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perspectives brief

title | **The inaugural John Deeble Lecture 2019**

Australian Parliament House, Canberra
18 October 2019

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The John Deeble Lecture 2019

Professor John Deeble AO (9 July 1931 – 5 October 2018)

Professor John Deeble AO was an Emeritus Fellow of the Australian National University, a Sax Medallist and life member of the Australian Healthcare and Hospitals Association (AHHA), and patron of the Deeble Institute for Health Policy Research, AHHA. Together with Dr Dick Scotton, he co-authored the original proposals for universal health insurance in 1968, when they worked together at the Melbourne University Institute of Applied Economic Research.

John was special adviser to ministers for health in the Whitlam and Hawke governments, chairman of the planning committees for both Medibank and Medicare, and a Commissioner of the Health Insurance Commission for 16 years. Other appointments included First Assistant Secretary in the Commonwealth Department of Health, Founding Director of the Australian Institute of Health and Welfare, and from 1989 to 2005, Senior Fellow in Epidemiology and Adjunct Professor in Economics at the National Centre for Epidemiology and Population Health at the Australian National University. Professor Deeble was a World Bank Consultant on health care financing in Hungary, Turkey and Indonesia, and for over 10 years to 2005, an adviser to the government of South Africa.

The Deeble Lecturer
Nigel Edwards, Chief Executive, Nuffield Trust, UK

Nigel Edwards is Chief Executive at the Nuffield Trust. Prior to becoming Chief Executive in 2014, Nigel was an expert adviser with KPMG's Global Centre of Excellence for Health and Life Sciences and a Senior Fellow at The King's Fund. Nigel was Policy Director of the NHS Confederation for 11 years and has a wealth of experience in health and social care. He joined the organisation from his former role as Director of the London Health Economics Consortium at the London School of Hygiene and Tropical Medicine, where he remains an honorary visiting professor.

Nigel has a strong interest in new models of service delivery and a practical focus on what is happening at the front line, as well as a wealth of experience in wider health care policy in the UK and internationally. Nigel is a well-known media commentator, often in the spotlight debating key policy issues. Nigel is currently working with the WHO Regional Office for Europe and the European Observatory on Health Systems and Policies on developments in health care provision in Europe. Nigel has been awarded an honorary Doctor of Science degree by the University of Westminster.

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1. Introduction

Thank you for inviting me to give this lecture.

I am honoured to be here and pleased to have a week away from the UK's gradual transition to becoming a failed state.

Researching for this lecture I found this on the AHHA website[1]

This is an appreciation I would aspire to, and these themes and my experience in the Europe challenge us to think about health policy and its implementation in a number of important ways. I am first going to use a case study drawn from recent NHS reforms to illustrate a number of lessons about what goes wrong in policy formation and implementation.

I will then make some suggestions about what needs to be done to improve this process and argue that traditional calls to get more evidence into policy miss important aspects of the world we now inhabit, but that there are some helpful strategies to do this. I will argue for the importance of intermediaries who can help all the participants by

- Challenging their preconceptions and assumptions
- Clarifying the questions and the diagnosis
- Synthesising the evidence
- Understanding the difference between theory and practice
- Connecting issues and different levels – the strategic and the operational
- Bring more diverse views and ideas to debates that are often inward looking

This is more necessary than ever because of the growth of complexity, the increased velocity of the world we live in, the challenges of large scale and broader changes in society.

2. Case study: So big it can be seen from space[2]

Let me introduce you to Andrew Lansley, now Lord Lansley, he was something of a policy wonk who found himself in power and presided over a text book policy failure – easily in the Brexit league. His experience offers a case study that follows the structure of a Greek tragedy and illustrates many of the things that go wrong in the policy process

1.1 Act 1: Hubris

Andrew Lansley became secretary of state for health in 2010 having spent an unprecedented six and a half years in the shadow role – he had a plan based entirely on his own ideas and it was not really clear who he listened to in developing them.

His idea was to boost the NHS quasi-market giving GPs purchasing power and organising them into groups to do commissioning. There would be much more emphasis on patient choice and competition, including price competition. The idea was to simplify the system and, a favourite of all politicians, to 'reduce bureaucracy'. As part of this, and as an attempt to remove ministers from the day to day running of the NHS, he wanted to establish two arm's length organisations: one for commissioning, one for economic regulation with ministers removed from day to day operations.

The half-finished project of making hospitals autonomous would be completed and there would be greater private sector involvement.

The policy was formulated in broad strokes in 2007 but the overall implementation timetable remained unclear, as did a lot of the detail. No revisions or changes were made even when the 2008 financial crash led to a prolonged period of austerity and years of flat funding for the NHS.

As the 2010 election approached the Conservatives were leading the polls and realised that talking about technocratic reform of the NHS was at best boring and at worst might alarm the electorate who often did not trust them on health. So, they talked about choice, promised to cut the bureaucrats, maintain current spending plans and said that there would be 'no more pointless top-down reorganisations'.

Talking in populist generalities was a sensible electoral strategy and the debate focussed elsewhere. But this meant that the proposals got very little, if any, scrutiny. It's clear that his cabinet colleagues had little idea what was planned, and Lansley was hard to engage. He was often prickly and dismissive and was not open to challenge.

Very unusually for the UK, the 2010 election resulted in a coalition.

In the discussions leading up to the formation of the government, health seems to have been almost forgotten and what resulted was a mess. It felt like something cobbled together at the last minute, on a hot afternoon when everyone was tired – and once again there was no real discussion of what was being proposed.

Once in power, Lansley set out realising his plan – and ignoring the agreement.

1.2   Nemesis

The government was in a great hurry and was not interested in the detailed scrutiny of its proposals. In fact it didn't have the expertise or machinery to do so – they abolished it on coming to power.[2] This meant that No.10 failed to understand the radical scope of Lansley's project and were shocked when they learned about it. One issue is that in the previous changeover of government after a long period of one party dominance the civil service was seen as having been contaminated and their advice was discounted. This time they were determined to avoid this and the emphasis was on delivering the policy rather than testing and challenging it.

It soon became clear that the commitment to avoid a major reorganisation didn't work. The reforms created a logic that left many parts of the structure without a clear role. With the added pressure to reduce costs driven by the tight finances, the result was organisational changes which the then CEO of the NHS described as so large they 'can be seen from space'. Further trouble came from different sources and came very fast:

Lansley thought he had the British Medical Association (BMA) on-side. He didn't, the BMA's view was split with the hospital specialists being particularly hostile. Politicians and the Treasury became very nervous at the idea of £80 billion being handed to independent contractors with what seemed to be very little accountability or oversight – the NHS was already in financial trouble and the reforms risked a complete loss of grip on the money

Political opposition came from many quarters – Lansley had in the words of one colleague 'managed to unite Luddites and reformers'. [2]

The Royal College of Nursing (a large nursing trade union) passed a motion of no confidence in Lansley by 98% - he avoided the main conference and met a small group of nurses where he was roasted. In response he said "I am sorry if what I am setting out to do has not communicated itself". We will come back to that telling way of constructing the problem.

There was an unprecedented 'pause' in the progress of the bill and a panel of the great and good convened to look over it. Significant changes were made to strengthen oversight and accountability, water down the competition and price competition components and increase the emphasis on integration.

But the general verdict was that the Bill was still a mess and most stakeholders were not happy. It was neither what Lansley envisaged and the compromises left many issues unresolved.
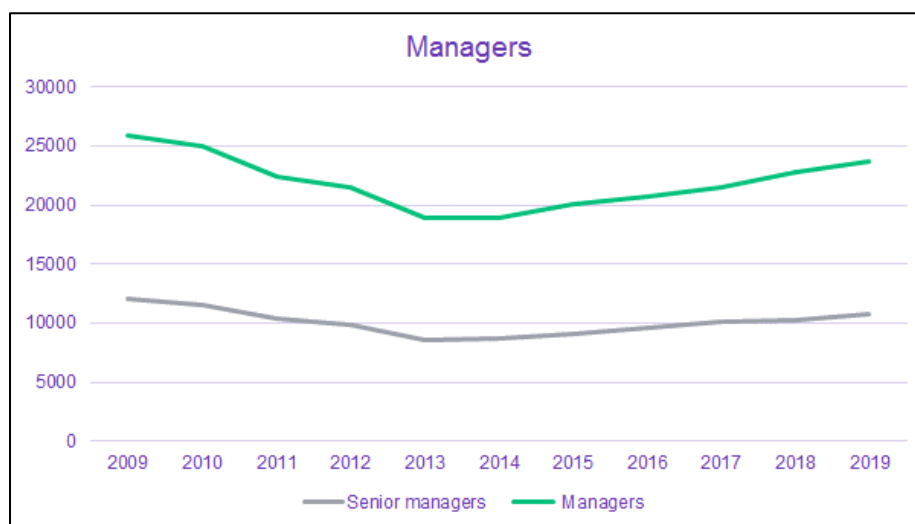
Lansley was demoted and things moved on.

1.3 Partial catharsis

The governance structure of the NHS was not simplified
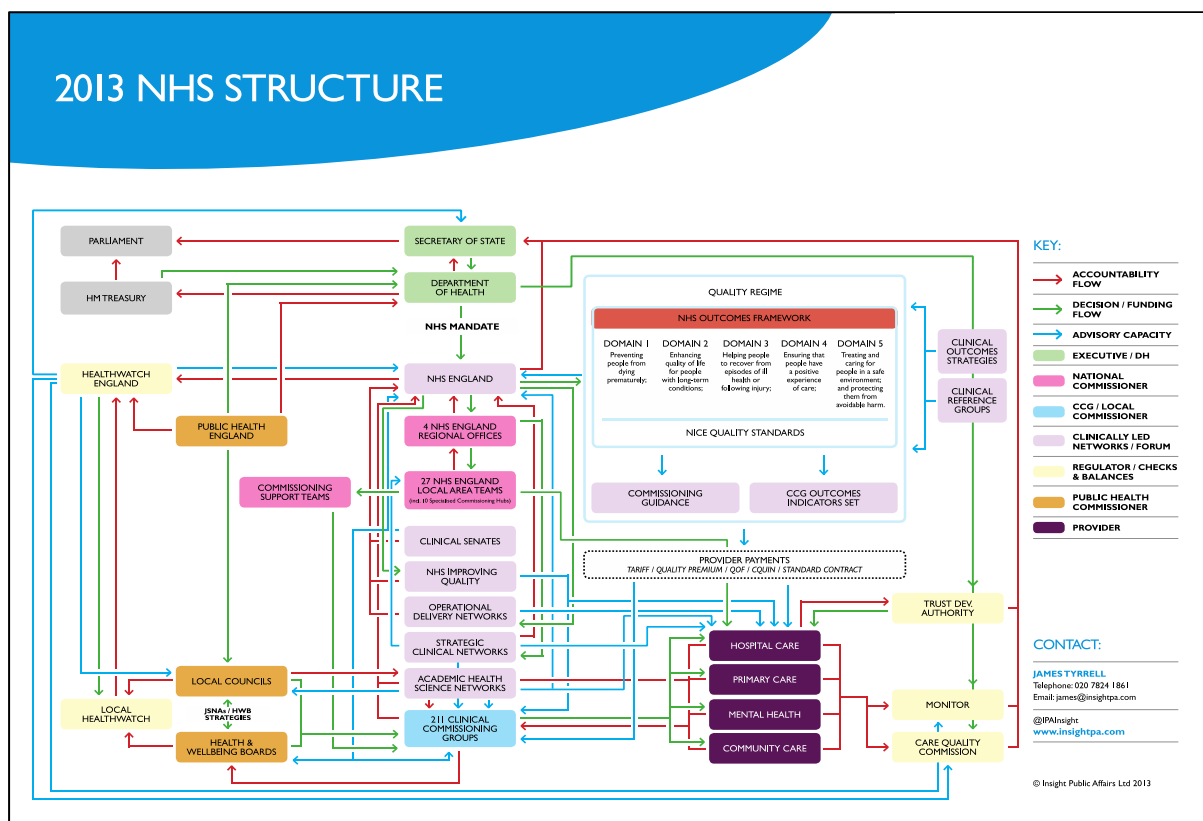
And although the number of managers fell initially, this has grown back.

The move to hospital autonomy foundered on austerity.

Many aspects of the reforms have unravelled. As is the case with many large complex organisations, you have to really break it to stop it returning to its previous shape. Lansley even failed at this. The system has found ways to get around a lot of the Act and much of the legal framework has been ignored, or worked around – especially that related to competition regulation and mergers, choice, competition between providers and the separate roles of the regulators – which are increasingly re-merging and where further legislation is being proposed

2   Lessons – Policy Design

There are a number of important lessons here – and a few others from elsewhere which I will bring into what follows

2.1   Models and theories

> *"Practical men, who believe themselves to be quite exempt from any intellectual influences, are usually the slaves of some defunct economist"* [3]

The theory of policy making as a purely rational process has long been superseded by theories that acknowledge bounded rationality in which some options are not considered, and policy makers will satisfice rather than optimise or maximise[4].

The problems of Lansley's reforms go beyond those of the rational choice approach. They were to a large extent based on a theoretical model drawn from the economics and policies of the privatisation of utilities.

While all models are flawed, some can be useful, so the first step is to ask, is the model useful? The danger is that the model has been developed in different times or sectors and that it does not properly translate into the current context or that the model relies on theories and evidence that have been oversimplified, distorted or are just wrong. Lansley designed his reforms in a period of plenty and implemented them in austerity – he made no attempts to change them.

2.2   Context and history

The second step when examining a policy idea is the extent to which it fits with the context and history. There is a reason why path dependency is a powerful driver of policy ideas and direction. Having due regard for this is one of the reasons why the 20 year project of reform in the Dutch health system seems to have been relatively so successful.

> *People make their own history, but they do not make it as they please; they do not make it under self-selected circumstances, but under circumstances existing already, given and transmitted from the past.*[5]

The neglect of context and history often leads to bad ideas being resuscitated or borrowed from elsewhere and applied in situations in which they are unlikely to work. It's also worth checking that the ideas being borrowed actually works as well as is claimed.

Policy makers in large systems have a particular problem because of variations in the starting points of local systems, the burden of local history layered on the national picture and other contextual factors that make a difference. They sometimes find it convenient to ignore these and create cookie cutter policy which works 'on average' and therefore, has a poor fit in places that are not average – i.e. most of them. Even worse is the temptation to design the policy for the least capable part of the system which undermines those already making good progress.

2.3 Poor conceptualisation

Some poor design emerges from a failure to really understand the nature of the problem or how the problem interacts with the system. Common issues here include:

- Faulty logic and theories about causality – it's not uncommon to see logic models in which the connection between the actions and the results are not really supported by evidence.
- Conceptualising problems as being about a failure of incentives, structures or rules when they be more about culture, behaviour and relationships and therefore some way out of reach of most policy instruments.
- Assuming that the recipients of the policy will respond in the way that you intended. They may be rational actors but could have different ways of evaluating the signals produced by the policy or be optimising / satisficing in ways that are different from those you assume, or they may be getting so many imperatives, market signals or other pressures that some policies are simply ignored, subverted or watered down.
- A tempting response to the problems of complexity, context dependence, heterogeneity and the other problems listed here is to simplify the issue – but this means that many of the subtle qualifications and conditions to make the idea valid are lost. A particular hazard comes from the personal experiences of the politicians being used as a guide to the other 60m users of the system.

A related issue is the attempt by policy makers to frame an issue in a way that is helpful to their argument – for example, 'we need to rationalise hospitals because of issues of safety or critical mass.' The problem here is often that:

1) the evidence behind the framing is contested
2) other stakeholders have a different way of thinking about the issue and different criteria for determining what the trade-offs are – e.g. valuing short travel times; and
3) stakeholders may simply not believe the account they are given.[6]

2.4 Too many or unclear objectives

Policy making theory recognises the problems of trade-offs between objectives but there is a particular issues where policies are created with more objectives than they can sustain or which generate tensions. For example, amongst other things Lansley's reforms aimed to reduce bureaucracy while creating a very large volume of transactions.

Mission creep and 'Christmas tree' policy making, in which additional objectives are loaded onto the policy, can happen at any point in the development process. For example, the objectives set for the introduction of Diagnostic Related Group (DRG) payment systems in England included:

- Improving efficiency
- Benchmarking

- Budget setting
- Reducing emergency admissions
- Increasing planned admissions to reduce waiting lists
- Rewarding quality and best practice

Two of these are directly contradictory - both reducing and increasing admissions.

This is a particular feature where there is internal competition between policy leads. These policy entrepreneurs will try to grab the opportunity of attaching their policy goal to an instrument that is fashionable or is gaining traction, for example:

The ambition of many civil servants who had policy responsibility for specific disease areas was to get an incentive relating to the management of that disease into the GP's quality and outcomes incentive framework. This led it to become overblown and overly complex and meanwhile other policy makers were sending quite different signals by incentivising access.

Having so many competing objectives has bedevilled the search for the right size for commissioning organisations. Too small and they cannot manage risk, lack expertise, have high costs and do not have leverage with hospitals. Make them too large and they cannot engage with primary care very well.

2.5   Poor design process
In 2002, the then Secretary of State Alan Milburn announced 'radical plans to allow the private sector, charities and universities to take over management of England's failing hospitals.' The idea was called franchising – borrowed from the commercial sector. This illustrates three interesting design problems [7]

- **Retrofit –** the policy idea was announced before it had been worked out. Unhelpfully Milburn added enough detail to the idea that it constrained the policy makers ability to turn it into something sensible.
- **Cargo-cult policy –** the idea was borrowed but without a clear understanding of what it really meant so that the outward appearance of the idea was replicated but the actual active ingredients which made the policy effective in, for example, McDonalds was not.
- **Solutions looking for problems –** it was by no means clear that the reason for the problems that the hospitals were having were related to the quality of its existing management. The evidence that simply changing the management team improves performance is not encouraging.[8]

Another element of a poor design process that is far too common and was a major feature of the Lansley debacle, is failing to elicit or listen to feedback – particularly from wider stakeholders beyond the usual suspects or people you can guarantee will agree.

This failing is often associated with the selective use of the evidence and ignoring findings that do not support the direction: - called policy based evidence. Sometimes, as in the assumption that out of hospital care is always cheaper than care in hospital, this seems to be based on wishful thinking or on a failure to understand the context in which the decision is being made. (Out of hospital care is definitely cheaper if the alternative is building more hospital capacity – it may not be if activity if shifted out of hospital without major changes to the shape of the hospital system that allow sunk costs to be released – that is, entire sites are closed).

This type of group think is exacerbated by a lack of serious scrutiny– this is identified as a major contributor to failure by King and Crewe in their survey of a large number of UK government failures. Amusingly, but probably with some justification, they point to the problem of scrutiny by PowerPoint which tends to over simplify, obscure issues and risk and even to brainwash.[9]

> *"Power corrupts. PowerPoint corrupts absolutely."- Edward Tufte[10]*

The most obvious design problem comes from the short time horizon of ministers and their need for rapid results. The electoral cycle is a problem in many countries, but ministers often come and go even faster which incentivises speed over careful design and engaging with the messy realities.[11] The political will necessary to drive long-term policy-making also tends to dissipate over time.[12]

3   Implementation

The good news is that quite a lot of policy does manage to avoid the design problems I have mentioned here. However, there are a range of hazards that occur between designing a good policy and implementing it. The more 'transformational' it is the more likely that these will create failure. Anecdotally it is often said that 70% of transformation programmes fail – which is why achieving transform

Perhaps the most significant issue for complex transformation programmes in many health systems is the lack of a strong narrative which is well articulated in a compelling way. Let me remind you of Andrew Lansley's approach:

"I am sorry if what I am setting out to do has not communicated itself".

If you are relying on a complex multi-layered policy to explain itself without any assistance you are already lost. A failure to communicate the benefits, the case for change and what needs to be done is quite common and the last two big reform plans in England (The Five Year Forward View and the NHS Long Term Plan) have had something of a similar problem. While intellectually and in terms of coherence and practicality miles ahead of Lansley, they both suffer from the problem of being highly technocratic with long lists of deliverables and conceptual ideas about integration that are somewhat abstracted from reality. They gave little clue to what should be done to implement them and lacked a theory of change – a common issue with health policy in many countries – are we relying on professionalism and intrinsic motivation, managerial command and control, the invisible hand of the market or telepathy? It is not always clear.

One long-standing issue in some systems is the division of labour between purchasers/commissioners and providers in the design and implementation of policy. In England, unlike other countries with a purchaser/provider split, we have asked the commissioners to do too much of the detailed design of local implementation and to get overly involved in day-to-day issues. This is odd because the expertise about services and the management capacity to change them is located in providers.

This has led to a long-standing disappointment with commissioners but indicates an important implementation lesson – put responsibility for change with the bodies that can make it happen, then use the commissioners to hold them to account and ensure that they do it. There is no point in having a dog and barking yourself.

The other areas to highlight resonate with much that is already in the business literature

- Poor process and unclear leadership
- Timescale – policy makers are very prone to optimism bias. Complex change requires continual negotiation and often takes place in unpredictable ways and at varying speeds. People need to build new relationships and establish different ways of working, and the logistics of getting clinical staff together are challenging. There is little that can be done to compress the time that is needed for these tasks.
- The most extreme version of this is failing to understand the difference between issuing the policy and having it implemented

I overhead this exchange in about 2006:

> *Prime minister's advisor: "we've got payment by results, we've got competition and GP commissioning, we just need to let it rip"*
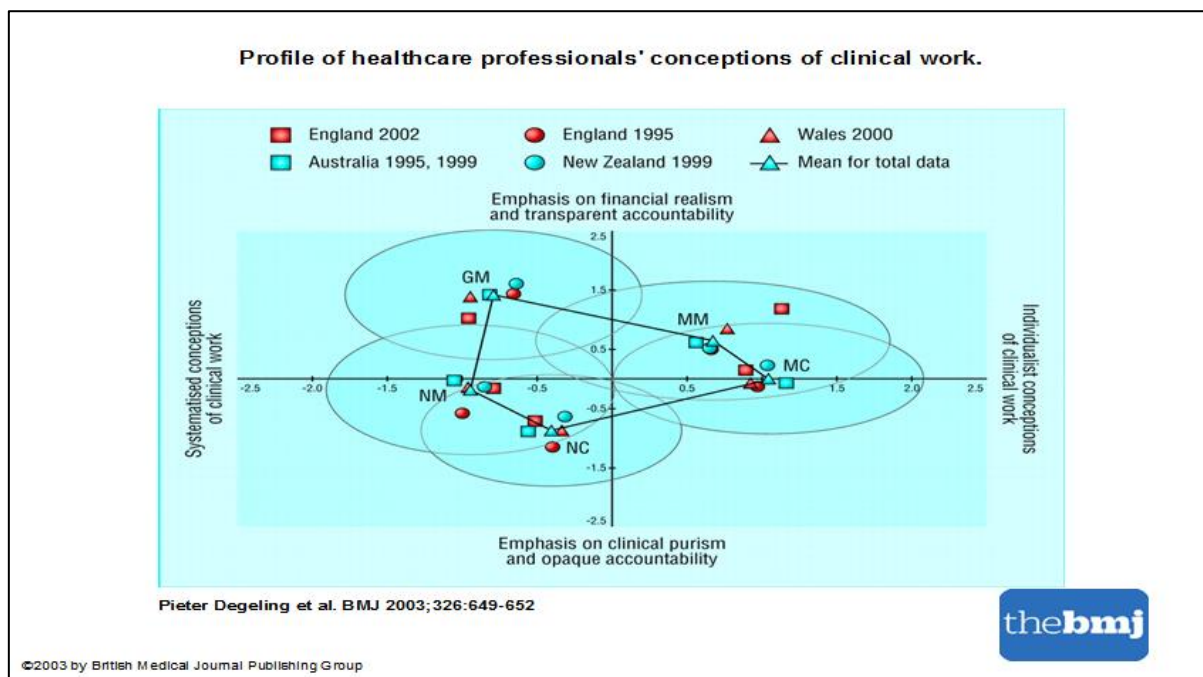> *Secretary of State's advisor: "No, we've just said we've got them, that's not the same thing"*

I am afraid the list goes on:

- Insufficient resources especially for double running, organisational development and change management
- Not enough attention to workforce, capital, IT or other infrastructure requirements
- Payment systems and regulatory machinery that are misaligned – a particular issue where DRG based funding is used in systems trying to reduce hospital admissions
- More policies and procedures being issued on top of a multiplicity of existing policies and procedures[13]
- Pilot projects that are hard to convert into sustainable change[14]
- Unintended consequences that are unhelpfully powerful and unexpected
- Superficial attempts to change deep culture

A particular aspect of this is additional challenge introduced by having a large and powerful workforce with views and values that are often not aligned with those of management. Pieter Degeling's work measuring the attitudes of nurses, doctors and managers found similar divergence on key dimensions in different countries (although China was different)[15].

- Autonomy vs accountability
- Responsibility for resource use vs clinical purists who are not comfortable with the idea that clinical decisions have financial implications
- Attitudes to team working and power
- Willingness to adopt systemised work processes

All three groups were in different places from each other with clinical managers often stranded in a no-man's land between them.

Profile of healthcare professionals' conceptions of clinical work.

Pieter Degeling et al. BMJ 2003;326:649-652

©2003 by British Medical Journal Publishing Group

More recent unpublished work suggests that new generations of clinicians and managers are closer together, but there are still differences that matter. Clinical leadership is often vital for implementation of many policies but simply co-opting clinical leaders to sell a management message can backfire.
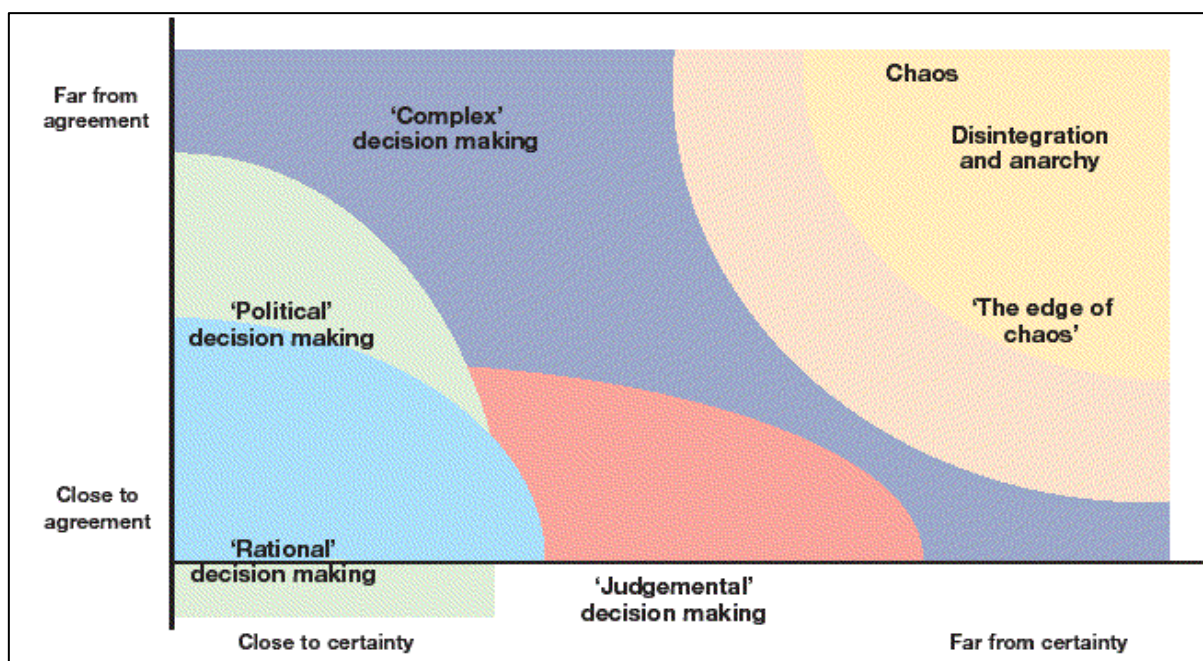
4   Complexity, velocity and scale

There are a number of factors acting on the system that mean that these problems are not easy to solve.

Health care has many of the characteristics of a complex adaptive system with high levels of interconnectedness.[1617]   A useful way to look at this is the space defined by levels of agreement about goals and values on one hand and certainty about the causal relationships on the other.[18]

So, for example:

- **No agreement, uncertainty:** War on Drugs vs decriminalisation
- **High agreement, high certainty:** clinical guideline
- **Low agreement, high certainty:** location of a hyper-acute stroke unit
- **High agreement, low certainty:** reducing emergency department waits

Many of the issues faced by healthcare systems are in the middle of this map. Even apparently obvious candidates for rational decision-making models, for example, which hospitals should be centres for hyper-acute stroke or PCI can end up in the political realm.

It's also easy to take the wrong lessons from policies that worked - Policy makers in England had great success with a combination of QI methods, support and data monitoring to reduce healthcare acquired infection – the same approach failed for developing models of integrated care. Whereas the former consisted of a well-defined and evidence-based interventions which had little interaction with other processes – the latter was just too messy, contested and unclear.

This calls for different a different repertoire from leaders and policy makers.[19]
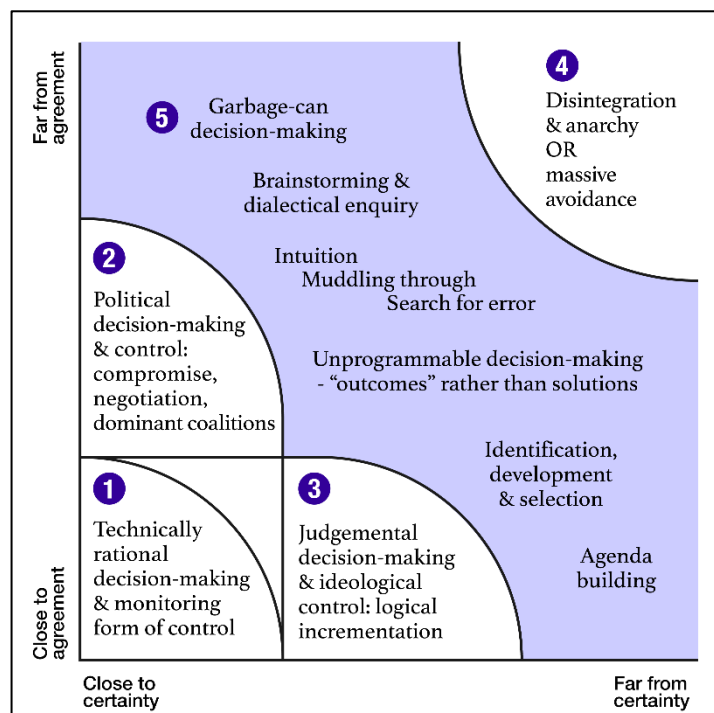
Different parts of the system will be in different places on this map over time and there is not a linear trend in any one direction although Coiera argues that "Diversity and complexity can arise by simple accumulation of random events. In biology, the "first law" holds that evolutionary systems accumulate such diversity and complexity over time, independent of natural selection".[20]

He goes on to say that the more dependencies there are in a system, the more likely they will be in conflict (through competing demands), flattening the [fitness] landscape and diminishing the potential for improving system fitness. Thus, the more complex a health system becomes, the more difficult it becomes to find any system design that has a higher fitness.

Paradoxically this potential for inertia seems to be accompanied by increased velocity in terms of ideas and debate which further muddies the water.

In England and other systems currently going through a wave of centralisation – these factors are exacerbated by increased scale – especially when combined with increased heterogeneity in local contexts. It looks tempting to set not just the "what" of policy but also the "how" from the centre. But this is deceptive, scale increases complexity, obscures important local issues and attenuates the relationships and trust required for the agile mutual adjustment that are needed to deal with complexity and high velocity. This may be why, in Europe at least, those health systems that operate at scales of 1-5 million people seem to do better.

5   Role of policy intermediaries

The response to many of these issues has been the idea of evidence-based policy and to try and get policy makers to pay more attention to evidence. It's also important that they commission research to evaluate its impact although they often prove reluctant to do so.

There is a lot of rhetoric about evidence informing policy but many studies have noted that that knowledge use by administrators and politicians is a more complex, social and political process than rational models of policy-making allow for.[21,22,23,24,25] In Maybin's empirical study she found that the daily work practices of civil servants were not directed toward technocratic problem-solving, but instead the building of connections to "make policies happen".[26]

In a number of countries, the use of evidence has improved and organisations that sit between the worlds of research, policy making and management practice play a key role in making the translation between these different domains. This is particularly useful where there are risks of group think or evidence that is difficult to interpret.

Here is my list of what we need:

Better questions and diagnosis -There needs to be more rigour in testing the questions being posed and in particular the easy emergence of group think.

More critical thinking about solutions - particularly where there is divergence between the rhetoric of policy and the actions being taken, major design problems or ideas where the caveats and qualifications are being downplayed – again this is also a defence against group think

The Brexit debate illustrates a real problem of some very visible policy areas. Those of us who understand the complexities of the issues and the importance of context think that these should be the way that policies are analysed and assessed.

Unfortunately, in the political arena much simpler, less cerebral and more immediately arresting analysis is much more likely to be effective. 'Cutting bureaucrats' or 'taking back control' – the slogan of the Brexiteers – are more immediate and impactful that the careful and qualified arguments that come from understanding the real complexities. Policy intermediaries can help to ensure that there is clarity about the objectives, values and principles underpinning policy ideas and correct misinformation. But where the debate is highly polarised, bound up with questions of identify, based on feelings rather than facts – which seems to be a feature of quite a lot of today's politics - the answers are not so easy.

The question is how to avoid the simple trumping the complex – I hope we can discuss this as I don't have a good answer

Diversity of disciplines - There is more to do to being ideas, analytical frameworks and methods from other disciplines such as sociology, political science, anthropology, organisational psychology, geography, etc. Some of these are going to need help in translating their ideas and concepts in ways that are useful for policy makers and, in some cases comprehensible to people outside their discipline. This means that there is an important role for skilled generalists who can span disciplines and methods – but also know when to bring in a specialist

Diversity of views - Getting the right balance between top down and bottom up in policy making is a perennial challenge. Policy makers often need to connect to a wider range of views and voices from different levels of the health system, from different geographies, from patients, carers and stakeholders outside the system. Policy intermediaries can assist with this and reduce the risk of the usual suspects being brought in each time.

Using history and comparative studies - Many policy ideas have been tried before or in other settings and countries. These require care in their interpretation.

Better **policy evaluation** and learning needs to be a strong part of this – ministers are generally reluctant to fund this and so there is a key role for independent bodies.

More experimentation - The complexity challenge means that there is going to be more muddling through and experimentation. Many health systems, particularly in the UK, are littered with pilots that were never scaled up and so caution is necessary. Policy makers need to get much better at the design and evaluation of experiments and being able to distinguish between processes that are about discovery and those that are meant to develop models for wider implementation. Action research methods rather than just straight trials have a key role here.

Designing better support for implementation - Better approaches to the problem of context. Much of the writing on this area has good frameworks but is weak in describing how these can actually be used in practice.[27] They tend to have be a list of rather obvious headings, such as this one by Pettigrew and Whipp, but it is not very clear what to do about these issues or how to measure them.[28] Bate makes the argument that it does not focus enough on the importance of the interaction between the bubbles rather than just what happens within them.
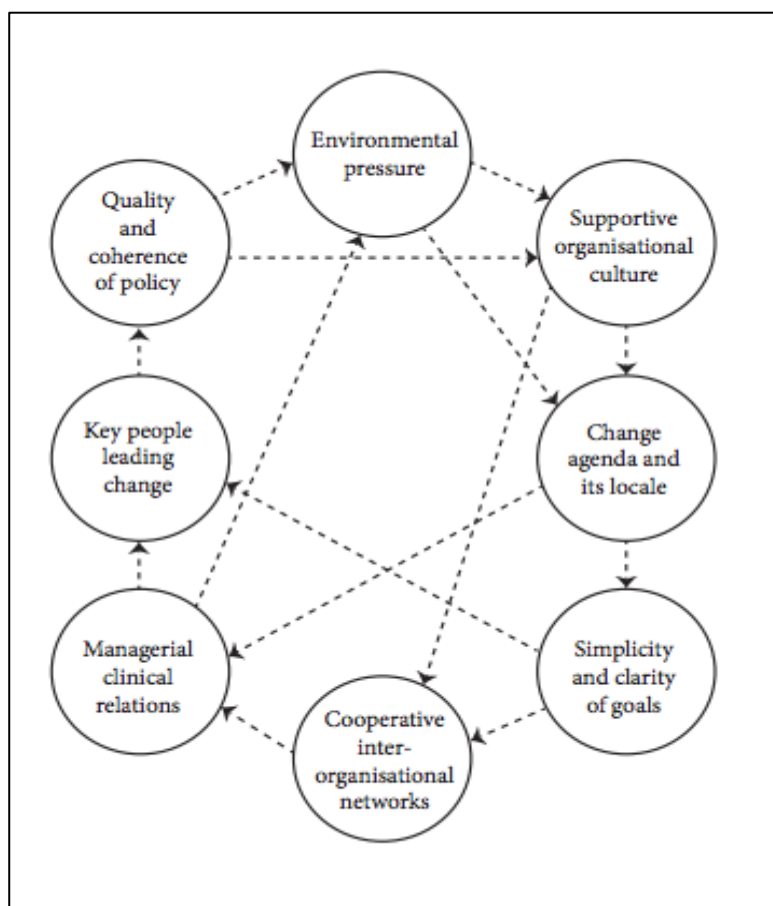
Mary Dixon Woods[29] argues that in adapting QI initiatives to their local context there is a need for a different type of knowledge than is usually deployed. I think the same is true for policy. She goes to Aristotle and others to identify four different types of knowledge

- **Episteme:** concrete facts and knowledge about things
- **Techne:** the capability and capacity to accomplish tasks.

She says we also need:

- **Phronesis:** practical and social wisdom, which is the result of experience in the real world -
- **Metis:** intuition that uses ruses, shortcuts, and other tactics to get results: 'Metis is the form of ad hoc reasoning best suited to complex social tasks where the uncertainties are so daunting that intuition and 'feeling the way' is most likely to succeed. '

And finally –

Short digestible synthesis of the evidence - It is very difficult for researchers to hear that their 100 page report is unlikely to be read by many people and hardly ever by senior managers or policy makers. Generally, far too little effort is put into creating a hard-hitting short research summary that captures the key points and that is written in ways that will have impact with policy makers, managers and clinicians. Developing these is a key skill that policy intermediaries can bring. There is a particular role for communications experts who also have good knowledge of the field rather than just being specialists on media, the web or public affairs.

Bringing these different approaches together will greatly increase the chances that policy will work better. Independent bodies that can speak truth to power or, perhaps less grandly, inject doubt into false certainty, remind people of the history, test that the solutions fit the problems and have the requisite level of simplicity or complexity, occupy a key role and have a duty to speak up and avoid the temptation to be co-opted into the system as well helping to find new pathways to solutions.

We may not be able to see the results of this from space but we ought to experience many improvements closer to home.

[1] https://croakey.org/vale-professor-john-deeble-father-of-medicare/

[2] *In addition to my personal involvement I have drawn heavily on*:
Timmins, N. Never Again? The story of the Health and Social Care Act 2012 Institute for Government. 2012 https://www.instituteforgovernment.org.uk/publications/never-again

[3] Keynes, JM. (1936), General Theory of Employment, Interest, and Money, in *The Collected Writings of John Maynard Keynes.*

[4] Simon, HA. (1956), Rational choice and the structure of the environment. 63: 1129-38

[5] Marx, K. The 18th Brumaire of Louis Napoleon
https://www.marxists.org/archive/marx/works/download/pdf/18th-Brumaire.pdf

[6] Jones, L. and Exworthy, M. (2015), Framing in policy processes: a case study from hospital planning in the National Health Service in England. *Social Science & Medicine*. 124, 196–204.

[7] https://www.theguardian.com/politics/2002/jan/15/publicservices.uk2

[8] https://www.kingsfund.org.uk/publications/financial-failure-nhs

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[10] Tufte, E. (2003). PowerPoint is evil. Wired, 11 (9). https://www.wired.com/2003/09/ppt2/

[11] Hudson, B. Hunter, D. and Peckham S. (2019), Policy failure and the policy-implementation gap: can policy support programs help? *Policy Design and Practice*. 2;2(1):1-4

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