Leadership in Health Systems: A New Agenda for Interactive Leadership

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Commentary

Leadership in Health Systems: A New Agenda for Interactive Leadership

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In global health development circles, leadership is known to be critical for the high performance of health systems and for ensuring good population health.1 Yet, for a field that claims to be driven by evidence and the need to know what works, the term leadership is often used vaguely without reflecting the complexities of health systems and the real world. Moreover, much of the peer-reviewed literature on health leadership focuses on individuals at the national level and their role in steering health ministries or departments.

We have chaired the Advisory Group for the Flagship Report on Leadership in Health of the Alliance for Health Policy and Systems Research because we believe that a new agenda for health leadership is needed, one that promotes collective leadership and recognizes the range of leaders at many levels who contribute in different ways to the strengthening of health systems. We consider leadership as the ability to identify priorities, set a vision, and mobilize the actors and resources needed to achieve them. We set out below why such an agenda is important and suggest what its initial priorities might be. Clearly, this list will not be exhaustive or even applicable across the myriad health systems around the world. But we do hope that it will spark new debates on the role of leadership in health systems, on those recognized as leaders in health, and what, as a global health development community, we can do to support this.

MANY SYSTEMS, MANY LEVELS, MANY LEADERS

In current debates on leadership in health, the leaders referred to are usually high-level policy makers. This is particularly the case in discussions of universal health coverage, which emphasizes the importance of macro decision making and the role of the state. However, leadership in health occurs at many levels and leadership roles are undertaken by many actors during the lengthy process of policy initiation, selection, development, implementation, and evaluation.
In most health systems, there are broadly three levels of leadership. The first is at the national level, where policy decisions are made and where accountability to the wider political system rests. Policy implementation usually takes places at the regional (second) level. This is where decisions made nationally are translated across disparate, large, and unwieldy systems. Finally, there is the operational (third) level—the most important part of any health system—where policy and practices are implemented by providers and program managers.

National policy functions—and those tasked with carrying out those functions—are clearly essential in bringing together partners and synchronizing their efforts in the pursuit of a common goal. Yet no matter how skilled or effective these leaders are, the impact of their policies in strengthening health systems and improving population health ultimately depends on leaders at other levels throughout the system who are responsible for implementing changes and maintaining system functions. With our growing understanding and appreciation of complex systems, the image of a national leader as the captain of a ship with a firm hand on the tiller issuing instructions to the crew and steering the way no longer applies in health. As our understanding of health and its determinants evolves, the influence of national leaders will become more subtle and complex and will increasingly manifest itself through interactions with leaders at different levels within the system as well as actors in other sectors. The need to look at leadership beyond macro policy decisions became even more obvious considering the fact that top policy makers often rotate through jobs rapidly while health systems evolve over time.

Who, then, are these other leaders? From outside of the corridors of health ministries, they are clear to see. To name but a few: the regional managers of health authorities, local government service commissioners, health care providers, and heads of clinical teams all have vital leadership roles. Neither must we forget the leadership of patients, families, and community groups who push for improvements to health systems. Finally, there is the operational (third) level—the most important part of any health system—where policy and practices are implemented by providers and program managers.

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Who, then, are these other leaders? From outside of the corridors of health ministries, they are clear to see. To name but a few: the regional managers of health authorities, local government service commissioners, health care providers, and heads of clinical teams all have vital leadership roles. Neither must we forget the leadership of patients, families, and community groups who push for improvements to health systems and hold system leaders to account. Civil society already drives innovation in health systems, whether by actively creating new services or by passively registering dissent so that poor systems can be changed.

**LEADERSHIP IS ABOUT SYSTEMS AND BEHAVIOR, NOT INDIVIDUALS**

The role of leadership in this new era is to mobilize and leverage action by multiple actors at all levels to achieve a common vision. This comes down to how different groups of people deal with one another, and how they engage and interact in complex systems.  

The conventional hierarchical environment must be challenged not just through participatory decision making but by deploying a rather more complex set of attitudes and competencies. The focus at the national policy level will need to shift to mobilizing and leveraging influence rather than top-down leadership. This would mean collaborating on an equal basis with regional and local leaders who might—mistakenly—previously have been thought of as subordinates. Similarly, providers of clinical and public health services would need to work collaboratively with patients and families as well as community and patient groups.

We can also already see that community and patient groups, as well as civil society, are no longer passive players waiting for opportunities to participate as dictated from on high. They are actively finding ways to exert their influences over or reshape decisions by policy makers or professionals. They will do so with or without permission from those accustomed to occupying the conventional role of decision makers.

Taken as a whole, this is what we call interactive leadership.

**SO WHAT MUST WE DO?**

To most who work within health systems, acknowledgment of the influence of multiple actors at different levels within the health system will seem obvious, even platitudinous. For the global health development community, it poses a particular challenge. If we accept that these individuals are indeed leaders who drive change, inspire others, and carry the vision and values for improvement, what actionable agenda will be developed to support them?

We need a concerted and constant effort toward system-wide, interactive leadership to enforce change that cannot be brought about by only central policy decisions. We need action and leadership to implement policy changes, and this leadership must come from health personnel and managers within the service system, as well as communities, families, and civil societies.

In order to create more positive changes, the traditional top-level leaders need to recognize the importance of systemic interactive leadership. They must work to harness their potential to create synergy rather than deterrents or barriers to collaboration for better health. At the same time, for those who are not in conventional leadership positions, there is a need to build confidence, to start new modes of interaction, to develop new competencies, and to engage one another to create a culture of interactive learning through action.

Clearly such interactive leadership also requires health systems to be well resourced, with easy and strong communication, though resource constraints will always be a challenge.
We hope that this new agenda will be debated in health and education institutions around the world, so that they can begin to develop it or create their own models to follow. The old ways must change if we are to face the big challenges ahead—whether obesity, infectious diseases, or antimicrobial resistance—and achieve productive and sustainable universal health coverage systems.

We propose the following four points for a new agenda on leadership in health:

1. Acknowledge the need for interactive leadership and the leadership roles of different actors within the health system. National policy makers are only one set of leaders among many and they need to encourage and facilitate interactive approaches to leadership.

2. Empower operational leaders to assert themselves as leaders. New working environments and mechanisms are needed to encourage sharing and learning from actions among those at the operational level to cultivate leadership for change and build a learning health system.

3. Enable patients, families, and community groups to participate in health leadership via new platforms and attitudes of current leaders. Platforms that facilitate dialogue and learning to break down the divide between practitioners and patients in health systems will contribute to a more collective leadership.

4. Advance research and development in the field of leadership so we know what works and can replicate successes across diverse health settings. Research is required to properly understand how leadership can be measured and assessed, to understand how leadership functions differently in diverse health systems, and to uncover the best way to communicate best practices both within and between health systems. Evidence must be at the heart of the new agenda for leadership.

DISCLOSURE OF POTENTIAL CONFLICTS OF INTEREST

No potential conflicts of interest were disclosed.

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