

UNIVERSITY OF PÉCS
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**A Typology for Developing Effective Reform Programs based on the
Systemic Market Orientation Paradigm**
The Incidence of the Hungarian Healthcare Reforms

PhD THESIS
(Extractions and Summary)

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EXTRACTIONS

Background:

The continuous failure of Hungarian healthcare reform over the past two decades has been investigated from a wide range of perspectives. However, the importance and interplay of stakeholder paradigm gaps with policy planning and implementation has not received sufficient appreciation. It is also worthy of notice, that there have been calls for revisiting the Kuhnian understanding regarding the content and transformation processes of paradigm. Moreover, simplified methods grasping the complexities involved in assessing paradigm and the transformational processes haven't been frequently available. The antecedents of Market Orientation (MO) have proven its positive link to optimized stakeholder satisfaction, and in reducing perception-expectation gaps. MO had been appreciated as a philosophy, culture, model, and performance measurement but not as a 'paradigm'. MO, especially from a systemic perspective (SMO) enjoys qualities that can serve the operationalization of the complex paradigm content.

Aims:

The study's main aim can be summarized as "*assessing the continuous failure of Hungarian healthcare reform in terms of stakeholders' paradigm, from a systemic market orientation perspective*". More particularly, the study aimed at :

- (1) Extending understandings and insights regarding the definitions and content of paradigm
- (2) Developing a simple yet comprehensive method/typology for the investigation of paradigm, its levels and transformation . (searching for new theories)
- (3) Further investigating the qualities of Systemic Market Orientation for building the mentioned typology
- (4) Applying the method/typology to the incidence of the stakeholders of Hungarian healthcare through a longitudinal study.
- (5) Reporting the findings and new theories for future reform policy planning, and program design.

Methods and Design:

A '*multi-method qualitative study*' was found most appropriate for reaching the aims of the research. A combination of the following methods built within the frame work of '*Reflexive Grounded Theory*' were used. :Consulting, Participative Action Research (PAR), Auto-Ethnography. The 10 year -long design helped minimize the effect of political trends on the implications of the study. The investigation took place under two main sections:

- (1) Codifying the dimensions and building the typology ;
- (2) Systematic re-examination of the codes in order to ensure arrival at the point of saturation.

Section (1) 2001-2006 : Building the typology through the extraction , codification (open, axial and selective) and external validation of stakeholder paradigms through reflexive PAR with four management consulting clients (surgeons employed by the Hungarian public healthcare) and their peers working within the same and different contexts, as well as a larger scale survey across

other stakeholder groups. The researcher's influence was continuously extracted and reported using auto-ethnography.

Section (2) 2006-2011: the coded dimensions extracted from Section (1) were subjected to continuous testing for saturation within the framework of PAR and Reflexive Grounded Theory. Participants: (n=95) from 7 stakeholder groups with distributed age, gender, specialization. A so-called Healthcare Learning and Innovation Platform (HLIP) serving as a Zone of Reflective Capacity (ZRC) was designed and delivered in line with the requirements of the PAR and Reflexive Grounded Theory. The learning processes were extended to a network initiated by the participants for assisting healthcare reform and decentralization.

New Findings and Results:

- Thesis-1: "Paradigm" represents the most universal milieu of 'thought', 'action' and 'transformation'. Consequently, the Kuhnian conceptualization of incommensurability and paradigm shift (leaving one paradigm and entering another) are insufficient. It is more appropriate to think of only one single paradigm with different development levels for all stakeholders.
- Thesis-2: The most comprehensive dimensions of stakeholder paradigm can be observed through perceptions of 'Roles', 'Goals', 'Time Orientation / Transformation'
- Thesis-3: Paradigm level transformation is an 'internal individual process' complimented by external loops of co-learning and co-creation of reality (Perceptions of Role, Goal, Time).
- Thesis-4: The existence of at least one leader (Post-Conventional, More Knowledgeable than Other) at a given time and setting is important for initiating transformational learning systems.
- Thesis-5: Reform requires stakeholders' psycho-socio-economic transformation, which is a long-term outcome of upper level transformation reaching Triple Loop and Quadruple Loop learning.
- Thesis-6: The co-creating nature of stakeholders' paradigm formation and transformation, requires the institutionalization of learning systems which support Reflexive, Participative Action Research, initiating knowledge sharing for joint development.
- Thesis-7: Market Orientation from a Systemic perspective, can be taken as the single, most universal paradigm. Systemic Market Orientation Paradigm represents the upper level learning loops and the occurrence of the psych-socio-economic transformation (reform)
- Thesis-8: Stakeholders' level of development and areas of convergence and divergence can be reliably observed through a typology. Stakeholders go through transformational processes under the 'Mechanistic' and 'Organic' levels, on their way to Systemic Market

Orientation Paradigm. The typology was developed, operationalized and tested through 16 codes in the current study.

- Thesis-9: Healthcare reform failure in Hungary, lack of stakeholder participation in the bottom-up processes can be explained by the high level of divergence (gap) from the Systemic Market Orientation Paradigm. These are represented at all levels of policy Content (Optimized Stakeholder Goals), Context and Actors (Governance, Roles), Process (Transformation and Decentralization)
- Thesis-10: Healthcare reform success requires the design and implementation of capacity building, empowerment and learning systems tailored for reducing gaps and promoting systemic market orientation. The '*Healthcare Learning and Innovation Platform*' and the '*Community of Practice*' (Healthcare Leadership and Management Development) tailored for the purpose of the current study provide reliable incidences for future planning and program design purposes
 - **Reflection on Hungarian results:** (Optimized stakeholder satisfaction, Participation, Synergy)
From the total participants of the programs (n=52/95) reached upper levels of transformational learning and the Systemic Market Orientation Paradigm. The mentioned group of stakeholders established the first knowledge based Community of Practice for assisting healthcare reform. One case represented minimum participation in the transformational processes, proving the importance of 'entry level screening ' and 'redirection to complimentary learning pathways'.

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List of Abbreviations	Meaning
CCPA	Content, Context, Process, Actors
CDP	Continuous Development Programs
CoP	Communities of Practices
DLL	Double Loop Learning
EFQM	European Foundation for Quality Management
FINMOUSE	Finance, Incentives, Niceness, Minimal State, Output Orientation, Unit-size, Subsidiarity, Efficiency
GCI	Growth Competitiveness Index
HDI	Human Development Index
HLIP	Healthcare Learning and Innovation Platform
HiT	Healthcare Systems in Transition publications
LPC	Linking Pin Client
MCLT	Management Consulting and Leadership Training
MKO	More Knowledgeable than Other
MMOP	Mechanistic Market Orientation Paradigm
NHS	National Health System
OMOP	Organic Market Orientation Paradigm
PAR	Participative Action Research
QLL	Quadruple Loop Learning
R-G-T	Role-Goal-Transformation
SECI	Socialization, Externalization, Combination, Internalization
SLL	Single Loop Learning
SMOP	Systemic Market Orientation Paradigm
SWB	Subjective Well-Being
TLL	Triple Loop Learning
ZPD	Zone of Proximal Development
ZRC	Zone of Reflective Capacity

SUMMARY

1. Background of the Study :

The researcher's interest in the study of "*paradigm levels' transformation*" through Quadruple Loop Learning (QLL) and the application of systemic market orientation (SMO) to this field, had coincided with an initiative for the design and delivery of '*capacity building*' programs aiding healthcare reform under a management consulting and leadership training contract (MCLT). The aims of the MCLT contract had included- '*exploring the reasons for the continuous failure of the Hungarian healthcare reform and the design and delivery of training programs aiding stakeholder participation in bottom up processes of reform policy making and implementation*'.

At an ontological level, the researcher's arrival at the topic of the study had included a background on the Kuhnian approach to the conceptualization of '*paradigm*', '*incommensurability*' and '*paradigm shift*'. However, the mentioned had been perceived as insufficient, by the researcher, deserving to be revisited. According to Kuhn (1962); paradigm shift occurred when subject to the existing dominant paradigm the practitioner could no longer answer her questions. Paradigm shift, based on the Kuhnian approach implied '*leaving an older universe of thought and action, and entering a newer paradigm*'. This understanding had represented an internal paradox according to the researcher. Symbolically, thinking of isolated universes would undermine the prior understanding of paradigm as the '*most comprehensive milieu*' firstly implying that other types of areas outside these separate universes do exist and 2)- that one universe may exist without links to the other.

The researcher on the contrary, taking a systemic perspective, had perceived paradigm to represent a single universe / milieu covering various stages of transformation. According to the researcher paradigm was best defined as '*the universal milieu of thought, action and transformation*' with internal development levels. In other words, development and transformation occur amongst various levels within a single, (rather than multiple paradigms).

The incidence of the continuous failure of the Hungarian healthcare reform and the MCLT contract provided a valuable opportunity for studying and examining the above mentioned concerns. The continuous failure of Hungarian healthcare reform has been investigated from various inquiry paradigms (paradigm levels) by earlier studies. However, the very "*paradigm level gaps*" existing in the areas of inquiry and problem -solving have remained less appreciated within this domain. The philosophical misalignment (gaps) has been evident at *ontological, epistemological, methodological axiological* levels of inquiry. The importance of paradigms impeding a *fundamental psycho-socio-economic change* (shift or reform) have been recognized.

Earlier studies have referred to paradigmatic dilemma amongst various scholars and practitioners

distinguishing the application of the general concepts and principles of economics and management to the incidence of healthcare. Still, there have been shortcomings either at the level of proposals for remedies and / or testing of the proposed remedies . Numerous international and Hungarian studies have addressed shortcomings at the level of the systems' *capacity for reform*, especially in the areas of *leadership competence, governance and decentralization*. Saltman *et.al.* had called on categorizing attention to levels of *content-context-process-role of actors* (CCPA) when analyzing reform failure. In line with the same. Dreschler (2000) had suggested the FINMOUSE checklist for the same observational purpose .

The need for creating a learning community and a system wide participation of stakeholders in reform policy planning and implementation have been continuously postulated. In order to assist TLL and QLL (transformational learning leading to reform), there have been suggestions that the presence of an outsider to a certain cultural system (i.e. the researcher and the context of Hungarian healthcare) , provides grounds for taking the system to upper levels of learning (basics of diversity learning). Yet the outsiders' presence alone won't be sufficient for the institutionalization of a system wide stakeholder participation in bottom up processes of reform. On the other hand management and transformational leadership competence are important vehicles for taking participative transformational learning to an upper level (QLL) allowing psycho-socio-economic change (reform) in a continuous manner (see for example Farkas 2003 on the consequences of leadership on knowledge processes).

At the practitioners' level, lack of access to simple and applicable models for paradigm gap analysis had been perceived as a potential reason for the low number of proposed remedies coming from the paradigm level helping system-wide transformational learning . The antecedents of SMO, as a philosophy , system's model and organizational culture had proven its positive links to continuously '*optimized stakeholder satisfaction*', '*synergy building*' and '*clear understanding of roles*' aiding participation and '*integrated governance*'. SMO's features provided potential models for creating the investigation tools for the study of paradigm(s) transformation. Earlier studies have given primary attention to systems' performance levels in the domain of '*operational and re-distributional efficiency maximization*'. Shortcomings in other areas such as '*strategic management*', '*integrated governance*', '*participative inquiry*' and '*stakeholder synergy building*' have been justified in terms of resource constraints and '*redistributive-operational efficiency*'.

There have been arguments regarding the impossibility of effective healthcare management due to the ethical sensitivities at play in this industry. On the other hand the failure of reaching a '*decentralized*', '*stakeholder empowered*' and '*participative*' system, promoting joint planning and implementation have been indicated by a smaller number of studies underlining the importance of '*capacity building*' for overcoming this problem . This group of studies (amongst all EU observatory's Healthcare Systems in Transition series, Saltman and Fuergas 1997) have

emphasized that ‘*decentralization*’ can only be successful when backed up by an increased number of purposefully designed and delivered training packages in the fields of sophisticated leadership and management (see also Mark 1995 and Szocska et.al.2005). The fundamental significance of the design and delivery of such programs has not only been less appreciated at the Hungarian level , but they have also faced pressure of justification due to the presiding paradigm level gaps in this sector. (i.e. researcher’s own correspondence with the Ministry of Health)

2.The main understandings framing the hypotheses – The researcher’s perception arriving at the topic of the study:

1. Proposition :“*Paradigm is the milieu of stakeholder thought, interaction and transformation*”. Stakeholders’ paradigm influence all levels of reform planning , implementation and institutionalization of reform.
2. The Kuhnian understanding of ‘*paradigm shift*’ and ‘*incommensurability*’ are insufficient and deserve revisiting. (Proposition: Development enjoys an intrinsic value guiding perceptions of Roles and Goals within the domain of a single paradigm with different transformational levels)
3. The continuous Healthcare Reform failure in Hungary has been an outcome of stakeholders’ paradigm marked by lack of stakeholder participation in bottom up processes of policy planning and implementation
4. Stakeholder Paradigm Level Gaps are high. Misperceptions exist regarding stakeholder Roles, Goals and the process of Transformation.
5. A simplified model or typology for assessing and addressing paradigm levels has not been available
6. Reform failure has been due to the absence of well designed and sufficiently promoted capacity building programs, essential for the institutionalization of an ‘integrated governance’ within the framework of a strategic management system. (Reform success requires Capacity Building programs through sophisticated training in the area of leadership and management)
7. The conceptualization of Market Orientation (MO) deserves revisiting. MO from a Systemic (SMO) perspective is a paradigm. SMO promotes clear ‘Role’ understanding , Responsive / Participative Goal-Setting for optimal results. Through SMO continuous stakeholder value optimization through participative inquiry, knowledge sharing, synergy building can be achieved
8. Communities of Practice (CoP) are essential for promoting system wide learning and innovation across the socio-economic networks and their development cycles towards Triple Loop

3.Aims of the current study:

1. Revisiting the definition of ‘paradigm’, domain, dimensions and incidences in the field of economic policy and healthcare reform policy planning, the process of paradigm level transformation including an extraction of the best methods for paradigm level analysis

- Exploration of the stakeholder paradigm (levels) impeding successful healthcare reform in Hungary- *“paradigm level gaps as sources of continuous Healthcare reform failure in Hungary”*
2. The extraction and structuring of the researcher’s own field related *a priori* knowledge and experience (main understanding, perceptions, questions, hypotheses)
Accounting for the interplay of the researcher’s role and his paradigm influencing the course and outcomes of the study .
- 3.a. Developing *“a simple integrated typology for classifying and analyzing stakeholder paradigm levels”* from a Systemic Market Orientation (MO) perspective
- 3.b. *“Applying the typology”* to the incidence of the Hungarian Healthcare stakeholders
4. Based on the typology *„Design-Delivery (testing) Capacity Building Programs”* assisting paradigm gap level reduction , upper level transformational learning , stakeholder involvement in the bottom-up processes of reform policy planning and implementation

4.Method and Design, Sections and Phases of the Study:

The predominant nature of the whole study –endeavoring to explore main dimensions of stakeholder paradigms of the Hungarian healthcare – demanded ontological realism .(i.e. Zammito 2004) Therefore, A qualitative framework was found most suitable in line with Ospina (2004), stating that the application of the qualitative design had to best serve the purpose of : ”.....advancing a novel perspective of the phenomenon not ...well understood because of the narrow perspectives used before”, “ endeavoring to understand the social phenomenon from the perspective of the actors involved, rather than explaining it (unsuccessfully) from the outside”, (i.e. here the stakeholders of Hungarian Healthcare) “trying to understand the complex phenomena in whole its complexity, especially that has been dismissed by mainstream research because of the difficulties to study it, or that has been discarded as irrelevant, or that has been studied as if only one point of view about it was real” (i.e. here the notion of universality in our paradigm)

Sections, Phases of the study:

A 10 year long , qualitative longitudinal investigation divided into two main sections was used for achieving the aims of the study. Longitudinal design was used to allow replication and saturation in light of the changing psycho-socio-political environment. Regarding point of saturation the prominent writings of Glaser & Strauss (1967); Strauss & Corbin (1990); Wester, (1995) were taken advantage of. The positions of Yin (1984), Maso & Smaling (1998) regarding ‘*theoretical sampling*’, or ‘*replication logic*’ were considered.

The intention here at first had been to come up with a ‘typology’ for assessing paradigms. Therefore, room had been opened for grasping the existing variation which could be explained by a typology for further use. The decade long design- flexibility was found important for reaching the point of saturation.

The research project began subject to jointly agreed structure of the Management Consulting contract which very soon took the form of Participative Action Research (PAR) within the framework of Reflexive Grounded Theory. Modes of „*Praxis Intervention*” were adopted in order to open room for collective working on the researcher’s and participants’ settled mental models for continuously improving their „*Praxis Potential (Phronesis)*” through joint reflection over the course of the study. The above were found exactly in line with best practices for the study of stakeholders’ impeding paradigms related to healthcare reform.

Although, the researcher’s arrival at the subject of study was with *a priori* knowledge, the disturbances were dealt with through continuous reflection, internal and external comparison. Room was also opened for parallel examination of the findings in newer incidences in order to assist generalization.

Smaling (2003), had established general criteria in terms of ‘*fairness*’, ‘*ontological authenticity*’, ‘*educational authenticity*’, ‘*catalytic authenticity*’ and ‘*tactical authenticity*’ had to be accounted for . He had asserted “*the research should join in with the way of life of potential users and go on from there , instead of starting with a theory from the professional literature*”. Based on the same “*fairness*” referred to discussing everyone’s view with equal serious attention through open and equal negotiations regarding their conscious experience of ‘the world’ leading to “*ontological authenticity*”. Helping everyone’s understanding of the point of view and of the interpretations of the other stakeholders increase making “*educational authenticity*” actual. Smaling added : “*The study should make taking action or making changes easier, even stimulate it (catalytic authenticity). This overlaps with utilization value. The study and carrying it out should lead to empowerment of all participants by the fact that they are recognized as a sort of co-researcher (tactical authenticity)*”. A degree of flexibility in structuring reflexive grounded theory had been considered with parallel and readjusting

processes in order to allow optimum responsiveness and inclusion of newer findings in due course of the study based on Smaling (2003).

The selected design and methodology of the current study has been an effort in line with the above criteria.

SECTION I: (2001-2006)

Phase 1. Covered four inter-related/ parallel blocks

- a. The open exploration block (open coding), under the management consulting and leadership training project (MCLT)

Goals of the MCLT: Re-examination of the sources of reform failure from a bottom-top perspective. The design and implementation of a capacity building program aiding bottom-top reforms

Setting: 400 bed university hospital in the city of Pécs.

Participants and Roles: (n= 4) clients - all practitioners , one junior practitioner and 3 senior department leaders , all between their 30 and 50 years of age, all with international experience, one with non Hungarian heredity, employed at a large public university hospital provided the opportunity for modeling a comprehensive qualitative study. One client served the role of a Linking Pin Coordinator (LPC) allowing the extension of the project to the day-to-day setting. Through clients' close involvement possibilities for action research had been provided

- The Researcher (Consultant, Coach, MKO) : Above 30 years of age at the time of the study, with 4 years of experience as rotational health assistant at 4 different departments, international experience, non Hungarian heredity, above 7 years of parallel experience at various business management positions in the fields of construction and agriculture, management consultant with high affinity to systemic approaches to market orientation and strategic management, the field of triple loop and quadruple loop learning, Kuhnian approach to incommensurability and shift in the study of paradigm, theories of role and time perception, knowledge based development. The researcher had had experience with adopting BSC, EFQM and the Baldrige model of excellence in practice.

- b. Literature survey on the state of art in the field of 'paradigm ' and its influence on economic and healthcare reform policy for identifying potential gaps and arrival at synthesis helping a better structured *a priori* knowledge , assisting awareness parallel to

the primary investigation.

Explicit references were made to the following main sources:

WHO's model for goal setting in healthcare, OECD's model of healthcare excellence, EFQM's excellence model, the 360 degree balanced score card, NHS model of clinical governance, a variety of patient-centeredness models and market orientation models especially addressing impact of perceptual gaps on optimal performance. The value of learning orientation and entrepreneurial orientation to optimal results the FINMOUSE and CCPA checklist for reform policy plans, Knowledge Based Economics for optimal wellbeing (vs. Positive , Normative approaches to welfare and the role of the government) . Tinbergen's hierarchy of preferences and utility, Quadruple Learning and its components, Management and Leadership competences vs. theories of Role development, Time perception , goals and Paradigms for empowerment , decentralization, psycho-socio-economic transformation (fundamental change or reform)

c. Extraction of researcher's own understanding , experience , perceptions or hypotheses as a result of *a priori*

d. Joint Axial and Selective Coding

Data Collection:

Data collection was planned for the understanding, extraction and codification in the following areas with the overall goal of identifying patterns and relationships amongst data which would better explain resistance (namely reasons why stakeholders fail to move to third and fourth loop of learning):

F1)-perceptions of the contextual constraints including resources, setup/structure, processes,

F2)-perceptions of the content and goal of reform vs. own competences (K.S.A.O.s) and goals,

F3)-perceptions of own role and others' role

*Above were taken as the potential dimensions of the frame of references impeding SMO- mainly measured in terms of the goal of 360 degrees stakeholder satisfaction optimization.

* Suggestions of Smaling (2003) regarding transferability were considered in interactions with the clients clarifying:

- the status, position and roles of the researchers in the research situation (after all, these can have an influence on the research results);
- the selected fellow-workers, researched subjects and informants;
- the situations, conditions and social contexts of the research project;
- the selected methods, techniques and concepts; the (meta-)theoretical orientation;
- the reasons used to make the diverse choices mentioned above; and
- ‘thick description’.

Data Sources:

MCLT clients: Open ended interviews, formal/informal consultation sessions, participation in informal day-to-day events and occasions and visiting clients’ working context, clients’ memos and daily diaries, formal documents (integration of action research, ethnography and grounded theory as basic approaches). All included systematic and continuously recorded reflection

- ☞ Clients’ peers: Cross-examination and exploration of the same mainly through informal discussions and visits , reviews of diaries and memos with a diverse range of clients’ peers practicing within the same system (n=24) was conducted. The distribution was from similar fields of general and plastic surgery (n=8) and other specializations (n=16), with senior practitioners (n=18) and junior practitioners (n=6) in Hungary. Care was given that individuals whom had been predisposed to some type of prior management training are also engaged and involved in the exploration phase .Also, a diverse range of senior and junior practitioners in other EU systems (n=12) . These peers had been from Greece, UK, Germany and Sweden. The purpose had been to search for signs of additional items and to compare judgments of non-members of the same culture (i.e. how non-CEE doctors perceived the questions of contextual limitations especially their rankings, systems’ vs. doctor’s goals , having a holistic perspective etc. in interactions with direct and indirect stakeholders)
- ☞ Secondary resources on case incidences and observations elsewhere, especially from within the transitional CEE region and the other EU countries, the US, UK, Canada and India (n=15). Areas of focus and extraction covered the SMOP building blocks as perceived by the researcher. Secondary resources were applied in order to assist external validation of the results
- ☞ Researcher’s own paradigm evaluated through the same process and with reference to the researcher’s competence and context of practice, memos and diaries

Interventions:

Generally, the systemic market orientation approach was used for setting the goals of the project, communicating and interacting with the clients. Coding occurred through joint reflections on earlier sessions and recordings. A variety of explicit models were also used especially in formal consultation sessions to aid clarification of perceptions in order to extract the above areas. With higher exposure to explicit codes and terms, further consensus was experienced. Visual models/maps of the system showing the processes, structure and interactions were the most effective. Reference to experiences elsewhere and exposure to statistics / evidence on outcomes lead to consensus. It was interesting to note that the latter only occurred when it was combined with a “*positive approach to communication*” by the researcher in comparing ‘what is ‘ with ‘what should be’ in the context of practice, especially regarding the MCLT clients’ perceptions of their own and the stakeholders’ role. The same was experienced when the researcher showed “*concern for consequences of the context and content on their quality of life and daily activities*”. Consensus, co-operation and involvement was reduced in the absence of the above .Cross-examination , (especially on the field) lead to different results

*An open eye was kept on other influencing factors, especially the biases brought by the Hawthorne and Pygmalion effects (peers and colleagues were kept unaware of the comparison purpose study and received no feedback on outcomes elsewhere)

SECTION I Outcomes and Results :

1. The extracted 17+1 codes fine tuned further to reach 12+4 axial codes were extracted from the above qualitative study and tested for external validity through parallel literature survey and case study reviews. MCLT clients were consistently mapped in terms of their frames of reference. b)- A systemic perspective was used for selective coding via participative reflection . Three main dimensions (selective coding) were identified for building an assessment typology based on SMOP , these had been the perceptions of stakeholders’ ‘*Role Maturity and Context*’, ‘*Goal and Content*’ , ‘ *Time Orientation and Transformational Process*’ . For stakeholder level-gap assessment purposes each category was classified between lo -med-hi development (0-2 pts) depending on the level of resistance/openness and maturity of current role perception (impeding/promoting transformation).

2. Design and Development of the Paradigm Level Typology (2002-2006)

a)-An SMOP assessment typology was designed as a result of extracted dimensions of researcher’s perceptions and the further interactions with the

MCLT project. The typology was applied to the three dimensions and 12+4 codes .

5. Typology for Reform Paradigm Analysis based on Perceptions of Roles, Goals, Time (R-G-T)

Paradigm/Frame	Role Perception (Vision)	Goal Perception (Mission)	Time Perception (cycle of change)	Reform Emphasis
Subjective /Organic Market Orientation (OMOP)	Transitional Adult (<i>Conventional-Altruist</i>) Defined by Hierarchical heritage	Organic (<i>Normative-Traditional</i>) Liberal, Welfare , Solidarity	Pre-Destined (<i>individuals' and environments' past a good picture of the future</i>)	Social and Environmental Equity (<i>gaining external harmony</i>)- Redistributing wealth of a few wealthy
Objective/ Mechanistic (MMOP)	Transitional Infant (<i>Egocentric -Conventional</i>) Own Picture and Position	Mechanistic (<i>Positive-Darwinian</i>) Monetarist, Classical, growth of the wealthy	Evolutionary (<i>future /destiny can always be changed</i>)	Maximizing Interests (<i>enhancing competitiveness</i>) Securing wealth
Systemic/ Enactment (SMOP)	Adult (<i>Internally and externally Responsible-environment is not distinct from the person</i>)	Development (<i>Value Network Development-360 degrees Optimized Satisfaction</i>) Human Capital D.	Enactment (<i>past and present are part of the future changes with our change</i>)	Optimizing State of Wellbeing (<i>enhancing knowledge based performance</i>)

The typology was successfully used to observe the degree of SMOP (+)/GAP in terms of:

- Perceived Role Maturity (‘Adult’ or Kohlberg’s Principled/Post-conventionalist, ‘Leaders developing Leaders’),
- Goal (optimized 360 degrees stakeholder satisfaction, through leading, training, synergy building)
- Time Orientation (neither past nor future oriented- Enacted and systemic future) and Transformational Process (SLL,DLL,TLL,QLL)

All 4 clients were positioned at various levels of the MMOP paradigm (see below). Role maturity was based on Hershey and Blanchard’s (1996) situational leadership and Kohlberg’s levels of moral development :

- i. Mechanistic Market Orientation Paradigm (MMOP): Role mat.: ‘Transitional Infant’ with goals of securing wealth, maximizing interests and enhancing competitiveness. Explicit exposure brings convergence to evolutionary growth (Darwinian) and future orientation. Minimal state, capitalism , secured growth of the few wealthy (positive, classical and monetarist tendencies). Statement representing this category *“My job is to serve the patient for my own (psychological and physiological interests. I should and will change the system ”*
 - ii. Organic Market Orientation (OMOP): Role mat. : ‘Transitional Adult’ with goals of altruism, conventionalism, gaining external harmony. With explicit exposure; convergence towards: ideas of redistributing the wealth of a few wealthy, past a good picture of the future, pre-destined futures (not necessarily in a religious sense), liberalism, normative, welfare economics, government intervention and solidarity occurred. Statement representing this category : *“It is the systems’ job to serve interests of the patient and my interest. My job is to assist the system if I want to assist myself. System should change and then I will too”*
 - iii. Systemic Market Orientation Paradigm (SMOP): Role mat. ‘Adult’ with goals of 360 degrees optimization of well-being and satisfaction , past and present are part of the future , the future is every next moment and has to be continuously enacted. With explicit exposure convergence to: enhancing knowledge based development and performance, value networks as basis of the system, decentralization for continuous innovation with fostered synergy building by leaders and entrepreneurs continuously developed through training. Statements representing this category: *“There is no system without me or vice versa. I’m an outcome of the past and a part of the future but the past-present and future build the reality of the same story in life. We should offer the same stewardship and care to the environment as we expect from the environment. My job is to sometimes decide on behalf of the patient but also to train, involve the patient and the family to care for themselves and myself as a part of the society”*
- ❖ **Analysis:** MCLT (4) represented OMOP with signs of medium level of resistance while all other MCLT clients were positioned on the MMOP . MCLT (3) represented signs of a higher than average level of resistance. MCLT (1) and (2) with medium resistance to change. Role Maturity was categorized as moderate (transitional infant). It was interesting to note that the project idea had been initiated and by MCLT (1) whom had volunteered for the LPC role, proving

- Note : The MCLT clients withdrew from the training and formal consultation

contract after the first 6 months but continued as available sources for examination to the researcher. This opportunity paved the grounds for a longitudinal study. The MCLT clients were reserved as a control group for continuous re-examination and comparison with newer subjects throughout the various phases of the 10 year long examination

b)- a Hungarian wide survey was designed based on the said typology (12 cities and 4 major hospitals) . The survey was conducted in a parallel manner with another team , for assessment of stakeholder paradigms and readiness / capacity for participation in bottom-top reform

The results confirmed the existence of wide perception gaps.

- **Doctors** perceive lack of patient centered attitude strongly linked to ‘*requirements of practice*’ (termed general approach to treatment) and equally with high strength to ‘*working environment constraints*’ (including low wages).
- **Department leaders and upper hierarchies** perceive illness-centered attitude only moderately as ‘*requirements of practice*’ (termed general approach to treatment) and highly to ‘*working environment constraints*’ (including low wages).
- **The patients** confirm absence of ‘*communication and partnership*’ concerns by the doctors during the visits . Interest on the ‘*effect of illness on patient’s life*’ and ‘*health promotions*’ received highest divergence. Working environment constraints are considered relevant to doctor’s attitude. The perception on ‘central goal of healthcare’ strongly tends towards ‘*treatment of patient as a person*’ and ‘*satisfaction of the patient*’ . Here the widest gap was traced.
- **Representatives of public at large** strongly perceive ‘*communication and partnership*’ as well as ‘*participation in treatment*’ the most important factor for better results, with rating ‘*patient’s satisfaction*’ as important. ‘*Working environment constraints*’ are considered important.

SECTION 2: (2006-2011)

Further examination of the typology (testing saturation level) through a designed Healthcare Learning and Innovation Platform (HLIP):

Timeline : 5 year period with 7 starting points and avg.13-14 participants for training and continuous learning towards the 4th loop under an established community of practice (CoP)

Setting : Faculty of Business and Economics University of Pécs.

Participants: (n=95), professionally and demographically diverse stakeholders of the Hungarian Healthcare seeking to improve their knowledge and skills in the area of healthcare leadership and management (100%), with minimum graduate degrees (all) , and two years of experience for Junior physicians(n=3). Positions included: Practitioner Leaders and Senior Decision makers (n=35), Other Senior Physicians (n=20), Nurses (n=9), Lab specialists (n=3) covering also IT Specialists (n=2), Emergency Technicians (n=2), Lawyers (n=3), Medical Engineers (n=2), Biologists (n=1), Med. Researchers (n=1), Economists (n=5), Administrators (n=4) , Insurance Inspectors (n=2), Private representatives and entrepreneurs (n=3) . Gender distribution 48 M/47F, with age distribution between 25-66 and 77% falling between 25-50, coming from all across the country (note: southern Trans-Danube accounted for 83%). Participants at the entry phase, had highlighted the importance of receiving a clearer overview of the direction of the healthcare system and to be able to understand – relate to the various level, goals and processes within the system

Intervention :

The Healthcare Learning and Innovation Platform (HLIP) + Community of Practice (CoP)

Part 1.

Participants were subjected to an incubation period with a pre-determined structure (4-6 month period), with in-class, on-site and on-line training, referred to as the “*Planning and Re-Engineering*” phase . Entry included a “*pretest*” followed by an “*interactive capacity audit*” and the submission of a “*change plan-program*”

- *Pretest: Role-Goal-Time (R-G-T) perceptions observed through Likert scale and open ended questions in order to determine SMOP convergence degree (R=Adult Role, G=Value Optimization, T=Enacted Future)*

- *Consultation for joint capacity-audit :* Participants, through interaction were lead to designing a self assessment of R-G-T to determine SMOP(+,-) providing them with evaluation and feedback. A tailor made strategic audit was used to compliment the R-G-T assessment (two types of scaling were used to determine the level resistance/openness and also one highlighting SMOP Role maturity level) . Participants were requested to explicitly write their Visions (how do I see myself ?), Missions (what do I do ‘for’ and ‘offer to’ myself & stakeholders, why? under what norms, mores and values?). The Mission was later refined if necessary further to an environmental audit . This level included: capability assessment , recognition of horizontal and vertical value chain participants (assisting movement from the single loop cycles and enter the first cycle of the second loop)

- *Change Project Plan :* (moving to the second cycle of the second loop)

Participants were lead to a topic for their “*change project*” and to work on designing implementation plans / complimentary programs that would serve the Mission (subject to SMOP) through a balanced scorecard (BSC) of key performance indicators (KPI). The design and delivery of programs in the form of a strategic management system was common amongst all participants. The participants , depending on their R-G-T’s were lead to propose strategies and policies supporting change programs (in line with the BSC defined there in). In addition to being exposed to group based learning, explicit-tacit spillovers, diversity learning , the participants were lead to moving towards the second cycle of the second loop of learning. All submitted operational plans included explicitly defined Roles, description of tangible and intangible exchanges within their value networks (applying the VNA model for system-roles-deliverables)

Part 2.

Participants were offered assistance in the form of teams for “*Implementation and Leadership of Organizational-Wide Change*”

- *Implementation and leadership for organizational-wide change (entry level of the third loop) :*

Timeline: 5 years with 7 starting points

Setting: Faculty of Business and Economics University of Pécs

Assisting Teams: Teams from Multidisciplinary LIPs made up of graduate (BA, BSc.), post-graduate (MA., MSc.) and (PhD.) students of various faculties of the universities of Pécs, and Ohio. Business students from the Sheffield university (one occasion) and university of Subotica (Szabadka) participated in the said projects.

Change Projects of HLIP participants:

HLIP participants were offered assistance for implementation (if deemed necessary).

Participants and Projects:

(n=9) participants received assistance for implementing the strategic management system and leading their specific project focus to operationalization through this parallel process. These included the following areas:

- Onco-therapy technology’s services at a public hospital, initiated by the head of finance : Two Tier System for promoting an innovative
- Anesthesiology, head of a department : Foundation of the first Private Locum services to assist the system with shortcomings in the field of Anesthesiology
- Junior Healthcare Manager : Private International Medical Tours
- Head of healthcare IT department at the nephrology clinic: Monitoring and

feedback systems initiated by the Two tier portfolio development and marketing for extending private plastics, burns and cosmetic surgery by a senior plastic surgeon

- Primary Care GP: Private Portfolio Diversification and marketing
- Endocrinologist: Cooperation strategies, value chain and supply chain cooperation partnership development for optimizing public-private practice
- Head of a public convalescent hospital: Implementing and institutionalizing the strategic management system for reaching a two tier portfolio of services
- Head of the Department of Marketing of a Non Profit Healthcare Association: Synergy building through appropriate leadership and redefining governance processes

Part 3.

Through a joint initiative the establishment of a Community of Practice for the institutionalization of SMOP and the completion of quadruple cycles needed for decentralization

- *Institutionalization of SMOP : The Foundation of a Community of Practice around the HLIP by the participants (moving to the fourth loop learning, institutionalization of SMOP for sustainable development, involvement-empowerment-leadership-innovation)*

The participants of the HLIP were supported and fostered towards the foundation of a joint knowledge based network in the form of a community of practice (CoP) - The first Healthcare Leadership Development and Management Institute in the region. This was taken as the primary evidence of the completion of the fourth loop for achieving innovations, breakthroughs and socio-economic transformation.

Timeline: The CoP was established with (n=38/52) participants after the 3rd year of the HLIP .After the fourth group of participants (n=52) had fulfilled (Part1), and further to their submission of a “change plan” (in written format and via oral discussion), and participation in the written post –test (in the form of an open book analytical exam centered around SMOP based approach to analysis) together with a Reflective Overview for cross examination of the state of knowledge absorption and the more intangible levels of R-G-T perception.

Setting: Foundation of the CoP under a non- profit association in southern Trans-Danube region of Hungary at the capital of Baranya County –the city of Pécs

Participants: The CoP is a knowledge based network organization registered by the participants (n=38/52). From the remaining participants (n=43), (69.7%) of them (n=30) have reached the qualified level and have submitted requests for joining the CoP. The Motto implies “*we are the change we want to see*” (self involvement and leadership)

Design: Members participate in jointly designed development projects. Each member joins the CoP with his/her own development project. Project teams are made-up of members and non-members (partners) and are fostered by committees involved in the various levels of knowledge generation, codification, promotion and dissemination. Monitoring and feedback is conducted via two SMOP based tools to monitor attainment of the quadruple loop cycles in a continuous manner. The *personal development barometer* and *the healthcare development map*

SECTION 2 Outcomes and Results:

The SMOP model for planning capacity building based on preparedness was successfully tested through the design and formation of a Healthcare Learning and Innovation Platform. The degree of preparedness were observed via a pretest based on the SMOP model results (structured Likert scale and open ended combination) showed the following categories amongst the representatives:

1. Organic Market Orientation Paradigm (n=54) or (56.8%) with (n=2) or (3.7%) showing signs of exceptionally low resistance levels (n=12) or (22%) showing signs of exceptionally high resistance to change
2. Mechanistic Market Orientation Paradigm (n=38) or (40%) with none (n=0) showing signs of exceptionally low resistance and (n=10) or (26.3%) showing signs of exceptionally high resistance to change
3. Systemic Market Orientation Paradigm (n=3) or app. (3%) showing early signs of SMOP

6.New Findings and Discussions

- Thesis-1: “Paradigm” represents the most universal milieu of ‘thought’, ‘action’ and ‘transformation’. Consequently, the Kuhnian conceptualization of incommensurability and paradigm shift are insufficient. It is more appropriate to think of only one single paradigm with different development levels for all stakeholders.
- Thesis-2: The most comprehensive dimensions of stakeholder paradigm can be observed through perceptions of ‘Roles’, ‘Goals’, ‘Time Orientation / Transformation’
- Thesis-3: Paradigm level transformation is an ‘internal individual process’ complimented

by external loops of co-learning and co-creation of reality (Perceptions of Role, Goal, Time).

- Thesis-4: The existence of at least one leader (Post-Conventional, More Knowledgeable than Other) at a given time and setting is important for initiating transformational learning systems.
- Thesis-5: Reform requires stakeholders' psycho-socio-economic transformation , which is a long-term outcome of upper level transformation reaching Triple Loop and Quadruple Loop learning.
- Thesis-6: The co-creating nature of stakeholders' paradigm formation and transformation, requires the institutionalization of learning systems which support Reflexive, Participative Action Research, initiating knowledge sharing for joint development.
- Thesis-7: Market Orientation from a Systemic perspective, can be taken as the single, most universal paradigm. Systemic Market Orientation Paradigm represents the upper level learning loops and the occurrence of the psych-socio-economic transformation (reform)
- Thesis-8 : Stakeholders' level of development and areas of convergence and divergence can be reliably observed through a typology. Stakeholders go through transformational processes under the 'Mechanistic' and 'Organic' levels, on their way to Systemic Market Orientation Paradigm. The typology was developed, operationalized and tested through 16 codes in the current study.
- Thesis-9: Healthcare reform failure in Hungary, lack of stakeholder participation in the bottom-up processes can be explained by the high level of divergence (gap) from the Systemic Market Orientation Paradigm. These are represented at all levels of policy Content (Optimized Stakeholder Goals), Context and Actors (Governance, Roles), Process (Transformation and Decentralization)
- Thesis-10: Healthcare reform success requires the design and implementation of capacity building, empowerment and learning systems tailored for reducing gaps and promoting systemic market orientation. The '*Healthcare Learning and Innovation Platform*' and the '*Community of Practice*' (Healthcare Leadership and Management Development) tailored for the purpose of the current study provide reliable incidences for future planning and program design purposes



- **Reflection on Hungarian results:**
(Optimized stakeholder satisfaction, Participation, Synergy)

From the total participants of the programs (n=52/95) reached upper levels of transformational learning and Systemic Market Orientation Paradigm. The mentioned established the first knowledge based Community of Practice for assisting healthcare reform. One case represented minimum participation in the processes, proving the importance of entry level screening and redirection to complimentary learning pathways.

Based on the findings of the current study , for successful reform , achieving a universal understanding of development and direction for transformation of stakeholder paradigms (including the politicians) is possible. The study reconfirmed that clear vision, sense of direction, better goal setting in line with the 360 degrees well-being, strategy and innovation can be promoted through capacity building programs. Openness to co-learning and co-investigation as well as the continuous isolation and reflection on the influences of the researcher's own paradigm can be claimed to be the strengths of the study.

7.Future Research

The following areas are suggested for complimentary future investigations

- Investigations should continue for monitoring the emergence of newer codes not revealed across the extension of the 10 year period of the current study.
- The 'Entry' level screening methods will require improvement. It would be interesting to note and keep an open eye for the frequency and size of recurrences of cases such as that of the single participant (G.B.) in who's case the program had been only slightly effective, due to lack of engagement and participation in the orientation period.
- The participants had ranked ' *better perspective* ', ' *understanding the system* ' as the most important expectations from the program. The participants had coded the outcomes as per ' *New Knowledge* ', ' *Better Perspective* ', ' *Constructive Spirit* ', ' *Social Capital* ' and ' *Independent Thought* ' . These areas deserve continued monitoring for newer findings. However, a cumulative study of all foundation HLIP participants may lead to newer findings.
- The programs did not engage those stakeholders without higher education and those falling out of the defined age range . Given the fact these groups do have a high impact

on the success and failure of reform , additional research regarding methods of engaging the mentioned group is worthy of consideration.

- The reasons for high fluctuations in the number of participants especially in 2007 had not been addressed (important for planning).
- The number and quality of the newer programs can have a high impact on the effectiveness of the current programs deserving continuous monitoring. The current study did not provide a comprehensive assertion regarding the ranges and modes of government support (i.e. number of new courses, volume and value of investment starting points, expected short to long term ROI etc.)
- '*Knowledge Acquisition*', '*Flexible Schedule*' , '*Good Proximity*' have been ranked as the most important reasons for choosing one program option over the other . It is still interesting to note that regulatory pressure put on leaders for acquiring managerial training has been a significant trigger for participation. This driver can have important implications for the future planning and policy making decisions.

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