Introduction

Introduction to the Special Issue on “Effective Leadership for Health Systems”

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This special issue on “Effective Leadership for Health Systems” is organized and sponsored by the Alliance for Health Policy and Systems Research, along with a flagship report on health leadership,¹ both to be launched at the 4th Global Symposium on Health Systems Research in Vancouver in November 2016. The Alliance decided to examine the role of leadership in strengthening health systems, at the urging of its Board, in recognition of the challenges posed by complex health crises such as Ebola and by the new Sustainable Development Goals. The Alliance conducted a literature review on leadership in the health sector and then commissioned a survey with health professionals and decision makers in 62 countries as well as interviews with 20 health leaders. The results of this effort will be presented in a background report prepared by the Economist Intelligence Unit.²

This special issue of Health Systems & Reform includes several articles commissioned by the Alliance as well as others submitted in response to a call for papers. The goal of this special issue and the Alliance’s flagship report on leadership is to stimulate debate and research on the nature of effective leadership in health systems and how to create more effective leaders and systems for health in the 21st century. This introduction summarizes the key points of the 12 essays that follow and presents their diverse perspectives on the challenges of defining and creating effective health leadership.

DEFINING EFFECTIVE HEALTH LEADERSHIP

The special issue begins at the national level, with six articles written on the theme of defining effective health leadership.

The editorial by Somsak Chunharas and Sally C. Davies argues that “the term leadership is often used vaguely without reflecting the complexities of health systems and the real world.” They define leadership as “the ability to identify priorities, set a vision, and mobilize the actors and resources needed to achieve them.” In their view, a new agenda for
health leadership is needed that recognizes the role of “interactive leadership.” This perspective considers leadership as involving “many systems, many levels, many leaders”—from the national, to the regional, to the local point of health delivery—all under a broader global umbrella. Their metaphor for leadership is not an individual national leader holding onto the tiller of a ship, but a panoply of players pulling in diverse directions. Aligning these multiple actors across various layers to move the health system forward is a daunting challenge. Central policy decisions, for example, often do not play out as intended because leaders elsewhere in the system pursue different paths. Chunharas and Davies propose four changes to promote the new agenda for health leadership: (1) acknowledge the need for interactive leadership in health; (2) empower managers and implementers to assert themselves as leaders; (3) enable patients, families, and community groups to participate in health leadership; and (4) advance research in the field of health leadership. Embedding these changes in real-world institutions will not be easy—but it will be critical to implementing the new agenda for interactive health leadership to meet the complex challenges of the future.

Japan’s Minister of Health, Yasuhisa Shiozaki, next provides a concrete example of how to exercise national leadership in his commentary on “A Leadership Vision for the Future of Japan’s Health System.” He explains that how Japan addresses the challenges of a rapidly aging society holds important lessons not only for Japanese citizens but also for health futures in other countries. To imagine new health futures for Japan, Minister Shiozaki convened a panel of young leaders, drawing on promising people both inside and outside government, seeking new minds and new ideas. Their report, *Japan Vision: Health Care 2035,* articulated new principles and a paradigm shift for Japan’s health system, from quantitative to qualitative, from inputs to patient-centered value, from government regulation to autonomy, from cure to care, from fragmentation to integration. Similar transformative challenges confront the health systems of many countries. How Japan does in moving these principles into practice will be of great interest around the world. This commentary also emphasizes that effective leadership not only addresses current population needs but also prepares for future needs.

The next commentary, by Ethiopia’s current Minister of Health Kesete-Birhan Admasu, explains the role of national leadership in “Designing a Resilient National Health System in Ethiopia: The Role of Leadership.” The case of Ethiopia’s health system is well known around the world for its emphasis on strengthening the primary health care system and its deployment of health extension workers at the community level. The country has shown political commitment at the highest levels—starting with the prime minister’s office—to “building the system from the ground up through primary care by involving community-level stakeholders.” The results are impressive. Ethiopia is a leader in Africa both in delivering health care to communities (99% of the population has access to primary health care) and in advancing important indicators of health (Ethiopia achieved the Millennium Development Goals for child and maternal health). As the Minister concludes, “Community participation is our secret weapon.” Understanding how Ethiopia created top-level political commitment to a bottom-up strategy of health system development is critical to applying these lessons to other environments.

Lucy Gilson, in her short article on “Everyday Politics and the Leadership of Health Policy Implementation” explores what actually happens at the frontline of delivery in the health system. She emphasizes how frontline leaders, who implement policies decided somewhere above them, must manage the “everyday politics” of how institutions work (and don’t work)—“such as the constant demands of managing staff, supply shortages, policy instructions from above, sudden meetings being called or visitors arriving at the last minute, limited budget authority, and the importance of working with local communities.” According to this bottom-up theory about implementation, things happen only when leaders in delivery institutions manage these uncertainties and push the process forward. She says, “Implementation is rarely straightforward” and requires the exercise of power by frontline leaders—rather than the proclamation of magical instructions issued by top-level leaders sitting in the capital city (in a command-and-control model). In short, countries need to find ways to nurture these frontline leaders and help them manage the uncertain realities of everyday life—in order to make health systems perform better. How health systems do this, in concrete steps, is not at all obvious. This essay highlights the importance of doing applied political analysis at the frontlines of policy implementation as well as the highest levels of policy adoption.

The research article by Tolbert Nyenswah, Cyrus Y. Engineer, and David H. Peters examines the role of leadership in crisis, using the case of Liberia’s response to the Ebola virus disease. This article presents how leadership changes as crisis moves through four descriptive phases: (1) crisis recognition and early mobilization, (2) the emergency phase, (3) the declining epidemic, and (4) the long tail. They emphasize five key crisis leadership tasks (sense-making, decision making, meaning-making, crisis termination, and
learning) and how these evolved in the four phases of Liberia’s crisis. The article uses the concepts of “distributed leadership,” which views leadership as a “collective and social process” (similar to the concept of interactive leadership presented by Chunharas and Davies), rather than focusing on the individual leader. Their analysis of the four phases in Liberia shows how many groups struggled with the Ebola epidemic and sought to bring it under control—but without much success in the early phases when traditional hierarchical leadership prevailed. They argue that the move to a distributed leadership approach during the emergency phase “proved to be highly effective” in bringing the crisis under control, but “a return to a largely hierarchical leadership approach” occurred subsequently. The authors conclude that in the final phase “the appetite for learning from the experience does not seem large.” They suggest that the restoration of the old order makes Liberia vulnerable to another health crisis. The lack of institutional learning is particularly disheartening. Understanding the obstacles to institutional learning for ministries of health, in Liberia and elsewhere, and finding ways to address those obstacles is without a doubt a high priority task for health leadership around the world.

The last commentary in this section, by Tolbert Nyenswah, provides an extraordinary personal reflection on frontline leadership in a health crisis. The author served as incident manager of the Incident Management System in Liberia, starting after the Ebola disease had reached a crisis. His essay is remarkably open and self-reflective about the challenges he confronted in trying to bring people, systems, and resources together to battle the Ebola virus—to save his country, his friends, his family. His six lessons for leaders confronting a crisis are pithy and practical—such as avoid having too many people in the room (“sometimes nearly 100”), especially if you want a discussion and a decision. This essay of practical wisdom should be required reading for any leader, because any leader may confront a crisis. The lessons articulated here have broad relevance and deep implications, far beyond Ebola in Liberia, far beyond the health system.

CREATING EFFECTIVE HEALTH LEADERSHIP

The next six articles in this special issue examine different processes for creating effective health leadership.

One of the major challenges in creating effective health leadership is training programs for leaders. The article by Michael R. Reich, Abdo S. Yazbeck and colleagues reports on a leadership training course to improve health system performance and equity that has operated for the past two decades. The Flagship Program on Health Sector Reform and Sustainable Financing was developed through collaboration between the World Bank and the Harvard T. H. Chan School of Public Health and other institutions that began in the mid-1990s. Flagship courses have been presented to more than 19,000 participants at national, regional, and global levels in the past two decades. The textbook for the course, Getting Health Reform Right: A Guide to Improving Performance and Equity, emerged from the early years of teaching and provides the structure, logic, language, and analytical methods that define the Flagship training approach to improving health systems. This approach emphasizes that health reform requires technical, ethical, and political analysis and cannot be viewed as a simple technocratic process and provides participants with tools to do all three kinds of analysis. The course teaches participants how to use five policy levers as “actionable” instruments (financing, payment, organization, persuasion, and regulation) to improve health system performance and equity. The authors conclude,

Two decades of experience show that the Flagship Program has been both effective and popular in creating and supporting country-based leadership for improving health system performance. The Flagship course provides participants with a language, methods, and concepts—a common mindset—on how to navigate the complex technical, ethical and political issues of health reform.

The next article by Karla I. Galaviz and colleagues presents a leadership training program for public health professionals from low- and middle-income countries, with a focus on interdisciplinary competencies to address the challenges of noncommunicable diseases. The training combines leadership and implementation competencies, emphasizing the importance and interaction of these two skill sets in leading and managing health systems. The authors describe the program as providing “a blended learning experience that includes face-to-face, e-learning, and practical experiences with world-leading experts in an interdisciplinary setting.” The program has trained four cohorts of participants (from 2013 to 2016), including 67 participants from 11 countries, through a collaboration between Emory University, the National Institute of Public Health in Mexico, and the Public Health Foundation of India. Known as the Public Health Leadership and Implementation Academy (PH-LEADER), the training program has received financial support from the Fogarty International Center at the US National Institutes of Health (NIH). The program is currently seeking funds to sustain the program after the current grant from the NIH is completed. This experience reflects the challenges of expanding innovative leadership training programs for health system leaders to meet the great demand that exists around the world.
One persistent leadership challenge for the health sector is promoting more women into leadership positions. The article by Dena Javadi and colleagues uses phenomenological analysis of the stories from five influential women leaders in health to understand how these women became effective leaders and the challenges they had to overcome. Some of the key strategies to become leaders, used by these five women, include challenging status quos, practicing compassionate and attentive leadership, and building partnerships. The authors argue that more gender-balanced leadership is not only good for empowering women, but it is good for society overall given the propensity of female leaders to invest in social systems and promoting equity. Based on this analysis, the article makes three recommendations to assist more women to become effective health leaders.

One important mechanism for creating effective leadership in health systems is through building partnerships. Abi Sriharan and colleagues, in their research article, examine the lessons of successful global health partnerships to foster continuing medical education. They use a realist research approach to explore two case studies of successful partnerships for continuing medical education. They conclude that success in these two cases is “highly dependent on human factors,” including both motivational factors of individual players and relationship factors among individuals (such as trust, communication, and mutual understanding). The authors suggest that similar kinds of factors could be at work in other global health partnerships. They emphasize the importance of “building trust between individual stakeholders and between institutions” and examine two types of trust: cognitive trust (trust based on knowledge) and affective trust (trust based on feelings). Understanding how to create these two types of trust represents an underappreciated challenge for global health partnerships, and for leaders of health systems.

Continuing the theme of collaboration in the next article, Noriko Fujita and colleagues examine how a network of health managers helped to improve health systems in nine Francophone African countries. The authors describe how Vision Tokyo 2010 Network emerged as an idea at meetings that included human resource managers from national ministries of health in Africa along with public health specialists from Japan’s National Center for Global Health and Medicine. Participants developed a “house” model as “a visual symbol” to show how health systems can support the “assessment, analysis, and the generation of appropriate human resource policy and planning.” The network then connected national leaders in human resources for health across the nine countries to support each other in developing and implementing their own solutions appropriate to national contexts. This example of participatory processes and peer-based learning illustrates how a network can support health leaders in addressing persistent problems (such as human resources) in health systems. The authors emphasize the importance of similar problems, a common strategic vision, shared values and language, and a strong sense of network ownership. The authors conclude, “Investment in such networks is a cost-effective means of improving resource use and strengthening of health systems at the country level, especially in resource-limited settings.”

The short article by Peter F. McGrath and colleagues also examines how a network can support leadership development, organized through the InterAcademy Partnership, an association of 78 academies of medicine and academies of science with significant medical membership. This effort seeks to develop young physician leaders to create the next generation of physician leaders in low- and middle-income countries. The formal program includes a short course (less than two days) on leadership training plus participation at the World Health Summit—combined with mentorship by senior leaders and ongoing network activities with past participants (now over 100 people from 30 countries in five years). The authors conclude by noting the “strong demand” to provide leadership training for young physician leaders (it is typically not taught in medical school) from both individual participants and member academies—but they also recognize that their program is “barely scratching the surface of the training needs for young health care professionals around the globe.”

CONCLUSION
This special issue on “Effective Leadership for Health Systems” fits with the aim of Health Systems & Reform to serve as a platform for sharing knowledge and experience that will improve health systems around the world. Despite general agreement about the importance of leadership for health systems, little has been written that helps us understand this critical topic. This issue takes an important step forward in advancing our understanding about many aspects of leadership in health by including academic analyses alongside personal reflections. The articles in this issue explore the diverse challenges to creating leadership for health through networks, partnerships, and training programs and the complexities in managing everyday politics at the frontline. The commentaries seek to stimulate policy dialogue, challenge conventional thinking, and catalyze further research about how to strengthen effective leadership for health systems. This special issue highlights the theme of interactive and distributed leadership, involving multiple leaders throughout a health system. But we should not forget the critical role of
the individual leader, the orchestra conductor who needs to keep everyone playing on the same page, in harmony, and moving forward. As Recep Akdağ, Turkey’s former minister of health (now back in office), wrote about reforming health systems, “The first principle is that transformational leadership requires deep motivation and unfaltering decisiveness to bring change in favor of the public.”

The essays in this special issue highlight the many challenges that confront efforts to strengthen leadership in health systems. Efforts are required to assure participation from diverse actors in health systems, encourage dialogue and debates on critical issues (such as increasing women leaders in health), and provide improved opportunities for all actors to achieve their leadership potential. The essays in this special issue challenge the health systems community to take a closer look at how they can address these leadership challenges in order to help health systems thrive in the Sustainable Development Goals era, especially in resource-poor settings.

DISCLOSURE OF POTENTIAL CONFLICTS OF INTEREST

No potential conflicts of interest were disclosed.

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