





Strengthening system leadership for the District Health System

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Those working within the South African (SA) District Health System (DHS) have various roles in addressing population health and wellbeing needs. These include motivating and co-ordinating local providers offering community, primary healthcare facility and district hospital services, including prevention and promotion services, and facilitating whole-of-government and whole-of-society collaboration with other government and social actors. These roles cannot be fulfilled by exercising traditional, command-and-control public sector managerial authority. Instead, distributed system leadership is required: a form of leadership practised by individuals and teams that enables the collective action needed to address complex health needs, and that is supported by wider organisational structures and processes. Based on a range of experience, this in-practice article presents the rationale for, and description of, system leadership within the DHS; appraises current approaches to leadership and management development in South Africa from this perspective; and outlines a system leadership development approach that offers promise for DHS and health system strengthening.

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It is widely recognised that leadership and management (L&M) are essential in developing strong health systems.^[1] In South Africa (SA), repeated calls have been made to prioritise health system L&M development,^[2,3] most recently in the National Department of Health's 2030 Human Resources for Health Strategy.^[4] Over the years, a range of dedicated initiatives have also been established to strengthen L&M, including accredited postgraduate and in-service leadership training programmes. However, coverage with these programmes remains patchy and, despite some evidence of individual-level benefits,^[5,6] their long-term impact on the health system is unknown.

This in-practice article seeks to prompt renewed thinking about how to strengthen health L&M development. It draws from the practical experience of its authors, which includes health system leadership, support for leadership development and conducting research about health systems and leadership. It specifically considers the District Health System (DHS), as this system level is critical in strengthening primary healthcare to meet the majority of people's health and wellbeing needs.^[7] The article, first, outlines the main roles of the DHS and linked L&M activities, highlighting the need for a new form of leadership within the DHS: system leadership (Box 1).^[8-11] Second, it appraises current approaches to L&M development in SA in terms of their potential to support such leadership, and third, it presents a new approach to L&M development that offers promise for health system strengthening by supporting system leadership.

What are the key DHS roles, and what does L&M entail in the DHS?

The roles of the DHS have been well established globally^[12,13] and, for SA, are outlined in the National Health Act No. 61 of 2003.^[14] The DHS supports the delivery of community- and facility-based primary

Box 1: System leadership:^[8-11]

- is associated with a set of behaviours and practices that enable people working in many different places, spaces and levels, and across professional and disciplinary boundaries, to act collectively to address complex health needs;
- is practised by individual leaders and by leadership teams, working within and across organisations, who offer purposeful leadership in the parts of the system where they have influence;
- entails both collective action to address complex health needs and intentional change in workplace routines to nurture and sustain collective leadership; and
- is enabled by senior organisational managers who take action to spread organisational authority and adapt structures and processes to support system leadership.

care services, including prevention and promotion services, as well as first-level hospital referral services (the district hospital). It should also co-ordinate local providers (e.g. government, non-governmental organisations and private), and facilitate collaboration with other government and social actors to address the social determinants of health. In addition, the DHS is the key interface between the local level and healthcare frontline and higher strategic levels, and plays a critical role in policy implementation.^[15]

The L&M activities that enable the DHS to fulfil these roles are listed in Box 2, and inevitably span the L&M continuum. Managerial activities, such as items 4 and 5, are, in organisational terms, 'inward-looking', focused on the technical elements of planning, organising, implementing, and monitoring and evaluating within the public sector.^[12] The other activities listed require more of an 'outward-looking' set of leadership behaviours and actions that

Box 2: Key leadership and management activities within the District Health System (based on consideration of DHS roles outlined in the National Health Act^[14]):

1. Enable and co-ordinate:
 - relationships with community groups and other social actors to support community-based and community-led action for health promotion and protection
 - relationships with other government sectors and social actors to support intersectoral action
 - primary healthcare provider networks – from community-based services to district hospitals, and partnering with other public, private and alternative/traditional practitioners
 - primary healthcare quality improvement initiatives that span from the district hospital to the community-based services platform.
2. Motivate and inspire public health staff at all levels within the DHS to innovate and be creative in responding to community and service needs.
3. Lead and support policy implementation – by adapting centrally developed policies to meet frontline realities and, in a feedback loop, identifying critical frontline realities to feed upwards to inform future policy-making.
4. Ensure appropriate and efficient use of all available financial, human and physical resources, including holding staff accountable for their work.
5. Support ongoing assessment of opportunities, challenges and achievements to enable and strengthen DHS performance.

include: creating a vision and strategic direction for the organisation; communicating the vision to those working in and being served by the organisation; and inspiring, motivating and aligning people and the organisation to achieve this vision.^[16] However, management and leadership are interconnected, and leadership skills are also needed for the more inward-looking activities.

Indeed, many of the listed activities point to the importance within the DHS of working with multiple teams, both within and outside the public sector. Multidisciplinary teams work across health professional silos to support improved quality of care, supported by functional teams across the clinician/support or corporate service boundary.^[17,18] Teams that comprise both health staff and those from other government sectors, civil society, local authorities and local businesses are, moreover, integral to the whole-of-government and whole-of-society approaches needed to address complex health and wellbeing population-level challenges (Box 1).^[8,15]

Senior managers in the DHS cannot, therefore, simply use their bureaucratic authority to direct activities. Instead, they must delegate authority and create space for the exercise by many others of the form of distributed leadership that enables people working in many different places, spaces and levels, and across professional and disciplinary boundaries, to act together.^[8-11] Such leadership draws on the talents and capabilities of all team members.^[19-21] At its heart, then, leadership within the DHS must pay particular attention to the social processes that enable people to work together to achieve results that they could never achieve working alone^[22] (Box 1).

The current challenges to developing system leadership within the SA DHS

Existing, dedicated SA L&M development interventions (those focused entirely on developing leadership and/or management competencies) range from workshops of one or a few days' duration on very specific management issues, to more formal, accredited qualifications. These training initiatives target a variety of audiences – from 'business' managers generally, including health managers,

to courses aimed at all public sector managers, to those targeting health system managers, or clinicians, specifically. They are offered by higher education institutions (HEIs) across the country, business schools inside and outside HEIs, a range of non-governmental agencies (such as the Foundation for Professional Development, the Anova Health Institute and the Aurum Institute) and the National School of Government.^[11]

A review of organisational websites and engagement with health system managers indicates that such training activity often emphasises generic role-specific management (such as primary healthcare management, pharmacy practice management), or technical competencies (such as financial, human resource or supply chain management), rather than the wider knowledge sets, practices and behaviours needed in system leadership for the DHS. As argued earlier, the relational competencies that enable social processes are crucial in navigating multiple complex relationships, which are particularly important in the DHS, while the competencies that support strategic thinking and adaptation to new situations and needs, such as reflective practice, critical thinking and systems thinking, are also needed.

L&M training interventions linked to higher level qualifications, meanwhile, largely target individuals scattered across the health system, rather than directly engaging teams.^[5,6] As a result, they cannot fully address teamworking competencies, and are likely to have limited impact on the DHS as a key level in the health system. Finally, these interventions are primarily classroom-based, rather than proactively adopting the workplace-based learning approaches increasingly recognised as important to all forms of leadership development,^[23] including system leadership.^[24]

Beyond the nature of the available L&M training, public health system workplaces, including the DHS, themselves place two sets of limits on the impact of these interventions.

On the one hand, health system graduates of formal training programmes commonly feel disillusioned on return to their workplaces. They indicate that existing practices and cultures resist new forms of leadership and do not encourage learning and innovation.^[1,6,25] Such challenges derive from public sector governance structures and organisational culture. For example, within the DHS there can be a mismatch between managerial authority and responsibility – for example, limits on the delegations of authority for staff appointments, due to political or budgetary constraints, undermine district managers' ability to ensure adequate resourcing to maintain service provision (Box 2, point 4).^[15,25,26] In addition, multiple, vertical lines of accountability (such as to the Office of Health Standards Compliance, the Auditor General's office and national health programmes) demand a focus on compliance with standards, and contribute to a climate of blame- and responsibility-shifting within the DHS.^[15] As a result, punitive L&M styles based on bureaucratic power are incentivised, rather than the practices of system leadership that enable teams to innovate to tackle shared challenges, and that create spaces of leadership learning and distribution within everyday routines.^[15,27]

Current human resource management and development processes suggest that system-scale L&M development is not seen as critical for health system development. For example, as is widely experienced, managerial appointment processes generally do not require an L&M qualification, job descriptions only weakly consider L&M roles and training is provided as an individual career development opportunity rather than being managed as a system-strengthening intervention. It is also simply not clear what proportion of the available training budgets of provincial health departments is allocated to L&M. Instead, many SA health L&M development programmes have been donor-funded, limiting their sustainability.

A new approach: System leadership development for the DHS

Given the challenges faced, SA experience suggests that developing system leadership for the DHS demands new understandings of relevant competencies and new approaches to L&M development. In this section, we draw on some of the work of the Partnership for Health Leadership and Management (PAHLM) Capacity Development, a collaboration between the Western Cape Department of Health and Wellness and three HEIs.

Delineating system leadership competencies

A foundation for developing any form of leadership is delineation of relevant competencies. PAHLM developed a leadership competency framework,^[28] linked to an individual-level leadership behaviours charter, reflecting international experience and tested and developed through two rounds of workshop engagements with >800 public health system managers across the Western Cape. This work was commissioned and approved by the Western Cape Department of Health and Wellness, and received ethics clearance from the University of Cape Town Health Research Ethics Committee (ref. no. 855/2014).

This framework can be considered a system leadership competency framework (SLCF). It is underpinned by two key sets of principles.

First, reflecting Box 1, it identifies three sets of competencies and capabilities for system leadership:

- Individual-level competencies focus on a set of personal leadership behaviours and practices relevant to people from various disciplines, at different stages of their management careers, and working in any part of the system.
- Team-level competencies focus both on team establishment, considering how they are constituted, connected and capacitated for their required functions, and on the team-level behaviours that are required to sustain responsive teams as units of leadership. These competencies are relevant to the teams structurally defined in an organogram, as well as to those that are formed for a specific purpose or function, and that may straddle organisational components or extend to other sectors and partners.
- System-level competencies represent the organisational capabilities required to sustain system and distributed leadership, supporting teams and individuals to work towards collective goals by innovating and adapting the parts of the system over which they have influence.

The inclusion of team and system-level competencies distinguish this framework from the many other leadership competency frameworks that are based on individual competencies only. The inclusion of team competencies recognises that, as already discussed, tackling health challenges through, and delivering healthcare within, the DHS always requires teams, enabled by the leadership behaviours and practices that support people to work together. SA public service frameworks do not currently recognise teams as a unit of competency. The inclusion of system level competencies and capabilities (Box 3),^[29] meanwhile, acknowledges that workplace and public sector norms

Box 3: System level competencies/capabilities (adapted from Baser *et al.*^[29]):

- the existence of a shared systemic vision that enables value alignment and supports accountability and risk-taking
- an appropriate balance of delegated authority and central direction
- robust human resource development and management systems
- processes that enable internal and external teamwork and collaboration and create an ongoing learning environment
- practices that demonstrate integrity and trustworthiness.

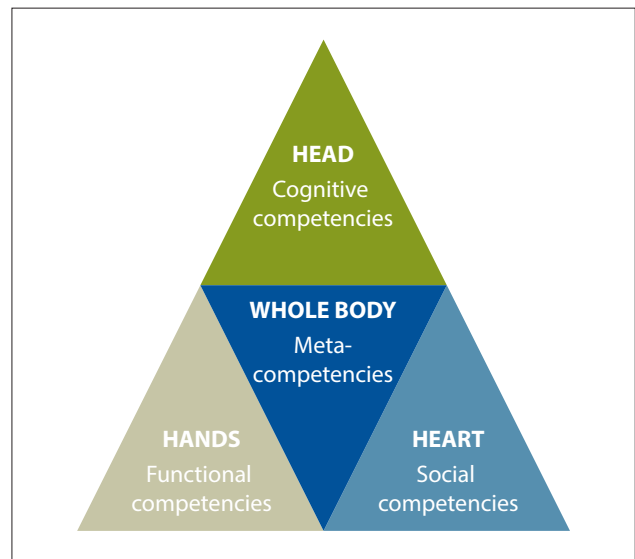


Fig. 1. The four competency domains of system leadership (adapted from le Deist and Winterton^[30]).

are critical influences that must be addressed to enable system leadership within the DHS (Box 2).

The second core principle of this SLCF is that team and individual-level leadership competencies cover four key domains, as illustrated in Fig. 1.^[30]

Cognitive competencies (the head) support a leadership practice that develops, shares and inspires organisational vision and strategy.

Functional competencies (the hands) address the more classic managerial tasks of, for example, planning, monitoring, analysis and synthesis, as well as those linked to specific roles, e.g. supply chain management, clinical governance.

Social competencies (the heart) speak to the social processes (behaviours, confidence and relationship-building) needed to fulfil many DHS roles.

Meta-competencies (the whole body) allow a focus on the overall system, and include system awareness, and the skills for system thinking, reflective practice and sense-making that are required to navigate complex social challenges in unpredictable contexts.

Applying the SLCF to support DHS system leadership development

Review of the PAHLM framework prompts further thinking about how it can be applied by public health managers and leadership development partners – to strengthen the DHS as a dynamic system.

First, it is important to take a long-term and system-scale perspective, recognising that leadership development must be a sustained rather than a one-off process, and must purposefully address health system strengthening, rather than individual career development needs. Ultimately it must seek to ‘[expand] the collective capacity of organisational members to engage effectively in leadership roles and processes.’^[31] Such an approach will also, therefore, be important in addressing the need to ensure succession planning for those currently in formal management positions.

Second, for human resource development (HRD) practitioners, the framework can be used to assess existing L&M assets and needs in particular DHS settings, as a basis for further L&M development. For example, the framework can inform surveys of current leadership strengths and blind spots; it directs attention to the importance of mapping the existing teams in the DHS as well as the spaces, such as meetings, where they gather, and the practices that shape how those

spaces themselves affect leadership development. A team context analysis allows assessment of whether the right teams exist for the range of DHS functions, and so can inform the creation of fit-for-purpose teams that have a clear vision and purpose, in which all members are well equipped to offer leadership. The team level of the framework is itself a reminder that a system leadership development programme should focus on teams, and not only individuals, to support distributed leadership, and so HRD practitioners might consider how to support the recruitment into the programme of teams from the same workplace.

Third, the framework and related assessments can provide a foundation for HRD practitioners' engagement with relevant partners to design a tailor-made system leadership development programme for a specific DHS context, as all are different.

Such a programme should seek to equip both current and future cohorts of leaders and teams, and through them, to create spaces for internally driven L&M development. It might, for example, combine a package of interventions offered to DHS teams – such as short, onsite training activities, coaching and mentorship at individual and group level, other workplace-based learning (WPBL) activities and longer, offsite formal training programmes. Within these interventions, the framework can itself be used to promote personal and team reflection about existing system leadership competencies. WPBL activities could, meanwhile, range from requiring assignments that are based on workplace priorities and activities, to facilitated action-learning projects, implemented by teams over time, to peer review, exchange and networking (e.g. across districts).^[23,32] These activities offer the promise, themselves, of contributing to the wider organisational change important in routine, system-based L&M development.^[11]

Alternatively, HRD practitioners might use the framework to select a set of initiatives that together address the full set of competencies, or that address competency sets that are currently least well developed. For example, during the development of the PAHLM SLCF, social competencies were identified by participating health staff as the most challenging and the most essential, given the relational nature of system leadership. Meta-competencies are a second crucial set that, given the common focus on traditional management practices, are often overlooked in SA L&M development.

Fourth, the framework can be used at DHS and provincial level to consider which current system capabilities need to be strengthened to support DHS system leadership development. A starting point could be a DHS-wide leadership vision that can motivate and inspire staff, and be translated into a system leadership behaviours charter. Given the challenges discussed earlier, Box 4 also highlights critical HRD and human resource management processes that must be strengthened to support system leadership development. Purposive and long-term investment is particularly important, considering budgets, time commitments and partnerships.

Finally, the implementation of any system leadership development programme must be accompanied by monitoring, evaluation and learning processes addressing all three levels of the SLCF. At team and individual levels, these processes can support programme adaptation and development. At system level, such processes are an integral part of the programme, allowing the system capability factors that challenge system leadership development at scale to be identified and fed back to health system decision-makers for their further action.

Conclusion

Although L&M are widely recognised as vital for health system development, current SA experience raises questions about the relevance and impact of existing L&M development interventions.

Box 4: Human resource development and human resource management processes that need attention to support system leadership development:

- development of a strategically focused human resource development plan aimed at strengthening system leadership across the organisation, and addressing the necessary competencies (individual, team, system)
- motivating for appropriate funding for the System Leadership Development Programme, to ensure sustained and long-term activities
- development of District Health Service (DHS) managerial job roles and descriptions that reflect system leadership functions and activities
- review of how system leadership is required and rewarded within existing recruitment, appointment and promotion criteria, and in performance appraisal processes, for individuals and teams
- reviewing how individuals from the DHS are selected for leadership and management training, and what training is offered to which staff
- considering how team development can be promoted and strengthened in the DHS – in relation to, for example, selection into leadership development programmes.

Strengthening the DHS, specifically, is vital in strengthening the health system and, given its roles, requires distributed, system leadership. Developing such leadership must be based on long-term partnerships between provincial departments of health and those, such as HEIs, who can offer sustained support for interventions that embrace a team focus, systems thinking, workplace-based learning activities and purposeful development of system and organisational capability.

Such a system leadership development programme represents a promising approach to future health system strengthening that must be trialled and evaluated.

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