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CONFERENCE ABSTRACT

The impact of vertical (dis)integration on the co-productive capacities of hospital providers and patients

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Introduction and problem statement

In hospitals, co-production of services helps assure that care is responsive, accountable and patient-centred. Patient participation in surveys, improvement teams and committees provide important opportunities for co-production. System reforms aiming for vertical integration entail an initial disintegration as services are moved from hospital to community. Our aim is to better understand how such changes to hospital mandate impact the co-production capacities of providers and patients and how these capacities contribute to hospital efforts to become network players in integrated systems.

Methodology

We conducted a nested case study of co-production activities at central, departmental and unit level of a hospital in Quebec, Canada over 10 years when reforms emphasized vertical integration. A rich dataset (30 interviews, documents, observation) integrating perspectives of patients, administrators and clinicians was analyzed through the lenses of institutional work and collaborative governance to understand how reforms toward a networked system impacted on co-production capacities of providers and patients.

Results

We identified three main reform effects on co-production in the organization. First, under pressure to speed discharge, clinicians increased their efforts to collaborate with patients to plan and navigate the post-hospital course. Second, patient committees, legally mandated to defend patient rights within the hospital, lost jurisdiction over services when they were moved, opening up gaps in oversight and recourse. Third, the hospital's restricted acute mandate justified cuts to patient education and support programs that had generated co-production capacities and an important pool of engaged patients within the organization.

Conclusion

The move to vertically integrated systems provides an opportunity to increase co-production capacities of providers and patients and shift the institutional logic of providers, "from fixers of problems, to facilitators who work alongside their customers to

find solutions" (Sorrentino 2017, p.1428). However, greater attention is needed during these reforms to sustaining spaces for collaboration among patients, and between patients and providers, and to extending these across sites as care is shifted from hospital to community. Links between patients in co-design and oversight roles across the system could help prevent gaps from emerging in the disintegration phase of reforms.

Lessons

In line with theory of collaborative governance, external "threats" make interdependencies palpable and spur collaborative efforts. Structural reforms impact the capacities of patient committees to support accountability, calling for them to find ways of assuring their continued relevance as patients move between organizations. Finally, hospitals constitute important venues for developing social capital (Putnam 1993); efforts are needed to protect this role within vertically integrated systems, at least until alternate venues are identified.

Limitations

Vertical integration reforms are undertaken differently between systems and were, in this case, especially centralizing. While this heightened their impact, it may make results less transferable to other jurisdictions. We further recognize that while the study includes administrative, clinician and patient perspectives across levels of the hospital, it may not capture all views within the organization.

Future research

Further research is needed to understand the range of patient roles within integrated care systems, and linking mechanisms that would strengthen co-production across care settings.