Leadership and Governance Within the South African Health System

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Leadership is a necessary element of strong health systems, and so it is vital that SA nurtures and sustains leaders who can work strategically within their complex environments to develop a rights-based health system that promotes health equity.

The importance of health management has long been noted in South Africa (SA). Most recently, the 2010-2014 Negotiated Service Delivery Agreement identified health management strengthening as a core element of health system strengthening, and the 2010 health management competency assessment was an important first step in this effort.

However, there has so far been limited open discussion about the nature of leadership required within the South African health system, or sustained engagement about how to develop leadership across the system. Both sets of issues are addressed in this chapter.

Leadership is a necessary element of strong health systems, and so it is vital that SA nurtures and sustains leaders who can work strategically within their complex environments to develop a rights-based health system that promotes health equity.

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Introduction

> Successful implementation of policies to promote equity and inclusion requires a focus on human interactions at the micro level, as well as the development of supportive institutional systems for financing, information and regulation. Development of a rights-based health system that increasingly addresses the systematic barriers to care experienced by poor and vulnerable groups requires managers who are more than administrators, managers who understand a given context and are able to take appropriate action.[1]

Internationally, leadership and governance is recognised as a critical entry-point in strengthening health systems and attaining the Millennium Development Goals.[2] Indeed, the opening quote of this chapter, taken from the report of the UN Millennium Project's task force on child health and maternal health, emphasizes the importance of managers who lead the health systems transformation necessary to promote equitable health care and a rights-based health system.[1] Change in the structures and financing of health systems must be married with concern for the human dimensions of every health system. Managers who lead such change make their own decisions about how to meet local-level needs within the policy and resource frameworks that guide them, rather than simply administering instructions received from their bureaucratic and political principals. Similarly, *The World Health Report 2008: Primary health care now more than ever*, concludes that leadership reforms are one of the four sets of reforms needed to transform health systems so that they can better meet the range of existing health challenges.[3]

At national level the importance of health management was already recognised in the 1998 edition of the *South African Health Review (SAHR)*.[4] It remains important – and indeed, is an element of the Negotiated Service Delivery Agreement (NSDA) between the President and the Minister of Health. This agreement identifies three activities in strengthening management:

- developing a common competency framework and using it to assess current managerial performance;
- delegation of managerial responsibilities and functions to facility level; and
- developing managerial training as well as support and performance management systems.

The first activity has now been implemented, and additional actions to strengthen management and leadership are proposed within the National Health Insurance (NHI) Green Paper[5] and the Human Resources for Health Strategy for the health sector 2012/13 - 2016/17.[6]

However, there has been limited national conversation about the nature of leadership required to re-engineer primary health care (PHC) and implement NHI, or coordinated and coherent strategies of leadership development. This chapter seeks to contribute to current policy debates by:

- looking outside the country to understand how health leadership is discussed and considered elsewhere;
- reminding ourselves who the South African health leaders are and what we already know about the opportunities and challenges they face; and
- outlining what support health leaders are likely to need over time to strengthen their practices.

The significance of such discussions in achieving the health system goals enshrined in the NSDA is well noted by Julio Frenk, former Minister of Health of Mexico, as follows:

> Probably the most complex challenge in health systems is to nurture persons who can develop the strategic vision, technical knowledge, political skills, and ethical orientation to lead the complex processes of policy formulation and implementation. Without leaders, even the best designed systems will fail.[7]

What is leadership?

Although 'health management' is the more commonly used term in South Africa (SA), this chapter focuses on issues of leadership. Both management and leadership are important in health system development; however, wider experience suggests that the complex demands of bringing about change within health systems requires leadership. Leadership is not, then, a luxury to be pursued when 'the management is right', but a vital aspect of health system strengthening.

The difference between management and leadership is commonly summed up as follows:

- management focuses on being efficient, doing things right; and
- leadership focuses on being effective, doing the right thing.[8]

On the one hand, managing entails organising the internal parts of the organisation to coordinate resources and implement activities to produce reliable performance. Relevant processes include planning, budgeting, organising and staffing. On the other hand, leading is about enabling those within and outside the system to face challenges and achieve results under complex conditions. Leadership thus involves creation of a vision and strategic direction for the organisation, communication of that vision to the people and customers of the organisation, and inspiring, motivating and aligning people and the organisation to achieve this vision.[9,10]

For the health sector, the critical importance of leadership lies in the fact that it comprises a complex set of people and organisations – inside and outside the health sector and inside and outside of Government – all of whom work within a dynamic environment of changing health needs, medical and technological advances and resource conditions. Given this complexity, leadership is necessary to guide and enable the different parts of the system to work towards common goals. As Management Sciences for Health argue, based on experience in many different countries, health managers must therefore always be 'managers who lead'.[11]

However, as Table 1 illustrates, becoming a manager who leads requires significant changes in an individual's mind-set. Instead of understanding management as primarily a mechanistic or administrative function, entailing efficient implementation of pre-designed roles, tasks and instructions, such a manager must see management as a dynamic and strategic process occurring in conditions of uncertainty. Table 1 also suggests that such leadership demands a focus on promoting the common good and taking responsibility for working with others on problem solving to achieve that goal.

Table 1: Key features of leadership mind-sets

Managers that administer	Managers that lead
Focus on individual actions	Focus on collaborative actions taken by groups
Express despair and cynicism about problems and obstacles preventing change	See possibilities to make things better
Blame others for problems and failures	Take responsibility for challenges and take the initiative to tackle them
Focus on scattered, disconnected activities undertaken for their own sake, with no larger purpose in mind	Focus on purposeful work directed towards achieving results that matter
Preoccupation with own needs and interests	Display generosity and concern to serve the common good, and inspire others to do the same

Adapted from Galer and Vriesendorp, 2005.[9]

The importance of values

Values also matter to the leader's mind-set, since they underpin not only the common good being pursued, but also personal action.

Personal values guide the daily decisions leaders make and the behaviour they role model to others. Indeed, values can be seen as the motivational drivers of managers – stimulating them to take responsibility and providing a kick-start to their use of knowledge and competencies in providing leadership.[12] The range of values underpinning positive leadership encompasses integrity and commitment, respect and trust, courage to take calculated risks and openness to learning.[9]

For public sector leaders, the notion of public value allows consideration of the common good or outcomes being pursued. It also focuses attention on the different sorts of outcomes pursued in the public sector as compared to the private sector.

Whereas shareholder value ultimately drives private sector leadership, the notion of public value suggests that outcomes pursued by public sector leaders are those judged as valuable by the public at large as well as by political stakeholders and policy makers.[13] These outcomes go beyond service delivery, to encompass the wider impacts of services on the broader circumstances in which citizens live.[14,15] In other words, they include impacts on the wider community rather than only on the individuals benefiting from services – on future generations and not just today's users – and impacts on trust in and the legitimacy of Government.[15] A health system may not only be seen as valuable by the public because it offers treatment in times of sickness, but also because it acts as a safety net for all – and particularly the most vulnerable – in times of personal and health crisis, or because it promotes processes that the public deems valuable in themselves, such as being treated respectfully.[16,17]

At the same time, the notion of public value focuses attention on the nature of management and leadership required in the public sector. Unlike in the private sector, public sector leadership occurs within a political context, in conditions of high transparency and accountability, and is directed at multiple (and often ambiguous and contested) goals. So these leaders need political analysis and leadership skills, and may be required to manage across organisational boundaries rather than just within them.[18]

Based on his experience of working with public sector managers, and reflecting on the idea of managers who lead, Moore argues that the pursuit of public value requires public managers to take active roles in policy and management processes rather than being simple administrators, thus, "public managers are seen as explorers who, with others, seek to discover, define and produce public value … [they are] strategists rather than technicians".[13]

Their strategic action or leadership has three core dimensions: engagement with a range of stakeholders – and particularly the public – to establish common purposes and agreed upon outcomes; securing political support for actions, both by responding to political direction and also by being prepared to challenge it; and concern for ensuring efficient organisational functioning to support activities. Moore terms these three dimensions managing outwards, managing upwards and managing downwards.

At its best (see also Box 1), such leadership invests policy and management decisions with a high degree of legitimacy, power and accuracy, because it ensures that they have both of the following:

- *substantive virtue,* because they are based on all relevant available evidence to show the values at stake in the decision, the main choices available to policy makers, and the likely consequences of the decision; and
- *process virtue,* because they are generated through consultation processes between officials and citizens, engaging actors by listening not instructing, while working within the legal rules governing decision making.

Box 1: Three key leadership abilities for PHC reform

1. Use a wide range of data and information in decision making, going beyond the statistics normally produced by health information systems to draw on field-level experimentation and adaptation, and identifying operational and systemic constraints;
2. Exercise authority through participation and negotiation, rather than control and command, establishing fair and transparent procedures that engage key stakeholders (political authorities, the scientific community, health professionals, civil society and citizens) in the process of decision making, generate legitimate decisions and contain the influence of particular interest groups; and
3. Manage the political and implementation process actively to secure high-level political support and other resources needed to initiate reforms, and to bring about changes in organisational structure and culture that sustain implementation and limit resistance to change.

Source: World Health Organization, 2008.[3]

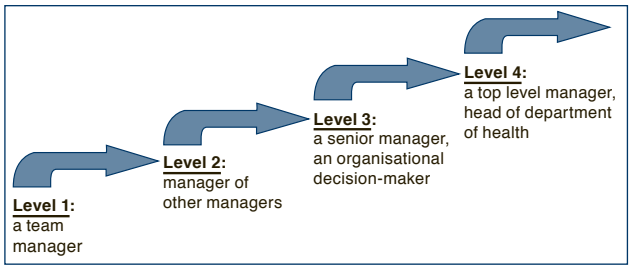
Who provides leadership within the South African health system?

Leadership is often thought to be provided only by those located at the apex of the health system. However, the notion of distributed leadership emphasizes that leadership must be seen as a collective capacity in any organisation or system.[18] Managers at every level of the system and in both the public and private sectors must thus become *managers who lead.*

Drawing on Figure 1, which represents the different levels of managers, the leaders of the SA health system thus include the often forgotten public PHC facility managers and clinical managers who, like hospital chief executive officers, are managers of teams. In addition, in the public system there are district and

sub-district managers, provincial and national managers, and the heads of health departments within local, provincial and national Government. As with any organisation, there are also informal leaders who may not hold managerial positions but draw authority from (for example) their personality, practices or reputation. These may be experienced colleagues, those who have been in their positions for a long time, or those who can link into wider networks of power and support (personal or professional).

Figure 1: Leadership levels within the health system



Source: Derived from Galer and Vriesendorp, 2005.[9]

Table 2 illustrates the tasks of managers at different levels and their different skill needs.

Effective leadership requires that those at all levels are aware of their different and yet interconnected roles in the system. While facility and district managers in the public sector are at the front-line of service delivery, managers at provincial and national level are removed from service delivery but provide the guidance, frameworks and support that enable coordinated action across the system. Those in the middle, at provincial level, have particularly critical roles as the intermediaries between the local and national levels, and need to ensure that local-level needs and concerns are heard in national policy debates, and to provide support for local-level leadership.[9] Effective leadership thus requires not only effective managers but also a set of processes that enables coordination among them.

Why does leadership matter to health system governance in SA?

As in other countries, there are two main reasons why leadership matters to current South African health system improvement and development initiatives. First, new efforts to strengthen the health system, such as re-engineering PHC, introducing NHI or improved quality assurance, must recognise the complexity of policy implementation and the leadership it demands. Second, leadership is needed to transform the existing organisational structures and culture of the public health system in particular, and translate new policies into routine ways of doing business within the system. Both issues are considered here.

Challenges of policy implementation

The challenges of policy implementation in SA are widely recognised across sectors, and were clearly identified as a key health system weakness in the 2008 'Road Map' report of the Development Bank of South Africa (DBSA).[19]

Existing experience of health policy implementation in SA has demonstrated that new policies have generated unexpected and sometimes negative outcomes. These include:

- throwing up barriers to access rather than removing them;[20,21]
- resistance to equity-promoting health management action;[22]

Table 2: Different tasks and skills of different managerial levels

Level	Critical management and leadership tasks	Critical skills
1. Managing a team	Continues to work directly with patients, but also: • makes sure work of team clearly defined • ensures that tasks are assigned to right person • spots new tasks and distributes among team • ensures each team member has resources and support to do job well	• Organising work • Delegating • Recruiting staff • Networking
2. Managing other managers	• Makes sure managers reporting to them receive necessary support so that their units can fulfil mandates • Maintains facility's reputation in community, good relationships with authorities and community leaders • Produces results spelt out in annual and three-year plans • Helps first-level managers to support their staff	• Spotting leadership talent • Giving constructive feedback and support • Holding first-line managers accountable for results and managerial work • Deploying and redeploying resources among units or teams • Managing competing priorities and conflicts
3. Becoming a senior manager	• Pays more attention to strategic issues than their own area of technical expertise • Manage themselves in the public eye as they manage crises and criticism – role model for constructive behaviour • Develops managerial and leadership talent, fosters collective success	• Strategic thinking • Coaching others • Managing external consultants contracted to do work • Managing conflict • Using reflective skills
4. Managing at the top	• Needs to consider all regions, specialities, functions – understands all parts of the business • Has to have some understanding of how to anticipate changes and trends – prepares organisation for the future	• Demonstrating belief in self and others • Fostering independence • Model integrity and authenticity • Using authority wisely • Being a systems thinker • Being a strategic thinker

Source: Galer and Vriesendorp, 2005.[9]

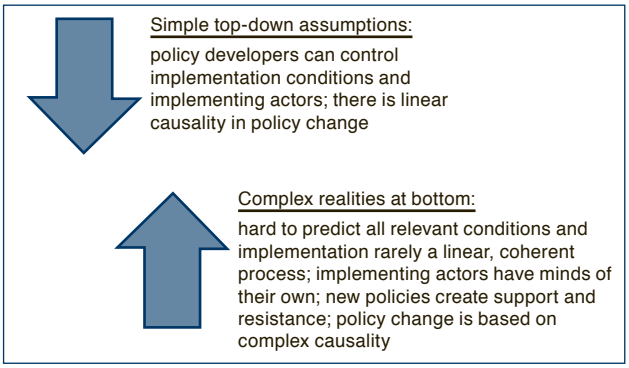
- undermining quality of care rather than improving resource-use efficiency;[23]
- undermining provider-patient relationships rather than strengthening them;[24] and
- undermining health provider motivation rather than strengthening it.[25]

Such studies have also highlighted the complexity of policy implementation:

- New policies always interact with existing policies in unpredictable ways, even when the policy goals are widely accepted. For example, user fee removal in 1994 and 1996 to reduce access barriers was implemented in parallel with a wide range of other policy and health system changes – and came to be seen by many health staff as just an extra burden.[21] Similarly, proposed staff reallocations to under-resourced areas in Cape Town in 2003 occurred against a backdrop of system-wide change, and only generated resistance to further change.[22]
- Local leaders have a strong influence on how policies are actually implemented and hence experienced by health workers as well as patients and the community, regardless of the level of central direction and guidance. Examples here include determining how 'rural' was defined in implementing the 2004 rural allowance,[25] selecting which of an existing group of voluntary community health workers (CHWs) would be chosen to receive the smaller number of new stipends available through the 2003 CHW policy,[20] and interpreting the Public Finance Management Act to fit operational realities.[23]

These experiences demonstrate that the usual 'command and control' approach to public sector policy implementation is flawed. Figure 2 highlights the complex realities at 'the bottom' – the implementation level – illustrated by these experiences, indicating how they contradict the inherent assumptions of the top-down approach.

Figure 2: Contrasting understandings of policy implementation



Policy implementation approaches that recognise these complex realities entail instead considerable local-level decision making to be responsive to complex local needs, problems and circumstances. PHC in particular requires dynamic interventions based on local decision making to change people's behaviour in conditions of great uncertainty – uncertainty about the particular person presenting for care, their health needs and the social determinants of those needs.

Effective PHC interventions therefore cannot all be standardised and routinised, for example through clinical algorithms. Many require interaction with the broader community about the circumstances generating health needs and cross-sectoral action to tackle the root causes of health problems, both environmental and social. Developing these interventions and managing the networks of actors involved in implementing them requires local-level decision making.[3,9,26]

Nonetheless, some central direction and guidance is important, since it can establish the vision and goals for new policies and set clear parameters within which implementation can occur (e.g. of management authority or resources). In this way it enables the flexible local-level decision making necessary to adapt policies to local circumstances through listening to and working together with local actors, and by establishing deliberate strategies for innovation, evaluation, learning and reflection.[27]

Rather than command and control leadership, therefore, those at national and provincial levels must adopt policy implementation approaches that support and enable distributed leadership – leadership across the health system.

International experience with quality improvement[28] and public sector innovation[29,30] shows the value of combining top-down and bottom-up processes of decision making. Indeed, the World Health Organization has noted that "while some types of health challenges, e.g. public-health emergencies or disease eradication, may require authoritative command-and-control management, effective stewardship (leadership) increasingly relies on 'mediation' to address current and future complex health challenges"[3] (such as PHC reforms).

South African experience with the introduction of syndromic management guidelines for sexually transmitted infections (STIs) and antiretroviral rollout are two of the few experiences that have been specifically examined in order to understand the influence of policy implementation approaches on their achievements. These demonstrate the value of implementation processes that engage multi-actor networks and enable learning through doing, allowing policy design details to be developed by local decision makers during implementation (Box 2).

Box 2: Experiences of successful policy implementation in SA

Case 1: Syndromic management guidelines for STIs[31]

Initiated in 1996, development of the STI syndromic management strategy was based on networking among researchers and managers at national, provincial and district level, allowing for and learning from provincial experimentation and variation. Ultimately a set of harmonised guidelines was developed for application across provinces.

Against the backdrop of the HIV epidemic, in 18 months this process supported a shift from a situation of often poor-quality STI care provided only in specialist facilities, to syndromic management being applied in over 80% of PHC facilities nationwide. Good access to a service vital in the era of HIV and AIDS was assured.

Case 2: Antiretroviral (ARV) rollout 2005-2007[32]

Comparison of early experiences in the rollout of the ARV programme in Gauteng, Free State and the Western Cape shows that despite clear national policy guidance and funding, provincial experiences differed considerably. It suggests that differences in performance (e.g. in terms of coverage) between provinces reflect different approaches to strategic management of the rollout process.

Stronger performance in the Western Cape province appeared to have its roots in a model of partnership between Government and external actors that allowed for experimentation and learning through doing, and through which standardised approaches were developed. A supportive political context and networks with the activist community also facilitated this experience.

Ultimately, therefore, leadership for policy implementation requires: "a strategic mentality that colours how they think about their responsibilities and actions ... much of it lies in the realm of inspiration, intuition, and informal problem-solving".[33]

Challenges of organisational structures and culture

The second critical leadership challenge in SA concerns the organisational structures and culture of the South African public health system, which often act as a barrier to new policies intended to establish a PHC-oriented health system and promote health equity and human rights.

Against the demands of PHC, Box 3 outlines five common structural shortcomings of healthcare delivery anywhere, all also found to different degrees in SA. Tackling fragmentation and specialisation is perhaps less often discussed than the other shortcomings, yet these barriers are particularly influential since they are part of routine practices and ways of doing business in the health system – i.e. part of the organisational culture. All shortcomings also reflect and are underpinned by the particular configuration of power balances within the health system: of consultant over junior doctor, of specialist over generalist, of doctor over nurse, and of provider over patient.

Box 3: Five common shortcomings of healthcare delivery

Inverse care: People with the greatest needs and least resources consume the least health resources, and those with least need and most resources consume the most health resources.

Impoverishing care: People fall into poverty because they pay out of pocket to access services (not just for consultations, but also for transport, drugs, etc.).

Fragmented and fragmenting care: Excessive specialisation of healthcare providers and the narrow focus of many disease control programmes discourage a holistic approach to individuals and families and do not appreciate the need for continuity of care. Health services for poor and marginalised groups are often highly fragmented and under-resourced.

Unsafe care: Poor system design that is unable to ensure safety and hygiene standards leads to high rates of hospital-acquired infections and other avoidable problems that are an underestimated cause of ill-health and death.

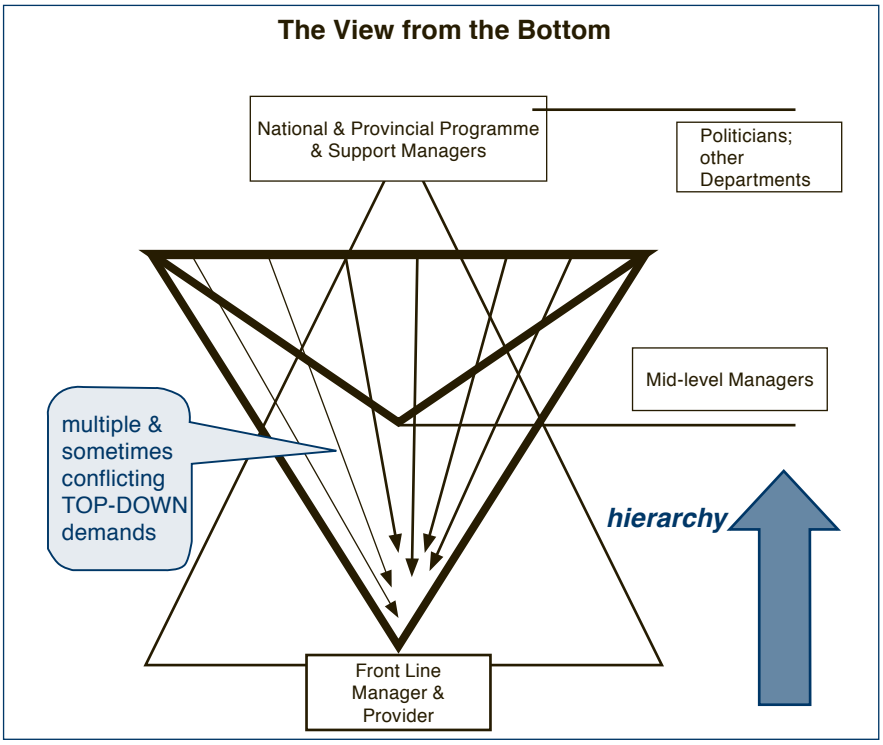
Misdirected care: Resource allocation favours curative care, neglecting the potential of primary prevention and promotion to prevent up to 70% of the disease burden. At the same time, the health sector lacks the expertise to mitigate the negative effects of other sectors on health and to work with them to promote health.

Source: Adapted from World Health Organization, 2008.[3]

A sixth widely recognised problem in SA, that of abusive provider attitudes towards patients, is also almost a routine practice – an element of organisational culture – and widely recognised as a critical barrier to providing equitable and respectful health care.[34] Again, available evidence shows that this problem reflects the existing power balances within the health system, indicating that action to address it has to confront and change those balances. Indeed, the key challenge of implementing the Patient's Rights Charter intended to empower patients within the health system and protect their rights is ultimately that of how to re-engineer power relationships within the health system.[24] PHC re-engineering will inevitably face similar challenges.

As shown in Figure 3 and Table 3, the dominant experience of those who work within the public health system is that "people at every level [of the health system], but particularly front line managers and providers, feel that they work in isolation from others at their own level, and face a top heavy and rigid management hierarchy that imposes multiple and often conflicting demands".[35] The persistence of this experience is demonstrated by comparing Table 3 and Box 4, which present the voices of health system leaders in 2001 and 2011 respectively.

Figure 3: The inverted pyramid within the South African health system



Source: Local Government and Health Consortium, 2004.[36]

Table 3: The voices of health system leaders, 2001

Category of experience	PHC facility managers	Hospital managers	District managers	Provincial and national managers
Job demands	High workload and low remuneration. Increasing workload demands from service expansion, without increasing resources	Salary scales do not recognise managerial position. Delays in appointment	Heavy workload and wide span of control	
Lack of authority	Increasing responsibilities without necessary rank, skill and guidance	Little authority to resolve problems	Lack of control over resources	
Weak support and organisational culture	Ineffective district, regional and senior management and systems	External demands on time – authoritarian management styles of seniors. Poor relationships with provinces. Lack of consultation with hospitals in planning services. Bureaucratic red tape. Ineffective and inappropriate structures and systems of management	External demands on time – authoritarian management styles of seniors. Lack of provincial support (50%). Lack of integration between support systems and service delivery.	Excessive and unpredictable demands, from higher levels, arbitrary and unrealistic. Political layer a major source of day-to-day demands on managers. Poor prioritisation. Depersonalised environment of bureaucracy – culture of not giving a pat on the back, forgetting people's achievements. Bureaucratic administrative procedures.
Infrastructural challenges	Limited physical space. Security and crime	Poor infrastructure	Lack of office space – infrastructure	

Source: Health Systems Trust, 2001.[35]

Box 4: Messages for the Minister of Health from participants at the 2011 Celebrating Innovative Health Management Conference

Challenges of bureaucratic structures

- Bureaucracy in the system creates a lot of operational challenges for the implementers
- We must encourage one another and not work in silos
- Provide autonomy and decentralised decision making with accountability

Need for support

- Give us recognition as people and individuals to make mistakes and learn from them in a conducive learning environment
- Managers are willing to address the challenges in the health system but support from provinces/national is paramount
- Managers need to be supported, especially by the national department, and not only to have fingers pointed at them when there is a crisis
- Allow managers the space to manage. Hold them accountable, by all means, but allow them to manage (try out new things, learn from failures)
- Health managers are willing to take risks and lead by example; a vital issue in their area of work is limited resources for effective and efficient delivery of service
- Strengthen management capacity

Political challenges

- Managers' positions are threatened every day with situations they are faced with in their institution. They need a platform with the Minister to express their challenges, because what the Minister says is not what our provinces say when he has left
- Remove political interference in the procurement system of medical equipment
- Clean up political appointments
- Develop task-oriented health managers to implement policies and give them the required support without political interference

Source: Doherty and Gilson, 2011.[37]

Together these experiences clearly demonstrate that the organisational culture of the health system is strongly hierarchical, with decision making dominated by command and control approaches implemented through organisational silos (of directorates and units), in which management is traditionally seen as an administrative function rather than a proactive process of enabling learning, and in which control is exercised in an authoritarian manner. This organisational culture resists the new policies and organisational changes needed to ensure equity-promoting performance improvements.

As Von Holdt and Murphy note from their assessment of public hospital experiences:

> Bureaucratic inertia caused by the fragmentation and dispersion of decision-making and accountability structures and the pervasive constraint of complex and drawn out rules and procedures, together with embedded hierarchies as well as the sheer scale of many state institutions such as departments of health, make them relatively impervious to new policies and attempts to introduce change. The accumulated weight of existing practices and procedures, together with embedded hierarchies that institutionalise a specific distribution of power and privilege, tend to overwhelm rational policy debate and the implementation of new policy.[38]

There are no simple interventions to bring about changes in organisational culture, since this always requires multiple actions.[28] Macro-level financing and structural changes, such as those envisaged in relation to NHI, set parameters for health system functioning and offer institutional signals as to what is valued within the system. Perhaps the most critically needed structure change in SA is the devolution of management authority to public hospitals and districts within a coherent accountability framework.[19]

However, structural change will not be enough by itself to secure change in organisational culture – and changes in organisational culture are essential to sustain the actions needed to achieve the goals established within the NSDA. Bringing new values alive and embedding them within the everyday practices of the health system requires leadership that inspires and encourages new routines among the many different people and organisations that comprise the health system as a whole. Indeed, that is the critical role of leadership.

It is leadership that creates a sense of organisational mission, establishing the organisational values and purpose that fosters positive performance across an organisation.[39-41] In building a rights-based health system, attention has to be paid to human interactions and not only to financing, information and regulation.[2]

Strengthening leadership within the South African health system

The Celebrating Innovative Health Management Conference organised by the University of Cape Town in June 2011 provided many examples of health leaders and leadership from all levels of the system in SA. Presentations were made by organisational and professional leaders based in hospitals, districts, provinces and at national level, working both within the public sector bureaucracy and through partnerships bringing public sector and external actors together. These diverse speakers all offered positive examples of health system leadership. As one delegate noted, the most valuable lesson of the conference was: "that we should have hope. There is an enormous amount of wisdom among us and collectively listening to each other we can correct the system and improve service delivery".[37]

So what can be done to build on this base and strengthen South African health system leadership? First, we need to develop a system-wide understanding of what leadership entails to guide its development; and second, a wide-ranging and sustained leadership development strategy is required.

Developing an understanding of leadership

The 2010 assessment of managerial competencies was an important foundation for South African leadership development. However, to become more than a once-off assessment it is important that the competency framework underpinning it (see Table 4) is subject to review and translated into a set of human resource (HR) development and management approaches.

From the perspective of this chapter, a key question is whether it pays enough attention to the difference between management and leadership discussed earlier. An initial and superficial review of the framework suggests that it has some clear strengths in this regard. It emphasizes the importance of values-based leadership,

for example, and combines a focus on the more managerial end of leadership (as reflected perhaps in programme and project management and financial management) with concern for competencies important in managing complexity – such as change and knowledge management, and communication.

However, comparison with the UK National Health System's 2011 leadership competency framework,[42] an alternative from which SA could draw lessons, suggests there may be room to strengthen, for example, the focus on personal qualities and on networking. The UK framework has six domains, two of which are 'demonstrating personal qualities' (demonstrating effectiveness in developing self-awareness, managing yourself, continuing personal development and acting with integrity) and 'working with others' (demonstrating effectiveness in developing networks, building and maintaining relationships, encouraging contributions, and working within teams).

Certainly, emotional intelligence (recognition of one's emotional state and the ability to manage that state) and social intelligence (the interpersonal abilities that support teamwork, relationship building and networking) are as important to leadership as cognitive intelligence (the ability to problem solve).[12] Wider and more detailed consideration of these issues is needed.

In addition, to ensure sustained leadership development across the whole health system it will be important to review whether existing tools for HR development and management support its implementation. The UK framework, for example (and reflecting Figure 1) recognises four stages of career progression: moving from a focus on your own practice and immediate team; to building relationships across and working with teams; to working across teams and departments within the organisation; to building broader partnerships across and outside the usual organisational boundaries.

Moreover, the overarching UK leadership framework is complemented by a medical leadership competency framework for doctors who wish to get more actively involved in planning and service delivery transformation, and a clinical leadership competency framework for clinicians. The framework has also been translated into a set of indicators for various work situations (to demonstrate the types of activities that would represent leadership), into supporting tools (including a 360° appraisal tool, entailing feedback from subordinates, colleagues, superiors and even clients), and is linked to examples of learning and development opportunities.

Leadership development

International experience suggests that leadership support interventions should focus on developing practice, values, people and teams, systems, and an outcomes focus.[9] In terms of the learning process it highlights five different forms of leadership development: formal training, on-the-job training, action learning and non-formal training.[18,44-47] On-the-job training itself encompasses a wide range of activities, including use of 360° feedback processes to enable personal development, mentoring and coaching, learning networks and in-service training courses. Finally, non-formal training is essentially self-directed learning, such as colleagues supporting each other in peer groups or networks which are sometimes also called communities of practice.

Table 5 summarises the pros and cons of each of these approaches in relation to leadership competency development. Although there is surprisingly little empirical evidence (nationally or internationally) on the relative value of the alternatives, existing experience does suggest that a combination of approaches is likely to be important.[48] While formal training gives people the space to stand back from their experience and acquire formal knowledge of relevance to aspects of leadership, practical experience generates the tacit knowledge that allows them to make use of this knowledge and the related skills – and, as importantly, to develop leadership behaviours.

Table 4: Competency framework used in assessment of senior management 2010

Competency name	Competency definition
Strategic capability and leadership	Must be able to provide a vision, set the direction for the organisation and inspire others in order to deliver on the organisational mandate.
Programme and project management	Must be able to plan, manage, monitor and evaluate specific activities in order to deliver the desired outputs.
Financial management	Must be able to compile and manage budgets, control cash flow, institute risk management and administer tender procurement processes in accordance with generally recognised financial practices in order to ensure achievement of strategic organisational objectives.
Change management	Must be able to initiate and support organisational transformation and change in order to implement new initiatives successfully and deliver on service delivery commitments.
Knowledge management	Must be able to promote the generation and sharing of knowledge and learning in order to enhance the collective knowledge of the organisation.
Service delivery innovation	Must be able to explore and implement new ways of delivering services that contribute to improvement of organisational processes in order to achieve organisational goals.
Problem solving and analysis	Must be able to systematically identify, analyse and resolve existing and anticipated problems in order to reach optimum solutions in a timely manner.
People management and empowerment	Must be able to manage and encourage people, optimise their outputs and effectively manage relationships in order to achieve organisational goals.
Client orientation and customer focus	Must be willing and able to deliver services effectively and efficiently in order to put the spirit of customer service (Batho Pele) into practice.
Communication	Must be able to exchange information and ideas in a clear and concise manner appropriate for the audience in order to explain, persuade, convince and influence others to achieve the desired outcomes.
Honesty and integrity	Must be able to display and build the highest standards of ethical and moral conduct in order to promote confidence and trust in the public service.

Source: Adapted from South African Department of Public Service and Administration, 2003.[43]

Table 5: Advantages of training approaches in achieving selected goals

Training approach	Formal	On-the-job	Action learning	Non-formal
Acquire knowledge	●	ϴ	●	●
Understand concepts	●	O	●	ϴ
Understand techniques	●	ϴ	●	
Acquire skills in use of techniques	ϴ	●	●	O
Acquire skills in analysis of organisation problem	ϴ	●	●	O
Acquire skills in developing and implementing action plans	ϴ	ϴ	●	O

Key: ● High potential; ϴ Medium potential; O Low potential.

Source: Kerrigan and Luke, 1987.[49]

These experiences suggest that there is a need to strengthen existing training programmes in SA as well as to move beyond them. For example, taught courses could be structured differently to allow for more action-oriented, hands-on learning periods and to provide time to reflect on and absorb new ideas.

In addition, more innovative approaches to experiential and action learning might include:

- Internships: Allowing younger leaders to work with more experienced colleagues, perhaps within the context of formal training programmes;
- Mentoring and coaching systems: To allow reflective learning through peer and other support;
- Innovation fellowships: To support dedicated efforts to introduce innovation within the health system through projects and activities undertaken with expert and peer support; and
- Sabbatical and reflection periods: To allow experienced leaders to take the time to stand back from experience and reflect on it, with others, to distil lessons to strengthen their own and others' leadership.

Participants at the 2011 Celebrating Innovative Health Management Conference also highlighted ways in which networking could support leadership development (Table 6).

Table 6: Supporting health leadership in SA

What do you believe could support you in sharing experiences and networking with fellow health managers?	
Category of response	**% (out of total 99 responses)**
Establishing networks and communities of practice	35
Conferences to allow sharing and networking	23
Establishing an electronic communications platform	19
Sharing publications on experience	6
Training	5
Sharing contacts and presentations after the conference	5
Smaller, regular meetings	4
Resources, team building	2

Source: Doherty and Gilson, 2011.[37]

Finally, provincial HR development units must develop more strategic approaches to developing health leadership across the system. There have been very few partnerships between Government and training organisations to jointly develop training programmes or other forms of learning support or, more ambitiously, a set of leadership interventions. Yet the development of distributed leadership requires such strategic thinking.

Team training is also widely recognised to be valuable in building a critical mass of people with common understandings and skills, but is rarely undertaken in SA. Provincial HR development units need to see training as an opportunity to support career enhancement for individuals as leaders and managers. Training programmes should be selected to match both personal and organisational career objectives.

Conclusion

Much of what is proposed here is not new, although the language may have changed a little. In the *SAHR 1998* Schaay and colleagues from the then Public Health Programme at the University of the Western Cape outlined many similar ideas, concluding their chapter on Health Service Management Training with these recommendations:

> Changing the nature of management will require strong leadership, adequate funding and a degree of vision, innovation and risk taking from all concerned ... The focus has to shift away from bureaucracy and administration towards people-centred service delivery, where there are incentives for better management by effective, multidisciplinary teams. In addition, there is a need for a decisive management training needs assessment to be conducted which defines the required knowledge, skills and attitudes for managers at each level, identifies the level of current management capacity, and assess the training required to fill the gap. In support of this any evaluation of current management training must be done within the context of the overall management development process and the organisational structures which support it – as well as looking at what is now required in terms of training methodology and programme content.[4]

It is an indictment of the level of attention paid to health leadership that action has only recently begun to be taken to address these recommendations, more than 10 years later. Yet without support for large-scale leadership development activities which move beyond training, efforts to re-engineer PHC, improve quality or implement steps towards NHI will most likely achieve less than what is intended.

To capitalise on the 2010 competency assessment conducted by the DBSA, strategic and focused leadership development efforts based on long-term partnership between Government and training and other organisations are needed. The key requirements are:

- developing a shared understanding of health system leadership competencies for SA among all concerned actors – that is, leaders and future leaders, the organisations that employ them and those interested in supporting leadership development;
- debate and discussion about the substance and approach of formal training programmes that seek to support development of leadership practice;
- developing a coherent set of formal training opportunities for people at different stages of their career, that support career development for health management and leadership;
- developing a range of practice support initiatives to complement formal training opportunities;
- adopting approaches to HR development for management and leadership that focus on personal and system issues, supporting both;
- clear identification of the organisational constraints on effective leadership and advocacy for action to address them; and
- evaluation and regular review of all formal and practice-based training activities.

The Institute for Leadership and Management in Health Care proposed within the recent Human Resources for Health strategy[6] could provide the vision and direction required to stimulate and coordinate such actions, facilitating networking and wider initiatives among relevant actors.

Finally, as noted, both leadership development and structural change are needed to embed the new routines and practices that are necessary within the health system to sustain implementation of new PHC initiatives and NHI development.

Leaders across the system make a difference – but together they will be much more effective when there is real devolution of authority to them, this within clear frameworks of accountability.

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