LEAPFROGGING THE ELEPHANTS: MAKING HEALTH SYSTEM TRANSFORMATION HAPPEN FASTER

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Summary: The economic and social costs of failing to address noncommunicable diseases (NCDs), coupled with an inability to transform health systems fast enough, are increasingly acknowledged. There is a particular urgency about health system transformation in favour of health promotion and public health if significant costs are to be avoided. It will mean confronting powerful vested interests which pose barriers to obstruct change and finding ways of leapfrogging in order to make faster progress thereby avoiding the pitfalls some mature countries have experienced. But there are grounds for optimism with examples of leapfrogging from countries across Europe holding valuable lessons for others.

Keywords: NCDs, People-centred, Resilience, Health Systems, Transformation

Introduction

Despite noncommunicable diseases (NCDs) being the largest cause of mortality in the World Health Organization (WHO) European region and a priority for countries, change continues to be uneven and often piecemeal. There is an urgent need to make more rapid progress as health systems come under mounting pressure from preventable illnesses. People-centred and resilient health system responses to NCDs remain a cornerstone to universal health coverage within the context of the Sustainable Development Goals.

The economic and social costs of inaction related to NCDs are increasingly acknowledged and the failure to transform health systems so they become more oriented toward prevention and health promotion, even if politically inconvenient in some countries, will incur significant costs over time. This is especially so in middle income countries (MIC) where progress needs to be accelerated. To help meet the challenge, the notion of leapfrogging is of value.

Leapfrogging has been defined as a way for MICs to use innovation to accelerate development and achieve results equal to, or better than, those of older and more mature economies, and in less time. In respect of those newer economies faced with NCDs that threaten to bankrupt...
their health care systems, some observers insist that ‘there is a triple opportunity to follow a different path’. Three types of innovation are critical to successful leapfrogging: new disruptive technologies, new operating models, and new behaviour change initiatives. None of these were available to high income countries when they were first confronted with NCDs although leapfrogging is an option available to any country. Rich countries are actively adopting it in order to build integrated care systems designed to tackle the social determinants of health, and promote population health both for quality and efficiency reasons and because they believe the evidence supports such action.

Some of the changes resulting from leapfrogging are straightforward, others are harder to achieve and require a receptive context for change (see below) in order to drive change at a policy level. MICs, or emerging countries, can often invest in new solutions more easily as they have fewer sunk costs in expensive infrastructure, equipment and hospital buildings, and weaker vested interests defending the status quo or advancing their particular interests. But there is little to prevent any country from building, or adapting, a health system in order to confront NCDs, using leapfrogging to make rapid progress.

When taken together and reinforcing each other, these factors can guide and shape transformational change efforts. There needs to be some alignment among the factors because, if they push and pull in different directions, then preserving and sustaining successful change is put at risk. The framework has informed the health system transformation initiative led by the authors on behalf of the WHO Regional Office for Europe’s Division of Health Systems and Public Health. Following meetings of invited experts in Madrid, Spain in 2015 and Durham, UK in 2017, the aim is to support Member States engaged in transforming their health systems. Comprised of eight factors, five are pivotal:

**Factor 1: Environmental pressure**

Environmental pressure can come from various sources, including trends in NCD outcomes and their impact on the organisation of health services, changing competencies in the health workforce, financing strategies, drug policies and information technology solutions. Citizens themselves may also generate important environmental pressure for change. The public in most countries no longer accepts a passive role and rightly demands a greater voice in how health services are designed and delivered.

As the evidence shows, if environmental pressure is not conducive to the change efforts being implemented then it can be potentially disruptive. For example, financial crises can result in a range of reactions when it comes to transforming health systems, including delay and denial, collapse of morale, and the scapegoating and removal of managers. But financial crises need not be viewed only as a threat – they can also be seen as offering a ‘burning platform’ and an opportunity for radical reconfiguration and leapfrogging to enable change to

Looking ahead

A well aligned system is preferable to loose, disconnected structures and many countries, recognising this, are making good progress to overcome fragmentation despite political and other obstacles. Leapfrogging will also come from single payer health systems which are not only more cost-effective, but make the alignment of services easier to implement when tackling NCDs. Countries which are systematically adopting accepted best practice guidelines in health care and wellbeing, including no longer investing in interventions that do not add clinical value, offer another example of leapfrogging. Although we realise that there is no alternative to the ideal of aligned, comprehensive health system strengthening efforts, importantly, leapfrogging is possible and can be effective in accelerating change in selected policy areas or individual interventions only.
occur faster and at less cost. Digital health solutions and information sharing offer examples.

The political context, and impact of politics on shaping the environment governing large-scale change, is critical. Politics is a feature of all health systems and can determine whether and how far large-scale change succeeds or is resisted. This is especially so in respect of the so-called ‘elephants in the room’ which can seriously hinder progress. Two particular elephants are: the role of industry, and the overuse of medical services. In order to tackle these challenges, we require new forms of partnership and a rebalancing of the power structure so that governments and citizens set the agenda. There is a need for a regulatory framework based on transparency and joint accountability and risk sharing guiding traditional public-private partnerships, which are increasingly mistrusted and often deliver ‘white elephants’ in the form of expensive and unnecessary hospitals rather than what is required to improve health based on equal risk sharing and strong governance mechanisms. Instead, a new ecosystem built around people-centred primary health care that delivers health services across the life course approach and incorporates the essential public health operations, such as prevention, will reduce hospitalisation and pharmaceutical utilisations.[3] This is very timely given the 40th Anniversary of the Alma-Ata Declaration, 25–26 October 2018.[4]

The Framework Convention on Tobacco Control is an example of what can be achieved to strengthen public health by confronting one of the ‘elephants in the room’ – the tobacco industry – and is viewed as a model for similar frameworks in other policy areas. Slovenia is a good example where tobacco control is being supported by a powerful coalition made up of government, civil society, creative individuals, media, international organisations like the WHO and the general public.

An important factor in achieving change is the temporal challenge. Electoral cycles often militate against long-term change when quick results are wanted. If the 3.0 Transformation Framework health system, with its emphasis on health promotion and integrated care is to thrive, it will require supportive policies that incorporate longer-time horizons.[5] At the same time, and this is an advantage of leapfrogging, having an ‘expectation of success’ and some quick wins offer reassurance to policymakers, who may be under attack over their policies.[6] They also build resilience and ensure that policymakers remain confident that what they are doing is worth sharing and spreading. For example, since 2000 cancer networks in England have brought National Health Service organisations together to deliver high quality, integrated cancer services to their local populations. Leapfrogging can add value in health systems that are not controlled by powerful entrenched professional interests. Information solutions can also be a powerful game changer catalysing integration of health services and stratification of the population into risk groups for NCDs as Israel, Denmark and Estonia have been showing.

**Factor 3: Key people leading change**

Leadership is paramount in developing and implementing policy. But the deep changes necessary to accelerate progress against the most intractable problems arising from NCDs require a unique type of leader – ‘the system leader, a person who catalyses collective leadership’. They also require unprecedented collaboration among different organisations, sectors and professions. A review of system leadership identified a number of common themes, which we have adapted, as shown in Box 1.

Building teams with vision and commitment is a key element of system leadership. It requires a skill set comprised of ‘soft’ skills in alliance building, persuasion, influence and political astuteness which are often the hardest skills of all to acquire or apply. Developing such skills may be easier in health systems that are less cluttered by existing powerful professional groups that can block change.

With regard to the health workforce, meeting the demands from NCDs entails revisiting and redesigning professional roles to ensure a skill mix that is flexible and adaptable in the face of growing complexity. For example, in some countries the deployment of community pharmacists is being actively encouraged to provide a first point of contact in local communities and reduce pressure on general practitioners (GPs). In another initiative, primary care practitioners are becoming skilled at social prescribing which poses a direct challenge to the overuse of services and treatments. It enables GPs, nurses and other primary care professionals to refer people to a range of local, non-clinical services including swimming lessons, organised walks, gardening, and cookery lessons. The Bromley by Bow Centre in London is one of the oldest and best known social prescribing projects.
Other leapfrogging health workforce changes include the expanded task profiles of nurses and midwives of the kind introduced in Ireland.  

**Factor 4: Supportive organisational culture**

‘Culture’ is a fashionable and often over-used term. We use it to refer to deep-seated assumptions and values, officially espoused ideologies and patterns of behaviour. Culture can serve as a barrier to change and create inertia, especially in countries which have long-established health services in place.

In contrast, a supportive culture can be about challenging and changing beliefs about success and how to achieve it. Leaders can be champions for culture change. Key features governing successful culture change include: flexible working across boundaries (e.g. developing ‘boundary-spanners’, that is, people who operate at the edges of organisations and are skilled at working across them); encouraging risk-taking; openness to research and evaluation; and a strong value base.

All health systems comprise a complex set of multiple cultures, many of them arising from the diverse professional and occupational groups or ‘tribes’ which make up health systems, and trying to shape these in order to improve quality of care has been at the heart of many, though not all, large-scale change initiatives. In MICs, where there may be an absence of powerful professional interests, it may be easier to overcome resistance to change if the political will exists. At the same time, some MICs can display as much resistance to change as more mature health care systems with powerful groups, like doctors with jobs in the public and private sectors, unwilling to forego their privileges.

Innovative ways of engaging key stakeholders have been successfully implemented in the Basque Country region of Spain and in Scotland where structured forms of engagement require groups of clinicians, managers and others to come up with solutions that are driven from the bottom up.  

**Factor 5: Managerial-clinical relations**

While relations between managers and all staff groups are important, the managerial-clinical interface is critically important in health systems, especially at a time of rapid change which can seem threatening to notions of clinical freedom and responsibility. Clinicians who are not supportive of change can exert a powerful block on it, even going so far as to sabotage it. Finding an acceptable accommodation between clinicians and managers is critical to the success of efforts to tackle NCDs.

Working to understand each other’s cultures and roles may seem obvious but does not always happen naturally, especially in those health systems which have matured over many years. Tribalistic loyalties to their clinical base tend to prevail. Finding champions for change is an essential prerequisite for sustainable change. A study of five professional sub-cultures (medical clinicians, medical managers, nurse clinicians, nurse managers, and lay managers) conducted in English and Australian hospitals argues that medical and nurse managers are best placed to support change, with nurse managers the most supportive. But even within the ranks of medical clinicians and medical managers are a significant minority who could be regarded as the future change champions as they support a team-based work process control model, and strategies that seek to improve work systemisation and service integration. In so doing they have distanced themselves from their medical colleagues. Leapfrogging would allow countries to focus on such individuals, developing and nurturing them and appointing them to key positions as appropriate.

**Conclusion**

Transforming health systems is a complex, and often messy, business. This is especially so in countries which have mature health services with well-established organisations and professional groups. While such systems possess many strengths, there are often particular challenges in bringing about much needed innovation and adaptation to changing circumstances. A tendency towards path dependency can make change harder to achieve and embed. While leapfrogging can apply, it is likely to meet resistance from structural interests. But for newer health systems in MICs, leapfrogging can potentially achieve much more, and more quickly, thereby saving time and resources. Leapfrogging needs to be accelerated and opportunities sought to enable those elephants in the room to be confronted. These are perhaps the most urgent tasks in the crusade against NCDs.

### Box 1: Common themes in system leadership

- System leadership is not easy but possible with blood, sweat and tears
- It requires a conflicting combination of constancy of purpose and flexibility
- It takes time to achieve results
- It starts with a coalition of the willing and a Vision
- It is important to have stability of at least a core of the leadership team across those involved
- Patients and carers are crucial in helping design the changes
- System leadership is an act of persuasion, political astuteness and managing emotions
- It helps to have tools, including an evidence base for change, which can help persuade the unconvinced
- System leadership requires distributed leadership instead of command and control
- There is a need for capacity strengthening to develop system leaders with the requisite skills
- Communication
- Culture change

Source: Adapted from Source
References


In Memoriam: Professor Alan Maynard (1944–2018)

It is with great sadness that everyone connected with Eurohealth learnt of the recent passing after a long illness of Alan Maynard, Emeritus Professor of Health Economics at the University of York. Alan can be rightly considered one of the pioneering giants of health economics, and we were fortunate to be able to publish several of his contributions to the journal over the years. He also was a member of the International Advisory Board for the Health System Reviews (HT) series published by the European Observatory on Health Systems and Policies. While much of his career was spent at York, some of us also had the opportunity to work with Alan on European health policy, technology assessment and other issues at the LSE in the early 2000s. Alan believed passionately in the importance of taking an evidence-based approach to health-policy making, something he often felt was not adhered to. He was not certainly afraid to speak his mind and to more than ruffle a few feathers on a regular basis. In recent years he also embraced social media to get his message across through blogs and tweets. His arguments were highly influential in the decision to include what he deemed to be the ‘fourth hurdle’ of cost-effectiveness (along with quality, safety and effectiveness) as part of the decision-making criteria for the National Institute for Health and Care Excellence. ‘Maynard Matters’, a wonderful collection of Alan’s own writings, together with new pieces by colleagues celebrating his contribution, now published and freely available from the University of York serves as a fitting tribute.

On a personal level we shall remember that Alan was very kind, witty and more than a little mischievous. He was also an avid sports fan, which among other things included watching and inviting colleagues to watch Test Match cricket and other sporting events. He made health economics fun and will be very much missed.

* available at: https://www.york.ac.uk/che/publications/books/maynard-matters/