

Leading health system transformation to the next level

Expert meeting
Durham, United Kingdom, 12-13 July 2017



Acknowledgements

This publication stems from the second WHO Europe expert meeting on health system transformation that took place from 12 to 13 July 2017 in Durham, United Kingdom. The report was written by Kate Melvin (rapporteur), David Hunter and Rafael Bengoa. Guidance and review were provided by Hans Kluge and Elke Jakubowski. The report is based on the invaluable inputs of the experts on health system transformation who attended the meeting (Annex 2).

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ABSTRACT

This expert meeting on implementation of health system transformation took place in Durham, United Kingdom, 12–13 July 2017. It focused on progress that had been made in implementing large-scale health system transformation in Europe since the first expert meeting held in Madrid in December 2015 as well as on exploring appropriate mechanisms to support the development of macro level reforms.

The meeting had the following specific aims:

- To identify lessons learned in the implementation of health system reforms at a macro level that could strengthen the existing evidence base;
- To provide insights from health system policy-makers on how to initiate reforms and/or how to accelerate or improve their implementation, and on any barriers or inhibitors encountered and how they may be overcome;
- To consider and review a draft instrument offering a structured approach to assessing readiness for change and implementation; and
- To consult on steps that the WHO Regional Office for Europe could take to develop a policy-level implementation agenda and potential mechanisms for collaboration.

KEYWORDS

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CONTENTS

| | |
|--|----|
| Executive summary..... | iv |
| 1. Purpose of the meeting..... | 1 |
| 2. Large-scale health system transformation: the what and the why | 3 |
| 2.1. The Regional Office context for health system transformation: the what | 3 |
| 2.2. Reasons for large-scale health systems transformation: the why | 4 |
| 3. From policy to implementation | 7 |
| 4. The how challenge | 11 |
| 4.1. Recent experiences..... | 11 |
| 4.2. Some challenges | 17 |
| 5. Towards an appropriate framework for change..... | 31 |
| 5.1. Audience..... | 31 |
| 5.2. Purpose and nature | 32 |
| 5.3. Structure and format | 33 |
| 5.4. Suggested additions to content | 34 |
| 6. Selected highlights..... | 36 |
| 7. The way forward..... | 37 |
| References | 38 |
| Annex 1: Programme..... | 40 |
| Annex 2: List of participants..... | 42 |
| Annex 3: Background document | 45 |

Executive summary

This expert meeting on implementation of health system transformation took place on 12–13 July 2017 in Durham, United Kingdom. Over 25 invited experts from WHO Member States reflected on their experiential learning from leading, promoting, participating in or evaluating the implementation of large-scale health system transformations. The event built upon the discussions that took place at the meeting in Madrid, Spain, in December 2015, where experts debated the ingredients of, and conditions for, successful approaches to large-scale transformation in health systems.

The objectives of the meeting in Durham were to:

- identify lessons learned in the implementation of health system reforms at a macro level that could strengthen the existing evidence base;
- provide insights from health system policy-makers on how to initiate reforms and/or how to accelerate or improve their implementation, and on any barriers or inhibitors encountered and how they may be overcome;
- consider and review a draft instrument offering a structured approach to assessing readiness for change and implementation; and
- consult on steps that the WHO Regional Office for Europe could take to develop a policy-level implementation agenda and potential mechanisms for collaboration.

The focus of the meeting was on understanding further how, and in what way, policy-makers have moved forward in implementing health system transformations; what the main challenges and facilitating factors facing them have been; and the extent to which a checklist – *Assessing your readiness for change* – would provide help and encouragement to European countries.

This report captures the highlights of the conversations that took place during the meeting, and incorporates examples from selected case studies that provide key insights from change efforts conducted in various health systems. The case studies presented at the meeting included examples from Belgium, England, Finland and the Republic of Moldova. The methodology adopted to frame the discussions was the receptive contexts for change framework (Pettigrew, Ferlie & McKee, 1992).

During the meeting, participants drew attention to a number of critical factors and tensions they have experienced in the process of large-scale health system transformation in their own countries. These included tensions between bottom-up and top-down approaches; the need for a coherent vision, ongoing political buy-in, appropriate leadership across the health and social care landscape, and investment; and the role of information technology.

The meeting concluded with the emergence of consensus on the challenges to be confronted, how they may be overcome, and how and in what way a checklist would provide the necessary support for large-scale health system transformation.

This report provides many of the specific elements that could help health system leaders in moving forward with the implementation of large-scale change in their respective contexts. The Division of Health Systems and Public Health, WHO Regional Office for Europe, directed by Hans Kluge conceived this meeting as one of the principal mechanisms to support knowledge exchange, helping policy-makers to identify common solutions for emerging challenges and to strengthen their institutional and intellectual capital.

Against this background, the WHO Regional Office for Europe will continue to encourage and support initiatives between and within countries in large-scale transformational change, with support from professors Rafael Bengoa (Director, Institute for Health & Strategy, Spain) and David Hunter (Professor, Institute of Health and Society, Newcastle University, United Kingdom; former Director, Centre for Public Policy and Health and the WHO Collaborating Centre on Complex Health Systems Research, Knowledge and Action, Durham University, United Kingdom).



The focus of the meeting was on understanding further how, and in what way, policy-makers have moved forward in implementing health system transformations; what the main challenges and facilitating factors facing them have been; and the extent to which a checklist – *Assessing your readiness for change* – would provide help and encouragement to European countries.

1. Purpose of the meeting

The meeting on health system transformation took place in Durham, United Kingdom, on 12–13 July 2017 (see Annex 1 for the programme). Participants were ministers of health, senior policy-makers, change-management experts and health policy and system experts invited in their personal capacity from the following WHO European Region Member States: Belarus, Belgium, Croatia, Finland, Hungary, Kyrgyzstan, the Netherlands, the Republic of Moldova, the Russian Federation, Sweden, Switzerland, the United Kingdom and the United States of America. Participants also included WHO representatives (see Annex 2 for the list of participants).

Durham University hosted the meeting under the joint coordination of professors Rafael Bengoa and David Hunter, in collaboration with the Division of Health Systems and Public Health of the WHO Regional Office for Europe.

To set the context for the meeting, organizers prepared a background paper for participants. It outlined the conceptual framework that underpinned the health system transformation project, and provided updates on thinking and relevant literature since the first meeting in Madrid, Spain, in December 2015 (see Annex 3 for the background paper). In turn, this informed the design of *Assessing your readiness for change*, the checklist presented at the Durham meeting for discussion. The Regional Office is developing the checklist for use by countries undertaking large-scale change. It will be available on the website in the coming months.

Since the Madrid meeting, the political and economic environment has become even more challenging for policy-makers as they embark upon, and continue with, their efforts to undertake large-scale health transformation. This has created a sense of urgency to move faster.

Similar to the proceedings in Madrid, the setting in Durham was informal. The meeting focused on learning first-hand the experiences of those implementing reforms, those advising policy-makers on implementing reforms, and academics immersed in studying the developments. The key objectives of the meeting were to:

- identify lessons learned in the implementation of health system reforms at a macro level that could strengthen the existing evidence base;
- provide insights from health system policy-makers on how to initiate reforms and/or how to accelerate or improve their implementation, and on any barriers or inhibitors encountered and how they may be overcome;
- consider and review a draft instrument offering a structured approach to assessing readiness for change and implementation; and
- consult on steps the Regional Office could take to develop a policy-level implementation agenda and potential mechanisms for collaboration.

Participants, in particular those currently implementing reforms, were able to explore experiences and detail both barriers and enablers in the reform process that were common across very different country contexts.

After identifying strategies and processes that could enable transformation, they scrutinized the draft checklist *Assessing your readiness for change* and suggested amendments. Significantly, they also highlighted appropriate contexts for its use.

A consensus arose that, irrespective of context and level or stage of health system transformation in individual countries, the meeting provided a unique opportunity for participants to develop further the conceptual framework needed to address critical challenges. These challenges include moving towards a more proactive and preventive model; giving more voice to patients and citizens; addressing inequalities; improving quality; managing population health; and ensuring the sustainability of health systems.

During the meeting, four policy-makers presented details of progress in the health reforms of their countries. These presentations were followed by small-group discussions exploring universal barriers and enablers in large-scale health system transformation. On both days, the sessions drew upon the discussions in Madrid and the background paper.

The remainder of this report is divided into the following sections. Section 2 sets out the context of large-scale transformation in the Region and outlines why health system transformation is needed. Section 3 explores the complexity of implementing large-scale change. Section 4 provides examples from four European countries, and further discusses barriers and enablers in large-scale transformation as experienced by participants. Section 5 details the draft checklist *Assessing your readiness for change*, with additional suggestions for improvements. Section 6 highlights key issues from the meeting. Finally, Section 7 considers next steps.

2. Large-scale health system transformation: the *what* and the *why*

2.1. The Regional Office context for health system transformation: the *what*

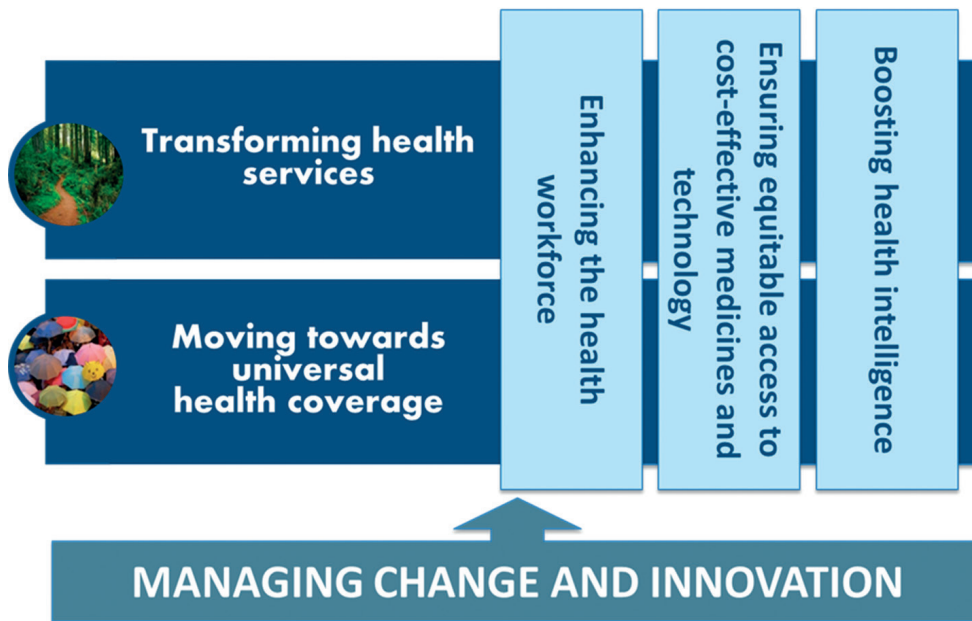
In keeping with the structure of the Madrid meeting, this report is framed within the strategic priorities of the WHO Regional Office for Europe in the area of health systems strengthening for 2015–2020. It takes its vision from the European health policy framework Health 2020 (WHO Regional Office for Europe, 2013) and the commitments set out in the Tallinn Charter: health systems for health and wealth (WHO Regional Office for Europe, 2008).

These strategic priorities were endorsed by the 65th session of the WHO Regional Committee for Europe in Vilnius, Lithuania, in September 2015 (WHO Regional Office for Europe, 2015). The Regional Office supports Member States in strengthening health systems to become more people-centred in order to accelerate health gains, reduce health inequalities, guarantee financial protection and ensure the efficient use of societal resources.

Good health and well-being underpin the majority of the Sustainable Development Goals (United Nations, 2017). In 2015–2020, the Regional Office will work closely with Member States in two key priority areas: transforming health services to meet the growing challenges of the 21st century, and moving towards universal health coverage for a Europe free of impoverishing out-of-pocket payments.

Enhancing the health workforce, ensuring equitable access to cost-effective medicines and technology, and improving health information and health information systems are all essential for the required large-scale transformation of European health systems (Fig. 1).

Fig. 1. Priority areas of work for health system transformation



Source: reproduced from *Priorities for health systems strengthening in the WHO European Region 2015–2020: walking the talk on people centredness* (WHO Regional Office for Europe, 2015).

2.2. Reasons for large-scale health systems transformation: the why

Experts at the Madrid meeting agreed on the broad spectrum of challenges presently confronting European health systems of all types, including those originating from Beveridge, Bismarck, Semashko and/or mixed models. These include more traditional challenges, such as changing demographics, economic constraints, increasing medical complexity and the need for technological innovation, as well as more recent challenges, such as migration, overuse of services, a disconnect between policy and research, political culture, and waste in the system.

Governments and policy-makers also widely agree on the need to redesign the often fragmented and reactive health system model, which is generally acknowledged as no longer fit for purpose. The report on the Madrid meeting (WHO Regional Office for Europe, 2016a) and the background paper (Annex 3) discuss this in further detail.

Implementing and progressing health system reform in order to advance the change agenda within complex and diverse country contexts remains the central challenge facing policy-makers today.





Each of these challenges poses an enormous implementation challenge but there is increasing evidence to demonstrate that, despite the difficulties, many countries are discovering how to move forward in these areas.

3. From policy to implementation

Although the key drivers for large-scale health system transformation emerge from the problems and challenges facing policy-makers and experienced by health systems globally, the precise mix of these drivers and pressures varies across and within systems, just as contexts vary across systems and countries. The way in which the case for change is framed and communicated is therefore critical, and demands new styles of leadership.

The meeting's adoption of the receptive contexts for change framework (Pettigrew, Ferlie & McKee, 1992) and its discussions of the background paper and the *Assessing your readiness for change* checklist aimed to address these issues. These elements informed dialogue that enabled participants to learn from those leading health system transformations, and assisted those presently facing such challenges.

As noted in the background paper, observations of policy design at a macro level and policy implementation at a meso level are now beginning to provide a complex but realistic picture of the policy process. Best et al. (2012) offer a review of examples of successful and less successful transformation initiatives, exploring many of the components of change. These include context, support from system stakeholders, leadership styles, engagement of staff and health-care professionals, and involvement of patients and the public.

A more recent meso-level study of state policy capacity and leadership for health reform in the United States identifies similar factors as determinants of the success or failure of large-scale change (Forest & Helms, 2017). The study, supported by the Milbank Memorial Fund, was based on interviews with officials and legislators about their experiences of developing and sustaining the capacity needed for major transformation.

The literature on transformation is growing, but there remains a lack of both published research and, more importantly, documented experience and practical guidance on making the leap from policy-making to implementation and ensuring the ongoing coherence of policy vision, goals and plans.

The separation between policy and implementation – what King & Crewe (2014) call operational disconnect – can be partial or complete. Of particular relevance is the asymmetrical relationship between high-level policy-makers and front-line workers. Whereas those working on the front line do not necessarily need to take into account the considerations of those working at a higher level, the latter cannot succeed without a grasp of what happens on, or close to, the front line. On the basis that governments, and those working at a higher level, do genuinely want policies to be effective, serious attention must be given to how effective relationships can be achieved.

Presenters at the meeting drew attention to relatively new modes of thinking in this sphere, such as deliverology (Barber, Kihn & Moffit, 2011). Deliverology is an approach to managing reform initiatives that, although somewhat mechanistic and instrumental, does highlight a number of important features. These include the management of expectations and the importance of quick wins.

Greater emphasis is now being placed on the uptake of health services research and its impact on policy and practice, and, conversely, on how policy concerns inform the agendas of health services research. Thought is being given to how to shift the focus of research from Knowledge generation to problem-solving, how to ensure that knowledge is co-created by policy-makers working in collaboration with researchers, and how to ensure that knowledge is context-driven rather than viewed exclusively through an academic lens.

Participants recognized the importance of these efforts, noting that policy is frequently not informed by research-based evidence. Some nonetheless observed the need for distinctions between areas that have been well researched, such as tobacco control, and areas where knowledge is less voluminous, and where influences such as lobbying, peer-group pressure, the internet and social media are frequently key factors in shaping policy.

On this topic, they also drew attention to the work of the European Observatory on Health Systems and Policies, which explores the relationship between the policy community and academia. They discussed examples in the United States of academics working within government policy departments, as well as the Finnish Government's extensive consultation with academics during their ongoing reform process and its advocacy for easier access to research data.

Some questioned the idea of general progress in this area, however, and particularly the attractiveness of a career path in policy-making for young academics. Experiments in the United Kingdom with embedded researchers and the researcher-in-residence approach have demonstrated both the strengths and weaknesses of developing closer relationships between researchers and policy-makers.

Another area now accorded far greater emphasis is patient and citizen involvement in the transformation process, and the prerequisites needed for effective engagement on both collective and individual levels. Often neglected or seen as tokenistic or ineffective in the past, this topic was a thread of debate throughout the meeting.

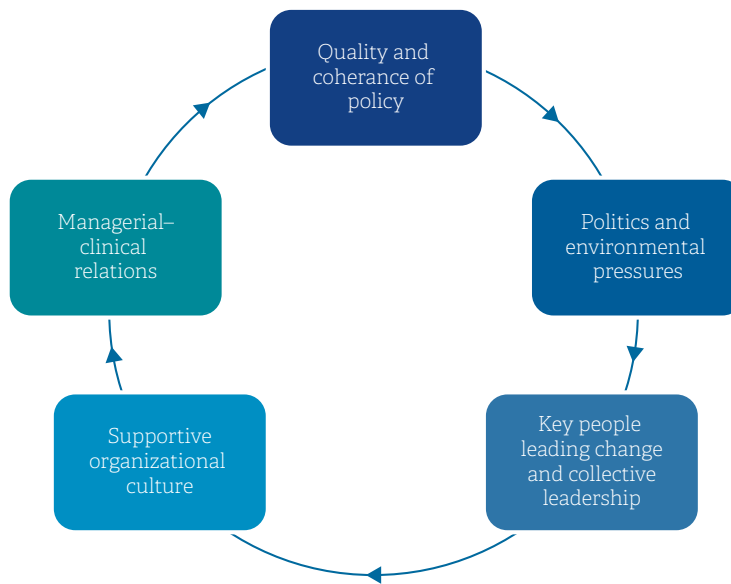
Significantly, participants emphasized the need for adaptive as well as technical change, citing a lack of adaptive change as one of the main causes of failure in the implementation of reforms (Heifetz et al., 2009). While technical change involves a well-defined problem and accompanying solution, adaptive change focuses on more than simple, causal relationships between interventions and outputs; it seeks solutions that are emergent rather than predetermined. As such, engaging in adaptive change requires stakeholders to abandon preconceived ideas, established or traditional ways of working, and accepted cultural practices.

When introducing a technical change, adaptive processes are essential. The introduction of e-health records or the transformation of facilities, for example, may fail without accompanying shifts in patient pathways or the establishment of a more horizontal management structure – adaptive changes that involve reassessing long-held beliefs and which enable the required deeper transformation.

Many large-scale transformations occur without a clear implementation plan, and it seems feasible that having a framework to organize such complex change could increase the chances of success. Experts at the Madrid meeting

acknowledged that the receptive contexts for change framework offered a sound basis for both thinking about and undertaking large-scale health system transformation. In particular, they identified five of the eight factors that make up the framework as instrumental to successful change: quality and coherence of policy; politics and environmental pressures; key people leading change and collective leadership; supportive organizational culture; and managerial-clinical relations (Fig. 2).

Fig. 2. Contexts for change



Source: adapted from Pettigrew, Ferlie & McKee, 1992.

These factors are not merely a list for identification and achievement. Each requires challenging the prevailing and context-dependent status quo, and engaging in a level of deep questioning and thinking about processes, belief systems, traditions and behaviour. Thus, although transformation may well involve technical changes, its central process involves adaptive change. Indeed, through the very process of identifying the framework's factors and elements within their particular context, policy-makers and others driving change are instinctively drawn towards the adaptive pathway.

As they did the Madrid meeting, participants stated that no single framework is likely to capture all the elements that need to be addressed when undertaking change in complex settings, but that it is helpful to have one in order to address the practical mechanisms needed to steer change.

This particular change framework, having been tested, is best able to capture the multifaceted and contextual nature of bringing about sustainable large-scale health system change in complex settings. The background paper

expands on this point and draws attention to other frameworks that have provided useful supplements to the receptive contexts for change framework (see Annex 3). These offer valuable reflections on implementing large-scale transformation and corroborate essential elements of the receptive contexts for change framework, such as the need for plans to be coherent and aligned, for an understanding of when to implement change, for a sense of urgency, for quick wins, etc.

Participants also pointed to alternative frameworks, notably the European framework for action on integrated health services delivery (WHO Regional Office for Europe, 2016b). Given its focus on the *what*, this framework can benefit from the change-management knowledge encompassed in the adapted receptive contexts for change framework.

4. The *how* challenge

4.1. Recent experiences

To demonstrate some of the complexities inherent in implementing large-scale transformation across the diverse health systems in the WHO European Region, four invited policy-makers reported on their respective experiences of implementing reforms (boxes 1-4). The examples reveal both enabling and inhibiting factors in the change process, and show that while reform is always complex, cultural and political contexts play different roles in varying settings. A challenge in one context may be more of an enabler in another.

The examples raise important questions and illustrate a number of relevant issues, including:

- the possibility of tensions between bottom-up and top-down approaches;
- the importance of ongoing political buy-in;
- the need for a coherent vision and plan over a long-term period;
- the need for coherence at the top government level to oversee reforms;
- the need to ensure the legal framework is fit for purpose;
- the need for buy-in from leadership across the health and social care spectrum;
- the role and remit of external investment; and
- the development of IT and its potential role in the process of implementation.

Box 1.

Transforming care in England

The Five Year Forward View

In a context of changing population needs and financial constraints, the traditional divide between primary care, community services and hospitals in England was becoming an increasing barrier to the personalized and coordinated health service that patients needed.

The *NHS Five Year Forward View* (NHS England, 2014), reviewed again earlier this year in the *Next Steps* report (NHS England, 2017), primarily shifted the focus of reform from continuous administrative reorganizations to service improvements and outcomes. The reforms now emphasize continuous





improvement and adaptive, evolutionary change rather than a single event. They avoid a one-size-fits-all approach, back new and innovative leadership where appropriate, and work in more co-productive ways with partners both internal and external to the NHS.

The reforms are being operationalized through 50 national Vanguard, which aim to unlock some of the barriers between primary and secondary care, physical and mental health, and the health system and social care. The four key pillars of the Vanguard are clinical engagement, patient involvement, local ownership and national support.

As part of the reforms, 44 Sustainability and Transformation Plans (STPs) are being developed across the country as a partnership between existing NHS organizations and local governments. Presently, each STP is at a different stage of development and all are moving at varying speeds. Indeed, STPs have now become sustainability and transformation partnerships.

Key points of interest

- The map of health care in England resulting from the reforms will vary from region to region, with the potential for Accountable Care Organisations and Accountable Care Systems to operate in some areas, and for devolution to join up health and social care in others (for example, in Manchester and Surrey).
- Emphasis on greater clinical engagement in the reform process has reportedly led to enthusiasm across the clinical spectrum.
- On the basis that no single organization is able to solve all problems, reforms place a strong emphasis on local partnerships that include local governments as well as community organizations. Although the involvement of public health has been slow, a number of local authorities are becoming increasingly interested.
- While patient involvement was once a so-called tick box activity, it is now considered pivotal to the success of the Vanguard. All efforts are being made to ensure that policy-makers are responding to patient feedback.
- Far greater weight is now attached to evaluative processes than in previous pilots, so that learning can be internalized as programmes develop.

Box 2.

Major health and social care reform in Finland

The reform programme

Finland's health and social care changes are considered a critical part of the Government's reform programme. Further, recent political events have indicated that unless such changes align with the political administration, they are likely to fail. The country's reforms were drawn up to meet the challenges of the future, rather than difficulties already present in the system.

Underpinning the reforms are major structural and administrative changes that involve shifting the responsibility of public service provision to 18 regions rather than approximately 200 municipalities. Added to these changes was the proposed introduction of privatization and use of competition and market mechanisms to improve quality, choice and cost containment. The ideological shift to the open market, however, received opposition and raised concerns from the Parliament's Constitutional Law Committee. The reforms are now on hold.

Key challenges and facilitators

- While the shift to provide funding directly to the 18 regions based on demographic needs assessments received some criticism, it was equally viewed as an enabler: it encouraged local politicians to become interested in the reforms, particularly in how money might be spent in the regions.
- Tensions arose between the apparently top-down set of reforms and accompanying local initiatives emerging in the 18 regions, which will be semi-autonomous and possess a number of new freedoms.
- Ensuring ongoing buy-in from all parties and all interests was key, but risked the emergence of political differences and reform fatigue.
- Instead of involving clinicians in the reform process, they were encouraged to support the reforms through the restructuring of hospital provision and the development of national centres, such as the new national centres for cancer, neuroscience and genomics.
- Although Finland already had a national electronic health and social care record system, further digitalization was a major tool of the reform process as well as a goal in itself. Digitalization has encouraged people to feel more responsible for their own health. It has also functioned as a facilitator in terms of attracting entirely new groups and businesses to the opportunities it presented.
- In spite of the potential splitting of the health-care market by the proposed privatization measures and the current number of private health providers, digitalization was considered to be a mechanism for enabling greater integration of provision. This would necessitate that the required legislation be put in place.

Box 3.

Implementing large-scale health reforms in the Republic of Moldova

The reform package

Over the last 10 to 13 years, the Republic of Moldova has developed and strengthened its health-care system, shifting from a Semashko model to a mixed model of fully state-funded health care and a social insurance system based on mandatory contributions to health insurance that now covers 85% of the population. Central to the reforms are six key objectives:

- improving the health of the population, including through the introduction of family medicine and the decentralization of primary health care;
- increasing capacity in the system;
- using resources efficiently;
- ensuring access to medicines;
- ensuring universal access to high-quality and safe medical services; and
- strengthening the capacity of public health services.

The country is achieving these objectives through an overhaul of the hospital care system, public health system and primary care system.

Implementing change

Key features of the Republic of Moldova's implementation process included the following:

- setting up a Strategic Advisory Board to support the planning, implementation and monitoring of large-scale health system reform, and to facilitate political and technical decision-making to increase the political feasibility of the reforms (this also provoked the question of who at what level will make, for example, strategic purchasing decisions);
- developing a dedicated unit for implementation and for monitoring the hospital sector reform, which will work alongside international teams;
- making systemic changes to the governance of the health sector with the introduction of the Ministry of Health, a move approved by Parliament;
- providing higher salaries based on length of service and performance targets;
- strengthening the national health-care procurement system to ensure more efficient organization of medicines (this has also resulted in increased effectiveness of diagnosis and treatment in a number of disease areas);
- developing and expanding community medical services, including home care, youth centres and mental health care;





- strengthening the public health system through the creation of local public health councils, the development of national public health programmes, and the establishment of performance laboratories; and
- initiating a debate among participants as to whether there should be an entry point for external advisors (given the international support that the Republic of Moldova has received) such as a single health issue leveraged to generate enthusiasm, or whether the emphasis should be on strengthening the system internally first, particularly in terms of capacity and capability.

Box 4.

The civil service perspective: large-scale transformation in Belgium

The reforms

Health consumer indices in Belgium showed that the country had high patient satisfaction, but only moderate outcomes. In 2014, a new era of reform began with a total of 20 reform programmes launched under the new regime. Several were perceived as highly ambitious, including the organizing and financing of hospitals, the reorganization of the administration of the health sector, and the changing of the role of insurance providers. Given the complexities of these transformations, some of which are detailed below, the reform package now comprises just five reforms.

Implementation challenges

- The budget for transformation was never stable and could change at any time. Fears over budgeting arose every three to four months, and led to reform paralysis. Cuts were regularly coupled with the diversion of money for out-of-the-ordinary events such as security threats.
- Launching 20 programmes may have been ambitious, but singling out specific issues was difficult – they were intertwined partly as a result of the lack of substantive reform over the previous political periods, during which incremental reforms rather than large overhauls were the norm. Nonetheless, reform fatigue set in among both supporters and dissenters.
- While there was consensus in the sector regarding the necessity of reform, differences persisted between the overall shared vision, goals and plans, and the reality posed by each reform at a local and operational level.





- In a corporate system accustomed to operating in a wealthy environment, the public sector was weak, had little authority and lacked financial means; as such, the competencies needed for appropriate stewardship (for instance, programme management) did not exist.
- The health administration was complex, with eight ministers of health, governance and coordination, and 250 consultation boards. Additionally, policy decision-making was largely centralized and the representatives of the sector were disconnected from the operational level. Thus implementing the necessary changes demanded advanced negotiation skills.
- The lack of local autonomy may have negated opportunities to generate local energy and innovation.
- The health sector represented a complex matrix: hospitals and emergency care were financed at the federal level but non-urgent care was financed at the regional level; the required number of doctors was decided at the federal level but the number of specialists was decided at the regional level; and so on.
- The environment was changing faster than the policy implementation.

Lessons learned

- A goal is not a vision, and a vision is not a plan.
- Managing political decision-making, managing ministers and adapting to changing political realities are all key.
- While it is tempting to focus exclusively on content, disruption is a matter of course in the political process as administrations change at regular intervals.
- Advanced programme management skills are critical for overseeing a proliferation of programmes and projects, as are appropriate experience and capacities at federal, regional and municipality levels.
- Practise what you preach. While the political administration was advocating for greater integration in the sector, more efficiency and a greater focus on outcomes, the administration itself was cumbersome, top-heavy and fragmented.

4.2. Some challenges

In small groups, participants debated the main barriers and enablers they had encountered while attempting to implement large-scale health system transformation. These were organized under four of the five enabling factors contributing to receptivity in the receptive contexts for change framework. The fifth factor, managerial-clinician relations, was not specifically discussed as a separate and distinct factor during the meeting as it appeared to interlink with the other four factors. A number of participants also pointed out that it may be a mistake to maintain a narrow focus on this aspect, even though its importance is clear.

Presenters later brought forward additional reflections on this factor. One suggested that there should not only be an emphasis on clinical buy-in – reforms equally had to “make sense” to clinicians. Additionally, unless buy-in is maintained through actual managerial action and change, rather than just promises, scepticism about any change may re-emerge. The link between managerial-clinician leadership and the remaining four factors is nonetheless embedded within the following discussion.

While some barriers and enablers displayed a degree of overlap by falling into more than one category, some also moved across the four factors depending upon how they were perceived. Participants saw information technology (IT), for instance, as a goal in developing a supportive organizational culture as well as a facilitating mechanism cutting across all areas of receptivity. Similarly, they perceived patient engagement and involvement in very different ways in different contexts. This served as a reminder of how critical political and cultural contexts can be.



On this topic, participants reported upon and discussed their own experiences. These are grouped into several themes below.

4.2.1. Quality and coherence of policy

As detailed above, the quality of policy developed nationally and locally is important in terms of both analytical and process-related elements. Policy informed by evidence and data is important in presenting a sound case for change and persuading stakeholders to support it. Successful policies demonstrate coherence and alignment between goals, feasibility and implementation.

On this topic, participants reported upon and discussed their own experiences. These are grouped into several themes below.

Consistent policy and plans: Participants in almost all of the groups noted the importance of coherence in visions and plans. They saw changing political administrations that may or may not want to halt or stall reforms, and coalition governments with competing vested interests and priorities, as major challenges in the implementation of reforms. In Kyrgyzstan, for example, given changes in the coalition government over an 18-month period, it was especially difficult to maintain a consensus on health policy and reform. In the Russian Federation, policy-makers are circumventing implementation problems arising from frequent administration changes by looking at a longer-term planning cycle to convert priorities and policies into one overarching system.

Participants also considered shifts in ideology to be debilitating, as shown in the case study of Finland (Box 2). This was a concern for senior civil servants in other countries as well: when a relevant minister changes, the new leader may want to develop alternative implementation plans, perhaps driven by a different theory of change. Such scenarios can be further exacerbated when more assertive political players focus on serving their own or others' interests, thereby affecting the stability of the plans.

Size of ambition: Participants drew attention to the potential barrier of overly large ambitions, as shown in case studies from Belgium (Box 4), the Netherlands and Wales. Ambitions may be too large not only in terms of the size of the reform programme; they may also raise concerns among stakeholders, including clinicians and patients, and lead to reform fatigue. Key to avoiding this problem is maintaining the balance between the scale and pace of reforms and the scale and pace of transformation.

Participants questioned whether the size of the country has any bearing on the appropriate size of ambition. They discussed whether large-scale transformation is easier to implement in a smaller country, such as Northern Ireland, Scotland or Wales, for example, rather than in England. They did not draw conclusions on this point, but one group considered it to be more difficult to maintain a coherent policy and plan with appropriate capacity where ambition is large and the country diverse.

Regulatory frameworks: A number of discussions explored whether or not the regulatory framework needed adjustment or changes in order to implement the reforms. Some highlighted the value of adjusting incentive structures, for example, to allow more time for patients and service provision rather than focusing upon capacity. Participants drew particular attention to the case of the Netherlands, where the incentive structure of the legislative framework ran contrary to the reform development that aimed to reduce hospital capacity.

It is critical that the policy agenda at the national level align with priorities at the local level. More widely, it is essential to maintain a whole-system approach so that all incentives and levers are pulling in the same direction.

Evidence base: Although participants noted the importance of the international evidence base as an enabler in the implementation of Swedish reforms, they rarely referred to it in other discussions.

In the Russian Federation, where the lack of appropriate, measurable benchmarking data and metrics was a distinct barrier to health reforms, reform programmes are now beginning to use data to educate the public and raise expectations. In this way the evidence base is becoming more of an enabler.

In all settings, participants saw adequate data as an enabler, particularly for providing feedback to clinicians on their practices and creating or reaffirming the evidence.

Coherence of plans: Participants agreed that when all stakeholders are able to understand or “make sense of” the plans, this understanding functions as an essential enabler. A clear narrative and theory of change should underpin reforms, which need to be pertinent to policy-makers and technocrats but must also appeal to, and be understood by, the wider stakeholder group. If the narrative is not clear and consistent, it is unlikely to reach the front line; this gap increases the potential for misinterpretation or reinterpretation at the local level.

For example, despite a perception that the reforms in England were not built on any particular theory of change, they have generally been acknowledged to possess a clear narrative and coherent vision (NHS, 2014; NHS, 2017). Nevertheless, ensuring coherence across all regions has been a challenge to implementing the plan. This challenge may become greater with the evolution of the Accountable Care Systems and the impact of devolution in some areas. Further, the perceived technocratic nature of the policy narrative may have failed to resonate with regional and local staff. In the Netherlands, the development of so-called pioneer hospitals that have managed to decrease hospital capacity has inspired other hospitals.

A key consideration is balancing the importance of showcasing the successes of local pilots and pioneer sites against the reality that subsequent expectations of such successes rolling out across the system may not be met. Some participants equally considered the benefits of change being perceived and developed as a business strategy, rather than simply as a policy initiative; this can encourage consensus on what will bring about success and ensure alignment with implementation plans.

Additionally, a number of participants discussed the importance of aligning national and local implementation plans and trying to ensure congruence between policy intent and local implementation. Common to a number of European countries, and particularly post-Soviet states, was a lack of both synchronicity and coherence between national or federal and regional administrations. This created political tensions and thus implementation challenges.

Some argued for seeking local organizational buy-in in order to develop ownership of the implementation plans.

Stakeholder involvement: In some countries, the reform process has involved continuous discussions and seminars/symposiums with key stakeholders at national and local levels comprising both local players and practitioners. In the Netherlands, for example, the development of quality indicators as a basis for payment inspired both buy-in and ownership among clinicians.

However, subsidiarity can function as a barrier in that it demands appropriate capacities and competencies at the local level in order to implement the plans. Once again, the size of the country and the scale of the reforms may play a part in the success or failure of this approach.

Participants drew attention to the possible use of different media, including social media and online community forums that address health and well-being, and the use of large datasets that can provide convincing material for presentation at all levels, including to politicians and the public.

Involving and engaging patients in the reform process at both a collective and an individual level in order to build public confidence and trust can be an enabling factor. A lack of understanding of reforms and/or the fear of losing favoured facilities can be a barrier to implementation. For instance, in Wales, although integrated purchaser-provider organizations were established, the reforms largely centred upon secondary care. Creating public confidence in a non-hospital-based environment was somewhat difficult.

In England, too, the STPs were seen to have failed in terms of engaging support from the wider public. This is in spite of a policy to influence public discourse by emphasizing gains to the public rather than losses. Shifting and influencing the public discourse to encourage perceptions of gains and not losses is a challenge, but also potentially an enabler.

Although working with formal and informal community groups and associations may positively influence users' views, participants agreed on the need for more progressive and effective methods and tools for involving patients and citizens in order to understand what they want. These are needed at both local and national levels. Presently, there are no obvious mechanisms for this. Some countries with a lack of community organizations, such as Belarus, have focused on communication with and involvement of governmental agencies at the local level. Of concern in the Russian Federation and elsewhere is the potential compromising of patient associations, which tend to be sponsored by pharmaceutical companies.

Evaluation: Participants generally considered ongoing evaluation and feedback loops to be essential to the alignment of policy and implementation. They saw quick wins as enablers, but noted a difference between small, incremental wins and iconic wins. Iconic wins capture the imagination of both politicians and the public. Again, balance is key: reporting quick wins serves to maintain the momentum, consistency and coherence of reforms, but quick wins should not command too much attention and detract from the reform process (as was reported to have happened in Belgium).

Participants saw the exploration of unintended consequences as another enabler. This involves celebrating positive consequences, but also mitigating the risks of the negative ones by proactively monitoring them. In this context, delegates noted the implications of achieving greater efficiency in hospitals, which could result in overcapacity and, in turn, attract more patients. As this could lead to the provision of more expensive services, costs may remain high.

As one expert commented, it is critical to “continuously scan the environment” and communicate with all stakeholders. The key question of how to pick up successful local-level interventions and feed results back into the national visionary framework remained. One suggestion involved creating teams within teams to work together to constantly assess both progress and the process itself.

4.2.2. Politics and environmental pressure

The necessity of acknowledging the political nature of large-scale transformation was a strong focus of discussions at the meeting. The impact of politics on the environment governing large-scale change demands awareness of and connections with the political context.

Different political contexts in different country settings create a variety of challenges. Participants clearly saw national and local governance arrangements as barriers in many European countries, ranging from Belgium (Box 4) to Croatia, where policy-makers are dealing with 21 health administrations. In the Russian Federation, too, there are 85 regions, all of which have their own health administrations.

There was consensus that politics could and should not be avoided. Negotiating the political playing field is evidently a key feature in a number of the post-Soviet states. In Kyrgyzstan, for example, where there is an ongoing need to negotiate and influence at the presidential level in spite of repeated changes in the administration, the politicization of the health-care agenda became an additional barrier.

In other settings, the relationship between politicians and civil servants had to be negotiated. Again, changes in administration played a role in this. Political ambitions, technocracy, democracy and urgency must all be balanced, not least since health transformation is a slow process and rarely, if ever, fits within the electoral cycle. Most agreed that building trust with stakeholders was a further enabling factor in this context.

While many participants considered political instability at the top to inhibit more bottom-up approaches, some questioned whether “stability and reform” was indeed an oxymoron, and whether, and to what extent, disruption was an enabler. While opinions varied, the view that disruption must be controlled if it is to be an enabling factor was common.

This, in turn, initiated a debate over whether a so-called burning platform – a crisis leveraged to justify immediate change – was actually necessary for creating the climate for reform. Ministers, for example, may argue that the starting point for reform is not a crisis, but rather political survival and the need to deliver a legacy. In the face of a current or foreseen policy problem, it seems that a balance between a sense of urgency and the careful design and planning of policy and implementation creates the right environment for change. It is important for policy-

makers to be prepared for the arrival of crisis – and also of consensus. Investment in change capabilities, systems, competencies and relationships are all part of this process.

The crisis of budget cuts and the lack of adequate transformation funds to facilitate change presented a fundamental challenge for reforms across the board. Further, with money shifting midterm either as an austerity measure or due to events such as security threats, some countries, including Belgium, had experienced what they called “fiscal terror”.

Some participants also noted the link between the lack of adequate transformation funds and the length of time allocated to, and the sense of urgency of, reforms. In England, for example, people expected more from the STPs, and latterly the Accountable Care Systems, than was possible in the time frame and with the level of funding available. Representatives from Kyrgyzstan pointed out that, as well as arguing for external investment and support, reframing the need for health in economic terms and detailing the potential financial gains has been effective.¹

4.2.3. Key people leading change

The development of appropriate leaders is critical in large-scale transformation. These are not heroic leaders of a traditional command-and-control type, but rather those who lead with a more adaptive, distributive style. During the plenary discussions, experts in the field drew attention to the difference between “old power”, which encompasses more traditional and transactional forms of power, and “new power”. They described new power as an energy formed through shared goals – a concept that is largely relational. The two forms of power are not mutually exclusive; the real enabler for development and opportunity for change exists where they interact and interconnect.

In this context, participants brought up the structure-versus-agency debate. Many of the traditional mechanisms of large-scale transformation are based on changing or shifting structural mechanisms, including performance goals, targets, competition, programme management, and so on. Yet beyond these tangible processes are more intangible actions; an agency perspective focuses on building the capacity and capability of the system, and fostering leadership that operates in a more distributive and collective way.

A key enabler is a balance between moving forward while encouraging leaders in the system to take action, and allowing leaders to develop ownership while inspiring them to feel and believe they are taking action in a way that is meaningful to them. Recognizing the crisis or the impetus for reform and change is merely the first step in making progress, encouraging transparency and forming new and trusting relationships. The goal is not to develop leadership in order to micromanage, but rather to provide an enabling environment in which to close the gap between policy and organizational realities.

¹ This is at the core of the Tallinn Charter: investing in health systems for better health and wealth (WHO Regional Office for Europe, 2008).

Participants drew attention to examples such as the Netherlands, where opportunities for both purchasers and providers to become local entrepreneurs were made available at a local level, thereby encouraging new initiatives.

Changes in leadership may also necessitate different approaches to management. In place of a command-and-control structure, a more fluid networking approach built upon horizontal rather than vertical lines could enable contact across teams and organizations, contributing to a network of learning and action.

4.2.4. Supportive organizational culture

The most important influence on behaviour in health-care organizations is culture. Culture involves deep-seated assumptions and values that lead to particular patterns of behaviour. These patterns can serve as barriers to change and create inertia. Health systems tend to comprise a complex set of multiple cultures, but leaders in the organization can act as pivotal agents for cultural change.

Participants perceived that managing transition through local involvement, consultation, conversation and outreach enables change at a local level and within organizations, and acts as a catalyst for minimizing resistance and promoting buy-in. Again, however, leaders must strive for the optimal balance between addressing the urgent need for reform and acknowledging that such processes require time.

At the same time, they noted that allowing room to manoeuvre and enabling those at a local level to experiment and make mistakes is a facilitating mechanism and a key enabler. This is particularly true given the need for stakeholders, and particularly managers and clinicians at a local level, to change behaviours and working practices.

Experts in the meeting contested that the presentation of an appealing narrative is key to improving ways of working and organizational behaviour. *Esther's Story*, for example, is a narrative used to illustrate a patient's trajectory through the health system. Following an elderly woman with heart failure, it enables practitioners to consider her needs by seeing her journey through her own eyes, rather than through the eyes of the medical profession.

Improving working conditions for professionals through longer-term contracts and changes to the basis on which payments are made was an effective enabler in some countries. However, in many countries the absence of strong leadership from the health community, in terms of what they thought the system ought to look like in the long term, was a real barrier. Some remarked that, while clinicians are often adept at pointing out the drawbacks of proposed reforms (that is, how they may harm patients), they may lack a strong vision for the future of health care at a clinical level. The need to bring in different voices to address this disconnect is clear.

As noted earlier, local involvement is integral to successful implementation. This entails involving end users, seeking to understand their views and exploring how to incorporate them into reform and decision-making processes and efforts to improve provision.

Participants once again emphasized that developing a new culture in organizations means working with patients, families and carers in more imaginative and diverse ways, and exploring the more intangible elements of change rather than relying on traditional structural mechanisms. Patients themselves are the most important innovators, and listening to their views is critical – not least because it is difficult for politicians and professionals to serve those who insist on the shortcomings of the system.

Discussions gave rise to an important distinction between patient input and involvement for developing elements of care such as patient pathways, and for wider issues such as policy changes, deployment of resources or designing the shape of the system. The key question to ask is whether patients should be involved in a *care-quality* change or a *design* change.

Some argued that this was not clarified in the drive for greater engagement in the development of the New Care Models and Vanguard in England. Underpinning this debate is the distinction between patients and the public – a dimension discussed less often in the United Kingdom – and the extent to which their respective roles within the engagement process can be easily delineated.

Discussions yielded a spectrum of thought on the use of IT and other technologies. In Finland, for example, electronic health (e-health) and accompanying technologies were seen as encouragement for local enterprise and entrepreneurship – almost as ends or reforms in themselves. In Belgium, however, they were used more as facilitating mechanisms. Most participants viewed the use of IT as integral to change and the change process, and observed its growing importance. They brought attention to the various ways in which it might be a critical enabler to establish outcome-based performance indicators, support organizational change, to develop patient pathways across systems, and so on.

Box 5 highlights the main challenges and enablers discussed by participants. The table reflects the commonality of challenges across countries and contexts. Additionally, it demonstrates that each key enabler that emerged from discussions clearly relates to, and mirrors, those listed within the receptive contexts for change framework and the draft checklist *Assessing your readiness for change*, itself derived from the framework. Significantly, the enablers also represent and demand adaptive processes rather than simply technical change, thus reflecting the complexity of health systems transformation.

Box 5.

Quick reference guide – challenges and enablers

| CHALLENGES HIGHLIGHTED | ENABLERS SUGGESTED |
|--|--|
| Changing political administrations | <p>Become adept at managing political decision-making, managing ministers and adapting to changing political realities.</p> <p>Negotiate disruption and ensure policy vision.</p> <p>Engage with the political framework.</p> <p>Negotiate relationships between civil servants and national politicians to build trust.</p> <p>Balance the need for a so-called burning platform to enable reforms and the need for politicians to survive politically and deliver a legacy. Nonetheless, prepare for a crisis.</p> |
| Terror of the budget | <p>Be prepared for mid-reform cuts and the transfer of funds elsewhere.</p> <p>Have transformation monies.</p> |
| Complex governance systems of health administrations | <p>Develop an overarching plan.</p> |
| Lack of coherence of plans | <p>Ensure a consistent narrative among all stakeholders.</p> <p>Ensure that national and regional administrations are in line, if relevant.</p> <p>Ensure that regional pilots/pioneers are in line with national narrative and policy.</p> <p>Balance expectations with reality when showcasing local pilots and pioneer sites.</p> <p>Ensure local organizational buy-in for local ownership of reforms.</p> |





| CHALLENGES HIGHLIGHTED | ENABLERS SUGGESTED |
|---|---|
| Overly ambitious but interwoven plans, potentially coupled with reform fatigue | Maintain a balance between the scale of reforms and the scale of transformation. |
| Need for ongoing evaluation | Ensure constant feedback loops. |
| Difficulty communicating success of local-level interventions to inform national vision | Distinguish between quick wins and iconic wins to capture the imagination of all potential stakeholders. Do not let quick wins detract from pursuance of reforms. Create teams at a local level, but link them to the national level to assess progress and the process itself. |
| Legislative framework out of synch with desired reforms | Ensure the legislative framework is able to underpin reforms. Synchronize national levers and incentives with local ones. |
| Lack of evidence base for reforms | Search for international evidence. Encourage greater linkages between academia and policy-makers. Use data to encourage appropriate behaviour change in clinicians. Use data to build public support for reforms. |





| CHALLENGES HIGHLIGHTED | ENABLERS SUGGESTED |
|---|---|
| Lack of internal capacity | <p>Develop adaptive and distributive leadership, paying attention to the interplay between “old power” and “new power”.</p> <p>Understand and employ the agency approach.</p> <p>Provide an enabling environment for local leaders to develop ownership, fill gaps between policy and organizational realities, and encourage local entrepreneurship.</p> |
| Lack of supportive organizational environment | <p>Encourage local involvement, consultation, conversations and ongoing outreach.</p> <p>Encourage clinicians to be fully involved in reform designs.</p> <p>Give permission for failure and making mistakes.</p> <p>Improve working conditions for health-care staff, including through changes in contractual arrangements.</p> |
| Dependence on external support | <p>Use a single entry point as a lever.</p> <p>Ensure that the internal system is robust and capable.</p> |
| Lack of stakeholder engagement | <p>Encourage clinician involvement in and ownership of reforms.</p> <p>Introduce value- and quality-based payments.</p> <p>Ensure adequate competencies and capabilities within local stakeholder groups.</p> <p>Collect and share patient narratives.</p> <p>Use media and online communities.</p> |





| CHALLENGES HIGHLIGHTED | ENABLERS SUGGESTED |
|------------------------------|--|
| Lack of patient involvement | <p>Build an understanding of reforms to ensure that patients and the public feel they are gaining instead of losing.</p> <p>Distinguish between the patient/public voice at collective and individual levels.</p> <p>Distinguish between the use of the patient/public voice for pathway/care-quality reforms and for health-care design.</p> <p>Distinguish between patients and the wider public.</p> <p>Hold consultations with end users.</p> <p>Connect with patient associations/community groups/nongovernmental organizations.</p> <p>Use media and online communities.</p> <p>Seek out more effective kinds of involvement.</p> |
| Need for increased use of IT | <p>Distinguish between IT as a facilitative mechanism for reforms and as a reform in itself.</p> <p>Encourage technological opportunities for a wider stakeholder group.</p> <p>Use IT to facilitate the communication of reforms.</p> |



Next, presenters shared the draft checklist *Assessing your readiness for change*. This section explores participant responses to the checklist and reviews its ability to support the processes necessary in large-scale transformations.

5. Towards an appropriate framework for change

Participants were asked to debate the usefulness of the receptive contexts for change framework both within the context of their own country and at a more generic level. They determined that the framework remains sufficiently robust and flexible to allow for refinement and adaptation to include key aspects for bringing about success. Although other frameworks, as discussed in the background paper and by participants, were useful and offered additional concepts, the receptive contexts for change framework allows for adaptive change processes in large-scale transformation and remains fit for purpose.

Before the checklist was specifically discussed, participants were asked to consider whether implementation demanded such a structured approach. Change experts acknowledged the potential necessity for some level of structure and a predesignated endpoint, depending upon the nature of the element being transformed. Certainly, evidence suggests that a level of structure is useful, if only as an assurance that all stages have been completed (this can also be corroborated by appropriate feedback loops).

Yet, there is a danger of the process becoming overly mechanistic, and thus denying opportunities to shift mindsets and rethink and reframe power relationships and leadership processes. While a structure may be particularly useful for a relatively linear process that moves from cause to effect, for more complex change with a less certain, unfamiliar or totally unknown endpoint, a more flexible or networking-based process that works around and/or within the structural space may be more appropriate.

Next, presenters shared the draft checklist *Assessing your readiness for change*. This section explores participant responses to the checklist and reviews its ability to support the processes necessary in large-scale transformations.

5.1. Audience

Throughout the discussions, participants emphasized the need to clarify the checklist's intended audience, pointing out that without such clarity its usefulness will be seriously limited. On this topic, they voiced a broad spectrum of views. Some, for example, argued that it was not appropriate for the ministerial level since most ministers would not look at it; instead, the checklist should target policy teams and those working at the administrative level. Others suggested that it was most appropriate for single organizations as they are more likely to be in control of the elements it covers, but noted that it could apply to a whole range of sectors.

The language and emphasis of the checklist open up the possibility for different perspectives on how to create and enable change, which would in turn encourage different ways of thinking among organizations as well as policy-

makers. Moreover, if it were simply for policy-makers and those focusing on the quality and coherence of policy, it would reinforce a top-down notion of change; however, it may not be possible to pursue change in isolation from organizational and workforce-related issues.

Overall, participants viewed this lack of clarity as both a strength – in terms of the checklist’s generality and therefore its flexibility – and a weakness. Ideally the checklist’s audience will vary, and different versions might be needed for different groups.

5.2. Purpose and nature

Again, there was lively discussion as to why the checklist might be used. Common among participants was a view that it was a proposal or framework to organize, and to help support, the complex change process.

Some argued that implicit in the framework is an assumption that the more questions are answered with “yes”, the more successful the process of implementation might be. A scale of success, similar to the Likert Scale, might be more useful, enabling the checklist to function as a measure of readiness. As such, the checklist would enable greater situational awareness and function as a more practical tool. Meaningful discussions could then take place with ministers as to the level of work or progress needed in each area before implementation begins. Not all items would be applicable to all contexts. The detail captured in the checklist would provide pointers on the journey, making it clear that transformation is not a linear process while enabling new thinking and the creation of new capabilities. If used in this way – as a checklist for readiness for action – it should be firmed up and adapted to different audiences.

Alternatively, some questioned the use of the checklist at the start of the implementation process, instead suggesting that it may be suitable for assessing progress when plans are already in action. In providing an opportunity to acknowledge what might not be working and to evaluate it effectively, the checklist would enable cultural change that in turn would benefit future implementation guided by the framework.

More generally, there was a strong call to make the checklist’s purpose more explicit, and to include greater detail about a reasonable pace of change and scale of ambition given the context and culture of the individual country. It might also be useful to outline what could realistically be changed and what could not.

Some remarked that not all change is compelling, and thus more detailed indications of the nature of different changes may be useful. Others noted the potential ambiguity of terms such as “organizational culture” and “capacity”. At a more substantive level, some expressed that the items on the checklist appeared to be simply a first step, providing little indication of the actions that might be needed to support the process. This pointed to a lack of clarity as to when the checklist might be used in the process of transformation, and the nature of dependent factors.

An underpinning theme in the discussions was the connection between the *hows* and the *whats*, and the need for closer linkage. A greater source of debate, however, was the complexity of balancing the need for having clear goals for change – a necessity for some – with the equally important need for exploring change, pushing the boundaries of thought and behaviour, and building goals cooperatively. In line with the process of adaptive change, some perceived the process of transformation through the metaphor of a boat trip: while one is aware of the technical issues, what to organize and what supplies to pack before departing, the journey ahead remains an “open-ended discovery”. Preparation in advance may be possible, but the end point, or destination, remains unknown.

Integral to this discussion were the concepts of diagnostic and dialogical approaches to transformational change (Helen Bevan, NHS England, unpublished data, 2015; Bushe, 2009). The diagnostic approach assesses a situation and considers the individual components and how they might be achieved. The dialogic approach views the conversation about the change as the transformation in itself – as a vehicle for encouragement, engagement and discussion that will give rise to more adaptive change.

Experts thus considered that the framework would act as a necessary catalyst, that is, as a diagnostic tool to explore the context, the level of transformation needed, and potential barriers and enablers to facilitate discussions with ministers and others. It would also function as a dialogical tool for understanding change more comprehensively.

5.3. Structure and format

Experts offered a number of useful suggestions to improve the format and structure of the checklist. Box 6 lists them in no particular order.

Box 6.

Suggestions for the structure and format of the draft checklist

- The checklist needs to strike an appropriate balance between focusing on the mechanisms of change and on the more conceptual framework, and between structure and process.
- The text should be less dense or, alternatively, it should more clearly delineate the context and items on the checklist.
- The checklist should clarify its intended audience, as well as the contexts in which it would be most useful.
- Its language needs to be more “punchy”, containing more active verbs.

5.4. Suggested additions to content

Although many noted that further items added to the checklist may in fact provide little gain or added value to the overall process, they pointed out some areas where additions could prove useful. Box 7 lists these in no particular order.

Box 7.

Suggestions for additions to the draft checklist

- The checklist needs to place more emphasis on how the conceptual framework inspires and boosts the more operational actions. Here, some drew an analogy to the difference between but also the interdependence of one's physiology and one's anatomy. Without an understanding of adaptive processes, referred to as the "lifeblood" of health system transformation, the framework will be meaningless.
- It should make stronger links with political and cultural contexts.
- It should stress the importance of cultural change as a prerequisite for health system transformation.
- It should outline ways to identify necessary capacities and capabilities and to develop them appropriately. It should also provide a more robust explanation of capacity that details capacity for *what*. It should prioritize an exploration of the notion of leadership capacity as well as appropriate level of ambition.
- It should identify and map potential stakeholders and partners, such as insurance companies, nongovernmental organizations, local enterprises, and so on.
- It should emphasize that involvement of public health is critical.
- It should stress the importance of looking at and understanding resistance, and how both vested interests and opposition could be curtailed and/or prevented.
- It should outline ways in which entrepreneurs, or policy champions, can be identified, nurtured and encouraged.
- It should suggest ways to use patient narratives.
- It should emphasize citizen involvement and patient engagement in the process, outlining different purposes and levels.
- It should make explicit references to a more positive outlook, stressing the need to build on assets and resiliency and exploit aspects of the system that are working well, rather than adhering to a deficit model.
- It should recommend the use and purpose of the international experience base.





- It should highlight the use of IT and other new technologies, and the myriad ways they can be used as tools for facilitating change as well as change mechanisms in themselves.
- It should highlight the need for constant evaluation, not only to assess the quality and coherence of the implementation plans as a whole but, as importantly, their constituent parts. Different evaluative methods might be applicable to different processes, but evaluation should be a component of all five factors in the framework.

6. Selected highlights

This section brings together several central themes that emerged during the two days, including those in which challenges remain.

- 1. Invoking adaptive change.** Creating a receptive context for change requires abandoning business as usual and challenging long-held beliefs and traditional ways of working and thinking. Large-scale change with comprehensive stakeholder involvement has to be adaptive as well as technical, with emergent solutions rather than relying on predetermined ones.
- 2. Basing policy on research and evidence.** Knowledge and research are not communicated well or regularly to policy-makers. Promoting close interaction between researchers and end users using a co-production approach is key. Presently, academic research appears to be one of the least-used sources of evidence by policy-makers; the reasons for this need to be explored and better understood.
- 3. Negotiating the political and administrative landscape.** The importance of mapping the political landscape is clear. Challenges in this area include regular changes in administration, competing theories of change and political ambitions. Developing a strategy and implementation plan to negotiate this landscape is critical.
- 4. Effectively engaging and involving patients and the public.** Exploring and defining the potential use of patient and citizen engagement in health system transformation remains a priority. Clarity of purpose of engagement and involvement is integral to this process. A more fundamental shift in thinking and in processes is needed to avoid tokenistic approaches and to build understanding of how to create more meaningful engagement with patients and the public at both collective and individual levels. Greater thought needs to be given to cultivating this understanding, and knowing when, where and in what capacity patient and public involvement should play a part.
- 5. Using IT.** Exploring and defining the uses of IT in different contexts within implementation plans is key.
- 6. Using ongoing evaluation to communicate and disseminate results.** Demonstrating quick wins, which may have different uses (such as bolstering confidence in reform plans or developing political legacies), is critical. Further work is needed to explore the most effective ways of obtaining feedback and incorporating successful wins at the local level into national implementation plans.

7. The way forward

It is neither possible nor desirable to place the themes that emerged from discussions at this meeting within a hierarchy or arrange them as a linear process for large-scale health system transformation. Rather, taken together, they demonstrate the complexity of change. At the same time, they serve to highlight key matters for policy-makers operating in a range of cultural and political settings.

Certainly, enthusiasm among participants with regard to the health system transformation agenda grew over the two days as they shared knowledge of how, and in what ways, change can take place. New ideas emerged and different ways to confront challenges were explored. The process of transferring and applying this learning to countries' health reforms needs documenting in the next phase of the transformation journey.

Concluding the meeting, participants made the following suggestions.

- Develop a forum of ministers, with or without senior civil servants present, so that ideas can be exchanged, the receptive contexts for change framework can be further discussed, and experiences and approaches to problem-solving can be shared.
- Provide consultancy and support on a “critical friend” basis to countries embarking on large-scale health system transformation, but for a fixed period to avoid dependency. This could take place via webinars rather than face-to-face contact only.
- Develop further case studies detailing the reform processes in different political and cultural settings. Tell the story, both when transformation is successful and when it involves particular challenges or even failures.
- Explore different mechanisms and tools for patient and citizen engagement, and consider how the public may enter into the dialogue process in a responsible, informed and receptive way.

Echoing the discussions in Madrid two years ago, the participants in Durham acknowledged the urgent need for large-scale transformation, and sought to learn from others present at the meeting. Despite the countries represented at the meeting being hugely diverse and at very different stages of implementing change, many of the challenges appeared common.

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Annex 1: Programme

LEADING HEALTH SYSTEM TRANSFORMATION AT THE POLICY LEVEL

Durham, United Kingdom

12-13 July 2017

12 July 2017

Sharing and learning from country experience

| | |
|---------------|---|
| 08:30 – 09:00 | Registration |
| 09:00 – 09:30 | Welcome |
| 09:30 – 10:00 | Introduction and scoping <i>A taster on WHO's work on health system transformation and meeting rationale</i> |
| 10:00 – 10:30 | Refreshment break |
| 10:00 – 12:00 | Country experiences <i>Exchanging policy makers' experiences in leading system transformation</i> |
| 12:00 – 13:30 | Premier Lunch |
| 13:30 – 15:00 | Country experiences (continued) <i>Learning from country experiences in leading system transformation</i> |
| 15:00 – 15:30 | Refreshment break |
| 15:30 – 17:00 | Next steps in securing large scale transformation <i>A presentation of a background paper, followed by discussion</i> |
| 19:00 – 19:30 | Welcome drinks |
| 19:45 | Dinner |

13 July 2017

Towards an implementation instrument

- | | |
|---------------|--|
| 09:00 – 10:00 | Supporting a structured approach to implementation: the tool <i>Presentation of an implementation instrument consisting of a checklist</i> |
| 10:00 – 10:30 | Refreshment break |
| 10:00 – 11:30 | Towards an implementation tool <i>Reviewing the tool in smaller groups</i> |
| 11:00 – 11:30 | Reporting back and conclusion |
| 11:30 – 12:00 | Next steps for WHO Europe <i>Consulting on steps WHO Europe could take to develop a health system policy level implementation agenda and potential mechanisms of collaboration</i> |
| 12:00 – 13:00 | Premier lunch |

Annex 2:

List of participants

SECOND WHO MEETING ON “LEADING HEALTH SYSTEM TRANSFORMATION AT THE POLICY LEVEL”

Durham, United Kingdom

12-13 July 2017

Mr Tom Auwers

President of the Board of Directors
Federal Public Service Health, Food Chain Safety and
Environment
Ministry of Health and Social Affairs
Brussels, Belgium

Ms Aigul Baisalykova

Chief Expert
Department for International relations and Cooperation
Ministry of Healthcare of the Republic of Kazakhstan
Astana, Kazakhstan

Professor Talantbek Batyraliev

Minister of Health
Ministry of Health
Bishkek, Kyrgyzstan

Ms Nicola Bedlington

Secretary General
European Patients' Forum
Brussels, Belgium

Dr Rafael Bengoa

Institute for Health & Strategy
Vizcaya, Spain

Ms Helen Bevan

Chief Transformation Officer, Horizons Group NHS
England
Coventry, United Kingdom of Great Britain and Northern
Ireland

Mr Andrei Cazacu

Head of Department of Foreign Affairs and European
Integration at Ministry of Health
Chisinau, Republic of Moldova

Dr Adalberto Campos Fernandes

Minister of Health
Ministry of Health
Lisbon, Portugal

Mr Jan-Luuk de Groot

Director Quality & Innovation
Arnhem, Netherlands

Mr Nigel Edwards

CEO, Nuffield Trust
Bushey Heath
Bushey, United Kingdom of Great Britain and Northern
Ireland

Mr Pedro Facon

Director General
Directorate General for Healthcare
Federal Public Service Health, Food Chain Safety and Environment
Ministry of Health and Social Affairs
Brussels, Belgium

Dr Anne Hendry

National clinical lead for Integrated Care
Joint Improvement Team, Scottish Government
Edinburgh
United Kingdom of Great Britain and Northern Ireland

Mr Göran Henriks

Chief executive of Learning and Innovation
Region Jönköping County
Qulturum
Ryhov Hospital
Jönköping, Sweden

Professor Bob Hudson

Visiting Chair
Centre for Public Policy and Health
School of Medicine, Pharmacy and Health
Wolfson Research Institute for Health and Wellbeing
Durham University
Durham, United Kingdom of Great Britain and Northern Ireland

Professor David James Hunter

Professor of Health Policy and Management
Director, Centre for Public Policy and Health
School of Medicine, Pharmacy and Health
Wolfson Research Institute for Health and Wellbeing
Durham University
Durham, United Kingdom of Great Britain and Northern Ireland

Dr Ruth Hussey

Chair, Parliamentary Review of health and social care in Wales
Cardiff, United Kingdom of Great Britain and Northern Ireland

Dr Mederbek Ismailov

Head, Department of Coordination and Implementation of Reforms
Ministry of Health
Bishkek, Kyrgyzstan

Dr Patrick Jeurissen

Chief strategy and knowledge management group, Economic Affairs and Labour Market Policy Department
Ministry of Health, Welfare, and Sport and Chief Celsus Academy on Sustainable Healthcare, IQ Healthcare, Radboud University Medical Center
The Hague, Netherlands

Mr Charles Kleiber

Former Secretary of State
Geneva, Switzerland

Dr Abraham Klink

Professor of Care, Labour and Political Governance
Vrije University
Amsterdam, Netherlands

Dr Dumitru Laticevschi

The Global Fund to Fight AIDS, Tuberculosis and Malaria
Geneva, Switzerland

Dr David Melik-Guseinov

Director
Research Institute of Public Health and Health Management
Ministry of Health
Moscow, Russian Federation

Dr Christoph Schwierz

Deputy Head of Unit 'Labour Market, Health and Social Services'

Structural Reform Support Service

European Commission

Brussels, Belgium

Dr Miklos Szócska

Director

Health Services Management Training Centre

Budapest, Hungary

Dr Siniša Varga

Deputy Club of the Social Democratic Party

Croatian Parliament

Zagreb, Croatia

Professor Liisa-Maria Voipio-Pulkki

Director

Department of Social Affairs and Health Services

Ministry of Social and Health Services

Helsinki, Finland

Mr Peter Walsh

Chair and Chief Executive's Office

NHS England

London, United Kingdom of Great Britain and Northern

Ireland

Mr Harold Wolf

Director, Practice Leader for Information and Digital

Health Strategy

The Chartis Group

Chicago, United States of America

Mr Maksim Yermalovich

First Deputy Minister of Finance

Sovetskaya 7,

Minsk, Belarus

World Health Organization

Regional Office for Europe

Ms Susan Ahrenst

Administrative Officer, Division of Health Systems and Public Health

Copenhagen, Denmark

Dr Jose Marimont Figueras

Director

European Observatory on Health Systems and Policies

Brussels, Belgium

Dr Elke Jakubowski

Policy and Strategy Senior Advisor

Division of Health Systems and Public Health

Copenhagen, Denmark

Dr Hans Kluge

Director, Division of Health Systems and Public Health

Copenhagen, Denmark

Dr Ellen Nolte

Coordinator

European Observatory on Health Systems and Policies

London, United Kingdom of Great Britain and Northern

Ireland

Interpreter

Ms Katerina Burgess

Rapporteur

Ms Kate Melvin

Annex 3:

Background document

Next Steps in Securing Large-Scale Transformation: Background Paper

Introduction

- 1.1 An initial expert meeting on implementation and health system transformation was held in December 2015 in Madrid. Attended by over 20 invited experts from WHO Member States who reflected on their experience of implementing large-scale health system change, the meeting had three objectives: to identify lessons learnt in implementing health system reforms; to provide advice to policy-makers on how to initiate reforms and accelerate or improve implementation; and to identify steps WHO Europe could take to develop a health system policy level implementation agenda working in collaboration with Member States. The meeting resulted in a report which captured the learning from the meeting (WHO 2016).
- 1.2 Building on the report on the Madrid meeting and the discussions which took place, this background paper has been produced to inform the Durham meeting being held in July 2017, comprising invited senior policy-makers from WHO Europe Member States. It develops further the conceptual framework and thinking underpinning the health system transformation (HST) project which was presented at Madrid for the first time, and provides a quick review and update of relevant selected literature which has informed the design of the Assessing Your Readiness for Change checklist to be presented and discussed at the Durham meeting. Following the July meeting, the checklist will be further revised and finalised prior to testing it in the field in a sample of WHO Member States drawn from different parts of Europe.

The background paper is presented in four sections:

- Context
- From What to How
- Revisiting the Receptive Contexts for Change Framework
- Introducing the Assessing Your Readiness for Change Checklist

- 1.3 The **Context** section describes the rationale for HST which has become something of a movement across European health systems and those elsewhere. The reasons for why HST has become so pressing in countries are briefly reviewed. But while there is widespread agreement over why large-scale transformation (LST) is needed, when it comes to putting it into practice and ensuring that the changes are implemented in a joined-up and sustainable way, there is less certainty about how to effect change of the type required. This may be because the evidence base is weak or the lessons from the evidence which does exist fail to inform policy or get acted upon.

- 1.4 The second section, From **What to How**, develops the thinking that was captured at the first meeting of health system transformers in Madrid in 2015 (see WHO 2016). It revisits the key issues which emerged at the meeting in regard to the implementation gap evident in many countries and which makes it difficult to secure change of the type required at scale and pace.
- 1.5 Building on the receptive contexts for change framework, around which the Madrid workshop was organised, section three expands on, and updates, the learning derived from the literature, some of it of recent origin which has emerged since the Madrid event.
- 1.6 As section three makes clear, both sections one and two of the background paper have informed the content and design of the **Assessing Your Readiness for Change Checklist** at all stages of its development. The two documents should therefore be studied together and viewed as linked. The content of the checklist has been informed by both the receptive contexts for change framework and the evidence emerging around both LST and HST which is reviewed in the background paper.

Section One: Context

Continuous health care reform

- 1.7 The past decade or so has witnessed numerous reforms in health and health care globally, many of them of a system-wide nature. There is widespread acknowledgement, and a general consensus among governments and policy-makers, over the need to redesign the present fragmented and reactive health system model that is no longer seen to be fit for purpose.
- 1.8 Agreement also exists on what the key components of such change are: moving towards a more proactive and preventative model, giving more voice to patients and citizens, addressing widening inequalities, improving quality and managing population health, as well as ensuring the sustainability of health systems.
- 1.9 But while there exists reasonable clarity over the lines of action to be pursued, with sound evidence to underpin them, the central challenge facing policy-makers is how to progress the change agenda in complex systems and effectively lead the desired transformation especially when change of this magnitude takes time and patience to bring about and embed.

Large-scale transformation: a definition

- 1.10 Based on the Institute for Health Improvement's Triple Aim (Berwick et al 2008) with its focus on population health, effective care and per capita cost, our working definition of large scale transformation (LST) is drawn from Best et al (2012: 422):

Large-system transformation in health care are interventions aimed at coordinated, system-wide change affecting multiple organisations and care providers, with the goal of significant improvements in the efficiency of health care delivery, the quality of patient care, and population-level patient outcomes.

Although there is nothing particularly exceptional or novel about this definition, it has the merit of being based on a realist review conducted over a six month period in 2010 by the Knowledge to Action for System Transformation (KAST) project. The KAST team conducted a rapid systematic review and synthesis of knowledge about LST for the provincial Saskatchewan Ministry of Health in Canada. Because the team was aware that evidence on LST is complex and nuanced and can be interpreted differently by different stakeholders, an international expert panel was set up composed of eight leaders from Canada and the United Kingdom. In addition, a consultation group of 44 international leaders participated in a short online survey.

- 1.11 A crucial influence on LST is the strategic political and institutional context at both macro and meso levels. The focus of all the planned transformation activities is on policy at these levels which is why our principal audience, both in Madrid and Durham, comprises senior policy-makers. The key drivers for LST emanate from the problems and challenges facing policy-makers and being experienced by health systems globally.
- 1.12 The precise mix of these drivers and pressures varies across and within systems, just as contexts vary across systems and countries, but it includes: funding pressures, ageing populations, silo working across health and social care, overspecialisation in medicine, lack of priority attached to public health, workforce issues centred on capacities and capabilities. Given the existence of such pressures and drivers for change, how issues get framed and communicated become critical matters as do issues around the need for new styles of system leadership and ways of engaging the public in making the case for change.
- 1.13 Both the background paper and the Assessing Your Readiness for Change checklist address these matters in preparation for, and to inform, discussion aimed at learning from those who have been in leading positions and whose experience in health system transformation can assist others facing similar challenges.

Section Two: From What to How

The difficulty of getting things done

- 1.14 We know that policies do not succeed on their own merit. Observations of policy design at a macro level and policy implementation at a meso level are providing a more complex but also more realistic picture of the policy process. Evidence from evolving transformations is beginning to accumulate and in this section we draw on several examples to illustrate the critical issues at stake.
- 1.15 For instance, there are important insights/pointers for LST drawing on Best et al's (2012) synthesis review of examples of successful and less successful transformation initiatives. These include the requisite leadership styles (a combination of top-down and distributed leadership) and staff engagement required; reporting on short and long term goals to achieve sustainable change; an appreciation of context to avoid pitfalls and

strengthen support from system stakeholders; the reliance on significant physician (and other staff group) engagement in the change process as well as engagement by public and patients which traditionally has either been neglected or treated in a somewhat superficial or tokenistic manner.

- 1.16 In similar vein, is a more recent meso level study of state policy capacity and leadership for health reform in the US supported by the Milbank Memorial Fund based on interviews with officials and legislators about their experiences developing and sustaining the capacity needed for major health system transformation (Forest and Helms 2017). The study identifies the importance of factors such as leadership, resources and public support with their combination determining success or failure.

From policy to implementation

- 1.17 The literature on making policies stick is not extensive unless the larger literature on implementation science is included. But it is the link between the two – policy and implementation – that is of primary interest here with a particular focus on getting things done in government and at sub-national level about which there is even less in the literature (Barber 2015). And practical guidance to aid those undertaking or considering large scale health system transformation is in even shorter supply when it comes to confronting the divorce between policy-making and implementation which is all too often the case in reality.

- 1.18 In their extensive review of the blunders of successive governments in the UK, King and Crewe (2014) state that the divorce can sometimes be partial and sometimes virtually complete. What they term ‘operational disconnect’ is a major feature of modern government and by no means confined to the UK. Central to this notion is the asymmetrical relationship between high-level policy-makers and lower-level frontline workers (this can be a problem at both macros and meso levels). Whereas those on the frontline can do their job adequately without taking into account considerations that belong to a higher level, the reverse is not true. Those operating at higher levels cannot succeed without having some grasp of what actually happens on, or close to, the front line.

- 1.19 This of course assumes that policy-makers actually want to get from A to Z and that they care about whether or not they get there. Sometimes policy can be of symbolic importance only with governments either not truly committed to its successful enactment or purposely announcing policy as a substitute for action. However, we are not concerned here with policy undertaken for such reasons. Our assumption is that governments and their agents at a macro level *do* care about what happens to policies and if that is the case then it requires serious attention to, and investment in, how they are going to reach their goal.

Delivering change

- 1.20 The gap in our knowledge concerning what can be done to address the phenomenon of operational disconnect is being filled by what has been termed the ‘missing science of delivery’ or ‘deliverology’ (Barber et al 2011; Barber 2015). The science of delivery views the world from inside government looking out. It is claimed to be

valuable regardless of the size of the state, or whether it is organised in top-down or bottom-up fashion or a mix of the two. It offers a disciplined process rather than a policy prescription and is an important ingredient in accountable government (Barber 2015: xxvi). In its analysis of tackling long-term challenges in government, the Institute for Government (IfG) offers a number of lessons and tasks for government in the areas of politics, vision, institutions, capability and alignment (Ilott et al 2016).

- 1.21 In the Milbank Memorial Fund study noted earlier, several major themes emerged including the policy roles and mechanisms in place at the start of the reform process and the contribution of leadership to the reform process; the state of policy capacity; and the financial and technical resources for policy development and implementation and the utility of the support received (Forest and Helms 2017). There are echoes here of the three key components which combine to allow deliverology to succeed: establishing a small team focused on performance; gathering performance data to set targets and trajectories; and having routines to drive and ensure a focus on performance (Barber et al 2011).
- 1.22 What also emerges strongly from these observations and analyses of transformational change – the Canadian study, the UK study of delivery led by Barber, the recent IfG review, and the recent US Milbank study – is the critical role of relationship building at all levels of governance. Nothing is likely to succeed for long without successful relationships being established and nurtured, especially those between high-level policy-makers and frontline delivery staff responsible for implementation, the so-called ‘street level bureaucrats’ whose significant discretionary power can prove instrumental in determining the success or failure of a policy (Lipsky 1980).
- 1.23 There are two further issues meriting attention when confronting the challenge of getting things done. First, is the issue of having a reliable and timely evidence base in order to inform the change process as it proceeds so it can be modified as and when appropriate. Second, is the need to engage the public and/or citizens in the redesign of health systems since their support for, or more likely opposition to, changes in the delivery of care can be critical in ensuring that transformation either does, or does not, succeed.

Evidence-informed policy

- 1.24 Despite some governments contributing significant funding to health services research, there is often little relationship between investment in research and its take-up and impact on policy and practice. The reasons for this disconnect are multiple. Often it is because the research and policy timetables are not aligned so that any potentially useful findings from evaluation studies appear too late in the process and therefore fail to be seen as either timely or useful. But there are other reasons to account for the failure of research to have impact. An important one lies in the research design process. Invariably, research questions are defined by the academics who have secured funding to investigate them but in the absence in most cases of any meaningful input from those who might benefit most from having those questions addressed.

- 1.25 In regard to evidence and getting knowledge into action, evaluation research is often viewed as a distinct activity, important but not integral to the delivery of health or care or services. This view is held by, and within, many healthcare organisations, where research is often perceived as detracting from care and competing for funds within tight budgets. The perception also holds within academia, where research funding mechanisms, incentives and academic priorities perpetuate independent knowledge creation, or what has been called Mode 1 research, that is, conventional scientific research, driven by curiosity and dispassionate inquiry, which produces evidence that is taken up and applied – or not – by decision-makers who had no influence on its focus or approach.
- 1.26 While Mode 1 research will, and should, continue, there is a need to rethink the current division of research and practice or policy. Ideally, research and practice would not be seen as separate activities undertaken by distinct groups of people (researchers and practitioners or policymakers), but would be conceptualised as an overall approach to linking the generation and use of evidence.
- 1.27 There is increasing recognition of these problems in academia with efforts being made to encourage the use made of research through devising means of co-creation or co-production so that those at whom the research is aimed are engaged from the outset in its construction and development (Holmes et al 2016). Experiments are also underway with initiatives such as embedded researchers and researchers in residence so that the researchers work alongside health care staff and are located within the contexts where they work. In particular, such ways of operating offer a greater chance of research being conducted in ‘real time’ with rapid feedback a key feature thereby allowing for adjustments and modifications to be made as the transformation occurs. When combined with Plan Do Study Act cycles to managing health system transformation in complex settings and improvement science approaches, there is a much greater chance of research having real traction on what happens in practice and of successful change being embedded and sustained.
- 1.28 Mode 2 research offers a way forward to meet the need for timely and relevant research. It is problem-based and collaborative, with questions framed by those who plan, deliver and receive services working with researchers to co-produce and implement knowledge. In studying complex problems, the term ‘engaged scholarship’ is used to describe a participative form of research for obtaining the different perspectives of key stakeholders.
- 1.29 In addition to how the research is designed and prosecuted, there are then matters of presentation and communication of completed research to consider. These are far from being of secondary importance and yet are often overlooked. As a consequence, academic research tends to get written up in lengthy, ponderous and usually inaccessible reports or for publication in academic peer reviewed journals. While such outputs have a legitimate purpose, they are insufficient if the intention is to encourage policy-makers and practitioners to engage with research and get its findings into practice within the timescales they are required to observe. Health care professionals and managers rarely have the time or capacity to trawl through lengthy research reports and draw out potentially useful lessons.

Public or citizen engagement

- 1.30 The second key issue often neglected in transformation initiatives is engaging the citizen and public and allaying fears and suspicion that change is designed to cut costs, reduce quality and result in an overall diminution of care or service. A belief that all health system transformation is an excuse for replacing what are often regarded as good enough services with inferior ones runs deep in any public reaction to changes affecting their local health care services.
- 1.31 Even when efforts are made to engage the public and involve citizens in understanding why change is both necessary and desirable, too often they are dismissed as ineffective, symbolic or tokenistic and as representing a failure genuinely to listen to the views expressed. This is often perceived to be the case when politicians or managers lead the discussion. In contrast, there is a greater willingness to listen and understand when senior clinicians are put in the position of heading up the public consultation process. There is therefore a need to invest greater effort in identifying ways to engage the public in not only understanding the reasons for health system transformation but in becoming advocates for it since if successful it will improve population health and wellbeing. A healthier community building on its assets is also a more productive one (Wanless 2004).

Section Three: Revisiting the Receptive Contexts for Change Framework

- 1.32 The Madrid meeting acknowledged that having a conceptual framework in which to locate the discussions was a useful means for organising ideas and highlighting the key factors enabling successful transformation. The 'receptive contexts for change framework' (Pettigrew et al 1992) chosen for, and presented at, the meeting by general agreement offered a sound basis for both thinking about and undertaking large scale health system transformation. Five factors in particular making up the framework were viewed as instrumental in enabling successful change to occur and our Assessing Your Readiness for Change checklist focuses on these. However, it is also the case, and one acknowledged at the Madrid meeting, that no single framework is likely ever to capture all the key elements which need to be addressed when undertaking change in complex settings. This was evident from the discussion at the Madrid workshop and in subsequent discussions captured in the report on the meeting (WHO 2016). In this section, therefore, we draw on other frameworks that have useful things to offer HST to supplement our favoured framework.
- 1.33 The receptive contexts for change framework was selected because it best serves our purpose in capturing the multi-faceted and contextual nature of bringing about sustainable large-scale health system change in complex settings. This should come as no surprise since the framework was developed from studying change in the UK NHS. It was also directed at the strategic policy level and acknowledges the political nature of large scale transformation (LST).
- 1.34 We consider that the receptive contexts for change framework remains sufficiently robust and flexible to allow for refinement and adaptation to include key aspects of bringing about successful and lasting change. These aspects may be implied in the framework devised by Pettigrew et al but merit being showcased more explicitly or being added to the framework if necessary. For this purpose, although we draw on other frameworks,

notably Kotter's 8 steps for successful change and Kingdon's often cited multiple streams approach and 'policy windows' (e.g. it is mentioned in the IfG study of what makes policy stick), we do not consider that either of these alternative approaches is superior to the receptive contexts for change framework or should replace it. Rather, they offer additional important insights when considering implementing LST. The Pettigrew et al framework therefore remains central as an overarching integrative one with its core emphases on context, complexity and culture within a public policy setting as well as on the importance of relationships and relationship-building between key stakeholders. Hence the privileging of these dimensions within our checklist.

Extending the receptive contexts for change framework (1): Kotter

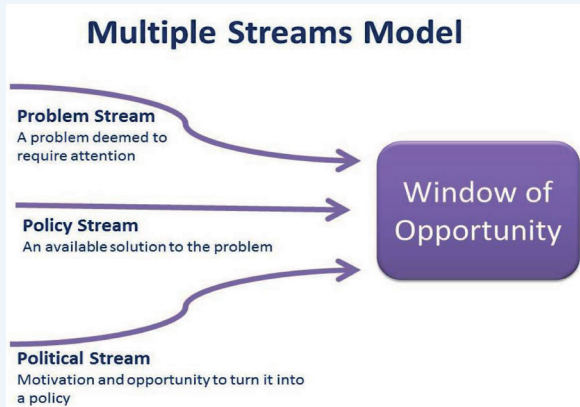
- 1.35 There are two particular factors which, though implicit in the receptive contexts for change framework, need surfacing and making more explicit in any discussion of factors making change happen. They figure in Kotter's 8 steps for successful change (Kotter 1995). First, is establishing a sense of urgency so that the need for change cannot be ignored or deferred indefinitely until, for example, there is further evidence available making the case for change unavoidable. This emphasis on urgency is also a factor in the approach to delivery described by Barber (2015) and is behind the notion of the 'burning platform' serving as a trigger for HST.
- 1.36 Second, is enabling quick wins in order to demonstrate that the changes sought are having a positive and immediate impact even if embedding them in practice at pace and scale will take considerably longer. It provides confidence and hope that change is possible. Barber refers to this as the 'expectation of success'. Having quick wins offers reassurance to policy-makers who may be under attack over their policies and enables them to provide interim evidence that their changes are working. They also build resilience and ensure that policy-makers remain confident that what they are doing is worth sharing and spreading.

Extending the receptive contexts for change framework (2): Kingdon

- 1.37 Given the intensely political nature of HST, as reflected in the environmental pressure factor in the receptive contexts for change framework, drawing on Kingdon's (1995) multiple streams approach has much to commend it and extends the mention in Pettigrew et al's framework of successful policies being those which demonstrate coherence and alignment. In practice, achieving either let alone both can be difficult.
- 1.38 Kingdon's first stream – the *problem stream* – comprises research and evidence that establishes the existence of an issue such as the drivers for HST noted in paragraph 1.7 above. The second stream – the *political stream* – considers the political aspects that may shape agendas, including the influencing role of key stakeholders. The third stream – the *policy stream* – is the process whereby stakeholders involved discuss ideas and solutions about the issue concerned. When the three streams are aligned, they create, or open up, a 'window of opportunity', or 'policy window', so that policy change can be activated (see Figure 1).
- 1.39 Kingdon's primary concern is with 'big windows' at a national policy-making level but 'little windows' at the meso or local level are equally important to bring about policy change. Sometimes windows are closed and

ways need to found to navigate around these in order to create open windows. Navigating and creating ‘windows of opportunity’ may occur with and require the assistance of policy entrepreneurs. Their job is to create policy windows and then successfully exploit them, using their knowledge of the process to advance their own policy ends. Policy entrepreneurs may be politicians, leaders of interest groups or those who promote particular causes.

Figure 1: Kingdon’s Multiple Streams Model



1.40 Kingdon’s three policy streams are reflected in several of the factors making up Pettigrew et al’s framework, notably the importance of leadership, the existence of a supportive organisational culture, cooperative inter-organisation networks, and robust high-trust relationships between key stakeholders.

1.41 The identification and role of policy entrepreneurs are important activities which cut across many of the factors making up the receptive contexts for change framework, notably those mentioned in paragraph 1.37. The key ingredients of successful entrepreneurship are: test early, test often, do not grow too fast too soon, collaborate with like-minded people across sector boundaries, and have a compelling narrative of what you intend to do and why (Weiss 2014).

Making policy stick

1.42 The IfG analysis of what makes policy stick, which is informed by Kingdon’s policy streams, warns that policy windows generally do not remain open long and that incumbent governments seeking to drive a new policy or major transformational change initiative ‘must take advantage of critical junctures at which the opportunity for change presents itself’ (Ilott et al 2016: 47). Such junctures might refer to a new incoming government keen to put its stamp on HST. Or they might include ‘burning platforms’ (noted earlier when referring to Kotter’s steps for successful change) which can be essential catalysts for such transformation. Often such platforms are externally driven and can include an extreme budget crisis (e.g. in the UK, the recent transformation of the NHS in England is being driven in part by the climate of austerity affecting public spending), or public examples of health system failure.

1.43 The IfG concludes its analysis of the actions that government can take to make long-term policies work (Ilott et al 2016: 6-7) by describing three phases in the policy cycle:

- A period of rising salience during which an issue becomes politicised, gaining ministers' attention (akin to Kingdon's problem and politics streams)
- A building blocks phase during which politicians and officials put in place the policies to resolve the problem (Kingdon's policy stream)
- A period of embedding to ensure that the policies implemented to tackle the problem do deliver even when political interest may diminish or be on the wane.

1.44 What happens, or does not happen, in each of these phases will determine whether a policy survives and succeeds or fails in the long term. And in respect of complex change like HST the long term is crucial. While quick wins are needed to ensure continuing political support and to demonstrate that the policy is working, as noted earlier, it is accepted that deep-seated culture change can take between 5 and 10 years at least to put in place and embed.

Checklists and rules to aid HST

1.45 The Milbank Memorial Fund study referred to above concludes with a capacity checklist targeted at policy-makers embarking on health system transformation initiatives. The checklist comprises five dimensions:

- *Leadership* – this factor is paramount in developing and implementing policy
- *External resources* – these include funding, technical assistance and communication forums
- *Management core* – a cadre of policy leaders with sufficient experience of managing change is critical
- *Analysis* – relevant data and information are central in both monitoring the implementation of policy but also in evaluating their success and impact
- *Implementation* – operational skills are critical and yet are often neglected with the consequence that staff recruitment and retention is given insufficient attention.

1.46 In their systematic realist review and synthesis of large-scale transformation in health care conducted as part of the KAST project in Canada described earlier, Best et al (2012) offer five simple rules:

- *Engage individuals at all levels in leading the change efforts* – leadership must be both designated and distributed
- *Establish feedback loops* – but acknowledge that measurement can be counterproductive especially when many transformative efforts are not easily measured if they can be at all – a combination of quantitative and qualitative approaches is required
- *Attend to history* – the success of LST can depend on local history although lessons and important learning from the past should not be viewed as predictors of how things will unfold in the future
- *Engage physicians* – they are critical stakeholders because of the power and influence they possess and they can make the difference between LST succeeding or ending in failure

- *Involve patients and families* – there are very few examples of a successful effort to truly engage patients in LST but they can be important players.

1.47 In keeping with the capacity checklist described in paragraph 1.45, they single out the importance of leadership but go further in emphasising the importance of leadership styles. They maintain that LST in health care systems requires both top-down leadership committed to change as well as distributed leadership and engagement of personnel at all levels of the system. Distributed leadership is desirable to ensure frontline commitment to change and to lead it where appropriate since in a complex system, top-down leadership is unable to be sufficiently adaptive and flexible to respond to rapidly changing circumstances (McChrystal et al 2015). In their study of the challenges facing the US army in Iraq, McChrystal and his colleagues refer to the notion of ‘empowered execution’ which involves decentralising managerial authority to where the action is. This is in response to what they perceive to be more and more ‘chaotic mess’ solutions in the years ahead. They state: ‘we will need to confront complex problems in ways that are discerning, real-time, responsive, and adaptive’ (p.248).

1.48 What is missing from these simple rules is any mention of the public or of citizens and the need to engage them in an active dialogue about the need for and direction of HST. It is not enough to focus on patients and their families although even successfully engaging these groups poses a challenge to health care services.

Section Four: Introducing the Assessing Your Readiness for Change Checklist

1.49 What is evident about the critical success factors emerging from the various examples of large-scale health system transformation and streams of work described in this background paper is their commonality and how often the key factors are repeated and resurface even if the terms used to describe them might vary on occasion. This in itself should offer a degree of reassurance over what needs to be put in place in order for successful transformation to succeed. Conversely, their absence is likely to result in policy failure.

1.50 What also emerges from the various analyses of LST, including those focusing explicitly on health system transformation, is how useful and durable the receptive contexts for change framework is in capturing all the key factors that come into play when considering what needs to happen to make policy stick. That is why we have used it in the design of our checklist.

1.51 Basing the Assessing Your Readiness for Change checklist we have developed, and which accompanies this background paper, on the five key factors comprising the framework is a pivotal step in answering the ‘How’ question. At the same time, there can be no manual, blueprint or prescription which policy-makers can refer to which will steer them through HST in all its myriad complexities. There can be no such thing as a panacea for HST – the precise circumstances and details will always vary and be different for different contexts.

1.52 This is why our checklist differs in its purpose from many others, including the well received and highly praised WHO Surgical Safety Checklist. The Surgical Safety Checklist addresses a tame or complicated, but not a complex, problem and therefore lends itself to an approach which sets out a standardised set of steps to be

observed in order to ensure surgical safety is performed throughout every hospital in any country. Indeed, the accompanying implementation manual is designed to help ensure that surgical teams can implement the checklist consistently. A mechanistic, prescriptive approach of this kind is both possible and desirable.

- 1.53 But, as we have sought to clarify, HST involves tackling complex systems which are highly contextual and political in nature. This in turn means choices having to be made about what sort of health system a society wishes to support to address the challenges such a system poses. It is therefore simply not possible or even useful to attempt to produce a tool or checklist which can be applied to any setting.
- 1.54 Consequently, our checklist is not a 'one size fits all' aid for policy-makers and managers but one which needs to be adapted and customised to each context. Its purpose is to inform and steer the discussion and to indicate those factors that need to be addressed in order to strengthen the chances of successful change being possible. But it cannot tell policy-makers what to do in precise or exact detail. Whereas critics may perceive that to be a weakness of the checklist, we consider it to be a strength thereby adding to its appeal and durability.

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David J Hunter

Centre for Public Policy and Health
Durham University

Rafael Bengoa

Institute for Health and Strategy
Bilbao

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World Health Organization Regional Office for Europe
UN City, Marmorvej 51, DK-2100 Copenhagen Ø, Denmark
Tel.: +45 45 33 70 00 Fax: +45 45 33 70 01
E-mail: contact@euro.who.int