Shifting Sands of Health Leadership in Canada: Key Insights from PHSI (Update)

Purpose:

To provide Network Partners with regular updates on key insights coming out of the four-year research project into the role of leadership in health system redesign.[1]

Background:

Quality leadership has been shown to be important to overall health system performance. For example, the recent (2013) summative report of the Health Council of Canada found that leadership was the number one enabler of organizational and system performance. This PHSI project was initiated in 2010. Shifting Sands is the third in a series that attempts to chronicle developments of interest to the decision-makers and Network Partners as the project has progressed. It follows the final meeting of the cross-case analysis group hosted by the University of Toronto on November 22, 2013. The final research roundtable or "Deliberative Dialogue" session will be hosted in March 2014, at which time these insights will be amended and give way to formal "findings".

Overview:

By far the biggest challenge facing leaders in health care today is the constant shifting sands of the policy environment within which leaders function. The shifting sands have several dimensions:

- *Shifting political sands:* Leadership changes at the senior political and policy level are a constant. Over the course of the study, new governments have been elected and new ministers have been appointed in virtually every jurisdiction. With political changes have come new policies and programs, with a healthy mix of approaches to leadership and governance.
- *Shifting economic sands:* The project spans one of the deepest and most long-lasting economic downturns in Canadian history. Health leaders report that the uneven and uncertain pace of economic recovery is especially challenging, although the federal government's commitment to long-term funding certainly has improved overall budget predictability.
- *Shifting sands of senior officials*: It was observed some time ago by CHLNet that the shelf life of senior health officials has dropped dramatically over time, from 4.5 years in the mid-1970s to less than 2 years by 2005. Casual empiricism suggests this decline has continued and, in fact, accelerated. For example, the November meeting of the Council of Deputies will have only two returning members. Turnover of senior staff changes can have a profound effect on system change. Several of the case studies are now chronicling whether transformation change can survive changes at the senior staff or elected levels.

[1] The project is funded by the Canadian Institutes of Health Research (CIHR) and the Michael Smith Foundation for Health Research ($850K over four years). A high level description of the overall study objectives is available on the chlnet.ca website.

Phase Three: Key Insights[2]

1. ***Leadership Matters:*** The project confirms that quality leadership is essential to organizational and system performance in Canada's health sector. Leaders exert influence throughout the system, playing a central role in building a vision based on shared goals, trust, understanding and respect. Communities of practice of heath leaders are emerging from all levels (i.e. macro, meso, and micro). Executive leaders must more meaningfully engage leaders at the clinical and frontline levels across Canada to tackle the major leadership and change management challenges facing Canada's health system. A clear and compelling vision for the system is missing; one that would put Canada back on top of international performance.

2. ***Coming Together:*** All complex systems have a tendency toward fragmentation unless leadership intervenes. Centrifugal or "tug" forces appear to be overwhelming centripetal or "hug" forces in the Canadian health system, as organizations struggle to stay true to their vision and goals, mainly due to unforeseen economic or political circumstances. There have been significant leadership changes at the senior political and policy levels in every jurisdiction across Canada. With each change comes a loss of momentum and new policies and priorities. As leaders constantly change, it is increasingly difficult to identify and embrace means of coming together to achieve the higher goal of enhancing citizen and patient wellbeing. The *LEADS in a Caring Environment* leadership capabilities framework is increasingly being seen as a unifying force across Canada.

3. ***Alignment:*** Across the six case studies several key themes emerged around the general lack of alignment between vision and action (good leaders "walk the talk". There is also an emerging theme around the tension between alignment on the one hand ("everyone singing from the same hymn book") and allowing the flexibility to deal with complexity in a "naturally occurring", distributive leadership context. Finally, leaders are struggling with aligning authorities and accountabilities in a system exhibiting decentralization and centralization at the same time. Overall, there is a strong alignment (in a different sense) between the case study reports and the results of the NVIVO thematic analysis. This increases the study team's confidence in the key insights and emerging results.

4. ***Leadership Capacity:*** There are mixed results in terms of overall leadership capacity and leadership capabilities. Some are quite concerned about the aging of the senior executive leaders, while others have tremendous optimism that if we accept the distributive model of leadership there is a tremendous, untapped well of potential leadership capacity. Historically, leadership development was all top down, competency-based, and only for the high performers. A new view of leadership is emerging; one that emphasizes experiential learning (reflecting on one's experiences) as key to leadership development. Leadership capacity is also increasingly viewed in a dynamic context: if we are to realize the goal of better health through better leadership, there is a commensurate collective need to do a better job of mentoring and coaching the next generation of health leaders as a shared resource. This, in turn, is associated with the need for both formal and informal training and development opportunities cutting across the spectrum of leaders (physicians, administrators and other health professionals). In the end, multiple solutions are required to enhance capacity.

5. ***Distributed Leadership:*** There is increased talk about the need for more distributed or shared leadership models, but continuing reliance in some quarters on hierarchal, heroic leadership models. Leadership occurs at all levels and the case studies underline the need for positive,

[2] These "insights" are based on a careful reading of all six case studies from the perspective of one designated "decision-maker". It is informed by the deliberations of the cross-case analysis group, but should not be seen as study findings or results.

concerted action to achieve more empowerment, ownership and commitment. Formal leaders no longer have the same power or privilege as before and institutional knowledge is being lost. This power has been shifted to those who have the ability to influence others, increasingly seen through the use of Internet and social media. There is a significant value in learning from each other but few opportunities to do so. Distributing leadership across several roles, all with the same vision, is beginning to show positive results in some cases.

> "When all is said and done, more is said than done."
> Aesop.

6. ***Situational Leadership:*** "Change is the currency of leadership". Leadership is increasingly being seen as unique to time, place and circumstances. There is no "one size fits all" approach. Situational leadership is all about doing the right things, at the right time, to get the right result for patients and people. It is ever present in the Canadian health system. This requires more complex adaptive leadership, with an increased focus on family or patient-centered care. Leadership is neither inherent nor a function of one's position; rather, it is a skill to be acquired. Individual leadership is important; therefore, self-awareness and improvement must be built in.
7. ***Enabling Innovative Leadership Pathways:*** At the macro or systems level, there is a heightened level of awareness and concern about where the leadership will come from or "who is going to play the convenor role". The federal government has vacated its traditional leadership role. Premiers have attempted to fill this void (e.g. Health Care Innovation Working Group), but there are concerns about both the legitimacy and sustainability of this approach. There is an acceptance that we need to move from innovation by accident to innovation by design, but there is an absence of structures, processes, policies and programs to help align micro level adjustments to enable true system transformation. The case studies support the conclusion that leaders motivate others to explore new models to sustain and align innovations by providing supportive environments for taking "measured" risks.
8. ***Striking the Right Balance:*** Health systems are increasingly complex and interconnected. Leadership involves striking the right balance between a number of pull and push forces, including: centralization and decentralization forces; designated and distributed leadership; accountabilities and authorities; organizational and system performance; consensus and engagement strategies. Each of these can be seen as a trade off or as complementary leadership strategies. Striking the right balance is a function of time, place and circumstance.
9. ***Rapid Turnover Continues:*** Reliable/meaningful metrics of success (inputs, outputs and outcomes) and leadership capacity are required throughout the system. The shelf life of senior health leaders has dropped dramatically over time, especially in government. The turnover of senior staff changes can have a profound effect on system change. More effective performance measurement and succession planning is required to identify leaders early on at all levels of the health system and across jurisdictions (including the education system).
10. ***Learning to Listen to Lead:*** The importance of two-way, effective communications cannot be overstated. Leaders must be clear and speak plainly, but also must be good listeners. The case studies suggests that, while senior and executive leaders believe they are effectively communicating the vision for a better future, messages are not getting through to mid-level and frontline leaders. Reliable structures and processes (formal and informal) need to be created to ensure that groups, such as physicians and employees, have a voice but at a time and way that works for physicians – e.g. scheduling meetings beyond regular work hours. Engagement…early and often…is pivotal to effective leadership, as it is leaders who shape an organization's culture. We learned that leaders must see engagement as a continuum (more or less engaged), within a context (such as with patients, organizational goals, etc.).

Bill Tholl, Executive Director
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