

Health system transformation: making it happen

Expert meeting
Madrid, Spain, 17-18 December 2015



ABSTRACT

This expert meeting on implementation of health system transformation took place in Madrid, Spain, 17–18 December 2015 with the following specific aims:

- To identify lessons learnt in the implementation of health system reforms at policy level which could serve as an evidence base
- To provide advice to health system policy-makers on how to initiate reforms and/or how to accelerate or improve implementation
- To identify steps the WHO Regional Office for Europe could take to develop a health system policy level implementation agenda and potential mechanisms of collaboration

This meeting was framed in a context where health systems in Europe and beyond are either already undergoing extensive macro level reforms or are in great need of undertaking these.

KEYWORDS

DELIVERY OF HEALTH CARE – organization and administration

HEALTH CARE REFORM

HEALTH POLICY

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Abbreviations

| | |
|---------|--|
| ehealth | electronic health (the use of information and communication technologies for health) |
| GDP | gross domestic product |
| IT | information technology |
| LST | large-scale transformation |
| PDSA | plan-do-study-act |
| QI | Quality Improvement |
| SMART | specific, measurable, achievable, relevant and time-bound |
| TQM | total quality management |
| WHO | World Health Organization |

Executive summary

This expert meeting on implementation of health systems transformation was held 17–18 December 2015 in Madrid, Spain. More than 20 invited experts reflected on their experiential learning from leading, promoting, participating in or evaluating the implementation of large-scale health system transformation.

The objectives of the meeting were: to identify lessons learnt in the implementation of health system reforms at macro level which could serve as examples for other countries; to provide advice to health system policy-makers on how to initiate reforms and how to accelerate or improve implementation; and to identify steps the Regional Office could take to develop a health system policy level implementation agenda and potential mechanisms of collaboration.

The focus of the meeting was on understanding and capturing better how policy-makers have moved forward and adopted new policies, models of care and financing schemes rather than on merely describing what they have done. Moreover, time was devoted to the analysis and identification of the drivers and enablers for change as well as the barriers and obstacles to be overcome in securing transformational change.

This document reports on the highlights of the conversations which took place during the meeting, incorporating the selected case study examples that provide key insights from change efforts conducted in various health systems. Case studies presented included examples from England, Estonia, Hungary, Portugal, Scotland, Spain, and Turkey. The methodology adopted to frame the discussions was the ‘receptive contexts for change framework’.

The meeting concluded with a high level of agreement around the main ingredients of a more coordinated approach to large-scale transformation, and the essential conditions required for supporting its implementation in health systems. The report provides many of the specific elements which could support health system leaders in moving forward with the implementation of large-scale change in their respective contexts.

WHO 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 (the Regional Office) will continue to encourage and support initiatives in large-scale transformational change.



The focus of the meeting was on understanding and better capturing how policy-makers have moved forward and adopted new policies, models of care and financing schemes rather than on merely describing what they have done.

1. Purpose of the meeting

This meeting took place in Madrid, Spain, 17-18 December 2015 (see Annex 1 for the programme). Participants were senior (ex) policy-makers and experts invited in their personal capacity from the following WHO Member States: Belgium, Estonia, Hungary, Italy, Kyrgyzstan, Netherlands, Poland, Portugal, Republic of Moldova, Slovenia, Spain, Turkey, the United Kingdom of Great Britain and Northern Ireland, and the United States of America – as well as representatives of the WHO Regional Office for Europe, (see Annex 2 for list of participants). The University of Deusto hosted the meeting under the joint coordination of Professors David Hunter (Durham University) and Rafael Bengoa (Deusto Business School Health) in collaboration with the Division of Health Systems and Public Health of the Regional Office. They also prepared a background paper to set the context for the meeting, orient participants to its purpose and introduce the receptive contexts for change framework adopted to structure the programme and discussions (see Annex 3).

This meeting on implementation of health system transformation was timely because health systems in Europe and beyond are either already undergoing extensive macro level reforms or are in great need of undertaking these.

The meeting was devoted to learning first-hand in a free, frank and friendly atmosphere from the experiences of the implementers of policy level reforms and of academics who have studied and/or been involved in these developments. The main expected outcomes from the meeting were the following:

- to identify lessons learnt in the implementation of health system reforms at macro level which could serve as an evidence base,
- to provide advice to health system policy-makers on how to initiate reforms and/or how to accelerate or improve implementation,
- to identify steps the Regional Office could take to develop a health system policy level implementation agenda and potential mechanisms of collaboration.

The focus of the meeting was on understanding and better capturing how policy-makers have moved forward and adopted new policies, models of care and financing schemes rather than on merely describing what they have done. Meeting participants were particularly keen to identify the drivers and enablers for change as well as the barriers and obstacles to be overcome in securing transformational change.

As previously assumed, there was a broad consensus at the meeting that it is more difficult to implement and sustain than to design large scale reform at pace at the policy level. Policy-makers welcomed practical advice and guidance on how to move forward based on how others have succeeded, on the lessons learned, and on insights derived from relevant academic research.

Moreover, implementation research at the policy level is still weak and there is limited evidence on the effectiveness and cost-effectiveness of large scale transformation (LST), including a proper taxonomy of health system transformation, due to the fact that the magnitude, ambition and scope of systemic changes differ greatly globally and are often context-specific.

Therefore, the focus of the meeting was on leading the implementation of large scale change rather than on the design or content of any specific reform. A key overarching theme of the meeting was how to prepare and manage a receptive context for health system transformation.

In the sections which follow, Section 2 sets out the context for health system transformation in the WHO European Region. Section 3 reviews the reasons for LST that are evident in many health systems and the pressures giving rise to it. Section 4 considers the implementation challenge and how LST can be successfully embedded and sustained and the challenges countries face. Section 5 draws together and highlights the key themes to emerge from the meeting in regard to securing LST. Section 6 looks at the way forward and lists possible mechanisms for taking forward the learning about LST. Finally, Section 7 offers some conclusions from the meeting in regard to adopting a more coordinated approach to LST and its implementation.

2. The WHO Regional Office for Europe context on health system transformation: the WHAT

This report is framed within the strategic priorities of the Regional Office in the area of health systems strengthening for 2015–2020, taking its vision from the European health policy framework Health 2020 and sustaining the commitments set out in the Tallinn Charter Health Systems for Health and Wealth. The strategic priorities were endorsed by the 65th session of the Regional Committee in Vilnius, September 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 an efficient use of societal resources.

To strengthen value-driven health systems, the Regional Office will work intensively with Member States over the 2015–2020 period in two priority areas (see Fig. 1):

- (1) **transforming health services** to meet the health challenges of the 21st century; and
- (2) **moving towards universal health coverage** for a Europe free of impoverishing out-of-pocket payments.

To make progress in these areas requires whole-of-society and whole-of-government efforts to embrace intersectoral actions, while designing effective and evidence-informed policies on service delivery and health financing. In addition, high-quality health system inputs make it possible to transform health services and move towards universal health coverage, including in the areas of the health workforce, medicines and other health technologies, and health information.

These three areas may be regarded as comprising the essential foundations of health systems as follows:

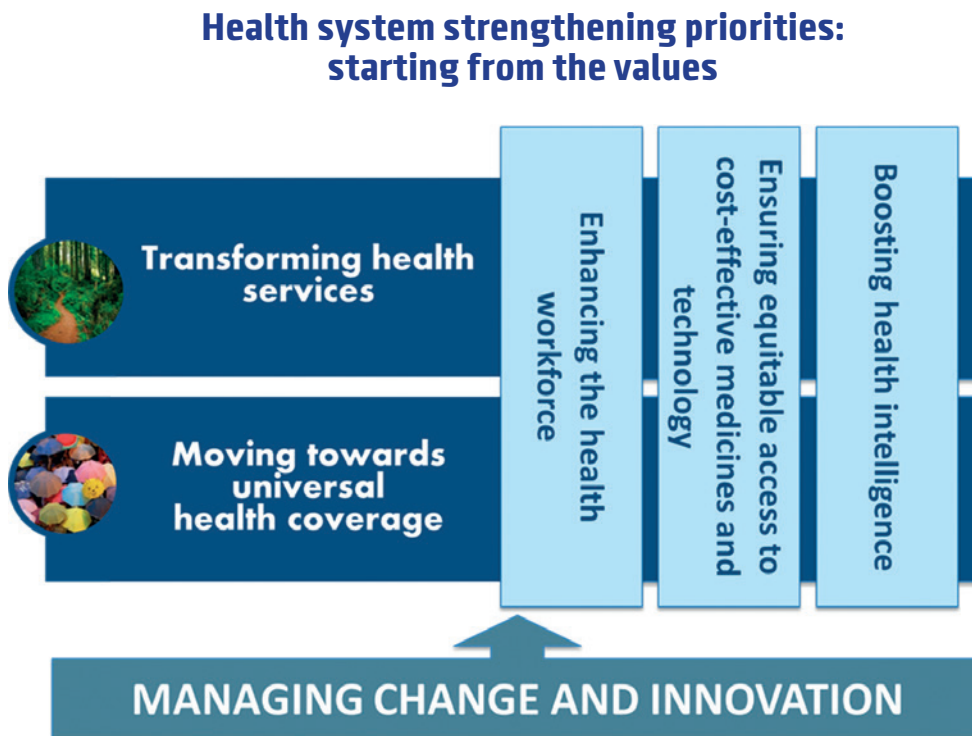
- a) **Enhancing the health workforce.** The health workforce is an essential input in health systems and improving health outcomes is dependent on the availability, accessibility, acceptability and quality of the requisite skills and capabilities needed. The health workforce is central to the transformation of health system delivery to meet 21st century needs and to translating the vision of universal health coverage into improved health and health care on the ground.
- b) **Ensuring equitable access to cost-effective medicines and technology.** Ensuring the availability of and equitable access to cost-effective medicines and technology is an important input into health systems, in particular for transforming health services and moving towards universal health coverage.

c) **Improving health information and health information systems.** Health information and research are the foundations for strengthening health systems and health policy, and health information systems are an integral part of health systems (World Health Assembly resolution WHA60.27). This includes strengthening not only the information content but also the information systems themselves, including health information platforms and infrastructure, as well as eHealth. Strengthening health information systems is therefore a key prerequisite for the implementation of Health 2020.

The health system strengthening priorities of the WHO European Region call for the identification of change management strategies to ensure implementation. The health system strengthening priorities thereby provide a mandate to the Regional Office to identify strategies towards LST.

This report sets out some of the challenges Member States face in implementing the initiatives noted in these three priority areas.

Fig. 1: Health system strengthening priorities.



Source: Report of the 65th session of the WHO Regional Committee for Europe (2015).

3. Reasons for large-scale health systems transformation: the WHY

Complex health systems continually mutate and metamorphose in response to various environmental pressures including demography and epidemiology, to scientific and technological breakthroughs, and to disruptive innovations that are altering clinical practice.

A compelling set of challenges for health systems worldwide were listed at the Madrid meeting including:

- demographic challenges arising from increasingly aged societies
- epidemiological challenges, characterized by chronic diseases and rapidly increasing multimorbidity
- new roles for, and expectations of, patients and citizens in health systems
- pervasive fragmentation in health care delivery
- hospital orientation, with weak primary and community care and public health services
- increasing clinical complexity
- unfinished universalization agendas and inequities
- quality and safety gaps
- technological innovation and evolution of medicine
- economic constraints (economic pressures and the need to contain costs).

In addition to these traditional challenges there are more recent ones creating even more pressure on health systems. They include:

- migration and refugees
- a tendency to back away from universal health coverage
- health care architecture: silos vs. systems
- complexity of needs (i.e. health care, social) in the population and individuals
- overuse of health services
- fragmentation in institutions and governance failures (top down or laissez faire)
- privatization pressures
- cost containment agenda
- ageing health sector workforce
- political turbulence and frequent governmental changes undermining the direction of reforms and resulting in lack of continuity, lack of time, lack of trust
- political culture and political cycles
- disconnect between policy and research (especially evaluation)
- waste in the system



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.

- behaviour of industry (lobbying by tobacco, food and beverages, Big Pharma among other corporate interests)
- disruptive technologies (i.e. Big Data, mobile, genomics).

It was agreed that the pressures for change are fundamental but that many of these pressures can be considered as providing opportunities for, rather than imposing barriers to, change. Some countries and policy-makers manage to enact change in spite of the challenges, possibly by transforming challenges into opportunities for reform. The question then arose as to how they went about achieving these changes.

Transformational Agendas

Before addressing the implementation issue the group noted the general trends countries are following in the direction and content of their reforms. All types of health systems are undergoing change. In Europe there are different types of health systems in terms of their organization and funding (i.e. Beveridge, Bismarckian, mixed) but they share common challenges and also some weaknesses.

As a result of the aforementioned challenges, all health systems suffer from suboptimal coordinated care, most are paying for volume and not for value and use more than 50% of expenditure on only 5% of the population; all have key challenges in prevention, quality and patient safety, everywhere people with chronic conditions receive avoidable care that is not integrated or continuous, and all health systems could reduce numerous and unnecessary hospital admissions and readmissions. Whether spending 8% or 17% of GDP, no health system is achieving the best outcomes possible, and all are far removed from offering a population-based preventive and proactive model of care (Halfon et al. 2014).

Consequently, most countries appear to want to intervene and reform their systems although not all countries or regions in Europe are in the same situation or stage of development to enact or manage complex reforms. History, culture, values, regulations, resources, and so on all contribute to shaping health systems and their readiness for large scale reforms.

The general trends evident in current reforms in Europe are linked to the following areas of intervention:

- expanding access and coverage
- integrated care
- patient empowerment
- IT and integrated informatics
- knowledge management
- value-based payment methods
- achieving population health and community engagement over the life course.

All these challenges constitute an urgent policy priority and, if not confronted, the sustainability of current health systems in Europe is seriously endangered. The broader implication is that health systems are operating less than optimally and are in need of transformation. Their growing complexity as policy-makers and managers wrestle with 'wicked issues' for which there is no simple or single solution only reinforces the need for transformational change (Rittel and Webber 1973). Since the end of World War II, Europe has not had to confront such a complex transformation agenda.

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.

The notion that different systems share very similar challenges implies that despite different contexts there are potentially some common responses or patterns across countries in both the policy levers being used and the implementation approaches available. This suggests that all countries may benefit from sharing knowledge and be able to learn from these various experiences.

This is a key issue because there is a lack of methods and resources available to enable top health system leaders to learn in a systematic and rigorous way how to implement whole system transformation. This report seeks to provide a lead on some of those approaches based on the real-life experiences of policy-makers as captured during the two day meeting in Madrid.

The question raised at the meeting was: "What can we do in relation to these challenges?" It would seem that the WHAT agenda can be structured around the following areas on which policy-makers are seeking to impact through large scale changes: population health; coverage and payers; providers; technology and workforce; patients; public and citizens. The many "whats" vary across countries and/or local settings, each with their respective rhythms, particular contexts, and priorities, but all are involved in growing the evidence.

Most of the reforms facing health systems involve complex changes and there may be disconnect and misalignment between them. It is well known that changes often occur independently of one another and that the complete picture, comprising all the changes and their interaction, is rarely described or even visible.

There is a large gap in the implementation of the above "whats". An improved understanding of the "hows" is therefore needed. In particular, what does all this mean for the political level which is used to viewing health systems through a double lens: trying to improve the health system while at the same time seeking the largest number of votes?

This gap in our knowledge affords a great opportunity to bring together all the above policy concerns and responses and learn from the multiple initiatives that have been implemented or are being tested in countries, thereby allowing us to draw important and useful lessons to share and spread, and apply elsewhere. Drawing on this rich source of experience, this report focuses on "how to transform" and achieve sustainable LST.

Some emerging themes on “**How to transform**”:

- Do not forget that the politician’s mindset is framed by the need for votes.
- The impact of a reform depends on particular health cultures and these differ across Europe.
- Lots of unconnected innovations exist across Europe with some being well documented, and others less so.
- Even where innovation is flourishing there is a lack of alignment.
- There is a disconnect between policy research, policy impact monitoring and policy practice, and evaluation often comes too late to be of use for policy decision-making.
- All these innovations need to be presented in a structured way and rooted in a population health and systemic focus. Policy-makers provide the ‘framing’ and alignment.
- It is necessary to move from an ‘input/activity’ mindset to one focused on outcomes, although process is also important and an outcome in itself.
- Financing must be linked with outcomes or system objectives (health, quality and value).
- The solutions must be co-created with the relevant stakeholders, particularly with patients and citizens. People are the most important stakeholders of all.
- Most reforms aim at changing or influencing clinicians’ behaviours but reforms fail to engage them in a constructive way.
- The “whats” are not only technical but also social and political.

Therefore, there are many WHATs, and there is compelling evidence on most of them... but there is an urgent need for HOWs: here there exists a significant implementation gap.

4. The implementation challenge: the HOW

A key assumption of this meeting, based on the literature on organizational change and on the professional experience of the organizers, is that change has to be led and strategically managed. In order to do so effectively, it is necessary to create a receptive context for change.

Although such change is highly complex and often context-specific, it is necessary to study, reflect and learn from the significant dynamics and patterns of the change process with regard to the multiple levels and actors within the system. This ambitious and systemic change is called deliberate large-scale, or large-system, transformation.

Securing transformational change in health systems is viewed as a top priority if they are to survive, be sustainable financially and able to provide care of high quality especially in those health systems where care is free at the point of use (Hunter et al. 2015; Lukas et al. 2007). Not surprisingly, therefore, most European countries are introducing system-wide reforms in health care. Furthermore, at a meso-level many are introducing new initiatives to improve performance based on Total Quality Management thinking, improvement science methods and Lean methodology (Best et al. 2012).

Preparing a receptive context for change

This section is based on the Pettigrew et al. (1992) receptive contexts for change framework. It provides an overarching structure and common language by which critical enablers of success can be communicated and implemented at all levels of the system to optimize the chance of system change and reduce the 'implementation gap'.

There are many reasons for this gap in implementation that are described in Annex 3 of this report. To address the gap, a receptive context for sustainable change must be created. As defined by Pettigrew and colleagues, 'context refers to the why and when of change, and concerns itself both with influences from the context external to the provider (such as the prevailing economic, social, political environment) and influences internal to the organization under study (for example its resources, capabilities, structure, culture and politics).' Applied to health care by Pettigrew et al., the framework comprised eight factors relevant to achieving successful strategic change. These factors provide indicators for receptivity for change: environmental pressure; quality and coherence of the policy; key people leading change; supportive organizational culture; managerial and clinical relations; cooperative inter-organizational networks; a fit between the change agenda and its locale; and the simplicity and clarity of organizational goals and priorities. The factors are dynamically linked and form a framework receptive to the planned change.

There is no recipe by which these factors axiomatically come together to achieve success. However, appropriately managed, the likelihood of successful change is greater if and where all of these factors are in place.

Contexts are dynamic, therefore understanding the policy context is a formidable challenge. To bring about different behaviours and results in a system is not a one-off exercise, but a continuous process that utilizes appropriate monitoring and evaluation strategies, including analysing contexts and their receptivity for change. Clearly, there are no ready-made “importable” recipes, formulas, magic bullets, standard approaches or best practices for bringing about changes in systems. Instead, the challenge appears to be one of analysing context, detecting system components and connections between them, and understanding the behaviour of the system. If we understand the behaviour of the system, then we can incorporate and adapt explicit knowledge from other contexts, best practices and high performing systems. Successful spread and share tactics demand such rigour.

Receptive contexts are defined as situations where there are features of context, and also of management action, that seem to be favourably disposed to change, and are associated with forward movement. On the other hand, non-receptive contexts are those situations where a combination of conditions effectively creates blockages or resistance to change.

For the purposes of the meeting, and from experience in applying the receptive contexts for change framework in other research contexts, meeting participants singled out five factors as being especially important for both understanding the “hows” and for embedding transformational change in practice. They are shown in Fig. 2.

Fig. 2. The receptive contexts for change framework



Adapted from Pettigrew et al. (1992)

The five features of receptivity should be viewed as a highly interrelated combination which can be used to guide and shape implementation efforts. For successful change to occur there needs to be some alignment among the factors and a certain degree of development and acceptability in each one. If capability is lacking or there is non-receptivity in several factors, the causes must be analysed and identified in order to start acknowledging them, or at least to ensure that they are “neutral”. This notion is particularly important for ensuring a supportive organizational culture and for the quality of managerial clinical relations.

Pettigrew et al.’s framework has several advantages:

- It addresses the whole health system and in particular the role and importance of context in helping to shape change whereas other frameworks tend to focus on individual leaders and ignore the wider environment and context.
- It has been successfully applied to the health sector.
- It offers hope and is more optimistic in its outlook than frameworks which tend to focus on failure and the negative aspects of achieving change.
- A further advantage of the framework is that it is both flexible and scalable and can be used by the WHO European Region, and at national, subnational, or local levels as well as by individual organizations.

For all the aforementioned reasons the group adopted this framework to structure both the meeting and the content of this report. Moreover, participants believed the framework offers policy-makers and those responsible for implementation a common language in which to conduct a discourse on transformational change and how to achieve it.

The next five sections consider each factor separately, both theoretically and practically, drawing on the lessons of invited senior level (ex) policy-makers and experts who presented 'pitch talks' (short and concise up to five minutes of presentation on key points) at the meeting. The key messages of their 'pitch talks' and the subsequent debate among the participants have been summarized in each section.

Some of the experts provided focused case studies that describe the developmental stories as narratives of their transformational efforts. None of the cases offers a precise roadmap for other international health systems, but all of them provide useful insights into the strategies and tactics, implementation processes and lessons learned on the transformational journey. A key strength of this approach is that all invited experts have been requested to highlight details of the "how" in their case narratives, focusing on barriers and facilitators and their own personal assessment of what they believed worked well or not and why. The highlights from each case study are included in the following sections.

4.1. Environmental pressure

Environmental pressure can be especially critical in creating the conditions for transformational change and in ensuring that they remain in place long enough for the change to become embedded. Conversely, if environmental pressure is not conducive to the change efforts being implemented then it can be potentially disruptive.

Large-scale environmental pressure can trigger radical change while short term pressure, especially of a financial nature, can produce adverse effects such as deflecting or draining energy from the system. Financial crises can result in a range of reactions within organizations, including delay and denial, collapse of morale, and the scapegoating, bullying and removal of managers. Financial crises need not be viewed only as a threat to the organization but can also be seen as an opportunity for radical configuration, for instance in triggering disinvestments into ineffective services or other means of reducing inefficiencies and waste.

As important, if not more, is the political context and impact of politics on shaping the environment governing large-scale change. The importance of politics is a feature of all health systems and can determine whether and how far large-scale change succeeds or not. The temporal challenge is especially acute when electoral cycles often militate against long-term change given the pressure for getting results in the short term. This is especially evident in the type of change favoured. Whereas structural change or change involving regulation and/or inspection can occur quite quickly and easily, especially in national systems of health care, cultural change of the kind desired to change behaviours and ways of thinking about health and well-being takes far longer to achieve and is usually less visible. As Halfon et al. point out, if the 3.0 Transformation Framework to guide large-scale health system reform is going to

thrive, it will require supportive policies that incorporate longer time horizons (Halfon et al. 2014). A policy framework that prioritizes short-term rewards for existing groups and organizations is no longer ‘fit for purpose’.

When looking at pressures coming from the environment, the whole health system must be considered, as well as the wider network of interdependencies between the external environment and the relevant implementation context. Policy and management are highly interrelated and the management of change is critical to successful implementation of policy.

To contextualize this discussion a pitch talk based on the experience of Hungary was selected (see summary in Box 1).

Box 1.

System-wide reform introduced into the Hungarian health care system

Background

The Hungarian pitch talk was focused on recommended actions for improving the management of LST. Several key factors influenced the cycle in Hungary, and all are strongly linked to managerial constraints that affect change. With the exception of one full mandate, health ministers were constantly changing (nine in office in the first decade of democracy). But it is generally acknowledged that the magnitude of their planned re-engineering of the health care system needed at least 4–6 years of steady effort for effective implementation to occur.

Frequent changes in administration also brought change in management in many state owned or municipal hospitals. In the past, the new minister brought in new people with new ideas not just to political positions but also to administrative positions, even in health care institutions. They are rarely well prepared or equipped in terms of planning and administrative capacities. The bureaucratic approach to health reform is culturally determined yet universal. The reforms were mainly pursued through new regulations, structural interventions, and normally the only instrument of change was legal compliance supported by loosely coupled training assistance. Using law and regulation to effect change is seen as coercive with only one-way communication.

Between 2010 and 2014 the Minister of Health served a full electoral term as Minister of State for Health of the Hungarian Government. Besides managing to maintain the sustainability of Hungarian health services during the economic crisis, Hungary also introduced a broad range of critical health reforms. The most important reform intervention was the implementation of a radical public health regulatory





framework with popular support. This included a ban on smoking in public and workplaces, introduction of public health product tax on food and beverages with added sugar or salt, and safety limitation of trans fat content of food. During the four years the Minister introduced central capacity planning for rationalization and regionalization of the health care delivery system and designed new efficient patient pathways, laying down the frameworks for a national health service. Part of the rationalization effort included closing 14 acute hospitals and an overall reduction of 5% in acute beds.

How it was implemented?

To understand the interrelatedness of implementing policy and managing change, first the Minister looked at patterns of policy development that shape the environment of change in health care organizations. The process of reform is part of a policy cycle.

Three key elements were essential at time of takeover: an evidence based health policy (reform) programme that bears the approval of the fiscal decision-makers; a team (or an existing network of people) that is capable, willing and intrinsically motivated to execute it – they have to “own” the plan; a clear activity plan for the first six-nine months. Basically, if any of these is missing at the time of takeover, the probability of sustainability of change is severely impaired, because governance duties will saturate the receptors of your intellectual capacities, interest groups will shade your judgement and human resources policies, and daily problem solving requirements will overload your action potential. To minimize the risk of failure a strong project management team and infrastructure was built. These change management methodologies included other innovative methods in health policy and organizational development like big data and social networks for stakeholder mapping and analysis.

Finally, utter determination, a “blood, sweat and tears” approach coupled with a transparent policy with communication and consultation with all the stakeholders in their local environments allow the execution of major changes without demonstrations opposed to them. This was a demanding task for the Minister and his team requiring a lot of visits to the villages and towns affected to explain with transparency and rigour the new policies.

Results

The unprecedented nature of the reforms resulted in many projects to change public health and health care delivery.

Source: Szócska MK et al., 2005

Several points were raised during the debate to explore how to manage the environmental pressure. Some related to the balance between evidence and innovation in health reform policies, how to gather a critical mass in support of the reforms at the operational level, (middle management level is often powerful enough to block reforms), how to manage a transformational agenda when short term pressures are enormous, the role of strong national/ regional identities and cultures, the power balance within governments, particularly between the Ministries of Finance versus Health, the role of patients and their representatives in LST (there are very strong advocacy groups and it is necessary to include them and engage patients and their associations), and how to deal with the political opposition and the media.

The main conclusions and points highlighted focused on **how to tackle the environmental pressure** were the following:

1. **Look in – look out.** Study and analyse your internal organization to identify corrective actions to implement but also look outside and take up solutions and learning from others to avoid reinventing the wheel.
2. **Define and manage a double agenda.** This agenda should contain both a strategy for low-hanging fruit and for a longer term transformational agenda.
3. **Conduct a political stakeholder mapping exercise** to identify who holds power on issues; visualize relationships between stakeholders, and identify resources, opportunities and obstacles among key influencers, allies and constituencies.
4. **Engage a critical mass at all stages.** Reform is highly dependent on success in engaging people; a critical mass of the key stakeholders must be on board. Therefore, people's needs and expectations must be understood. You cannot convince everyone but you need to talk with everybody. Early wins are needed to keep people on board. But a critical mass of people is required all stages and includes a group of earlier followers, sustainers, late followers and continuous change managers. Uncertainty is a big barrier to change. Invest time in training.
5. **Use the evidence available to convince and reinforce your actions.** An evidence-based case for LST is a key building block to enhance the prospects of change.
6. **Manage your communication.** Communication is a powerful tool to persuade and gain critical mass, engage stakeholders including citizens, members of parliament and media, and get them on board. Having a strategy to deal with the opponents of LST can help to mitigate the absence of a high level of political support.
7. **Communicate and disseminate the early wins.** Keeping stakeholders informed can help to engage people and get them on board as well as persuade those who were sceptical of the process.

8. Knowing that their ‘window of opportunity’ is narrow, ministers have to **intervene at the start of their mandate** if they want to secure lasting change. To tackle serious problems they instigate far reaching interventions that are codified in new regulations.

4.2 Quality and coherence of policy

The quality of policy developed at national and local levels is found to be important in terms of both its analytical and process perspectives. Having policy that is informed by evidence and data, especially at a local level, is important in presenting a robust case for change and for persuading sceptical staff, notably clinicians, of the merits of the exercise.

Despite being important, coherence and alignment are probably the most controllable factors in managerial terms and they are usually a way of assuring receptivity because the coherence depends in many cases on a proper selection of the key change leaders.

To contextualize this discussion two pitch talks based on the experiences of Turkey and Portugal were presented (summarized in Boxes 2 and 3).

Box 2.

Universalization policies in Turkey

Sometimes the lack of coherence comes from the complex interplay between politics, policies and management. The pitch talk from Turkey showed that with committed leadership, middle-income countries can achieve substantial progress towards universal health coverage and simultaneously improve population health, financial risk protection, and user satisfaction — health system goals to which all countries should aspire.

How it was implemented?

The issue of health system goals was key in the case of Turkey – policy makers set clear goals and focused on them. These ensure coherence at all levels avoiding organizational ‘noise’. A two-pronged approach was used:

- a) An urgent action plan focused on early wins to get the public on board. Public support is the most important tool for any government which wants to take a reform initiative, so a “low-hanging fruit”





was picked by the Minister. The issue of “hostages” (patients retained until they pay) in hospitals was immediately solved.

- b) A mid-term strategic plan was produced to consolidate the reforms. Strategic alignment with all the stakeholders required leadership efforts and commitment involving 345 site visits by the minister, face-to-face informal conversations as well as formal meetings with the public, health staff, political party members, and professional associations.

In Turkey the reforms were carefully sequenced, with flexible implementation informed by public receptivity to change. Major policies were implemented when the sociocultural, economic, and political contexts were favourable, and tactical changes, such as reduced co-payments and expanded choice of providers, were used to improve users’ experience of the health system, increasing their satisfaction and support.

Implementation was facilitated when the transformation team worked closely with ‘field coordinators’, acting as change agents, who oversaw day-to-day operations and gathered real-time intelligence to rapidly address implementation bottlenecks by refining the scope, speed, and sequence of reforms.

Results

As a result of this implementation strategy, health reforms introduced between 2003 and 2010 that separated policy-making, regulatory, financing, and service provision roles achieved outstanding results. Between 2003 and 2011, the number of Green Card beneficiaries (a social scheme to ensure health care provision to the financially disadvantaged, vulnerable population groups) increased from 2.4 million to 10.2 million — 13.8% of the population, including more than 60% of those in the lowest income decile (a further 24% of the lowest-decile population was covered by contributory health insurance). Insurance coverage also improved in all other income deciles, and 85 to 96% of people in the top deciles were covered by contributory health insurance by 2011.

Source: Atun R, et al.. 2013

Box 3.

Three decades of reforms in Portugal

Background

The pitch talk from Portugal reflected on policy and managerial fads looking at the similarities between current reforms and those of the 1990s. The approach highlighted that in many southern Europe countries, despite well-prepared staff, many reforms failed due to the fact that they relied excessively on 'big bang' solutions, based on 'perfect legislation', and that they tried to satisfy all the stakeholders. In short, they were too ambitious and the ground for them to be implemented had not been prepared in advance.

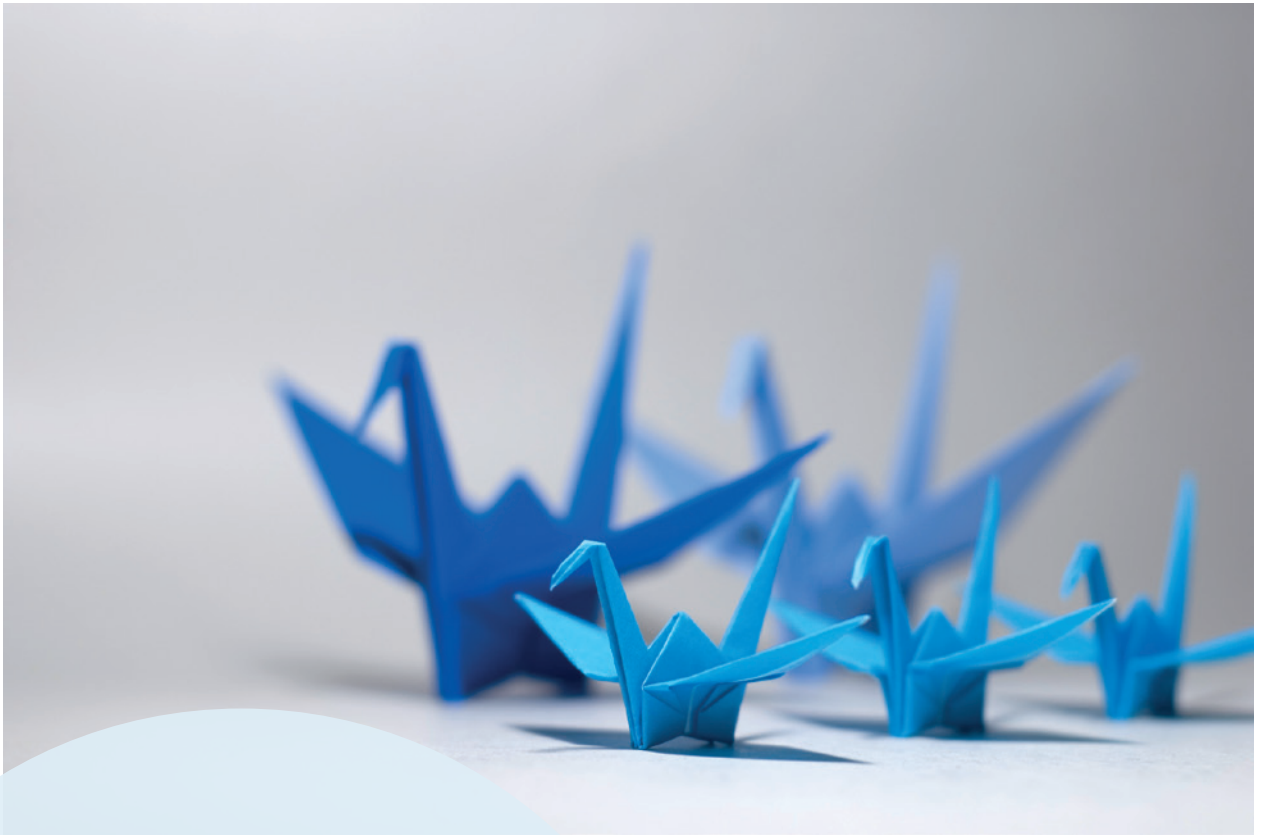
How it was implemented?

A more 'organic' transformational approach was advocated, beginning with commitment at the top, capacity generation (through training, international benchmarking, intellectual investment), and a culture of improvement. With these ingredients at the fore, high quality policies developed in more favourable conditions are more likely to emerge. Additionally, policies must be sustainable and robust. The current focus on transformation has substituted the former focus on reforms and marks the arrival of a new reality.

Although gathering the ingredients for success is difficult, it is easier to identify the ingredients for failure:

- ✓ Big bang = big failure
- ✓ Perfect law = impossible to implement
- ✓ Excessive corporate power = reform delay
- ✓ Satisfaction of all stakeholders = excessive spending
- ✓ Low political profile = zero movement

Several lessons have been learned: the critical role of top leadership; engaging politicians from the outset; LST takes time; policy design must be underpinned by solid analysis and include an implementation approach that goes beyond traditional top-down diktats; key stakeholders should be involved although there is a need to achieve equilibrium between involvement and the speed of reform (the window of opportunity is narrow).



Having people in critical posts leading change is an important feature. This does not mean heroic leaders of a traditional type operating in a command-and-control fashion ...

The main conclusions and learning points highlighted focused on **how to ensure quality and coherence of policy**:

1. **Look at the system as a whole and avoid offering partial solutions.** All parts of the system are interrelated and changing one part can have unintended consequences on others. A solid analysis will help identify the main issues to be overcome in any strategy.
2. **Learn from others.** Study and analyse the internal organization to identify corrective actions to implement, but also look outside and adopt solutions and learning from others to avoid reinventing the wheel.
3. **Define SMART objectives with clear indicators.** Define both process and outcome indicators, the results of which can be useful to communicate early wins. Put in place pragmatic changes linked with defined objectives. Agree actions directly linked to SMART objectives defined and focused on achieving outcomes and deliverables on time. SMART objectives with clear indicators will also facilitate a robust scheme for monitoring and evaluation of the progress, drawbacks and outcomes of reforms.
4. **Co-create a coherent Plan which engages all stakeholders** and which allows the engagement of all the key stakeholders in LST and is aligned with the clinical culture. Avoid top-down diktats – change cannot be imposed on anyone with an expectation that they will be committed to it.
5. **Go fast in the definition and put the major effort into the implementation process.** Policy-makers usually invest most of the time in designing and polishing the Plan instead of its implementation. The implementation process is more related to cultural change than a particular method and takes much time and effort.
6. **Invest in a good data mining system.** Ministers tend to invest in new technologies but usually forget to implement a good data exploitation system which allows the policies implemented to be assessed and evaluated.
7. **Introduce some method or methods** which promote continuous improvement and ensure the implementation and scaling up of reform (project management, Lean process, PDSA and so on).
8. **Create innovation labs** to generate quick evidence to be scaled up and take into account that successful LST usually takes several attempts.
9. **Promote experimental government but do not compromise on good governance.** Problems cannot be solved by simply doing the same thing time and again. Where possible, experiment (especially if there is a political culture that tolerates failure, something very rare in the experience of most of those attending the meeting) and evaluate in rapid cycles.
10. **Evaluate plans.** Although high quality and coherent policies should be easily evaluated, either most reforms are not systematically evaluated or their evaluations follow a traditional ‘academic cycle’ that it is not useful

for policy-makers. Rapid evaluation cycles are an anomaly at the policy level, but some approaches are needed because transformational efforts usually involve several attempts that require adjustment and fine tuning as they evolve.

4.3 Key people leading change

Strategies alone do not lead to transformative change. Having people in critical posts leading change is an important feature. This does not mean heroic leaders of a traditional type operating in a command-and-control fashion but those who exercise leadership in more nuanced and subtle ways and adopt a systems-wide approach. Examples might be quiet or servant leaders working across a whole system (Mintzberg 1999; Greenleaf 1977). Building teams under collaborative approaches with unifying vision and commitment to see it happen, is a key element of such leadership.

Paradoxically, stability in the effective leadership of change is a key requirement in terms of **likely success and sustainability**. This is especially important in regard to major cultural change which requires sustained commitment and continuity. As Berwick notes, 'culture change and continual improvement come from what leaders do, through their commitment and encouragement, compassion and modelling of appropriate behaviours' (Berwick 2013).

To contextualize this discussion two examples were used: from North East England and Scotland respectively. The first example is interesting for what it has to say about how to get people on board with transformational change and how to learn from the effects of an unforeseen and unexpected change of direction in health reforms. The Scottish example presented a transformation for organizational change focused on quality improvement and based on committed leadership, vision and organizational stability.

Box 4. North East Transformation System

The North East Transformation System (NETS) is a region-wide implementation of Lean principles for quality improvement in **all** NHS organizations in the North East of England from 2007 to the present. It draws on the Virginia Mason Production System (VMPS) and uses a 'three legged stool' of **Vision, Compact** and **Method**.

The principal aim of the NETS was the achievement of a step-change in the quality of health services delivered to people living in the North East region of England.





Following a **formal evaluation**, the main lessons learned were:

Commitment from the top and empowerment everywhere else: Allow people to take ownership of the new proposals and encourage constancy of purpose (with leaders in place who have the confidence to ignore 'noises off'). The study sites that encouraged both top-down and bottom-up leadership were associated with long-term commitment to the NETS. Also, study sites that showed evidence of successfully implementing and embedding the NETS tended to be those that understood the NETS to be a long never-ending journey and not a short term solution.

Experiences in mobilizing and empowering people leading change and role of champions: Key people leading change must include clinicians and technicians, not just managers and directors. Whole system, regular, large-scale 'share and spread' events were a key enabler helping to embed the changes over time.

Achieving whole systems change is particularly vulnerable to the vicissitudes of politics especially where that system, like the United Kingdom NHS, is itself subject to those very same pressures. Yet, despite having an enormous influence on health policy, the political context is frequently avoided in research or not regarded as instrumental in determining the outcomes in respect of transformational change. This change requires time to become embedded and demonstrate results especially when focused on changing culture and behaviour. The consequence is that bold and ambitious efforts like the NETS are not given the space and stability to prove themselves. Too often, politics and external environmental pressures intrude in ways that may prove dysfunctional and negative.

The importance of context for the likely outcome and success of complex transformational change initiatives should not be overlooked – it is critical.

Box 5.

Distributed leadership for Quality Improvement (QI): the case of Scotland

Context

NHS Scotland is a recognized world leader in quality improvement and patient safety. Although much progress has been made in the last decade in Scotland, there is a recognized need to increase the pace and scale of improvement.

How it was implemented

The change theory was: a clear and stretch goal, a method and predictive, iterative testing. One of the goals was defined as making Scotland the best place in the world to grow up in by improving outcomes, and reducing inequalities, for all infants, children, mothers, fathers and families and to ensure that all children have the best start in life.

A new process for implementing changes was introduced known as the Quality Improvement Approach. Too much time is often spent in the conference room planning processes and it is hard to engage with the real world. With this new approach the design time was shortened and those leading the changes went fast in the real world to test and modify things as they went. The key questions in the whole process were: what do you want to change? By how much? By when? And by what method?

An example of the process was provided: 800 people from every area in Scotland (practitioners related to child health from different sectors including health professionals, teachers, social workers and others) come together every 6 months to discuss practical changes. First, they set aims, agree the drivers of change and the actions required to make the changes happen are written down. The practitioners then return home and test the changes.

The main lessons learned from the Scottish example were:

- **The importance of setting clear goals** and sound QI methods, as well as the difficulties of spreading and sustaining improvement. Outstanding achievements in patient safety were presented that have been achieved by implementing QI methods.
- The **power of collaborative approaches** was exemplified with the Scottish Early Years Collaborative. It is the world's first multiagency, bottom up quality improvement programme to support the transformation of early years. Its focus is on strengthening and building on services using improvement methodology.





This method enables local practitioners to test, measure, implement and scale up new ways of working to improve outcomes for children and families.

- **In terms of leadership, a lot of improvements add up to, and make, a big improvement.** Presently, 530 improvement projects are active.

The discussion which took place following these examples raised several recurring issues:

- the role of politicians in LST, whether embedded or not
- the role of information systems for monitoring progress in a continuous and systematic way
- the different approaches to QI: whether purely technical in stable clinical process (e.g. patient safety) or more participatory and innovative when new and adaptive change processes are being designed (e.g.. Early Years Collaborative)
- the importance of narrative ensuring emotional attachment
- the role of clinical leaders and teamworking
- the ability to generate grassroots capacity
- the difference between disruptive innovation vs incremental innovation – improvement can be achieved by perfecting current processes but transformation may require the adoption of completely new approaches, e.g.. integrated care models including Vanguard, Integrated Care Pilots and the like
- the possibility to move to a culture of innovation without a previous TQM/Lean culture.

Some shared conclusions in relation to the main characteristics and attributes to be developed and promoted in key people leading changes were: How can policy-makers create the conditions for dealing with LST? More concretely, **how can policy-makers help develop key people leading change?**

1. **Strong leadership is critical** but does not mean top down, charismatic, or heroic leadership. In most places strong leadership means distributed leadership.
2. **Promoting the development of innovation and acquiring knowledge about improvement methods**, like Lean, PDSA (Plan Do Study Act), rapid evaluation cycles, etc. and new technologies: real world data, visualization technologies, big data, and so on.
3. **Proposing an attractive vision for the reforms that transcends short-term cycles.** Narrative is very powerful. It should define ambitious but reachable goals.

4. **Developing the ability to focus on the whole transformation.** Sometimes this creates tension as a result of the inability to evidence the impact of a single intervention due to complex interdependencies elsewhere (noise in the system).
5. **The most successful policies are those which consider questions of coherence and alignment between goals, feasibility and implementation requirements.** A broad vision is more likely to generate support for change than a detailed blueprint.
6. **Developing team vision.** LST is not a personal change but is a change that is made with a team. Thereby requiring the development of a task force composed of different and complementary profiles.
7. **Leadership development: increasing capacity at the point of care.** Developing a good balance between technical capacity and leadership capacity. There are big cultural differences between countries and regions: e.g. cultures of trust vs cultures of scrutiny. In some places therefore, the focus is on capacity generation whereas in others it is focused on audit and inspection; effective communication is essential (transparency and authenticity); the role of the champions as role models.
8. **Supporting and increasing good practices:** establish a Knowledge hub for collecting best practices in empowering key people leading change.

4.4 Supportive organizational culture

‘Culture’ here refers to the deep-seated assumptions and values, officially espoused ideologies and patterns of behaviour which exist and get played out in organizations. Culture can serve as a barrier to change and create inertia. In contrast, a supportive culture can be about challenging and changing beliefs of what constitutes success and how to achieve it. Leaders can be agents for culture change. Establishing a social contract, or compact, with staff linked to incentives can be important. Key features governing successful culture change include: flexible working across boundaries (e.g. boundary-spanners); encouraging risk-taking; openness to research and evaluation; strong value base. All health systems comprise a complex set of cultures and trying to shape these in order to improve quality of care has been at the heart of many, though not all, large-scale change initiatives.

However achieving cultural change of the kind desired to change behaviours and allow fast implementation takes far longer to achieve and is often less visible. It is evident from the above that it is necessary to ensure a receptive organizational culture.

The experience of managing organizational culture in the last reform in Estonia was used to contextualize the debate. In Estonia the economic and financial crisis of 2008–9 provided a window of opportunity to introduce reforms that had been planned for a long time. The main issue to achieve a supportive organizational culture is that

the reforms have been value-driven. In this regard, the reform of the Estonian health care system may serve as a role model for Europe.

The discussion covered the following issues:

- does strict performance management undermine staff morale and innovation?
- how to foster a culture of accountability
- the role of incentives: intrinsic (celebrate success) vs monetary. Intrinsic motivation is key
- staff have to be engaged, therefore a degree of autonomy is needed
- the value of bringing people together in LST (breaking organizational silos).

Some shared conclusions emerged in relation to **how to create and nurture a supportive organizational culture**:

1. **Developing coherence of policy and organizational culture.** Health policy is characterized by long implementation processes. There is a need to be coherent and persistent to permeate strong professional and organizational cultures.
2. **Focussing narratives on patient needs.** As mentioned earlier, the importance of narrative conveying emotional attachment is very powerful in supporting people to lead change and can be equally compelling in communicating patient needs. Look at patient pathways to define interventions.
3. **Telling the story of the reform and trying to engage people,** having in mind the different impacts on people of a technical or an engaging story which gets them on board with the changes.
4. **Identifying key people to tell the stories.** “Messenger is as important as the message”.
5. **Developing structured processes for the contribution of different stakeholders.** This is especially relevant for staff engagement. Professionals have solutions if you ask the right questions and allow local experimentation. Encourage the emergence of ideas and solutions.
6. **Being imaginative and opening new spaces for collaboration.** The bureaucratic approach to health reform is culturally determined yet universal. In many countries reforms occur mainly through new regulations, structural interventions, and often the main instrument of change is legal compliance supported by loosely coupled training assistance. As mentioned, using the law and regulation as a single mechanism to effect change is seen as coercive.
7. **Developing cooperation and collaboration and learning by doing this among countries.** There are more and more issues that are common to different countries including: price of drugs, patients’ rights legislation, health technology assessment, and so on.

8. **Working on values and incentives in the development of professionals**, taking into account that rewards, celebrations and other intangible incentives could have more impact in mobilizing people than money or other tangible incentives.

4.5 Managerial clinical relations

The managerial clinical interface is critically important especially at a time of rapid health system change (Kornacki 2015). Of course relations with all staff groups and professions are important but given the pivotal role of clinicians in health systems, their engagement is especially important and essential to secure. Managerial clinical relations vary markedly in practice and as Kornacki observes ‘the disconnect between managers and doctors is not exactly news’. Clinicians who are not supportive of change can exert a powerful block on it even going so far as to sabotage it. Working to understand each other’s cultures and roles may seem obvious but does not always happen naturally. Managers need to be immersed in clinical work in order to understand what clinicians value.

For their part, clinicians in key managerial posts can be important in gaining commitment from colleagues to change. Managers need to identify such people and foster alliances with them if the anxieties and stress that accompany adaptive change are to be acknowledged and resolved.

The disconnect between management and clinical cultures it is a kind of classic element in most health systems. However, it requires a special focus because the managerial clinical interface is critically important to allow fast implementation of LST and ensure that relevant patients and populations benefit from the interventions that are going to be implemented. If clinicians are not supportive of change they can exert a powerful block.

A key challenge for many of these relationship-building endeavours is bridging professional cultures (for example, across managerial and clinical domains), understanding the strengths and limitations of dual roles played by ‘clinician-managers’, and improving accountability processes. In some regions, dyadic leadership models have emerged which involve both administrative and clinical leads, while key individuals (or teams) now assume responsibility for strategic projects at the provincial and organizational levels. These initiatives are being accompanied by collaboratively developed performance measurement strategies that increase project visibility, accountability and shared ownership of project achievements.

To contextualize this discussion a pitch talk based on the experience of the Basque Country was used (see summary in Box 6).

Box 6.

Large Scale Transformation in the Basque Country (Spain): bottom-up innovation to engage clinicians

Context

Located in the north of Spain and extending over 7,000 km², the Basque country region has a population of nearly 2.2 million people and, together with neighbouring Navarra and Madrid, a GDP per capita above the European mean. The Basque public health system is a single-payer national health system offering universal coverage for all residents and mainly financed through taxation. The Department of Health and Consumer Affairs of the Basque Government is responsible for policy-making, for public health and for planning and financing health care. In turn, Osakidetza is the only public provider of health services in the region.

How it was implemented?

The process followed for formulating and implementing the Strategy for Tackling the Challenge of Chronicity in the Basque Country provides useful lessons. This process was quite innovative, certainly departing from the usual dynamics of the Spanish public administration. Policy-makers in the Basque Country were quite aware that such system-wide transformation would require time, effort, leadership, vision and commitment, as well as a shared narrative, inclusiveness, interaction with local implementers, muddling through and constant learning. Hence, the usual command-and-control approach to formulating and implementing health policies was replaced by a consensual, collaborative and far “messier” process (inspired by Mintzberg’s theories). Underlying the Strategy, there is an understanding of the limits to the capacity of government to lead such transformative initiatives alone and the need, instead, to “develop favourable policy environments”, “stimulating” new ways of thinking, carry out “joint” initiatives and “encouraging a distributed leadership approach”. Actually, in parallel to the work conducted to formulate the Strategy, working groups where managers and health staff interacted to work on different areas (integrated care for chronic diseases, particularly for patients with multiple chronic conditions) were set up, which helped to prepare the momentum for the Strategy.

From the start, there was an attempt to sustain the reform with sound evidence of what was working at the local level. In order to support the production, compilation and dissemination of evidence, a number of institutes or bodies were set up or brought into a new focus. The following agencies played a substantial role as change facilitators: O+Beri (Basque Institute for Health Innovation) focused on promoting innovation and evaluation; Kronigune was set up to research on health services for chronicity and facilitate the dissemination of innovative models of care; finally, a Chronic Care Office, responsible for the monitoring of the strategic projects, was set up.





To advance this agenda, an action-oriented research programme was implemented that explicitly seeks to monitor results and understand innovation processes. More than 150 projects were funded through different ways particularly through the contract programme between the commissioner (Basque Health Department) and the provider organizations of the Basque Health Service (Osakidetza). These 150 bottom-up innovation projects were mostly led by clinicians, and managers and clinicians jointly participate in the action research teams.

Despite many unfavourable contextual conditions, the results of the Strategy were important. The main reasons were the following (lessons learned): organized powerful team acting as parallel government to avoid bureaucratic slowdown; very strong team technically although politically weak (but it worked); importance of “Narrative of Change” linked to the needs of chronic “patients”; cultural move, not relying on legislation or incentives for stimulating change; hit the road running; managerial continuity (most existing managers continued) has helped to jump political cycle.

But also, other things went wrong or were beyond control: Some members of the top team not on board (they said “yes” when they meant “no”), thus slowing things down; top leadership should have ensured everyone was genuinely on board; failure to manage “ambitions”; failure to take some decisions (like firing top leaders not on board); and finally, lack of a robust implementation framework.

Sources: Bengoa, 2013; Nuño-Solinís R, 2012

The main conclusions and points highlighted focused on the issue of **managerial clinical relations**:

1. **Break silos.** Sometimes professional cultures are the biggest and most resistant silos. Silos have to be demolished at the micro, meso and macro levels using team-working, integrated care networks, systemic thinking and population health approaches. New patient-centred, non-paternalistic, team-working oriented professional cultures are needed (medical education has to change in order to accommodate such requirements).
2. **Engagement of clinicians through narratives that are appealing and emotionally stimulating for them.** Staff engagement is essential.
3. **Change the nature of the conversation between managers and clinicians:** the need for a new compact and professional accountability.

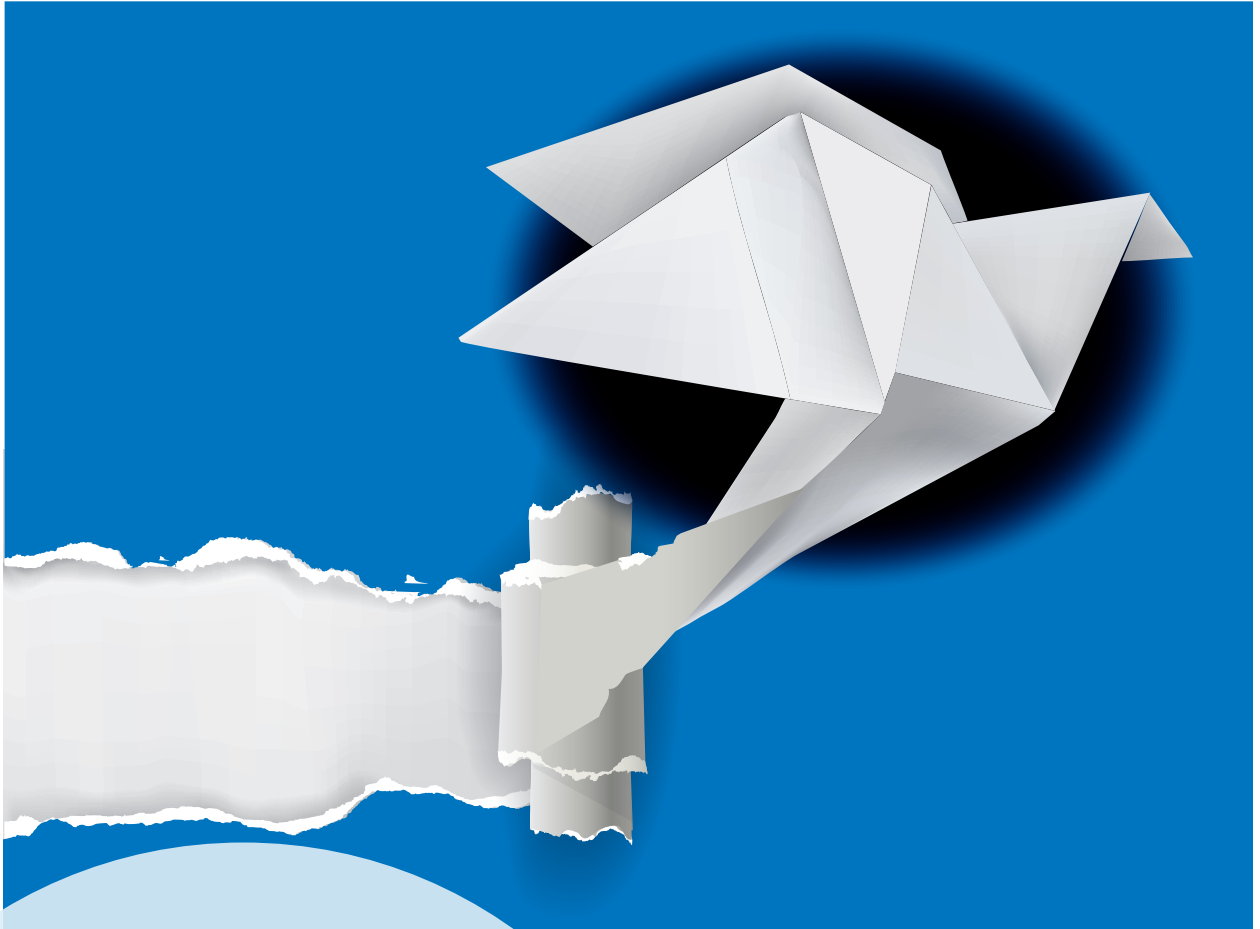
4. **Distributed/grassroots leadership** is key to the sustainability of change efforts and must involve clinical champions and managers at the local level.
5. **Enabling frontline bottom-up innovation is an effective way of engaging clinical staff in LST.** Play with intrinsic motivation instead of the obsession with financial incentives. This also applies in places where corruption at the clinical level is pervasive.

5. Selected highlights

This section describes each of the key themes discussed in the meeting and highlights key applications in the context of the featured LST examples during the meeting.

1. **Long-term vision.** In successful system transformation projects, the decade-long journeys undertaken by Jonköping County Council (Sweden), Veterans Health Administration (USA) and other organizations worldwide emphasize the need for a long term v cile with changing political cycles or fluctuating funding environments. Yet as noted in the meeting it is possible to manage a ‘double agenda’ balancing short term needs and long term focus.
2. **The value of a systems perspective.** Initiatives often ignore systemic issues that can undermine their success (for example, effective leadership, the role of value and beliefs, governance and shared learning). By targeting only local level barriers and motivators to change, achievements are inadvertently limited to local level outcomes or ‘first-order shifts’ in the system. To achieve sustainable change in large and complex systems, solutions should target the root causes of barriers to change rather than symptomatic problems, both during the design phase and iteratively throughout implementation as the system evolves. These overarching ideas are broad by design, and include a number of key systems-thinking ingredients that are critical for enabling system transformation.
3. **The narrative of change.** An engaging, inspirational narrative of change is a key element for LST.
4. **Knowledge-based health policies and management.** There is a clear need for evidence to inform policy and policy to inform evidence; research to inform practice and practice to inform research; improved use of information; and learning strategies to scale up improvements. The value of knowledge as well as its transmission across disciplines, teams, organizations, levels and sectors was emphasized. Knowledge based management and knowledge based policies are quite different to the Evidence Based Medicine movement. In a complex terrain like LST, the randomized controlled trial is an impoverished way to learn. Critics who use it as a truth standard in this context are incorrect (Berwick 2008).
5. **Engagement of a critical mass.** One key issue that arose is that successful reform is highly dependent on engaging people – most of the key stakeholders must be on board. Therefore, people’s needs and expectations and expectations must be understood. You cannot convince everyone, but there is a need to talk with everybody. Early wins are needed to keep people on board. Uncertainty is a big barrier to change. Investing time and resources in training is also necessary. Moreover, communication is a powerful tool to persuade and gain critical mass, engage stakeholders, including citizens, members of parliament and the media.

6. **Communicate and disseminate the early wins** to evidence the results of the implementation process. Keeping stakeholders informed can help to engage people and persuade those who are sceptical about this process. Although designing and planning reforms, as well as implementing them, take time there is a need for early strategic policy and planning to recognize and measure performance against short-term targets, aligned with the long-term targets. The quick wins around low-hanging fruit are key to providing strong signals of real change to staff and to grasp the public's attention, and are essential to achieving lasting and sustainable LST exploiting the 'window of opportunity' that in most countries is narrow and short-lived.
7. **Conduct a political mapping exercise** to identify who holds power on issues; to visualize relationships between stakeholders, and to identify resources, opportunities and obstacles among key influencers, allies and constituencies.
8. **Balance between top down and bottom-up implementation.** The importance of balancing centralized planning and coordination with local-level autonomy. Large-scale initiatives require a balance between centralized strategic planning and coordination, and autonomy and empowerment at the local level to generate innovation and more sustainable engagement. Investing in the skills and resources at the point of clinical care is vital but needs to be supported by an overarching body that can provide high-level strategic alignment, large-scale coordination, consistent provision of standardised and specialized resources and training, and the removal of obstacles that are beyond the ability of local departments.
9. **Big bang, punctuated equilibrium or incremental change.** Organizational maturity is a key feature here. In some immature or stagnant contexts, there is a need for 'context-busting' initiatives, such as top-down enforced rules and 'big bang' approaches. However, while sometimes effective, they may also have unintended side effects, including staff disengagement and poor morale, and reform fatigue. LST benefits from complexity absorption change strategies rather than complexity reduction approaches, but this requirement needs to be balanced against the history, culture, organizational mindsets, and the institutional maturity prevailing within countries. Complex problems demand complex solutions which need to be actively embraced and not rejected in favour of simplistic ones.
10. **Scaling up is systematically signalled as an unsolved issue in LST.** Complex large-scale change in health must spread across more stakeholders than in other sectors. Health professionals are a particularly strong stakeholder group in health systems. Breaking professional silos is needed through nurturing and supporting 'boundary spanners' and through other means including developing system leadership. The 'this change could not work here' syndrome has to be challenged. Of course, change may need to be adapted to particular contexts and cannot proceed simply on a 'lift and shift' basis but there are generalizable learning points which can be transferred within and between health systems to inform the change process.
11. **Strong project management is needed.** This requires resources, particularly time and space for transformational thinking and action research (money is not the big issue). A culture of trust that allows failure is needed so that effective learning can take place.



Knowledge exchange coupled with political will and the preparation of a receptive context with sufficient critical mass are essential ingredients in initiating planned change processes.

6. The way forward

The themes discussed at length during the Madrid meeting are not sequential milestones in a linear transformative journey. Rather, they provide a robust foundation and sensible starting point to help guide the development of coherent evidence-informed policy strategies with which to transform health systems, and for building integrated platforms for comparative learning opportunities.

Therefore, participants have a responsibility to spread this knowledge through several mechanisms. At the end of the meeting the following suggestions for achieving this aim were offered:

- Creation of a network (experts, practitioners, academics) on this topic: Network of transformers
- Training workshop directed to top policy level
- Awareness tools for media, general public and others
- Development of a health system assessment tool to measure readiness for change at the policy level
- Development of tools for tracking (and guiding) progress in LST
- Development of case studies as a good method for synthesizing knowledge on LST. Case studies should focus not only in successes but also on failures and they must cover the diversity of the WHO European Region particularly eastern Europe and the less documented reform examples. The focus of case studies should be on 'experiential' evidence.

Many of the participants recognized that there is some urgency in the system reform agenda and that knowledge exchange coupled with political will and the preparation of a receptive context with sufficient critical mass are essential ingredients in initiating planned change processes that wherever possible seek to avoid the unintended consequences and pitfalls of many change approaches.

The Mayo Clinic motto 'Think big, start small, go fast' was suggested but recognizing also that with disruptive and game-changing innovations on the near horizon, there is a need to be innovative at the policy level with new approaches such 'experimental government' coming into play.

7. Conclusions

During the intense two days of discussion many thoughts and reflections were shared on the implementation challenges associated with LST in the health sector. Clearly, one overarching conclusion emerged on which all participants agreed:

Large-scale implementation is not easy. There are no magic bullets.

Moreover, the present pace of change is slow, with many barriers to be overcome and fragmentation of the process an ever-present risk. Transforming health care requires continuity and consistency, somewhat paradoxically given the turbulence evident in political contexts and electoral cycles. Instead of being rewarded for transforming health care, policy-makers are usually rewarded for preserving the status quo or making minimal improvements, that is, maintaining the system rather than transforming it. The focus is on short term 'gains' rather than on innovations in the 'business model'. Not surprisingly, leaders are rewarded for surviving the existing system, not for producing a more resilient and sustainable one.

The complexity of the transformational endeavour in 'whole systems' is well-known in the management literature (Best et al., 2012). In the health sector, we deal with meta-complexity: complexity of change coupled with complexity of the health sector amounts to it being the most complex human activity. The good news is that frameworks exist to guide these processes and that lessons have been learnt by policy leaders who have shared their experiences.

The Pettigrew et al. framework and the literature on systems thinking are clear on the importance of several features such as the recognition of context (local and historical) and the impact this has on transformative initiatives; the value of relationships: understanding, fostering and supporting interdisciplinary and inter-organizational connections; the need for a long-term vision (at least mid-term) that seeks to understand the lasting changes associated with transformation (including those that are unexpected); the emphasis on the practical rules that promote successful self-organizing behaviour that will most likely benefit LST efforts; the need for strong knowledge management in regard to the WHAT, the HOW, the PROGRESS and the IMPACT of LST.

There is emerging agreement around what a more coordinated approach to LST might look like, and the foundational conditions required to support its implementation in health systems. Critical activities are thought to include:

1. **Creating strategic alignment.** Health care has numerous stakeholders, each one pulling in different directions. A vision is needed. No vision = no alignment = no change.
2. **Recognizing the need for a systemic approach and a clear understanding of both the drivers and agents of change.**
3. **Acknowledging the connections between the WHYS, WHATs and HOWs of change.** Although the focus of this report is on the HOWs, they are interconnected.
4. **Working with professional cultures, particularly the clinical culture, is unique and without parallels in other human professions.** The strong clinical culture pervades the whole health system; although this is not immutable, it should not be neglected.
5. **Creating enabling environments.** Here an inspiring and embracing narrative of change is a key issue.
6. **Nurturing new leadership approaches based not on heroic leaders but on distributed and adaptive leadership.**
7. **Increasing patient and public engagement.** Although it is still in its infancy co-creating change with patients and citizens is perceived as a key issue for achieving successful system transformation but also as an ethical issue and a political value.
8. **Supporting the development and implementation of evidence-informed policy as knowledge at the policy level is broader than the randomized controlled research perspective which is inappropriate for understanding complex systems and informing the successful implementation of transformational change.**

Building on these foundational conditions requires an explicit focus on relationships; clear links between what needs to be done and the people that need to do it; greater integration of research and policy-making in academic, government and health authority organizations; and an organizing framework for fostering collaboration across disciplines.

These principles have critical implications for the design and implementation of quality improvement initiatives, primary health care reform, innovations in health care delivery and in public health, as well as strategies to increase patient-centredness and integrated care. They also help to understand the importance of an enabling environment that supports professional cultures and the critical roles of leadership, ongoing performance improvement and measurement, historical context, and the active engagement of patients and practitioners in transformation efforts.

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Annex 1: Programme

MEETING ON IMPLEMENTATION OF HEALTH SYSTEM TRANSFORMATION

Madrid, Spain

17–18 December 2015

Thursday, 17 December

| | | |
|---------------|--|--|
| 09:00 – 09:30 | Objectives of the meeting <ul style="list-style-type: none">■ Rationale and motives for this meeting, what we expect to get out of it, and how outcomes will be used. | <i>Hans Kluge</i> |
| 09:30 – 10:00 | Reasons for large scale health system change <ul style="list-style-type: none">■ Plenary round table sharing and confirming reasons underlying the need for large scale change. | <i>David Hunter/ Rafael Bengoa</i> |
| 10:00 – 10:30 | Different countries, similar reforms <ul style="list-style-type: none">■ Most countries have set out a clear vision for large-scale change.■ Plenary round table reviewing the general trend of the reforms which are being undertaken. | <i>Nigel Edwards</i> |
| 10:30 – 11:00 | A framework to create a receptive context for change <ul style="list-style-type: none">■ Although most countries have set out a clear vision for change, there has been little sharing of experiences of how to get to those visions.■ The Pettigrew framework on Receptive Context for Change will be proposed to organize the discussion on how to move forward on large scale change. | <i>David Hunter</i> |
| 11:30 – 13:00 | Environmental pressures: opportunities and risks <ul style="list-style-type: none">■ Experiences on managing politics, financial pressures and other environmental factors influencing reforms, followed by a discussion on lessons learnt. | <i>David Hunter</i> |
| 14:30 – 16:00 | Quality and Coherence of Policy <ul style="list-style-type: none">■ The need to ensure coherence of goals and implementation requirements is likely to be make change more successful.■ Having policy that is informed by evidence is key to advance on large- scale change. | <i>Rafael Bengoa</i> |
| 16:00 – 17:30 | Key people leading change <ul style="list-style-type: none">■ Command and control and/or distributed leadership.■ Leadership stability over time to obtain a sustainable new norm for a reform.■ Experiences in mobilizing and empowering people leading change and role of champions.■ A discussion on lessons learnt to obtain a critical mass of changers. | <i>Elke Jakubowski</i> |

Friday, 18 December

| | | |
|---------------|--|--|
| 09:00 – 9:15 | Quick Overview of the first day | <i>Elke Jakubowski</i> |
| 9:15 – 10:15 | Creating supportive organizational cultures <ul style="list-style-type: none">■ Experiences in creating a supportive organizational culture and capacity for large-scale change at multiple levels.■ Engaging local, regional and national levels on large scale reform■ The patient and the community | <i>Nigel Edwards</i> |
| 10:15 – 11:15 | Managerial – clinical Relations <ul style="list-style-type: none">■ Engaging health professionals to support large scale change is critically important.■ How to pull this off and understand the cultural differences among stakeholders needs special approaches.■ Fostering the right alliances with health professionals | <i>Rafael Bengoa</i> |
| 11:45 – 12:45 | Spread of change in social systems, innovation and scaling up. <ul style="list-style-type: none">■ Scaling up is systematically signaled as an issue in change.■ Complex large-scale change in health needs to spread across more stakeholders than in other sectors.■ It requires broad engagement in order to achieve mass movement and sustainability of change over time. | <i>David Hunter</i> |
| 12:45 – 13:30 | Bringing it all back together | <i>David Hunter/ Rafael Bengoa</i> |
| 13:30 – 13:45 | Final comments and closure | <i>Hans Kluge</i> |

Annex 2:

List of participants

MEETING ON IMPLEMENTATION OF HEALTH SYSTEM TRANSFORMATION

Madrid, Spain

17–18 December 2015

Professor Recep Akdag

Member of Parliament
Turkey

Ms Nicola Bedlington

Secretary General, European Patients' Forum
Belgium

Dr Mircea Buga

Minister of Labour, Social Protection and Family
Republic of Moldova

Professor Henry Burns

University of Strathclyde
United Kingdom of Great Britain and Northern Ireland

Professor Antonio Fernando Correia de Campos

National School of Public Health
Portugal

Mr Nigel Edwards

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

Mr Jonathan Erskine

Executive Director, European Property Network
United Kingdom of Great Britain and Northern Ireland

Dr Anne Hendry

National clinical lead for Integrated Care
United Kingdom of Great Britain and Northern Ireland

Professor David James Hunter

Durham University
United Kingdom of Great Britain and Northern Ireland

Dr Ruth Hussey OBE

Chief Medical Officer, Wales
United Kingdom of Great Britain and Northern Ireland

Dr Ainura Ibraimova

Project Director, Abt Associates Inc.
Kyrgyzstan

Dr Patrick Jeurissen

Ministry of Health, Welfare, and Sport
Netherlands

Dr Marcin Kautsch

Jagiellonian University Medical College
Poland

Professor Dusan Peter Keber

University Medical Centre Ljubljana
Slovenia

Dr Anne Kilgallen

Deputy CMO, Northern Ireland
United Kingdom of Great Britain and Northern Ireland

Ms Charlotte McArdle

Chief Nursing Officer
United Kingdom of Great Britain and Northern Ireland

Professor John McDonough

Harvard TH Chan School of Public Health
United States of America

Dr Verdiana Morando

FS Sanita, Healthcare Strategy Unit
Italy

Ms Ivi Normet

Deputy Secretary General on Health
Ministry of Social Affairs
Estonia

Dr Miklos Szócska

Director, Health Services Management Training Centre
Hungary

Professor Peter Smith

Imperial College London
United Kingdom of Great Britain and Northern Ireland

Ms Sandra Tušar

State Secretary
Ministry of Health
Slovenia

Deusto Business School Health, Spain**Professor Rafael Bengoa**

Director

Roberto Nuño-Solinís

Head of Innovation

Patricia Arratibel

Head projects, management and coordination

Joana Mora

Senior Project Leader

Ms Aida Jerez

Technical operations, logistics and planning

World Health Organization

Regional Office for Europe Division of Health Systems
and Public Health

Ms Susan Ahrenst

Administrative Officer

Mr Guillaume Dedet

Technical Officer, Health Technologies and
Pharmaceuticals

Mr Tamas Evetovits

Acting Head of the WHO Barcelona Office on Health
Systems Strengthening

Dr Elke Jakubowski

Programme Manager, Public Health Services

Dr Hans Kluge

Director

Annex 3:

Background document

MEETING ON IMPLEMENTATION OF HEALTH SYSTEM TRANSFORMATION

Madrid, Spain

17–18 December 2015

Venue : Deusto Business School Health, Spain

PREPARING A RECEPTIVE CONTEXT FOR HEALTH SYSTEM TRANSFORMATION

By: David J Hunter, Professor of Health Policy and Management, Durham University and Rafael Bengoa, Director Department of Health Policy, University of Deusto

The Madrid meeting: background and purpose

In preparation for the WHO Europe meeting in Madrid on Implementation of Health System Transformation, this briefing paper was commissioned by the WHO Europe's Division of Health Systems and Public Health to provide some context and background for the discussions. It also seeks to orient participants so that they are focused on, and understand, what is expected of them.

The meeting is timely because health systems in Europe and beyond are undergoing extensive macro level reforms. What the meeting is intended to tease out, understand and capture better is *how* policy makers have moved forward and adopted new models of care rather than merely describe what they have done. We are particularly keen to identify the drivers and enablers for change as well as the barriers and obstacles to be overcome in securing transformational change.

The meeting is devoted to learning first-hand from the experiences of the implementors of policy level reforms and from academics who have studied these developments. The main outcome from the meeting is to *provide advice* based on real life experience for other European policy makers engaged in reforming their health systems.

The assumption behind the meeting, based on our experience and familiarity with the evidence and literature, is that it is more difficult to implement and sustain than to design large scale reform at pace at the policy level and that policy makers would welcome practical advice and guidance on how to move forward based on how others have succeeded, on the lessons learned, and on insights derived from relevant academic research.

The focus of the meeting is therefore on *implementing* large scale change rather than on the design or content of any particular reform.

Why are policy makers and managers undertaking large scale reforms?

In Europe there are different types of health care system in terms of their organisation and funding (i.e. Beveridge, Bismarckian, mixed) but they share common challenges and also some weaknesses.

All health systems suffer from sub-optimal coordinated care, many are paying for volume and not for value, all use more than 50 % of expenditure on only 5% of the population (NIHCM 2012), all have key challenges in prevention, quality and patient safety, generally chronic patients receive care that is not integrated or continuous, and all health systems could avoid numerous and unnecessary hospital admissions and readmissions. Whether spending 8% or 17% of GDP, no health system is achieving the best outcomes possible, and all are far removed from offering a population-based preventive and proactive model of care (Halfon et al. 2014).

All these challenges constitute an urgent policy priority. The broader implication is that health systems are operating less than optimally and are in need of transformation. Their growing complexity as policy-makers and managers wrestle with 'wicked issues' for which there is no simple or single solution only reinforces the need for transformational change (Rittel and Webber 1973).

The main challenges are reinforced by an aging population, internal cost pressures and concerns about future sustainability, performance issues, patient centredness and patient safety. Each of these items poses an enormous implementation challenge but there is increasing evidence to demonstrate that many countries are discovering how to move forward in these areas.

The notion that different systems share very similar challenges implies there are potentially some common responses across countries in both the policy levers being used and the implementation approaches available. This suggests we can all share and learn from these experiences.

What reforms are being implemented?

The general trends of the reforms share a number of common features: integrated care, patient empowerment, IT and integrated informatics, knowledge management, value based payment methods, achieving population health and community engagement over the life span. Overall, the intention is to move to a system focused on optimising health and wellbeing as much as on ill-health and care in keeping with the 3.0 Transformation Framework set out by Halfon et al. (2014). The framework does not assume that change in complex health systems evolves in a sequential, linear fashion or is even inevitable. Complex health systems continually metamorphose in response to various pressures including rapidly changing epidemiology, policy jolts (like the expansion of universal health care), to scientific and technological breakthroughs and to disruptive innovations that are altering medical practice.

There are numerous initiatives occurring in countries in regard to each of these initiatives and the evidence base concerning what works and why is growing.

Transformation and change: the evidence

Securing transformational change in health systems is viewed as a top priority if they are going to survive, be sustainable financially and able to provide care of high quality especially in those health systems where care is free at the point of use (Hunter et al. 2015; Lukas et al. 2007). Not surprisingly, therefore, most European countries are introducing system-wide reforms in health care. Furthermore, at a meso-level many are introducing new initiatives to improve performance based on Total Quality Management (TQM) thinking, improvement science methods and Lean methodology.

Despite the many changes underway, the reality of most implementation initiatives is disappointing. Depending on the context, numerous reasons are advanced to account for the disappointing implementation of ambitious projects. Some of the most common reasons advanced are:

- The absence of buy-in from clinicians and other staff
- 'Big bang' momentum that is not sustained over time
- Cost-cutting so that investment in change is lacking or insufficient
- The existence of weak capacity to make change work
- Burn out and 'reform fatigue' with constant churn and change of focus
- Loss of interest
- Too much change, too fast
- Promotion or departure of person in charge so leadership changes position
- The role of politics which can divert energy and derail change thereby contributing to the above reasons for change being unsuccessful.

Studies from change initiatives from the commercial sector conclude that:

- 70% of all change initiatives fail to achieve their stated objectives
- Only 30% of Fortune 100 companies' initiatives achieved a bottom-line performance improvement that exceeded capital cost
- Only 28% of projects in large companies meet stated project, budget, timeline and target objectives.

Consequently, there is a growing recognition that change needs to be managed and thus the focus should be on the *how*, that is, on the change process whereas most managers focus only on the content of change.

Therefore, the meeting in Madrid will focus on identifying the ways in which policy makers can ensure they are creating and sustaining a receptive context for successful change. For change to survive and become embedded requires between 5 and 10 years of sustained commitment.

Creating receptive contexts for change

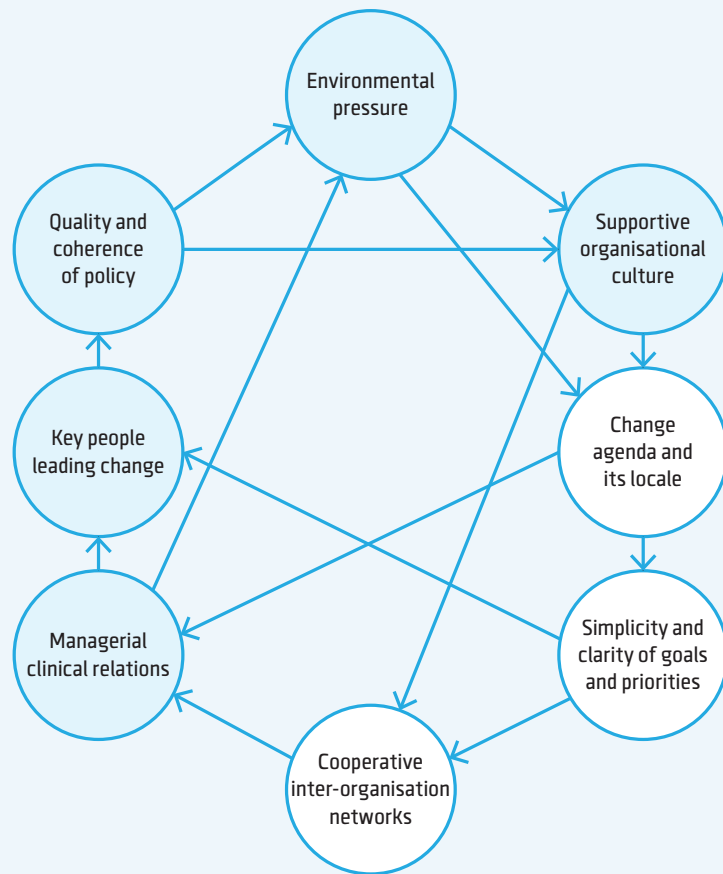
It is evident from the above that it is necessary to ensure a receptive context for change and this seems particularly necessary and challenging for large scale change initiatives occurring in complex settings. Here there is a need to challenge established mental frames, norms, rules, structures, economic interests and social relationships which tend to stabilise systems. While there is a need for some freezing of systems and organisations to permit change to flourish, it is essential to avoid rigidities in these systems when committed to transforming them. As Kotter (1995) notes, 'in reality, even successful change efforts are messy and full of surprises'.

In reviewing the various frameworks, notably Kotter's eight phases to achieve successful change (Kotter 1995), we decided to adopt Pettigrew et al.'s (1992a and b) 'receptive contexts for change' framework for the purposes of structuring the discussion around transformational change and identifying the enablers and barriers affecting its chances of success or otherwise (see Figure 1). There are several reasons for adopting this particular framework which we consider to be especially well-suited to our purposes.

First, it addresses the whole health system and in particular the role and importance of context in helping to shape change whereas other frameworks tend to focus on individual leaders and ignore the wider environment and context. Second, the framework we have chosen is derived from a health systems perspective rather than a business one in contrast, for example, to Kotter's. And, third, the framework offers hope and is more optimistic in its outlook than frameworks which tend to focus on failure and the negative aspects of achieving change such as those listed above.

A further advantage of the framework is that it is both flexible and scalable and can be used at in the WHO European Region, national, subnational or local levels as well as for individual organisations. It therefore potentially offers policy-makers and those responsible for doing the implementation a common language in which to pursue a discourse on transformational change and how to achieve it.

Figure 1 Receptive Contexts for Change Framework



Source: Pettigrew et al. 1992

The framework comprises eight factors and the five shaded ones are those we consider to be most important for embedding transformational change in health systems. They are listed here:

- Environmental pressure
- Quality and coherence of policy
- Key people leading change
- Supportive organisational culture
- Managerial clinical relations.

Together these five factors frame the discussion which follows and also the programme for the two day meeting.

Factor 1: Environmental Pressure

Environmental pressure can be especially critical in creating the conditions for transformational change and in ensuring that they remain in place long enough for the change to become embedded. Conversely, if environmental pressure is not conducive to the change efforts being implemented then it can be potentially disruptive.

Large-scale environmental pressure can trigger radical change while short term pressure, especially of a financial nature, can produce adverse effects such as deflecting or draining energy from the system. Financial crises can result in a range of reactions within organisations including delay and denial, collapse of morale, and the scapegoating and removal of managers. Financial crises need not be viewed as a threat to the organisation but can also be seen as an opportunity for radical configuration. However, in health systems there may be a greater tendency to view them as a threat.

As, if not more, important is the political context and impact of politics on shaping the environment governing large-scale change. The importance of politics is a feature of all health systems and can determine whether and how far large-scale change succeeds or not. The temporal challenge is especially acute since electoral cycles often militate against long-term change since results are looked for in the short term. This is especially evident in the type of change favoured. Whereas structural change or change involving regulation and/or inspection can occur quite quickly and easily, especially in national systems of health care, cultural change of the kind desired to change behaviours and way of thinking about health and wellbeing take far longer to achieve and are often less visible. As Haflo et al. point out, if the 3.0 Transformation Framework health system is going to thrive, it will require supportive policies that incorporate longer time horizons (Haflo et al. 2014). A policy framework that prioritises short-term rewards for existing groups and organisations is no longer 'fit for purpose'.

Factor 2: Quality and coherence of policy

The quality of policy developed at national and local levels is found to be important in terms of both its analytical and process perspectives. Having policy that is informed by evidence and data, especially at a local level, is important in presenting a robust case for change and for persuading sceptical staff, notably clinicians, of the merits of the exercise. The most successful policies are those which consider questions of coherence and alignment between goals, feasibility and implementation requirements. A broad vision is more likely to generate support for change than a detailed blueprint.

Factor 3: Key people leading change

Having people in critical posts leading change is an important feature. This does not mean heroic leaders of a traditional type operating in a command and control fashion but those who exercise leadership in more nuanced and subtle ways and adopt a pluralist and systems-wide approach. Examples might be quiet or servant leaders working across a whole system (Mintzberg 206; Greenleaf 1991). Building teams with vision and commitment to see it happen is a key element of such leadership. Paradoxically, stability in the effective leadership of change is a key requirement

in terms of likely success and sustainability. This is especially important in regard to major cultural change which requires sustained commitment and continuity. As Berwick notes, 'culture change and continual improvement come from what leaders do, through their commitment and encouragement, compassion and modelling of appropriate behaviours' (Berwick 2013).

Factor 4: Supportive organisational culture

'Culture' is a fashionable and often over-used term as well as being a difficult topic to study. Here it refers to deep-seated assumptions and values, officially espoused ideologies and patterns of behaviour. Culture can serve as a barrier to change and create inertia. In contrast, a supportive culture can be about challenging and changing beliefs about success and how to achieve it. Leaders can be agents for culture change. Establishing a social contract, or compact, with staff linked to incentives can be important. Key features governing successful culture change include: flexible working across boundaries (e.g. 'boundary-spanners', that is, people who operate at the edges of organisations and are skilled at working across them rather than being located at the centre of organisations); encouraging risk-taking; openness to research and evaluation; strong value base. All health systems comprise a complex set of multiple cultures and trying to shape these in order to improve quality of care has been at the heart of many, though not all, large-scale change initiatives. Pettigrew et al. (1992: 281) found that 'tremendous energy is required to effect cultural change'.

Factor 5: Managerial clinical relations

The managerial clinical interface is critically important especially at a time of rapid health system change (Kornacki 2015). Such relations vary markedly in practice and as Kornacki observes 'the disconnect between managers and doctors is not exactly news'. Clinicians who are not supportive of change can exert a powerful block on it even going so far as to sabotage it. Working to understand each other's cultures and roles may seem obvious but does not always happen naturally. Managers need to be immersed in clinical work in order to understand what clinicians value. For their part, clinicians in key managerial posts can be important in gaining commitment from colleagues to change. Managers need to identify such people and foster alliances with them if the anxieties and stress that accompany adaptive change are to be acknowledged and resolved.

Using the framework

These five features of receptivity should not be viewed or regarded as a shopping list but rather as a highly interrelated combination which can be used to guide and shape transformational change efforts. For successful change to occur there needs to be some alignment among the factors. If they push and pull in different directions and there is at the same time instability and frequent shifts in policy often based on no or poor evidence, then preserving and sustaining successful change becomes even more challenging and less likely to occur. However, even where such conditions do apply and the settings appear receptive for change, the process in practice remains complex with outcomes often indeterminate and unpredictable. As Pettigrew et al. (1992) conclude, there is 'no simple recipe or quick fix in managing complex change'.

It is also the case that notions of receptivity and non-receptivity are dynamic not static concepts. As Pettigrew et al. (1992: 276) state, although 'receptive contexts for change can be constructed through processes of cumulative development such processes are reversible, either by the removal of key individuals or ill considered or precipitous action'. Equally, movement from non-receptivity to receptivity is possible, encouraged either by the environment or policy changes at higher levels and by professional and managerial action at local level.

What does seem important, however, and lies behind the Madrid meeting, is a recognition and acceptance that too often change occurs without the learning either being captured or referred to in order to inform future change initiatives. The Madrid meeting aims at exploring (in)formal ways and networks to be established to support current policy makers in pursuing health system transformations by avoiding past learning being too easily lost and a constant reinvention of the wheel. If the latter will be achieved, then the Madrid meeting will have succeeded in meeting its purpose. It would then also be the start of a potential stream of work at the Division of Health Systems and Public Health of the WHO Regional Office for Europe to advance ongoing work on health systems strengthening.

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The WHO Regional Office for Europe



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