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Original Research Article

Meeting the challenge of health system transformation in European countries

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Abstract

Transforming health systems is a complex, messy business with no quick or simple solutions. Countries struggle to make it happen with policy failure often the result. Reporting on a World Health Organization Europe project aimed at understanding how health system transformation can succeed, the paper draws on three European country case studies to offer insights and lessons for policymakers elsewhere engaged in similar efforts. Critical to success in implementation is the adoption of a receptive context for change. Building on the policy capacity literature, it emphasizes the importance of environmental pressure, the quality and coherence of policy, leadership style, supportive organizational culture, and managerial-health profession relations.

Keywords: health system transformation, implementation, policy capacity

Health system transformation (HST) is underway in countries across the world. The reforms that have been enacted, or are under consideration, share a number of common features: a shift to integrated care reflecting demographic changes and the growth of multimorbidities; a renewed focus on population health to tackle rising health inequalities and the growing disease burden from Non-Communicable Diseases, much of which is lifestyle related and largely preventable; patient empowerment and community engagement as health care seeks to become more patient centered; IT and digital health; knowledge management; and value-based payment methods.

Overall, the intention is to move to a system centered on optimizing health and wellbeing and away from one dominated by ill-health and care much of which is provided in hospitals. Such a shift is in keeping with the 3.0 Transformation Framework set out by Halfon et al. (2014). The framework does not assume that change in complex health systems evolves in a sequential, linear fashion or is even inevitable. Complex health systems continually metamorphose in response to various pressures, including rapidly changing epidemiology, policy jolts (an extreme example being the impact of coronavirus (COVID-19) with implications for health systems that remain to be fully realized), to scientific and technological breakthroughs, and to disruptive innovations that are altering medical practice. Many of these developments were already underway prior to the COVID-19 pandemic but what it has done is to hasten their take-up and absorption into daily practice. Changes that might have taken 5 to 10 years to enter into routine practice have become the new normal within a few weeks in many countries. However, had countries been more advanced in having in place a proactive, integrated, and preventive

population-based health system, the COVID-19 crisis might have been better, and more quickly, controlled. Accordingly, it has been suggested that COVID-19 should be seen as a syndemic rather than a pandemic since it reveals biological and social interactions that have important implications for health policy (Horton, 2020). In particular, the impact of the virus is most pronounced within social and ethnic groups according to patterns of deeply embedded societal inequalities that have been evident for some time but which policy-makers have done little to address. Indeed, in some cases, their actions, whether intentionally or not, have exacerbated them.

Despite there being widespread agreement over why large-scale transformation (LST) is needed when it comes to putting it into practice and ensuring that the changes are implemented in a joined-up, coherent, and sustainable way, there is far less certainty about how to effect the change of the type sought or to understand the factors that might impede it. This remains the case even where there exists sound evidence to underpin the desired changes.

While a policy-implementation gap is nothing new and was the subject of a seminal paper by Gunn (1978), the policy context has become considerably more complex as "wicked problems" to which there are no simple or single solutions have come to dominate the agenda (Grint, 2008; Rittel & Webber, 1973). Such problems have been identified as "adaptive challenges" (Heifetz et al., 2009). As has been pointed out, "a complex system clearly does not change merely because someone devises and then mandates a purpose designed solution" (Braithwaite, 2018). Four broad contributors to policy failure can be identified: overly optimistic expectations, implementation in dispersed governance, inadequate collaborative policy-making, and the vagaries of the political cycle (Hudson et al., 2019).

In their conception of policy capacity, Wu et al. (2015) argue that much of the work on policy capacity lacks specificity in regard to how it can be deployed effectively, including the skills, competences, and capabilities required to help make it succeed. To address these weaknesses, they devised a policy capacity typology comprising skills and competences organized into three types—analytical, operational, and political—each operating at three different levels when it comes to resources and capabilities—individual, organizational, and systemic. From the nine types of policy capacity generated, it is hypothesized that high levels of capacity are linked to better policy outputs and outcomes while capacity deficits are viewed as major causes of policy failure and suboptimal outcomes.

For the World Health Organisation (WHO) HST project, a conceptual framework was chosen derived from research examining the reform of the UK National Health Service (NHS) in the early 1990s (Pettigrew et al., 1992). It was selected because it best served our purpose in capturing the multifaceted and contextual nature of securing sustainable large-scale change in complex settings. The fact that it had been developed from a study of health system change was viewed as an added strength of the framework, as was its focus on the strategic policy level and its acknowledgment of the political nature of LST. The framework also has the merit of addressing the whole health system, including different levels, i.e., macro, meso, and micro, and wider context. It can also be viewed as offering hope and optimism in its outlook in contrast to some frameworks, which focus on failure and the negative aspects of securing change.

Finally, it was considered that the framework remained sufficiently robust and flexible to allow for refinement and adaptation to include key aspects of bringing about successful and lasting change. Although other frameworks were considered, notably Kotter's eight steps for successful change (Kotter, 1995), and Kingdon's multiple streams approach and "policy windows" (Kingdon, 1995), it was not thought that either of these was superior to the receptive contexts for change framework or should replace it. Rather, they were included and cited to provide reinforcement and refinement to the insights offered by the Pettigrew et al. framework. In the WHO project, therefore, this framework remains central as an overarching integrative one. The remainder of the paper is structured as follows. The next section presents the receptive contexts for change framework together with a review of issues arising from it. This is followed by a brief description of the WHO HST project and its purpose.

Findings from the three country case studies selected for analysis—Sweden, UK, and Portugal—are then presented, followed by a discussion of common themes arising from the country examples and a review of the complementary merits and strengths of the policy capacity and receptive contexts for change approaches. A concluding section completes the paper.

Methods

We consider that the receptive contexts for change framework capture many of the aspects of policy capacity that features in the framework proposed by Wu et al. (2015). In his discussion of a theory of organizational readiness for change, Weiner (2009, p. 69) makes the point that while "some organisational features do seem to create a more receptive context for innovation and change," such a context does not translate directly into readiness. Even where a receptive context exists, it is no guarantee that successful implementation of a particular change will occur. Acknowledging such an outcome, Weiner's proposed theory regards a receptive context for change as a possible determinant of readiness rather than readiness itself. For readiness to exist, there needs to be agreement on the specific change being undertaken in a particular context. In the country case studies presented later, describing attempts at HST, agreement on the changes proposed was a precondition of their selection, thereby demonstrating a commitment to change.

The original "receptive contexts for change framework" devised by Pettigrew and colleagues comprised eight factors and five of these were viewed as instrumental in enabling successful change to occur (Pettigrew et al., 1992). The five factors are as follows:

- Environmental pressure
- Quality and coherence of policy
- Key people leading change
- Supportive organizational culture
- Managerial-health profession relations. Each of these factors is described in turn below.

Factor 1: Environmental pressure

Environmental pressure is critical in creating the conditions for transformational change and in ensuring, they remain in place long enough to become embedded, thereby enabling sustainable change to occur. Environmental pressure can come from various sources, including financing strategies, political context, impact of politics, and electoral cycles, and changing competences in the health workforce. Citizens can also generate important environmental pressure for change.

Factor 2: Quality and coherence of policy

The quality of policy developed at national and subnational levels is important in terms of both its analytical and process perspectives. Having policy that is informed by evidence and data, especially at a local level, is important in presenting a robust case for change and for persuading skeptical staff of the merits of the exercise. The most successful policies are those that consider questions of coherence and alignment between goals, feasibility, and implementation requirements.

Factor 3: Key people leading change

Leadership is paramount in developing and implementing policy. People in key posts leading change are critical—not heroic leaders of a traditional command and control type but those who exercise leadership in a more adaptive, distributed style. HST requires a unique type of leader—the system leader who can catalyze collective leadership. Quiet or servant leaders are often more effective than those who lead from the front and claim to have all the solutions to complex problems (Greenleaf, 1991; Mintzberg, 2006).

Factor 4: Supportive organizational culture

Health systems comprise a complex set of multiple cultures, many of them arising from diverse professional and occupational groups, or "tribes," inhabiting them (Degeling et al., 1998; Hunter, 2002). Culture involving deep-seated assumptions and values leading to particular patterns of behavior can serve as a barrier to change and create inertia especially in countries that have long-established health systems In contrast, supportive culture can challenge and change beliefs about success and how to achieve it. Flexible working across boundaries, encouraging risk-taking, and openness to research and evaluation are called for.

Factor 5: Health professions, including 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 (Kornacki, 2015). The disconnect between managers and clinicians is a feature of all health systems. Those opposed to change can block or sabotage it. Managers and clinicians need to understand each other's worlds and reach a mutually acceptable accommodation.

These five factors can guide, shape, and influence where and how transformational change occurs, but they are not items on a shopping list that can be chosen or not at random. The factors are interrelated and must be aligned; if they push and pull in different directions, which is all too often the case in practice, efforts to achieve change are likely to fail. Conversely, even if all the factors are properly aligned, success is not guaranteed—there is "no simple recipe or quick fix in managing complex change" (Pettigrew et al., 1992). It is worth noting that all five components of the framework can be linked to COVID-19. The pandemic constitutes the environmental pressure demanding a response from governments and the other four factors form the basis of what needs to be in place to enable a robust system response. Successes, as well as gaps or deficiencies in country responses, can be traced back to these factors.

Building on the five factors, there are two particular issues that, although implicit in the receptive contexts for change framework, merit surfacing and making more explicit in any discussion of how to make change happen. They figure in Kotter's eight steps for successful change (Kotter, 1995). First, is establishing a sense of urgency so that the need for change cannot be ignored or deferred indefinitely until, for example, further evidence emerges making the case for change unassailable. This emphasis on urgency is also a factor in the approach to delivery described by Barber and is behind the notion of the "burning platform" service as a trigger for HST (Barber, 2015). A current, if extreme, example of such a platform is surely the COVID-19 pandemic and the changes to working practices in health care services that have occurred in a matter of weeks. Under normal circumstances, such changes involving online virtual consultations with primary care physicians, using apps to order repeat prescriptions, would take years to become embedded in day-to-day practice not because the technology did not exist but because of a reluctance and innate conservatism among the workforce and public to change their behavior.

The second issue that needs to be surfaced is enabling "quick wins" in order to demonstrate that the changes sought are having a positive and immediate impact even if embedding them in practice at pace and scale will take considerably longer. It provides confidence and hopes that change is possible. This has been referred to as the "expectation of success" (Barber, 2015).

Being able to point to quick wins offers reassurance to policy-makers who may be under attack over their policies and enables them to provide interim evidence that their changes can succeed and are working. They also build resilience and ensure that policy-makers remain confident that what they are doing is worth sharing and spreading.

As noted earlier, in real-life situations, transforming complex health systems and implementing change are never easy or guaranteed: "in reality, even successful change efforts are messy and full of surprises" (Kotter, 1995). Context is all-important. Noting that most European countries are actively engaged in introducing system-wide reforms in health care, the project reported in this paper was concerned with how securing transformational change in health systems could optimally be achieved given the complexities evident and the generally disappointing record when it comes to implementation and to making policy stick (Ilott et al., 2016).

Results

WHO throughout its existence has focused much of its activity and analytical capacity on understanding health problems across member states and on devising solutions to them. It has paid less attention to, and indeed has largely ignored, the issues countries have had to confront and struggle with when it comes to implementing change and making policy stick (Ilott et al., 2016).

To understand better the notion of policy failure in health systems and how to make policy stick, WHO Europe's Division of Health Systems and Policies launched the HST project in 2015 comprising two expert meetings (held in Madrid, Spain, and Durham, UK, respectively) and the compilation of

three country case studies (WHO, 2016; 2018a). The starting point for the project was that whereas policy-makers possessed robust evidence concerning the nature of the problems they were seeking to address, and the possible range of solutions available to tackle them when it came to the issue of how to implement change successfully, there was less attention given to the challenges confronting them. Invariably, there was no reference to the literature on policy capacity, readiness for change, and receptive contexts for change and nor to the evidence and guidance to assist progress. And where change had been successfully conceived and implemented, there were few systematic efforts to capture the learning and identify the lessons and insights that might be of value to policy-makers in other health systems. Even in those settings where evaluation had been commissioned, the findings once reported were often too late to be of value or were disseminated in lengthy academic reports and peer-reviewed publications that failed to reach policy-makers and those charged with effecting change at different levels. On this point, there are lessons to be learned from countries' experiences in managing the impact of the COVID-19 pandemic. Learning from HST, including its implementation, will help WHO and others to focus on implementing interventions to enable recovery from COVID-19. Crucially, recovery will depend on the implementation capacity present in countries.

From the outset, the WHO project sought a different approach and one that centered on identifying the drivers and enablers for change as well as the barriers and obstacles to be overcome in securing transformational change. At the same time, and unlike traditional management consultancy, the project was to be informed and underpinned by relevant academic research and analysis. But such work was not foregrounded or allowed to overshadow the key messages the project sought to convey since the primary audiences were government ministers and their advisors.

The main outcome of the project has been to provide accessible advice based on real-life experience for policy-makers across Europe (possibly beyond too) engaged in reforming their health systems. From the experience of the project's architects, what policy-makers would welcome most is practical advice and guidance in real time on how to move forward based on how others have succeeded, on the lessons learned, and on insights derived from relevant academic research expressed in clear, accessible language.

The project was launched in December 2015 with a 2-day meeting of over 20 invited experts held in Madrid, during which they reflected on their experiential learning from leading, promoting, participating, or evaluating the implementation of LST (WHO, 2016). The meeting was informed by the Institute for Health Improvement's Triple Aim (Berwick et al., 2008) with its focus on population health, effective care, and per capita cost. The working definition of LST was adopted from Best and colleagues:

> *Large-system transformation in health care are interventions aimed at coordinated, system-wide change affecting multiple organisations and care providers, with the goal of significant improvements in the efficiency of health care delivery, the quality of patient care, and population-level patient outcomes* (Best et al., 2012, p. 422).

The focus of the meeting was on understanding and capturing better how policy-makers have moved forward and adopted new policies, models of care, and financing schemes rather than on merely describing what they have done and why. Brief case studies were presented including examples from UK, Estonia, Hungary, Portugal, Scotland, Spain, and Turkey. The meeting was conceived as one of the principal mechanisms to support knowledge exchange, helping policy-makers to identify common solutions for emerging challenges and to strengthen institutional and intellectual capital.

Participants acknowledged that having a conceptual framework in which to locate the discussions was a useful means for organizing ideas and highlighting key factors enabling successful transformation and/or accounting for policy failure. Although the receptive contexts for change framework described above were agreed to offer a sound basis for both thinking about and undertaking large-scale HST, meeting participants acknowledged that no single framework was likely ever to capture all the key elements that needed to be addressed when undertaking change in complex settings.

The second expert meeting held in Durham in July 2017 was attended by over 25 invited experts from WHO member states and built on the earlier event held in Madrid, which some of the participants had also attended. Participants drew attention to a number of critical factors and tensions they have experienced in the process of large-scale HST in their own countries. These included tensions between bottom-up and top-down approaches; the need for a coherent vision, ongoing political buy-in, appropriate leadership across the health system, and investment; and the role of information technology

(WHO, 2018). Among the suggestions discussed for a subsequent work program, was curating a library of case studies detailing the reform processes in different political and cultural settings. The idea was to tell the story of HST, both when it is successful and when there might be a failure.

Following the Madrid and Durham events, three country case studies were commissioned by WHO to be conducted between 2019 and early 2020. Sweden, UK, and Portugal were chosen with Sweden acting as a pilot to explore the approach. Each case study followed a similar methodology comprising a rapid scoping review of key documents relating to that country's reform journey to provide background to the second stage. This took the form of short visits to each country to conduct semistructured interviews with key informants (7 interviews in Sweden, 14 in the UK, and 8 in Portugal) who were either already known to the project leads or who were recommended after careful investigation.

Following the visits, the interview notes were compared between the project leads and written up in country reports structured around the five factors described earlier for submission to WHO. During the fieldwork, the project leads were invited to give two seminars in the UK to share their findings: one held at the Office of Health Economics (October 2019), and the other held at the London School of Economics (January 2020). The audiences were a mix of policy-makers and academics and the two events provided a timely opportunity to sense-check and informally validate the emerging findings.

In the next section, brief profiles of the three countries studied are provided highlighting the reform issues being undertaken in each. This is followed by a discussion section that draws together common themes across the three case studies.

Country case studies

Sweden's strategy for health

Sweden benefits from a highly rated healthcare system. Life expectancy is high: 81 for males and 84 for females (https://www.who.int/countries/swe/en/). Sweden also spends 11% of its Gross Domestic Product (GDP) on healthcare, which is above the EU average of 9.9%. Results include a high quality of care with good outcomes and good accessibility: There are few complaints regarding the quality of care or unmet needs (European Commission, 2017). This is achieved through Sweden's decentralized structure: The nation is divided into 290 municipalities and 20 county councils/regions with healthcare being managed primarily at the county council level. The national government's involvement is to establish guidelines and principles while also setting the political agenda for healthcare (https://sweden.se/society/health-care-in-sweden/).

This relatively successful structure has been the result of decades of reform and thus makes the Swedish experience of health system reform a useful study and a positive example. There may be lessons other countries can learn from the Swedish experience over the years. This is especially true for other decentralized countries in Europe.

Sweden is in the early phases of implementing a new *Strategy for Health* (SfH), which aims to deliver "good, equally accessible health, quality welfare services, and persistent, sustainable procedures" (SALAR, 2017). The strategy, which entails LST, emerged in 2015 from a meeting of the Congress of the Swedish Association of Local Authorities and Regions. It is important to note that data triggered the discussion and fed the process of decision making. The Congress voted to draw up a strategy to meet the challenges facing policy-makers and providers of health and welfare services.

The SfH represents a natural progression from the reforms of the last few years. Swedish healthcare still has issues in need of attention including waiting times (there is mixed success in meeting the government's waiting time rules), chronic care management in primary care settings, and fragmented health information systems (European Commission, 2017). The SfH seeks to address these problems as well as give higher priority to health prevention and promotion. In addition, as in other countries, which are addressing population needs and inequities, this entire process was launched to ensure the future sustainability of the health system in Sweden. The SfH is a transformational challenge and to be successful must comprehensively address the organizational, professional, and social contexts within which the policy is being implemented. SfH is also a major intersectoral effort covering schools, social services, elderly care, and health and care. Policy-makers are aware that it requires a major effort of horizontal integration if it is to succeed.

In monitoring terms, the SfH is related to a series of aims and indicators that directly or indirectly affect health and where welfare services can contribute to the difference. The system leans on

a national database where facts at local, regional, and national levels can be tracked with comparable indicators of all levels. The following are examples of these indicators:

- The self-assessed health of those aged 16–84 has increased by at least 3 percentage points: Differences between different socio-economic groups have decreased.
- The proportion of sedentary leisure time, aged 16–84, has decreased by at least 5 percentage points: Differences between different socio-economic groups have decreased.
- Injuries from falls among individuals aged + 80 years have decreased by at least 20%.

Simultaneously, Sweden is conducting a major reform of primary health care based on person-centered, integrated health care adopting a whole system approach (Swedish Government, 2017, 2018). Connecting with, and complementing, the SfH is of importance since both initiatives are part of the same drive to transform the Swedish health system.

UK's HST initiative

UK's NHS, now in its 71st year of existence since its foundation in 1948, enjoys iconic status with the public mainly resulting from its universal coverage and access to care that is free at the point of use for those in need. Compared with many other countries, the NHS is already well designed in terms of its architecture. Certainly prior to the COVID-19 pandemic, the NHS enjoyed generally high levels of patient satisfaction, improving outcomes, strong overall efficiency, and relatively high levels of care coordination. Since the pandemic, waiting lists for elective care have grown significantly and staff shortages continue to be a problem.

Despite its popularity, the NHS is not without its problems and struggles over the years mainly resulting from the actions of successive governments exhibiting different political views and ideologies about how best to fund, organize, and deliver health care. As a consequence, and notably in England the NHS since the mid-1970s has undergone almost continuous structural reform. Indeed, it is probably the most reorganized health care system in Europe, if not globally (Alderwick et al., 2021; Hunter, 2011).

Constant structural reform carries a heavy price in terms of high transaction costs and loss of staff morale. The various changes have veered from introducing greater competition through the mechanism of an internal market, which emerged in the early 1990s, to eschewing competition in favor of collaboration on which the current reforms are focused.

It is notable that few of the reforms have been informed by evidence of what works. Indeed, for the most part, they have been enacted without any recourse to the evidence or what evidence exists has been used to support already adopted positions. Despite the fact that the UK invests significant amounts of funding in health services research, little of it appears to inform or shape policy.

Although many of the English NHS's current problems and pressures can be traced back to changes and legislation introduces in 2012 and are one of the reasons for the transformation that has been put in place since 2014 leading to the long-term plan (LTP) published in early 2019, there are other more deep-seated causes requiring attention. Many of these find parallels in other health care systems across Europe.

Apart from being subjected to successive waves of restructuring throughout most of its existence, the NHS is also grappling with severe financial challenges caused by chronic underfunding (Anderson et al., 2021). This resulted from government cuts across the public sector that commenced in 2010 in the aftermath of the global financial crisis, and unrealistic goals for efficiency saving schemes that have had an adverse impact on the quality of care. By 2021, it is expected that just 6.6% of GDP will go toward health when the average across Europe is 10.4% of GDP. The effect of funding constraints is felt more acutely in a climate where demand for NHS services is higher than ever due to an aging population and also one exhibiting less healthy lifestyles as evident, for instance, in rising obesity levels and poor mental health.

The other major challenge facing the NHS concerns the workforce and the severe shortages of staff. Partly this is the result of staff reaching retirement age but it is also proving difficult to recruit and retain staff when the working environment is proving so challenging as a result of the financial pressures noted above. The continuing uncertainty around Brexit is also having a significant impact on workforce issues in both the health and social care sectors.

Since 2014, following the arrival of a new Chief Executive to head up the NHS in England, a different approach to HST has begun to take shape. It marks a clear departure from the direction set out in the Health and Social Care Act 2012 and calls for the NHS to reinvent itself in order to meet the health challenges of the 21st century. The key message was that the NHS needed to work more effectively as a joined-up system rather than as a collection of organizational silos in the form of hospital trusts, groups of primary care professionals, and social care while public health was the responsibility of local government. The emphasis was on whole systems thinking to tackle population health, manage demand for hospitals by keeping people away from them and provide more accessible and appropriate support in the community through primary care and social care.

None of these pressures is especially new or unforeseen but they are becoming more acute and threaten to render the existing NHS model unsustainable. This model, with its strong emphasis on emergency treatment and hospital care, is no longer seen to be fit for purpose. Hence, the commitment to give a greater emphasis to prevention and population health as well as to primary care, all aimed at promoting health and wellbeing while reducing hospital admissions and demand for inpatient care.

The next step in the journey was the publication of a 10-year plan for the English NHS in early 2019 (NHS Executive, 2019). The LTP goes into considerable detail about the challenges facing the NHS and the changes required to tackle them. At its core, the LTP sets out a new service model for the 21st century centered on five major practical changes:

1. Boosting "out-of-hospital" care, and finally dissolving the historic divide between primary and community health services
2. Designing and reducing pressure on emergency hospital services
3. Giving people more control over their own health, and *more personalized care* when they need it
4. Mainstreaming digitally-enabled primary and outpatient care across the NHS
5. Local NHS organizations increasingly focused on population health and local partnerships with local authority-funded services, through new Primary Care Networks and Integrated Care Systems to be established across the country by 2021.

Importantly, the new service model is less about structural change (although there will be some changes of this nature) and more about system changes and changes in relationships and the way in which people and organizations work together. Importantly, and reflecting the evidence in regard to what works, it is acknowledged that enabling more joined-up and coordinated care is less about structures and much more about culture change and relationship-building in order to secure and strengthen high trust relationships. The approach favored is evolutionary—not "big bang" changes that sap morale and distract.

Portugal's health system and its future survival

The NHS in Portugal will be 40 years old in 2020. There are expectations that a new Basic Law is being prepared to reinstate and reinforce the NHS: 2020 is therefore a key moment to design and implement a stronger NHS. The challenges facing the Portuguese health system have changed since the original design of its NHS. These include demography, multimorbidities, patient expectations, and so on, and, like other countries, the NHS in Portugal needs to be adapted to meet these challenges.

The Portuguese healthcare system is made up of the universal residence-based NHS, a social security scheme, and also voluntary private health insurance used by one-fifth of the population (https://www.expatica.com/pt/healthcare/healthcare-basics/healthcare-in-portugal-106770/). The Portuguese Ministry of Health oversees the Servico Nacional de Saude, which covers primary and secondary care. There are fees for certain services. The Portuguese health system is funded by taxes, social security contributions from working people, and the aforementioned service fees. Vulnerable low-earning groups, dependencies, the retired, and the unemployed are exempt from social security contributions and most service charges. Portugal, as of December 2019, was the 12th highest EU spender on health within the EU (9.1% of GDP). About 70% of expenditure is public and 30% is private. Portugal's health service is recognized as being of a high standard and was ranked 13th on the 2018 Euro Health Consumer Index.

Portuguese healthcare was hit hard during the financial crisis of 2010–2014, coming off the back of the 2008 crash and a long-running economic downturn affecting Portugal since 2001. This has left

a lasting impact on resources and financing by way of significant debt. Portugal also faces problems typical of other European nations: aging population, increase in multimorbidity, and the need to be more accessible to the public (ibid). Health inequalities and problems with equity in care across the nation are also long-standing problems in Portugal (Crisp, 2015).

Briefly, the different documents basically signal the same improvements for Portugal. There is widespread acknowledgment and a general consensus over the need to redesign the present fragmented and reactive health system model that is no longer fit for purpose; to move toward a more proactive and preventative model, to give more voice to patients and citizens, to address widening inequalities, to manage population health, as well as ensuring the sustainability of health systems.

Integral to Portuguese HST is a shift toward "person-centered" care, following the trend of an increasing focus on patients observed around Europe (WHO, 2018b). Improving the quality of care is also central to the incumbent government's plans. A digital transformation is also high on the agenda, granting health care professionals, and patients access to tools and programs that contribute to greater integration. This would also lead to increased transparency, which is generally regarded as good practice.

The combination of all those transformations for Portugal fits well with the definition of LST being used in all three case studies (see Best et al., 2012). The socialist government appears to acknowledge many of these issues and its policy reflects efforts to address them. The government is also aware that there will be considerable implementation difficulties and that they will require some sort of implementation plan if their proposals are to succeed.

Uppermost among the challenges that need to be confronted in order to achieve a resilient and universally accessible health care system is the continuous hemorrhaging of publicly trained health professionals moving to the private sector. Changing the incentive structure is seen as an urgent requirement in any agreed implementation plan. The next two or three years will be key for the Portuguese health care system. The shape things take in Portugal will also be a key example of WHO's commitment to Universal Health Coverage as this can have an impact beyond Portugal, especially in Latin America.

Discussion

A number of common themes and issues were raised by all those interviewed for the case studies. Each country could point to a "burning platform" or "policy window," which was driving efforts to reform health care. In Sweden, this can be seen to have resulted from the urgency of a growing aging population and the pressures it is placing on the welfare budget and wider economy. These pressures helped create a sense of urgency and build a momentum for transformational change and the emergence of a consensus around the importance of prevention and improving population health across several sectors: schools, social care, and health care.

The "burning platform" for change in the UK can also be seen to have resulted from the urgency of responding to a growing aging population and the pressures it is placing on the NHS and especially on hospitals. These pressures, combined with those resulting from 10 years of financial pressures following the global crisis of 2008–10, helped create a sense of urgency leading to a consensus around the importance of improving population health and care outside hospitals with the rise of noncommunicable diseases.

The situation in Portugal is somewhat different from the other two countries since its commitment to HST has yet to commence in any systematic, whole system manner. Here, the "burning platform" appears to be the very survival of the country's NHS. While all countries share a similar scenario, unlike what is happening elsewhere there is an emerging trend in Portugal, which further complicates reform. The issue is not simply one of investing additional resources into the current model but of fundamentally revisiting that model given its progressive weakening as a universal tax-based system alongside a growing private sector threatening the emergence of a two-tier system. Until the future of the NHS is resolved at a political level, it is hard to see how the other system changes that are acknowledged to be needed can take root.

Another difference between the conduct of HST in Sweden and the UK on the one hand and Portugal on the other is the importance of legislative change as a basis for reform. In both Sweden and the UK, the need for legislative change was not viewed as essential or critical since the changes required could be undertaken within the existing statutory framework, which offered sufficient flexibility. In late 2019,

the NHS in England decided that legislation was required to remove existing barriers to integration across health and social care bodies. Consequently, a Health and Care Bill was introduced and passed into law with the Health and Care Act 2022. In contrast, the situation facing Portugal was regarded as one where legislative change was seen to be an essential prerequisite in order to preserve and safeguard the NHS prior to its transformation.

With reference to the five factors comprising the receptive contexts for change framework, the remainder of this section focuses on the *How* question, namely, what were the key issues arising from attempts to bring about HST. Inevitably, therefore, most of the discussion relates to Sweden and the UK, with Portugal being cited where relevant. But we consider it important to retain Portugal as one of our case studies since the issues the country is grappling with, many of a fundamental nature, are clearly important and may be of interest to other countries struggling to both preserve their health systems while also seeking to transform them.

Factor 1: Environmental pressure

- An increasingly complex and challenging environment characterized by rapid advances in medical science and technology, erosion of traditional organizational and professional boundaries, rise in multimorbidities, and the interconnectedness of just about everything was acknowledged to exist and drive HST in all three countries.
- Evidence has been a powerful tool used to drive the reform agenda in all three countries, pointing to where the pressures are and why a system-wide approach is needed.
- The compelling, evidence-based case for change, combined with a sense of urgency that action is needed quickly, has enabled political support for many of the key changes across party lines in Sweden and the UK.
- The unique position of the English NHS's CEO, resulting from the legislation introduced in 2012, has enabled him to occupy a space in the development of health policy that previously had rested with the Secretary of State for Health and Social Care. The shift in power has resulted in a more sophisticated policy response to the pressures facing the NHS and the need for a new service model to address them that requires empowering the frontline and a sustained commitment to the changes over a substantial period of time. How sustainable this shift will prove to be is in doubt following the government's proposals to reform the NHS, which include enhanced powers of direction for the government (Department of Health & Social Care, 2021).
- Given the significant impact COVID-19 has had on all three countries' health systems, exposing them to many of the concerns that underlie the reforms being implemented, it might be expected that this will provide further contextual pressure for more rapid and urgent system change. It therefore provides a new "burning platform" or "policy window" to implement change and transform health systems more rapidly than might otherwise have been possible.

Factor 2: Quality and coherence of policy

- The direction of HST set out in Sweden and the UK has widespread buy-in from key stakeholders at different levels of the system, which provides a solid basis for moving forward. They include senior managers and professional leads who were consulted about the proposals for reform before they were finalized and agreed.
- In contrast to Sweden and Portugal, in the UK, a significant volume of research is in hand to track and evaluate the changes. How far any of the findings from such research will inform future policy and adjustments to its implementation is unclear. If history is any guide, then it seems unlikely that much of the research in hand will be heeded. However, there is also evidence of a strong desire to learn from its findings.

Factor 3: Supportive organizational culture

- The changes underway in Sweden and the UK and the manner of the execution are adopting a "loose-tight" approach: tight on outcomes being sought but loose over the means to achieve these allowing for local discretion and contextual factors. This appears to be a powerful approach to monitoring the final impact and the success of implementation. The management approach adopted is closer to learning by doing than one based on targets. System leaders in both countries will be able to learn from successes and failures and make the required adjustments. In UK, this is radical thinking for

an NHS that traditionally has been loose on outcomes and tight on means. Whether the culture has shifted sufficiently for this new approach to succeed is a major concern. At this point in time, the jury is out.

- While in there is an explicit implementation framework providing implementation support, there is less clarity in Sweden over what implementation support might entail although the issue is seen as important to avoid failure.
- There are contrasting styles evident in Sweden and the UK with the former less focused on direction from the center, while in the case of the latter, the perception is that the center may need to let go more in order to enable local agencies to adapt the desired changes to their particular contexts.
- Both Sweden and the UK recognize that while legislation can be useful as a means of nudging the system forward, legal means alone are insufficient to bring about cultural change and sustainable new ways of working. In Portugal, the situation is different and legislation is seen as essential.
- Additional funding to aid transformation may be regarded as essential. Enough must be available to lubricate the process and signal serious commitment. After a decade of financial austerity involving severe budget restrictions, transformation funds were seen as essential in UK although not in either of the other two countries.

Factor 4: Key people leading change

- Leadership development is embedded in real transformation work conducted in specific contexts, not in the classroom. The notion of systems leadership is especially relevant in the context of integrated care and it requires particular qualities and capabilities as proposed by Edmonstone (2019). These include being flexible and agile, an ability to work with uncertainty and tolerate ambiguity, an ability to engage and build relationships, and a preference for achieving outcomes over managerial processes.
- Such a strongly decentralized and local approach to implementation may be particular to Sweden (Ohrling et al., 2021) but may offer useful know-how for other countries in Europe with devolved governance arrangements. There are also lessons for UK where the move to lessen central control and direction and allow regions and local areas to exercise greater discretion has been widely welcomed by NHS staff and academic observers. But this devolved approach is now under threat from changes proposed by the government in July 2021 which, as noted above, seek to introduce new powers of direction for ministers.
- The large-scale changes envisaged are emergent and adaptive when it comes to their implementation in all three countries; all stakeholders appear to be comfortable with complexity and ambiguity, which is an important finding and one worth stressing when many governments seek clarity and certainty even when it cannot realistically be achieved.
- The new and unfamiliar approach, centered on an acceptance of ambiguity and being adaptive in the face of complexity, implies agreement on the importance of shared leadership, and an acknowledgment that it requires taking a long-term view of transformation. To this end, ensuring political support at all levels is critical.
- The changes in Sweden and the UK are data-led which, in terms of implementation, implies that there is a strong belief that demonstrating progress and improved performance on key indicators will stimulate change in others.
- While there is no formal delivery unit as such working with the national government to implement change, implementation support is being provided by agencies of different types in Sweden and the UK.
- Implementation is different and more challenging if it involves a strategy for *health* rather than a strategy for health services since the engagement with the community and other stakeholders needs to be much broader and requires targeting different audiences in ways that will encourage their support.

Factor 5: Health professions, including managerial–clinical, relations

- Engaging clinicians in the overall change process in particular is key. An important way to engage doctors was to give them the sense that they are effecting change and taking the lead.
- The changes promoted in the Swedish, English, and Portuguese reforms are intended to encourage health professionals to track people's health rather than simply attend to their ill-health. Managers

must also be accountable for improving health and not only for meeting traditional management targets.

Although we employed the receptive contexts for change framework, selecting in particular five of its eight factors, to structure and analyze the country case studies, there is clearly an overlap between Pettigrew et al.'s framework and the notion of policy capacity developed by Wu et al. comprising three sets of skill and competences and three levels of resources and capabilities.

We suggest that both approaches offer useful lenses through which we study and explore HST with neither being superior to the other. Rather, they may be viewed as complementary, each possessing particular merits and strengths. For example, the Pettigrew et al. framework pays particular attention to the overall external environmental context, which may create or contribute to the pressure and conditions for policy-making. It also stresses the importance of the quality and coherence of policy if it is to stick. At the same time, Wu et al.'s notion of policy capacity usefully emphasizes the skills and competences required at different levels—individual, organizational, and systemic—if policy failure is to be avoided. Leadership is an important factor in the Pettigrew et al. framework and while it may be implicit in the definition of policy capacity, it is not singled out for particular attention nor is the notion of culture, which is an important factor in the receptive contexts for change framework. However, while Wu et al. stress the importance of political capacity at all three levels, it is less explicit in the receptive contexts for change framework.

Conclusion

The discussions arising from the WHO HST project suggest a growing awareness of the challenges presented by complex HST and how to navigate them. Policy-makers are aware that efforts need to be actively managed, rather than left to chance as has often been the case in the past. Change cannot be realized by outmoded or inappropriate structures or by people who lack the skills or mindset to make it happen. Solutions to the most complex challenges facing health systems require collaboration across sectors and an acceptance that such solutions are neither obvious nor simple and might need to be adapted to different contexts.

This demands a new emphasis on how to change, not just what to change and should be at the core of strengthening policy capacity along the lines Wu et al. propose and of creating receptive contexts for change in the manner set out by Pettigrew et al.

From the list of key issues emerging from the three country case studies and reported in the preceding section, it is evident that the countries are engaged in creating a receptive context for change to guide their actions and to ensure that organizational readiness is present. They may not be adhering explicitly to these five factors, but what they are doing is nevertheless an acknowledgment of their relevance and importance. This would seem to suggest that the framework adopted for the HST project may be something other countries would wish to consider in order to have in place an organized approach to implementation which, although no guarantee of success, will strengthen its likelihood. The framework also captures the levels of resources and capabilities as well as skills and competences described in the model presented by Wu et al. albeit with different emphases as discussed in the previous section.

What the discussions we conducted for the WHO project and the country case studies have also revealed is that no matter how good the plan or how careful the implementation, the unexpected will almost certainly occur. Indeed, COVID-19 is an example of this tendency if an extreme one. Over time, contexts change in unforeseen ways, which requires political flexibility and a need to be able to exploit "policy windows" when appropriate so that changes can be modified and adapted in line with experience and evidence.

Finally, the WHO HST project was completed shortly before COVID-19 became a global health crisis affecting, and in some cases, threatening to overwhelm, health care systems in all countries. It is too early to predict the impact of the virus on the health system reforms described in this paper. In some cases, like digital health and IT systems, it is likely to hasten change, whereas, in others, it may delay progress or shift the agenda to other more immediate concerns such as pandemic preparedness, including numbers of Integrated Care Unit and acute hospital beds, and safety and staffing in care homes. There is also a case for strengthening public health systems and paying attention to the widening health gap between social groups that have been neglected for too long. Too often investments in

prevention and public health capabilities are undervalued so an upgrade of public health infrastructure both locally and nationally is a priority area to address (Sneader & Singhal, 2021). But regardless of the impact of COVID-19, and the changes to health systems arising from it, successful implementation and the avoidance of policy failure will require adherence both to a receptive context for change, and the five factors that have formed the basis of the work described in this paper, and to organizational readiness for change implied in the notion of policy capacity.

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Conflict of interest

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