JOURNAL OF MANAGEMENT AND BUSINESS SOLUTIONS

Identifying the Barriers to Innovation in Public Sector Organizations: A Case Study of Healthcare Policy Implementation

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ABSTRACT

This study aims to identify and analyze the key barriers to innovation in public sector organizations, with a specific focus on healthcare policy implementation within Iran's centralized public health system. A qualitative research design was employed using a case study approach centered in Tehran. Data were collected through semi-structured interviews with 23 purposively selected participants, including healthcare policymakers, administrators, and frontline managers actively involved in policy implementation. Interviews continued until theoretical saturation was achieved. All interviews were audio-recorded, transcribed verbatim, and analyzed thematically using NVivo 12 software. Thematic analysis followed an inductive approach to coding and categorization, and peer debriefing and member checking were used to enhance validity and credibility. Three overarching themes emerged: (1) Structural and Bureaucratic Barriers, including centralized decision-making, rigid hierarchies, and inflexible procedures; (2) Cultural and Human Resource Challenges, such as risk-averse organizational culture, lack of innovation mindset, and leadership resistance; and (3) Policy and Systemic Constraints, including political interference, fragmented accountability, and underutilization of data. Participants emphasized the implementation gap between policy design and practice, the lack of innovation-related performance metrics, and limited stakeholder engagement. The barriers were found to be interrelated, reinforcing a cycle of stagnation that undermines innovative efforts. Innovation in public healthcare policy implementation is hindered by entrenched structural, cultural, and systemic constraints. Addressing these barriers requires decentralizing authority, fostering a supportive innovation culture, enhancing employee skills, and reforming policy processes to be more inclusive, data-informed, and adaptive. The findings offer actionable insights for policymakers, managers, and reform advocates seeking to foster innovation in similar public sector contexts.

Keywords: Public sector innovation; healthcare policy; qualitative research; bureaucratic barriers; organizational culture; policy implementation; Iran.

Introduction

Innovation has become a critical imperative in public sector organizations, particularly in the context of healthcare, where rapidly evolving social, demographic, and technological challenges demand adaptive, creative, and responsive governance structures. Unlike the private sector, where competition drives innovation organically, public institutions often struggle with entrenched bureaucracies, rigid hierarchies, and political oversight, which collectively inhibit the successful adoption of novel practices and policies (Borins, 2001; De Vries et al., 2016). In

Article history:
Received 12 November 2023
Revised 14 December 2023
Accepted 25 December 2023
Published online 01 January 2024

How to cite this article:
Sattarian, N., & Khalouei, P. (2024). Identifying the Barriers to Innovation in Public Sector Organizations: A Case Study of Healthcare Policy Implementation. *Journal of Management and Business Solutions, 2(1),* 1-9. https://doi.org/10.61838/jmbs.2.1.2

the healthcare sector, where the efficient implementation of evidence-based policies can significantly improve population health outcomes, understanding and addressing these barriers to innovation is both urgent and essential.

The growing complexity of public health needs—ranging from non-communicable diseases to pandemics—requires healthcare systems to be not only efficient but also agile and innovation-oriented (Gault, 2018). Yet, public healthcare institutions are frequently constrained by legacy systems, procedural rigidity, fragmented leadership, and a lack of incentives for experimentation (Brown & Osborne, 2013). Innovation, defined as the introduction and application of new ideas, processes, or services that improve efficiency or outcomes (OECD, 2015), is particularly difficult to foster in environments characterized by centralized control and risk aversion. The implementation of healthcare policies in such settings is often delayed, diluted, or derailed due to structural and cultural barriers deeply embedded in the public governance apparatus (Hartley, 2005).

Prior research has established that innovation in the public sector is not simply a matter of transferring private-sector practices into government organizations. It requires a deep understanding of contextual variables, including political influence, administrative traditions, stakeholder dynamics, and organizational capacity (Walker, 2006; Bason, 2018). In countries with centralized bureaucracies, such as Iran, the interplay between regulatory mandates, political patronage, and institutional inertia adds layers of complexity to the innovation landscape. Public servants often lack the autonomy, resources, or motivation to challenge the status quo, even when doing so aligns with broader policy goals (Lægreid & Christensen, 2011).

A critical but underexplored area within this field is the process by which healthcare policies are translated from legislation into practice within such public systems. The "implementation gap"—the disconnect between policy design and execution—has been a recurring theme in public administration literature (Hill & Hupe, 2014). This gap is often exacerbated by organizational silos, poor interdepartmental coordination, a lack of evidence-informed decision-making, and fragmented accountability structures (Ferlie et al., 2005). While scholars have examined innovation at the macro policy level, fewer studies have investigated the micro-level barriers that frontline managers, policy implementers, and administrative professionals encounter in their day-to-day work within public healthcare institutions.

Healthcare, as a labor-intensive and service-oriented domain, is especially vulnerable to such institutional rigidities. For instance, innovation in healthcare policy might entail the adoption of integrated care models, digital health platforms, or new preventive programs. However, successful implementation often hinges on organizational readiness, leadership support, staff engagement, and access to enabling resources such as training and data infrastructure (Greenhalgh et al., 2004; Sørensen & Torfing, 2012). Where these are lacking, well-intentioned policies may remain unrealized or ineffectively executed, undermining public trust and wasting resources.

Barriers to innovation in public healthcare policy can be categorized into structural, cultural, and systemic challenges. Structurally, many healthcare systems remain hierarchical and siloed, with limited scope for horizontal coordination or bottom-up feedback (Cinar et al., 2019). Procedural rigidity, in the form of inflexible budgeting, strict procurement laws, and excessive oversight, limits agility and experimentation (Lewis et al., 2018). Culturally, public organizations often cultivate a risk-averse mindset, discouraging employees from proposing or attempting new approaches for fear of reprisal or failure (Bekkers et al., 2011). Moreover, leaders may resist change to maintain control or avoid destabilizing long-standing institutional norms (Morris & Farrell, 2007).

Systemically, political instability and inconsistent regulatory frameworks pose additional challenges. In many developing contexts, policy priorities shift with changes in political leadership, undermining the continuity needed

for innovation to mature and scale (Torfing & Triantafillou, 2016). In such settings, innovation is not only a technical but a political endeavor, vulnerable to disruptions from electoral cycles, leadership turnover, and shifting agendas. The absence of robust monitoring and evaluation mechanisms further impedes the ability to assess and iterate on innovative policies (Dunleavy et al., 2006). Moreover, frontline stakeholders—those responsible for implementation—are often excluded from the policymaking process, resulting in poor ownership, resistance, or misunderstanding of reform objectives (Ansell & Gash, 2008).

Recent studies have called for a more nuanced and context-sensitive approach to public sector innovation, one that accounts for institutional logics, actor agency, and embedded power structures (Hartley et al., 2013; Arundel et al., 2015). In the case of Iran's healthcare sector, previous research has identified challenges such as limited decentralization, bureaucratic inefficiencies, and inconsistent leadership support for reform (Khodaveisi et al., 2018). Yet, there is a lack of empirical studies that systematically identify and categorize these barriers from the perspective of practitioners directly involved in healthcare policy implementation.

This study seeks to fill that gap by conducting a qualitative investigation into the perceived barriers to innovation in Iran's public healthcare system, focusing specifically on policy implementation. Using a case study approach centered in Tehran, and drawing on semi-structured interviews with 23 participants—including policymakers, administrators, and healthcare managers—this research aims to uncover the institutional, cultural, and systemic impediments to innovative practices in healthcare governance. The focus on frontline voices and real-world implementation experiences provides valuable insights into how innovation is constrained or enabled in practice, beyond formal policy discourse.

By thematically analyzing the data using NVivo software and reaching theoretical saturation, this study contributes to a growing body of literature on innovation in the public sector, offering practical and theoretical implications. Practically, the findings can inform policy design by highlighting the structural reforms, leadership behaviors, and resource strategies needed to enable innovation. Theoretically, the study enriches our understanding of how innovation barriers manifest in centralized and politically complex governance systems. Ultimately, identifying these barriers is a critical step toward designing more responsive, agile, and citizen-centered healthcare systems capable of meeting 21st-century public health challenges.

Methods and Materials

Study Design and Participants

This study employed a qualitative research design to explore and identify the key barriers to innovation in public sector organizations, with a specific focus on healthcare policy implementation. A case study approach was adopted to allow for an in-depth understanding of contextual and organizational factors influencing innovation processes within a real-world public sector setting. The participants were purposefully selected from various departments and management levels within Tehran's public healthcare system, including policymakers, administrators, senior healthcare managers, and policy implementers. A total of 23 individuals participated in the study. Selection was based on their direct involvement in policy design, execution, or oversight, ensuring the relevance and richness of their insights.

Data Collection

Data were collected through semi-structured interviews, which allowed for both guided inquiry and flexible exploration of emergent themes. The interview guide consisted of open-ended questions covering areas such as organizational culture, bureaucratic procedures, leadership style, interdepartmental coordination, regulatory constraints, and resource availability. Interviews lasted between 45 and 75 minutes and were conducted in person at participants' workplaces across various public healthcare institutions in Tehran. Interviews were recorded with informed consent and transcribed verbatim for analysis. The process of data collection continued until theoretical saturation was reached—that is, when no new conceptual insights were emerging from additional interviews.

Data analysis

Thematic analysis was employed to analyze the interview data. NVivo software (version 12) was used to assist in the coding, categorization, and retrieval of data segments. Initial codes were generated inductively from the data and then grouped into broader themes through iterative comparison and refinement. Constant comparison was applied throughout the coding process to ensure consistency and to allow new codes to emerge as data analysis progressed. The research team conducted peer debriefing sessions to validate interpretations and enhance the credibility of the findings. Member checking was also employed by sharing synthesized interpretations with selected participants to confirm the accuracy of themes and interpretations.

Findings and Results

Theme 1: Structural and Bureaucratic Barriers

Centralized Decision-Making:

Participants widely described the top-down nature of decision-making in the healthcare system as a key barrier to innovation. The lack of autonomy at lower levels of the organization prevented units from tailoring solutions to local challenges. One policymaker noted, "We have to wait weeks for central office approval, even for pilot ideas—it kills momentum." This hierarchical rigidity limited the agility necessary for innovative practices.

Rigid Hierarchies:

Interviewees emphasized how multi-layered bureaucratic hierarchies slowed the implementation of new ideas. With strict adherence to a chain-of-command structure, many frontline staff reported feeling disempowered. A healthcare manager shared, "I can't make a single change without passing it through four layers—it discourages any initiative." This structural inertia discouraged cross-functional collaboration and independent problem-solving.

Procedural Inflexibility:

Fixed procedures and document-heavy processes were repeatedly cited as barriers that hinder adaptation and timely responses. Respondents described the system as "rule-bound" with little room to experiment. "Innovation is impossible when everything must follow a 10-step process designed 20 years ago," remarked one senior nurse administrator.

Resource Allocation Inefficiencies:

Budget rigidity and delayed disbursement of funds further obstructed innovative efforts. Many participants highlighted a mismatch between allocated resources and actual needs. "Funds come in too late or are tied to

outdated categories," said a participant from the financial department. The absence of a dedicated budget for innovation was a recurring concern.

Poor Interdepartmental Coordination:

The siloed structure of public healthcare institutions led to duplication of efforts and inconsistent goals between units. Participants described coordination as ad hoc and largely dependent on personal relationships. "Sometimes we find out another unit is working on the same issue only after both teams have done the same job," a project coordinator noted.

Inconsistent Regulatory Oversight:

Respondents pointed to contradictory mandates and fluctuating policy requirements as sources of uncertainty. Legal ambiguities often created hesitation in pursuing innovative solutions. One policymaker explained, "Sometimes we want to try something new, but we're unsure if it's even allowed—regulations change without notice."

Theme 2: Cultural and Human Resource Challenges

Risk-Averse Organizational Culture:

An overwhelming majority of participants cited a pervasive fear of failure and blame as a deterrent to innovation. Experimentation was discouraged in favor of sticking to established routines. "If you make a mistake trying something new, you'll be held responsible—even if it had potential," said a health unit supervisor.

Lack of Innovation Mindset:

Many participants described a workplace culture that does not value creative problem-solving. Innovation was often perceived as unnecessary or even disruptive. A middle manager observed, "Here, being innovative means causing trouble—it's safer to keep your head down and follow protocol."

Leadership Resistance:

Leadership was frequently portrayed as unsupportive of innovation. Respondents explained that senior leaders often enforced traditional practices and resisted change. One healthcare analyst shared, "Our directors rarely support new ideas—they prefer sticking to the manual, even if it's outdated."

Employee Disengagement:

Low morale and burnout were commonly linked to organizational inertia. Participants felt that their ideas were neither heard nor appreciated, resulting in disengagement. "When nobody listens and nothing changes, eventually you stop caring," said a nurse with over 15 years of experience.

Skill Gaps and Training Deficits:

Participants cited a lack of access to upskilling opportunities and interdisciplinary learning as significant barriers. The system failed to equip staff with the competencies needed to implement innovative practices. "We're expected to innovate, but no one trains us in the tools or methods," stated one interviewee.

Theme 3: Policy and Systemic Constraints

Political Interference:

Shifting political priorities and frequent leadership turnover were reported as major disruptors to long-term innovation efforts. "Every new administration resets our goals—what was urgent last year becomes irrelevant today," remarked a senior policy advisor. Such instability discouraged sustained investment in innovative projects.

Misalignment of Policy and Practice:

Participants highlighted the disconnect between policymakers and implementers. Policies were often drafted without consulting practitioners, leading to unrealistic expectations and unfeasible strategies. “Policy looks great on paper, but it doesn’t fit our daily reality,” one hospital administrator explained.

Fragmented Accountability:

Confusion about roles and responsibilities was a common theme. Participants described a “culture of finger-pointing” where failures were diffused across multiple stakeholders. “If something fails, no one takes responsibility because it wasn’t clearly anyone’s job,” noted a healthcare project officer.

Insufficient Performance Metrics:

Innovation was not built into the evaluation framework of public sector work. Participants expressed frustration that success was measured by compliance rather than creativity. “We’re evaluated on whether we followed instructions, not whether we solved problems,” said a clinic manager.

Regulatory Barriers to Innovation:

Strict legal frameworks and lack of flexibility in licensing and approvals were also identified as structural impediments. Respondents noted that even promising initiatives were often blocked by regulatory compliance hurdles. “There’s no allowance for pilots or experimental programs—it’s all or nothing,” observed a department head.

Limited Stakeholder Engagement:

Top-down policy formulation excluded voices from the ground level, resulting in low ownership and minimal buy-in. “We’re the ones doing the work, but no one asks our opinion before the policy is finalized,” a nurse team leader stated.

Lack of Data-Driven Decision-Making:

A major limitation reported was the underutilization of data in shaping policy or guiding innovation. Data was either not available, not shared, or not trusted. “We make decisions based on guesswork more than evidence,” confessed a senior analyst.

Discussion and Conclusion

The findings of this study, based on semi-structured interviews with 23 healthcare professionals and policymakers in Tehran, reveal a complex and multi-layered set of barriers impeding innovation in the public healthcare sector. These barriers are grouped into three overarching themes—**structural and bureaucratic**, **cultural and human resource-related**, and **policy and systemic constraints**—each reflecting deep-seated institutional challenges. This discussion explores these findings in relation to existing scholarship, highlighting both consistencies and nuances that enrich our understanding of public sector innovation.

The results confirm that rigid organizational structures and bureaucratic inertia significantly obstruct innovation in public healthcare. Centralized decision-making and hierarchical control were widely viewed as suppressing local initiative and responsiveness. This aligns with previous research indicating that centralized governance often limits adaptability and the potential for bottom-up innovation (Walker, 2006; Hartley et al., 2013). Borins (2001) similarly emphasized how multi-layered hierarchies in public institutions restrict idea generation and experimentation by placing excessive authority at the top.

Procedural inflexibility, in the form of standardized protocols and lengthy approval chains, also emerged as a recurring issue. These processes, while intended to maintain control and uniformity, often prevent the real-time

adaptations necessary for innovation (Brown & Osborne, 2013). Similar conclusions were reached by Cinar et al. (2019), who found that excessive administrative procedures significantly slowed policy implementation in public health services.

Another barrier identified was inefficient resource allocation, particularly delays in budget disbursement and the absence of earmarked funds for innovation. Prior studies have highlighted that innovation efforts often fail due to financial constraints and lack of institutional mechanisms to fund pilot programs (De Vries et al., 2016; Arundel et al., 2015). Our findings suggest that the mismatch between financial planning cycles and innovation timelines is particularly damaging in healthcare contexts, where time-sensitive needs are common.

In terms of organizational culture, the study reveals a strong tendency toward risk aversion, a common issue in public sector settings (Bekkers et al., 2011). Participants described an environment where mistakes are punished, and status quo behavior is rewarded—factors that collectively discourage creativity and innovation. This aligns with the findings of Morris and Farrell (2007), who reported that punitive workplace cultures inhibit the emergence of innovative behavior among public employees.

Another theme was the lack of an innovation mindset, both at the leadership and staff levels. While innovation is often presented as a strategic goal in policy documents, it is not meaningfully internalized within day-to-day organizational practices. Leaders, according to participants, neither model innovative behavior nor empower others to do so—echoing findings from Hartley (2005) and Sørensen and Torfing (2012), who argued that transformational leadership is critical for fostering public sector innovation.

The study also highlighted human capital limitations, including a shortage of relevant skills, inadequate training opportunities, and weak interdisciplinary collaboration. Greenhalgh et al. (2004) noted that successful innovation requires not just structural reform but also investment in professional development and cultural capacity-building. Our findings reinforce this argument by showing that staff, even when motivated, often lack the necessary competencies or support systems to implement novel solutions.

Political interference and unstable leadership emerged as prominent systemic barriers, with participants reporting frequent changes in priorities, leadership, and directives. These findings support earlier work by Dunleavy et al. (2006), who showed that political turnover leads to discontinuity in public initiatives, particularly those requiring long-term commitment. Similarly, Khodaveisi et al. (2018) found that inconsistent leadership in Iran's health sector undermines policy coherence and the scaling of reforms.

A significant barrier identified was the disconnect between policy formulation and implementation, commonly referred to as the "implementation gap" (Hill & Hupe, 2014). Participants described policies as being crafted without sufficient input from practitioners, leading to strategies that are impractical or misaligned with on-the-ground realities. This reflects findings by Ansell and Gash (2008), who emphasized the importance of collaborative governance in bridging this divide.

Fragmented accountability further complicates innovation, as unclear roles and overlapping mandates result in a diffusion of responsibility. Participants echoed findings from Ferlie et al. (2005), who highlighted how blurred accountability lines reduce motivation and ownership of innovative practices. Furthermore, the absence of innovation-related performance metrics means that even proactive staff are not rewarded for taking initiative—an observation that matches the conclusions of Lewis et al. (2018), who emphasized the role of aligned evaluation systems in sustaining innovation.

The study also revealed legal and regulatory barriers, such as inflexible licensing requirements and lack of legal exemptions for pilot projects. These findings resonate with research by OECD (2015), which underscored that legal frameworks must evolve to accommodate experimental and iterative policy development. In the absence of such flexibility, innovation becomes constrained by the very rules meant to ensure order.

Finally, weak stakeholder engagement and underutilization of data were also highlighted. Participants lamented the lack of opportunities to contribute to policy design, a finding consistent with Arundel et al. (2015), who argued that front-line inclusion in decision-making enhances innovation outcomes. Moreover, the reliance on intuition rather than data for policymaking corroborates previous studies on the limitations of evidence-informed governance in the public sector (Gault, 2018).

Acknowledgments

We would like to express our appreciation and gratitude to all those who helped us carrying out this study.

Authors' Contributions

All authors equally contributed to this study.

Declaration of Interest

The authors of this article declared no conflict of interest.

Ethical Considerations

All ethical principles were adheried in conducting and writing this article.

Transparency of Data

In accordance with the principles of transparency and open research, we declare that all data and materials used in this study are available upon request.

Funding

This research was carried out independently with personal funding and without the financial support of any governmental or private institution or organization.

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