

tion in health research, if we succeed in striking creative global partnerships that will shape and harness this new science to improve health and healthcare and if we succeed in diminishing the disparities between those that have access to this new science and those that do not, then we will pass on a better world to our children.

(Based on the keynote address delivered by Dr. Alan Bernstein, O.C., FRSC, President, Canadian Institutes of Health Research, at the historic, inaugural meeting of the Canadian Academies of Health Sciences, on September 21, 2005, Vancouver, BC.)

The Leadership Gap in Healthcare – The True Deficit

Three years ago Roy Romanow released his landmark report on Canada's national healthcare system. The report, embraced by politicians of all stripes, recommended sweeping changes to the Canadian healthcare system. And while governments have continued to throw money at the system, very few of Romanow's recommendations have actually been implemented. Why is it that after three years and billions more in spending our healthcare system still teeters on the precipice? Waiting times for treatment grow longer, emergency rooms are packed to overflowing and many Canadians do not have a primary physician. Clearly there is more to this crisis than dollars. The real deficit in our healthcare system is leadership.

Across all industries and sectors 70% of strategic initiatives and change fail to deliver on the outcomes expected. The bottom line is that it is relatively easy to analyze the situation and make recommendations about what needs to happen. It is significantly more challenging and takes leadership to actually create momentum for action to happen. The Romanow report provides ample proof of good analysis and recommendations followed by failure with regards to implementation.

For some reason we expect our leaders to go farther, be faster than a speeding bullet and have a plan that can scale tall buildings in a single quarter. Is it any wonder that 40% of leaders in new roles leave within a year? Historically the pronouncement of what needs to happen was followed by people scurrying to act for fear of their jobs. Now the fear of doing something wrong outweighs individual accountability. Fear, money, deals and other similar motivators do not work in changing the health system, which is made particularly complex because of all the powerful stakeholders. It is our experience that leaders are looking for effective approaches to implementing a plan – how to do it is the key to their success.

The fundamental requirement to motivate people to change is a shift in leadership style from “tell and sell” to “engage and

enable.” One of the recommendations from the Romanow report is to foster collaborative leadership. But it is more than collaborative leadership. Waving the flag and declaring a crisis is passé; people are too cynical and mistrusting of those who call out to rally the troops. Employees and stakeholders need to be actively involved in creating and implementing a vision that they own. They need to be listened to when the environmental and systemic barriers are standing in the way of success, and they need to be guided successfully through challenges to their thinking, interpersonal and values-based conflict and resistance. Good leadership means engaging the right people to create vision, workable strategies and concrete, practical action plans. More importantly good leaders are able to work with those who are on board, those who are skeptical and the full-on resisters, when it comes to implementation. Leaders must change the environment to enable professionals and managers to achieve the desired outcomes; otherwise bureaucratic inertia ensues and operational, managerial and financial outcomes will be thwarted.

Most urgently leaders must be willing to learn more than the technical details and rationale for the solution, and they must learn about leading a strategic process and adapt to work with groups in the various stages of change. And yes it is messy but it works. Top down direction, decision-making and delegation followed by expectations that it will happen without appropriate processes, environment, coaching and development of individuals and groups of people is unrealistic. The ensuing micro-management that typically follows when results are not forthcoming suffocates creative, capable people.

We believe there are several critical elements for healthcare leaders to focus on in decision-making and change:

- The health system primarily exists to prevent and preempt disease and to care for people with disease. Patient-focused processes crossing the silos of different professional disciplines will automatically create effectiveness and efficiencies. Patients create the focus of an organization, not buildings, equipment and structures.
- The system must be prioritized first on prevention, then diagnosis and lastly options such as drugs, surgery or other interventions.
- Information sharing must replace all the superfluous structures that are set up to plan and monitor. Accountability requires that the measures be integrated in the process and not be managed or enforced by third parties.
- All structures outside of primary health service delivery need to be reviewed to ensure they have a purpose in service of the patient health delivery system and are organized to deliver the service. Assume none are required until a simplified and effective patient service requires something.
- Political and executive leaders need to engage the system in

a real and meaningful way – they must establish boundaries (such as patient outcomes; vision, goals, values; health professional retention as well as financial and other sustainability parameters) that the entire system will embrace and work within. They must learn to lead and manage the collaboration across the system as well as the challenges and conflict within the system.

- Most importantly managers must learn to be leaders: setting direction, plans and goals, attracting, developing and retaining the right people, creating a motivating environment, tracking results and managing performance (not tasks).
- Innovative grassroots (emerging) leaders must be given the opportunity, experience and the environment to implement solutions and enhance their success whether they are physicians, nurses, other health professionals or professional managers. Action to observe successful change must be done as pilot projects before transitioning the whole system.
- At the very top we need leaders with vision, who are guided by principles, and who will take the courageous steps to engage those who want to make a difference.

Canadian spending on healthcare has increased by more than 40% in the past five years and we have one of the highest per capita healthcare spending in the world next to the USA. The issue is not the amount of money for health. We are in complete agreement with those health professionals and external experts who acknowledge that more money is not the solution. There are those who point to private healthcare as a panacea for curing what ails the system. In creating the option for more private healthcare, the doctors, nurses, facilities, equipment and information by themselves will not change very much or very quickly. Ultimately we have to recognize the simple and obvious fact that the leadership deficit in healthcare is unsatisfactory and must undergo transformation.

It is now that we need to expand the talent pool to identify, recognize and develop current and potential leaders. Leadership experience (not clinical knowledge) is required at all levels: leading change across disciplines and organizations, building performing teams and organizations, and motivating people through developing their interests and capabilities. What are the leadership qualities required and how can they be developed? Effective leaders are those who behave, make decisions

and act based on values and outcomes; they consistently enable their people through shifting the environment, creating opportunities, engaging accountability and addressing non-performance. They listen to ideas, assess possibilities, understand data and facilitate change. Their organizations collaborate and have diverse perspectives; they know how to work through conflict and learn from mistakes.

Effective leaders are calm during times of adversity, create big visions and goals, acknowledge reality and have the courage, discipline, humility and tenacity to provoke, challenge and inspire momentum. The effective healthcare leader must be compassionate with patients as well as colleagues and employees. Our leaders must effectively communicate what cost-effective care looks like and ensure the resources to do it. At the same time management of patient-focused processes must be implemented to ensure the best allocation of all resources: human capability, time, equipment, facilities and money.

From our observations and experiences in the health system, and clearly the Supreme Court’s perspective, the true deficit is not financial deficit, but rather leadership. It is time for the creativity, commitment and capability of front-line nurses, technologists and physicians to be allowed to flourish and openly influence how patient services are delivered. Leaders must ensure policy, structures and other controls that prevent effectiveness are removed or changed.

When the leadership gap and management processes are reinvented, significant capacity is created, and likely the financial deficit will be drastically reduced while the stress and conflict is also reduced. The new leadership in healthcare need not be superhuman, merely human.

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– Eileen Page
CEO, PeopleProcessSolutions

“Change has a mean streak. It can rip the heart right out of an organization and kill the spirit of individuals - if you let it!”



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