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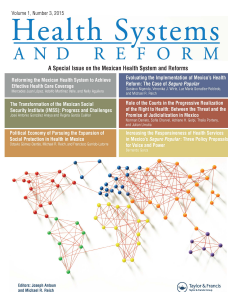
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Everyday Politics and the Leadership of Health Policy Implementation

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Abstract

This paper aims to prompt reflection about the everyday politics of health systems, their importance to health policy implementation and what sort of leadership, provided by whom, is required to address them. It is founded on insights drawn from empirical and theoretical literature, combined with practical experience developed through relevant research and teaching. Ultimately it argues that the everyday politics of the health system represents the multiple actors, interests and choices that frontline leaders routinely address, and that influence the collective action taken through the system in pursuit of public value. Leadership to address this everyday politics entails the practice of power and support for collective sense making - nurturing these political leadership skills through new forms of leadership development is, therefore, a vital component of health system development.

Introduction

Leadership is a vital element of health system development and reform. As Frenk has argued:

*Probably the most complex challenge in health systems is to nurture persons who can develop the strategic vision, technical knowledge, political skills, and ethical orientation to lead the complex processes of policy formulation and implementation. Without leaders, even the best designed systems will fail.*¹

But for policy implementation specifically: who are these leaders and what skills do they need?

Frenk, like many others, considers leaders to be those who develop new health policy and reform alternatives, gather high level political support for them, and then translate them into the legislative, regulatory or administrative policy instruments required to initiate the implementation process, with efforts to secure resources.^{2,3} This understanding of leaders and leadership focusses, however, on public policy formulation and, perhaps implicitly, goes hand-in-hand with an understanding of policy implementation as a top-down process: propelled through multiple organizational layers and chains of people by the exercise of administrative authority and hierarchy. This process is sometimes called command-and-control leadership.⁴

However, implementing any new policy or reform demands more than a policy instruction around a document, or a well-designed set of policy instruments accompanied by standard operating procedures. Health policy implementation is a much more challenging process, working through the whole health system and ultimately taking effect or being blocked at the frontlines of service delivery and community engagement -- be they hospitals, clinics, or communities. Indeed, it is those working at these frontlines who ultimately translate policy intentions into practice, influencing the lived experience of patients and citizens.

This paper focusses on the critical role of frontline public sector health leaders in policy implementation and health system change. It seeks to illuminate: 1) the everyday politics of the health system that they work with; 2) the importance of distributed leadership in enabling health system change; and 3) relevant leadership

practices. It draws on empirical and theoretical literature from within and outside the health sector -- but most importantly, two decades of close engagement, as a researcher and as an educator, with health system managers in South Africa.

What's it like at the frontline?

In thinking about everyday politics and leadership, imagine the following situation -- drawn from multiple South African experiences and illustrating just another day in the life of a frontline health leader:

It's a Monday. Its 6.30 am. Sister Xunu arrives at her clinic early: she is the clinic manager and wants to start the week by planning ahead a little -- thinking through the key events of the week. On Tuesday there's a meeting with neighboring clinic managers to discuss their experience of the recent facility audit round, linked to implementation of a new national policy of quality assurance. The local clinics didn't do well in the recent audit. They have also only just completed the regular seasonal diarrhea campaign, during which they have encouraged and cajoled staff to go the extra mile for their communities. The managers are aware they have no choice but to implement the new quality audit process, but they are feeling a bit overwhelmed about it as they just don't understand what is expected of them. So they are getting together to try and help each other think through the process, including how to manage their staff who was really resistant to it. On Wednesday late afternoon it is the clinic committee meeting; this has been held over for some weeks and she knows there are a lot of pending issues the members want to raise. Then on Thursday it's the monthly clinic managers' meeting - with her line manager and other colleagues at the district office. Across the other days she also has to prepare for a disciplinary hearing that will take place in the following week, for a staff member who had stolen milk powder (intended for mothers) from the store room. Her manager will lead the process but she has to be on hand -- and she dreads the thought of it. Disciplinarys are always a last resort as they are so time-consuming and demanding, and bad for staff morale. But she had no choice in this

case. She is particularly worried about the Union representatives, who can be quite confrontational. But she is relieved that she has the back up of her manager, whom she knows will conduct the process firmly and fairly.

As Sr. Xunu arrives at the clinic, she finds the patients already queuing outside. It's a rainy day and so she requests the security guard to invite them to wait inside until consultations start. It's a small clinic, the tiles on the floor of the waiting area are scuffed, and the wooden benches lined against the walls are worn and marked. The paint peeling from the walls is almost visible behind the array of health education posters and the 'Batho Pele' ('People First') service delivery principles and patients' rights. Sister Xunu goes to her small and cramped office, and takes off her coat. A set of shelves in the office is lined with files, each neatly labelled; and on the walls are multiple graphs and lists, the tools of her trade. They include one showing daily diarrhea cases during the recent campaign, a list of planned leave dates for her staff and the year's set of dates for the clinic committee meetings. She pulls out her diary and runs through the week's events in her head, thinking through what preparation is needed.

She then calls the staff together in the team room to clarify their duties for the day. Two nurses are missing, one has called in sick but no one has any knowledge of why the other is missing. She re-arranges the staff allocation across work stations to manage this problem -- but is challenged by Nurse Balfour who simply will not move stations. In the meeting, the pharmacy assistant reports that the clinic is running short of a particular TB drug as the expected stock did not arrive the day before. She adds this problem to her list of things to do for the day -- which includes: phoning the local manager's office to get more standard record forms, and to get someone to repair a broken window. She ends the meeting, encouraging all staff to go their stations and begin work -- except Nurse Balfour, who she asks to remain behind. But before she can engage Nurse Balfour the clerk comes running in to say there is an argument breaking out among the waiting patients -- with one mother accusing another of trying to jump the queue. Sister Xunu goes to mediate; and seeing the chair of the clinic committee,

Mrs. Mashaba, waiting in the queue, asks her to assist. She leaves the chair negotiating with the mothers, and goes back to talk to Nurse Balfour -- only to find the nurse has simply left the clinic, complaining about the amount of work she is expected to do, how little appreciation she gets and how often other staff members leave them in the lurch. To manage the staff shortfall, Sister Xunu is getting ready to provide services -- but then remembers she has to tackle her list of urgent things to do, so walks back to her office. Mrs. Mashaba comes to her as she has just picked up the phone, and reports that the queue problem did not lie with the mothers but rather with the clerk's attitude towards them -- which is high-handed and rude. She notes that this clerk has a poor reputation among patients and that the clinic committee wishes to discuss this and other issues of staff performance at the next meeting. Sister Xunu agrees but excuses herself from a longer conversation right then given the need to get on with her phone calls.

Just as Mrs. Mashaba leaves her office the phone rings: it is the local area manager's office, calling her to an unexpected meeting at 10.30am. Sister Xunu asks what the meeting is about but all she learns is that it is to meet with some colleagues from the national office about a new initiative. She groans. It is already 9.00am. She has a queue full of wet and cold patients, a clerk treating them rudely, three missing staff members, a broken window through which rain is now leaking, a pharmacy running low on some key drugs, the prospect of a tempestuous clinic committee meeting later in the week for which she must prepare -- but now she must drop everything to rush to a meeting about yet another new initiative that will make more demands on herself and her staff!

The range and depth of challenges faced by primary care managers inevitably varies between settings -- both within South Africa and between countries.⁵⁻⁸ Nonetheless, this wider experience shows there are commonalities -- such as the constant demands of managing staff, supplies' shortages, policy instructions from above, sudden meetings being called or visitors arriving at the last minute, only limited budget authority, and the importance of working with local communities. There are also clear examples of managers

who do cope and manage, as in this scenario, often despite barely any prior preparation or training and generally with limited support.

The everyday politics of the health system

Many policies are ultimately implemented in environments like that outlined in the scenario -- and many processes of health policy implementation, from user fee removal to the roll out of new point-of-care diagnostic technologies to supervision of community health workers, are led by clinic managers like Sister Xunu, in collaboration with their line or area managers and, in the best cases, with community actors. As the scenario outlines, the challenges of implementation that they face include multiple competing demands and policy imperatives, the struggle simply to manage the routine demands, resistance from staff-as-implementers and lack of clarity and misunderstanding of policy intentions.⁹ In these circumstances, implementation is rarely straightforward -- especially as new policy goals may be unclear, the details of how to implement them may need to be worked out as they are implemented, and policy timeframes and resourcing may change unpredictably as a result of wider political pressures. These experiences represent the 'everyday politics' (see Box 1) of the health system, and are reflected across countries and sectors.^{3, 10}

Not surprisingly, therefore, a large body of theory sees policy implementation as a complex process that entails working with and through policy actors, people and organizations,¹¹ in contrast to the more common top-down and command-and-control understanding. This theory emphasizes that the particular political and administrative settings -- and their histories and traditions - shape actors' values and interests, as well as the spread of formal power amongst them; thereby influencing their responses to new policies and to changes within the system in which they work. Policy implementation also engages policy actors both inside and outside the public sector, and is shaped by wider national and international economic and social forces. Such 'bottom up' theory considers policy to be implemented only when it is reflected in the actions of implementers, recognizing their discretionary power to translate policy in their practice.¹²

This exercise of power in implementation is also illuminated by theoretical debates. Lipsky (2010), for example, notes the risk of unintended consequences from attempts to control implementing agents through a command-and-control management approach -- as it can lead these street level bureaucrats to exercise their own power in contradiction of policy goals.¹³ Empirical evidence from the health sector, meanwhile, outlines the wide array of practices of power exercised by implementing actors -- sometimes in pursuit of policy goals, sometimes contradicting them and sometimes contradicting them but nonetheless achieving wider societal benefit.¹⁴

Sr Xunu, for example, has to face the discretionary power of the nurse who simply refuses to stay at work as well as the power of her managers to call her to an unexpected meeting. She exercises power, meanwhile, in inviting the patients into her clinic before consultation hours, in asking the clinic committee chair to mediate with the women in the queue and in arriving early to reflect on her week ahead. Every day she has to make choices about how to spend her time and energy. Perhaps most crucially, Sister Xunu's response to the patients waiting outside the clinic, to the interactions between mothers and the clerk, and her engagement with the clinic committee are all political acts, influencing the experience of health care by the wider community. In the health system, street level bureaucrats' exercise of discretionary power influences citizens' access to and experience of health care, with consequences for their health and life chances as well as their trust, as citizens, in the health system.^{10, 15}

Distributed leadership

Policy implementation theory in the bottom-up tradition,¹³ as well as wider theory about leadership in complex systems¹⁶⁻¹⁸ emphasizes, moreover, that leadership of this everyday politics, of actors and power, just *is* the job of front-line managers. Rather than only administering or organizing activities, they must offer leadership in working with and through others.

More specifically, as the scenario shows, such leadership entails working with:

- staff, to gain commitment for routine or new activities, and to ensure efficient operations;
- their own managers, to mediate centrally-driven imperatives and secure authority for their own actions;
- and actors outside the organization who are partners in achieving shared goals, including patients and citizens;
- as well as looking ahead, to anticipate and plan for new challenges threatening activities and goals, or for opportunities to develop new ways of meeting goals.^{3, 19, 20}

Crucially, frontline managers connect the operational core of an organization with higher management levels, and in this sense they are what Rouleau (2005) terms mid-level managers.²¹ From this position, their leadership must, therefore, enable the interactions and networking among actors that sustain collective action towards shared goals, and support innovation and adaptation.^{17, 22} The distributed leadership underpinning such collective action is the fulcrum of policy implementation and system change.

In other words, systems simply cannot be led from the center through command-and-control approaches. Rather, distributed leadership is required: chains of leaders located across levels and positions within a particular system, who represent a flow of energy and power that harness the wide range of actors across the system to achieve collective goals.^{13, 16-18}

What does the leadership of everyday politics aim at and entail?

Everyday political leadership is needed, first, just to maintain services and ensure good quality of care. Sister Xunu has to exercise political skills in balancing and managing the relationships among people and resources that influence services on an everyday basis. Second, such leadership is also essential in bringing about change -- in enabling the organizational changes that institutionalize new policies in routine practice (reculturing the organization;²³ or the enculturation of change;²⁴ and in encouraging local innovation.¹⁷ Sister Xunu will need to exercise such leadership in implementing the new quality audit processes, for

example, or any other primary health care initiative. The leadership of everyday politics is, ultimately, therefore, about the generation of public value through the health system -- that is, producing and distributing health care (and health), and ensuring efficient and accountable organizations.²⁰

Moreover, as power relationships are central to everyday politics, the leadership of such politics itself inevitably entails the practice of power. This lesson is one that is currently being actively debated in the development community, in a body of work called 'Thinking and Working Politically' (TWP^a), as well as related work.²⁵ Although addressing development practitioners rather than health managers, TWP work offers insights of relevance for health leadership. TWP thinkers specifically note that:

*'...development is not just a technical or economic process but also one that is inherently political... development requires leaderships, coalitions, and, crucially, collective action... Leadership is a fundamentally political process, about power and bargaining, influence and change.'*²⁶

Power has many dimensions, but Lukes' (2005) insights remain critical.²⁷ Beyond the ways in which actors behave towards each other, or the ways in which pressure can be brought to bear on decision-making behind the scenes, Lukes reminds us that power is embedded in the prevailing norms, beliefs or values that shape actors' behaviors. In complex adaptive systems, this invisible power can be seen as the (often unrecognized) mindsets that shape agent behavior. Acknowledging mindset power points to the importance of sense making as a leadership task that is, developing the collective meanings that shape actors' behavior.²⁸

Bearing in mind that the leadership of everyday politics entails practicing power and supporting collective sense making, four inter-linked sets of practices are proposed as important for frontline leaders.

^a <http://www.dlprog.org/research/thinking-and-working-politically-community-of-practice.php>

1) Perhaps the most critical personal practice is ethical behavior, as moral purpose is always essential for leadership.²³ Those working in frontline health settings need specifically to recognize that through their power they not only influence others, but also, as discussed above, the distribution and nature of public value achieved. These are profoundly political acts.

Sr. Xunu's effort to prepare carefully for her week, to think before she acts, is, for example, an important step in the reflective practice that underpins ethical behavior.

2) Actor analysis is an important leadership tool, more commonly known as stakeholder analysis. It allows frontline leaders to consider the other actors that are likely to influence efforts to bring about change in their activities, whether inside or outside their organizations or systems. But also, most importantly, it requires leaders to think about what makes other actors tick, what shapes their behavior, and what forms and levels of power they are likely to hold.³⁰ Such considerations then provide a basis for thinking about how to build coalitions of support for decisions or which actors need to be most carefully managed because of their power and potential resistance to change - as well as how to influence them. Nonetheless, it is also important to listen to resisters -- for what insights they offer of value in understanding challenges and change.²³ By simply preparing for her meetings -- with staff, the community, even her colleagues -- with these ideas in mind, Sr. Xunu would develop insights into how to build collective commitment to the decisions and agreements made in the meetings.

3) Recognizing actors' positions and power also provides the basis for acting to shape collective sense making. Sense making entails making meaning of the world. To support collective sense making leaders must be nurture the collective meanings that shape group behavior by working with the invisible norms and beliefs that shape actors' conceptions of their interests and values. Such collective sense making around the quality audit is likely to be an important task for Sr. Xunu. Staff may currently oppose it because they see it as a way for managers above them to criticize or discipline them; Sr. Xunu's task might then be to encourage the staff

to see it as an opportunity for them to take action to improve care for the patients, fulfilling their own personal goals as nurses.

The personal practices outlined in Box 2 are all important to Sr. Xunu in this task. For example, she could hold a staff meeting to provide everyone with the time to think about their own clinics, using the audit tool -- identifying problems, unpacking root causes and thinking about ways of tackling them within the clinic. Making this sort of time to think allows collective learning and the development of the shared understandings and meanings, and mutual accountability for shared goals that underpin future action (point 1, Box 2).^{23,28} She might also have to have some difficult conversations with Nurse Balfour and the clinic clerk (point 2 Box 2). And she can support the process by 'walking the talk' -- role modelling the respect for others that is important in relationship-building, using words about the audit that capture the sense of it as a clinic-led process through which staff can fulfill personal professional goals, persistently engaging with staff to hold them to account for their actions -- and just recognizing that implementing change takes time (point 3-5, Box 2).^{16,23}

4) Finally, in implementing sustained change, pursuing small wins³¹ can be a really important first step. Small wins can be understood as easy-to-take steps - that demonstrate success, and so may build actors' confidence, mindset and the momentum for future change. The most effective small win is not only easy to implement and unlikely to be resisted, but also one that can be repeatedly applied in undermining a key constraint to longer-term change. Such small wins can open up the possibilities of longer-term, more profound change -- for example, by building relationships, changing understandings, or developing shared goals. Small wins also allow the possibility of learning through doing, generating information -- about the feasibility of new activities or why certain actors resist change -- that allow activities to be revised and strengthened. The value of encouraging such adaptive learning, combining problem solving and locally generated solutions, is another lesson of current development thinking.³² Perhaps Sr Xunu could involve the clinic clerk in the discussions about how to respond to the quality audit, for example. Simply by

acknowledging him as a member of the clinic team he might begin to feel more pride in his job, and not only begin to be more polite to patients but also offer really useful insights in developing approaches to improving clinic services.

Conclusions: everyday politics and the leadership of health policy implementation

Politics infuses health system decision-making and functioning. Leadership of this everyday politics is central to health policy implementation and is the job of frontline managers. They are not only responsible for health system maintenance, but also play vital roles in enabling and sustaining equity-promoting improvements.

Through their leadership practices they can enable distributed leadership and shape the collective action taken through the health system in pursuit of public value.

Nurturing these new forms of political leadership within health systems will, however, require new approaches to leadership development. Leadership must be seen more as an apprenticeship than a knowledge to be imparted or learnt, and opportunities for leadership development should be available to managers across the health system, and not only to ministers and senior civil servants. Relevant programs must, moreover, actively embrace workplace-based and team learning approaches, and provide life-long learning opportunities to strengthen and deepen skills.³³ Such approaches to leadership development are vital to health system development.

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Boxes:

Box 1: Understanding the everyday politics of development

In everyday politics institutions are contested, shaped, implemented, avoided, undermined or amended, and contingency, critical junctures and windows of opportunity disturb old patterns or open up new possibilities. Crucially, this is where different players use different forms and degrees of both de jure and de facto power

(4).

Box 2: Public leadership: five key personal practices (all of which are challenging in the demanding context of primary health care) (29)

1. Attention - allocating time purposefully, enough time with enough focus; to be effective, to build personal rapport with others, to empower others, to learn, to be effective

2. Conflict management – being able to manage the fall out of taking people outside their comfort zones, of challenging the status quo towards new goals or to adapt to changes in the world
3. Commitment – caring about an issue and demonstrating that in words and actions, and so eliciting commitment from others to that same cause
4. Rhetoric and performance – recognizing that the soft power of leaders is vital, the power of persuasion, inspiration, mobilization
5. Patience and timing – leaders need to be able to bide their time, laying the groundwork for change and, where possible, seizing the moment to act. They need stamina and patience.