Closing the gap: a Canadian health leadership action plan

Kelly Grimes, MHSc and
Gillian Kernaghan, MD

Abstract

Strong leadership, including high-quality physician leadership, is a critical factor in the performance and success of our health care system. The time has come for a collective approach to increasing Canada's leadership capacity and capabilities, one that is linked to policy imperatives, such as "Triple AIM" (better care, better health, and better costs) and patient experiences and outcomes. Such an approach requires a national health leadership action plan that can form a foundation for an evidence-informed conversation among Canada's health care leaders.

CHLNet as a value network

In 2013, the Canadian Health Leadership Network (CHLNet), a purpose-built coalition of 40 organizations (called network partners of which the CSPE is one) initiated a consultative process to develop a Canadian health leadership strategy. Created in 2009, this value network is founded on the belief that it can achieve something collectively that leaders cannot do on their own. Its members believe that new and more innovative ways of working together to cultivate leadership capacity are required and that no one organization can own leadership in health. Over the last year, an ad hoc expert working group made up of network partners has guided efforts to draft a working paper and action plan on this topic.

What the research says

Most major policy reports[1–3] identify strong leadership as a critical factor in improving performance and quality in our health care system. Yet a leadership gap exists across Canada. The recently released Canadian Health Leadership Benchmarking Survey Report[4] shows that 84% of health care leaders are concerned about the overall leadership gap, with 42% of Canadian academic health sciences centres reporting that they do not have the leadership they need to meet the challenges of the future.

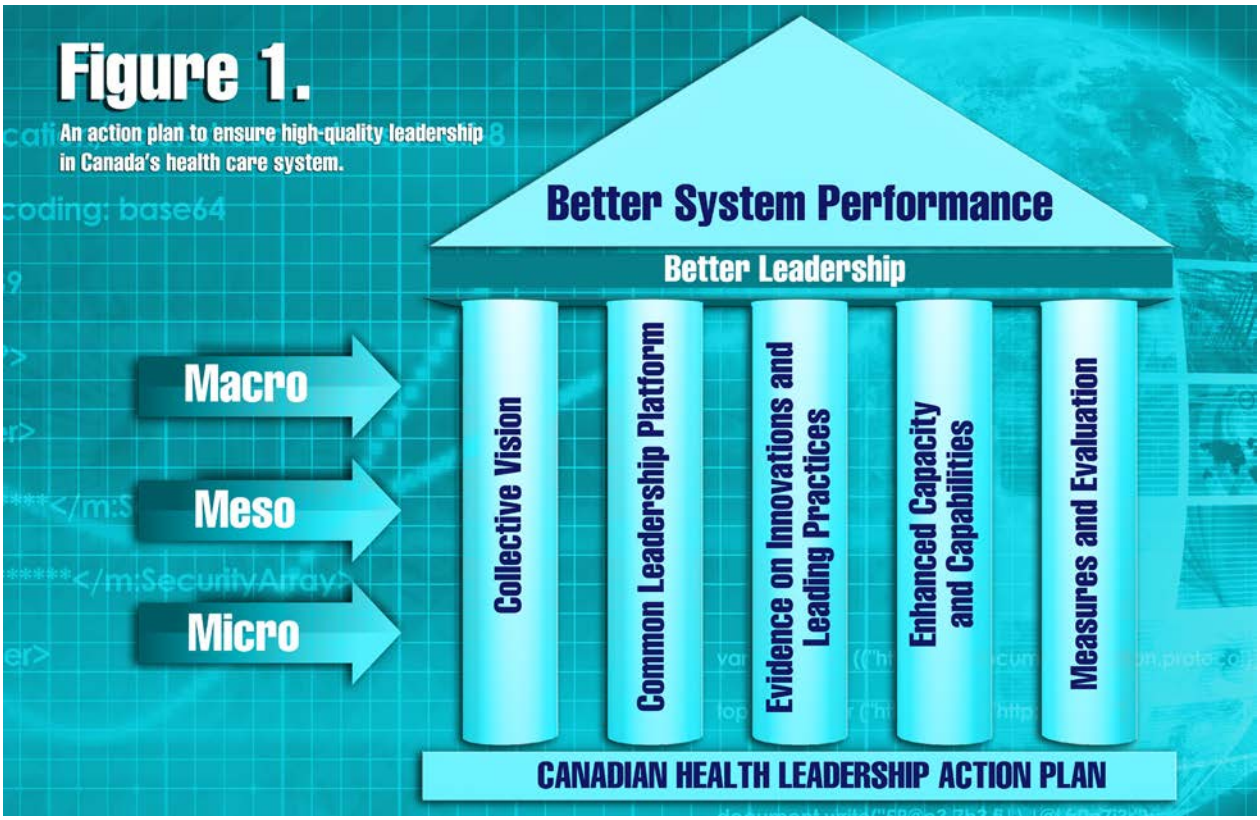
In the wake of the 2008 recession, Canada is also still feeling the results of one of the deepest and most long-lasting economic downturns in its history. Health system performance continues to decline when compared internationally. Recent research shows that leadership, especially quality physician leadership, is a key enabler of health system performance and health reform and that new leadership skills are needed for formal and informal leaders.[2,5] Aging of our current leaders, increased scrutiny of their work, and the requirement for greater public accountability are making it difficult to attract and retain talent.

A health leadership action plan

The time has come for a collective approach that cuts across jurisdictions and health disciplines over the life cycle of leadership, from emerging health leaders to senior executives. Concrete actions are required. Key elements have been outlined below after consultations with CHLNet's network partners; a Healthcare Leadership Forum cosponsored by the Canadian Association for Health Services and Policy Research, the Canadian Foundation for Healthcare Improvement, and CHLNet (Montréal, 14 Feb. 2014); a deliberative dialogue session hosted by McMaster University (4 Mar. 2014); and a presentation to the Federal/Provincial/Territorial Committee on Health Workforce, which comprises assistant deputy ministers. The intention is to bring a proposal to the Conference of Deputy Ministers of Health in fall 2014.

Recent research and expert opinion[6,7] show that growing quality leadership requires a multi-pronged and collaborative strategy to achieve large-scale, transformational change. Based on the evidence gathered to

date, a five pillar action plan is proposed (Figure 1) with each pillar representing the elements that would be applied at macro, meso and micro levels of the health system, with the overall objective of improving health system performance. Only a macro level approach is discussed here.



Confirm a collective vision:

A common vision with clear and compelling shared goals with measurable outputs and outcomes is essential as a reference point for a collective approach to building the distributed leadership capacity needed to realize Canada's leadership potential. Countries such as the United Kingdom[8] and Australia[9] have created national strategies linked to their national health reform agendas.

Endorse a common leadership platform:

Although many options exist, LEADS in a Caring Environment (LEADS)[10] has become the preferred health leadership learning platform and provides a common language and focus. Created in 2006, the LEADS framework is a useful basic building block for leadership in a complex adaptive system with distributed leadership at its core.

British Columbia's deputy minister at the time provided the initial $3 million earmarked for a "proof of concept" provincial leadership talent development strategy over three years. Adoption of the resulting framework was accelerated by pioneering organizations, such as CHLNet, the Canadian College of Health Leaders, Accreditation Canada, the Canadian Medical Association, provincial governments (BC Health Leadership Development Collaborative, Alberta, Saskatchewan, Manitoba, Yukon, Nova Scotia, and Prince Edward Island) and numerous health regions (Alberta Health Services, Eastern Health and others) across Canada. Even Australia has adapted it for its own context, with many other countries expressing interest.

Gather more evidence on innovation and leading practices:

Evidence and leading practices must continue to be gathered from a variety of sources and this information used to influence action in a purposeful way, even though significant research has been

undertaken on health leadership in the last decade.[3,11] We need to fund and coordinate research and knowledge-mobilization efforts and sustain a Canadian health leadership research network (or clearinghouse) as an ongoing collaboration of researchers, service providers, and decision-makers.

Enhance capacity and capabilities:

Large-scale change requires new or enhanced capabilities for our formal leaders around systems thinking, strategic thinking, relationship development, and self-leadership.[2] It seems that leadership development programs are not letting us get to where we need to be and are often the first items to be decreased in the face of budget constraints.[12] Planning and coordination of health leadership is required as part of broader health human resources or talent management strategies, so that health leaders are seen as a collective and succession planning as a top priority.

Health care organizations must help build capacity, but governments must encourage and promote capacity and the new capabilities required through funding and other incentives. New programs to support future leaders that are action research oriented and occur in situ (at the local level) are shown to be needed. Such programs would not replace other leadership offerings, but instead could be built on existing leadership programs.

Measure and evaluate success:

A clear and compelling vision must be supported by key measures of success. What are the expected results or desired outcomes and how will the system know when these have been reached? If results are not met and evidence shows a need to change, how will corrective action be taken? Targets and benchmarks must be defined through national dialogue to monitor pan-Canadian health leadership and its effect on health system performance on an ongoing basis.

Conclusion

A decade ago, leadership was not on the policy landscape. Leadership was assumed, but evidence shows that better, stronger, more supportive health leadership, especially for physician leaders, is required to put Canada back among the best performing health systems in the world. It will take collective action that cuts across jurisdictions and disciplines. We believe such action should be focused on our future leaders and be built with an evidence-based approach, tailored to each jurisdiction but tied together nationally.

Acknowledgements:

We thank CHLNet's ad hoc working group who provided invaluable input guiding efforts around drafting a Canadian health leadership action plan: Graham Dickson (CHLNet senior policy advisor), Bill Tholl (HealthCareCAN), Carla Anglehart (Health Association Nova Scotia), Anne Sutherland-Boal (Canadian Nurses Association), Jocelyn Chisamore (Emerging Health Leaders), Emily Gruenwoldt Carkner and Joshua Hambleton (Canadian Medical Association), Frank Krupka (University of Manitoba and Winnipeg RHA/ Centre for Healthcare Innovation), Suzanne McGurn (Ontario Ministry of Health and Long-Term Care), Paddy Meade (Deputy Minister, Yukon Health), and Brenda Rebman (Alberta Health Services).

References

1.Better health, better care, better value for all: refocusing health care reform in Canada. Ottawa: Health Council of Canada; 2013.

2.Dickson G, Tholl B, Baker GR, Blais R, Clavel N, Gorley C et al. Partnerships for health system improvement, leadership and health system redesign: cross case analysis. Ottawa: Canadian Institutes of Health Research/Michael Smith Foundation for Health Research Study; 2014.

3.Swensen S, Pugh M, McMullan C, Kabcenell A. High-impact leadership: improve care, improve the health of populations and reduce costs [white paper]. Cambridge, Mass.: Institute for Healthcare Improvement; 2013.

4.Canadian health leadership benchmarking survey report. Ottawa: Canadian Health Leadership Network; 2013. Available: http://chlnet.ca/wp-content/uploads/CHLNet-Leadership-Benchmarking-Study-Final-Report.pdf (accessed 15 Aug 2014).

5.Welbourn D, Ghate D, Lewis J. Systems leadership: exceptional leadership for exceptional times — literature review. London, UK: Colebrooke Centre for Evidence and Implementation; 2013.

6.Best A, Greenhalgh T, Lewis S, Saul JE, Carroll S, Bitz J. Large-system transformation in health care: a realist review. Milbank Quarterly 2012;90(3):421–56.

7.Dickson G, Tholl W. Bringing leadership to life in health: LEADS in a caring environment. London: Springer; 2014.

8.Healthcare leadership model: nine dimensions of leadership behaviour. Leeds, West Yorkshire, UK: NHS Leadership Academy; 2014. Available: www.leadershipacademy.nhs.uk/discover/leadershipmodel (accessed 15 Aug 2014).

9.National health workforce innovation and reform strategy framework for action, 2011–2015. Adelaide, Australia: Health Workforce Australia; 2011.
10.Dickson G, Briscoe D, Fenwick S, Romilly L, MacLeod Z. The Pan-Canadian health Leadership Capability Framework Project: a collaborative research initiative to develop a leadership capability framework for healthcare in Canada. Ottawa: Canadian Health Services Research Foundation; 2007.
11.Avolio BJ, Walumbwa FO, Weber TJ. Leadership: current theories, research, and future directions. Annual Review of Psychology 2009;60:421–49.
12.Lavis JN, Moat KA, Rizvi Z. Issue brief: fostering leadership for health system redesign in Canada. Hamilton: McMaster University; 2014.

Authors

Gillian Kernaghan is president and CEO of St. Joseph's Health Care, London. She is an assistant professor at the University of Western Ontario and is currently on the faculty of the Canadian Medical Association's Physician Management Institute. She is past-president of the CSPE and, in that capacity, chairs the CHLNet's Working Group on a Canadian Health Leadership Strategy.

Kelly Grimes is the executive director with CHLNet. She is an experienced consultant, who has participated in numerous federal, provincial, and organizational initiatives, such as Barriers and facilitators to physician engagement; Strengthening primary health care in Alberta through family care clinics; Evaluation of family health teams in Ontario; and Integrating needs for mental well-being into human resource planning.
Correspondence to: Gillian.Kernaghan@sjhc.london.on.ca or kgrimes@chlnet.ca

This article has been reviewed by a panel of physician leaders.