PRIMARY HEALTHCARE REFORMS THROUGH THE LENS OF INNOVATION; - Comparative Case Studies from Western Balkans and Eastern Europe

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I. INTRODUCTION

1.1 Primary Healthcare reforms in Eastern Europe

Most transition countries in Central and Eastern Europe (CEE) are engaged in health reform initiatives aimed at introducing primary health care (PHC) centered on family medicine to enhance performance of their health systems. This has been particularly challenging with examples of unequal adoption, professional resistance and poor sustainability. This has lead to difficulties for subsequent diffusion and scaling [1].

Why Primary Care in Eastern Europe and Western Balkans?

Systems with a strong primary care are considered to rely both on equity and efficiency. Drawn into the origin and evolution of primary care definition we find the term “primary care” to date back to about 1920, when the Dawson report was released in the United Kingdom [2]. The aim of this policy was the provision of integrated, accessible health care services by clinicians trained to address a large majority of personal health care needs. Primary health care emphasizes health education, prevention and wellness, as well as screening for the early detection of disease. Sustained relationships between patients and clinicians are an important component of primary health care. Bio-psychosocial models of primary health care stress patient-centeredness, interdisciplinary teams and a holistic approach to health [3, 4, 5 and 6]. Moreover, ever since the WHO Alma Ata Declaration in 1978, strengthening the primary care level of health care systems has increasingly been considered to be of great importance to dealing with specific health care system challenges (e.g. rising costs, multimorbidity) and improving the overall performance of a health care system [7].

It can be concluded that a primary care system can be defined and approached as: a multidimensional system structured by primary care governance, economic conditions, and a primary care workforce development, facilitating access to a wide range of primary care services in a coordinated way, and on a continuous basis, by applying resources efficiently to provide high quality care, contributing to the distribution of health in the population. Primary care contributes through its dimensions to overall health system performance and health [8].

Most of the CEE countries come from the socio Health-economic system common framework as they have been under the Soviet Semashko model. The health care systems of CEE countries were not identical before transformation and they roughly fell within two categories: the systems based on the Soviet Semashko model and the system of former Yugoslavia. Recent changes have been far-reaching in all areas of the health care system, especially in primary care. In the post-Semashko countries, the institution of primary care and general practice/family medicine needed to be implemented from the beginning, which was often assisted by international support [9].

The changes in primary health care coincided with the fall of communist ideology and regimes in late 1980s and early 1990s. After that, the former communist countries took different approaches to social and political transformation.
Some of the countries became members of the European Union, while the others struggled with economic and political instability.

The expansion of the European Union had an important effect on CEE countries. Although organization of health care is left to the member states, Europe is moving towards common standards in health care provision [10]. PHC has been a dominant discourse in the development of CEE health systems and subsequent reforms as evidenced by the prevalence of terminology used to describe the “efficient and effective primary care” such as integrated care, interdisciplinary teams, and patient centeredness were quite innovative forms of practicing healthcare. This has resulted in changes in: legislation; organization and ownership of services (including privatization of services in some countries); improvement of physical assets; introduction of new care methods through evidence-based protocols; changes in the professional profile of PHC staff; training of physicians and nurses; definition of the package of services to be provided in PHC; and methods of contracting and provider payments [1].

Given the centrality of these changes to policy in many CEE health systems then the scale pace and perceived success of these innovations is clearly a subject of interest to many actors in the system.

1.1. Theoretical Background and relevance;

1.1.1 Understanding Innovation

The academic literature contains a number of definitions of innovation, each revealing important aspects of it. Hereby we aim to present some key definitions about innovation such as diffusion of innovation models with a special focus on Public Administration and Healthcare setting.

1.1.2 Innovation a definition; An innovation can be defined as ‘an idea, practice, or object that is perceived as new by an individual or other unit of adoption’ (Rogers, 2003, p. 12). An innovation presents an individual or organization with a new alternative or alternatives, with new means of solving problems [11]. This novelty does not have to be objective, but only perceived though it can refer both, to a technological advancement or to a managerial intervention leading to new processes. Several authors at earlier versions of innovation definition emphasize newness, including anything perceived to be new by the people doing it or innovation as something different for each organization into which it is introduced, or as the generation, acceptance, and implementation of new ideas, processes, products or services in an applied setting. Some see it as early adoption of a new idea, others as synonymous with creativity, still others as the same thing as improvements, and a final group as substantive but not revolutionary changes [12].

1.1.3 Innovation within healthcare or health systems refer to new medicines, diagnostics, health technologies, new ideas, practices, objects or institutional arrangements perceived as novel by an individual or a unit of adoption (p. 67)(13). Lännsisalmi et al. [13] suggested that “These novelties are directed at improving health outcomes, administrative efficiency, cost effectiveness, or users’ experience and are implemented by planned and coordinated actions (p.582).

Innovation is considered crucial both for improving health outcomes in high-income countries [14] and in countries of low and middle income as well as achieving the Millennium Development Goals [15].

1.1.4 Diffusion of Innovation is “the process by which an innovation is communicated through certain channels over time among the members of a social system. It is a special type of communication, in that the messages are concerned with new ideas”. Diffusion in this sense is a kind of social change, the process by which an alteration occurs in the structure and function of a social system. The classic innovation diffusion model of change suggests that the adoption on innovations is a rational and linear process, which is conditioned by the interaction of perceived (by adopter) innovation attributes with the characteristics of adopters and influences of social system [11].

1.1.5 The innovation characteristics include the following:

1. the relative advantage of an innovation, including economic advantage, social prestige, convenience, and satisfaction;
2. its compatibility with existing values, past experiences, and needs of potential adopters; and
3. its complexity, trialability (the extent to which new adopters can practice with and test the innovation), and observability (the extent to which the innovation’s effects are easily observed by the adopters).

This early innovation diffusion work has been criticized, however, for taking a simplistic rational view.

1.1.6 Complex innovations and adaptive systems definition within healthcare

Later work in the same tradition has partially addressed this simplistic way of conceptualizing by considering adoption within organizations [11]. Healthcare innovations constitute particularly complex outputs, since they frequently combine either product and process novelties or embodied and disembodied components with diversified levels of materiality or tangibility [11, 16].

In this context, PHC reforms can be considered to be a complex innovation; they include multiple elements of organizational and process innovations as mentioned [1].

Evidence from the fields of knowledge transfer and diffusion of innovation suggests that it takes a range of purposeful actions to innovate including supportive management [17].

The importance of communication (dissemination) process is critical to innovation success. Most diffusion research has addressed proactively developed innovations whose main mechanism of spread is centrally driven and controlled (defined as dissemination). But many innovations in service delivery and organization occur as “good ideas” in local services, which spread informally and in a largely uncontrolled way (diffusion) [18].
In the light of such empirical evidence we aim through this article to examine the introduction of PHC reforms in Eastern European using an analytical framework based on key aspects of innovation; “an innovation lens”

II. AIMS OF OUR STUDY

In this study, we examine the introduction of PHC reforms in Eastern European using a comparative case study approach using an analytical framework based on key aspects of innovation; “an innovation lens”. Using this approach we aim to identify and generalize some of the key factors to understanding the innovation diffusion process in an eastern European context. Our study is based strongly on the Atuns work (BiH and Estonia case reference) but is novel because it merges different features of PHC in different post-communist countries, providing empirical evidence on PHC reforms in particular eastern European countries both in developed and remote areas (Romania), EU (Slovenia) or non EU countries (Albania).

III. METHODOLOGY, DESIGN/APPROACH;

3.1 Sample and case studies recruitment strategy

We adopted a comparative case studies analysis as our primary method using cases selected from the Western Balkans and Eastern European Countries. We identified our case studies for analysis based on a systematic review of published literature on health reforms in each country selected, supplemented by documentary analysis of published reports, studies published in peer reviewed journals and policy documents and user surveys. We searched for peer-reviewed articles, reports from the multilateral as regional agencies and searched the grey literature including web sites, to identify Eastern European countries and Western Balkans considered being exemplars of success or failure of primary care reforms implementation as complex innovation - involving one or all the elements such as organizational, financial, clinical and relational changes.

The case studies selected were analyzed using the framework developed from our analysis of innovation determinants, our “lens of innovation”; the cases identified represent the range of innovative approaches to delivery primary care both in urban or rural underserved communities.

In order to improve internal reliability we tested the case study analysis approach with a range of experts with knowledge of the health innovation field. These external experts were selected on the basis of their participation in the European network on medicine and management (see http://www.dr-in-mgmt.eu). This network, funded by the European Union under the seventh framework brings together researchers and experts who examine why physicians are drawn into management, and how this impacts on control, user voice, and innovation.

Their disciplinary fields of expertise ranged from medicine and nursing to management, sociology, public health, and health economics; thus warranting a multi-disciplinary outlook upon the framework of innovation adopted by this project.

3.2 Analysis of Case Studies

The case study analytical framework was primarily developed from the work of Rogers, Greenghal, and Denis at al Berwick’s findings [11, 18, 19, and 20]. The key aspects of their work cover four dimensions of the diffusion process that influence the rate and pattern of adoption of an innovation: the nature of the innovation and its attributes; the adopters and their characteristics, both individuals and groups/organizations; the communication process; the context within which innovation diffusion takes place; and the interactions and interconnections between the innovation, adopters and the assimilation process.

This “lens of innovation” was then applied to the previously identified case studies (Figure 1).

Figure 1 - A framework for analyzing the introduction and diffusion of PHC reforms as a complex innovation

IV. RESULTS

Overall 5 cases from 5 Central and Eastern Europe were derived using constant comparisons on the innovation dimensions. Table 1 provides main findings for each case selected.

4.1 Findings on The diffusion of Innovation

4.1.1 Results on Innovation attributes dimension (perceived Innovation Characteristics)

Perceived characteristics of innovation as are considered good predictors of success or failure of the diffusion innovation (Berwick, Denis et al, Greenhalg). A very extensive evidence base from medical sociology, supports the notion of key attributes of innovation (as perceived by prospective adopters), which explain much of the variance in innovations’ adoption rates [18]. So Innovations that have a clear,
Adopters’ characteristics, Communication Channels, Context, Key barriers

Table 1. Case studies main findings; main results deriving from the case studies regarding the Innovation Attributes, Adopters’ characteristics, Communication Channels, Context, Key barriers

<table>
<thead>
<tr>
<th>Country</th>
<th>Innovation Attributes</th>
<th>Adopters’ characteristics</th>
<th>Communication Channels</th>
<th>Context</th>
<th>Key barriers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albania</td>
<td>Reputational of HC</td>
<td>Absence of community involvement</td>
<td>Partnership with local NGOs</td>
<td>Low quality of primary health care; Lack of any data on PHC patients or costs; fragmented financing and management of PHC;</td>
<td>Lack of any data on PHC patients or costs; Fragmented financing and management of PHC;</td>
</tr>
<tr>
<td>HIS(23)</td>
<td>* Health outcomes</td>
<td>* Information on patients, processes and Performance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Romania</td>
<td>Central role in service delivery</td>
<td>Large community involvement, GPs open to new skills</td>
<td>Partnership with local NGOs</td>
<td>Low awareness of rural community of Contraceptive; Lack of Capacity at the district level for promotion;</td>
<td>Policy barriers; Incipient decentralization; Lack of fluid communications MOH;</td>
</tr>
<tr>
<td>Contraceptive project(24)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Slovenia</td>
<td>* Staff motivation;</td>
<td>Lack of trust; Low involvement of GPs in QI; Lack of awareness for systematic QI; No emergency to change</td>
<td>Need for modern approach to QM</td>
<td>Lack of a “quality culture” Deficient infrastructure; Insufficient leadership; Dominant role of the pharm industry in CME</td>
<td>Existing values; Subordinate PHC role; Lack of structures; insufficient incentives; Staff attitude; No flexible HC;</td>
</tr>
<tr>
<td>PCQM(25)</td>
<td>* Patient satisfaction;</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BiH</td>
<td>Holistic and user-centric healthcare;</td>
<td>GPs expected a greater involvement; New professional identity; Inter-professional relationship; (changes sometime heightened tensions between professionals or expanded teamwork)</td>
<td>Planned dissemination of the model by the ministries of health and the multilateral agencies; Many felt that the innovation had been “imposed”; Lack of involvement of academic institutions</td>
<td>The war and its consequences resulted in an inherently complex setting for the reforms and assimilation; Immaturity of the political system</td>
<td>The fear of the unknown (“inadequate information”) created a barrier to adoption; “threat” existing status, the loss of “power base” and diminished “authority”; Political behavior</td>
</tr>
<tr>
<td>HPH complex innovation(26)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estonia</td>
<td>Better payment mechanisms;</td>
<td></td>
<td>Close collaboration between policy and operational levels; realistic policies; University staff and FM Association involvement;</td>
<td>Politicians were focused on economic reforms rather than health but still were supportive to initiatives (new graduates and in-service training for specialists working in PHC were introduced).</td>
<td>Absence of opinion leader</td>
</tr>
<tr>
<td>PCH complex innovation(27)</td>
<td></td>
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unambiguous advantage in either effectiveness or cost-effectiveness. Innovations that are compatible with the intended adaptors’ values, norms, and perceived needs and Innovations that are perceived by key players as simple to use, furthermore visible to intended adaptors, are more easily adopted [19, 21, 22].

This is a well-known concept, and the four of our cases demonstrate strong impact of innovation attributes or “desired perceived outcomes” of primary initiatives in the success of implementation process.

The Romanian case has been instrumental in building upon the benefits of the health care system reform that gave primary care physicians a central role in service delivery. It has helped guide and improve upon the reforms by strengthening primary care, not only by giving family health doctors the chance to act as gatekeepers of the health system when providing family planning services for healthy people, but also by enabling them to open gates for clients in need for more specialized care.

The Bosnia and Herzegovina case give us a broader view of new Primary Healthcare reforms perceived outcomes. Key advantages of the new PHC model were identified as greater emphasis on holistic and user-centric healthcare with expanded services especially health promotion and prevention. “more human, friendly health care model”, with a “holistic approach to the population’s health needs”: Perceived benefits for the users included “improved access to the system”, “improved doctor-patient relationship” and “an increased individual responsibility for the health professionals towards the user”, and “respect for one’s time”. The innovative model and the accompanying organizational/financing changes led to a “more meritocratic payment system” with the introduction of “performance related pay”, which created “an opportunity for promotion of those who
perform well”. The perceived economic benefits related to improved productivity and equity, as family medicine was seen to be “more rational and cost effective”, introduced “gate keeping” to reduce unnecessary hospitalizations, and increased accessibility to health services which improved equity in the system [24, p.33].

Moreover the Estonian case with “A new mix of payment mechanisms” created an incentive for FPs to improve the organization and delivery of PHC services and effectively manage clinical and managerial aspects of the practice: for example avoiding unnecessary intervention and treatment and managing human resources in their practices. Overall the new system increased coverage of the whole population; had a focus on the user; was perceived as more personalized service; enhanced “continuity of care and overview”; gave health professionals ability to treat all age groups; increased professionalism at PHC level, with enhanced role of family physicians and nurses and increased independence.

Meanwhile the lack of urgency to change of the Primary Care Quality Management Tool in the Slovenian Case underlines the fact that poor perceived attributes of innovation hamper the implementation. Management of quality was, indeed, not perceived as a burning issue in primary care in Slovenia; hence this explained the low rate of response to this pilot project. Key perceived advantages and possible changes that the “Quality Management” project would bring were poorly understood by key stakeholders. For example, GPs were not sure what the impact of quality improvement activities on the satisfaction of patients. They were more confident about the positive effect of quality improvement on staff satisfaction and motivation. GPs were divided about the expected effect of quality improvement activities on staff workload but only a few expected a reduction. Quality management activities were expected to result in an increase in administrative work. In both regions, the majority of GPs thought quality improvement activities would not alter the professional freedom of staff. The opinions of the remaining GPs differed between the two regions. A small majority of the GPs in both regions expect the reputation of their organization to improve as a result of quality improvement activities. GPs were fairly convinced that quality improvement activities would result in better health outcomes. GPs were not sure what the impact of quality improvement activities would be on the practice costs, but about half of the GPs expected an increase in costs [27, p.71].

4.1.2 Results on The adopters Characteristics dimension

According to Rogers [11] the adopters are divided into categories: innovators, early adopters, early majority, late majority, and laggards.

The approaches to implement new models of PHC have relied on consensus of all the possible groups of stakeholders and adopters. In the Bosnia and Herzegovina case, the changes brought by the reforms were aligned with the expectations of the adopters. Many individual adopters noted that their expectations as professionals had changed along with those of the population - in that they wanted to be valued as professionals, improve their skills, be part of a more meritocratic system and have a better relationship with users, who they expected to have a greater involvement in the health production process; the new family medicine model and the service model it brought, had a major impact on “professional identity”, “This evolution of the role and identity empowered family physicians and motivated them to be actively involved in the adoption and diffusion of the new model [26, p.34].

Doctors sought to improve their knowledge and skills and further develop their competencies - which in turn helped them “feel more valuable”; as they could now provide quality service to their patients”. “Inter-professional relationships” The new model afforded more responsibility to the health professionals also enabled them to exercise more control over their professional duties.

Nurses perceived this as an upgrade of knowledge and clinical and communication skills improvement; a completely new type of nurse: more advanced, more confident and efficient.

While improving inter-professional relations of workers at PHC level, the changes heightened professional tensions between family physicians and narrow specialists and - organizational routines: expanded teamwork: among advantages associated with the new family medicine team development, which in turn helped to enhance quality and efficiency of services.

The Estonian Case PHC reforms were rolled out rapidly in all regions except for the capital Tallinn, where the heads of polyclinics supported by Tallinn Municipal Health and Social Care Department resisted change and advocated retention of polyclinics with salaried doctors.

At the organization level there was a lack of mutual trust between stakeholders in the Slovenian Primary Care Quality Management project; the professions seemed to be defensive as a result of the growing influence of the purchaser of health care services. Only a few GPs saw quality improvement as a core task. As they were focused on direct patient care, they had no time for quality improvement. Moreover, they also lacked awareness of the need for systematic improvement of the quality of their services. Low level of involvement of GPs in formalized structures aligns with earlier findings among the managers that quality management mechanisms were poorly implemented, especially in Ljubljana.

4.1.3 Results on The communication (Dissemination) process dimension

Most of our selected cases have used multiple channels of communication (dissemination) to diffuse the new PHC model, though the results have not always been as expected. So in the Bosnia and Herzegovina the communication process involved a planned dissemination of the model by the ministries of health and the multilateral agencies such as the World Bank and WHO.

Despite this attention to communication the project noted; “Reluctance to adopt innovation” was noticed among professionals because of “inadequate information” or
the "shock of change! Many felt that the innovation had been "imposed" and their "fear of the unknown" created a barrier to adoption. Others felt that a "threat" to "job security" and "existing status", the loss of "power base" and diminished "authority" were the main reasons for resistance from clinicians and managers - a resistance which was unpredictable or concealed. "The communication between the faculty of medicine the ministry and the health insurance fund is not very good; it appears that they are all detached."[26, p35].

Close collaboration in Estonia created a link between policy and operational levels and enabled development of "realistic policies" which were "organized in the right order". University staff and FM Association were cognizant of the importance of this flexible and orderly approach. The policy makers were careful not to encourage excessive publicity in the early stages of PHC development and worked to identify paths of least resistance for implementation. This policy of "lying low", before a critical mass of FM providers had emerged, was an explicit tactic pursued by the policy makers.

Meanwhile, Partnership with local NGOs - in Romanian case - has been crucial to the success of the program which is not only an affiliate of International Planned Parenthood Federation providing reproductive health services, it is also adept at community outreach, building networks, and conducting participatory training.

The decentralization process, with the lack of fluid communications among the different programs at all levels of the MOPH, served as a barrier, reduced the number of activities; and at times, caused them to be disconnected from the availability of the new services.

Also Community participation has been critical to increasing the demand for and quality of family planning services. Multi-stakeholder district commissions proved to be effective forums for identifying and addressing local health priorities. It was felt quite important to promote and disseminate information on modern approaches to quality management in primary health care, materialized at Slovenian Primary Care Quality Management project.

4.1.4 Results On The Context and the key Barriers perceived dimension

Literature of innovation stresses the importance of “system readiness” to implement the innovation.

In Slovenian case the lack of a “quality culture”, played a dominant role in implementation phase. The experts concluded that the infrastructure for quality in health care was also deficient. Situation for quality management could be described as fragmented: quality management of primary care in Slovenia had not been entrusted to a particular body or structure that could coordinate activities and initiatives; Leadership on quality improvement at all levels was lacking. Moreover, a feeling of self-satisfaction that hampers progress in primary care development, Slovenians think their health system is the best in the region. A lack of formal involvement of organizations representing the professionals in quality issues was also a barrier toward diffusion process.

Continuous Medical Education system were existing, but is more driven by the "credit points" that all practicing doctors need to gain rather than by real educational needs or professional shortcomings based on regular (self-) assessment. The expert group thought that innovation in the area (towards continuing professional development) was hampered by the current dominant role of the pharmaceutical industry in CME.

Making health systems more “quality aware” requires the development of a strategy, an analysis of the current situation, and innovation (that is the implementation of desired change). The perceived major obstacles to the improvement of quality management in primary care in Slovenian case were: - existing values and general vision in terms of health care and quality improvement; - the relatively subordinate role of primary care compared to other levels of health care (especially with regard to funding); - the lack of structures for the promotion, coordination, implementation and control of quality management initiatives. The current strict norms for GPs that result in a very high patient workload and little time for education and professional exchange.

Two thirds of the managers of the Slovenian case answered that they had insufficient effective incentives for realizing change. Anyway the managers of PHC expected more “more decentralized decision-making would make my center more flexible and open to change” managers perceived the attitude of staff towards innovation as an obstacle. They also seemed to acknowledge widely that the motivation of health care workers to provide better care was not up to the desired level. “More active involvement of patients will help improve primary care as well”.

As for the Estonian case, rapid pace of liberalization at that time meant that the politicians were focused on economic reforms rather than health but supported initiatives aimed at improving health services for the citizens.

The Albanian model addressed the low quality of primary health care, lack of any data on PHC patients or costs, bypassing of PHC clinics for specialty polyclinics or hospitals, fragmented financing and management of PHC, and the absence of community involvement. The pilot was a bottom-up approach that informed the development of an integrated PHC delivery system that is affordable to the Albanian economy.

In BiH, the war and its consequences resulted in an inherently complex setting for the reforms and the assimilation of the family medicine model by PHC organizations. The immaturity of the political system and the precarious transition from the socialist past to a democratic constitution was noted to be an important factor which influenced adoption of the innovation.

The Romanian Family Health Initiative can be considered as a successful PHC innovation.

The integration of family planning into more than 80 percent of the primary health care services nationally has dramatically increased access to contraceptives - by 40 percent between 1999 and 2004. This has contributed to a
drastic reduction in the rate of abortion - more than 260 percent - during the same period, with a concomitant reduction in the rate of maternal mortality due to abortion of nearly 37 percent.

Quality services became available in most rural communities and with the new approach family health doctors have the authority, updated knowledge, and supplies they need to provide quality, client-centered family planning services.

Some policy barriers proved insurmountable, vested interests sometimes narrowed options for implementation or assimilation, and the ongoing process of decentralization resulted in unpredictable changes in management and supervision structures.

Capacity building was considered as "needed" at the district level for supportive supervision, combined with a monitoring and evaluation mechanism. Because of the decentralized nature of Romania’s healthcare system, some districts have developed effective supervision systems while others are bureaucratic and ineffective.

Provider in-service training was not complemented by comparable efforts to develop pre-service training curricula for medical students, which is essential for sustainability.

Pre-service curricula development will require buy-in from influential academic OB/GYNs, who still question the ability of general practitioners to provide family planning services.

Nonetheless, in 2006 the pilot project began collaborating with relevant academic institutions and other organizations to begin developing an integrated family planning curriculum for medical students.

V. DISCUSSION

Narratives on successful innovation often describe grand schemes and quantum leaps, the reality as documented by many commentators from the field is that innovation is more likely to be evolutionary rather than revolutionary and requires a whole systems approach and attention to all actors in the innovation ecosystem [28].

Our selected case studies rely on small (pilot) projects and sometimes over prolonged time frames.

Mainly our results brought out themes found in the literature of innovation diffusion, stressed in previous studies. In more details, Bradley et al. 2001 found that ‘Presence of shared goals for improvement, availability of training and information support systems and structures to facilitate learning and sharing (Shortell et al. 1998), and a culture characterized by communication, involvement, creativity and learning by experimentation (Ham et al. 2002) have been found to positively encourage adoption and diffusion of innovations.’ Plsek andGreenhalgh include presence of opinion leaders, social networks, the organization’s absorptive capacity for new knowledge and a ‘receptive context’

Overall the success or failure of these projects was strongly determined by Innovation perceived characteristics.

In one of our cases staff seemed to lack a sense of urgency to change, as a sense of self satisfaction with status-quo. This finding is consistent with earlier findings in PHC (key factors influencing adaptations of an innovation in primary care)

Effective communication between providers with regard to roles and responsibilities was reported to be key to effective team functioning. Though there are contradictory published materials about communication process within primary care, especially regarding patient safety.

The active engagement of clinicians in the innovation process is crucial and a good determinant of success [29]. This fact has been pointed out in several research papers stressing the clinicians’ importance toward innovation process [30, 31]. In our cases this is best described in the Estonian Case where the “opinion leaders”, doctors with a good reputation, hampered the new payment scheme.

It should be noted that although these countries came from a common background, within the fall of communist system, local social and political culture, workforce constraints and resource capacity remain unique to each of the communities examined in these case studies.

Therefore, aligning these best practices with local circumstances should be a key component under girding communities interested in replicating a model that has been successful elsewhere.

The imperative to innovate in healthcare has recently intensified under the economic challenges and the increasing demands of an ageing population.

5.1 Disruptive innovation and process of re-invention

Because the Romanian family planning program has achieved such impressive results, it has provided a foundation on which to build many other reproductive health services - such as safe motherhood, post abortion care, cervical and breast cancer screening, HIV/AIDS prevention and treatment, and domestic violence interventions - into comprehensive, sustainable, and high quality health services at every level. Romania's family planning program is also a model for other countries in the region, offering innovative ideas and practical approaches that can be adapted by program managers and policymakers throughout Europe and Eurasia.

5.2 Patients voice in innovation process;

The voice of patients and carers is also largely absent in the field. Innovators wherever they are tend to ask questions in challenging and possibly provocative ways the response they get is frequently unpredictable [30].

In Albania for example the patients are considered inactive with a concerning apathy toward involvement in decision making process [32]. More active involvement of patients will help improve primary care as well in Slovenia, and active community in Innovation process was the determinant actor on the Romanian Family planning project.
5.3 Last words about innovation

Innovation remains a hard nut to crack. There is evidence that healthcare systems in developed countries within regards the perception that healthcare organizations are among the most knowledge-rich and scientifically-based institutions, still suffer considerable difficulties in implementation, and experience major delays in diffusing novel initiatives, quite the same thing happening in the developing countries [20, 30].

In healthcare invention is hard, but dissemination is even harder and it results in the deepening of the gap between knowledge and practice.

5.4 Study limitations:

This is a small qualitative study and our sample is not quite representative of all Central Eastern European reforms in PHC, but it satisfies our research aim since gives a panoramic view of innovation dimensions and through the selected projects (cases) we could point out the facilitators and barriers to diffusion of innovation (in terms of reforms administration) in public healthcare.

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