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Governance and Management of Change in Canada's Health System

by

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Highlights

- Despite numerous health care system reform projects over the past fifteen years or so, the need for change is as strong as ever:
- Producing transformations is an interdependent social process requiring consistency in the actions taken and in the decisions made by various governance levels.
- In order to promote change, new forms of governance and new governance practices are required.
- Our analysis identifies the need to change organizational and professional practices and proposes integrating structural change into agents' interaction and learning dynamics.
- Three strategies to produce transformations are analyzed: regional governance, experimentation and organizational leadership.
- Analysis of regional governance suggests that it must revitalize its role and benefit from lasting political support.
- Analysis of experimentation reveals that this strategy permits effective co-opting of professionals with regard to change and emphasizes the importance of not over-standardizing programs and organizational methods.
- Analysis of leadership emphasizes the importance of collective leadership in the health care system. Establishing effective collective leadership is a difficult and important organizational issue.
- Analysis of these three strategies for change is linked to a certain perception of transformation. Progressive radical change appears to be a viable option for the health care system. To produce this kind of change, it is proposed that the federal government stimulate the development of human capital by investing in change management training programs, encourage experimentation through a decentralized venture capital program and contribute to the development of inter-regional and inter-provincial sites for experimentation and regulation, and of a monitoring system in order to disseminate information and knowledge on the transformation management processes.

Executive Summary

Most OECD member countries have initiated significant reforms to their health care systems. Despite these efforts, several governments are concerned about the ability of the health care system to meet the challenges of changing technology and an aging population. The interest shown in the idea of integrating care and services is an indication of the difficulty experienced by health care systems in effecting changes in their organizational and professional practices, in order to change their methods of care and service delivery. Our study addresses the factors and processes that can promote change in the health care system, more specifically the relationships between governance and change in the health care system.

Three change strategies are analyzed: regional governance, experimentation and leadership. Regional governance relies on the implementation of a new structure to modify regulation of the health care system. Experimentation consists in promoting change through incentives and interactions between agents. Leadership is akin to an entrepreneurial mode of producing change that emphasizes the vision, legitimacy, competence and unifying abilities of certain agents.

Implementation of Regional Governance and the Ability to Change

Nine of the ten Canadian provinces have considered regional governance to be an appropriate way of promoting reform. In several cases, this kind of governance led neither to the satisfactory renewal of organizational methods of health care and services nor to a significant change in the relationship between citizens and the health care system. However, empirical analysis from the viewpoint of the agents involved in these structures demonstrates a significant investment on their part in reform projects and a desire to participate in regional governance. These agents are called upon to effectively meet a central government's expectations.

Analysis of regional governance suggests that it is a complex system of action based on managerial control, political negotiation and democratic involvement. Regional action in reform processes is dependent on the position adopted by the central government. Regional governance encountered two major limitations in its ability to effect change: its dependence on the central government's mandates and desires, and its difficulty in having an effect on practices from an inter-organizational standpoint. In order to motivate regional governance to favour change, it is suggested that it renew its role in support of emergent change, make use of a set of levers of change, and ensure ongoing support by the central government and sufficient public participation to legitimize change.

Experimentation as a Strategy for Change

Experimentation is a strategy frequently used to promote change. The Health Transition Fund program has financed a considerable number of pilot projects, including approximately forty in Quebec. A cross-section analysis of these projects reveals two crucial types of experimentation: i) prototype experimentation and ii) what is called convergent or do-it-yourself experimentation. Prototype experimentation faces two significant challenges: total implementation of an innovative model and development of systemic conditions to ensure its sustainability and

eventual general application. Do-it-yourself experimentation primarily encounters the obstacles of local change and its dependence on systemic change. Pilot project analysis reveals the importance of supporting emergent change and providing resources and incentives that are conducive to a lasting commitment, on the part of agents, to adapt health care delivery. Less complex projects are likely to produce the expected changes; however, they do not lead to significant transformations.

The proposal is to stimulate local and emergent change through venture capital programs, to co-opt professionals into change management, and to develop regional and central governance that is likely to encourage, monitor and perpetuate promising innovations.

Leadership as a Strategy for Change

Professional organizations are characterized by a division of influence and authority. This begs the question of the procedures to be used to direct change. Several empirical studies in health care organizations demonstrate the importance of instilling effective collective leadership that supports change. Effective collective leadership possesses specific characteristics that enable it to harness all of the expertise and clinical and administrative sources of legitimacy required to meet the challenges of change. There are three pitfalls to establishing collective leadership: rivalry among leaders, separation of the change project promoted by leaders from the organizational base, and a gap between the change project and what the community requires. Several organizational or systemic factors contribute to intensifying or diminishing the significance of these various pitfalls. These observations point to a series of recommendations concerning the development of collective leadership.

Conclusion

Our analysis shows that transforming the health care system is a complex task in which the decisions made and the actions taken at different governance levels must fit together in a consistent manner. In order to modify organizational and professional practices, it is important to promote local and emergent change and to accept variations in the health care system. Structural change can be useful; however, it must fit within a much more dynamic interpretation of change. A realistic transformation scenario for the health care system would involve radical and progressive change. This hypothesis assigns a transformative role to the federal government in organizing the different governance levels, financing a decentralized venture capital program to promote emergent change, and developing change management abilities and a monitoring system to distribute and share information on the transformation of the health care system.

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Introduction

Pressure for significant transformations in health care delivery is present in the health care systems of all OECD countries and is giving rise to numerous reform projects (Saltman and Figueras, 1998; Contandriopoulos and Souteyrand, 1996; Contandriopoulos, 1994). Although there is considerable consensus on the inevitability of change in health care delivery, it is important to acknowledge our considerable unfamiliarity with the processes by which to achieve such transformation. In addition, we know little about the nature of the changes actually achieved. Furthermore, we note that a number of these changes, including changes to the payment system for physicians, greater co-ordination of health care and services and inter-professional collaboration, have not been successfully implemented. At the same time, many ideas concerning the need for and the relevance of certain changes have been suggested and are becoming more widely accepted. Thus, our analysis seeks to gain a better understanding of the conditions that would make it possible to implement the desired changes and transformations.

The question posed by the Commission on the Future of Health Care in Canada is an important one because it relates directly to our ability to impact upon the progression and organization of the health care system. More specifically, it enables us to address the factors that are conducive to the production, distribution and institutionalization of change in this system. This more general question is complemented by three specific questions concerning i) the appropriateness of the procedures used to monitor health care and services, ii) the system's ability to manage the integration of health care and services, and iii) developing the ability to change. These specific questions will be addressed throughout this document and the importance they are given will vary depending on the section.

In this study, we concentrate primarily on the organizational and inter-organizational dynamics that can foster change to varying degrees. To this end, we first identify the problem of organization in the health care system, and put forward a concept of governance aimed at a clearer understanding of the relationship between directing policies and organizations and the ability to change. Next, we discuss three cases we feel are illustrative of the relationship between governance and change. The first discusses significant structural change in a health care system linked to the implementation of regional governance. The second involves experimentation as a strategy for producing change, using the example of the Health Transition Fund (HTF). The third presents an entrepreneurial method of producing change, focusing on organizational leadership. These three change strategies open up a debate on the relevance of forms of governance, the revitalization of change and the role of management in producing change.

I – Change and Governance

For the purposes of this study, change is defined as the modification of a system of values – of agents' perceptions of a situation, structures or practices in a given organizational field. Governance relates to the systems and practices that allow agents to develop a plausible perception of their future, to design and implement effective change strategies, and to rely on values that create trust and solidarity (Hatchuel, 2000; Aggeri and Hatchuel, 1999; Callon, Lascoumes and Barthes, 2001; Chevalier, 1996; Lascoumes, 1996). Saltman and Ferroussier-Davis (2000) suggest that the legitimacy of governance will be even greater if it relies on a strong appreciation of collective responsibility.

The theme of organizational change is the subject of numerous works (Brock, Powell and Hinings, 1999a,b; Powell, Brock and Hinings, 1999; Hinings and Greenwood, 1988; Greenwood and Hinings, 1996; Pettigrew, Ferlie and McKee, 1992; Kitchener, 1999). Change goes hand in hand with the uncertainty in clinical and administrative practices and in agents' behaviour. The problem of change is a central dilemma for reform, among others because of the multiplicity and complexity of the relationships between principals and agents (Elsenhardt, 1985) and the difficulty in establishing appropriate mandates for organizations and professionals (Denis and Valette, 2000). Furthermore, it is important to note that the process of change is not separate from the social and organizational contexts in which it takes place. Evaluations of health policies and programs have provided many examples of the impact of the organizational context on the outcome and effectiveness of interventions (Scheirer, 1981, 1987; Giacomini et al., 1996). A number of sociology studies (Perrow and Guillén, 1990; Meyer and Zucker, 1989) rely on the concept of "organizational failure" to account for the difficulty that many organizations have in adapting to their environment. Thus, the concept of change relates to our collective ability to implement the new policies and programs necessary for a sustainable development of the health care system.

The concept of change is in itself quite imprecise. For example, basing themselves on the makers on the work of Miller and Friesen (1984), and Tushman and Romanelli (1985), Greenwood and Hinings (1996) propose a distinction between convergent and radical change on the one hand, and evolutionary and progressive change on the other. These distinctions are important for the purposes of our study. Radical change means changing the direction of organizations and of the health care system. It disturbs both the organizational structure and the agents' perceptions of their roles, practices and fields of activity. Convergent change consists in making adjustments within existing structures and perceptions. It is more akin to a social reproduction process (Bourdieu, 1980, 1992; Giddens, 1984). This distinction leads to a fundamental question for future health care: Should radical changes be implemented or should we rely on convergent change in order to ensure sustainable development? The distinction between progressive change and revolutionary change relates to the speed at which change is implemented. Do we need to act quickly or should change be introduced gradually in order to ensure sustainable development? Authoritarian or coercive (top-down) strategies or participative strategies can be used in order to promote change. Analysis of the three cases reveals a change process that varies in terms of the nature of the change, the rate of change and the degree to which it is hierarchical or authoritarian in nature (Minzberg, Ahlstrand and Lampel, 1999). We suggest that a realistic change project for health care organizations and for the health care system

would focus on radical changes proceeding in a progressive manner, by relying on strong, emergent dynamics. Quite simply, our initial hypothesis is that the considerable and recurring effort aimed at reforming health care systems in various OECD countries (Saltman and Figueras, 1997; Drache and Sullivan, 1999) are indicative of dissatisfaction with the changes that have actually been achieved. Bureaucratic or political reform projects that seek to introduce rapid change to the entire health care system result in major upheavals, without necessarily effecting any in-depth change in practices and procedures (Ferlie and Fitzgerald, forthcoming). Thus, it seems important to consider alternate ways of effecting change that focus more on incentives and learning.

Several works in the field of political science seek to define the structural conditions that govern the evolution of national health care systems (Tuohy, 1999; Ruggie, 1999). These give a good description of the evolutionary and convergent nature of change over long periods of time and they provide valuable information about the bases of current organizational methods. Our approach involves a shorter time frame and seeks to identify resources and processes to effect change in a deliberate manner, in order to limit the problems associated with the operation and legitimacy of the health care system. Thus, our study concerns the efforts directed at transforming Canada's health care system. These have had to deal with a double imperative: to renew or adapt the provision of health care, while at the same time controlling costs more effectively. There is a constant tension between these two objectives and there is no simplistic solution to resolve this dilemma easily. In addition, we have decided not to specifically analyze changes to the health care system that could have resulted from challenging the very logic of this system. If we were to address health determinants or population health, this could significantly alter our perception of health care and, consequently, our perception of the role and operations of the health care system (Hayes and Dunn, 1998; Evans, Barer and Marmor, 1994).

To meet the need to regulate organizations and the health care system, governance relates to the organizational design of the health care system and the sharing of responsibilities and activities among its various entities, the production and information distribution systems and mechanisms, and the modes of financing organizations and professionals (Contandriopoulos, Denis, Touati and Rodriguez, 2001). In order for governance to be effective, it must also address the consistency of decisions made and actions taken at the clinical, organizational and general policy levels. The way in which health care systems will structure governance is a social and political issue in itself. For some, governance is, first and foremost, a matter of democratization of political and administrative structures (Bickerton, 1999; Bohman, 1996). It is an instrument for acting on the distribution of influence in a given system and for producing radical change. In addition, governance clearly poses the problem of managing uncertainty. Exercising governance means getting involved and new relationships between agents in order to determine appropriate action and ensure the viability and legitimacy of the system (Callon, Lascoumes and Barthes, 2001). In this respect, democratic government includes a dimension of learning, as it makes it possible to generate new political options for a given social system for which one cannot assume that any agent possesses all the resources and expertise required to design and implement solutions to collective problems (Hatchuel, 2000; Lascoumes, 1996; Alter and Hage, 1993; Bryson and Crosby, 1993). These considerations cast the role of governance in terms of strategies that lead to change to the health care system on a functional level, and in terms of acting on the understanding that social agents have of the conditions for legitimacy of this

system (Bickerton, 1999; Hatchuel, 2000; Callon, Lascoumes and Barthes, 2001). To renew governance, that is, the ability of health care organizations and systems to assess, induce and direct change, several strategies or levers can be used: incentives, influence, regulation, formal authority including structural change, and moral commitment (Valette, Contandriopoulos and Denis, 2000; Contandriopoulos, Fournier, Denis and Alweiler, 1999; Hood, 1983; Ferlie et al., 1996). Our analysis concerns three variable strategies to revitalize governance: i) regional governance, which consists in structural modifications of the health care system in order to bring some of the regulatory processes and mechanisms toward a new area; ii) experimentation, which relies primarily on incentives and commitment; iii) leadership, which uses influence, vision and formal authority to produce change.

II – Establishment of Regional Governance and the Ability to Change

By creating new organizations, regionalization policies seek to establish enhanced strategic capacities at the intermediate level of the health care system (Denis and Valette, 1997). Establishing regional governance involves both centralization and decentralization (Lemieux, 1999). The central government delegates some of its decision-making and action powers to regions. Local communities or health care institutions also delegate part of their decision-making and action powers to regional authorities. Some view regionalization as having the potential to perform various functions more effectively, including resource allocation, services planning, and facilitating public participation in governance (Smith, 1979; Rondinelli, 1981).

In Canada, regionalization has been a major form of experiment in health policy. Nine of the ten provinces have adopted a regionalization policy thus relying on the potential of this structural change to bring about reform (Bickerton, 1999; Church and Barker, 1998; Mahtre and Deber, 1992). Various initiatives along this policy focus on radically different conceptions of the merits of regionalization. For some (Church and Barker, 1998), regionalization has not yet proven itself in terms of co-ordination and integration of health care and services. For them, regionalization is a rational instrument for achieving the objectives of efficiency and effectiveness in service delivery. For others (Bickerton, 1999; Mahtre and Deber, 1992), regionalization has not brought about the greater democratization of administrative structures and service systems expected. According to the latter, regionalization is an instrument for government renewal, which makes it possible to avoid exchanging a traditional bureaucratic government for a competitive one likely to relinquish its responsibilities for social policy (Bickerton, 1999; Trottier et al., 1999). These analyses offered an overall assessment of regionalization policies, showing that the latter pursued objectives difficult to reconcile with each other, and that the various Canadian provinces adopted diverse organizational arrangements to establish regionalization (Denis et al., 1998). These more macroscopic analyses suggest that regionalization has had imperfect results in producing change; although it may have made it possible to initiate reform and to provide an avenue for action in complementarily with central governments.

Other works (Lomas, Veenstra and Woods, 1997a,b,c; Lomas, 1997; Lewis et al., 2001) address the attitudes, motivations and perceptions of board members of regional authorities. These studies provide a portrait of regionalization in some Canadian provinces from the perspective of regional stakeholders. They demonstrate that board members take their mandate very seriously and devote a considerable amount of their time to it, that they are middle-class and have had previous experience as board members. Board members recognize that they defend particular geographical or group interests. They feel less equipped technically in terms of needs analysis and planning; however, they are well informed about the processes and rules of deliberation. They feel they are better informed about costs and service utilization than about service benefits, citizens' preferences and the opinions of key players in the community. These results suggest that regional boards are more likely to respond to the wishes of the central government than to local preferences. Although they acknowledge that they do not have all the information they deem useful for decision-making purposes, they believe that, on the whole, they are still able to make good decisions and support reform projects. In addition, these references

demonstrate a lack of consensus on the central government's role in terms of support for or obstacles to local reform. Most respondents believe that they are held accountable for elements that are not entirely within their control, and that the central government's rules are too constraining.

In general, these empirical works on the viewpoints of agents of regional governance suggest that regionalization policies have produced some changes. They have made it possible for regional agents to participate in boards, to become involved in reform projects and to actively manage a health care policy rather than a health policy.

Regionalization as a Lever to Produce Structural Change

Based on empirical studies conducted in different regions of Quebec and France (Denis, Langley and Contandriopoulos, 1995; Denis et al., 1998; Denis, Langley and Contandriopoulos, 1998; Denis, Contandriopoulos, Langley, Valette and Rodriguez, 1999; Denis and Valette, 1997, 2000; Denis et al., 2001), we analyzed the role of regional authorities in restructuring the provision of health care. These works reveal certain dynamics that link regional governance and change, namely the role of reformist ideologies and structural changes in reform.

In Quebec, regionalization found its legitimacy in part by evoking a specific reformist ideology (Rocher, 2001), that is population health. This trend also had a strong impact on the reformist position of several Canadian provinces (Hayes and Dunn, 1998; Mahtre and Deber, 1992; Davidson, 1999; Casebeer and Hannah, 2000). Such position, if translated in operational policies, may represent major changes for organizations and the health care system. It can lead to substantial change in the resource allocation scheme within a region, hence the distinction usually made between the preventive and curative sectors of service delivery, or to a focus on cross-sectoral policies and programs in areas such as access to income, housing or education. Within this perspective, the regional authority effects change by relying on a stronger health care policy that focuses on the efficiency and effectiveness of health care, and by assuming a more assertive advocacy role toward other authorities for pro-health actions (Evans, Barer, Marmor, 1994). At first glance, Quebec regional authorities took strong action to restructure health care provision and, through their public health management, they played an advocacy role.

In concrete terms, the strengthening of regional governance in Quebec in the 1990s led primarily to tight control over resources allocated to health care as well as a reallocation in the areas of social services, prevention and out-of-hospital health care programs. In other words, regionalization coupled with a strong policy to control central government expenditures made it possible to limit the development of in-hospital health care delivery. By way of illustration, between 1995 and 1998, the Montreal area experienced a 16% decrease in hospital budgets and a 25% decrease in the number of hospital beds (Observatoire sur la transformation des organisations de santé: www.santemontreal.qc.ca). In addition, the 1990s were marked by a number of institutional mergers or consolidations, which significantly changed the autonomy of these organizations and the structural landscape of the entire health care system. There is no need to outline all of these changes here. Among other considerations, these structural changes sought to augment the use of outpatient practices, including day surgery, and to curb the imbalance

between the provision of hospital care and community care. Some of these changes are in line with trends in the health care systems of other industrialized countries, while demonstrating the ability of regional authorities to induce structural change and, as such, to promote change in hospital practices (Denis, Langley and Contandriopoulos, 1995).

Overall, in spite of a reformist ideology in Quebec focused on “population health,” regional authorities have been a special instrument of structural change at a time of significant resource constraints (Lomas, 2001). They likely helped to speed up certain trends in the evolution of hospital care provision, such as the development of outpatient health care services. In addition, outside large urban areas, they promoted a territorial health care framework on a smaller scale by merging health care institutions serving small areas. Such changes lead to two observations about the regional government's ability to produce change.

First, regional health authorities took strong action in order to restructure health care delivery without necessarily being able to promote or effect change in the practices associated with health care and services co-ordination between collaborating institutions (Leatt, Pink and Guerriere, 2000; Denis, Lamothe, Langley and Valette, 1999). In order for regional governance to be effective, it is important that the various levers, including the compensation of medical resources and the funding of medical practices, come under the regional authority (Contandriopoulos, Denis, Lamarche and Touati, 2002; Contandriopoulos, Denis, Touati and Rodriguez, 2001). Some provinces have chosen to integrate health care institutions under the regional authority, and thus to abolish independent boards. To our knowledge, there are few, if any, studies that address systematically the potential of this integration measure while making it possible to compare its benefits and limitations with a regionalization model where institutions preserve their autonomy. Logically, it would seem that an integration such as this would promote the co-ordination of health care and services, yet adversely affect the identity of organizations and the motivation of professional and managerial teams (Denis, Lamothe, Langley and Valette, 1999).

Second, the province of Ontario, without having established regional governance, was also able to strongly intervene in health care structures (see the HSRC report, March 2000). There are therefore several governance options to bring about structural change. However, it is important to remember that, in Quebec at least, such actions directed at health care institutions had previously been impossible. The restructuring limitations of adapting the provision of health care suggest that there can be significant change without necessarily transforming the relationships between organizations and professional groups in order to co-ordinate health care and services more effectively.

Regionalization as a Democratization Tool

As we mentioned at the outset, for many, the issue of governance is essentially a problem of citizen participation in the conduct of public affairs. According to this view, the desired change will enhance citizen participation in governance. In a previous study, we addressed the question of the role of public consultation in the decision-making process for difficult decisions such as closing public hospitals (Denis, Langley and Contandriopoulos, 1995, 1998, 2000). This study of a decision-making process in a large metropolitan area revealed that the regional authority

supported public consultation within a rigorous technocratic framework. The consultation process was well-planned and used for purposes of information (Forest et al., 2000) as well as persuasion, while leaving the regional authority open to demands from various segments of the community. Public decision-making was a way of demonstrating the merits of the policy advanced by the regional authority and of limiting the pressure that different groups could exert directly on the decision-making process. We also observed at that time that a crucial component of a regional authority's ability to handle external pressure was the unwavering solidarity of its management team and board. Thus, in this case, social technology associated with democratic governance, that is public consultation, coexisted with a competent and cohesive technocratic and administrative apparatus.

That observation led to the suggestion that regional governance is definitely a hybrid mode of action seeking to combine the advantages of democratic participation, managerial control and political negotiation with influential groups in order to have a legitimate impact on the provision of health care (Denis, 1999; Denis, Contandriopoulos, Langley and Valette, 1999; Denis and Valette, 1997). When the regional authority has no power of taxation, the central government's directions and desires largely control its governance capacity. In addition, the regional authority sometimes requires the co-operation of institutions to bring about change, while minimizing the negative impact of certain constraints on the availability and accessibility of health care services. This is where political negotiations with institutions present on its territory come into play. Among other considerations, public participation could be used to anchor the regional authority in a local political culture in order to establish its legitimacy and possibly reduce its dependence on the central government. This proposal is consistent with the analyses of Bickerton (1999), who views regionalization as a means of renewing government, and who refers to a realistic conception of public participation in health care systems (Contandriopoulos, Denis and Langley, 2001).

Regional Governance and Change

Does regional governance promote or permit significant changes in citizens' relationships with the government and its administrative apparatus and in the provision of health care?

The potential of regional governance cannot be assessed without considering a central government's initiatives and capacity for action. In Quebec's case, decisions made by the central government, such as the early retirement of health care professionals including nurses, adversely affected the freedom of regional authorities to bring about change. The tensions created by such decisions in organizations' operations and the potential patient dissatisfaction with service availability and accessibility have dealt a severe blow to the legitimacy of reform. In fact, one basic problem of governance and change is maintaining the legitimacy of regional reorganization projects when decisions from higher administrative or political levels threaten coherence and the resources allocated to these projects. In addition, the evolution of regionalization in Quebec demonstrates quite clearly that regional action in the health sector has become more fragile and less legitimate in the eyes of the central government (Turgeon, CJYR, 2001). This trend is also evident in other provinces (Lomas, 2001). The Quebec example shows that ensuring the political conditions that make it possible to renew lasting governance is a fundamental problem in change

management. Once again, we do not think there are simple solutions to ensure sufficient political support for regionalization and decentralization policies.

In general, the relationship between regional governance and change can be expressed as follows. Establishing strategic abilities at the regional level made it possible for the health care system to come through difficult times and bring about significant restructuring. Health care organizations and professionals have been severely affected by these change processes, which have been rapid, rather than progressive. These structural changes are probably convergent in the sense that they can strongly threaten the existing equilibrium without significantly reconstituting the provision of health care, including the co-ordination of health care and associated services. The approach used to bring about these changes was authoritarian or hierarchical in several cases, because regional authorities had to quickly impose strong constraints on health care organizations. Regional governance was built, according to the circumstances, with or without the presence of independent institutions and was exercised within the context of maintaining considerable independence for the medical profession.

This analysis of the relationship between regional governance and change leads us to make recommendations that convey a particular vision of organizational change. Following a significant phase of structural change, regional governance must move toward a supportive and catalytic role in terms of the dynamics that bring about changes in practice, enhanced co-operation between agents and organizations, and consequently, more effective integration of health care and services. In order for such changes to take place, regional governance must have strong and lasting legitimacy in the health care system, and it must approach structural change as the next stage after the adoption and understanding, by agents, of an ideology that promotes the integration of health care and services.

Proposal 1: To produce transformation, regional governance needs to target organizational and professional practices.

Proposal 2: To produce transformation, regional governance, in addition to carrying out its responsibilities relating to control, needs to play a supportive and catalytic role with regard to the organizations within its territory.

Proposal 3: To produce transformation, regional governance needs to rely on a combination of strategies in order to revitalize and channel change, including incentives, training, political negotiation and structural modifications.

Proposal 4: To produce transformation, regional governance projects need to receive consistent and sufficient support on the part of the central government.

Proposal 5: To produce transformation, regional governance needs to gain control of various levers that enable it to promote the integration of health care and services in the community. These include the remuneration of medical personnel, closer co-operation with highly specialized health care facilities and methods of funding that promote institutional co-operation.

Proposal 6: To enhance its ability to effect change, regional governance needs to stimulate local, public participation so that change projects can realize their full potential and be sustained as needed without exhausting human resources in the health care system.

III – Experimentation as a Mode of Producing Change in the Health Care System

This section deals with a particular mode of producing change, experimentation through funding pilot projects in the health care system. Experimentation has long been viewed as a special learning mode in complex social systems (Campbell, 1969). In order to discuss the relationship between experimentation and change, we will mainly use the results of a cross-section analysis of HTF projects carried out in Quebec (n = 40 projects, Desbiens, Dagenais, Joubert et al., 2001; Denis, 2001; Denis, Lamothe and Langley, 2000, 2001a) and the results of studies of specific projects (Touati et al., 2001; Béland et al., 2001a,b; Lamarche et al., 2001a,b). This is not an in-depth look at the HTF experience in its entirety, but rather some observations on the relationship between experimentation and the production of change in health care systems. Here, we are interested in a situation quite different from the one analyzed previously; we are not dealing with projects that create new structures and forms of governance, but rather with projects that seek to produce local change by maintaining a relative consistency in the current boundaries and rules of the health care system. Thus, the analysis of the HTF program makes it possible to assess the potential of convergent and progressive changes in transforming health care provision. These changes can, through a domino effect, produce more substantial change in the long term in the organization and operation of the health care system. However, as we shall see, local initiatives very often require transformations on other levels in order to promote lasting, substantial change. Some of the interest in these projects lies in the frequent involvement of health care professionals or providers in more subtle dynamics of change compared to major reform led by policy, central governments and public bureaucracy (Ferlie and Fitzgerald, forthcoming; Brunsson, Andersson and Sahlin, 2000).

In this section, we begin by briefly presenting the context and diversity of HTF projects in Quebec. Then, we discuss the transformation potential of practices and organizations associated with these projects, ending with a discussion of the resources and factors that are conducive to producing change in the health care system and the role of experimentation in these processes.

Presentation of the HTF Experience

HTF projects took place within a specific economic and political context. They represent a special approach adopted by the federal government in Canada in recent years to finance targeted programs in a context where its financial involvement in the health care system has decreased. In addition, provincial health care systems and organizations that received funding during this experiment were at a relatively low ebb when the HTF program began in 1997. Thus, change represents an enormous challenge. Two important questions underlie the HTF program: i) How to ensure that the resources allocated to innovative projects are not redirected into the standard elements of the system and, in particular, not used to fill the gaps caused by periods of fiscal austerity? ii) How to ensure that human resources, under great pressure to deliver health care and services, become involved in innovative approaches? Finally, assessment processes associated with all HTF projects allow us to draw conclusions about the relationship between the production of knowledge and the production of change.

Most of the projects (31/40) financed by the HTF in Quebec involved the integration of health care in order to enhance the efficiency or quality of services provided. A number of others (17/40) involved the introduction of technological tools such as new information systems or clinical practices guidelines. In addition, the projects also differed in their choice of intervention targets seen as priorities. These involved such things as a specific clientele (e.g. the frail elderly, or monitoring persons with a specific disease, or the organization of health care and services for a community or territory with mixed clienteles and pathologies (Desbiens, Dagenais, Joubert and al., 2001). These different project types highlight some essential facets of change in health care systems. They demonstrate that there is considerable interdependence in effecting change in health care systems. In fact, it is difficult to limit change to one specific field – to clinical practices, for example – without having to make changes at some time or another to governance, including resource allocation and economic incentive (Contandriopoulos, Denis, Touati and Rodriguez, 2001; Contandriopoulos, Denis, Lamarche and Touati, 2002). This empirical observation is consistent with the idea that organizational change is an overall process requiring new alignment between agents' values and interests and organizational design in the broad sense of the word (Greenwood and Hinings, 1996; Minzberg, Ahlstrand and Lampel, 1998, 1999).

Different Experimentation Modes to Produce Change

Returning to experimentation as a technique to effect change in the health care system, HTF projects in Quebec gave rise to three distinct experimental approaches: i) prototype grafting, ii) introducing new interventions with no direct patient impact, and iii) renewing current practices and procedures. Here, we discuss change processes associated with prototype grafting and with renewing current practices. The experimentation mode that involves introducing new technologies or interventions for professionals will be discussed in more detail below in the section analysing internal change processes in health care organizations.

Prototype experimentation (e.g. the SIPA project) consists in grafting a new service delivery model onto the usual operation of the health care system (Béland et al., 2001a,b). Prototype experimentation is appealing because it seems to offer a more controlled vision of change. Prototype experimentation encourages stakeholders to invest considerable energy into project implementation. With this mode, it may seem easier to intervene in favour of change during the experimentation. However, prototype experimentation raises certain challenges. The prototype itself represents an alternative to usual organizational modes and health care and service delivery modes. Thus, revisiting the model at the end of the experimentation clearly raises the question of the capacity for replacing the usual organizational or intervention modes by the prototype – replacing the usual home care model by a SIPA-type model. Implementing a prototype during experimentation may also be incomplete. Several HTF projects involved testing a capitation financing formula without being too localized. It also raises the issue of harmonizing a health care and services model that is developed for a specific clientele with the health care system as a whole. Several pilot projects represent just one specific component of the more integrated health care models (Denis and Lamothe, 2001).

As an example of prototype experimentation, the SIPA project clearly illustrates the interdependence involved in effecting change. It demonstrates that a planned and conscious approach to change under the responsibility of committed professionals can produce practice-related changes during experimentation. Furthermore, in order for it to continue and remain consolidated, local change must be based on systemic changes. Thus, there are major uncertainties as to the capacity of organizations and local agents to institutionalize significant changes. To act toward change, it seems useful to consider the complementarity of the participative and emergent local modes of change using a more directive and centralized approach with the potential to modify some health care system rules and enhance the system's ability to adopt innovations.

Unlike prototypes, other experimental projects push change toward resources and current health care system structures. These projects may be based on an injunction from a governing authority, for instance to seek alternatives to institutional mergers in order to attain the objectives of resource downsizing and enhanced coordination of health care and services (Lamarche et al., 2001a); on perceived threats in the community such as the possible closure of a small hospital (Touati et al., 2001); or on a strong conviction on the part of local stakeholders that it is possible to do more with the resources at hand. It involves a change that is, by nature, locally entrenched – and has been for a long time – and has strong emergent dimensions. It appears less planned than the prototype experimentation and seems more like a resourceful do-it-yourself experimentation. Several lessons may be drawn from the dynamics associated with this type of experimentation (Lamarche et al., 2001a,b; Denis, Lamothe and Langley, 2000; 2001a). Various initiatives may be launched to produce change; however, structural change seems to have limited potential. In fact, in order for structural changes to produce pay-offs in terms of health care and services coordination, they must be in synergy with the existing dynamics of cooperation among stakeholders. Approaches to structural change have a greater chance of being productive if they complement emergent changes already in place. Moreover, the changes that benefit patients are changes to professional practice – the way professionals provide health care and services. This is also one of the strong points in experimenting with new prototypes of health care and services delivery. In addition, in order for the dynamics between agents to converge, including co-operation among doctors, organizations and other professionals, incentives must become the focus of change. In this respect, change cannot be strictly structural or voluntarist, it must rely on a synergy between these two factors and the incentives (Denis, Lamothe, Langley and Valette, 1999). As well, promoter involvement in the various projects facilitated consolidation of one vision of changes to be made, and lent legitimacy to developing and setting up implementation strategies. We will revisit this question in section III dealing with organizational leadership.

A plausible strategy for managing change is being developed in the health care system and organizations using these two modes of experimentation (prototype and do-it-yourself). HTF projects have led to changes that are closer to an emergent mode, that is a mode that distances itself from bureaucratic downsizing which gave precedence to the structural change mode in the health care system (Denis, Lamothe and Langley, 2000). They clearly show the importance of not approaching change strictly as a *top-down* process, but instead relying on the emergent (*bottom-up*) dynamics created by professionals working closely with service and care delivery (see, for example, the Umbrella Project in Alberta). This more flexible approach to change, combined with the need to assess innovative projects, may provide considerable new

knowledge and the emergence of new alliances between practicing and academic circles (Denis, Lamothe and Langley, 2001a). It is also consistent with an adaptive perspective of organizational design that is more in line with the imperatives of professional production and knowledge-based management of organizations (Alvesson, 2001; Anderson and McDaniel, 2000; Empson, 2001a,b; Lowendhal, Revang and Fosstenlokken, 2001; Lamothe, 1996). However, the question of the dissemination and durability of local change remains unanswered.

Capacity to Institutionalize Change

Three dilemmas limit the potential for change associated with experimentation in the health care system (Denis, Lamothe and Langley, 2001a). The first dilemma concerns the very nature of the organizational models or structures arising out of experimentation. Several projects aim to enhance coordination between organizations and must constantly adapt to an essentially vertical structure in the health care system. The second dilemma lies in the conditions for committing the stakeholders to the experiment. In several projects, uncertainty as to the continuity of an experiment, which is a fundamental characteristic of this mode of production change, undermines the commitment and may adversely affect the conversion of experimentation resources into permanent transformations to organizational modes in health care and practices. A third dilemma deals with the issue of the fragmented health care system, raised by numerous health care commissions in various Canadian provinces (Fyke, Clair, etc.). The HTF program gave rise to multiple experiments that are difficult to understand and integrate into an overall policy for the health care system. Therefore, experimentation requires the structuring and controlled use of the emergent local phases, and the more centralized and generalized change phases in the health care system. This culture of experimentation must be both strengthened and maintained, while envisioning it as a special objective of governance in the health care system. To be more precise, strategies must be developed to enable an ongoing, effective interaction between governance, which is responsible for ruling on the relevance, sustainability and funding of experiments, and promising local initiatives, without unnecessarily restricting their possible development. Courses of action are being developed in order to renew the roles of regional governance, studied in the previous section on, among other things, the relationship between knowledge production and knowledge use, the training of agents for change, and the decision-making process in experimental programs.

Resources for Change

It is possible to define all the resources for change from an analysis of the HTF projects (Denis, Lamothe and Langley, 2001a; Denis, 2001). The HTF experience shows the importance of bringing together operators, professionals and others staff to develop change projects. Physician co-operation is essential, yet difficult to achieve in many projects. For the most part, HTF projects involve a decentralized mode of change production, which has certainly been instrumental in introducing diversity into a system that is rather focussed on uniformity. HTF projects have very often focussed on the emergence of flexible structures, such as coordinating or consultative committees that can promote change when they have access to the necessary resources. These flexible structures are obviously much less disruptive for the agents than more rigid structural changes. Moreover, they are more effective in an experimentation context, which

makes it easier to monitor certain resources through such structures. The HTF experience likely teaches us very little about the effectiveness of these flexible structures in the usual context in which such structures have to mobilize resources under institutions' control. In addition, the HTF projects are rather clear evidence that agents need resources and time in order to develop changes to professional practices. Change is also fostered through the presence of promoters or leaders who have a vision of the transformations to be effected. This vision is akin to a reformist ideology but one whose outlines are locally defined and thereby enable agents to identify with the change project. These resources can make it possible to get the most of the experiment.

The Complexity of Projects and the Potential for Transformation

Therefore, HTF projects have represented an extremely varied program in terms of change management. In the health field, and to consider the interdependence in change production, we defined three areas where change must come about: i) the clinical system, which includes the way of providing health care and the relations between professionals; ii) the administrative system, which includes the terms and conditions for funding the management system and the information system; and iii) the collective system of representations and values (Contandriopoulos, Denis, Touati and Rodriguez, 2001). An experimentation project will be all the more complex as it expressly seeks to make changes to the three areas listed. In light of the analysis of the HTF experience, it appears to be difficult to make any significant change in one area without disrupting the others. An analysis of the HTF experience also allows to form a hypothesis about the relationship between the complexity of a project and change production. Projects dealing with the clinical and administrative aspects, with the values and relationships between the local and the overall operation of the health care system, are eminently more complex than those limited to a localized clinical dimension. A simple project, such as an education program for asthma patients, will produce predictable changes but will probably be a source of only rather moderate transformation of the health care system. Conversely, a complex project that seeks to make changes in the different areas that we have just described, such as the restructuring of health care and services of an entire rural territory, will have a high potential to transform the health care system but may run into a number of difficulties in fulfilling this potential.

These statements clearly show the importance of incorporating change projects in the long term since that is when the most significant transformations may come about. Including change on a time horizon is appropriate in that arguments may be made about the ability to produce more radical changes in a progressive manner. To date, the health field has provided several examples of the difficulties involved in producing radical change at the administrative level and in terms of relations between professions. Established support from a governing authority in favour of experimental projects could likely play an instrumental role in making radical and progressive change in the health care system a reality. This also begs the question of whether the governing authorities have the capacity to participate in the long term. From our perspective, when projects are as ambitious as we have just described and when they are based on strong professional dynamics, there is a potential for major transformation. One important target of managing change in the health care system is an enhanced ability to properly monitor local

initiatives and their relations with changes that must be produced at other levels of human and financial resources management.

This analysis of experimentation as a mode of change production leads us to make the following proposals:

Proposal 1: To produce transformation, it is important to promote local and emergent change.

Proposal 2: To produce transformation, it is important that strategies be developed to ensure the involvement of professionals and others in local change projects. Incentives appear to be essential in ensuring the commitment of independent professionals.

Proposal 3: To produce transformation, experimentation alone will not suffice; there must be reliance on the roles, resources and skills of central and regional governance authorities in order to promote, monitor, disseminate and institutionalize experimentation.

Proposal 4: To produce transformation, it is important for all governing authorities to develop “venture capital” type programs in partnership with health care organizations.

Proposal 5: To produce transformation, experimentation must rely heavily on the development of agents’ cognitive capacities. By cognitive capacities, we mean a capacity to visualize complex change processes. In this respect, the training of agents involved in change management and implementation appears to be an important aspect.

Proposal 6: To produce transformation, experimentation must be part of a cyclical process alternating between the emergence and planning phases of change management.

Proposal 7: To produce transformations, it is important to manage the coherence of the local project and its place within the systemic context.

IV – Leadership as a Strategy for Change

Organizational leadership represents an entrepreneurial mode of change production. In this section, we examine the factors that are conducive to the emergence of an organizational leadership that favours change.

Strategic Change and Leadership in Health Care Organizations

For over ten years now, we have followed change processes in health organizations, particularly in university hospitals (Denis, Langley and Cazale, 1996; Denis, Lamothe and Langley, 1999, 2001b; Denis, Langley and Pineault, 2000). Recent works (Brock, Powell and Hinings, 1999) suggest that professionals, including doctors, see the context of their practices undergoing transformations while managing to maintain a strong autonomy. Currently, the recruitment of medical workers and the mobility of this professional category suggest a growing autonomy of doctors vis-à-vis organizations. This raises the question of what organizational conditions are required for producing and controlling change in such a context.

Several studies shed light on the role of managers in steering organizations and implementing changes (Hambrick and Mason, 1984; Finkelstein and Hambrick, 1996). This work is often developed around a very individualistic and grandiose vision of organizational leadership. This perspective appears ill-suited to the workings of complex organizations marked by a fragmented authority structure. This led us to focus on the specific characteristics of leadership in these types of organizations. The concept of collective leadership highlights the importance of a multiplicity of agents in the development of change projects. It is based on the necessity of ensuring that the clinical and administrative areas are represented in leadership positions. Organizational leadership would be based on both the promotion of diversified skills and different sources of legitimacy. To harmonize these different resources for the exercise of leadership, the functional properties of a collective leadership can be defined as follows (Denis, Lamothe and Langley, 2001b). To enhance change abilities, collective leadership must be distinct, specialized and complementary. The differentiation of leading roles is related to an effective division of roles among the leaders of the organization. This differentiation could prevent unproductive rivalries among those individuals. There may also be a greater capacity for leadership if leaders have specialized and complementary roles, so that they may deal with all of the change issues.

Issues in the Development of a Collective Organizational Leadership

The collective leadership approach allows for an understanding of the role of change agents. There needs to be strong leadership for change to occur. However, the existing leadership may be a source of inertia; in such situations, it must be reconstructed and considered as a prime target for change. Three factors threaten the stability and effectiveness of a collective leadership: i) rivalry between leaders to dominate organizational processes; ii) the separation of the leaders' strategic project from the organizational base; and iii) the weakness of the change project in relation to environmental requirements. These factors can prevent an organization from building enough leadership skills to manage significant changes.

Specific organizational processes lie behind these three factors that threaten the practice of a collective leadership. Rivalry between leaders may be linked to structural factors such as the scarcity of opportunities or the identification of leaders with different segments of the organization. The separation of the leaders' project from the organizational base may depend on the inability to mobilize professionals in collective leadership development. Lastly, the significance of power struggles and divergent opinions on the future of an organization may push leaders to make significant compromises with respect to the scope of a change project. These compromises may jeopardize the consistency of the organizational strategy with environmental trends. The importance of the vision in managing change processes (Kotter, 1995) takes on its full meaning insofar as it can prevent change projects from drifting too far off track.

Change Management and Organizational Leadership

Acknowledging the importance of leadership in health care organizations has several consequences for change management. It shows how the reconstruction of management teams in organizations is closely linked to the ability to produce change. An empirical analysis of the processes of merging teaching hospitals also suggests that any major change is accompanied by destabilization of relations between the different components of the organization, in this case between administrative agents and professional or clinical agents. We need to know more about the mechanisms that are conducive to generating or maintaining trust between these key agents of the organization. Effective co-optation of leaders from the professional sphere can help to build trust. Moreover, the social and organizational dynamics surrounding the deployment of a collective leadership cannot produce change by themselves. If change projects are significant enough, they will have varying impacts on agents and groups of agents. Ideally, these impacts will maximize benefits for the greatest number of agents in an organization and in their environment. These benefits, already mentioned in the HTF analysis, can be in the realm of learning and autonomy in the completion of new models of health care organizations and practices. However, it is also clear that the benefits arising from the introduction and implementation of major changes will not be the same for all groups and agents (Miller, Greenwood and Hinings, 1999). Collective leadership in favour of change – as consolidated as it may be – must be able to rely on incentives that are consistent with the desired changes.

Therefore, it appears that change management is a complex process within organizations, and it becomes more complex when it involves several organizations that are distinct yet required to cooperate more closely. The dimensions of a functional collective leadership and the mechanisms likely to foster the coexistence of multiple identities in one single organizational project will be more difficult to produce in inter-organizational spaces (Denis, Lamothe and Langley, 2001b). The co-opting of professionals is central but must be promoted through effective incentive systems. Management tools such as quality strategies and performance indicators may also help to channel the behaviour of autonomous agents towards change (Berry, 1983; Oakes, Towney and Cooper, 1998). However, so that these approaches may bring about change, they must be supported and guided by a strong organizational leadership.

The dynamics of leadership in favour of change lead us to make the following proposals:

Proposal 1: To produce transformation, it is important to achieve solid cooperation between agents in the clinical field and in the administrative field in steering change.

Proposal 2: To produce transformation, it is important to develop a collective vision of organizational leadership.

Proposal 3: To produce transformation, the agents in a leadership position share the leader roles effectively and accept changes to those roles over time.

Proposal 4: To produce transformation, leaders must pay special attention to communication and to the validation of change projects with the organizational base. This validation includes an inventory of costs of change for the various agents and groups of agents.

Proposal 5: To produce transformation, leaders must be in a position to strike a balance between the agents' preferences within an organization and outside pressures for change.

Conclusion

In this study, we have analyzed different basic processes for building capacities for change in health care systems and organizations. We quickly realized the interdependence of governance and change capacities. Change of a local, voluntarist and emergent nature is not sufficient in the health care system. If this were the case, there would be no operational problems in the current health care system, nor any shortcomings in the renewal of practices. Throughout this study, we have worked on the assumption that a radical change should come about progressively through the standardization of policies and of initiatives at the macroscopic level of government, as well as at the organizational and clinical levels in the health care system. Convergent change comes about through fine-tuning and does not significantly modify agents' perceptions of their areas of activity, current modes of operation and practice, and the degree of cooperation and coordination between the different components of the health care system. Radical change affects all of these elements so as to significantly alter practices, organizational forms and the interpretation by agents of critical issues for the sustainable development of the system. The recent evolution of the health care system and organizations has converged towards a need for radical change. The problem associated with the integration of health care and services is a good indicator of the importance of implementing such changes. Moreover, recent experience with health care reforms demonstrate the need for wisdom in the speed of implementation of change. The health care system in Quebec shows that it is possible, in a short time, to make major structural changes and, in so doing, to destabilize the health care system and organizations. Such upheaval did not facilitate the implementation of radical changes to the fundamental operating logic of the system. It is through these observations that the idea of a progressive radical change appears to produce results. By favouring such an approach to change, the role of governance gains importance.

To bring about transformation, governance must take its supporting, expert and incentive role seriously in emerging change projects in the health care system. An analysis of regional governance shows potential for significant intervention, but one that is geared toward promoting experimentation. An analysis of the HTF experience shows its limitation to a strictly local change production. The incentive of professionals and organizations and the development of human resources through change training should have preferential status in governance practices. A leadership analysis shows the need to develop an organizational elite able to assume the control of change and adapt their roles to the progressive character of that change. In all of the processes we have analyzed, the costs and benefits of change for human resources must be considered. In a professional context, these benefits can involve a key learning component. However, learning cannot take place if changes lead to excessive and seemingly disruptive upheavals in clinical work.

This leads us to make the following recommendations. These recommendations translate the results of our analysis into courses of action for the federal government. They are based on the assumption that the federal government is maintaining and will seek to maintain a role in the evolution of the health care system in Canada. They are also influenced by the notion that there must be diversity in a system so that it can renew itself. A support role for the federal government in the renewal of the health care system thus seems reasonable. The experience with the HTF program suggests that it is possible to promote experimentation; special attention should

however be paid to the sustainability of initiatives that appear to be promising. This likely compels greater synergy between the various governance levels in the health care system.

Recommendation 1

To help produce the transformation required in the health care system and organizations, the federal government must pay special attention to the need for consistency between the initiatives taken at the different levels of policy and administrative decision-making. This recommendation is based on the importance of the interlocking logic of change production in complex systems.

Recommendation 2

To help produce the transformation required in the health care system and organizations, the federal government needs to rely on human capital development, and invest resources in the training of agents for change. This recommendation is based on the critical role human capital plays in professional organizations, on the necessary autonomy of agents and on the importance for agents to develop favourable perceptions of the implementation of change.

Recommendation 3

To help produce the transformation required in the health care system and organizations, the federal government must invest in a decentralized risk capital program to promote experimentation with new organizational models and practices. This recommendation is based on the importance of making resources available so that agents can commit to change and of the role of local governance structures in revitalizing change. This risk capital program must be integrated with other governance structures instead of directly addressing the local level.

Recommendation 4

To help produce the transformation required in the health care system and organizations, the federal government needs to foster the emergence of inter-regional and inter-provincial spaces within which a collective leadership may be exercised in favour of change. This recommendation is based on the acknowledged limitations of local change and on the need to create new political spaces to resolve crucial issues related to the funding of organizations and professional practices and to the availability of human resources.

Recommendation 5

To help produce the transformation required in the health care system and organizations, the federal government needs to invest in a monitoring system to document, follow up and share information on innovative experiments. This recommendation is based on the importance of information and knowledge in influencing agents in favour of change.

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