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HEALTH FORUM

DIALOGUE
SUMMARY

FOSTERING LEADERSHIP FOR
HEALTH-SYSTEM REDESIGN IN
CANADA

4 MARCH 2014

EVIDENCE >> INSIGHT >> ACTION

Dialogue Summary:
Fostering Leadership for Health-System Redesign in Canada

4 March 2014

McMaster Health Forum
>	For concerned citizens and influential thinkers and doers, the McMaster Health Forum strives to be a leading hub for improving health outcomes through collective problem solving. Operating at the regional/provincial level and at national levels, the Forum harnesses information, convenes stakeholders, and prepares action-oriented leaders to meet pressing health issues creatively. The Forum acts as an agent of change by empowering stakeholders to set agendas, take well-considered actions, and communicate the rationale for actions effectively.

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Citation
>	Moat KA, Lavis JN. Dialogue Summary: Fostering Leadership for Health-System Redesign in Canada. Hamilton, Canada: McMaster Health Forum, 4 March 2014.

Dialogue
>	The stakeholder dialogue about fostering leadership for health-system redesign in Canada was held on 4 March 2013 at the McMaster Health Forum in Hamilton, Ontario, Canada.

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SUMMARY OF THE DIALOGUE

Dialogue participants focused on six main issues when deliberating about the problem: 1) the lack of a shared understanding of core concepts related to leadership and its goals in Canada; 2) the unfairness and downside of using language that implies that the problem is in some way a failure of existing leadership; 3) missed opportunities to learn from the pockets of innovation and examples of leadership excellence that exist across the country and internationally; 4) hierarchical management and accountability structures that conflict with the realities of healthcare as a complex-adaptive system; 5) the degree of health-system fragmentation across the country and the challenges that arise with any efforts to enhance coordination; and 6) the over-politicization of healthcare and the resulting disincentives for innovation and risk-taking.

Participants generally agreed that there is a need to move forward in three domains even though some tensions remain, particularly between accountability-driven health-system leadership and complex-adaptive systems thinking. First, dialogue participants generally agreed about the need to support and iteratively bring coherence over time to local, provincial, regional and national calls to action for preparing leaders to achieve health-system transformation that puts our health systems back at the top of world rankings (e.g., Triple Aim). They also agreed that the notion of acting locally [and provincially], connecting regionally, and learning nationally and globally' should be incorporated in such efforts. Second, they supported promoting a Canadian dialogue about the language and logic of complex systems, of leadership to support transformation in complex-adaptive systems (including the LEADS in a Caring Environment Capabilities Framework), and of talent management that identifies promising leaders, supports their 'learning by doing,' and holds them accountable while not blaming them for taking measured risks. Related to this, they also supported allowing others to work on – but not emphasizing – context-appropriate forms of credentialing, curricular coherence, database development, human resource planning and explicit expectations for leadership and leadership programs. Third, participants called for strengthening the network(s) that can identify and evaluate innovative practices in leadership for health-system transformation and in leadership enhancement and disseminate and scale up 'what works.'

Participants committed to take personal actions to foster leadership for health-system redesign, including: committing to keeping the conversation going; 2) adopting more compelling language in all aspects of their work to promote leadership; 3) raising the profile and highlighting the importance of leadership development in meetings; 4) setting the 'leadership bar' higher for those working within their organizations; 5) developing tools that make use of frameworks such as LEADS to promote leadership development; and 6) helping people use existing databases and resources to take stock of innovative practices in leadership development, identifying critical gaps, and developing tools that can be used to improve access to this knowledge. They also committed to collaboratively identify opportunities to engage with and improve existing (and to create new) networks and collaborations that can be used to foster leadership.

SUMMARIES OF THE FOUR DELIBERATIONS

DELIBERATION ABOUT THE PROBLEM

Participants generally agreed with the many features of the problem that were presented in the issue brief. However, six main issues served as the focus for much of the deliberation: 1) the lack of a shared understanding of core concepts related to leadership and its goals in Canada; 2) the unfairness and downside of using language that implies that the problem is in some way a failure of existing leadership; 3) missed opportunities to learn from the pockets of innovation and examples of leadership excellence that exist across the country and internationally; 4) hierarchical management and accountability structures that conflict with the realities of healthcare as a complex-adaptive system; 5) the degree of health-system fragmentation across the country and the challenges that arise with any efforts to enhance coordination; and 6) the over-politicization of healthcare and the resulting disincentives for innovation and risk-taking.

First, many participants noted the lack of shared understanding of core concepts related to leadership and its goals in Canada, including how leadership can be essential to health-system redesign. Several participants noted that a challenging paradox exists: while improving on health-system leadership in Canada may result in a clearer vision for health-system redesign and how to achieve it, a clearer vision may also help to strengthen health-system leadership. Participants did not have a clear answer for how to overcome this challenge, although many agreed about the need to start by developing a shared understanding about:

- why do we need leadership and for what purpose?
- what health-system goals exist in Canada, and which of these are priorities that leaders in all provincial and territorial health systems can agree to?
- how is health-system redesign defined, and how is success with respect to redesign measured?
- what is meant by the idea of a health system being complex and adaptive and what does this mean for the types of leadership required?
- what is the right balance between the need for accountability-driven leadership approaches that hinge on clearly defined goals and objectives, and the need for complexity- and adaptive-learning leadership approaches that would be unhelpfully constrained by such goals and objectives? and
- what are the most important properties of leadership development, both formal and informal?

Second, a number of dialogue participants expressed concern about using language that implies that the problem is in some way a failure of existing leadership. Some participants expressed concern that such wording is unfair (given the constraints under which many leaders are working) and has a significant downside (given that it will complicate efforts to craft creative solutions). One participant noted that existing leaders are the very people who need to be engaged in efforts to reshape the leadership landscape in the country and to develop a collective vision for how to lead health-system redesign. This individual noted that if the right language is not used to engage existing leaders they are likely to block efforts to foster leadership for health-system redesign.

Third, and in a way the flip side of the challenge related to acknowledging any shortcomings in existing leadership, a few participants argued that we frequently miss opportunities to learn from the pockets of innovation and examples of leadership excellence that exist across the country and internationally. One participant noted that in Canada health-system leaders can experiment and sometimes achieve great success with their experimentation. Participants cited the Saskatchewan government's adoption of the LEADS framework to assess leadership capacity and promote leadership development for health-system redesign as an example of an innovation that other provinces and territories can learn from. Some participants noted that there are good examples from other countries (e.g., Sweden and the U.K.) and sectors (e.g., business) that should also be considered to help guide leadership development in Canadian health systems.

Fourth, a few dialogue participants argued that existing hierarchical management and accountability structures conflict with the realities of healthcare as a complex-adaptive system. They highlighted that such structures lead to inappropriately mechanistic and linear approaches that fail to acknowledge the complex nature of health systems and the need for continuous adaptation and learning (e.g., in response to aging populations and patients with multiple morbidities and diverse needs). While many participants agreed with this point, there were some who argued that this observation may only be relevant at higher levels of the system, where the interdependencies between healthcare and other sectors are greater, and others who argued that there are benefits (not just limitations) to hierarchical structures, particularly with respect to ensuring accountability.

Fifth, several participants lamented the degree of health-system fragmentation across the country and the challenges that arise with any efforts to enhance coordination. Canada's federal system of governance has resulted in what are now 13 unique health systems embedded within a national healthcare framework that is, in the view of a few dialogue participants, losing significance given the federal government's curtailed role in health-system stewardship. As a result, some participants agreed that it is up to provincial and territorial governments to take responsibility for fostering leadership for health-system redesign in Canada. Many participants embraced the idea of greater regional coordination (i.e., coordination across several provinces and territories), if not greater national coordination, particularly if it is pursued by provincial and territorial governments themselves.

Finally, several dialogue participants also lamented the over-politicization of healthcare and the resulting disincentives for innovation and risk-taking in health-system redesign. The fear of being blamed for failure within highly politicized health systems has created a situation in which it is very difficult to find strong leaders who are willing to take on the challenge of leading redesign initiatives. However, participants all agreed that it was important to 'push back' collectively against this politicization and its consequences as a way to create a more positive climate within which to pursue such initiatives.

DELIBERATION ABOUT ELEMENTS OF AN APPROACH

The elements of a potentially comprehensive approach to fostering leadership for health-system redesign that were presented in the evidence brief were generally positively received, although most participants agreed that they required further consideration and some re-framing in order to account for the many nuanced aspects of the problem that emerged during earlier deliberations about the problem. Participants collectively and iteratively re-framed many of the elements, and the majority of participants indicated their comfort with the re-framings. However, while many participants felt that these elements can be considered a good start with respect to addressing existing problems, it was acknowledged that there are still some unresolved tensions that will need to be considered going forward.

Element 1 – Create and implement a pan-Canadian initiative that will support a dramatic enrichment of leadership capacity

The deliberation about the first approach element began with a general agreement that adjustments needed to be made to the wording and scope of the element, given the nature of the deliberation about the problem and its causes. One initial re-framing that was suggested at the outset of deliberations acknowledged the role of local and regional innovation and excellence in fostering leadership development, and had as its goal to "support and iteratively bring coherence to local and regional calls to action to enrich leadership capacity." Although many participants agreed that this re-framing was an improvement on the original wording, four issues were raised in the discussions that followed.

First, several participants flagged that the proposed re-framing failed to acknowledge the vital role that is required at the national level. One participant suggested that omitting a complementary national dimension to the element in favour of focusing only on local and regional calls to action was, in effect, taking a step backwards. Most participants agreed that it was necessary to clearly state that there is a role to be played at the national level, and that this is essential for success.

Second, some participants highlighted the need to acknowledge the temporal nature of leadership development at any one level (i.e., local, provincial, regional or national). These participants reminded the group that leadership development will not be happening in all places at the same time and at the same pace. As such, 'coherence' needs to be understood through a temporal lens to ensure that realistic expectations are set.

Third, many participants noted the need for establishing clear, measurable outcomes that reflect the overall aim of leadership development in Canada. Some participants argued that using the 'Triple Aim' as the goal may be the most tractable way to define outcomes that resonate with stakeholders at all levels. Other participants argued that putting Canada back atop world rankings of health-system performance should be the goal, and hence the driving force behind leadership development in the country. Still other participants noted the tension between establishing accountabilities for achieving either goal, and understanding the health system as a complex-adaptive system that requires a different approach to leading change. While many participants continued to push for clear goal-setting, several participants concluded that the tension between accountability-driven health-system leadership and complex-adaptive systems thinking was still unresolved and would continue to pose a challenge.

Fourth, some of the participants who were supportive of accountability-driven health-system leadership noted the need to establish the right balance between individual and collective accountabilities and among local, provincial, regional and national levels accountabilities.

After taking these issues into consideration, an additional re-framing of the first element was considered: "support and iteratively bring coherence over time to local, provincial, regional and national calls to action for preparing leaders to achieve health-system transformation that puts our health systems back at the top of world rankings (e.g., Triple Aim)," with the notion of "acting locally [and provincially], connecting regionally and learning nationally and globally" incorporated in these efforts. Most participants felt that, despite some unresolved tension noted above, this re-framing was a good start in addressing some of the key challenges discussed in the deliberation.

At the conclusion of deliberation about the first element, some participants still felt the need for a clearer definition of the 'what' and the 'how' of developing leadership capacity for health-system redesign. Additionally several participants suggested that there is also a need for the creation of a 'burning platform' that compels people to take notice and support large-scale, bold changes to health-system redesign across the country.

Element 2 – Create and implement a pan-Canadian succession-planning project

The deliberation about the second element began with the acknowledgement by many participants that a vital first step is to promote the establishment of a common understanding about what is meant by leadership, leadership development, and leadership in complex-adaptive systems (and a common language based on this understanding). Some participants suggested that the LEADS framework could serve as an appropriate starting point for such discussions, although it was also acknowledged that this framework, as with any framework, will likely need to evolve over time. As one example of using a common language, most participants agreed that the term 'talent management' is preferable to 'succession planning.'

Much of the remaining deliberation about the second element focused on the apparent tension between informal and formal approaches to leadership development and talent management. On the one hand, several participants who supported the use of informal approaches to leadership development argued that leadership skills are largely developed through 'hands-on' experience and 'learning by doing.' One participant noted that there is a "need to develop more 'know how' not [acquire] more 'knowledge'." Those that shared this view stressed the importance of mentorship and the fact that leadership is an 'experience-based' phenomenon. Most participants agreed that mentorship was a core component of the 'learning-by-doing' model. Participants advocating for informal approaches expressed concern that introducing greater formalization, including curriculum standards and structured apprenticeship programs, would 'over-professionalize' leadership and lead to 'over-specialization' in leadership (thereby promoting what one participant called "credential creep"), and would reinforce the types of rigid hierarchical systems of leadership that were identified as a challenge during the deliberation about the problem. A few participants reiterated that this concern reinforces the need to further explore how thinking about leadership and health-system redesign intersects with thinking about complex-adaptive systems.

On the other hand, participants who supported the use of more formal approaches to leadership development argued that, while the challenges associated with its formalization were real, it was also important to acknowledge that leadership development is far too fragmented and inconsistent across the country. These participants argued that a more formalized approach would "put everyone on the same page" to move forward with leadership development in Canada. Additionally, while acknowledging the limitations of the traditional 'guild' approach to education, several dialogue participants suggested that this should not mean that there are no structured programs and resources available to aspiring leaders seeking to build a core set of skills. Many participants agreed with this argument and acknowledged that, despite the need for informal approaches, "people generally want to see that leaders have" credentials, and apprenticeship models need to strike a balance between experiential and formalized learning.

Turning to the apparent tension between informal and formal approaches to monitoring where we are with talent management, participants focused primarily on the specific question about whether to create a centralized repository of data about leaders in the country, which could contain data about their training, skills, credentials and experience. Some participants felt that such a repository was a step too far, while others argued that it was critical to know the characteristics and distribution of Canadian health-system leaders. One individual who supported the creation of a repository suggested that it could be structured according to the LEADs framework.

The deliberation about the second element led to most participants agreeing on a revised framing that took into account many of the issues that had been discussed, as well as additional issues that emerged:
1) promote a Canadian dialogue about the language and logic of complex systems, of leadership to support transformation in complex-adaptive systems (including LEADS), and of talent management that identifies promising leaders, supports their 'learning-by-doing,' and holds them accountable while not blaming them for taking measured risks; and
2) allow others to work on (but don't emphasize) context-appropriate forms of credentialing, curricular coherence, database development, human resource planning and explicit expectations for leadership and leadership programs.

Element 3 – Coordinate research and knowledge mobilization efforts about health leadership in Canada

Deliberations about the third element began with participants discussing how to best re-frame the element in order to reflect what was discussed at earlier points in the dialogue. The suggested wording that most participants agreed upon was: "create the network(s) that can identify and evaluate innovative practices in leadership for health-system transformation and in leadership enhancement," and disseminate and scale up 'what works.' One participant reminded the group that the Canadian Health Leadership Network does this type of work, while recognizing that it could do better to achieve this aim across the country. Most participants agreed that the Canadian Health Leadership Network could serve as a 'way in' to this element (and hence the wording 'create' could be changed to 'strengthen').

A large proportion of the remaining deliberation about this element focused on the functions, likely challenge and possible impacts of such a network or networks. First, several participants suggested that a key function would be to learn from the best available research evidence and from the experience of leaders in the field. Second, one participant suggested that another key function would be to identify critical gaps in the available research evidence base. Third, several participants suggested that one way to operationalize such functions would be to create an online 'clearing house' that would serve as a 'one-stop shop' for those in the network who want to quickly access knowledge related to leadership development. A few participants noted that such an initiative should build on existing technologies and efforts, rather than starting from scratch. Fourth, some participants highlighted that a key challenge for the network(s) would be to establish appropriate criteria for determining 'what works,' and that this should be addressed in future discussions. Fifth, some participants indicated the work of such a network or networks could help to establish support for leadership development among a wider range of stakeholders in the country, and thereby contribute to the scaling up of the network(s) and hence a broader platform to push forward leadership development at local, provincial, regional and national levels.

Considering the full array of approach elements

Participants generally agreed that there is a need to move forward even though some tensions remain, particularly between accountability-driven health-system leadership and complex-adaptive systems thinking.

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Many participants agreed that defining a clear vision that is agreed upon and can be used as a rallying cry is important to gain traction on this issue, however, politicization, blame avoidance and risk aversion will continue to pose challenges to any efforts to foster leadership for health-system redesign in Canada. While it was generally agreed that some adjustments could be made to the elements in future, the following re-framings were largely supported by participants:

1) support and iteratively bring coherence over time to local, provincial, regional and national calls to action for preparing leaders to achieve health-system transformation that puts our health systems back at the top of world rankings (e.g., Triple Aim), with the notion of acting locally [and provincially], connecting regionally and learning nationally and globally incorporated in these efforts;

2) promote a Canadian dialogue about the language and logic of complex systems, of leadership to support transformation in complex-adaptive systems (including LEADS), and of talent management that identifies promising leaders, supports their 'learning by doing,' and holds them accountable while not blaming them for taking measured risks (as well as allow others to work on – but not emphasize – context-appropriate forms of credentialing, curricular coherence, database development, human resource planning and explicit expectations for leadership and leadership programs); and

3) strengthen the network(s) that can identify and evaluate innovative practices in leadership for health-system transformation and in leadership enhancement, and disseminate and scale up 'what works.'

DELIBERATION ABOUT IMPLEMENTATION CONSIDERATIONS

Participants identified several barriers that exist in relation to implementing the elements as they were re-framed. First, some participants suggested that leadership development is not currently viewed as a priority healthcare issue in Canada, and as a result there is a lack of perceived urgency to address it. Second, the use of any language that implies that the problem is in some way a failure of existing leadership will understandably create ill will among existing leaders and drain support from efforts to foster leadership. Third, the current hierarchical nature of management and accountability structures in the country are very much aligned with the 'guild' culture, which is very difficult to transform given the many vested interests it has created and supported over time. Fourth and finally, most participants agreed that the over-politicization of healthcare has created a pervasive culture of blame avoidance and risk aversion, which impedes those leaders best positioned to engage in health-system redesign.

However, despite these barriers, most participants agreed that there was cause for optimism in fostering leadership for health-system redesign in Canada, and three identified three specific windows of opportunity that could be used to further promote action around the issue. First, the pending federal election in 2015 was viewed as an opportunity to get leadership and health-system redesign on the federal government agenda, including specific ideas for the types of investments needed. Second, the National Health Leadership Conference to be held in June 2014 in Banff, Alberta was viewed as an opportunity to share ideas related to leadership enhancement and gain support for some of the strategies that were discussed in the deliberation about approach elements. Third, many participants felt that momentum was building around the issue of leadership and that there are opportunities to build on some of the initiatives currently being rolled out across the country (e.g., the Institute for Health Services and Policy Research's recent launch of the SPOR network in primary and integrated healthcare that aims to link together knowledge producers and users on targeted policy topics, and the Canadian Health Leadership Network's many efforts in this domain).

DELIBERATION ABOUT NEXT STEPS FOR DIFFERENT CONSTITUENCIES

During deliberations about next steps, participants generally committed to either taking personal actions in their own settings that would help to foster leadership for health-system redesign, or further engaging in collaborative efforts to foster health leadership in Canada. Personal commitments made by participants included a range of actions, but broadly fell into one of the following categories:
1) committing to keeping the conversation going;
2) adopting more compelling language in all aspects of their work to promote leadership;
3) raising the profile and highlighting the importance of leadership development in meetings;
4) setting the 'leadership bar' higher for those working within their organizations;
5) developing tools that make use of frameworks such as LEADS to promote leadership development; and
6) helping people use existing databases and resources to take stock of innovative practices in leadership development, identifying critical gaps, and developing tools that can be used to improve access to this knowledge.

Collaborative commitments generally fell into one of three categories:
1) identifying opportunities to engage with existing collaborations and networks that can help to promote leadership development and knowledge sharing (e.g., Canadian Health Leadership Network's efforts to create a national leadership development action plan, Strategy for Patient Oriented Research-supported networks focused on mental health and primary care);
2) incorporating lessons learned during the dialogue to inform and shape existing networks as a way to leverage capacity and move forward with leadership development; and
3) purposefully creating and developing new collaborations or networks that will serve as a magnet for others interested in fostering leadership for health-system redesign in Canada.