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HEALTHCARE PAYOR AND PROVIDER PRACTICE

Frontline lessons in health care transformation:

An interview with Brendan Drumm, MD

The first CEO of Ireland's Health Service Executive, the organization created by the Irish government to transform health care delivery, describes his experience implementing reforms.

In 2005, Ireland began to transform the way it delivers health services to its 4.5 million people by consolidating responsibility for primary care, hospital care, and many social services into a single organization, the Health Service Executive (HSE). Despite strong initial resistance to many of its reforms, as well as hostile political and media criticism, the HSE has improved care delivery significantly. Waiting lists have declined sharply. More patients have access to high-quality primary care. Hospital quality and safety have improved.

In this interview, Brendan Drumm, the HSE's first CEO, speaks frankly about what has been achieved, what is still in process, and what challenges he has faced. Professor Drumm, who is stepping down as CEO this year after completing his five-year term, also outlines what he learned at the HSE's helm. The interview was conducted by Martin Dewhurst, a director in McKinsey's London and Dublin offices.

The *Quarterly*: *Why was the HSE such a major change for Ireland?*

Brendan Drumm: Until 2005, ten unconnected regional health boards were responsible for delivering health services in Ireland. Politicians were strongly represented on these boards, and many of them were determined to maintain existing health services in their localities, even when doing so was not in patients' best interests.

The government decided—rather bravely, I think—to decouple politics from health care by amalgamating these boards into an independent organization, the HSE, that would be responsible for delivering all health and personal social services.[1] The government funds the HSE at an annual rate of €15 billion through a service contract with the Department of Health and Children. An unusual feature of the arrangement is that the HSE's CEO is personally responsible for budget overruns.

The *Quarterly*: *The HSE had a difficult gestation. What were the biggest challenges you faced on day one?*

Brendan Drumm: When the HSE was established, the conventional wisdom held that the health system's basic problem was underfunding. Countering this argument was virtually impossible because there were no meaningful performance measures. It was easy to create the impression that all health professionals were markedly overworked. Underperformance was not visible. Waiting lists bulged. The misimpression suited many because it protected the status quo. Virtually every problem could be blamed on resource shortages. As a result, those who shouted loudest and created a media storm were most likely to get funding—often ahead of groups delivering services more effectively.

In this environment, patients felt privileged to consult a clinician and were therefore reluctant to complain, even though, as taxpayers, they were picking up the bill. And because health professionals were constantly getting positive feedback from patients, they had little motivation to change.

The dearth of performance data created other difficulties. Before the HSE was established, and for a few years afterward, all political parties and health professionals' associations argued that the solution to growing waiting lists was to create 3,000 additional acute inpatient beds—a 25 percent increase. The capital cost would have been €1.5 billion to €2 billion, and the cost for extra staff would have been approximately €1 billion annually.

[1] Personal social services are nonmedical services needed by the elderly, the disabled, children, and other vulnerable groups.

The irony was that by international standards, Ireland already had more beds than necessary, given the average age of its population. Audits carried out in 2007 and repeated since showed that, on any particular day, up to 40 percent of patients in acute hospitals did not need to be there. Almost half were being kept in the hospital simply because they were waiting to see a clinician. We also found that average lengths of stay for the same procedure were much longer in some hospitals than others, for no discernible reason. Nevertheless, the "more beds" claim seemed plausible to the public.

Transforming a health system that has little performance data is always a major challenge. But the challenge is especially great in an environment in which most problems, including long waiting lists, clinical errors, and budget overruns, are blamed on funding shortages and there is a universal call for more acute beds.

The *Quarterly*: *What did you focus on first?*

Brendan Drumm: We had to get clinicians to accept that the system needed more than just money—that we had to radically change the way health services were organized and care was provided.

We began by looking at the journey patients take through the health system. Consider Tom, a hypothetical older patient with alcoholism, depression, and diabetes who recently had a leg amputated. He no longer lives with his family. Were the services we provided best organized to meet Tom's needs?

The most obvious problem Tom faced was that the many people providing services to him (including general practitioners, a psychiatrist, social workers, community nurses, and disability support staff) were all working independently and rarely communicated with one another. Furthermore, these community-based professionals had no formal links with the local hospital's clinicians. The only person coordinating Tom's care was Tom—a confusing and frustrating situation for him and the people providing his care. Tom's situation was not unusual: a local manager once told me about a family being visited by 17 different people from the health and social care system, few of whom were in contact with one another.

Tom's situation and similar examples were helpful in explaining to clinicians the reality that existed for patients. Clinicians began to accept that the best way to meet the needs of people like Tom was to develop multidisciplinary primary care teams in communities across the country and to reconfigure hospital services so that care was delivered in the most effective settings. In addition, all services had to be integrated so that patients could get seamless service delivery, regardless of how many clinicians they saw.

Using patients' needs as the starting point, we began developing multidisciplinary primary care teams, each designed to serve 8,000 to 10,000 people. This approach requires all community-based care providers—including general practitioners (GPs), speech and language therapists, physiotherapists, public-health nurses, and social workers—to stop working in isolation, to share information, and to mobilize resources based on patients' needs. About 300 primary care teams now serve more than 50 percent of our population. Not all of these teams are fully integrated yet, but we are on our way.

Brendan Drumm

Education
Graduated in 1979 from the School of Medicine, National University of Ireland, Galway

Career highlights
Health Service Executive
(2005–present)
CEO

University College Dublin
(1990–2005)
Professor and head of the department of pediatrics

Hospital for Sick Children and the University of Toronto
(1981–89)
Pediatric resident, research fellow, assistant professor, and consultant in pediatric gastroenterology

Fast facts
Member of the editorial board of 3 publications and a reviewer for more than 20; has published more than 100 articles, book chapters, and reviews

Is a fellow of the Royal Colleges of Physicians in Canada, Ireland, and the United Kingdom

Is one of the first gastroenterologists awarded a fellowship by the American Gastroenterology Association in recognition of his lifetime contribution to research in gastrointestinal disease

The *Quarterly*: *What beliefs did you start with when you began to transform the health system?*

Brendan Drumm: I believed that we had to reorient care delivery so that we could provide more basic services closer to people's homes—or even in their homes—in a way that would increase care quality, value, access, and convenience. That meant ceasing to run separate organizations for community services and hospital services. We needed a single management structure responsible for budgets, people, quality, and performance in both care settings.

I also believed that we had to resolve the problem of many isolated, unconnected interactions between patients and health professionals. This is why our first major change was to move community-based health professionals into the primary care teams I described earlier.

The *Quarterly*: *Why was a single management structure for hospital and community care so important?*

Brendan Drumm: Previously, hospital and community service providers had often tried to protect their budgets from any service demands that could be met by another provider. For example, there was no incentive for a community service provider to respond immediately to the needs of an elderly patient ready for discharge on

a Friday. The community budget could be protected a bit longer if the patient were kept in hospital for the weekend. We had dischargeable patients in the hospital who wanted to go home, while others waited in the emergency department for admission.

So we merged the management of our hospital and community services at the national level, and we are now rolling out 18 integrated service areas (ISAs) to devolve joint management locally. Each ISA brings together, under a single manager, at least one secondary care hospital, all local primary care teams, and other community services in the hospital's catchment area. All health professionals will be accountable for the performance of their ISA, not just the unit they work in.

The *Quarterly*: *In Ireland, as in many countries, most GPs are solo practitioners. How hard has it been to set up primary care teams?*

Brendan Drumm: Our GPs are independent contractors, and it could have taken us 20 or 30 years to get them all to buy into the concept of primary care teams. So we gave them a financial incentive. Using a public-private partnership model, we offered GPs the opportunity to come together locally to build primary care centers, and we committed to relocating public-health nurses, social workers, therapists, and other team members into those centers. For the GPs, this is a very attractive investment opportunity. They own the new facilities and have a blue-chip tenant to help pay off the investment. Our lease, however, is dependent on the GPs remaining part of the primary care team.

This approach has been very successful in getting GPs to participate—so much so that they are delivering the new infrastructure more quickly than expected. As a result, we are selling off a significant amount of our community infrastructure. The new facilities have also enabled many clinicians traditionally based in hospitals to move their services into the community, which means that many patients don't have to travel as far for treatment. I believe that our approach to infrastructure development has possibilities for other health systems.

Team building among the health professionals is critical for developing multidisciplinary primary care teams. However, developing infrastructure for the teams to work in is equally important if the professionals are to believe that our commitment to them is genuine. By 2013, we expect to reach our target of 500 primary care teams, many operating from state-of-the-art facilities.

The *Quarterly*: *How did you reconfigure hospital services?*

Brendan Drumm: Ireland has approximately 50 acute hospitals—large, medium, and small—for its 4.5 million people. For about four decades, political and local pressure had prevented any significant modernization in the way hospital services were provided. As a result, practices that, from a quality and safety perspective, should have stopped were allowed to continue. For example, many smaller hospitals had little surgical activity but full surgical teams on call. They had intensive care units that ventilated only two or three patients per week. These types of subscale activity put patients at risk and incurred costs that prevented us from investing adequately in our larger hospitals.

The first step in reconfiguring our hospitals was therefore to move many complex services from smaller hospitals to larger institutions.

Although this effort is now well advanced, it began slowly. We started modernizing services in one region, learned what worked particularly well, and then broadened the program to other regions. Our current focus is on three regions covering about 40 percent of the population.

Initially, this effort faced angry resistance from politicians and the public. Most people had no idea how little complex work was going on in many small hospitals or that low activity levels make it difficult for health professionals to maintain their skills. Most people believed that all hospitals were extremely busy and that all the clinicians in them were overworked.

We were able to go forward because of the support we received from clinical leaders. They have engaged with local and national politicians to reassure them about the need for change, and they have helped educate the public. They have also spoken with the local and national media. The involvement of clinical leaders is a remarkable break from the past, when many clinicians used political influence to prevent change. Although pockets of clinician-led resistance still exist in Ireland, their impact is limited, given that national and local clinical leaders are planning, supporting, and often managing the reconfiguration agenda.

The staged approach we used reduced the risk that the entire political system would unify in opposition to reconfiguration, a problem that arose during earlier attempts at reform. Delivering good results in one or two areas first reassures politicians and the public that change can lead to service improvements.

The *Quarterly*: *You mention the importance of clinical leaders. How did you get them on board?*

Brendan Drumm: As a group, clinicians are often skeptical and sometimes cynical about health system change. Many—perhaps most—of them may agree that service reconfiguration is needed, but they are reluctant to become identified with a change program. Before the HSE, there was a visible divide between the clinical community and the health system's managers; the two groups did not have a constructive relationship.

To convince the clinical community that change was not just necessary but possible, we decided to involve a small number of clinicians who accepted that the system needed to change and who, we believed, were potential leaders. We then needed to find a way for these clinicians to gain wider support from their colleagues. To accomplish that, we developed close relationships with the postgraduate colleges for physicians, surgeons, and other health professionals, which came together in a new organization called the Forum of Irish Postgraduate Medical Training Bodies.

With the support of the Forum, we introduced doctors across the medical spectrum to the concept of clinical leadership and its importance in improving health services. We pointed out that the advent of the HSE was a once-in-a-lifetime opportunity for clinicians to adopt leadership roles. The Forum's endorsement made it possible for more clinicians to come out of the shadows and support the transformation agenda, which then made it easier to establish effective working relationships between clinicians and managers. I think other countries could find this approach helpful in driving forward health sector change.

A lesson we learned is this: although widespread clinician support is important, the actual

number of clinical leaders should be kept relatively small to increase their credibility and authority. A cross-departmental approach is also important if the clinical leaders are to be effective in developing an integrated health system. Our clinical leaders are not simply the clinical directors of departments of surgery, medicine, or pediatrics. They are responsible for all the clinical services delivered within a hospital; eventually, they will oversee the services delivered in the hospital's community catchment area as well.

The *Quarterly*: *How did you instill performance management?*

Brendan Drumm: Initially, we had no performance data that were relevant to clinicians. Large amounts of information were collected and presented in reports, which I don't think clinicians ever read and which could not be interpreted by anyone trying to understand the key problems with our processes.

For example, there was no measurement of waiting lists for outpatient services, no quantification of operating-theater throughput, and no way to gauge the potential for additional throughput. Community-based services such as speech therapy, physiotherapy, and public-health nursing operated without any measurement of their activity or comparisons with benchmarks. In those areas in which waiting lists were monitored, the lists were often quite long—in some cases, because people believed that a long waiting list was the most likely way to attract more funding.

We therefore focused at a very early stage on developing a comprehensive performance-measurement system. Health professionals respond to peer pressure, especially when their performance is compared with others'. We assumed that once performance was measured and compared, highly skilled professionals would want to achieve high performance levels.

We adapted an approach that Baltimore, Maryland, has been using to improve local government performance and developed a suite of metrics that we believe reflects our health system's performance. The metrics for hospitals include emergency-department and elective-surgery waiting times, day-case rates, number of new outpatients seen by consultants, staff numbers, and case mix. For community care, we measure such things as childhood vaccination uptake and the number of new families seen each month by child and adolescent mental-health teams. We have yet to add outcome metrics, however.

The information is analyzed by a program called HealthStat. We meet regularly with area managers and senior clinicians to discuss results. Both groups know they are accountable for developing action plans to address areas of underperformance. HealthStat also enables them to compare their results directly with performance in other areas in the country. We have found that most managers and clinicians are pleased to get results and that the reports have improved the relationship between them. Both groups want their units to succeed and know that success will be recognized and commended.

We also publish the results monthly on the HSE's Web site for the public to see. However, we don't have evidence yet to indicate that the public has started to use this information to determine which provider to see or to question performance.

The *Quarterly*: *You've alluded to difficulties you've had with politicians and the media. Have you had any support, or has this transformation been an entirely uphill battle?*

Brendan Drumm: I was fortunate in that there was only one minister for health and children, Mary Harney, while I was CEO of the HSE. She is someone with a proven track record of being able to stick to a challenging change agenda and ensure that changes are implemented. Her support has been crucial to the success we've achieved.

Although we did encounter strong political opposition in many places, there were also many politicians who genuinely wanted to see change occur, even if it affected their local hospitals. The critical component required to gain their support was clinical leadership. Many politicians said to us, "We will stand with you if clinicians can defend the changes you are proposing." In some cases, we had to get clinical leaders from one area to go into other towns and help us convince local people that service reconfiguration was important, despite the fears of local clinicians.

The *Quarterly*: *What were the biggest barriers you encountered—the biggest pain points you experienced in getting change moving?*

Brendan Drumm: The biggest barrier has been operating within a public-sector environment. In the private sector, jobs often depend on the success of a change program. In the public sector, people's jobs are usually guaranteed, and there are often few consequences for poor performance. And so it can be difficult to make change happen.

A second barrier has been the public's unwillingness to challenge the health system at the front line. Most people feel vulnerable when interacting with clinicians and are very slow to demand better-organized care. If a man arrives in an emergency department with his elderly mother and she must wait 24 to 36 hours before admission to a ward, he should demand to know why care was not provided more efficiently. This type of questioning happens infrequently—it needs to be widespread. Until the public demands accountability from those directly providing care, it will continue to be difficult to transform the health system.

The *Quarterly*: *Some experts have argued that if patients had to pay out of pocket for health care, they would act more like consumers and demand better care. Yet Ireland has a mixed health care economy. More than 50 percent of people have private health insurance.*

Brendan Drumm: Having a mixed health care economy has not made Irish patients more like consumers. Our clinicians are paid by the government but are also permitted to work in the private sector on a fee-per-service basis. Private health insurance helps many people pay for private services. However, the services delivered in the private sector tend to be elective, fairly low-intensity procedures; patients needing complex or critical care must usually use public hospitals.

A dual system such as ours creates unusual incentives for the clinicians who work for both public and private hospitals. It is not in their interest to increase the public sector's efficiency, because doing so reduces the number of patients who might seek treatment from them in the private sector. This supposition is confirmed by the fact that access to emergency care in Ireland is reasonably good, whereas access to elective care in the public sector is usually much more challenging.

"A lesson we learned is this: although widespread clinician support is important, the actual number of clinical leaders should be kept relatively small to increase their credibility and authority."

I am not averse to the idea that health systems should include both public and private services, but there can be major issues if the same professionals deliver both services.

The *Quarterly*: *The global recession has hit Ireland especially hard. How have budget cutbacks affected the health system?*

Brendan Drumm: In the past few years, we've experienced significant budget cutbacks. This has not been all bad. Previously, most people within the system thought that change had to be accompanied by extra funding. Now, there is greater acceptance that additional investment is not likely and that other ways must be found to make services more effective.

The current economic environment raises two broader questions. First, should Ireland continue to underwrite poorly performing institutions? If the care offered by one hospital is markedly inferior to that delivered at another hospital nearby, should some services at the poor provider be discontinued? Should the poor provider be allowed to close? Such actions are currently impossible. However, I believe that a sustainable health service needs a competitive environment.

Second, can Ireland continue to provide as broad a range of services as it currently does? We may have to make choices about what we fund and what we don't fund. From a political perspective, these decisions will be extremely difficult. In my mind, the worst scenario would be simply to cut funding across the board, which would reduce our effectiveness in many areas while forcing us to continue to provide nonessential services.

The *Quarterly*: *In closing, what achievements are you proudest of?*

Brendan Drumm: It is now accepted in Ireland that the health system's problems are not just funding problems. Most clinicians understand that a new model of integrated care delivery is needed. We've already moved many of our community-based professionals into a new way of working. The idea that hospital services must be reconfigured and become much more effective has finally taken root; this change is occurring across the country, led by clinicians or with significant clinician involvement. We've found a way to develop excellent clinical leaders and shown how essential they are in driving change. We've proved that the system can deliver more services with less funding. Although we have not yet fully embedded performance management in the health system's culture, we have put the tools in place to achieve this.

In addition, by operating as a single national agency, we've become much more efficient in areas such as procurement and facility management. As a result, we've reduced our costs by €1 billion over the past three years.

When we started, I was advised by experts that the change program would take at least 10 to 15 years. What I have tried to do is to put the HSE on the right track and set things up so that the transformation to an integrated health system would become unstoppable. I think we've succeeded in that.