The next phase of healthcare improvement: what can we learn from social movements?

P Bate, G Robert, H Bevan

To date, improvement in healthcare has relied mainly on a “top down” programme by programme approach to service change and development. This has spawned a multitude of different and often impressive improvement schemes and activities. We question whether what has been happening will be sufficient to achieve the desired scale of change within the time scales set. Is it a case of “more of the same” or are there new and different approaches that might now be usefully implemented? Evidence from the social sciences suggests that other perspectives may help to recast large scale organisational change efforts in a new light and offer a different, though complementary, approach to improvement thinking and practice. Particularly prominent is the recognition that such large scale change in organisations relies not only on the “external drivers” but on the ability to connect with and mobilise people’s own “internal” energies and drivers for change, thus creating a “bottom up” locally led “grass roots” movement for improvement and change.

Healthcare systems around the world are engaged in striving to make radical and sustainable changes through various programmatic approaches to improvement. For instance, in the UK the NHS Plan was published in July 2000 promising “a revolution in health care” over the next 10 years. “Radical action” through increased investment and reform would put “patients and people at the heart of the NHS”. The words and language of this and other similar international programmes leave no doubt that what is being envisaged is big, bold, transformational change.

The Institute of Medicine in its seminal 2001 report, Crossing the Quality Chasm: A New Health System for the 21st Century describes the “chasm” between the unacceptably poor standards of current care delivery systems and what it could and should be in the context of the USA. It provides a challenging manifesto for transformation of the American healthcare system as a whole.

The Australian Council for Safety and Quality in Health Care has set out a radical platform for investment in health systems redesign, system capacity building, cultural development, and enabling patients to be partners in their own care.

Internationally there is a parallel realisation and understanding that the design of the existing healthcare system will not deliver what is required for the future. All these plans and publications set out bold aims and targets. However, none of them specify how the leverage that will deliver the changes will be created.

A MOVEMENT FOR HEALTHCARE IMPROVEMENT

Most ideas that underpin contemporary healthcare improvement initiatives are derived from planned or “programmatic” approaches to change. These approaches are most frequently described in the literature on organisational and management studies which encompasses organisational development, strategy and design, and individual and team development (as well as increasingly significant research that focuses upon sensemaking). However, there is another so far unused research base in the social and political sciences that offers an entirely different perspective on how large scale change occurs. This is social movements theory which seeks to explain “why collective episodes [such as movements and protest] occur where they do, when they do, and in the ways they do?”.

As part of a wider initiative led by the NHS Modernisation Agency (box 1) to encourage closer links between theory and practice, a number of leading improvement practitioners, healthcare managers, clinicians, and policy makers in the UK met in July 2002 to debate and challenge the dominant ideas in this field of research (box 2).

In particular, the group considered what implications other theories of large systems improvement may have for the way healthcare modernisation and reform might be approached in the future, thereby enacting the notion of transferring research into practice. During the colloquium the group explored the potential of social movements theory as distinct from the usual “programmatic” approach and, in particular, considered its applicability to the concept— and feasibility of creating—a healthcare improvement movement.

The colloquium attempted to draw out some of the contrasts between the programmatic and social movement perspectives on change that are pertinent within the context of approaches to healthcare improvement and modernisation (table 1).

These two perspectives are based on very different underpinning assumptions about change which have important implications for NHS policymakers. For instance, with regard to
Lessons for healthcare improvement from social movements theory

Formal and informal organisations might positively assist "positive" epidemics of their own. Tipping Point, which examines the social epidemics that movements develop and change. Indeed, the presence of formal and informal organisation might positively assist movement formation. The social movement framework may therefore be useful for understanding large scale mobilisation efforts inside healthcare systems.

Social movement organisations alike have recognised that change is usually gradual and evolutionary, often running out of steam before reaching its final destination. This is also why, in recent years, a number of private sector organisations have themselves turned away from traditional organisational development and formal programmes of change to more informal "communities of practice".

Aims
To explore NHS modernisation and improvement from the alternative perspective of social movements and identify the implications of this perspective for the way we go about modernisation.

To understand how a movement works and unfolds—dynamics, stages, preconditions and essential elements.

To consider how we might begin to engender a "movement mentality" or movement sensibilities around NHS modernisation.

Method
The approach adopted was that of a "joint interpretive forum" which brought together members of different stakeholder groups to jointly reflect upon and interpret academic research and to examine its significance in terms of action as part of an ongoing process of collective sensemaking. A discussion paper and questionnaire were pre-circulated. After an introductory presentation and feedback on the questionnaire responses, group discussion was facilitated by the authors (PB, HB and GR). The proceedings were taped and transcribed.

Attendees
Fifteen individuals were invited to provide a cross section of people closely involved with planning and implementing NHS modernisation. The group included staff drawn from across the NHS Modernisation Agency, the Institute for Healthcare Improvement, policy makers, a hospital trust chief executive, and clinicians who had been closely involved with one or more modernisation programmes.

THE SOCIAL MOVEMENTS PERSPECTIVE

Although the objection to the application of a social movements perspective is usually that social change is different from organisational change, there are in fact strong similarities in terms of the mechanisms by which organisations and social movements (such as environmental or peace movements) develop and change. Indeed, the presence of formal and informal organisation might positively assist

<table>
<thead>
<tr>
<th>Programmatic approach</th>
<th>Social movements approach</th>
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<tbody>
<tr>
<td>A planned programme of change with goals and milestones (centrally led)</td>
<td>Change is about releasing energy and is largely self-directing (bottom up)</td>
</tr>
<tr>
<td>&quot;Motivating&quot; people</td>
<td>&quot;Moving&quot; people</td>
</tr>
<tr>
<td>Change is driven by an appeal to the &quot;what's in it for me&quot;</td>
<td>There may well be personal costs involved</td>
</tr>
<tr>
<td>Talks about &quot;overcoming resistance&quot;</td>
<td>Insists change needs opposition—it is the friend not the enemy of change</td>
</tr>
<tr>
<td>Change is done &quot;by&quot; people or &quot;with&quot; them—leaders and followers</td>
<td>People change themselves and each other—peer to peer</td>
</tr>
<tr>
<td>Driven by formal systems change structures (roles, institutions) lead the change process</td>
<td>Driven by informal systems, structures consolidate, stabilise and institutionalise emergent meanings but create nothing</td>
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</table>
practice” based approaches, not that dissimilar from social movements thinking. The common emphasis of these approaches is on self-managed change which is much more unplanned and spontaneous and which finds its energy from the commitments of those involved both to the ends they are collectively seeking to achieve and to each other—“adherence to the spirit of the change goals rather than just to the letter”.

Broadly, the purist social movements perspective would advocate that healthcare improvement strategies need to extend beyond the present centre led programme by programme approach to embrace a concept of citizen led (healthcare staff and/or user) change that draws upon unstructured and largely self-organising autocatalytic (self-fuelling) phenomena. Such factors characterise social movements where “elites” seek to set mobilisation processes in motion (and then help coordinate and resource them) rather than establish yet another new programme. This is why we find the phrase “orchestrated social movement” in the literature when referring to organisational movements, suggesting that change is not managed as such but liberated, channelled, and enabled. Questions raised at the colloquium therefore included:

- What are the characteristics of successful large scale mobilising efforts?
- Why do people join movements and why do they become activists?
- Why would people join a healthcare improvement movement as they might any other movement?
- Are those staff currently involved in improvement activities the most important people for delivering radical changes in the quality of health care provided on the ground?

THE NEXT PHASE OF HEALTHCARE IMPROVEMENT

Overall, attendees at the colloquium concluded that those leading and implementing modernisation in the NHS may benefit from considering the change task from the alternative perspective of social movements, as distinct from the usual organisation studies and change management perspective. Figure 1 presents a three stage model of building such a movement which arose from the colloquium.

A key challenge arising from applying this model in a health care context is how, firstly, to leverage the existing latent potential for change within a specific healthcare system and, secondly, to secure wider and deeper participation in a movement for improvement. In other words, how to enable healthcare staff to enrol voluntarily or sign up and participate actively in improvement activities.

The social movements perspective (table 1) suggests that the more one person’s meanings, values, aspirations, identity, and personal biography align with those of the movement (the individual’s receptivity to change), the more likely that person is to join and invest significant emotional energy. This is not just a matter of chance or coincidence. Alignment is very much a matter of how the case or cause is “framed” and presented by the leaders—that is, the actual words and language that make up the “script” for improvement will be decisive in capturing people’s attention and intention. This begs the question as to whether existing scripts are the right ones or whether there are better “mobilising frames” and narratives for fostering solidarity. This question resonated with attendees at the colloquium—for example, existing improvement programmes in the NHS (such as the Cancer Services Collaborative’s) with their explicit focus on improving patient outcomes and experiences and the close involvement of clinicians in objective setting were proving more successful in terms of engaging clinicians than programmes focusing solely on improving access to services (such as the booked admissions programme’s). Social movements theory would suggest that the latter are less congruent with the “frames” of the clinical community. Securing this initial involvement is the crucial issue since, once individuals have joined, the interactions and relationships they build tend to ensure that they stay with the movement. Thus, from this perspective, sustainability and mainstreaming is very much a social issue—a question of collective identity, commitment, and purpose.

The core issue in social movements theory is “local mobilisation” or grass roots change. At the individual level, mobilisation refers to the concrete actions taken by a person in the direction of change while, at the organisational level, mobilisation refers to the process of rallying and propelling segments of the organisation to undertake joint action and to realise common change goals.

Social movements theory postulates that changes are only likely to “catch hold” on the ground—or even be recognised as viable possibilities in the first place—if they are consistent with local customs, habits, aspirations, and passions. Participating in a movement does not appeal to, nor find its forward movement from, reason but from emotion—from seeing participation as an opportunity or a challenge. For a movement to form, people must be “moved”; Spence et al talk about the mobilisation of “sentiment pools”—people’s inner feelings which can help to overcome uncertainty and difficulties.

This in turn raises the question of whether a publicly funded healthcare system such as the NHS is too big (and diverse) for a single movement. We know that most movements begin in localities (geographical and professional) and, if successful, may ultimately run into and join up with each other: “a merger or coalition of existing groups rather than an organisational offshoot of a single group”. A typical hospital system or community in the NHS will currently host up to 50 separate improvement initiatives: how can they be joined up so that the sum may become greater than the parts? From this social movements perspective the NHS Modernisation Agency’s shifting emphasis away from national policies aimed at shaping local policy agendas and towards creating capacity for modernisation and improvement locally is a direction which fits well with what a social movements perspective would prescribe. Movements need local “activists” and “flag bearers” who will “convert” their peers and so form the critical mass of support for sustained change and improvement, and again the Agency’s “Modernisation Associates” initiative at the hospital level is highly consistent with social movements thinking.

Some words of caution are needed. Firstly, some commentators remind us that “the outcomes of most movements are modest”, that most “operate on the margins of success with
Lessons for healthcare improvement from social movements theory

Key messages

- To date, healthcare improvement and modernisation has mainly relied upon the classic planned incremental “programmatic” approach to service change and development.
- The results from these approaches are encouraging. However, in the UK, for example, it is estimated that fewer than 15% of NHS staff participate in these formal improvement activities. We ask whether current programmatic approaches are sufficient to achieve the scale of change required in the shortest possible time.
- Evidence from the social sciences suggests that a social movements perspective may help to recast large scale “transformative” organisational change efforts in a new light by offering a different, but complementary, approach to current healthcare improvement thinking and practice.

CONCLUSION

Attempting to implement a social movements type of approach in contemporary healthcare systems may have the potential for unintended and perhaps unwelcome consequences. However, this is no justification for not temporarily stepping back from the current widely accepted approaches to modernisation and questioning whether social movements thinking may offer “added value”. Indeed, we would argue that the components of a social movements and a programmatic approach to large scale organisational change are not necessarily mutually exclusive and may represent the next phase of healthcare improvement.

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