Leadership for the Sustainability of the Health System

Part 1 - A Literature Review, January 2012
Foreword

I am pleased to present this three-part report on Leadership for the Sustainability of the Health System. It addresses the challenges involved in improving and sustaining an effective health system to meet the needs of the Australian community and makes recommendations for future activity.

Health Workforce Australia (HWA) is an initiative of the Council of Australian Governments and has been created as a cross-jurisdictional body operating in the government and non-government health sectors, as well as the higher education sector, to address Australia’s critical health workforce planning, training and reform challenges.

In August 2011 the Ministers approved the National Health Workforce Innovation and Reform Strategic Framework for Action 2011–2015 (HWA 2011). This policy framework will guide the innovations and reforms necessary to deliver a sustainable health workforce into the future. Leadership for the Sustainability of the Health System is a key domain for action.

At the national level there are major reforms foreshadowed or underway, and strong leadership capacity will be required to guide the workforce changes required to support national reforms. Effective leadership will build and support capacity for innovation and change.

In order to ensure evidence-based approaches to its work in the leadership domain, HWA commissioned a study to guide consideration of the priority steps. The report provides a thoughtful analysis of some of the challenges faced by health leaders nationally and internationally.

Recommendations include:

- improving the content, delivery and evaluation of current leadership development offerings
- emphasising leadership at all organisational levels and in every area of health care
- supporting the integration of both clinical and corporate leadership development
- transforming organisational cultures to foster innovation, creativity and change
- thinking in system terms and engaging with others across sectors and jurisdictions
- engaging with consumers, patients and communities as a critical part of system improvement.

The report also highlights the need to increase the number of leadership development opportunities available to Aboriginal and Torres Strait Islander people in the health workforce. HWA is collaborating with Aboriginal and Torres Strait Islander organisations and key leaders to determine an appropriate course of action. This is in line with a commitment in the National Health Workforce Innovation and Reform Strategic Framework for Action 2011–2015 to ‘Accelerate progress in achieving the goals of Closing the Gap by building and supporting the leadership capacity of the Aboriginal and Torres Strait Islander health workforce’ (HWA 2011).
The report makes a worthwhile contribution to the leadership discussion with particular resonance for those interested in health. I commend it to leaders and to those working in the areas of health workforce development and leadership education.

Mark Cormack
Chief Executive Officer, HWA
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Executive summary

One of the five domains of the National Health Workforce Innovation and Reform Strategic Framework for Action 2011–2015 (HWA 2011) concerns leadership for the sustainability of the health care system. Work to ensure that health care systems can be sustained is an urgent priority for governments globally. Leadership capacity is essential to success in introducing the innovation and change that will sustain the health care system. Health Workforce Australia (HWA) commissioned a report to inform thinking about the next steps needed to develop that capacity.

The report comprised:

- an environmental scan of national and international activity in leadership as it applies to implementing innovation and change
- a literature review of the theories, research and evidence on leadership, leadership development, and other organisational and system enablers that affect the return on investment of leadership development
- a summary of the findings of informant interviews on the current status and future direction of leadership development
- an analysis of the material captured in the environmental scan, informed by the conclusions and recommendations of the literature review and interviews
- a synthesis of the key findings and recommendations from the literature review, interviews and environmental scan to provide advice and recommendations for HWA on how to best build on and support existing efforts in leadership development in Australia.

This paper presents the findings and recommendations of a review of the literature on effective leadership and its development in health systems.

Major challenges facing health leaders

The central challenges facing health leaders, identified in the literature review were how best to:

- provide leadership for services and providers that focuses on consumer and community need, and encourages staff to engage deeply with consumers, and view them as a rich source of information to drive innovation, improvement and change
- take account of the complex and adaptive nature of the health system when making changes, where changes in one part may lead to intended and unintended consequences in other parts, and adaptation to changing structures and policies may be functional or dysfunctional
- address the divisions among professional groups, and build capacity for flexible deployment of the workforce and for multidisciplinary team care
- increase the speed at which improvements and innovations are generated and spread through the health system
- build organisational cultures that enhance capacity and tolerance for innovation and change
- lead health professionals whose values and codes cause them to focus more strongly on the autonomy of their professions and patient or population outcomes than on organisational or corporate outcomes
- deal with high levels of cynicism and scepticism about the motivations of leaders based on experience of multiple reforms and restructures and the perceived failure of these efforts to positively impact on clinical, preventive and organisational outcomes
- provide incentives to health professionals to promote innovation that leads to improved community and patient outcomes.

Recommendations

Suggested improvements to leadership programs

To ensure health system leaders are capable of addressing these challenges, the literature suggests several improvements to the content, delivery and evaluation of current leadership development offerings.

Content

If the return on investment in leadership development is to be maximised, the program content should:

- incorporate the findings of recent re-evaluations of the transformational leadership style that shift the focus from a ‘heroic’ style (centred around an extraordinary person with charisma leading from the front) to an engaging and distributed style of leadership that emphasises:
  - shared and collaborative responsibility for outcomes
  - enabling the followers
  - acting with integrity
  - being accessible
  - displaying humility
  - demonstrating a deep concern for others and for outcomes for consumers and communities
• emphasise the importance of bridging the divide between physicians, nurses, allied health staff and hospital administration

• provide techniques to achieve this aim, such as:
  - how to clearly communicate cross-disciplinary organisational goals, values and successes
  - how to model relationships and appropriate behaviour with other professional groups
  - how to foster and facilitate consensus building

• support both clinical and corporate leadership

• train health leaders on how to engender organisational loyalty in health professionals

• provide education on how to transform an organisation’s culture to foster innovation, creativity and change, including:
  - training in innovation and improvement methods, such as building ‘innovation factories’ (small-scale functional units with strong processes and support/reward mechanisms that enable and encourage employees to develop and trial new ideas in the workplace)
  - using flat structures with flexible, empowered, autonomous and cooperative teams
  - creating support mechanisms that reward creative and innovative behaviour
  - encouraging management teams to feel comfortable with acceptable risk and to evaluate ideas fairly
  - developing open communication styles that build trust

• develop health leaders’ ability to think in systems terms and effect change in complex adaptive systems, by training them in the skills needed to:
  - address interconnected issues
  - build coalitions among disparate stakeholders
  - form intra- and inter-organisational partnerships and networks
  - monitor and measure outcomes at the system, organisational, personnel, consumer, and community levels

• build understanding that consumer feedback and information is an essential source of the intelligence necessary to inform the kinds of innovation, improvement and redesign of health systems that will reflect the patient experience, and support population health outcomes

• introduce leaders to effective techniques for consumer engagement and feedback, such as:
  - experience-based co-design—captures the subjective experiences of both patients and staff at crucial points in the care pathway and uses it to redesign all or part of a process to bring about sustained improvements in those experiences
- co-leadership— Involves users in activities such as sitting on management boards and interview panels
- mutual learning— Incorporates user experiences into student and staff training
- primary health care councils/citizens’ juries— Education and information exchange processes that allow evidence-informed consultation with community members about principles and priorities of health service delivery
- develop understanding and effective use of current financial incentives (pay-for-performance and social impact bonds) and non-financial incentives (benchmarking, education, job satisfaction, sense of meaning and success/pride). Use these to encourage the uptake and dissemination of innovation while being aware that financial incentives may have negative as well as positive impacts, and paradoxically can cause professional workforces to believe their intellectual satisfaction in their work or their autonomy to act in the public interest is diminished.

Delivery
The delivery of leadership development programs could be improved in these ways:

- use approaches that address practical ‘real-world’ leadership problems facing the individual or team, rather than teaching abstract leadership theory and leaving the learners to apply it when they return to the workplace on their own
- follow the evidence from the training and development literature that suggests that short three- to four-day workshops delivered away from the workplace without ongoing learning and support are less effective than programs delivered in situ and spread over longer periods of time
- incorporate ongoing mentoring, coaching, learning modules, service improvement projects and personalised development plans.

Evaluation
With the exception of a handful of isolated studies, there is very little currently available evidence on the impact of leadership development on organisational outcomes, especially in the health sector. Further systematic longitudinal evaluations in the health context are needed to demonstrate the effects of leadership development on organisational outcomes, and to support the sustainability of investment in leadership development.
Introduction

Background

One of the five domains of the recently completed National Health Workforce Innovation and Reform Strategic Framework for Action 2011–2015 (HWA 2011 ['the Framework']) concerns leadership for the sustainability of the health care system. Work to ensure the sustainability of the health care system is an urgent priority for governments globally. The Framework and its Background Paper identify the need for innovation and change to meet increasing challenges to sustaining the way health services are currently staffed and delivered.

Health Workforce Australia (HWA) commissioned this work to inform thinking about next steps in developing the type of leadership capacity that is essential to success in introducing the innovation and change that will sustain the health care system.

The terms of reference were to:

- conduct an environmental scan of publicly available documents, initiatives, meetings, conferences, and prominent researchers and writers to identify national and international activity in leadership as it applies to the implementation of innovation and change

- conduct a comprehensive review of the leadership literature that extends beyond the health sciences databases to incorporate organisational psychology, change management and business literature database searches

- interview key informants to seek their views and advice on the current status and future direction of leadership development in Australia and internationally and whether what has emerged in the environmental scan and literature review reflects the situation in the Australian health sector

- prepare draft advice and recommendations for HWA about the format, timing and participants of a Leadership for Sustainable Change Roundtable.

This paper addresses the second term of reference and provides background research and evidence around what works in leadership development to inform decisions about how to progress capacity building in leadership in the Australian health system. The review also canvasses other organisational and system enablers that affect the return on investment in leadership development. A final report that ties together all the above terms of reference and provides recommendations and suggests possible directions to build on and support existing efforts in leadership development in Australia has also been developed.
The case for change and the place of leadership

In December 2005 the Productivity Commission identified the demand and supply issues in health that Australia must confront in the next decade. These issues included:

- a changed mixture of disease burdens, including increasing numbers of people who will be suffering type 2 diabetes and dementia
- increased individual spending on health care, and increased expectations of timely access to high-quality health services
- the need for different models of care and new workforce practices to accommodate and utilise the wider range of treatment possibilities arising from new technologies
- an ageing and longer-living population that will significantly increase health expenditure and the incidence of chronic disease
- the increasing average age of health workers and the need to replace greater numbers of retiring workers, in a context where health workforce supply already fails to keep up with demand.

In all OECD (Organisation for Economic Co-operation and Development) countries, total spending on health care is rising faster than economic growth, and it has been predicted that the cost of health care could reach 20% of gross domestic product by 2020 owing to the increasing affluence and longevity of populations in developed countries (Fogel 2004). Australia’s changing age profile will significantly increase health spending. Spending on the over 65s may be as much as four times more per person than on those under 65 (Productivity Commission 2005).

In light of the global nature of health and health workforce challenges, and the results of research and evidence both at home and overseas, the momentum towards health service redesign must increase, and the workforce reform and innovation necessary to support it must also increase. The pace, level and nature of the needed change and innovation demand significantly increased leadership at all levels of the system.

The current focus is on:

- increasing numbers in the workforce—increasing numbers of clinical training places, encouraging re-entry and supporting retention
- redesigning to support increased productivity—organisational and service redesign to increase engagement in direct patient care by health professionals
- role redesign—efforts to ensure all professions work to their full scope of practice and maximise return on investment in specialist training, including through creation of assistant roles
quality and safety efforts to reduce adverse outcomes and avoidable admissions and attendances at health services.

While these are important aims, the evidence strongly suggests that they will be inadequate to address threats to the sustainability of the health system, the appropriateness of models of service delivery, and the structure and availability of the health workforce. The extent and nature of population needs are changing rapidly and require a different order of change at national, regional and global levels.

What is considered possible is constrained by thinking that continues to focus on working forward from the existing professions and their interests, skill demarcations and responsibilities. What is required is leadership capable of promoting a paradigm shift in ways of thinking about health system and workforce design and planning—ways that work backwards from outcomes for consumers and communities and population need.

Leadership development to achieve this paradigm shift demands new ways of thinking. The system needs increased capacity in its leaders to design health systems that follow the patient journey, engage patients and communities in the change process, and promote and support wellness as well as treat disease.

About Health Workforce Australia

HWA is an initiative of the Council of Australian Governments and has been established to address the challenges of proving a skilled, flexible and innovative health workforce that meets the needs of the Australian community, now and into the future.

HWA was established following the development of a $1.6 billion National Partnership Agreement on Hospital and Health Workforce Reform by the Commonwealth and State and Territory Governments in November 2008.

HWA reports to Health Ministers and operates across health and education sectors to devise solutions that integrate workforce planning, policy and reform with the necessary and complementary reforms to education and training.

HWA’s functions include:

- the provision of comprehensive, authoritative national workforce planning, policy and research advice to ministers, governments and key decision makers in the health and education sectors

- improving and expanding access to quality clinical education placements for health professionals in training across the public, private and non-government sectors; this will be achieved through programs that expand capacity, improve quality and other diversity in
learning opportunities; this also includes a national network of simulated learning environments to enhance the quality, safety and efficiency of clinical training

- developing and implementing a national program of health workforce innovation and reform; this will encourage the development of new models of health care delivery, facilitate interprofessional practice and equip health professionals for current and emerging demands on the health care sector

- facilitating a nationally consistent approach to international recruitment of health professionals to Australia.

Method

A series of searches combined the traditional bibliographic database, catalogue and internet searching with a more focused strategy by following citation trails within individual highly cited papers relevant to the topic area (using the Scopus database). Search terms used included ‘leadership’, ‘innovation’, ‘risk’, ‘organizational change’ and specific topics relevant to health reform. The focus of the search was on literature written in English over the past 10 years, originating within and outside the health industry.

While peer-reviewed literature comprises a significant portion of the health sciences knowledge base, important information, policy documents and research papers are published in places other than peer-reviewed journals. To ensure adequate coverage of peer-reviewed literature, we have gone beyond the premier resource of MEDLINE to include a key bibliographic database, PsycINFO. PsycINFO is a particularly useful tool in searching for material that may be considered ‘grey’ literature: it indexes publication forms other than peer-reviewed journal articles, editorials and letters, including technical reports, conference papers and proceedings, dissertations, books, book chapters, systematic reviews, technology assessment reports, practice guidelines and the like [a full list of document type is available for PsycINFO at: <www.apa.org/pubs/databases/psycinfo/index.aspx>].

In addition to conventional databases, new web tools such as Google Scholar and Scopus were used to enhance access to scholarly literature published in sources outside the indexing scope of the bibliographic databases discussed above.
The literature review

Building leadership that supports innovation and change in the health system

The health care industry constantly faces the challenge of how to do more with less. It must manage the quality and safety issues facing an overextended workforce, and at the same time seek ways to improve productivity and efficiency for the sake of improved patient access to timely and appropriate treatment. The quality of leadership in the health system directly and indirectly affects the quality of patient care, and is shown to be an important factor supporting best practice.

Leadership exists at various levels of health care (governance, management and clinical care). A large body of research indicates that the quality of leadership affects people, their satisfaction, trust in management, commitment, individual and team effectiveness, the culture and climate of organisations, and ultimately individual and collective performance (Bell et al. 2004; Burke et al. 2006; DeGroot, Kiker & Cross 2000; Dirks & Ferrin 2002; Gerstner & Day 1997; Kouzes & Posner 2007). Other factors such as economic stability, political agendas, organisational and industry history, and individual differences may also influence these outcomes, but leadership plays a central role in mobilising people towards a common goal (Avolio, Walumba & Weber 2009; Kouzes & Posner 2007).

The importance of leadership in health systems was demonstrated by the findings of a study of 1300 hospitals across the United States and Europe, which found that well-managed hospitals with clinically qualified leaders produced a higher standard of patient care (Dorgan et al. 2010). Further evidence for the importance of leadership comes from health workforce surveys in the United Kingdom, which have shown that the higher the leadership quality of senior managers (as rated by staff), the higher the organisation rates in performance and the lower the number of patient complaints (CQC 2011).

A recent study by Roebuck (2011) suggests that leaders who can encourage disengaged staff to become engaged can lift individual performance by up to 57%. Roebuck also found that leaders capable of clearly illustrating the alignment between individual and corporate objectives can improve employee effort by up to 28%, and providing unbiased, accurate and fair feedback to employees can improve effort by up to 39%. Several other recent studies verify this strong linkage between leadership and positive outcomes in health care organisations (see Admasachew & Dawson in press; Topakas, Admasachew & Dawson in press).

Effective clinical leadership and its development are clearly vital in the current Australian context of health care reform and change. The National Health and Hospitals Reform Commission has
acknowledged and emphasised the importance of fostering clinical leadership at a national level. The Commission stated:

At a national level, we have called for a systemic approach to encouraging, supporting and harnessing clinical leadership across all health settings and across different professional disciplines. This includes promoting a continuous improvement culture by providing opportunities for clinicians to participate in teaching, research and quality improvement processes across all health service settings (NHHRC 2009).

The following sections of this review:

- cover the history of research and theory development about leadership
- describe the most evidence-based approach to understanding leadership
- present recent research on leadership in health systems
- discuss clinical leadership, management and corporate leadership
- identify what works in leadership development
- outline the gaps in knowledge about what works, owing to a lack of outcome-focused evaluation.

**A brief overview of leadership research and theories**

Understanding the nature of leadership has been the subject of a significant body of work in the behavioural sciences. More than 90 variables have been identified as elements of leadership (Winston & Patterson 2006). Identifying which of these common attributes and behaviours contribute to positive leadership practice has formed the basis of much leadership theory and research.

In recent decades, many attempts have been made to observe and then explain what makes an effective leader. The various theories have emphasised personality, behaviour, context or relationships. The most influential theories have been:

- leadership trait theories
- leadership behaviour theories
- contingency or situational theories
- contemporary theories.
Leadership trait theories

At first, leadership researchers were interested in individual characteristics or traits that differentiated leaders and followers, and most of their research focused on identifying these ‘leadership traits’.

In line with this approach, the early theories of leadership stressed a trait approach—leaders are simply made of the ‘right stuff’. These theories assumed that leaders are born and not made.

A wide range of individual characteristics was investigated, such as gender, height, physical energy, intelligence, personality, need for achievement and the need for power. This initial search for the universal leadership traits proved futile and caused researchers to turn their attention to the behaviour of leaders (Stodgill 1948).

The trait paradigm, however, later re-emerged with the introduction of a number of new trait-related leadership theories that have stood up to empirical investigations. For example, McClelland’s (1961) ‘achievement motivation theory’ focused on how a concern to achieve excellence in accomplishments through one’s individual efforts contributed to leadership effectiveness. More recently, McClelland (1975) proposed a ‘leader motive profile’, which suggested that effective leaders have a greater innate desire to influence and direct others, rather than a desire to interact socially and be accepted by others, and they have a high concern for the moral exercise of power.

The predominant contemporary model of leadership—‘transformational leadership’—is also a trait-related theory that focuses on charisma, inspiration, intellectual stimulation and individual consideration (Burns 1978; Bass 1985). It is outlined in more detail below.

Leadership behaviour theories

Disheartened by the initial failure of the trait paradigm, other researchers turned their attention to studying the behaviour of leaders—what a leadership role involved and the relationship between different leadership behaviours and effectiveness. These theories assume leaders can be made rather than born.

An early research program, the Ohio State University leadership research program, developed the Leader Behaviour Description Questionnaire (LBDQ) (Hemphill & Coons 1957). The LBDQ revealed that a significant proportion of the differences in behaviours between leaders could be explained by two clusters—personal relationship skills (‘consideration’) and task accomplishment skills (‘initiation of structure’). Identifying these clusters of behaviours proved to be an important advance in understanding leadership and its effects.

More recently, Blake and Mouton (1985), building on the LBDQ, developed what is known as the ‘managerial grid’. The grid combined the two dimensions of leadership identified by the LBDQ to describe four leadership styles: authoritarian (high task, low relationship skills); team leader (high
task, high relationship skills); country club (low task, high relationship skills); and impoverished leadership (low task, low relationship skills).

Research based on these four leadership dimensions failed to identify one ideal set of leadership styles that would lead to effective outcomes in any given situation. It also gave minimal consideration to context or situation that could influence leader behaviours.

It may be that different styles are more or less effective in different contexts, or that a complementary set of skills is essential to ensure that goal clarity and task focus do not override relationship skills essential to staff engagement and building trust and commitment in the workforce.

**Contingency or situational theories**

Other researchers had begun to investigate ‘contingency’ or ‘situational’ leadership theories. These theories suggest that the situation determines the personal traits and behaviours required in a leader.

One of the first such theories was Fielder’s (1967) contingency theory, which proposed that the effectiveness of a high task- or relationship-oriented leader depended on the extent of the leader’s situational control—their level of positional power, task structure and the nature of their relationships with followers.

Hersey and Blanchard’s (1982) situational leadership theory described four typical leadership styles, each of which involved different levels and combinations of task and relationship behaviours: encouraging, coaching, delegating and structuring. They also suggested that varying situational factors, particularly follower competence and motivation, determined which of these leadership styles was most likely to succeed.

Another well-known contingency theory is ‘path-goal theory’ (House 1971; House & Mitchell 1974). Path-goal theory identified four leadership styles that affect follower motivation differently: directive; supportive; participative; and achievement-oriented styles. Each of these leadership styles was thought to be optimal in different contexts. The situational factors this theory considered were the nature of the task, and the motivation and capability of followers.

Finally, ‘cognitive resource theory’ (Fielder & Garcia 1987) argued that situationally induced stress affected the leadership traits most likely to be effective. Under low stress, a leader’s intelligence was positively correlated and experience was negatively correlated with performance. In contrast, under high stress, a leader’s intelligence was negatively correlated with performance and experience was positively correlated.
Contemporary theories

Contemporary leadership theories offer a more sophisticated view of leadership that considers not just the leader, but those they lead, and the context, as integral factors.

‘Leader-member exchange’ theory describes how relationships between leaders and followers may affect leader behaviour (Graen & Cashman 1975). It suggests that rather than using the same style in dealing with all employees, leaders develop a different type of exchange with each employee.

The key premise of leader-member exchange theory is that the quality of these relationships that develop between leaders and employees predicts outcomes at individual, group and organisational levels.

‘Transformational leadership’ theories primarily address the actions of leaders that cause employees to want to change their values, goals, needs and aspirations, so that they become aligned with those of the organisation (Burns 1978; Bass 1985). The leadership behaviours needed to inspire followers in this way depend on the characteristics of the leader, the followers and the situation. Transformational leadership generally comprises four major components: individualised consideration, intellectual stimulation, inspirational motivation and idealised influence (Judge & Piccolo 2004). It is the predominant model for leadership in many modern organisations.

‘Implicit leadership’ theory focuses on how followers’ beliefs are associated with leadership. It proposes that people have preconceived notions about the behaviours, traits and characteristics of typical leaders (Lord 1985). Further, it suggests that individuals need to exhibit leadership behaviours that embody these traits to be perceived as an effective leader. In other words, implicit leader theory suggests that perceptions of leadership depend on how far an individual leader matches followers’ implicit expectations.

In contrast to implicit leader theory, ‘social identity’ theory focuses on group norms. Social identity theory suggests that leadership perceptions are increasingly influenced by prototypes held by significant groups. It proposes that in order to be perceived as an effective leader in these groups, individuals need to embody the ideal norms of the group (Hogg 2001).

Emerging trends

A number of trends have emerged as the leadership literature has developed. It seems there is no one best way of leading. A leadership style that is effective in some situations may not be successful in others.

Accordingly, a number of leadership researchers have introduced the concept of ‘behavioural flexibility’ (e.g. Kenny & Zaccaro 1983; Zaccaro et al. 1991). It proposes that effective leaders are competent across a large repertoire of behaviours: they are able to select the most appropriate leadership style for a specific situation, and to select alternative styles as the situation changes.
Recent research has supported this notion by asserting that flexibility in leaders’ behaviour is a necessity for effective leadership (Silverthorne & Wang 2001). Studies that have examined the role of social or emotional intelligence in leader effectiveness also support this view (e.g. Ferentinos 1996).

An article on ‘What great managers do’ in the Harvard Business Review also noted the importance of behavioural flexibility in a list of leadership fundamentals, and said that effective leaders tailored praise to employee preferences and adapted coaching to employee learning styles (Buckingham 2005).

**Leadership versus management**

While it is helpful to understand the genesis of contemporary leadership theory in order to appreciate current approaches to leadership development, it is also important to recognise the difference between leadership and management.

There is a body of research that suggests that the terms ‘leadership’ and ‘management’ and their meanings are often used interchangeably (Kotterman 2006; Kotter 1999; Bass 1990). Kotter (1990) proposes that the purpose of leadership is to bring about movement and constructive change, while the role of management is to provide stability, consistency, order and efficiency. While the two processes both have essential roles in the functioning of an organisation, they serve two distinct purposes. Generally speaking, management can be seen as necessary to keep an organisation ‘running’; that is, to keep things on schedule and within budget, and to make sure predetermined targets are met. Leadership is needed to provide a vision for the future, drive organisational change, align employee efforts with organisational goals, and motivate and inspire employees to achieve results beyond expectations.

To explain the management–leadership distinction further, Levy and Carroll (2008) assert that the choice to use either a management or leadership approach may hinge on the nature of the problem at hand, or on the comfort level of the individual in adopting a particular approach. They suggest that problems may fall into the category of technical work (known problems solved through proven solutions) requiring a management approach, or adaptive work (unknown or uncertain problems requiring a new process to create solutions), which requires leadership. Both the choice and capacity of executives to deal with uncertainty, and foster learning, can determine whether a management or leadership response is applied.

The qualities, skills and attributes required to be a good manager differ from those needed to be a good leader. Zaleznik (2004) differentiates managers and leaders on concepts such as personality, goal attitudes and work conceptions, describing managers as ‘process engaging, stability maintaining problem solvers’, whereas leaders are said to be able to tolerate a lack of structure and are willing to delay problem solving to understand issues more fully. Levy and Carroll (2008) say that leadership occurs when leaders and followers raise one another to higher levels of motivation, drive, creativity and achievement.
Research examining the attributes of individuals in positions of leadership (e.g. management) across various Australian industries highlights the need to recognise this distinction between management and leadership. The report of the Industry Task Force on Leadership and Management Skills commissioned by the Australian Government (Karpin 1995) said that many individuals in leadership roles were adept in hard skills (management), yet weak in people-oriented skills, the so called ‘softer’ interpersonal skills necessary for driving effective leadership (communication, motivation, delegation, negotiation).

Support for a transformational approach to leadership

Of the theories outlined above, transformational leadership, a person-oriented style of leadership, has the most robust empirical support as the style of leadership that produces optimal organisational results and committed followership (Bass 1985, 1998; Bass & Avolio 1994; Judge & Piccolo 2004; Kouzes & Posner 2007). Transformational leadership is associated with higher levels of self-reported organisational commitment, work effort, satisfaction with the leader and job satisfaction, and reduced burnout and intention to leave the job (Taunton et al. 1997; Vandenberghhe, Stordeur & D’hoore 2002; Stordeur, D’Hoore & Vandenberghhe 2001; Borrill, West & Dawson 2003).

Transformational leadership has been described as one of the most suitable styles for addressing modern complexities and leadership challenges (Kouzes & Posner 2007). It includes leading and managing people, working with finite resources, and supporting the physical, emotional and psychological wellbeing of staff. The fitness of this style for the nature of work in health care has led the Institute of Medicine (2003), the Royal College of Nursing UK, the Clinical Leadership Programme UK (Large et al. 2005) and the King’s Fund (2011) to support transformational leadership as a strategy for achieving best practice and shaping the design of leadership development programs for the resource-constrained environment where health care is delivered.

The original theory of transformational leadership had four elements: charisma, inspiration, intellectual stimulation and individual consideration (Bass 1985, 1990). ‘Charisma’ excites and motivates the listener through sharing a vision and sense of mission, instilling pride, and gaining respect and trust. It is a product of personality and interpersonal skill. The ‘inspiration’ factor involves communicating high expectations, using symbols and images to focus efforts, and expressing important purposes in simple ways. ‘Intellectual stimulation’ requires the leader to promote intelligence, rationality and careful problem solving. Finally, ‘individual consideration’ involves giving personal attention to each follower, treating each employee individually, and coaching and advising each follower.

More recent United Kingdom research on transformational leadership argued that the previous model was developed several years ago, and ‘what is leadership’ in the 21st century should be re-evaluated.
An updated set of characteristics specifically relevant to leaders in the health care setting should be developed. Alimo-Metcalfe & Alban-Metcalfe (2005, 2006) suggested these six factors:

- valuing individuals
- networking and achieving
- enabling
- acting with integrity
- being accessible
- being decisive.

‘Valuing individuals’ was defined as showing genuine concern for others’ wellbeing and development, and corresponded to the ‘individualised consideration’ aspect of Bass and Avolio’s model. However, the authors believed it was a richer construct, and involved valuing both the developing team and the individual. It was identified as the most important factor, rather than ‘charisma’ as in the United States model.

‘Networking and achieving’ meant being an inspirational communicator, similar to the ‘charisma’ factor in the older transformational model, but with added ‘sensitivity to the agenda of different key players’—that is, people feel they are taken into account in the organisation’s vision. It placed strong emphasis on working together with stakeholders, understanding their agenda, and uniting all parties to create and work towards a shared vision.

‘Enabling’ meant the extent to which responsibility was delegated to lower level staff, and the degree to which they were given greater autonomy as a result of the leader’s genuinely trusting staff. ‘Enabling’ empowered members to feel they were playing their part in realising the leader’s long-term organisational vision, and matched the ‘individualised consideration’ factor in Bass and Avolio’s model.

‘Acting with integrity’ was described as not only having integrity, but also being consistent, honest and open. It corresponded to the ‘inspirational-charismatic’ factor in the United States model, but it was given more weight in this new model, which also put greater emphasis on humility and ‘vulnerability’ in the leader.

‘Being accessible’ involved being approachable and in touch, and adopting a non-threatening and non-formal interpersonal style, in addition to being aware of the impact on followers. The ‘individualised consideration’ and ‘intellectual stimulation’ factors of the United States model had some of these elements, but did not directly address accessibility.

Finally, ‘being decisive’ not only required making tough decisions, but also taking risks, achieving goals and having self-confidence. This factor had some similarity to Bass and Avolio’s ‘charisma’, but was presented more subtly.

Gender and culture were taken into account in developing the Metcalfe model, which focused on the effect of direct or ‘nearby’ leaders and managers (a direct superior or line manager), rather
than ‘distant’ leaders described in earlier United States models (the Bass and Avolio model studied senior managers and chief executive officers) (Alimo-Metcalfe & Alban-Metcalfe 2005, 2006).

The most prominent difference between the models is the relative importance of ‘genuine concern for others’ well-being and development’ in the later model, in contrast to ‘charisma’ in the earlier model. The United Kingdom researchers said the focus needed to shift away from ‘charismatic’ or ‘heroic’ leadership, and that ‘charisma’ as a dimension of leadership could lead to narcissistic and self-serving leaders who took credit for others’ work and punished criticism. This could create a toxic environment, which would inhibit the creativity and collaboration necessary for innovative thinking and sustained change. Instead, the focus was drawn away from ‘heroic’ leadership and emphasis was placed on increasing followers’ self-efficacy, creating a shared vision and meaning, and fostering a sense of proximity and openness (Alimo-Metcalfe & Alban-Metcalfe 2005).

This research lead to the development of a 360-degree feedback tool, the Transformational Leadership Questionnaire, which clustered factors into three independent scales: leading and developing others, personal qualities, and leading the organisation.

Leadership is not a solo, heroic role—today’s leaders need well-honed skills in collaboration and diversity. Sustainable health leadership stems from ordinary people who have the courage and resilience to tap deep into themselves and harness the support of others in extraordinary ways (Bond et al. 2010).

A more recent iteration of this model by Alimo-Metcalfe and Alban-Metcalfe (2008) continued to highlight the importance of ‘nearby’ leadership, and introduced the concept of an ‘engaging’ style of leadership. The behavioural description of this style was expanded to include a fourth cluster, and the questionnaire was renamed the ‘(Engaging) Transformational Leadership Questionnaire’. The clusters included:

- ‘engaging individuals’—showing genuine concern, being accessible, enabling and encouraging questioning
- ‘engaging the organisation’—supporting a developing culture, inspiring others, focusing team effort and being decisive
- ‘moving forward together’—networking, building a shared vision, resolving complex issues and facilitating change sensitivity
- ‘personal qualities and core values’—acting with integrity, and being honest and consistent.

This updated model of leadership continues to differ from the American models. As opposed to being an ‘extraordinary person’, leaders who adopt this style are ordinary, vulnerable, humble, open and transparent. Themes of teamwork, collaboration, ‘connectedness’, removal of barriers to communication and ideas, questioning and challenges to the status quo are noted.
In this way, a culture that supports development and change is created, and the leader is a role model for learning (Alimo-Metcalfe & Alban-Metcalfe 2008).

In a recent article, Alimo-Metcalfe and Alban-Metcalfe (2010) stipulate that public health, in particular, would benefit from this style of leadership and lead to higher morale, wellbeing and productivity. To this end, medical school and teaching hospital leaders should focus on building learning cultures that value the individual learner, encourage transparency, increase collaborative behaviour and model professionalism (National Patient Safety Foundation 2010).

The King’s Fund recently released its final report on leadership and management needs within the United Kingdom National Health Service. The recommendations in the report echo those of the Metcalfe. The report cited evidence from both the public and private sectors that the ‘superhero’ approach to leadership (associated with the United States models of transformational leadership) was becoming increasingly ineffective as complexities increased and the state of the global economy worsened. Increasingly, health leaders must influence, cooperate and contract with a range of bodies outside their organisations—responsibilities that require an entirely different skill set from the traditional ‘cavalry charge’ for a single organisation (King’s Fund 2011).

Shared leadership and collaboration

The movement away from the ‘great leader’ model towards a ‘post-heroic’ model of leadership requires people to engage in leadership who do not necessarily see themselves as personally exceptional, senior or inspirational to others. It needs people who simply believe they can see what needs doing and can work with others, as colleagues, to achieve the necessary outcomes. These individuals are referred to as ‘informal leaders’; individuals without positional power (power conferred on an individual by virtue of occupying a position of authority) who influence others without formal authorisation (Hartley & Bennington 2010). The advantage of informal leadership is that individuals without positional power have much closer contact with the frontline and therefore have crucial information that can be hard for formal leaders to obtain (Heifetz 1994). Informal leaders are also less constrained by roles, rules and expectations, and are therefore better placed to be bold and take risks (Heifetz 1994). According to Turnbull James (2011), the ‘post-heroic’ model of leadership involves:

- multiple actors who take up leadership roles both formally and informally and importantly share leadership by working collaboratively. This takes place across organisational or professional boundaries. Thus shared and collaborative leadership is more than numerically having ‘more leaders’.

Turnbull James (2011) also proposes that leadership should be distributed across an organisation to ‘leaders at many levels’, rather than being centralised at the top. Distributed leadership implies that the role of formal leaders is less about leading from the front than about enabling others to lead (Hartley & Bennington 2010).
It recognises that natural leaders, people who feel committed to the best outcomes for the organisation and its clients, who take initiative and mobilise activity when necessary, exist at all levels and in all occupational streams and are powerful forces for change in an organisation (Turnbull James 2011). By enabling their followers to lead, leaders empower their followers and reduce their followers’ dependence on them (Buchanan 2003).

This distributed and shared approach to leadership described by Turnbull James and by Ferlie and Shortell (2001) is closely aligned with the concept of ‘organisational citizenship’ introduced by Organ (1988). As organisational citizens, employees perform their duties to the highest level, while voluntarily assisting their employer and promoting the organisation’s excellence, without an explicit or implicit promise of reward (Organ 1988). A shared approach to leadership is also recommended by Dovey and White (2005) and Garcia Morales, Lloréns Montes and Verdú Jover (2008), who recommend empowering all individuals to contribute ideas and expand the knowledge of the group and organisation as a whole in what they refer to as ‘collaborative team learning’.

Grundstein-Amado (1999) refers to this shared and distributed approach to leadership as a ‘bilateral’ transformational leadership style, and stresses that it involves group values and goals being agreed upon by all group members, rather than being dictated by the leader. This instills a greater motivation in employees to collaborate in creative thinking and risk taking than simply telling them to ‘go out and innovate’ (Stamm 2009). It also acknowledges that each individual has an area of interest, perhaps even passion, and is best engaged through appeals to his or her own emotional reactions to the goals and values of the organisation and through opportunities to contribute to the areas of interest. When opportunities are provided for shared development of goals and agreed values, all team members become aware of each other’s values and goals, and how they may best work together to achieve an agreed objective.

Several researchers suggest that it is ultimately the formally appointed leader’s role, as the person contractually assuming responsibility for the organisation, to demonstrate a shared approach to leadership and to foster the elements that encourage a culture of collaboration at all levels of the organisation (Stamm 2009; Sarros, Cooper & Santora 2008; Masood et al. 2006).

The transformational leadership literature refers to fostering shared leadership and collaboration as ‘providing individual consideration and intellectual stimulation’ (Bass 1985), or ‘valuing individuals’ and ‘enabling others’ (Alimo-Metcalfe & Alban-Metcalfe 2005). The appointed leaders in an organisation provide others with access to the knowledge, skills and environment where change happens, and where the risks of change are acknowledged and minimised and failure seen as an opportunity to learn. In the health care context, the role of the appointed leader (clinical or otherwise) is to provide opportunities to problem solve as multidisciplinary teams, and trial new ways of working, thus facilitating the shared successes that build trust and self-confidence.

In summary, appointed leaders in the health sector can have a transformational impact when they model engagement and provide opportunities for collaboration.
When they do so, it shows that they believe in the potential of individuals throughout the organisation to take leadership roles for different purposes and in different contexts, engaging their colleagues across professional and occupational streams in the pursuit of goals that support best practice and high-quality patient care.

Leadership in the health care sector

In health care, varied leadership roles are critical for managing and overcoming a wide range of challenges. Ultimately, most leadership roles in health embody a degree of common purpose associated directly or indirectly with attaining the best outcomes for patients (Jasper & Jumaa 2005). One cohort that is receiving increased attention is clinical leaders, owing to their ability to influence best practice at the service level (Edmonstone 2008; Ham 2003; McKenna, Pugno & Frist 2006; Victorian Quality Council 2005).

Health care organisations tend to have an inverted power structure, where staff at the service level mainly shape the practical activities of patient care, not those who are ‘in control’ at the top. Frontline leaders have greater influence over decision making and the immediate quality of patient care (Ward 2005). Clinical leaders are often the champions of quality of care at the service level (Jasper & Jumaa 2005). They are in a position to shape and champion beliefs, behaviours and culture, and ensure that behaviours and attitudes on the frontline align with organisational goals of best practice to enhance the safety and quality of patient care.

Clinical leadership

A recent report identified the lack of clinician involvement in leadership as one of the central weaknesses of the United Kingdom’s National Health Service (King’s Fund 2011). The development of effective clinical leadership is considered vital in the current Australian context of health care reform and change. There is a specific need for frontline clinical leaders, who will be well placed to influence best practice at the service level, as well as indirectly at the organisational level (Edmonstone 2008; Ham 2003; McKenna, Pugno & Frist 2006; Victorian Quality Council 2005). In fact, a growing body of literature suggests that clinical leadership must be in place for effective change to occur in the health care sector (Ham 2003; Reinertsen 1998; Ward 2005).

There is little agreement on a universal definition of clinical leadership. A recent discussion paper by Edmonstone (2008) exploring the National Health Service’s concept of clinical leadership determined that managerial leadership is primarily focused on the overall needs of the organisation (macro-level budgeting, planning, analysing and controlling), while clinical leadership is focused on enabling and championing best practice, progression towards best patient outcomes and meeting service needs (micro-level quality of patient health care). In Australia the Victorian Quality Council (2005) defines clinical leadership as ‘both a set of tasks to lead improvements in the safety and quality of health care, and the attributes required to successfully carry them out’. A report commissioned by the Clinical Leaders Association of New Zealand (2001) for the Ministry of Health described clinical leadership as ‘leadership by clinicians of clinicians’. This simplified definition...
extended to all health professions involved in direct patient care. Taking these definitions together, clinical leadership can be defined as an ongoing process of engagement between a credible health care professional and fellow service providers and support staff, where the locally connected clinician champions the cultivation of high-quality patient care at the service and individual level.

Effective clinical leadership is thought to involve identifying issues, insights and solutions arising from activity at the service level and feeding these upwards to management to support sustainable change (Ham 2003). It also encompasses the identification of mutually negotiated goals and targets, and provides the support and motivation needed to achieve those goals and targets, processes that require clinical leaders to engage effectively with fellow clinicians (Davidson, Elliott & Daly 2006). However, this may present clinical leaders with a unique challenge, as highly educated and autonomous professionals may be unwilling to follow colleagues in a leadership role (Davison et al. 2006). To promote clinician followership and sustain change in service delivery, a leader must therefore not only be connected to the frontline, but also be perceived as credible among their peers (Kouzes & Posner 2007). Clinical leaders are also more likely to gain traction with their fellow clinicians when they adopt the distributed and collaborative ‘engaging’ style of leadership discussed earlier in which collegiate relationships are reinforced through opportunities for shared problem solving, and colleagues take turns leading on issues most important to them and on which they are the experts. While some clinicians may be unwilling to follow their clinical colleagues, they are more likely to be influenced by clinical leaders who have ‘walked a mile in their shoes’ than leaders without a clinical background (Reinertsen 1998). Additionally, due to the inverted power structure found in health care, clinical leaders at the ‘bottom’ often have greater influence over decision making and day-to-day business than the managers and policy makers at the ‘top’ (Ward 2005). For these reasons, clinical leaders are powerful leverage points for change and improvements in the health sector (Ward 2005).

The following factors are considered key to ensuring effective clinical leadership exists in health organisations:

- provide continuous education and development from the first year of training and throughout clinicians’ entire careers in the skills required to be followers, leaders and team players (e.g. leading and developing teams, understanding organisational systems, processes and interdependencies, and redesigning services)
- provide career structures that combine leadership and clinical responsibilities
- place value on medical leadership roles by financially rewarding and publicly recognising individuals who take them on and by developing organisational cultures that value and encourage clinical leadership as a vehicle for improving service delivery and performance
increase the proportion of clinicians involved in leadership roles to shift the perspective that leadership positions are a minority interest to one that views leadership as an expectation of all clinicians (Spurgeon, Clark & Ham 2011; Ham 2003; Reinertsen 1998).

According to Spurgeon, Clark & Ham (2011) there is a need for both bottom-up, clinician-led approaches and top-down manager and policy maker-led approaches. As mentioned previously, change led from top down without the engagement of clinicians risks not being carried through by frontline staff; equally, change led from bottom up will not lead to system-wide improvement and will only result in pockets of improvement. A sustainable strategy of change and innovation must therefore link clinical leadership in health care organisations with system-wide leadership (Spurgeon, Clark & Ham 2011).

Leadership development

Understanding of what constitutes leadership in modern organisations (including health care organisations) has grown during the past several decades, and there is now a significant body of research that tells us which leadership styles produce the best organisational outcomes and in what context. The research also shows that leadership capacity can be developed. This section will outline approaches to leadership development and methods of training thought to be effective in achieving desired learning outcomes.

Leadership development: what works and what doesn’t

Koo and Miner (2010) have argued that health should take the same rigorous, evidence-driven approach to workforce development as it does to science, and they recommend a framework for health workforce education integrating three approaches: adult learning theory, competency-based education and professional skills progression. Merriam (1996) said that, in undergraduate, graduate or continuing professional education, learning was enhanced by understanding both how adults learn and the conditions in which they learn most effectively. Self-directed and transformational learning were major contributions to the growing body of adult learning theory, with implications for training in the health professions.

Leadership is a multifaceted construct, and the skills and attributes required to lead an organisation and its people effectively are varied and complex. It is not reasonable to expect that such skills can be successfully cultivated in an individual in a short time. For example, Malling et al. (2009) failed to find a significant improvement in the leadership skills of a group of Danish doctors one year after they participated in a seven-day leadership development course. The authors concluded that the period of a year between the training course and the follow-up assessment may have been too short to show improvement in leadership skills.

Training designers note that, to enhance transfer of learning, course materials should be delivered via methods that complement the skills to be acquired (Wexley & Latham 2002).
The complex reasoning and verbal skills of leadership are classed as intellectual or higher-order cognitive skills (Voss, Wiley & Carretero 1995; Goldstein & Ford 2002).

In order to maximise the transfer of such skills, spaced learning (the repeated practice of a concept) and error learning (identifying and rectifying mistakes made by peers, oneself or from field-relevant case examples) are both required (Joung, Hesketh & Neal 2007). A short course of two to four days’ duration could not allow enough time to implement these training methods. Spaced practice and error learning training are vital for developing higher order cognitive skills and habits of reflection, mindfulness and self-correction (Levy & Carroll 2008). They also contribute to constructive conflict resolution. Such skills need to be used on a daily basis to facilitate skill practice (Voss, Wiley & Carretero 1995; Hesketh 1997).

It is important to recognise the cognitive limitations that may apply in the early stage of skill acquisition, as well as constraints on the trainees’ attentional capacity (Kanfer & Ackerman 1989). These factors could limit their uptake of complex new ways of thinking and behaving in the early stages of learning, and sequential, developmentally paced learning would better support changed attitudes and behaviours. Taken together, these methodological issues imply that short-course leadership development programs will not facilitate transfer of learning to the workplace.

Successful integration of the principles acquired during training into the workplace also requires that post-training variables such as practice opportunity and learning support must be considered (Salas & Cannon-Bowers 2001; Aguinis & Kraiger 2009). To achieve this goal, leadership development literature specifies that ongoing development in the form of a development plan is required (Riggio 2008). Leadership development plans may include a written agreement between an individual and a mentor figure, as well as a mentoring component. Such agreements usually outline desired goals, the steps required to achieve them, and a specified timeline. Kanfer et al. (1994) demonstrated that goal setting, combined with repeated application of a skill, enhanced performance. In a review of training literature, Hesketh (1997) also proposed that goal setting is an effective way to maintain commitment to acquiring a skill.

Reflection is an important concept in leadership development—observing one’s own behaviour and reflecting on feedback from others of their observation of one’s behaviour (Styhre 2008). Riggio (2008) recommends investment in leadership development programs that include mentoring opportunities to enhance self-awareness and encourage introspection. Kombarakaran et al. (2008) coached executives of a global pharmaceutical company in 12 sessions over six months via telephone or email and helped them understand the impact of their behaviour on others, enhance their confidence and maximise their productivity. Baker (2011) stresses the importance of partnering experienced managers with clinical staff entering leadership roles.

Evaluation of leadership development

This review began by highlighting the positive effects that strong leadership is thought to have on employees, their satisfaction, trust in management, commitment, individual and team...
effectiveness, the culture and climate of organisations, and ultimately individual and collective performance. However, very few rigorous evaluation studies have been conducted to determine whether these outcomes can be achieved through leadership development programs.

The first study to investigate evaluations of leadership programs systematically found that, of the 55 evaluations studied, the majority evaluated only short-term outputs such as the number of participants who attended the program and their satisfaction with the workshops. Very few measured mid- to long-term outcomes and impacts such as improvements in trust, culture, team effectiveness, commitment and satisfaction (Russon & Reinelt 2004).

Leadership occurs over time, and consequently the true impact of leadership development cannot be determined without longitudinal evaluation. This lack of assessment of mid- and long-term outcomes was thought to be the result of insufficient funding, an absence of knowledge on how to best conduct an evaluation, and the low priority placed on long-term evaluation. Most programs relied heavily on subjective and bias-prone self-report data from participants without triangulating it with other data sources. As a result, very few evaluations were capable of determining the true impact of leadership development on organisations, communities or systems (Russon & Reinelt 2004).

Building on the findings of Russon and Reinelt, a study was recently commissioned to evaluate the longitudinal outcomes of leadership development (Black & Earnest 2009). About 80% of the program participants described significant long-term improvements in personal growth, self-confidence, personal power, creative thinking, communication and networking skills, valuing of time, business skill building and modelling behaviours. Unfortunately, the findings of this study were severely limited by its exclusive reliance on self-report data, which is prone to bias.

However, promising results have been noted in two recent studies. Roebuck (2011) found that organisations with strong leadership development systems have a return on earnings and profit that is 7% higher than that of competitors with poor leadership development systems, and an evaluation of the UK NHS Leadership Programme found that increasing the leadership skills of senior management reduced staff turnover, increased job satisfaction and reduced reliance on expensive external consultancies (Vaithianathan 2010). With the exception of these isolated studies, there is very little currently available evidence on the impact of leadership development on organisational outcomes, especially in the health sector. Further systematic longitudinal evaluations in the health context are needed to demonstrate the effects of leadership development on organisational outcomes, and to support the sustainability of investment in leadership development.
Conclusion

The literature suggests that leadership development programs need to be structured in a way that enables trainees to learn an array of complex skills, and have opportunity to apply such skills in situ.

Leadership development programs should offer spaced training, incorporate multiple methods such as error learning and reflection, provide ongoing support in the form of mentoring and coaching, and enable trainees to monitor their progress in relation to a set training plan. They should also incorporate strong evaluations of short-, mid- and long-term individual, community, organisational and system outcomes that extend beyond self-report data collection.

Transformational leadership models remain the most evidence-based models on which to develop training programs. Current leadership development models, competency frameworks and programs should be updated with research (Alimo-Metcalfe & Alban-Metcalfe 2005) that suggests alternative key factors in transformational leadership appropriate for the health care sector.

Research strongly supports the role of transformational leadership characteristics and behaviours in producing improved organisational outcomes in health and other industries. However, on the basis of available evidence, no strong conclusions can be drawn about the impact of investments in leadership development efforts in health care to date.

In a study examining relationships between physicians, health managers and staff, findings indicated that manager empathy was positively related to transformational and inspired behaviour on the part of stakeholders. Democratic leadership styles are preferred by modern health professionals, as are managers with social awareness who practice relationship management.

Developing relational skills and improving emotional intelligence can help physicians relate better to other members of the health care team and create cultures of openness, which have been linked to innovation and creativity in health service delivery.

Leadership arrogance or hierarchical models of power, and control over members of the health care team, is said to be the enemy of cooperation and innovative collaboration in health systems, and a grave cause of danger for quality of patient care when these behaviours replace competence (Snowdon, Shell & Leitch 2010:25).
Key messages

- There are now strong, empirically based models of leadership that are applicable in modern health systems, and there is sound evidence for the best way to deliver leadership development. However, there is a lack of adequate longitudinal outcome-based evaluation of the impact of the investment in leadership development in health care systems.
- Transformational leadership has, until recently, been widely accepted as the most suitable style of leadership for addressing modern complexities and challenges and is broken into four factors: charisma, inspiration, intellectual stimulation and individual consideration.
- A recent re-evaluation of transformational leadership has shifted the focus from a ‘heroic’ style (with an emphasis on an extraordinary person leading from the front with charisma and inspiration) to an ‘engaging’ style of leadership (with an emphasis on shared and collaborative leadership by ordinary, vulnerable, humble and transparent people).
- The engaging style of leadership centres around:
  - valuing individuals
  - networking and achieving
  - enabling
  - acting with integrity
  - being accessible
  - being decisive.
- Short course leadership development programs will not facilitate the transfer of learning to the workplace. Ongoing development is required through:
  - mentoring (partnering experienced managers with clinical staff entering leadership roles)
  - coaching
  - practice in situ
  - self-reflection and reflection on the feedback of others
  - introspection.
- Leadership development programs should have strong in-built evaluations of short-, mid- and long-term individual, community, organisational and system outcomes that extend beyond self-report data collection.
Addressing the challenges leaders face in the health care system

Development of leadership competencies is an important goal, but the effectiveness of leadership also rests on situational factors (Hollenbeck, McCall Jr & Sizer 2006).

Research over several years in the South African health system demonstrated that even investment in high-quality, well-funded and evidence-based transformational leadership development at health district level was unable to address the barriers to innovation and change when central office command and control mechanisms did not change (Dovey 2008). In particular, Dovey (2008: 48) noted that those who have been trained for innovation and change management:

- live dangerously within functional hierarchies where, given the challenge they throw out to the formal leaders of the organization, they are generally viewed with suspicion and fear. Often labelled as ‘troublemakers’, their generosity to risk themselves willingly in the interests of the organization is interpreted as disloyalty to the prevailing political order.

The broader literature suggests several key issues facing transformational leaders that, while not unique to the health system, present particular challenges in the health system. There are 12 challenges most frequently discussed in the international health literature. Five of them, while supported anecdotally, lack adequate empirical support, and have therefore not been included in this review. The seven remaining challenges have implications for the content and process of leadership development, and entail:

- understanding that the health system is a complex adaptive system, and learning to think in systems terms when implementing change
- understanding the diffusion of innovation and learning how to use this knowledge to maximise the rate of diffusion
- understanding how to build organisational cultures that enhance the capacity and tolerance for innovation and change
- understanding how to address the deep culture of the professions and early enculturation and socialisation, which can limit capacity for innovation and change
- understanding how to deal with high levels of cynicism and scepticism about the motivations of leaders based on experience of multiple reforms and restructures, and the perceived failure of these efforts to positively impact on clinical, preventive and organisational outcomes
• understanding how to make use of intelligence from consumers to inform innovation, improvement and the redesign of health systems so they better accommodate the patient experience and journey and population wellness

• understanding how to provide incentives to health professionals to promote innovation that leads to improved community and patient outcomes.

These challenges may help to clarify what can reasonably be expected in the return on investment from best practice leadership development. They also indicate the extent and nature of other workforce development initiatives that may be necessary to enable the innovation and reform needed to sustain the health system.

This section takes these challenges one at a time, discusses the evidence for them, and then suggests their implications for leadership development efforts.
Challenge 1

Understanding the health system is a complex adaptive system, and learning to think in systems terms when implementing change

There is a misconception that change is a controlled, orderly and rational process. The reality is that change is often chaotic, involving discontinuous activities, shifting goals, and unexpected events and outcomes (Dawson 1996). There are no simple solutions to the complex cross-cutting problems facing managers of change in the health system. Managing change in the health system is a ‘wicked problem’—a term originally developed in the social planning literature to refer to the tendency for all aspects of a problem to be considered symptoms of another problem (Rittel & Webber 1973). ‘Wicked problems’ must be addressed in a very different manner from ‘tame’ or ‘technical problems’.

Systems theory is an attempt to conceptualise and address the complexities inherent in change processes in entities such as health systems. It is a trans-disciplinary approach to building theory and models where a system is considered as a collection of differentiated functional units that interact as a dynamic and complex whole (Boulding 1956). Within the ‘health system’ are hospitals, community health, specialised health services (alcohol and drug, mental health, oral health) and population health. Each of these is a system, and within each system there are several smaller systems, comprising the various professional and occupational streams with their own cultures and norms.

Researchers have developed a number of theories about systems. An example is Bronfenbrenner’s (1981, 1992) ecological systems theory, which takes into account the individual, the organisation, the community and culture as interacting levels of a system.

Another theory frequently applied to the health system is the complex adaptive system (Plsek & Greenhalgh 2001; Trochim et al. 2006). Plsek and Greenhalgh defined a complex adaptive system as a collection of individual ‘agents’ with freedom to act in ways that are not always predictable, and whose actions are interconnected so that one ‘agent’s’ actions change the context for other agents. Complex systems typically have fuzzy boundaries, which may include changes of membership, or a single agent being a member of several systems. This is even more complex when each agent’s rules are not necessarily identical to others’, and as a consequence the system is non-linear. Systems can also be embedded within other systems, and co-evolve. A culture of individuals may exist within an organisational system, which in turn rests within a broader health care system. Each of these parts is affected by individual, organisational and community or societal systems, and at the same time helps shape these systems (Patton 2010; Bronfenbrenner 1981).

This complexity has implications for the way in which individual changes are introduced into broader systems, since each system will have an impact on the others (Plsek & Greenhalgh 2001;
Patton 2010). For example, training a mid-level manager to use a certain style of leadership to initiate change and innovation in procedures and methods within a culture is an individual, personnel-level intervention. Culture is disseminated from higher managers, and so this action will meet with limited to no success if that culture is stagnant or oppositional. If an intervention at the personnel level, such as leadership development, is not supported by interventions at organisational, community and health system levels, its impact will be attenuated. LaFond, Brown and MacIntyre (2002) developed a model (Figure 1) to inform and measure interventions for capacity building in health care and understanding the determinants of performance in health systems.

![Figure 1: A systems approach to reviewing and evaluating (LaFond, Brown and MacIntyre 2002)](image)

The ‘health care system’ refers to the entirety of a health care system within a country. This includes public and private, and primary, secondary and tertiary care. All resources, individuals and institutions are included in this level. The overarching system itself performs certain functions independent of all else and can be targeted for intervention. Policies about funding, reimbursement and priority setting are examples of system-wide issues.
The ‘organisation’ level focuses on structures, institutions, process and managerial systems that allow specific organisations to function. Human, physical and knowledge resources are employed, and processes transform these resources into services and products. The personnel level refers to the people who work within the system and who make judgments and employ techniques, diagnostic and treatment processes, administrative practices and leadership. Their capacity to work effectively is dependent on their skill, ability, morale and commitment and can be enhanced or diminished by the culture of the organisation and the supports and constraints of the system.

Importantly, this model draws attention to the fact that the health system sits within the community and is influenced by it. Similarly, the users of the health system, who are themselves influenced by the same societal and community influences, make health-enhancing or health-damaging choices, and place either less or more pressure and demand on the health system. Taking a systems approach to understanding the determinants of health system performance alerts planners and those seeking to improve performance that intervening in any part of the health system will impact on many other areas in anticipated and unanticipated ways that can be both desirable and undesirable.

It is possible to achieve better system-level outcomes (e.g. financially) but have negative consequences on the retention of workers or on access for individuals to needed therapeutics or other services. Taking a systems approach forces planners to go beyond the simple, uni-causal, structural and mechanical cause-and-effect view of problem solving, which is limited and outdated (King’s Fund 2011). It also requires a commitment by health leaders to working across organisational and professional boundaries and silos, which traditionally separated clinicians, administrators, government bodies, users and other stakeholders.

Finally, taking a systems approach encourages leaders to use the concept of ‘attractors’ to create small and non-threatening changes that attract people rather than threaten them (Zimmerman, Lindberg & Plsek 1998). This approach allows the natural energy of the complex adaptive system to be used to bring about change. It represents a significant shift in approach away from the outdated method of implementing large-scale change, which tends to incite active resistance that must be fought off (Zimmerman, Lindberg, & Plsek 1998).

Leadership development needs to build the capacity in leaders to think in systems terms and be mindful of the possible negative impact of implementing interventions in one level of the system without attention to the other parts of the system that may be challenged or adversely affected. For example, change at only the personnel level without equal attention to the impact of deeply ingrained professional cultures and other system-level drivers can diminish the capacity to implement new ways of thinking and doing. Getting leaders ‘all dressed up with nowhere to go’ or, worse, punishing new leaders or those trying to lead in new ways not only wastes investment in leadership development but potentially raises distrust and strengthens barriers against future efforts. To invite excitement and trust in change and then create obstacles to change, or, worse, to punish
those who take up the challenge, strengthens and feeds the cynicism about change already high in many health systems.

Addressing the ‘wicked problems’ involved in implementing change in complex and adaptive systems such as the health system requires more than merely encouraging leaders to think in systems terms. A whole new style of ‘adaptive’ leadership that echoes the recommendations of Alimo-Metcalfe and Alban-Metcalfe (2008), outlined above, is also required. Leaders must be able to address interconnected issues, build coalitions between disparate stakeholders, form intra- and inter-organisational partnerships and networks, and ‘achieve measurable outcomes with and for communities and other stakeholders’ (Bennington and Hartley 2009). They do not carry this burden of responsibility alone. By creating the environment and opportunities for collaborative effort, staff take up the challenge and help to build coalitions and networks for achieving outcomes that inspire others to action.

The focus of leadership development must also shift from developing individual leaders in retreats away from the workplace to developing the entire leadership team in situ in the workplace, applying their newly learned skills, reflecting on the successes and challenges they encounter and accepting feedback from others (Bennington and Hartley 2009). It may be most effective to teach by beginning with a practical problem the leadership team is actually facing and using collaborative problem solving to teach the team leadership theories that will help in the process of resolving the problem (Bennington and Hartley 2009). This view is supported by Turnbull James (2011), who emphasises that leadership development must be deeply embedded in and drawn from the specific organisational context and problems that leaders are collectively facing.
Key messages

- Systems theory is an attempt to conceptualise and address the ‘wicked problems’ inherent in change processes in complex adaptive systems such as the health industry, where a problem is often the symptom of yet another problem and intervening in any area of the health system will impact on many other areas in anticipated and unanticipated ways that can be both desirable and undesirable.
- When thinking in systems terms, the levels of the health system at which changes can be implemented are external environment, individual/community, health personnel, organisation and the health system.
- Interventions at the personnel level, such as leadership development, must be supported by interventions at the organisational, community and health systems levels if they are to have the desired impact.
- Leadership development needs to:
  - build the capacity in leaders to think in systems terms
  - produce ‘adaptive’ leaders who are able to address interconnected issues, build coalition between disparate stakeholders, form intra- and inter-organisational partnerships and networks, and achieve measurable outcomes with and for communities and other stakeholders
  - develop the entire leadership team in situ in the workplace rather than in a retreat
  - begin with a practical problem the leadership team is facing and teach the team some leadership approaches that will help in resolving the problem, rather than teaching abstract leadership theory and letting the team members apply this on their own when they return to the workplace.
Challenge 2

Understanding the diffusion of innovation and learning how to use this knowledge to maximise the rate of diffusion

Ninety per cent of ideas never get beyond the desk of the idea generator, and of the 10% that do, only 1% are successfully adopted by organisations (Howell 2005). This is not surprising when one considers that the common approach to introducing an innovation is to focus 80% of effort on the innovation itself and only 20% on encouraging its diffusion (Austin, Klasko & Leaver 2009). This section will first provide a general outline of what innovation is and will then describe the characteristics of organisations, employees and the innovation itself that determine the rate at which innovations diffuse.

One of the earliest and most widely accepted theories on the diffusion of innovation is by Rogers (1971), who conceives of innovation as an object, practice, process or idea that is perceived as new by an individual. It is irrelevant whether or not a long period of time has passed since the idea was conceived; in Rogers’ view, if the idea seems new to the individual, it is an innovation. An updated definition describes innovation as:

> a dynamic and iterative process of creating or modifying an idea or innovation and developing it into products, services, processes, structures and policies that are perceived as new to the organisation (Nohria and Gulati 1996).

In this definition, ideas or inventions become innovations only once they are put to use. It is also important to note that innovations can take the form of both tangible products/objects and services, as well as intangible processes, structures and policies.

According to Rogers (1971), innovation diffusion is a special form of communication concerned with the dissemination of messages about new ideas through interpersonal and/or media communication channels among members of an organisation. Once the message about the innovation is received by members of an organisation, they can either decide that the best course of action is to make full use of the new idea (adoption) or they can decide not to adopt the new idea (rejection).

Stages of innovation

The stages of innovation can be grouped into two phases: innovation generation and innovation adoption. The generation phase involves idea creation and problem solving to generate the new processes and products (Gopalakrishnan & Damanpour 1997). The adoption phase as conceptualised by Rogers (1995) occurs in five stages.

The process begins with initiating an awareness of the innovation in the potential adopter (Rogers 1995). At this stage the individual lacks information on the innovation.
In the second stage, known as the ‘persuasion’ stage, the individual’s interest is aroused and he or she actively seeks more information about the innovation (Rogers 1995). It is at this stage in the process that individuals with the ability informally to influence the attitudes and behaviour of other members of their organisation, known as opinion leaders, perform their role.

The next stage is the decision stage, when the individual weighs up the advantages and disadvantages and comes to a decision whether to adopt or reject the innovation (Rogers 1995). If the individual decides to adopt it, he or she enters the implementation stage and employs the innovation and determine its usefulness. The process concludes with the confirmation stage, in which the decision to continue using the innovation or to discard it is made (Rogers 1995).

Characteristics of innovation that affect rate of diffusion

Rogers (1971) states that there are five primary characteristics of an innovation that determine whether an innovation will be adopted and how quickly it will be diffused. Leaders who are aware of these characteristics can accommodate them and plan the introduction of the innovation in a manner that maximises the likelihood that the innovation will be rapidly disseminated and adopted.

These five primary characteristics of an innovation as described by Rogers (1971) are:

- **relative advantage**—the degree of superiority an innovation is perceived to possess relative to the existing idea/object/practice: again, the objective superiority of the innovation is of no consequence, and it is the perceived advantage that determines the rate of adoption; the greater the relative advantage, the faster the innovation will be adopted and diffused

- **compatibility**—the degree to which an innovation is perceived as being in keeping with the prevalent values, norms, needs and experiences of the individuals in an organisation; adoption of an incompatible innovation will be slow unless a new value system is adopted prior to the introduction of the innovation

- **complexity**—the level of difficulty associated with understanding and using the innovation; new ideas that require little investment in learning by an organisation’s employees will be adopted more quickly than those that necessitate the development of new skills and knowledge

- **trialability**—the degree to which an innovation can be trialled on a small and limited scale without investing a large amount of time or resources; triable innovations represent less risk to an organisation and are therefore more likely to be adopted more quickly than those that cannot be trialled

- **observability**—how visible the results of an innovation are to potential adopters; the higher the visibility of results, the more rapid the speed of adoption will be.
Innovativeness

The relative advantage, compatibility, complexity, trialability and observability of an innovation are not the only factors that can affect how quickly an innovation spreads. Individual employees’ propensity to view innovation positively and readily adopt it, also known as their innovativeness, has a strong effect on the rate of adaption of innovation (Rogers 1995). Rogers classifies members of organisations into five groups based on their levels of innovativeness (ordered from the most rapid to the least rapid rate of adoption): innovators (venturesome), early adopters (respectable), early majority (deliberate), late majority (sceptical) and laggards (traditional). However, an individual’s innate level of innovativeness can increase in the presence of resource restriction. Developing nations such as China, India and Brazil are creating and adopting faster, smaller, cheaper and better innovations because they are not burdened by the ‘innovation handicap’ of having a comfortable level of financial support available to them (PWC 2005). Financial resources are scarce in these countries and this drives them to rapidly develop and adopt more efficient technologies, strategies, processes and business models (PWC 2005).

An example of this is Dr Devi Prasad Shetty of Bangalore, India, who, driven by an absence of high-payer reimbursement and a lack of resources, has become a master at process refinement (Anand 2009). He has perfected high-volume throughput and supply chain management so efficiently that he can break even on $1500 heart surgery. The physicians he manages specialise in one type of operation and consequently become highly skilled. Dr Shetty also uses medical technology efficiently to lower his costs and increase patient access to care. As a result, Dr Shetty’s profit margin is higher than that of the average United States hospital.

This same trend is found in military conflicts, where necessity and a lack of resources drive medical innovation:

A doctor was treating a patient with a bullet wound through his intestines who had recently received a colectomy. The wound would not heal because of constant seepage. Without access to the necessary equipment to resolve the issue he was forced to find an alternative solution. He obtained some bubble gum from a US soldier and after soaking it in warm saline solution to soften it, applied it to the wound. The bubble gum absorbed the seeping fluid and the wound healed (Personal anecdote: Medic with the Australian Army during the Korean War).

Much of the work on the diffusion of innovation outlined thus far is theoretical. The next section offers empirical evidence for the theory.

Empirical evidence for diffusion of innovation theory

A recent meta-analysis of 20 empirical studies on the general determinants of successful and rapid diffusion of innovation in organisations found six major determinants (from the most to the least often mentioned):
- management support for an innovative culture
- a customer focus
- strong communication and employee networking
- human resources strategies that emphasise innovation
- strong knowledge management systems
- leadership (Read 2000a).

The author recommends that the balance and emphasis of these determinants be moulded to suit the nature and context of the organisation, so as to increase innovativeness and maximise the likelihood of successful adoption of existing innovations (Read 2000b).

A further review of empirical studies on innovation in the health system found that innovation diffuses rapidly in organisations that are able systematically to identify, capture, interpret, share, reframe and re-codify new knowledge; link it with its existing knowledge base; and put it to appropriate use (Greenhalgh, Robert & Bate 2005). The review suggests that the best way to develop these prerequisites for rapid diffusion is to create a knowledge or innovation ‘ecosystem’. Knowledge ecosystems are self-organising, with emergent networks of communication that link entities that cope with and respond to rapidly changing environments. A number of studies have found that highly innovative organisations where rapid diffusion occurs outperform less innovative organisations (Atuahene-Gima 1996; Subramanian & Nilakanta 1996; Yamin, Gunasekaran & Mavondo 1999).

It is commonly believed that innovations do not diffuse as rapidly through the public sector as through the private sector. However, several studies have found relatively little difference in the capacity for innovation and change. A meta-analysis by Robertson & Seneviratne (1995) of 47 planned change interventions found no significant difference between public and private sectors in the amount of change induced. An earlier study found public sector interventions displayed a very similar pattern of results to private sector interventions (84% success rate in public sector versus 89% in private sector) (Golembiewski, Proehl & Sink 1982). The results of these two studies should be interpreted carefully. Public sector organisations are inherently complex, and consequently, the process of innovation adoption and change is far more challenging than in private organisations (Illes & Sutherland 2001). Small, low-scale interventions are likely to have an equal probability of success in public and private institutions, but ambitious innovation and change initiatives are more likely to be challenged, diverted and deflected by the inherent complexity (Damanpour 1996), size (Fritsch 2001), power dynamics (Stocking 1985) and traditions (Illes & Sutherland 2001) of public sector organisations.

The health industry has unique attributes that act as additional barriers to the dissemination of innovation, such as complex personnel structures, for-profit ownership as well as not-for-profit
ownership, price inelasticity, dealing with life-and-death issues on a daily basis (which results in a risk-averse culture), diverse collection of stakeholders and ‘change fatigue’ (Austin, Klasko & Leaver 2009; Ringel, Hosek & Vollard 2002; Burt 1987).

**Key Messages**

Leadership development programs need to make leaders aware of the following points:

- innovation is an object, practice, process or idea that is perceived as new by an individual
- innovation diffusion is a special form of communication concerned with the spreading of messages about new ideas through interpersonal and/or media communication channels among organisations
- there are two major phases of innovation—generation and adoption
- the adoption phase is further broken down into five stages—awareness, persuasion, decision, implementation and confirmation
- there are five characteristics of innovations that determine their rate of diffusion—relative advantage, compatibility, complexity, trialability and observability
- people can be classified into five groups based on their levels of innovativeness—innovators, early adopters, early majority, late majority, laggards
- innate levels of innovativeness can be increased by the presence of resource scarcity as evidenced by the high levels of innovativeness found in health systems in developing nations and war zones
- the major determinants of successful diffusion of innovation are management support, a customer focus, strong communication and employee networking, human resources strategies that emphasise innovation, strong knowledge management systems and leadership
- a number of studies have found that innovative organisations outperform less innovative organisations
- there is no evidence to support the notion that diffusion of innovation is more difficult or less apparent in public sector organisations relative to the private sector.
Challenge 3

Understanding how to build organisational cultures that enhance the capacity and tolerance for innovation and change

Organisational culture
Culture refers to an organisation’s norms and beliefs, and to the way the organisation acts collectively. The literature makes it apparent that culture is a primary factor in implementing innovation and change, and that leadership is a key factor in creating a receptive culture (Gumusluoglu & Ilsev 2009; Aragon-Correa, García-Morales & Cordón-Pozo 2007; Weston 2008; Jaskyte 2004; Masood et al. 2006).

Elements of the ‘bilateral’ transformational style of leadership, such as intellectual stimulation, empowerment and shared values, are said to lead to a culture of increased risk taking in creativity and ideas, as well as communication, trust and a team spirit. This in turn leads to sustained change through increased acceptance of and participation in change (Figure 2).

<table>
<thead>
<tr>
<th>Transformational leadership processes</th>
<th>Changes in organisational culture</th>
<th>Innovation and sustained change</th>
</tr>
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<tbody>
<tr>
<td>• Vision</td>
<td>• Increased risk taking</td>
<td>• Acceptance of change</td>
</tr>
<tr>
<td>• Collaboration</td>
<td>• Trust</td>
<td>• Active participation in change</td>
</tr>
<tr>
<td>• Value activation</td>
<td>• Collaboration among leaders and followers</td>
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<tr>
<td>• Individualised consideration</td>
<td>• Creativity</td>
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<tr>
<td>• Intellectual stimulation</td>
<td>• Shared knowledge</td>
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</tr>
<tr>
<td>• Co-ordination</td>
<td>• Solid team spirit with everybody contributing</td>
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Figure 2: Change through acceptance of and participation in change.

Scott et al. (2003) observe that organisational culture has increasingly been seen as an important consideration in health care reform. They argue that ultimately innovation and organisational change cannot happen unless there is a culture conducive to change. The norms, social status and hierarchy of an organisation influence its members’ behaviour and determine whether change and innovation occur rapidly or slowly (Rogers 1995). Norms set out the behaviour expected of members of an organisation. They can be roughly grouped into two conceptual types: modern and traditional.
Organisations with modern norms are technologically developed, rational, scientific, empathic and change oriented, whereas organisations with traditional norms are the opposite (Rogers 1971). Innovations diffuse faster in organisations with modern norms than those with traditional norms (Rogers 1971).

To foster an innovative culture in organisations with more traditional norms, Snowdon, Shell and Leitch (2010) suggest building ‘innovation factories’. These ‘factories’ are small-scale functional units with strong processes and support and reward mechanisms that enable and encourage employees to develop and trial new ideas. A further idea is to designate idea champions within organisations who are charged with the responsibility of developing new initiatives. Opinion leaders are best suited for this role, owing to their ability to influence fellow employees’ opinions, attitudes and behaviour. These idea champions would actively seek out improvements and challenge the existing norms and procedures of the organisation.

Martins and Terblanche (2003) developed a model for developing a culture of innovation that looks across systems to identify the dimensions and determinants of culture that influence creativity and innovation. Their model is shown in Figure 3.
### Figure 3: Building organisational culture that stimulates creativity and innovation: Martins and Terblanche 2003
Martins and Terblanche identify five major determinants of an innovative culture. ‘Strategy’, the first determinant, means having a strategy for developing new products and services. This is achieved through sharing a vision and mission that each employee understands. An example is a vision that emphasises creative and innovative behaviour: ‘Our company will innovate endlessly to create new and valuable products and services and to improve our methods of producing them.’

The second determinant is ‘structure’ and refers to the operation of the organisation. A flat structure with autonomous and cooperative work teams is recommended. Flexibility and freedom through autonomy and empowerment is identified as ideal for fostering creativity and innovation, which is hindered by rigidity, control and predictability.

The third determinant is ‘support mechanisms’ and includes rewards and recognition for creative behaviour. If creative behaviour, which results in the development of innovative strategies, is rewarded, it will become the dominant way of behaving. ‘Support mechanisms’ also include availability of resources that can help contribute to creativity, and include time, information technology and creative people.

The fourth determinant is ‘behaviour that encourages innovation’. Taking risks with ideas for change contributes to an innovative culture, and the way mistakes by employees are handled will influence risk taking in the organisation. Fair evaluation of ideas, balance in how well risk taking is tolerated and support for change are recommended ways to influence innovation.

‘Communication’—an open and trusting communication style—is the fifth determinant. An open-door communication policy between peers and departments is recommended. Disagreement is acceptable under certain circumstances, as it can expose paradoxes in processes and ideas and promote openness of communication (Martins & Terblanche 2003).

Research that reflects on both leadership and culture suggests that the style of leadership itself does not directly affect the organisation’s capacity to implement innovations and change. Rather, it ‘transforms’ the people and the culture in such a way that innovation, creativity and change are the norm (Sarros, Cooper & Santora 2008; Aragon-Correa, García-Morales & Cordón-Pozo 2007; Masood et al. 2006).

To build a culture supportive of innovation, leaders should encourage followers to learn from their failures, as well as their successes (Hartley & Bennington 2010). Research by Edmondson (2004) suggests that hospitals do not learn from failure because the traditional professional cultures and hierarchies inhibit questioning and challenge and because there is a tendency towards quick-fix solutions to problems rather than systematic problem solving and root cause analysis.

In a recent paper entitled ‘Innovation takes leadership’, about a perceived a lack of leadership in the Canadian health system, Snowdon, Shell and Leitch (2010) say the need for innovation and change is a key factor in coping with shifting priorities and challenges in health care. Leadership is essential to building a culture supportive of innovation and change for sustainability.
Snowdon, Shell and Leitch (2010) give this advice on how to build a culture of innovation through leadership:

- If ‘innovation’ is the silver bullet in the battle to achieve health system sustainability...then the best hope for creating a ‘culture of innovation’ is having leadership with a capacity to empower individuals to improve their own work environments and the system as a whole. Strategic, innovative leadership is crucial for achieving long-term sustainability in health care.

- Skilled leaders, who can cope with complex health management issues, while building and sustaining organisational cultures of innovation, are more critical than ever.

- To date, research on leadership and its role in supporting innovation has focused almost entirely on the role of physicians with no mention of other members of the health care team. It is telling that there is no mention of other professions in this literature. Clearly, there is substantial work to be done to examine how health care teams can work together to achieve innovation in health care and determine what type of leadership is needed to accomplish this important goal.

- Create cultures of innovation in health care: turn patient care service delivery into ‘living laboratories’ for innovation.

- What does a culture of innovation mean? It means that every employee, health care professional and manager is supported and encouraged to look for new ideas and new ways to provide patient care more efficiently and effectively. It means these ideas are then tested using focused pilot studies, so that the potential for innovation can be quickly identified. It means rewarding and recognizing innovation and promoting the emergence of ‘idea champions’ who lead innovation cultures.

- Innovation just doesn’t happen: we need to educate and socialize health professionals and researchers in innovation and entrepreneurship.

- Health education curriculums (in medicine, nursing, social work, psychology, EMS[emergency medical services] allied health, etc.) need to integrate innovation and entrepreneurship as core competencies for health professionals and leaders. Course work in health innovation, entrepreneurship, and strategy should be required in every health related curriculum. Business schools need to partner with health science faculties to deliver this curriculum to ensure it is most current. Opportunities for students from health disciplines and business schools to socialise, collaborate and learn together about innovation in health care need to be created and encouraged.
- Build collaborative networks of multi-sector partners to support innovation in health care.

- Health care is a complex system that will require the combined expertise of many partners to shift health care towards a culture of innovation. The challenges health care faces are extraordinary, and can only be solved by combining a wealth of expertise from sectors, including health leaders from private industry, business, entrepreneurial organisations, policy institutions and academia.

In summary, the literature suggests that a culture that fosters appropriate risk taking, the generation of ideas for change, collaboration, creativity, change readiness, knowledge sharing, trust, communication and learning is necessary for the sustainability of the health system. Innovative strategies can come from both leaders and other members of the team, and it is the leader’s job to coordinate development of a vision, encourage change, and also create and implement change.
Key messages

- Culture refers to an organisation’s norms and beliefs, and to the way in which the organisation collectively acts.
- A culture of innovation means that every employee, health care professional and manager is supported and encouraged to look for new ideas and new ways to provide patient care more efficiently and effectively.
- Sustained organisational change cannot occur unless the culture is conducive to change.
- Leadership development needs to:
  - train transformational leaders who encourage intellectual stimulation, empowerment and shared values, as this creates cultures with increased risk taking, communication, trust and team spirit. This leads to sustained change through increased acceptance of a participation in change
  - teach leaders how to foster innovative culture through the introduction of ‘innovation factories’ (where new ideas can be trialled) and idea champions (who are charged with the responsibility for developing new initiatives)
  - train leaders capable of building organisational cultures that influence creativity and innovation using:
    o strategies for developing new processes and services achieved through a shared vision and mission
    o flat structures with flexible, empowered, autonomous and cooperative work teams
    o support mechanisms that reward creative and innovative behaviour and encourage the management team to feel comfortable with risk
    o behaviour that encourages innovation such as fair evaluation of ideas and tolerance of risk taking
    o a communication style that is open and trusting.
- Help leaders understand that their role is to transform followers and the culture in such a way that innovation, creativity and change are the organisational norm.
Challenge 4

Understanding how to address the deep culture of the professions and early enculturation and socialisation which can limit capacity for innovation and change

This section draws on literature from the health sector to explore the hypothesis that a high representation of professional staff produces an organisational culture where commitment is mainly to professional groups rather than the organisation and that this limits participation and enthusiasm for innovation and change.

The research seems to indicate that there is a divide between physician groups and hospital administration, and it leads to tension and opposition. It is suggested in the literature that this professional separation is a result of differing values and goals, and can lead to difficulties in implementing innovation and change. A collective approach to leadership may circumvent these effects.

Maintenance of professional boundaries

The creation of new health professional roles (such as physician assistants) and the extension of existing roles (such as giving nurses prescribing privileges) are two recent innovations in health industry work design that have incited some active resistance from practitioners (Wilson, Pearson & Hassy 2002). These innovations challenge professional identity, which may result in opposition as individuals and professional interest groups fight to maintain their professional boundaries (Dickson, Pearson & Emmerson 1996).

In short, the pace of reform of health professional roles and service delivery models has been slower in Australia than in many other comparable OECD countries. Protection of professional boundaries and the continued reliance on models of health service delivery and health education that is based on existing professional roles are seen by many as being largely responsible for this slow pace of reform (Sweet 2011).

The debate in Australia is between the government and well-funded and well-organised special interests—the AMA [Australian Medical Association], private health insurance companies, the Pharmacy Guild, state governments and their health bureaucracies... Where possible they [the special interest groups] avoid real debate and respond occasionally in personal and ideological terms. They rely on their lobbying power. They corrupt public discussion and debate. There are about 900 full-time lobbyists in Canberra, many in the health field. There are 34 lobbyists for every cabinet minister. The most powerful and secretive lobbyists for the status quo in health are the state governments and their health bureaucracies.
They are major contributors to our dysfunctional federation in health. Different programs and different interests have produced what Tony Abbott has rightly called a ‘dog’s breakfast’ (Menadue 2010).

Some common reasons for opposition to role extension and the creation of new roles are that it leaves physicians to handle the more challenging patient problems, which some are keen to avoid (Charles-Jones, Latimer & May 2003), and it can result in excessive workloads for individuals in extended roles unless staff numbers are increased (Adams, Lugsden & Chase 2000).

To protect their traditional role boundaries, professional special interest groups often rally around laws and regulations on licensure, scope of practice and payment that were originally instated to protect consumers from negligent care (AHA 2010). However, thanks to the rapidly advancing levels of education and training resources available to health professionals, there is now a strong case for shifting the perspective on consumer protection from limitations on ‘who can do what to whom’ to performance and outcome-based measures (AHA 2010).

New legislation may be required to aid in lessening the disruptive impact of unhelpful professional boundaries. This was achieved in England in 2006, when legislation that extended prescribing privileges to nurses was passed, thereby expanding their role. Concern over legal liability was overcome by requiring that all general practitioners demonstrate that they had taken appropriate steps to ensure nurses were adequately supervised and trained (Sibbald, Laurant & Reeves 2006). A promising move in this direction in Australia is the recently established Health Practitioner Regulation National Law Act (2009). This new Act sets out the following objectives for the national registration and accreditation scheme:

- to provide for the protection of the public by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered
- to facilitate workforce mobility across Australia by reducing the administrative burden for health practitioners wishing to move between participating jurisdictions or to practise in more than one participating jurisdiction
- to facilitate the provision of high-quality education and training of health practitioners
- to facilitate the rigorous and responsive assessment of overseas-trained health practitioners
- to facilitate access to services provided by health practitioners in accordance with the public interest
- to enable the continuous development of a flexible, responsive and sustainable Australian health workforce and to enable innovation in the education of, and service delivery by, health practitioners.
Values

Challenges to professional boundaries are not the only cause of employee resistance to change and innovation. Different professional groups have divergent values about ‘what is right and good’ that align with their training and experience, and can result in some professional groups viewing an innovation as worthwhile while others perceive it as useless (Ferlie, Fitzgerald & Wood 2005). For example, assertive community treatment for patients with severe psychotic disorders has been extensively and scientifically validated and proven to improve quality of life and patient satisfaction and to provide cost benefits. However, a recent study showed that professional groups who favoured traditional medical approaches to mental health (e.g. psychiatrists) strongly opposed it, while professional groups who favoured social approaches to mental health (e.g. social workers) supported it fervently (Denis et al. 2002). In situations such as this, where profound value differences exist, dogmatically emphasising the scientific evidence is unlikely to encourage adoption of the innovation by all parties. Enabling face-to-face discussions to build consensus and find mutual understanding is more likely to succeed (Thomas & Trevino 1993).

Divisions among professional groups

Divisions among professional groups caused by divergent values are commonplace in the health system and can have negative impacts on care delivery, innovation and change (Bartunek 2011; Rice 2007; Scott et al. 2003; Snowdon, Shell & Leitch 2010). According to Austin, Klasko and Leaver (2009), ‘Successfully navigating change in health care requires an understanding of the difference between the expert and collective culture that exists within any health care system’.

Ferlie et al. (2011) describe professional groups as cellular, self-sealing and institutionalised, with different knowledge bases and research cultures. They say these communities are reinforced by roles, identities and traditional work practices.

Writing about the intergroup relationships in health organisations, Bartunek (2011) says that, although health groups such as physicians, nurses and administrators often work together, there is a cultural divide that acts as a deterrent to quality improvement work. According to Bartunek, clinicians and other groups are socialised to adopt a shared professional identity within communities of practice. He describes the slow and drawn-out process of socialisation in medical communities: at resident level clinicians still think of themselves as students, but as they progress in qualification, they arrive at an ingrained identity connected to the profession that only those with similar professional backgrounds would understand.

The socialisation process is also described by Scott et al. (2003), who, using the example of the Royal Medical Colleges in the United Kingdom, argue that through their control of training, the professional bodies are able to influence trainees to internalise professional core values. This socialisation in communities of practice is comparable to the concept of a ‘hidden curriculum’—the complex and pervasive normative influence exerted on young professionals during their training (AFMC 2010).
According to Bartunek (2011) and Ferlie et al (2005), communities of practice will create and share knowledge and innovation within the community, but not between communities. They suggest that the identity conflicts that occur when professionals work with staff outside their community inhibit potentially valuable innovations from being implemented and flowing across professional boundaries. These findings are supported by a recent paper presented by John Menadue (2010) at the 11th National Rural Health Conference:

I guesstimate that a 40% improvement in health workforce productivity over 10 years is possible if we could break down the professional silos and the restrictive work practices that abound in health. In a highly technical sector, we have work practices akin to that of cottage industries centuries ago.

Divisions between clinicians and the organisation

An additional effect of socialisation into professional communities of practice is that clinicians’ allegiances become more aligned towards their own professional bodies than the organisation or institution in which they work (Scott et al. 2003; Spurgeon, Clark & Ham 2011). This leads to differences between clinical and administrative staff members’ values, goals and views on the needs and subsequent feasibility of interventions within the organisation (Denis et al. 2002). According to Denis et al., this difference in values, goals and views reduces cohesion between the groups and impedes collective action. Scott et al. cite it as a key inhibiting factor in disseminating innovation and change. Snowdon, Shell and Leitch (2010) suggest that the situation is worsened in the case of specialists because often they are not employed directly by the hospital. This places them in a unique role in the hospital’s decision-making processes.

Bridging the divide

According to a recent review of the literature by Clark and Ham (2011), professional engagement is central to overcoming the divisions caused by socialisation into professional groups. Engagement can be described as ‘a persistent, positive affective motivational state of fulfilment in employees that is characterised by vigour, dedication and absorption’ (Schaufeli & Bakker 2003:22). Studies of professional engagement in a health context have shown it is positively correlated with performance, innovation, hospital profitability and employee wellbeing (Harter et al. 2006; Macleod & Clarke 2009; Toto 2005). These clear links between professional engagement and organisational and individual performance reinforce the vital role that leaders have to play in building appropriately supportive cultures that enhance engagement. Spurgeon, Clark and Ham (2009) provide the following recommendations to organisations seeking to develop cultures of engagement:

- develop stable executive teams that ‘promote and foster relationships, set expectations and lead by example’
- select doctors for leadership and management roles through open competition based on ‘ability, attitude, leadership aptitude and potential’
• promote mutual understanding, respect and trust between managers and doctors and develop an acceptance of professional differences to ensure they work together effectively

• build trust and develop relationships through ‘open, honest communication that is persistent, widespread and inclusive’

• ensure managers and doctors are united in a common goal to provide high-quality care to patients

• ensure both managers and doctors are empowered to improve the organisation

• ensure managers and doctors are accountable by clearly communicating organisational expectations and dealing with unprofessional behaviour and infringements upon patient safety quickly and firmly

• provide leadership support, development and opportunities to professionals at all levels by:
  - investing in mentoring, coaching and leadership training
  - ensuring that formal and informal leadership opportunities exist
  - identifying and supporting talent
  - engaging in succession planning.

Bartunek (2011) expands on the recommendations of Clark and Ham and suggests that leaders of each professional community should take responsibility for improving cross-disciplinary relations by creating all-encompassing goals. Additionally, he stresses the importance of leaders modelling relationships and appropriate behaviour with other groups. Bartunek also recommends that health care administrators pay greater attention to involving the entirety of the health care team in collaborative innovation and change processes from the outset, so that they begin with curiosity about one another’s perspectives rather than entering late with defensiveness about perceived (or real) misunderstandings. This would also help members of separate professional bodies become more comfortable with working with each other. The author also stresses the importance of clearly communicating organisational values, goals and successes that span professional boundaries.

Bartunek’s and Clark and Ham’s recommendations are consistent with the transformational leadership literature presented earlier in this paper, which suggests that a more collective style of leadership, where all leadership groups work together, could increase innovation and change. Steps in this direction are being made in Australia, as evidenced by a recently proposed initiative, Lead Clinicians Groups. The Department of Health and Ageing position paper on Lead Clinicians Groups lists ‘providing a pathway for clinical advice to be provided to local health service managers’, ‘providing a forum for clinicians from across sectors to collaborate and raise issues with regards to health service delivery’ and ‘providing a national focal point for the engagement of senior clinicians’ as three of the body’s central objectives (Department of Health and Ageing 2011).
Finally, recent moves to interprofessional educational platforms in the training of health professionals also show potential to reduce these barriers to building cultures of innovation and change in the health system.

Conclusion
The literature presented in this section suggests that the enculturation of health professionals into professional disciplines via hidden and explicit curricula is a barrier to developing the level and nature of interprofessional practice and collegiality necessary to support the innovation and change required to sustain the health system. The advice from the literature also supports the transformational leadership models noted earlier, as updated by the Metcaifes’ recent research. It underlines the importance of engaging practitioners across disciplines in collaborative effort and reciprocal leadership roles, and thus builds their allegiance to the system they serve.

Even leadership development programs based on updated transformational models needs to pay specific attention to professional enculturation.

The training programs of health professionals need to become more focused on developing interprofessional competencies and cultures.
Key messages

- Distances between doctors and the hospital limits acceptance of change and innovation.
- The divide between physicians, nurses, allied health staff and hospital administration created by early socialisation into ‘communities of practice’ with differing values, goals and allegiances negatively affects delivery of care, blocks change, and slows the adoption and diffusion of innovation.
- Leadership development needs to train leaders in the following techniques to bridge the divide:
  - introduce interpersonal educational platforms in the training of health professionals
  - clearly communicate cross-disciplinary organisational goals, values and successes
  - encourage leaders to model relationships and appropriate behaviour with other professional groups
  - foster collective leadership styles where leadership groups work together and engage in face-to-face consensus building.
Challenge 5

Understanding how to deal with high levels of cynicism and scepticism about the motivations of leaders based on experience of multiple reforms and restructures, and the perceived failure of these efforts to positively impact on clinical, preventive and organisational outcomes

Published observation and research suggests that the long history of repeated health industry reform and organisational restructure has led to a workforce that is change weary. The literature on strategies to address this issue is sparse, but a few approaches have been recommended.

The pace of change in an organisation affects its ability to adopt innovation. Innovations diffuse more slowly in young organisations or organisations undergoing rapid change than they do in organisations where working systems have been allowed to achieve ‘maturity’ and the pace of change has lessened (Gustafson et al. 2003). A cycle of constant change creates ongoing organisational turbulence, which diminishes employee enthusiasm for the change process (Dixon Woods et al. 2011). Staff members are often hesitant to begin a new project pursuing change or innovation because they fear their work will be lost and the innovation abandoned in the next restructure or change of leadership. Evidence of this lack of enthusiasm for change among the health workforce is perfectly illustrated in the following excerpt. It is from a satirical article, ‘A surrealistic mega-analysis of redisorganisation theories’, written by four senior health workers and published in the Journal of the Royal Society of Medicine:

**Background**

We are sick and tired of being redisorganised.

**Objective**

To systematically review the empirical evidence for organisational theories and repeated reorganisations.

**Methods**

We did not find anything worth reading, other than Dilbert, so we fantasized. Unfortunately, our fantasies may well resemble many people’s realities. We are sorry about this, but it is not our fault.

**Results**

We discovered many reasons for repeated reorganisations, the most common being ‘no good reason’. We estimated that trillions of dollars are being spent on strategic and organisational planning activities each year, thus providing lots of good reasons for hundreds of thousands of people, including us, to get into the business. New leaders who are intoxicated with the prospect of change further fuel
perpetual cycles of redisorganisation. We identified eight indicators of successful redisorganisations, including large consultancy fees paid to friends and relatives.

**Conclusions**

We propose the establishment of ethics committees to review all future redisorganisation proposals in order to put a stop to uncontrolled, unplanned experimentation inflicted on providers and users of the health services (Oxman et al. 2005).

A number of reports have been published describing a state of low morale and feelings of uncertainty, stress and confusion in health workforce employees subjected to the constant health service reforms over the past few decades (Garside 2004; Ham 2006; Perkins et al. 1997). This reaction to change is known as ‘reform fatigue’ and results in employees becoming resistant to new ideas, innovations and change.

A study of the Australian health workforce found that reform fatigue is less likely when the change is based on a well-articulated vision that is appropriately communicated to and understood by followers; the proposed change is consistent with staff members’ beliefs and views on the health system and their roles in it; and staff understand the local, national and international context in which their organisation is placed (Dovey 2009). Dovey recommends that a sense of shared future be established where a feeling of ‘being in it together for the long run’ is achieved among followers. To attain this goal, he stresses the importance of establishing trusting relationships where ‘mutual support, voluntary cooperation and reciprocity are the norm; and communal endeavour is founded on a negotiated political order featuring new and appropriate forms of ownership, governance and power management’ (Dovey 2009). To prevent or overcome change fatigue and effect successful change, trust must be developed and enacted at two separate levels—the company leadership, and the followers governed by that leadership.

**Trust and leadership**

Building trust in leaders can be achieved by following this set of principles set out by Handy (1995, cited in Dovey 2009):

- **Trust has limits.** Unlimited trust is inappropriate and impractical. Leaders should strive to create freedom within boundaries. The limits to trust can be managed through suitable performance measurement.

- **Trust requires learning.** Trust is more easily developed in cultures where change is accompanied by openness to learning and self-renewal. Failure is tolerable when it results in learning and transformation; however, failure to learn from experience destroys trust.
Trust is a human quality. Leaders should forge strong interpersonal relationships and improve collective performance through inspirational communication, knowing and believing in their followers and principled personal example.

Trust is tough. Confront followers who violate a leader’s trust.

Trust needs ‘touch’. Significant one-on-one time is required with followers to build trust. Significant interpersonal engagement makes shared commitments ‘real’ and sustainable.

Trust needs multiple leaders. Trust thrives in contexts where specific endeavours are led by the most knowledgeable/experienced member(s) (referred to as ‘situational leadership’).

In addition to these principles, Garside (2004) recommends leaders provide staff with predictability and capability. Staff should be informed where the process of change is heading before it begins, and the leaders in charge of the change process need to be regarded as capable of producing the desired results.

Trust and followers

In addition to building trust at the leadership level, trust must also be developed at the follower level. Organisations are social networks, and to participate openly and effectively in them, individuals must possess a range of skills, attributes and dispositions. In particular, effective participation depends on the social confidence of employees and their ability to build and sustain relationships across diverse groups. Collapse of relationships or failure to forge them owing to a lack of employee social competence quickly erodes trust (Dovey 2009). It is important to hire socially confident staff, whose demeanour reflects authenticity, reliability and respect. It is also important to create opportunities for regular direct face-to-face interaction among employees: it creates the opportunity for staff to learn to value the contributions each other makes, and to get to know whether, and in what circumstances, they can place trust in each other (Handy 1995). Successful completion and implementation of jointly achieved initiatives will restore faith that lasting real benefits to the health system are possible, and that investment of self and effort is worthwhile.

Conclusion

Without trust in their leaders and trust in their fellow followers, it is likely that change fatigue will continue to plague the health system. Health staff will be unwilling to risk the potential threat of failure and humiliation posed by the adoption of roles, technology and processes they are unaccustomed to. Asking employees to be flexible and adaptable enough to adjust to constant change requires that they move out of their comfort zones and engage in significant retraining and learning. Without trust and the attendant confidence that they will be supported through this process, such challenges will be embraced by few and resisted by many.
Key messages

Leadership development needs to:

- Build awareness of ‘reform fatigue’—a reaction to the constant health reforms that have occurred over the last decade and result in resistance to innovation and change.

- Teach leaders that reform fatigue is less likely if the proposed change is:
  - based on a well-articulated and understood vision
  - aligned with employees’ beliefs and views
  - employees understand the local, national and international context
  - trust exists between the leaders and the followers.

- Teach leaders to adhere to the following principles to build trust:
  - place limits on trust
  - failure that results in learning and transformation should be tolerated but failure to learn from experience should not
  - forge strong interpersonal relationships through inspirational communication, principled personal example, and knowledge of and belief in followers
  - confront followers who violate trust
  - devote time to one-on-one interpersonal engagement
  - encourage situational leadership in which the team member with the most knowledge or experience leads the project.

- Train leaders to build trust at the follower level by hiring socially competent staff and creating opportunities for face-to-face interaction between employees.
Challenge 6

Understanding how to make use of intelligence from consumers to inform innovation, improvement and the redesign of health systems so they better accommodate the patient experience and journey and population wellness

Often there is a ‘disconnect’ between changing trends in population health needs, and the structure of how health services are organised and delivered. This disconnect is described in the following statement:

*We routinely take the latest medical technologies of the 21st century and embed them within a service delivery and patient flow process—with its appointments, waiting rooms, and so on—that has remained fundamentally the same since the 1950’s* (Scott, K [2009] quoted in Snowdon, Shell & Leitch 2010:41).

This chapter first draws on consumer engagement literature from non-health-related industries, outlining the benefits to be gained by engaging in open innovation and involving and sharing information with interested consumers and consumer groups. Next, evidence of system-wide reticence by the health industry to listen to and learn from consumers is described, and strategies to address this issue are drawn from management and health-related literature.

In 2007 Dell created a revolutionary online user innovation community called Idea Storm (www.dellideastorm.com), a website where users could freely create new products or modify existing products and share these ideas with community members and Dell. These ideas were reviewed, discussed and voted on by the user community. Dell adopted some of the most highly rated ideas. Dell’s Idea Storm allowed the company to harness the power of ‘user innovation’, a term that refers to innovation initiated by the users of products and services, rather than by the suppliers (Bogers, Afuah & Bastian 2010).

Dell is not the only company to benefit from user-generated products and services. Some of the most lucrative, novel and leading-edge innovations have been developed by users attempting to tailor existing products or services to suit their needs better (Luthje, Herstatt & Von Hippel 2005; Thomke & Von Hippel 2002). Some notable examples include the ‘mystarbucks idea’ by Starbucks, ‘i-prize’ by Cisco, and Apple allowing users to sell their ‘hacked’ (user modified or generated) iPhone applications on the online Apple store, iTunes. The advantage of such user innovation is that it supports continuous innovative development and provides external expertise from individuals who are intimately familiar with the products and services. It also increases an organisation’s capacity to align itself with a rapidly changing environment (Di Gangi & Wasko 2009).

User innovation is just one example of an increasingly popular approach known as ‘open’ innovation.
According to a leading expert in the field, organisations must take an open innovation approach by combining both the internal and external components (such as end users) of an organisation if they are to develop and adopt innovations successfully (Chesbrough 2003a, 2003b). A similar view is held by Laursen and Salter (2006), who say, ‘The network of relationships between the firm and the external environment play an important role in shaping performance’.

This aligns with the recommendation by LaFond, Brown & Macintyre (2002) to consider carefully what they call the ‘individual/community’ level of their systems model of health care performance when effecting change. This makes intuitive sense, since innovation does not have to originate within an organisation for the organisation to benefit from it. Additionally, because it is financially impossible for one organisation to hire all the existing experts in a field, organisations should be leveraging user innovation to develop ideas externally, without expending organisational resources (Di Gangi & Wasko 2009). Adopting user-generated ideas and innovations signals to customers that the organisation is responsive to their needs, which in turn strengthens relational bonds and goodwill (Di Gangi & Wasko 2009). Finally, being open to, and understanding, users’ suggestions and preferences is known to be a critical contribution to innovative success (BCG 2008).

Despite these obvious benefits, health organisations around the world, including in Australia, generally remain closed to open innovation and user experience. Health industry leaders are aware of the need to understand the needs and experiences of the patients they serve more deeply, yet they do not act on this awareness by harnessing readily available sources of user information (Stamm 2009).

One such source is social networking websites. Social networking has the potential to create collective wisdom among patient groups whose members are experts at experiencing the disease, and are therefore strongly motivated to manage and control symptoms. An example is the PatientsLikeMe website, which claims to have up to 5% of the world’s sufferers of Amyotrophic Lateral Sclerosis as its members (Frost & Massagli 2008). Such websites could provide health professionals with an unprecedented ability to uncover symptomatic trends and responses to treatment (Miller & Sim 2004), but they have yet to be embraced and leveraged by the health sector.

The health industry’s reticence to listen to and learn from the experience of its users is further displayed in the slow pace at which it has introduced the Personally Controlled Electronic Health Record (PCEHR). A PCEHR is an electronic application that allows patients to manage and maintain their own health information. The information is under the control of the patients, and allows them to import existing information and to self-generate new information, and to share all of it with whomever they desire (Kaelber et al. 2008). Despite the potential to have access to a rich source of patient data, only half the doctors surveyed were willing to use PCEHRs as part of their clinical work, and only 9% were currently using them (Markle 2011).

It is thought that medical reticence to applying user experience obtained from sources such as PCEHRs and websites is the result of an ingrained distrust of patient-provided data (PWC 2011).
Doctors and organisations will need to become more comfortable with and competent at differentiating between data that is irrelevant or insufficient for clinical decision making, and data that is relevant, accurate and useful. To aid in this process, all patient-provided data should be marked as such, and decisions need to be made about which elements can be extracted as structured and discrete data for analysis and trending (PWC 2011). Research on best-practice strategies to redesign health care services to incorporate user experience information generated by these technologies is also required.

The doctor is, or should be, well informed about diagnostic techniques, the causes of disease, prognosis, treatment options and preventive strategies, but only the patient knows about his or her experience of illness, social circumstances, habits and behaviour, attitudes to risk, values and preferences. Both types of knowledge are needed to manage illness successfully, so both parties should be prepared to share information and take decisions jointly (Goodare & Lockwood 1999).

People living with chronic illness and their carers have a wealth of knowledge, understanding and personal experience that is currently being ignored by our health system. But how can the health system harness this experience? Is there a way to involve users in designing innovative ways to prevent, manage and mitigate chronic conditions?

Increasing user involvement

The limited amount of literature on methods for increasing user involvement in innovation and change in the health system suggests that there is no single best way to involve users. Rather, a variety of practical approaches exists. Outmoded approaches based on ownership of power, where the users regain and exert their power by ‘voting with their feet’ or “exercising choice”, have been superseded (Hardy & Clegg 1996). More modern approaches consider how user involvement and power may be generated and shared through experience-based co-design, co-leadership, mutual learning and citizens’ juries (Greenhalgh 2010; Mooney 2010).

Co-design

Experience-based co-design (also referred to as co-creation) envisages a new role for users in which they are no longer solely on the receiving end of services. Instead, they are central to the design and delivery of services. In co-design, the point is no longer to deliver distributed versions of traditional services. Users work together with health professionals through a process of dialogue that goes beyond the perspectives of any one party to identify needs and then propose, test and implement solutions (Cottam & Leadbeater 2004).

Co-creation does not involve brief one-off consultations in which professionals give users the opportunity to express their views on a limited and predetermined number of alternatives. It is an interactive and creative process that challenges the perceptions of all involved parties and seeks to blend professional and user expertise in new ways (Cottam & Leadbeater 2004).
Experience-based co-design involves capturing the subjective experiences of both patients and staff at crucial points in the care pathway and using this to redesign all or part of a process to bring about sustained improvements in those experiences. It has been successfully used to improve services for cancer treatment (Bate & Robert 2007), chronically sick adolescents (van Staa et al. 2010), and people with dementia and their carers (Iliffe et al. 2008).

To implement the co-design approach to user involvement successfully, it may help to follow the 10 tips recommended by Greenhalgh (2010):

- think carefully about the sort of users you ask to participate and what you hope they will contribute. Recruitment strategies may need to vary with the different user groups and sub-groups
- scaled-down ‘taster’ experiences of involvement are good to introduce users to the idea of what participation will involve
- address the ‘what’s in it for me’ question by viewing the user involvement experience through their eyes—make involvement simple, fulfilling and flexible
- address travel, expenses and reimbursement matters as they can be incredibly important for low-income participants and will encourage diverse participation
- ensure all participants are clear on what is required of them
- ensure all expectations are clear and are agreed to
- create a supportive and safe atmosphere to encourage honest and constructive criticism of services as they exist at present
- to generate effective solutions ensure imaginative thinking is supported
- when selecting solutions and planning the recommended changes, mitigate any conflict between participants with consensus-building techniques
- consider how to achieve closure and realise that if user involvement has been prolonged, intensive or addressed sensitive issues, participants may need further support.
Co-Leadership

Co-opting service users into leadership positions, or ‘co-leadership’, entails involving users in a variety of activities ranging from sitting on management or lay boards through to interview panels for new employees. However, if users are to participate effectively, they must receive sufficient training in processes, systems and technical knowledge, which is often costly and delays the decision-making process (Greenhalgh 2010). Consequently, at present this approach is seldom used by health organisations.

Mutual learning

Users’ stories and subjective experiences can make for invaluable teaching material for health students and staff. Ziebland and Herxheimer (2008) concluded that rather than rivaling biomedical evidence, patient experiences should be part of the evidence base on which students and staff draw when making treatment choices.

By involving users in education and training, students and professionals are forced to switch their view of the role of the patient from a passive to an active one. Involving patients as teachers offers more than the acquisition of skills—it changes attitudes in a positive manner and provides real life experiences that enhance students’ understanding (Livingston 2004; Repper 2006).

A ground-breaking training program that incorporates mutual learning was introduced by the United States Department of Health and Human Services in May 2011. Partnering to Heal is ‘a computer-based, video-simulation training program on infection control practices for clinicians, health professional students, and patient advocates’ (Department of Health and Human Services 2011). The dramatisation used in the training program was developed in consultation with patient advocates and experts from various disciplines.

Primary health care councils and citizens’ juries

Building on successful community engagement initiatives (see Nutbeam et al. 1993), interest in engaging with communities to identify their principles and priorities has remerged recently under the name of ‘citizens’ juries’.

Early successful attempts in Australia include the Mackay Health Region in 1991, where the initial and successive strategic plans were based on the informed deliberation of primary health care councils, which were joint efforts of the regional health authority, local government, industry and communities. More recently, a citizens’ jury was successfully convened in Western Australia, where in October 2005, a jury decided to exchange a few small and inefficient hospitals and emergency departments for increased resources for mental health, greater equity, more prevention and greater transparency in decision making (Mooney 2010).

The National Health and Hospitals Review Committee recommends the use of citizens’ juries as a means through which health service managers and Ministers can learn what the community wants
from their health services (NHHRC 2009). Citizens’ juries assemble a random sample of 12 to 20 people from the community; inform them that they are there as citizens and not individuals; provide them with background information on the issues to be debated; allow them to question experts in the field to add to or clarify the provided information; and ask them to reflect on the issues at hand and provide recommendations (Mooney 2010).

Citizens’ juries are not decision-making bodies: they are tasked solely with recommending the principles, priorities and objectives that citizens believe should form the foundations of their health services (Mooney 2010). The health service managers and Ministers make the decisions based on these principles and priorities.

Primary health care councils, citizens’ juries and similar initiatives promise to bring health services and the community together, thus preventing health care institutions from becoming technocratic organisations unresponsive to their users’ needs and desires. Advocates have argued that, as it is ultimately citizens’ resources that are being allocated, it should be the citizens’ preferences that count.

Conclusion

Substantial benefits remain to be gained by harnessing users’ advice to inform innovation, improvement and health system reform. While a tendency to distrust patient-provided information is behind clinicians’ reticence to listen to and learn from consumers, a number of strategies to overcome this reticence and encourage user involvement have been developed. These include mutual learning, co-leadership, experience-based co-design and citizens’ juries.
Key messages

- Adopting user-generated ideas and innovation strengthens relational bonds and goodwill with users and the community, improves performance and reduces costs.
- Leadership development needs to:
  - support increases in the use of consumer perspectives on service system design
  - train leaders to build the capacity to tap into consumer ideas and experience on a continuous basis
  - teach leaders to understand and leverage user innovation for continuous innovative development and increase an organisation’s capacity to align itself with rapidly changing environments
  - teach approaches to encourage user involvement in the health system, including:
    - experience-based co-design—captures the subjective experiences of both patients and staff at crucial points in the care pathway and uses this to redesign all or part of a process to bring about sustained improvements in those experiences
    - co-leadership—involves users in a variety of activities such as sitting on management boards and interview panels
    - mutual learning—involves user experiences for student and staff training
    - primary health care councils/citizens’ juries—informed and educated consultation with community members to provide recommendations on health service principles, objectives and priorities.
Challenge 7

Understanding how to provide incentives to health professionals to promote innovation that leads to improved community and patient outcomes

Organisations from a cross section of industries have demonstrated that those that compensate chief executive officers for improving the performance of organisations outperform those that do not (Zingheim, Schuster & Thomsen 2005). Incentive programs such as this fall under the domain of ‘pay-for-performance’, the ethos of which is summed up perfectly by Paul Keckley from the Vanderbilt Centre for Evidence-Based Medicine: ‘If we were to reconstruct incentives around outcomes and processes, not around visits, we could actually increase the effectiveness of primary care and increase its efficiency.’ (PWC [2005]. Health Cast 2020: creating a sustainable future. Price Waterhouse Coopers' Health Research Institute)

The design of remuneration systems and incentive systems sits outside the control of most health care leaders who work at the operational level running or providing health care services. However, a number of commentators reflect on the nature of incentives on the capacity for innovation and change in the health system. Porter and Teisberg (2006) note that to the extent that competition exists in the health sector, it is ‘dysfunctional competition’ that is the result of:

misaligned incentives and a series of understandable but unfortunate strategic, organisational, and regulatory choices by each participant in the system that feed on and exacerbate each other. All the actors in the system share responsibility for the problem.

They go on to say:

The only way to truly reform health care is to reform the nature of competition itself...only aggregate-level incentives will shift the focus to population-based performance and shared learning across sites, thus accelerating the spread of what works (Porter & Teisberg 2006).

They then argue that:

while physicians, policy makers, and others can continue to debate whether rewards make a difference in improving quality, an important consideration is how to more strategically leverage current and future investments to accelerate large-scale, population-based improvement (Porter & Teisberg 2006).

To achieve population-based improvement, a portion of rewards and incentives needs to be aligned to this purpose (Porter & Teisberg 2006).
Pay-for-performance has the potential to be used to financially reward health care providers for outcomes, cost efficiency, patient satisfaction, adherence to processes, and the creation and adoption of innovation (PWC 2005). However, at present, pay-for-performance financial models currently in use in health systems are largely preoccupied with cutting costs and maintaining quality of care (Briesacher et al. 2009; Hanse 2006).

An example of a pay-for-performance initiative that specifically incentivised innovation was introduced by Brown and Toland Physicians, an independent practice association of more than 800 community physicians in San Francisco. The physicians developed a ‘preferred’ physician program that obligated a small group of aligned physicians to implement electronic health record (EHR) systems in exchange for ongoing bonuses and EHR subsidies that reduce financial barriers to EHR adoption (Austin, Klasko & Leaver 2009).

In developing the performance measures to be used with new pay-for-performance financial incentive models, it is recommended that the measures have demonstrated effectiveness in promoting positive change and are actionable. They need to be flexible enough to adapt to a rapidly changing clinical environment, and create incentives for areas that are within the control of the individuals charged with achieving the targets (PWC 2008). Failure to achieve targets for reasons outside an individual’s control can act as a further disincentive to change. Finally, pay-for-performance measures should assess both clinical performance and organisational performance, which encompasses business processes and management (PWC 2008).

Another promising new financial model that incorporates performance-based payments to incentivise the adoption of innovation is the social impact bond model. Under this model, the government contracts a social impact bond-issuing organisation (SIBIO) to act as a private sector financing intermediary and fund a change/innovation program within a health organisation. If the health organisation fails to achieve performance targets, the SIBIO is not paid by the government. The role of the SIBIO is to obtain upfront capital to fund the operating costs of the change/innovation program from private investors in exchange for a share of the government payments should the performance targets be met (Liebman 2011).

The main advantage of the social bond model is that it transfers the financial risk of failing to meet innovation and change program performance targets from the government to private investors. This ensures that promising but unproven innovative strategies and programs that would otherwise be perceived as too risky (and would potentially waste tax payers’ dollars) are given an opportunity to be trialled. To take this risk, private investors must first be convinced that the change program model and management team are strong enough to ensure the performance targets are met. Once they have invested in a program, both the SIBIO and the private financiers have a strong incentive to closely monitor and improve the performance of the program. This rigorous ongoing evaluation speeds up the process of learning what works and what does not, and ensures that programs that fail to achieve results are cancelled immediately (Liebman 2011).
Owing to the very recent development of this new financial model, there are very few available case studies on its implementation. The first trial of the social impact bond model is currently underway in Peterborough, England, where it is being used to reduce prisoner recidivism (Walker 2010). If the reoffending rate drops by 7.5%, the SIBIO financing the trial will receive government payments.

The first Australian pilot of a social impact bond model has been proposed by the Centre for Social Impact in New South Wales (CSI 2011), which has determined that New South Wales has the necessary market conditions to make the new funding model feasible, but further work is required before the pilot goes ahead. The Centre for Social Impact has supplied recommendations for the development of the social impact bond pilot to the New South Wales Government.

The Centre for American Progress has written a report recommending the introduction of social impact bonds to the United States as a means to accelerate innovation in the public system and improve government performance, but this has yet to happen (Liebman 2011). Social impact bonds are a promising but as yet untested means through which to incentivise and fund innovation and change programs.

An unintended consequence of financial models such as pay-for-performance and social impact bonds that involve performance measurement and external rewards is the potential to damage intrinsic motivation, the desire to perform a task for its own sake. An incentive program could be perceived as pressuring rather than supportive if clinicians are held accountable for factors outside their control, feel they are under surveillance, or performance regimes are unfair or ambiguous. In contrast, reward systems that engender feelings of competency and autonomy in contexts perceived as supportive rather than pressuring are likely to stimulate intrinsic motivation (McDonald & Roland 2009).

Ideally, incentive programs should induce ‘identified regulation’, a state in which ‘people have a full sense that the behaviour is an integral part of who they are and is self-determined’ (Gagné & Deci 2005). Incentive programs should therefore be designed so that the context is supportive, individuals are able to identify with the goals and values of the program, and individuals feel they have a degree of autonomy in its delivery.

Non-financial incentives

Financial rewards are only one of several motivators of desirable professional behaviour. A recent study found that stakeholders consistently rated benchmarking and public reporting as the strongest incentives to instigate change (after financial pay-for-performance reimbursement) (PWC 2008). The findings suggested that this was due to that match between these incentives and clinicians’ sense of professionalism and healthy competition (PWC 2008). Unfortunately, these two non-financial incentives are limited by the quality and availability of data and the ability to disseminate this data quickly and accurately.
Employees can also be incited to change and adopt innovation through education. One example of the use of education to overcome resistance comes from The Maimonides Medical Centre in Brooklyn in the United States. Managers used training, newsletters and other educational efforts to convince physicians that a new health information technology system would increase their productivity and save them time and save their organisation money (Lorenzi & Riley 2003).

Good incentive design also requires evidence on what motivates health care providers and health professionals. In practice, health care providers are motivated by a range of factors, including the health and well-being of patients and earnings, but also by factors such as autonomy and intellectual satisfaction. The relative weight placed on these factors in different decision contexts will determine the effectiveness of incentives in terms of the extent to which health professionals react to them and change their behaviour. If health professionals are only partially motivated by money, financial incentives may not be the most effective way of achieving an objective of interest (Scott & Connelly 2009:1).
Key messages

Leadership development needs to:

- promote understanding and effective use of both financial (pay-for-performance and social impact bonds) and non-financial incentives (benchmarking, education, satisfaction, sense of meaning and success/pride) to promote innovation and change and reduce resistance to change

- promote understanding of the potential for misaligned incentives to have negative consequences on the capacity for change and innovation. Incentives that intrude on perceptions of professional autonomy and intellectual satisfaction are often counter-productive.
The results and implications of the literature review for leadership development

Leadership development is important to drive the innovation and change necessary for the sustainability of the health system.

Recently available evidence suggests that the courses could usefully be updated and made more appropriate to the culture of health systems by:

- incorporating the findings of recent re-evaluations of the transformational leadership style, which shifts the focus from a ‘heroic’ to an ‘engaging’ and ‘distributed’ style of leadership
- complementing courses with ongoing development through mentoring, coaching, reflection and introspection
- developing entire leadership teams in a workplace rather than in a retreat, and teaching leadership approaches that address particular problems facing the team rather than teaching abstract theory
- emphasising the importance of bridging the divide between physicians, nurses, allied health staff and hospital administration, and providing techniques to achieve this, such as collaborative problem-solving and innovation projects
- incorporating information on the determinants of the successful diffusion of innovation and how to build innovation factories where hidden innovators can bring forward new ideas that can be trialled in the workplace
- providing education on the strategies, structures, support mechanisms, behaviour and communication style necessary to build organisational cultures that support change, creativity and innovation
- developing curricula that assist health leaders to think in systems terms and take action to change the design of health systems so they better reflect the patient experience, journey and population wellness needs and make better use of intelligence from consumers about appropriate innovation and change
- including an understanding that leadership development is a necessary but not sufficient solution to the multifaceted challenges to the sustainability of the health system; it must be accompanied by commitments at all levels of the health and political systems to culture change, reduction in command and control structures, addressing change weariness, and rebuilding trust between clinicians, managers and political governance structures
• developing an understanding in leaders about the current formal and informal incentives and disincentives for clinical, management and support staff for the uptake and dissemination of innovation

• considering how current courses and investments could be introduced in an age- and stage-appropriate way to interprofessional courses for undergraduates and postgraduate students in health care professions, including how to be good followers in contexts where this is required.
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