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Closing the 'Know-Do' Gap for Health Systems Reform at the Policy Level

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1 Introduction

The World Health Organisation (WHO) has become quite skilled at promoting what changes are desirable in health care systems, and why, but has largely left how to implement those changes to individual countries. Although certainly no one solution will fit all countries, some evidence-informed guidelines and insights about how to implement change successfully may help ensure progress in large-scale health system transformation. To explore these issues concerning how to make policy stick and what needs to be in place for change to succeed, the WHO Regional Office for Europe launched health system transformation project in 2015 led by Bengoa and Hunter. Today's seminar reviews the project's progress to date.

2 The 'What', the 'Why' and the 'How'

The 'what' of health system transformation is similar across countries and it centres on population health, integrated care and patient-centredness. With respect to 'how', each country context is different, but enough threads are similar so that countries should be able to learn important lessons from one another. Capturing the 'how' is not as easy as it might seem. Describing the 'whys' and the 'whats' of policy decisions are much easier to achieve than producing accounts of how change was accomplished – or not.

Large-scale transformational change, adopting the definition by Best et al. (2012), entails 'interventions aimed at coordinated, system-wide change affecting multiple organisation and care providers, with the goals of significant improvements in the efficiency of health care delivery, the quality of patient care, and population-level outcomes.' Medicine, public health or population health,

and efficiency are involved simultaneously in such an endeavour known as the Triple Aim (see Figure 1).

Source: Institute for Healthcare Improvement (2020)

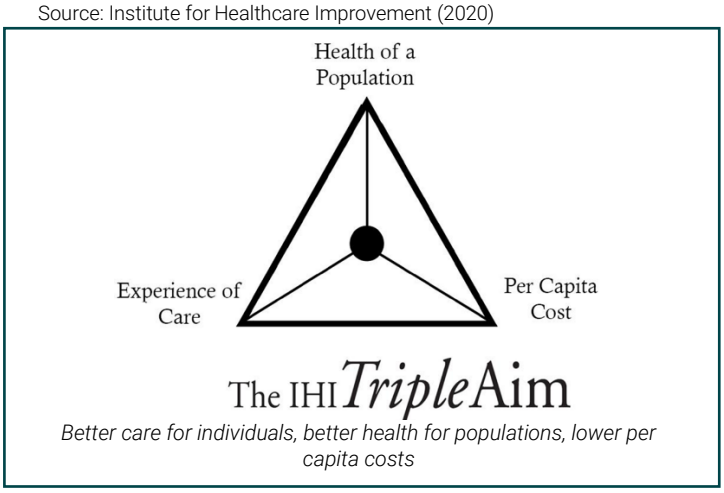

FIGURE 1. IHI - TRIPLE AIM

Discussions about the challenges of healthcare in most countries describe what might be called 'perpetual white water'—rapid, continuous, radical change in the policy environment. This increasingly complex and challenging environment is characterised by:

- rapid advances in medical science and technology
- information overload
- erosion of traditional organisational and professional boundaries
- interconnectedness of just about everything
- increase in multi-morbidity
- focus on innovation in procedures, drugs and devices coupled with indifference to the delivery of health and health care.

Such an environment makes far-reaching change more difficult to design and implement than ever before. In response, the role of WHO and other such organisations needs to adapt in order not only to suggest the direction of change, but also to help identify the challenges that will arise in implementation and how these might be met.

Good intentions and a good plan alone are not enough to improve a health care system. Reform efforts fall into one of four quadrants (see Figure 2). The policy responses most likely to be successful are those with more resources and a plan for transformation (see upper left quadrant). Those countries that find themselves in one of the other quadrants would seem most likely to benefit from the 'how' suggestions that WHO Europe might provide.

Source: SI-Health

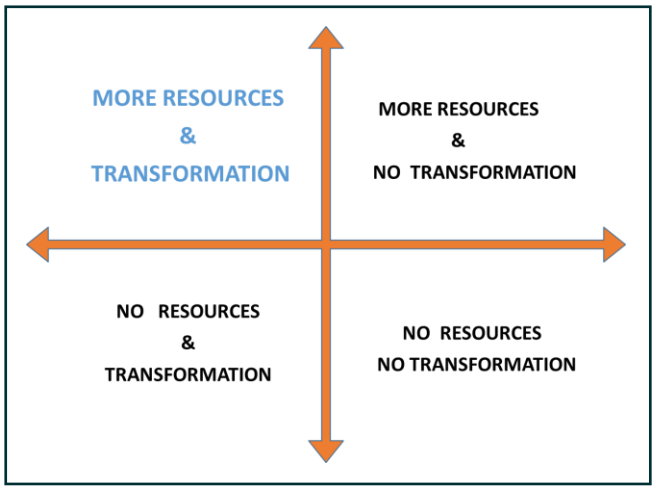

FIGURE 2. POLICY RESPONSES

3 WHO Health System Transformation Initiative

The focus of the WHO Europe initiative is on the 'how' aspect of health systems change. Two meetings of high-level policy-makers and academics from countries across Europe have been convened - one in Madrid in 2015 (WHO Regional Office for Europe, 2015), and a follow-up meeting in Durham in 2017 (WHO Regional Office for Europe, 2018). One of the conclusions from the second meeting was that a number of country case studies should be undertaken to explore the 'how'-question and provide learning from efforts to transform health systems.

To develop a knowledge base about the 'how,' we interviewed individuals in health systems across Europe at all levels — macro, meso and micro. It is not enough to influence only the macro level. Important changes are necessary at the meso level, e.g. moving from hospitals as 'islands' to integrated acute hospital networks, integrating such networks with primary care, and integrating clinical systems with community systems that manage population health. At the micro level, patients and health professionals need to work as a team; health professionals themselves need to embrace teamwork and be supported by strategic clinical networks. Even the best plan will fail if it cannot be implemented at the meso and micro levels.

As a basis for the country visits, we used the 'receptive context for change' framework developed by Pettigrew and colleagues in 1992 (Pettigrew, Ferlie and McKee, 1992). From the eight factor framework they devised, we selected five factors as the most critical for today's policy-makers engaged in transformational change:

- environmental pressure
- quality and coherence of policy
- key people leading change
- supportive organisational culture
- managerial-workforce relations.

Factor 1: Environmental pressure

Environmental pressure is critical in creating the conditions conducive to transformational change and maintaining them long enough for change to become embedded. Consistent political support at every level is crucial. Persistence is important: although structural or regulatory change can happen virtually overnight, it is cultural change that determines eventual success or failure and that takes much longer to accomplish.

Factor 2: Quality and coherence of policy

The quality of policy nationally and locally depends on both analytical and process elements. Persuading sceptical health systems actors, particularly clinicians, to participate in change requires that policy be informed more by evidence than by ideology. To succeed, policies must be cohesive, i.e. goals, feasibility and implementation must be aligned.

Factor 3: Key people leading change

The third factor is leadership; leadership and leaders are different things albeit clearly related. The 'heroic' leaders of old who knew all the answers and 'drove' change appear to be less effective today than leaders with a more adaptive, facilitative style. Today's leaders engage more closely with those who are essential to implementing change effectively, recognising that desirable change is a gradual process. These 'quiet' or 'servant' leaders excel at building teams across the entire system to collectively find solutions to complex problems.

Factor 4: Supportive organisational culture

The fourth factor is organisational culture. The NHS, for example, is made of numerous silos — primary care, hospital, social care, public health — all with their own particular ways of working, goals and reward systems. Realising change becomes more difficult when it involves divergent cultures. Leaders must work across these cultures, encouraging flexibility in working together towards the same goals.

Factor 5: Managerial-clinical relations

When Pettigrew et al (1992) identified this fifth factor, the focus was on clinical engagement in health care reform. We have broadened this to be more encompassing, recognising that health care professionals and staff other than clinicians also must be part of systems change. Nevertheless, clinicians remain crucial and will resist change particularly if their autonomy is threatened. The interface between management and clinicians has always been characterised by tension. But without the full support of clinicians, change will either not occur or not achieve its original goals.

These five factors can guide, shape and influence where and how transformational change occurs, but they are not items on a shopping list that can be chosen or not chosen. The factors are interrelated and must be aligned; if they push and pull in different directions, which is all too often the case, efforts to achieve change are likely to fail. This may appear obvious, but it is amazing how often the reorganisation of complex systems seems to ignore what most of us would consider simple common sense. Note that, finally, even if all these factors are aligned properly, success is not automatic or guaranteed — there is no simple recipe or quick fix.

A variety of factors can lead to failure in implementation. Many are well documented in the literature and our interviews across Europe certainly have caught echoes of those. The most common are listed in figure 3. A particularly critical point, noted above, is interaction with clinicians and other health care staff. Major, complex change often fails either because clinicians and staff do not expect

the momentum to be maintained, or because they expect that another attempt at major change will soon follow. Communication and management of expectations, then, is a core part of successful health systems change.

- absence of buy-in from clinicians and other staff
- 'big bang' momentum that is not sustained over time so, paradoxically, little actually changes
- cost-cutting so that investment in change is lacking or insufficient
- the existence of weak or undeveloped capacity required to make change work
- burn out and 'reform fatigue' as the result of constant churn and frequent change of focus
- loss of interest as the result of too much change, too fast
- promotion or departure of key person in charge
- the realities of politics, which can divert energy and derail change
- perception of change exclusively as 'technical change' rather than 'adaptive change'

FIGURE 3. REASONS FOR IMPLEMENTATION FAILURE

Transformational change requires investment. Although sufficient finance is not enough on its own to ensure success, lack of it may very well be enough to ensure failure. Sufficient finance signals a commitment to success to those who must work the hardest to make change — clinicians and other healthcare professionals. Certainly, attempting to cut costs while also trying to restructure a complex system is a poor decision.

Change requires sufficient capacity in the right places to be effective and lasting. This capacity might be in the makeup of the workforce, or managerial skills, or organisational foresight. The NHS in England, as an example, is replete with people who are burnt out and suffer from 'change fatigue' as the result of near-constant change over the past two to three decades. This may be enough in itself to scuttle attempts at change — it goes beyond resistance to change to completely disengaging from change, with no interest in seeing that change succeeds.

Change must be embedded in the organisation to ensure that many important players have a strong stake and commitment to it. It is common, and at the outset may even be desirable, to have a key person leading change; building on long-standing individual relationships can be an important factor in getting change started. If that person leaves, however, the gap created can seriously damage the prospects for success, even eliminate them entirely.

Finally, change must be presented and perceived as more than technical. Forays into digital health or Artificial Intelligence (AI), amounting to a kind of 'Star Wars' approach to policymaking, will not result in lasting change without accompanying cultural change.

The explanations for policy failure listed in figure 4 are similar to explanations for implementation failure. Policy expectations may be overly optimistic at the outset, with insufficient understanding of

the complexities of implementation at the three levels — macro, meso and micro. If expectations and plans are not aligned appropriately, the effort at change will suffer from operational disconnect where the centre's attempts to pull levers are futile because the levers are not connected to anything. Alan Milburn, a former Secretary of State for Health in England, complained about pulling what he found to be rubber levers. He thought he was making a statutory change in the health service on the ground by pulling levers but quickly discovered that he was having no impact at all because the levers were not connected to anything: people had not read the plan, or did not know what the plan was about, or did not feel any particular commitment to doing anything about it. Operational disconnect is most likely when policy is made more or less in a vacuum, not sufficiently engaging the key people who will be responsible for making it happen, or when the vagaries of the political cycle make policy short-term and ideological in nature. Three to five years is usually the limit of political patience for any policy to be implemented; sustainable complex change often takes considerably longer, eight to ten years at a minimum. The last of these explanations is particularly important: policy-makers often focus on the 'front end' of policy making, the actual delivery of the plan or the strategy or the document setting the agenda, but then neglect implementation and the difficult steps needed to make the policy stick.

- overly optimistic expectations
- implementation in dispersed governance: 'operational disconnect'
- inadequate collaborative policy making
- vagaries of the political cycle
- dominance of 'front end' in policy-making – agenda-setting and formulation, neglect of implementation.

FIGURE 4. EXPLANATION FOR POLICY FAILURE

4 Trends in How Policy-Makers are Approaching Change

Our discussions with policy-makers to date suggest a growing awareness of the challenges presented by complex health systems change. They are aware that efforts need to be actively managed, rather than left to chance as has often been the case in the past. A revitalised planning and leadership approach is needed: change cannot be effected by outmoded or inappropriate structures or by people who lack the skills or mindset to make it happen. Solutions to the most difficult challenges often require collaboration across organisations; most healthcare problems are now intersectoral with solutions that are anything but obvious or simple. This requires a new emphasis on how to change, not just what to change. Collaboration, in some senses, may be even more difficult than competition; certainly, it requires a different set of skills and an honest willingness to work across boundaries.

Our structured interviews with policy-makers covered the following topics:

- Is there a vision for change?
- Is that vision agreed and shared and owned by everybody who needs to own, understand and share it?
- Is the policy built on a concept of value?

- Is the policy based on the best evidence available?
- Have all possible stakeholders been engaged in designing the policy?
- Have all the key people been engaged in the policy design?
- What weaknesses or what areas in the organisation need to be addressed and what capacity built to realise the vision?
- Does implementation require legislative change?

Readiness for change requires that certain perspectives, attitudes and plans be in place. First, the strategic alignment that is a prerequisite for successful change requires a clear, underlying vision that acknowledges and builds on the interdependencies between the 'whys' and 'whats' and the 'hows' of change. Success depends at least as much, perhaps ultimately more, on implementation—the 'how'. Strategic alignment and the realities of implementation require an emphasis on bottom-up engagement, rather than top-down control. The system needs to be allowed the space to find solutions that are appropriate in the local context. This requires relationship-building at all levels, which takes time; policy-makers historically have been too impatient to invest in such work.

New leadership approaches that are more inclusive and holistic will be essential because so many elements will be involved in finding solutions to complex problems. Although having a vision is crucial, so is flexibility about means. Policy often is oriented the other way around, becoming obsessed with symptoms, such as waiting times, and losing sight of the ultimate objective of better healthcare. That was certainly the situation under the last Labour Government, in the late 1990s and early 2000s, when the focus was heavily on meeting performance targets; how delivering on these would produce improvements in health and wellbeing was not entirely clear.

With the above in mind, the key steps to success in ensuring health system transformation are as follows:

1. Leadership that takes a whole system view, drawing on the expertise available in all sectors
2. External resources, which include financing, technical assistance, and an effective communications strategy that makes the ends, means and expectations clear to everyone and at every level
3. A management 'core,' a cadre of experienced change managers
4. Evidence and analysis, culling and making use of the most pertinent evidence available to inform policy and arranging to collect additional evidence if needed; evidence is essential to both monitoring implementation and evaluating impact
5. Implementing in such a way that the process and commitment to change are embedded at every level of the system, recognising that virtually all healthcare systems are collections of interdependent organisations operating in a range of contexts.

Assuming the appropriate design has been created and is in place, there are some practical steps that might be considered to guard against failure and help encourage wholehearted efforts at implementation. These include:

- A delivery unit at the centre to track and assess progress. Its purpose would not be to act as a punitive watchdog, not to bully or threaten, but to help people understand the process and the policy and to track, assess and support the process.

- Help also could come as implementation support, including guidance and opportunities for learning and the exchange of information as well as upgrading project management and leadership skills. Such support, however, must not add to the burden or confusion that change creates. What we found in some of our interviews is that too much supportive activity can be overwhelming, crowding out opportunities for experiential learning and possibly discouraging innovative local solutions.

- Implementation 'brokers', with particular skills in encouraging and managing change, might be considered. This has not been a common approach in the UK, for example, but worth exploring.

- A similar approach is seconding people from sites were change has been made successfully to places that are finding it more difficult. Again, this may or may not work, since some issues may be specific to the local context.

- Funding is essential. Enough must be available to lubricate the process and signal serious commitment, although how much that might be is debatable.

5 Conclusions

No matter how good the plan or how careful the implementation, the unexpected will almost certainly happen. Over time, contexts change in unforeseen ways, which requires some political flexibility. To some extent, the relative freedom of action currently enjoyed by the NHS in England's Chief Executive exists because politicians are distracted by other issues, such as Brexit. This has created an unusual opportunity for the NHS; it is important to recognise that the situation *is* unusual and not likely to continue forever. Similar situations are likely to occur in other health systems.

Even without political interference, plans have unintended consequences — good and bad — that can require a change of course. The ten-year plan will almost certainly look different after even a year or two. The plan itself needs to be somewhat flexible, in keeping with the vision but based on experience with implementation. 'Muddling through' can be a positive, revealing areas where adjustments are needed and those where the plan is succeeding.

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