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Rolling-out Lean in the Saskatchewan Health Care System: Politics Derailing Policy

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Abstract

Following on the work of Marchildon (2013) this paper examines the political challenges faced by the government of Saskatchewan in rolling out their Lean reforms to the entire provincial health system. The government's Lean reforms were meant as a vehicle to empower patients and workers in the redesign of service delivery and the creation of a patient-centred system. Lean focuses on continuous improvement, priority setting, employee engagement and the elimination of waste. The reforms appear to have been derailed to a significant degree insofar as key actors inside the system, the media and the public have challenged the goals of the reform, the Lean methodology and process, as well as the cost of the consultants employed to oversee the process. The government's implementation of the roll-out suffered both from the ability of key actors to withdraw their support and challenge the viability of the reforms in public as well as from a public relations perspective that put the government on the defensive about how people inside the system were being treated with the reforms. As the government moves forward it will have to adjust its implementation processes and strategy in order to overcome the now strong resistance within the health sector.

Cet article fait suite à celui de Marchildon (2013) et étudie les obstacles politiques rencontrés par le gouvernement en Saskatchewan quand il a voulu étendre ses réformes « Lean » au système de santé dans son ensemble. Par ces réformes, le gouvernement voulait donner leur mot à dire aux patients et aux producteurs de soins dans la recomposition de la délivrance des soins et la création d'un système centré sur le patient. « Lean » vise l'amélioration permanente, l'établissement de priorités, l'engagement des employés et la chasse au gaspillage. Il semble que les réformes aient échoué pour une bonne part parce que des acteurs clés à l'intérieur du système, les médias et le public ont remis en cause leurs objectifs, la méthodologie et le processus de « Lean », ainsi que les coûts des consultants employés pour conduire le processus. La mise en place de la généralisation par le gouvernement a été malmenée à la fois par la capacité des acteurs clés de retirer leur soutien et de remettre en cause publiquement la faisabilité des réformes, mais aussi par une opération de relations publiques ayant contraint le gouvernement à défendre la façon dont les personnels étaient traités par les réformes. Quand le gouvernement voudra avancer sur ce dossier, il devra ajuster les processus de mise en place et sa stratégie afin de dépasser des réticences maintenant fortes au sein du secteur sanitaire.

Key Messages

- As it rolled-out its Lean reforms to the entire provincial health system, the Saskatchewan government failed to fully appreciate that key actors within the system (namely nurses and physicians) had the independent ability to push back against the initiative, thus derailing implementation and raising doubts in the minds of the public.
- The Saskatchewan government was caught off-guard by the storm of criticism about the nature of the reforms being implemented, their cost and the manner of implementation, thus putting it on the defensive.
- As it moves forward with Lean in health care, the Saskatchewan government must come to terms with the reality that it cannot implement Lean in the top-down, directive manner displayed to date but must accommodate other powerful decision-makers in these sectors.

Messages-clés

- *Quand il a généralisé ses réformes Lean à l'ensemble du système provincial de santé, le gouvernement de Saskatchewan n'a pas pleinement anticipé que les acteurs clé dans le système (à savoir les infirmières et les médecins) avaient la capacité de remettre en cause l'initiative, et ainsi d'en faire dérailler la mise en place et de faire lever des doutes dans l'esprit du public.*
- *Le gouvernement de Saskatchewan a été pris au dépourvu par l'avalanche de critiques s'étant abattues sur la nature des réformes, leur coût et la façon dont elles étaient mises en place, ce qui l'a placé sur la défensive.*
- *Quand il voudra avancer sur ce dossier Lean dans les soins de santé, le gouvernement de Saskatchewan devra reconnaître qu'il ne peut imposer le procédé Lean d'en haut, de la manière autoritaire employée jusqu'ici mais devra composer avec d'autres décideurs puissants dans ces secteurs.*

1 BRIEF DESCRIPTION OF THE HEALTH POLICY REFORM

Beginning in 2012, the Saskatchewan Ministry of Health undertook a process for the implementation of Lean management principles and processes in the bureaucratic and administrative operations of both the Ministry of Health and the province's regional health authorities. As Marchildon (2013) described this initiative, it consisted of the creation of so-called *Kaizen* (or Continuous Improvement) Offices across the province, massive staff training in Lean operations and a commitment to expanding Lean's application to "back office functions in all of the province's regional health authorities" (2013, 2). This reform initiative set the stage for the next phase of Lean implementation in the province which was its roll-out from back-office into the frontline delivery functions of the health system (hospitals, clinics, long-term care facilities, etc.) This roll-out or scaling-up of Lean's application in the province is the moment that, in a sense, Lean went truly public in Saskatchewan. Lean would no longer be simply about how the government administered the health care system but would now involve those who delivered care both as public sector workers and private actors under contract to government. It is this roll-out or scaling up of Lean into the health care system proper that is of interest here precisely because it brings into the implementation equation new stakeholders with different sets of interests. In addition, it begins to involve the public (and draws the attention of the media and the opposition in the legislature) in Saskatchewan's Lean experiment.

Though there are a number of examples of single health care facilities employing Lean processes, mostly in the United States and the United Kingdom, Saskatchewan is the first political jurisdiction to attempt to employ Lean processes and methods across an entire, integrated health care system, including not only the bureaucratic and administrative oversight and management of the system, but also the organization, coordination and delivery of care to patients (Kinsman *et al.* 2014; Burgess and Radnor 2013; Toussaint and Berry 2013). Lean would be applied across the board to all health service delivery functions and be the vehicle by which to guide the coordination of care. All of this was done with reference to the idea that Lean was the means by which to achieve "patient-centred" care which was the public cornerstone of the provincial government's approach to health care.

As Marchildon notes, some parts of Lean had, by 2012, already been implemented in some parts of the hospital sector. "*Releasing Time to CareTM (RTC) was one of the first Lean process improvements in Saskatchewan: it was originally aimed at improving the quality of care and reducing waste in hospital-based nursing units in acute care facilities. ...By 2012, RTC had been implemented in all hospitals in the province*" (2013, 2). But by 2014 and 2015, Lean's principles of waste reduction and quality improvement techniques were being pushed out across the system and beginning to encounter push-back and resistance from health professionals, their unions, professional associations and regulatory bodies. Some of these stakeholders had been (or at least appeared to have been) originally supportive

of Lean's initial iterations, but their public resistance, as discussed below, fundamentally changed the dynamics of Lean's implementation in the province to the point of perhaps derailing it altogether.

2 HISTORY AND CONTEXT

From the moment of its election in 2007, the centre-right Saskatchewan Party government of Premier Brad Wall sought to articulate a vision of health care that would differentiate it from that of the outgoing centre-left New Democratic Party (NDP) which had ushered in Canada's model of publicly administered health insurance in the 1940s in the province of Saskatchewan. Like all provincial governments in Canada, the Saskatchewan government inherited a health care system beset with major challenges—lengthy wait times for key services (especially advanced diagnostics and some elective surgeries such as hip and knee replacements), shortages of both primary care physicians and nurses and a shortage of long-term care options for an aging population (Lazar *et al.* 2014).

The government's initial blueprint for health care came in the form of the Patient First Review led by Tony Dagnone that articulated a somewhat different direction for the Saskatchewan health care system (Saskatchewan Health 2009). Most of the common health reform tropes of the last fifteen years are present—primary care reform, quality improvement, team practice, better efficiency, etc. But Patient First differed in two important ways.

First, there was the desire to put the patient at the centre of the system rather than the health professional. Giving voice to the patient through the continuum of care was the new watchword.

Second, there was a commitment to a number of key principles that are often associated with Lean initiatives in health care even though Lean processes are not specifically mentioned. The report focuses on innovation and quality improvement through engaging workers, stakeholders, the public and patients.

Lean also held great ideological appeal to the Saskatchewan government. What better way to stamp their imprint on publicly-administered care than by using a private sector-derived model of waste reduction and efficiency to achieve the public goals of improved quality of care and patient-centredness. If successful it would mean the Saskatchewan Party did what the NDP seemingly could not, make public health care both sustainable and efficient while also improving care.

3 GOALS OF LEAN

Lean's implementation in Saskatchewan draws on the work (and direct involvement) of American Lean consultant John Black's adaptation of the Toyota manufacturing processes and stresses four key elements:

1. Continuous quality improvement (*Kaizen*)
2. Setting strategic priorities (*Hoshin Kanri*)
3. Elimination of waste (especially in regard to time use, overproduction, motion and inventory issues)
4. Active employee engagement in quality control and improvement (Miller and Black 2008; Black 2008).

4 FACTORS THAT INFLUENCED THE ROLL-OUT DECISION

The planned roll-out of Saskatchewan’s Lean initiatives to encompass the entirety of the system was clearly driven from within the Ministry of Health and, in particular, with the enthusiastic support of Dan Florizone, the Deputy Minister of Health from 2008 until 2013 (Mandryk 2014). It was not about putting the issue onto the government’s agenda, but rather taking the next step after applying Lean to the internal operations of the Ministry and the Regional Health Authorities (RHAs). The challenge in this part of the Lean implementation was that it would directly engage with a variety of new stakeholders, namely those who delivered care and their representatives.

Saskatchewan governments have historically had a generally positive relationship with the Saskatchewan Medical Association (SMA) and the Saskatchewan Registered Nurses Association (SRNA) (McIntosh and Ducie 2013). Likewise, the Saskatchewan Party government has had a generally positive relationship with the Saskatchewan Union of Nurses (SUN) which had experienced quite open conflict with the previous NDP government.

So there is reason to believe that the government did not foresee a significant difference between implementing Lean in the “back office operations” of the health system and its full-scale introduction into the health system proper. Their internal belief seems to have been that what had been a success on the bureaucratic and administrative side would be equally successful on the care delivery side. And though they would later disavow Lean, SUN admits to being optimistic about its implementation in care settings at the outset (SUN 2014).

But with each of these factors there are warning flags that failed to be acknowledged. First, there is neither publicly available data that confirms the government’s insistence that Lean’s implementation has been a success nor any independent evaluation of cost-savings or efficiencies implemented. Second, the generally positive relationship between the government and the health professions always rested on the government’s acknowledgement of and respect for the autonomy and authority of those professions within the system and, especially, at the point of care. Lean calls for a reorganization of the health care hierarchy and for an opening up of decision-making and thus, by its nature, raises at the very least the potential for conflict with professional autonomy.

What is not particularly clear is how Lean and patient-centredness can be applied simul-

taneously in an environment with multiple centres of power and decision-making authority. That is, Lean applied to manufacturing involves delegating (but not devolving) authority down the hierarchy to encourage innovation to flow upward. But health care in Canada lacks the hierarchical structures of a factory. The Ministry of Health holds certain authority (and the purse strings) but the professions, especially medicine and nursing, maintain professional and regulatory autonomy that predate Lean and which historically governments have not impinged on lightly. To the extent these professions saw their autonomy threatened, they were prepared to push back against the government's plans.

5 HOW THE IMPLEMENTATION FAILED (OR WAS STALLED)

The roll out of Lean to more and more of the health care system began to raise issues about how committed these key professions were to changes that might be seen to compromise their autonomy in the decisions around the delivery of care. In a posting on the SUN website the union president explained their disenchantment:

Now that Lean is being put into practice we are seeing the primary focus is on creating efficiencies, waste reduction and budgetary savings only, it fails to take into account patient acuity and complexity and is unfortunately proving to have little impact on direct care at the bedside and patient outcomes. ...The fact is we are finding that Lean does not fit with the registered nursing process, safe nursing practice, registered nurse decision-making or the formulation of nursing diagnoses. Lean is viewing important knowledge-based aspects of registered nursing, such as consultations, as wasted time. The linear, production-line approach to creating efficiencies does not take into account the flexibility needed to deal with increasing and evolving complexities and acuities of patients we are seeing today. (SUN 2014)

As Poksinska (2010) has noted, Lean implementation in health care can (or can be seen to) compromise professional autonomy and therefore meet strong resistance from health professionals. Unlike its application to the back office operations of the health authorities, Lean's implementation at the point of care depends on the consent and participation of a variety of stakeholders whose authority within the health system is independent of the Ministry itself. To the extent that Lean challenges the established professional hierarchy and is perceived as diminishing the autonomy of health professionals, it is likely to engender resistance.

It is also at this point that Lean begins to attract more widespread attention from the media and the opposition. As organizations like SUN begin to make their concerns public, the media start to ask increasingly pointed questions about Lean's goals and its achievements. By the spring of 2014, Lean's implementation was subjected to a barrage of media,

public and health sector criticism. There is ridicule over reports of bureaucrats and health professionals being required to use Japanese terminology like *hoshins* and *kaizens* instead of “priority” or “continuous improvement”. More seriously, the government’s insistence that Lean was saving the system money was met with accusations that it was not really about quality improvement but rather about cost-cutting. SUN linked Lean to decreases in patient safety (Canadian Press 2014; Canadian Press 2015; CBC News 2014a). A government survey of health care workers found 64% of doctors questioned Lean techniques and goals (Slater 2014).

In the legislative assembly, the opposition NDP attacked the government for what it characterized as the excessive spending involved in the C\$40M consultant’s contract, including bringing in *Senseis* from Japan to lead Lean workshops for health system managers across the province (CBC News 2014b; Mandryk 2015).

The Saskatchewan government seemed unprepared for the criticism. Though the government insisted that Lean has resulted in significant cost-savings and improvements in care (CBC News 2015a), there is little independent evidence that such is the case. The government did, however, eventually cancel the contract with Black and Associates, declaring that provincial officials were now sufficiently trained to carry on Lean implementation themselves (CBC News 2015b).

This was simultaneously an implementation and a communications failure on the part of the government. It never fully grasped the difficulty of implementing Lean in an environment characterized by multiple centres of decision-making authority and stakeholders with professional and regulatory autonomy. It was the government that went ahead with the rolling out of a policy innovation that it had to know would be disruptive to the status quo inside the health care system and yet it made little effort to ensure the cooperation of those who had the capacity, for good reasons or bad, to derail the implementation.

On the communications side, the government soon lost the public relations war over Lean. It stuck almost exclusively to the defence that whatever had been spent on Lean implementation, was more than made up for by what was saved in efficiencies. But this only increased suspicion that Lean was about cuts and cost-saving and not really about “patient-centredness” and “empowered workers”. The government has yet to offer any substantive indication that quality of care has improved as a direct result of Lean’s implementation. When Lean was described as a cult and its curious language likened to Scientology, it mattered little in the public’s mind whether it was saving much money or not.

6 EVALUATION

The roll out of Lean in the entirety of the care delivery system in the province was undertaken without any publicly available independent evaluation by the Ministry of its initial results in the bureaucratic and administrative back rooms of the Ministry and the RHAs. In early June 2015 the government released the initial Patient First Review Update

(Saskatchewan Health 2015) which touts a number of accomplishments of Lean processes and systems, but fails to offer much in the way of concrete evidence supporting these assertions. There is talk of millions of dollars saved, but no real breakdown of how those figures were calculated. In short, the document seems more aimed at retaking the high ground in the communications battle over Lean than in providing a serious, independent evaluation of the process.

In December of 2015 the Provincial Auditor reported that while Lean appears to bring improvements in coordination and efficiency, there is no evidence available to judge whether the quality of services is better or whether there is value for money in its application (CBC 2015c). A recent systematic review of Lean initiatives in health found little evidence of quality improvement overall and singled out Saskatchewan's experience as costing far more to implement than was achieved in savings (Moraros, Lemstra and Nwankwo 2016).

Saskatchewan's experience in rolling out Lean to the totality of its health care system provides some lessons for the province. First, it needs to be acknowledged that there are differences between applying Lean in institutions with single lines of authority and accountability (i.e., a government department or health authority) and those with multiple centres of decision-making and differentiated levels of autonomy such as the health care delivery system. Professional associations, unions and regulatory bodies have both legal autonomy and political power that can undermine attempts to unilaterally change how the system operates.

Second, there is a fundamental contradiction in the messaging around Lean that says it is all about empowering workers and patients to improve quality by engaging them in decision-making while imposing these processes from above and insisting that workers adopt a particular way of speaking about their work and a particular way of articulating solutions to problems they identify.

Third, the government needs to be prepared to present evidence as to Lean's effectiveness and its ability to cut costs. Perhaps it is in the nature of a centre-right government to fixate on "saving public money" but when it comes to services like health care, the public is also concerned about quality, timeliness and effectiveness.

As the full-scale implementation of Lean proceeds inside the Saskatchewan health system the government risks heightening the tension and conflict it has created unless it begins to pay attention to those voices inside the system that are asking important questions about the process.

7 STRENGTHS, WEAKNESSES, OPPORTUNITIES AND THREATS

Table 1: SWOT Analysis

STRENGTHS	WEAKNESSES
<ul style="list-style-type: none"> • Committed leadership and policy champions inside Saskatchewan Health • Committed political leadership from Minister and Premier • Some evidence of gains made through initial implementation • Willingness to invest in implementation and wide-scale training 	<ul style="list-style-type: none"> • Failed to properly evaluate initial implementation • Failed to account for autonomy of key professions in decision to scale up • Processes for empowering patients never had clear public buy-in. • Rigid insistence on adoption of new language and concepts made it look like a “top-down” process.
OPPORTUNITIES	THREATS
<ul style="list-style-type: none"> • First jurisdiction to attempt such a wide-scale application of Lean processes • Could provide significant voice for patients in managing their own care • Possibility of measurable quality improvement and some cost-savings 	<ul style="list-style-type: none"> • Unions and professional associations had different political and policy agendas and the autonomy to pursue them. • Media quickly focused on issues that made government look rigid, silly or incompetent. • Public and media concern over cost of consultants and unnecessary spending

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