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Innovation in primary care in Flanders. The case of the Primary Care Academy

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1. INTRODUCTION

This essay takes you along the journey I have experienced leading towards the foundation of the Primary Care Academy and the first half year of its existence. It provides you with my view on innovation which I apply to this innovative experiment in primary care in Flanders, Belgium.

I will take you along the journey by first providing background information about the Academy and the dynamics leading towards its foundation. Afterwards, I reflect on the key determinants of innovation in public health care in general and in the Academy in particular. For each determinant I assess the growing edges of the Academy and myself as the leading manager and co-founder of the Academy.

The following definition of innovation will be used: "*novel behaviors, routines, and ways of working geared toward improving health outcomes, administrative efficiency, cost effectiveness, and users' experience and that are implemented by planned and coordinated actions*" (following the definition of Greenhalgh et al., 2004, p. 581).

2. BACKGROUND

Worldwide, there is a growing number of people with complex and long-term care needs due to concurrent chronic conditions, functional and cognitive impairments, mental health challenges and social vulnerability (Barnett et al., 2012; Kuluski et al., 2017). The growing number of people with complex care needs and chronic conditions puts pressure on health and social expenditures (World Health Organization, 2015). In Belgium (and elsewhere), people's preference to live and age healthy in their home environments, combined with their increased health consciousness and literacy, have vast consequences on current health and social policies and practices (World Health Organization, 2008). The recent shift in Belgium from a focus on acute and institutional care to complex and long-term care is recognized and documented in many policy plans and position papers (Paulus et al., 2012; Vlaams Ouderenbeleidsplan 2015-2020, 2016; Woonzorgdecreet, 2009). However, care provision does not yet respond sufficiently to the day-to-day living strategies of care receivers, which is a consequence of a fragmented and poorly coordinated healthcare system that lacks a holistic, person-centred approach (Agentschap Zorg en Gezondheid, 2017; Verté, 2017).

Belgium is a small and complex country, with many levels of decision-making (Sub regional levels, Flanders/Brussels/Walloon Regions, Federal level). This makes any innovation in the public sector especially difficult, but not impossible. Prior to founding the Academy, the team members engaged in many (some still ongoing) health and social innovations Belgium. To name a few: Protocol 3, Vitalink, E-health, Geïntegreerd Breed Onthaal, Bind-Kracht, Caring society, 'Healthy Communities', Zorgproeftuinen, neighborhood-oriented care and connecting welfare and health care services (e.g. G-care). Despite of the recent upsurge of care and social innovations in policy, practice, and academia, the initiatives are not aligned with each other nor are they intertwined, let alone implemented or improve patients health. On top of that, all of those innovations depend(ed) upon funding from governing bodies. This resulted in a call at which we responded with an independent and coordinated care innovation initiative that merges all present potential in primary care to reinforce the existing capacities, to accelerate primary care innovation, and to ensure positive changes in the experience of all primary care stakeholders (care receivers and formal and informal care providers). Hence the foundation of the Academy.

3. INNOVATION IN A COMPLEX HEALTH ORGANISATION

According to a literature review performed by Lloyd et al. (2018) successful innovation in health care is determined by a complex interaction of determinants i.e.:

1. a clear and shared vision;
2. structure, support and resourcing for innovation;
3. leadership;
4. organizational culture; and
5. organizational learning.

Given that these determinants are grounded in health care, I will use these determinants to discuss the innovation in my case. More specifically, in this section I reflect on each of the innovation dimensions building on the case of the Primary Care Academy.

3.1. Clear and shared vision

A lack of common language amongst primary care professionals of different backgrounds (e.g. general practitioners, nurses, social workers, primary care psychologists) hampers effective adoption of care

innovations (Rapport et al., 2016). These characteristics of interdisciplinary primary care practice and policy also trickled down into the initial stage of founding the Academy. Despite this, due to the bottom-up approach and because of the intense participatory decision-making process, a shared vision and strategy was developed, and a common language emerged, which allowed the Academy to evolve towards maturity.

More specifically, after different consultation rounds the team members of the Academy all agreed upon the general aim to realize inclusive, proactive and person-centred primary care in the large population of people with moderate complex problems. To achieve this, the Academy defined three strategic goals:

1. To build an interdisciplinary network of teachers and researchers in primary care that enforces state-of-the-art primary care practice in teaching and research;
2. To develop and implement innovative tools and strategies for proactive and person-centred primary care, built upon the principles of goal-oriented care, self-management and interdisciplinary primary care networks embedded in the community;
3. To build capacity of care receivers and formal and informal care providers in primary care.

After defining the vision and strategy, operational targets for six "product lines" (in research projects also called work packages) were determined and milestones were set, each time through an intensive co-design process.

3.2. Support, structure and resourcing for innovation

As the Academy finds itself at the beginning of the S-curve, in the "Era of Ferment", most of the resources are spent on research and development. However, due to the intrinsic nature of the Academy, research and development will always be the main focus. To manage the journey from searching to executing, the Academy knows what phase "the products" (as in tools and strategies for primary care 2.0) are in. The life cycle for each of the six "product lines" of the Academy beholds creating and testing ideas, followed by a learning and modifying phase, and eventually leading to scaling up the validated tools and strategies (Viki et al., 2017). To improve primary care and ensure public health policies are well grounded, it is imperative to translate science into action (Rapport et al., 2016). Nonetheless, implementation and adoption of health and social care research is often hampered. In response to this, the Academy has made it imperative to complete the full life cycle by also concentrating on implementation of the new tools and strategies by creating a governance structure "Knowledge Transfer

Interface" and a dedicated product line or work package "Evaluation and implementation of primary care interventions".

The value hypothesis is a huge strength of the Academy. To meet the customer needs the Academy bears on a systematic user co-creation approach integrating research and innovation processes. This systematic user involvement is integrated in the research and teaching of the Academy using a co-creation and evaluation approach to innovative ideas, scenarios, concepts in real life primary care cases. In particular, the Academy adopts the concept of "living labs", which is a user-centred open-innovation ecosystem that can be compared to the concept of experiential learning (i.e. users are immersed in a social space of designing and experiencing their own future) (Bergvall-Kareborn & Stahlbrost, 2009). Consequently, the Academy involves user communities not only as observed subjects but also as a source of creation at the earlier stage of research and teaching, and throughout the complete project life cycle (Farmer et al., 2018). This approach has a proven track record to enhance implementation and adoption for it creates a sense of co-ownership. This strategy of knowledge creation also incorporates market learning on a structural basis. Moreover, adapting to change in patient or citizen needs, public policy or the market is part of the Academy's DNA through the governance structure and the strategic innovation management. What is interesting here, is that the Academy's core is being an accelerator for primary care innovation. Separate processes for managing innovation versus core business therefore does not apply to the current Academy.

The big challenge will be the growth hypotheses of the Academy. How will we grow and ensure revenues and paying customer numbers? Although it is not the aim to profitable, financial self-sustainability is crucial for longevity of the Academy. This brings us to a care paradox. In public health the end-consumers, the health and social care receivers, assume they have the "right" to high quality care at low cost, which is a consequence of the Belgian social security system. They pay taxes and expect a return. This, in turn, influences the price setting by primary care providers. In light of the cuts in public spending and the care paradox, the Academy that prides on her neutral position, will have to be utterly creative and be both internally and externally innovative to achieve a sound state of self-sustainability.

3.3. Leadership

The Academy enforces a person-centred, empowering approach that is perceived as a fundamentally new paradigm for the provision of services to people with moderately complex care needs (Bengtson & Settersten, 2016). Moreover, it is part of the Academy's mission to turn around the long-lasting

negative perspective in care toward a positive, empowering care paradigm. Theories that guide consumer-directed initiatives in policy and practice revolve around the autonomy of an individual, assuming maximum decision-making power and control over care negotiations (Hooyman et al., 2016). This correlates perfectly with the way the Academy is led by the executive management. The emphasis on capacity building and learning (i.e. growth mindset) is not only directed externally to the primary care community, but also internally to the team members.

Leadership behaviour that is rooted in ethical and caring behaviour gains importance due to the societal changes (van Dierendonck, 2011). Being in charge of the day-to-day management of the Academy, I aim to demonstrate servant leadership through empowering and developing the team members, through expressing authenticity, trust and safety, and through providing direction (van Dierendonck, 2011). Leading innovation-concepts like “freedom in a box” and “leading by example” as suggested by John Metselaar (2018), perfectly describe the leadership style that is displayed in the Academy. Given the fact that the Academy adopts a participatory process for making and implementing decisions, its governance is all about the best possible process for making those decisions as opposed to making ‘correct’ decisions. The Academy subscribes to a high-quality dyadic relationship which requires active involvement of all stakeholders (team members, policy makers, care receivers and care providers). The governance structure of the Academy reinforces a multi-stakeholder approach by mediating, actively involving and managing relationships with:

- the six project teams through the “Steering Committee”, at operational level;
- the primary care sector through the “Advisory board”, at strategy level;
- international experts in health and social (primary) care through the “International Panel”, at strategy level; and
- broader society and other relevant stakeholders through “Friends of the Primary Care Academy”, at the operational level.

3.4. Organizational culture

As the Academy revolves around primary care and ultimately is about quality of life of both care receivers and care providers, it is part of the open innovation culture that each team member frequently goes out to the community to witness the impact of their work. It makes the values of the Academy more concrete and inspires team members to generate ideas and to perform and excel in their work.

Being a peculiar start-up organization, the Academy lacks the power of a strong brand, a heritage or tradition. An effective leader is also responsible to intentionally plan the culture for the benefit of the

organization (Kuslina & Widjaja, 2018). Accordingly, a culture of trust should be formed, and the Academy and its key stakeholders should be bound in a shared destiny. Moreover, the Academy should become a place where the staff wants to stay and grow. The shared decision-making process to generate a mission and vision, and to determine the strategic goals in the earliest days of the Academy was a first step to shape a shared identity. The Academy could however take it up a notch by organizing a playful and creative brainstorming session for executives and key team members to consolidate our identity and invent a robust brand for the Academy.

However, it will remain a challenge for the Academy to overcome the different organizational cultures that the different team members bring along. The Academy can be perceived as a large project of cross-cultural collaboration, where multiple cultures interact and organizational processes merge. According to Smits & Brownlow (2017) this complexifies the context of the Academy as it politicized execution strategy considering the competing priorities among and between the team members. When members of the Academy execute strategies in such a complex context, they must continually re-examine the unity of the Academy's culture and must give way their individual corporate culture to the "Emergent we", which in this case is the Academy.

3.5. Organizational learning

The Academy emphasizes cross-fertilization between team members of the Academy and enables primary care learning communities in society. The teams were composed on the basis of maximum variety of disciplines and backgrounds, learning opportunities within and outside the Academy occur continuously. The commitment of the Academy to positively balance disciplines and knowledge institutions (maximum variety), gender (male/female), years of service (senior/junior), and geographical distribution (coverage of Flanders) creates an open innovation culture, encourages personal development and wellbeing of the team members, and improves overall team performance. Finally, also the innovation strategy of "living labs" and the annual network meetings add to the learning culture.

4. CONCLUSION

Innovation is critical to the sustainability and feasibility of Belgium's health system and is the driver of cost-effective and more efficient ways to address the challenges of cuts in public spending and increasingly complex care needs. Through the foundation of the Academy, a neutral collaborative hub

for primary care innovation, knowledge creation and dissemination was created, which is the first of its kind in Flanders, Belgium. The extensive state-of-the-art knowledge and network of the team members ensures spillover effects in both research and teaching, which accelerates innovation in primary care on the one end, and reinforces the interprofessional teaching and dissemination capacity in Flanders on the other end. The Academy is aware of the common struggle of translating science into action and therefore strategically decided on completing the life cycle by investing in operationalization and implementation of tools and strategies in primary care practice. Although the co-design DNA and the open innovation strategy sounds promising, the challenge lies in creating possibilities for synergetic collaboration between team members and economical self-sustainability of the Academy.

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