Developing leadership and management competencies in low and middle-income country health systems: a review of the literature

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About RESYST

RESYST is a 5-year international research consortium that aims to enhance the resilience and responsiveness of health systems to promote health and health equity and reduce poverty. We conduct our research in several low and middle-income countries in Africa and Asia, seeking to identify lessons that are transferable across contexts.

Research focuses on three critical health systems components:

- **Financing**: focusing on how best to finance universal health coverage in low and middle-income countries.
- **Health workforce**: identifying effective, practical interventions to address human resource constraints.
- **Governance**: studying the relationships among frontline actors and mid-level management, and leadership in health policy implementation processes.

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Executive summary

Strong leadership and management competencies have long been identified as key elements for encouraging health systems that are responsive to population needs (de Savigny and Adam, 2009; Vriesendorp et al, 2010). While these competencies are important in any context, the particular circumstances of low and middle-income country (LMIC) health systems, characterised by resource scarcity and high burdens of disease, suggest that these skills are particularly needed.

This paper undertakes a review of the existing management and leadership literature from LMIC settings with a view to unpacking the roles of leaders and managers, the competencies required, and the key approaches to developing these management and leadership competencies.

1. Introduction

Strong leadership and management competencies have long been identified as key elements for encouraging health systems that are responsive to population needs (de Savigny and Adam, 2009; Vriesendorp et al, 2010). National level management and leadership typically includes setting policy and overseeing strategic direction, managing resource allocation, and monitoring policy targets and outcomes. At the operational level, hospital, district and primary health care facility managers are responsible for converting inputs and resources such as finance, staff, supplies, equipment and infrastructure into effective services that produce health results and are responsive to population needs (World Health Organization, 2009). As decision space is transferred to these operational levels the perceived need for leadership and management capacities has become more urgent (Diaz-Monsalve, 2004; Monekosso, 1993; Comninellis, 1994; Collins and Green, 1994).

The importance of management and leadership is also apparent in relation to the need to scale up HIV/AIDS, child health, maternal health, tuberculosis and malaria services in order to meet the health-related Millennium Development Goals (MDGs) (Waddington, 2007). Despite increases in development assistance for health, many low and middle income countries may miss these targets, and weaknesses in general managerial capacity at all levels of the health system have been cited as one of the contributory factors in failing to scale up effective health services (Egger and Ollier, 2007; Egger et al, 2005; Scheneider et al, 2006; Puoane et al, 2008).

This paper undertakes a review of the existing management and leadership literature from LMIC settings with a view to unpacking the roles of leaders and managers (hereafter L&M), the competencies required, and the key approaches to developing these management and leadership competencies.

2. Strategy for literature search

Several databases, websites and search engines were used to retrieve relevant literature, including:

- Academic databases - EBSCO-CINAHL, OVID MEDLINE, Science Direct and Emerald.
- Search engines – Google scholar and Google.
- Specific organisational websites – World Health Organization (www.who.int/topics/management/en/), HRH Global Resource Center (www.hrhresourcecenter.org), USAID (www.usaid.gov), Health Systems 20/20 (www.healthsystems2020.org), Management Sciences for Health (www.msh.org).
- Specific journals, including: Journal of Healthcare Management, Leadership & Organizational Development Journal, Nursing Leadership Forum, International Journal of Training and Development, Journal of Health Organization and Management, International Journal of Public Sector Management, International Journal of Health Planning and Management, Human Resources for Health, Journal of Health Organization and Management and the Bulletin of the World Health Organization.

The following key words were used to search for literature, in combination with "developing countries":

- Health facility managers/management.
- District health managers/management.
- Hospital managers/management.
- Management of health services.
- Local health management.
- PHC facility management.
- Health leadership development.
- Health management development.
- Health management capacity strengthening.

The search was limited to articles, reports and books published after 1990 in English; however in some instances literature published after 1970 was included when no other relevant literature was retrieved. In addition to searches in databases and websites, references from the retrieved articles were tracked.

3. Results

The majority of the literature included in the review was identified through reference tracking and searching in the specific listed journals. Very little literature was traced through searching in databases and search engines. Identified literature focussed broadly on hospital management, hospital autonomy, decentralization, the role of the primary health care facility manager, the role of the district health system manager, and approaches to developing managers and leaders in developing countries. Literature that speaks to the management of specific diseases (e.g. HIV/AIDS) was also included as it provides a contextualization of the management and leadership problems that need to be addressed in developing countries.

3.1 What is health management and leadership?

While leadership and management are theoretically distinct, in practice they overlap. Dorros (2006) and Kotter (2001) view management as the set of task-oriented processes of planning, budgeting, organizing, staffing, controlling and problem solving. Conversely, leadership is viewed as a process of enabling others to work in a specific context. It involves the creation of a vision and strategic direction for the organisation, the communication of that vision to staff and stakeholders, and inspiring, motivating and aligning actors and the organization to the achievement of the vision.

Given the need to implement health policies in resource poor and challenging contexts, health L&Ms require both managerial and leadership competencies (Dorros 2006). Vriesendorp et al. (2010) argue that a conceptualization of "managers who lead" provides a holistic approach to running health care programmes, organizations, or facilities, where strong leadership and managerial practices strengthen organizational capacity and result in higher-quality services and sustained improvements in health. Management and leadership are an important part of the same job (Bolden 2004; Mintzberg 1975; Gosling and Mintzberg 2003) and are both necessary for success in complex organizations (Kotter 2001).

3.2 Who are health leaders and managers and what do they do?

The majority of health L&Ms in developing countries are trained health professionals (doctors, nurses, clinical/medical officers and pharmacists) who rarely have any training or experience prior to being offered a managerial position (World Health Organization, 2009; Byleveld et al., 2009; Dorros, 2006; McConnell, 2002). New managers are often promoted on account of clinical expertise: they may be ill prepared for their new responsibilities and may be expected to gain managerial capacities by learning on the job or through brief training courses (Waddington, 2007; Egger and Ollier, 2007).

The scope of work of health L&Ms in developing countries is well documented and typically includes both clinical and public health services. Aspects of the work include managing health services (including planning, supervising, and monitoring volume, quality and coverage); managing resources (including staff, budgets, drugs, equipment, buildings and information); and managing stakeholders (external relations, partners, community members, service users and intersectoral stakeholders) (Egger et al, 2005; Vriesendorp et al, 2010; Byleveld et al., 2009; Waddington, 2007; Goergen et al, 2004).

While the overall scope of work is broad, in many settings the decision space of managers in districts and primary health care facilities is narrow. Typically, they are responsible for following administrative directives and standard operating procedures and for meeting targets that are issued from higher levels of the health system (national, provincial or regional levels). Often managers do not set their budgets or the distribution of their budgets across line items, are not involved in setting their service targets and cannot hire their staff (Dorros, 2006). Administrative and technical accountability is often to multiple authorities i.e. national, provincial/regional levels. In this centrally controlled environment, there may be little incentive or support for managerial initiatives and innovations that improve responsiveness (Byleveld et al., 2009; Waddington, 2007).

Nonetheless, managers still have the space and responsibility to lead in the sense of motivating their staff and colleagues, or working constructively with external stakeholders.

3.3 What competencies do health leaders and managers need?

Competencies include the knowledge, behaviour, skills, attitudes and values that underlie leadership and management actions (Byleveld et al., 2009; Boyatzis 1982 and 2009; Filerman 2003). While these competencies are variously described in the literature, one useful approach is to think of three types of intelligence:

- Cognitive intelligence, including:
    - Business skills – the ability to plan, budget, coordinate and monitor services.
    - Systems thinking and pattern recognition - the ability to perceive multiple causal relationships to aid in understanding phenomena.
- Emotional intelligence, including:
    - Self-awareness - the ability to perceive ones own emotions and attitudes, their effects on others and on oneself.
    - Self-confidence – the ability to know one's strengths and weaknesses and act accordingly.
    - Self-management – the ability to govern one's emotions, attitudes and habitual reactions.
    - Self-motivation – the ability to generate inspiration and commitment in oneself towards chosen actions.
- Social intelligence, including:
    - Social awareness and relationship competencies - the ability to network, develop trust, collaborate, empower others, display empathy and manage conflict.

(Boyatzis 2008, Day 2001, Zand 1997, Hogan and Kaiser 2005, Gardner et al., 2005).

The above listing suggests that the process of leadership development is not about acquiring particular skills. As suggested by Csikszentmihalyi, "a leader will find it difficult to articulate a coherent vision unless it expresses his [or her] core values, his [or her] basic identity … one must first embark on the formidable journey of self-discovery in order to create a vision with authentic soul." However, a risk for the health system is that a L&M that displays a measure of the above competencies may seek to work in an environment aligned with his/her capabilities and sense of calling (Boyatzis, 1982, 2006, 2008 & 2009; Boyatzis and Sala, 2004;; Egger et al, 2005; Waddington, 2007). One implication is that leadership development processes might lead to the loss of promising future leaders if these individuals perceive that the health sector is cramping innovative leadership practices.

4. Leadership and management development approaches in LMIC health systems

LMIC approaches to leadership and management development fall broadly into three categories: formal training, on-the-job training and action learning.

4.1 Formal training

Formal training remains the most common approach used in LMIC contexts. The offerings include modules within Masters programmes, diplomas, certificates and short courses, whether provided through face-to-face instruction or distance learning (Byleveld et al., 2009; Egger and Ollier, 2007; Day, 2001). Some of these are specifically designed for employed health managers and can be taken on a part-time basis.

Given that formal training programmes are normally offered by universities or colleges, the curriculum tends to focus on the "cognitive intelligence" aspect of L&M competencies, including programme management, financial management, human resource management and information management. Topics related to current public health policy and the district health system are also typically included. Teaching methods include lectures or case study approaches that are designed to transmit information and, in some instances, to build problem solving skills. However, one challenge of teaching management in this way is that it assumes that there is a model of ideal management behaviour (Dorros, 2006) and that leadership and managerial competencies can be attained through cognitive processes. If leadership is about doing the right thing then clearly having the capacity to do human resource planning is the first step; having the ability to work with others to implement the plan, despite potential opposition, is also important.

4.2 On-the-job training

On-the-job approaches range from informal and even unintentional learning to more formal programmes of induction (Dorros, 2006). Commonly used practices include 360-degree feedback, use of technical advisors, mentoring, coaching and learning networks (Vriesendorp 2010; Egger and Ollier 2007; Dorros 2006; Hartley and Hinksman 2003; Day 2001). These may be offered from within the organisation (internal mentoring for example) or through externally appointed coaches and consultants.

4.3 Action learning

Action learning is also known as action training and research, action research, learning by doing, capacity building, joint development activities, participatory capacity building, and collaborative learning (Dovey, 2002; Ferrelli et al., 1997; Omaswa et al., 1997; Kerrigan and Luke, 1987). It typically combines formal training with on-the-job mentoring and support and uses assignments and reflection drawn from the work context as the learning vehicle (Pedler, 1991). This approach assumes that leadership and management development is best achieved if integrated into the work and activities being managed (Lave and Wenger, 1991; Raelin, 1997; Dovey, 2002; Dorros, 2006).

Research into action learning suggests that the approach has potential for management and leadership development (Ferrelli et al, 1997; Omaswa et al, 1997; Dovey, 2002) although there is a need to assess and document its impact on overall health system performance. For example, in reflecting on the impact of a participatory action research project known as the Tanzania Essential Health Intervention Project (TEHIP) Gilson (2007) noted that it remains unclear if and how the TEHIP experience can be scaled up nationally, or what impact the project would have if it were implemented entirely through routine district management systems.

4.4 Strengths and limitations of current approaches

Considering the three intelligences ideally needed by health L&Ms, there are limitations to the existing development approaches. As previously suggested, many approaches focus on the technical and operational skills of planning and budgeting (the cognitive intelligence aspects) with limited attention paid to the emotional and social intelligence aspects including the ability to inspire and motivate others, to mentor, and to lead organisational change processes, amongst others (Gilson 2007; Waddington 2007).

Lord and Hall (2005) argue that the attainment of leadership competencies can be understood as a shift in identity and selfhood - where leadership becomes an aspect of the person's sense of their life purpose. This, they argue, is important to provide the motivation required to develop and practice challenging leadership competencies and to go through the journey of awareness building that is needed to develop emotional and social intelligence. They argue that identity (a) provides a structure around which relevant knowledge can be organized; (b) is a source of motivation that determines the extent to which the leader voluntarily puts him/herself in developmental situations; and (c) may provide access to personal material (i.e., stories, core values, etc.) that can be used to understand and motivate colleagues.

Following this notion, they propose that leadership skills are first learned through problem-related experiences or observational learning in specific contexts and then are organized into increasingly higher level systems of awareness that guide behaviour, knowledge and social perceptions. These systems develop along with emerging personal identities in which leadership roles and skills become more central to an actor's sense of who they are. Thus, over time, leadership skills and knowledge become inextricably integrated with the development of a person's self-concept as a leader (Lord and Hall 2005).

This model suggests that leadership development is not a cognitive process. Managerial and leadership training delivered through didactic educational processes can be useful for providing ideas, material and motivation, but the extent to which these become integrated into the personal identity of the individual will depend on the extent to which he/she chooses to practice and integrate the skills into daily life. This can be supported through internal or external coaching and mentoring processes, particularly if these help the L&M to integrate these practices into the existing organizational culture and routine processes of the health system, and/or draw on these practices to strengthen the organizational culture in a way that encourages responsiveness. And this in turn will be easier to do if others in the organization support the use of new practices, and if the leadership and development approach finds synergy with other practices and processes in the system.

5. Discussion and conclusions

This paper is based on a review of the leadership and management literature in LMIC health systems. It seeks to understand who health L&Ms are, how they find themselves in a managerial role, the scope of their job, the ideal competencies required, the current health management and leadership development approaches and the fit between these approaches and the set of competencies ideally required to encourage responsive health systems development.

Drawing from the reviewed literature, most health L&Ms have a health professional background and are often promoted into a managerial position based on their length of experience or competence as a health professional. While their scope of work ranges from planning to evaluation, they work in a system that is constrained by a lack of resources and inadequate support systems. Formal training offered by academic institutions remains the predominant leadership and management development approach. Other approaches, including on-the-job training and action learning, reflect a growing recognition that key leadership competencies can best be gained within real life settings. However, whether the latter approaches are successful in strengthening health systems remains to be seen.

As would be expected, current approaches tend to focus on managerial skills – the cognitive intelligence aspects including business and, more recently, systems thinking skills. This is understandable given how little we know about how leadership identity is formed and how emotional and social intelligence is developed. We have therefore tended to focus on routine planning, budgeting and similar skills that can be gained through formal training programmes, and have left L&Ms to develop the other skill sets themselves. While this is one approach, the results have not delivered the sorts of competencies that are needed to transform health systems. The findings from this literature review indicate that it would be worthwhile to experiment with action learning approaches (that include a mix of formal training, on-the-job training, mentoring and support) and to insert the learnings into routine practices and processes.

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