

Organizational change—key to capacity building and effective health promotion

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SUMMARY

Contemporary health promotion is now a well-defined discipline with a strong (albeit diverse) theoretical base, proven technologies (based on program planning) for addressing complex social problems, processes to guide practice and a body of evidence of efficacy and increasingly, effectiveness. Health promotion has evolved principally within the health sector where it is frequently considered optional rather than core business. To maximize effectiveness, quality health promotion technologies and practices need to be adopted as core business by the health sector and by organizations in other sectors. It has proven difficult to develop the infrastructure, workforce and resource base needed to ensure the routine introduction of high-quality health promotion into organizations. Recognizing these problems, this paper explores the use of organizational theory and practice in building the capacity

of organizations to design, deliver and evaluate health promotion effectively and efficiently. The paper argues that organizational change is an essential but under-recognized function for the sustainability of health promotion practice and a necessary component of capacity-building frameworks. The interdependence of quality health promotion with organizational change is discussed in this paper through three case studies. While each focused on different aspects of health promotion development, the centrality of organizational change in each of them was striking. This paper draws out elements of organizational change to demonstrate that health promotion specialists and practitioners, wherever they are located, should be building organizational change into both their practice and capacity-building frameworks because without it, effectiveness and sustainability are at risk.

Key words: health promotion; organizational change; capacity building

INTRODUCTION

Organizational change is included in capacity-building frameworks for health promotion (NSW Health, 2001) but is insufficiently explored as an element in its own right of quality planning frameworks. Here, we argue that organizational change should be applied more purposefully to both types of frameworks, quality and capacity building, if health promotion is to be strengthened. Organizational change needs to be explicitly addressed in every organization involved in sustainable and effective health promotion practice.

In this paper, we first examine the conceptual dimensions of quality in health promotion and then capacity building. Three illustrative case studies about health promotion are then presented, each drawn from larger studies that are reported elsewhere (Heward, 2003; Hutchins, 2003; Keleher *et al.*, 2005). Here, our analysis is on what we have learned about organizational change and its centrality to the situations we studied. Finally, we locate our learning in the broader literature, proposing a redefining of capacity building in health promotion to ensure organizational change is included as an imperative rather than an optional extra.

Our studies were conducted in Victoria, Australia, where the government is progressively strengthening the health promotion agenda. Strategies developed include a community health policy framework (DHS, 2004a), an emphasis on integration and partnering (DHS, 2004b), investments in workforce development programs, changes to funding guidelines and funding streams and raised expectations about the contribution of various types of services to the health promotion effort. Emphasis is increasingly on the social, economic and environmental determinants of health and on strategies to reduce differentials in health status (DHS, 2003).

There has been a proliferation of conceptual frameworks and heuristic devices to help guide health promotion theory into practice (Maycock and Hall, 2003). This paper will not attempt to summarize or critique the enormous body of work about strengthening health promotion practice. Instead we will focus on common elements from our studies that inform and develop our understanding of organizational change for health promotion and suggest how their incorporation into practice will strengthen quality and capacity-building frameworks.

QUALITY IN HEALTH PROMOTION

Through the 1990s, the interpretation of quality methods into health promotion programs became a preoccupation in the international literature (Davies and Macdonald, 1998; Goodstadt, 1999; Haglund *et al.*, 1998; Keijsers and Saans, 1998). This was perhaps related to the competition for scarce resources, particularly in the climate of competitive contract tendering, as well as recognition of the critical role that quality plays in program effectiveness (Haglund *et al.*, 1998).

Common to the principles of quality management and health promotion is the use of evidence, planning and theoretical frameworks to inform program development, with a myriad of planning models produced worldwide to guide practitioners through planning processes. Models provide guidance for practitioners in designing health promotion programs through a continuous series of steps or phases in planning, implementation and evaluation. They are not prescriptive, recognizing that health promotion is interpreted and practiced in many different ways. Grounded in the disciplines of epidemiology, the social, behavioral and educational sciences and health administration,

planning models also serve to organize existing theories and constructs (variables) into a cohesive, comprehensive and systematic view of relations among those variables important to planning and evaluation of health promotion.

Program planning is considered as one of the key technical processes within health promotion practice and is considered critical to its effectiveness (Keijsers and Saans, 1998; Hutchins, 2003). The emphasis on quality in health promotion has embraced this with a shift in language to *quality health promotion* practice, partially reflecting the implicit nature of quality in what is defined as good practice planning in any given health promotion process (Davies and Macdonald, 1998). Kok (1993) argued that the effectiveness of health promotion programs depends to a large extent on the quality with which the projects are planned. A meta-analysis by Mullen *et al.* (1985) revealed that the quality of planning of programs is actually more important for the program effectiveness than the specific methods that are used.

The use of planning frameworks within health promotion shifts underlying concepts, principles and practice to a more explicit position. They force practitioners to reflect upon the extent to which their organization is incorporating health promotion principles into programs. Maycock and Hall (2003) identified that a quality management process ensures that practitioners who may have varying levels of knowledge and skills at least adhere to best practice or even better, reflect critically on what they are doing and why.

But practitioners are only part of the quality picture. An emphasis on infrastructure, systems and organizational development has also been argued as key to the creation of supportive environments for quality health promotion practice (Bensberg, 2000; Heward, 2003). The existence of planning frameworks and professional knowledge of these frameworks will change little or improve the quality of practice if they do not also affect the effort put into implementation (Keijsers and Saans, 1998; Hutchins, 2003).

CAPACITY BUILDING IN HEALTH PROMOTION

There is limited research into the process of introducing and maintaining quality improvement processes in health promotion (Maycock and Hall, 2003). The introduction of capacity building in

the 1990s, however, has provided a guiding framework to support the introduction of quality concepts into organizations.

Capacity building grew out of understanding that three core components are required to ensure that a service system has an adequate health promotion response. These are: a mandate to act, a framework for action and the capacity to act (Harris *et al.*, 1995; Bowen *et al.*, 2001). Building the capacity to act was originally labeled as the 'invisible work of health promotion' required to reorient health systems for quality health promotion practice (Hawe *et al.*, 1998). It is now described as a tangible approach to the development of sustainable skills, organizational structures, resources and commitment for health improvement necessary for health gain (Hawe *et al.*, 2000).

Capacity building as a set of strategies can be applied both within programs and across systems to lead to greater capacity of people, organizations and communities to promote health. New South Wales (NSW) Health have been instrumental in building the case for the role of building capacity of health and other sectors to ensure quality, effective health promotion practice. Five key action areas have explicitly guided the capacity building effort within Australia including organizational development, workforce development, resource allocation, leadership and partnerships (NSW Health, 2001).

The NSW capacity-building framework also introduces practical tools to evaluate capacity for quality health promotion practice (Hawe, 2000). However, while capacity building as a collective of strategies answers some of the *what and how* of the change process, these cannot be pre-determined and need to be shaped, given the contextual features of the organization or

system (NSW Health, 2001). For quality health promotion practice, there needs to be explicit responsibility and importance placed on planning. This must be coupled with the ability to manage the organizational context so that change processes are implemented in a reflective cycle of improvement (Heward, 2003).

ORGANIZATIONAL CONTEXT FOR CHANGE, IMPROVEMENT AND INCREASED QUALITY

There is no single theory that neatly explains how organizations change and the sheer size and scope of the literature makes it difficult to draw conclusions or find guidance (Iles and Sutherland, 2001). Most of the literature relating to change management is aimed at the private sector whose core business is to create profit rather than improve social and health outcomes. There is a scarcity of literature specifically related to practical examples of managing change in the health promotion field. This might be a result of the relative infancy of a situation where its means something more than projects being delivered when grant funding is released (Heward, 2003). Despite this there are lessons to be learnt, as there are similarities within organizations from the private and public sectors (Garside, 1998).

Organizational change is typically described as a staged process. Hamlin *et al.* (2001) offers a generic composite model for managing organizational change, as shown in Figure 1.

This staged process is only a guide as an organization's behavior cannot often be predicted and change does not occur in a neat sequential process (Garside, 1998). Organizations are

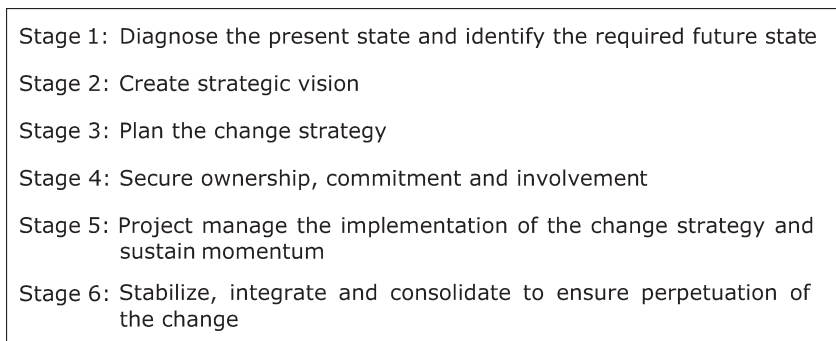


Fig. 1: A generic model for managing planned organizational change.

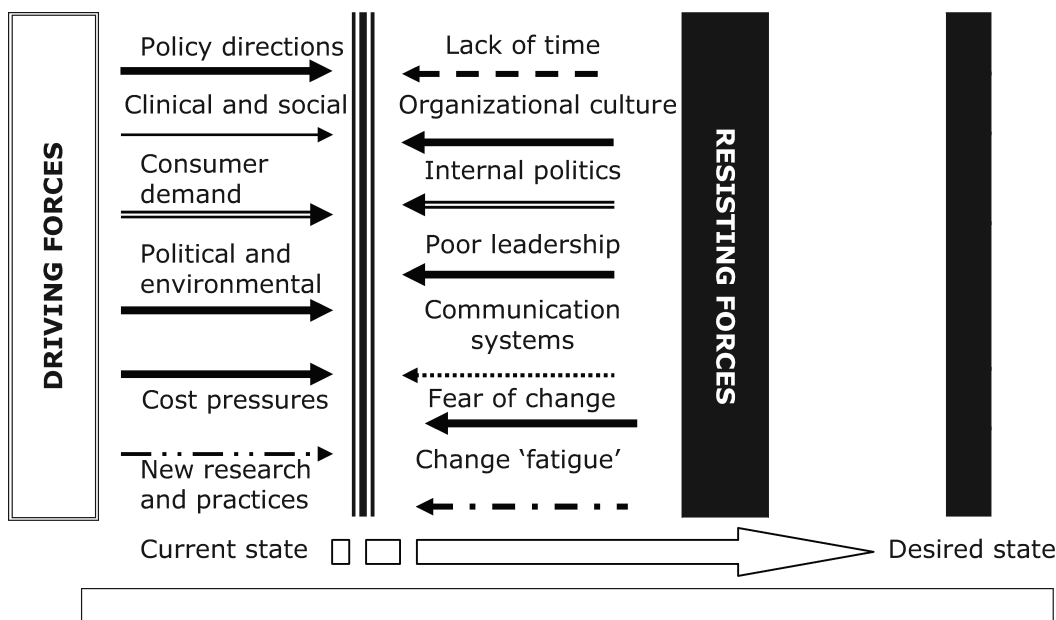


Fig. 2: Organizational change force field model (adapted from Lewin by Heward, 2003).

complex and often described as layered where change is influenced by the environment from its broadest level of structure through to its teams and individual staff members. Understanding of how an organization functions, its structure, culture and core business is essential before effective strategies for change can be developed (Hamlin *et al.*, 2001). The literature abounds with theories and frameworks that try to make sense of organizational behavior, but two models provide useful organizational change frameworks.

A model applied in the early 1990s to the NHS by Pettigrew *et al.* (1992) proposed that change within an organization could be understood within the organization's historical, cultural and political context. The model outlined successful change as a result of interaction between the context, process and content of change. They described the internal and external context as the *why and when* of change, and the process of change as the *how* or the actions of various stakeholders in the change process. The content of the change process is referred to as the *what* of change, for example, within the health sector this may mean the introduction of a new planning framework. This model recognizes that any intervention (be it a set of strategies to promote health or the introduction of a tool to improve quality) is introduced into a pre-existing set of social, political and structural contexts and the effects of

change should be anticipated and planned for, particularly where resistance is predicted.

Lewin's (1951) force field analysis (Figure 2) describes organizational change as a process shaped by the balance or equilibrium of the driving and restraining forces for change. The process, as Lewin describes it, involves unfreezing the current organizational change equilibrium, changing to a new position (the desired state) and refreezing the new equilibrium position. The driving forces are described as those that initiate or keep change going, ultimately pushing change in the direction of the desired state (Figure 2). The restraining forces are those acting to reduce the effect of the driving forces (Iles and Sutherland, 2001).

In reviewing Lewin's model, Iles and Sutherland (2001) and Siler-Wells (1987) suggest that for the equilibrium to be shifted toward the desired state (where organizational change occurs), the important factors include:

- (1) Developing a state of readiness for change.
- (2) Decreasing the resisting forces where possible. This relieves tension and by default shifts the equilibrium to the desired state. Increasing the driving forces results in an increase of the resisting forces, so in effect the equilibrium does not change because there is greater tension.

- (3) Understanding that organizational culture, internal politics and group norms are key resisting factors.

A fundamental aspect of ensuring change is managing the dynamic process that is triggered by the innovation or 'the upsetting force' (Yeats, 2002). Equally as important is recognizing that change in practice is more often a continuous process rather than discretely sequential or linear (Garside, 1998; Hamlin *et al.*, 2001; Iles and Sutherland, 2001).

Organizations are richly layered, and a collective of organizations within a system adds dimensions that need to be interpreted and understood in order to develop effective change processes (Bensberg, 2000; Yeats, 2002). Change in health systems requires a vision and understanding of the core functions of the system and infrastructure supporting those core functions. Change involves a range of players and needs to be both led and managed (Garside, 1998; Heward, 2003).

Complex adaptive systems are defined as 'a collection of individual agents, who have the freedom to act in ways that are not always totally predictable, and whose actions are interconnected such that one agent's actions changes the context for other agents' (Zimmerman *et al.*,

1998). Relating this thinking to health organizations and systems, the literature suggests that control and preset benchmarks are only appropriate for simple systems (Zimmerman *et al.*, 1998). While chaos should always be avoided, there is a space between simple and chaos, the 'zone of complexity', which requires a systematic yet flexible approach to implementation and the change management strategies required (Figure 3). Much of the policy and practice related to health promotion probably sits in this zone of complexity. The task sits with assembling the evidence to increase certainty about the effects of action and to use change management techniques actively and appropriately to increase agreement (Speller, 2001). For successful institutionalization of changes, an implementation design is required that corresponds with all levels of the organization or system. This ideally includes a joint top-down and bottom-up approach (Butt, 1998) that is flexible and informed by a reflective review process (Hancock, 1999).

The literature demonstrates the need for both explicitness about quality in health promotion and distinct organizational development strategies. These factors are encompassed in the key action areas of the NSW capacity-building framework (2001). However, the literature supporting this framework is also very clear that

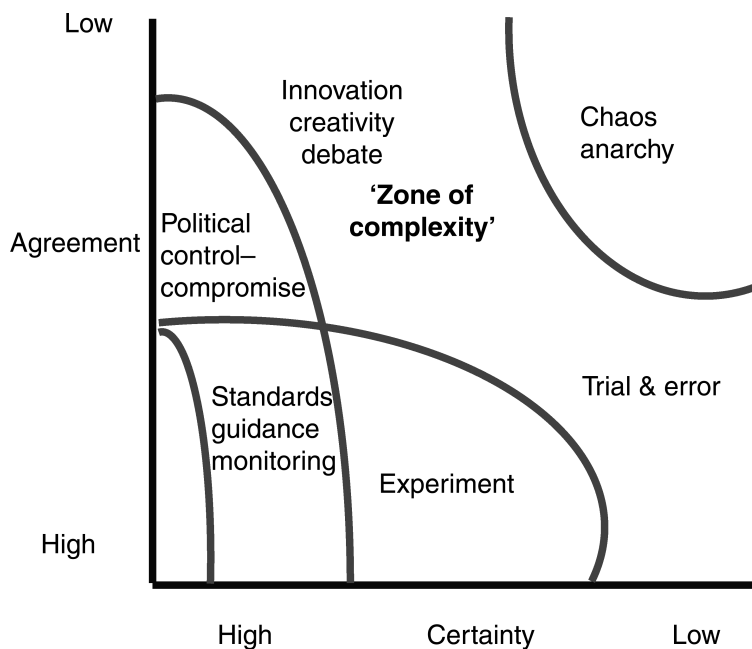


Fig. 3: Stacey's Agreement & Certainty Matrix (Stacey, 1999; adapted by Speller, 2001).

capacity building as a collective of strategies answers some of the *what* and *how* of the change process. These strategies need to be shaped, given the contextual features of the organization or system (Heward, 2003).

Each of the case studies presented here was concerned in different aspects of health promotion, but all revealed aspects of organizational change as essential for effectiveness and sustainability.

CASE STUDY 1: HEALTH PROMOTION POLICY INTO PRACTICE – CREATING STRATEGIC VISION

Since 2000, the Victorian Department of Human Services (DHS) has invested significant resources into building collaborative partnerships to improve the capacity of the primary and community health sector to plan, implement and evaluate health promotion with a focus on integration and partnerships. This resource input was reinforced with financing reforms, which reinvigorated the emphasis on planned health promotion programs in the community health sector. The literature on quality in health promotion practice, capacity building and organizational change is complementary. They all make repeated calls to be explicit about having an emphasis on planning at the practitioner level *coupled* with change processes at the organizational level to ensure sustainable, evidence-based programs. The NSW capacity-building framework (2001) and Lewin's (1951) force field model were iteratively used to build a conceptual model to map and analyze capacity building strategies implemented by the DHS in one region of Victoria, as an exemplar, from June 2000 to September 2003. The region covers significant rural areas and several provincial towns and cities. The mapping exercise demonstrated that a broad range of strategies have been implemented to support integrated practice across a range of sectors. Four key elements of capacity building and change were identified:

- (1) the policy environment;
- (2) trust, relationships and readiness for partnerships;
- (3) leading and validating the role of health promotion and
- (4) workforce development.

The key driving and resisting forces emerging from these elements concur with those identified in change management theory including communication with all layers of the system; active commitment and involvement of managers; having a clear consistent vision and having adequate resourcing for practice and internal change. This needed to be balanced with an external supportive environment where there is a managed policy process for change.

Upon reflection these forces seem obvious but the significance of change and the role that DHS policy officers and key champions in the sector need to play as change managers or facilitators has sometimes been forgotten in the search for quantifiable outcomes and the application of practice tools. If these steps are forgotten, then change is unlikely to occur. The reflection process used in this project demonstrated how using overt steps of review and change diagnosis can reveal key driving and resisting forces. Developing policy is an intertwined web of political and policy implementation actions. A lack of reflection on the implementation of policy strategies was recognized as a crucial impediment to ensuring policy relevance, improving operational programs and informing new policy environments.

CASE STUDY 2: PLANNING A CHANGE STRATEGY

The Victorian computer-based planning tool, Quality Improvement Program Planning System (QIPPS), was trialed for six months (2002–2003) within a large community health centre, with the aim of improving health promotion service plans written by staff from multidisciplinary backgrounds. The study framework was designed to increase an understanding of the process of change within the staff and the organization when the QIPPS tool was trialed. Lewin's forcefield analysis and a model applied to the NHS (Pettigrew *et al.*, 1992) were applied to analyze qualitative data gathered. The data were used to critically assess the progress of the trial and inform strategies to support staff to adopt QIPPS. After six months, use of QIPPS by staff had improved slightly but the adoption of the planning tool was not widespread. The change management models provided a useful framework to uncover the main barriers to change and to understand the cultural,

political and historical contexts within the organization to those barriers. For instance, a critique of the strategies planned to support the introduction of the tool found that the work plan did not reflect upon the readiness of the staff and the organizational cultural context for the change. In devising a plan to introduce QIPPS, the management team fell into the trap of not sufficiently managing the organizational culture or recognizing some of the less visible aspects of the culture that were not ready for change. Critical reflection of the results with the literature provided many more insights into the apparent failure of the organization to adopt QIPPS as its new program planning system.

These insights formed the basis for a set of recommendations directed at management and staff to improve staff and organizational readiness for change. A review of the literature revealed that the articulation of a vision for the desired future is essential to implementing change. Management were encouraged to focus on communicating the vision, values and priorities outlined in the organization's policy documents to staff.

At an individual level, the research indicated that staff did not have the knowledge, understanding or skills required to undertake a quality program planning process and they needed more support to use the QIPPS. It was recommended that any future informal or formal training strategies should include conceptual learning (new frameworks for understanding situations and events) and operational learning (learning steps required to perform tasks and routines). In addition, training should be based upon adult learning principles to increase the likelihood that staff will engage in solving organizational problems if they can see links between the organization and their own interests.

The study's recommendation launched a new approach for the organizational adoption and application of QIPPS. Six months after the start of a new approach to change the planning tool was being used more by staff and management.

CASE STUDY 3: WORKFORCE DEVELOPMENT—INSUFFICIENT FOR ORGANIZATIONAL CHANGE

As part of a statewide workforce development strategy that linked with the policy reforms

explained in case study 1, DHS funded the development and delivery of a five-day Short Course in Health Promotion (the Short Course), which was completed by over 800 participants in 2001–2002 and another 800 in 2002–2003. Course participants were drawn from primary and community health, acute health, alcohol and drug services, local government and sports assemblies. In 2003, evaluation research was conducted with the first 800 Short Course participants. The research design utilized a triangulated study incorporating a survey distributed to all participants, and interviews/focus groups with over 80 stakeholders, results of which are reported elsewhere (Keleher *et al.*, 2005). In summary, the majority of respondents reported that the course built their knowledge, understanding and skills and improved their capacity to understand the language of health promotion. The Short Course provided them with the confidence to access networks, and a knowledge and evidence base that was previously beyond their reach.

Organizational change emerged as a major theme in the study and involved the barriers to participants attempting to implement change in the workplace after completing the course. Participants were dissatisfied with aspects of health promotion infrastructure and capacity within their organizations, placing greater importance on domains of organizational capacity than on organizations' actual performance in change to support health promotion. The barriers to health promotion were most commonly described as systemic, structural or funding. One common viewpoint was the need for more management support with an emphasis on systems. Capacity building of more senior staff was thought necessary to help them understand health promotion concepts and orientation. While there was wide agreement about the value of quality advanced health promotion training to shift organizations toward health promoting work, barriers to participant uptake of the knowledge and skills learned in the Short Course were primarily about the degree of opportunity to practice health promotion within their own organization.

Managers commented that the changes need to occur from the top down, while course participants were more inclined to argue for the need to develop skills in 'managing up'. Understanding what it means to build infrastructure for health promotion in the organization was seen to

require a big shift in culture. Organizational change depended on a shared language and a focus on the social determinants of health. Health promotion planning was understood to be everybody's business, so organizational change was about the embracing of health promotion across inter-disciplinary teams. Mentor systems to support the growth of health promotion and shifts in funding toward health promotion targets were also identified as elements of organizational change. Networking and partnership outcomes had shifted over time, from being somewhat nebulous to more defined for their capacity to strengthen health promotion.

DISCUSSION

The relevant literature, and the findings of our research, as illustrated by the case studies, indicates the need to expand the capacity building model to include organizational change. Organizational development is insufficient for this purpose. The case studies demonstrate that practitioners and managers who understand organizational change provide vital leadership for ensuring the efficiency and effectiveness of health promotion. Case study 1 illustrates the principle of creating strategic vision. Case study 2 highlights the difficulties of introducing new technical tools without a deliberate focus on organizational change to secure ownership and commitment to the new tools. Case study 3 illustrates the centrality of organizational change to workforce development which should not happen in a vacuum—support for staff to change their practice is critical to ensuring the investment in workforce development is maximized. Organizations as separate entities are not set up to work in partnerships, and they will always need some level of change practice to bring all the jigsaw puzzles of organizational partners together, particularly across sectors.

Understanding the multiple layers of organizational change in terms of both capacity building and quality planning is therefore necessary. Few health promotion managers or practitioners are likely to have a background in change, yet this is where a multilayered change approach is required. The case studies show that just applying a capacity building strategy in isolation, such as a short course for workforce development or a planning tool, has limited effect. We often think about where we want to get to, have a

vision and plan but if we do not think about the process to get there, none of those components will be sufficient to effect sustainable change.

Reducing organizational change to step-by-step models such as that provided in Figure 1 is a straightforward approach, but is rarely done. Diagnosing and visualizing how the program, policy or project is being implemented, together with understanding what multilayering is required and how to implement the different strategies to support change, are characteristics of managerial effectiveness for health promotion development.

Frameworks reduce action to things that are manageable and discreet but frequently organizational change is perceived as intangible, so it is overlooked or forgotten. Frequently this reductionist approach is applied by implementing tangible things such as training, which is highly valued and easy to tick off as a task completed. Less valued are the informal and more complicated elements of workforce development such as networking and partnering, information sharing and mentoring that are critical success factors for consolidating change.

CONCLUSION

To increase efficiency and effectiveness of health promotion, capacity-building frameworks for health promotion must position organizational change as central to core business. Research is essential to strengthen the knowledge base and to emphasize organizational change as an action area of health promotion. Our three case studies reinforce that far from being peripheral, organizational change is a critical element to effective action. Health promotion specialists and practitioners, wherever they are located, should be building organizational change into their practice and their capacity-building frameworks because without it, effectiveness and sustainability are at risk.

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