

The challenge of clinician and health system leadership

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Health System leadership

All the OECD nations face a challenge in terms of health system sustainability, affordability and fitness for purpose. Two common and inter-related barriers to successful reform in this context are a shortfall in clinician and health system leadership and inadequate health system intelligence.

Health System leadership

The shortcomings in clinician and health system leadership largely arise because leadership in health is generally not highly valued and as leadership skills are not usually regarded as a core element of health professionalism.

Health System leadership

The Medical School approach:

A focus on communication skills and patient-ethics in professionalism development.

The Navy approach:

Career planning and explicit leadership development – a focus on values based and contextual leadership styles.

Health System leadership

A major problem in developing health system leadership is in defining the purpose of that leadership. That is, If the answer is “better clinician and health system leadership”, then just what is the question being asked?

Health System leadership

Question One:

Who is going to govern and manage the health system?

Question Two:

What is needed for OECD nations' health systems to become sustainable, affordable and fit for purpose?

Governance and management

Most senior health appointment processes are characterised by a limited number of suitable candidates. The development of a health system governance and management cohort requires talent spotting, mentoring and apprenticeship.



**Course work
in leadership**

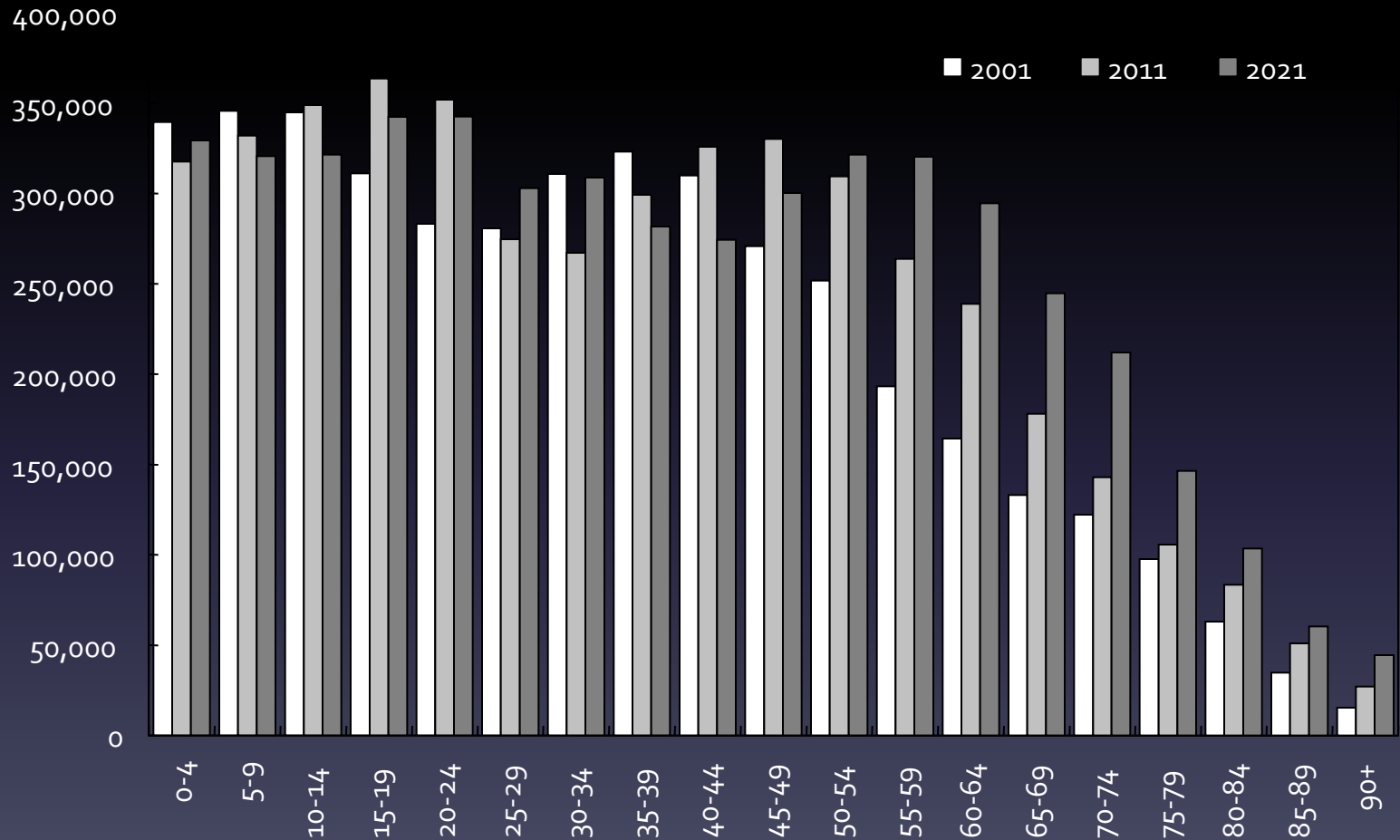
**Mentoring and
careers advice**

Apprenticeship

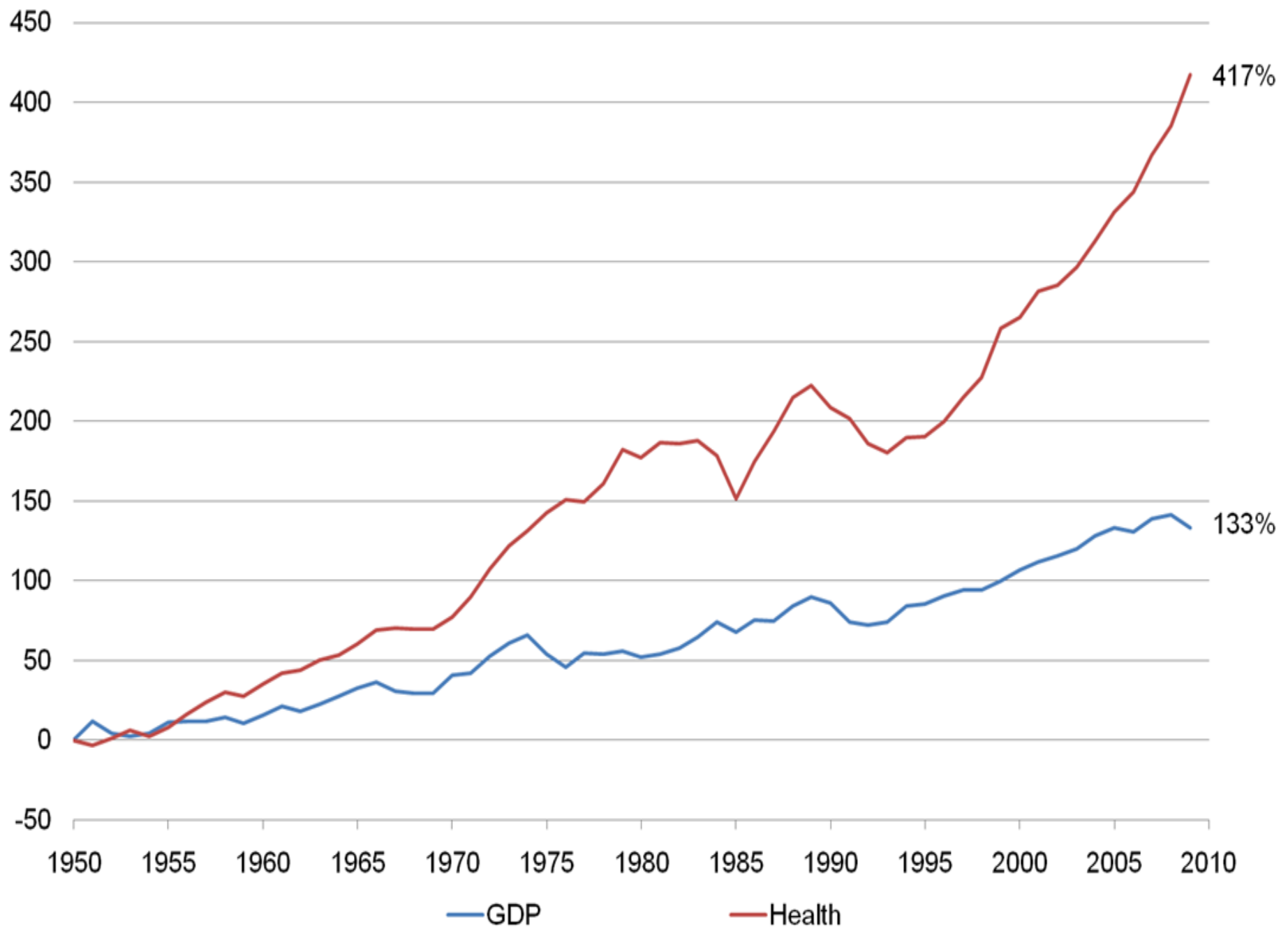
Sustainability, affordability and fitness for purpose

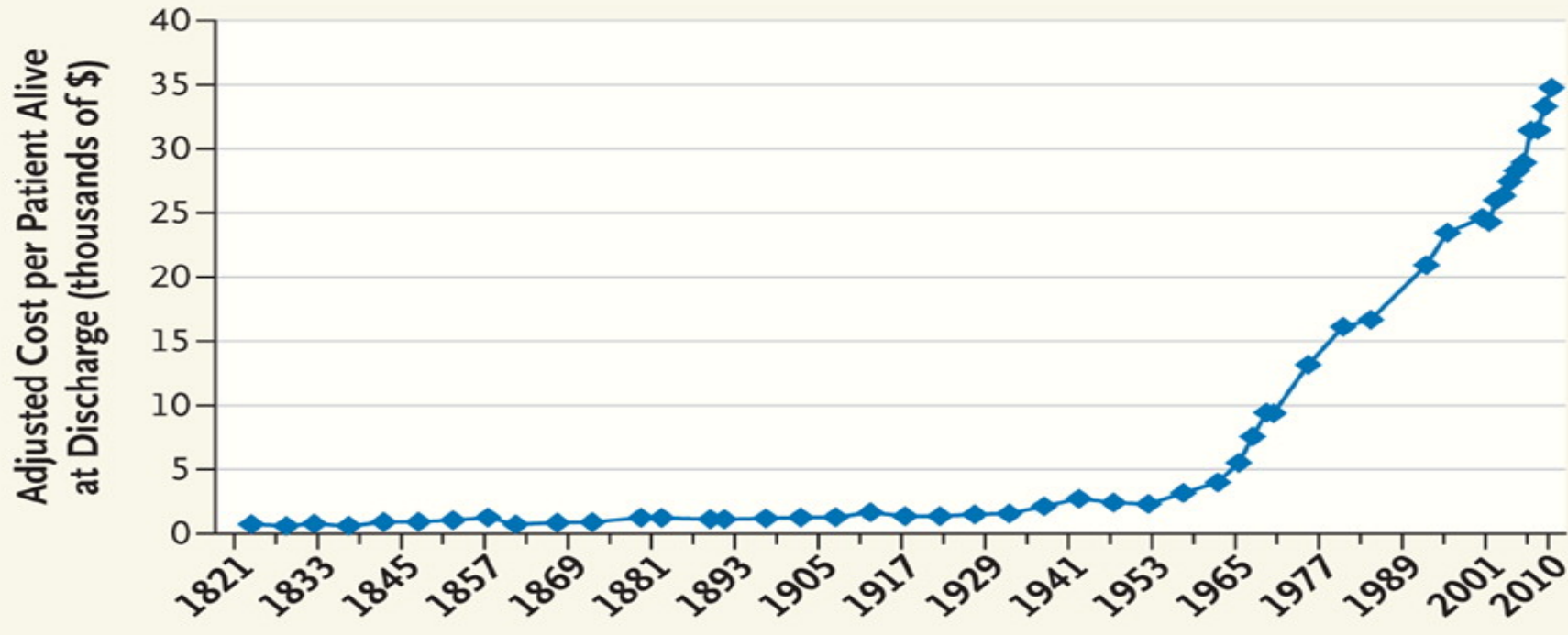
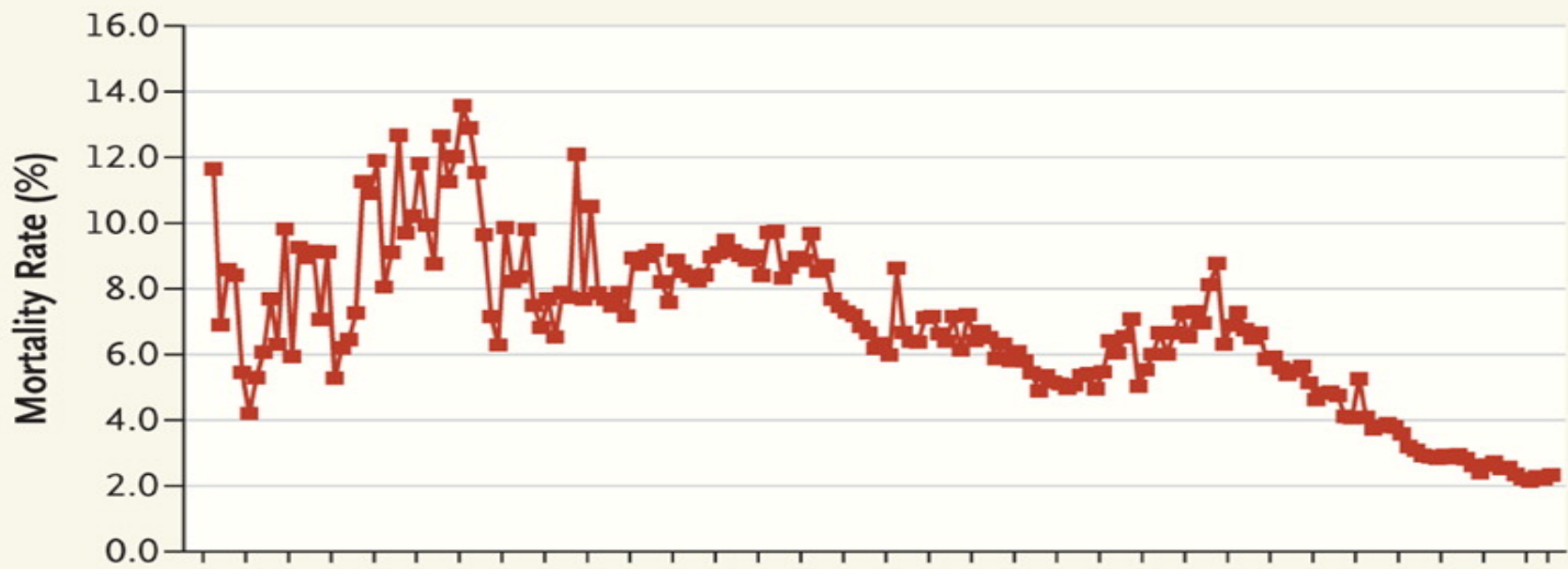
- Problem definition.
- The elements of health system inflation.
- The failure of “managerialism”.
- The skill sets and a business model for leadership at the patient-provider interface.

NZ Population Projections by Age Cohort (Assuming medium population growth)



Cumulative % change





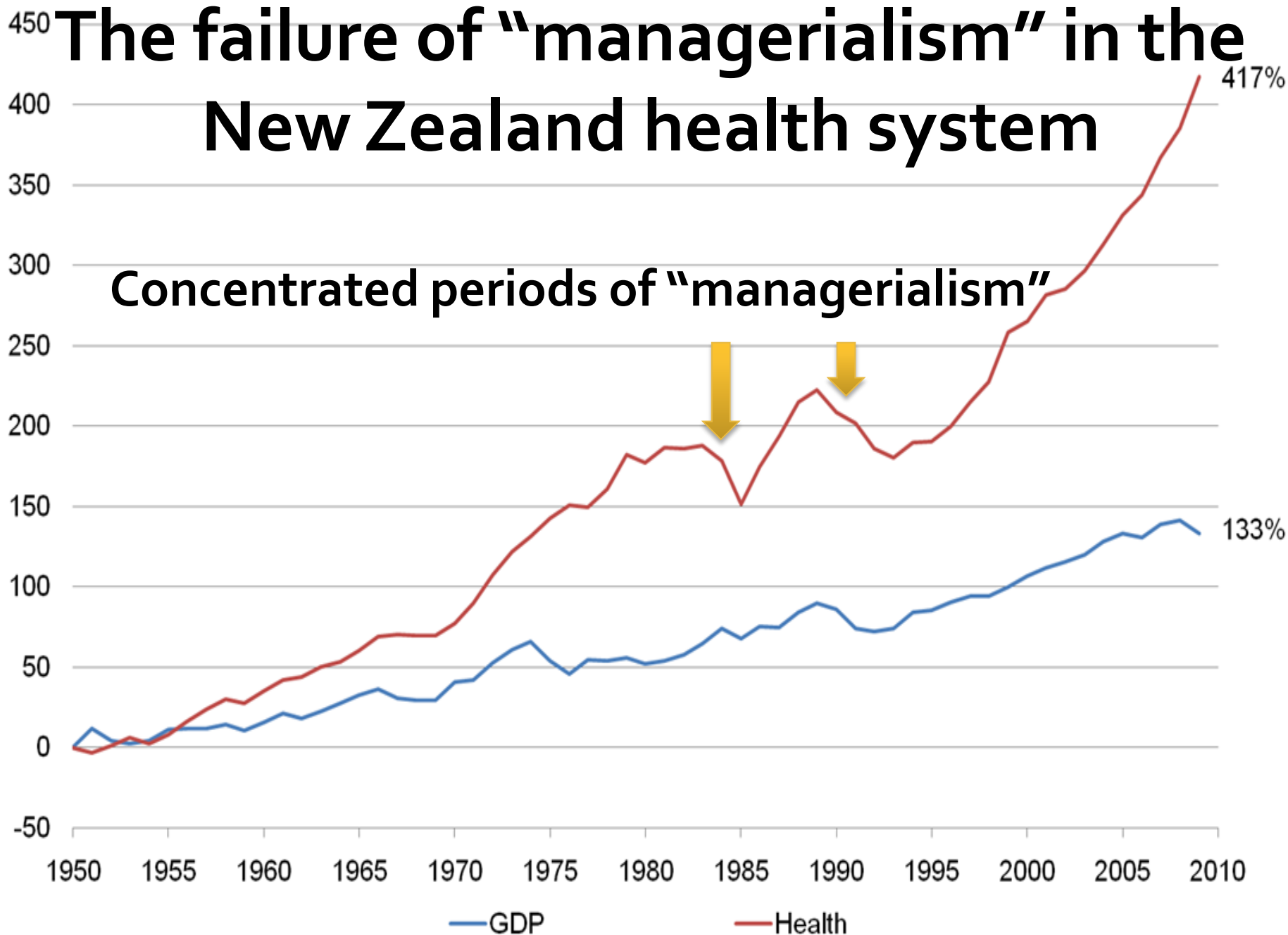
Health system inflation

- In the context of negligible gains in the quality of health outcomes, what do significant increases in health costs indicate?
- What contributes to the 8.5% per annum health cost inflation in New Zealand?
- What is the ethical basis of rationing in a wasteful health system?

Cumulative % change

The failure of "managerialism" in the New Zealand health system

Concentrated periods of "managerialism"



Sustainability, affordability and fitness for purpose

- The skill sets for leadership at the patient-provider interface.
- A business model to empower leadership at the patient-provider interface.
- The principles of behavioural economics.

A business model to empower leadership in health

A focus for clinician leaders on innovative clinical developments and for managers on consequent implementation – execution matters and is generally the weakest function of most health systems.

A business model to empower leadership in health

Commit appropriate intelligence and resources to identify and manage barriers to successful implementation of innovative models of care and service configurations.

A business model to empower leadership in health

As well as shortfalls in clinician and health system leadership, common barriers are inadequate health system intelligence, restrictive business models and (often perverse) funding systems, restrictive regulatory practice, the threat of litigation, and territorial behaviour by potentially disrupted craft groups and professions.

A business model to empower leadership in health

Given that “you get what you pay for”, use behavioural economics principles to solicit desirable leadership behaviours or preferably to achieve desirable health outcomes that depend upon effective leadership.

Campbell SM. Effects of pay for performance on the quality of primary care in England. NEJM 2009; 361: 368-78

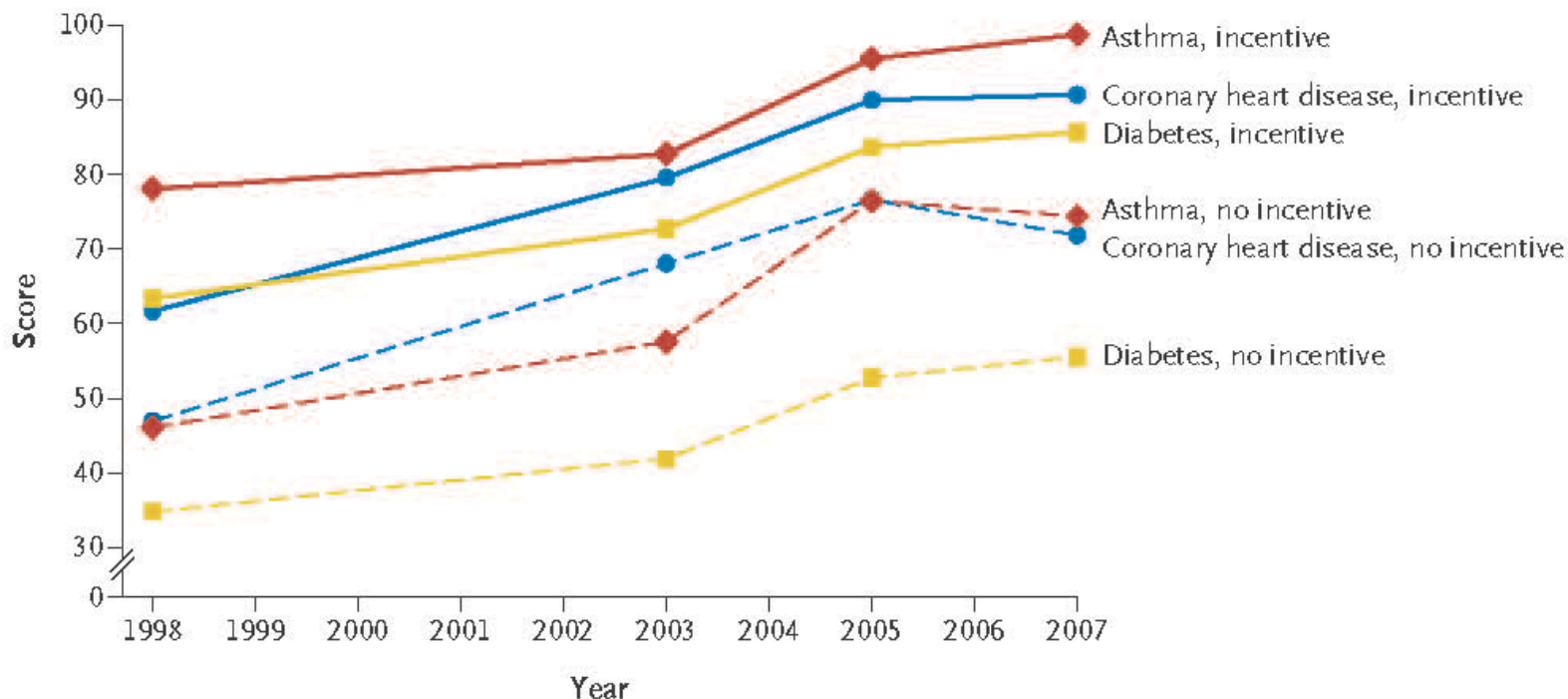


Figure 2. Mean Scores for Clinical Quality at the Practice Level for Aspects of Care for Coronary Heart Disease, Asthma, and Type 2 Diabetes That Were Linked with Incentives and Aspects of Care That Were Not Linked with Incentives, 1998–2007.

Quality scores range from 0% (no quality indicator was met for any patient) to 100% (all quality indicators were met for all patients).

Figure 6: Average hours worked per week by work role at main work site

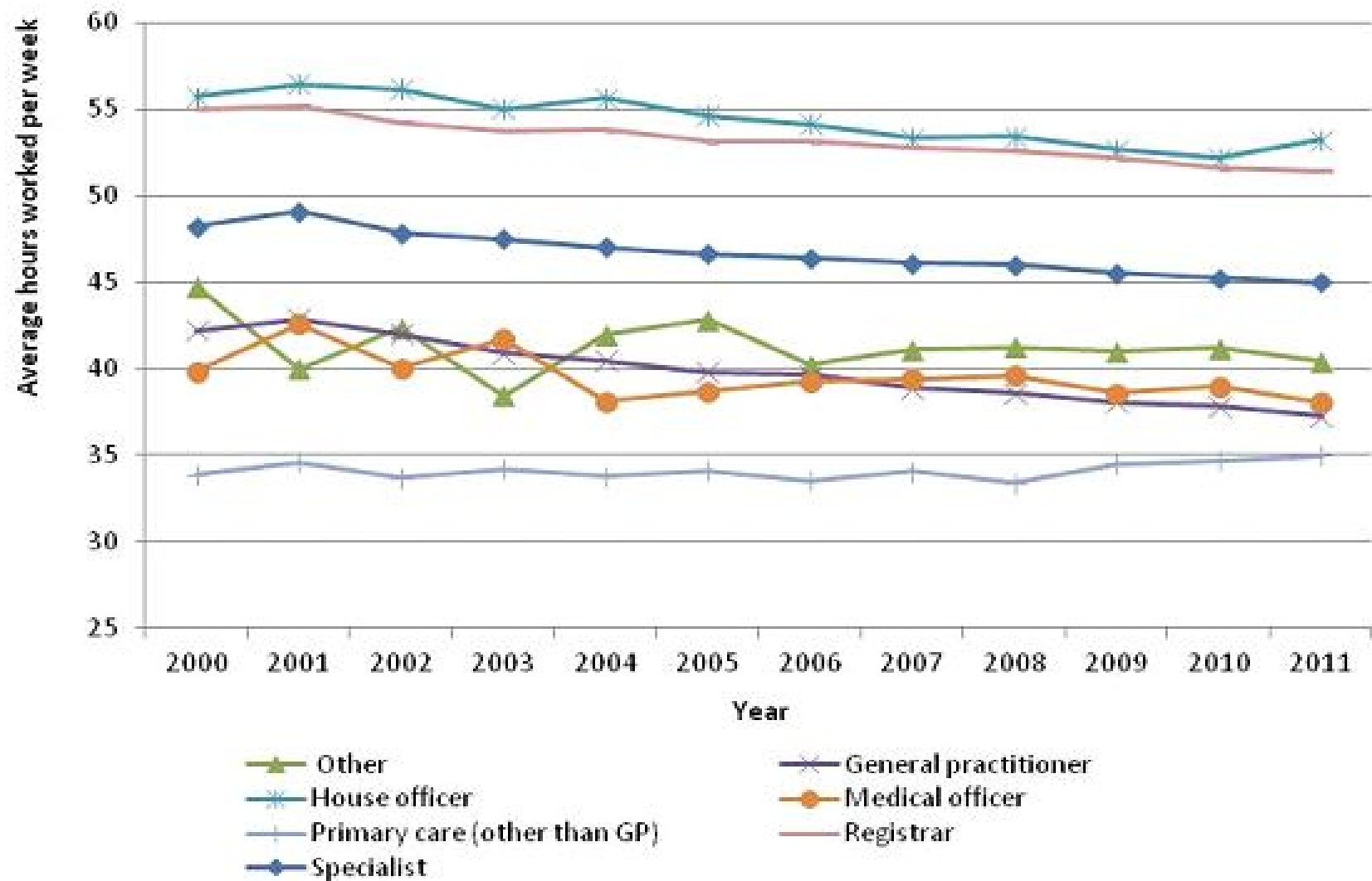
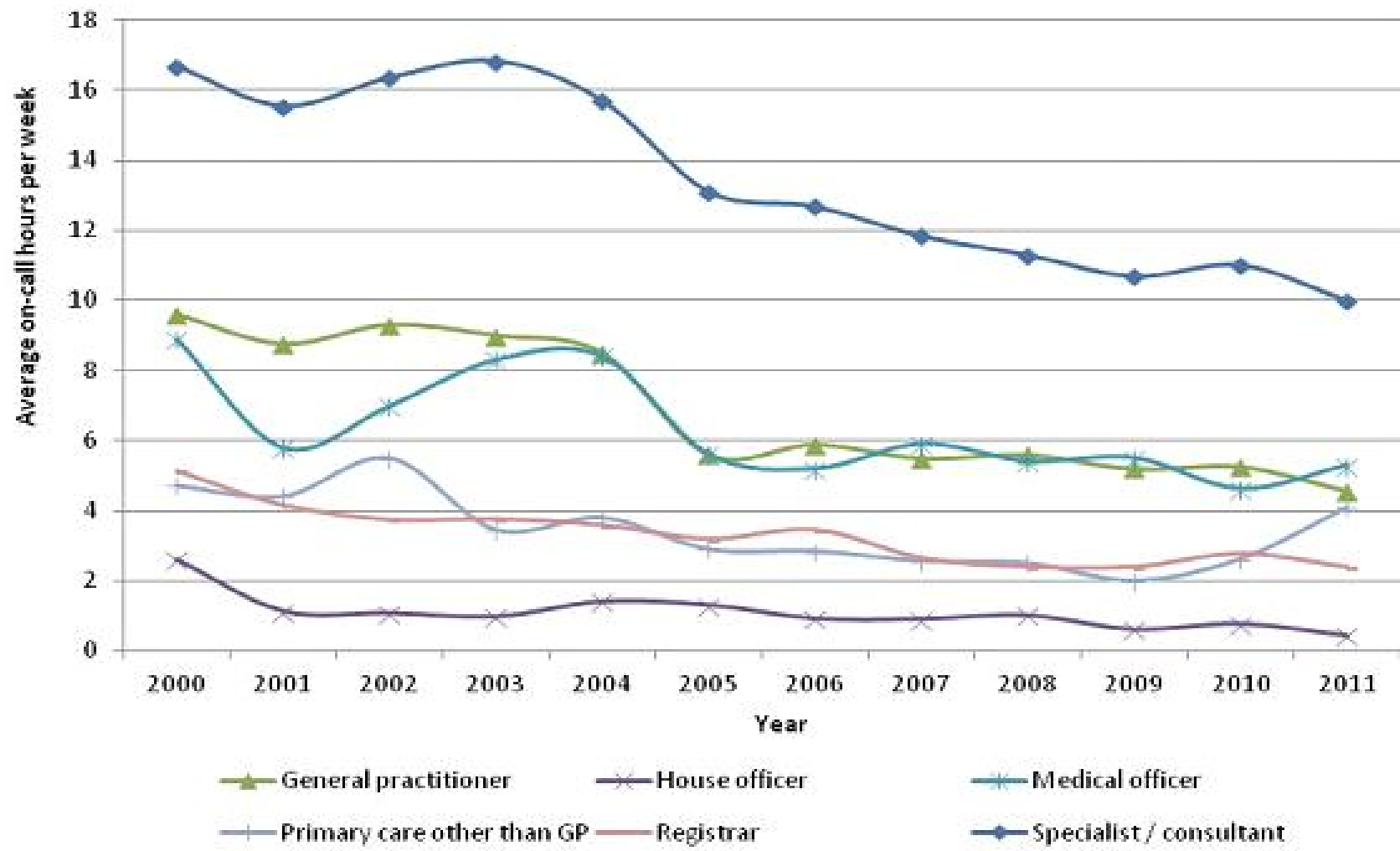


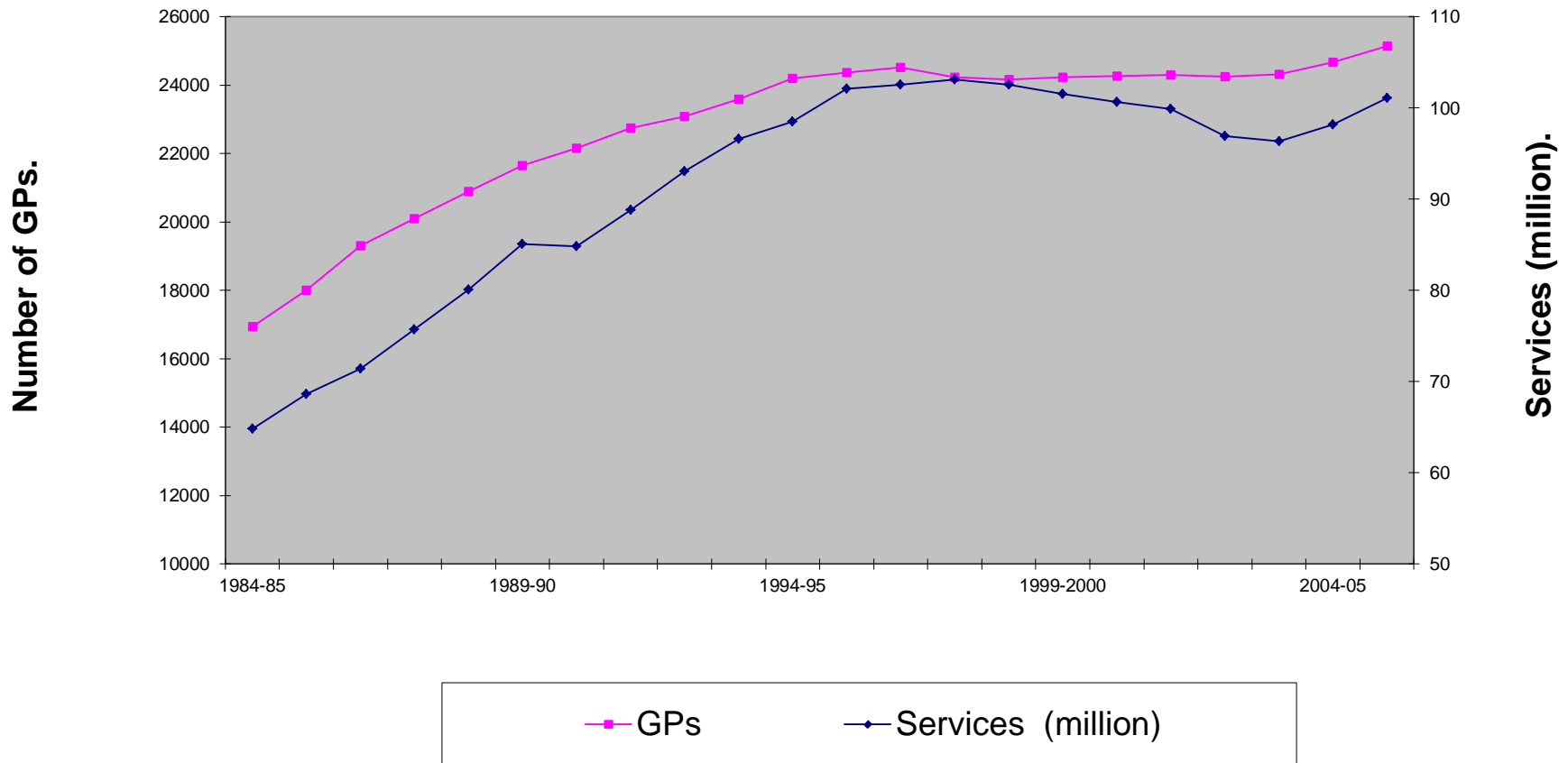
Figure 8: Average on-call¹ hours, by work role at main work site



¹ On-call hours are defined as hours when the doctor was on call, but not actually working.

Relationship between GP numbers and services in the Australian fee-for-service health system

GP Numbers and GP Services 1984-85 to 2005-06



Behavioural economics

Despite the relatively poor experience of paying healthcare providers for performance, there are lessons that can be derived from this experience and that are applicable to the leadership in health agenda.

Behavioural economics

Lessons from the UK:

- Do not reward people for what they do anyway.
- Involve clinicians in system design and in road testing.
- Be clear about objectives and desirable changes.

Lessons from the UK:

- Create a scheme that can evolve.
- Avoid large bureaucracies and over-engineering.
- Publish (accurate and clinically-owned) benchmarking data.

Behavioural economics

Lessons from the UK:

- Do not rely on remuneration alone to improve leadership performance.
- Incentivise contextual leadership.

Lessons from the UK:

What are needed are middle managers and clinician leaders who can set and measure performance goals, and can use available improvement tools.

Behavioural economics

Lessons from the UK:

- Be careful in how you link leadership activity and rewards to avoid gaming and unexpected perverse outcomes.

Lessons from the UK:

- Employ a national leadership reward network, but ensure system flexibility for local applications.

Behavioural economics

Lessons from the US:

- Use a series of incentives rather than a single 'mega'-incentive and a series of tiered thresholds rather than one absolute threshold.

Lessons from the US:

- Minimise the time between the behaviours or outcome being incentivised and the receipt of the reward.
- Use withholding measures as these are more effective than bonuses.

Behavioural economics

Lessons from the US:

- Keep incentive schemes simple.
- Use shared-savings or shared-risk programs.
- Separate rewards for leadership from usual reimbursement.

Lessons from the US:

- Use in-kind rewards rather than cash.
- Pay enough or don't pay at all.
- Use a broad dashboard of measures.

Health System leadership

All the OECD nations face a challenge in terms of health system sustainability, affordability and fitness for purpose. Successful reform in this context will require correction of the shortfall in clinician and health system leadership.