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A two-dimensional perspective of healthcare leadership in non-Western contexts

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ABSTRACT

As we witness an alarming change in the delivery of healthcare worldwide, there is a need for transformational leadership that can inspire and empower healthcare professionals, and patients alike. Due to the lack of economic, infrastructural and human resources especially in developing countries, the organisation and delivery of healthcare services is even more challenging. Hence, the focus of leadership development in resource-limited environments should be to facilitate knowledge building, interprofessional collaboration, empowerment and inclusion.

In this paper, we use two exemplary cases to illustrate the impact of, and the challenges facing leadership capacity building in non-Western contexts with special reference to India and Curaçao. These cases demonstrate that there is a place for validated medical leadership models in developing countries with promising outcomes for the collective health status of communities at large. Such models, however, need to be contextualised to fit the individual country's economic and sociopolitical context. Also, the stakeholders should be prepared to create healthy professional cultures that embrace respect (for self and others) and focus on effective communication practices within their local environments.

INTRODUCTION

The delivery of healthcare across the globe is changing, and it is occurring at a considerably fast pace. Several factors have been linked to these changes and include the constantly fluctuating geopolitical and socioeconomic landscapes in many countries. Currently, there is a global crisis of mass migration occurring both within and between many countries, most of which have been the direct results of human-related displacements (eg, economic or conflict related), natural disasters as well as the outbreak of disease epidemics. Furthermore, the patterns of the diseases being reported, both existent and emergent are changing, demanding that different and novel approaches are needed to train clinicians to practice their craft.[1 2] Therefore, in order to meet the current and future healthcare needs of populations, the practice and training of clinicians has to be transformational.[3 4] This means that a different kind of leadership is needed in our healthcare systems, one that will inspire, include, empower and transform communities[3 5–8]

CONTEXT

In most developing countries, the organisation, delivery and access to healthcare services are challenging. This is mainly due to the lack of economic, infrastructural and trained human resources,[7 9] which in turn defines the content and focus of leadership and leadership decision-making. Due to the limitations described above, the focus of leadership training in resource-limited environments should be directed towards knowledge building, interprofessional collaboration, empowerment and inclusion.[9 10] How this focus is eventually defined, developed and implemented though, is largely determined by the local needs and context of healthcare systems.

Currently, there is a need for effective leadership in healthcare delivery due to limited material and human resources, especially in non-Western developing countries.[1 3 9] The UN Sustainable Development Goals (SDGs) attests to the fact that new strategies are needed that would yield high healthcare impacts with minimal investments in many developing countries. This is articulated in the 3rd SDG goal of achieving healthy lives and promoting well-being for all ages[11] and also by the WHO indicators and measurement strategies for developing health systems.

AIM

At the 2019 'Leaders in Healthcare' conference (LIH), organised by the FMLM,UK and BMJ in Birmingham, KG and JOB met serendipitously at the session on 'Promoting Excellence—Competency Frameworks from Across the Globe'. The authors' presented their leadership development experiences from two different non-Western developing countries, namely India and Curaçao, and shared the outcomes of the interventions in the respective healthcare systems. The experiences from these interventions aligned with two of the six building blocks of the WHO's health systems framework namely health workforce and leadership/governance development. The separate cases presented by the authors highlighted the learning points from their respective experiences published in peer-reviewed journals. In this paper, the authors summarise new insights they gained from the joint presentation in the session at LIH. They highlight the importance and need for healthcare leadership development in resource-restrained environments and discuss how this influences the design of healthcare services to patients in such non-Western contexts. By combining and publishing these cases in a single paper, an attempt is made to provide a comparative overview of the challenges to leadership capacity building in their respective settings. Using real-life examples of two different healthcare initiatives, an overview is provided of the rational for development, process of design, development and implementation and the outcome of the interventions. Further, an analysis of the different

leadership strategies associated with the initiatives is provided with illustrations of how these contributed to the outcomes in the different contexts. Finally, a summary of the lessons learnt with some recommendations is provided.

The two dimensions

Case 1: India—individual focused leadership development (uniprofessional)

Context

In India, the healthcare sector is quite diverse and comprises both public and private sectors. Private hospitals are considered more efficient and are preferred, though more expensive than public hospitals.[12] Through the Pradhan Mantri Swasthya Suraksha Yojana (PMSSY)[13] and Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana (AB-PMJAY)[14] schemes, which are two ambitious government initiatives, numerous reforms have been implemented in India's public health sector over the past two decades. Nonetheless, lack of leadership and management capability in the health sector is one of the main factors responsible for the PMSSY scheme's underperformance, which was highlighted by the performance audit report of the Comptroller and Auditor General of India.[15] There is also a lack of effective policy frameworks to develop the leadership capability in health system. It is well-known that developing countries spend very low percentages of their gross domestic product (GDP) on healthcare and this is <2% in India. Challenges in the healthcare systems of non-Western countries differ significantly from those in Western settings. These vary for example, from malnutrition, safe drinking water, sanitation facility, low income at a personal level to a lack of adequately trained and an insufficient number of health professionals at a systems level. Further there are differences in the size and diversity of the healthcare systems. In India for example, the healthcare composition is diverse, unique and complex, including modern and traditional systems of medicine for example, Allopathy, Homeopathy, Ayurvedic in addition to urban and rural components.

Rationale

Medical leadership has historically been hierarchical and 'by chance' in India. There are very few leadership development programmes (LDPs) available for undergraduate, postgraduate or in-service levels, thus leadership roles are attained mostly by rotation or seniority.[16] This causes a significant 'leadership competency gap' among doctors both at consultant and resident levels in the country. Thus, to determine the magnitude of this competency gap, authors (KG and CS) conducted the first of its kind research in India on leadership competency of doctors in public and private sector hospitals.[17]

Process

Authors (KG and CS) developed a survey questionnaire, which comprised of questions about demographic characteristics, medical leadership competencies adapted using Medical Leadership Competency Framework (MLCF) of National Health Services (NHS), UK (2010),[18] and perceived need and preferred design of LDPs for doctors in India. The competencies (n=30) were distributed across all domains of MLCF (see box 1).

Reliability of the questionnaire was assessed using Cronbach alpha score (found to be 0.95). Data were collected from four metropolitan cities of India and response rate was 54% (n=540, 290 from private; 242 from public sector; and 8 others). Doctors were asked to self-assess their proficiency level for each of the leadership competencies on a Likert scale ranging from 1 to 5 (1 being very poor to 5 being very good) and also to rate their perceived level of importance of each competency on a similar scale—1 (not important) to 5 (very important).

Box 1 Leadership competencies included in the survey questionnaire

Competency and MLCF domain

Demonstrating personal qualities
1. Supporting and mentoring high potential talent.
2. Ability for fostering environment of mutual trust.
3. Ability to communicate organisational mission, vision and strategic plans.
4. Ability to inspire every member to imbibe and work towards the organisational goal.
5. Time and stress management.

Working with others
1. Developing effective relationships and collaborations in support of organisational goals.
2. Ability to influence key decision-makers who determine future government policies.
3. Facilitating staff retention, motivation and high level of commitment.
4. Creating an organisational climate that encourages teamwork.
5. Public relations and media management.
6. Ability to provide and receive constructive feedback for improvement.
7. Facilitating conflict negotiation and dispute resolution.

Managing services
1. Conducting need analysis, identifying and prioritising requirements.
2. Ability for constructing and maintaining governance systems.
3. Holding self and others accountable and responsible for organisational goal attainment.
4. Adhering to legal and regulatory standards.
5. Knowledge of HR, procurement, financial and contracts management.
6. Information management system planning and implementation.

Improving services
1. Ability for problem solving, forecasting and planning strategies for overcoming obstacles.
2. Ability for promoting and managing change.
3. Using latest technologies and their clinical applications.
4. Ensuring accuracy and integrity of information.
5. Developing quality assurance and improving patient safety.

Setting direction
1. Establishing organisation's vision, mission and goals.
2. Exploring opportunities for organisational growth and improvement.
3. Demonstrating ability to integrate, analyse and evaluate information from various sources to make decisions.
4. Ability for transforming strategic plans into workable operational plans.
5. Ability for practicing value-shared decision-making.
6. Knowledge of interdependency, integration and competition among healthcare sectors.
7. Envisaging potential impacts of decision-making on operations, healthcare, human resources and quality of care.

Table 1 Top 10 highly rated perceived importance leadership competencies

Setting direction	1. Establishing organisation's vision, mission and goals 2. Exploring opportunities for organisational growth and improvement 3. Ability for transforming strategic plans into workable operational plans 4. Envisaging potential impacts of decision-making on operations, healthcare, human resources and quality of care 5. Demonstrating ability to integrate, analyse and evaluate information from various sources to make decisions 6. Ability for practicing value-shared decision-making
Working with others	1. Public relations and media management 2. Creating an organisational climate that encourages teamwork 3. Facilitating staff retention, motivation and high level of commitment 4. Information management system planning and implementation

Outcomes

Majority (72%) of public sector doctors rated their competencies as 'average' to 'good' and 12.1% rated as 'poor' to 'very poor'. In contrast, 76% of private sector doctors self-assessed their competencies as 'good' to 'very good' and only 5% as 'poor' to 'very poor'. Statistically significant difference was noted both in public and private sector doctors between the mean score of 'self-assessed proficiency levels' and 'perceived importance levels' of all the 30 competencies, thus, establishing the presence of a significant leadership competency gap in both the sectors.[17]

Overall analysis of the 'perceived importance' level of competencies among doctors from both public and private sector revealed that the top 10 competencies were mainly in the NHS-MLCF domains of 'setting direction' followed by 'working with others' (see table 1).

The most important competency found was 'establishing organisation's vision, mission and goals'.

While making comparisons between the competence levels of public and private sectors doctors, the 10 most deficient competencies were found in the NHS-MLCF domains of 'working with others', 'managing services' and 'setting direction',[17] though the rating of each competency was higher in the private sector group. The most low-rated competency among public sector doctors was 'knowledge of HR, procurement, financial and contract management' while 'ability to influence key decision-makers who determine future government policies' was most deficient among private sector doctors. Further, deficiencies related to 'time and stress management' and 'conducting need analysis, identifying and prioritising requirements' were confined to public and private sector doctors, respectively.[17]

Interestingly, majority (95%) of doctors indicated the need for LDPs.[19] Accordingly, an offsite residential LDP was conducted, involving 96 physicians as participants.[20] A combination of pedagogical approaches was used and preassessment and postassessment of 30 medical leadership competencies was done using the same questionnaire. Statistically significant difference was noted in preassessment and postassessment mean scores for all 30 leadership competencies.[20] In the preassessment group, majority (72.4%) rated their competencies between Average to Good (Levels 3 and 4) with a mean score ranging from 3.19 (SD: 0.94) to 3.98 (SD: 0.79). However, in the postassessment group, 85.3% of participants rated their competencies from Good to Very good (Levels 4 and 5) with mean scores ranging from 3.81 (SD: 0.95) to 4.38 (SD: 0.61). Participants rated maximum improvement in the competency 'information management system planning and implementation' whereas they indicated least improvement in competency 'holding self and others accountable and responsible for organisational goal attainment'.

Lessons learnt

Our study was the first one in India to evaluate medical leadership competencies of doctors, revealing significant medical leadership competency gaps and providing a framework to design LDPs specific to Indian healthcare needs. It also highlighted the effectiveness of LDPs on enhancing leadership competencies demonstrating positive outcomes. We believe that this study can possibly provide a guideline for design and conduct of future LDPs to meet Indian national health policy's objective to build leadership capacity in healthcare.[21] Further, it can also serve as a resource for the policymakers in low- and middle-income countries for developing leadership capacity specific to their health systems.

Case 2: Curaçao—team focused leadership development (multiprofessional)

Context

Curaçao is one of three self-governing Dutch Caribbean islands with an estimated population of 158 665 inhabitants.[22] The island is located about 100 km north of the Venezuelan coast and is 62 km long with a surface area of about 444 km^2. People from more than 45 different nationalities reside on the island and the languages spoken include Dutch, Papiamento, English and Spanish. Up until November 2019 and before transitioning into the Curaçao Medical Center, The St. Elisabeth Hospital (SEHOS) was the sole general hospital in Curaçao. With approximately 536 beds, it provided secondary and tertiary care to the inhabitants of Curaçao (and environs) in all major clinical specialties. Most of the approximately 284 medical professionals working in Curaçao are Dutch trained.[4] One hundred and forty are medical specialists, 110 family physicians, 294 allied healthcare professionals (eg, physiotherapists), 6 registered midwives and 54 dental professionals.[23]

The healthcare system in Curaçao is based on the Dutch healthcare model where family physicians' function as the gatekeepers of care. There is a national healthcare insurance scheme funded by the social Insurance Bank and also an option for private healthcare insurance. In 2011, the estimated expenditure on healthcare in Curaçao was US$503 million (ANG 900 million), or 16.6% of the island's GDP. With an historical lack of transparent government policy on healthcare organisation, the assurance of optimal patient care and sustainable healthcare systems in Curaçao has been under constant jeopardy. Like most developing countries, the organisation and delivery of healthcare in Curaçao is complex, fragmented and unsynchronised. The prevalence of chronic diseases is relatively high and financial resources are limited and poorly distributed. There is also a dearth of human capital needed to sustain optimal and effective healthcare services. Hence, new and improved models of care are needed that can satisfactorily address the urgent health demands of the community.[7]

Rationale

Over the past decade, we investigated strategic benefits of competency-based training in Curaçao and how it can be used to build workforce capacity and improve healthcare delivery.[7 24] These studies have identified different requirements needed to successfully implement healthcare change initiatives, in a resource restrained environment like Curaçao.[10] In 2018, we designed a healthcare improvement project based on our previous

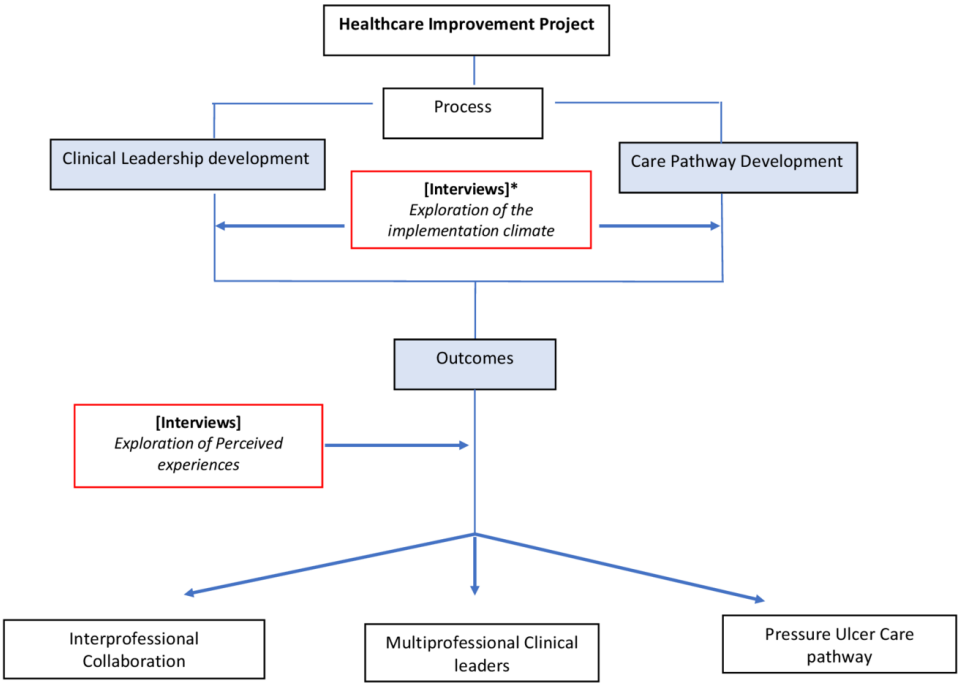

Figure 1 Flowchart of the healthcare improvement project.[5]

research.[4 7 10 24 25] The aim of this project was twofold. One, was to create a health improvement programme tailored to CHCIs in Curaçao. The model we used for this initiative was based on the recommendations from a case study on the implementation of a competency-based health system in Curaçao and also on the results from earlier research on interprofessional collaboration.[24 25] The second aim was to explore the perceived growth in leadership competencies of different healthcare professionals and how much (if any) could be attributed to the leadership training and/or participation in the care pathway development.

Process

Decubitus (or pressure) ulcer was the critical healthcare issue (CHCI) that was chosen for this project. This was because it was considered a serious health challenge for patients in SEHOS and also a major quality indicator of hospital care.[26] A mixed team of health professionals (n=34) were selected for this project and they were all actively involved in the selection and development of the chosen care pathway. The implementation approach was divided into two, namely (1) workforce resource development and (2) focused healthcare improvement with predefined outcomes. The predefined outcomes included the participation in a multidisciplinary, team-based leadership development programme (MTLP) and the development of a care pathway for decubitus ulcer (figure 1).

Outcomes

The MTLP was run over a 12-month period and comprised of 3 blocks. Two blocks (1 and 3) were primarily instructional modules and workshops and block 2 was dedicated to the development of the CHCI intervention, that is decubitus ulcer pathway (see table 2).

We measured the impact of the intervention based on the participants' reported experience and benefits from participating in the MTLP (n=22) and the development of the decubitus ulcer care pathway in the process. Prior to commencing the training, 76% of the respondents claimed to have had some form of leadership education in the past. We evaluated the instructional part of the MTLP using the Learning objective review instrument.[27]The participants scored the content of MTLP positively and valued the interdisciplinary approach with a mean of 4.14 (SD: 0.64) on a Likert scale of 1=totally disagree and 5=totally agree. They acknowledged the added value of a training programme that addressed their personal growth and leadership development (alignment with learning goals) with a mean score of 4.14 (SD: 0.70, see table 3).

In addition to the conception, development and implementation of the care pathway, the MTLP served as a catalyst for the development of a concrete healthcare improvement intervention. The participants experienced that there was more dialogue and understanding among themselves, which resulted in productive team activities and more interprofessional collaboration. In particular, great value was given to the collaborative attitude they experienced during the meetings and the sense of empowerment they experience as equal contributors to the project.

Table 2 Contents of the leadership curriculum

Block 1	Block 2	Block 3
► Value-based Healthcare ► Leadership or management ► Achieving excellence ► Authentic leadership ► Quality of care and safety ► Basics of quality improvement ► Measuring quality indicators ► Project management	Development of the quality improvement intervention that is, decubitus care pathway	► Sharing experiences ► Analysing results of care ► Learning from failure ► Compassionate leadership ► Multidisciplinary teamwork ► Effective negotiation ► High impact leadership ► Dry-runs

Table 3 Mean score per item on the LORI

Evaluation report of the multidisciplinary, team-based leadership development programme									
	Content quality	Learning goal alignment	Feedback and adaptation	Motivation	Presentation design	Interaction usability	Accessibility	Reusability	Standards compliance
Mean	4.14	4.14	4.10	4.36	4.09	4.14	3.82	4.50	4.05
N	22	22	21	22	22	21	17	22	22
SD	0.64	0.71	0.63	0.66	0.81	0.79	0.73	0.51	0.65

LORI, Learning Object Review Instrument .

Lessons learnt

The achievement of interprofessional practice requires an investment in interprofessional education and targeted leadership development for all members of the healthcare team. In situations where there is effective interprofessional collaboration, the general well-being of employees improves, which in turn enhances organisational engagement.[28] By involving and giving ownership to the participants in a guided interactive programme, like we did, we highlighted the need and benefits of leadership development in members of the interprofessional team. We also identified relevant themes that could be applied directly to improve the local health situation and also showed why collaboration within teams and the presence of collaborative attitudes are hallmarks of successful interprofessional practice.[28]

DISCUSSION

Globally, healthcare organisations employ 234 million people with an estimated financial outlay of US$8.7 trillion.[29] Unarguably, physicians enjoy the power to determine resource allocation and play a critical role in driving healthcare improvement initiatives. However, formal leadership development programmes for physicians are recent and diverse in terms of their conduct and impact assessment.[30] In addition, several barriers to leadership development have been identified, namely lack of resources and organisational support, cultural differences, lack of trained workforce, and so on.[31] The purpose of this narrative therefore was to highlight the importance and need for healthcare leadership development in resource-constrained environments and show how this influences the design of healthcare delivery in these settings.

Interest in developing leadership capacity in healthcare has greatly increased over the past two decades and there is increasing evidence that physicians' participation in leadership activities contribute to better patient care and organisational efficiency.[32] The national health policy of India (2017)[21] recognises the need for leadership capacity building in Indian health sector. The physician-leadership competency assessment study in India revealed significant leadership competency gaps among doctors at all levels. Our study results highlighting the disparities in competencies between public and private sector doctors can be extrapolated to the fundamental differences in economic and social conditions that exist between both sectors. Physicians in the private sector are primarily concerned with generating revenue, while physicians in the public sector have unique values and interest in providing and enhancing services. As a result, doctors in the public sector are increasingly concerned with efficiency, social involvement, community service and substantive assignments—much more than their counterparts in the private sector.[16 17 19]

The best measure of a health system's performance is its impact on health outcomes. Curaçao's health system is currently at a critical crossroad, requiring reasonable management and consistency of service delivery to its people. Sustenance of the desired healthcare changes demands strong leadership and for this, medical and allied health professionals need to repossess a leading role in the healthcare delivery system. This is because healthcare professionals are believed to possess and clearly demonstrate competencies needed for patient-centred care, teamwork and leadership, quality improvement, accountability, cost-consciousness and most of all professionalism. Further, it is important that all stakeholders in the healthcare system contribute to the process as equal partners of decision-making process.

As we have shown, evidence-based leadership training can play a critical role in enhancing the capabilities of the healthcare workforce and implementation of a competency-based health system. Competency-based medical education (CBME) for example, has been recognised as an effective strategy to educate and evaluate the next generation of doctors. Despite the benefits of CBME however, various issues and challenges, namely increased administrative requirements, need for human resource development, lack of versatile curriculum models, and so on have been identified regarding the implementation of CBME frameworks.[33]

While an evidence-based approach to leadership development is crucial, it is still not clear which approaches are most successful in achieving positive clinical outcomes. Several approaches, such as, self-reflection, participatory action learning and developmental assessment have been identified as necessary in order to highlight cultural differences and avoid postcolonial trends in westernizing leadership development in non-Western health systems.[31] Still, it is difficult to incorporate leadership development into the existing curricula of medical education, which is quite rigid and complex. That does not mean, though, that leadership development during and after the basic medical training is not achievable. To begin with, we need to acknowledge that there is no 'one-size-fits-all' solution, as health systems need flexibility to adapt their leadership development to their ultimate organisational objectives.[34] Therefore, any proposed leadership training curriculum will have to concentrate on highlighting and integrating key leadership capabilities that are related to professional standards, roles and responsibilities, transparency and quality assurance. Also, for the successful implementation of the training in practice, there would need to be an environment that is suitable for change and different organisations willing to join forces to achieve more interprofessional collaboration.

Furthermore, based on the different healthcare systems described in the two non-Western contexts, one may argue that a standardised and tailored medical leadership model for healthcare leadership capacity might be a potential option for building leadership capacity in developing countries.

On reflection, we identified a similarity in the leadership model that we used to design our separate interventions that is, situational leadership theory (SLT). Often referred to as the Hersey-Blanchard Situational Leadership Theory, this model focuses primarily on two types of leader behaviour that is, task

behaviour and relationship behaviour. SLT argues that "leader effectiveness" results from appropriate amounts of leader task and relationship behaviours provided to subordinates at different levels of maturity.[35] The developmental level however is determined by the level of competence and commitment of the individual. SLT also identifies two key behaviours for effective leadership, which were inherently relevant to our chosen interventions namely, being supportive and directing.[36] The directing behaviours included giving specific directions and instructions and attempting to control the behaviour of group members, while the supporting behaviours included encouraging subordinates, listening and offering recognition and feedback to them.

Despite their inherent differences, the two cases complemented each other in terms of leadership capacity building in their respective contexts. The Indian case study reflected a monoprofessional approach to leadership development focusing on doctors only. The novelty of this first of its kind study from India, is that it reveals the significant gaps in medical leadership skills, establishes the need to design and conduct Indian healthcare-specific LDPs and also shows that LDPs can play a key role in strengthening leadership competencies. Conversely, the Curaçao study highlights the inherent transformative value of collaborative and systems-based interventions by involving various healthcare professionals. The multiprofessional approach used is valuable through its potential as a model unit line for a large country as India. Unit model lines are scalable examples of business ideas or configurations and often serve as test cases for future products of the same nature. Regularly used for market testing, model units determine whether or not full-scale production of such items are profitable for a business, which can be of health and economic advantage to a country like India. The Curaçao study also provides an evidence-based framework for future development strategies to India 's critical healthcare problems, offering recommendations for its successful implementation and evaluation. The Indian study on its part, corroborates and justifies the need for leadership development programmes, while highlighting essential leadership competencies relevant in non-Western contexts.

CONCLUSION

There is general consensus that the world would fail to meet the health-related targets without immediate changes in health system efficiency. Considering that health systems are extremely context-specific, there is no single set of best practices that can be viewed as a blueprint for improved performance.[37] Non-Western health systems need to adopt innovative strategies, good governance systems, distributed leadership, a culture of learning and development, decentralisation of services and a philosophy of partnership and relationship building. The Indian case study in this paper shows that a significant leadership competency gap exists within Indian healthcare system especially in the public sector as well as highlights the need to conduct LDPs for doctors at all levels. The study from Curaçao demonstrates that it is worthwhile to invest in improving the quality of healthcare and that interprofessional collaboration is an effective vehicle to achieve this goal, especially in resource-limited environments. These two cases highlight the potential challenges and impact of leadership capacity building in non-Western contexts. In our opinion ensuring that models are contextualised within a country's economic and sociopolitical context would be a better fit when we aim for leadership development in these environments. We also believe that it is important to determine whether singular or multiple models of leadership can represent all components of unique healthcare systems in low-income and middle-income countries considering their sizes, local challenges, pre-existent infrastructures, availability of resources and governance structures.

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