Improving the performance of health services: the role of clinical leadership

Chris Ham

Reform of health-care systems in the past decade has been driven by ideas such as public/private partnerships, managed competition, managed care, and integrated care. These abstractions betray the grand nature of ambitions harboured by reformers. Faced with funding pressures on the one hand, and failures of service delivery on the other, policymakers have entertained radical solutions in the hope they will lead to improvements in health-system performance. In practice, reform has generally fallen short of both rhetoric and expectations, leading to reappraisal of the strategies pursued and a search for new policies.

The failure of radical solutions stems in part from their limited effect on clinical practice. Improvement of the performance of health care depends first and foremost on the views, preferences, and needs of individuals and the clinicians they entrust to care for them. Their daily work is driven by underlying values and beliefs, and limited by practical constraints. The strategies pursued and a search for new policies. These abstractions betray the grand nature of ambitions harboured by reformers. Faced with funding pressures on the one hand, and failures of service delivery on the other, policymakers have entertained radical solutions in the hope they will lead to improvements in health-system performance. In practice, reform has generally fallen short of both rhetoric and expectations, leading to reappraisal of the strategies pursued and a search for new policies.

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A key feature of professional organisations, as Henry Mintzberg noted over 20 years ago, is that professionals have a large degree of control. As a result, the ability of managers, politicians, and others to influence decision-making is more constrained and contingent than in other organisations. Thus, ways to have found of generating change bottom-up, not just top-down, especially by engaging professionals in the reform process. This includes recognition of the importance of collegial mechanisms in professional organisations and the role that leaders from professional backgrounds themselves can have in bringing about change. Mintzberg’s insights into the nature of professional organisations have been reinforced by studies of the effect of quality-improvement initiatives in health-care organisations in several countries, and we now draw on findings of these studies to explore the challenges entailed in improvement of performance.

Engagement of clinicians

Accepting that influences on clinical practice are many and varied, no one approach to improvement of performance is likely to be sufficient. Rather, several interventions are needed, including educational initiatives, use of opinion leaders, peer-review mechanisms, and financial and other incentives. In many of these interventions, clinicians need the time and space to review established practices, and to introduce new and more effective ways of delivering services.

Of particular importance is the need to understand what motivates professionals in their daily work. As research in the UK has shown, the desire to help people by offering a high standard of service in a timely and courteous manner remains the main motivation of clinicians, notwithstanding well-publicised examples of failures of clinical performance.

Strategies that appeal to this motivation—such as the provision of opportunities for professional education and development—are more likely to attract commitment than are those with the view that professionals need tighter control to deliver services in an effective way. The limitations of initiatives that direct professionals to change what they do has been underlined in studies of the effect of organisational reform.

A good example is a study of the effect of re-engineering of an English hospital. Workers on this study showed that changes in working arrangements initiated by managers had a variable and limited effect. Hospital doctors and their clinical colleagues were unwilling to make changes unless they could see benefits for their own practice and for patients. As a result, many anticipated gains were not realised, and the centrally directed approach to achievement of change that characterised this initiative at the outset gave way to an approach that was adapted to the needs and preferences of individual clinical services and staff working in these services.

This approach was more effective in bringing about change because professionals felt they were leading the process instead of having change imposed upon them. As the study concluded:

“Significant change in clinical domains cannot be achieved without the cooperation and support of clinicians . . . Clinical support is associated with process redesign that resonates with clinical agendas related to patient care, services development and professional development . . . To a large degree interesting doctors in re-engineering involves persuasion that is often informal, one consultant at a time, and interactive over time . . . clinical commitment to change, ownership of change and support for change constantly need to be checked, reinforced and worked upon.”

Researchers on other UK studies have reported similar findings, and have underlined the fragility of changes that are introduced without effective engagement of clinical teams. These studies echo work in Canada that has highlighted the need to show that clinicians will benefit from changes designed to improve the experience of patients. The more general lesson here is that hospitals and other health-care organisations have an inverted power structure, in which people at the bottom generally have greater influence over decision-making on a day-to-day basis than those at the top.


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basis than do those who are nominally in control at the top. In these disconnected hierarchies, organisational leaders have to negotiate rather than impose new policies and practices. Failure to recognise this fact and to carry professionals along with change will invariably result in part implementation of reform efforts.

Bringing about change entails slow and painstaking work in which reformers need to engage clinical leaders and opinion formers in persuading their colleagues to do things differently. In the process, various methods are likely to be needed to achieve change, and there is no evidence that any one method is superior to others. It is also the case that the source of reform is often to be found in the clinical community, and the task of managers is then to lend support to clinicians in making change, by providing money, time, and other resources. As research in the USA into quality improvement initiatives has shown, substantial change is most likely to take place in organisations in which managers work together with clinical champions to introduce new ways of working.12 In other words, both clinical and managerial leadership are needed to bring about improvement in these organisations.

The changing context

Yet, if reformers have to be sensitive to the realities of professional organisations and the motivations of clinicians, so too do professionals need to understand the imperatives faced by policymakers. The days in which the role of governments and funders was simply to provide the framework and resources to enable professionals to practise autonomously have long gone, if they ever existed. The combination of financial pressures, rapidly rising public expectations, and legitimate concerns about unacceptable variations in clinical practice have led to questioning of professional performance. In this context, the challenge for clinicians and the organisations speaking on their behalf is to acknowledge the inevitability of increased accountability and to work with reform.

To be more specific, this work entails refocusing on the education and training of clinicians to achieve a new equilibrium between autonomy and accountability. It also means renewed efforts to inform clinicians about the implications of resource constraints and the need for medicine to be practised within a managed framework, which includes recognition of the imperative for doctors to play a bigger part in management of budgets and services than has traditionally been the case. In view of the difficulties of managers controlling medical work, it is through well-developed systems of clinical leadership that effective change is most likely to be achieved. Clinical leadership needs to be supported by provision of information about clinical practice and development of organisational cultures that value such information and encourage its use as a vehicle for improvement of performance.

In the process, leaders need to be equipped with skills in service redesign and health-care improvement that have been developed and applied in several settings.13 At the heart of these skills lies the ability to see services from the patient’s point of view and to streamline the process of care to eliminate unnecessary steps for patients and to tackle bottlenecks that prevent clinical teams delivering the standard of care to which they aspire. Also important is matching demand for services with capacity to ensure that services are aligned with patients’ needs. Studies of the application of redesign skills in the UK National Health Service (NHS) have reported several service improvements,12–14 even if there have not been the breakthroughs sometimes claimed for these methods.

Obstacles to change

There are two obstacles to engagement of clinicians effectively and development of clinical leadership. The first is to be found in the nature of professional work in health care. Autonomy remains highly valued, and there is reluctance on the part of some doctors to lend support to their peers who take on leadership roles. Not only this but also the incentives for respected clinicians to become leaders are by no means obvious, especially when management has to compete for time and attention with clinical work, research, opportunities to enhance personal income, and leisure time. And in view of the fact that the support available to clinicians who want to move into leadership roles is variable, and career structures underdeveloped, it is easy to see how the default position of independent clinical practice succeeds. Indeed, rejection of the proposed consultant contract in the NHS has served as a timely reminder of the importance attached by doctors to professional autonomy.15

Action is, therefore, urgently needed to make the transition into and out of leadership roles as easy as possible, and to recognise the contribution of leaders both financially and by valuing clinicians who take on these roles. In the case of the NHS, a start has been made on this process, with development of medical director and clinical director roles in hospitals, but much remains to be done to extend these leadership arrangements into primary care. Policies to improve performance also have to confront the paradox that hospitals and primary-care practices contain conservatives and innovators, and left to their own devices these organisations are typically slow to change. This points to the continuing role of managers and policymakers in creation of the context in which effective clinical leadership can be exercised.

To make this point is to highlight the second obstacle to progress, namely the impatience of reformers and those they serve. If changes in health-system performance and clinical practice are best achieved through clinical engagement, and by a series of incremental steps rather than through a big bang, then this process might not satisfy policymakers and taxpayers, who increasingly expect to see quick results. The risk then is that reformers will resort to the radical solutions that, at best, have had partial success. The result will be a widening gulf of understanding between politicians and clinicians. To avoid this risk, policymakers need to be reminded of the limited effect of big-bang reforms, and they need hard evidence that bottom-up changes introduced incrementally over time really will result in more effective and enduring service improvements. This means building on evaluations of past and present improvement programmes and showing how high performing organisations, in which professionals are fully engaged in the process of change, have developed effective systems of clinical leadership.

The way forward

Assuming these obstacles can be overcome, which could yet prove to be an heroic assumption, then two points need particular emphasis. The first is that leaders need followers to be effective.16 Arguably, development of followship is an even bigger challenge in health-care organisations than development of leadership. Creation of organisations in which professionals are willing to follow their leadership will require as much attention as encouragement of clinical leadership. In this sense, successful reform needs to focus on organisational development, not merely leadership development.17
The second point is the importance of developing a better understanding of leadership in health-care organisations. Here, research into leadership in Canadian hospitals underlines the role of leadership teams rather than heroic individuals. It also highlights the fragile and contingent nature of leadership and the tendency for reform to proceed through fits and starts. More studies of leadership practices and their results in different systems are urgently needed to provide an evidence base to lend support to programmes of leadership and organisational development. In the absence of such studies, there is a risk that insights that can be drawn from experiences of health-care reform will not be translated into effective interventions by policymakers who recognise the weaknesses of big ideas and who are searching for more soundly based alternatives.

Conclusion

There is now a growing body of evidence on how to improve performance of health services. Alongside the mainly negative evidence on the effect of radical solutions promulgated by health-care reformers, there is increasing understanding of the conditions that need to be in place for change to happen. In professional organisations like hospitals and primary-care practices, these conditions include engagement of clinicians to bring about changes, development and strengthening of clinical leadership, and provision of professionals with the time, resources, information, and skills needed to achieve change. In view of this evidence, the role of reformers is less to search for the next eye-catching idea than to build the capacity for change and innovation to occur from within health-care organisations. Building the capacity of people and organisations to bring about improvements might be slow and unglamorous work, but in the long term it is likely to have a bigger effect than further bold policy strokes. Policymakers and managers also have a role in provision of systems and institutional leadership and framing of the agenda for reform.

The trick that has to be accomplished is to harness the energies of clinicians and reformers in the quest for improvements in performance that benefit patients. Succeeding with this trick needs reformers to develop a better appreciation of the organisations they are striving to change, and clinicians to acknowledge that change is needed. The importance of linking top-down and bottom-up approaches to performance improvement has never been greater. On this link, nothing less than the future of organised health-care systems depends.

Conflict of interest statement

Chris Ham has worked with international agencies and governments in several countries on improving the performance of health services and health-care reform. He is presently working on secondment as director of the strategy unit in the Department of Health in London on the reform of the National Health Service in England.

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