Programme Design and Continuity of Healthcare Reform: the Case of Greek Mental Care

Kyriakos S Hatzaras  MEng ACGI MPhil CEng
HaCIRIC10
23rd September 2010

Partly based on the Ex Post Evaluation of the European Social Fund (2000-2006), VT/2008/085, carried out on behalf of the European Commission DG Employment, Social Affairs and Equal Opportunities; views expressed are not necessarily shared by the EC.
Why study mental care reform?

- social costs associated with mental illness: unemployment, homelessness, violence, crime
- mental illnesses increase risk of communicable and non-communicable diseases; co- & multi-morbidity (Prince et al, 2007)
- large savings in hospital costs have resulted from treatment improvements (Buxton et al, 2004)

→ reforming mental care may lead to substantial economies of health expenditure (see KCL, KI study on dementia)
Why look at stakeholders, and their engagement in reform?

- ‘Programme’ or ‘project environment’ of healthcare infrastructure and/or service reform programmes: several stakeholders, e.g. int’l organisations, national government, care staff, patients, communities play a part
- Stigma associated with (mental) health conditions :: relevant to delivering care in the community
- Consensual, or pluralist polity; the role of civil society
Research design

→ definition of key concepts:
  ‘stakeholders’: actors that (i) take interest in organisational action, and (ii) have relevant expertise (Blair & Fottler, 1990; Savage et al, 1991; Moss, 2002:4-5);
  ‘reform’: an instance of organisational action;
  ‘stakeholder engagement’: actor participation & expertise input during reform with a view of positive influence;

→ hypothesis: intermittent stakeholder engagement in programme design & implementation induces deficiencies in programme delivery and puts reform at risk;

Research design (cont’d)

→ hypothesis tested on evidence of four research tasks:

• a systematic review and qualitative content analysis (Flick, 2002) of programme documentation;
• a systematic review and qualitative content analysis of academic papers and policy studies;
• a systematic review and qualitative content analysis of British and Greek press reports published electronically;
• qualitative content analysis of semi-structured interviews with staff of the ESF Monitoring Authority of Greece.

→ social constructivism used to examine stakeholder action.
Greek mental care reform in 1984-1995

- mental care prior to reform: institutional care for virtually all pathologies, ten overcrowded hospitals, uneven geography, lack of alternative services and qualified staff
- reform prompted upon entry of Greece to the EU (EEC)
- a 4-year programme designed with input from EC, WHO to:
  - replace institutional care with primary & acute care;
  - place long-stay hospital patients in extramural social and vocational rehabilitation structures within communities;
  - upgrade hospital infrastructure, provide care staff training.
- Finance: yearly matched funding, national and EU at 55%.
Greek mental care reform in 1984-1995

→ programme stakeholder roles and expertise:

<table>
<thead>
<tr>
<th>Stakeholder</th>
<th>Role</th>
<th>Expertise</th>
</tr>
</thead>
<tbody>
<tr>
<td>EU</td>
<td>funder; policy maker</td>
<td>Multi-annual programme management</td>
</tr>
<tr>
<td>National government</td>
<td>funder; policy maker</td>
<td>Domestic policy &amp; administration</td>
</tr>
<tr>
<td>Experts</td>
<td>expert knowledge provider</td>
<td>Primary, acute care methods per type of psychopathology</td>
</tr>
<tr>
<td>Care staff</td>
<td>care provider</td>
<td>‘frontline’ knowledge of current services, patients, pathologies</td>
</tr>
<tr>
<td>Local government, residents</td>
<td>facilitator of new,</td>
<td>Local community</td>
</tr>
<tr>
<td></td>
<td>community-based services</td>
<td></td>
</tr>
<tr>
<td>Citizens, civil society</td>
<td>policy reviewer</td>
<td>Local community, domestic policy &amp; administration</td>
</tr>
<tr>
<td>Patients</td>
<td>new services user</td>
<td>Current services; own pathology</td>
</tr>
</tbody>
</table>
Greek mental care reform in 1984-1995

- irregular stakeholder engagement led to:
  (a) delays in site selection for new service infrastructure;
  (b) very slow progress with construction;
  (c) slow progress with care staff completing training;
  (d) absence of programme monitoring.

- these were not addressed by the national government, or other stakeholders

- (a) – (c) persisted → funding withdrawal → reform at risk
Greek mental care reform in 1984-1995

→ in 1989: EC intervened, introduced own expertise and rallied other stakeholders:

• periodic monitoring and evaluation established, uninitiated projects were cancelled; three new expert groups introduced to review progress.

→ national gvt presented special actions, a revised programme

→ expert groups working with national gvt and care staff on delivering primary and acute care services, new legislation, balancing the geographic distribution of new services

→ programme completed in 1995, due to active stakeholder engagement after 1989.
Greek mental care reform in 1995-2009

- continuity of reform: two further programmes to broaden de-institutionalisation, extramural rehabilitation, primary care
- reform financed by national funding and EU Structural Funds: ERDF, ESF, greater EU funding availability after 2001;
- stakeholder engagement promoted by the EU:
  - support for concerted actions in psychiatric hospitals;
  - emphasis on developing motivated, qualified staff;
  - stakeholder participation formalised: EU, national government, representative organisations became members of programme Monitoring Committees (EU1260/99), reviewing progress periodically.
Greek mental care reform in 1995-2009

→ 1995, 2001: stakeholders’ **new** roles & expertise:

<table>
<thead>
<tr>
<th>Stakeholder</th>
<th>Role</th>
<th>Expertise</th>
</tr>
</thead>
<tbody>
<tr>
<td>EU</td>
<td>funder; policy maker</td>
<td>Multi-annual programme management, <strong>monitoring</strong>; <em>previous programme</em></td>
</tr>
<tr>
<td>National government</td>
<td>funder; policy maker</td>
<td>Domestic policy &amp; admin, <strong>multi-annual programme management</strong>; <strong>monitoring</strong></td>
</tr>
<tr>
<td>Experts</td>
<td>expert knowledge provider</td>
<td>Primary, acute care methods per type of psychopathology; <em>previous programme</em></td>
</tr>
<tr>
<td>Care staff</td>
<td>care provider; <strong>policy maker</strong></td>
<td>‘frontline’ knowledge of patients, pathologies; <em>new mental care methods</em></td>
</tr>
<tr>
<td>Local government, residents</td>
<td>facilitator of new, community-based services; <strong>policy maker</strong></td>
<td>Local community</td>
</tr>
<tr>
<td>Citizens, other</td>
<td>policy reviewer</td>
<td>Local community, domestic policy &amp; admin</td>
</tr>
<tr>
<td>Patients</td>
<td>new services user; <strong>policy maker</strong></td>
<td>Current services; own pathology</td>
</tr>
</tbody>
</table>
Greek mental care reform in 1995-2009

→ intermittent engagement in the design and implementation of the 2002-2008 programme led to these deficiencies:

(a) priority on patient exiting hospitals prior to expanding capacity of extramural & primary care service network;

(b) finance plan disproportionately reliant on EU funding: lack of additional funding channels e.g. philanthropy, irregularity of national funding;

(c) no care quality guidelines, or assessment developed;

(d) little, unsuccessful engagement of local stakeholders in specific projects.
Greek mental care reform in 1995-2009

→ these led to care delivery issues after 2005, putting -once again- reform at risk:

(a) patient safety incidents;

(b) inconsistent quality of care;

(c) new privately owned extramural structures came to be underfunded after 2005, compromising care quality further;

(d) loss of commitment to reform on the part of care staff;

(e) negative reaction by local residents towards new services.

→ 2009: EU and national gvt secured funding, established a quality management and control system.
Conclusions (preliminary due to ongoing research)

- support for hypothesis: intermittent stakeholder engagement induces deficiencies in reform design and implementation;
- nature and regularity of stakeholder engagement and contribution matter: roles and expertise important to agree, map, communicate and evaluate at every stage of reform;
- periodic, or exception reporting seemingly not suitable: Prince2™, or Agile appropriate as a PM method?
- finance systems supporting reform may affect continuity of care: multiple funding redundancy is required;
- consensual vs pluralist polities; the role of civil society.
Your questions

Programme Design and Continuity of Healthcare Reform: the Case of Greek Mental Care

Kyriakos S Hatzaras MEng ACGI MPhil CEng
HaCIRIC10
23rd September 2010
References


References


References


References


The case of Greece: essential aspects

- Three successive programmes in the period 1984-2009
- European and national funding (only)
- Domestic and international stakeholders
- Pluralist civil society and polity

→ focus of this paper: stakeholder engagement in effecting the reform of Greek mental care