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

PhD THESIS

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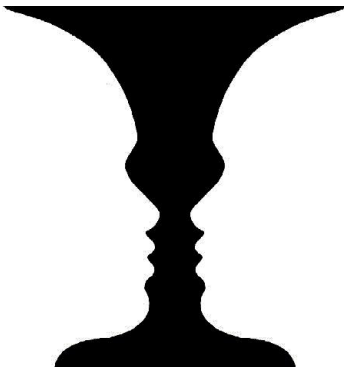
„The way we see the problem, is the problem"
Stephen Covey



1. Introduction

1.1. Background and Aims of the Study

Systemic Market Orientation (SMO) deals with *"the processes of continuously achieving 360 degrees optimal stakeholder satisfaction through stakeholders' synergistic participation for value design and delivery*". Due to its qualities, SMO can be regarded as a paradigm (P) for theorizing and practice (SMOP). The aims of the current study have included a historical literature survey in the field of paradigm studies for arriving at a conclusion regarding the qualities of SMO as a paradigm. Based on such understandings, the study has aimed at complimenting the secondary research through qualitative primary research in order to arrive at a typology for designing research and training projects in this field. The continuous failure of healthcare reforms especially in the CEE countries and Hungary has been the subject of extensive studies. However, this concern has not been addressed with regards to SMOP. In terms of perfromance as far as health status and avoidable mortality, Hungary among the countries with the worst health status and highest rate of avoidable mortality in the EU (life expectancy at birth trailed the EU27 average by 5.1 years in 2009), prevention and health promotion are underfunded, their organization underdeveloped inter - sectoral activities are poorly coordinated, and growing inequities have yet to be addressed in an appropriate manner (see HiT 2011).

Patient satisfaction remains at very low levels (52% in comparison to 89% in some EU countries by a gallop study). Doctor and healthcare outward mobility due to low wages, bad governance and decision making, job content and working environment, has become an increasingly severe issue (yearly 1200 added to the 4000 deficit app. 7000 by the end of 2013). On the other hand incentives for inward mobility have become almost extinct (35 in 2010 in comparison to 169 in 2006). This is while the system has remained predominantly centralized with weak or non existing bottom-up processes for negotiation, knowledge sharing, joint decision making and finally accountable, equitable and participative governance. Gaal et.al 2011 posited "*Looking back at the recent health reforms (since 2004), transparent, evidence-based policy-making often played a limited role in the area of health policy in several important respects. Major reforms have usually not been supported by detailed policy instruments, such as discussion papers, strategies, action plans or impact assessments. At the same time, mechanisms allowing stakeholders to take part in the decision-making process in a timely and transparent manner have been lacking*". To compliment the same there are suggestions, to believe that sufficient attention hasn't been paid to the importance of "*the psycho-socio-economic frames of reference"* or paradigm which influence the complex process of transformation (reform) towards sustainable development. One reason for the absence of such attention by strategists, scholars, policy makers and practitioners could have been be due to the breadth and complexity of the domain of paradigm and the lack of available simple and reliable methods for handling and researching this field .The importance and need for appropriate guiding models, metaphors, theories for policy and action have been thoroughly respected by thought leaders. Yet, due to the continuously changing state of psycho-social learning of the human society as a whole and/or particular group of the community, the validity and reliability of the origins and bases for the said models have been questioned again and again. A big group of scientists with mechanistic paradigm orientations (sometimes referred to as quantitative scientists) have asserted that validity and reliability are achieved, subject to the limits and capacities of the state of art in the field of mathematics. Other groups of scholars have emphasized the limits of math as a one and only language for self exploration and systems' exploration. An often recurring problem has been short-sightedness in seeing and accepting the fact that state-of-art in science is the outcome of the co-created perception of realities and co-existing capacities for defining, accepting, disseminating and transforming the perceived realities along the processes involved in co-

creation/transformation. Fields such as 'Paradigm studies', 'Social and Organization Learning' have dealt with the mentioned concerns.' Paradigm studies' with an incorporation of transformational learning (triple loop and quadruple loop) in different contexts, have frequently included confusing references to notions such as "*old vs. new paradigms*", *"paradigm shift"*, or "*conflicting paradigms*". These multi-dimensional references have endeavored to point at the underlying universality and the all-inclusive nature of the domain of paradigm studies, calling on for the creation of converging approaches. Still, diverging approaches have dominated the '*Ontological*' , '*Epistemological*' , '*Methodological*' and '*Axiological*' level debates when approaching the afore mentioned concerns. Amongst all, the question of whether or not it is appropriate to think of paradigm- this 'universe of thought and action', as a combined or unified single universe? Once agreed upon it is worthy of consideration to question whether or not this single universe enjoys a traceable holistic goal? Otherwise, incase we're facing more and separate universes, do those separate universes enjoy detectable converging or diverging goals? How do these goals influence the systems within and beyond and the roles and goal of the stakeholders of these systems? Do these goals and roles have permanent, temporal, transformational and developmental natures? Are they reliant on a learning curve? i.e. Policy making and implementation in a field like healthcare? Healthcare reform has traditionally been defined in terms of "planned *changes towards the better organization, financing, provision and regulation of the public/private mix leading to more accessible, affordable, equitable, efficient and quality healthcare*". The contribution of a number of psycho-social factors to reform failures have been criticized by practitioners and scholars at the Hungarian level (factors such as : *asymmetric information, informal culture of practice, ideology and misperceptions of roles and goals leading to corruption, political complexities and bureaucracy* amongst others). Yet, common wisdom in Hungary still widely connects the repeated failures predominantly to lack of finance-related and technology-related policies or actions. It is interesting to note that failure has also been increasing in light of the constant growth in budget and different types of additional and/or restructured investments. According to Gaal et.al. under the new *government's "program of national cooperation*" proposed in May 2010 the following priorities had been considered:

- linking capacity planning with health needs assessment to reduce geographical and human resource inequities;
- ceasing the privatization of hospitals;

- decreasing pharmaceutical co-payments and expenditure, facilitated in part through long-term agreements between the government and the pharmaceutical companies;
- increasing overall public spending on health care as a share of GDP;
- refining incentives to increase generic competition;
- restoring the personal ownership of pharmacies;
- maintaining a single health insurance scheme;
- establishing a clearer career path model for health professionals;
- improving the quality assurance system by strengthening the mandate of the NPHMOS in this area. (Government of the Republic of Hungary, 2010).

The paper concluded: *"the current government seems to be returning to the health policy pattern of the governments in power between 1990 and 1994 and between 1998 and 2002, focusing on ensuring strong public influence in the governance and in the organization of the health care, while the payment methods are to be improved through incremental technical up scaling of innovations. However, it is not clear from the current policy papers how the government wants to address the serious problems of resource collection, which is the main cause of the long-lasting crisis of the Hungarian health care system*". Based on an article from www.ecostat.hu under "Between Two Crises" (*A magyar gazdaság wargabetűje*-1990-2010-ig) healthcare budgeting between 1993-2009, had increased from 306 billon huf to 1420 billion huf with a little slowdown in 2007 due to newer policy programs. Between 1990 and 2006 the number of healthcare visits had systematically grown above all EU countries. A the same time the number of active chronic beds increased as a result of the quantitative change policies and the equal regional distribution of beds was reinforced consequently. In order to reduce the overall fixed costs of the system the total number of beds were also reduced continuously and this the fall was drastic after 2007. Neither of the so-called 'reform policies' had been effective. Still common wisdom showed more attraction to approaching the concern from a financial, technological and at best legal aspect. For example the solutions of problems such as "*informal economics*" in the healthcare, "*gratitude money*" paid to the public physicians, or the "*brain drain phenomenon*" had been repeatedly linked to the short term financial constraints within the local / national system. However, a deeper understanding of the system's actors' perceptions of

their "*roles*", "*goals*" and *"the institutionalized culture of their interactions*" deserve similar attention prior to policy planning for healthcare reform. In 2007 the ruling government's (MSZP-SZDSZ coalition) proposed an economic qualitative change policy (referred to as reform policy) through the implementation of a 'visit fee' component (300 huf) per primary care reference (600 huf) per secondary care reference and (300 huf) Per Diem for in-patient care up to 20 days of stay (above 20 would be free or redeemable). The government targeted increasing income for the system, creating disincentives for unnecessary referrals by the patients and introducing the culture of sharing costs of care by the public. This all was implemented without pilot studies, assessment of stakeholder perceptions and expectations, lack of appropriate communication, failure in addressing obstacles in implementation, all naturally leading to an overall failure. Two major changes did occur as a consequence of the short lived implementation 1)- Reduced number of visits to the healthcare system 2)- Expenditure and consumption grew in the are of OTC drugs initiating a growth in the number of pharmacies and also the allocated amount of OTC retail points. Some earlier constraints of minimum 50% ownership by pharmacists for establishing pharmaceuticag retailing license was also nullified. In response to the governments' policy measures the opposition coalition took the stance that this WAS NOT REFORM POLICY BUT RATHER MONEY COLLECTION FROM PEOPLE. As a result of a polling in 2008 regarding private payment organizaed by then the opposition party (currently ruling party FIDESZ and ist coalition partner KDNP), 82% said no to direct payments by the patients (translated as no to privatization by FIDESZ-KDNP**).** Answers measured by Yes or No to the following questions:

- Do you agree with the decision that from January 1st in the following year Per Diem payment for In Patient care shouldn't be paid directly by the patients ?
- Do you agree with the decision that from January 1st visit payments (300 huf shouldn't be paid by directly by patients for Primary Care, Dental care, and Outpatient care?

The immediate assessment of Financial Times had been: „ this polling was nothing but the battle of the parties" .

Fig.1. ***Referrendum on reforms towards co-sharing health costs (No=above 82%)***

The inappropriate method of questioning was itself evidence of perceptual shortcomings of the opposition alike the policy makers during the mentioned period. Public preparedness, strategic HR management and development, management and leadership training were all areas that never really received priority over the years (evidence from the new government's program above). This is while the system has been continuously failing in the economics and management related areas. The field of Healthcare Management education has received attention in Hungary as early as the 1990s. However, the number, frequency and quality of education in management and economics related fields witnessed a jump only after 2005. One of the reasons maybe linked to the regulations for structuring managerial positions at hospitals announced by the ministry in 2003. (2003/11). According to the said law hospital directors and their three directors were to be assisted by a professional management boards the consent of which was necessary for some management issues, including the strategic professional plan of the institution and its quality management policy. The mentioned all had to hold a university degree in healthcare management first formalized at the Universities of Semmelweis in Budapest and in Debrecen. (Healthcare Management training and educational courses were held as early as 1990s at the university of Pécs as well). Although, such regulations had been put into place the implementation and institutionalization of training and development in fields of management and economics received a very low acceptance for a long while. (i.e. according to a 2006 survey none of the department leaders at the 400 bed hospital in Pécs held a management related accreditation). Unfortunately,

in many instances professional rounds responsible for the accreditation of higher education and continuous learning in the field of management and economics had been medical professionals. In an official letter in 2008 the '*complimentary healthcare education committee*' dismissed the extension of sufficient credit points to management studies at the University of Pécs, justifying the decision as' *management competences are unrelated to the field medical service*'.

While WHO defines the health system in terms of one covering "*all activities whose primary purpose is to promote, restore and maintain health*" other perspectives defined the system in terms of the '*inter-relationship between the public and private sector concerning organization, financing and delivery healthcare goods and services'*. (See Saltman.*et.al* and Mark 1997) .The observation of the evolution of healthcare systems has proven that the grounds for reaching a more universal understanding should be prepared through appropriate '*capacity building programs*'. The design and implementation of higher level learning systems aiding psycho-socio-economic "*paradigm shift*", building capacity for a mutually constructive stakeholder contribution to reform are essential. '*Capacity building programs*' sit at the center of such learning systems, not only for aiding symmetry of stakeholder knowledge and information regarding reform, but more importantly for helping '*decentralization*' through stakeholder empowerment for a proactive, innovative and synergistic participation. The design and implementation of such learning systems/platforms seem unavoidable, especially, under the continuous prevalence of unresolved perception conflicts regarding the main dimensions of reform policies and its '*content*', '*context*' and '*processes*'. At the Hungarian level it is easily conceivable that the questions of systems' "*goal-setting*" (i.e. curative systems' results vs. those indicating long term measures of relative state of wellbeing), and definition of "*stakeholder roles*" (i.e. curing vs. caring system, doctor as authority vs. doctor as a consultant) haven't been understood and accepted by the systems' stakeholders. In fact, the processes and procedures for such knowledge sharing / negotiation for reducing '*Perceptual GAPs* hasn't been thought of and /or put in place by far (conflicting perceptions in the area of "*Ethics, Equity, Equality, Universality, Solidarity*" vs. stakeholder satisfaction). Given the complexity and multi-dimensional nature of the discussed concern, attempts regarding the design and implementation of research activities as well as the design and delivery of change programs face a similar challenge of complexity. In line with the same, there have been calls for the creation of simpler

yet more comprehensive models in order to aid research and the design and delivery of change programs in this field. The current study is a response to the said calls. The study aims at adding value through extracting the ideographic dimensions of unfavorable stakeholder frames of reference and to come up with a typology for their assessment. Systemic Market Orientation (SMO), as defined under the *systems'* philosophy and world view, approach to institutional design and strategy, enjoys the comprehensive qualities of a paradigm. The antecedants of SMO have proven its positive link to continuosly optimized stakeholder outcomes. The institutionalization of the Systemic Paradigm across the networks within the system occurs through higher level learning processes such as "Triple Loop" (TLL) and "Quadruple Loop" learning (QLL). The mentioned have important implications for healthcare reform policy making in Hungary, at both macro and micro economic levels**.** The ten-year long qualitative investigation, which began as a '*management consulting – leadership training*' (MCLT) project was conducted through a longitudinal design. The MCLT phase of the study was built around a mixture of action research, ethnography, auto-ethnography and grounded theory. Market Orientation (MO) especially from the systems perspective (SMO) delivered priceless value for the creation of a typology for classification of psycho-socio-economic paradigms as early as the MCLT phase. The four MCLT clients had appointed the researcher as a consultant for an exploration of the impeding factors in their context and an observation of their training and development needs. The contract included the design and delivery of a proposal for capacity building and organizational transformation programs as well as development monitoring tools tailored to their specific needs. In the course of the project the importance of SMO, the link between quadruple learning, systems of innovation as well as the need for the creation and promotion of Communities of Practice (CoP) promoting knowledge based sustainable development by the MCLT clients had been appreciated separately. Regarding monitoring level concerns, to support macro and micro level mapping, monitoring various indexes were suggested over the course of interactions with MCLT clients. However, the fundamental need for in-depth understanding of context-specific psycho-socio-economic frames of reference required the development and testing of a simpler comprehensive model (typology) which was aimed at by the current study. The mentioned typology was used to assist both the planning and monitoring areas. The conceptualization and examination of MO as a single comprehensive 'psycho-socio-economic' frame of reference for thought and action (paradigm) had neither been the subject of

sufficient attention. The Hungarian incidence offered expansive grounds for adding value to MO's fields of study. The implications of the study are considered valuable for the enrichment of the theory and practice of market orientation. The unsuccessful healthcare reforms in Hungary especially when measured in terms of '*low levels of stakeholder satisfaction*' brought a worthy possibility for examining the antecedents of SMO through the longitudinal - qualitative design. The researcher, seen as an outsider to the specific context-cultural system of Hungarian healthcare practice; at the beginning of the MCLT project, had enjoyed affinity to the theory and practice of SMO as well as specific field related experience. The above mentioned conditions brought additional advantages to the design and conduct of the study offering sufficient maneuverability and role play by the researcher if and when needed (such a position can effectively aid third loop learning).

<u>The aims of the current study could be summarized as:</u>

1.)- Exploration of the stakeholder paradigm (levels) impeding successful healthcare reform in Hungary- "*pardigm level gaps as sources of continuous Healthcare reform failure in Hungary"* through a mixed qualitative research (Intervention Praxis + Longitudinal Grounded Theory) for extracting paradigm alignment or gap with regards to : *'Ontology', 'Epistemology', 'Methdology',' 'Axiology'*

1.)- Literature survey on the state of art in the field of 'Paradigm ' and its influence on economic and healthcare reform policy for identifying potential gaps and arrival at synthesis helping a better structured *a priori* knowledge , assisting awareness paralell to the primary investigation. (Researcher's understanding , perceptions or hypotheses as a result of *a priori*)

2.a.)- Developing "*a simple integrated typology for classifying and analyzing stakeholder paradigms*" from a Systemic Market Orientation (MO) perspective
2.b.)- "*Applying the typology"* to the incidence of the Hungarian Healthcare stakeholders for observing divergences which explain-predict reform failure

3.)-„*Proposing and Testing Change Programs*" assisting bottom-up processes through reducing the said divergences.

Since the interplay of the researcher and his paradigm will not only have an influence on the outcomes of the study , but accounting for the implications are essential since the researcher had assumed active roles over the course of the study:

4.)-Continuous extraction and reflection on the researcher's own presumptions throughout the course of study, for delivering discussions and isolating the influences over the course of the study, highlighting the importance of the role of the MKO.

1.2. The Phases of Investigation, Structure and Method of The Study

It is important to note that indeed the very question of selecting a 'best method of inquiry' had itself been a debated paradigmatic 'objective-subjective' world views incommensurability concern. The predominant nature of the whole study –endeavoring to explore main dimensions of stakeholder paradigms of the Hungarian healthcare – demanded ontological realism. (i.e.Zammito 2004). Therefore, A qualitative framework was found most suitable in line with Ospina (2004) , stating that the application of the qualitative design had to best serve the purpose of :

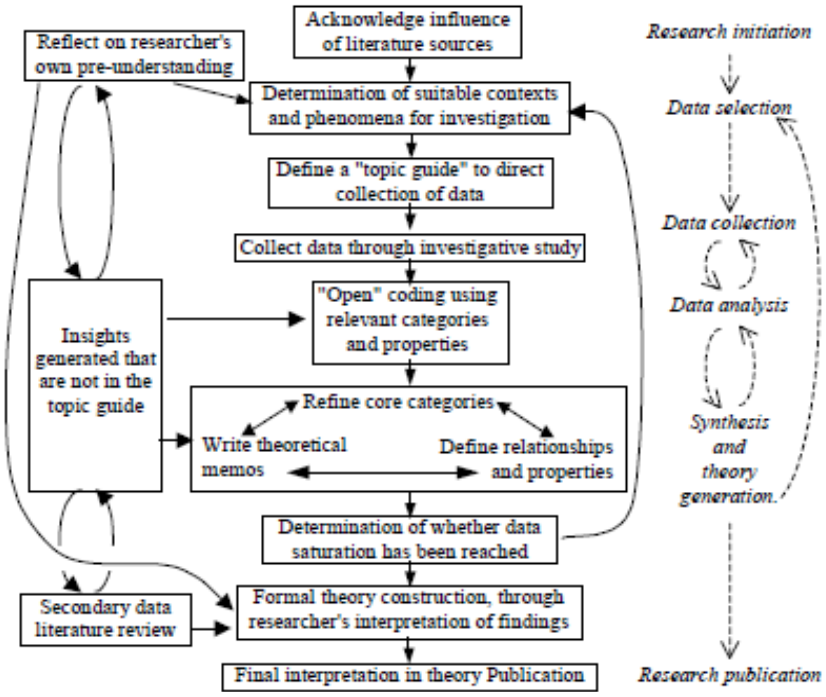
- ."..advancing a novel perspective of the phenomenon not …well understood because of the narrow perspectives used before",
- " endeavoring to understand the social phenomenon from the perspective of the actors involved, rather than explaining it (unsuccessfully) from the outside", *(i.e. here the stakeholders of Hungarian Healthcare)*
- "trying to understand the complex phenomena in whole its complexity, especially that has been dismissed by mainstream research because of the difficulties to study it, or that has been discarded as irrelevant, or that has been studied as if only one point of view about it was real" (*i.e. here the notion of universality in our paradigm*)

Table. 1. A comparison of Nomothetic and Ideographic Methods

Nomothetic Methods	Ideographic method
Deduction	Induction
Covering laws and causality (ethic)	Explanation of subjective meaning and learning by understanding (emic)
Generation and use of quantitative data	Generation and use of qualitative data
Use of statistical controls	Commitment to research in every day settings to allow access to and minimize reactivity among the subjects of research
Highly structured to ensure replicability	Minimum structure

The above re-affirmed the appropriateness of the choice of a mixture of different qualitative methods. The complexity and multi-dimensionality of the field of study required an adoption of a mixture of qualitative research methods applied in a *'reflexive-partcipative'* manner over a longer period of time to more cases in order to ensure *'data-saturation*'. The research project began as a Career Coaching and Management Consulting Project (MCLT) which very soon took the form of Participative Action Research. Modes of „*Parxis Intervention*" were adopted in order to open room for collective working on the researcher's and participants' settled mental models for continuously improving their „*Praxis Potential (Phronesis)*" through joint reflection over the course of the study. The above were found exactly in line with best practices for the study of stakeholders' impeding paradigms related to healthcare reform (observation of the thought-action-learning relationship). Although the researcher's arrival at the subject of study was with *a priori* knowledge, the disturbances were dealt with through continuous reflection, internal and external comparison Self-refelction on the researchers' and participants' own perceptual biases is an embededd component of Action Research and especially Praxis Intervention . However, inorder to improve the transferability of findings , additional components of reflexive grounded theory were included to the 10 year long investigation (in the form of a doctoral research after the MCLT project).

Fig.2. Main Process /Stages involved in „Reflexive Grounded Theory" research



Summary of the Aims and Phases:

a-1)-development and application of a typology for the exploration and codification of stakeholders' frames of reference (paradigms) impeding TLL / QLL and bottom-up participation in healthcare reform.

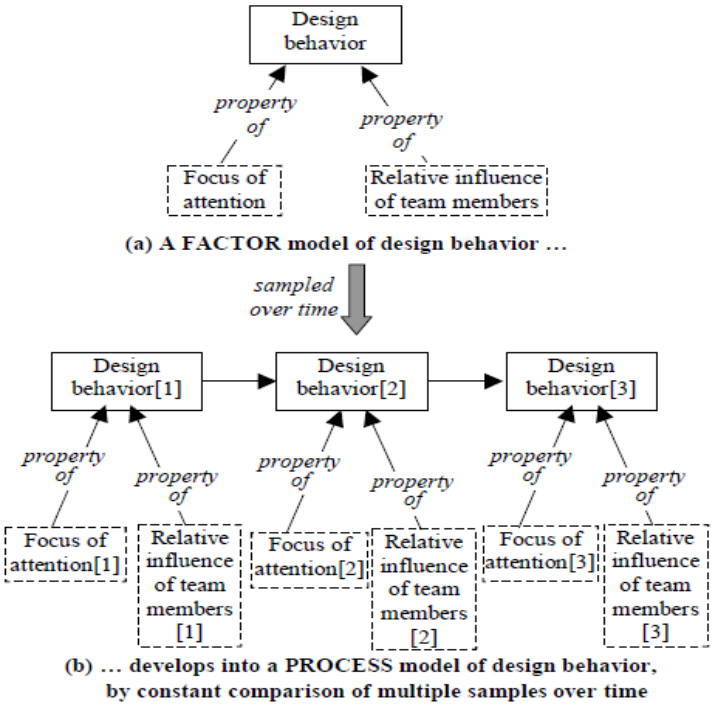
a-2)-proposing capacity building and change programs to promote QLL and transition to newer frames of reference (paradigm shift) based on the extractions .

a-3)- Testing the implementation of the said programs at smaller and larger scales .

a-4)- continuous assessment and reporting of results in terms of achieved level of convergance of psychosocio-economic frames of reference until a „*point of saturation*" has been arrived at. A large scale survey of the perceptions of the stakeholders of Hungarian healthcare was conducted based on Likert scale questionnaires seeking traces of additional implications in a parallel manner.

b)- The Learning and Innovation Platform termed ’HLIP’ (healthcare learning and innovation platform) used for larger scale examination: First series of the extended examinations based on the summary of MCLT results. The design and delivery of capacity building programs at the end of the fifth year of the above study (2006-2007) began with 10 participants . They were repeated across the following five years in order to arrive at the satisfactory level of saturation . The LIP was designed in two main blocks. b-1)- The intensive on-line, in-class and on-site training period for „*joint design of a change plan*”. Duration : normally 4-6 months long but in some cases extended to one year and in one case 18 months. b-2)- on-site consultation phase for ’implementation ’. The evidence of SMOP convergance were extracted through the submitted change project as a part of a strategic management system design (written and verbally discussed via Q&A session) which revealed the shifting perception of ’Role’, ’Goal’ and ’Time’ in comparison to the entry phase and pre-test (interviews, consultation, open ended and close ended sessions). A basic KSAO model of competence was applied across the LIP period. The additional reflections were extracted and re-coded based on submitted ’reflective overviews’ seeking the learning process and evidence of movement from single loop to double loop and higher levels. The evidences created synergy , learning from peers, group dynamics and learning to learn were extracted and accounted for. The closure of the intensive three hour long open book examination. Arriving at implementation and institutionalization of the strategic management system were taken as evidence of the reaching the higher levels learning. At the same time the contextual changes were continously accounted for and monitored. By the end of the fourth year (2009/10) the participants based on their own initiative established a Community of Practice for the implementation of their change projects through knowledge networks. (The first Healthcare Leadership and Management Development Institute in the region) showing evidence of arriving at the 4th level of learning and paradigm shift.

Fig.3. The suggested process for arriving at saturation through repeated experimentation over a long period



The above mentioned phases of investigation were embedded in the following structure and chapters of the study. *Chapter one* currently discusses the background of the study highlihting the influence of stakeholder paradigms in healthcare reform failure. The aims and main hypotheses of the study are discussed in terms of understanding the diverging dimensions of Hungarian stakeholders' frames of reference in order to be able to propose and examine relevant change programs promoting quadruple learning. The gaps in the fields of padarigms and SMO were breifly indicated order to provide an understanding of the structure and phases of the current inductive-exploratory study. Later, *Chapter two* provides an extended overwview regarding the field of study and the relevant areas through a review of the main literature, justifying the hypotheses , approach and frameworks for the qualitative research the scopes and areas of data collection, codification and classification. The important conclusions of the chapter are with regrads to the definition of paradigm and the pillars, perceptions of „Role", „Goal and „Time" influencing economic policy planning and implementation in the field of heathcare *Chapter three* is an in-depth discussion of the MCLT project (Management Consulting and Leadership Training). The outputs and phases of MCLT are reviewed. The aims and approach of the mixed qualitative study and the process of continuous reflection are discussed. The phases /

methods of codification for arrival at a typlogy for examination of the perceptions of the clients, the researcher, the clients' peers and non peers regarding the context of practice and stakeholder 'roles' and 'goals' are clarified there in. *Chapter four* reflects on the findings of the MCLT project for larger scale examination of the typology seeking arrival at saturation levels through the design and delivery of the capacity building programs across 5 years with 95 + 10 participants (6 group + 1 ongoing). These programs were designed and delivered under a so-called foundation level of the 'Hea;thcare Learning and Innovation Platform' (HLIP) which played the function of an intervention praxis assisting joint inquiry and co-creation. The results of each phase were monitored in terms of the level of SMOP convergance (systemic market orientation paradigm typology) broken down at the levels of perceptions of 'Role', 'Goal' and 'Time' (the researcher and an assistant acted as mentors/consultants. 8 senior management experts participated in the foundation level of HLIP) . The incidences of triple loop and quadruple learning were extracted and recorded. The role, influence and role shift of the researcher and his assistant were also accounted for and are reviewed in this chapter. *Chapter five* discusses the occurrence of upper levels of transformational learning under the TLL and QLL through the incidence of the co-foundation of a knowledge based community of practice(CoP) for fostering bottom-up involvement in reform (the HLMDI). *Chapter six* reflects on the conclusions and implications of the study, providing extended discussions for future policy making in the field of capcity building for decentralization in the public healthcare sector. *Chapter seven* is a review of the shortcomings of the current study and suggested areas for future investigation.

2. The theoretical framework, summary of main literature

"*Under normal conditions the research scientist is not an innovator but a solver of puzzles, and the puzzles upon which he concentrates are just those which he believes can be both stated and solved within the existing scientific tradition"* Thomas Kuhn

The aim of this chapter is to extend an in-depth understanding of the field of paradigm and its significance in healthcare reform planning and implementation, arriving at the main hypotheses for examining the reasons for the failure of Hungarian healthcare reform through a qualitative research.

2.1. Paradigm Research: constituents, domain and hypothetical gaps

The notion of paradigm as an over reaching framework which organizes our perceived world was highly popularized through Kuhn's writings under the '*Scentific Revolution*'in 1962. Paradigm in this sense influences our understanding, decisions and responses throughout the processes of inquiry, theorizing, learning, planning, policy making, organizing, strategizing and executing. Although, the exploration of the constituents of stakeholder paradigms influencing the failure of healthcare reform appears to be an obvious and essential inquiry at the first sight , methods of grasping the dimensions of such a domain demands a separate prior study itself. The closeness of the essence of paradigm to the constituents of the stakeholders' worldview does bring us a step closer to this field and domain of study. However, providing an in-depth understanding of 'paradigm' itself becomes in turn too complex and often confusing due to the absence of simplified and pre-examined methods for such study. Similar dilemma have fallen directly in line with ontological and epistemiological debates, most importantly built around the question of *„How do we know what we know?"* , referring to the degree of completeness, truth and accuracy of what 'can be' and 'is' considered as knowledge. The concern reaches intersting forefronts upon arrival at Descarte's reductionist „*Archimedean point*" –the indubitable belief in own existence as the single most important basis for epistemological justification (knowing that we exist is not subjected to the bias of our untested beliefs). These debates have opened horizons for dicussions regarding the 'collective-systemic' or 'individual' nature of paradigm (debated notions that *a prioiori* and *posteriori knowledge* are influnced by *epistemic culture* in a given setting). The 'Systems-Thinking' came as contradictory to positions such as those of Descartes highlighteing the importance of the web of relations both in inquiry and problem solving. Generally 'relative', 'conceptual' and 'perceptual' knowledge were promoted by systems thinkers, realizing that relationships and interactions are not static and do not occur in a closed system local system. The mentioned occur in a dynamic manner subject to a globally open system. On the existence of a universal level of principles, outcomes and inquiry targeting the same, Von Bartalanffy (1968) added, ... *seems legitimate to ask for a theory, not of systems of a more or less special kind, but of universal principles applying to systems in general*."Also, questions regarding the importance of empiricism vs. theory have been prevailing in the conceptualization of paradigm. 'Strategic thinking' (distinguished from strategic planning)

according to Mintzberg is a "*synthesizing process utilizing intuition and creativity whose, outcome is an integrated perspective of the enterprise*." Earlier studies have either taken the definition of paradigm (milieu of thought and action) as an obvious given and as a uniformly shared and understood term, others have been widely inconclusive. The latter have referred to the impossibility of building an objective method for investigating and testing in this field. Kuhn (1996) defined paradigm in the following manner: "*A paradigm is an accepted model or pattern... (of thought and behavior)*" . *"* He added: "*...conclusions which contradict the paradigm cannot be accepted (by stakeholders) as valid no matter how good they sound otherwise. Unless the continuing presence of contradictions; forces the paradigm to shift or to be modified* ". Various other definitions have been attributed to paradigm, for example: "*something which defines a broad sweep of reality, a Gestalt or holistic perception of a figure*"... Stephen Covey defined paradigm as people's 'perceptual or mental maps' about '*how things are'* and '*how they should be*' : "*Paradigms are generally defined as the way we see the world, not through visual sight but through our perceptions, understanding, and interpreting. They are like maps and each of us has many, many maps in our head, which can be divided into two main categories: maps of the way things are, or realities and maps of the way things should be, or values. We interpret everything we experience through these mental maps*." Some scholars have taken paradigms as an 'ideology' in the field of policy making which 'functions as an organizing principle"… *providing a unifying set of values , core beliefs, concepts, language, aims and policy tools* " (see for example Coleman , Sabatier and Coats 1998) . Harrison (1994) refers to the extent of paradigm's impact on our assumptions, perspective and consequently actions. He uses the term 'paradigm effect' for this impact and 'paradigm paralysis' for the ultimate negative level of this impact. Distinguishing between 'paradigm paralysis' and 'confirmation bias' which is a tendency for people to favor information that confirms their preconceptions or hypotheses, regardless of whether the information is true or not he said: "*As you probably know, a paradigm is a model or a pattern. It's a shared set of assumptions that have to do with how we perceive the world. Paradigms are very helpful because they allow us to develop expectations about what will probably occur based on these assumptions. But when data falls outside our paradigm, we find it hard to see and accept. This is called the PARADIGM EFFECT. And when the paradigm effect is so strong that we are prevented from actually seeing what is under our very noses, we are said to be suffering from paradigm paralysis*." On the PARADIGM-POLICY relationship

Hall (1993) cautioned: "*Paradigm, is so influential in policy making precisely because so much of it is taken for granted and un-amenable to scrutiny as a whole*". He added as an example: "*existing policy paradigm being challenged, as it fails to account for empirical reality and accumulating anomalies*". These discussions further sensitivity in assessing paradigms' impact on scientific efforts, especially due the cautions of Harrison (1994) whom had recognized 'paradigm paralysis' as distinct from 'confirmation bias' (implied especially in deductive scientific research) . In reference to Luckmann (2008), he re-asserts: "*Human experience is certainly fallible and details that present themselves as facts may turn out to be illusory. But the fact of all facts, that the world is there, cannot be ignored without self-contradiction"*. Thanks to the contributions of Heron and Reason (1997) a new window was opened for arguing the possibility of a shared, co-created and experiential reality, through a so-called „*participative world view* " (as opposed to either merely a relative Cartesian or a disassociated absolute metaphysical worldview). An extracted summary of the most popular definitions of 'paradigm' are connoted in the here –in-below statements:

Table.2.Popular definitions of 'paradigm'

Definition of Paradigm	Scholar
Problem solving frames of reference for practitioners	Kuhn
A changing worldview based on participation and participative realities	Heron, & Reason
Ideologies and organizing principles especially in the field of mental	Coleman, Sabatier and Coats
Mental Maps of what is and should be	Covey
Moods, Myths ,Patterns, Metaphors, Models for our perceptions of the world and a reference for developing expectations and goals	Harrison, Ogilvy
Frames for policy making	Hall

**The practitioner, in the process of her problem solving, either arrives at newer understandings and/or devises newer terms to assist her problem solving efforts.*

The on-line Merriam-Webster dictionary defines paradigm as " *a philosophical and theoretical framework of a scientific school or discipline within which theories, laws, and generalizations and the experiments performed in support of them are formulated; broadly: a philosophical or theoretical framework of any kind. a successful archetype*". At the terminological level, finding the exact boarders between 'philosophy' and 'the supporting experiments' may require further sensitivity.

The main debate in arriving at an all-inclusive definition would require addressing the questions of whether or not paradigm could be understood as a:

1. 'philosophy and theory?' or rather
2. 'experiment and practice?'
3. 'a psychological and social process, pattern covering thought, action, learning, transformation?'
4. 'a context or milieu' encompassing all above?

An easy early conclusion would find resolution in the fourth option. However, even the perceived clarity in some of the sub terms used in the above definitions may deserve a closer review. More, critically the question of '*what falls out of the domain of paradigm?*' would be an interesting question. In approaching the terms 'philosophy', 'science' and 'experimentation', reflecting on the ontological and epistemological level concerns are important. Generally speaking while 'thought' is frequently distinguished from action, in efforts to arrive at an all-inclusive definition of paradigms, keeping in mind assertions such as those by MacMurray (1957) would be beneficial. He indicated, "… *you cannot divorce action in the world from thought* ." Also, Skolimowski (1994) concluded "*things become what our consciousness makes of them through the active participation of our mind .The cosmos or the universe is a primordial ontological datum, while the 'world' is an epistemological construct, a form of our understanding*."

Historically, philosophy' has been at times understood as the integral part of science (with its experimental dimensions) and at other times as an independent field. The word 'science' for a major part of the nineteenth century implied the disciplined study of the natural world taken to be independent of human intervention. Levels and groupings under 'natural' and

‘social’ sciences, ‘formal’, ‘empirical’ and ‘ interdisciplinary’, ‘applied’ sciences’ became popularized to compliment the domains of curiosity, thought and theorizing . A helpful reference could be to the American Heritage Dictionary (2000) regarding the definition of philosophy:

- Love and pursuit of wisdom by intellectual means and moral self-discipline.*(an implication of maturity of thought, wisdom and reaching self-discipline)*
- A system of thought based on or involving such inquiry *(process and procedures of inquiry within the same)*
- The critical analysis of fundamental assumptions or beliefs.*(philosophy used to argue, accept or reject fundamental assumptions)*
- Investigation of the nature, causes, or principles of reality, knowledge, or values, based on logical reasoning rather than empirical methods. *(Principles of reality are questioned through philosophies. They encompass logic, experiments and experiences but they are not necessarily an academic school of thought)*

Collins dictionary emphasizes on the academic dimension of ‘philosophy ’ highlighting ‘epistemology, reality and super natural reality -meta-physics, ethics , semantics’ :

- the academic discipline concerned with making explicit the nature and significance of ordinary and scientific beliefs and investigating the intelligibility of concepts by means of rational argument concerning their presuppositions, implications, and interrelationships;
- in particular, the rational investigation of the nature and structure of reality (metaphysics), the resources and limits of knowledge (epistemology), the principles and import of moral judgment (ethics), and the relationship between language and reality (semantics).

Perhaps the three relieving questions suggested by Guba and Lincoln (1994) for scientific inquiry, paradigms can be taken as the best resolution for clarifying the here-in-above debate regarding the ‘experimental-dependant’ and ‘philosophical- independent’ nature of paradigms:

a)- The ontological question related to subjectivity or objectivity nature of reality (or their combination) as perceived by the stakeholders (platform for our vision and perspective) :

"What is the form and nature of reality and, consequently, what is there that can be known about it?"

For example Heron 1996 posited that as a result of the mind-cosmos interaction reality is resulted through a "*co-creating dance*". The process of interaction for figuring out and agreeing upon reality. According to Heron at.al "*…any subjective-objective reality articulated by any one person is done so within an inter-subjective field, a context of both linguistic-cultural and experiential shared meanings… a tacit mutual experiential knowing and understanding between people that is the primary ground of all explicit forms of knowing".* Merleau –Ponty (1962) also emphasized the participatory nature of the process of the co-creation of the perception of reality *"….ways the outside has of invading us and certain ways we have of meeting the invasion*"

b)- The epistemological question regarding the nature of knowing and the 'roles-hierarchy' of participants in the process of their interaction with themselves and the reality.

"*What is the relationship between the knower or would-be knower and what can be known?"*

Heron et.al. appropriately highlight the importance of 'critical subjectivity' in approaching this question "*It involves an awareness of the four ways of knowing, of how they are currently interacting, and of ways of changing the relations between them so that they articulate a reality that is unclouded by a restrictive and ill-disciplined subjectivity*". The four ways of knowing based on the same are : experiential, presentational, propositional and practical.
'*Experiential knowing'*-is the perceptual enactment of reality as a result of encounter with it. *'Presentational knowing'*- is the codification or aesthetic dressing of such reality through language, arts, metaphors etc. '*Propositional knowing*'-is knowing in conceptual and descriptive terms built on the experiential and presentational levels. 'Practical knowing'- is knowing how to do something presented in skills and competences.

c) - The methodological questioning how to know and policies/injunctions to follow, (strategies and policies as a results of, and in approaching the epistemological question)

"*How can the inquirer... go about finding out whatever he or she believes can be known about?"*

In efforts to ensure inter-dependence is respected both 'political' and 'epistemological' participation are necessary. Researching 'with the subjects' as opposed to merely 'researching on the subjects'.

Heron et.al. summarized their findings in terms of the here-in-below(implying the relationship between goals and policies in light of the hierarchy):
"*Deciding for others, with others, and for oneself. .... hierarchy is authentic when it seeks the developmental emergence of autonomy and co-operation. Collaboration roots the individual within a community of peers, offering basic support and the creative and corrective feedback of other views and possibilities Autonomy expresses the creative, self-creating and self-transfiguring potential of the person*". Elsewhere, Senge (1990) asserted " *...from seeing ourselves as separate from the world to connected to the world , from seeing problems as caused by someone or something 'out there' to seeing how our own actions create the problems we experience* '. Senge (1990) refers to the systems' view of organizational learning in his book the fifth discipline : "*systems thinking makes understandable the sublest aspect of the learning organization*".

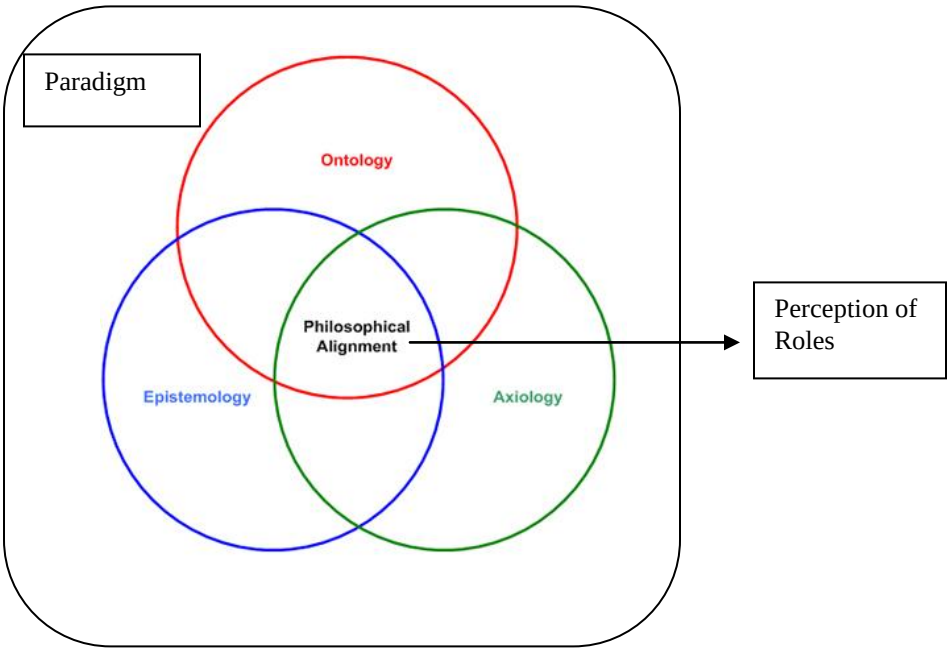
d)- Heron et.al. adds a fourth question in terms of the 'axiological' level-the 'goal' or value of knowing within and across the hierarchy:

" *What is intrinsically valuable in human life, in particular what sort of knowledge, if any, is intrinsically valuable?"*

Fals – Borda (1996) emphasize that the purpose of co-creation of reality is ' *to change the world*' Heron (1996) stressing that the ultimate goal of knowing enjoys an intrinsic value and is an end-in itself, concluded that the co-creating, action based approach to inquiry termed 'transformational inquiry' have primary value as opposed to those targeting merely propositional knowledge. He suggests the 'goal' and valuable type of knowing in the following manner "*knowing how to choose and act ... to enhance personal and social fulfillment and that of the eco-networks of which we are a part. Such human fulfillment is consummated in the very process*

of choosing and acting…. intellectual knowing is of instrumental value in supporting practical excellence". With what was said the proposed all-inclusive definition can be : "Paradigm is the milieu covering the context –process-pattern of psycho-social (political-economic) learning, experimenting, decision making and implementation, forming and transforming the perception of roles, goals through transaction with the psycho-socio-political network towards continuous innovation and development". Shortly: "Paradigm is the milieu of psycho-social learning interacting with the political, economic, dimensions" .

Fig.4. Philosophical Alignment



As asserted by Polanyi (1944) *"… man's economy, as a rule, is submerged in his social relationships",* given the high degree of economic embeddedness in the definitions of social 'roles' and 'goals' on the one hand, the network dependant and developmental nature of paradigm, a re-written conclusion can be :

"*Paradigm is the stakeholders' psycho-socio-economic milieu of learning and development across the global network*"

In answering the earlier challenging question of '*what falls out of the domain of paradigm?'* attention to the approaches taken by paradigm scholars in analyzing 'paradigm shift' is important. Reflections on the notion mode and process of occurrence of 'paradigm shift' , finally temporal/permanent consequences especially in relationship with 'time' and 'space' are considered beneficial. 'Paradigm shift' according to Kuhn occurs when new paradigms emerge "*….sufficiently unprecedented to attract an enduring group of adherents away from competing modes of scientific activity*," and "*…sufficiently open-ended to leave all sorts of problems for the redefined group of practitioners to resolve*." He refers to the books of Copernicus's *De Revolutionibus* or Newton's *Principia* as enjoying such quality. Social scientists, such as Hanada (1986), introduced the idea of "social paradigm" in the context of social sciences. The Kuhnian phrase "paradigm shift" was taken to denote a change in how a given society goes about organizing and understanding reality. A "dominant paradigm level" refers to the values, or system of thought, in a society that are most standard and widely held at a given time. Dominant paradigms are shaped both by the community's cultural background and by the context of the historical moment. As Elias (1992) put it, *'meaning is the memory patterns related to the culture as they are constructed over time, and it is the expectations and preoccupations involved in the temporal issues of exchange and relationship'*. Based on Gotved (2006) "*The interactional part of time is perhaps the most difficult to spell out in all its complexity, but a common denominator is regulation. We are interacting with time through cultural patterns of meaning as well as through structural representations, and thus we are interacting in time and with time. Time is a basic element of (social) processes,… Often, the function of time is to regulate and coordinate the interaction (thus interweaving with the structural aspects), but time as an inherent quality in processes of every kind needs to be addressed as well. We use the patterns of time to regulate ourselves in relation to each other and the environment, and even without the clock, we are able to navigate through the day. In other words, to capture time in an analysis of interaction is (again) to remain open and to keep an eye out for time's possible regulatory role across the variations in interaction".* Paradigm, can only be understood in the context of a *Hermeneutical cycle* within the '*Structure of the Paradigms'*. It supersedes mere interpretation or just bringing understanding. It implies that '*paradigms are developmental*' by nature, moving in a hermeneutical cycle instead of a process of recurring mechanistic circles. A highly important

caution was that of Clarke and Clegg (2000). Expanding on '*conceptual imprisonment*', as the negative impact of paradigms (alike the notion of paradigm paralysis) they state that in a system which is ecologically interdependent; a change in one aspect of the paradigm would translate into a change across the whole (re-defining the whole). There are both static and adaptive levels for interpretation of reality along the cycles of experience/interaction. In Piaget's understanding an adaptive 'human intelligence' should represent both the static and transformational aspects of 'reality' which to him was "*a dynamic system of continuous change, involving transformations and states."* Based on the same:*"Transformations referred to all manners of changes that a thing or person can undergo and states to the conditions or the appearances in which things or persons can be found between transformations*". The 'operative intelligence' in his terms, was "*responsible for the representation and manipulation of the dynamic or transformational aspects of reality"* and that 'figurative intelligence' was "*responsible for the representation of the static aspects of reality* ".While a valid criticism of constructivist approach to learning has been existing (suggested by Jean Piaget, Lev Vygotsky and other supporters), Vygotszky had drawn valuable attention to the importance of social interaction and learning , in the form of a '*a co-operative or collaborative dialogue*', with the MKO (More Knowledgable Other; a leader/skilful peer/ tutor-mentor/parent/teacher/ trainer-coach/consultant etc.). The MKO or leader, according to this proposition acts as a role model for learning social behaviors. Farkas (2003), building on the assertions of Nonaka and Takeuchi (1995), highlighted the importance of approaches to leadrship in promoting knowledge processes, through three types of Hungarian and German organizations.

Vygotsky postulated that learning was essential and universal aspect of the process of developing culturally organized psychological function. He placed even a higher emphasis on social contributions to the process of development (as a prereqisite or a priori for development). The socio-psychological ecology or milieu of interaction for learning was termed as ZPD, a zone or stage of proximal learning for development. In his terms through interaction within the socio-cultural environment the Elementary Mental Functions, Attention, Sensation, Perception, Memory are developed into more sophisticated and effective mental functions which he refers to as Higher Mental Functions. In his terms in collaborative learning, group members should have different levels of ability so more advanced peers can help less advanced members operate within their ZPD. Vygotsky saw cognitive functions, even those carried out alone, as affected by

the beliefs, values and tools of intellectual adaptation of the culture in which a person develops and was therefore socio-culturally determined. While the ideas of Vygotsky's ZPD originally were used strictly for one's ability to solve problems, Tharp and Gallimore (1988) point out that it can be expanded to examining other domains of competence and skills. These specialized zones of development include cultural zones, individual zones, and skill-oriented zones. Through their work with collaborative groups of adults, Tinsley and Lebak (2009) have identified the "*Zone of Reflective Capacity*." This zone shares the theoretical attributes of the ZPD, but is a more specifically defined construct helpful in describing and understanding the way in which an adult's capacity for reflection can expand when collaborating with other adults with similar goals over an extended period of time. Tinsley and Lebak found that as adults shared their feedback, analyses, and evaluations of one another's work in a collaborative working environment, their potential for critical reflection expanded. The zone of reflective capacity (ZRC) expanded as trust and mutual understanding among the peers grew. More recently and further to the writings of Wenger (1998) the notion of 'Communities of Practice' or CoPs became more and more popularized for promoting ZPD and ZRC miliue of learning and innovation . According to Lave & Wenger (1991) CoP is "*a group of people who share an explicit competence , craft or profession. The group can evolve naturally because of the members' common interest in a particular domain or area, or it can be created specifically with the goal of gaining knowledge related to their field. It is through the process of sharing information and experiences with the group that the members learn from each other, and have an opportunity to develop themselves personally and professionally. CoPs can exist online, such as within discussion boards and newsgroups, or in real life, such as in a lunch room at work, in a field setting, on a factory floor, or elsewhere in the environment".* According to Dalkir (2005) "*The type of information that is shared and learned in a CoP is boundless* " . Duguid (2005) Communities of practice help the individual bridge the gap between knowing *what* (tacit) and knowing *how(explicit).* As members of communities of practice, individuals report increased communication with people (professionals, interested parties, hobbyists), less dependence on geographic proximity, and the generation of new knowledge. (i.e. Ardichvilli, Page & Wentling 2003). Wenger (1998) describes the structure of a CoP as consisting of three interrelated terms: 'mutual engagement', 'joint enterprise' and 'shared repertoire'.

- "Mutual Engagement: Firstly, through participation in the community, members establish

norms and build collaborative relationships; this is termed mutual engagement. These relationships are the ties that bind the members of the community together as a social entity.

- Joint Enterprise: Secondly, through their interactions, they create a shared understanding of what binds them together; this is termed the joint enterprise. The joint enterprise is (re)negotiated by its members and is sometimes referred to as the 'domain' of the community.

- Shared Repertoire: Finally, as part of its practice, the community produces a set of communal resources, which is termed their shared repertoire; this is used in the pursuit of their joint enterprise and can include both literal and symbolic meanings"

In terms of methods of assessing the added value and relationship of the training offered and promoted by the CoPs , in comparison to the developed competences by the by traditional educational programs (and even the extended Life Long Learning Programs), change of attitude and deep personal thoughts required for paradigm level gap reduction can be highlighted (thanks to knowledge spillovers and environment of tacit exchanges). In the area of 'attitudinal change' influenced by management training it is worthy to consider Mark's (1993) position could be considered as an important guide, highlighting the difficulties in interpreting and measuring change, Mark sought the signs of "*a transfer from a positivist or ostensibly objective approach to a more phenomenological or subjectively influenced appreciation of management*" As far as designing training programs, Revans (1980), and Mark (1997) referred to the contributions of 'action learning' to outcomes both with homogenous and heterogeneous participants (p.116). The stakeholders coming out of the training period and going back to organizational settings, should be supported in order to assist the development of effective processes of information dissemination , promotion and re-distribution extending possibilities for knowledge and economic networking. The formation of formal knowledge based Communities of Practice (CoP) may be considered as important for complimenting cycles of learning in response to calls by Revans and Mark.

In approaching the short term/long term relationship of the individual and the psycho-social system of the economy, three major perspectives open windows for grasping the earlier

discussed levels of paradigm (objective, subjective and combined). The first perspective, taking the Cartesian relationship proposition puts the individual (with various socio-economic roles and goals) at the center of the world defining it as the initiative, the means and ends of the economic efforts. This paradigm level opens opportunities for viewing the relationship in the form of a so-called '*objective-rational*' model, under which understanding and observation of the relationship may be achieved through the decomposition of the relationship to its rational components. The concepts of '*conflict of interest and choice*' are explained through an evolutionary view of competition for growth and survival (embracing Darwinism). This paradigm level is symbolized in the classical, neoclassical, rational choice and monetarist views of economics). Proponents of the 'objective paradigm' take a utilitarian or '*positive approach*' when they value the freedom of choice and emphasize the importance of free competition. Many schools belonging to this paradigm see stakeholders as the so-called *homo economicus*. According to this paradigm '*all inherited structures can be changed through the evolutionary process and interactions between the individual and the context. Newer traditions can be made and the look should be to the future*'. The second level of paradigm has tendencies towards the "*subjective-organic*" perspective, putting higher emphasis on the collective importance in a system, the relationships and interactions there in. The inherited and predetermined hierarchies have to be accounted for and respected by the individuals according to perspectives originating from this paradigm level. In line with the same, competition should not be taken to a level that undermines the collective interests, according to the proponents (i.e. Keynesian, neo-Keynesian, Marxist, or a major group of synthetic approaches). The proponents take a '*normative approach* 'demanding an exertion of external regulations for balancing the individual and the system level utility. Prescriptions of tradition, the ecological environment and the pre-determined hierarchy 'ought to be followed' (closer to the normative approach). The claim is that: '*we are made by the environment and are born out of the predetermined hierarchy, namely the family. Our choices are limited and relationships are neither purely individual nor rational. The past cannot be remade'*) . The 'systems' or 'systemic' perspective regards the relationship of the individual and systems' under a third paradigm level. The individual-system relationship, as suggested by Limerick and Cunnington (1993) are characterized by *"cultures of collaborative individualism. entrepreneurship and action learning"*. Meadows, Meadows, and Randers (1992) define a sustainable society as "*one that has in place informational, social and institutional mechanisms*

that keep check on . . .feedback loops."Clark and Clegg (2000) drawing on the importance of time in economic growth under this paradigm level, posit that : "*a shift occurs from the economies of scale to the economies of time*". They add : "*learning capacity becomes the most important management attribute*" The so-called "*systemic or enactment*" paradigm puts a high emphasis on the importance of '*learning*', '*synergy building'* and targeting '*all win goals*' when defining the goals for the individual and the system. Senge *et.al.* (1999) refers to an environment *"...where collective aspiration is set free and people learn how to learn*". Naisbit (1982) had highlighted societal patterns moving to "*decentralized, networked, hi-tech information society*". Respecting both the objective and subjective aspects of reality, neither the individual nor the systems are given higher value. Both are seen as integral components (the concept of 'out of the system' and 'exogenous space' are extinguished). In line with the same the hierarchy is both inherited and re-made and the past does not enjoy a higher importance than the future (or vice versa). Morrison (1996), highlights shifts in perceptions around three major areas: 'the Market', 'the Organization', 'the Individual'. At the level of the Market he highlights a shift towards 'demand-driven' as opposed to the 'supply-driven' approach (scarcity and dynamism on the demand side rather than the supply side). He continues stating that the shift has occurred towards giving higher importance to 'Knowledge' and 'People' instead of 'Capital' and 'Money'. According to Morrison (1996), at the organizational level, attention has shifted to 'individuals and networks' instead of 'corporations'. We've been witnessing higher emphasis on 'culture' rather than 'business processes' in his terms. Maturity is determined in terms of 'Virtual Integration' instead of mere 'Horizontal and Vertical Integration'. A shift towards attending to an '*Ecological Reality*' (rather than an '*Engineered or Re-Engineered'* single process or dimension of the total reality) has been discussed. The 'Organic Organization' has been valued, rather than the 'Mechanistic Organization' in line with the same. At the individual level ' Hyper-effectiveness' has replaced 'Hard work' "*Now is a part of the past and the future and is enacted continuously by the participants*". It takes a normative perspective when targeting a balanced goal setting for optimal stakeholder results, where transparency and knowledge sharing are prescribed , but remains predominantly positive when placing the individual at the top of the hierarchy, leading herself and the system to a continuously optimized and sustainable position (development). Finally, the resolution towards the creation of an integrated perspective for economic policy planners was suggested by Jefferson (2004) by emphasizing the need for

planners (as both facilitators and experts, MKOs) to consider the human nature and look into themselves while formulating the plans (Jefferson himself being a skeptic that integration can ever be reached):

a. *"Self-Reflection:* Recognition of their own ownership of the countervailing views will make it possible for planners to not only better accept them, but also to engage in an incremental effort to creatively deconstruct them. Failure to take such stock will make it more difficult for him or her to serve effectively as either facilitator—which requires an ability to identify and relate to planning process participants—or expert informer—which requires thinking outside the so-called black box"
b. *Encouragement of planning society:* Commitment to long term collaborative learning and education amongst all individual and institutional stakeholders of the society
c. *Analysis of Context:* Understanding the current state of the world views of the stakeholders (through direct information gathering) in order to be able to best address the gaps through public policy planning. Questioning is itself not only a part of the join-inquiry process but will also directly contribute to co-learning , stakeholder ownership and involvement in the process.
d. *Decision model and the assumption of Roles:*

   -"*Technician*"*(Tech.Facil)*: In this role, the planner is primarily concerned with the gathering and analysis of data and integrating this as information into the decision-making process

   - "*Incremental facilitator*" *(Incr.Facil)*: In this role, the planner enters a bargaining process in which actors are focused on achieving incremental change in relation to preferences, functional objectives, and the delivery of goods and services

   - "*Trans-active facilitator"(Trans.Facil)*: In this role, the planner is a prime organizer of a bargaining process in which actors are focused on learning about each other and the issues, and the achievement of change consistent with values and the improvement of society

   - *"Progressive advocate"(Adv)*: In search of an overriding public interest, the planner in this role encourages and provides for the involvement of interest groups in the planning process to support his or her advocacy of particular goals and values

Breaking down processes into projects Jefferson (2004) depicted his perception of how knowledge projects ought to be defined and planner roles delegated to them in a chart with the following dimensions:

- Context –(here stakeholders' worldview): Citizens' vs. Interest Groups' world view [subjective- objective, termed ecological-expansionist by Jefferson]
- Project characteristics – State of knowledge vs. other systems' impacts
- Method of evaluation- Data, Values, Logic vs. Compatibility level of original worldview

Before arriving at conclusions it would be worthwhile to reflect on questions brought here –in earlier once again:

a)- Can the predominant paradigm (level) of the Hungarian healthcare stakeholders be considered as an inherited source of resistance to change (at a certain time or period of observation) along the stakeholders' development curve?

b)- Can paradigm levels be manipulated towards a shift? Through which personal-interpersonal-social processes?

c)- Is there dynamism in the formation of paradigm (levels)? Are paradigm levels being continuously created or reshaped ? Would it be appropriate to consider an inter-temporal component along transitional phases? Is there a learning curve involved? Can we see signs that indicate the importance of experiential, presentational, propositional and practical learning?

In answering the above questions and in responding to the goals of this section, a summary of conclusions , propositions and hypothesis extracted from the here-in-above literature review are brought here-in- below:

Conclusions – Appreciating the implications of the state-of-art understandings in the field of study :

1. Stakeholders of Hungarian healthcare may have been suffering from ‘paradigm paralysis (driven by level GAPs)’ impeding reforms. A shift in the paradigm level can occur through most important psycho-social processes, which is learning.

    - Economic Policy and Healthcare policy planning and implementation are influenced by paradigm.
    - Perceptions of ’Roles’ , ’Goals’, ’Time-Space’ and their transformation over time occur for the sake of development of the whole system. The mentioned are the constituents of paradigm and its levels
    - It is more appropriate to think of one paradigm as a single universe of thought and interaction having subsytems at different stages of development complimenting and contributing to the overall development; as oppposed to having more paradigms (universes) in competition. In this sense ’paradigm shift’ occurs towards development.
    - From an ontological perspective it is more appropriate to view paradigm from a combined ‘objective-mechanistic’ and ‘subjective’ perspective of the total realty (universal/systemic). The universal (systemic) level is ‘*enacted through participation and co-creation with participants*’
    - Imprisonment in one level is equivalent to the divergence (GAP) from the combined or the universal level .

      {(Objective/Mechanistic) + (Subjective/Organic)= (Universal/Systemic)}
    - Paradigm paralysis (imprisonment) is an outcome of the divergence or ‘GAP”
    - The learning patterns and processes of transformation and development within the paradigm occur through a hermenuetical cycle over time
    - The dominant paradigm (levels) at each stage of the hermeneutical cycle may lead to ‘Paradigm paralysis’ also ‘perceptual / paradigmatic gaps’ may exist throughout the different stages of paradigm development. These, if not accounted for and if not dealt with, will have a negative and/or impeding impact on the course of change, reform, transition and transformation.
    - Change in one aspect of the paradigm influences change across the system of participants and the paradigm.

- Capacity for adapting to , participation in and promoting change requires training and development programs
- Paradigm shift can be promoted and initiated by the aid of the milieu of interaction (paradigm reinforcement) , collaboration psycho-social learning and the presence of the facilitator -MKO (more knowledgeable other) and peers enjoying higher levels of knowing (experiential, presentational, propositional and especially practical knowledge).
- The development of *ZPD*s, *'cultural zones', 'individual zones' ,'skill-oriented zones'* and the *'zone of reflective capacity'* in collaboration with peers having similar goals (over a period of time) promote the occurnce of paradigm promotion (shift) from one 'subjective', 'objective' or combined level to a more developed level.

Proposition and Hypothesis (1) :

" *Hungarian healthcare reform failure has been due to the stakeholder paradigm (level) Gap*"- [No Gaps= successful reform]. Analysis conducted at individual levels

Note:

Reform failure due to paradigm level GAPS are observed through :

(a) Reform failure due to gaps in stakeholders' "Perception of Role"

(b) Reform failure due to gaps in stakeholders' "Perception of Goal"

(c) Reform failure due to gaps in stakeholders' " Perception of Time and State of Change"

Proposition and Hypothesis (2):

"*Hungarian healthcare reform failure has been due to the absence of wide spread and appropriate capacity building programs for learning modes of embracing change, adapting to change,participating in and promoting change towards the universal paradigm"* – [Widespread capacity building programs for promoting the universal paradigm = Narrow or No Gaps = improved reform succes over time]

Hyps

(a) Reform failure has been due to Low number of capacity building programs addressing decentralization , empowerment and improved stakeholder participation for in Hungary

(b) Reform failure has been due to Lack of Educational and Training Programs Designed for Capacity Building and empowerment towards decentralization and reform success

Proposition and Hypothesis (3):

"*Hungarian healthcare reform failure has been due to the absence of widespread CoPs ZPD*'s, *'cultural zones'*, *'individual zones'* ,*'skill-oriented zones'* and the *'zone of reflective capacity'* in collaboration with peers that similar goals (over a period of time). [Widespread Capacity Building (Hyp2) + CoPs = Narrow or No Gaps= improved reform succes over time]

(a) Reform failure has been due to the absence of CoP's supporting / complimenting tacit-explicit learning and innovation required for decentralization

Proposition and Hypothesis (4):

"*Hungarian healthcare reform failure has been due to the absence of MKOs and leaders for creating and participating in the ZPDs"* [MKO/leader presence and participation + widespread Capacity Building (Hyp1) + CoPs (Hyp2) = No Gaps = improved reform succes over time]

(a) Reform failure has been due to the absence of MKO presence and participation in this field (for initiating and following through the implementation of the program)

2. Appropriate 'Goal Setting' for successful reform should include an inquiry (audit and research) in the field of paradigm which takes account for the inter-dependence of stakeholders' level of paradigm gap, (the inquirers' and inquired level of gap), and should

also be conducted through a combination of auto-ethnography and participative –action research.

Proposition and Hypothesis (5):

"Goals of Hungarian healthcare reform have not been set as a result of participative inquiry-action research accounting for the MKOs' , inquirers' and inquires' level of paradigm level gap(paralysis) " [Goal setting based on participative inquiry addressing the level of gap = appropriate reform programs and successful implementation]- Note: The fact that scholars are continuously subjected to their own milieu of psycho-social learning, calls on the importance for parallel accounting of their own paradigm gap levels.

(a) Reform planning hasn't been successful due to the fact that inquiry in the field of the failure of healthcare reform has not been conducted through a 'participative design' (i.e. Action Research) involving stakeholders and accounting for their paradigm gap level

In the following section the above implications and conclusions are examined further.

2.2. Paradigm levels , Economic Policy and Reforms: Extended propositions

This section aims at providing further insight in answering the earlier questions and the formulated hypotheses. The influence of paradigm level on economic policy and later healthcare reform based on the example of Hungary sit at the center of focus. In a general sense this influence can be thought of in the following major areas:

a. Goal-Setting and Content of the Plans or reforms (Vision and Expected Qualitative, Quantitative-short to long term Outcomes of Reform) – *Basis: Governments' Economic School and affiliation, Philosophy and chosen Model. Past performance. Information on changing stakeholder wants and needs in light of the international context*

b. Context of Socio-Economic and Socio-Political Relationships and the Governments' perception of Roles and hierarchy (centralized-decentralized) in light of the above Goals / Plans-*Basis: Governments' choice of Philosophy and perception regarding the areas and degree of intervention in the economy and its processes*

c. Process of goal-setting and planning reform, modes/goals/areas of intervention, and implementation of reform plans - *Basis: Governments' Vision, Perception of Roles (hierarchy ,position, governance), Philosophy and chosen Model. Past performance. Information (arising from feedback systems) on changing stakeholder wants and needs in light of the international context*

The three paradigm levels, discussed in the previous section: *'the Mehanistic'* level with rather positivist tendencies, *'the Organic'* level with rather normative tendencies, and *'the Systemic'* level taking a combined approach, have influenced the field of economic policy and reform policy planing (healthcare being natuarlly subjected to the same). *Economic Policy*; deals with the governments' approach to intervention in the system of economy and can be defined as: *'the discipline that studies public economic action, through examining processes under which social preferences are formed, the choices of institution are made and finally the current decision of the government are formulated'*. The relationship of classical scarcity with the unpredictable wants, needs and demands have also been the core content of extensive investigations, very much inspired by tendencies of mainstream economics. The issue of perceived 'impossibility' of targeting both efficient and effective performances opens concerns based on paradigms influencing the selection of benchmarks, norms, indicators and methods for assessing performance and development. (*see* for example Fleurbaey M. 2008). Based on rational approaches reasoning the importance of '*all-win*' decisions especially by the propositions of welfare economists and social choice theorists (i.e. Pareto's efficiency, Nash equilibrium and the game theory) has been around the debate on whether or not the foundation of collective and individual point of view differ? Sen A.'s (1999) famous question on having committee-based 'social choices' was: "*how can it be possible to arrive at cogent aggregative judgments about the society (for example, about 'social welfare, or 'the public interest,' or 'aggregate poverty'), given the diversity of preferences, concerns, and predicaments of the different individuals within*

the society? How can we find any rational basis for making such aggregative judgments as 'the society prefers this to that,' or 'the society should choose this over that,' or 'this is socially right'? Is reasonable social choice at all possible, especially since, as Horace noted a long time ago, there may be 'as many preferences as there are people". Such stances had given room to questioning whether or not at the individual level a point of resolution can ever be reached without intervention in settling the conflict of individual preferences (utilities)? (i.e. ref. Arrow's impossibility theorem). If so to what degree? Are social settings important? Can changing preferences be forecasted? To what degree may a responsive system for simultaneous stakeholder knowledge sharing be developed? Would the proactive, conscious involvement of individuals play a role here? Can asymmetry of information ever be resolved in any setting (*see for example* Greenwald, Bruce; Stiglitz, Joseph E. , 1986 for such concerns). Finally, whether or not a healthy resolution maybe sought amongst the 'generic' and/ or 'case specific' models through which the society/industry/institute/individual define their roles and aims at a given time?

Reform policies' of the government, are policies leading to a fundamental shift in the mechanism of demand-supply-redistribution as a result of government's philosophy and newer approach to the design, process and monitoring of the system. (see for example postulations of Tinbergen 1952). These policies should be distinguished from the rather more peripheral change policies referred to as 'Quantitative' and 'Qualitative' policies. Dreschler W. (2000) denoted" *…Public Administration is a field that prima facie looks unattractive to many if not most in Central and Eastern Europe, because bureaucracy does, even to those who appreciate the state: inefficiency, corruption, and boredom seem to be associated with it…* " . He'd gone on to suggest checklist for public administration reform he termed FINMOUSE :

> **"Finance**: - is budgeting, accounting, and controlling done transparently, efficiently, and cost-effect-related?
>
> **Incentives**: - does the unit get, promote, and keep the best members available with the specific incentives the state has? (job security, promotion, prestige)
>
> **Niceness**: - is there anything that can be done to improve citizen satisfaction and control without causing financial or other problems?

Minimal State: - is the task performed not better, or equally well, by a non-state entity?

Output-Orientation: - is the fulfillment of the task measured by output, while keeping in mind that overdone controlling costs more than it saves, yet easily prevents the development of civil service ethos?

Unit Size: - are the units in the hierarchy small enough for humaneness and supervision but big enough to avoid too much red tape?

Subsidiarity: - is the lowest functioning unit in the hierarchy performing the given task?

Efficiency: - given the requirements of democracy and *Rechtsstaat*, is the task performed and the office structured (business-)efficiently?"

Many advocates have been critical about short-sightedness in designing and implementing economic policies based on those models which look sound merely on paper Paul Krugman (2009), in his reflections on the problem of paradigmatic gaps between positive and normative approaches to economics, asked ' *How did economists get it so wrong?*'. Elaborating on the short-sightedness of both Salt-Water and Fresh-Water gaps in accounting for the whole picture and the realities on the ground. Krugman had referred to both groups with criticism whom had taken impressive looking mathematic models as truth: „*...they have been digging themselves in perfectly sound mathematical models, while the realities on the ground have been working otherwise...*". He critically wrote: "*As I see it, the economics profession went astray because economists, as a group, mistook beauty, clad in impressive-looking mathematics, for truth* ". Hall (1993) had reminded that, policy makers work within a *'framework of ideas and standards that specifies not only the goals, but also the very nature of the problems they are meant to be addressing*.' Nobel prize winner, Myron Scholes (2005) in his speech at the NYU/IXIS conference brings attention to the importance of accounting for 'meta-models' and 'inter-relationships' in a system when designing or chosing an idealized model: " *We make models to abstract reality, but there is a meta- model beyond the model that assures us that the model will eventually fail. Models fail, because they fail to incorporate the relationships that*

exist in the world". These inter-relationships and meta-models are very much implied in Kuhn's and Covey's definitions of 'paradigms'. In expanding on the wider inter-relationships between the stakeholders and their paradigms, Dutt (2007) brought attention to the 'contextual' circumstances for observation highlighting sector/segment related dynamics*: "Analytical views of the economy refer to understandings of how individuals or groups in the economy behave, in and with which aspects of reality they interact, and the characteristics of these aspects of reality. These views need not be absolute in the sense of applying to all times and places, but may depend on the context to which it is applied. It may also be the case that segments of the economy may in principle be seen as being characterized in different ways."* Dutt, referring to Sen (2006) emphasizes the multiplicity of stakeholders' perceived roles and identities which are not always in line with those of the profit maximizing homo-economicus:" *individuals are driven by motives other than self-interest, such as, for instance ethical considerations. Thus, they have multiple identities, not just the identity of the homo economicus. Awareness of these issues can also change behavior as people begin to appreciate their own multiple identities. Thus decision makers in corporation and in government may not just see themselves as profit or income maximizers, but also as religious and ethical people, and brings it upon themselves to help the poor and protect the environment*". In terms of "goal-setting " and establishing indicators for monitoring performance a new paradigm level can be detected under the development (and sustainable development) perspective which includes both positive and normative dimensions (salt water and fresh water). In line with the same, efforts have been made for creating a simple model or indicator of human competence, health and development resulted in the creation of the Human Development Index (HDI). Mahbub ul Haq (1990) together with development economists among others Anand ,Desai, Griffin, Ranis, Stewart, Streeten, Sudhir and later on joined by to a certain degree by Amartya Sen had the deliberate effort ''*to shift the focus of development economics from national income accounting to people centered policies*''. These efforts lead to the definition of a simplified index under the 'Human Development Index' adopted by the U.N. since 1990. The HDI combines three dimensions:

. Life expectancy at birth, as an index of population health and longevity

. *Knowledge and education*, as measured by the adult literacy rate (with two-thirds weighting) and the combined primary, secondary, and tertiary gross enrollment ratio (with one-third weighting).

. *Standard of living*, as indicated by the natural logarithm of gross domestic product per capita at purchasing power parity.

From other valuable efforts for creating simple models, studies the "Quality of Life (QOL)l" , "Subjective Well-being" and "Competitiveness Indexes' have received attention by the researcher. On QOL Constanza R. (2008) advocated "*While Quality of Life (QOL) has long been an explicit or implicit policy goal, adequate definition and measurement have been elusive. Diverse "objective" and "subjective" indicators across a range of disciplines and scales, and recent work on subjective well-being (SWB) surveys and the psychology of happiness have spurred renewed interest*". The subjective, in some cases 'difficult-to-accurately-measure' nature of "Satisfaction with Life" and "Happiness" have been highlighted not only by critiques but also with their own proponents. However, in judging the inter-relatedness of 'standard of living' and 'income' as measurements of 'happiness', critiques have postulated: "*as much as it can be measured, standard of living does not necessarily increase correspondingly with the comfort that results from increasing income. As a result, standard of living should not be taken to be a measure of happiness"* triggering sufficient need for additional mixed researches (qualitative and quantitative) on the content of happiness. In line with the same efforts to create more comprehensive yet simple measurements of development and performance, the world economic forum WEF classifying countries into three main categories, has adopted the 'Global Competitiveness Index' report or the GCI with integrating 9 main blocks, '*measuring the set of institutions, policies, and factors that set the sustainable current and medium-term levels of economic prosperity*'. 'Paragim effect' can be traced in approaching the paradox of hi-low rationality in stakeholders' 'goal-setting' towards sustaining the long term well-being, also remains to be an open question.. The preferences and choices an adult makes adressing her or his short to long term goals. Jochelson K. (2005) reacted to the difficulty in rational evaluation, through raising the following question "*Are smoking, drinking and eating unhealthily any different?*" Then continues "*Governments cannot ban these activities, nor can it* (they) *compel people to do things they do not wish to. But* (…) *case studies suggest they can encourage better*

choices through regulation, taxation, advertising codes and informational campaigns. These may restrict individual choices a little, but they also make it easier for individuals to make healthier choices if they wish." The here-in-above mentioned debates arising from paradigm effetct , paradigm level gaps, and very often paradigm paralysis suggest that reform plolicy planning and inplementation in the past has been rather tending towards either the Mechanistic-Objective or Organic-Subjective levels but almost never towards the universal Systemic-Enactment paradigm. The implications of this conclusion can be summarized in the following manner:

1. <u>Goal Setting and Planning (Content)</u> under the Systemic Paradigm is more in line with bases arriving from: stakeholder utility perceptions and preferences (not merely that of the homoeconomicus), targeting optimization across the system for continuous (sustainable) satisfaction, happiness, wellbeing, health and learning i.e. HDI, NWB, SWB, GCI etc. (application of the FIMOUSE checklist, with especial attention to transparency and reduction of asymmetric information as a result of reform planning. Decentralization needs capacity building and empowerment)

   Prop./Hyp. (6) *„Hungarian Healthcare Reform policy, as a part of the Economic Policy Planning suffered from paradigm level gaps with the systemic paradigm and therfeore did not have set aims, goals, targets or combination of policies and instruments built on the systemic paradigm"* [Low Goal Perception Gaps=Systemic Paradigm= sucessful Goal setting/Planning for satisfaction optimization= successful healthcare reform for sustainability, Systemic Paradigm convergence]

   (a) Reform failure has been due to paradigm level gaps (divergences) with the systemic (participative and enactment) paradigm.

2. <u>Context of Socio-Economic and Socio-Political Relationships:</u> under the Systemic Paradigm the relationships are viewed across eco-sociological network necessitating a participatory approach by ALL stakeholders in the reform policy planning and implementation. Role of the government is more towards the upholder of the security, regulator, administrator, coordinator and reference for complaints rather than that of a

contender and service provider(namely healthcare) buying and selling on the market. Achieving 'minimal state', reduced hierarchy and decentralization defines a governments role around the coordinating and administering body handling an effective and efficient dissemination of knowledge and information across the system.

Proposition And Hypothesis (7) "*Hungarian governments' perception of Role in understanding the socio-economic and socio-political context at the local and global areas and in planning and implementing reform policies has suffered from Systemic Paradigm Gap emphasizing high intervention, top-bottom and centralization as opposed to decentralization and bottom-up processes*" [Low Role Perception Gaps= Systemic Paradigm= Decentralization=successful healthcare reform]

3. Process of Goal –Setting and Implementation under the systemic paradigm, considering stakeholders' psych-socio-economic life cycle stage, implementation through promoting learning and development for the paradigm level (systemic gap) reduction (assisting fundamental transformation where needed) is the most important process for achieving sustainability. Enacting the future rather than merely, past, present future orientation is considered.

   Proposition and Hypothesis (8) " *Healthcare Reform policy implementation hasn't been with highest respect to the life cycle stage and state of the economy, leading to the design and promotion of learning and development processes in the short and long term in line with the sustainable wellbeing vision targeted by the systemic paradigm"* [Hi Learning Orientation= Low Systemic Paradigm gap= Successful Reform towards sustainable well-being]

These conclusions are further examined with a focus on the Goals, Role, and of governments presence in healthcare and the design and development of reform programs adressing the goals.

2.3. Healthcare Reform Failure, Capacity Building, TLL and QLL

"It is not enough to do your best; you must know what to do, and THEN do your best."

—W. Ed. Deming

Healthcare Reform policy plans are directly framed by the governments' overall economic policy plans. The emphasis of the Nuffield Council (2007) was " *People are much healthier today than they were 150 years ago. Since the turn of the 20th Century, life expectancy has increased by nearly 70%, equivalent to 16 hours per day. Much of this change is a result of what might be seen as quite interventionist public health policies such as provision of clean water, sanitation and mandatory vaccination, as well as protection of workers and children through specific legislation. In all of this, the state has played a central role in improving people's health*". In referring to the problem of central planning and the role of the government at the level of transitional CEE countries Rose (1993) posited:

"…the direction of the political and economic changes in the most post-communist countries during the 1990's led the reforms of the healthcare systems to a similar path. Politically, the obvious way of change was a shift to the right. Economically, a break with central planning and the introduction of market reforms was the clear choice, largely dependent on the speed of the legal and institutional changes… One of the clearly identified common strategies integrated by the majority ….into healthcare reform designs was the decentralization of healthcare financing and provision systems…"(*see also* Rose R.,1998 Lesson-Drawing in Public Policy) . The governments' ideal „Role" and degree of intervention in healthcare reform , has met with simple questions such as: '*What is a healthy redistribution of resources and income?*' , '*How may the government help?*'and also '*How may the government facilitate production and growth?'*. The obvious impact of the method, process and aims of public administration reforms on healthcare reforms at the CEE level were also accounted for by other studies. Raisio (2009), in his paper on the Hungarian healthcare insurance reform, claims : "*It is most often the case that planners of health care reforms and policies try to solve highly complex, or wicked problems. Issues that have no single experts. Collectively, by gathering many different people and bringing them to genuine deliberation, we can, however, create an emergent understanding and commitment, which helps us to tackle these problems.*" Lawrence (2001), reflecting on such endeavors, had praised the efforts of many , especially that of S. Marks. In his article he refers to the statement :"*The emphasis on 'health practice', however, may emphasize*

'health care' to the detriment of public health" . He then continues: "*.... a declaration on 'Human Rights and Public Health' would stress the critical importance of creating the conditions for populations to be healthy - e.g., physical environment (clean air and water), built environment (livable cities and decent housing), informational environment (health education and regulation of commercial advertising), nutrition (adequate diet and safe foods), reduction in risk behaviors (safer sex and needle sharing), and elimination of health disparities based on socioeconomic status, race, and sex and gender.* The original questions of ethics in healthcare and the content of 'economic value' of the healthcare services have lead to debates on the degree and areas of governments' direct intervention in the economic cycle, taking the roles of suppliers or buyers, designing and delivering social security and most importantly the governments' role in regulating public / private insurance and in ensuring the ethical and moral conduct in this domain. The typical worry in allowing individual choice comes from the concept of asymmetric information from the side of the public (seeking governments' direct intervention). The commonly argued trends towards privatization and re-privatization have also been a subject of historical debate. The same worry is reinforced especially when emergency and tertiary care seem to become more expensive private services, while shifting all the costs of care and treatment to the care seekers. In Europe we see as well that the public perception is positive when a more active role is given to the governments' intervention. The transitional healthcare system of Hungary, in spite of its peculiarities has shown no exception as far as the afore mentioned are concerned.

Weller and Manga (1983) addressing policy makers of three countries asserted "*Progress towards the equity objective in health has been seriously threatened in recent years by attempts to halt or reverse the direction of postwar policy and re-privatize the health care systems of Canada, Britain, and the United States*. " *Normally, mistrust originates from the perception that the private sector does all it can to maximize its profits at the expense of the care seekers' health, while the government does not have such an ambition* ". The ethical „*Role*" of the government, the public system, the service providers and physicians have also been the subject of debate. In a joint analysis (2002) under "*Public health ethics: Mapping the terrain*" from a disciplinary point of view, the authors first emphasize "*Public health ethics, like the field of public health it addresses, traditionally has focused more on practice and particular cases than on theory, with the result that some concepts, methods, and boundaries remain largely undefined*." They go on

to raise the question " *how may we distinguish public health from medicine?*" then argue "*While medicine focuses on the treatment and cure of individual patients, public health aims to understand and ameliorate the causes of disease and disability in a population. In addition, whereas the physician-patient relationship is at the center of medicine, public health involves interactions and relationships among many professionals and members of the community as well as agencies of government in the development, implementation, and assessment of interventions. From this starting point, we can suggest that public health systems consist of all the people and actions, including laws, policies, practices, and activities, that have the primary purpose of protecting and improving the health of the public*". The next statement from the same article is closely tied to some of the main motivations of the current research. "*While we need not assume that public health systems are tightly structured or centrally directed, we recognize that they include a wide range of governmental, private and non-profit organizations, as well as professionals from many disciplines, all of which (alone and together) have a stake in and an effect on a community's health*". On the role of the government the authors conclude: "*Government has a unique role in public health because of its responsibility, grounded in its police powers, to protect the public's health and welfare, because it alone can undertake certain interventions, such as regulation, taxation, and the expenditure of public funds, and because many, perhaps most, public health programs are public goods that cannot be optimally provided if left to individuals or small groups*". The complexity of healthcare, originating from a common perception of high risk regarding people's 'state of well-being', requires more comprehensive-systemic approaches to 'governance and stakeholder management.

The antecedents of systemic market orientation SMO have proven its link to superior stakeholder outcomes especially when measured in terms of optimized stakeholder satisfaction, lesser job stress and better understanding of roles. However, the institutionalization of MO (SMO) across the hierarchy of the Hungarian healthcare has been the subject of resistance under the current dominant paradigm levels. In observing reform success across various sectors of the economy, the healthcare sector represents one of the most challenging with slower-than-expected speed of change since the downfall of communism. Studies had shown that almost a decade into the post communist period, the overall efforts of the Hungarian state for promoting a successful transition had already brought positive results in different sectors, with the exception of healthcare. In efforts to investigate the most important determinants of positive long term results

healthcare a wide range of studies have linked stakeholder satisfaction and especially patient satisfaction with improved long term results. These have been validated by the researcher and his colleagues, especially at the micro economic level linking it positively to: *stakeholder Learning Orientation (LO), Entrepreneurial Orientation (EO), Economic Network Synergy Optimization, Effective and Efficient Tacit / Explicit Knowledge generation–promotion-dissemination and codification, Stakeholder perception-expectation gap reduction , transparency and reduced stakeholder asymmetric information, reduced job stress, employees and contact employees understanding of role, responsiveness and competitor awareness, informal monitoring and promotion of value exchanges in the network, promoting decentralized and bottom top processes, promoting clear communication and stakeholder involvement, leadership effectiveness, 360 degrees stakeholder satisfaction, effective implementation and institutionalization of the balanced scorecard approach for performance, improved practitioner and contact employee attitudes, improved working morale and ethics of conduct.* The consumers of healthcare had been amongst the least satisfied in comparison to other sectors (see for example Rekettye, 2000). The ongoing slow speed of transition in healthcare had been many times influenced by the misperception of the actors of this industry regarding the content and goals of transition, also misperceptions regarding the newer stakeholder roles in the transitional and post-transitional periods. Rekettye, (2000), had highlighted the diminishing satisfactions of the residents regarding the quality of healthcare service. According to the same study (p.6), the residents had felt rather "defenseless and endangered", and definitely "not served " when seeking healthcare service at any level in Hungary. They'd felt that "change" had only appeared in the hallow rhetoric of the politicians representing newer governments with no real substance or results in the post communist period. Serving the ultimate goals of *'promoting the relative state of psycho-social and physiological well being*' (WHO), would require complimentary bottom-top processes linking the individuals, the families and institutions within the system. The philosophy, main goals, set-up, of healthcare systems and the roles of their participants remain to be the subject of high debate. 'Healthcare reform' especially towards 'decentralization' and or performance in terms of 'effectiveness' 'equity' , 'patient centeredness' and 'responsiveness' (WHO 2000), has also remained more or less a problematic phenomenon by many measures internationally. The conditions in Hungary share common case and case- specific attributes (*see for example* Füzesi Zs., Ivády V., Kovácsy Zs.,Orbán K. 2005). The numerous attempts to

reform the system have almost never involved a "psycho-socio-economic preparation" phase or content which was the very subject of attention in the current study .

From a broader perspective when approaching healthcare reform strategies , Saltman and Figueras (1997) in their analytical paper, under "*European Healthcare Reform- Analysis of current strategies*" stipulated that much of the debates of the 1990s in the area of healthcare reform had been around 'the fiscal imperative of cost constraints' and 'the efficient and effective use of healthcare's scarce resources' along efforts for 'maintaining the social good character of healthcare and solidarity', all measured in terms of '*health status'* and '*equitable access'*. (p.1) . They'd questioned the existence of a full-fledged understanding regarding the 'context' 'process', 'content', and 'roles of agents' by both policy planners and the main stakeholders of healthcare reform, highlighting cultural and social mores-norms as significant barriers. In their words "*health systems mirror deeply rooted cultural –social expectations of a society as a whole*". They had gone on to emphasize that there hadn't been conclusive arrivals regarding a best model for healthcare reform, nor had there been a homogenous understanding regarding the context, content and process of "healthcare reform" across western European and the ex-communist CEE or CIS countries. In many countries, according to them, the debate had been centered on 'ideological and moral' debates rather than those based on 'evidences of improved short to long-run performance.' In line with the same, healthcare reform has often been a part of state supported welfare programs. Saltman *et.al.* had cautioned that the implementation of reform programs should be an integral part of the process of reform and not separate from it. Their suggestions linked the complexity of implementation to factors coming from healthcare and non healthcare related areas, most importantly , political, ideological , cultural, social, economic, structural, organizational, health status and access . For the purpose of analysis they'd proposed addressing "*the role of values*", "*the macro-economic realities*", and "*demographic-social pressures*". They re-emphasized the importance of the interactions between the Process, Context, Content of Reform with the Actors . At the level of the "process of reform", in Saltman *et. al.* , 'structural but long term', rather than 'evolutionary' and 'purposive change' leading to 'institutional changes', rather than 'haphazard changes' had been paid attention to. The paper concluded that the "*capacity for successful reform* " is highly influenced by:

a)- The number of individuals with sophisticated management training

b)- The level of penetration of IT in the health system

The concern became even more alarming in the case of Hungary, since in spite of fundamental changes in the country's and industry's context over the past two decades , the worries have remained predominantly unchanged. Although, one may have expected that after this relatively long period of transition the trend should have shifted towards a more decentralized system (due to the learning curve effect), the situation on ground has shown different signs. As denoted by Füzesi et.al in the case of Hungary:

"*Decentralization is a bipartisan issue: any governmental intentions fail in the absence of local acceptance and support...as of yet the observation of the Hungarian healthcare system has not revealed any perfect solutions to current problems.*" They suggested that attention should be given to 'principles' (philosophies the system is built on) as well as 'non-systemic characteristics' (not directly originating from the system. i.e. the role of other stakeholders besides the government) to back-up future decision making. The success of such bottom-top processes and the creation of synergy within the system, are at the same time highly reliant on the human capital capacities especially at the individual level. The area of '*capacity development*' for successful 'decentralization', 'stakeholder empowerment" and "involvement', the need for shift to higher "transparency" at all levels of the "systems' governance" , the creation of 'innovation driven- knowledge based healthcare' have sat in the center of recent investigations. These studies have been valuing well-being as the ultimate goal of development economics in all sectors including healthcare. In accordance with the earlier discussed shortcomings in Hungary , the proposed strategies for actualization of long term reform had also stood short of dealing with the paradigms and perceptual gaps impeding successful design and implementation of reform programs. This calls on for consistent in-depth studies for aiding understanding of the mentioned gaps. In the more recent investigations, the importance of changes at the level of human capital competencies and belief systems has been acknowledged. (see for example Szirmai 2005, 2010 on health-healthcare-education and development) Ensor (2003) had directed attention to regulatory perspectives the '*informal payments*', '*corruption*', '*lack of transparency*' phenomena in healthcare complimented by physicians' and authorities' '*abuse of power'* and '*collusion*'. In his words : "*There is growing evidence to suggest that unofficial health care fees are likely to distort health care priorities and change the impact of*

health system reform. It is important that ministries of health and international organizations take into account this impact in designing more effective policy." He suggested that further study is required in the area of '*health-specific corruption*' at national and international levels. Elsewhere on the incidence of Hungary, in his paper titled, "*Hidden in an Envelope*", Koronai (2000) proposed that the stage of reform progress to be measured in terms of size and incidence of informal payments : "*The incidence and size of gratitude payments and the progress made with eliminating them can serve as a yardstick. They make a good proxy for where the health reform stands. More importantly still, they indicate where Hungary stands with the structural transformation and moral purging of its society and its political sphere.*" In analyzing the impact and influence of the human factor, through a qualitative study looking at the perceptions and beliefs, Vian *et.al.* concluded that perceptual gaps between the parties influenced the very phenomenon of informal payments: "*In the eyes of providers and the public, informal payments are both a necessary coping mechanism and a destructive practice that hurts efficiency, trust, and health. Providers and members of the general public do not always have the same perceptions or beliefs about motivations and expectations for informal payments when interacting during service delivery*". Other studies have also brought attention to the area of human factor's competencies for successful reforms. Saltman *et.al.* had called on further attention to observing the interplay between *content-context-process-actors* when analyzing healthcare reform policy planning and implementation failure at the CEE level. The studies (including Saltman *et. al*.) have indicated insufficient and / or inappropriate "*capacity building* " programs for improving stakeholder competences, especially in the field of 'leadership' and 'management' as a major obstacle for transitional healthcare systems . The overall efforts of the Hungarian state for promoting a successful transition through programs had resulted in a diversity of outcomes amongst different sectors. According to the above, real reform would require newer or transitioned frames of reference and capacity building that would not only increase openness to change at psycho-socio-economic levels but would also promote complimentary bottom-up processes involving stakeholders. The value of the human capital and "capacities for reform" has once again been considered beyond financial and technological capacities. (Knowledge and the relative state of health as the scarcest resources. Human factor as both means and ends in the system of the economy). Frames of reference for '*thought and action*' (here paradigm and its levels), the interference of perceptual gaps on stakeholder 'roles'

and ‘goals’ leading to conflict of interests had been frequently held responsible. The earlier studies had specifically brought attention to misperceptions which considered healthcare as a distinct sector which could not follow the conditions of scarcity and effectiveness as defined by mainstream economics and management. Such misperceptions were held responsible for lack of stakeholder participation, compliance and also for stakeholder resistance to the institutionalization of advanced governance models. Saltman and Figueras (1997) had called on attention to the unattended difficult process of *“ negotiation between the key actors as defined by each society’s history, traditions and culture*” for healthcare reform policy planning and implementation. In line with this group, it is deemed beneficial to review the conclusions of Szocska et.al, with special care. The authors’ had found that ‘*reform policy planning’* and ‘*competencies in the area of change management*’ are interrelated dimensions that have been widely overlooked. The study regards reforms between 1990-1998 in Hungary to have been superficial and politically driven: *“…changes are mainly politically driven and do not help the development of sustainable health reforms. Indeed they increase confusion and fuel the perverted policy cycle”.* As the most important problem of reforms they refer to the ‘perceptual gap’ between senior managers and policy makers, they called – a synaptic location: “*The gap in perception between policy makers and organizational managers shows the location of a special interface (a synaptic location) between policy makers and organizational managers. The ignorance of the nature of exchange at this interface (synaptic junction) is one of the most important causes of failed attempts to reform*”. However, attempts towards capacity building have neither produced tangible results (see appendix for complimentary data). Reflecting on the status in U.K.’s NHS, Hicklin (1992) had stated: ”*Management is the syphilis of NHS. Doctors usually acquire it in unguarded moments. It is much more pleasurable than work, but produces illusions of grandeur*”. Mark (1995) had emphasized the need for creating a shared value system between physicians and managers in order to able to develop managers out of doctors successfully. Adjusting similar misperceptions about management could be considered as a minimum positive outcome of extending training in this field. In order to facilitate the ‘paradigm development’ (shift from one level to another) it is important that the stakeholders acquire the skills and creativity for seeing the bigger picture. The transformation to more innovative, responsive and sustainable systems, would require first and foremost, capacity-building in the area of sophisticated leadership and management training and development for acquisition of

skills for looking at the broader picture and more creative activity of strategy building. (see amongst others Feunzalida-Puelma 2002. The traces of negative perceptions of physicians about the link between their roles and managerial roles (i.e. Hicklin T. 1992) , are still found in Hungary alike many systems. Reflecting on *stakeholder involvement, information sharing and communication* a list of "*Sources of Resistance*" and "*Managerial Approach and Competence Constraints*" were suggested by Szocska et.al. building further understanding regarding perceptions and competences as challenges in the earlier fields:

Table.3. Causes of Resistance to Change Projects at Micro Levels

1) Lack of information related to the actual change project
2) The people expected to implement the changes are not involved in the decisions and the preparation of decisions
3) Hectic, contradictory, and disturbed top-down communication leads to repeated misunderstandings; management loses its credibility among employees
4) Interest in the organization is mainly dominated by private and group interests that are antagonistic to those of the organization and the employees
5) Financial incentives supporting the changes are lacking
6) General uncertainty about the future state; who will do what and how?

(source: Szocska et.al)

Table.4.Basic Managerial Competency and Approach problems

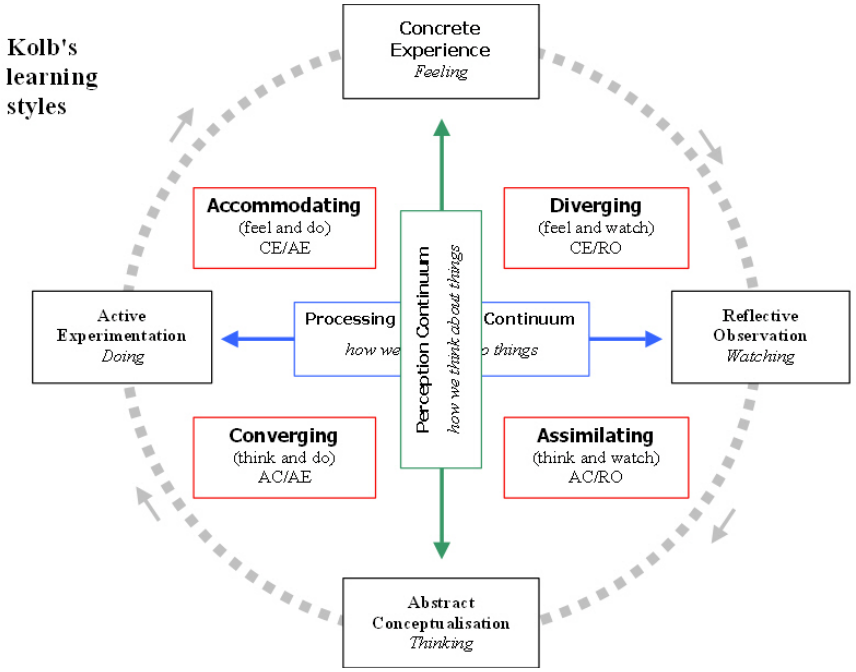
1) The manager has no exact vision of the end state of organizational changes
2) The manager does not consider the risks during change and forgets to set up contingencies and alternative actions
3) The manager is bounded by their personal interests and leaves the previous system's authoritarian and hierarchical relationships unchanged
4) The manager does not establish relevant administrative capacities (personnel, infrastructure, etc) to implement changes
5) The manager sets unrealistic goals and objectives, so the half finished project has to be stopped
6) Without analysis, the manager forces changes that ignore present realities, the decisions are made ad hoc
7) No plans and procedures are prepared for the change so the project is not implemented systematically

8) The manager has no training and attitude relevant to the needs of the change, and they do not have learning strategies
9) The managerial board or top management has no agreed strategy
10) The manager does not take organizational resistance into consideration. Thus they repeatedly lose initiatives on resistance from employees or other stakeholders
11) Obstacles emerging in the project cause the manager to suddenly give up the organizational vision
12) No strategies exist in the organization for ensuring that tasks are done; tasks are done in a casual way
13) The manager does not clarify and does not make the change objectives understandable for employees; communication is disturbed and noisy
14) The manager has no personal credibility, or has not built up their personal credibility; their words carry no weight for the employees
15) The manager does not take steps to clarify changing roles and responsibilities
16) The manager does not establish formal channels of communication in the organization that could support the change project

(source: Szocska et.al)

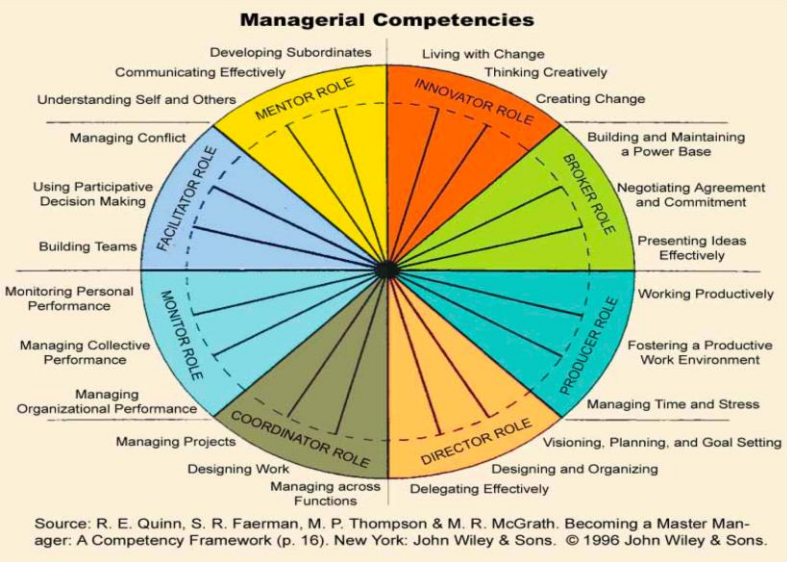
The conditions and frameworks pertaining to the field of acccreditation in the field of healthcare management were devised and defined under the 1990 summary. (Link: www.egeszsegugyimenedzser.hu/kepzesek .) In terms of remedies through the design and delivery of programs for '*change*' at such deep personal and interpersonal levels, not only effective leadership competence are required but also a complex learning process design was needed which would promote "*Triple Loop Learning"* (TLL) and *"Quadruple Loop Learning*" (QLL) .

Fig.5. Kolb's learning styles and the processes of learning and reflection



These designs would need to move beyond the mere centralized and socio-technical systems of "*Single Loop Learning*" (SLL), which function well only at the level of S.O.P.s (standard operating procedures). The "*Double Loop Learning*" (DLL) systems (learning through the re-evaluation of SLL goals) are more flexible and are able to achieve a higher effectiveness through productivity, efficiency, goal-setting and planning (in comparison to effectiveness merely achieved through 'stability' and 'information management' at the single loop learning levels) the improved competitive position is still achieved through centralization. Quinn, Faermann, Thompson and McGrath (1996) have conceptualized the relationship between managerial competencies and roles across the learning processes. (Fig.6.)

Fig.6. Managerial Competencies and Roles needed for the promotion of TLL and QLL



Under DLL Systems "producer " roles (managing time and stress, working productively, fostering a productive work environment) and "director" roles (visioning , planning and goal setting, designing and operating, delegating effectively) appeared as most important areas while under the SLL the "coordinator" roles (managing across functions, designing work and managing across functions) as well as "monitor" roles (monitoring personal performance, managing collective performance, managing organizational functions) were the most important. TLL systems open up to cross-cultural knowledge management, embrace diversity of the meaning of knowledge across cultures. Their shift to open and decentralized systems, arises from contacts with perspectives coming from other horizons. Measures of effectiveness are built around 'Adaptability' 'Readiness-Preparedness for Integration', 'Growth', 'Resource Acquisition' and 'External Support' . As far as managerial roles the following are the most important: " Innovator" roles (Living with Change, Thinking Creatively, Making Change) , "Broker" roles Maker (Building and Maintaining a Power Base, Negotiating Agreement and Commitment, Presenting Ideas Effectively)

Summary and conclusions:

This review brought in this chapter addressed highlighted significance and ***influence of paradigm level gaps*** in reform policy planning and implementation. The analysis suggested the gaps to be understood in comparison to the integrated –universal level or the "**Systemic Paradigm**". The first section of the chapter concluded that the mentioned gaps are best to

observed across three major dimensions (R-G-T); stakeholder perceptions of their **R**oles vs. Competence, **G**oals vs. the System, and **T**ime / state of development (transition/transformation). The needs for the creation of a simplified tool for the assessment of stakeholder paradigm level gaps across the (R-G-T) dimensions were highlighted. Remedies for reducing paradigm gaps were discussed indicating the importance of information gathering and feedback loops in the system, complimented by the creation and leadership of eco-networks for participative inquiry (researching with), joint research, co-learning and synergistic collaboration for innovation, all subjected to and reinforcing the systemic paradigm. The presence of self aware MKO role, for the design and delivery of the said programs, the facilitation and fostering of CoPs to promote Triple Loop and Quadruple Loop Learning were found crucial. Goal setting and Policy Plan content was to aim composite development measures assessed through 360 degrees stakeholder value expectations for sustainable development (i.e. QoL, HDI, SWB, NWG, GCI). The dynamic "Process" of co-investigation, participative planning and implementation relies on and promotes a learning and epistemic culture within the Systemic Paradigm in order to achieve and sustain optimal empowerment and decentralization . The "Context" of relationships, Roles and Hierarchy are built for and around project-networks with project related hierarchy and structure (network structure) with optimal levels of decentralization. The ultimate goal of the government is to serve an empowered, healthy -happy society. An empowered , transparent and accountable society requiring a 'minimal state' as conceptualized under the FINMOUSE. In such society MKOs and more competent peers proactively participate in self reflection and co-learning for a sustainable ALL-WIN society. Evidence from the Hungarian Healthcare not only proves that the number of capacity building programs in the fields of management and leadership have been insufficient since the down fall of communism but attention has not been paid to the design and delivery of programs serving successful healthcare reform towards sustainable results. The said studies showed that a new frame of reference is indeed under the systemic paradigm for the design and delivery of extended programs which ensure transition towards the systemic paradigm for sustainable results. The theory and practice of Market Orientation (MO) and the evidence from Systemic Market Orientation (SMO) offers extensive opportunity for the conceptualization of *Content* (Goals), *Context* (Roles, Hierarchy), *Processes* (learning and development cycles) of Healthcare reform in line with the Systemic Paradigm (SMO encompassing ALL characteristic of the systemic paradigm. The Management Consulting and

Leadership Training project (MCLT) discussed in Chapter 3. Below, initiated a ten year long providing extensive opportunities for the examination and reflection upon the conclusions and extractions of this chapter especially in applying SMO for the design and delivery Management Consulting Tools, Training Programs, Governance of CoP's and the institutionalization of the epistemic / learning culture aimed at successful reforms. At a hypothetical level it can be asserted that even in the absence of appropriate knowledge sharing and/or government assisted awareness building programs, stakeholders will arrive at a point and level at which the need for management training is felt. However, the felt need will not automatically lead to participation in training and development. Perceptions of role, goal and time have a major influence on the decision .

3. **Building the SMOP Typology through MCLT- (PAR) and Reflexive Grounded Theory**

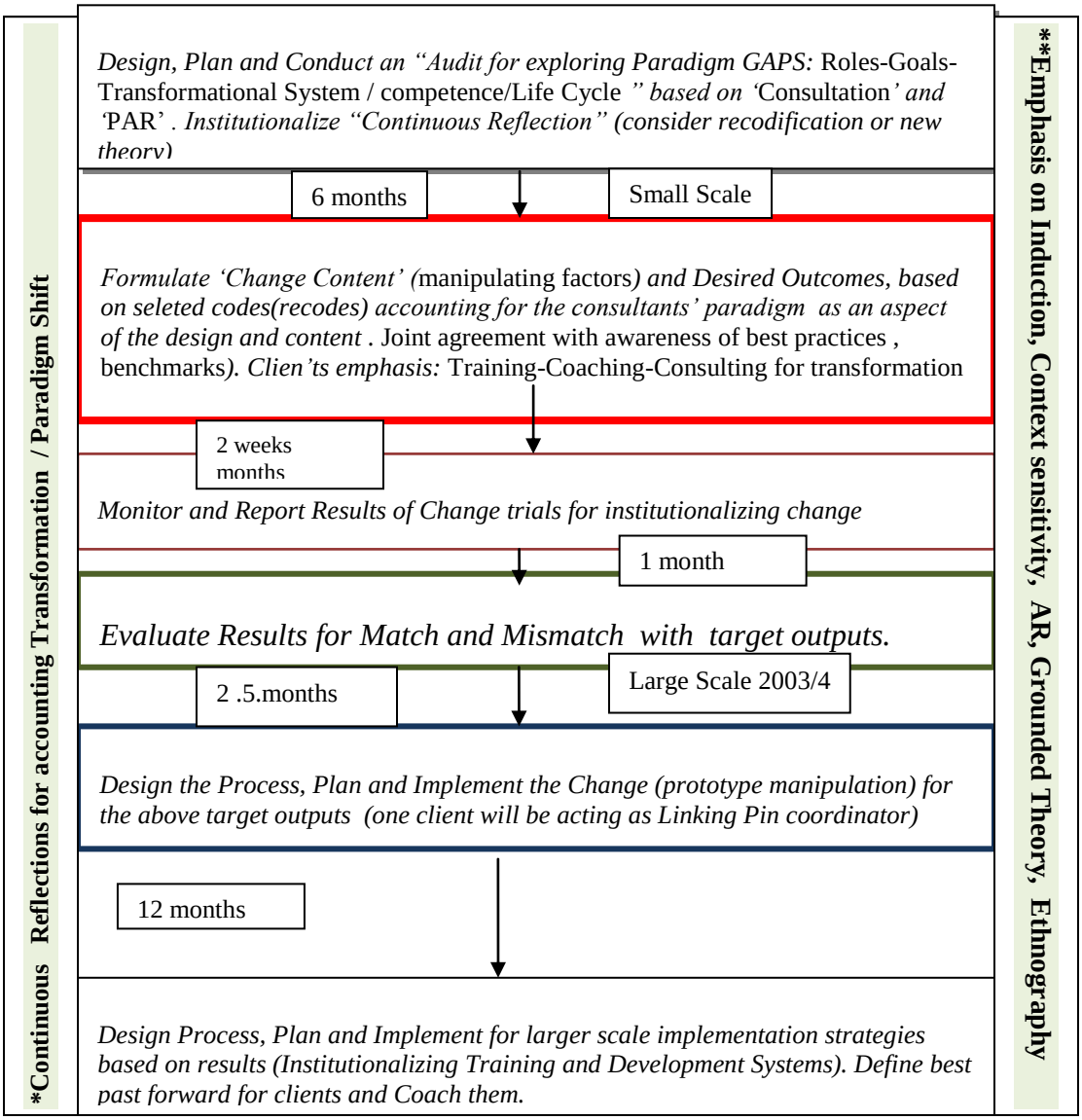
3.1 Subject, Setting, Participants and General sources of Data

The original motivation behind the current study came from a management consulting and leadership training project (MCLT) in 2001 . The MCLT project covered the exploration of the causes of healthcare reform failure especially when linked to low stakeholder satisfaction and degree of decentralization . The perception had been that the problem had been linked to the lack of sufficient number and appropriately designed management and leadership training , leading to the absence of strategic intent, strategic management systems and complimentary processes such as governance for fostering participative inquiry, inclusive knowledge sharing and stakeholder satisfaction. MCLT's approach for hiring a consultant at their own initiative inorder to aid chose a better direction and improve the results of their short to long term activities was not a common practice in this sector in Hungary. MCLT clients represented study worthy incidence for the exploration of the content and processes of paradigm level transformation, the initiation and participation in upper learning loops. The joint initiative, could have been taken as a proof for Kuhn's approach in perceiving 'paradigm shift occurrence' as a result of '*current paradigm's shortcomings in answering the needs of the practioner*'. At the same time from a learning and transformational perspective referring to the

researcher could have been a proof of the importance of an MKO for leading and promoting transformation. MCLT project's targeted outputs covered the design and delivery of training courses for practitioners of a surgery department, taken as an example for other departments of a large public university hospital (amongst top 1-6) at one of Hungary's big cities (Pécs). The department had been affiliated to one of the top four hospitals of Hungary with 400 beds (large hospital in Hungary). The overall aims of the project included also, the investigation of the main barriers to healthcare reform in Hungary from an institutional and individual perspective (taking the example of the department). Lack of such understanding, (as discussed under 2.3. above) had been highlighted by Saltman and Fugeras (1997). Saltman *et.al.* had highlighted shortcomings in addressing capacity for implementing reforms by the policy planners.The spread of informal economics and payment in this sector had shown good reasons for worries (posited by Vian *et.al*., Kornai 2000, Ensor 2003), reinforcing the absence of sufficient attention to the psycho-socio-economic context . Lack of compliance with the planned healthcare reforms (WHO 2000 , HiT) during the post-communist period had been the central question posed by the MCLT clients of the project. The project included the proposal of alternative remedial programs assisting such compliance . The method of the study had started out in the form of '*management and career development consulting/coaching*' but given the nature and context of the concern, the framework soon shifted to that of 'Action Research'. (*see* for example Gill 1986 for processes of such shift Table.2.) The clients (n=4) surgeons and predominantly department level leaders (n=3) at a large Hungarian hospital had participated in joint planning with the researcher (consultant at the beginning of the contract). The researcher's (MCLT consultant's) contract had included the verification of the major impeding perceptions of the clients building an exploration based on their case regarding the main causes of lack of compliance / proactive participation in the process of reform. Once the psychological (individual) - social – economic (industrial –institutional) dimensions of such 'impeding perceptions' had been explored the project was to extend its scope beyond the incidence of the clients. According to the MCLT contract , once these dimensions had been explored, and the ailing areas verified , the researcher was to assist the clients in extending the remedies across the department (implementation of change through training and development and/ or other preparatory measures) . The example of the small scale project was to be taken as benchmark for the successful initiation of bottom-top processes for stakeholder involvement in Hungarian

healthcare reform planning and implementation providing valuable lessons for healthcare systems in transition within the CEE region.

Fig.7. ***The mutually agreed generic process of the MCLT project based on the contract***



**Awareness of the Transformation of the 'Perceptions of Roles and Goals' as a result of interactions, consultation, information sharing, reactions, coaching and training etc. requires a systematic and continuous attention. This is in fact the most important deliverable of the MCLT project for future training and development systems' planning*

***The consultant's role had included the presentation of the state-of-art findings in the field (MKO). However, pre-occupation of the consultant and the other participants should be monitored, accounted for and isolated from the realities on the ground. This is important since other unknown relationships or theories might potentially grow out of a thorough examination of the context of stakeholder's planning and practice.*

The importance of an inductive approach to structuring the study, in order to explore the context and the participants were given priority. At the same time the continuation of the project in the framework of a PhD dissertation had an important impact on the roles and goals of the researcher, taking him and the team of cooperating clients away from the mere consultant role towards that of an action researcher especially at the 'entry' and 'contracting' stages of the study (see Table. 5). This was supported with a senior surgeon accepting to play an active role as the co-supervisor of the doctoral study. However, very soon the 'Diagnosis' stage was shifted solely to the researcher himself (a condition very similar to that of basic research as conceptualized by Gill,1986)

Table 5. Stages of Action Research, Consultancy and Basic Research compared, Gill J. 1986.,p.103

Stages	**Action Research**	**Consultancy**	**Basic Research**
Entry	Client or researcher presents problem , goals agreed mutually	Client presents problems and defines goals	Researcher presents problem and defines goals
Contracting	Business and psychological contracting, Mutual control	Business contract, consultant controls client	Researcher controls as expert. Keeps client happy. Minimal contracting
Diagnosis	Joint diagnosis. Client data/researcher's concepts	Consultant diagnosis. Often minimal. Sells package	Researcher carries out expert diagnosis. Client provides data
Action	Feedback. Dissonance. Joint action plan. Client action with support. Published	Consultant prescribes action. Not published	Report often designed to impress client with how much researcher has learned and how competent he or she is
Evaluation	New problems emerge. Recycles. Generalizations emerge	Rarely undertaken by neutrals	Rarely undertaken
Withdrawal	Client self-supporting	Client dependant	Client dependant

Summary of main statements of the Clients

The perception of the clients regarding barriers of successful healthcare reforms had been generally linked to the following: (These are detailed in tables 5 and 6 below)

-‘lack of appropriate preparedness and training for transformation’ (needed for triple loop and quadruple loop learning levels, influencing Role Perceptions and SMOP level gap)

- *highlighted generally by Saltman et.al. 1997., Schultz 2003, Szócska et.al.2005*

-’misperceptions regarding the importance of management and leadership training and the role of managers in healthcare service and its operations’ (The earlier discussed Hicklin’s effect *...management as the syphlisis disease for doctors*...)

-‘ the absence of a good understanding of the healthcare systems’ and its participants’ perceived goals ’ (*emphasized also by Mark 1995, Sen 1998,Vian et. al. 2000, Streeten 2003)*

- ‘the confused roles of the participants at each level’. (*emphasized also by Mark 1995, Vian et.al. 2000.,, Szócska et.al.2005., Füzesi et.al. 2005)*

-’lack of appropriate participation in reform planning and implementation’ *(i.e. emphasized by Fuenzalida –Puelma 2002, Gaál 2004)*

- ’ absence of governance resolution processes for ethical dilemma, lack of transprency, misperceptions of social responsibility’, *(i.e. highlighted by Weller and Manga 1983, Childress et.al. 2002, Kornai 2000, Van et.al. 2000, Golesrkhi et.al.2005)*

General Sources of Data

The details of the perceived sources of these barriers and their related dimensions as-perceived-by-the-MCLT clients had been extracted and jointly codified as a result of the analysis of the following sources: (*see* Table.6. for summary, also *see* Data Collection in the following section: *Co-operative inquiry relies on rational verbal reports of experience, as well as imaginative storytelling and metaphors*)

- personal memos
- participatory observation
- participation in structured/jointly planned discussion sessions
- structured/semi-structured interviews as well as
- unstructured/unplanned meetings
- informal talks especially regarding chanegability of perceptions as a result of newer exposures over shorter periods
- interviews with a diverse range of stakeholders and informants to come up with an understanding regarding the patterns of collective perceptions and paradigms
- Published Hungarian and International literature and statistics for external validity
- Published Hungarian and International Case Studies for external validity

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

A list of subjects appearing in general discussions and reflections:

- Common Wealth's model of healthcare excellence
- the building blocks of the Corporate and Clinical Governance,
- the importance of Patient-Centeredness as well as;
- understanding and responding to the expectations of other stakeholders,
- the role of the Doctors , Nurses, Patients, Families and Community towards prevention and promotion,
- role of insurance companies, technology suppliers, the government and NGOs in healthcare

Project Subject(as agreed in the early stage): Career Coaching/Management Consulting and Leadership Training project (later framed under action research)- A joint Needs Assessment and the formulation and Implementation of a joint Change Plan. The results and design of the project were to be used in order to reach saturation with respect to results (later framed under a repeated qualitative study). It is worthy of consideration to note that the clients were used as the control group throughout the extended part of the longitudinal study

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

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

Participants:

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

Groups :

- Department and Unit leaders seeking a better approach to managing their units,
- Senior practitioners, junior practitioners, thinking about best possibilities and alternatives
- Junior practitioners, thinking about best possibilities and alternatives

(MCLT1)- Newly employed MD with ambitions in the area of surgery and plastic surgery
(MCLT 2)-Senior specialist, Head of Department, Surgeon, PhD
(MCLT 3)-Senior Specialist, Leader of the Labor Union, Surgeon, PhD
(MCLT 4)-Senior Specialist, Head of Unit, Plastic Surgeon

Note(2): With respect to the nature of the investigation at the early stages, an approach similar to the 'embedded case study design' had been assumed as appropriate (Yin , 2003). Therefore, each client had been considered as a separate case

Table.6. Clients' Background

Case	Position	Area	Level	Gen.	M.T.*	O.E.*	Hungarian	Initiative	Add. Co-op*
MCLT1	New Recruit.	Surgeon	MD Junior	M	None	Yes	No	Own	Linking Pin
MCLT2	Department Head	Surgeon	Senior Specialist PhD	M	None	Yes	Yes	Own	No Additional
MCLT3	Head of Labor Union	Surgeon	Senior Specialist PhD	M	None	Yes	Yes	Own	No Additional
MCLT4	Head of Unit	Plastic Surgeon	Senior Specialist	M	None	Yes	Yes	Own	No Additional

(M.T*) = Prior Management Training, (F.E.*) = Prior Overseas Experience,(Add. Position*) = Add. Co-operation

- ***The Researcher :*** Above 30 years of age, with 4 years of experience as rotational health assistant at 4 different departments, international experience, non Hungarian heredity, above 7 years of parallel experience at various business management positions in the fields of construction and agriculture, management consultant with high affinity to systemic approaches to market orientation and strategic management, the field of triple loop and quadruple loop learning, influenced by Constructivist, Post-Positivist, Kuhnian, Covey-ian within the context of systemic approach to paradigms, theories of role and time perception, knowledge based development. The researcher, acquainted with the theory and practice of MO, had had experience with adopting Strategic Management System, BSC, EFQM and the Baldrige model of excellence in practice.

Method and Approach:

The method of study was highly compatible with the demands of the "Ideographic Method".(Table.1.). Given the goals, expected outcomes, context and participants of the study on the one hand and the advantages brought by a combined multi-method, (PAR and Grounded Theory) was found most suitable for the purpose instead of the original career coaching and management consulting and training . Participants accepted extended roles as co-subjects , contributors to idea generation, design and management of project. In line with the same , PAR 'Participative Action Research' (extended to Intervention Praxis) was assumed as a framework for the primary phase. PAR method was uniquely important in the case of the MCLT project since the main concern of the clients had been an understanding of their 'roles' and methods to best identify and pursue their career goals and paths while contributing to the development of the whole system and stakeholders of healthcare (participation in the bottom-up processes…). Referring to PAR Fals-Borda and Rahman, (1991) had appraised it in the following manner *"process of self-awareness through collective self-inquiry and reflection*". Reason (1994) proposed that this method is very successful in the incidence of two types of groups:

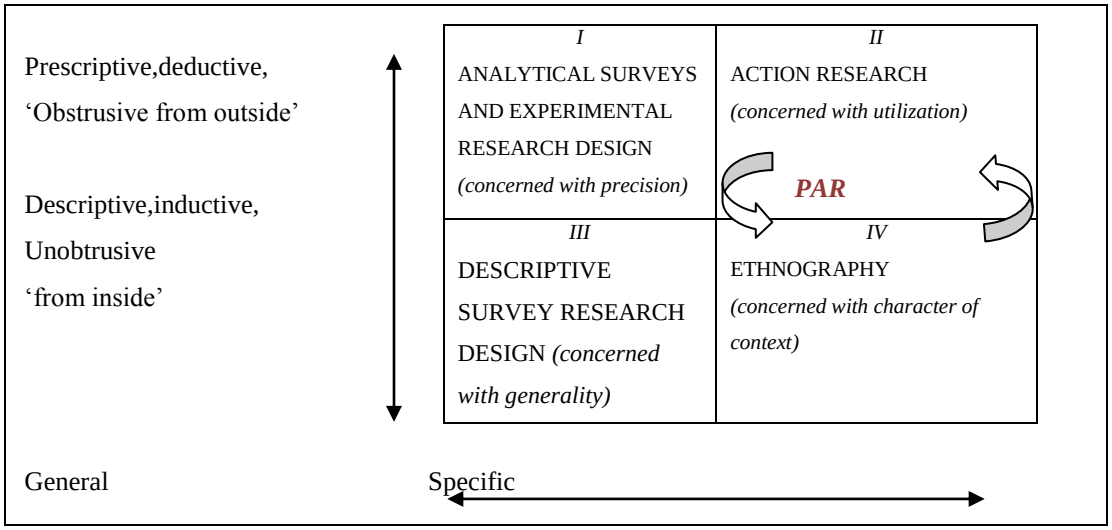
a)- where a small empowered professional group., i.e. doctors, managers, teachers wish to change certain aspects of their living context for improved well-being;

b)- where a group of disempowered people come together for the same purpose with the assistance of a facilitator / leader *(MKOs)*in the initial phases.

Reason (1994) drew attention to the importance of enjoying certain qualities and skills (a wide ranging and subtle attention) for being able to work with others and conduct valid in joint-inquiry. He continues that such attention can only be developed in the higher stages of ego and personality development. (very much in line with the notion of 'praxis potential' and Aristotle's ' phronesis'). In referring to his personal communication with Torbert in 1992, he highlighted that action inquiry is most fit for those most deeply committed to participatory inquiry "*...persons who wish to play leadership roles in cultivating this process with others and who wish to inquire about their actual effects as they do so*" . Although the arrival of the researcher

(consultant) to the subject had been with *a priori* knowledge, the approach taken for the study was selected in a manner more compatible to that of "*inductive research*" (isolation from earlier bias) , complimented with continuous self reflection in order to identify, record and report the critical sources of bias throughout the study. It is worthy of consideration that under the MCLT consulting and career coaching contract the presence of such bias was not a major concern, since the researcher (consultant) was expected to deliver his overall judgments as an MKO (more knowledgeable other/leader) of the joint inquiry. Since the MCLT clients viewed their management field related competences closer to that of Reason's (b) category above (where an MKO/facilitator would be advantageous), the researcher's prior experience and knowledge was seen as a critical component.

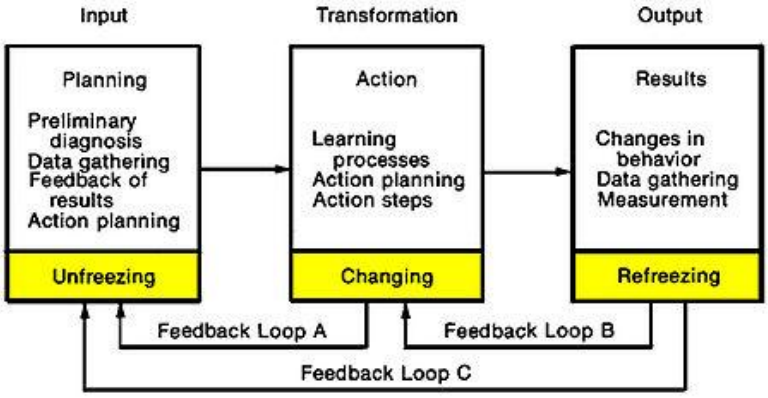
Fig.8. PAR method incorporates aspescts of ethnography (from Gill. and Johnson 1997, pp.155)



3.2. The Co-Researchers the LPC, the Researcher and the Research

The MCLT clients' arrival at the point of requesting the researcher's assistance was not only an important sign of the 'unfreezing' stage for building the first fundamental feedback loop of 'A Action Research' but also proving the distinctive qualities and mindset of the MCLT group.

Fig.9.Feedback loops in Action Research



A reflection on the problems -as perceived by the MCLT clients- and arriving at newer agreements was necessary for re-planning the study and its design in the form of an extended longitudinal study (a would be PhD dissertation proposal). The decisions on the new roles, the relationships with the LPC , time span and access had been important issues for consideration. It was interesting to see the degree of enthusiasm and appropriate perspective in identifying both 'problematic areas' and aspects deserving appreciation in the early stages of the study. In the course of discussions the LPC brought up an important phenomenological concern in his words:

„ **criticizing the system regarding mismanagement can only be fair if there is continuous awareness building in this area and support coming from the healthcare system for training and development in this area . There is hardly any financial support for studying management, not to speak of the problem of the increased administrative workload and demands. We have to participate in various Life Long Learning programs for collecting CDP credit points. Management and leadership training programs are not accredited by the authorized bodies in the healthcare system. We should find out whether or not the perception gap exists within the policy making rounds or perception misfit belongs to the practitioners , represented by the MCLT clients . Lack of participation in the process of reform only gains meaning if the goals and processes of reform are well understood and valid.** „

In reflecting on his own reactions to the current state of the project and raised concerns by the LPC, the researcher had taken account of the influence of the prior international exposure of the MCLT clients which had probably been responsible for their broader perspective of healthcare reform. A review of the problems expressed by the clients suggested the high interplay of psycho-sociological factors, stakeholders' frames of reference, especially drivers of perceptions which had to be isolated and reinvestigated at all levels. A set of Problems (Pr.s) expressed by the clients (discussed in the next chapter) were linked to perceptions of trust, mutuality and cooperation with the hierarchy, policy makers and the patients. As Gordon, (1996) posited "*when trust, mutuality, coordination efforts are perceived differently, perceptual differences arise, and such differences influence the interactions and cooperative effectiveness between groups*." Reflecting further on the nature of the perception-of-problems - by- the- clients leading to possible perceptual GAP (PoPGAP) areas summarized as:

PoPGAP (1)-Stakeholder perception-expectation- satisfaction gaps [(P-E) vs. S], regarding the mains GOALS , content(value) vs. the actually delivered service,

PoPGAP (2)- Perception of the Level of Development – Needed Competencies for fulfilling the position which is highly related to perceptions of position and rank on the Career Path – Learning/Experience Curve. This GAP influences the perceptions in regarding "*explicit Management Training*" and /or "adoption *of advanced models*", "*recruitment of Trained Managers*" etc. as leaders and managers of the system. (Lack of belief, trust ,interest in, and understanding of the advanced approaches to management also belong to the same)

PoPGAP (3) – Perception of ROLES in the social and organizational context . This GAP influences the norms, modes and patterns of decision making and interaction with the hierarchy and the system . Perception of Roles is mainly concerned with the stakeholders' perception of norms modes and types of involvement in following (disobeying), extending and creating legal and moral conventions.

It had been easily conceivable that being a post-communist country, inspite of all the criticism extended to healthcare reform failure in Hungary, obviously a high amount of time had been

necessary for signs of effective psycho-socio-economic change to become evident. A good method of benchmarking the pace and process of the psycho-socio-economic levels of reform appeared to be comparison with other OECD and EU accession countries attempting to decentralize their healthcare systems. Finally an inter-industrial benchmark comparing the response of the other sectors of the Hungarian economy to reform during the post communist period were considered to have benefits for deepening insight in this area. A major issue which in the mind of the researcher which had to be eventually dealt with was the extent to which the concerns raised by the clients enjoyed a common and generalize-able nature amongst other practitioners coming from a larger group across the industry in the country, other transitional central European healthcare systems or even globally for that matter. The researcher, respecting Bell and Newby's (1997) statement that "*idiosyncrasies of person and circumstances are at the heart not the periphery of the scientific enterprise*" was convinced regarding the achievement of generalize-ability (ecological validity) inspite of the context dependant variations. Another newer aspect regarding which agreement had to be arrived at had been the renegotiated of the ideal length of the period for study (2-5 years). Also, with the expressed worries regarding the percieved contribution-time constraints of the MCLT clients for a longitudinal study, renegotiation with MCLT clients regarding their long term committment and contributions had to be considered. The MCLT study could best serve the long term goals through the creation of a well-founded ground for investigating the basic dimensions and codes .The researcher, relying on earlier experience in working in this field, familiarity with the theory and practice of sustainable economics, market orientation had arrived at the study with a wealth of earlier exposure to successful as well as unsuccessful incidences. The researcher's self- reflection had to help identify methods for isolating, recording and monitoring the researcher's 'own perceptions and influence' on the aims , design and the process of the study. The need for a deep exploratory analysis before further structuring of the study was without question. However, along with the importance of avoiding obsession with a rigorous structure-disallowing clear understanding of the problem, openness and creativity, (for example Mintzberg 1979), ensuring that systematic recording took place from day one was important. Being conscious of both the '*detective work*' (when the researcher looks for order and pattern) and the '*creative leap'* (entailing generalizing beyond one's data) as denoted by Mintzberg, there were also thoughts regarding the need for assuming the role of a '*change agent'* (a

necessity in Action Research as well). The fact that the study began as a consultation project (with perceived predetermined outputs) called on for an increased need to ensure awareness of the proneness to bias arising from the researcher's and clients' perceptions/expectations of the study (indexicality), as well as the interplay of the above in moderating or determining all aspects of the Action Research. The researcher's attempt-in order to help him remain as aware as possible of the idiosyncrasies and indexicality a check list of the most critical steps for documenting and relecting on the most importnat areas had been prepared:

(a) Extraction and Documentation of Researcher's prior 'exposure to', and 'socialization into' the dilemmas in the theories and practices related to the field of study

(b) Extraction and Documentation of Researcher's own code of Ethics

(c) Extraction and Documentation of Researcher's philosophical assumptions regarding the theory and practice of market orientation (etics and emics)

(d) Extraction and Documentation of Researcher's assumptions regarding what constitutes warranted knowledge as an outcome of this study

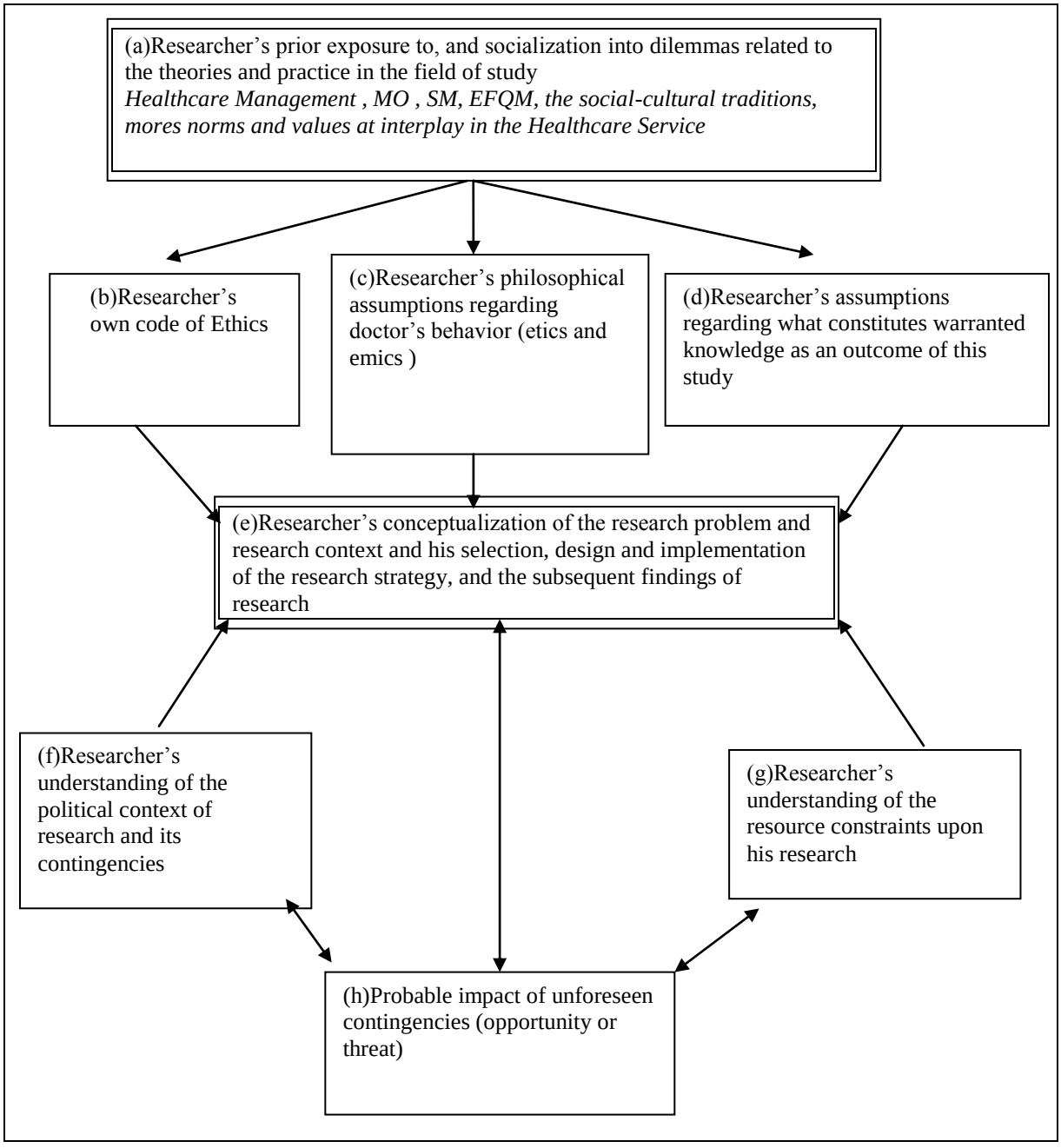
(e) Extraction and Documentation of Researcher's conceptualization of the research problem and research context and his selection, design and implementation of the research strategy, and the subsequent findings of research

(f) Extraction and Documentation of Researcher's understanding of the political context of research and its contingencies

(g) Extraction and Documentation of Researcher's understanding of the resource constraints upon his research

(h) Extraction and Documentation of the Probable impact of unforeseen contingencies and Changes within real-life context of the Researcher on the subject of the study (opportunity or threat)

Fig 10. "Research methods for managers" The researcher's impact upon research and the dilemma's Adopted from Gill J., & Johnson Ph.,(1997.), p.152



(a) ***Extraction and Documentation of Researcher's prior 'exposure to', and 'socialization into' the dilemmas related to the theories and practices in the field of study***

Approaching the MCLT clients with the question of the problems of medical service from a perspectives other than that of a physician carried conflicting as well as constructive results. Mutual trust existed based on the preliminary conditions around the MCLT contract. The international expsures of MCLT clients and the researcher built a common language as far as „*other psycho-socio-economic contexts of practice*". This being itself an important initiator of the MCLT project.Also, being a systems' thinker brought sufficient conflicts of perspective with the objective-subjective supporters. Both of the above aspects had been considered as the main sources of bias. Details aspects of the mentioned conflicts have been discussed in the following sections. Care was taken that the researcher's earlier exposure was not translated into 'confirmation-bias' neither at the Consulting and Coaching phases nor the Action Research due to his role nor longitudinal (Grounded Reflexive Theory) phases with the aim of reaching saturation.

Researcher's prior exposure had initiated the following questions:

1)-Do we have one or more paradigms? (one or more universes of thought and action?)
Can paradigm and its subsystems be mapped for the sake of strategy making and sustainable development? How?

2)-Should paradigm be mapped at the individual level or at the social level? Why?How?

3)-If SMO is a philosophy, culture and organizational model having optimization of stakeholder satsifaction through stakeholder participation in learning and development as its main process and set-up ...why can't it be taken as a paradigm? (what other characteristics does a paradigm have?)

4)- How can a continuous all-win situation be achieved in a system or subsystem? Is healthcare or any ethical sector different? Conflict of value perceptions (extreme question:

should we kill the doctors to save the patients? Is starving to death less emergent than bleeding after a car accident that's why all resources are given hospitals rather than food stores?)- Does systemic market orientation built on balanced stakeholder scorcard and learning processes lead to a resolution

5)- Can we have a system targeting the development of the number of leaders? Is Role Maturity linked to leadership? Is follower development the main goal of leadership?

Table.7. Researcher's Notes from the diary of the third consulting session

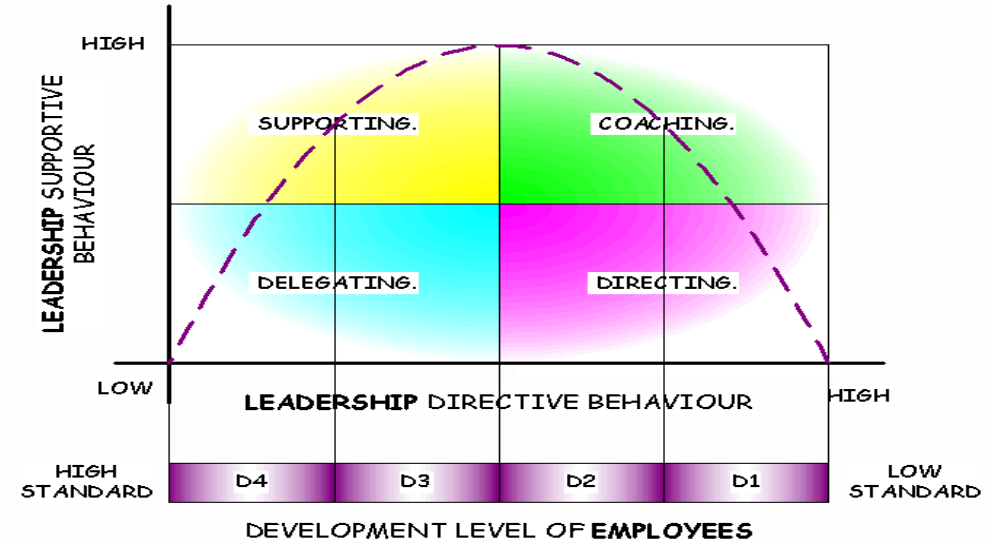
WHAT ARE THOSE FACTORS WHICH EXPLAIN INDICATE OR DETERMINE 'PREPAREDNESS FOR DECENTRALIZATION IN HEALTHCARE?' DOES STAKEHOLDER SATISFACTION DETERMINE DECENTRALIZATION AND/OR DOES THIS BECOME A MUTUALLY REINFORCING RELATIONSHP IN THE NEXT PHASES ? WHAT IS THE PROCESS OF THIS (CROSS) IMPACT AND INFLUENCE.? CAN THE CREATION OF A LEARNING COMMUNITY AND/OR A COMMUNITY OF PRACTICE (CoP) PROMOTE PREPAREDNESS FOR DECENTRALIZATION?

Problems in Healthcare and the context of practice as preceived by the researcher prior to study :

- All-Win situations are difficult to achieve in practice (i.e.as a consequnce of healthcare reform)- especially in light of stakeholder perceptual gaps
- 'Task orientation' is hardly, ever substituted with 'Relationship Orientation' in the majority of healthcare departments, especially surgery due to lack of appropriate governance and follower readiness (*Hershey and Balnchard's situational leadership conceptualization*)- Failure of decentralization arises from the same problem
- Paradigms and frames of reference do not sit at the center of attention in reform planning and policy making- *paradigm level gaps are responsible for reform failure*
- Misperception of ethics in healthcare: Mortality , Morbidity may have other sources besides mistreatment and malpractice. Higher relative importance of ethics in the area of medical services have been exaggerated.

- Resources are always scarce (not just in healthcare) and may damage well-being of all citizens (doctors and nurses included) . Willingness to Pay and Cost Benefit analysis of reform policy programs in healthcare are hardly if ever considered / communicated
- Practice of ethics is not compatible with the declared codex in some situations (namely expecting gratitude money from patients or using patients as experimental material)

Fig.11. Leader Orientation and Staff Development: Hershey, Blanchard and Johnson 1996



The researcher's arrival was with a readily available pool of questions regarding the further examination of the "*Theories and applications of Market Orientation (MO) from a Systems' Perspective*"(SMO). The most important question being whether or not SMO especially can qualify as a paradigm? Based on th extracted definition of the researcher „*Paradigm is the milieu/universe of psycho-socio-economic learning*" (see chapter 2. Above p.27). MO's context and 'paradigm shift' through triple loop (and quadruple loop) learning had been an exciting subject. The MCLT project had extended a very good opportunity for further examinations in this field. Kuhn's opinion regarding the natural transformational character of paradigm shift: *„...when the existing frames of reference do not provide solutions to our problems...*" only showed one side of the reality , in the mind of the researcher. Paradigm in the researcher's understanding had had an essence closer to that of „the universe of thought and interaction/learning)". On the one hand in line with Kuhn's understanding, the universe does change (expand/shrink/evolve), and the newer characters make it a bigger, smaller or more or

less sophisticated system. However, its universal nature never changes. In other words all fish even if they grew wings are doomed to remain in the same bowl/universe and cannot fly to another bowl becasuse there is no other bowl. Therefore, paradigm shift should only be interpreted as going out of one subsystem of thought and interaction to another, never leaving the larger system. Leaving an older paradigm and entering a newer paradigm was an insufficient conceptualization under the researcher's perceptions. It was also, clear that the universe grows internally. So the subsystems are the actual drivers of evolution and development. Bing bang started at one small point, therefore biggest changes begin at the smallest points, and perhaps paradigmatic bing bangs can start by one leader. MCLT had provided grounds for experiencing the processes through which MO as a philosophy, culture and model influenced the networks and their responses in the system of economy, ensuring sustainable innovation and continuously optimized results were important drivers. Moreover, given MO's impact on external as well as internal contexts, links with economic policy making at the macro level and strategic management systems at the micro level were perceived to have gifted the project with a set of readily available theories and applications. The above mentioned curiosity received yet an additional depth with the extended dimension brought by the MO perspective, since according to the researcher's earlier investigations, he'd perceived the antecedents of MO to have positive links with performance regardless of the systems' and sub-systems' type, size, specialization and industry. The researcher had been highly attracted to observing the antecedents of MO in different settings and its link with various economic and organizational models. Investigations regarding MO's link with areas of 'strategic management', 'sustainable management', 'transformational leadership' and 'knowledge based systems' , had received attention along with the practice of implementing TQM in the areas of car manufacturing, industrial tools manufacturing, construction contracting and sub-contracting as well as GMO-based agricultural production. In his earlier years, following the participation in *'rotational on job training as a health assistant'* in 4 different healthcare departments, he'd gone on to participate in series of education and training in the fields of marketing and sales in order to be able to fill in positions at the 'international sales and marketing' department at a partly family owned business. Serving as the member of group of representatives and negotiators for international contracting of a large construction company on the one hand and familiarization with the concepts such as CSR in corporate governance had brought attraction to the fields of stakeholder conflict resolution and

synergy building. With the emphasis of the newer versions of MO on continuous 360 degrees stakeholder satisfaction, knowledge management and the institutionalization of TQM and its sub areas, there'd been high interest in gaining the opportunity for examining this perceived 'too-good-to-be –true model'by common wisdom. The MCLT project and the incidence of the Hungarian Healthcare Service carried additional value and provided a study worthy case. The above all had a direct influence on the design of the MCLT project and the content and form of interactions with the MCLT clients (as well as the design of the doctoral study).

Table 8. Researcher's prior 'exposure to' and 'socialization into' field related dilemma

Main Areas of Concern		Dilemma as perceived by the researcher
1.	Kuhnian definition of Paradigm-Shift insufficient	Paradigm is ' *the universe of perceptions and learning* ' . Shifting out of the universe cannot occur (only shifting levels possible)
2.	Mapping Paradigm is not a part of the policy making and strategic management process	Paradigm influences all aspects of social activity, development and reform but is not mapped or accounted for . Tools are not available in this areas
3.	SMO has received attention as a philosophy,culture, model with antecedants of positive impact on sustainable performance especially when measured in terms of stakeholder satisfaction	SMO is very compatible with the qualities of a paradigm but has not been conceptualized as a paradigm. Given its link both to philosophies and managerial models its interesting question to address
4.	SMO's implementation and institutionalization relies on adoption of a range of governance, quality management (i.e.EFQM), strategic management and knowledge management systems, combined with moral and role perception maturity of the leaders and a system seeking 'relationship orientation'	Implementation of the Balanaced Scorcarecard and achieving SMO's goal of continuous stakeholder satisfaction requires highly developed culture of participative inquiry, knowledge sharing, synergistic cooperation towards triple loop learning

Earlier extractions from the literature survey (ref. Chapter 2. Above):

Main Hypotheses

- " *Hungarian healthcare reform failure has been due to the stakeholder paradigm (level) Gap*" (in terms of perceptions of Role , Goal, Time)
- "*Hungarian healthcare reform failure has been due to the low number and unfit capacity building programs*

  "*Hungarian healthcare reform failure has been due to the absence of widespread CoPs ZPD*'s, *'cultural zones', 'individual zones' ,'skill-oriented zones'* and the *'zones of reflective capacity'*
- "*Hungarian healthcare reform failure has been due to the absence of MKOs and leaders for creating and participating in the ZPDs"*
- *"Goals of Hungarian healthcare reform have not been set as a result of participative inquiry-action research accounting for the MKOs' , inquirers' and inquiries level of paradigm level gap(paralysis) "*
- *Paradigm Level shift occurs at the individual's level*

(b) Extraction and Documentation of Researcher's own code of Ethics

Very much in line with perceptions of advocates such as Sir David King regarding the importance of an explicit declaration for a universal code of conduct (under an oath) for researchers across the globe, the researcher perceived himself as being committed to the 8 principles code (7+1) for the scientists' action as the basis for 'minimum compliance':

Table.9. Researcher's perceptions of the minimum principles for code of scientific conduct

• Act with skill and care in all scientific work. Maintain up to date self knowledge and skills and assist their development in others • Take steps to prevent corrupt practices and professional misconduct. Declare conflicts of interest once these become evident. Consider the ecological environment and the rights of the past and future generations • Be alert to the ways in which research derives from and affects the work of other people, the environment the past and future generations, and respect the rights and reputations of the mentioned • Ensure that your work is lawful and justified within the contexts of your practice (industry , academy, society, community, institute and family)

- Minimize and justify any adverse effect your work may have on people, generations, animals and the natural environment.
- Seek to discuss the issues that science raises for society. Take proactive measures for establishing communication pathways with others. Listen to the aspirations and concerns of others.
- Seek to establish an effective communication through proactive participation . Assist decoding, encoding, recoding signals, data, information within the physical, ecological and social contexts .
- Do not knowingly mislead, or allow others to be misled, about scientific matters. Present and review scientific evidence, theory or interpretation honestly and accurately

The researcher's theoretical affiliation to Systems' thinking, Sustainable Development and more advanced versions of CSR combined with the years of working in the ethically sensitive fields (healthcare , GMO etc.) had contributed to a good understanding of notions such as „*conflicts of interest* „ and „*voluntary action supporting the interest of all stakeholders*". The researcher perceived that a good strategy relies on a conscious and proactive approach to ethical conduct which was an outcome of ongoing engagement with the stakeholders, accounting for and addressing common interests. In essence he believed that the interplay between psycho-socio-economic factors along stakeholders' process of transformation as the main enablers for resolving stakeholders' ethical-moral dilemma. The same were required for capacity building when approaching a concern regarding the establishment of an ethically and morally balanced scenario under which sustainable optimal results are achieved as an outcome of effective leadership and startegic approach to stakeholder management (governance and effective communication).

The following reactions to some major dilemma, reflect best on his stances:

1. Bio-Ethics -i.e.stances regarding GMOs and GM seeds for fuflling needs and/or research purposes : „*exerting conscious damage on the ecological environments for the sake of research or market growth is unacceptable. However, the evaluation of such damage should incorprate not only the potential short term outcomes but the long term implications as well. The aims of knowing more and learning are the most saint endeavors which ought to be balanced with the carrying load capacity of the stakheolders at one given time".* In the researcher's

terms the human race with all its destructive and/or constructive attitude is a part of the nature's system. From a de – ontologocal perspective , nature's responses cannot be given higher value than that of the human race since we're all the very members of the same system. The co-creating dance applies to this relationship as well.His stances are concluded in the following statement:

„ *Ends don't justify the means regarding GMO research and commercialization but we cannot think of the nature as a superior entity nor can we think of the human race as such*".

2. Gratitude Money given to public doctors :

„*Giving or accepting gratitude money are both wrong due to the psycho-social contracts with the public doctors*"

In a broader sense the time experimented golden principles reminded by S.Covey under:

„*do unto other what you would have done to your self"* or „*seek first to understand and then to be understood*"

best defined the main pillars of the researcher's code of ethics. These were time experimented values of effective people that worked through ages regardless of the social context demanding hardwork and maturit for their mastery. They ought to be distinguished from quick fixes that can be learnt over night. Covey's caution in allowing to 'see beyond' and understanding our perceptions of truth rather than endeavoring to understand truth or reality explained the essesnce of researcher's attraction to the concept of paradigms. (i.e.Covey's example of perceptions resenting the attitude and appearance of a family and children on the public train before and after realizing that they were coming from the hospital etc). Following those predefined norms and standards by the community or the context of practice was 'necessary- but- insufficient' target. The researcher identifies his affiliation to that of a system's thinker, therefore his perception of morality and ethics is very much in line with the holistic perspective of thought and action emphasized by Von Bertalanffy and Mintzberg discussed earlier. According to the researcher such integrated norms and principles require an internally and combined moral language

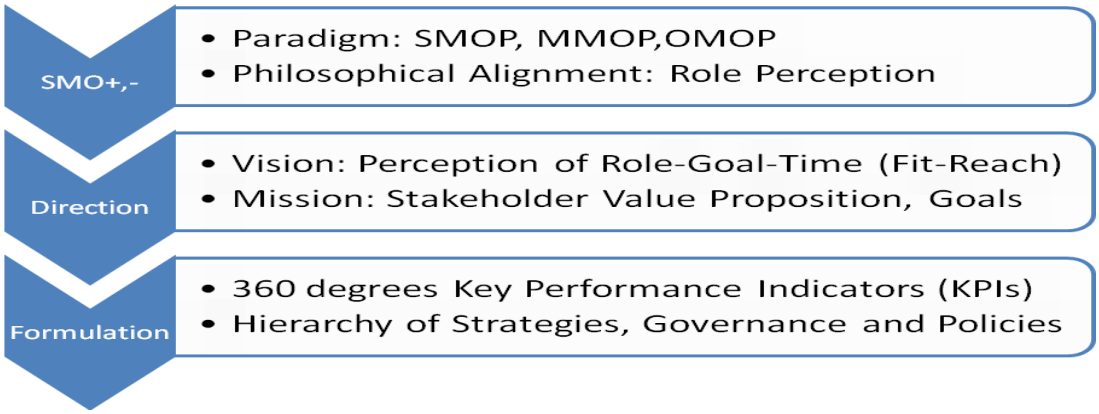
bringing together emotional, rational, legal and cultural concerns continuously re-aligned and improved through interaction with the incidences, stakeholders and the context of interaction. Since, in his view communication was an important enabler technqiues / principles such as that of the *'OK Corral Transactional Analysis* 'played an important role in achieving ethically and morally OPTIMAL situations. The context of SMO provided room for achieving the mentioned situation. Nevertheless, conceptualizations of Kohlberg and Piaget especially in showing the levels of moral development had been used as a basis by the researcher for proposing a „Paradigm Level Typology". The typology emphasizes the the paradigm levels of the individual, institution and community as well as their deontological, ontological understandings influences their MECHANISTIC-SUBJECTIVE-SYSTEMIC. Based on researcher's conceptualization ; „*role maturity*" sits at the center of paradigm level shift , enabling triple loop and quadruple learning, most importantly making the continuous attainment of ethically and morally optimal situations for all stakeholders possible. The researcher had gained experience using tools such as the „*Strategic Audit*" for building a „*strategic management system*" in the field of Management Consulting. The design and implementation of a Balanced Scorecard as a tool had also proven to be a uself tool for monitoring performance by linking the various results to the enablers , as best depicted by the EFQM model. Through experience the researcher had realized that moral development stage may or may not be age dependant in every individual's case as suggested by Kohlberg (although thsi may hold true in the majority of cases) In otherwords individuals may stop at one development stage while their bilogical age may continue to pass through newer stages. Also, some individuals may already have the capacity to understand the higher levels at younger ages. It had been interesting for the researcher to notice that those individuals whom had been able to deliver their „*Role Perception*" through presentational knowledge (in some explicit manner , especially in written form) showed characteristics closer to that of the higher destages. Generally, there had been links between the conceptualization of '*Vision*' (picture of self especially if expressed in a manner that enacting time has been implied) and the capacity to explicitly express „*Perception of Role*" (therefore indicating arrival at a higher moral stage). Explicit conceptualization of their „*Mission*" indicated their package of broadly defined goals.

Table 10. Kohlberg's Moral Development Stages Map

Logical stage (Ego)	Moral Stage (Super-Ego)
Piaget Stages 1.Sensori Motor 2.Prelogical Intuitive Thought 3.Concrete Operations	*PRE-CONVENTIONAL MORAL STAGE* Stage 0: The good is what I want and like Stage 1:Obedience and punishment orientation Defense to a superior power Stage 2: Egoisitic orientation. Language used to get what you want.Actions as means of hedonistic satisfaction REWARD – PUNISHMENT
4.Formal operations	*CONVENTIONAL MORAL STAGE* Stage 3.Good boy or girl orientation, interpersonal relations of mutuality conformity to stereotyped cultural images Stage 4.Orientation to maintaining social order, fixed rules and authority TRADITION-LAW-BIBLE
True Formal thoughts 5.Mature Intuition (Metavert) 6.Fall Realization	*POST-CONVENTIONAL LEVEL MORAL STAGE* Stage 5A:Orientation to interpersonal commitments, social contracts, utilitarian law making Stage 5B:Looking to developed conscience and higher law Stage 6: Commitment to principles with ethical universality and commitment I HAVE STUDIED.WE AGREE THIS IS FAIR

It was interested to notice those whom were capable of expressing their goals in terms of a wider range of stakeholders' value expectations (especially the environment) had showed signs of higher moral stage.

Fig.12.Strategic Posture: Paradigm , Perceptions of R-G-T, Strategy and Policy Formulation



In attempting to understand and explain the approaches taken by the system, clients, co-workers and peers the following had deserved distinction as a result of his working experience :

- Perceptions regarding Postion / Job-related ethics: In addition to concerns and reservations regarding the selection process of medical doctors, which has been scrutinized for having created an inner circle especially in some highly paid areas of specialization, the researcher had also been concerned regarding the approapriate definition of personality and behavior when extending 'the permission to practice'. The 'Researcher' and 'Consultant' positions vs. 'Medical Doctors' code of conduct should all fall under similar norms. Doctor as care provider/consultant vs. doctor as curer/authority. Acting according to best of knowledge and in clients' and stakeholders' interest (see Golesorkhi 2007, Golesorkhi, Fojtik, Rekettye 2004) . Unfortunately, by large, doctors tend to disregard the fact that many chronic illnesses can be 'managed', but 'not cured', not because they are delinquent in learning, but because the science is not there.
- Perceptions regarding Emergency and Priority setting- ethics : Ethical priority setting criteria when allocating time, attention and resources. Degree of doctors' and systems' commitment to patients with less emergent /acute cases. Investing all of the resources into one acute case for best quality (sacrificing resources which could be extended to the next accute patient as well). Problem of monitoring, knowledge sharing in the public and nonprofit organizations in Hungary with high wastes of public investments and lack of strategic approach (see Golesorkhi and Fojtik 2007,Golesorkhi and Fojtik 2005). When interviewed many doctors perceive 'time' to be their main constraint for the lack of their

customer oriented attitude. Waitzkin H (1984) showed that doctors underestimate the amount of information patients want and overestimate how much they actually give. The same study covered 20-minute office visits, interestingly doctors spent only about one minute per visit informing patients but they believed they were spending nine minutes per visit doing so. Lown (1996) showed that the patient desires to be known as a human being, not merely to be recognized as the outer wrappings for a disease. According to the same study doctors who encouraged patients to talk about psychosocial issues such as family and job had more satisfied patients and the visits were only an average of two minutes longer. According to a study by Korsch & Harding, (1998) doctors do more talking than listening. A well recognized study by Marvel et al. (1999) found that 72% of the doctors interrupted the patient's opening statement after an average of 23 seconds (patients who were allowed to state their concerns without interruption used only an average of 6 more seconds). A separate study shows last minute questions occurred less frequently when the patient was invited to talk. Further confirmations exist that the health of the doctor-patient relationship is the 'best predictor' of whether the patient will follow the doctor's instructions and advice.

- Perceptions regarding Role Maturity-related ethics: Rotter & Hall (1992) argued that a relationship which accepts the patient's unique knowledge as well as expectations as important can serve better outcomes.Extending care, stewardship, knowledge sharing, join decision-making and care, transparency, integrity, respecting privacy. (Role – Position development typology developed by the reseracher). As indicated by Lown (1996) if a patient is ready to be helped, even a little, and grateful for the marginal, it enhances the doctor's commitment to fostering a relationship between equals. Only such a relationship, bonded by understanding and respect, can deepen into a true healing partnership. The doctor's moral development stage determines the type of participation in the context of practice in working together with her/his peers as well as the patients, community and other stakeholders (playing a proactive role in voluntarily promoting ethical and moral norms. In setting new standards for ethical practice within the profession. Proactive participation in 'governance')
- Regarding the perceptions of communication ethics, types and areas of knowledge sharing: In addition to the 7+1 principles (table.10), researcher's position supported a

balanced codex implying both the Mertonian CUDOS and awareness of the counter norms highghlighted by Mitrof (1974) under Solitairiness, Particularism, Interstedness and Dogmatism. It was interesting for the researcher to note that doctors perceived patients generally 'unreliable narrators' and charted patient observations through a certain skepticism, using phrases such as "*the patient believes*" or "*the patient denies*." Suchman et al. (1999) showed that doctors often ignore the patients' emotional health. This study found that when patients dropped emotional clues or talked openly about emotions, the doctor seldom acknowledged their feelings. Instead the conversation was directed back to technical talk.

- Perceptions regarding Social-Cultural-Legal Context.-related ethics: Respecting cultural and context related mores and norms but instead of keeping a merely tolerance policy working on finding mutual interests zones, building trust and synergy for common goals in the long run (I change, you change, we change for the sake learning and development). 'Diversity' everywhere and especially in Healthcare is a component of continuous learning and innovation, if dealt with in a strategic manner. Building culturally responsive systems will result in stronger healthcare systems at global, regional and national levels. (*see* Golesorkhi, Gombar 2006, Golesorkhi et.al. 2005, Golesorkhi et.al. 2004) . The 'legal context' of medical practice has also been an external constraint influencing the relationship. Doctors feel constrained subject to severe malpractice laws. There is again evidence that the doctors' communication skills, through which patient information was carefully received and treatment alternatives delivered by the doctors, stakeholder perceptions positively dented the event against malpractice and filing complaints.

Referring to Parsons (1951) , the researcher and his colleagues had concluded that the role of the doctor is complimentary to the role of the patient (Golesorkhi et.al.), acting in full mutual cooperation for the benefit and the welfare of the patient and community. Parsons believed that the amount of illness is controlled through the socially prescribed roles for doctors and patients, which facilitate interaction, and ensure both parties 'work together' to return people to a state of health and normal role performance as quickly as possible. Parsons had emphasized that doctors ought to use their knowledge and technical skills not for their own benefits but other

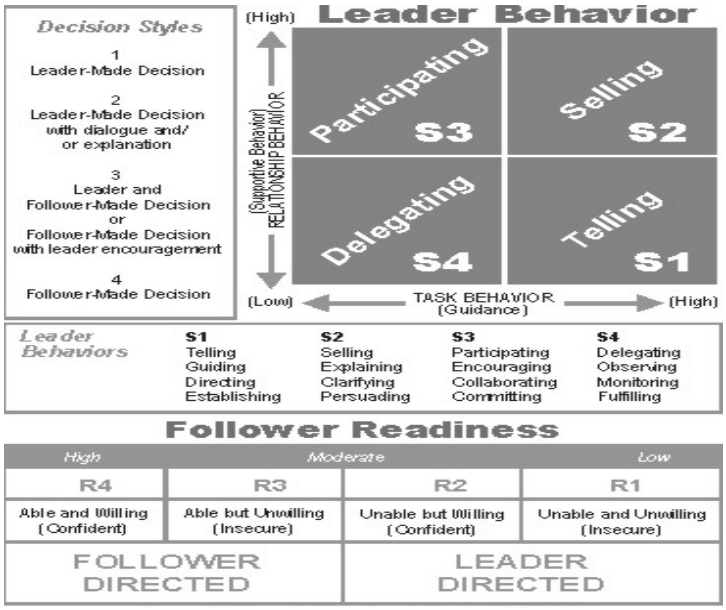
stakeholder's benefits. He'd highlighted the importance of trust in the service encounter emphasizing the patients' vulnerability and knowledge of intimate details about the patient and/or intimate physical examination. On the one hand doctors' objective and emotionally detached approach (to be guided by the rules of professional practice) had been highlighted by Parsons but at the same time very importantly mentions the conflicts arising from the doctor's own perceptions of his roles and goals, with the expectations exerted on him by the profession, patients and the community . While Parsons viewed doctors as enjoying 'considerable autonomy' in executing their professional skills and occupying a position of authority in relation to the patient, he agrees that success can only be achieved through cooperation, mutual understanding and partnership between the doctor and patient. Parsons' analysis identifies how roles may facilitate interaction in the consultation, as both parties (as well as the profession and the community) become aware of how each other is expected to behave (the value of knowledge sharing and symmetry of stakeholder information). Golesorkhi et.al., based on SMO had added to Parsons understanding, through highlighting steps for achieving optimal stakeholder satisfaction through capacity building, knowledge sharing and continuous learning amongst the stakeholders, concluding "*unhappy doctors and nurses cannot serve the happiness of patients in the long run*". Also, through the mentioned process role and goal perception are better clarified and a constructive communication process institutionalized (system of care service providing rather than cure service providing, doctor as consultant rather than authority). Incidentally, doctors also benefit from the patient-centered approach, they feel more job satisfaction and are less likely to burnout.

During the first rounds of interaction with the clients the following ethical dilemma were mentioned by the clients:

- the perceived de-ontological aspects of the healthcare systems' oath to the society : „*scarce healthcare resources vs. endless healthcare needs*", - role of the government and national insurance in redistribution of resources the perceived unethical presence of the private sector by the doctors and the society at large
- the perceived de-ontological aspects of doctors' oath to the patients and their community: „*doctors' and their families' wellbeing vs. that of the patient , their families and the community"*- patients' and their family's attitude in referring to the doctors many times is neither ethical towards the doctor nor the community.

- the doctors' commitment to own career development and the medical community-*using patients as means not ends*
- the diverging perceptions regarding relationship with roles, hierarchy, governance, peers, profession and the community- high degree of role confusion, fear of jobloss, task orientation and unclear processes for participation in a governance which adresses a 360 degree value system

Fig.13. Researcher's understanding regarding the role of the leaders in peer role development

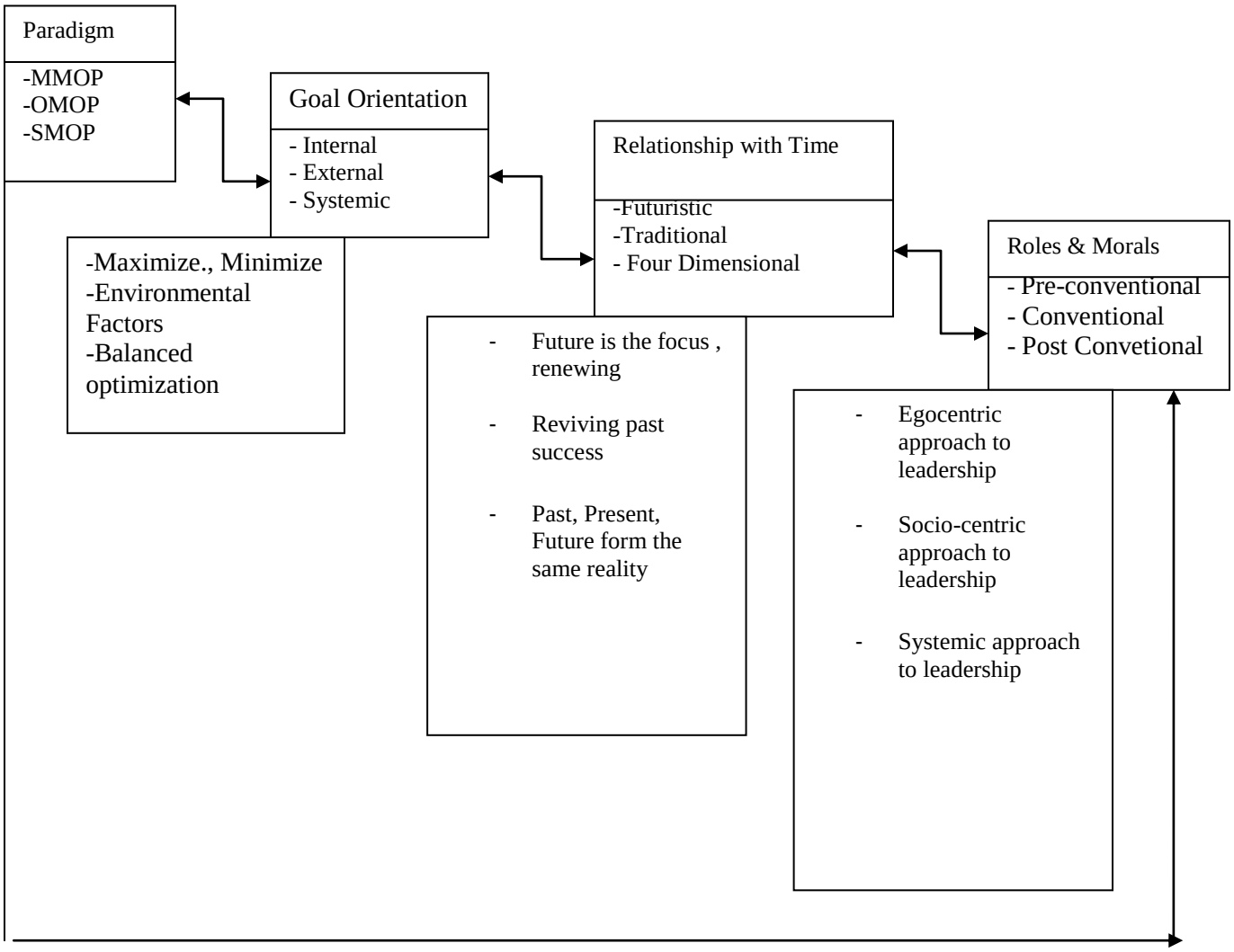


As a result of early interactions with the MCLT, an important extraction had been that the leaders , especially at the department under study (surgery) did not approach peer development with the goal of promoting social and group level leadership competences, but there were also records of case incidences regarding extra curricla support received from senior peer. 'Follower Readiness' was neither dealt with through a formal and/or conscious process. Further to exposure to concepts in situational leadership (a case at the trauma department) the MCLT were receptive to the idea of promoting training and development in this area, finding a direct link with their day-to-day needs. The MCLT were also disposed to such success stories such as the '*Aravind Eye Hospital*' and the *'Aravind Eye Care System*' case incidence under which limited financial resources had been dealt with through leadership, clear vision, market orientation, stakeholder management for synergy building, community building, transparency, societal marketing, CRM, care providing (as opposed to extending cure), whole process –systemic perspective and learning

orientation. Results of this exposure were favorable in setting a common vision for the investigation. Aravind features and performance:

1. Has been constantly growing locally ,internationally as a model . Produces 10 times the national average.
2. Winner of the most pretigious quality assurance prizes in the industry.
3. Taking advantage of the local psycho-socio-economic dynmaics Aravind built an innovative redistribution system: 'One richer pays for two poorer' principle.
4. Aravind builds on innovation and learning processes extending to all stakeholders .

Fig.14. Moral stages Perceptions of Roles-Goals-Time under Mechanistic, Organic, Systemic Paradigms



(c) Extraction and Documentation of Researcher's philosophical assumptions regarding the theory and practice of market orientation (etics and emics)

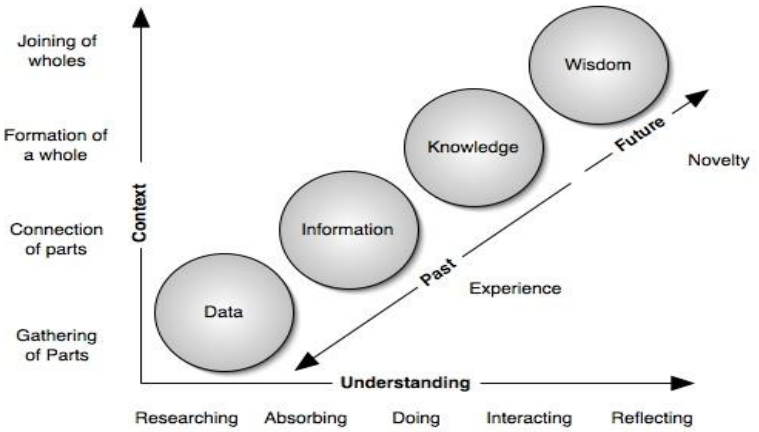
The researcher's earlier exposure to System's Thinking and the theory and practice of MO from this perspective had framed his position regarding the what he perceived as the intersecting areas of ontological, epistemological and axiological dimensions -philosophical alignment (*Fig*.4.). The following sub areas of this concern are worthy of consideration :

- *Ontology:* The question of the nature and form of reality and the subjectivity-objectivity involved in this perception -what can be known about it? The tacit mutual experiential knowing between people that is the primary base for all explicit knowing. (i.e. as suggested by Guba and Lincoln discusssed in chapter 2 has been very much influenced by the systems' approach to such definition (universal and participative).

- *Epistemology:* In line with the same the question of the researcher's perceptions of relationships, hierarchy and roles within the context of his philosophical / paradigmatic assumptions (here SMO) is worthy of consideration.Hierachy *–relationships-roles between what is known is known is worthy of consideration between the knower, would be knower and what can be known* (experiential, presentational, propositional and practical knowing)

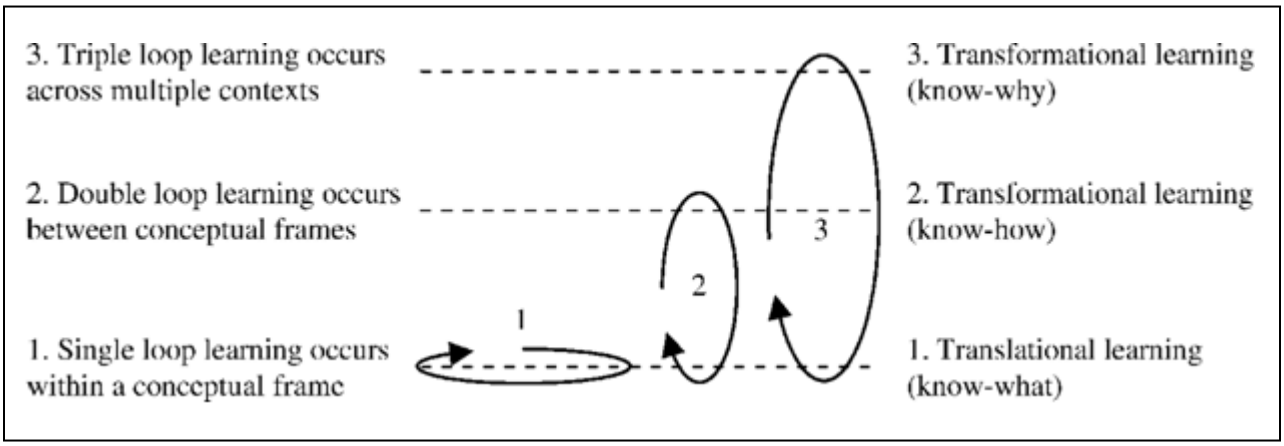
- *Axioliology:* In line with Fals – Bordaunder which the purpose of co-creation of reality is ' to change the world' and Heron's position that the ultimate goal of knowing enjoys an intrinsic value and is an end-in itself, that transformational inquiry have primary value as opposed to those targeting merely propositional knowledge his stances were close to that of Heron's "*knowing how to choose and act … to enhance personal and social fulfillment and that of the eco-networks of which we are a part. Such human fulfillment is consummated in the very process of choosing and acting…. intellectual knowing is of instrumental value in supporting practical excellence".*

Fig.15. Researcher's view regarding the continuum of knowledge and wisdom within the context



Researcher's caution regarding the extraction and recording areas which may lead to 'confirmation bias' , had been leass worrying subject to the systemic approach of co-creation of reality. To the researcher concerns regarding 'Etic" and 'Emic' in approaching MO were viewed in terms of originating from 'stages of development of role perception' and ' transfomational learning across multiple contexts(with potential role perception conflicts)' rather than the incommensurability phenomenon. Here again the triggers and processes of triple loop and quadruple loop learning promotion sat at the center of his attention.

Fig.16. Researcher's understanding regarding the transformational levels vs. conceptual frames



Regarding the relationship of MO with values and beliefs, Miller and Friesen (1982), Tushman and Romanelli (1985) had emphasized that becoming market orientated would require a change in fundamental values and beliefs of the organization. They'd stressed the essential need for a

"paradigm (level) shift" in becoming market oriented from not being market oriented . The writers implied an understanding of MO being that of a paradigm.This all had been perceived to be achievable through the design and implementation of a learning system with advanced modes for stakeholder involvement in knowledge processes for continuous synergy building and innovation. Reflections on various perspectives MO and approaches to '*Etic-MO*' and '*Emic-MO*' [coded Mechanistic MO (MMO) and Organic MO (OMO)]. While understanding through decomposition had received higher attention in researches observing MO at the level of etic, getting to MO through understanding frames of reference and shared meaning had been the ultimate focus of researches directed at MO the level of emic.

- **<u>Etic and MO</u>**:

(1)The Objective Mechanistic MO (MMO):

Positive/Objective/Mechanistic approach (see for example Kohli and Jaworski 1993 and Barksdale and Darden 1971). Researcher: Outsider role and perspecticve. To research 'on' rather than research 'with' approach. The efforts at this level had been in line with an understanding that causes and effects of the organizations' interaction with the environment are deterministic and can be estimated through the observation of the 'deterministic relationships' between cognition , behaviors and actions of an organization (and its managers). In this view managers' actions represent managers' belief and world view. Also, that 'laws' regarding organizational functions and performance can be approached and discovered. Under this view "MO is a set of behaviors". As a consequence managers are perceived to be masters of organizations' destiny and strategy formulation-implementation processes to be an outcome of explicit information gathering, planning and implementation. (see amongst others Hart 1992 and Simon 1972). In terms of identifying and promoting MO from a behavioral perspective, Shapiro (1988) had provided a "check-list" for market-oriented behavior very much centered around information responsiveness, proactive stewardship/follow-up, trust-worthiness (making reasonable promises, setting realistic performance standards and keeping both). The same line was followed under the activity-based construct of MO as conceptualized by Kohli and Jaworski (1993) and especially their operationalization of MO (Kohli and

Jaworski, 1990) in terms of an organization – wide activity / process for intelligence generation (i.e. regarding customers', employees' current and future needs), dissemination and responsiveness to intelligence. The management had been perceived to have control over the facilitation, implementation of MO into the day-to-day operations. The emphasis here, had been on linking MO to the existence of certain behaviors which have to be learnt and performed. The fact that research of MO is approached from a behavioral perspective is influenced by the acceptance of causality between components of MO belief and behavior in a deterministic sense. In other words MO observation can be accomplished through breaking it down to its major components

- **Emic and MO:**

The Subjective-Organic MO (OMO):

Insider/positive/subjective/organic (see for example , Narver and Slater 1994 and 1993, Desphande , Farley and Webester 1993 and Webster 1988). MO at this level has been conceptualized as pattern of shared beliefs , an outcome of shared meanings, values which are reflected in both the organizational culture and business philosophy and policies (i.e. leading to superior stakeholder value). The interpretations of Narver and Slater (1990) of MO as an organizational culture, had highlighted the influence of the context for MO's successful implementation along the acceptance of MO and commitment to MO by top management and other stakeholders. They'd casted : "*Market orientation is the organizational culture that most effectively and efficiently creates the necessary behaviors for the creation of superior value for buyers and, thus, continuous superior performance for the business*". McNamara (1972) had emphasized the importance of stakeholders' acceptance (especially that of top managers') needed for MO's successful implementation and institutionalization. The importance of idiosyncracy amongst cause and effect in observing the relationships between the metaphors and frames of reference through which the organizations' stakeholders view and interact with their environment are highlighted. (Gerbing and Anderson, 1998, Hart,1992 Churchill, 1979)

The researcher's own approach as conceptualized had been that of a synthesized –systemic model (SMO) combining the two levels. From this perspective organizations, their internal and external stakeholders continuously perceive and interact, over time learn and change their perceptions and the essence, processes, goals and outcomes of their interactions in line with these changes (i.e. as emphasized by Heron regarding the intrinsic value of knowledge). Above all it is important to note that the researcher's studies in the field of MO had brought him to an arrival suggesting that SMO could be considered beyond a perspective. To him SMO could be taken as the equivalent of 'paradigm'. This was a higher level and combined definition in comparison to those such as Felton (1959) to whom MO merely represented a '*state-of-mind'*, or as referred to by some as a '*philosophy*' (i.e. in King 1965, Barksdale and Darden 1971 Narver and Slater 1990, amongst others), and by some others as an '*organizational culture'* (i.e. in Deshpande and Webster 1989; Deshpande, Farley, and Webster, 1993) Conclusions of the researcher had been based on the investigations of the process of MO's acceptance in different settings as cautioned by McNamara back in (1972), implementation and institutionalization for creating a better understanding of MO. The fact that "*philosophies and goals*", "*process and change*", "*content*" and "*actors*" demanded simultaneous observation was an important trigger for taking the investigation to a higher level of inquiryto study MO as a "*paradigm*". The interplay of the levels and actors, carried an essence which was continuously transformational, requiring enactment through leadership and continuous learning. This was built on notions suggested for example by Weick (1969), Smircich and Stubbart, (1985) emphasizing that organizations and their stakeholders 'enact' their environments subject to their perceptions Smircich et. al. had also referred to the fact that the managers' attention (originating from their values beliefs) leading not only to reactions or responses to the environment but also to proactive steps for creating / reshaping their environment.

(d) Researcher's assupmtions regarding what could be considered warranted knowledge as a result of the study

Since the content of knowledge and its development processes have been an important part of the study, assumptions of the researcher have been exentsively discussed throughout this paper.

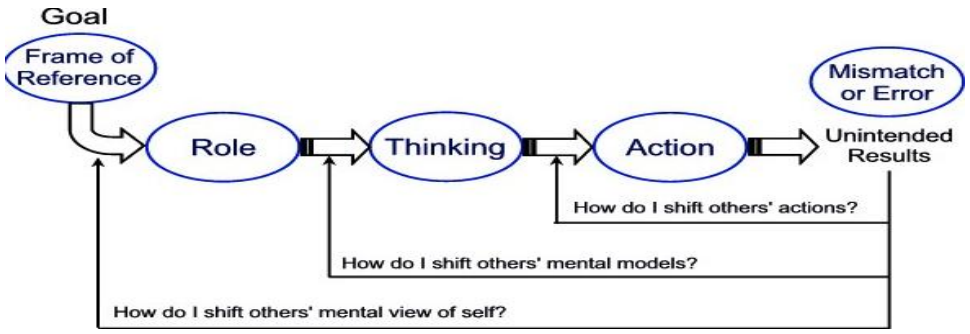
(e) Extraction and Documentation of researcher's conceptualization of the research problem and research context and his selection, design and implementation of the research strategy, the subsequent findings of research

The researcher's arrival at the subject of investigation had been further to earlier exposure to the current area of inquiry. His earlier understandings of the field of paradigm studies, the theory and practice of SMO as well as the dilemmas of healthcare policy making and practice (outside Hungary) had had direct impact on the 'initiation' , 'esatblishment of aims' and 'design' of the study. Moreover, as an internationally oriented, systems thinking, business manager in his early 30's, whom had decided to expand business operations to Hungary, the researcher could not have been free from prior assumptions regarding the dilemmas involved in the context of Hungarian healthcare service. The importance of accounting for the human factor in scientific inquiry, her/his assumptions/presumptions and culture has been a subject of central concern (researcher dependance). The above had been reviewed and decisions were made before reaching an optimal research design. Under the mentioned, an optimal design was defined in terms of one which involved both the value of prior research, researcher's and participants' assumptions and possible hypothesis were extracted , accounted for and incoporated in the process of the study. In line with the same chapter 2., (above) was a reflection on the extractions from field related literarture. Hypothesis on the sources of conflict and gaps had been extracted and suggested as a result of this reflection (an important block of the reflexive grounded theory process). In terms of the long term implementation of the design, the fact that the study received a newer frame under the doctoral dissertation, allowing the re-examination resolved many of the earlier constraints exerted on the study (paradigm studies require a longitudinal design) .

Earlier studeis have suggested methods for resolving the debate between mechanistic and organic perceptions of the world, and their influence on scientific inquiry or vice versa. The researcher's position has been that of a systemic approach. Inductive and deductive approaches have been viewed as complimentary as opposed to incommensurable by the researcher. In his terms „*the presence of the human factor enjoys the most axiomatic, subjective and objective aspect of any inquiry"* . These have been discussed in details in the previous sections. In line with the same due to the presence of the human factor in all stages of inquiry, especially during the formation of the research idea, concept, vision and goals of the research, both inductive and

deductive inferences occur. The researcher , the participants and the subjects of the study go through processes of engagement and reflection many times consciously and subconciously, actively and passivley. The most important commitment should be around accounting for the sources of bias which may occur due to the presence of the human factor, especially the researcher her/himself when selecting a mixed or qualitative research design (the goals of the current chapter). The MCLT had provided a perfect opportunity for the design of a method that allowed the researcher to address the afore mentioned aspects. The combination of the earlier agreed '*Action Research*", *'Ethnography'* and *'Reflexive Grounded Theory'* (extended to a 10 year long study) provided grounds for the researcher's immersion into the day-to-day context of decision making, planning and practice for the exploitation of the hidden realities of the context and needs assessment in the area of training and development. The 'participant-dependant' nature of the study of paradigm has been observed in the previous chapters. Attention had been drawn to the fact that the philosophical alignment of participants should be investigated at the intersection of the ontological, epistemological and axiological understandings of the participants (paradigm covering all) in the above sections. Philosophical alignment of the participants are best revealed through his her perception of 'Role'. The link between the level of moral development and participants' perception of role had also been refelected on in details. Participants' development stage is directly linked with the capacity for transformational learning (upper loops of triple-loop learning) above signle loop and double loop learning, necessary for paradigm level shift.

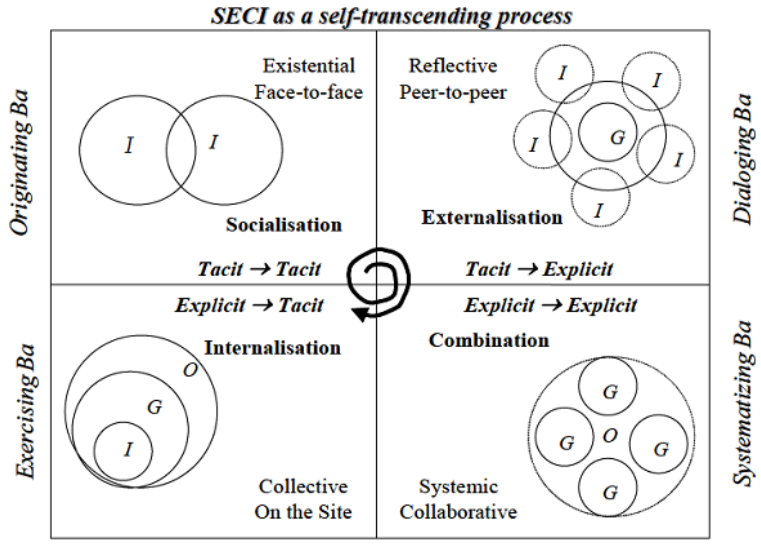
Fig.17. Self reflection process initiating paradigm level shift and TLL



Further to the MCLT project and mutual discussions regarding the selection of a fit research method for the study of paradigm (with the help of SMO based models), agreement was reached

on a design which covered the exploration of '*attitudes*', '*perceived values*' (cognition), '*abilities'* and '*behaviors*' through participative action research (PAR). The processes of perception formation and development through learning and interaction with the political, legal, economic and social contextes were given priority. Above all the processes of Socialization, Externalization, Combination, Internalization of tacit – explict learning needed to be dealt with and explored. Given the researcher's prior exposure, ehe application of SMO to the case incidence of the MCLT project had been an important concern. The development and examination of a typology for assessment and improvement of SMO through capacity building programs had been considered by the researcher. Attention had been brought to the field related MO literature inorder to extract paradigm related SMO features. The existing gap in MO related literature regarding the approaches and conceptualizations of MO had to be addressed, in order both to enrich the study and to be able to evaluate the contributions of the current study to the MO's state-of-knowledge.

Fig.18. The SECI models as a self transcending process



In this sense the subject and aim of the study had already been considered with a dual implication far as the MCLT and the extended theorizing for its application in the area of management capacity building for successful healthcare reform. (Investigation of SMO as a paradigm and observational analysis of impediments of bottom-top impediments to healthcare reform from the SMO Paradigm level perspective). Stakeholder satisfaction, according to most

MO studies could be considered as a comfortable benchmark for the identification and measurement of the degree of its adoption and institutionalization. Stakeholder perception-expectation-satisfaction gap could also be linked to the main set of concerns expressed by the clients.

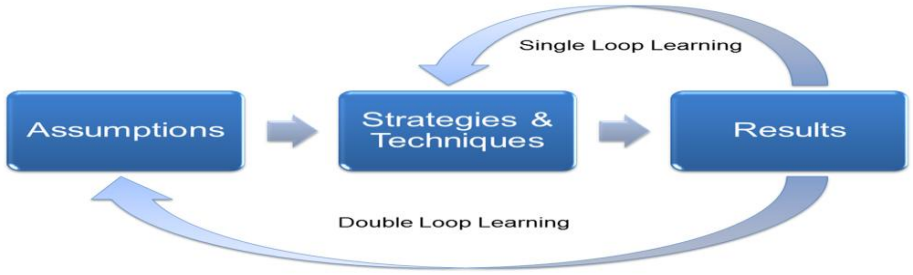
The recorded and reconfirmed areas of Perceptual GAP were the following:

Table.11. Perception gap areas

Gap 1. Stakeholder (health service provider and receiver) expectations vs. Management perception of that expectation
Gap 2. Management perception vs. Service attributes and specifications
Gap 3. Service attributes and specifications vs. Service delivery processes and outcomes (covering follow up and post delivery monitoring)
Gap 4. Service Delivery vs. External communications which influence expectations
Gap 5. Stakeholder (health service provider and receiver)expectations vs. Stakeholder perceptions of the delivered service

In order to be able to operationalize the R-G-T dimensions subject to the SMOP an integration of two models, based on the researcher's earlier experience the EFQM and the Strategic Management System conceptualized by Wheelen and Hunger had been found most beneficial for best promoting the learning loops , building system-wide synergy

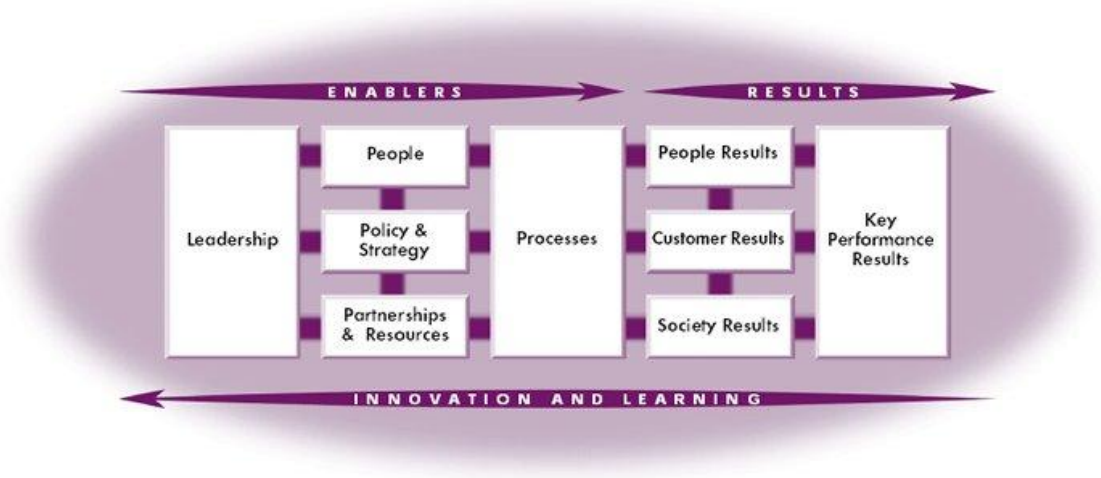
Fig.19. The Single and Double Loop Learning



The basic elements of EFQM had been considered for adoption in the system. The observation of its state was discussed with the MCLT clinets . The adoption, and implementation of the EFQM excellence model at the organizational level held sufficient justification for resolving a major group of denoted problems by the clients in the early meetings. The observation on the applicability of EFQM in healthcare had already been discussed during the consultancy sessions. (*for example amongst others* Gene-Badia J., Jodar-Sola G., Peguero-Rodriguez E., Contel-Seguera JC, Moliner and Molins C 2001, for application in primary care levels) . According to Black & Crumley, (1997) "*EFQM defines self-assessment as a comprehensive, systematic and regular review of an organization's activities and results measured against a model of business excellence*." The EFQM Excellence Model's links with the Problems shown in the next chapter. Fundamentals categorized within two major groups of factors (a) The enablers (b) The results leading to continuous learning, innovation and improvement:

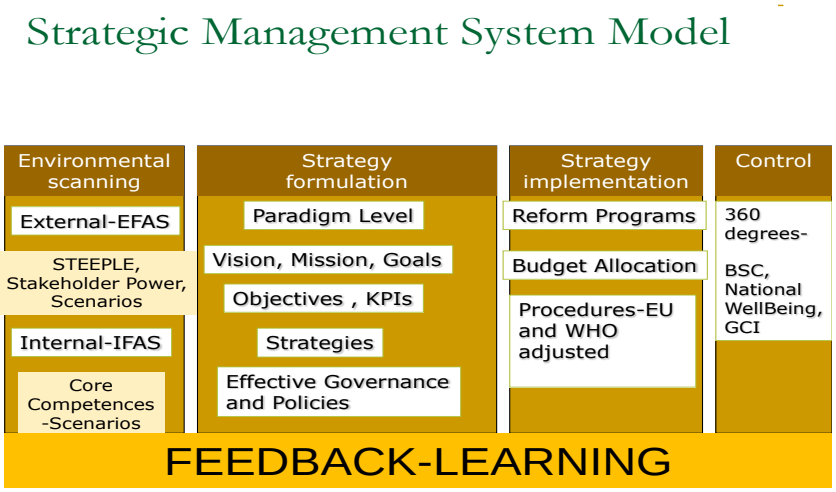
- Customer Focus
- Results Orientation
- Partnership Development
- Leadership & Constancy of Purpose
- People Development & Involvement
- Management by Processes & Fact
- Corporate Social Responsibility
- Key Performance Results

Fig.20 . The EFQM excellence model



The strategic managment model (below) provides a broader perspective of the systen. The environmental (internal and external) factors, their trends (extended to potential scenarios) are seen in light of the „*Paradigm Level*", „*Vision"*, „*Mission*" and „*Objectives*". Implementation, with a view to „*change / reform programs*" and results are linked to „*360 degrees satisfaction, optimized wellbeing.*

Fig.21. The Strategic Management System



Inorder to be able to operationalize the strategic management system the „audit scorecard" suggested by Wheelen et.al. were used (pg 361-365) . The mentioned score card with 96 basic questions was expanded with a variety of most effective tools in management consulting compiled by Silberman („The Consultant's Toolkit") The model has an important impact on learning *(fig.20.)* Inorder to be able to operationalize the strategic management system the „audit scorecard" suggested by Wheelen et.al. were used (pg 361-365) . The mentioned score card with 96 basic questions was expanded with a variety of most effective tools in management consulting compiled by Silberman („The Consultant's Toolkit") . Aspects at the Internal level -the Internal Factor Analysis (IFAS) five core competence areas were used including those highlighted under the EFQM model as enablers and results (with extended weights and rates) .

These included (the 5Ps of competence):

-**P**ast or Heritage including life cycle stage of the stakeholder, entreprenuer and organization, past performance

-**P**eople or Human Capital: Knowledge, Skills, Abilities (covering learning styles, EQ, EI, IQ), Other Characteristics as well as leadership styles

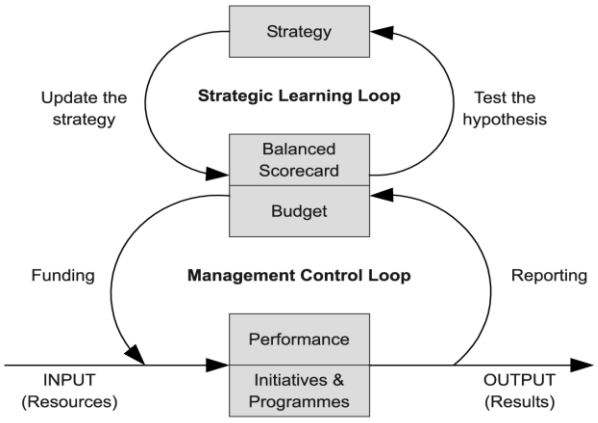
-**P**roximity and Place –Highlighting geographical position as an advantage in terms of closeness to the factors of production, resources. Also covering degree of virtual presence

-**P**roducts and Services- The scope and quality dimensions (extended by Kim and Mauborgne's approach to product-service augmentation), vs. the scale / quantity and price dimensions (ability to produce higher number of products) and the implications and applications to various target segments

-**P**rocesses and Resources- The system's functions, structure and hierarchy (value chain and network), Governance and Culture, Logistics and othe resources including Knowledge

The external factor analysis or the EFAS covered the STEEPLE, Stakeholder's (Power x Interest) analysis and their trends, Porter's 5 forces and their ternds , industry and market structure of competition and their trends, value networks and the future scenarios. The learning, inquiry and feedback loops in the strategic management system are demonstrated in the following figure (fig.22)

Fig.22. The link between strategy and learning loops as conceptualized by Kaplan and Norton 2000



Source: Kaplan and Norton (2000)

(f) Extraction and Documentation of Researcher's understanding of the political context of research and its contingencies

The researcher had been aware of the sensitivities that might have gone together with his presence and the subject of the study. As 'an outsider' -he was not a physician, not a public worker at the time of the research, and not a Hungarian, and as 'an insider' acquainted to the field , invited for the study as an expert and a friend by the peers and colleagues. This was despite the fact that one of the MCLT clients had been the head of labor union.By so far evidence had shown signs of a mechanistic and task oriented approach at the level of hospital and department under study , implying a sufficient degree of resistance. However, his impression had been that a healthy balance existed between his perceived 'insider/outsider' positions. The main outcomes of the study carry important implications for reform policy making especially at the level of the Hungarian Healthcare. The influence of secondary resources on researcher's perception of the political context of practice have been discussed in details in the previous chapters. The researcher was aware of the fact that while areas such as „ *Inclusive-Participative Governance*", and „*decentralization*" might be highly unattractive for the short term politics his impression had been that due to the all-inclusive target of the study , the outcomes of the study serve the purposes of all interests groups especially the politicians. Sufficient attention had been given to the design and conduct the study in a manner to support the participants' prestige, especially given the sensitivities coming from the society, community, hierarchy, peers, profession and other colleagues. It was important to consider that Hungary, which had been a country striving for EU accession at the beginning of the study, has already become an EU member and a signatory to EU since 2004. Subject to EU's policies, values and principles in the area of healthcare the following had received emphasis: Mottos such as „*Health in All Policies*", „*Health for Growth*", „ *Inclusive Healthcare*", „*Patient-centerdness*", „*Prevention and Promotion*"„*Equity-Equality*", „*Quality*" „*Access"*, „*capacity building*", and above all a „*partcipative governance* „ for joint decision making, risk and knowledge sharing towards sustainable development. The mentioned had been considered in negotiations, especially with the hierarchy and authorities in justifying the aims, modes and conduct of the study. With the mentioned considerations , although the researcher had been confident of „*politically aligned*" approach regarding the consequences of the study, sufficient care was given to culturally-

sensitive and responsive handling of the phases of the study as far as the current and predictable political context was concerned. The researcher had been invited by the MCLT to participate in several ’morning report’ as well as ’department gatherings’ in order to be able to detect potential signs of barriers towards bottom-up decision making processes. The researcher had been seeking implications of ’*integrated governance*’ and/ or ’*clinical governance*’ or any paralell form or equivalent process of communication, information exchange and joint decision with regards to the following (in-line with an implied or explicit SMO compatible Mission , explicit strategies, FINMOUSE directives or WHO/EU compatible policies):

(1) Clinical Audit: Information exchange regarding performance review and feedback against previously agreed performance criteria, namely ’standard’ and ’augmented quality’, ’complaints and malpractice’, ’patient feedback’ , ’peer satisfaction’, ’queue management’, ’productivity’, ’improved monirtoring’, ’safety’ etc. Above all , priority setting and distribution of time based on current performance (scheduling, re-scheduling etc.).

(2) Clinical Effectiveness regarding particular interventions: Joint discussions and exchange of information regarding, the Cost-Benefit Analysis on the outcomes of the newer interventions that have been used and information regarding others that can be used, seeking peer’s opinion and professional experience as well as feedback received from the patients (and their families regarding their experience with a particular type of intervention)

(3) Implementation projects based on R&D results: Joint policy making, design and definition of procedures and protocols (at internal levels to be negotiated at external levels as well) for the conduct of continuous R&D and the translation of the results into implementation projects. The question of any inventions by the peer that can be translated into an innovation through joint-planning ?

(4) Risks and level of compliance with satutories: Signs of discussions regarding issues related to ’Risks to the Patients’, ’Risk to the Doctors’ , Risk to the Health Workers’, ’Risk to the Larger Community’

(5) Information Management related discussions: Infrastructure, processes and approaches for extracting, handling, and re-distributing, patients as well as other

demographic and socio-economic data. Proactive policies for collecting, distributing and coding data, through newer information path designs

(6) Approach to Continuous Development, Education and Learning: Discussions regarding needs for education in newer areas which are linked to better goverenance, and its sub-areas and also those which are linked to promoting „Caree Development Path „ of colleagues

(7) Openness: Signs of explicit processes for systematic knowledge sharing and communication with a larger scope of direct and indirect stakeholders , experts inorder to learn, train, understand, negotiate, build synergy and reduce resistance in a continuous manner. Distribution of roles in Quinn's terms for Quadruple loop learning did not exist. However , there were incidences of „club" like groups and gatherings but neither represented Communities of Practice type of approach.

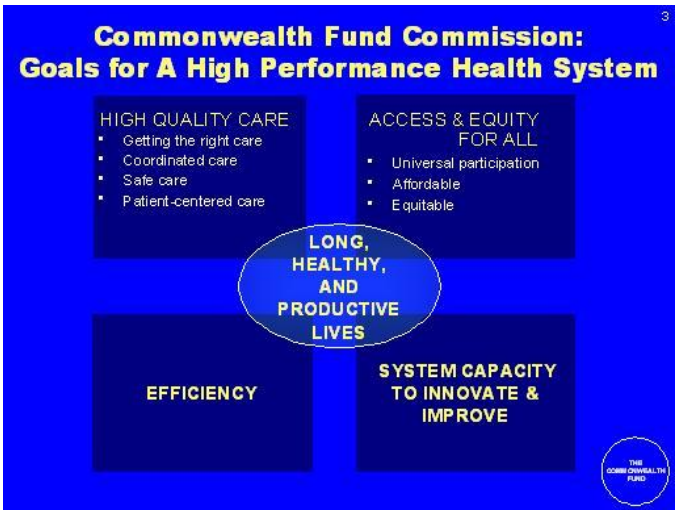
The following had been observed and documented in the first round:

- A clear reference to an explicit 'Mission' , which had been universally understood and accepted by all participants was hardly detected . Strategic direction unclear
- Leadrship style and tendency had been in line with 'task orientation'.
- FINMOUSE and WHO/EU directives regarding the central goal of care , not a predominantly accepted or understood guideline
- Signs of formal Governance in the 'Integrated' and/or 'Clinical' form were not found, but the gatherings did include some of the components in a recurring and systematic manner
- Concerns 3,5,6,7 were not addressed. Concerns 1,2,4 were only slightly attended to.
- Financial Manager at the clinic complained in several occassions and finally resigned from her position. She'd delivered numerous presentations on financial status, submitted proposals for change but had not been received by the big majority and only passively received by a small group.The Deputy of Central Financial Affairs complained that gathering of heads of departments has never lead to discussions and consensus regarding a joint direction, agreement on joint strategies in line with an explicit 'vision' and 'mission'.

- Training and development in the areas of management for clinicians was not a major concern. Absence of field related knowledge had also been held accountable for lack of participation .

- Morning reports were held with a predominantly operational / problem-detecting perspective (reference to protocols and references to CBA /effectiveness of interventions were discussed in line with this approach rather than one addressing the mission or strategy)
- Adoption of quality standards had gradually improved , however the institutionalization of a compliance culture at all levels in an organizational –wide sense had been highly absent
- Inner circles amongst physicians vs. non-physicians (triggered by physicians), one specialization vs. other specializations , higher ranks vs. lower ranks (regardless of seniority), even one gender vs. another gender (triggered by males) were observed.

Fig.23.Commonwealth Fund Commission model for a High Performance Health System



(g) Extraction and Documentation of Researcher's understanding of the resource constraints and the impact upon his research

With the expansion of the action research project to a higher number of people and sites and repetitions , resource short comings could have been a concern. This problem became more important in a later stage of the study when a survey for observing stakeholders' perceptual gap

regarding the central goal of care was to be conducted. However, in a general sense the reseracher did not perceive this factor as one undermining the quality of conduct , analysis or outcomes of the study.

(h) Extraction and Documentation of the Probable impact of unforeseen contingencies and Changes within real-life context of the Researcher on the subject of the study (opportunity or threat)

In a general sense, the future direction of the study had been perceived as compatible with the researcher's own career path and personal life interests. The aims of the study had been highly compatible with his endeavor to resolve the dilemma of new theory building as an outcome of the researchers' internal development path and inquiry process (termed as subjective) as opposed to the widely perceived external nature of the inquiry process (termed as objectived) . The investigation of Systemic Market Orientation as a paradigm through a longitudinal study had been perceived as enjoying unique value by the researcher. The changing environment , especially the socio-political and socio-economic , had been considered an advantage for being able to examine the assumtions of the study as independentaly as possible to these trends However, given the nature of longitudinal studies , thay are all predisposed to threats arisining from negative influencing factors sometimes with dramatic consequences on the context and subject of the observation .

3.3. A Typology for Paradigm analysis based on SMO

Generally, the systemic market orientation approach was used for joint goal-setting of the project, communicating and interacting with the clients. The perception was to examine the effectiveness, of the approach setting examples for the client in their day-to-day interactions with stakeholders (actual reference for the clients' own market oriented approach in defining their roles and goals within the context of practice). The following typology was extracted based on findings of chapter two and the discussed field studies (see also table 13.below)

Table 12. Typology for Reform Paradigm Analysis based on Perceptions of Roles, Goals, Time (R-G-T)

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

Source: the author

Table.13.Rational/Mechanistic Perspective And Organic Perspective

	Mechanistic/Objective MO MMOP	**Organic/Subjective MO OMOP**	**Systemic/Enactment MO SMOP**
Authors	i.e.Barksdale and Darden (1971); Kohli and Jaworski (1990); Jaworski and Kohli (1993)	i.e.Webster (1988) Narver and Slater (1990); Deshpande, Farley, and Webster (1993); Slater and Narver (1994)	i.e.Golesorkhi, Fojtik,Rekettye (2004) Golesorkhi (2005,2006,2007,2008, 2009,2010)
Definition of MO	Market Orientation as Implementation of Activities	Market Orientation as Values and Beliefs	Market Orientation as a co-created Paradigm of thought and action
Operationalization of MO	Intelligence/ Information-Related Activities	Organizational Values and Beliefs	Congruence Between Self Perception, Values/Beliefs, Strategies, Activities
Measures of Market Orientation	Behavioral Measures	Cultural/Attitudinal Measures	Composite Measure, Balanced Scorecard, Quadruple Loop Learning
Relevance Academic	Explicating Structural Relationships between Market Orientation, Antecedents, and Business Performance	Investigating Organization's Cultural Environment and Its Relation to Business Performance	Comprehensive attention including Ontology, Axiology, Epistemology. Highlights inconsistencies between behavioral and cognitive acceptance of MO at different levels of moral development / transformational learning Balanced view of the adoption processes
Managerial	Guideline of a Set of Specific Behaviors	Management of Cultural Change	
Disciplinary Tradition	Behavioral Psychology; Industrial Organization Economics	Anthropology; Sociology	Organizational Cognition
Research Assumptions	Objective world -deterministic -rationality/bounded rationality -Understand by decomposition	Subjective world -idiosyncratic -metaphoric -Understand shared meanings	Enacted world -Subjective attention -actions "create" "objective" reality -Understand relationships between knowledge and action

3.4. Joint- Reflections on the outcomes of the MCLT project and process of open, axial and selective coding

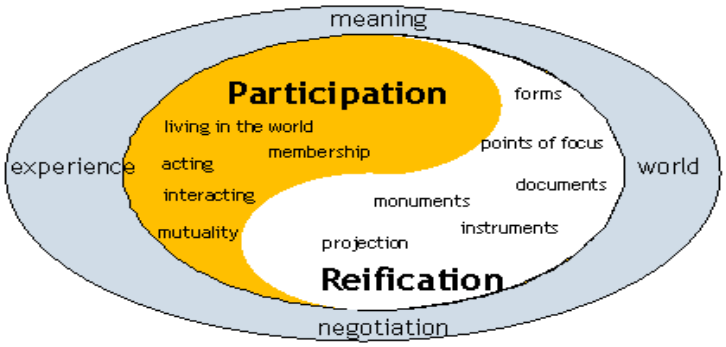
MCLT clients had arrived at the need for management training and advanced leadership skills as a result of their social and career development stage. In due course of the discussions the MCLT clients had been continuously predisposed to the state-of-art concepts and models, in order to ensure a well-grounded common understanding of the perceived problems and areas of training. (*see* Table .15. for the list of perceived problems as a result of early exchanges used for preliminary labelling -open coding). Material and subjects frequently used in the course of discussions and reflection:

- the decentralization and capacity building policy principles (HiT publications),
- the FINMOUSE and CCP checklist for reform policy plans,
- Knowledge Based Economics for optimal wellbeing (vs. Positive, Normative approaches to welfare and the role of the government). Tinbergen's hierarchy of preferences and utility
- The Strategic Management System's Model. (Screening the environment and actors, formulating your Vision and Mission statement, writing KPIs)
- Mintzberg's approach to System's thinking
- Hershey and Blanchard's situational leadership model (simplicity in illustrating approach to leadership depending on the maturity of followers in line supporting capacity building)
- Kohlberg's typology of moral development (concept of Adult and Infant Roles)
- the SECI knowledge management model (Taekeuchi and Nonaka)
- Kolb's learning cycle (Importance of Learning Styles, Assimilators, Convergers, Divergers)
- the creation of a learning organization and paradigm shift via Triple and Quadruple Loop Learning,
- Quinn *et. al.* 's managerial competences and roles for quadruple loop learning
- Concept Mapping processes and building blocks
- the concept of Systemic Market Orientation
- the basic models of EFQM

- 360 degrees Balanced Scorecard (BSC) evaluation
- NHS model of clinical governance,
- case examples regarding the successful incidences of Communities of Practice (CoP)
- the application of the Value Networks Analysis (VNA),
- a variety of patient-centeredness models and market orientation models especially addressing impact of perceptual gaps on optimal performance. The value of learning orientation and entrepreneurial orientation to optimal results

At their own levels, it had been evident to the MCLT clients , that the enlisted aspects of reform had lacked a consistent process for linking the normative change criteria to the realities on the ground . The majority of aspects emphasized and initiated by the WHO, European Union and the various Hungarian governments during the transitional and post-communism periods had suffered from the mentioned problem according to the MCLT clients' perceptions. The processes of reform policy planning and implementation had lacked 'an appropriate adaptation', 'exchange of information', 'training and development', and most importantly 'stakeholder involvement' in the design and implementation of healthcare reform. Given the continued failure of healthcare reforms in Hungary, the central question that had been raised by the MCLT clients had been around the clarification of "*whether or not the Hungarian Healthcare Stakeholders had shared and understood the goals set by reform policy planners, had they been fully and appropriately involved in the due process and most importantly do the system and its sub-units / members enjoy the needed capacity for assisting reforms?* ". The MCLT clients had doubted that 'a shared view ', 'a clear understanding', 'appropriate involvement in the reform process' and above all 'the capacity for involvement in and assisting the implementation of reform plans' had existed, since in their own case and through their own experience such a preparedness had not been existent. Early extractions regarding MCLT perceptions of needs and problems, had been through the method of individual reflective memos and group discussions at the presence of the consultant.

Fig.24. Illustration Used by the Researcher During Consultation on Community of Practice model



Discussion summary on expected outputs

In order to arrive at a mutually agreed plan on how to set short to long term priorities of the project on the one hand and also to arrive at a consensus on the role and contribution of each member of the project, a meeting had been organized. During the meeting the parties had agreed that a "self examination" of the MCLT clients' own 'dominant paradigm ' has been essential in order to extract the FIT-GAP levels with perspectives such as the MO (as discussed under section B. the researcher was subjected to the same process of self examination) . The qualitative nature of this level demanded a longer term planning. Also, consensus was reached that the findings of the series of studies under "Healthcare Systems in Transition" (HiT) publications, most importantly the conclusions of Saltman *et.al* regarding reform planning and reform capacity provided a well founded basis for beginning the structuring of primary and secondary levels of the study. The mentioned should not have limited the consultant -researcher in questioning earlier studies as a result of his independent exploratory investigation. Based on Saltman *et.al.* , the following aspects had been given priority for assessing capacity for reform and the additional relevant areas:

- **Auditing Capacity for Participating in Reform- State of Management Training :** '*The number of people enjoying sophisticated management training'* along with ; MCLT clients HAD NOT received explicit training in such areas. Leadership Competencies FIT-GAP Analysis with the goal of designing and delivering a tailor made training program. The delivery of a report on the current 'Leadership Competencies FIT-GAP' as the most important enabler of the systems and sub-systems for reform based on thorough literature

survey for extracting explicit benchmarks / criteria (i.e. as verified under the EFQM model discussed earlier) . This will be the major part of 'the systems' audit' level of the project. The clients had requested a summary of competencies as defined by the state of art in the field of healthcare management. Taking an approach very similar to that of Fielder (1996), the researcher had viewed 'leadership' as a complex interplay between individual, organizational and socio-cultural levels in the context of practice. Under similar views, the development of leadership and management competences occurred through an interlinked web of multi-dimensional psycho-socio-economic processes with continuous 'self-development' and 'contextual/environmental' transformation as the main common outcomes for all participants and their milieu of interaction. (*see also examples such as* Wegner and Snyder 2000 on Communities of Practice) The expected outputs covered an investigation regarding the most important explicit-tacit processes of knowledge spillovers (i.e. circular migration and overseas missions as in the case of MCLT clients), training and development in the form of Continuous Development Programs (CDP) framed under a learning credit system, as a separate 'readily- available' or 'to- be- created' evaluation structures for multi-disciplinary training, were to be considered. The expectation had been that the audit would cover an investigation on the 'capacity to train' as well as well as the needed areas for training.

- **Auditing the Current Reform Plan 'Content' Compatibility (Vision-Mission FIT):**

  An analysis of '*the content of reform policy plan* ' covering the governments' reform priorities in the short to long term (i.e. whether or not they'd been in line with WHO , HiT and the EU perspectives addressing decentralization and promoting bottom-top processes, had been compatible with the philosophies Market Orientation, Patient-Centered and focusing on responsive-preventive healthcare, had 360 degrees stakeholder satisfaction-involvement , sustainable development and knowledge based principles as guidelines decentralization a central aspect etc.) . MCLT clients had perceived the current '***content (***Vision –Mission-Goals)**'** not to have been in line with enlisted aspects. A report on the FIT-GAP areas of the content had been included as a targeted outcome of the project. Dreschler's FIMOUSE had been selected as a basis for early assessments.

- **Auditing the Degree of Stakeholders' Dissimilar Perceptions of Content, (Vision-Mission-Goals):**

  Alignment of the stakeholders' perception of goals subject to their Ontological-Epistemological-Axiological understandings (philosophical alignment implied in the perception of roles). ' *The agents including the Care Providers, Financers, Government, and Community , understood and shared the goals of current system and that of reform*'. The MCLT clients did not perceive such an alignment had existed. The MCLT clients' experience was then to be extended into a larger mapping of the Psycho-Social Context as an impediment to paradigm shift.

- **Auditing the Alignment of milieu of Psycho-Social interaction within the Context observing stakeholder's perceptions of Roles and modes of interaction:**

  The delivery of a summary of investigations helping the better understanding of the perceptual GAPS and those Psycho-Social dimensions of the Context of Practice Impeding Reform towards bottom-top reform/ decentralization, the creation of a responsive and learning system aiding psycho-socio-economic wellbeing' were given higher priority. An analysis of the stakeholders' perception of Roles (within the healthcare system) had received attention as a result of the discussions. The parties had agreed that specific tools had to be adapted for the purpose of such investigation. The modes and methods , paradigms in approaching this level, had probably required an embedded investigation.

- **Auditing the Alignment of the Process of Reform Implementation :**

  Several sub areas had received attention under this block . Firstly, the question of whether or not 'appropriate governance' had been in place in order to support the bottom-top processes with a balanced 360 degree involvement in 'setting goals' (in line with WHO's vision and the stakeholders' own perception of goals, needs), 'clarifying the roles' of the agents in due process of reform. Concerns regarding perceptual GAPS regarding the importance of MO and Patient-Centeredness, conflicts of interest and power, informal economics, asymmetric information, lack of transparency, ethical

concerns had been raised again . The MCLT clients perceived a governance addressing these concerns to have been absent at the Hungarian level. Secondly, especially at the level of the healthcare industry, the importance of 'building a knowledge based community of practice (CoP)' through which the bottom-top processes and 'triple loop learning' were promoted had been proposed and confirmed. The consultant had been requested to propose an effective model for the mentioned CoP. Thirdly, paying attention to the suggestions of Dreschler *et.al* under the FIMOUSE checklist reflect on the current government's status.

Dreschler's FINMOUSE Model used in the course of discussions

"Finance: - is budgeting, accounting, and controlling done transparently, efficiently, and cost-effect-related?

- *MCLT Perceptions: Unanimously perceived low transparency, efficiency and cost-effectiveness . Published statistics had not been trusted*

Incentives: - does the unit get, promote, and keep the best members available with the specific incentives the state has? (job security, promotion, prestige)

- *MCLT Perceptions: Unanimously perceived weak HRM and HRD practices with no strategy . The system does not build on migration and circular migration opportunities. Gratitude money had been an evidence of low transparency and also insufficient salaries and incentives*

Niceness: - is there anything that can be done to improve citizen satisfaction and control without causing financial or other problems?

- *MCLT Perceptions: Unanimously perceived low attention to satisfaction and almost no conscious attention to involvement in governance . Market orientation when measured in terms of stakeholder satisfaction had been low. There'd also been high GAPs amongst stakeholders regarding their perceptions and expectations of service and it's Content.*

Context, Process and Roles. The findings of Saltman et.al. (reviewed below) regarding the "capacity for reform" had received high attention in discussions with the MCLT clients.

Minimal State: - is the task performed not better, or equally well, by a non-state entity?

- *MCLT Perceptions: Unanimously perceived high resistance to privatization, stakeholders have a negative perception in this area. However, the private sector had been present in certain primary care areas and had been an important player in the medical supplies and technologies chain. Private sourcing for supplies as well as subcontracting and outsourcing for non core areas through open tenders had been a practice . The state had been the predominant care provider.*

Output-Orientation: - is the fulfillment of the task measured by output, while keeping in mind that, overdone, controlling costs more than it saves, yet easily prevents the development of civil service ethos?

- *MCLT Perceptions: Unanimously perceived Output to have been defined in a uni - dimensional sense and control to have been a fundamental part of leading. Roles and Goals to have been far from clear. Task Orientation a common method of leading. Control in absolute term had predominated. Stakeholder involvement in the processes not a clear goal. TQM or EFQM like designs contexts non-existent. Due to the absence of strategic HRD, learning organizations and innovation based systems could not be implemented. Feedback systems not in line with 360 degrees feedback and monitoring Balance scorecard not recognized as an alternative for monitoring optimal output.*

Unit Size: - are the units in the hierarchy small enough for humaneness and supervision but big enough to avoid too much red tape?

- *MCLT Perceptions: Unanimously perceived that a conscious approach to Value Chain and Value Network strategies for Decentralization and Integration had been non-existent. In line with the same strategies and policies determining the 'unit size' had not been*

linked to the best output value. The system had been marked by lack of responsiveness to the subunits perceptions, involvement, state of development, appropriate communication and responsiveness

Subsidiarity: - is the lowest functioning unit in the hierarchy performing the given task?

- *MCLT Perceptions: Unanimously perceived that delegation had been low due to the predominance of task orientation. Also, due to the absence of Market Orientation, EFQM, strategic management, (brought up in discussions) redundancy and task confusion had been a common place*

Efficiency: - given the requirements of democracy and *Rechtsstaat*, is the task performed and the office structured efficiently?"

- *MCLT Perceptions: Unanimously perceived the system to have been inefficient. The function and presence of the National Health Fund , the mode and extent of intervention had been all perceived to be inefficient.*

The consultant / researcher had been also informed that the outputs of the project will be used as a reference by the MCLT clients in negotiations with the hierarchy through all available channels with the aim of aiding the healthy process of reform from a bottom-top approach. Finally, the importance of proposing a set of guidelines for adjusting the implementation, operationalization and monitoring processes (be it the extension of the earlier models-processes of the system or the establishment of new models based on the findings). The emphasis had to be on the missing bottom-top areas, taking perspectives coming from individual, institutional leadership, governance as a result of a systematic and in-depth analysis .The mutually agreed goals and outputs (O) had been broken down in the following manner:

O)- Delivery of a set of *guidelines on the best path or road forward* towards decentralization and a sustainable development:

Basis for analysis: the clients' perception of the context of the Hungarian system and their self perceptions regarding: "career development stage" , "targeted / idealized path forward" . Regards for their ' "competencies and resources" in light of their needs-wants-expectations".

Targeted Result(s) and Mode : Delivery of a thorough description of the current state. Mutual agreement on '*the best way forward* as a result of consultation and coaching sessions.

Arrival at the above required:

O-i..)- *Identifying obstacles for shifting towards advanced management models in line with the needs of decentralization*: Verification and Exploration of the root causes behind the 'perceived slow adoption and institutionalization of advanced management models' in the Hungarian Healthcare (in light of the persistent and growing problems as perceived by clients),

O-ii)-*Conceptualizing and Proposing map for guiding pathways towards decentralization.* Integrating the conceptualizations , pathways and plans promoted by the WHO, EU and the state, based on which the hypothetical coordinates of a given system and its agents can be identified

O-iii)-*Positioning the clients on the said Map* : Description , Analysis and Agreement upon common perceptions of the current positions of the clients (as well as their institutions) on the change map,

O-iv)-Identifying the optimal development path forward subject to the predefined criteria towards bottom-top reform / decentralization on the map. Determining optimal position GAPs in order to be able plan for capacity building and continuous development of personal level KSAO's as well as the acquisition of necessary competences at the network level

O-v)- Describing the *Shifting Roles as a result of decentralization:* Description of the Shifting Roles of the stakeholders and clients (along their career path) as the agents and / or facilitators of own and systems' change. ,

O-vi)- Tailoring *Feedback and Monitoring Tools adapted to the purpose of bottom-top promotion of reform in a decentralized context*: Creation of new tools, and/or Selection from the existing tools for continuous Development Tracking on the map and providing Continuous Feedback

- Devising '*an easily comprehendible concept and easy-to-use tool'* for analysis had received high attention during the meeting.

Regarding the distribution of roles and the clients' involvement in the study at the end of the meeting it was noted that one of the clients (from then on referred to as the LINKING PIN CLIENT or LPC) had expressed willingness to act as 'the intimate insider' serving as a bridge between the researcher and the subject of investigation, throughout the study. LPC was also the researcher's business partner and friend. LPC's presence brought promises for the possibility of conducting the study (at least at that phase) in the form of an action research. In terms of the setting of interactions; at the entry stage; the sessions had taken place under both 'formal' and 'informal', environments. An agreement was made to continue in the same manner.

3.5. Summary of the codification phases : Data Collection , Sources , Methods and Extractions

In co-operative inquiry rational verbal reports of experience as well as imaginative storytelling and metaphors have to be accounted for in the process of data collection (i.e. Reason and Hawkins 1988, Cunningham 1984). This had been considered. The processes *of understanding, extraction and codification* were considered through the following stages, with the overall goal of identifying patterns and relationships amongst data which would better explain SMOP level Gaps (namely reasons why stakeholders fail to move to third and fourth loop of learning).

Date Sources and methods of collection: *(see appendix for joint reflection questions and consultation session)*

- Open Interviews with MCLT clients , peers, hierarchy, patients and the members of the served community
- Open ended Questionnaire
- Formal/informal consultation sessions,
- Participation in informal day-to-day events and occasions and visiting clients' working context,
- Clients' memos and daily diaries,
- Monitoring reports regarding Daily Tasks, Administration Outputs , Patient Centeredness Approach, Quality Compliance and questions regarding ethical conduct, malpractice
- Staff satisfaction evaluation
- Staff diary
- Staff interviews
- Staff report
- Data logging
- External Expert evaluation

 Clients' peers: Cross-examination and exploration of the same mainly through informal discussions and visits , reviews of diaries and memos with a diverse range of clients' peers practicing within the same system (n=24) was conducted. The distribution was from similar fields of general and plastic surgery (n=8) and other specializations (n=16), with senior practitioners (n=18) and junior practitioners (n=6) in Hungary. Care was given that individuals whom had been predisposed to some type of prior management training are also engaged and involved in the exploration phase .Also, a diverse range of senior and junior practitioners in other EU systems (n=12) . These peers had been from Greece, UK, Germany and Sweden. The purpose had been to search for signs of additional items and to compare judgments of non-members of the same culture (i.e. how non-CEE doctors perceived the questions of contextual limitations especially their rankings, systems' vs. doctor's goals , having a holistic perspective etc. in interactions with direct and indirect stakeholders)

 Secondary resources: on case incidences and observations elsewhere, especially from within the transitional CEE region and the other EU countries, the US, UK, Canada and India (n=15). Areas of focus and extraction covered the SMOP building blocks as perceived

by the researcher. Secondary resources were applied in order to assist external validation of the results

 Researcher's own paradigm evaluated through the same process and with reference to the researcher's competence and context of practice, memos and diaries (discussed thoroughly under 3.2. above)

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

<u>Reflection on explicit references was made during interactions to aid coding:</u>

-WHO's model for goal setting in healthcare,

-Common Wealth's model of healthcare excellence,

-EFQM's excellence model, the 360 degree balanced score card

-NHS model of clinical governance,

-a variety of patient-centeredness models and market orientation models especially addressing impact of perceptual gaps on optimal performance. The value of learning orientation and entrepreneurial orientation to optimal results

-the FINMOUSE and CCP checklist for reform policy plans,

- Knowledge Based Economics for optimal wellbeing (vs. Positive , Normative approaches to welfare and the role of the government). Tinbergen's hierarchy of preferences and utility

-Quadruple Learning and its components, Management and Leadership competences vs. theories of Role development, Time perception, goals and Paradigms for empowerment , decentralization, psycho-socio-economic transformation (fundamental change or reform)

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

3.6. Details of the Codification Process

A list of the results of the expressed Problems (Pr), as-coded-by-the-clients (complimented with stories and case incidence examples) were extracted from open-ended interviews. These are summarized here in below in two sections. First table.15. a preliminary list of perceived problems, followed by an extended list as a result of the same as a result of interviews:

Table 14.Open coding: List of Un-coded , unranked problems as perceived by the clients

Problems as perceived by the clients	**Suggested Dimensions for selective coding**
-low patient and staff satisfaction, high perception-expectation-satisfaction gap. Staff satisfaction never a goal of reform	Goals: Low SMO, Lack of 360 degrees Mission, lack of 360 degrees value KPI optimization goals, Balanced Scorecard not institutionalized
-low payment and compensations to doctors and nurses (cross industry and EU benchmarks) as a barrier to reform	Context and Process: Perceived Contextual constraints of practice. Contextual barriers to reform. Absence of strategy. Low SMO. FINMOUSE: Incentives
-Culture of under table payments, confusion of ethics of accepting gratitude money, Lack of transparency and overall ethics of practice	Roles: Lack of philosophical alignment,
-high levels of avoidable job stress and role confusion	Roles/Governance: Low SMO, Absence of Governance
- misbeliefs regarding the concept and	Roles/Governance: Low SMO, Absence of Governance , lack of philosophical alignment

practice of quality management in healthcare,	
-Confusion in planning and prioritizing the allocation of budgets,	Goals: lack of 360 degrees KPI value optimization goals, Balanced Scorecard not institutionalized
-Lack of efficient communication pathways , frequent miscommunication,	Context and Process: Stakeholder Communication processes not perceived as an import component of reform
-absence of a formal / strategic approach to governance,	Governance and Strategy: Lack of an institutionalized strategic management system
-Lack of information and knowledge sharing processes , asymmetric information	Governance: Absence of a formalized governance
-lack of 360 degrees stakeholder involvement,	Governance : Absence of a formalized and institutionalized governance
-illness driven insurance system	Goal –setting
-disregard for management training, absence of explicit requirements for leadership and managerial competencies within the policies of high rank recruitments	Lack of Philosophical Alignment, Time and Transformation orientation barriers
- misfit between system –environment-objectives, no strategic management system,	Strategic Management System, EFQM
-migration proneness of practitioners , brain drain	Goal setting concerns, internationalization
- unpreparedness for EU level and non EU level integration	Contextual Constraints, Transformational Orientation concerns, Low SMO
-misperceptions and asymmetric information regarding privatization and two tier systems, continuous failure of reforms	Context of Reform: FINMOUSE /Minimal State

- inefficient treatment pathways	EFQM, Strategic Management System,

Extended statement of the clients' perception of the problem

In order to ensure the codification process occurs based on a more accurate understanding of the two sides regarding the main essence of the content and target of change as conceptualized by the clients (i.e. areas such as governance, career path monitoring, advanced managerial models etc.), given the prior experiences of all parties simplified illustrations were also exchanged between the two sides.

Pr-1)- "Highly centralized and hierarchical decision making processes. Low bottom-top involvement and information sharing in the sector." (This phenomenon was informally coded as '*the inherited feudalist system of the Hungarian Healthcare*' by the clients), leading to;

Axial Coding , key terms, words phrases:

- Perception of Hierarchy and Decision processes, implying "Governance" related issues
- Lack of Bottom-Up processes, knowledge sharing and involvement, implying "Governance" related issues

Pr-2)- "The absence of a conscious and formal approach to organizational and clinical governance". The communication, information sharing and decision processes are very much one way, with a task-oriented leadership style. The Quality Management and Evidence Based Medicine concepts are not institutionalized. They appear rather on paper only, as opposed to being integrated into operations and processes. Standard Operating Procedures (SOP), have also formally been adopted formally. Professional Labor Union is only a notion on paper and very superficial with minimal or no role in decision making. One of us (clients) has been elected as the president but has been pressured so much that is now seeking a position in the UK "

Pr-3)- "Low salary payments and compensations" in comparison to the perceived high degree of tasks' difficulty, occupational hazards, perceived high burden of psychological circumstances (i.e. guilty conscience, oath and feeling of duty regardless of circumstances) and professional

responsibilities (i.e. malpractice law), perceived high demand for input knowledge-skills-other competence mix , the high value of the outcomes of the service for the society, triggering ;

Pr-4)- "The further development of a culture of paying and accepting gratitude money " in certain areas of the service especially surgery and gynecology. According to the clients the existence of this phenomenon was directly linked to (Pr-3) above. In their words: '*this is a form of compensation considered by the patients and their families for the perceived low pay to the practitioners and also a gift to the doctor as a gesture to extend appreciation and gratitude. It is ethical for doctors to accept this money, because it is against etiquette to reject a gift and it is consistent with the role of the doctor to open ways for closer relationship building with the patients for psychological support. At the same time the physicians are left with no better choice except accepting the money if they want to make a living* '.

Pr-5)- "Patient-centered attitude is generally not rewarded by the hierarchy". In the best case scenario tangible or intangible rewards come from patients. However, experience has shown that low patient-centeredness attitude may open more room for filing complaints and law-suites by patients whom perceive to have been mistreated or have been the victim of malpractice. The higher number of complaints may trigger forced job transfer, translocation or forced job quit/job loss which makes the doctors eventually the losers of the game. On average, the hierarchy as well as the peers don't see patients as customers whose satisfaction could be a performance indicator (A curative approach i.e. No DRG's have been defined which target perception-expectation- satisfaction)

Pr-6)- "Feeling of job insecurity", due to continuous change programs under the so-called reform packages targeting the reduction of the number of beds and with beds number of doctors and nurses. In their words: ' *this is a system built under communism which is inefficient and has to change, but there is both no clear concept regarding how and where to start this change or it isn't communicated appropriately. The facts are that at the departmental and operational levels there is confusion about the what, how, when of the change. The feeling is that of a one-step forward, two- steps back approach when it comes to decentralization'*

Pr-7)- " Increasing amount of the burden of administration hours per doctors", in line with the reduction of staff and nurses leading to;

Pr-8)-"Increasing job stress and less time spent per patient" which might become a cause of patient dissatisfaction (consequences of which have been already referred to under Pr-5 as perceived by the clients)

Pr-9)- "Patients' and public's lack of knowledge regarding the method and mode of referral to the doctors" creating extra burdens and redundancies. Patients refer to on-call doctors during night shifts since they perceive this time to have the lowest traffic and can provide maximum direct access to the doctors

Pr-10)-" Confusion regarding the mode, method, processes of the distribution of the centrally planned budget by the National Health Fund (NHF) "with detrimental consequences on the modes of handling the Diagnosis Related Group (DRG) points for prescription and treatment. In their words " *Every now and then there is a new panic spread by the news on NHF's budgeting and DRG refunding policies are now extended or not extended to certain DRG areas. We're then asked accordingly to either report in favor of supported DRGs and to avoid reporting in favor of not supported DRGs creating an additional stress and confusion when prescribing or planning a course of treatment"*

Pr-11)- " Under developed basic convenience logistics of care" due to lack of sufficient centrally distributed money as claimed by the management. In line with the problem of lack of systematic quality monitoring when it comes to providing basic patient convenience , the standards are predominantly low. A newly operated patient may be the victim of high heat stress in the summer due to lack of a basic cooling or ventilating system at the ward. Sometimes doctors get to buy ventilating fans and distribute them from their own pocket money. Patients are sometimes asked to bring their own water and toilet paper with them for the time spent at the in-patient ward"

Pr-12)- “Absence of, or lack of respect for, an ethical codex”. A universally understood and respected guide on the standard Code of Ethics, is not always referred to for policy making. An example again was when a doctor decided to invest from pocket money into purchasing curtains to isolate elderly male and female patients at the ward. Once again such short comings were referred to the lack of sufficient money by the management.

Pr-13)- “ Misperception of current management about the real roots of the problem” Although the many problems all seem to have their roots in the current approach to the system’s design, planning and operations management, all problems are unidimensionally linked to lack of sufficient money and investment as well as the size of the inherited system in terms of the no. of beds and staff making all too expensive. Management doesn’t see a need for taking responsibility or being proactive in this area.

Pr-14)-“Lack of the knowledge of management and lack of interest in this field” by top decision makers running the system. This is complimented by the lack of trust or openness towards non-physician trained managers to join in the system. The administrators, financial experts , logistics personnel are hired at lower ranks in a hierarchical system managed by physicians whom are ranked according to professional knowledge in the field of medicine related research and practice. Terms like strategy, strategic management , strategic decision making are either not understood or remain at level of everyday understanding with no real value or appreciation”

Pr-15)-“Lack of transparency in recording and sharing knowledge in the system” which creates big question marks about centrally published statistics and/or positive or negative performance monitoring reports. Also, lack of sufficient use of the IT infrastructure for joint decision making, knowledge sharing, planning and operations (or patient relationship management for that matter).

Pr-16)- “Lack of a transparent recruitment system”, making entry based on explicit competencies quite rare and difficult. The inherited closed circle and insider approach to selection , still dominant at many levels and areas.

Pr-17)- “Growing tendencies for overseas relocation” due the above.

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

Table 15. List of the extracted variables and their interplay level importance as perceived by the clients

Variables/ Levels	High	Moderate	Low
1. Perceptions of Systems’ level of unfavorable centralization and hierarchical approach	X		
2. Perceptions of level of needed formal approach to Governance :			X
3. Perceptions of the relative Level of Salaries and Compensations			X
4. Perceptions of the level of consistency of the administrative burden of job content and position			X
5. Perceptions of the level of job stress	X		
6. Perceptions of the level of job security			X
7. Perception of the level of ethical aspects of organizational culture			X
8. Perceptions of the level of ethical aspect of doctor-patient relationship			X
9. Perception of the sufficient level of knowledge sharing	X		
10. Perception of the level of transparency	X		

11.Perception of the clarity of Vision, Mission, Strategy by the leadership	X		
12. Perceptions of the level of knowledge and skills of the leadership in the field of management	X		
13. Perceptions of the level of job loyalty	X		
14.Perceptions of the level logistics quality	X		
15.Perception of the level of IT competence	X		
16.Perceptions of the level appropriate budgeting for practice	X		
17.Perceptions of appropriateness of recruitment	X		

3.7. Outcomes : Finalizing the Axial Dimensions and Selected Codes

Preliminary Extractions and Outcomes:

17+1 coded items as the perceived determinants of bottom-top reform failures were extracted from the above qualitative study for further examination.

Table 16. Coded Problems (Preliminary Axial Dimensions)

Aspects		Denoted by	Codification	Process
1.	Decentralization	All Clients	Consultant	Joint Clarification
2.	Appropriate Goal Setting	All Clients	Jointly	Joint Clarification
3.	Stakeholder adherence, Resistance of Doctors to adoption	Clients 2,3,4	Jointly	Joint Clarification
4.	Strategic planning	All Clients	Consultant	Joint Clarification
5.	Responsiveness'	All	Consultant	Joint Clarification
6.	Patient-centeredness	All Clients	Clients	Joint Clarification
7.	Quality management	All	Clients	Joint Clarification
8.	Clinical Governance , empowerment	Clients	Clients	Joint Clarification

		1,3,4		
9.	Care giver satisfaction	All Clients	Clients	Joint Clarification
10.	Transparency	Clients 1,4	Clients	Joint Clarification
11.	360 degrees monitoring /feedback	All	Jointly	Joint Clarification
12.	Clarified Care Giver Role , proactiveness	All	Jointly	Joint Clarification
13.	Logistic Constraints	All Clients	Clients	Joint Clarification
14.	Training & Development Transformation programs	All Clients	Clients	Joint Clarification
15.	Networking and Community of Practice	All	Consultant	Joint Clarification`
16.	Importance of Information Sharing and information processes	All	Jointly	Joint Clarification
17.	Strategic HRD	All	Consultant	Joint Clarification
18.	Stakeholder perception GAP	All	Consultant	Joint Clarification

MCLT clients were consistently mapped in terms of their paradigms from a market orientation perspective. All 4 clients were positioned at various levels of the MMOP paradigm (see below).Three main categories were identified and each category classified as lo-med-hi depending on the level of resistance/openness and maturity of current Role perception (impeding/promoting transformation). Role maturity was based on Hershey and Blanchard's situational leadership and Kohlberg's levels of moral development) :

i. Mechanistic Market Orientation Paradigm (MMOP): Role maturity Level :

'*Transitional Infant*' with goals of securing wealth, maximizing interests and enhancing competitiveness. Explicit exposure brings convergence to evolutionary growth (Darwinian) and future orientation. Based on FINMOUSE 'Minimal state' (predominantly private system) , capitalism , secured growth of the few wealthy (positive, classical and monetarist tendencies). Philosophical Alignment: Egocentric Vision Content: Darwinist Power Generation. Doesn't perceive hierarchy as Inherited. Perceptions of the impact of contextual constraints on self performance: Perceives a high impact . Owes best performance to environments that extend

maximum resources. Due to self centeredness mission is limited to serving the customers, investors and narrow number of direct interest holders. Maximization and Minimization influence the overall performance measurement. Lack of belief in optimization Finance and Operations receive the highest attention. Proactively extending the domain of stakeholders beyond the narrow group defined above. Learning with goals up to "Double Loop" due to narrow socio-cultural openness. Mechanistic and quantitative measurement are better accepted and digested.

Approach to Minimal State (Private-Public Mission): Believes in Minimal State and accepts Darwinist principles in governance. Cost-Benefit of activities towards 360 degrees wellbeing: Cost-Effectiveness is influenced by the Darwinist perceptions , profit orientation, mechanistic / linear perception in calculating the value of life.

Statement representing this category :

"**My job is to serve the patient for my own (psychological and physiological) interests. I should and will change the system** "

ii. Organic Market Orientation (OMOP): Role maturity : 'Transitional Adult' with goals of altruism, conventionalism, gaining external harmony. With explicit exposure; convergence towards: ideas of redistributing the wealth of a few wealthy, past a good picture of the future, pre-destined futures (not necessarily in a religious sense), liberalism, normative, welfare economics, government intervention and solidarity occurred. Statement representing this category :

"It is the systems' job to serve interests of the patient and my interest. My job is to assist the system if I want to assist myself. System should change and then I will too"

iii. Systemic Market Orientation Paradigm (SMOP): Role mat. 'Adult' with goals of 360 degrees optimization of well-being and satisfaction , past and present are part of the future , the future is every next moment and has to be continuously enacted. With explicit exposure convergence to: enhancing knowledge based development and performance, value networks as basis of the system, decentralization for continuous innovation with fostered synergy

building by leaders and entrepreneurs continuously developed through training. Statements representing this category:

"**There is no system without me or vice versa. I'm an outcome of the past and a part of the future but the past-present and future build the reality of the same story in life. We should offer the same stewardship and care to the environment as we expect from the environment. My job is to sometimes decide on behalf of the patient but also it is to train and involve the patient and the family in caring for themselves and me as a part of the society**"

Table 17. Assigned SMOP value ranges

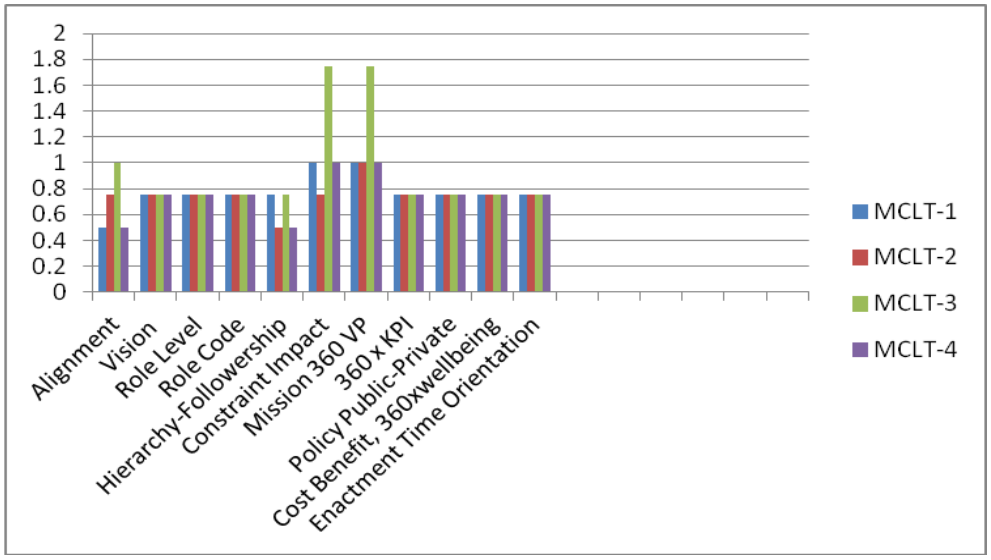
Paradigm (values)	***SMOP(-) MMOP (0.0-0.75)***	***SMOP(-) Trans. OMOP (0.76-1.0)***	***SMOP (-) OMOP (1.01-1.75)***	***SMOP (+) Trans. (1.76 -2)***	***SMOP (+) (2)***

Table 18. Selective coding –SMOP

R-G-T Paradigm Dimensions	Selected SMOP Codes	Defining Axial Relationships (RGT SMOP based)
Roles	Philosophical Alignment	Stakeholder adherence, Ethical Adherence, Transparency, De-ontological aspects of practice, systemic approach to role
	Vision	Picture of self as part of the international , national system and community
	Role Level	Care Giver Role, Development of Peer-Subordinates –Patients-Community Resistance of Doctors to adoption
	Role Code	Responsiveness, Strategic planning
	Hierarchy- followership	Responsiveness', Decentralization, Governance
	Constraints –Perceived as determinants (hi-med-lo)	Financial, Logistic, Administrative Constraints
Goals	Mission 360 x KPI	Optimized Goal Setting for 360 degrees satisfaction, Patient-centeredness, Quality management, Care giver satisfaction
	Policy Public-Private	Minimal State, Clinical Governance , empowerment
	Cost Benefit, 360xwellbeing	Healthcare and economic decisions as contributors to sustainable wellbeing
Enactment Time Orientation	Time	Past-Present-Future as a single time vs. Past, Present or Future orientations

Transformation	*Single Loop:*	Initiating inquiry, Strategy, Project based approach, Participating in Tacit Knowledge Creation
	Double Loop:	Change of assumptions, Leading Change , Life Cycle Management, Participative Inquiry, 360 optimization 360 degrees monitoring /feedback
	Triple Loop:	Revolution, Importance of Information Sharing and information processes for synergy building
	Quadruple Loop Learning	Networking and Community of Practice , breakthrough projects, self awareness and continuous paradigm level development of self and others, innovative co-creation

Figure 25. MCLT Paradigm Level 2002



The group tendency shows a dominant MMOP level paradigm with a Hi SMOP gap. MCLT3 showed lower gaps with regards to perceptions of contextual constraints as a barrier to reform (Role dimension) and close perceptions to the implied 360 degrees Value Proposition in the understanding of mission. The Healthcare Learning and Innovation Platform with a core level designed and delivered under "*The Certificate of Healthcare Management for Health Leaders and Practitioners*" was designed in 2004 and after rounds of negotiation with the management of

the faculty of business and economics of the University of Pécs the learning platform was accredited and first offered to 10 health leaders and practitioners in 2006 . It should be noted that the MCLT and their affiliated department expressed maximum support for participation in the HLIP , however neither the MCLT nor their direct peers have been participants of the HLIP. This provided the research with a unique opportunity for the comparison of the effect of HLIP on MCLT clients as a control group . Participation at the conditions were limited to the following:

i.Post Graduate degree in any area
ii. Language : English and Hungarian

At the suggestion of MCLT-1 the content of the course was measured against the state of art methdologies especially life long learning (LLL) courses offered to Healthcare Leaders and parctitioners. Contents of material and methods offered by the Medical Royal College of Surgeons (MRSC) in Ireland had been suggested by MCLT-1 (he'd spent a working year in Ireland during the first phase of the research). MRSC offerings had been successfully integrated in the structure and design of the promotional material for introducing the SMOP based HLIP as requested by MCLT-1. In essence the HLIP took the form of a mini-EMBA with capacities for entering learning pathways for on-job learning at the industry and/or continuing various short and long term courses at the university. (Career Path Barometer designed for self reflection of participants and MCLT clients). Based on the MRCS approach three price categories had been distinguished:

- Lowest prices extended to low earners of the public Hungarian healthcare , namely the Nurses (based on studies nurses in Hungary are not fully participating in triaging and treatment pathways. This in turn has translated into a vicious cycle of inefficiencies). Freshly graduated physicians also fell under this category
- Higher prices (by 15% in comparison to the first group) extended to public consultants, department leaders and seniors
- Highest prices (by 30% in comparison to the first group) extended to private earners, non Hungarian earners (working under at other systems) and participants coming from fields other than healthcare as well

No age limits, nor field of specialization limits had been set, inorder to promote the culture of cross industrial, cross specialty communication, appreciative inquiry and problem solving . To set examples for effective diversity learning, synergy building, leading to co-creation of innovative solutions. The goal had been to facilitate 'knowledge spill over', 'tactit exchanges' and the creation of common language , vision and dierction needed for successful inclusive and participative bottom-up processes.

Survey on the Stakeholder's perceptual Gaps : during the 2003/4 period based the researcher and his colleagues (Golesorkhi, Fojtik, Rekettye 2004) conducted and survey for examining stakeholder perception gaps on the central goal of healthcare via four types of Likert scale questionnaires from, randomly selected representatives of the public at large between the ages of 18 and 75 years, across twelve cities (n=1000), patients (n=1000), doctors (n=100), hospital / department managers / leaders (n=25), health officials (n=10), from primary care and tertiary care departments of four Hungarian state owned hospitals and their affiliated clinics (with the exception of traumatology patients). The observation was conducted over a consistent parallel two week period (with the exception of traumatology patients). All stakeholders except patients were practitioners. All stakeholders were offered clarifications on possible ambiguities. Care was taken in distribution of questionnaires amongst competent patients. Traumatology patients were not involved due to the emergency intensive nature of admissions (61%) where perception results could have had distorting implications. The patient centeredness model designed and examined by Little et.al. 2001 was extended by SMOP factors for the study. The results confirmed the existence of wide perception gaps between the stakeholders of Hungarian healthcare on the caregivers central objective and approach to treatment. While the caregivers perceive 'illness centeredness' a natural treatment requirement and lack of 'communication and partnership building' with the patients a 'consequence of working environment constraints' (most importantly amongst these constraints the low care giver salaries) , the care seekers consider 'communication and partnership' as well as 'patient centeredness' and 'satisfaction' the strongest determinants of improved care results. Based on the discussions in the previous chapters historical misconceptions on the side of care givers regarding their approach to treatment which has created tendencies and beliefs to highly disregard the importance of patients' satisfaction was verified as playing predominant role also in the Hungarian

environment. Therefore, alike examples from wealthier healthcare systems as long as such perceptions exist improved low market orientation levels even with improved wages and salaries will preside . The results confirmed the need for a holistic approach to analyzing stakeholder expectation-satisfaction .The importance of the perceptions the 'contact people' (doctors and nurses) and the impact of SMO for higher performance of the mentioned were highlighted.

Table19. Summary of utilized categories of factors for contrasting perceptions

1. ***general perceptions on the central goal of healthcare*** (treating 'patient' vs. 'illness, 'cure' vs. 'satisfaction')
2. care providers' ***approach to communication and partnership*** (a doctor who discusses and agrees the problem and treatment, sympathetic and interested in patient's worries and expectations)
3. ***personal relationship*** (doctor who knows the patient and their emotional needs)
4. ***health promotion*** (ways to prevent risks and future illness)
5. ***positive and clear approach to the problem*** (being definite about problem and when it would settle)
6. ***interest in effect on patient's life*** (interested on effect on everyday life and family)
7. ***general perceptions on the constraints*** encompassing the care giver (time, number of caregivers employed, number of logistics personnel, organizational rules and healthcare laws)

Source : The authors

Results:

The results confirmed the existence of wide perception gaps.

1. ***Doctors*** perceive lack of patient centered attitude strongly linked to '*requirements of practice*' (termed general approach to treatment) and equally with high strength to '*working environment constraints*' (including low wages).

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

4. Testing saturation and results: the 'Healthcare Learning and Innovation Platform' (HLIP) foundation level (2006- 2011)

Based on the planned goals of the MCLT the design and delivery of an environment which facilitates and fosters co-learning using the developed typology had been considered for further testing and exploration of newer codes (the Healthcare Learning and Innovation Platform) . The explicit tools and models used at the MCLT phase were taken advantage of for the operationalization of the extended examinations under final phases of the study. A foundation level was designed as a core component of the HLIP (Healthcare Learning and Innovation Platform) . The evealuation sub-areas of the foundation level:

a. *Pre-test:* Included 'entry level' a request for the delivery of C.V. and motivation letter, together with a short interview (open ended) to determine the reasons for chosing to attend the course (namely legal pressures, career development, own initiative or other etc.). Earleir Providing information about learning needs and approach (Philosophical Alignment). Results were recorded for subsequent extraction of codes. Pre-test also

included a semi structured questionnaire investigating responses to perceptions regarding ’the context of practice’, ’self and stakeholder roles’, ’self and stakeholder goals’.

b. *Pre-project Planning:* Included discussions on earlier K.S.A.Os and demands of the position. Preparing Vision and Mission statements as well as a preliminary SWOT analysis to reveal how participants perceived R-G-T

c. *Project Planning:* A change project topic was chosen jointly after two weeks of consultation. The most important criteria had been that the individual incorporates self role in the change process, taking on a leadership approach (essential for successful bottom-up involvement). Vision statement, discussion of own roles, accepting the prior importance of effectiveness (not efficiency) had been consistently a proven challenge that had to be overcome. Also, task orientation represented the major tendency across all groups

d. *Consultation, participative inquiry:* The change project was built within the framework of the strategic management system model adopted from Wheelen and Hunger. The model maps the relationship of concepts and processes in the system leading to a continuously optimized performance towards sustainablity , ultimately reaching a quadruple loop environment for continuous innovation. One-on-one as well as group level co-operation is forstered in classroom, on-job / on-site and informal environments with online forums and consultation

e. *Project delivery and Post-Test:* Submitted Change projects ahd to be defended and discussed in a formal session to show key aspects related to changes in the understanding of the system, own roles and goals. An open eye was held for newer and additional codes which could be used to extend the SMOP typology. Post test included an open book exam with case incidences from public policy, management, treatment (proactive prevention, promotion, stewardship), FIMOUSE aspects. Knowledge of key terms and tools were given high priority (presentational knowledge essential for promoting effective communication). Process of learning and self reflection including the tacit levels had to be summarized and submitted in the form of a ’course diary’ or ’Reflective Overview’ in order be able to better observe emerging or additional codes for observation.

f. *Community of Practice:* Participants demanded the continuation of HLIP in more forms , sites and incidences to assist bottom-up participation in reform and to sustain quadruple

loop learning, help the implementation of project plans submitted through joint efforts. In 2009 the first healthcare managers' club of the region was established and was officially registered in 2010 under the „Healthcare Leadership and Management Development Institute" (HLMDI: www.hlmdi.org). Joining this CoP was taken as an incidence of higher SMOP levels

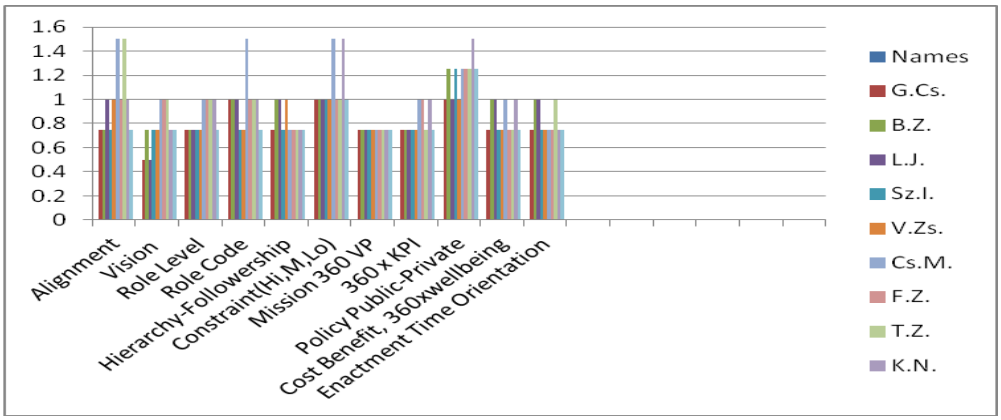
The foundation level of the learning and innovation platform was designed promoted for a preliminary test with the following 10 participants All medical doctors. 8 out of 10 participants had been seniors. Two entrepreneurs (a family doctor and a surgeon promoting innovative equipment for non-invasive treatment of coronary heart disease). In terms of specialization two family doctors and two gynaecologists. An even age distribution can be seen . Ranges 37-52 with 6 people around 44-46 of age. F/M ratio: 3/7

Table 20. Summary of utilized categories of factors for contrasting perceptionsThe list of first foundation HLIP participants in 2006

2006	Initials	Age	Gender	Specialization	Institute	Position	Joined the CoP
1.	G.Cs.	46 year	Male	Rheumatologist	Komló Hospital	Dept.Leader	-
2	B.Z.	37 years	Female	Family Doctor	Entrepreneur	Entrepreneur	+
3	L.J.	52	Male	Internist	Siklós Hospital	Head of Doctors	-
4	Sz.I.	45	Female	Family Doctor	Entrepreneur	Entrepreneur	-
5	V.Zs.	50	Female	Internist	Baranya CountyHopsital	Dept.Leader	+
6	Cs.M.	44	Male	Gynaecologist	Nyíregyház Hospital	Dept.Leader	+
7	F.Z.	45	Male	Urologits	PTE Urololgy Dept	Adjunct,consultant	-
8	T.Z.	45	Male	Anaesthesiologits	PTE Urology Dept	Adjunct,consultant	+
9	K.N.*	39	Male	Surgeon	Entrepreneur	Entrepreneur	-
10	M.Z	44	Male	Gynaecologist	PTE Gynaecology Dept	Adjunct,consultant	-

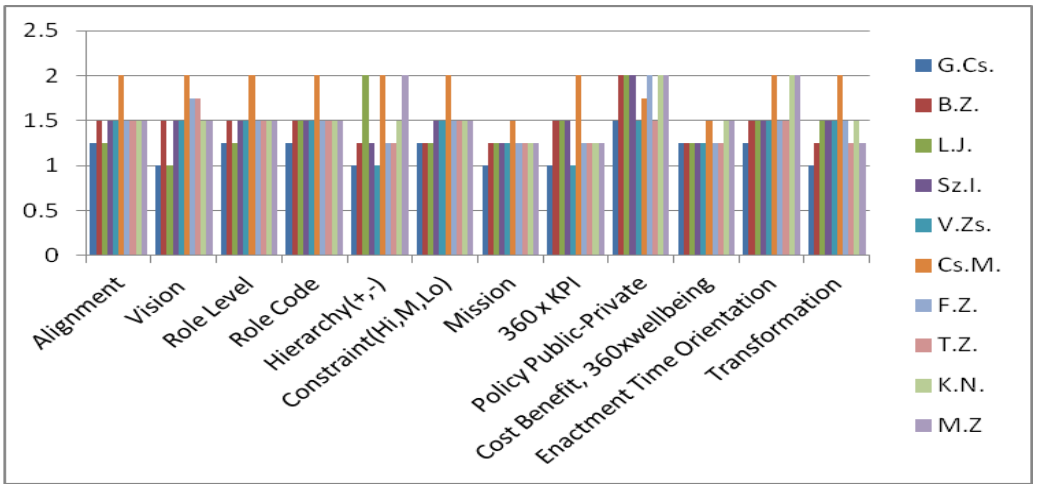
**Not born in Hungary*

Figure 26. 2006 foundation HLIP Participants' Paradigm Levels (Pretest)



The pretest results show that the SMOP paradigm level gap is high and generally close to the MMOP level. A majority of the participants had reached the MMOP level with regards to their perceived 'minimal state', the role of the government coded as 'public-private'.

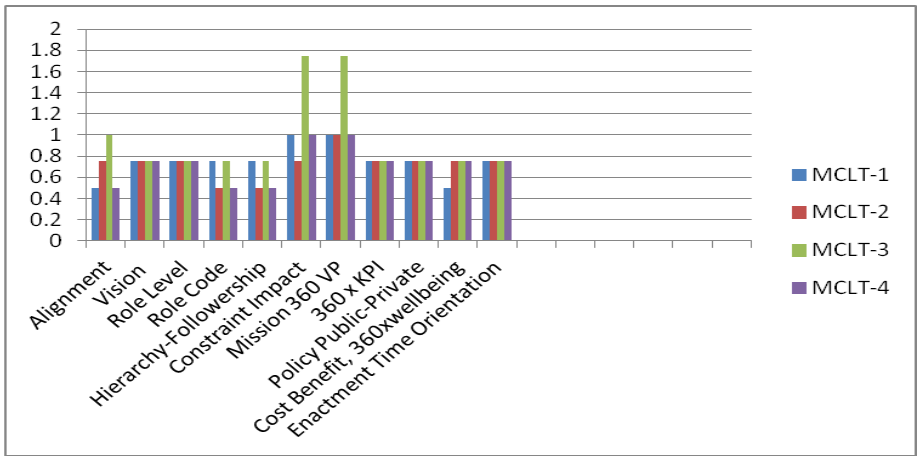
Figure 27. 2006 foundation HLIP Participants' Paradigm Level (Post Test)



The post test results show that the outcome of training has significantly reduced the SMOP paradigm level gap . 4 out of 10 participants were amongst the founding members of a community of practice the "Healthcare Leadership and Management Development Institute" assisting the implementation of designed projects and active participation in self and community

transformation. As far as influence on continuous learning one member joined a 2 year MBA with healthcare specialization in 2010 (complimentary phase of the HLIP)

Figure 28. MCLT 2006 control examination (none participated in MCLT)



MCLT levels did not show changes inspite of the political climate change. None participated in the LIP but continuously expressed their wish to do so if time constraints and financial constraints would allow such a possibility. This itself represents a condition where single loop learning is not automaticallz complimented by double loop and triple learning under a normal development and-or unstructured milieu of learning . (benefits of capacity building).

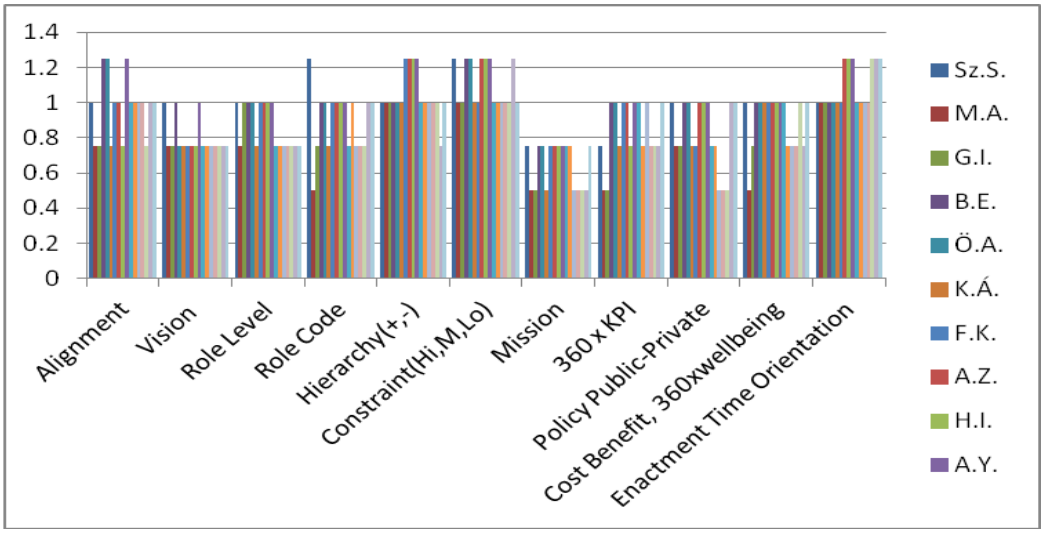
Table 21. List of 2008 foundation level HLIP participants

2008	Initials	Age	Gender	Specialization	Institute	Position	Joined the CoP
11	Sz.S.	54	Male	Heart Surgeon	PTE Heart Clinic	Head of clinic	+
12	M.A.	56	Male	Immunologist	PTE ÁOK	Vice Dean	+
13	G.I.	57	Male	ENT	PTE ENT	Deputy of Dept	+
14	B.E.	54	Female	Psychiatrist	MÁV Clinic	Head of Doctors	+
15	Ö.A.	47	Female	Internist	Sellyei Outpatient clinic	Head of institute	+
16	K.Á.	48	Female	Pediatrics	EEI Pécs	Head of institute	+
17	F.K.	39	Female	Anaesthesilogist	PTE Heart Clinic	Assistant professor	+
18	A.Z.	40	Male	Heart Surgeon	PTE Heart Clinic	Adjunct, Consultant	+
19	H.I.	41	Male	Heart Surgeon	PTE Heart Clinic	Adjunct, Consultant	-
20	A.Y.	45	Male	Oncologist	PTE Oncology	Adjunct, Consultant	+
21	V.M.	32	Female	Transplantation coordinator	PTE Nephrology	Transplantion coordinator	+

22	K.L.	30	Male	Healthcare IT	PTE Internal Medicine	Healthcare IT	+
23	V.M.	29	Female	Nurse	Irgalmasrendi Hospital	Nurse	-
24	P.I.	31	Female	Researching Physician	PTE ÁOK Public Health	Assistant professor	+
25	H.G.	29	Male	Surgeon	Szekszárd Hospital	Assistant professor	+
26	Sz.D.	22	Male	Economist	PTE KTK	New MSc.grad.	+
27	H.B.	44	Male	Surgeon	Komlói Hospital	Deputy head of doctors	+

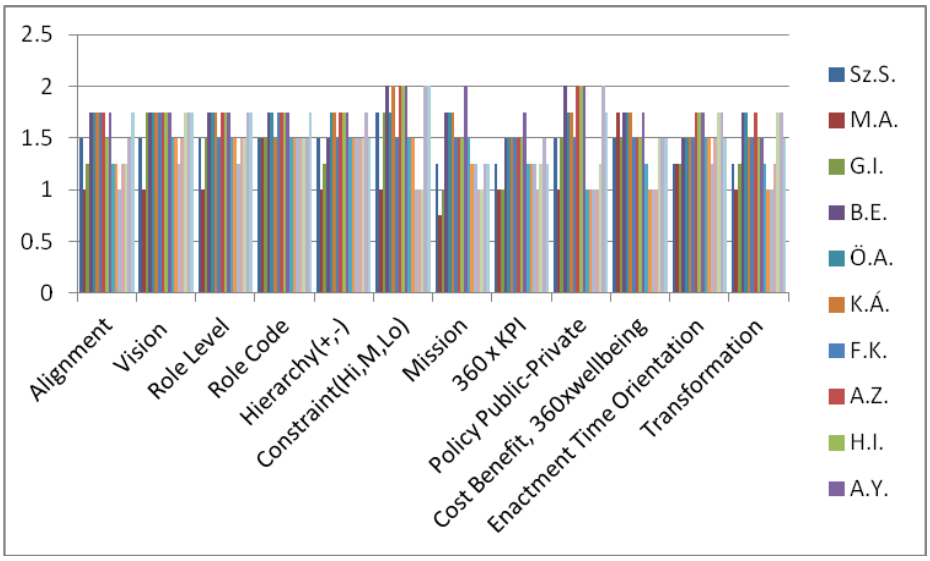
This group did not include entreprenuers but showed diversity in terms of specialization (healthcare IT, economist, administrating nurse, nurses). Consequently, in comparison to the 2006 participants wider variation in the distribution of age can also be seen (22-57), with 7/16 being under 40 years of age. Surgeons represented the highest relative number F-M ratio: 7/10

Figure 29. 2008 foundation level HLIP Participants' Paradigm Level (Pretest)



2008 participant's pretest shows high score and a lower level of SMOP-GAP with tendencies towards transitional OMOP. However, high level of SMOP gap can still be observed

Figure 30. 2008 foundation level HLIP Participants' Paradigm Level (Post test)



2008 participants' post test results reveal the effectiveness of the HLIP –SMOP resulting in reduced SMOP gaps and improving the levels to OMOP and transitional SMOP. Higher levels of transformation and entrance into triple loop learning can be seen. It was interesting to note that this group represented the largest number of founding members of the CoP . The highest relative number of high rank participants had also been another feature of this group. Additional codes and determinants were not distinguished (saturation conditions were satisfied). During the same period MCLT clients were also re-examined for documenting possible changes coming from life cycle related and/or contextual changes. Outcomes remained unchanged.

Figure 31. MCLT 2008 examination-results remain predominatly unchaged

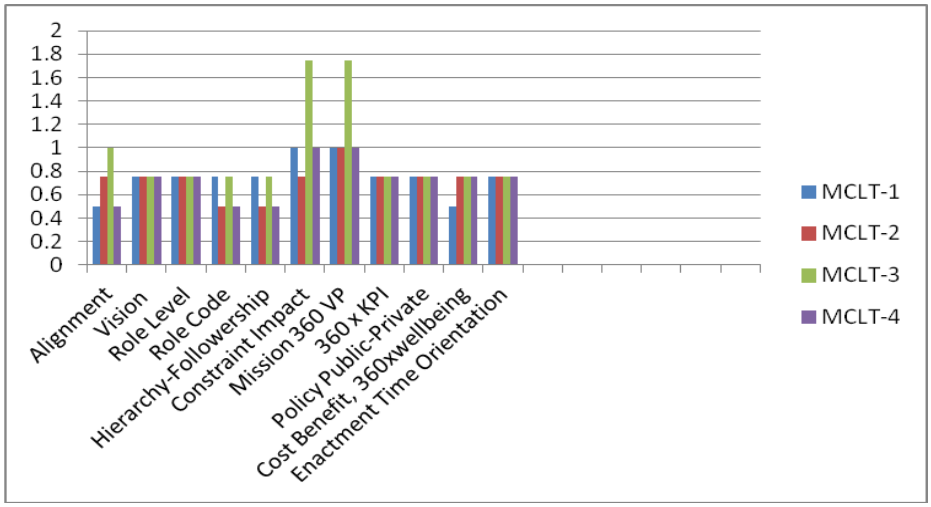
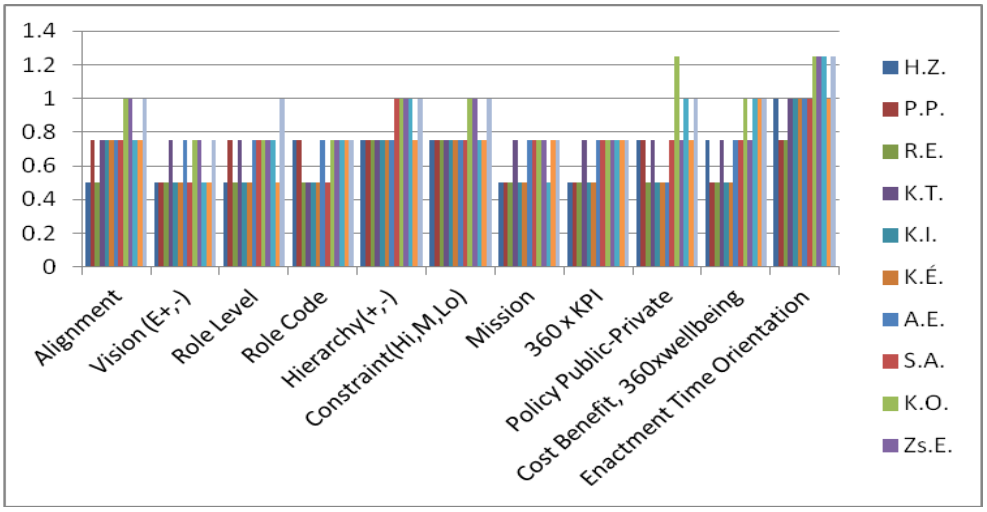


Table 22. List of the 2009 foundation level HLIP Group A participants

2009	Initials	Age	Gender	Specialization	Institute	Position	Joined the CoP
28	H.Z.	35	Male	Social worker	Baranya County Government	Vice president	-
29	P.P.	49	Male	Econimist	PTE ÁOK	head of finance	-
30	R.E.	50	Female	Professional assistant	PTE	Professional assistant	-
31	K.T.	46	Male	Pediatrics	PTE Pediatrics	Adjunct	-
32	K.I.	45	Female	Nurse	PTE ETK	Vice dean	-
33	K.É.	48	Female	Healthcare IT	OEP Szekszárd	Head of dep.	+
34	A.E.	54	Female	Quality inspector	PTE	Consultant	+
35	S.A.	51	Male	Occupational health	EEI Pécs	Consultant	-
36	K.O.	51	Male	Plastic surgeon	entreprenaur	Entreprenaur	+
37	Zs.E.	46	Female	Healthcare IT	EEI Pécs	System manager	+
38	V.A.	42	Female	Internist	Szigetvár Hospital	Consultant	+
39	N.Z.	21	Male	Economist	PTE KTK	New MSc grad.	+
40	K.L.	52	Male	Anesthesiologist	Dombóvár Hospital	Head of doctors	+

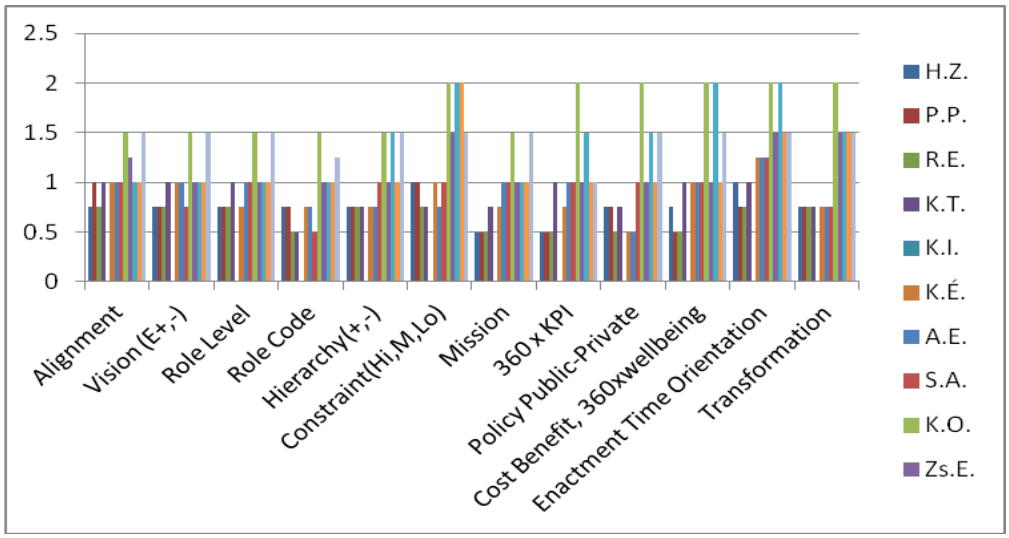
Although this group represented the most evenly distributed age-wise combination out of having a participant with 21 years of age brought additional diversity. 9/12 were between 45-52 with 3 / 12 belonging to a lower age range. F/M ratio: 5/7. The group included two economists and 2 IT specialists

Figure 32. 2009 Group A foundation level HLIP Participants' Paradigm level (Pre Test)



The pre test results of the 2009 Group A p revealed weaker levels of development and wider levels of SMOP gap at the starting point. One participant R.E. (50 year old professional assistant) had revealed lower SMOP gaps with regards to perceptions of the 'role of the government' and minimal state (under the GOALS) dimension as well as the relationship with time (past-present-future orientation).

Figure 33. 2009 Group A foundation HLIP Participants' Paradigm Level (Post Test)



The post test shows that the relative developments had been high as an outcome of the HLIP. However, the overall state of the results had been weaker than the outcomes of the earleir groups, due to a wider gap at the starting stage. Amongst the participants K.I. showed the highest relative development as a result of the HLIP. (52 year old anaethesiologist head of doctors at a rural hospital) followed by R.E. Entrance into upper levels of transformational learning can be see. From this group 7/12 joined the CoP. Additional codes and determinants were not distinguished (saturation conditions were satisfied).

Table 23. List of the 2009 Group B participants of foundation HLIP

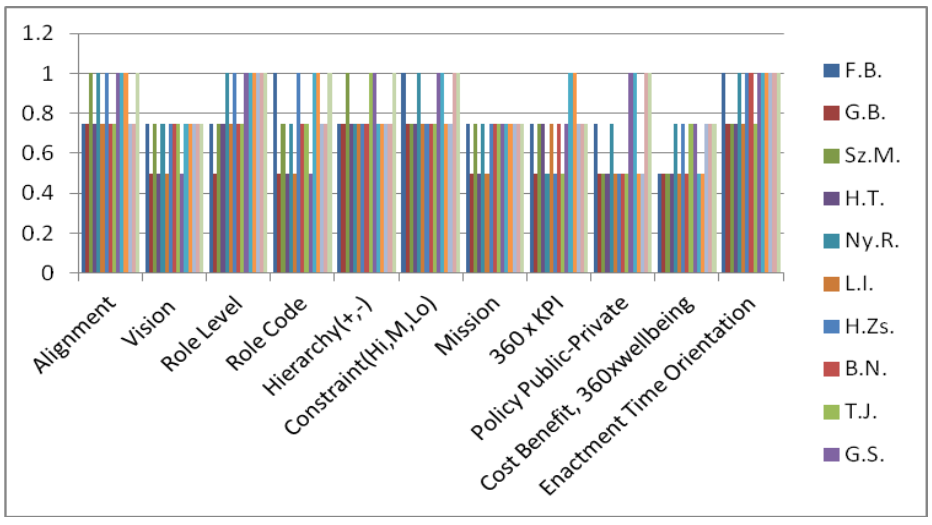
2009 fall	**Name**	Age	Gender	Specialization	Institute	Position	Joined the CoP
41	F.B.	35	Female	anesthesiologist	PTE Anest. Inst.	Assistant Professor	-
42	G.B.	24	Female	Freshly graduated Economist	PTE KK	Healthcare data security	+
43	Sz.M.	28	Female	immunologist	PTE Immunology Inst.	Phd student	-
44	H.T.	32	Female	IT	PTE Onkology	Administrator	-
45	Ny.R.	35	Female	Economist	PTE Onkology	Head of finance	-
46	L.I.	47	Female	Lab analist	PTE Medical Lab	Deputy manager	-

				technisian			
47	H.Zs.	37	Female	econnomist	PTE GF	Deputy manager	+
48	B.N.	25	Female	econnomist	PTE GF	administrator	-
49	T.J.	32	Female	Nurse	PTE Internal Medicine	Nurse	-
50	*G.S.	36	Male	Anesthesiologist	PTE Anest. Inst.	Assistant Professor	+
51	M.A.	31	Male	Nurse	PTE Internal Medicine	Nurse	+
52	B.A.	28	Female	Biologist	PTE Bioanalisis	Assistant Professor	-
53	B.I.	29	Female	Researching doctor	PTE Bioanalisis	Phd student	-
54	T.F.	54	Male	Pediatrics	Komlói Hospital	Head of Hospital	+
55	G.O.	25	Male	GP	PTE Radiology	Resident	+

*Not born in Hungary

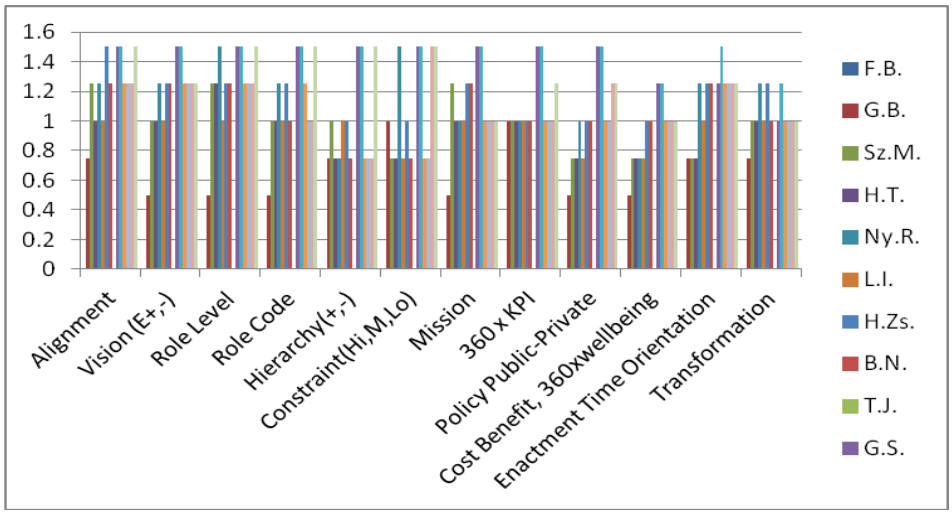
In this group 13/15 came from a lower than 40 years age. This group represents non doctors by a large number with Economists leading 4/15. F/M ratio:11/4 for the first time exceeded the Female participants exceeded the Male by almost three times. 4 out of 15 were in leadership positions.

Figure 34. 2009 Group B participants of foundation HLIP Participants' Paradigm Level (Pre-Test)



Pre-tests of Group B 2009 better results and show a lower SMOP GAPs in comparison to Group A with a tendency towards transitional OMOP.

Figure 35. 2009 foundation HLIP Group B Participants' Paradigm Level (Post-Test)



Post test reveals improved results changing tendencies towards OMOP . In one incidence 'G.B.' (24 year old female , freshly graduted economist) it was interesting to note that the resistance was high and that results of the HLIP did not her status very significantly. Complimentary examinations revealed that 'systematic and consistent' participation in the HLIP had been low , especially during the orientation period. G.B. had registered for PhD studies in economics during the orientation period. The interplay of this disturbance with her entry status - 24 year old fresh graduate with 'high SMOP gap' best explain her outcomes. G.B. represented a unique case where the paralell occurrence of critical events during the orientation for young participants d may reduce the relative impact of the HLIP. The implications of this case supported an integrated approach to designing learning and development paths (career development barometer) allowing a 360 degrees monitoring and redistribution especially in the case of younger learners' improving the effectiveness of the HLIP. Entrance into the upper levels of transformational learning can be seen. 6 /15 joined the *'Healthcare Leadership and Management Development'* CoP. Additional codes and determinants were not distinguished (saturation conditions were satisfied).

Figure 36. MCLT 2009 examination-results remain predominatly unchaged

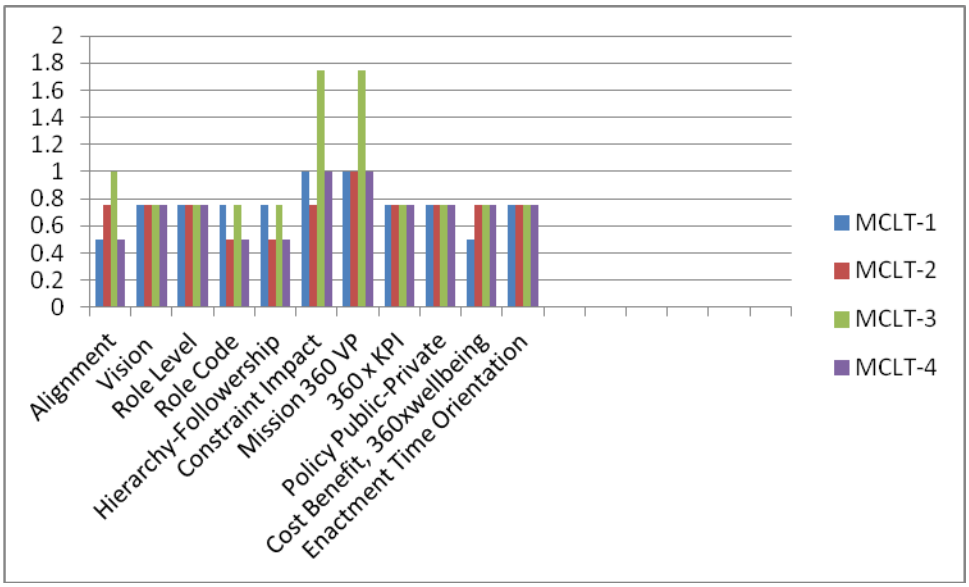


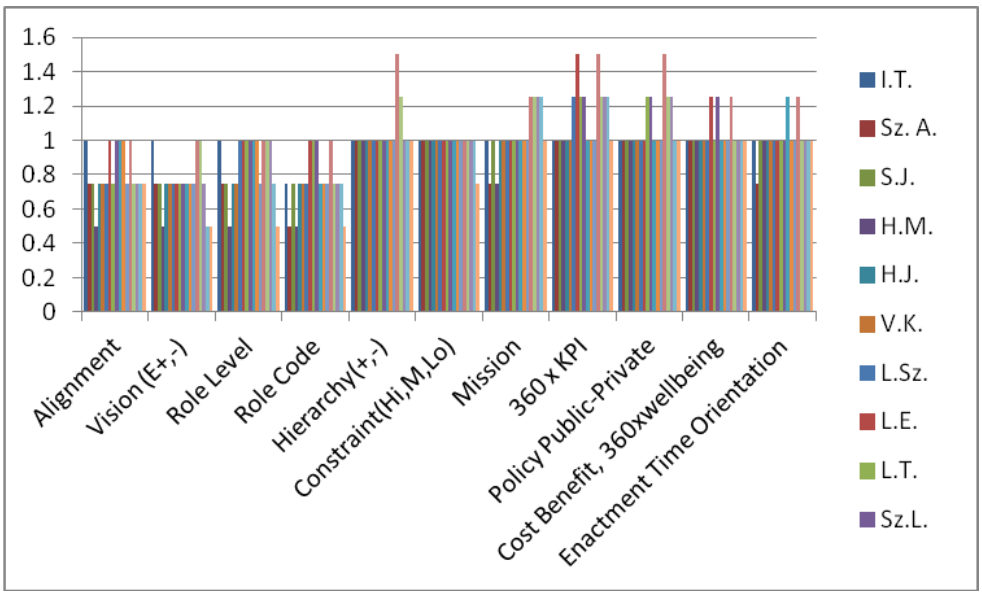
Table 24. List of the 2010 foundation level HLIP participants

2010 spring	Initials	Age	Gender	Specialization	Institute	Position	Joined the CoP
56	I.T.	52	Male	Orthopedic surgeon	PTE Orthopedics	Head of departmant	+
57	Sz. A.	27	Female	economist	PTE GF	Administrator	-
58	S.J.	56	Female	economist	Sikonda recreation Center	Head of Center	+
59	H.M.	56	Female	nurse	PTE OEKK	Coordinator	-
60	H.J.	50	Male	Surgeon	Budapesti Péterfy S. Utcai Hospital	Consultant	+
61	V.K.	47	Male	Surgeon	Szekszárd Hospital	Consultant	+
62	L.Sz.	36	Female	Nurse	PTE Internal Medicine	Nurse	-
63	L.E.	45	Female	economist	PTE Orthopedics	Head of finance	+
64	L.T.	42	Female	economist	Patient representative	Head of fundation	+
65	Sz.L.	50	Female	economist	Nagykanizsai Hospital	Head of finance	-
66	B.J.	66	Male	Surgeon	Nagykanizsa Hospital	Head of doctors	-
67	Cs. Cs.	44	Male	Internist	Szigetvár Hospital	Consultant	+
68	B. B.	38	Male	Traumatologist	PTE Surgeon	Consultant	-

69	N. Zs.	41	Female	Internist	Entreprenaur	Entreprenaur	+
70	B.E.	33	Male	Oxyologist	OMSZ	Consultant	+
71	T. Zs.	48	Male	Gynacologist	PTE Gynacology	Consultant	+
72	M.T.	51	Male	Gynacologist	Baja Hospital	Head of doctors	-
73	S.E.	43	Female	Economist	Baja Hospital	Head of finance	-

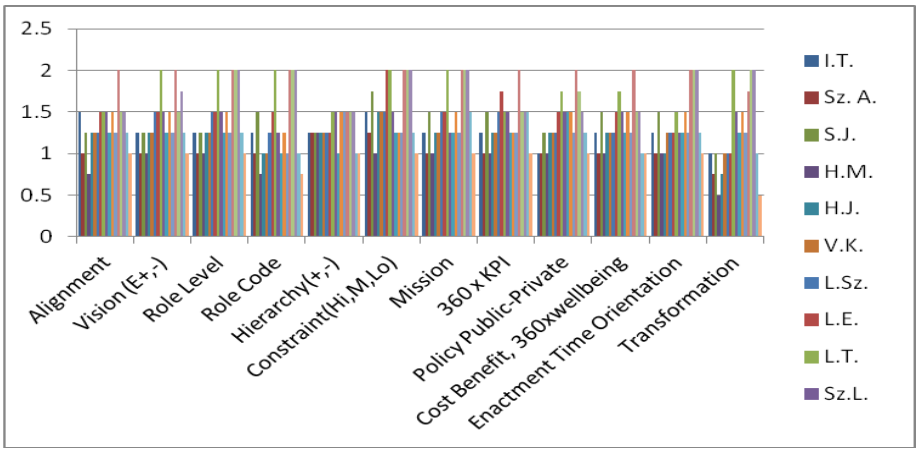
Age range between 27-66 with two participants below the age of 35 and 11 participants above 44 years of age. F/M ratio : 9/9. The distribution of professions was almost even 10 medical doctors and 8 non medical doctors (2/8 nurses). Economists represented the highest number in one profession with 6 participants followed by 4 surgeons. The group included 7/18 in leadership positions.

Figure 37. 2010 Group A foundation HLIP Participants' Paradigm Level (Pre-Test)



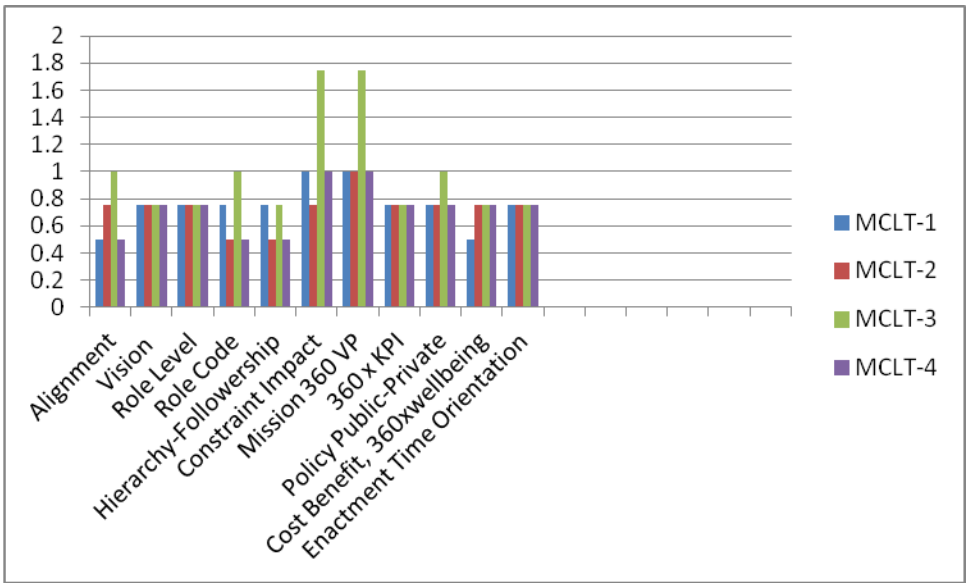
The pre-test results show strong starting points close to transitional OMOP and OMOP, with very close R-G-T levels.

Figure 38. 2010 Group A foundation HLIP Participants' Paradigm Level (Post-Test)



The post test results of the 2010 participants show the effectiveness of the HLIP with a good number of participants reaching higher levels of SMOP (lower GAP). Entrance into the upper levels of transformational learning can be seen. From these participants 8/18 joined the CoP. Additional codes and determinants were not distinguished (saturation conditions for selected codes were satisfied).

Figure 39. MCLT 2010 control group examination



MCLT -3 revealed 'Role Code' improvement from (0.75) to (1.00) and similar improvements in the area of the perceptions of the "role of government" and targeted "public-private" fields for reform. It should be noted that MCLT-3 was a part of circular migration waves to the U.K.over

the previous three years and the mentioned outcomes could have been influenced by tacit learning originating from his participation in the NHS or membership in networks indirectly influenced by his presence in the NHS. MCLT-1 had also shown changes reactions in the earlier years of leaving the Hungarian system and returning. However, the impact of this factor had also diminished during the last years (especially between 2009-2010)

Table 25. 2011 list of foundation level HLIP Participants

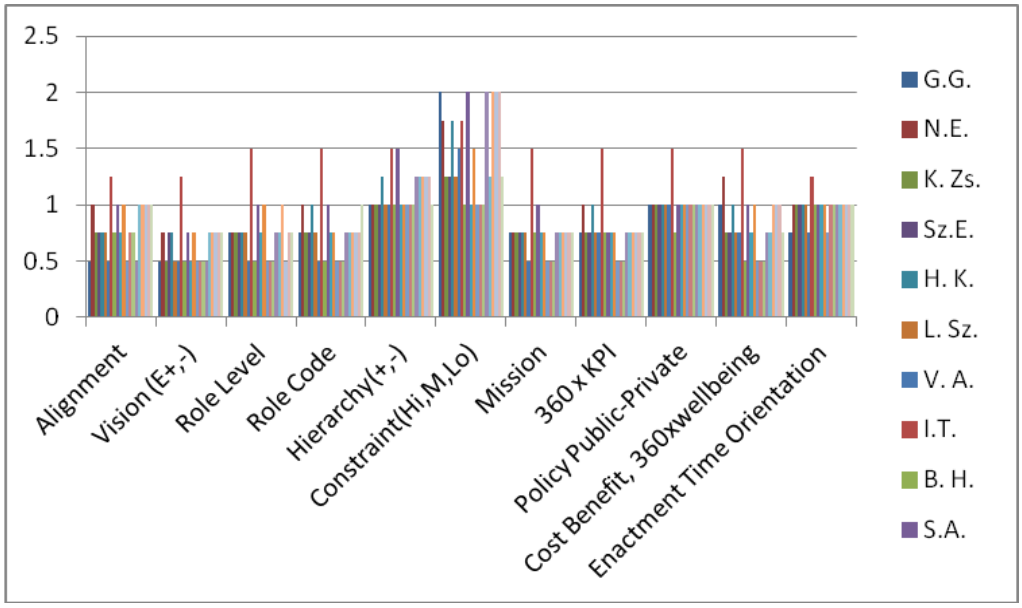
2011	Initials	Age	Gender	Specialization	Institute	Position	Joined the CoP
74	G.G.	34	Male	Surgeon	EGIS	Pharmaceutical sales	+
75	N.E.	51	Female	Neurologist	Sárvár Hospital	Consultant	+
76	K. Zs.	56	Female	Nurse	University of Pecs, Internal Medicine	Head of nursing	-
77	Sz.E.	56	Female	Nurse	University of Pecs, Clinical Center	Head of nursing	-
78	H. K.	41	Female	Training and Development Organizer	University of Pecs, Clinical Center	Coordinator	+
79	F.E. **	45	Female	Health Sciences Instructor	Astra Zeneca	Pharmaceutical sales	-
80	T.J. **	51	Female	Internal medicine	Astra Zeneca	Key account manager	-
81	G.A. **	45	Female	Pediatrics	Astra Zeneca	Pharmaceutical sales	-
82	Sz. A. **	50	Female	Pediatrics	Astra Zeneca	Pharmaceutical sales	-
83	L. Sz.	30	Female	Pediatrics	University of	Phd student	-

					Pecs, Pediatrics		
84	V. A.	28	Male	GP, Phd	University of Pecs, Heart Clinic	Consultant	-
85	Sz.A.	34	Male	Oncologist	University of Pecs, Oncology	Assistant Prof.	-
86	V. Zs.**	27	Female	Lawyer	University of Pecs, financial branch	Coordinator	-
87	B.B. **	53	Male	Lawyer	University of Pecs, financial branch	Dept. Head	-
88	K.G. **	42	Male	Engineer	University of Pecs, financial branch	Head of department	-
89	P.Á.**	51	Male	Engineer	University of Pecs, financial branch	Head of department	-
90	I.T.	41	Female	Economist	Sárvár Hospital	Head of finance	+
91	B. H.	36	Female	Nurse	Sárvár Hospital	Head of nursing	-
92	S.A.	35	Male	Researcher	entrepreneur	Entrepreneur	+
93	P. Zs.	43	Female	Nurse	Nagykanizsa Hosptial	Head of nursing	-
94	M. L.	47	Male	Oncologist	University of Pecs,	Head of doctors	-

					Oncology		
95	B. I.	41	Male	Cardiologist	Paks Outpatient Care	Head of doctors	+

From the above list of 13/ 22 participants have successfully fulfilled and passed the foundation level of the HLIP. The age range of the participants was between 27 and 56. Half of the participants 11/22 were above the age of 45 with 6 belonging to the 35 and under category. As far as the distribution of professions, 2 engineers and 2 lawyers participated in the foundation level of HLIP with nurses (n=4) leading numbers representing the professions. Employees of the private pharma industry reached (n=5) for the first time (1 Egis + 4 AztraZeneca). This group represented the second incidence under which the F/M ratio changed towards the Female participants F/M = 13/9. The ratio of medical doctors was 9/22 .

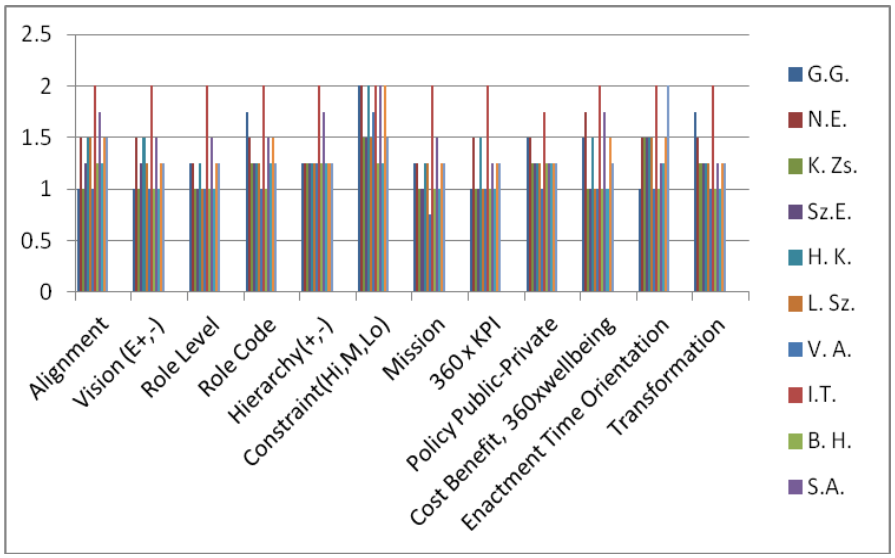
Figure 40. 2011 foundation level HLIP Participants' Paradigm Level (Pre-test)



Pre-test results represented one of the highest in terms of the number of SMOP+ entrants (n=5), with the maximum SMOP points with regards to certain dmesions of R-G-T. (here the perception of *'contextual constraints'*). At the same time this group represented the maximum degree of diversity as far as the distribution of the perceived R-G-T values, with members from all

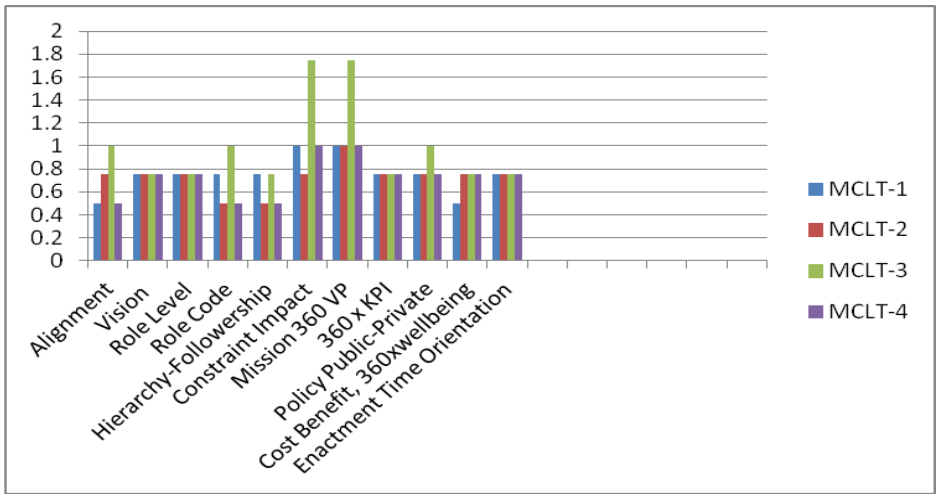
categories, MMOP, transitional OMOP, OMOP and in transitional SMOP and SMOP with regards to some dimesions.

Figure 41. 2011 foundation level HLIP Participants' Paradigm Level (Post-test)



Post test results prove the effectiveness of the HLIP in promoting the SMOP+ level and reducing the SMOP gap amongst 13/22 participants. Transformation learning levels have entered highre loop levels. Additional codes and determinants were not distinguished (saturation condition satisfied). The remaining 9/22 have extended the period of their participation (possible up to 6 months according to the design of the foundaton level HLIP).

Figure 42. MCLT 2011 control group examination



Examination of the MCLT clients did niether lead to the delivery of newer levels nor newer examination codes (determining factors) . The considered 5 year period for testing saturation

was considered sufficient for accepting the selected codes and dimensions of the SMOP typology. The model has been tested under other contexts successfully without newer findings as far as the afore mentioned levels, dimensions and codes.

5. QLL and Transformational Learning : Foundation of a CoP under the Healthcare Leadership and Development Institute (HLMDI)

The participants of the HLIP were supported and fostered towards the foundation of a joint knowledge based network in the form of a community of practice (CoP) - The first Healthcare Leadership Development and Management Institute in the region. This was taken as the primary evidence of the completion of the fourth loop for achieving innovations, breakthroughs and socio-economic transformation with a bottom-up process of involvement. The CoP was established with (n=38/52) participants after the 3rd year of the HLIP . After the fourth group of participants (n=52) had fulfilled (Part1), and further to the post test of the foundation level of the HLIP (fulfillment of the Change project, Defense, Reflective Overview, closing open book exam).Form: Foundation of the CoP under a non- profit association in southern Trans-Danube region of Hungary at the capital of Baranya County –the city of Pécs

The Participants and Design : The CoP is a knowledge based network organization registered by the founding participants (n=38/52) and continuously expanded by newer entrants upin completion of the foundation level of the HLIP from the remaining participants (n=43). Currently, (69.7%) of them (n=30) have reached the qualified level. Members participate in jointly designed development projects. Each member joins the CoP with his/her own development project. Project teams are made-up of members and non-members (partners) and are fostered by committees involved in the various levels of knowledge generation, codification, promotion and dissemination. Monitoring and feedback is conducted via two SMOP based tools to monitor attainment of the quadruple loop cycles in a continuous manner. The personal development barometer and the healthcare development map were offered as assisting tools.

Fig.43. The processes involved in the Learning and Innovation Platform

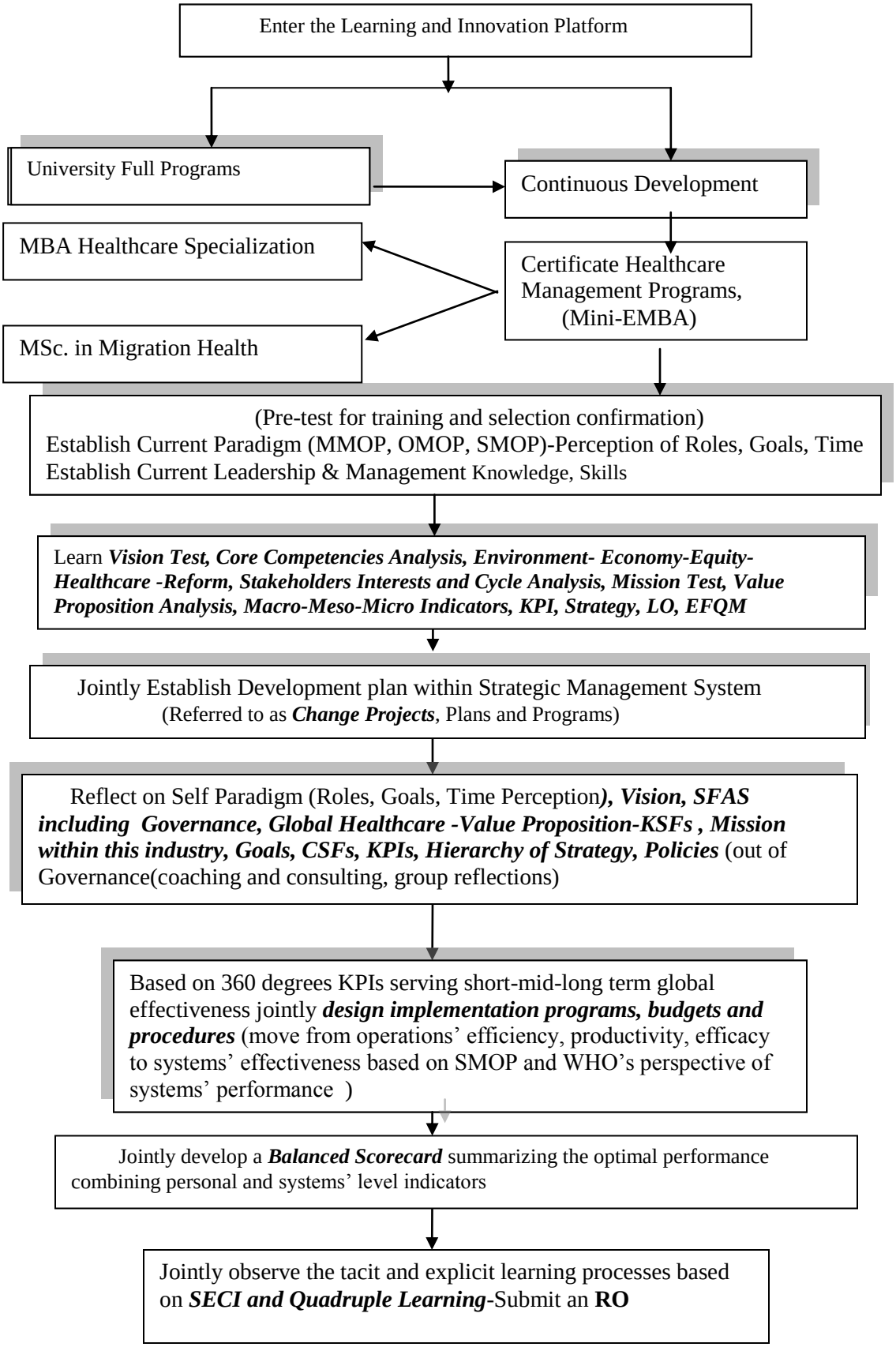
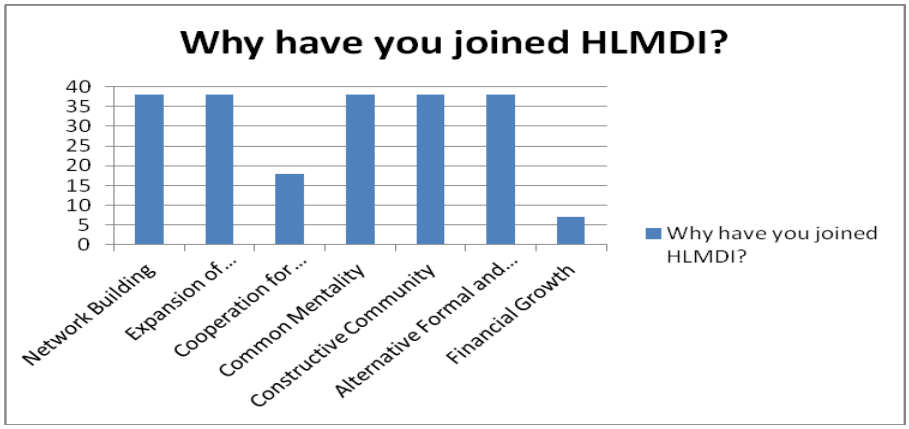


Figure 44. Foundation Level HLIP participants perceptions regarding the CoP (2006-2011)



Evidence of QLL : Extractions from HLMDI's website (www.hlmdi.org)

The motto implies "*we are the change we want to see*" (self involvement and leadership). „*We see our role as leaders of socio-economic transition towards a knowledge based healthcare industry, in line with WHO's understanding, an industry which is "effective" in promoting the relative state of people's socio-psychological, socio-economic and physical well-being".* Under core principles we can read :

1. The human capital is the most strategic asset of all societies
2. The development of human capital takes place at both psychological and physical levels
3. Development in any area requires consciousness, integrity and vision.
4. We're committed to consciously managing our time and ability to direct our own lives
5. Management and Leadership knowledge and skills are not only necessary for the formal requirements of our existentiality but they also have an impact on the informal sides of our lives
6. Our idealized future in the area of healthcare: improved relative psychological state of health, happiness and relative physiological health
7. Our idealized future in the area of Learning :

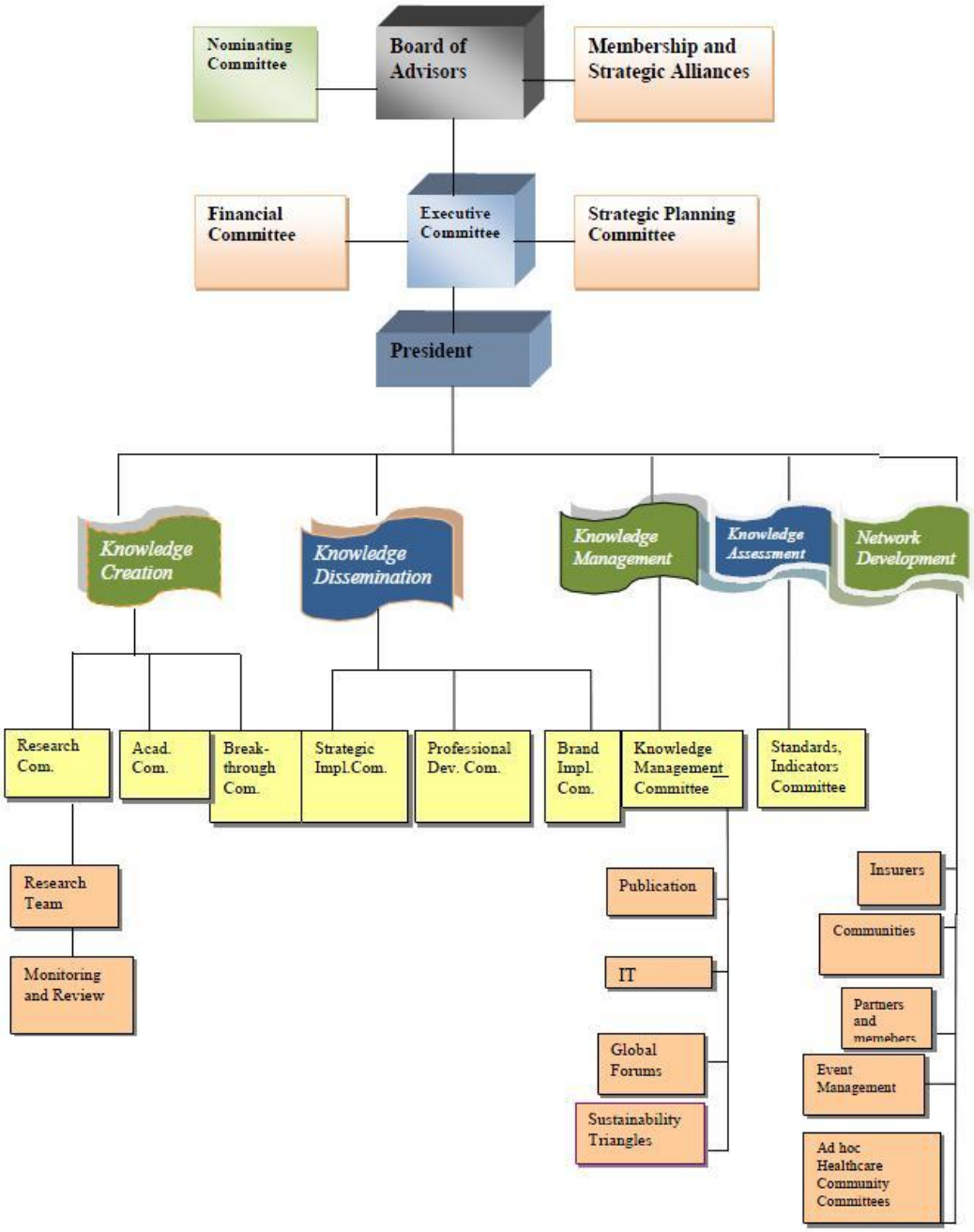
- Tacit: increased amount of experience and informal knowledge coming from unplanned and/or unstructured process

- Explicit: increased amount of measurable experience and knowledge coming from planned and/ or structured processes

- Institutionalized culture of continuous learning, especially relying on triple loop learning .

- General: Constinuously coding and communicating our growing bank of tacit knowledge

Figure 45. HLMDI:knolwedge based processes



HLMDI was established with the main goal of extending assistance to the members, partners and the local-international communities they represent , through the processes which help clarify the "*role*" of each participant in project definition and implementation in the areas of "self-development", "*community development*", "*industry development*" and "*synergistic cooperation"*. The projects aim at promoting measurable development of all healthcare industry stakeholders, through measuring the short-long term value of the participants' day-to-day activities for their own and their communities' strategic existence. HLMDI sees itself as an international knowledge based, learning organization oriented to the systemic approach in economics, representing goals defined under promotion of the state of 'Well-being' . HLMDI functions are directed at the four main areas being „*Research and Development*" continuously identifying stakeholder wants and needs, screening their capabilities-competencies and environment, the service functions under „*Consultation*" aiding the 'Implementation of Healthcare Change', the quality standardization function with a focus on „*Best practices-Industry benchmarks and metrics-Formal Quality promotion*", the most important function under „*Training and Development: with emphasis on Leadership and Management competencies*". HLMDI's complimentary function is directed at the socio-economic engagement of local and international stakeholders in the area of „well-being" driven economics. These stakeholders mainly belong to the supply side of economics and include 'registered' or 'to be registered' suppliers of resources, services and technology. HLMDI perceives the main areas of opportunity and threat belonging to the 'Migration' of information, human resources, technology and know-how, financials, businesses and the development of competencies which aid the creation of opportunities from the threats. Therefore, a separate function is extended to the management and leadership in the area of „Migration in the Healthcare Industry".

The extended version of what HLMDI stands for:

Happiness and maintenance of the relative state of well-being

Learning translated into the most important measurable asset of development

Management and Total Leadership for achieving synergy

Development in an Optimized and Sustainable Manner

Inspired and Inspiring attitude

6. New Findings of the Study and a List of the Theses

- **Thesis-1:** "Paradigm" represents *the most universal milieu* of 'thought', 'action', 'interaction' and 'transformation'. Consequently, the Kuhnian conceptualization of incommensurability and paradigm shift are insufficient. It is more appropriate to think of only one single paradigm with different development levels for all stakeholders.

- **Thesis-2:** The most comprehensive dimensions of stakeholder paradigm can be observed through perceptions of 'Roles ', 'Goals', 'Time Orientation / Transformation'

- **Thesis-3:** Paradigm level transformation is an 'internal individual process' complimented by external loops of co-learning and co-creation of reality (Perceptions of Role, Goal, Time).

- **Thesis-4:** The existence of at least one leader (Post-Conventional, More Knowledgeable than Other) at a given time and setting is important for initiating transformational learning systems.

- **Thesis-5:** Reform requires stakeholders' psycho-socio-economic transformation , which is a long-term outcome of upper level transformation reaching Triple Loop and Quadruple Loop learning.

- **Thesis-6:** The co-creating nature of stakeholders' paradigm formation and transformation, requires the institutionalization of learning systems which support Reflexive, Participative Action Research, initiating knowledge sharing for joint development.

- **Thesis-7:** Market Orientation from a Systemic perspective, can be taken as the single, most universal paradigm. Systemic Market Orientation Paradigm represents the upper level learning loops and the occurrence of the psych-socio-economic transformation (reform)

- **Thesis-8 :** Stakeholders' level of development and areas of convergence and divergence can be reliably observed through a typology. Stakeholders go through transformational processes under the 'Mechanistic' and 'Organic' levels, on their way to Systemic Market Orientation Paradigm. The typology was developed, operationalized and tested through 16 codes in the current study.

- **Thesis-9:** Healthcare reform failure in Hungary, lack of stakeholder participation in the bottom-up processes can be explained by the high level of divergence (gap) from the Systemic Market Orientation Paradigm. These are represented at all levels of policy

Content (Optimized Stakeholder Goals), Context and Actors (Governance, Roles), Process (Transformation and Decentralization)

- **Thesis-10:** Healthcare reform success requires the design and implementation of capacity building, empowerment and learning systems tailored for reducing gaps and promoting systemic market orientation. The '*Healthcare Learning and Innovation Platform*' and the '*Community of Practice*' (Healthcare Leadership and Management Development) tailored for the purpose of the current study provide reliable incidences for future planning and program design purposes

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

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

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

7. Extended Discussions

The results and findings of the study confirmed the findings of Farkas (2003) regarding the importance of leadership in promoting knowledge processes referring to German and Hungarian incidences, and the general assertions of Saltman et.al. 1997., Schultz 2003, Szócska et.al.2005, Gaál 2011

- 'misperceptions regarding the importance of management and leadership training and the role of managers in healthcare service and its operations' (The discussed Hicklin's effect regarding *management as the syphlisis disease for doctors*...)

-‘ the absence of a good understanding of the healthcare systems’ and its participants’ perceived goals ’ (*emphasized also by Mark 1995, Sen 1998,Vian et. al. 2000, Streeten 2003, Gaál 2004 and 2011 at the Hungarian Level)*

- ‘the confused roles of the participants at each level’. (*emphasized also by Mark 1995, Vian et.al. 2000.,, Szócska et.al.2005., Füzesi et.al. 2005)*

-’lack of appropriate participation in reform planning and implementation’ *(i.e. emphasized by Fuenzalida –Puelma 2002, Gaál 2004)*

- ’ absence of governance resolution processes for ethical dilemma, lack of transprency, misperceptions of social responsibility’, *(i.e. highlighted by Weller and Manga 1983, Childress et.al. 2002, Kornai 2000, Van et.al. 2000, Golesrkhi et.al.2005)*

The 10 year long results of the HLIP may be considered independent from the political and social transitional contexts (due to the time period and frequency considered). In line with the aims of the study the following results were observed:

Phase 1.

a. The management consulting and leadership training project (MCLT) lead to the exploration, extraction and codification of 17+1 items, for further examination. At the same time a categorical model for the further phases of the investigation were built.

b. The development and preliminary testing of a typology for SMOP observation was achieved. The typology was successfully used to show the link of the 17+1 coded items and to determine stakeholder paradigms from systemic Market Orientation Perspective. Three main types were distinguished by the typology: a) - The Mechanistic Market Orientation Paradigm (MMOP), b) - The Organic Market Orientation Paradigm (OMOP), c) - The Systemic Market Orientation Paradigm (SMOP). The perceptions of Role-Goal and Time (R-G-T) were grasped by the

typology and provided a simple yet comprehensive tool for showing the level of preparedness and ranking priority areas for capacity building.

- MCLT (4) represented OMOP with signs of medium level of resistance while all other MCLT clients were positioned on the MMOP. MCLT (3) represented signs of a higher than average level of resistance. MCLT (1) and (2) with medium resistance to change. Role Maturity was categorized as moderate (transitional infant). It was interesting to note that the project idea had been initiated and by MCLT (1) whom had volunteered for the LPC role, proving

Phase 2. The SMOP model for planning capacity building based on preparedness was successfully tested through the design and formation of a Healthcare Leaning and Innovation Platform. The major questions and concerns which had motivated the current study can be summarized in the following manner:

a. What are the reasons for the continuous failure of Healthcare reform, especially in terms of achieving 'decentralization' and 'stakeholder involvement' in policy planning and implementation? (postulations of Saltam et.al., Füzesi et.al., and Szócska et.al.)

b. If stakeholder paradigm is the most influential in stakeholder decision making and action, then why hasn't the study of this area received sufficient attention? Are concerns such as ethical conduct, gratitude money, mutual trust, 360 degrees stakeholder satisfaction influenced by paradigms?

c. Do we have access to well-tested tools or typologies for assessing and comparing favorable / unfavorbale paradigms and their tranfsormational processes? (these tools would be essential if the proactive promotion of favorable change would become a goal)

d. If the lack of capacity building programs in the field of sophisticated management and leadership training have been held responsible for healthcare reform in Hungary as early as 1997, why hasn't this area received explicit support or attention by various governments? (the interplay of the psycho-socio-economic paradigm gaps of the policy-

makers?). May clear vision or direction, better goal setting in line with the 360 degrees well-being, strategy and innovation be promoted through capacity building?

e. What should / can be the next constructive starting point or step for initiating the process of successful change/reform? Who 'is' or 'should be' the person asking this question? (the role and importance of the researcher in similar inquiries?)

When approaching the above questions, a wide spectrum of additional questions had to be dealt with at the theoretical level :

- Why are 'Decentralization' and 'Stakeholder Involvement' for joint goal setting and policy making, less attended to or actualized across all sectors and nations world wide?
- Why are the 'common public wisdom' and 'policy makers' approach' in Hungary considering efficient utilization of distributed scarce resources possible without developing the stakeholder paradigm, stakeholder competences?
- Why hasn't SMO been respected as a paradigm? Can SMO help the design of a typology for operationalization of paradigm dimesnions and their assessment? If the antecedants of Systemic Market Orientation (SMO) have qualified it as an economic/institutional model , philosophy , culture and measure of performance and that its adoption, implementation and institutionalization have proven superior results why hasn't SMO received sufficient acknowledgement. How best is the study of paradigm designed and conducted?
- In line with the above, if from an axiomatic perspective, paradigm implies a single universal domain / milieu of thought , action and development (transformation) then would it be appropriate to posite that the Kuhnian understanding of 'paradigm shift' (leaving one paradigm and entering a totally new paradigm) is insufficient? (transformation and development through learning is an intrinsic axionmatical value supporting the existence of a single universe of thought-action-development)
- Does the process of change start at one point like the big bang? In other words is the process of development an outcome of internal or external processes? Can the process of

change be promoted or sped up through conscious joint training for transformation?(i.e. supporting the upper learning loops such as the TLL and QLL)

The following conclusions were derived as result of the current study primarily framed as a joint inquiry (Participative Action Research) and extended within the framework of a Reflexive Grounded Theory:

a. Failure of Healthcare reform in Hungary has been appropriately linked to paradigmatic gaps . These gaps exist internationally especially amongst policy makers themselves leading to unfavorable outcomes at an international level.
b. The problem of 'common wisdom' and 'policy making priority setting' for healthcare reform originate from the same source, referred to as 'paradigm level gap' in this study. Concerns such as ethical conduct, gratitude money, mutual trust, 360 degrees stakeholder satisfaction are influenced by paradigms.
c. An accessible and easily utilizable typology or tool for stakeholder paradigm analysis and transformation monitoring has not been available. The (SMOP) R-G-T tool tested over a longitudinal study extends newer opportunities for designing and delivering capacity building programs in the field of stakeholder paradigms. SMO hasn't received attention as a paradigm, but the investigations of the current study revealed its qualities as the universal development paradigm . Since paradigms are outcomes of co-created reality arising from joint inquiry a design which responds to this systemic world view would be necessary. The MCLT successfully used a PAR design for jointly extracting the determining codes. The foundation level HLIP continued joint inquiry and co-creation over an extended five year period (funtioning as an intervention praxis), all leading to the foundation of a CoP for serving long term purposes as a ZRC to improve bottom-up participation in reform. These had been taken as signs of the occurrence of upper level learning (TLL and QLL)

d. Policy making paradigm level gap has been responsible for unattended capacity building programs which help further bottom-up involvement and an integrated approach to governance. Based on the findings of the current study achieving a universal understanding of development and direction for transformation of stakeholder paradigms (including the

politicians) is possible . Therefore, the current study finds the Kuhnian assetions regarding the content and nature of paradigm shift relevant but insufficient. Capacity building for reaching a common starting point and language was found essential in promoting upper level learning and transformation (TLL and QLL). The study proved that clear vision and direction, better goal setting in line with the 360 degrees well-being, strategy and innovation can be promoted through capacity building programs. Recent investigations continue to reconfirm the importance of leadership and management practices at all levels of the healthcare system carrying important implications for transitional system like the Hungarian Healthcare. In their article "*Management Matters*", Casro et.al. 2009 emphasizes the continued lack of consensus on the improved adoption of advanced leadership and management at clinical levels through the UK example. Based on a qualitative study regarding management performance across 104 NHS and 22 private hospitals, four measures (Lean Operations, Performance Management, Talent Management, Clinical Leadership) were observed showing clear advantages of adopting advanced management practices. In terms of the impact of management practices on performance results showed superiority as far as the following measures:

a)-Patient Safety,

b)-Patient Experience,

c) - Patient Mix,

d)- Cost.,

e)- Activity,

f)-Financial sustainability

g)- Quality of care provided.,

h)- Clinical Outcomes.

Amongst the authors conclusions there was reference to well managed systems' approach to talent management through three indicators: "emphasis on talent management", "retains talent", "rewards high performers". Given Hungary's improving crisis in the area of workforce shortage and mobility , attention paid to such conclusions regarding the adoption of advanced management systems for coping with such problems is worthy of consideration.Mountford and Webb (2009) have drawn attention to the importance of promoting leadership and management

at the level of clinicians, as opposed to the approach taken by many systems to separate administration and patient care , the first being the direct job of clinicians and the second the management. The authors refer to the importance of learning and innovation arriving from promoting leadership competences at the level of clinicians. The authors simplified selection, monitoring and promotion across three important leadership areas which have to be paid attention to in assessing competence according to the said paper:

a)- Overall Identity: Great frontline clinician who focuses on delivering and improving excellent patient care. High level of direct contact with patients

b)- Sources of Power: passionate about clinical work, credible to colleagues. Close to patients and front line realities. Can see opportunities for improvement

c)-Selected leadership skills and knowledge required: Understanding of systems and quality improvement techniques. i.e. process mapping operational improvement. Self-starter and able to work well in teams. These results are in line with the SMOP understandings and findings of the current study especially as far as participative methods of stakeholder involvement, stakeholder consciousness, the need for continuous development of leadership roles across the organization, taking a multi-facetted approach to learning. Bhatia, Meredith, Riahi (2009) in their article "*Managing the Clinical Workforce*" provide a comprehensive study of approaches to managing workforce and their mobility. They'd concluded that there has been a wide gap in terms of adopting a strategic approach to workforce mobility strategy and planning suggesting higher attention to be paid to adopting strategic management and the creation and support of strategist roles at micro and macro levels of the system. (Reference was made to Dumont and Zurn (2007) "Immigrant Health workers in OECD countries in the broader context of Highly Skilled Migration "). The mentioned study in line with the findings of the current investigation provides important implications for healthcare policy makers. The researcher and his colleagues have initiated HR Capacity Building Programs at the Hungarian level based on the findings mentioned here above.

e. The study supports the idea that paradigm level development is an internal process and that the extension occurs as a consequence of the MKO's self reflexive learning. However, as asserted by development scholars , transformation is reliant on the psycho-social processes along the life cycle, meaning that the creation of appropriate contextual environment will lead to

sped up and promoted transformatioal learning (TLL and QLL). The yearly growing number of HLIP participants proves the felt need for capacity building by the healthcare leaders. This is an important implication for policy makers as well as professional rounds for extending support and offerings in this field.

The SMOP typology was applied to newer cross sectional cases throughout the 10 year period. The typology can be used for assessing 'the level of preparedness for reform' guiding prior areas of need for capacity building as far as all KSAO areas. Also the typology is useful in aiding the design and delivery of various capacity building programs (covering all knowledge all knowledge management / learning levels). Although early levels of SMOP may be developed without the structured approach suggested here, the designed and fostered foundation level HLIP (healthcare learning and innovation platform) along with the CoP (HLMDI) provided important examples for capacity building programs targeting the promotion and institutionalization of quadruple learning. The above are essential for psycho-socio-economic quadruple learningand psycho-socio-economic transformation (reform) .The study confirmed that policies and programs in the area of capacity building for healthcare reform require an integrated and systemic approach by at least one stakeholder. It was interesting to note that being a non member of the context and community provides a good basis for shifting to the third loop of learning. However, incidences in the study showed that quadruple level learning was best achieved through leadership training and at the presence of the CoP, suggesting the design of the learning and innovation platform was important for the purpose. Although the MCLT clients brought incentives for the design and conduct of the current study, it was interesting to note that neither particpated in the HLIP (and consequently neither the CoP). This proves that although some participants of the system may arrive at the need for initiating joint inquiry and transformation, in the absence of SMOP contexts and training such an internally driven incentive alone may not lead to proactive particiaption in transformation and bottom-up reform processes. In responding to the question of the next step for policy making , the findings of the study clearly suggest integrating sophisticated management and leadership training for healthcare leaders and practitioners without excluding leading and decision making clinicians and most importantly extending supports and incentives for decision making clinicians to participate in such training programs. Also, it would be important to consider the importance of paradigms in pschyco-

socio-economic transition. The SMOP typology provides a useful tool for the purpose of paradigm gap assessment and the design and delivery of transformational capacity building programs. The continuous isolation and reflection on the influeneces of the researcher's own paradigm can be considered and strengths of the study.

8. Future Research Considerations

The following areas are suggested for complimentary future investigations

- Investigations should continue for monitoring the emergence of newer codes not revealed across the extension of the 10 year period of the current study.

- The 'Entry' level screening methods will require improvement. It would be interesting to note and keep an open eye for the frequency and size of recurrences of cases such as that of the single participant (G.B.) in who's case the program had been only slightly effective, due to lack of engagement and participation in the orientation period.

- The participants had ranked *' better perspective', 'understanding the system'* as the most important expectations from the program. The participants had coded the outcomes as per *'New Knowledge', 'Better Perspective', 'Constructive Spirit', 'Social Capital' and 'Independent Thought'* . These areas deserve continued monitoring for newer findings. However, a cumulative study of all foundation HLIP participants may lead to newer findings.

The results of the HLIP have been cross examined through various programs, subjected to a diverse range of contexts in and outside Hungary. However, the design has been highly reliant on academic infrastructure and its effectiveness has been tested only in the case of stakeholders enjoying university level knowledge. The design of this typology and examination of the reliability across stakeholders whom do not enjoy higher education but who's participation in bottom up processes is hypothetically essential for healthcare reform has to be considered. This is especially worthy of attention since the 2003/4 SMOP gap survey had revealed high gaps at various social groups (mostly the elderly and the youth) . With high gaps presiding amongst such groups arriving at optimal stakeholder satisfaction points as desired under the SMOP would be difficult. Also, the current study could not provide a comprehensive assertion regarding the ranges and modes of government support (i.e. number of new courses, volume and value of investment starting points, expected short to long term ROI etc.) At the same time it would be

interesting to note the frequency and size of recurrences such as that of the G.B. in who's case the HLIP had been slightly effective due to lack of participation in the orientation period . Future investigations regarding the reasons for fluctuations in the number of participants between the years 2006-2011, especially no participants in 2007 and two groups in 2009 are worthy of consideration. While , Knowledge Acquisition, Flexible Schedule , Good Proximity have been ranked as the most important reasons for chosing one program option over the other it was interesting to note that regulatory pressure put on leaders for acquiring managerial training has been the number one trigger for participation. A matter deserving complimentary investigation for linking the entry level SMOP gap . The participants had ranked ' *better perspective', 'understanding the system'* as the most important expectations from HLIP. The participants had coded what they'd received as per *'New Knowledge', 'Better Perspective', 'Constructive Spirit', 'Socail Capital' and 'Independant Thought'* . These areas deserve continued monitoring for newer findings. The age , gender, specialization diverstity has been sufficiently distributed . However, a cumulative study of all foundation HLIP participants may lead to newer findings.

Figure 46. Reasons for Application Foundation Level HLIP Participants 2006-2011

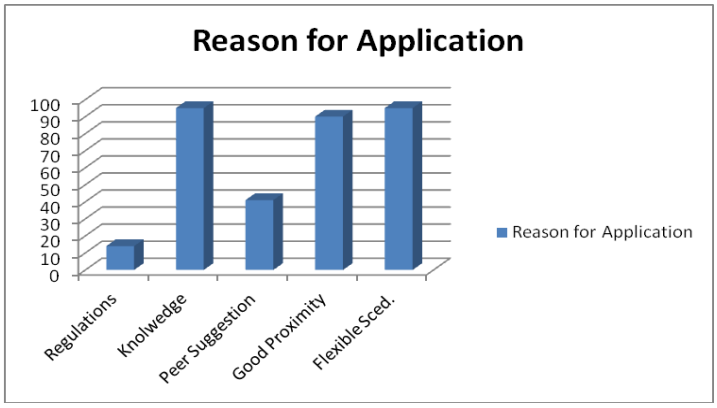


Figure 47. Reasons for Postponing Application Foundation Level HLIP Participants 2006-2011

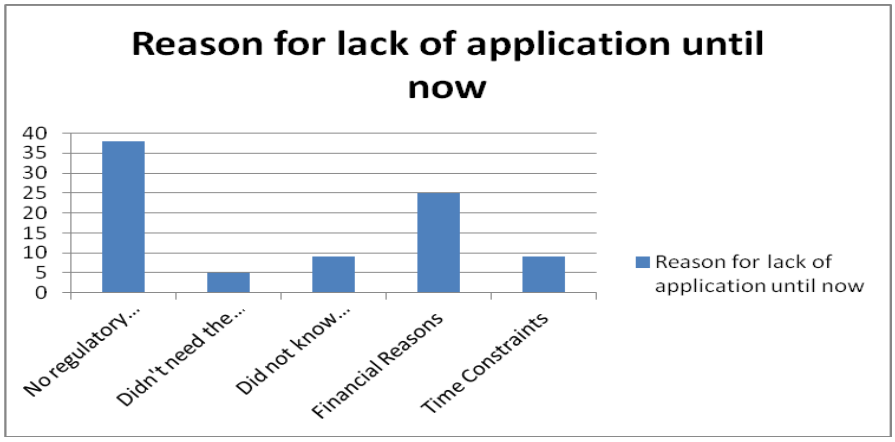


Figure 48. Participant Expectations from Foundation Level HLIP 2006-2011

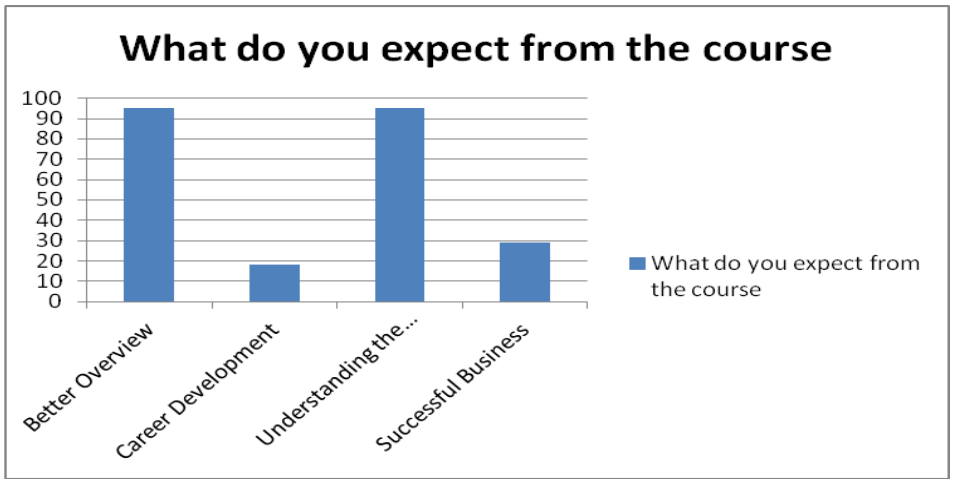


Figure 49. Participants' perception of outcomes: Foundation Level HLIP 2006-2011

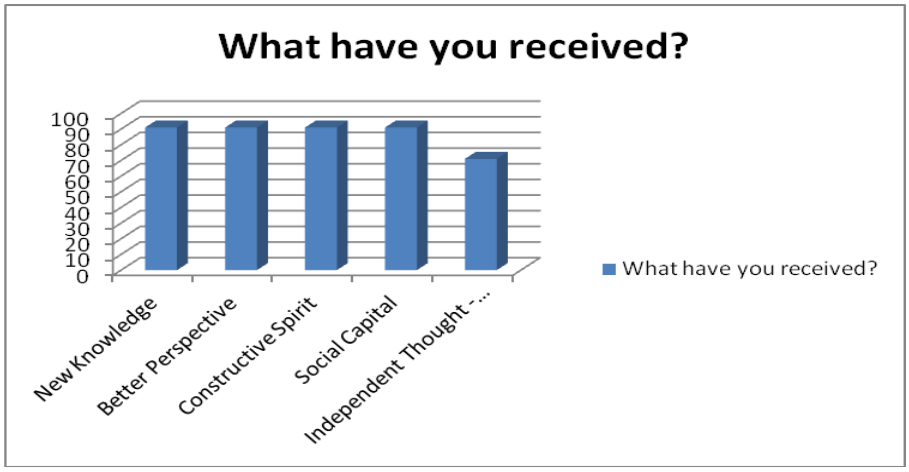
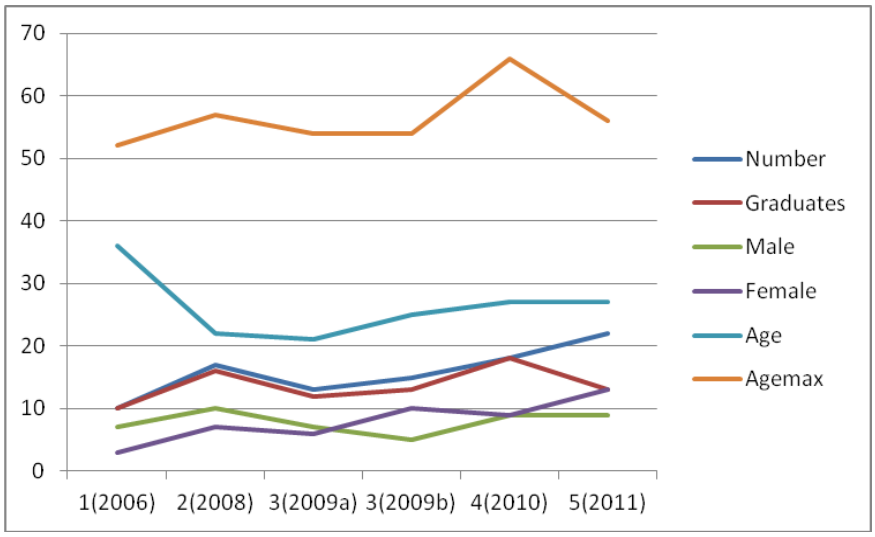


Figure 50. Age and Gender distribution of participants Foundation Level of HLIP (2006-2011)



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9. Appendix

9.1. An in-depth reflection on the definition of Role and Role Theory

attention is drawn to the definition proposed by the online free dictionary on the origins of the word “Role” . ‘Role’ was first recorded in English in 1606 , from the French rôle, from Old French rolle, *roll of parchment (on which an actor's part was written)*, from Latin rotula, diminutive of rota, *wheel* ; “*We all play many roles in life, such as parent or teacher, having the sense a part one has to play. From such uses it also came to refer to the text from which an actor learned a part. This use brought the word into the world of the theater where it has played an important role ever since. The theatrical meaning was then generalized to include parts played off the stage*.” Role became more prominent in sociological discourse through the theoretical works of Mead, Moreno, and Linton. Two of Mead’s concepts – the mind and the self – are the precursors to role theory. Each social role is a set of rights, duties, expectations, norms and behaviour a person has to face and to fulfill. The model is based on the observation that people behave in a predictable way, and that an individual’s behavior is context specific, based on social position and other factors. Although the word role (or roll) has existed in European languages for centuries, as a sociological concept the term has only been around since the 1920s and 1930s.

Depending on the general perspective of the theoretical tradition, there is a range of ‘‘types’’ of role theory. The theory posits the following propositions about social behaviour:

. The division of labor in society takes the form of the interaction among heterogeneous specialized positions that we call roles;
. Social roles included "appropriate" and "permitted" forms of behavior, guided by social norms, which are commonly known and hence determine expectations;
. Roles are occupied by individuals, who are called "actors";
. When individuals approve of a social role (i.e., they consider the role "legitimate" and "constructive", they will incur costs to conform to role norms, and will also incur costs to punish those who violate role norms;
. Changed conditions can render a social role outdated or illegitimate, in which case social pressures are likely to lead to role change;

. The anticipation of rewards and punishments, as well as the satisfaction of behaving in a prosocial way, account for why agents conform to role requirements. A key insight of this theory is that role conflict occurs when a person is expected to simultaneously act out multiple roles that carry contradictory expectations.

'Role Theory' : The psycho-sociological study of role development, is concerned with explaining what social-individual forces cause people to develop or perceive expectations of their own and others' behaviors in an everyday social setting, when acting as for example in the role of parents, economic agents, political decision-makers, researchers, doctors, tutors, ethical liaisons, judges etc. The theatre is a metaphor often used to describe role theory. Biddle (1986), classified the major 'Role Theory' models into five areas in terms of (a) the importance of norms exerted by the society and/or institution on the formation of role perceptions, (b) the individuals' interpretation as a response to behavior, also (c) the outcome of relationships between expectations and behavior his five models: (1) Functional Theory which examines role development as shared social norms for a given social position, (2) Structural Role Theory, which emphasizes the influence of society rather than the individual on roles and utilizes mathematical models, (3) Organizational Role Theory, which examines role development in organizations, (4) Symbolic Inter-actionist Theory which examines role development as the outcome of individual interpretation of responses to behavior, (5) Cognitive Role Theory, which is summarized as 'the relationship between expectations and behaviors' (see Flynn and Lemay). Here we will reflect on two selected models which represent the essence of the divergence in the above groupings in terms of the individuals' response in light of the norms exerted by the society.

❖ Functional Role Theory:

- Role as 'the set of expectations that society places on an individual', by unspoken consensus. Certain behaviors are deemed "appropriate" and others "inappropriate". Role is for example what the doctor does (or, at least, is expected to do) –'her expected

behavior attached to the position', while status is what the doctor is-'her position'. Roles are not limited to occupational status, of course, nor does the fact that one is cast in the role of "doctor" during working hours prevent one from taking over on other roles at other times: i.e. wife, husband, friend, mother, father, club member etc. Expected behavior from a doctor could be for example, to dress fairly conservatively, ask a series of personal questions about one's health, touch one in ways that would normally be forbidden, write prescriptions, and show more concern for the personal wellbeing of his clients than is expected of, say, an electrician or a shopkeeper. Social norms theory states that much of people's behavior is influenced by their perception of how other members of their social group behave. When individuals are in a state of de-individuation, they see themselves only in terms of group identity, and their behavior is likely to be guided by group norms alone. But while group norms have a powerful affect on behavior, they can only guide behavior when they are activated by obvious reminders or by subtle cues. People adhere to social norms through enforcement, internalization, the sharing of norms by other group members, and frequent activation (Smith 2007). Norms can be enforced through punishment or reward. Individuals are rewarded for living up to their roles (i.e. students getting an "A" on their exam) or punished for not completing the duties of their role (i.e. a salesman is fired for not selling enough products). Social norm theory has been applied as an environmental approach, with an aim of influencing individuals by manipulating their social and cultural environments. It has been widely applied using social marketing techniques. Normative messages are designed for delivery using various media and promotional strategies in order to effectively reach a target population. Social norms theory has also been successfully applied through strategies such as curriculum infusion, creating press coverage, policy development, and small group inventions. (Main Frame 2002). People display reactance by fighting against threats to their freedom of action when they find norms inappropriate. Attitudes and norms typically work together to influence behavior (directly or indirectly). The theory of planned behavior intentions are a function of three factors: attitudes about the behavior, social norms relevant to the behavior, and perceptions of control over the behavior. When attitudes and norms disagree, their influence on behavior will depend on their relative accessibility

❖ Symbolic Inter-actionist Role Theory:

- Role is not fixed or prescribed but something that is constantly negotiated between individuals in a tentative, creative way. It's not meaningful to think of a role for one person alone, only for that person as an individual who is both co-operating and competing with others. People take roles from those that they see around them, adapting them in creative ways, through the process of social interaction, testing them and either confirming them or modifying them. Investigations and writings of Mead G.H. (1934) on the ways children become part of the society through imaginative role taking in observing and mimicking others. In encounters where there is considerable ambiguity, but is nevertheless something that is part of all social interactions, each individual actively tries to 'define the situation and understand their role within it'; choose a role that is advantageous or appealing; play that role; and persuade others to support the role. Vygotsky discusses imitation in the context of how 'scientific' concepts, as opposed to 'everyday' concepts, are developed in children. In his discussion it becomes clear that conscious understanding plays an important role. In focusing on conscious understanding Vygotsky was building upon James Baldwin's distinction between simple imitation and persistent imitation (Valsiner and van der Veer, 2000). According to Baldwin, simple imitation involves a single invariant copy of an action while persistent imitation involves voluntary attention during repeated efforts to better approximate an action. Vygotsky similarly distinguished between two types of imitation: drill imitation based on 'trial and error' and imitation based on 'conscious understanding' (Vygotsky, 1986, p. 188). Drill imitation aims at making a copy of an action by considering it as a whole. Conscious imitation, however, involves understanding the different elements and their relationships to each other in the action being imitated. For the analysis of the general nature of these elements and their relationships paying attention to Activity Theory was found valuable. AT distinguishes activity from action; activity concerns social motives at a broad level (such as formal education) (Wertsch, 1985), whereas action is directed towards a goal which can be achieved by different operations, depending on the conditions; although operations can become automatized under changed conditions they can be 'reactivated' as consciously control- led (Donato and McCormick, 1994). An analysis of the imitation of behavior has divided imitation into two parts: the goal towards which behavior is

aimed and the means by which the goal is reached, generating three related notions: mimicry, emulation and imitation (Tomasello, 1999; Lantolf, 2006; Lantolf and Thorne, 2006). Tomasello describes mimicry as understanding neither the goal nor the means of an activity. Emulation entails understanding the goal but not the role played by the means. Imitation, however, entails understanding that the means is used to reach the goal, that is, the intention behind the behavior. Imitation thus requires taking this intentionally driven conjunction of means-and-goals as one's own. Role reversal is a type of imitation occurring in mutual activities (Tomasello, 1999), where someone who imitates another must put herself in that person's role. Based on Tomasello, the ability to imitate both goals and means of an action can be taken as indicative of development. A child imitating an adult pointing at herself must recognize that in order to imitate the adult, the child must not point to the same person the adult is pointing at (i.e. the adult) but rather at herself (i.e. the child). Tomasello explains this as understanding intentions within a joint attentional situation where social cues help the child acquire an 'external' perspective that includes both roles. This cognitive ability to recognize intentions underlies human social learning (Tomasello, 1999).

9.2. Stakeholder Perception questionnaire on the "Central Goal of Care"- Adopted from the Patient Centeredness Model of (Likert Scale)

Summary of the Perceptions on the Central Goal of Healthcare

Name of the institute and geography_____, Area of Specialization_____, Date_____, Age_____, Gender_____,

Statements of the Doctors	agree	Somewhat agree	Neutral/ somewhat disagree/disagree
Factor 1. General Perception			
Primary attention of the doctor should be to the "Patient" and not the "Illness"			
Primary attention of the doctor should be to the "Illness" not the "Patient"			
The whole satisfaction the patient is the foremost objective of the healthcare service not just treatment of the illness			
Treating the illness is the foremost objective of the healthcare service			
The doctor has a limited time to listen to the patients' stories so the doctor needs additional skills for best communication results			
Prevention, Promotion and Psycho-Social well-being are not the central goal of all medical specializations			
„Gratitude Money" is the minimum the society can return for the sacrifices of the doctors with low Hungarian wages			
If the Hungarian health system is under- performing the blame is on everyone else except the doctors themselves			
The Hungarian Health system is not under performing			
It is inappropriate to think of doctors as consultants and patients as clients			
The doctors' moral duty is defined by law and confined to his job title			

Hungarian doctors' expectation for top western level salaries is natural			
Private healthcare is more dangerous and unethical than government lead healthcare			
National insurance is playing its ethical role by asking low amounts from the society			
The doctor should focus first on the welfare of the society and the patient before his family and herself			
The doctor should not first focus on the welfare of the society and patients			
The doctor should focus on the welfare of all participants			
Good level of clinical and organizational governance needs trained managers and leaders			
It can be said that			
Factor 2: Communication and Partnership			
During the consultation I allocate time to discussing patients' worries about the problem			
During the consultation I express high interest when patient talks about his/her symptoms			
During the consultation I show support for what the patient wants to know			
In practical terms I even encourage patients to ensure they are clear on their questions			
During practice I am careful to explain the plan of treatment			
I try to sympathize with the patient			
I show interest in what the patient thinks the problem is			
I discuss and agree together with the patient on what the problem is			
I try to show the patient that I have considered what he/she thought was important to be done			
Factor 3: Personal Relationship			
My strategy in treating the patient includes establishing personal relationships with the patient			
I respect patients' different emotional needs and relate to each accordingly			
My strategy includes creating confidence in the patient that I know his/her emotional needs			
My strategy includes overall trust building between myself and the patient			
Factor 4: Health Promotion			
I tend to discuss ways to lower the risk of future illness			

I tend to provide advice on how to prevent future health problems					
Factor 5: Positive and Clear Approach to Problem					
Even if not the case I show definiteness on my position about the problem					
Even if not the case I show a positive belief about when the problem would settle					
Factor 6: Interest in Effect on Life					
I discuss the greater effect of the problem on patient's family or personal life					
I discuss the effect of the problem on the patient's everyday activities					
Factor 7: Perceptions on contextual circumstances					
I cannot be patient-centered due to limitations of time					
The service cannot be patient-centered due to limitations of the number of doctors and nurses					
I cannot be patient centered because my salary, and income is very low					
I cannot be patient centered because the limitations imposed by law					
The service and system isn't patient-centered and therefore the attitude of the doctor can't be different					
I cannot be patient-centered because my priority is treating the illness that's why I can't always serve the patients' pleasure or happiness					
The attitude and behavior of doctors cannot be patient centered because the principles and traditions of doctor-patient relationship dictate otherwise					
The service isn't patient centered due to infrastructural and logistic limitations					

The service cannot be patient centered due to supply and technological short comings					
I confess that under current circumstances in the Hungarian healthcare, the doctors are responding to the patients' expectations in the best possible manner					
It can be said that under the current circumstances the doctor-patient relationship is closed to ideal					
It can be said that Hungarian doctors are generally satisfied					
It can be said that there is a good culture of cooperation in the Hungarian health system					
It can be said that there is a high level of job security for Hungarian doctors					
Hungarian doctors follow a clear mission they believe in					
It can be said that managerial competence is high in the public Hungarian Healthcare					
It can be said that governance is highly well functioning and transparent in Hungary					

9.3. The Foundation HLIP under "The Certificate of Healthcare Management" :2006-2011

Certificate of Healthcare Management

Specific area (s)	***Healthcare Economics and Public Policy, Healthcare Leadership , Market Orientation of Healthcare Systems, Strategic Management, Healthcare Finance, Healthcare IT, Healthcare Operations Management, HR and Knowledge Management in Healthcare***
Course Supervisors	Kia Golesorkhi (Module Leader) Dr. Farkas Ferenc Dr. János Fojtik

Catalogue entry	The Hungarian Healthcare is marked by low levels of Market Orientation leading to low overall performance, especially when subject to financial measurements. The general goal of this module is to assist Healthcare Planners, Managers, Leaders, Administrators through providing further insight on the application of emerging management theories and models (market orientation), in the complex area of Healthcare. This is deemed to carry important value for the under course restructuring taking place in this sector. The understanding of the basic commonalities and differences of Healthcare Service organizations at global scale are demonstrated to set benchmarks based on experiences elsewhere. The significance of a strategic approach to managing and leading Healthcare Service Organizations is examined. Course available to Healthcare Managers / Leaders /
Other restrictions or requirements	Course available to Healthcare Managers / Leaders / Planners/ Decision Makers, Nurses and Medical Administrators, Medical Doctors. Requirements include completed application forms, 4 passport-sized photographs and application fees Note: The course directors will review all applications which arrive before the application deadline. Considerations will include seniority and achieving an appropriate mix of specialties and grades.
Duration of Course	The training course is held across 18 weeks with 70 + 8 contact hours and continuous online consultation under four types of schedules. a)- Intensive : 3 x 6 teaching days, starting every 5th week. b)- Regular: Every Saturday **Deadline for applications:** Spring semester Feb 27, Autumn Semester September 27 For queries and application forms write to: Kia Golesorkhi (kia@ktk.pte.hu)
Course Fees	Course fees are (850) EUROs. Consultants will receive a subsidy grant of (50) EUROs and (100) EUROs for other applicants working in the Hungarian healthcare..
Aims:	To enable the participants to understand and apply key principles of strategic management, operations design , finance, marketing and HR in a given healthcare organization, subject to the international , regional and national public policy. The overall aims of the course is capacity building for initiating Triple Loop and Quadruple Loop Learning within the healthcare context. The course aims at providing participants with an understanding of the competences needed for successful governance addressing the scarce resources, dilemma imposed by the questions conflict of interest , ethics, welfare economics and the role of leadership, IT technology , insurance and entrepreneurial orientation are given separate attention. The question of designing responsive learning system is based on methods to enhance communication and integration through systems' further IT orientation at the technological level. The definition of human relationships and processes are however dealt with as priority. Given the importance of organizational culture for implementing a sustainable change in the internal context and for optimizing healthcare service results, 'market orientation' as philosophy, culture and -practice enjoys core value. The needs for taking a strategic and holistic approach to planning are discussed and methods through which internal and external marketing strategies ought to be adapted subject to healthcare policies addresses. Also a compilation of theories and practices related to current problems of healthcare services management and marketing at global/regional and national levels are delivered.
Learning outcomes	KNOWLEDGE: At the end of this training, participants will be able to relate the basic stakeholder roles and goals within the local and international setting, valuing knowledge based

	development . Within the context of a learning system the participants will be able to understand the importance of strategies. The reasons for and relevant outcomes of utilizing market orientation and the methods of implementing the shift towards becoming market oriented in the context of Healthcare SKILLS: Participants should be able to design and implement a strategic management system subject to the public and private healthcare context (WHOs perspective of public health and market oriented approach to clinical and corporate governance).
Sessions (weeks)	
1.	- Theory and Goal of Economics subject to Saltwater , Fresh Water and Development Economics - Roles , Goals, Utility and Hierarchy of Preferences - WHO and the roles and goals of Healthcare Participants (Government, Service Providers, Technology Owners, Financers, Insurance and Customers. International Bodies) -Definition of and types of healthcare organizations- How do each approach value creation? -Value creation processes, chains, organizational functions their design and control
2.	-Basic managerial and leadership terminology within the concept of healthcare (international systems for classification of jobs and positions) - Lawrence Kohlberg's Moral Development scales - Hershey and Blanchard's Situational Leadership Model (subject to follower maturity) -Corporate and Clinical Governance basic understandings of 360 degrees stakeholder involvement and management -The basic idea of formal and informal network organizations -Capitalizing on Change through effective leadership and reorganization - the basic concepts and relevant issues -Organizational Culture, Learning Organizations and paradigm shift
3.	- The extended interpretations and metrics of value for various stakeholders - What do we mean by healthcare service "quality"? - Formal and Informal Quality standards - Relationship and contribution of variable / fixed and opportunity costs, along quality and stakeholder value (determinants of pricing) - Importance of Enabling Factors within the system the EFQM approach -- The summary of Strategic Management System (SFAS, Vision, Mission, Goals, KPIs, Policies)
4.	-Reflections on Health Economics Willingness to Pay, Cost Benefit analysis, basic concept of QALY, DALY and YLL -The German Point System, Capitation in Primary, Secondary and Tertiary Care - The " HBCS (Homogén Beteg Csoport) point system" , its basic mechanisms - Cases on auditing point system relevant performance of our unit - Cross Boarder Insurance and Health Financing in Prevention, Screening and Promotion (two case studies) - The US, UK and French, Dutch approaches to Health plans, evaluation systems and the role of private and state insurance
5.	- Systemic Market Orientation as a philosophy as well as a model for practice in the CEE healthcare service organizations. - Issues in strategic HR planning, promotion and performance management -Reform Case studies from the CEE (healthcare systems in Transition Publications) - Capacity Building, Paradigm shift and Quadruple Loop Learning
6.	- Enhancing effectiveness through operations strategy: Effectiveness and performance through peak seasons /days / time/scheduling and queue management - IT and its value to operations. IT assisted monitoring for supply chain and logistics and HR.

7.	Marketing healthcare services and products -Case incidences on patented , open source products - Case incidences on CRM and the contact employees - Case Incidences of Hotel Hospitals
8.	- Case studies on Quality compliance, quality assurance, internal quality audit. Quality audit standards to outcomes in EU, CEE, Canada and Australia
9.	Migration and Healthcare. Creating Migrant Responsive Healthcare Systems - Case Incidences on Developed and Developing Countries - Case Incidences on OECD countries
10.	- Reflection on Hungarian Reform Implementation across the transitional period Healthcare Economics as an EU member - Healthcare Finance in Hungary (reflections on HBCS in Hungary), Healthcare investment
11.	- Healthcare, research, the university , knowledge based economies in the EU context - A reflection on the theory of endogenous growth , diversity and integration in healthcare - The importance of EU funds in the area of innovation creation. Bio-Tech Cluster in Hungary and the Southern Trans Danubian Region
12.	- Applying for EU funds, the state of the country - Cases on applying for the funds through tenders. Experiences with the development plans
13.	- Implementing change in your own organization: Theory and practice (1) Vision , Mission, Value Proposition, Forecasting, Life Cycles, SWOT, TOWS, SFAS
14.	- Implementing change in your own organization: Theory and practice (2) KPIs, Hierarchy of strategy, Policies, Programs, Budgets and Procedures
15.	- Implementing change in your own organization: Theory and practice (3) The Balanced scorecard and Monitoring-feedback systems for optimization
16.	- Student projects and discussions
17.	- Student projects and discussions
18.	Final deliverables (Project oral discussion, open book exam, Reflective Overview and oral discussion)
Teaching and learning strategies:	This course will be taught through lectures, and case study material.
Course Material	Essential reading: Course material and presentation pamphlets will be extended to participants upon admission.
Assessment scheme:	Course Project and Oral discussion (50%); Open Book Exam (30%), Reflective Overview (20%)

9.4. Regulations pertaining to the required training in the field of Healthcare Management and Leadership

13/2002. (III. 28.) EüM rendelet
a gyógyintézetek vezetőjének és vezetőhelyetteseinek képesítési követelményeiről, valamint a vezetői megbízás betöltése érdekében kiírt pályázat részletes eljárási szabályairól

Az egészségügyi szolgáltatókról és az egészségügyi közszolgáltatások szervezéséről szóló 2003. évi XLIII. törvény 35. § (2) bekezdésének f) pontjában kapott felhatalmazás alapján a következőket rendelem el:

1. § (1) Egészségügyi közszolgáltatást nyújtó gyógyintézet (a továbbiakban: gyógyintézet) vezetésével olyan személy bízható meg, aki
a) (orvostudományi vagy egyéb) egyetemi szintű végzettséggel,

b) egészségügyi (szak)menedzseri képesítéssel vagy egészségügyi menedzsment szakirányú továbbképzési szakon szerzett képesítéssel, valamint
c) legalább ötéves vezetői gyakorlattal
rendelkezik.
(2) Az (1) bekezdés b) pontjában előírt képesítési feltétel alól - a 4. §-ban foglaltak szerint -, illetőleg a vezetői gyakorlat megléte alól a fenntartó felmentést adhat. Ha a gyógyintézet az egészségügyi közszolgáltatásért felelős szervvel kötött szerződés alapján nyújt egészségügyi közszolgáltatást, a felmentéshez ki kell kérni a közszolgáltatásért felelős szerv egyetértését is. Az Egészségügyi, Szociális és Családügyi Minisztérium (a továbbiakban: minisztérium) közvetlen felügyelete alá tartozó gyógyintézetek tekintetében a felmentésre a kinevező (megbízó) jogosult. Az (1) bekezdés b) és c) pontjaiban előírt feltételek alól együttesen is adható felmentés.

2. § (1) A gyógyintézet orvosvezetőjévé (a gyógyintézet vezetőjének orvosvezető-helyettesévé) az nevezhető ki, aki
a) orvostudományi egyetemi végzettséggel, szakorvosi képesítéssel (szakkórház esetében az adott szakterületnek megfelelő szakorvosi képesítéssel), valamint a megelőző tíz évben legalább öt év gyakorló orvosi tevékenységgel,
b) egészségügyi (szak)menedzseri képesítéssel vagy egészségügyi menedzsment szakirányú továbbképzési szakon szerzett képesítéssel vagy jogi szakokleveles orvos szakirányú továbbképzési szakon szerzett képesítéssel, valamint
c) legalább hároméves vezetői gyakorlattal
rendelkezik.
(2) Az (1) bekezdés b) pontjában előírt képesítési feltétel alól - a 4. §-ban foglaltak szerint -, illetőleg az előírt vezetői gyakorlat alól felmentést az intézeti vezető javaslata alapján a fenntartó adhat. Az (1) bekezdés b) és c) pontjaiban előírt feltételek alól együttesen is adható felmentés.

3. § (1) A gyógyintézet ápolási igazgatójává az nevezhető ki, aki
a) egészségügyi főiskola diplomás ápolói, intézetvezetői, szakoktatói szakán vagy tudományegyetemen szerzett diplomás ápolói oklevéllel,
b) egészségügyi (szak)menedzseri képesítéssel vagy egészségügyi menedzsment szakirányú továbbképzési szakon szerzett képesítéssel, valamint
c) legalább hároméves vezetői gyakorlattal
rendelkezik.
(2) Az (1) bekezdés b) pontjában előírt képesítési feltétel alól - a 4. §-ban foglaltak szerint -, illetőleg a vezetői gyakorlat alól felmentést - indokolt esetben - az intézeti vezető javaslata alapján a fenntartó adhat. Az (1) bekezdés b) és c) pontjaiban előírt feltételek alól együttesen is adható felmentés.

4. § Az 1. § (1) bekezdés b) pontjában, a 2. § (1) bekezdés b) pontjában, valamint a 3. § (1) bekezdés b) pontjában előírt képesítés alól felmentés abban az esetben adható, ha a pályázó (jelölt) a képzésben részt vesz, vagy vállalja a képesítésnek - a kinevezés (megbízatás) adásától számított - öt éven belül történő megszerzését.

4/A. § Az 1. § (2) bekezdésében, a 2. § (2) bekezdésében, a 3. § (2) bekezdésében szabályozott felmentéshez a gyógyintézet szakmai vezető testületének egyetértése szükséges.

5. § (1) A gyógyintézet gazdasági igazgatójává (gazdasági vezetőjévé) az nevezhető ki, aki
a) szakirányú felsőfokú iskolai végzettséggel vagy felsőfokú iskolai végzettséggel és emellett mérlegképes könyvelői vagy ezzel egyenértékű szakképesítéssel, valamint
b) legalább hároméves vezetői gyakorlattal
rendelkezik.
(2) Az (1) bekezdés b) pontjában előírt vezetői gyakorlat alól felmentést az intézeti vezető javaslatára a fenntartó adhat. A minisztérium közvetlen felügyelete alá tartozó intézmények tekintetében - az intézet vezetőjének javaslatára - felmentést a kinevező (megbízó) adhat.
(3) Gyógyintézet gazdasági igazgatója esetében szakirányú felsőfokú végzettség tekintetében a közgazdasági (pénzügyi) felsőoktatásban alapképzésben szerezhető képesítéseket kell irányadónak tekinteni.

6. § E rendeletben szabályozott vezetői, illetőleg vezető-helyettesi (orvos-, illetve ápolási igazgatói, gazdasági igazgatói), valamint osztályvezetői, illetőleg intézeti vezető főgyógyszerészi, intézeti főgyógyszerészi beosztások pályázati eljárás során tölthetők be. A pályázati feltételekre, valamint a pályázati eljárásra a közalkalmazottak jogállásáról szóló 1992. évi XXXIII. törvény egészségügyi ágazatban történő végrehajtásáról szóló 233/2000. (XII. 23.) Korm. rendeletet kell megfelelően alkalmazni.

7. § Az e rendeletben használt fogalmakra az egészségügyi szolgáltatás gyakorlásának általános feltételeiről, valamint a működési engedélyezési eljárásról szóló 96/2003. (VII. 15.) Korm. rendeletben meghatározott fogalmak az irányadók.

8. § Ez a rendelet 2002. március 31-én lép hatályba. Rendelkezéseit az ezt követően meghirdetésre kerülő pályázati eljárások tekintetében kell alkalmazni.