Stakeholder Health is a voluntary movement of people working in hospital health systems who are addressing the underlying causes of poor health in their communities by strategically shifting existing resources and partnering with diverse stakeholders.
What is Stakeholder Health?

By Molly Miller

When people are introduced to new concepts or organizations, such as Stakeholder Health, their natural instinct is to ask questions. Who came up with this idea? What is this organization all about? Why should I be interested? How will it benefit me?

You may be reading about Stakeholder Health for the first time, or you may have been engaged for several years. Regardless of which camp you fall into, hopefully, this primer will answer your questions and inspire you to help us grow the Stakeholder movement across the country.

How did Stakeholder Health start?

Stakeholder Health began with a site visit to Memphis that included representatives from the White House Office of Faith-Based and Neighborhood Partnerships, the Health and Human Services (HHS) Partnership Center, and a number of other agencies.

These representatives were so impressed with the innovation coming from Memphis' Congregational Health Network that
they convened a second meeting, co-hosted by the White House Office of Faith-Based and Neighborhood Partnerships and the HHS Partnership Center. There, leadership from 22 health systems discussed innovative ways in which their health systems could transform the health of their communities by reaching outside of their walls.

This group of leaders began as the Health Systems Learning Group and became what we now know as Stakeholder Health in 2013. A monograph sharing the learnings was published that same year. A second publication will be released in 2016.

Who is involved in the Stakeholder Health movement?

Today, **90 different organizations, including 53 hospital systems**, are involved in Stakeholder Health. Other types of organizations involved in the learning collaborative include governmental and community partners, denominational partners, coalitions, policy and research institutes, and think tanks.

Stakeholder Health is administered by a Secretariat housed at Wake Forest Baptist Medical Center made up of:

- Gary Gunderson, Secretary
- Teresa Cutts, Staff Liaison
- Tom Peterson, Communications Director
- Fred Smith, Faith Community Liaison
- Heidi Christensen, HHS Partnership Center Liaison
- Jerry Winslow, Chair of the Stakeholder Health Advisory Council (SHAC)

Why should I be interested in Stakeholder Health?

Stakeholder Health members are committed to open-source learning and a shared mission of building healthy communities by reaching outside of the four walls of the hospital system. Stakeholder Health's members have championed many innovations in public health including hotspotting, which focuses on identifying the most at-risk communities and intervening to reduce unnecessary healthcare utilization, and congregational health networks, which utilize an existing community (the church) to help care for those with chronic diseases.

How does Stakeholder Health benefit my community?

Members of the Stakeholder Health tribe benefit from shared knowledge and an increased opportunity to innovate within their communities. Maybe hotspotting won't work in your community in the same way that it worked in Camden, but your health system may be able to come up with a unique twist that makes it work for your community and others.

By bringing these innovations to the community and reaching outside of the walls of your healthcare system, you may be able to realize improved health outcomes for community members, lower healthcare costs, or even a stronger sense of community belonging.

If you are interested in adding your hospital, health system or organization to the Stakeholder Health tribe, email us [HERE](mailto:).
The Stakeholder Way

By Gary Gunderson

Stakeholder Health is a fellowship of learners making its way through the tangled guild-ridden thickets of healthcare, public health and community. Those thickets have roots deep in the rich soil of healthcare economics, which now account for nearly one-in-five of every dollar that will change hands in the U.S. this year. The flow of those dollars is channeled through an impossibly complicated array of deals that reflect a lot of science, but also lots of power and privilege. Every single type and sub-type involved has an association with publicists and lobbyists whose goal is protecting and then possibly increasing their share of all those dollars, ideally by locking in the pattern of payment within the federal reimbursement programs for the elderly and poor (Medicare and Medicaid) that pay for most things that do get paid for in healthcare.

Wow, that’s depressing! How could anything moral, decent or kind ever happen?

The fellowship of learners called Stakeholder Health is the last thing from naïve: we all work for the institutions trapped in those thickets and share licenses from one or more of the guilds to do something reimbursable. We are of, not above the reality we hope to change. And most of us are senior enough and experienced enough to know that this complex reality is changing all the time—and is doing so again. It may look immoveable, but we know its not. So we are not discouraged by how difficult change is; we know it is hard and the work long. It requires a way, not a gimmick or merely a program.

Stakeholder Health looks like an organization, so it is natural to ask about its principles and structure. But it is not really a noun; it is a verb. It is happening and is smart and significant because of how it is happening. If it were a horse, it would be interesting because of who is on it, how they got there and where it is going. It would not be very useful to ask about how the horse became a horse.
What’s the Stakeholder Way?

- **Learn with other people whose jobs depend on useful learning.** While “consulting” is an honorable field, Stakeholder people are nearly all full-time senior employees of the hospitals who sponsor the learning. So the learning isn’t valued by how pretty the powerpoints are, but on whether it gives traction to the organizations paying their employees to spend time doing the learning. Is it fuel for organizational success, not individual career advancement?

- **Stakeholder tends to value friends in tough places more than friends in high places.** The Supporters of Health in East Winston, North Carolina, are more interesting than the people S. News and World Report lists as best hospital in this or that. This is because we are mainly interested in the things most relevant to people on the margins, the most vulnerable. So we listen most carefully to those among them or at least unafraid to be with them.

- **The learning is multi-local, not national.** Stakeholder Health always values a local true story over a big national abstraction. The work in the hardscrabble town of Bithlo with Florida Hospital is more interesting than anything in DC. We think the future will arrive quietly down the street, not in a car with diplomatic flags flapping on shiny chrome.

- **Data really matters, but only if the data is looking at things that really matter.** Many of us read spreadsheets and regression tables like comic books, so we also know their integrity rests in how the formulas were constructed, what causal logic lies beneath them. So we ask about the missing columns and what was almost Data can be a flashlight to find our way or just a mirror showing what we expected to find.

- **We are suspicious of our own good news; we want our work to be good news for others.** All of our hospitals are “best” on many lists, so we are not easily impressed by each other. We want the truth about what works, so we can achieve what really matters to those we were born to serve (and nobody started a hospital to earn a magazine article).

- **We spend our own money first.** Stakeholder Health is paid for first by Stakeholder Health institutions that value it. The largest amount of learning and labor is given freely by the employees of those institutions, including all of the leadership time. Because of that integrity, it also attracts other funds from time to time.

- **We really want to be about the mission.** In every case, our institutions were born to serve the most vulnerable and
to give them a shot at what science and compassion could offer as mercy. This is our work, our mission; not just legal compliance or reimbursed intervention.

- **Faith shapes what we do, not just what we think.** Most of Stakeholder Health institutions have a faith history, but all of us know we are here for more than ourselves and that we have more than our own cleverness to draw on. We want our faith to make our learning smart and brave so that it serves our ability to serve. Many of us experience freedom and privileges because of our faith and mission; we know we only keep those freedoms by risking them on behalf of the most vulnerable.

- **We want our work to contribute to mission**—even as we know we work in tangled, conflicted, complicit human organizations finding their way through every kind of perverse incentive. We are never surprised, but we have not given up hope on the mission. Our Stakeholder Health friends lend each that hope, nurture it like a fire amid tinder with real intellectual rigor fed by experience and critical reflection.
Stakeholder Health Practices

By Molly Miller

If you take a close look at any organization, regardless of whether they are operating in the private or public sector, you will usually find that their mission and goals are attained through a tried and true set of best practices. Stakeholder Health is no different. While we operate as a learning collaborative and encourage innovation and tailoring practices to fit the needs of specific communities, there are several key practices that we have found to be especially helpful in creating strong linkages between hospitals or health systems and the communities that surround them. Below, we will explore a few of the more common Stakeholder Health practices (there are many) and share some innovative ways in which communities have implemented them.

Navigation Networks

Navigation Networks assist patients in navigating the complicated health care system in order to improve patient outcomes. The Congregational Health Network (CHN), which was founded in Memphis in 2007, provides an excellent example of what Navigation Networks can achieve. The Memphis CHN was designed to provide education, prevention services, support patients while they are in the hospital, ensure access to appropriate care, and get congregations involved in aftercare. By partnering hospital liaisons with volunteers from congregations across the city, the program was able to reduce readmission rates by 20% and cut mortality rates in half in its targeted communities during its first four years of operation.

While the CHN model was a success in Memphis, it also provides an example of why we encourage hospitals and health systems to find their own twist on Stakeholder Health practices. When the Memphis Model was attempted in Winston-Salem, North Carolina, it became obvious that the model would need to be changed to meet the needs of the community. Instead of using the CHN model, Environmental Services employees at Wake Forest were encouraged to...
talk to patients while they were in the hospital and engage with members of the community in after-care discussions.

While these two models are different, they both have the same positive outcome of reducing readmission rates and helping patients navigate an increasingly complicated health care system.

Strategic Partnerships

When most people think about strategic partnerships, they think on the macro level about businesses or non-profits partnering together to pool resources. When Stakeholder Health talks about strategic partnerships, we look to health systems to partner with each other, but we also look for unique groups of individuals who can partner with health systems to become advocates for health.

Advocates for community health are everywhere, sometimes we just aren’t looking in the right places. As previously mentioned, Wake Forest trained Environmental Services employees to be patient navigators. In Washington, D.C., barber-shops participating in the Hair, Heart, and Health program offer blood pressure and diabetes screenings in addition to haircuts, which allows hospitals to reach African American men, a traditionally difficult to reach population. Stakeholder Health encourages it's members to look in these unlikely places for partners in health.

Mapping

Using technology to track health system and community assets is a vital part of achieving the Stakeholder Health mission for several reasons. First, it helps to prevent overlap in resources and allows hospitals and health systems to create stronger strategic partnerships with other health systems. Second, it helps health systems align their resources with the resources of the community to build stronger, more effective programs. Finally, the process of mapping resources allows health systems to identify existing gaps in resources.

The key to successful asset mapping is including the community in the mapping process, which ensures that more intangible resources such as relationships and social capital are included in the list of community assets. A great example of this strategy in action is the hotspotting process, used by Methodist Le Bonheur (MLH) in Memphis. By using a variety of data sources, MLH was able to identify the zip code in Memphis that had the highest risk for chronic disease as well as the highest percentage of hospital readmissions, inappropriate emergency room utilization, and the highest amount of charity care write-offs. MLH was then able to partner with the Congregational Health Network to hold listening sessions designed to co-create a plan for

“I swore never to be silent wherever and wherever human beings endure suffering and humiliation. We must always take sides. Neutrality helps the oppressor, never the victim”

—Elie Wiesel
community health and hospital utilization. Between 2011 and 2012, this program not only **resulted in a drop in the overall hospital readmission rate** from 24.24% to 18.18%, but also a drop in hospital readmissions due to heart failure from 18.18% to 2.7%, a more than 90% drop in one year.

**Want More?**

These practices are just a sample of what Stakeholder Health is all about. To learn more about promising practices and case studies that are grounded in Stakeholder Health Practices, visit the following pages:

- **Strategic Investment**
  - Promising Practices: Strategic Investment
  - Case Studies: Strategic Investment
- **Integrating Care**
  - Promising Practices: Integrating Care
  - Case Studies: Integrating Care
- **Transformative Partnerships**
  - Promising Practices
  - Case Studies: Transformative Partnerships
- **Mapping Assets**
  - Promising Practices: Mapping Assets

**Current Investing Partners**

Adventist Health System
Advocate HealthCare
Ascension Health
Bon Secours Health System
Henry Ford Health System
Kettering Health Network
Loma Linda University Health
Methodist LeBonheur Healthcare, Memphis
Nemours
Promedica
Wake Forest Baptist Medical Center
How practices spread

By Tom Peterson

Inspired in 2002 by frequent blackouts, Brazilian mechanic Alfredo Moser (pictured) thought up a simple technology that’s literally a brilliant idea. Just fill a clear plastic soda bottle with water (add bleach to prevent algae clouding), cut a hole in the roof of the house and snugly place the bottle in the hole so the rain won’t get in. It takes less than an hour to make and install. And behold: the sunlight brightens the room as though it were a 50-watt bulb. Of course, it shines only during the day.

Moser’s idea slowly spread, and in 2011, news articles and viral videos about the solar bulbs suddenly increased awareness about his concept. They described how to make the lights and the unique ways that they were being used around the world. One group in the Philippines was installing 140,000 lights in slums across the country. Today these simple bulbs brighten once dark rooms for millions in Kenya, Peru, Mexico, India and many other countries. Entrepreneurs are even turning bulb making and installation into small businesses.

What is more powerful than the spread of a practice that improves life? And what is more wasteful than a great solution doesn’t spread? But how do good ideas spread?

Scaling up through the spread of ideas

Stakeholder Health is about spreading ideas and practices. It’s also about how we view the world and our role in it. It’s about health systems and the communities they serve learning together and sharing ideas that work—from one hospital and one community to another. Done well, we help improve the health of our most vulnerable citizens.

How does an improvement—a new practice or great tweak on an existing one—move from one system and go to scale? Being part of the Stakeholder tribe means we have the trust and the generosity to share deeply—not just the nuts and bolts of a practice, but also the deeper nuances of why a practice works in this place, what failed, and what we’re still trying to figure out. It means, too, that we are willing to learn from others and to ask for help.

What it takes to spread practices

Nicole Dubbs and Kerry Anne McGeary, were curious about how social change ideas spread. With the Robert Wood John-
son Foundation and the Monitor Institute they spent six months exploring with creative people and experts “what it takes to spread ideas that others adopt, adapt, integrate, and ultimately take up as their own.” They share four conclusions in the *Stanford Social Innovation Review*. And their findings speak directly to the work of Stakeholder Health partners:

- **Where you intervene in a system is important.**
- **Stakeholders don’t act on abstract ideas.**
- **Moving away from a traditional program focus is useful.**
- **Shape the rhetoric and shift action.**

Stakeholder Health intervenes in two key spheres: within a hospital itself and in the surrounding community outside of the hospital’s walls. Usually, somewhere within a health system, a handful of committed people are already reaching into their community. A few of these are strategically located (often one reports directly to the CEO), their jobs are relevant to improving the health of their community’s most vulnerable residents, and they have passion or “heart.”

They are realigning resources of the hospital with those of the community in a way that improves health of the most vulnerable. How each group moves forward within their own system and community depends on their local context. And along the way they share what they have learned, adding to the collective knowledge of the tribe.

So where within a community does the health system intervene? That depends, because each situation is different. When the hospital truly listens to the community, the correct actions will present themselves. Mapping exercises in the Hispanic community in Winston-Salem, North Carolina, resulted in the need to focus on getting identification cards for undocumented residents so they are able to get prescriptions and drive to a medical appointment without fear of being deported. In Toledo, Ohio, Promedica heard the need for a grocery store to bring healthy food to a food desert. Advocate Health Care in Chicago heard about ways to stop violence. In San Francisco, Dignity Health heard a need for below-market loans for nonprofits working towards improving the commu-

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Whenever you are in doubt, apply the following test: recall the face of the poorest and weakest person you may have seen and ask yourself if the step you contemplate is going to be of any use to them.

— Mahatma Gandhi
nity. Bon Secours Baltimore heard a need for decent housing. These and other health systems hear the challenges and, alongside their community partners, take action.

Community Benefits requirements of the Affordable Care Act are not the point. Rather, how does a hospital align its own resources and assets with those of its community in true partnership to improve health for the most vulnerable? Participating health systems now use phrases such as hotspotting, navigation networks or congregational health networks, health asset mapping, strategic investment, leading causes of life, outside the walls to describe their initiatives. These phrases and others inform actions and are translated into partnerships doing real-life work.

**Adapted not replicated**

From the outset, the Stakeholder community has shied away from the notion that a practice such as a congregational health network can be “replicated.” (Although using the categories of

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**Five Paths to Spreading Social Programs**

How do ideas spread? Nico van Oudenhoven & Rekha Ważir described five different paths for replicating social programs in a paper for UNESCO. The paper is worth reading in its entirety, but here’s a summary of their paths:

- **Franchise Approach.** With a central agency that provides “technical assistance, marketing, training and other services” in a “cookie-cutter” way. The rules are fixed, can’t be changed.

- **Mandated Replication.** Program is mandated top-down, usually from a government. No choice in how the program works.

- **Staged Replication.** Three stages:
  1) Pilot, the concept is tested; 2) Demonstration, the program is tried in a variety of settings; and 3) Rollout, go to scale.

- **Concept Replication.** Focus is on not the specifics of the prototype program but on the components and principles that made it work. These are then adapted to fit the local context.

- **Spontaneous Replication.** Program spreads by “spontaneous and informal contacts between like-minded individuals.” Communication is “a two-way process of convergence where participants ‘create and share information.’”

Which of these make sense for the spread of practices that will improve the health of our communities? There’s no right answer. Many successes will be a mix of at least two of these.
van Oudenhoven and Wazir (see below) most Stakeholder sharing would fall somewhere between “concept” and “spontaneous” replication.) These practices are really adapted as they move from one place to another. Hospitals are found in a place and each place has unique challenges and assets. A practice may move from Denver to Atlanta, but it would end up looking quite different because the health systems are different. So are the internal-champions the external partner organizations, the culture, the politics and many other variables. The practice can’t be replicated, but it can be borrowed and adapted.

These practices can’t mechanically “plug and play” into a new setting. To adapt a program that works in one hospital means understanding foundational principles (see Stakeholder Way). It means having heart for and commitment to the community and being willing to partner with others. This means being transparent and authentic, building trust, and being in a true relationship with the community. However, these are not the main drivers of most health system decisions.

How can we improve the chances that proven solutions will spread? The starting point has to be when people working on similar challenges pass their stories on to others. They share things that work and their hopes for the next phase, sometimes deeply, through webinars, data-filled PowerPoints, blog posts, and in conversations over lunch or on the phone. The result: spreading of practices and programs that work.

This, it turns out, creates momentum for large-scale change.

**Links**

9 Ways to Solve Social Problems by Spreading Ideas That Already Work. By Jeffrey Bradach and Abe Grindle

Six Steps to Successfully Scale Impact in the Nonprofit Sector. By Erin Harris

A Smart Way for Philanthropy Ideas to Spread Fast: Change Social Norm. By Howard Husock

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The notion of “sharing ideas liberally” defies the natural instinct to keep your ideas a secret. Yet, among the hundreds of successful creatives I’ve interviewed, a fearless approach to sharing ideas is one of the most common attributes. Why? Because having the idea is just a tiny step along the road to making that idea happen. During the journey, communal forces are instrumental in refining the very substance of the idea, holding us accountable for making it happen, building the network that will push us to go above and beyond, providing us with valuable material and emotional support, and spreading the word to attract resources and publicity. By sharing your idea, you take the first step in creating the community that will act as a catalyst to making it happen.

—Scott Belsky

Hospitals: Change agents for health

By Tom Peterson

Helping Americans move to better health seems like an impossible, quixotic dream. But it is possible. And because of their unique size and role, health systems could hold the key. The more than 5,000 hospitals have a combined budget of $3.8 trillion. Combined they are country’s second largest private employer and individually are often the largest employer in their community. While they mostly focus on medical solutions to specific illnesses, a growing number of hospitals are venturing outside their walls to improve health, wellness and quality of life of their communities.

When it comes to radically improving health, hospitals could act as giant change agents. And this movement is already started.

The Child Survival Campaign

The Child Survival Campaign, launched by Unicef’s James Grant in the 1982 State of the World’s Children, was touted as a “revolution.” Grant (pictured below) identified four practices that when put into place could radically reduce deaths and improve child health. Campaigns were rolled out to vaccinate against six childhood diseases, track children’s weight, encourage breast feeding and use oral rehydration therapy when needed. Believed to be game changers, these four efforts were deployed globally on an unprecedented scale.

The practices and principles were constant, but they played out quite differently from country to country and even within the nations. In some places the bishop or imam’s word made
the difference. Governments, nongovernmental agencies, faith institutions, schools, the media and others joined the effort. Rotary International stepped up to the challenge of eradicating polio. The Herculean efforts took place amidst poverty, corruption and every other imaginable hurdle. From the UN headquarters to a Salvadoran village, people doggedly pushed forward. Wars were even temporarily stopped so children could be immunized.

So how did it go? Here’s how Nicolas Kristoff describes it in a 2008 column in the New York Times:

The number of children who die worldwide each year before the age of five has dropped below 10 million for the first time in recorded history—compared with 20 million annually in 1960—Unicef noted in a report last month, “Child Survival.” Now the goal is to cut the death toll to four million by 2015.

Think about that accomplishment: The lives of 10 million children saved each year, 100 million lives per decade.

To put it another way, the late James P. Grant, a little-known American aid worker who headed Unicef from 1980 to 1995 and launched the child survival revolution with vaccinations and diarrhea treatments, probably saved more lives than were destroyed by Hitler, Mao and Stalin combined.

An estimated 5.9 million children under age five died in 2015. The goal of cutting it to 4 million was missed, but it’s still giant progress from the 20 million who died in 1960.

Journey of Health

U.S. health challenges are often seen as too complex and entrenched to be fixed. Protecting their self-interests, powerful industries may impede progress. The health of individuals and whole populations is tied to so many other “social determinants.” Yet these systems are no more complex than the world’s almost 200 countries, each with their cultures, governments and religions. If the child survival campaign and following efforts could cut both the rate and number of child deaths by more than half, surely, we can bring health and well-being to the world’s wealthiest

“I was taught that the world had a lot of problems; that I could struggle and change them; that intellectual and material gifts brought the privilege and responsibility of sharing with others less fortunate; and that service is the rent each of us pays for living — the very purpose of life and not something you do in your spare time or after you have reached your personal goals.”

– Marian Wright Edelman
Health systems are teeming with staff who chose their careers because they wanted to help others. Too often they can only wait inside their walls for the really sick to come in the door, often through the emergency room. The sickest are then treated and released back to their lives outside. To be fair, that’s what hospitals were generally designed to do. Inside the walls people are often cured and lives are saved.

But a person’s health journey takes place mostly outside the hospital walls. And in the emerging model, many hospitals are partnering with local businesses, schools, public health departments, nonprofits and other organizations to focus resources on the community where these sometime patients live most of the time.

They are trying to understand how to best engage with the most vulnerable people. They are sharing not just what programs work, but also what deeper principles undergird the programs that make them succeed. U.S. hospitals have a talent pool that is historically unprecedented, with it’s sheer size, amazing talent and motivation to bring about health.

Jonas Salk asked, “What must we do to evoke the greatest potential from ourselves and from others?” It’s a question every health system should ask about itself and its community. Many hospitals are stepping up and, as in the early years of the Child Survival campaign, they’re already seeing some early wins.

Photo: James Grant, Unicef.org. Art: Andreas Bogdain, Creative Commons.
Health in America is a Wicked Problem

By Tom Peterson

In 1973 Horst Rittel and Melvin Webber, two U.C., Berkeley professors, published a paper describing Wicked Problems. They said that the traditional scientific approach doesn’t work in solving social problems. Problem solving in the industrial age focused on efficiency, and the challenges our scientists and engineers address are similar. They all focus on “tame” or “benign” problems such as solving a mathematical equation or analyzing the chemical structure of an organic compound. For these, they say, “the mission is clear. It’s clear, in turn, whether or not the problems have been solved.”

A wicked problem is one that’s not easy to describe, it has many causes, it’s hard or impossible to “solve.” It occurs in a social context where diverse stakeholders understand it differently.

“Fixing” health in America, a wicked problem

Explore what’s involved in health in the United States and you’ll quickly find yourself tangled in a web of issues. Often referred to as “social determinants of health” they include poverty, lack of education, substandard housing, unsafe neighborhoods, and so on. But that’s just the beginning. As you dig deeper ( wherever you’re digging) you quickly discover the complexities.

“Poverty is the swamp,” said William Clapp. “It doesn’t create all the problems, but it’s the sticky goo you’ve got to wade through to solve anything, whether it’s environmental problems or political instability.” The health issues in my town and yours are related to poverty. And I believe the root of poverty is the lack of democracy. It’s about people’s ability to determine matters that impact their lives. So now we’re into issues such as voting rights, political influence, grassroots organizing. Add to that who controls city planning, who controls the media, taxes. These themes play out even more dramatically on the state and national levels.

That we all view the problems and connections in our peculiar way adds to the wickedness of the challenges in creating a nation of healthy people.

It’s all connected

Pull on a single thread of any wicked problem and you quickly discover you’re pulling many, many threads.
“Imagine a multidimensional spider’s web in the early morning covered with dew drops,” says Alan Watts. “And every dew drop contains the reflection of all the other dew drops. And, in each reflected dew drop, the reflections of all the other dew drops in that reflection. And so ad infinitum. That is the Buddhist conception of the universe in an image.” It’s also what a wicked problem can look like. Each piece reflects and connects to the others.

**Ten Characteristics of Wicked Problems**

Horst Rittel and Melvin Webber presented the ten characteristics of wicked problems:

- There is no definitive formulation of a wicked problem.
- Wicked problems have no stopping rule.
- Solutions to wicked problems are not true-or-false, but good or bad [or better or worse].
- There is no immediate and no ultimate test of a solution to a wicked problem.
- Every solution to a wicked problem is a “one-shot operation”; because there is no opportunity to learn by trial-and-error, every attempt counts significantly.
- Wicked problems do not have an enumerable (or an exhaustively describable) set of potential solutions, nor is there a well-described set of permissible operations that may be incorporated into the plan.
- Every wicked problem is essentially unique.
- Every wicked problem can be considered to be a symptom of another problem.
- The existence of a discrepancy representing a wicked problem can be explained in numerous ways. The choice of explanation determines the nature of the problem’s resolution.
- The planner has no right to be wrong (planners are liable for the consequences of the actions they generate).

Affordable quality health care in the United States is a wicked problem. So are economic disparity, racism, women’s rights, homelessness and so on. As is any fractal piece of any of these. Mahatma Gandhi didn’t completely “solve” his challenges of both independence and convincing Indians to live in harmony. Martin Luther King, didn’t solve his challenges. Neither have Gloria Steinem, Caesar Chavez, James Grant or Malala Yousafzai. They all took on extremely wicked problems. And we live today in a better world because of their work. Hope and progress lie in the struggle forward.

**Wicked Problems Links**

**Strategy as a Wicked Problem.** John Camillus, writing in Harvard Business Review.

**Taming Wicked Problems**

*Spider photos in order (all from Creative Commons): Mharti, Luc Viatour, Thisisbossi, Thomas Bressen*