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# ACCESS TO HEALTHCARE FOR REFUGEES IN BIRMINGHAM, UK

Module Code: BNM817J

# TABLE OF CONTENTS

## Background and Context of Problem Situation Unstructured – Stage 1

Access to healthcare for refugees in Birmingham has been a longstanding issue, driven by several interconnected factors. The primary barrier for refugees and asylum seekers lies in the lack of awareness about available healthcare services, compounded by language barriers, legal restrictions, and administrative hurdles. Many refugees are unaware of their right to access healthcare services, while others are deterred by the complex and bureaucratic processes involved in registering with a GP or seeking medical care. Furthermore, a lack of understanding of the UK's healthcare system, coupled with concerns about the potential consequences for their immigration status, leads many refugees to avoid healthcare altogether, exacerbating health inequalities (NHS Digital, 2020).

The NHS in Birmingham faces increased demand for services, often struggling with resource limitations and long waiting times. Refugees, many of whom have experienced trauma, face specific challenges, including mental health issues, physical ailments, and disabilities, all of which require immediate and continuous care. Despite various policies in place to support refugee access to healthcare, the system remains overburdened, and the services available are often fragmented (Birmingham City Council, 2021). Moreover, there is a significant gap in understanding of the role of healthcare providers in refugee care, which leads to inconsistent care and at times, discrimination (Refugee Council, 2022).

## Client Description: NHS England:

The notional client for this analysis is the NHS Birmingham and Solihull Integrated Care Board (ICB). The ICB is responsible for planning, commissioning, and overseeing healthcare services for the populations of Birmingham and Solihull, which includes refugees and asylum seekers. The ICB is particularly invested in improving access to healthcare for marginalized groups, including refugees, as part of its broader efforts to reduce health inequalities in the region. By understanding the barriers refugees face in accessing healthcare, the ICB aims to improve service delivery, streamline processes, and develop more inclusive policies that ensure refugees receive the healthcare they need.

## Complexity and Ambiguity of the Problem:

The problem is complex due to the intersection of various factors that contribute to healthcare access issues for refugees. These include:

- Legal Barriers: Refugees often face restrictions on their healthcare access based on their immigration status. There are limitations in the eligibility criteria for certain services, and refugees may fear that accessing healthcare could jeopardize their immigration status.

- Cultural and Language Barriers: Many refugees do not speak English fluently, making it difficult for them to understand healthcare systems and communicate their medical needs

effectively. Cultural misunderstandings between refugees and healthcare providers also complicate care delivery.

- Systemic and Structural Issues: The NHS faces funding constraints, staffing shortages, and administrative inefficiencies, which affect its capacity to meet the needs of all patients, particularly refugees who are already disadvantaged.

- Stakeholder Conflicts: There is often tension between stakeholders, such as the UK Home Office and human rights groups, regarding the extent of healthcare provision for refugees. The conflicting interests of these stakeholders contribute to the ambiguity of the problem and the lack of clarity in policy implementation.
- The ambiguity of the problem lies in the fact that it is unclear whether the primary barriers to healthcare access are political (immigration policies), social (language and cultural barriers), or systemic (NHS resource limitations). Additionally, there is no clear consensus on the best approach to solving the issue, as solutions like increasing NHS funding, improving cultural competency among healthcare providers, or modifying immigration policies all have different implications and trade-offs.

## List of Stakeholders and Roles and Relationships:

| Name | Relationships | What's on their mind? |
|---|---|---|
| Refugees | Bad – Face multiple barriers accessing healthcare | Concerned about long waiting times, language barriers, and fear of immigration consequences affecting their healthcare access. |
| NHS Staff (Doctors, Nurses) | Good – Want to provide care but overwhelmed due to high demand | Focused on providing the best care, but dealing with limited resources and long waiting times. |
| UK Home Office | Bad – Interested in controlling resource allocation | Focused on regulating healthcare access for asylum seekers and ensuring it fits within immigration policies. |
| Birmingham City Council | Good – Supports public health initiatives, including refugee welfare | Focused on integrating refugees into the local healthcare system and addressing health inequalities. |
| Charities (Refugee Council) | Good – Advocate for inclusive healthcare policies for refugees | Concerned with pushing for fair healthcare access, ensuring refugees are not excluded due to policy barriers. |
| GP Surgeries | Bad – Want to serve but face capacity and resource constraints | Struggle to meet the demand for healthcare services due to limited time, staff, and translation resources. |

| | | |
|---|---|---|
| Legal Aid Groups | Good – Advocate for equal healthcare rights for all, including refugees | Focused on ensuring refugees have access to healthcare services and are not discriminated against. |
| Department of Health & Social Care | Good – Responsible for public health policy implementation | Concerned with balancing healthcare access for refugees with available resources, ensuring the system is not overburdened. |
| Citizens (Taxpayers) | Bad – Concerned about the cost of healthcare for refugees | Focused on the economic impact of providing healthcare to refugees and whether resources will be stretched too thin. |
| Community Leaders (Religious Organizations) | Bad – While religious organizations may support refugees, their influence may inadvertently reinforce segregation | Concerned that their focus on community-specific issues may create silos, making refugees more isolated and reducing integration efforts. |
| Translators | Good – Essential in bridging communication barriers between refugees and healthcare providers | Concerned with facilitating clear communication, making sure refugees fully understand healthcare processes and services. |
| Mental Health Support Services | Good – Focus on providing necessary mental health care to refugees | Concerned about the mental health needs of refugees who often face trauma, stress, and uncertainty. |
| Social Workers | Good – Advocate for the welfare of refugees | Focused on helping refugees navigate healthcare, housing, and legal services to support their integration. |
| Advocacy Groups | Good – Raise awareness on healthcare access issues for refugees | Focused on amplifying the voices of refugees and advocating for policy changes to improve healthcare access. |
| Pharmaceutical Companies | Bad – Interested in profit-making and cost management | Concerned about the cost of providing medication and healthcare to refugees, and the reimbursement process. |

**Power Interest of Stakeholders - Matrix:**

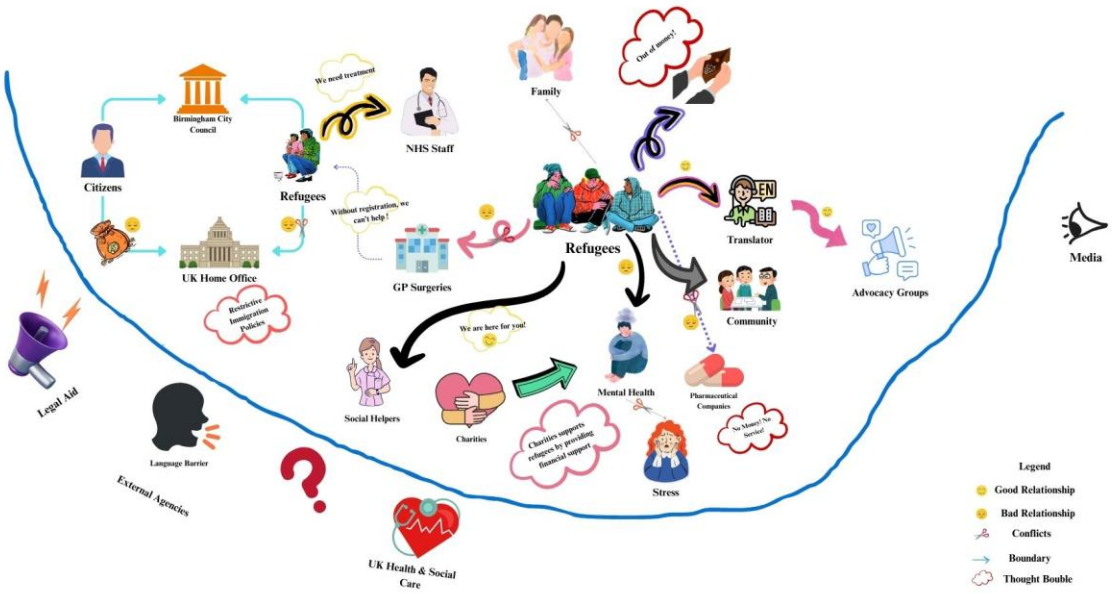
| POWER | | |
|---|---|---|
| HIGH | **Keep Involved:**<br><br>UK Home Office<br>Pharmaceutical Companies | **Key Players:**<br><br>NHS Staff (Doctors, Nurses)<br>Birmingham City Council |
| LOW | **Minimal Attention:**<br><br>Citizens<br>Community Leaders | **Keep Informed:**<br><br>Refugees<br>Charities |
| | LOW | HIGH |
| | **INTEREST** | |

## Problem Statement Expressed – Part 1 -Rich Picture – SSM Stage 2

### Introduction – Evidence of Research

Access to healthcare for refugees in Birmingham is a complex and challenging issue. Research identifies several key barriers including language difficulties, fear of immigration repercussions, lack of NHS capacity, and restrictive immigration policies (Refugee Council, 2022; NHS Digital, 2020). To explore this issue comprehensively, a rich picture using Soft Systems Methodology (SSM) illustrates stakeholders, relationships, processes, conflicts, and emotions, clearly defining internal and external boundaries.

## Rich Picture:




### Five Key Characteristics

### 1. Stakeholders Identified:

Clearly illustrated: Refugees, NHS Staff, UK Home Office, Birmingham City Council, Charities, GP Surgeries, Legal Aid Groups, Dept. of Health & Social Care, Citizens, Community Leaders, Translators, Mental Health Services, Social Workers, Advocacy Groups, Pharmaceutical Companies.

### 2. System Boundary:

Clearly defined boundary separating the healthcare provision system for refugees in Birmingham from external influences.

### 3. Relationships Between Stakeholders:

Positive: NHS Staff helping refugees, Charities advocating, Translators enabling communication.

Negative: Resource constraints (GP Surgeries), restrictive immigration policies (UK Home Office), economic concerns (Citizens).

### 4. Key Issues and Concerns:

Refugees: Language barriers, fear of deportation.

NHS Staff: Resource overload, high patient demand.

UK Home Office: Immigration policy controls healthcare access.

GP Surgeries: Capacity constraints, limited resources.

Charities: Ensuring refugees have fair healthcare access.

Citizens: Economic impact, sustainability of funding.

Community Leaders: Potential to create segregation.

**5. External Stakeholders:**

Legal Aid: Advocating against restrictive policies.

Media: Influencing public opinion.

Immigration Authorities: Enforcing healthcare eligibility rules.

General Public: Economic and social integration concerns.

**SSM Analysis – Stage 3: Purpose Statements:**

**Selected Conflicting Stakeholder Pairs**

1) Refugees vs. NHS Staff (Doctors, Nurses)
2) UK Home Office vs. Charities (Refugee Council)

**Power / Interest – Relationship and Conflict**

- **Pair 1: Refugees vs. NHS Staff (Doctors, Nurses)**

**Power/Interest:**

Refugees hold low power but have high interest in accessing healthcare services. Their ability to influence the system is limited due to legal, social, and language barriers. NHS Staff, on the other hand, have moderate power and high interest. They are directly responsible for delivering care and experience the operational challenges of dealing with high patient loads and system constraints.

**Relationship and Conflict:**

Refugees depend on NHS services for their physical and mental health. However, they often face delays, misunderstandings, and discriminatory practices, which lead to distrust and fear of engaging with the system. NHS staff, while generally committed to providing quality care, struggle with limited time, resources, and a lack of cultural training. This creates friction where staff feel overwhelmed and refugees feel neglected. The conflict lies in the mismatch between the expectations and needs of refugees and the capacity and preparedness of the NHS workforce.

- **Pair 2: UK Home Office vs. Charities**

**Power/Interest:**

The UK Home Office possesses high power but shows low interest in refugee healthcare. Its focus lies in immigration control, often at the cost of humanitarian concerns. In contrast, charities such as the Refugee Council have low power but high interest. Their mission is to protect the rights and wellbeing of refugees and asylum seekers.

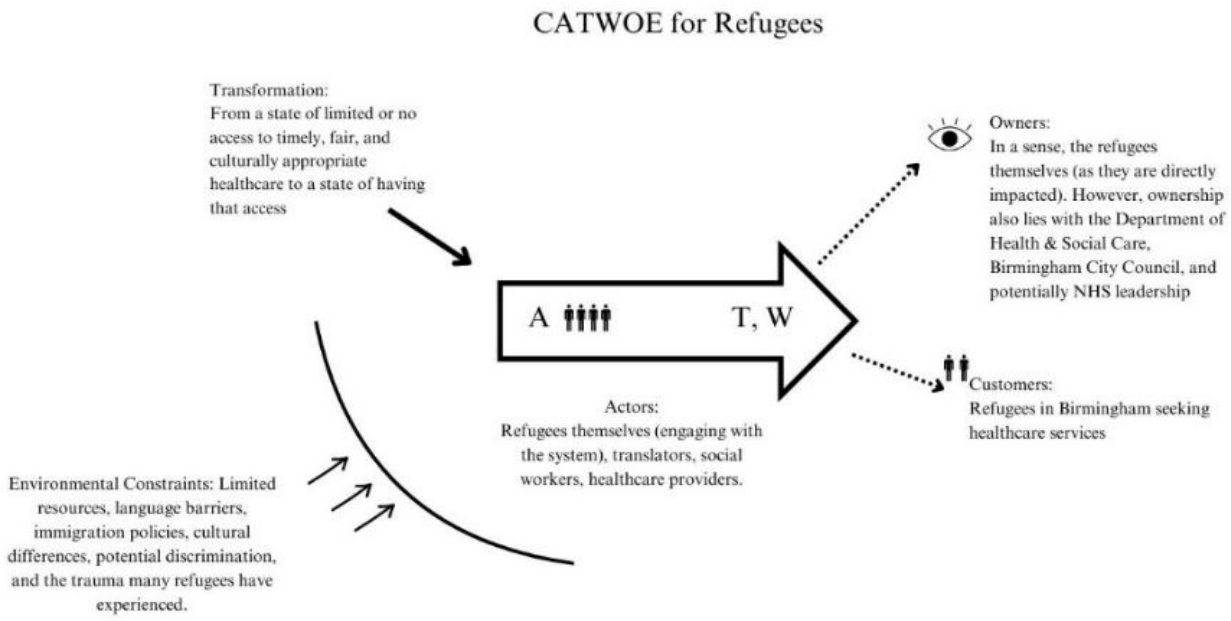
**Relationship and Conflict:**

The Home Office enforces regulations that can restrict healthcare access for asylum seekers, often using policy tools to discourage overuse of public services. Charities advocate for universal and unconditional healthcare access as a basic human right. This creates a direct conflict between enforcement of control and humanitarian support, especially when policies result in avoidable suffering or public health risks.

**PQR Statement:**

| Stakeholder | P – What | Q – How | R – Why |
|---|---|---|---|
| Refugees | A system to access timely, fair, and culturally appropriate healthcare services | By simplifying registration, removing legal barriers, and offering translation and mental health support | In order to safeguard health, build trust, and support integration in the host society |
| NHS Staff (Doctors, Nurses) | A system to deliver inclusive and effective care to all patients, including refugees | By improving staff support, enhancing communication tools, and providing cultural sensitivity training | In order to reduce inequality, improve patient outcomes, and ensure professional wellbeing |
| UK Home Office | A system to manage public resource access through immigration control mechanisms | By setting eligibility criteria, verifying legal status, and monitoring service use | In order to maintain lawful residency systems, manage costs, and support policy compliance |
| Charities | A system to guarantee equal healthcare access for all refugees and asylum seekers | By advocating for inclusive policies, providing support services, and removing discriminatory barriers | In order to uphold human rights, prevent health inequalities, and promote social cohesion |

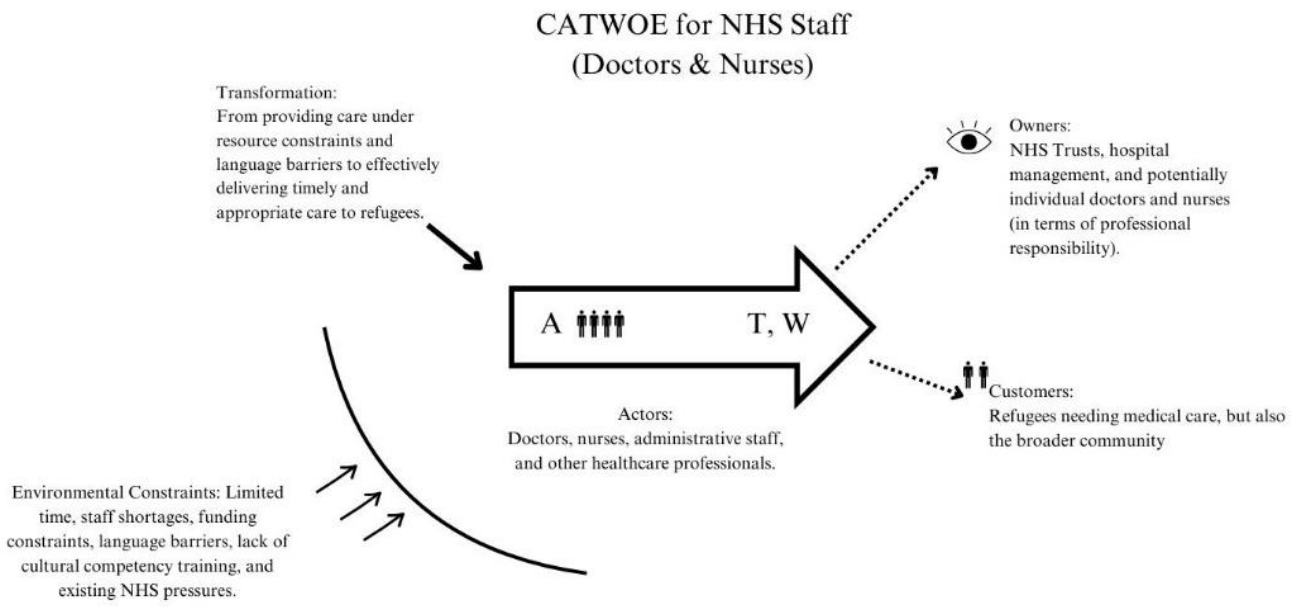
**CATWOE for Refugees:**




**Root Definition Statement for Refugees:**

From the refugees' perspective, the system transforms their situation "from limited or no access to timely, fair and culturally appropriate healthcare" to one in which these services are reliably available. Their worldview holds that healthcare is a fundamental human right essential for wellbeing and successful integration. Refugees themselves, alongside translators, social workers and frontline clinicians, enact this transformation, but face environmental constraints — notably language barriers, restrictive immigration policy, discrimination and scarce NHS capacity. Ownership of this change rests primarily with refugees (as those most directly impacted) but also with Birmingham City Council, NHS leadership and DHSC, who must ensure access regardless of status.

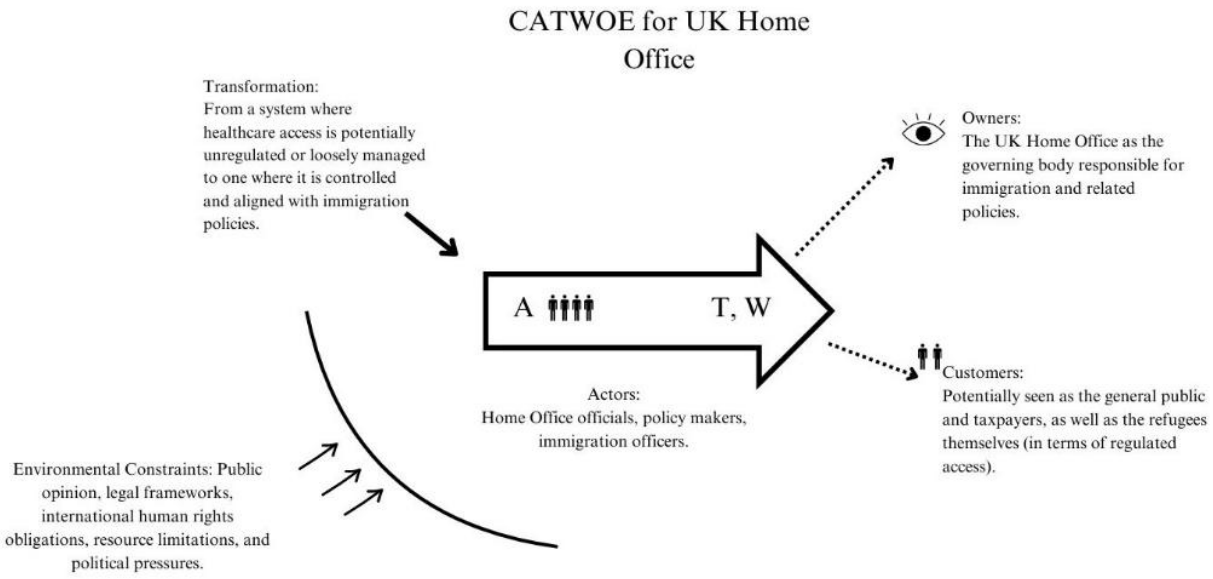
**CATWOE for NHS Staff:**




**Root Definition Statement for NHS Staff:**

For NHS staff, the CATWOE transformation is "from providing care under resource-strained conditions to delivering inclusive, timely and high-quality treatment to refugee patients." Their worldview emphasizes professional duty and equity: that every patient deserves compassionate care irrespective of background. As actors, doctors, nurses and administrators confront barriers of understaffing, long waiting lists, and inadequate translation support. Ownership of system improvement lies with NHS Trusts and hospital management, while environmental constraints — workforce shortages, funding pressures, and cultural competency gaps — shape the limits of what staff can achieve.

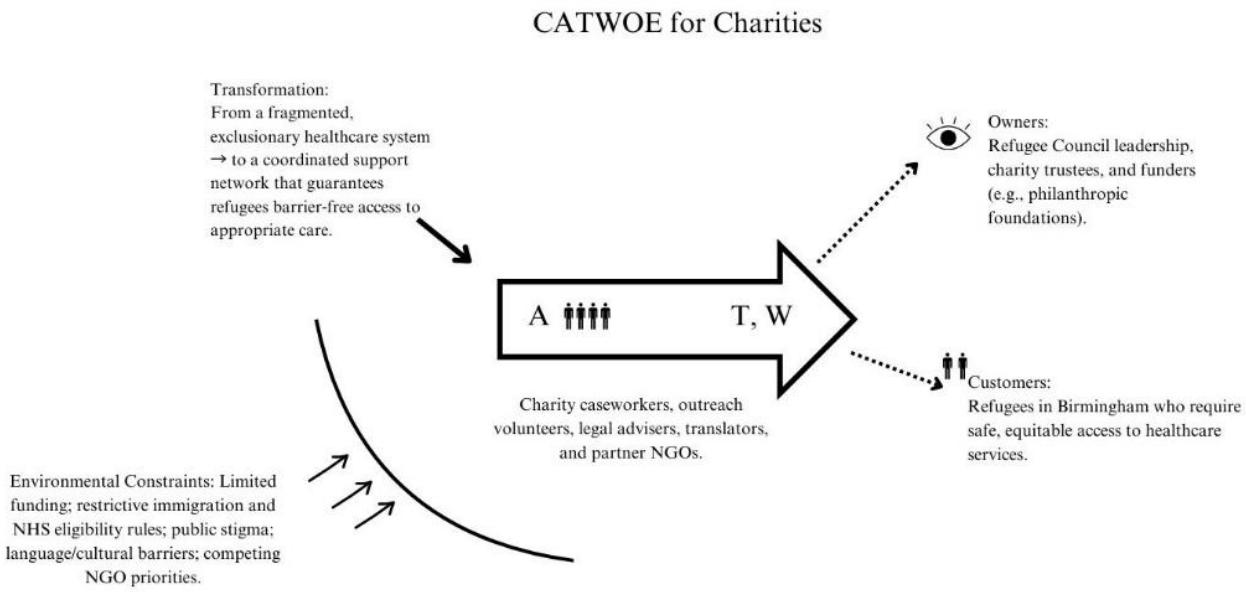
**CATWOE for UK Home Office:**




**Root Definition Statement for UK Home Office:**

The UK Home Office's transformation moves "from an unregulated approach to refugee healthcare access to one governed by strict eligibility criteria tied to immigration status." Its worldview asserts that public resources must be protected by enforcing legal boundaries. Home Office officials set and enforce these rules, yet face constraints from public opinion, international human-rights obligations, and NHS pressures. Ownership firmly rests with the Home Office itself. Environmental constraints include political pressure to balance immigration control with basic humanitarian obligations, and legal challenges from advocacy groups.

**CATWOE for Charities:**

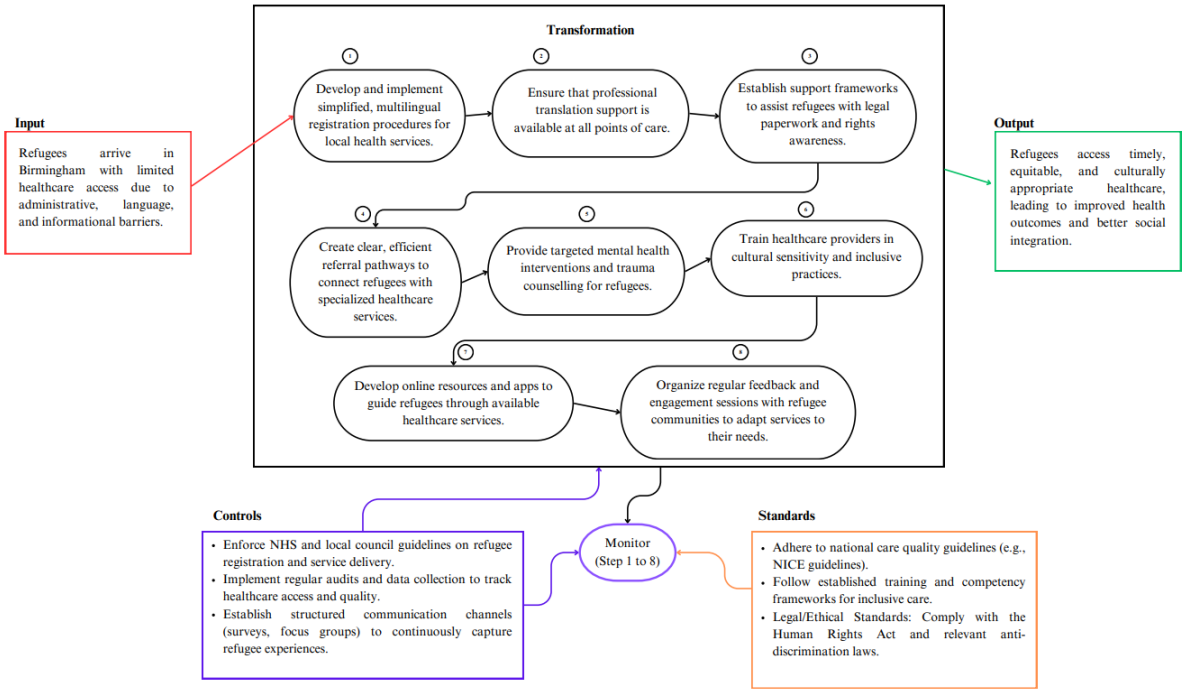



**Root Definition Statement for Charities:**

The Refugee Council's ideal system transforms the current patchwork of support into a single, navigable pathway enabling all refugees—regardless of status—to register, attend appointments, and receive follow-up care. Driven by a rights-based worldview, the charity mobilizes staff and volunteers to fill gaps left by statutory services. However, its capacity is constrained by budget limits, hostile policy environments, and negative public attitudes, which must be addressed to deliver truly inclusive healthcare.

## Conceptual Models – SSM Stage 4

## Conceptual Model for Refugees:



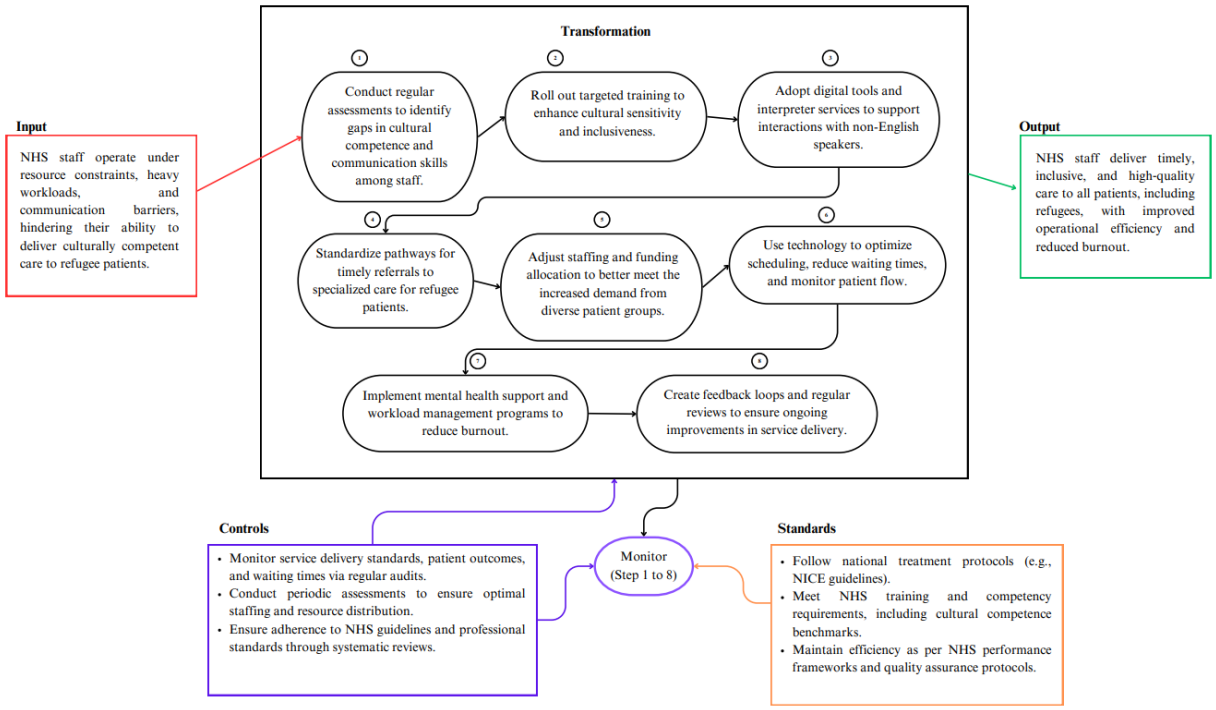

## 3E's for Refugees:

**Efficacy:** Ensures refugees receive the care they need by reducing administrative and language barriers.

**Efficiency:** Streamlines registration and referral processes to minimize delays and optimize resource use.

**Effectiveness:** Leads to measurable improvements in health outcomes and integration, enhancing overall wellbeing.

## Conceptual Model for NHS Staff (Doctors, Nurses):



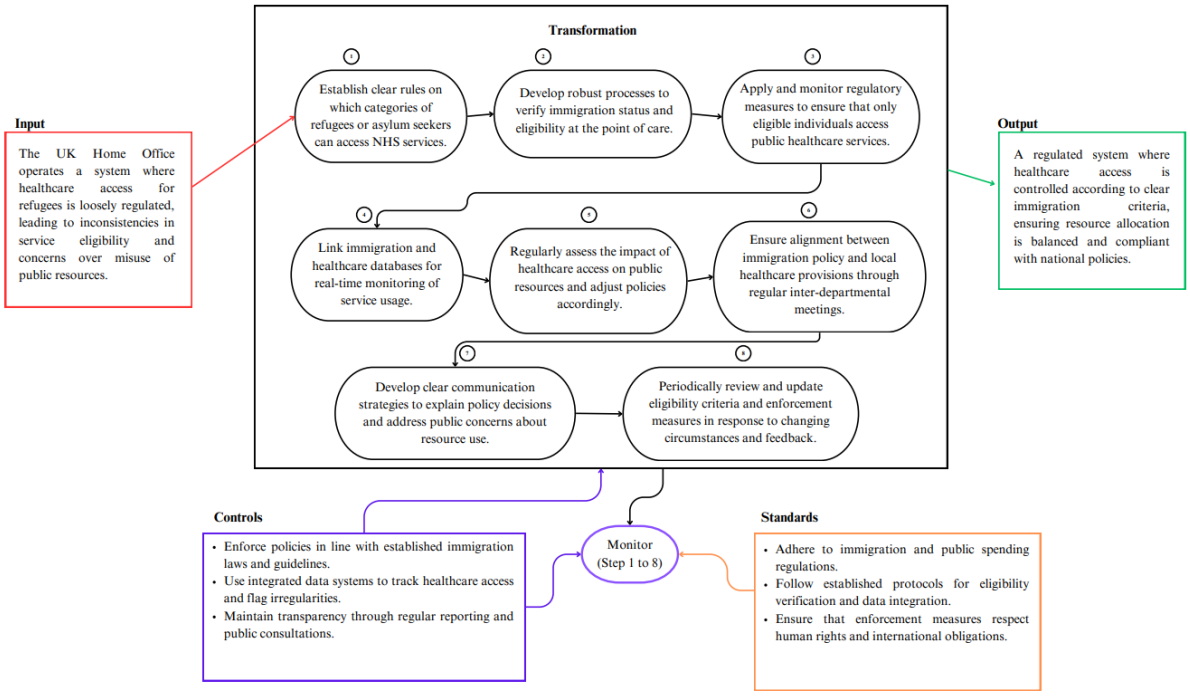

## 3E's for NHS Staff:

**Efficacy:** Improves care quality by equipping staff with the skills and resources needed to address diverse patient needs.

**Efficiency:** Optimizes workflows and resource allocation, reducing waiting times and administrative burdens.

**Effectiveness:** Enhances patient outcomes and staff wellbeing, leading to a sustainable, high-quality healthcare service.

## Conceptual Model for UK Home Office:



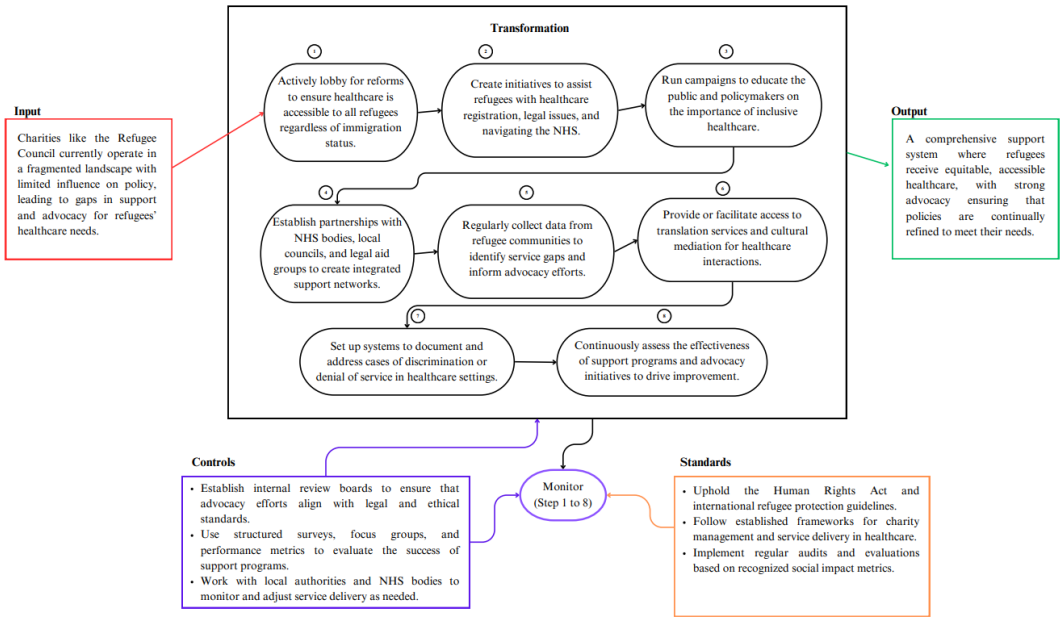

## 3E's for UK Home Office:

**Efficacy:** Ensures that only eligible individuals access public healthcare, maintaining system integrity.

**Efficiency:** Streamlines verification and monitoring processes to minimize administrative burdens.

**Effectiveness:** Achieves balanced resource allocation while upholding public trust and legal compliance.

## Conceptual Model for Charities:




## 3E's for Charities:

**Efficacy:** Empowers charities to drive change by ensuring all refugees receive the support they need.

**Efficiency:** Maximizes resource use by coordinating efforts across multiple partners and reducing service duplication.

**Effectiveness:** Delivers measurable improvements in healthcare access and outcomes for refugees, reinforcing social cohesion.

## Part 3 - Complementary Analysis - Part 3: SWOT Analysis

### Strengths

- **Integrated Approaches:**
  Collaborative efforts between the NHS, local authorities, NGOs, and community groups create a multi-sectoral approach to refugee healthcare. This integration fosters a shared vision and coordinated service delivery.
- **Evidence-Based Practices:**
  The adoption of established national care quality guidelines (e.g., NICE guidelines) and proven models of care ensures that interventions are grounded in best practice and research.
- **Strong Advocacy Networks:**
  Organizations such as the Refugee Council and legal aid groups actively advocate for refugee rights, ensuring that policy makers and service providers are held accountable and responsive to the needs of vulnerable populations.

- **Community Engagement:**
  Ongoing community outreach and engagement initiatives help build trust between refugees and service providers, promoting culturally sensitive care and improving the uptake of services.

**Weaknesses**

- **Funding Gaps:**
  Insufficient funding at both the NHS and local council levels can lead to resource constraints, limiting the availability and quality of services for refugees.
- **Implementation Barriers:**
  Complex administrative procedures, language barriers, and cultural misunderstandings impede the efficient registration and referral of refugees, reducing the overall effectiveness of healthcare delivery.
- **Policy Inconsistency:**
  Discrepancies between immigration policies and healthcare policies often result in conflicting directives, causing confusion among refugees and healthcare providers alike.
- **Limited Data Integration:**
  Fragmented data systems between immigration authorities and healthcare providers hinder effective monitoring and evaluation of refugee healthcare needs and service utilization.

**Opportunities**

- **Technological Innovation:**
  The integration of digital health platforms and mobile applications can streamline registration, referrals, and information dissemination, improving overall access and reducing administrative delays.
- **Increased Public Awareness:**
  Growing public understanding of refugee issues creates momentum for policy reforms and encourages community support, leading to broader acceptance and resource allocation for refugee healthcare.
- **Collaborative Partnerships:**
  Enhanced cooperation between the NHS, local councils, charities, and private sector partners (e.g., tech companies) offers opportunities to pool resources, share best practices, and develop innovative care models.
- **Policy Reform:**
  There is an opportunity to align immigration policies with healthcare needs through targeted policy reforms that prioritize human rights and public health, ensuring that refugees are not excluded from essential services.

**Threats**

- **Political Instability and Policy Shifts:**
  Changes in government priorities or political instability may lead to restrictive policies that hinder healthcare access for refugees, reducing the sustainability of current initiatives.
- **Economic Constraints:**
  Ongoing economic challenges could limit the funds available for public healthcare, particularly for initiatives targeting marginalized groups such as refugees.
- **Social Stigma and Discrimination:**
  Negative public attitudes toward refugees can exacerbate barriers to care, leading to discrimination in service delivery and lower quality healthcare outcomes.
- **Systemic Overload:**
  The existing strain on the NHS due to increasing demand from the general population may further limit the capacity to provide tailored services for refugees.

**Evaluation**

- **Measuring Outcomes:**
  It is essential to implement robust performance metrics that capture not only the number of refugees accessing healthcare but also the quality of care provided and improvements in health outcomes.
- **Resource Utilization:**
  Continuous assessment of resource allocation (financial and human) will help ensure that funds and staff are used optimally, mitigating any inefficiencies that could compromise service delivery.
- **Long-Term Viability:**
  Policy reforms and technological innovations should be evaluated for their long-term impact on system sustainability. This involves monitoring changes in healthcare access over time and adjusting strategies to address emerging challenges.
- **Expanding Impact:**
  Analyzing how improved refugee healthcare access affects the broader community—such as reductions in public health risks and increased social cohesion—will highlight the added value of these initiatives.
- **Systematic Change:**
  Changes in policies, procedures, and patient behavior should be tracked to determine if systemic improvements are being achieved. Regular feedback loops and adaptive responses will ensure the system remains responsive to refugee needs.
- **Stakeholder Engagement:**
  Renewed engagement with all stakeholders—from local communities to national policymakers—will be crucial for sustaining improvements and ensuring that services continue to evolve in line with real-world challenges.
- **Partnership Quality:**

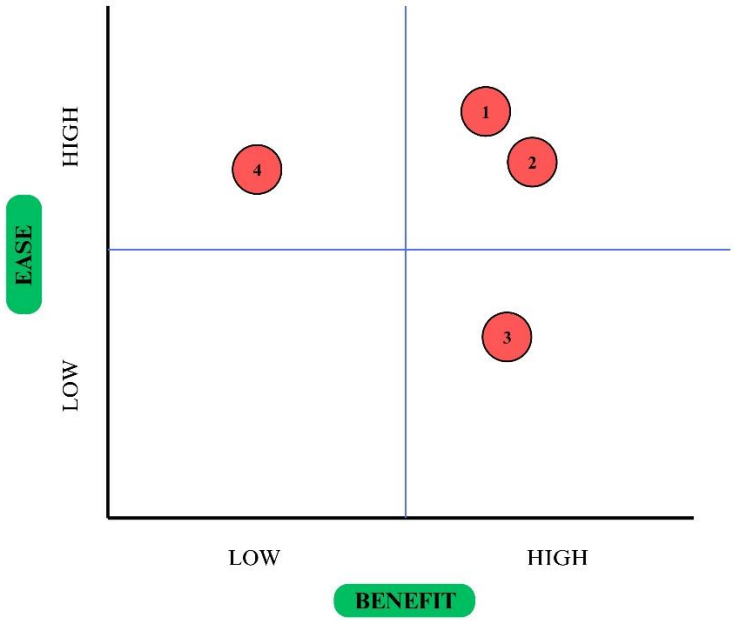
The effectiveness of collaborations between the NHS, local councils, charities, and other entities must be continually evaluated to ensure they contribute positively to the overall goal of accessible, equitable refugee healthcare.

## Recommendations – Part 4 - SSM Stage 5

### Recommendation table for Refugees:

| Ideal Activity | Real-World Scenario | Recommendations | Possible Changes |
|---|---|---|---|
| **1. Simplify Registration** | Refugees face long, complicated registration processes. | Introduce a digital, multilingual registration system to reduce paperwork. | Offer in-person help desks. |
| **2. Provide Translation Services** | Limited interpreter availability leads to communication breakdowns. | Partner with professional translation agencies; use phone/video interpreters. | Create a 24/7 interpreter hotline. |
| **3. Integrate Mental Health Support** | Trauma and anxiety remain unaddressed due to stigma and ignorance. | Embed mental health staff at community clinics; culturally sensitive counseling. | Offer group therapy sessions. |
| **4. Engage Community Outreach** | Services often mismatch needs due to limited refugee feedback. | Hold town halls and surveys to adapt services based on direct community input. | Involve local refugee leaders. |

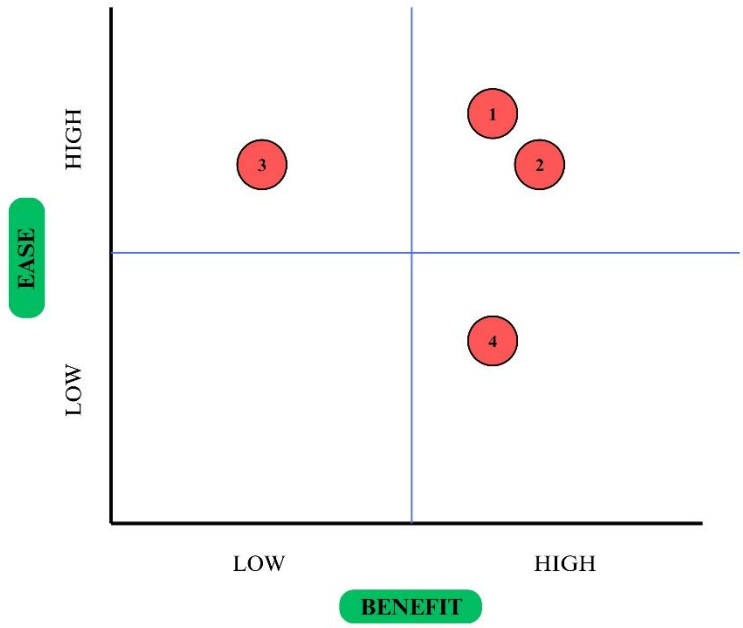
### Ease-Benefit Matrix for Refugees:



**Recommendation table for NHS Staff:**

| Ideal Activity | Real-World Scenario | Recommendations | Possible Changes |
|---|---|---|---|
| **1) Implement Cultural Training Programs** | Existing training is infrequent and lacks refugee-specific focus. | Develop mandatory, regular training modules focusing on refugee health issues. | Offer e-learning modules with CPD credits. |
| **2) Integrate Translation & Communication Tools** | Reliance on ad-hoc bilingual support; few digital tools are used. | Invest in standardized digital translation tools and interpreter services integrated into workflows. | Deploy secure interpreter apps. |
| **3) Reallocate Resources Strategically** | Staffing and resources are unevenly distributed; high-demand areas are understaffed. | Use data analytics to adjust staff allocations and improve resource distribution. | Conduct quarterly resource reallocation reviews. |
| **4) Monitor Staff Wellbeing** | No formal system exists to monitor burnout; wellbeing is often overlooked. | Introduce regular staff wellbeing surveys and create a dedicated mental health support hotline. | Implement monthly wellbeing check-ins. |

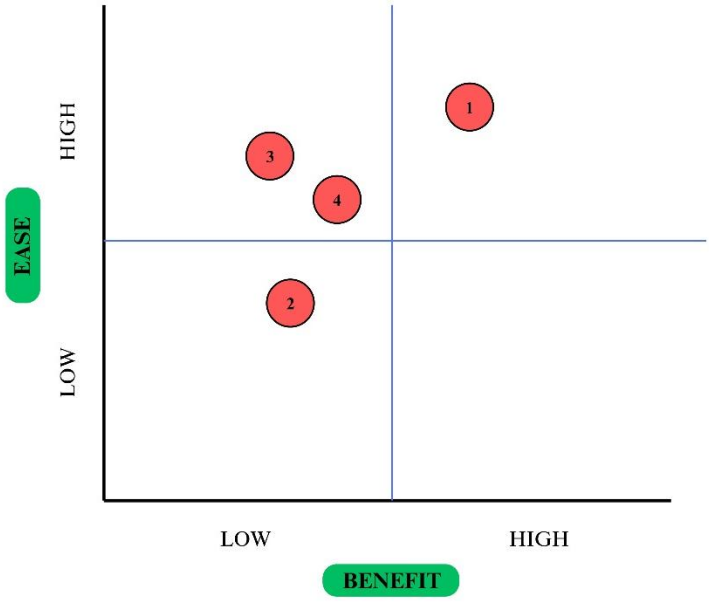
**Ease-Benefit Matrix for NHS Staff:**



**Recommendation table for UK Home Office:**

| Ideal Activity | Real-World Scenario | Recommendations | Possible Changes |
|---|---|---|---|
| **1) Define Healthcare Eligibility Criteria** | Criteria are vague, leading to inconsistent application at the point of care. | Publish clear, standardized guidelines that align with both NHS requirements and immigration policy. | Issue multilingual guidelines leaflets. |
| **2) Integrate Data Systems** | Data systems are fragmented, causing mismatches between immigration and healthcare records. | Develop an integrated, secure database system linking immigration and healthcare data. | Pilot a centralized IT solution. |
| **3) Coordinate with NHS & Local Authorities** | Coordination is sporadic and informal, leading to delays in policy implementation. | Establish formal liaison roles and regular meetings between the Home Office, NHS, and local councils. | Schedule monthly interdepartmental meetings. |
| **4) Conduct Policy Reviews** | Policies are rarely reviewed, despite changing demographics and needs. | Implement a structured policy review cycle, incorporating feedback from frontline stakeholders. | Set a biennial review schedule. |

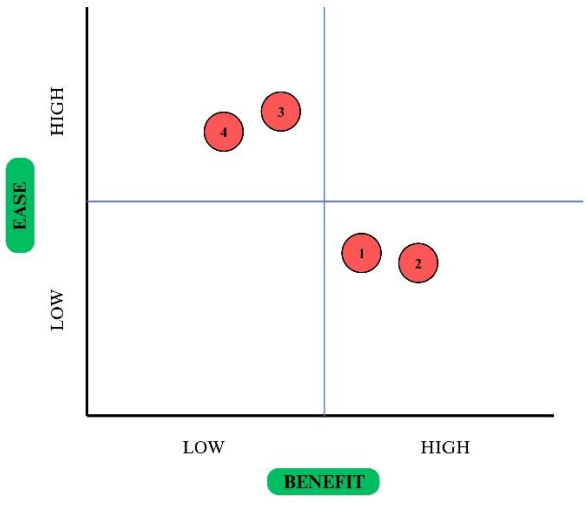
**Ease-Benefit Matrix for UK Home Office:**



**Recommendation table for Charities (Refugee Council):**

| Ideal Activity | Real-World Scenario | Recommendations | Possible Changes |
|---|---|---|---|
| **1) Engage in Policy Advocacy** | Advocacy efforts are intermittent and lack coordination among charities. | Form coalitions among charities to unify and strengthen policy advocacy efforts. | Establish a monthly coalition meeting. |
| **2) Develop Support Programs** | Support programs exist but are fragmented and rely on short-term funding. | Secure multi-year funding and create integrated "support hubs" for healthcare, legal, and translation aid. | Create dedicated support centers. |
| **3) Enhance Public Awareness** | Public campaigns are sporadic and have limited reach. | Launch a sustained, data-driven public awareness campaign to highlight refugee healthcare needs. | Partner with local media for continuous coverage. |
| **4) Monitor Discrimination** | Incidents of discrimination are underreported and inconsistently addressed. | Set up a formal, confidential reporting and response system for discrimination in healthcare settings. | Implement a digital reporting platform. |

**Ease-Benefit Matrix for Charities:**



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