Plotting the course

Ten crucial conversations about system change

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Introduction

We wouldn’t start from where we are, knowing what we now know. Health system and political leadership has never been more important.

–Dr. Mark Britnell, Chairman and Partner, Global Healthcare, KPMG International
Together we took a ‘virtual tour’ around the world to consider emerging approaches to improve population health and create more integrated systems of care – two of the most consistent elements of health system transformation in the jurisdictions we visited. We took snapshots of some of the most interesting practices that we saw in our journey, and along the way we learned from some of Canada’s own top healthcare leaders who are at the forefront of disruptive change. In this paper, we share some of the highlights from our expedition to help other leaders plot a course for health system transformation.

Every global jurisdiction that we reviewed is undergoing transformation. Governments are testing ways to significantly improve quality and value while shifting to community-based care, improving integration with primary care, limiting growth in healthcare spending through performance-based funding models and moving upstream to focus on population health. These transformations include both micro and macro level change, creating integrated systems across health and social care.

While integrated business models are not new, the desperate lack of resources for healthcare delivery and rising expectations of consumers present ripe conditions for more rapid cycle implementation to achieve sustainable transformation. The path forward, however, requires significant planning and effort, with each actor playing their part. In a recent assessment of the UK’s Sustainability and Transformation Plans (STPs), to integrate at a local level and move care to the community, Nuffield Trust found that expectations amongst funders and providers were too optimistic on the cost savings potential of their plans, potentially impacting future sustainability. The conditions for success require us to engage with funders, providers, front-line staff and patients and families in ways that are a departure from the status quo.

Our paper highlights ten crucial conversations we need to have to make rapid, sustainable transformation a reality.

Ten crucial conversations about systems change

Here are ten critical conversations that can help drive success in transformation, driven by our global review and our own experiences with change.

- **Payers are becoming ‘activist’**
- **Consumers are becoming activated**
- **Leading through change: from ‘sage on a stage’ to ‘guide on the side’**
- **Stop referring to them as ‘soft skills’**
- **Creating a social movement for change: a thousand points of light vs a supernova**
- **Accelerating disruption through technology**
- **You cannot plot a course forward by measuring backward**
- **Inspiring a workforce to thrive**
- **Ensuring a creative space for transformation**
- **Pathways to ‘population health’**

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*The Community Care Access Centres of Ontario, which were responsible for the delivery of publicly-funded home care, were restructured as part of Ontario’s health system transformation plan in 2017.*
In response to financial pressures, governments are using payment models to incentivize change in practice, behaviours and outcomes. There is a shift from volume-based payments to incentives and payments based on value (outcomes and quality). In the US, if Medicaid reforms continue under the new Administration, 50% of Medicare payments will be value-based by 2018, and 75% by 2020.2

There is a general acknowledgment and understanding among providers that payment systems will focus more on quality, value and risk.3 This is creating a new challenge for health providers and forcing them to replace traditional care delivery with innovative partnerships and new perspectives. Overall, providers do not feel well-equipped to respond to these changes, including bundled payments, increased risk sharing and value-based purchasing.4 However, providers do feel that reduced costs and improved outcomes can be achieved through truly integrated care.

The State of New York is taking the lead in the US through the transformation of its Medicaid system. As part of a wider system transformation, New York State is reforming payment models to pay for value instead of volume. Provider networks are incentivized to work together to realize shared savings and are entitled to keep the savings, depending on the risk-sharing model they sign up for. The payment model is a graduated system with four levels that increases the risk and rewards for provider networks as they mature and agree to take on more responsibility for the outcomes and health of the population. This funding reform was implemented through thoughtful tailored design, with a range of funding options to suit the maturity of providers and their readiness to take on risk. It was part of a significant investment by the State to implement, test and revise and deploying rapid cycle improvement to continuously improve outcomes.

In Ontario, Canada, the Ministry of Health and Long-Term Care has commissioned six integrated and bundled care pilots where payment models were tested – some based on payment for outcomes. A recently published review identified key success factors for bundled reimbursement programs.5 If we look to other jurisdictions we can extrapolate what shape things will take and what we can learn from those experiences – both success and failure – as well as from our own experience in moving to a future of population-based integrated care in Ontario.
Where Quality is the outcomes as defined by the patient, e.g., Safe, Effective, Patient-Centered

Goal
Delivering the Triple Aim – Better health, better care, lower costs

1. Improve access to care for all, without disparity
2. Integrate care to address patient needs seamlessly
3. Make cost and quality of care transparent
4. Pay for healthcare value, not volume
5. Promote population health

Source: KPMG in Canada

Our insight

Payment reform is not a panacea but has been successful in many jurisdictions around the world. These reforms are creating incentives to build formal, sustainable partnerships that through additional, purpose-built support, bring front-line providers together to address the health needs of the population. Although these funding models have been in the implementation phase for several years, it will be several more before we can say they have been completed at scale. These endeavors are long-term journeys that require investment and support to test, improve and spread what works.
There is a growing trend with consumerism amongst health “citizens” and patient populations. The proliferation of apps is having a spillover effect in healthcare. Consumers are increasingly interacting with their health and social care providers and organizations through business models that did not exist five or ten years ago.

Disruption continues to spill over into healthcare and will create a greater expectation, especially from a younger generation, that options exist for them to engage in the management of their own healthcare. As an example, Heal is an app that provides on-demand doctor house calls. According to Heal, the company has raised USD $52 million in funding and plans to grow its doctor visits exponentially as it expands its availability across key US locations by the end of 2017.

With the strong presence of social media, the growing popularity of rating websites for healthcare providers, and the increasingly strong voice of patient organizations comes an increased demand for transparency as patients want to understand where they can go for the service they want. Increasing transparency naturally leads to choice, which creates competition for healthcare providers that has not existed on this scale in the past.

The same tools that are disrupting traditional care models and methods for engaging with providers are enabling a new activated patient. These patients are fully engaged in their own self-management in partnership with clinicians, however take a more educated and active role in managing their health than traditional patient-clinician interactions.

Research has demonstrated that patients who are activated have better health outcomes at lower costs. As shown in the chart, it is clear that the activated patient is an unmatched source of value for health care systems – the key is to carefully and purposely respond to their expectations and ensure the system is sensitive to their needs. This can be achieved through active participation of patients in the co-design of processes, care pathways and systems that directly respond to their needs, enhancing their ability to provide an active role in their own care.

Discovery, a health insurer in South Africa, has adopted an innovative wellness program called ‘Vitality’ that has demonstrated the link between activation and the outcomes it provides, including lower hospital admit rates, lower costs per patient and reduced mortality. Members are rewarded for making healthy lifestyle choices, including preventive screening, purchasing healthy food, participating in exercise programs and nutritional counselling. Participants set goals using an online portal or mobile app and are rewarded for reaching their goals. Their members are being incentivized to be active participants in their health.

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1KPMG Global Healthcare Conference Survey 2014: 28% agree, 44% strongly agree that 'with the right support and empowerment, patients actively managing their own care creates better value care.'
Activated patients have better outcomes at lower cost.

As patients become more engaged in their own care (e.g. their patient activation scores (PAM) increase), outcomes improve and total costs to provide care go down.

**Our insight**

Individuals are the most important factor in their own health. We now have the tools to enable full participation in one’s own care. We need to enable clinicians to catch up to their patients so they can meet them where they are. Activating patients and delivering on what patients expect, we need equipped clinicians to engage differently and meaningfully.
Transformation requires that we move from a focus on the organization to the system. This requires the ability to work with multiple players and organizations across the system. The healthcare “system” is a complex adaptive system that requires a system leadership approach relying on relationships to drive transformation – where leaders have traditionally relied on hierarchical approaches to drive change. Provider incentives within the system are not always aligned and therefore require a different approach, for example the differing and sometimes competing payment models for physicians and provider organizations.

This means transitioning from hierarchical management (‘sage on a stage’) to collaborative leadership (‘guide on the side’). Here, leaders cannot dictate change because systems of care challenge positional authority. Instead, success is built through collaboration and relationships. What is it going to take to build collaborative leaders? It requires retraining leaders in collaborative approaches, often referred to as adaptive leadership. It means that those high performers may be different than the people currently holding leadership roles. Traditional leadership uses technical and hierarchical tools, however, it is adaptive leadership skills that are needed to make transformation successful. Current leaders often use technical and hierarchical tools to approach transformation whereas is the adaptive leaders who will set transformation on the road to success.

When the rubber hits the road and the pressure is on to transform, the gravest risk is that we revert to traditional leadership tools when an adaptive leadership tool kit is what is most critical. Adaptive leadership comes into play when the answer to the dilemma is not clear and new learning is required. On the front line, it is hearts and minds and not just behaviours that need to change. It requires actively managing multiple perspectives, where progress requires trial and error. Adaptive leadership often make smart people feel incompetent, disorients and scares people and it also takes time to lead adaptively and to produce meaningful progress on complex issues. A common cause of leadership failure is using a technical fix for an adaptive problem.

In Canterbury, New Zealand, the integration of primary care providers and secondary care was a clear demonstration of taking a systems approach utilizing collaborative leadership. Primary care providers came together with hospital-based physicians and administrators to create hundreds of standardized care pathways for integrating care between primary and secondary care. The success of this approach – improving patient flow and communication amongst providers around the needs of patients – has quickly spread to 28 health regions across Australia and New Zealand.

Our insight

The leadership model required to support healthcare transformation requires a complete rethink of the leadership principles and skills needed to lead this change. Leaders will need support and retraining on the system and collaborative leadership to create sustainable change and forge enduring relationships beyond their organizational boundaries.
Stop referring to them as ‘soft skills’

How often do we hear about the soft skills as “nice to haves” rather than the “must have” skills?

Currently, the competencies that are most usually associated with leadership and organizational management – which are those skills that are knowledge and logic-based – are referred to as the ‘hard skills’. However, for the kind of transformation required in health and social care around the world – to create integrated systems of care – this needs to change.

Leaders with highly evolved soft skills have the ability to capture the hearts and minds of people, understand what is most important to patients and their families, build trust, have difficult conversations, create a shared purpose and guide people along a transformation journey. These soft skills are not the “nice to haves”; rather, they are the required skills for transformation; leading, designing and implementing integrated systems of care requires a strong soft skill base; these are the key competencies that will differentiate technical leaders from adaptive, system leaders.

System leaders build relationships based on deep listening, allowing networks of trust and collaboration to flourish. Short-term reactive problem solving becomes more balanced with long-term value creation. These are the soft skills that will be required to win the hearts and minds of front-line staff and those managing them; to equip them with the capabilities to extend beyond their siloed clinical training to work in teams and build relationships outside their organizations, sometimes with individual primary care providers who are not used to working in this way.

These core capabilities include being able to see the larger system and the whole needs of the individual; Building and sustaining teams, and inspiring staff through generative conversations and time for reflection where teams are co-creating solutions in partnerships with clients and their families. This creates a system of continuous improvement towards the vision of integrated care and a more engaged workforce that takes ownership of integrated care delivery.

“The soft skills are not the ‘nice to have’ they are the ‘must have’ in order to create change on this scale.”
Moving from leadership to ‘leaderful’

The creation and ongoing nurturing of integrated care teams require us to move from leadership to ‘leaderful’; everyone must be empowered to lead and make recommendations and decisions for how the team works. There is a concurrent and collective shared responsibility for leadership. This is a complete cultural and philosophical shift, where front-line staff become empowered to lead care. It is the responsibility of good managers to enable and facilitate a ‘leaderful environment’, where individual team members feel safe and supported in making decisions.

The effort and capability required to build integrated systems of care cannot be understated. Relationship building is a core competency required to work across divergent providers. Building and sustaining relationships, particularly with individual primary care physicians, requires significant investment in time, and a skillset that is not part of the health professional curriculum. Building teams is also hard work and the core competencies known as soft skills: relationship building, establishing and maintaining trust, having integrity – are critical competencies to move to a population-based integrated service delivery model.

Furthermore, when health system leaders see that change is not happening at the pace and scale they need, traditional leadership can slide into habits of ‘shaming and blaming’ as a way to incentivize higher performance and ‘command and control’ behaviours to drive change. Neither of these actions creates sustainable change because the people on the front-lines are disempowered by these leadership behaviours. Adaptive leaders do the opposite, they seek to understand the best way to unleash the potential of people, drawing on the strengths and skills of different teams and individuals while shoring up areas where capacity is lacking.

Our insight

We need to acknowledge the soft skills as essential competencies for the next generation of health system leadership (and the current leaders) and we need to re-train and re-tool our leaders and our leadership programs accordingly. We also need to recognize that using ‘command and control’ and ‘shame and blame’ tactics will neither facilitate nor incentivize a culture of improvement. Instead, we need to focus on how best to build our people power to reach our goals.
Building a social movement: a thousand points of light vs a supernova

System change does not happen top down. It also does not happen through a thousand pilot projects. For real change in the system we need to inspire a social movement across consumers, carers, front-line staff and managers.

We have learnt through Helen Bevan, Chief Transformation Officer for the National Health Service (NHS), and others, not only do you need to activate all the players to create a social movement but you also need to inspire them to innovate and lead the change. Some of the most impactful change is generated from consumers and front line staff. We believe creating a social movement is a critical enabler to drive and hard wire transformation.

Social movements directed at health and care issues have been gaining increased attention. They take aim at a broad array of social, cultural and political changes such as promoting healthy lifestyles, de-stigmatizing mental health, experimenting with new approaches to knowledge creation, innovation, and policymaking. In the UK, a key component of the transformation of NHS England is the identification, support and spreading of effective social movements. As part of the support for the Five Year Forward View, the NHS launched a three-year program to support social movements in health and social care. Social movements are seen as one approach to system-level transformation that is so urgently needed in health and social care.17

Social movements can increase civic engagement in healthcare, and foster new thinking on many health and social care issues, such as the way we engage with primary care, breaking down siloes in health and social care, and identifying new models of care including digital and on-line access to care.

In Japan, it was a social movement that supported the creation of legislated policies that placed accountability for the care of the elderly on their children. This has translated to programs developed by Japan Post that offers the Post Office Watch system. For a monthly fee, post office employees check on elderly clients once or twice a month, using a standard checklist to confirm the person is safe and well. The result is

“ Without a social movement that drives change at scale you can have a thousand points of light but no supernova. ”
Social movements are used to inspire massive change. Two examples in creating social movements for change in healthcare include: NHS Social Movement for Health and Social Care Radicals and the social movement for improved AIDS treatment in the 1980s, and outside of healthcare include the women’s movement in the developed world.

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Driving a social movement for change requires creating platforms to engage patients, carers, teams and providers, so that the system can drive a conversation and change behaviour to reach goals at scale. The traditional approach of creating change (e.g. through ‘power’, ‘command’ and ‘control’) is less useful for driving complex change towards a new future state model. As Greg Satell states in What Successful Movements Have In Common,19

“It’s no longer enough to capture the trappings of power, because movements made up of small groups are able to synchronize their actions through networks. So if you want to effect lasting change today, it’s no longer enough to merely command resources, you have to inspire opponents to join your cause.”
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Our insight

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Increasingly, regions with reduced resources have been developing innovative and creative ways to deliver care and serve patient needs that often exceed developed countries models in efficiency and effectiveness.

For example, regions in Asia and Africa are using mobile phones to support care delivery and health promotion in remarkable ways. Although telemedicine has been around for decades – the US Navy has been using it to support medical field operations since 1995 – this traditionally involved primarily physician-to-physician transactions. Today, there is a growing use of telecare, direct from provider-to-patient in their home, or on their phone with the use of at-home diagnostics and wearables.

In the Netherlands, Focus Cura has demonstrated the benefits of home health monitoring in partnership with Slingeland Ziekenhuis. Patients are being supported in their homes through the use of wearables and telemedicine that create a direct connection to care coordinators and the care team, helping patients manage with Chronic Obstructive Pulmonary Disease (COPD), heart failure and other chronic conditions. What truly makes this model work is an integrated care team at the point of care, allowing all to have access to the patient’s care record as well as an awareness of their expressed goals for treatment. Additionally, these patients are activated and engaged in their own care, thereby actively contributing to their own outcomes and the attainment of goals. In many healthcare systems today, you might typically find this type of patient in a Complex Continuing Care unit, or in an acute setting waiting to be discharged to long-term care.

Telemedicine is only one example of technology creating new and improved care model. Israel is an example of a leader in the adoption of technology for the betterment of patients and care pathways; they have a fully integrated health record with patient and family applications that allow them to access their own information from hand held devices, where patients can communicate directly with members of their care team.

Our insight

Significant opportunities exist around the world – with demonstrated benefits – to leverage cost-effective digital health solutions as a means to improve the patient experience and support the activation of patients. Next generation applications that disrupt current care models could have a profound impact on transforming the way we interact with care teams. Health leaders should consider the application of virtual care where it has demonstrated a continued contribution to creating value.
We cannot use existing measures to measure the system of care for the future; we need metrics for new systems and new metrics for health outcomes, as well as new expectations for delivery.

Few health systems track real measures for integrated systems of care, patient reported outcomes and experience measures. We therefore evaluate quality of care, patient experience and health outcomes based on existing and easy to access data – which was never designed for the purposes we are using them for. We need to step back and ask:

- What are our goals?
- How do we measure them?
- What metrics do we need? If they are new metrics, how do we develop them?

While these questions may seem obvious, it is important to note most system transformation does not consider this line of questioning. We are therefore attempting to design a forward-looking design by measuring success looking backward through pre-existing metrics.

One possible solution is moving to an integrated, population-based model of care through the development of outcome measures that incentivize the right behaviours. This requires investments in data and analytics to measure outcomes that are important to clients/patients. In the State of New York, over 90 care bundles were mapped, grouping related activity to provide the foundation for payment reform based on the pertinent outcomes as shown in the graphic on the next page.

Using a population-based approach, healthcare administrators can also map disparities and areas of health need based on outcomes. Achieving this level of sophistication requires building systems that can track client/patient goals and their progress in meeting those goals.

![Our insight](image)

One of the key gaps in the transformation agenda in many jurisdictions is the lack of alignment between strategy, performance, quality metrics and public reporting. A data and analytics strategy is therefore essential to build the knowledge system required to shift outcomes. Forward thinking and new approaches to measurement of KPIs can facilitate and help incentivize the new patterns of behaviour.
“If you want to build a world class health system, you need to define what that looks like, and the measures to track when you’ve arrived.”

Care pathways developed for bundled payments in the State of New York

Integrated physical and behavioural primary care

Includes social services interventions and community-based prevention activities

- Maternity care (including first month of baby)
- Acute stroke (including post-acute phase)
- Depression
- Chronic care (Diabetes, CHF, hypertension, asthma, depression...)
- Hemophilia
- AIDS/HIV
- Chronic kidney disease
- Multimorbid disabled/frail elderly (FIDA population)
- Severe BH/SUD conditions (HARP population)
- Care for the developmentally disabled

Episodic
Focus on patient’s care pathways and resultant outcomes

Continuous
Encourage focus on outcomes and disease management with care coordination

Integrated primary care
Focus on overall population health and total costs of care

Source: KPMG in Canada
There are two main components to creating a workforce that thrives: engaging providers in caring for a ‘whole’ person, and partnering with patients and carers to achieve better health outcomes.

The health and social care system we want will not function on the traditional learned skills of most healthcare practitioners; the educational systems to support the development of healthcare providers has traditionally been very siloed, learning a discreet set of skills with the expectations that in practice things will operate very differently. Additionally, providers have learned skills to treat the immediate episodic needs of the patient – to drive system change and really address the needs of the client/patient, all providers will need to engage in team-based approaches to address the needs of the whole person.

This holistic and collaborative approach includes preparing the health workforce to focus on chronic disease management and care coordination, thereby addressing the underlying health issues that may be improved by addressing the social determinants of health. This will require a broadening of skill sets and enable providers to work to their full scope of practice. To provide a holistic patient experience, the workforce of tomorrow also needs to be able to take a systems view. This requires a workforce with a skill set emphasizing leadership, financial management, service improvement, taking a systems approach and strategic insight.

Building an integrated team of disparate providers, used to working in solo practices, can be difficult as it challenges the traditional ways that clinicians have been trained. This change requires a reorientation to understand and respond to the needs of citizens, to create a real and meaningful difference for patients and their caregivers. Moreover, it requires a full spectrum of traditional and non-traditional leadership skills that creates the conditions to inspire people and create an environment where they love coming to work every day. We have observed that when individuals work as a team and focus on the needs of clients, they become energized.

In the UK, ‘the Vanguards’ are new care models that are being implemented to transform patient care and the way providers across organizations work together. By investing in team-based care, these care models work to anticipate the needs of patients and carers instead of being reactive; this proactivity empowers clinicians and gives more voice to patients to play an active role in their own care. Additionally, the outcomes have resulted in reductions in avoidable hospital use.

In the State of New York, the 25 Performing Provider Systems (PPS) are creating care teams that stretch across multiple organizations, coalescing around the needs of patients. Through rapid cycle improvement, integrated care teams have been identifying the needs of high user patients to identify what patients need to keep them healthy. These interventions have included buying and installing air conditioners for COPD or diabetes patients during the hot summer months, or aiding in improving home air quality for children with asthma. In one PPS, upon completing a home health assessment, patients were offered air conditioners to help them cope with the extreme heat. The result was a significant drop in Emergency Department (ED) visits in the population, allowing providers across the network to share in the savings achieved from this intervention as a result of reduced emergency department visits.
“The health workforce of today requires a skill set that emphasizes leadership, financial management, service improvement, taking a systems approach to problem solving and strategic insight.”

**Key Subpopulations**
- The PPS will develop initiatives targeting populations with high cost of care (such as HIV/AIDS, or those with) intellectual and/or developmental disabilities.

**Investing in primary care**
- Boost quality and access to primary care. Invest in HIT, PCMH.

**Introduce “Systemness” into healthcare**
- Integrate providers, share data in real time; make healthcare a team sport.

**Addressing social determinants of health (SDH)**
- Integrate social care providers into PPS activities. Address social determents in a culturally competent manner.

**Quality**
- Tracking quality measurement will occur at all levels of care.

**Source:** Medicaid Redesign and Delivery System Reform: New York’s Story, New York State Department of Health

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**Our insight**

Changing the way providers think about the needs of patients will require fundamental changes to the way clinicians are trained. Expectations around outcomes will also change the conversation with patients, engaging them in discussions about their goals and how the system can support them in achieving it.
It is said that health system transformation is like changing a Boeing 747 into a stealth bomber in mid-air. This kind of complex system redesign requires infrastructure and industry expertise.

How is it possible that we expect existing health system providers and leaders to transform the system while they are fully employed and over capacity? Health system redesign needs a collective effort; we need to build in the space and capacity for change to happen and we need to ensure that people have the right skills to design and implement change.

Health system transformation requires people to adapt and change. This requires self-reflection and understanding of how our own behaviours and work habits need to change, regardless of role or position. Entrenched patterns of behaviour and ways of working can be significant barriers to transformation.

Globally, significant transformation efforts are already underway, with many being supported with dedicated infrastructure and financial support systems – thereby achieving the escape velocity required to launch sustainable system change. In the State of New York, an entire program of support has been developed to aid health system transformation focused on support for provider integration, workforce transformation, and payment reform. The State has been granted $8 billion USD from the federal Centers for Medicare & Medicaid Services (CMS) to invest in the transformation to 2020; The system serves a population less than half that of the Province of Ontario’s (6.2 million) with a spend of $62 billion USD in 2016.

Other jurisdictions have taken similar approaches, creating public and provider facing agencies to drive system level transformation, including Vancouver Coastal Health regional authority’s Clinical and System Transformation (CST) project to improve system reliability and sustainability; the public launch of the Five Year Forward View to support transformation in the UK; and the NHS’ development of more regional Sustainability and Transformation Plans – in addition to system-wide leadership training through the NHS Leadership Academy.

Our insight

Many jurisdictions around the world are launching significant transformation efforts of health and social care. Success requires a clearly articulated vision and support for front-line providers and leaders. Every ecosystem needs a clear roadmap (including expectations, milestones, and endpoints) which provides support for providers throughout the journey. We believe this strategic investment will reap dividends for years.
Changing the health of an entire population requires a shift in thinking and consensus on what we mean by ‘population health’.

The Public Health Agency of Canada (PHAC) defines population health as “an approach to health that aims to improve the health of the entire population and to reduce health inequities among population groups.” Core to this approach is the recognition that there are multiple determinants of health, many of which lie beyond the traditional scope of the health system. Equally important is the focus on the distribution of health across populations and the socio-economic gradient. A population health approach recognizes the importance of intersectoral partnerships at the community level, across and among different levels of government, and between health care providers and other professionals who have a role in influencing health.

The leadership in the US, by organizations such as Kaiser Permanente, and the Institute for Healthcare Improvement, with a focus on improving the health of populations, has developed approaches now used by accountable care organizations. These approaches aim to make provider networks and organizations responsible for the health of the population and take on some of the risks of managing that population by compensating providers for outcomes. For example, some of these systems are self-selecting populations, capable of selecting a typically healthier population to manage. Regardless of how populations are selected, the approach to population health is similar:

- Organizations must work together across systems to improve health outcomes for a defined population. This addresses the health needs of the entire population, not just those that show up at Physician offices or Emergency Departments, and targets vulnerable groups to improve health disparities and inequities.
- Different approaches are used to target segments of the population to meet health needs and address specific health risks. This recognizes that different segments of the population require different approaches and involvement from different system partners to be effective.
- Improving the health of the population requires a range of interventions at the individual level, addressing the broader determinants of health and may include: housing support, education, employment services, wellness and exercise, smoking cessation, etc.

Moving towards a population health approach requires significant enablement from population-based data and analytics (including segmentations of the population and an analysis of local needs) and shared budgets. Moreover, system
leadership which draws on the skills and experience from a range of organizations and sectors is required when developing the overall vision and strategy, including shared goals based on the analysis of local needs and evidence-based interventions. Community engagement and incentives are also needed to encourage collaboration between people and providers.

An example of how to best approach population health is The Robert Wood Foundation, which has significant investments in creating a culture of health with the creation of a Culture of Health Action Framework. The framework sets a national agenda for the US to improve health, well-being, and equity, articulating ten principles to guide all large scale change and improve the health of diverse communities. Exemplars of how best to approach population health or healthy communities exist. It is our opportunity to actualize these to improve the health of diverse communities.
Health systems all over the world are undergoing significant change to address issues of sustainability, building fit-for-purpose systems. The developed world’s healthcare systems evolved slowly over the last century, now requiring a transformational shift around the needs of the patient. Over the next decade, the voice of the patient will become prominent in defining care choices and system design.

This paper addresses ten critical issues and recommendations required to support this transformation. To get us there, health systems need to move beyond “patient-centered” and focus on activating patients in their care, building systems around empowered citizens. There is a need to recognize and equip the healthcare workforce with the necessary leadership skills to enable a more decentralized system, to enable decision-making at the front line and within teams. We will need to empower systems managers to lead in this environment, adopting more coaching-oriented styles of leadership. There is much to learn from the successes and failures of others, particularly where technological innovation can support the needs of patients. Lastly, system managers should be mindful of the space required for transformation to take place and the recognition of the effort required to get there. We must remember the health system is for all our benefit and requires a collective effort to build anew.
References


3. KPMG International (2012) Pre-conference survey something to teach something to learn, KPMG Rome 2012


“We must remember the health system is for all our benefit and requires a collective effort to build anew.”