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$L(H) \neq \Sigma(m^1, m^2 \ldots m^n)$

Jeffrey Braithwaite
Centre for Clinical Governance Research, Faculty of Medicine, University of New South Wales, Sydney, Australia

Abstract

Purpose – The purpose of this paper is to examine the case that health service leadership is more than the sum total of all the health service management activity observed; and to advocate for improved leadership in health services through an examination of top-down management structures and processes which "crowd out" leadership behaviours.

Design/methodology/approach – Application of historical and contemporary contexts to health service management and health service leadership approaches.

Findings – The neglect of leadership is discussed and the case is put for a tightly-crafted position on how leadership should be emphasised and raised to greater prominence. Formulae for conceptualising leadership are presented in order to show the constituent elements underpinning clear descriptions of leadership.

Research limitations/implications – Further research on leadership, and more targeted education for leaders, is needed.

Practical implications – One way to build leadership capacity is to create a sustainable partnership between health service academics and leaders in the field.

Originality/value – Developing formulae for framing leadership is not reductionist *per se* but specifies with precision the essential elements needed to express health services leadership success.

Keywords Leadership, Health services, Leadership development

Paper type Conceptual paper

Introduction

There has been a seemingly relentless cult of management intensification in health services across the world over the past sixty years. The National Health Service (NHS) is a case-study exemplar of this ubiquitous phenomenon. A historical narrative of the NHS during this period exposes waves of dominating and receding discourses about how to manage the system. Although not in as linear a way as it seems on the surface, the NHS iterated from a relatively centralist position at its inception (roughly, from 1948-1951) to a lessening of central control (1951-1960). In a third era (1960-1969) the centre and periphery tended to work together and then centralisation tendencies reasserted again (1979-1982). From 1983 general management was in vogue, invoked by the Griffiths inquiry (Griffiths, 1983). The Thatcher government, because of ideological interest, sponsored market forces from 1989 (Enthoven, 1985b, a; Le Grand *et al.*, 1998), predicated on an internal market and the introduction of managed competition.

In the current era the Blair government has focused on increasing funding and at least in its rhetoric took "a third way" modernising agenda, positioning itself between centralised control and market measures, and embraced ideas such as patient choice and a patient-led system. It is not clear how Prime Minister Gordon Brown, taking over from Tony Blair in mid-2007, will modify this stance.

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Scholarly and practitioner involvement in management

Scholars of and commentators on the NHS (and other health systems internationally) dating from the earliest eras construed health care management as essentially a set of administrative tasks or general health management concerns (Pollitt *et al.*, 1991). Considerable interest was mobilised in the 1970s and 1980s in dichotomising health service managerial and clinical practice issues as a dual hierarchy (Tap and Schut, 1987; Pool, 1991), i.e. in separating the two concepts. Through the 1980s and 1990s there was an ongoing flirtation with managerialism (Pollitt, 1993) with a focus on the application of business management approaches, thinking and techniques to public health care. From the mid 1980s to the 1990s (earlier in the case of Johns Hopkins Hospital in the USA) the idea caught on that fusing clinical and management interests would be useful, particularly through the establishment of clinician-managerial posts in clinical directorate structures (Braithwaite and Westbrook, 2004; Braithwaite and Westbrook, 2005). The contemporary academic position in the 1990s and 2000s, while complex, largely accepts that both effective management and good clinical practice organisation are needed to align the business and the care aspects health systems (Ham, 2003; Lawson *et al.*, 2003). Along the way, over quite long time sweeps, in the general management literature (e.g. Carlson, 1951; Stewart, 1967; Mintzberg, 1971; Kotter, 1982), and the health service management literature (e.g. Davies *et al.*, 2003; Braithwaite, 2004), researchers have increasingly been interested to empiricise management, expose its nature and figure out how it works, and works best, through an analysis of qualitative and quantitative data.

While use has been made of the NHS as an illuminative case study, these trends and staging points often had comparative events in counterpart health systems, although the emphases and timescales might differ. And although it is a broad generalisation, we may be reaching a stage of maturity in understanding about and even researching and theorising about health services management, or if that statement is contested, perhaps we might be inclined to accept the proposition that an academic field is being constructed. No doubt the field needs to evolve further. For instance, there are recent moves to put the disciplines of general, health services and clinical management on a more secure footing by advocating for evidence-based management (Muir Gray, 1997; Axelsson, 1998; Neuhauser, 2000; Walshe and Rundall, 2001; Stewart, 2002; Hewison, 2004; Pfeffer and Sutton, 2006).

Convergent with these developments, and to some extent stimulating them, we now have in health care compared with a generation or so ago vast numbers of clinician managers, quality managers, facility managers, clinical governance managers, IT managers and the like. Why do we have all of these posts? Presumably, so that the health care system is more effectively organised, and for example, resources are allocated more efficiently, human resources are better selected, trained and motivated, infrastructure is maintained, quality of care and patient safety are improved and information and communication technologies are harnessed for the benefits of clinical care and organisational performance.

Does management matter?

One key question, taking a “null hypothesis” approach, is does this profoundly matter? If we add together all the health service management research studies, and all the *in*

situ health service management practices are aggregated, assuming for a moment that either or both contribute to health systems being better managed, do they ensure that health systems are better led?

This is a question of more than theoretical importance, and at least in part depends upon the stance taken. It also rests on the definition of management and leadership adopted. While there are no commonly agreed definitions, management is more often than not seen in terms of normative direct action (e.g. Beil-Hildebrand, 2006) and achievement. It is invariably mobilised in language such as: getting things done, accomplishing aims and objectives and dealing with critical organisational functions (Lawrence, 1986). Leadership on the other hand is frequently construed as reflecting connections and influence, webs of networks and persuasion, more likely than not through indirect endeavour (Gardner, 1995). The language of leadership often speaks to the pre-eminence of the leader, he or she as the centre of focal activity, of relationships with followers, and of charismatic or convincing individuals being involved in morale-improving or persuasion-inducing behaviours (Bryman, 1996; Bolman and Deal, 1997; Wheatley, 1999; Dopson and Mark, 2003).

For some thinkers, management centres on exercising explicit power via the position and organisational sanction, whereas leadership is about exercising implicit power or inspiration through influence and personal traits or characteristics. Whilst a subset of theorists has conflated the two concepts (e.g. Hershey and Blanchard, 1982), Kotter dichotomises them (Kotter, 1990) by arguing that management is *inter alia* concerned more clearly with order, predictability and consistency and leadership is about developing a future-oriented vision, aligning people to the vision and striving to meet it.

The general consensus seems to be that both management and leadership are needed. Managers, if effective, can get things done in the short- to medium-term, accomplish key tasks and projects, can contribute to performance in organisations, and maintain the status quo or induce ongoing improvements. Leaders when effective can encourage, stimulate, inspire and motivate, take people and organisations to new places, and prepare people to embrace, even transform, the future.

Top-down tendencies in health systems

In many private health systems, centralisation has occurred such as under managed care so that head offices, boards of health care chains and large private providers control finances and dominate decision-making processes (e.g. Blendon *et al.*, 1998; Feldman *et al.*, 1998; Gaynor and Vogt, 2003). Mirroring this, in publicly funded health systems, managers have increasingly become subordinate to politicians' dictates and senior policymakers' demands. Party-political agendas permeate and often interfere with the effective running of heath services and locally-enabled allocative efficiency choices (Peckham *et al.*, 2005).

Top-down governance imposed by authority all too rarely gives a thought to bottom-up measures desired by much of the workforce – and in any case often has limited effects (see, for example, Addicott *et al.*, 2007). This is one major reason why there is a chorus of suggestions for more autonomy of the English NHS (Hawkes, 2007), a particularly acute example of the government-agency-as-political-football phenomenon. So far as public health systems are concerned, not all will be allowed

to become independent, and it may be that, despite the recent support, the English NHS will not, either. In Australian health services, too, there is growing concern over governments silencing dissent (Hamilton and Maddison, 2007) and engendering a climate of managerial subordination to the political will. The scope for managers to take initiatives, be creative or work in partnership with clinicians to fashion novel solutions is much diminished in such circumstances.

The neglect of leadership

The tragedy in these kinds of apex-to-base strategies is that they ignore so many leadership studies, beginning with the famous work of Lewin, Lippitt and White (Lewin *et al.*, 1939) nearly 70 years ago. They trained three types of leaders – in democratic, authoritarian and laissez-faire styles – and observed how each style played out in the supervision of boys' groups. Laissez-faire leadership was unsuccessful. Boys in the democratic groups were more cooperative, participated in class work, were more open, liked their group and had more fun than did those in the authoritarian group. Boys in the authoritarian condition displayed more dominating behaviours and more dependence on the leader.

There was no difference between these latter two groups in productivity. Kurt Lewin said this to Marrow, his biographer, about the expressions on the boys' faces on the first day of experiencing autocratic leadership: "the group that had been formerly friendly, open, cooperative, and full of life, became within a short half-hour a rather apathetic-looking gathering without initiative" (Marrow, 1969, p. 127; see also Schneider *et al.*, 2000).

These findings apply to organisations. The relevance and importance of engendering on-the-ground commitment, and encouraging workers and supervisors to take the lead, has been argued by many scholars for decades (e.g. Walton, 1985; Berggren, 1989). More recently, Ricardo Semler of Semco in Brazil (Semler, 1994) has shown how strengthening workers' choices and power structures, and delimiting senior managers' power, involvement in organisational processes and dominance of decision-making, can increase shop-floor leadership behaviours.

Raising leadership to prominence

It is a thesis of this paper that a critical task facing us is to stem the neglect, and raise leadership to prominence. On the basis of the foregoing, the sum of all the management activity we observe across health systems is not synonymous with leadership. Intensifying management development and practice, and increasing the numbers, scope and reach of say middle managers will not solve the problem that leadership represents a distinct, qualitatively different challenge and is needed as much as, perhaps more, than ever before (Guo and Anderson, 2005; Millward and Bryan, 2005). The formula $L(H) \neq \Sigma(m^1, m^2 \ldots m^n)$, is a precisely-specified, shorthand way of saying that leadership in the health services (L(H)) is not the same ($\neq$) as the sum (Σ) of all health management activities ($m^1, m^2 \ldots m^n$). It seems to be valid on this analysis. The case for journals such as *Leadership in Health Services* is therefore underlined, just in case anyone thought otherwise. The importance of empiricising, theorising and conceptualising the leadership enterprise, particularly the roles, practices and

contingencies of leadership in middle and more senior ranks, but also at the coalface, in the context of both public and private health systems, is well made.

A related point can be added as a penultimate contribution to this argument. Consider this aphorism. Napoleon, one of the most successful military leaders in history, is reputed once to have said: “An army of rabbits, led by a lion, will defeat an army of lions, led by a rabbit”. While the metaphor does not strictly hold in health care (clinical staff are mostly not rabbit-like, and some are highly lion-like), the lion-leader is very much needed in public and private health services today in order to construct counterbalancing forces as against the micro-management by centrally-leaning private health provider organisations and by governments and bureaucrats of public health care services. Private and public sector organisations can flourish if bottom-up discretion is permitted or even encouraged in otherwise increasingly centralised structures.

So we ought to encourage and support the lion-leader in contrast to the rabbit-manager in health care. This does not necessarily mean the heroic individualised leader who eschews the value of shared leadership; but it does mean people who are prepared along with other leaders to stand up and be counted. Let us research more deeply and adroitly than we have to date how, why and under what conditions such a role might most successfully be enacted, and the contributions lion-leaders can make at various levels in health systems.

Perhaps the formula $L(H)^{S} = f(\text{env.trust.emp})\,(\text{n.s.w.c.exp})^{\text{REv,T}}$ is needed. It states that successful leadership in health services ($L(H)^{S}$) is a function ($= f$) of an environment of trust which empowers its leaders (env.trust.emp) as well as a function of the number of leaders (n) multiplied by the skills (s) and willingness (w) of leaders to lead, multiplied by their capacity (c) to lead, multiplied by their leadership experience (exp). The superscripts REv, T denote that two powerful factors in achieving such a skilled set of leaders are the knowledge about leadership created by health services research and evaluation (REv) and the training (T) in leadership that academics and other researchers and educators supply to them. These latter are, and will be in the future, essential ingredients in future leadership success.

Conclusion

The strong suggestion is that we must provide useful and better research findings and supportive education to the next generation of leaders in health care (Bowerman, 2003; Block and Manning, 2007). The mission should be: grow empowered, coherent, articulate and above all democratic leaders, not necessarily more managers. Like all great leaders (see Gardner, 1995) they will need to have an appetite for standing tall against superiors’ dominance behaviours and controlling proclivities (see Braithwaite *et al.*, 2007), and go against the grain of received wisdom and short-termism. We also need to turn language into our ally, and publicly label those deserving of the title, leader.

Perhaps we need a new compact between academics in the health leadership field and practitioners in health services who are prepared to lead in the face of debilitating structures. Few more vital contributions can be made by scholars contributing to this journal than to help turn the cult of management into a cult of leadership in health services everywhere.

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Corresponding author
Jeffrey Braithwaite can be contacted at: j.braithwaite@unsw.edu.au

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