DEBATE

Organizational change theory: implications for health promotion practice

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SUMMARY

Sophisticated understandings of organizational dynamics and processes of organizational change are crucial for the development and success of health promotion initiatives. Theory has a valuable contribution to make in understanding organizational change, for identifying influential factors that should be the focus of change efforts and for selecting the strategies that can be applied to promote change. This article reviews select organizational change models to identify the most pertinent insights for health promotion practitioners. Theoretically derived considerations for practitioners who seek to foster organizational change include the extent to which the initiative is modifiable to fit with the internal context; the amount of time that is allocated to truly institutionalize change; the ability of the agents of change to build short-term success deliberately into their implementation plan; whether or not the shared group experience of action for change is positive or negative and the degree to which agencies that are the intended recipients of change are resourced to focus on internal factors. In reviewing theories of organizational change, the article also addresses strategies for facilitating the adoption of key theoretical insights into the design and implementation of health promotion initiatives in diverse organizational settings. If nothing else, aligning health promotion with organizational change theory promises insights into what it is that health promoters do and the time that it can take to do it effectively.

Key words: organizational change; innovation; capacity building; organizational development

INTRODUCTION

There is broad international consensus that building the capacity of communities, organizations and systems is a critical area of action for tackling the public health challenges of the 21st century. At the 7th Global Conference on Health Promotion in Nairobi, Kenya, a renewed call was made to build sustainable capacity and infrastructure to achieve the effective implementation of health and development strategies (World Health Organization, 2009). Ziglio and Apfel (Ziglio and Apfel, 2009), commenting on the actions required to address the priorities outlined by the WHO Commission on the Social Determinants of Health, emphasized the need to assess and build the capacity of health systems and other sectors. Capacities for policy advocacy, development, implementation and evaluation were highlighted as important. Most recently, in the Helsinki Statement on Health in all Policies issued at the 8th Global Conference on Health Promotion in Helsinki, Finland, there was recognition that building institutional capacity and skills will play a central role in achieving the implementation of Health in All Policies (World Health Organisation and Ministry of Social Affairs and Health – Finland, 2013). The Helsinki statement emphasized
capacity building in relation to the structures, processes and resources required for policy implementation across sectors.

Capacity building is understood to involve actions to improve knowledge and skills, support and infrastructure within organizations, and partnerships for action (New South Wales Health Department, 2001; Smith et al., 2006). The purpose of these actions is to create new approaches, values and structures for addressing health issues (Crisp et al., 2000) and ultimately sustainable systems for the ongoing execution of programmes (Potter and Brough, 2004). This situates organizations, their objectives and the way they conduct their day-to-day business, as a foremost concern in health promotion.

The settings’ approach, which has a central place in contemporary health promotion, has been described as essentially about developing a commitment to health within the cultures, processes and routine life of organizations (Dooris, 2006). In support of this, DeJoy and Wilson (DeJoy and Wilson, 2003) argue that the creation and maintenance of healthy workplaces is determined by organizational culture and leadership, reflected in practices, policies and values, and ultimately workplace climate, job design and job security. Whitelaw et al. (Whitelaw et al., 2012) have discussed the critical role of organizational capacity building in the development of Health Promoting Health Services (HPHS) in the UK, which involved creating a supportive policy context and alignment of HPHS with the underlying governance and appraisal mechanisms of health services. Efforts to develop healthy sporting settings have also given priority to organizational change (Crisp and Swerissen, 2003), so that policies and structures are put in place to enable the routinization of health promotion strategies.

The scaling up of health promotion strategies, and the engagement of partners within and outside the health sector in programme delivery, is another area of practice where organizational capacity building is of prime importance (Hanusaik et al., 2010; Hearld et al., 2012). Joffres et al. (Joffres et al., 2004), investigating the involvement of organizations in heart health promotion in Nova Scotia, Canada, found that leadership, management practices and sustained funding were determinants of the nature and extent of strategies that were implemented. In an evaluation of physical activity strategies by local councils in Melbourne, Victoria, Thomas et al. (Thomas et al., 2009) reached similar conclusions about the influence of senior leadership and internal management processes. The employment of a project officer with skills to engage senior managers and to facilitate collaborative planning within the councils was found to be a feature of those councils that were successful in achieving the programme’s objectives.

The creation of healthy settings and the development of partnerships to tackle the determinants of health are areas of practice where organizational development is a strategic priority. This places health promotion practitioners in the role of policy entrepreneurs and change agents, operating in organizational contexts that are often structurally, culturally and politically diverse. Devine et al. (Devine et al., 2008) report that the use of ‘independent’ people in worksite health promotion initiatives is fundamental for achieving mutually beneficial health and well-being outcomes through a change initiative. Health promotion practitioners may need to work with staff, managers and researchers, and consider the dynamics of the setting, the position of the change initiative within it, and then influence context, structure and culture. This raises the question about whether practitioners are equipped with an understanding of organizational dynamics and processes of change, to enable their work to be effective. Theory has a valuable contribution to make in this regard, for identifying influential factors that should be the focus of change efforts and for selecting the strategies that can be applied to modify these (Green, 2000; Lee et al., 2014). Theory also has an important role to play in guiding the evaluation of organizational change strategies and building the evidence base for this work (Birckmayer and Weiss, 2000). Little is known about knowledge and use of organizational change theory by health promotion practitioners, but one survey undertaken in Australia found that this was extremely low (Jones and Donovan, 2004).

As de Leeuw (de Leeuw, 2011) has argued, there is great scope for health practice innovation and improvement through interdisciplinary theoretical engagement. The purpose of this article is to review a selection of theories from management, education and social psychology disciplines that identify determinants of organizational practice and describe methods that can be used to instigate change. Models reviewed in this article include Diffusion of Innovations, Organizational Learning, Organizational Culture and Leadership, Action Research, the Three-step model and Field Theory and Receptive Contexts for Change. Following a
description of each, the theories are compared and contrasted, and their applications to current challenges in health promotion practice are considered.

**ORGANIZATIONAL CHANGE THEORIES**

A targeted literature search was conducted to identify influential organizational change models in the field of organizational development. Given the extent of this literature, the authors agreed on the following three inclusion criteria. Preference was given to theorists whose work appeared to have a foundational influence on the field. Additionally, theories that were explanatory in nature and therefore could provide interpretive value for health promotion were included. And lastly, theory developed from empirical research in settings to guide organizational change for health was included. The table below summarizes the key bodies of work that met these criteria, Table 1.

The review that follows will concentrate on common aspects across these organizational change models. For example, each perspective involves analysis of the setting, views change as a process and recognizes that each environment is unique. Additionally, each organizational perspective in the review that follows offers generic considerations applicable to any setting, and suggests that some conditions impinging on a setting can be manipulated to bring about a planned outcome.

**Lewin’s theories of change**

The work of Kurt Lewin has profoundly influenced the field of organizational development. He is most famously known for the development of field theory, group dynamics, action research and the three-step model of change. Burnes (Burnes, 2004) argues that the unification of these themes in Lewin’s work is necessary to understand and create change, and thus should be viewed by change practitioners in their totality rather than as separate theories. Field theory is a way of learning about group behaviour in a particular setting; it involves mapping the field in its entirety and considering its complexity and influence on the observed behaviours (Lewin, 1997a; Burnes, 2004). Lewin’s analysis proceeds from the conviction that individual behaviour is a function of the group environment or ‘field’. Field theory is ‘a method of analyzing causal relations and of building scientific constructs’; a focal point for analysis is the ‘nature of the conditions of change’ [(Lewin, 1997b), p. 201]. The field is the culmination of a number of interrelated factors in the environment; it is time dependent and maintained by varying ‘forces’ (Lewin, 1997b, c). These forces may include internal characteristics of the organization’s structure, strategy, management and personnel, or external characteristics, for example, the market and/or policy context. Lewin (Lewin, 1997c) argued that the analysis of these forces would enable practitioners to understand why groups act as they do and what forces would need to be diminished or strengthened to bring about planned change. Lewin (Lewin, 1997c) also wrote about group dynamics, noting that individuals are influenced by group norms and pressures to conform such that group behaviour should be the target for change. This is because group decision-making is powerful with respect to bringing about lasting behavioural change among group members.

The lessons from field theory and Lewin’s work in group dynamics have been incorporated into the development of practical approaches that could be applied by health practitioners to facilitate the process of change. These approaches include Lewin’s formulation of action research and the three-step model. An action research approach involves analyzing the current situation of an organization, identifying the range of possible change solutions and choosing the one that is most appropriate (Burnes, 2004). Concurrently, there needs to be a ‘felt-need’ for change, a realization by the group that change is necessary. Furthermore, success through action research involves a participatory process at a group level rather than individual level, which is consistent with the view about group behaviour being the target for change. Devine et al. (Devine et al., 2008) have described the use of an action research approach to address workplace health and safety issues at a mine in Queensland, Australia, whereby university researchers, management and staff worked together as agents of change to identify and address prominent health and safety concerns. The use of this approach led to staff agency and ownership over health and well-being and improvements in workplace conditions.

Lewin acknowledged that change can often be short lived in the face of setbacks, leading to the design of a three-step model to guide practitioners in this process:

1. Unfreezing—involves creating dissatisfaction with the status quo, benchmarking against
other organizations, internal performance barrier diagnosis and ‘survival anxiety’ that exceeds ‘learning anxiety’ (a realization that the potential benefits of change outweigh the potential negatives associated with the process) (Schein, 2010).

(2) Moving—is the implementation and trialling aspect of change, involving research, action and learning. Actions may include redesigning roles, responsibilities and relationships, training and up-skilling, promoting supporters/removing resisters.

(3) Refreezing—organizational norms, culture, practices and policies becoming realigned to support the continuation of the change. For example, aligning pay and reward systems, re-engineer measurement systems, create new organizational structures (Lewin, 1997c).

Heward et al. (Heward et al., 2007) described how the work of Lewin has been applied in the Victorian public service (Australia) to analyze the forces resisting change to health promotion capacity building. Lewin’s organizational change theory was used in two of the case studies of research undertaken in health promotion: in one case study, it was used to assist with conceptual analysis of capacity building implementation

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<th>Change theorist/s</th>
<th>Explanatory factors</th>
<th>Change strategy</th>
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<td>Kurt Lewin</td>
<td>The status quo is the product of a number of forces in the social environment that govern individuals' behaviour at a given point in time. As such causal relations can be analyzed. Change initiatives need to destabilize the status quo, implement the alternative and restabilize the environment. The implementation process involves research and performs a learning function.</td>
<td>Create the appropriate conditions for sustained change to occur through a group process of trial and error until an appropriate fit is found.</td>
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<td>Everett Rogers</td>
<td>Messages about new ideas are communicated within an organization and this brings about uncertainty. An organization’s propensity for innovation relates to structural factors within the organization, characteristics of individuals and external factors in the environment.</td>
<td>Innovations follow a sequential course within organizations, and attention to each stage is required for an innovation can fail before it has begun to diffuse.</td>
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<td>Chris Argyris and Donald Schön</td>
<td>The learning type of the organization and its members influences the acceptance of change. Organizational environments with a propensity towards defending existing norms have different capacity for learning and growth compared with organizational environments that are open and reflective.</td>
<td>To promote a culture of learning, attention needs to be given to enabling room for higher learning to occur by effort to bring about congruence between what is said and what is done — ‘the talk’ and ‘the walk’.</td>
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<tr>
<td>Edgar Schein</td>
<td>Culture can be observed and studied through the behaviour of groups and their beliefs, values and assumptions. The culture of the organization determines its actions. Culture is formed over time through shared experiences within groups.</td>
<td>To embed a change it needs to become cultural. Repeated experiences of success or failure for a group undertaking an action will lead to them forming an assumption about the value of that action. Values, beliefs and behaviours in support of that action indicate that it has become part of the culture of the group.</td>
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<td>Andrew Pettigrew, Ewan Ferlie and Lorna Mckee</td>
<td>The degree to which a public sector institution is amenable to change depends on a combination of variables that are associated with the process and setting for change. These include quality and coherence of policy, availability of key people leading change, long-term environmental pressure, supportive organizational culture, effective managerial-clinical relations, cooperative inter-organizational networks, simplicity and clarity of goals and priorities, and fit between the district’s change agenda and its locale.</td>
<td>Use the variables identified as part of a criteria for selecting settings that are likely to be receptive to change, and within those settings identify and manipulate the variables that are not static.</td>
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strategies. The second case study was about the implementation of health promotion technology in which Lewin’s work was used as the basis for a selective coding framework for content analysis of qualitative data that were gathered (Heward et al., 2007). Analysis of each case study indicated that efficiency, effectiveness and sustainability can be maximized by incorporating organizational change as a central component of health promotion practice and research.

**Diffusion theory**

Diffusion theory describes the communication of messages about an innovation within a social system. Rogers (Rogers, 2003) identifies three key characteristics that relate to an organization’s propensity for innovation: individual (leader) characteristics, internal characteristics of organizational structure and external characteristics of the organization. Within these broad categories, there are sub-variables such as organization size and leadership for change, which positively or negatively impact an organization’s capacity for innovation.

The variables identified by Rogers (Rogers, 2003) as characteristics of organizational structures are described in Table 2.

Organizations go through five stages as part of the diffusion of innovation process. The initiation and implementation phases are separated by the ‘decision’ to adopt or not to adopt. An adopted innovation proceeds through the three stages in the implementation phase. According to Rogers (Rogers, 2003), the rate of adoption of an innovation is to a large degree determined by how compatible it is with the values, beliefs and past experiences of individuals in the organization or social system, Figure 1.

Later stages in the innovation process cannot be undertaken until earlier stages have been completed, either explicitly or implicitly. A change focused initiative/innovation also requires a ‘champion’ to advocate for the change. Champions should have influence within the organization in which change is taking place, to energize the initiative, and should possess negotiation skills (Steckler and Goodman, 1989; Rogers, 2003). Champions are key for sustainability of health promotion initiatives (O’Loughlin et al., 1998), particularly in instances in which they share personal and social characteristics with the ‘recipients’ of innovation. Gates et al. (Gates et al., 2006) utilized diffusion of innovations theory to inform planning for a workplace programme to increase healthy eating and physical activity among manufacturing company employees. Focus group discussions were held with managers and staff to explore perceptions concerning the relative advantage, compatibility and complexity of actions to address these behaviours. These revealed individual and workplace factors that needed to be addressed to reduce barriers to adoption.

**Organizational learning— theories of action**

Argyris and Schön’s ‘organizational learning’ provides a valuable foundation for understanding the behaviour of individuals and groups in

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**Table 2: Rogers’ (2003) characteristics of organizational structure**

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<th>Variable</th>
<th>Description</th>
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<tr>
<td>Size</td>
<td>Size of the organization is related to propensity for innovation, generally the larger the organization the more innovative.</td>
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<td>Centralization</td>
<td>Centralization in an organization involves the concentration of power to a few individuals; this has a negative effect on how innovative an organization is. However, centralization can encourage the implementation of an innovation once a decision has been made to adopt.</td>
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<tr>
<td>Complexity</td>
<td>Complexity is the degree to which an organization’s team members have a range of specialties and high level of knowledge and expertise. This is positive for the valuing of innovations, but consensus about implementation can become a challenge with complexity.</td>
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<tr>
<td>Formalization</td>
<td>Formalization through rules and procedures makes an organization bureaucratic; this acts as an inhibitor for organizations to consider innovations but encourages the implementation.</td>
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<tr>
<td>Interconnectedness</td>
<td>Interconnectedness involves groups and individuals within an organization being interpersonally linked; new ideas can flow more easily in organizations that have higher degrees of network interconnectedness.</td>
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<tr>
<td>Organizational slack</td>
<td>Organizational slack is a factor that relates back to organizational size in that ‘slack’ is the degree of resources that an organization has available that have not been committed elsewhere. This may be something that larger organizations have more freely available; therefore, there is more opportunity to be able to focus on innovation.</td>
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organizations as well as organizational behaviour modification through change initiatives. Argyris and Schón’s (Argyris and Schón, 1996) ‘theories of action’ describe how the thinking of individuals and subgroups in organizations translates into behaviours that either encourage or inhibit organizational learning. Theories-in-use are motives, values and beliefs that are translated into action and are implicit in what people do as managers and employees. Theories-in-use govern individuals’ behaviour, because they are implicit assumptions that tell group members how to perceive, think and feel (Argyris, 1976; Argyris and Schón, 1996). On the other hand, espoused theory of action refers to the concept to which managers and employees give allegiance if they are asked to communicate their actions to others. However, the theory that actually governs individuals’ actions is their theory-in-use. For example, a manager’s espoused theory may be that health promotion strategies should be based on a review of the current evidence of what is best practice. But her theory-in-use is ‘our team is abreast of what “good practice” is’, and thus, a small group of practitioners discuss plausible strategies, begin implementation and in later reports link their actions to the evidence in the literature that supports their choice of strategies.

Effectiveness in organizational learning results from developing congruence between theory-in-use and espoused theory. Argyris and Schón (Argyris and Schón, 1996) describe two separate models (Model 1 and Model 2) of theories-in-use that lead to two different types of organizational learning. For both Model 1 and Model 2 theories-in-use, three elements influence the type of learning that an organization will experience.

Fig. 1: Stages of the innovation process in organizations. Adapted from Rogers (Rogers, 2003).

Those elements are governing variables, action strategies and consequences:

- **Governing variables** are beliefs, philosophies of the organization and workers within the organization. Model 1 has defensive governing variables such as ‘maximize winning and minimize losing’, whereas model 2 theory-in-use has more open governing variables such as ‘free and informed choice’.
- **Action strategies** are actions that will be executed depending on the governing variables.
- **Consequences** of action are broken down into two categories: consequences for the behavioural world and consequences for learning.

The ultimate aim for an organization interested in change is to move from Model 1 to Model 2 theories-in-use with their ‘double-loop learning’. Single-loop learning involves the detection and correction of error. Where something goes wrong, an initial port of call for many people is to look for an action that will address and work within the existing governing variables (beliefs and philosophies of the organization). Double-loop learning is learning that occurs when an organization’s governing variables are subjected to critical scrutiny. This type of learning may lead to an alteration of existing governing variables and ultimately shift the way in which strategies and consequences are framed. For example, this may involve the modification of an organization’s underlying norms, policies and objectives. Organizations that promote double-loop learning are likely to be more favourable settings for health promoters who are seeking to influence the values, beliefs and actions of an organization. This is because health promotion ideologies such as health equity may be viewed as
an innovative change to strategy, practice and structure. To achieve this kind of change, Rogers (Rogers, 2003) argued that proponents of innovation need to be granted some creative freedom and protection to ‘agenda set’ and ‘match’, followed by a decision to implement.

The value of theory that informs an open and reflective learning culture within organizations was highlighted in the SPEC: Learning and Changing by Doing project (Evans et al., 2011). To achieve its community health and justice goals, the project adopted an internal organizational learning lens to identify the conditions needed to support external community engagement and mobilization. These conditions included critical capacity and consciousness, shown by an awareness of the role of power dynamics, an orientation towards justice, an ecological approach and collaborative practice (Evans et al., 2011).

Theories of organizational culture
Schein’s work exploring organizational culture provides valuable insight for change practitioners seeking to modify culture, that is, to make an innovation central to what is believed and done. Schein (Schein, 2010) presents a model identifying different levels of organizational culture, using case studies from two multinational corporations. The organizational cultures of the two settings were then analyzed in three categories: (i) artefacts are visible things about the group, such as the physical environment, organizational structures, clothing and language; (ii) espoused beliefs and values are philosophies, goals and strategies that have become socially validated and confirmed through a shared experience by a group and (iii) underlying assumptions are taken for granted with little variation, because they have come about from continued success in the implementation of certain beliefs. Underlying assumptions can be so strong within groups that behaviours based on any other values or beliefs are unthinkable.

According to Schein (Schein, 2010), culture is formed through the beliefs and values of organizational leaders. These values inform the implementation of certain actions, and the view that any subsequent success of those actions is a result of effective organizational leadership and the culture and values it sustains. As a result, the perceived benefits of those actions lead to them being repeated, and after continual success of those actions the idea that those particular actions are good eventually transfers to a ‘shared assumption’ within the organization. Assumptions within an organization are difficult to change as they are often regarded as non-negotiable values. These values, and the behaviours that are subsequently exhibited by employees and leaders, form ‘the culture’ of the organization.

Within an organization, there may be more than one dominant culture, and the combination of cultures defines ‘regimes’ that make up the overall political context of an organization (Douglas, 1982; Wildavsky, 1987). Health promoters who are seeking to influence change in their own organizations need to analyze the culture of the targeted subgroup, as well as the broader culture of the organization, to identify the most conducive settings for change. In a Pennsylvanian study of organizational culture in nursing homes, Scalzi et al. (Scalzi et al., 2006) found that positive cultural changes occurred when residents, family members and facility staff worked towards a shared goal and with a critical mass of champions for the change.

Receptive contexts for change
Pettigrew et al. (Pettigrew et al., 1992) refer to ‘receptive contexts’ for change as those that enable the progression of a change initiative within the environment and ‘non-receptive contexts’ as those that hinder the progress of a change initiative. Their work is relevant to change within the public sector and bureaucratic organizations in particular. For example, Pettigrew et al. (Pettigrew et al., 1992) identified eight key variables linked to an organization’s receptiveness to change. These variables were derived from studies of change in the National Health Service (NHS) in the 1980s and included quality and coherence of policy, availability of key people leading change, long-term environmental pressure, supportive organizational culture, effective managerial-clinical relations, cooperative inter-organizational networks, simplicity and clarity of goals and priorities and fit between the district’s change agenda and its locale.

The authors reported that a shared vision that could be adopted by a stable workforce was crucial, so too was a sense of crisis in the broader context for adding pressure for change. Furthermore, a setting that values learning, evaluation and skill over status with workers who had a foot in both clinical and managerial camps was an enabler for leading change. Other variables that were found to be enablers for change included networking and sharing information across agencies, having simple
goals, patience and persistence in implementation, and understanding external agendas, obstacles and opportunities for making the change fit for purpose (Pettigrew et al., 1992).

Pettigrew et al. (Pettigrew et al., 1992) provide a point of reference for assessing the organizational context of a proposed health innovation. Consider one of the eight variables that influence change receptivity (that is, the ‘Fit between the district’s change agenda and its locale’) as an example of how their work may be used in health promotion practice. A health promotion practitioner may identify unmanipulable variables in a proposed ‘pilot site’ for an initiative and instead opt for a more receptive context for the pilot. The aim is to design a health initiative to fit within a receptive organizational context by ensuring that it accommodates the needs of that organization. This may involve a health promotion practitioner working to modify aspects of the organizational context (internally or externally as required or feasible) to achieve an agreeable fit between the goals of the health intervention and that organizational context (Pettigrew et al., 1992; Rogers, 2003).

DISCUSSION

Recent discussions in the international literature have emphasized the changing policy context for health promotion, the challenges that this presents for the field and the need to strengthen the foundations for practice. Sparks (Sparks, 2013) has argued that the recent history of health promotion has seen waves of new priorities (e.g. obesity, social determinants of health, chronic diseases), each with its own silo of activity that generally achieves a low level of integration within established programmes and infrastructure. The focus on activities needed to tackle these new priorities often fails to recognize that health promotion offers principles, approaches and strategies with applications across a broad range of issues. Organizational change represents one such cross-cutting area of action that is needed to build the infrastructure and capacity required to address contemporary health challenges. The ability of the field to act strategically in this work, by drawing upon the broad body of theory and research available, will to a large degree determine the scale and sustainability of the health impacts that it can achieve.

The organizational change theories examined in this article can be applied to the problem-solving function that is inherent in capacity building. Organizational learning theory (Argyris and Schön, 1996) states that the way organizations perceive and address problems is determined by their governing beliefs or ‘theories-in-use’. The capacity building task is to influence these beliefs to facilitate progression by organizations from single-loop learning, concerned with solutions to immediate problems, to double-loop learning, which entails critical reflection on established values and practices to bring about openness to innovation and reform. A challenge that practitioners face is identifying those organizations with preparedness for double-loop learning, which may in turn become catalysts for change within their broader sector.

A common theme across the organizational change theories described above is that there needs to be a degree of elasticity in the shape and pace at which the change takes as well as within the host organization. Rogers (Rogers, 2003) describes a ‘matching’ phase in the innovation process. O’Loughlin et al. (O’Loughlin et al., 1998) found that when an innovation is able to find ‘fit’ within the organization, it was more likely to be institutionalized and hence sustainable.

The theories reviewed in this article highlight the need to take account of the uniqueness of settings, through situational analysis, which will often require an iterative process. Steckler and Goodman (Steckler and Goodman, 1989) have observed that change is a process that often takes longer than allocated funding timelines allow for. Hanni et al. (Hanni et al., 2007) evaluated a 5-year chronic disease intervention in a low socio-economic area in California, concluding that sustainable community and environmental change is difficult to achieve within this time frame. The limitations associated with short-term funding include problems of staff retention and loss of corporate memory, which can delay and stifle implementation (Pettigrew et al., 1992).

Progression to longer funding cycles to achieve institutionalized change puts greater onus upon managers and policymakers to identify organizations that are prepared (or able) to embark on this change process. Organizational change theories draw attention to the sorts of questions practitioners need to ask in making assessments
of readiness for change. Examples include the following: ‘Can a previously identified problem for the organization be addressed through health promoting change?’ ‘Does the sector which the organization operates in pose a threat to innovation?’ ‘Is the structure and culture of the organization conducive to innovation?’ ‘Does the organization have a history of questioning the way things are done and seeking solutions that may challenge their governing variables?’ ‘Is there an opportunity for short-term group success that can be leveraged from?’ and ‘To what extent is the organization interconnected?’ In addition to these key considerations, the quality of the process undertaken is critical to success, including simple, clearly defined and agreed goals, elasticity of the initiative for the organization, sufficient external environmental pressure such as market or political forces, and the existence of internal proponents for the change (Douglas, 1982; Wildavsky, 1987; Pettigrew et al., 1992; Lewin, 1997c; St Leger, 1997; Rogers, 2003; Kotter, 2007; Schein, 2010).

In examining the reasons why organizational transformation efforts fail, Kotter (Kotter, 2007) stresses that the agents of change often declare success too early. He added that there may be political pressure on funders and funding recipients of short-term health promotion projects to declare success at the end of their funding cycle. Premature declarations of success in health promotion are problematic for all stakeholders and the discipline. The organizational change theories reviewed above indicate that time and continued effort are required to embed change well beyond the life of the initial ‘project’. This further suggests that health promotion should be viewed in a similar light to long-term institutional change. In the fixed-term, temporary funding environment (the status quo for health promotion) practitioners may be best placed to focus their efforts on analyzing the culture of the intended recipients of change, beginning with visible ‘artefacts’ (Schein, 2010) and aiming for early success (‘quick wins’) to engender stakeholder support. Contrary to funding objectives that are set within a political calendar, Schein (Schein, 2010) points out that a health promotion programme is most likely to influence the culture of the host agency with repeated success over time.

Lewin (Lewin, 1997c) would add that group experience plays a significant role in determining the behaviours, beliefs and values of its members, and subgroups within organizations often have distinct cultures (Grendstad and Selle, 1995). This draws attention to the need for health promoters to seek to influence group norms as opposed to just individuals in leadership roles. Schein (Schein, 2010) argues that when new actions are matched to existing operating environments of teams, continued positive experiences will lead to a shared team experience that validates the benefit of the adopted actions, and influence values and practices. It should be acknowledged that health promotion agencies have their own group dynamics, values and culture that will often differ from those of the organizations with which they are working. This focuses attention on the valuable role that ‘policy entrepreneurs’ and ‘champions’ can play, who share values and ambitions with the recipients of change within organizations, can balance the diverse needs of groups, and exercise strategic leadership (Pettigrew et al., 1992; O’Loughlin et al., 1998; Rogers, 2003; Hoeijmakers et al., 2007; Oakland and Tanner, 2007; de Leeuw, 2011).

Studies in the field of occupational health psychology have investigated the impacts of organizational change on workers’ health and well-being and have offered strategies for achieving adherence to change. Staff self-efficacy to cope with the demands of job change, staff having an ‘active’ approach towards problem solving, adequate provision of information to staff about change to aid predictability and clarity, and a high degree of readiness to change have been linked to well-being outcomes in organizations undergoing change (Parker et al., 1997; Cunningham et al., 2002; Jimmieson et al., 2004).

Pettigrew et al. (Pettigrew et al., 1992) emphasized the importance of the external environment in their Receptive Contexts for Change theory, similarly external forces (Lewin 1997a) receive attention in organizational change theory in general. However, it is arguable that the primary opportunities for health promoters to influence the functioning of organizations is through addressing internal variables. Steckler and Goodman (Steckler and Goodman, 1989) found that funding ‘brokers’ to institutionalize health promotion initiatives in other agencies was ineffective and concluded that funds should be directed to the host agency to bring about change from within. Riley et al. (Riley et al., 2003) reported that changing internal organizational factors was most influential in facilitating the adoption of heart health initiatives by public health agencies in Canada. This does not discount the valuable leadership role that health promotion agencies can play (Riley et al., 2003) but highlights
the fact that funding and equipping workers who are located within external organizations and can work with teams internally to instigate change may be the most effective use of health promotion resources.

CONCLUSION

The centrality of organizational change in health promotion capacity building is clear. Therefore, theory-informed research is needed to identify suitable targets of change, and effective strategies and implementation processes are needed to address these. It has also been argued that attention needs to be paid to factors that characterize unsuccessful change efforts (Biron et al., 2010). Nielsen et al. (Nielsen et al., 2010) recommend an evaluative focus in organizational change research that uses mixed-methods approaches to examine how and why health interventions succeed (or not). Traditional controlled studies are not usually feasible or adequate for these types of investigation (Nielsen et al., 2010).

Debate in this journal has highlighted the risks associated with the changing political discourse away from health promotion (de Leeuw, 2013). There is an imperative, therefore, to demonstrate the health, social and economic benefits that arise from organizational capacity building in health promotion. If culture is formed through repeated experiences of success or failure, it would be disastrous if over time shared assumptions among policy entrepreneurs shifted, because they were unable to see how health promotion can bring about lasting change.

REFERENCES


