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Understanding perspectives on major system change: A comparative case study of public engagement and the implementation of urgent and emergency care system reconfiguration

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ABSTRACT

Objectives: Major changes have been made to how emergency care services are configured in several regions in the Republic of Ireland. This study investigated the hypothesis that engagement activities undertaken prior to these changes influenced stakeholder perspectives on the proposed changes and impacted on the success of implementation.
Methods: A comparative case-study approach was used to explore the changes in three regions. These regions were chosen for the case study as the nature of the proposals to reconfigure care provision were broadly similar but implementation outcomes varied considerably. Documentary analysis of reconfiguration planning reports was used to identify planned public engagement activities. Semi-structured interviews with 74 purposively-sampled stakeholders explored their perspectives on reconfiguration, engagement activities and public responses to reconfiguration. Framework analysis was used, integrating inductive and deductive approaches.
Results: Approaches to public engagement and success of implementation differed considerably across the three cases. Regions that presented the public with the reconfiguration plan alone reported greater public opposition and difficulty in implementing changes. Engagement activities that included a range of stakeholders and continued throughout the reconfiguration process appeared to largely address public concerns, contributing to smoother implementation.
Conclusions: The presentation of reconfiguration reports alone is not enough to convince communities of the case for change. Genuine, ongoing and inclusive engagement offers the best opportunity to address community concerns about reconfiguration.

1. Introduction

Healthcare systems have been described as 'complex adaptive systems', consisting of the combination of organisations, resources and management required to provide health services to a population [1,2]. Such systems involve numerous actors operating at various levels and are subject to continuous change and adaptation, through formal and informal processes [3]. As the health needs of populations have changed and medical technology has advanced, health systems have faced pressure to adapt [4]. In the acute hospital sector, the policy response in many countries has focused on reconfiguration of services to a more centralised and specialised model, particularly for complex care conditions [5,6].

Reconfiguration may be defined as "a deliberately induced change of some significance in the distribution of medical, surgical, diagnostic and ancillary specialties that are available in each hospital or other secondary or tertiary acute care unit in a locality, region or health care administrative area" [4]. A synonymous term 'major system change' is also commonly used, defined as "interventions aimed at coordinated, system-wide change affecting multiple organisations and care providers" [7,8].

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1.1. Arguments for reconfiguration and opposing perspectives

Although reconfiguration is often presented as an 'evidence-based' approach to improving system efficiency and outcomes, a number of studies have characterised it as an inherently political and contentious process [5,9]. Proposals to reconfigure emergency care services have been found to be particularly controversial, often subject to strong community resistance [5]. Public opposition to the reconfiguration of emergency care has affected its implementation and revealed divergent priorities for healthcare provision across different stakeholder groups [10,11]. Research evidence on volume-outcome relationships has been employed to justify centralising care at large specialist hospitals [11]. However, this is contested and it has been argued that centralisation can actually hamper patient outcomes in certain circumstances and is detrimental to other aspects of the core mission of healthcare systems such as access and experience [4,9]. Critics have further argued that the centralisation approach is primarily motivated by a desire to reduce costs [12,13].

Jones and Exworthy explored 'framing' in the communication of arguments for changes to hospital services in the UK [14]. The policy of centralising hospital services was initially framed in terms of improving access and experience. However, over time there has been a shift towards portraying centralisation as a clinical necessity to address risks to patient safety which outweighs other concerns about access and experience. It is suggested that this was aimed at overcoming community opposition to changes, as was the co-opting of influential figures from the medical profession to 'champion' the changes.

1.2. Public engagement

The highly 'pluralistic' nature of public-sector healthcare bodies has been described in the organisational literature. Such bodies typically have multiple objectives, diffuse power structures and knowledge-based work processes, and these characteristics present a number of challenges to the implementation of strategic change [15]. Implementation depends on numerous interrelated contextual factors such as the nature of the change itself, relationships between key local actors, the presence of key change leaders and environmental pressures [16]. Denis and colleagues suggest that bringing about change in pluralistic organisations requires power, legitimacy and knowledge, as multiple interests must be satisfied. Thus, attention must be paid to the requirements of actors within and outside of the organisation in order to garner their support [15].

As a response to these pressures, formal engagement processes have been developed to involve stakeholders such as staff, patients and the public in planning around healthcare. Guidelines have also been developed to advise policy-makers and managers on how best to engage communities around reconfiguration [17]. A three-stage process has been employed in the UK, involving information-sharing, public meetings and final decision-making informed by public feedback [5,17,18]. In Ireland, a recently-produced guidance document has called for increased public participation in policy-making in order to improve public understanding of how policy is developed and enhance the 'legitimacy' of decision-making [19]. Within the Irish healthcare arena, there is a growing trend towards formal public and patient involvement in designing new policies and programmes [20].

Several authors have criticised current approaches to public engagement in healthcare [18,21], highlighting the lack of consistency in methods employed and poor measurement of their impact [22]. Barratt and colleagues explored public responses to emergency care reconfiguration programmes carried out in the UK [18], finding that the public felt their concerns were ignored despite the extensive engagement process conducted. The authors challenged the apparent belief among policy-makers that local communities can be convinced of the need for change if presented with the 'right' evidence, and it is argued that more effort must be made to address the range of community concerns around planned changes.

It has been suggested that the purpose of public engagement has not generally been well-defined, which has contributed to the lack of evidence regarding its direct impact on the success or failure of reconfiguration [22]. Jones suggests that public engagement in its current form is not a democratic and egalitarian sharing of views in order to reach a consensus, but is instead influenced by a positivist, rational and technocratic ideology which values abstract 'expert' knowledge over and above the experiential 'non-expert' knowledge of the public and patients [23]. It is argued that clinicians have been co-opted by policymakers to reinforce the framing of centralisation as a clinical necessity. In essence then, public engagement is characterised as providing a veneer of democratic involvement in decisions that are in fact made based on the views of an elite minority.

Terms such as 'consultation', 'engagement' and 'involvement' have been used interchangeably in the literature, with little consistency in definitions and methods associated with each term. In order to address this issue, the International Association for Public Participation [24,25] has created a descriptive public participation spectrum (Fig. 1) which outlines different levels of public engagement in planning, and typical methods associated with each category. Under this conceptualisation, public participation ranges from merely being informed of plans, to empowerment in decision-making. We have adopted the definitions outlined in the spectrum in our descriptions of public engagement activities.

The current study explores stakeholder perspectives on the public engagement undertaken during the reconfiguration of urgent and emergency care systems in the Republic of Ireland. Specifically, this study investigates the hypothesis that engagement activities undertaken prior to urgent and emergency care service reconfiguration influence stakeholder perspectives, and impact on implementation outcomes.

2. Methods

2.1. Setting

The Health Service Executive (HSE) is the public sector body responsible for the delivery of health care in the Republic of Ireland. It is responsible for the delivery of most urgent and emergency care in Ireland through acute hospital emergency departments, acute assessment units and minor injury units. A small number of private urgent care facilities also operate in Dublin, Cork and Galway. Public ambulance services are delivered by the National Ambulance Service and Dublin Fire Brigade. Primary care is largely delivered by private general practices. Privately-run out of hours primary care is also available in most of the country. Urgent and emergency care services are not universally free at the point of contact. Patients who attend a public emergency department without referral from primary care are liable for a charge (currently €100) unless they fall beneath an income threshold or into a set of clinical categories.

In 2006 the HSE introduced a programme designed to 'transform' healthcare provision, with the overall aim of improving system coordination, quality and efficiency [26]. One aspect of this programme involved region-level reconfiguration of acute hospital services, including urgent and emergency care. The implementation of reconfiguration has differed across Ireland; several regions have made changes to the configuration of services while others have made few changes. The changes have largely consisted of closing or downgrading the function of smaller emergency depart-