results this time?

Will LHIN planning exercises that are about to begin actually produce the outcomes that are promised? Will the public engagement and round table dialogues on the *Provincial Strategic Plan* lead to a better plan?

We don't know yet. But there is a good chance they might.

But some LHINs could engage in the same old traditional linear strategic planning exercises which Henry Mintzberg tells us fail 90% of the time. Will the LHINs actually get their network partners to be truly engaged in designing the future health service experience in their network together?

We can hope. But the truth is that we never have before. Issues of fear, anxiety, politics and control have stopped us in the past.

How could it be different this time? How could collaboration efforts actually be made to work at all levels of the system?

"Some LHINs could engage in the same old traditional linear strategic planning exercises which Henry Mintzberg tells us fail 90% of the time."

LHIN's Can Become A Positive Force

How could the LHINs be "in service" to the health service delivery partners that they fund?

How can the delivery agencies and institutions redesign themselves to become more customer-focused, customer-driven, integrated and aligned?

Part of the new DNA being designed into the delivery system are *Service Accountability Agreements* between the LHIN Boards (the funder) and the Service Delivery Organization Boards which will place a major focus on indicators that measure customer outcomes, customer service and customer satisfaction levels.

So a new era of accountability is arriving in Ontario.

However, as Senator Michael Kirby points out in **Policy Options** (July/Aug, 2006) "it cannot be stressed enough that the measures put in place to ensure greater accountability must function with as little bureaucracy as possible". He says that "top-down control by provincial bureaucrats of highly complex service delivery institutions make them less, rather than more efficient".

LHIN's can become a positive force if they operate in stewardship, rather than in control of the delivery agencies and institutions in their network.

The key question is: will they create the right balance of empowerment and accountability for results?

It is this jumble of complex structural and human dynamics that will impact on the system at the service delivery level -- where healthcare providers and consumers meet. However, in the absence of any shared vision at the community level, many of these same old power dynamics will simply add to the incoherence, anxiety and confusion across the delivery system.

When fear and anxiety are wide-spread in the system -- from the CEO to the front-line worker -- patient errors go up, and financial performance goes down.

The fact is that the design of the core systems, structures; incentives and processes that have evolved over time at Queen's Park, and the "short-term/quick-fix" mentality of politicians, public servants and organized vested interest groups are what has driven our poorly designed, highly political and unaccountable delivery system to achieve the sub-optimal results that are being experienced by the public today.

Blaming any one group is pointless -- it is the result of a set of dynamics rooted in behaviours that are aligned with the existing incentives in the system.

If we really want better results, we need to change the design of the system -- in alignment with the results we want. ***We need to change the rules of the game -- which will, in turn, change how the game is played.***

We believe that this is what ***Bill 8*** and ***Bill 36***; the Ministry's internal reorganization; the *Service Accountability Agreements;* and, the local *Integrated Health Services Plans* are doing. They are changing how the game is played. So, this is not the same game anymore!

This is different. The basic DNA of the system is being changed. This is the difference between what has happened under George Smitherman and all the other past attempts at health system reform.

Agree with him or not, George Smitherman is changing the system -- most likely for the better.

Lessons Learned From Past Failures

If you reflect on the box in our page four diagram called "**The Provincial Government"**, the following historical facts arise:

- Ministers and Deputies normally only last 18-20 months;
- ADM's last 20 to 30 months;
- Middle managers at MOHLTC, local offices and the staff at OHIP are deeply invested in controlling their silos -- for their own survival and safety. In this world, politicians, deputies, ADMs and *Results Tea*m members come and go -- but "the middles" will always be here;
- Tens of thousands of hours of system leadership time and energy is spent on urgent, unimportant crisis that are often self-created by both governmental and interest group bureaucracies that consume much of creative capacity and energy of the system's leadership -- but don't add any actual real value to patients, taxpayers, managers or governors;
- Patient satisfaction rates and staff/physician satisfaction rates still keep declining;
- The government and managerial rhetoric over the past ten years about the need for "seamless services" and "customer-focused care", continues to be just rhetoric -- despite billions of additional dollars in public spending;
- Patients/families/voters become increasingly frustrated by the lack of improvement in the healthcare system;
- Taxpayers continue to pay more and more for healthcare services through the premium tax -- but the services keep getting worse and worse;
- Preventable deaths and "adverse events" in hospitals still keep rising;
- Desperate politicians create more and more "optical illusions" -- so that it seems like they are "in charge", and "in control" of the file; and,
- Throughout the system, **trust** continues to erode, and the spirit and commitment of service providers continues to decline.

"Taxpayers continue to pay more and more for healthcare services through the premium tax -- but the services keep getting worse and worse."

If you step back from the diagram on page four and reflect on *"what is actually happening in our healthcare delivery system today?"*, you may sense that the pace of change (in the arrows throughout the diagram) is actually picking up speed.

This is no longer a slow "boiled frog process" in which the consequences are experienced further into the future. The speed of the changes, and the level of the chaos seem to be increasing, and the problematic results are coming at a faster rate.

However, the provincial government is now focused on **Five Key Transformations** according to Hugh MacLeod, the ADM for Accountability and Performance. These are:

- From bureaucratic skills for managing processes in silos, to collaborative skills for achieving outcomes for customers;
- From resources flowing to silos, producing fragmentation, to resources flowing to a system, promoting integration at the customer interface;

- From independent silos focused on provider interests, to interdependent organizations that are focused on the needs of the system's common customers and owners;

- From lack of integrated data-bases of key customer information, to an integrated information management system that can facilitate seamless care; and finally;

- From declining public confidence, to restoring public confidence.

These are certainly major shifts in a system which will produce counter-veiling forces to the ingrained habits and ways of thinking and doing things in the sector.

Will the government's change management strategy work? Will we transform the delivery system to achieve the vision that Smitherman is holding out as a possibility in each community?

The evidence on large-scale change initiatives at both the system and organizational levels tells us that only 30% of such efforts actually produce their intended results.

Do we have the leadership we need from the provincial, network and organizational levels to successfully transform the system? Are we actually moving towards a shared vision for our future system? Are we poised to make real changes -- or, is this just another bureaucratic make-work program?

Remember, we've been through the loop before many times. Our system leaders have lurched from crisis to crisis spending millions of dollars and tens of thousands of hours on bureaucratic information gathering processes that led nowhere -- and had no real impact on patients, taxpayers or the community partners who engage in these exercises.

Instead of using our system intelligence to solve problems using lean thinking and systems thinking, we got rid of people, cut quality and chopped budgets thinking that these were ways to become "more efficient".

How will it be different this time?

Will System Reforms Be Quality-Driven?

In their recent report to Health Canada, UBC authors Sam Sheps and Karen Cardiff point out that provincial ministries of health spend more time, energy and resources worrying about the financial health of their institutions than issues like patient safety or quality-of-care. They point out that obsession with safety, quality and public confidence in the overall system is front and centre in the transportation and nuclear industries.

Similar compelling facts are outlined in the recent essay, ***High Reliability vs. High Autonomy*** by Evans, Cardiff and Sheps which outlines how the airline and nuclear industries are becoming "ultrasafe" through the redesign of their systems, structures and work processes.

"If provincial governments and hospitals actually accounted for the cost of poor quality in the system, they would find that the biggest opportunity for cost savings actually lies in improving the quality-of-care."

This is not the case in the healthcare sector in Canada today -- which continues to trade professional autonomy for patient safety and proven quality processes and practices.

If provincial governments and hospitals actually accounted for the cost of poor quality in the system, they would find that the biggest opportunity for cost savings actually lies in improving the quality-of-care -- which would also happily result in improved customer and staff satisfaction rates!

While "win/win/win/win" is possible, the system is still paradoxically designed to prevent the system from producing better results.

In ***"Achieving High Reliability: Other Industries Can Help Health Care's Safety Transformation"***, Jeff Brown points out that "clinicians are commonly viewed as autonomous craftspersons, individually responsible for the safety in our existing system".

"A hospital is a place for physicians to have privileges, where they may practice medicine as individuals. The

burden of safety and quality-of-care is placed squarely on individual physicians, nurses and other clinicians" in this model", says Brown.

He points out that, "this perspective disavows the clinicians as part of a complex interdependent system of care managed by many people in a variety of clinical and non-clinical roles".

While health reform language incrementally morphs us towards integration vs. silos; towards teamwork vs. autonomy; towards system design vs. blaming people, we are not there yet. Far from it.

We still don't think and behave as a "system" with a "common owner". We are, at this stage, still a very fragmented system.

Will the creation of LHINs change this, or, will LHINs end up being designed with the same command & control DNA as the Ministry of Health and Long-Term Care?

Again, time will tell.

But Minister Smitherman and his senior officials are certainly saying and doing all the right things. So, perhaps there is good reason for hope and optimism that positive change for healthcare consumers, healthcare providers and taxpayers is just about to unfold over the next two or three years.

However, just because the Minister has good intentions does not mean that his strategies will be implemented the way he wants it.

None of the past efforts to reform the Ontario healthcare system have managed to get much beyond the healthcare sector's version of a *"military-industrial complex"* – the professional advocates whose business is the politics of the system.

Part of the traditional delivery system response to governmental power has been to create strong vested interest groups whose very purpose for existence is to advocate on behalf of their narrow self-interests -- so that they maximize the benefits of their silo or group.

We're not saying interest groups are "bad". We're simply pointing out that interest group behaviour is also driven by the macro system's design. In our current system, everyone is incented to be self-centred and political -- in fact people are often rewarded for the worst behaviours.

Good managers with a balanced budget are not rewarded. Bad management and deficits are rewarded.

Cooperation, collaboration and innovation are not rewarded -- political threats are. High quality isn't rewarded, cutting budgets are.

Political operators in the service delivery system who can get direct access to ADM's, the Deputy, or the Minister can always get to "do special deals" that benefit their organization or silo. Team players, who seek to find solutions through collaboration are still very often the losers.

"It is the silo-interests, the bureaucratic-interests and provider-interests -- not the public's interests -- that prevail in the existing design of the healthcare delivery system."

While historically the rhetoric has always been about "collaboration" and "partnership", the reality is that the fragmentation in the system is rooted in the design of government's own internal systems, structures, processes and reward systems.

System Alignment

What is encouraging in Ontario today is that Deputy Minister Ron Sapsford has embarked upon a fundamental restructuring and integration of the Ministry itself.

Queen's Park actually appears to be practicing what they preach: integration and mutual accountability are being introduced at the provincial level.

But will it work? Change isn't easy.

Evidence from all past health system reform efforts over the past 15 years would suggest that it is the silo-interests, the bureaucratic-interests and the provider-interests -- not the public's interests -- that prevail in the existing design of the healthcare delivery system.

Indeed, if the system is maintained as a political system (i.e. the status quo), then that is the outcome that will be produced: more and more politics, and more and more advocacy campaigns.

As long as the core systems, structures and processes that have been designed by Queen's Park remain controlled and micro-managed by the various Ministry silos; as long as there is no alignment between strategy, structure, culture and skills within the delivery system; as long as the behaviours of government, or the LHINs, or our governance boards reflect a hierarchical, command and control political-orientation; as long as the system's governors and managers are driven by the wrong incentives; and, as long as there is no stewardship for the delivery system; then, the system will not change!

We can add a LHIN; cut out the DHC's; threaten hospital CEOs; shout the word "quality"; or, say nice things about nurses in television ads -- but we will still produce the same results in the system.

While there is lots of sincere rhetoric from the McGuinty Government about producing "different results" in the healthcare system by election day on October 4th, 2007, we need to ask ourselves: **are we really on a path to accomplish anything different, or is this all just an optical illusion?**

The answer is: we could very well be on that improvement path -- if the LHINs, through their own behaviour and modelling, actually change the DNA of the macro system. If they take a more facilitative approach, and enable the healthcare providers to develop the integration plans and initiatives for their network, we could end up actually producing some very different results over the next few years.

That's because the system knows how to fix itself. But it needs support and the right designs to enable it to self-organize and mobilize its knowledge, talent and commitment.

If, on the other hand, LHINs adopt the same old command and control model from the local offices and from Queen's Park, we should also expect the same old results.

As the change management scholars tell us: "the results are embedded in the design of the system".

Designing New Systems, Structures & Processes

We could produce dramatically different results over the next two or three years -- if CEOs and Boards of service delivery agencies and institutions actually use the opportunity of creating *Local Health Service Integration Plans* to change their current levels of performance by redesigning and aligning their own internal systems, structures and processes from a customer-perspective.

We could indeed begin to produce some very different results, if healthcare delivery agencies and institutions adopt the *"Accountability For Results"* model rooted in a best practice *Balanced Scorecard*.

So, what are the current results we're producing in our healthcare system today -- given our existing industrial-age assumptions, designs and tools?

In addition to our out-of-control overall costs, today 7.5 percent of patients admitted to a hospital -- one in 13 -- suffers harm as a result of their care.

Our politicians are not ignoring the quality issue, but they have chosen to focus on another issue: wait-times for five surgical categories. The good news is: real progress is being made in this area. Finally, a cause for celebration! Change is possible.

Over the past two years Ontario hospitals have performed 42% more MRI Scans, 32% more hip and knee joint replacements, 17% more selected cardiac procedures, 16% more cataract surgeries, 11% more cancer surgeries and 8% more CT Scans by targeting an additional $189 million in increased volumes.

However, we believe that "quality" will ultimately emerge as the priority issue as the public learns more and more about our current circumstances -- through the expected increase in media attention to the increasing number of "patient horror stories" that are emerging.

The Baker/Norton study claims that 23,750 hospital patients die each year in Canada due to "adverse events" and to medical errors/mistakes.

The ***Canadian Institute for Health Information*** says that medical errors cost 1.1 million additional hospital days and adds over $750 million annually to the cost of providing healthcare services.

At the root of this is a culture driven by the needs/ wants of providers, rather than the needs/wants of consumers and their families -- or by the bottom-line requirements of the *"owners"*, who, in Canada, are the citizens and taxpayers.

According to the ***Ontario Health Quality Council***, Ontarians want their healthcare system to be safe, effective, patient-centred, accessible, efficient, equitable, integrated, appropriately resourced and focused on population health.

To achieve the system that the "owners" think they already paid for will require major changes in the system. For transformation to occur, people have to change how they think and behave.

"Is the LHIN the McGuinty Government's version of the traditional structural quick-fix?"

In their ground-breaking essay***, "Five System Barriers to Achieving Ultrasafe Healthcare"***, the authors (Amalberti/Auroy/Berwick/Bareach), point out that "becoming ultrasafe may require healthcare to abandon the traditions of autonomy that some professionals erroneously believe are necessary to make their work effective, profitable and pleasant".

While many physicians hold beliefs about what would make them happy, the truth is that the status quo does not make them happy. Still, various efforts to change have failed over the years and most physicians are, understandably, skeptical.

The problem is, we will never successfully transform the system unless physicians are fully engaged and aligned with the purposed solutions.

On the staff side, we also have to come to grips with plunging job satisfaction rates for front-line healthcare professionals – particularly nurses.

Canadian healthcare organizations have in fact become "one of the most toxic work environments in the country".

The ***CPRN-EKOS Survey*** (2000) shows Canadian healthcare workers with the lowest rates of job satisfaction among 15 work categories in Canada. The ***Statistics Canada Labour Force Survey*** tells us that nursing, technical and support staff in healthcare also have the highest number of days lost due to personal illness or injury of any occupation -- at more than double the national average!

Indeed, if the healthcare sector was to take measures that enabled us to only achieve the national average, we would add the equivalent of 7,500 nurses to the system!

In fact, the real looming crisis that our healthcare system is now facing is leadership talent and system knowledge as over 30,000 RN's and thousands of senior managers retire between now and 2008.

Leadership and system knowledge will become the new crisis in our healthcare system over the next few years.

Unfortunately, these sorts of "people issues" are usually not considered as compelling as "technology issues", or "capital spending" issues. These are the issues that tend to capture the attention of decision-makers who have never traditionally focused on the critical importance of our **human capital** issues.

Historically, human capital issues -- like leadership development and succession planning -- have not had a priority role in healthcare. Very few organizations invest the recommended minimum of 1% to 5% of payroll on the learning & growth of their staff. Very few Boards ask their CEO's about talent management and succession planning.

But failure to invest in our human capital over the years has produced and reinforced dynamics which have led to poorer quality and higher costs in the system.

Despite being a knowledge industry, the healthcare sector does not invest in its employees.

So where are the interests of the taxpayer/citizen/and healthcare consumer in this complex picture?

They are poking up out of the other side of the diagram on page four with the never-ending public demand that their healthcare system should be "fixed".

And, despite the promises of politicians, the system just gets worse, and more expensive.

Can We Stop the Pattern? Can We Learn?

We have been in this endless loop now for the past 20 years.

Governments are elected, and sometimes re-elected, on a promise to "fix healthcare" -- but they never do.

The "lesson learned" from history is that the *Escalating Causal Loop* pattern just repeats itself forever -- unless the circumstances are changed. If we are to succeed, the pattern has to be broken.

"Governments are elected, and sometimes re-elected on a promise to 'fix healthcare'-- but they never do."

Changing governments, changing deputies, changing ADMs and changing structures (mergers/LHINs/re-engineering) does not work on their own. We've been there many times in the past. We keep repeating the same/old "fixes-that-fail".

That's because we never deal with the full complexity of the organizational DNA that actually drives the performance of the delivery system.

Rather than focus on managerial skills, organizational strategy and process design, CEO's and senior healthcare managers in the delivery system have learned over the years how to succeed with political skills and spin-doctored communications.

In such highly threatening political environments, local governance often stops "acting in the public interest" (i.e. representing the "owners"), and instead, community boards of health service providers begin to act in the narrow self-interests of their own organizations.

In addition, the organized and well-financed vested interest groups that dominate the provincial healthcare agenda have evolved over time into silo bureaucracies which have become vested interest groups themselves -- another set of complex dynamics that keeps a whole industry busily engaged in health system bureaucratic dynamics/processes/political gamesmanship and general bureaucratic "busy work".

In Ontario, the most popular "*Fixes-That-Fail Archetype"* is the structural quick-fix. In the past, these have included: hospital mergers, reengineering, appointing inspectors, conducting operational reviews, imposing recovery teams, etc.

Is the LHIN the McGuinty Government's version of the traditional structural quick-fix? Or, is it really different, as Mr. Smitherman claims?

We will soon know. It now takes less and less time for us to discover that all of the "quick fixes" to structure fail.

Blaming People

People in the delivery system are understandably skeptical about health reform.

The diagram on the back cover on *Macro and Organizational Design* addresses the traditional blame-games in healthcare.

For example, there are people who will say, "the problem with the system is the CEOs and their senior managers -- or their dysfunctional Boards".

The diagram indicates that 7% of the time Boards and senior managers may indeed be the problem, but 93% of the time, the problem will in fact be rooted in the macro design of the system -- which is Queen's Park's responsibility.

There are others who will say "the problem is the behaviour of the doctors, or the nurses, or the staff" when it comes to unpleasant experiences by patients.

The Fixes-That-Fail Archetype

Fixes-that-Fail	Results
• Create a *Healthcare Restructuring Commission* to close acute care beds- before investing in community care. This was the Harris Government's top-down "structural quick-fix".	• Create systemic back-ups, trap elderly in hospitals and clog emergency departments. Government throws money at ERs to "fix" what is in fact a problem of community/home care underfunnding. Patient flow is the real issue. Process design is the solution.
• Merge hospitals to "save money" and "improve services" . Get hospital leaders to spend thousands of hours at hospital network meetings to focus on the power relationships among themselves.	• 80% of mergers fail to achieve their expected benefits. No money is saved. Costs go up, service standards and quality often go down, fragmentation at the service delivery level increases.
• Downsize staff (particularly nurses) to save money. Shift staff from full-time to part-time to "save" benefits costs. Have nurses work at several hospitals.	• Spend tens of millions on severance payments, followed by spending tens of millions to "hire 8,000 nurses", followed by tens of millions to sever them again -- all during a nursing shortage. (Multi-hospital employment contributes to the SARS crisis.)
• Engage DHC's, Health Commissions and Inspectors (and now perhaps LHIN's) to do "local planning", to their communities. "The (name of new fixer) will save you".	• We have already lived through what Mintzberg warned about: 90% of linear strategic planning methodologies fail to achieve their stated outcomes.
• Jar the CCAC sector with tighter bureaucratic controls through **Bill 130** and destablize governance/management and service delivery by downsizing the sector from 42 organizations to 14.	• New structures create the illusion that Queen's Park is in charge of strategy and leadership -- but they are simply positioned to blame. 14 CEOs of CCACs will have "dual accountability". Sector in fear and anxiety as performance worsens and patient flow issues emerge.
• Jar the hospital sector with tightened controls (**Bill 8**) that creates *"dual accountability"* for CEOs (a worst practice) -- who could get their salary lowered by 10% if the government decided that the CEO was not good.	• CEOs now have *"dual accountability"* (Boards and MOHLTC). Hospital sector feels isolated, blamed and shamed for the results/outcomes being produced on finances, quality and integration. Lack of trust producing retrenchment. 30% "on board" for system reform.

But the diagram points out that while 7% of the time problems could be caused by service providers, 93% of the time the problem is caused by the organizational designs/ structures/processes -- not by "bad people".

Indeed, Deming said that half the time that the problem was "people" (3.5%), the actual cause was a lack of skills or inadequate training.

So, people aren't the problem, unaligned delivery system designs, processes and structures are the problem.

However, this insight is often not well understood in a system that is so entrenched in its same/old, same/old blame dynamics and negative political spin-doctoring. If there is to be any progress, we will have to change the way we think about these issues.

The challenge is: how do we get people to think differently about their circumstances? How do we get people to see a "bigger picture" of reality?

"Is it possible that LHIN Board Chairs and CEOs will be driven by the interests of 'the owners' of our healthcare system: that is, by the citizens and taxpayers of Ontario and Canada and their community?"

How do we get our leaders to shift their focus from what they are "doing", to who they are "being"? How do we get our governance and managerial leadership to change the very nature of their conversations?

Changing The Conversation

The challenge for our healthcare leaders today is: how could the healthcare reform dialogue shift to a more positive and collaborative tone? What can the LHINs do to facilitate these new types of community conversations? How can real change occur at the customer-service level?

What we like about the causal-loop diagramming methodology for LHIN partner dialogues is that it is a technique that does not seek to reveal "who is to blame?"; rather, it is simply looking at the *relationships-of-effect*. It helps to slow down the pace by getting people to really listen to one another so that everyone can see a "bigger picture of reality".

In our page four diagram, the macro design of the healthcare system is shown as driving the thinking and behaviour of the operations component of the delivery system.

It points to "what is to blame"; not "who is to blame".

So, if we are to actually address the flaws in the design of the system, we need to take a long hard look at the macro and micro designs -- and understand how our existing designs actually impact on the delivery system's performance.

If the delivery system is to be redesigned at the network level – as well as at the customer service delivery level -- people really need to think more clearly about how the patient journey is designed.

And what is the LHINs role in the redesign of the delivery system?

It is possible that LHINs could emerge with the same flaws as the local offices, or as Queen's Park itself.

On the other hand, is it also possible that our new LHINs will emerge as true "stewards" of their communities – facilitating partnerships and generating system solutions that are in the community's best interests?

How could they do that? How could they make a positive contribution to their community -- as an arm of the provincial government (crown agent), that is governed by local citizens?

Can LHIN Boards and LHIN CEOs get comfortable with the fact that they don't have any answers -- but that the answers are actually within the hearts and minds of the people who work in the system -- at the service delivery level?

Can our new LHIN's avoid behaving like the old MOHLTC? Can LHIN staff learn to operate "in service" to the system, rather than "in control" of it?

Can they facilitate local decision-making and planning processes, rather than "manage consultations" for their own decision-making and planning processes?

Can they support the delivery system partners to shift from provider-focused designs, to patient/family-driven designs?

How can LHINs become catalysts that will spark self-organizing partners in the network who -- because they are customer-driven -- will design systems, structures and processes that will result in seamless, high-quality, cost-effective and compassionate care that the *"owners"* want?

Best practices teaches us that effective collaboration is emergent and self-organizing -- not mandated and tightly managed and supervised by either centralized or decentralized "authorities".

If that is the case, how could LHINs support service delivery CEOs and Executive Directors as they lead fundamental reforms and redesigns within their own delivery agencies and institutions?

Is it possible that LHIN Board Chairs and CEOs will in fact be driven by the interests of "the owners" of our healthcare system: that is, by the citizens and taxpayers of Ontario, Canada and their community?

And, with all this talk about *"accountability"*, can someone say **what the government is actually accountable for achieving, or, what a LHIN Board and staff will be accountable for providing to the agencies and institutions that actually deliver services?**

What is the mutual part of "mutual accountabilities"?

LHIN's Can Help the System Save Itself

While there will be those who claim that the LHINs will "save medicare", and those who claim that they will become "just another layer of needless political bureaucracy", the reality at this moment is that they are just another new structure in the box on page four that contains the macro design of the healthcare delivery system.

We are convinced that LHINs have the potential to work -- if they think, behave and act in ways that are fundamentally different from the existing DNA of the systems, structures, and processes at Queen's Park and their local offices. If not, they will be part of the problem we have described here.

LHINs that learn how to unleash the creative potential of their local delivery system by tapping into the internal collective intelligence and wisdom of those who deliver care, will become the catalysts for significant improvements to the healthcare delivery system within their communities.

"If the provincial reform agenda unfolds the way the Minister wants it to, then it will work -- signifcant improvements for patients, their families, taxpayers, and healthcare workers are very possible in the near future."

Rather than behaving as "hero leaders" and "system bosses", LHINs can help the system save itself.

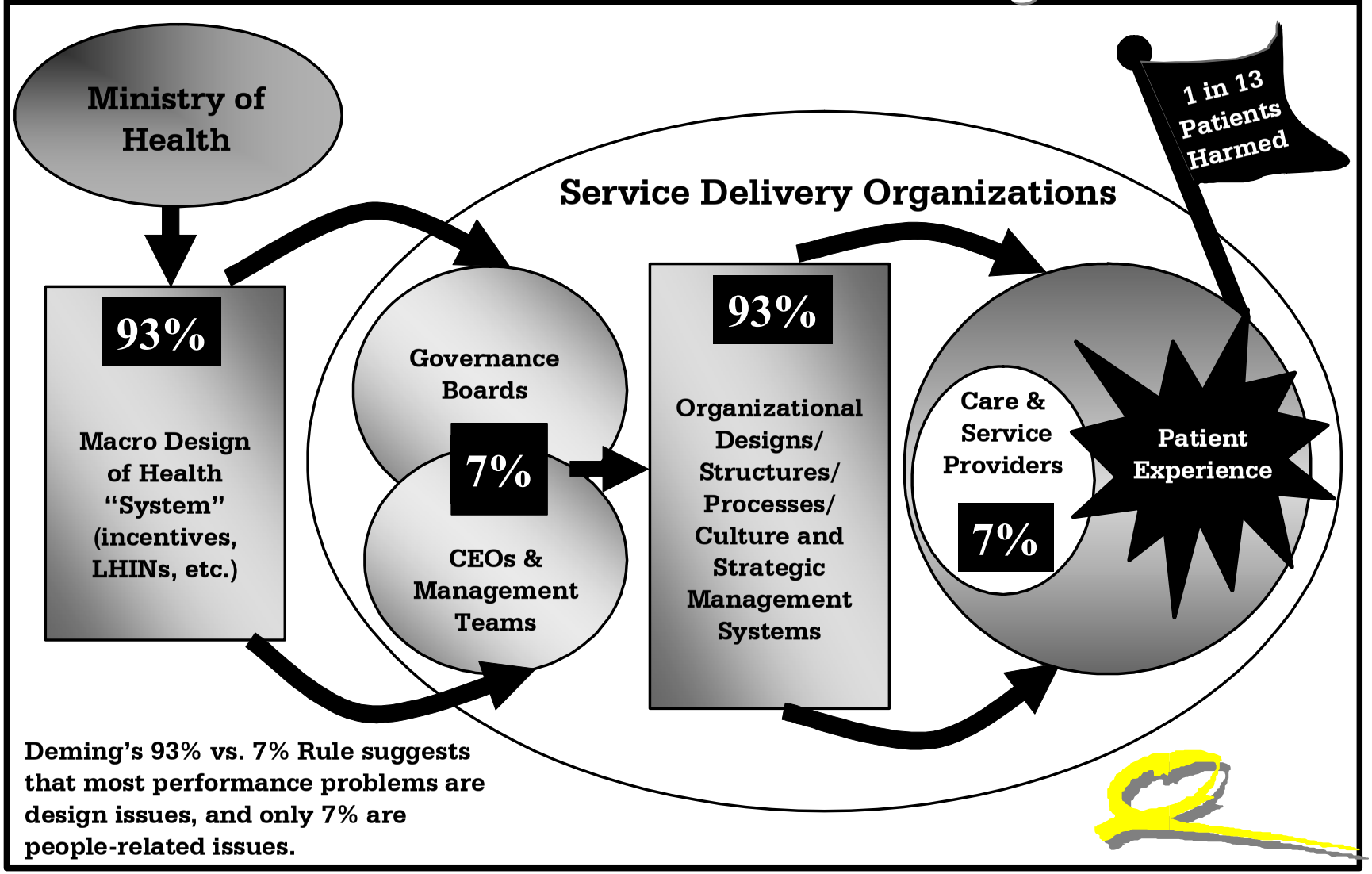
However, if the LHINs behave as a new "mini-Queen's Park", or think of themselves as a new location for the old local Ministry office (whose role is micro-management), the loop simply continues -- and no real change will occur at the service delivery level until the relationship changes.

It is about system design, and it's about culture. How we think and behave is key.

LHINs and their network partners have the opportunity to acknowledge and openly address these realities -- and commit to changing our past patterns and habits. Some LHIN's may ignore these realities, and take their place in the ever-growing list of *"Fixes-That-Fail"*; but from the vantage point of Fall, 2006, chances are that many will succeed.

If the LHIN's are to succeed, they really need to start their life being "in service" to the partners in their community -- rather than "in control" of them. That's what Minister Smitherman and his top officials say. But will the LHINs be able to do that -- or will the same old

Macro and Organizational Design And The 93% vs. 7% Deming Rule



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