

**‘What is Known about Effective Approaches to Managing  
Strategic Systems Change and What Are the Implications for  
Mainstreaming Inequalities?’**

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## INTRODUCTION AND PRESENT POLICY

This brief scoping paper explores literature streams and sources of evidence which may inform future evaluations of current health policy in relation to the desired reduction of health inequalities. It specifically highlights the organisational issues that emerge and locates different streams of literature which may be useful in building an evidence base. These literature streams are highly disparate and currently not well integrated. There is a small substantive literature drawn from evaluations of public health programmes, but also much broader literatures located within fields of health care management, public sector management and indeed generic management which relate to some of the management challenges facing those in PCTs who are trying to create partnership working which will reduce health inequalities. It is not simple to decide which of these literatures are important – for example, how direct is the read across from private management or American based literatures to NHS settings?

Another question is how ‘effective’ approaches are to be judged in this context. The bio medical literature stresses the primacy of the measurement of final clinical outcomes. The private sector organisational literature takes a mix of hard measures (profitability; market share) and soft or intermediate measures (ability to implement declared strategy; ability to learn, innovate or change). In public sector settings such as the NHS, ‘hard’ market led measures are elusive. The literature may rather mix performance assessment indicators (number of ‘stars’ a NHS Trust receives) and intermediate organisational indicators (ability to effect strategic service change).

The literature reviewed in the paper is more social scientific than bio medical in nature. Important work is published in research monographs and policy evaluations as well as in peer reviewed journals. Such work will not be readily captured by a search of bio medical data bases such as MEDLINE or even social science data bases such as ABI INFORM or BIDS. The work reviewed uses a range of methods, but is often case study based. Traditional bio medical methods such as RCTs are rarely employed. This begs the question of what research can be rightfully seen as ‘more rigorous’ in this field, and what indicators of quality should be used in making this judgement.

Given time constraints, this present paper has been written as a preliminary personal review. Further and larger scale work may be warranted if it is felt that the issues surfaced are important.

### *Present Health Policy and Some Organisational Implications*

The Department of Health has recently launched an ambitious programme of ‘investment and reform’ across health care. For example, ‘*Shifting The Balance*’ (DOH, 2001) proposes that reform should accelerate within health care, both structurally and (more problematically) within the cultural sphere. This change agenda implies the development of new organisations, roles and styles of working. Health organisations should move beyond delivering services to a more diffuse and influencing role in ‘shaping’ local health economies (‘shaping’ is very different from ‘directing’). The newly created

Primary Care Trusts (PCTs) have as a key strategic objective improving the health of the local community through community development and health promotion. They are expected to take a lead role in using a partnership based approach with other local agencies and with the benefit of a strengthened public health function (DoH, 2001). They should take a coherent view of the development of all NHS services within a defined geographical area, and think systemically across the patch. The recent 2002 White Paper on Public Service Agreements (Cm 5571, 2002) confirms that Objective 2 for the Department of Health is 'to improve health and social care outcomes for everyone', including a reduction in health inequalities in infant mortality and life expectancy at birth. This objective cannot be delivered by the NHS alone but requires partnership working from a range of different socially orientated agencies.

These policies suggest a need for PCTs to organise in a different way from traditionally 'command and control', vertically organised, NHS organisations. They suggest the need to develop a more subtle and indirect leadership style, often associated with the leadership behaviours contained within the model of the Learning Organisation (Senge, 1990). The focus is on the local health system as a whole, rather than single NHS agencies.

### **1. Previous Evaluations of The Implementation of Public Health Strategies**

The substantive policy domain is perhaps the least problematic area and a good place to start the review. Two empirical studies of the implementation of earlier public health strategies were located for this paper. Hunter et al's (1998) evaluation of the 1992/97 'Health of the Nation' strategy found it had little impact. They called for more shared ownership: horizontally (across agencies) and vertically (engaging CEOs). In order to achieve the latter, public health strategy needed to be included within mainstream performance management. They also drew attention to the possibility of initiative conflict and overload, with this initiative competing with many others for space on the agenda.

Using a political science perspective on agenda alignment, Exworthy et al (2002) report interim results from a ESRC funded study of the implementation of the post 1997 health inequalities agenda. Public health policy in this period was marked by greater national ownership than pre 1997, higher energy levels locally and a new emphasis on joined up government and partnership working locally (as now). However, there were still barriers to effective local implementation:

- time was spread thinly due to initiative overload;
- performance management was concentrated in higher profile areas;
- locally there were still obstacles to 'joined up government'

There may be useful *organisational analyses* (perhaps of an implicit as well as an explicit nature) contained within these and any other substantive evaluations which could inform the evidence base. Certainly one possibility would be to benchmark current strategy against the levers of – and barriers to – organisational change already highlighted in these prior evaluations.

*Literature Stream 1: it would be helpful to undertake a more comprehensive search for evaluations of the implementation of public health strategies and to draw out organisational analyses;*

## **2. More General Organisational Considerations and Literatures**

As well as this small substantive literature, there are broader literatures which may be helpful in forming an evidence base, particularly in providing an underlying change theory in which empirical data from any future evaluations can sit.

### *2.1 Two Public Management Narratives - 'Governance' (vs) 'the New Public Management'*

There is a growth of UK academic literature on the organisation of current public service organisations. This public sector management base may well be of interest to NHS organisations (which are after all funded through taxation and located in the public sector). One focus is trying to assess the implications of the rise of New Labour for underlying models of the organisation and management of public services. This literature mixes concepts from public management and political science.

The literature suggests a debate between two fundamental narratives of public service organisation. The first narrative is the *governance* narrative (Rhodes, 2000; Pierre and Peters, 2000; Newman, 2001; Sullivan and Skelcher, 2002) which takes a pluralistic perspective and stresses concepts of partnership; inter agency action; 'joined up government', and management through networks. It suggests that there are many actors within policy networks and that the State by itself is relatively weak and some academics suggest perhaps even becoming weaker. The nation state is being 'hollowed out' (Rhodes, 1994; 2000) losing control upwards (to the EU) and downwards (to Next Steps agencies; private providers of publicly funded services). The need to influence (given the impossibility of direction) may lead to the development of softer management skills. Government attempts to retain systemic 'steering capacity' (Pierre and Peters, 2000), even while losing direct control. This narrative was best articulated in the policy domain by the Cabinet Office document (1998) '*Modernising Government*' which stressed lateral linkages, partnership working and 'joined up government'. 'Wicked problems', such as social exclusion, required a systemic and integrated solution, and could not be compartmentalised within vertical silos.

Against this is the 'New Public Management' narrative (Hood, 1991; Ferlie et al, 1996; Pollitt and Bouckear, 2000) which takes a more 'closed' view of power sources within current public sector organisations. The central government (perhaps led by HM Treasury as the guardian of NPM type values) is here imposing more elaborate targets, performance management systems and audits on local agencies which are being required to deliver on targets. The mode of organisation is 'harder', being largely vertical, 'command and control' in style and measurement based. Governmental power remains

considerable, even subordinating and colonising its 'partners', such as organisms of civil society (Giddens, 1997) through its monopoly control over funding regimes. Current public health policies include elements of both models. Superficially the governance model appears dominant: for example, PCTs are enjoined to develop joined up solutions and partnership working (DoH, 2001) and also to take on the role of 'lead' coordinating partner. However, an element of NPM style government remains, given the creation of Strategic Health Authorities as performance managers and the pervasive influence of the Treasury on spending departments such as the Department of Health. This will be elaborated through departmental and then agency performance agreements.

A number of questions arise from the co existence of two apparently distinct modes of organisation. Can a network be performance managed or does it need to be coordinated through more indirect means? What are the management skills needed to 'shape' systems effectively? Will a governance based mode of lateral organisation reach its potential, or will it remain marginalized by a still powerful NPM movement (McNulty and Ferlie, 2002)? Is it possible to balance these two narratives of organisation or are they in the end contradictory? This debate has clear implications for the potential for partnership based working envisaged for PCTs.

*Literature stream 2: it may be helpful to review more comprehensively policy and academic literature on changing basic modes of UK public service organisation, picking out implications for health care organisations such as PCTs.*

## *2.2 The Management of Strategic Change in Health Care*

The well established literature on the management of organisational change has been recently reviewed by Iles and Sutherland (2000) with special reference to the management of health care organisations. In the 1980s, the focus of the generic organisational change literature moved from the traditional study of micro or incremental change processes to the study of larger scale, strategic and organisational wide change processes. Pettigrew's (1985) study of strategic change in ICI represents a key text. This work developed a more processual language of strategy formation and implementation very different from previous rationalistic models of strategy. Firms were shown to vary in their underlying change capacity and ability to implement declared strategies (Pettigrew and Whipp, 1991).

Until the 1980s, there had been little interest in organisational change literature inside the NHS. This changed with the introduction of general management in the NHS in the mid 1980s, as general managers had been often appointed with a remit to effect organisational change. So did they, and if so, how? Harrison et al (1992) found the ability of managers to achieve change – especially at micro level – was constrained by the continuing power base of clinicians and also an inherited culture. Pettigrew et al (1992)'s study examined higher order strategic change processes across whole District Health Authorities, using a matched pairs design. They found substantial variation in the ability of these DHAs to effect strategic change and developed the metaphor of 'receptive and non receptive contexts for change.' Change receptivity combined features of context but also of action,

and layers of change capacity could be slowly built up over time. Some of their indicators of receptivity (such as good clinical/managerial relations; cooperative interorganisational networks) may be relevant to the current public health agenda.

A Canadian team (Denis et al, 1999) has recently examined some of the obstacles to the effective management of strategic change (such as hospital mergers) in health care, such as the retention on clinical control over micro work practices. This suggests that desired strategic change may have to have a degree of 'fit' with acceptable professional working patterns, if it is to be implemented.

A quick scan suggests that little of basic significance has been published in the UK since Pettigrew et al (1992), reflecting the bias in the 1990s to the funding of short term and applied work which however quickly erodes. The NCC SDO is now funding a new generation of longer term studies on the management of change in the NHS and their results should be available in about three years time.

*Literature Stream 3: it may be helpful to review the literature on the management of strategic change in health care, particularly searching for material published in the last five years.*

### *2.3 Management by Networks*

Markets, hierarchies and networks are three different and basic ways of organising. They produce different governance structures and behaviours. Within networks, concepts of trust, reciprocity, coalition building and indirect influence are important. There is a strong strand of networks based form of management evident in commissioning organisations in particular (Ferlie and Pettigrew, 1996, supply some early empirical evidence on the rise of network based forms and associated managerial skill implications including for Director of Public Health). Huxham (1992) explored how collaboration can be developed across health and social care agencies. This style of management is likely to be important within PCTs, albeit mixed with hierarchical and market based strands in a sometimes unpredictable hybrid.

Within the wider organisational literature also, there is a marked growth of interest in laterally based modes of organising (Denison, 1997) both within the private and public sectors: strategic alliances; joint ventures; process redesign; lean production; network based management all represent variants on the same underlying theme of a laterally based process of organising. Particular industrial districts are held up as ideal types for the network form: Silicon Valley; textile production in Italy; Medium Sized Firms in South West Germany.

How are these networks effectively managed? Do they depend on informal trust relations or is this mixed with a formal contracting regime? Are all players equal in the network or are some more powerful than others? Can participants drop out of the network if it does not generate outcomes that they want? What are the disadvantages of network based

management? What are the additional HRM and skill requirements of network based managers (Ferlie and Pettigrew, 1996)?

There is likely to be a substantive evaluation literature on NHS networks emerging over the next two or three years, as the results of studies funded into experiments with network based forms of management (e.g. cancer networks) come through.

*Literature Stream 4: it may be useful to review the expanding literatures on network based management – both within and outside health care – and in particular identify the HRM and skill requirements of network based managers.*

#### . 2.4 Systems Perspectives

An increasing number of writers are using a systems perspective in analysing complex change processes, perhaps drawing on the ‘soft systems’ perspective pioneered by Checkland (1981). The systems perspective suggests that localised change is difficult to effect, as the underlying properties of the system will cause regression. One implication may be that ‘radical shock’ or multiple interventions may be needed to unfreeze a system, although the long term effects of this may be unpredictable.

A good example of the use of a systems perspective is Senge’s (1990, 1996) model of a learning organisation which suggests that managerial leaders will increasingly need to think and act systemically by:

- seeing interrelationships rather than static structures;
- understanding how systems evolve through time;
- focus on areas of high leverage;
- avoid symptomatic ‘solutions’ such as short term fixes (e.g. structural tinkering)

It is the organisation as a system which is able to learn in this model, rather than isolated, high learning, individuals or teams.

Iles and Sutherland (2000) suggest that the systems perspective is of increasing interest to the NHS because of:

- an increasing awareness of the multi factorial issues involved in health care which go beyond any one agency;
- interest in designing systems which can provide ‘seamless’ care;
- recognition of the need to develop shared values, purposes and practices within and between organisations;
- use of large group interventions to bring the perspectives of a wide range of stakeholders across a wider system.

Recent applications of systems thinking to change management in the NHS include the work of Pratt et al (1998) at King’s Fund. We need more high quality evidence as to the impact of these interventions.

*Literature Stream 5: it may be helpful to review the use of systems thinking as a change management tool, both within and outside health care, and assess the evidence as to impact;*

## 2.5 'Mainstreaming'

'Mainstreaming' is a word which appears often in relation to discussions of public health policy. What does it signify? In organisational terms, this suggests that the public health agenda is essentially 'owned' by a specialist function (public health medicine) that may lack the power to get its issues high on the overall corporate agenda. The organisational literature on corporate change programmes (Pettigrew, 1985; Beer et al, 1993; Pettigrew, 1998) similarly deals with the fate of change programmes which are sponsored by specialist functions. Pettigrew (1985) examined the differential impact of Organisational Development specialists within different division of ICI. The implication is that the breadth and depth of ownership of the issue needs to be broadened: 'get it in the line'; or make CEOs accountable for reporting. The ability of the specialist function to 'work' the rest of the organisation is also important, where there may be dangers of separatist ideology, 'groupthink, zealotry and an inability to cross boundaries (Pettigrew, 1985).

*Literature Stream 6: it may be helpful to review the literature on how change programmes sponsored by specialists are or are not 'owned' by the rest of the organisation, including line management.*

## **DEVELOPING AN EVIDENCE BASE**

This brief review has already highlighted six different streams of literature which may be relevant to building an evidence base. Some important questions arise.

### *Which Literature Streams Should be Included?*

It is not obvious which literatures should be included in any future work. The substantive stream of literature is most clearly connected to the field in question, but it is small scale. It also tends to be more empirical than theoretical. A theoretical underpinning would help enhance the utility of policy relevant evaluations. Against this, some of the other streams of literature highlighted may be located in international, private sector, settings where the direct utility to the NHS is highly limited.

### *Quality Indicators*

How can the reader make quality judgements about these literature streams, given that the conventional 'hierarchy of medicine' model is difficult to apply? Should certain types of evidence weigh more heavily than others? One strategy is to weight outputs that have gone through a peer review process more strongly – especially those that have been published in top quality journals or as research monographs published by leading academic publishers.

### *Creative Analysis and Synthesis*

A conventional 'meta analysis' is also difficult to apply in a field where studies have been undertaken using different methods and theoretical stances. 'Making sense' of the literature – even when it has been assembled – is likely to require creative analysis, judgement and synthesis, and an ability to cross paradigm and disciplinary boundaries. Much of the material discussed in the paper, for instance, is informed by social science. Even within the broad umbrella of social science, there are various disciplines represented, for instance, the discipline of political science as well as organisational analysis.

### *Coordination of Research Strategy*

Any future research in this field should be coordinated with other major research funders such as NCC SDO who are now commissioning basic work in related areas.

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