Real Reform Begins Within:  
An Organizational Approach 
to Health Care Reform 

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Abstract  Health care systems are under pressure to control their increasing costs, to better adapt to evolving demands, to improve the quality and safety of care, and ultimately to ameliorate the health of their populations. This article looks at a battery of organizational options aimed at transforming health care systems and argues that more attention must be paid to reforming the delivery mechanisms that are so crucial for health care systems’ overall performance. To support improvement, policies can rely on organizational assets in two ways. First, reforms can promote the creation of new organizational forms; second, they can employ organizational levers (e.g., capacity development, team-based organizations, evidence-informed practices) to achieve specific policy goals. In both cases organizational assets are mobilized with a view to creating complete health care organizations—that is to say, organizations that have the capacity to function as high-performing systems. The challenges confronting the development of more complete health care organizations are significant. Real health care system reforms may likewise require implementing ecologies of complex innovation at the clinical, organizational, and policy levels. Policies play a determining role in shaping these new spaces for action so that day-to-day practices may change.  

Ask any policy maker or health administrator about health reform, and he or she will confirm that improving health care systems while meeting rising demands and expectations is a constant struggle. Yet it is impossible to deny that health systems are in dire need of reform to control increasing costs, better adapt to evolving demands (e.g., chronic diseases and complex long-term conditions), and improve the quality and safety of care (Pauly 2008; Orszag and Emanuel 2010). At the same time, reform
risks compromising performance (Pettigrew et al. 2003) at the very time that an organization is most under pressure to meet escalating demands. The challenge for health care systems and organizations is to respond to demands for adaptation and improvement without losing consistency and performance. The challenge for reformers is to find strategies that minimize this risk and to demonstrate enough persistence to reap the benefits of reform.

A recent study on innovation in the biopharmaceutical and alternative energy industries (Dougherty and Dunne 2011) developed the concept of organizing ecologies of complex innovation. Such ecologies aggregate a set of organizing principles to support the design and implementation of complex innovations on a routine basis. This study extrapolates these concepts to the health sector and provides insights into how health systems can capitalize on their organizations’ assets to develop more complete organizations.

Our approach to health care system reform suggests that new organizational forms and levers may enable systems to safely move away from the status quo and sustain their improvement efforts. It rests on the assumption that just as there is a plurality of organizations providing care, there is more than one way to achieve complete organizations. We also take the position that it is not enough to create new organizations; real reform requires an environment that enables these organizations to continually innovate and flourish. Real organizational innovations also suppose that resources will not continue to flow with the same magnitude and through the same circuits. In a recent article on health care reforms, Coeira (2011: 1) argues that system inertia is a fundamental reason why reforms frequently fail to meet expectations. He defines system inertia as the “tendency for a system to continue to do the same thing irrespective of changes in circumstances.” Because innovative organizations and levers challenge systems characterized by inertia, they need to be supported and governed properly.

The Role of Delivery Mechanisms

Delivery mechanisms are crucial to health care systems’ overall performance. Current debates surrounding the implementation of accountable health care organizations in the United States clearly show the need for — and the challenges associated with — renewing delivery mechanisms to achieve better cost control, quality, and access (Singer and Shortell 2011; Corrigan and McNeill 2009). By targeting organizations, the
expectation is that agents will be placed in a variety of practice contexts that are conducive to innovations and ultimately to better care and performance (Gawande 2009; Mechanic 2008). More effective organizations will lead to health care systems that maximize their resources and minimize their dysfunctions (e.g., inadequate use of emergency departments, poor follow-up of patients in the community, and insufficient care coordination and integration) (Bentley et al. 2008). Policies that positively and directly affect health care delivery organizations may even alleviate the pressure to implement wholesale reforms.

To optimize organizational change and development, new connections must be forged between health policies and the science of organizations. However, efforts to renew health care organizations may prove to be as much an art as a science, as suggested by preliminary results from the Physician Group Practice demonstration project in the United States (Wilensky 2011). The project was designed to encourage physicians operating under a fee-for-service basis to provide higher quality at lower cost. The evaluation of groups participating in the initiative reveals that physicians did very well on quality improvement but performed more poorly in terms of cost savings.

One explanation for these results may be the mismatch between the project’s overall incentive schemes (comparator groups, availability of timely information to improve practices) and its cost savings objective. These findings underline the importance of the dialectic between policy and organizational changes in bringing about change. Policies must target more explicitly and directly elements that have a clear effect on organizational performance.

Organizational Approach

Recognizing this tension between policy and organizational dynamics represents a major shift from the predominant method of health system reform. Traditional approaches to health care renewal promote uniformity, inspired by best practices and evidence-based decision making. It is well known that a broad social, political, and policy/regulatory environment plays a determining role in system evolution, but public policy has traditionally neglected or downplayed the importance of organizational arrangements in policy making and its outcomes (Robichau and Lynn 2009; O’Toole 2000). Until recently little attention had been paid to the analysis of specific organizations or subsystems that achieve better or outstanding performance and their implications for policy making (Baker et
al. 2008). Since organizations are on the receiving end of almost every innovation that diffuses into health systems (Christensen 1997), organizational context represents a promising space for converting policy intentions into concrete actions.

The organizational approach addresses three problems at the interface of policies and delivery organizations. The first is actualization, where policy intentions are not implemented in organizations and practice settings and consequently do not produce the desired outcomes (Jennings 2010). The second problem is destabilization, where policies hamper the delivery of care without any (or with insufficient) positive effects. In the case of the NHS, Hunter (2011) recently underlined this problem with current reform. The third problem revolves around learning, where policies are not adequately informed by key aspects of health care delivery. For example, the Commonwealth Fund and the Organisation for Economic Co-operation and Development have devoted much effort to comparing the overall performance of national health systems in order to extract broad policy lessons for system improvement.

The organizational approach has its limitations. It does not deal directly with broader policy elements, such as the fundamental social contract between the medical profession and the state in a given system (Tuohy 1999) or the determination of politicians and society as a whole to take action to improve the system or address the major determinants of a population’s health. Instead this approach to health reform demonstrates how care delivery organizations can rely on their own assets and capacity to implement changes in line with broad reform goals—efficiency, quality, access—and, to a certain extent, compensate for limits imposed by political or policy environments.

**Organizations as Assets for Health Care System Reform**

To cultivate real reform, policies can capitalize on organizational assets in two important ways. First, policies can promote the creation of new organizational forms. In this case organizations are treated as multitask policy instruments. By creating new organizations (e.g., medical homes, health care networks, primary care groups), reformers hope to induce a significant shift in the logic that drives the delivery of care. In such cases real reform consists of implementing new organizations across a system. The caveat to such changes is that providers and patients may perceive the new organizations as a more radical transformation.
The second policy plank to mobilize organizational assets relies on organizational levers (e.g., capacity development, team-based organizations, evidence-informed practices) to achieve specific policy goals. In this instance reform consists of implementing well-circumscribed policy instruments to stimulate change and performance. This option takes a more incremental approach to reform. Of course, the two strategies are not mutually exclusive. Hunter (2011) and Baker et al. (2008) underline the limitations of structural changes that lack clear policy goals and capacity development supports.

New Organizations

In a recent article, Berwick, Nolan, and Whittington (2008) indicate that achieving the triple aims of quality, cost savings, and accessibility depends on implementing effective integrators in health care systems. Integrators are organizations that orchestrate diverse levers (e.g., incentives, coordination mechanisms, information infrastructure) to support the delivery of high-quality care to predefined populations (Ham 2009).

The best approach to creating such integrators is open to debate. Some evidence (e.g., Veterans Health Administration, Kaiser Permanente, Geisinger) suggests a benefit in relying on structural integration to achieve higher performance (Oliver 2007; Dixon and Alakeson 2010; Paulus, Davis, and Steele 2008). These studies deal mostly with US cases, whose particular historical conditions and competitive pressures may limit their transferability to other jurisdictions.

In public health care systems (e.g., in Canada and the United Kingdom), some of the structural requirements of integrated systems (a clear structure of authority, relatively integrated funding) are in place at the macrolevel. But there is much less integration at the delivery level; care and services are poorly coordinated, or incentives are weakly aligned with improvement objectives. This highlights the need to develop new organizational capacities to enhance health care delivery (Goodwin et al. 2012).

Attempts in many jurisdictions (e.g., medical homes, primary care groups) to improve the organization of primary care and to implement health care networks (Rittenhouse, Shortell, and Fisher 2009; Steiner et al. 2008; Ferlie et al. 2010) represent promising efforts to implement effective integrators at the delivery and community levels. Networks can also support the production and circulation of knowledge (primary care research networks, the Collaboration for Leadership in Applied Health
Research and Care in the United Kingdom) with the potential to positively affect both care practices and delivery (Thomas et al. 2006).

Experience has shown that imposing new organizational structures on a large scale poses significant challenges. For some experts the alternative is virtual arrangements such as disease-based networks (Fulop et al. 2002). These networks can increase synergy and coordination among providers and organizations, enabling them to function more efficiently and effectively without the need for formal structural integration. These more flexible organizations build on existing relationships among professionals and providers and rely on contracts or other incentives and various collaborative strategies to achieve common goals. For instance, the extended medical hospital staff model in the United States promoted by Fisher et al. (2007) utilizes relationships among providers — primarily physicians and hospitals — to implement new delivery models in local health systems.

Implementing such arrangements is not without its own set of challenges, attributable largely to institutional and political rigidity. The development of networks to better coordinate care or to share human resources and services across health regions in a given system may be constrained by organizational or jurisdictional autonomy.

Organizational Levers

Real reform also relies on specific organizational levers that can bring about change without creating new organizations. Three key levers can contribute to successful health care reform: delivery models founded on practice-based innovations, the development of new capacities (knowledge, competencies), and new forms of engagement.

Practice-Based Innovations

Practice-based innovations that test current professional roles and scopes of practice have gained importance in recent policy debates (Frenk et al. 2010). Interprofessional collaboration and team-based organizations are examples of initiatives aimed at deploying professional expertise and human resources in new ways. While evidence of the payoff of interprofessional collaboration needs to be strengthened (Zwarenstein, Goldman, and Reeves 2009), interventions to restructure work within organizations have a long history in organizational scholarship and may inform policies and experiments aimed at improving care and services (Wiskow, Albreth, and de Pietro 2010).
New models of care for complex conditions in the past twenty years reinforce the need to adapt professional practices to patient needs. Analyses of these models highlight the importance of developing professional capacities, creating organizational contexts that support learning in practice, and implementing strategies to adapt these models across jurisdictions (Challis et al. 2006; Nolte, Knai, and McKee 2008).

**Development of New Capacities**

A recurring theme in debates around health system improvement relates to the intensity of knowledge utilization in care delivery settings (Ferlie et al. 2005). To effect positive change, managers and providers require the knowledge, skills, and competencies to design and implement improvements.

Levers targeting capacity development can take various forms, as the following examples illustrate. Taking patients’ perspectives into account in designing service improvements (Goodrich and Cornwell 2008) incorporates new sources of knowledge in organizations that deliver care. The development of board-level governance capacities and responsibilities for quality and safety is another area in which policy can improve care and services (Jha and Epstein 2010). And some authors suggest that the ways safety knowledge and practices in the aviation industry are routinely transferred to health care could promote safer care (Lewis et al. 2011).

These examples reflect a growing recognition that substantive improvements cannot be achieved without the development of new capacities in delivery organizations.

**New Forms of Engagement**

The development of new capacities is intricately linked to the level of providers’ engagement. In many jurisdictions, physician engagement is now considered a prerequisite to the better delivery of care (Darzi 2008; Dwyer 2010; Burns and Muller 2008).

In Europe several health systems have used a range of strategies—with varying success—to increase physicians’ participation in governance (Neogy and Kirkpatrick 2009). For most organizations, involving clinicians in organizational improvement initiatives continues to be a major challenge (Berwick and Nolan 1998). Recent studies of the participation and integration of physicians into organizations (Exworthy et al. 2010; Kitchener, Coronna, and Shortell 2005) indicate that physicians have
adapted to practicing in more formal organizational contexts while preserving their autonomy.

While physician engagement is considered a key element for service improvement and cost savings, the results of the Physician Group Practice demonstration project indicate that such engagement needs to take place in a well-designed environment. Research in the United States and the United Kingdom (Audet et al. 2005; Doran and Roland 2010; Burns and Muller 2008) underscores the limitations of relying strictly on economic incentives to induce physicians to commit to the improvement of quality and systems.

Physicians’ engagement can be seen as a subset of broader strategies to reform work arrangements in health care organizations. While this section of our article has addressed only the engagement of physicians, we recognize that the mobilization of other professional groups is equally critical.

The potential of these levers to bring about improvement depends on individual circumstances, as is the case for any policy instrument. Specific policy and organizational contexts affect both the ability to mobilize these levers and the payoffs of doing so.

**Complete Organizations for Complex Innovations**

Analysts of public-sector innovations suggest that such reforms often attempt to create more “complete organizations” (Brunsson and Salhinn-Andersson 2000). By complete organizations they mean entities characterized by a strong sense of organizational or local identity, hierarchy, and rationality.

*Identity* requires autonomy in governance, the establishment of clear organizational boundaries, and a unique sense of purpose. *Hierarchy* refers to a centralized authority that guides and coordinates the actions of an organization and its members. It is a precondition to creating effective accountability regimes. *Rationality* refers to the organizational goals as well as to the use of standards and measures to stimulate their attainment.

The complete organization concept does not refer to the creation and implementation of specific organizational arrangements. Complete organizations have the capacity to perform different functions properly at the core of high-performing systems. Examples of new organizational forms and levers discussed previously must be assessed in light of their potential to achieve the functions of these systems. These functions have been
widely debated in the context of US health care reform (Singer and Shortell 2011; Bohmer 2011).

Bohmer (2011) recently addressed the four habits of high-value health care organizations. He contends that policy makers risk losing the battle of health care reform if they focus on implementing a predominantly organizational model across a whole system. Instead, policy makers and governance authorities should consider a variety of models that could implement comprehensive clinical-management systems in specific local and policy contexts. According to Bohmer, the four habits that form the foundation of such systems are (1) specification and planning, including the management of specific subgroups of patients; (2) the design of specific infrastructure (e.g., staff, information, technology) to match the needs of subpopulations; (3) the capacity to properly monitor an oversight process and measure outcomes of care; and (4) strong knowledge management to learn from positive and negative deviations in outcomes and care.

**Achieving Real Reform**

In the end, real reform is largely an exercise in organizational development—an undertaking fraught with challenges. This may be why so many reforms focus on broad reorganization without achieving substantive changes at the delivery level. Creating more complete organizations is a disruptive and complex process for systems that are often characterized by fragmentation and unclear goals and accountability.

In this article we propose that policies aimed at bringing about real reform can rely on implementing new organizational forms and/or activating specific levers. These organizational changes are intended to develop more complete delivery organizations that will be in a position to design and implement the functions of high-performing systems.

Complex innovations are characterized by both a high potential to add value to their systems and a high level of ambiguity and uncertainty regarding their payoffs (e.g., new delivery models, new incentives). Such innovations take shape over long periods of time and are the result of interactions among multiple agencies and agents. They are also characterized by broad encompassing purposes. These include the sustainability of a public health care system, strategies to allow agents and organizations to sustain long-term commitment to these goals, increased connections among providers and organizations across the system to increase learning, and appropriate regulatory and governance roles to support the design
and implementation of complex innovations. It is the role of policies and governance bodies to carefully monitor and facilitate complex innovations and to make necessary adjustments to these risky processes.

Real health care system reforms may likewise require implementing ecologies of innovation at the clinical, organizational, and policy levels so that day-to-day practices may change (Dougherty and Dunne 2011). Taking a more serious look at organizations in health care reform implies framing radical change as incremental processes—processes that evolve over time through proper support and monitoring to implement and sustain the functions associated with high-performing organizations.

**Conclusion**

Putting into practice our organizational scenario for real reform will depend, as do any reformatory templates, on specific political and policy landscapes. Several jurisdictions have developed enabling institutions—for example, the National Institute for Health and Clinical Excellence and the National Institute for Innovation and Improvement in the United Kingdom and quality councils in various provinces in Canada. These institutions represent promising options to support large-scale changes and improvements.

Although it is premature to assess these organizations’ full potential to support real reforms, the momentum the institutions have already created suggests that providers and delivery organizations are prepared to evolve in and adapt to more challenging environments as well as to environments that are tailored to support more complex innovations. This points to inherent strengths within the system that have been overlooked for too long.

### References


