Occasional Paper: An Urgent Call to Professionalize Leadership and Management Health Care Worldwide

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OCCASIONAL PAPERS

An Urgent Call to Professionalize Leadership and Management in Health Care Worldwide

Health care in developing countries is a multibillion-dollar endeavor. Yet the people charged with leading and managing this work have little formal preparation to succeed. Until this truth is recognized, the billions of dollars being pledged by donors—plus the huge investments that countries make in health—will not achieve the hoped-for results.

Two key issues underlie this growing dilemma: While the roles that doctors and nurses play in the delivery of health care in developing countries have changed dramatically, the preparation they typically receive in medical and nursing education has not kept pace. And the role of health managers is not as valued as the roles of surgeon, specialist, or clinical nurse.

The objective of this paper is to galvanize action so that *all current and future health managers will be well prepared to lead and manage to achieve results.* The paper describes this challenge in the words of the health care providers and managers coping with difficult circumstances; indicates developments that point the way toward improving these dire conditions; outlines new paradigms that can be part of an urgently needed solution; and recommends actions to move forward.

"I remember I was appointed a District Medical Officer in 1993, straight from a surgery ward as a medical officer, and within a week I had to manage an entire district. . . . It was a totally different world."

—Dr. Willis Akwahle
Director of the Malaria Control Program, Kenya

The science of medicine is thousands of years old. The discipline of management sciences, which includes the study of leadership, is less than 100 years old. Management sciences applied to health care is still in its infancy. Yet important progress is being made to advance leadership and management and prove their combined empirical value in the pursuit of health goals worldwide.

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Technically and medically, we in the health field already know what to do to save millions of lives and reduce illness. A key limiting factor in applying what is already known in primary health care is effective leadership and efficient management. According to a recent working paper of the World Health Organization (WHO), "The lack of 'managerial capacity' at all levels of the health system is increasingly cited as a 'binding constraint' to scaling up services and achieving the Millennium Development Goals" (Egger et al. 2005).

Health leaders in developing countries have conveyed a constant message: Those leading and managing health services were not, and still are not, sufficiently prepared to succeed in the leadership roles they now have. They face challenges that seasoned chief executives would find difficult: unstable work conditions with changing roles and relations, often as a result of decentralization; improving staff performance at all organizational levels; and reducing staff turnover, as many leave for better jobs overseas or because of illness. Because of the magnitude of these challenges and lack of preparation at the outset, they could use help. When they receive assistance, they achieve results.

Leading well means enabling others to face challenges, achieve results, and create the positive future that people envision. Managing well means ensuring that sound strategies and approaches are in place and resources are used effectively. By creating and scaling up approaches for developing health managers' abilities to lead and manage well, health services in developing countries can experience a full range of benefits. These must be customized to optimize learning by those who assume management and policy-making roles in the health sector—typically doctors and nurses, but also non-clinicians.

Experience and evidence within and outside health care (presented in Section III) demonstrate that preparing capable people to lead teams to achieve results can produce:

- more productive staff;

- more satisfied patients;

- stronger accountability and clearer results;

- reduced financial loss or waste and more effective use of limited resources;

- a greater ability to understand and influence the "culture" of health services;

- improved recruitment, development, and retention of health professionals.

When motivated, capable people pursue a common goal, their endeavor usually succeeds. Success also depends on political, regulatory, and organizational environments that give leaders and managers the permission and tools to innovate and improve. Fostering such environments through leadership and management development will be critical for the newly launched Global Health Workforce Alliance, which supports health workers and helps prevent their emigration from developing countries.[1]

The objective of this paper is to galvanize action to ensure: All current and future health managers are well prepared to lead and manage to achieve results. With good preparation, they will be able to develop and manage the kind of health services that achieve health goals, reduce illness, and save lives. Drawing from experiences in countries around the world and from health care, industry, and education, this paper:

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[1] The Global Health Workforce Alliance is a partnership formed to mobilize key stakeholders in global health to help countries that face a shortage of health care workers to better plan for, educate, and employ health workers. For more information about the Global Health Workforce Alliance, see http://www.globalhealthtrust.org/.

- describes the challenge in the words of health care providers and managers trying to cope with their overwhelming situation;

- indicates current developments that point the way toward improving these widespread conditions;

- outlines new paradigms that can be part of an urgently needed solution;

- recommends actions to move forward.

Doctors and nurses worldwide enter medical and nursing schools to become doctors and nurses, not health managers or leaders. When they begin practicing, most are competent at directing the care of individual patients. However, when their caseloads begin to grow, their lack of preparation in leadership and management—in planning, organizing, delegating, motivating, and teamwork—begins to frustrate them and threatens to undermine the quality of patient care and service.

The symbiotic relationship between investing in leadership and management and achieving desired results in business is becoming clear. The US-based MetrixGlobal LLC company, a consulting firm that provides coaching services, found in one study that $7.90 was returned for every $1.00 spent on executive coaching and leadership development (Robertson 2005). The same company found the return from coaching to be 529% (Anderson 2004). Of 43 managers who received coaching and development, the 30 who replied to a questionnaire reported significant improvements in team chemistry, the quality of service delivery, and retention rates.

While profits are the benchmark of commercial industry, patient and public health outcomes are the measure of success in health care. Virtually every physician or nurse placed in leadership and management positions in low-income countries has a similar story to tell about the lack of personal preparation to lead and manage teams and organizations toward good outcomes and improved public health.

Call for Better Preparation from Health Managers Worldwide

Kenya—Dr. Willis Akwahle, Director of the Malaria Control Program, remembers, "I was appointed a district medical officer in 1993, straight from a surgery ward as a medical officer, and within a week I had to manage an entire district. . . . It was a totally different world. I learned more by accident. . . . The first one or two years were not easy. After two years, I realized I had to abandon my work on the ward and concentrate more on management and preventive work. [Young doctors] definitely need training in leadership and management, and it should not be short term. It needs to be incorporated at various levels of their training, both in class and out in the field."

Egypt—Dr. Abdo Hassan Alswasy, Consultant in Obstetrics and Gynecology, states, "When I was in medical school, I thought my job would be to treat suffering people. I received no leadership and management training in medical school. Today, my leadership and management challenges are many, such as reducing maternal mortality, increasing community awareness of post-abortion care, ante-natal care, and improving the performance of obstetricians in district hospitals. My team needs all the leadership and management skills I received."

Afghanistan—Guljan Jalal, Director of Nursing, Ministry of Public Health, says, "In nursing school, it was my great desire to serve my people as a skilled nurse. The curriculum focused on managing the patient and safe delivery of medication. . . . Now I cooperate and coordinate with institutions, NGOs, and government departments to manage human resources. I advocate for nursing staff by mobilizing stakeholders to support capacity building. In nursing school, nurses need to learn how to create vision and accept challenges. They need to know how to manage their time, obtain results, and use training facilitators in an efficient and effective manner."

Brazil—Dr. Henrique Sa, Dean of the University of Fortaleza Medical School, says, "I learned nothing about leadership and management [during medical school] and what little I learned about administration was obsolete and old fashioned. In medical school, there is (and it seems that it continues to be) a hidden curriculum that the physician is a 'born leader.' Medical students need structured knowledge on management and leadership as well as practical experience. They need to understand how a health system operates, how health services are managed and how a health facility is managed."

Nicaragua—Dr. Josefina Bonilla, Executive Director of NicaSalud, comments, "People can learn leadership. [Doctors] need to develop competencies for understanding and respecting the other person. Cultural norms in Nicaragua do not encourage these skills, but doctors need to improve at human relations and work-related communication. Doctors raise barriers and believe in hierarchical differences. Any training that could focus on changing these attitudes would be good."

Uganda—Professor Sam Luboga, Deputy Dean, Faculty of Medicine, Makerere University, recalls, "I thought my role in health care would be to treat the sick, but I realized there would be few doctors compared to the size of the population. So I began to realize I would have to lead non-medical people. But I had no formal training in leadership or management, only informal experiences. Today, my biggest leadership and management challenge is motivation, finding a way to motivate people to 'run to work,' to have one thing they want to achieve this week."

The Philippines—Dr. Florante P. Magboo, Field Operations Advisor, observes, "[While in medical school] I envisioned myself doing clinical work in the field of surgery or obstetrics/gynecology. To get any leadership and management training in the Philippines, you need to pursue a master's degree in public health or hospital administration. The leadership and management development I see a need for is people management, health financing, resource mobilization, and strategic planning."

Haiti—Dr. Mozart Cherubin, Medical Director at the Beraca Medical Center, indicated, "I didn't learn anything in terms of leadership and management when I was a medical student. The training there was focused above all on making us into clinicians who could respond to the demands of curative medicine. In human resource management, there are several challenges: How to arrive at an elevated rate of staff retention despite non-competitive salaries? How can we attract health professionals to a health institution in a rural location like ours? How can we have optimal use of available human resources?"

Source: Management Sciences for Health, "Survey of Health Professionals Who Lead," Spring 2006.

Throughout developing countries, doctors typically head ministries of health, regional and district hospitals, health-related nongovernmental organizations (NGOs), faith-based organizations (FBOs), and multisectoral task forces and commissions. A 2005 inventory in Uganda revealed that 55 out of 56 directors of district health services are physicians and the other is a dentist (Uganda Ministry of Health 2005). In some countries, hospital superintendents are educated in hospital administration. With added preparation in leading teams and as partners with doctors, this cadre could help lead health programs and health services at subnational levels.

Doctors and nurses are frequently assigned to fill these management jobs without appropriate training or background in management and leadership. When they apply their training in clinical diagnosis, therapeutic protocols, and treatment techniques, their patients benefit, but only if everything else that supports patient care is in place: the right staff; with the right information, drugs, supplies, and equipment; at the right time; in an environment that is clean and conducive to quality care. The role of managers is to ensure that all these factors are present.

It is commonly assumed that a health degree means that one can be a manager. As a result, new graduates without managerial and leadership skills or experience are given a wide range of management and supervisory responsibilities. For example, a new doctor is put in charge of an entire district at the age of 25. A pharmacist without any management training is put in charge of and held accountable for 25% of the total Ministry of Health budget. Junior staff or middle managers are left on their own to handle internal issues of corruption.

During their careers, it is assumed that these young doctors or nurses "learn by doing." They learn from role models, take an occasional training course, read books and articles, or have a skilled mentor. This is, however, a "hit or miss" approach to the development of management and leadership skills.

The consequences of this circumstantial approach are exemplified by real problems that

health care providers and researchers have mentioned in interviews.[2]

- The director of a health facility is asked to increase the number of people who come for voluntary counseling and testing. His staff consists of nurses and young HIV/AIDS counselors. They might have good ideas on how to add to the numbers, since they know their patients well, but the director never asks them.

- Garbage and medical waste at a district hospital spills over. It is hidden from sight because of tall grasses, but a dog sniffing around finds the waste and drags some of it away. There is an official waste disposal policy, but no one is responsible for implementing and monitoring it.

- Expensive computerized laboratory equipment purchased with new sources of funding is broken and sits unused in laboratories because no one took pre-cautions to protect the equipment from electrical surges. The technicians who can fix the equipment don't see their role as preventing the problems in the first place.

- Doctors and nurses overwhelmed by caring for too many patients experience serious stockouts and lack of feedback from the central level. No effective problem-solving is done during rare supervisory visits.

- One hospital has an obstetrician and another hospital (not far away) has an anesthesiologist. Neither hospital has both. Women die in childbirth because neither hospital can perform cesarean sections with the staff it has.

- A rural hospital has an obstetric operating room that has not been used in long time because the surgeon who left was not replaced, despite many requests to the central level.

- Tens of millions of dollars worth of drugs, supplies, and equipment are misused, lost, or stolen because of the lack of effective controls and ethical leadership.

Health care leaders and managers from low-income countries note eight key challenges that they commonly face in their organizations.

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[2] Management Sciences for Health, focus-group discussions on leadership and management in international health care, Boston University School of Public Health, June 22, 2005 and Aug. 18, 2005.

Are those who are currently charged with leading and managing health services prepared to meet these kinds of challenges? The evidence at the provincial, district, and municipal levels in low-income countries indicates that few have had the opportunity to gain the leadership and management skills they need to succeed. This paper proposes ways to respond to their call for help in Sections IV and V.

REDUCING RISKS AND ACHIEVING THE BENEFITS OF LEADERSHIP AND MANAGEMENT IN HEALTH CARE

"People do not stop to realize the cost of poor management and leadership. Nothing uses up precious resources in public health quicker than bad management, but people really don't focus on the cost of doing it well until it is too late."

—Jonathan Quick, President and Chief Executive Officer, Management Sciences for Health

The decision to invest in leadership and management can be viewed as a glass half empty or a glass half full. There are risks associated with not investing and rewards to be gained from investing—but neither is fully appreciated. The combined value of leadership and management has been learned the hard way in health care in developed countries like the United States and United Kingdom, where

high-profile health system failures have revealed the unequivocal importance of strong leadership and management.

Waste in resources. In England, where 93% of health care is delivered through the National Health Service (NHS), a range of studies by the National Audit Office (NAO) found that roughly 20% of the NHS's then $60 billion budget was lost or wasted due to ineffective governance and management decision-making ("The NHS Money Drain," pp. 1–6). In 1999, the NHS introduced a massive corporate governance process to give managers and leaders the knowledge and tools to assure that public resources were used to best effect (United Kingdom Department of Health 1999).

A follow-up study two years later found that the average self-assessed scores for meeting national governance standards increased from about 50% to 65% across more than 550 organizations, and the level of awareness of the risks from loss and waste at the managerial level was far greater. Most important, the study found that high-performing organizations could improve *without* new resources or interventions far more than low-performing organizations could improve, even *with* additional resources and interventions (United Kingdom Department of Health 2002).

Patient safety. The patient safety movement has taught developed countries some hard lessons. On average, about 10% of patients experience at least one significant error in their care (Leatherman and Sutherland 2003). Data on the causes of these errors shows that *leadership failure* is a root cause in 13% of "sentinel" events, while *breakdowns in an organization's culture* account for 10%. In addition, management problems cause overwhelming percentages of these

events: *communication failure* (65%) and *poor orientation and training* of staff (58%).[3]

Staff behavior and financial performance. Good leadership and management affect *staff behavior* and, as a result, *patient satisfaction* and *financial performance.* US hospitals with the lowest levels of employee engagement[4] incurred an average of $1,120,000 more in malpractice claims per year than hospitals with the highest engagement scores (Medlin 2005). In England, NHS data show that a leading factor in a patient's decision to sue an NHS doctor or hospital is how the patient was treated. Patients who felt devalued were far more likely to sue than those who felt respected by their providers.[5] Strong leadership and management can promote respect for clients among staff.

Brain drain. Causes for the emigration of doctors and nurses from developing countries include staff nonengagement and job dissatisfaction, occupational risks, and community factors, such as crime and political insecurity. They leave their homeland to practice medicine in countries where there are better conditions and better pay (Mullen 2005).

Stemming the brain drain will require increased investment to improve the work environment

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[3] Joint Commission on Accreditation of Healthcare Organizations, Oakbrook Terrace, IL, http://www.jointcommission.org/SentinelEvents/. Events have a combination of causes. The Joint Commission defines a sentinel event as "an unexpected occurrence involving death or serious physical or psychological injury [of a hospital patient], or the risk thereof…. Such events are called 'sentinel' because they signal the need for immediate investigation and response."

[4] For more information on employee engagement, see pp. 12–13 of this paper.

[5] Steve Walker, Chief Executive, NHS Litigation Authority, remarks at a conference, Perth, Australia, Feb. 2000.

and tools for health workers and raise their morale. In-country research opportunities, greater appreciation of the power and impact of teamwork, reward programs, incentives, a professional development track for health managers, have all been recommended to address causes of the brain drain (Pang et al. 2002). The efforts of the Global Health Workforce Alliance could provide a solid foundation to strengthen health care capacity in developing countries.

Decentralization. The Pan American Health Organization evaluated 15 management training programs that were part of health sector reform. Despite investments of millions of dollars in training and improvements in infrastructure, the region's capacity to deliver equitable health services of acceptable quality has not improved greatly. Poor management in decentralized entities is considered one of the principal reasons for this failure (Homedes and Ugalde 2005).

The process of decentralizing health systems has produced confusion over roles and responsibilities. Role ambiguity undermines job satisfaction, involvement, performance, and retention. Through good organizational leadership, however, managers can develop clarity about their roles: what they should be doing, how to get things done and in what order, and how to act in various situations (Bauer and Spencer 2003).

Among the advantaged in the developed world, many have realized the importance of leadership and management in health care through the lens of wasted resources and patient safety. Health managers in low-income countries recognize it through experience with emigration of providers and failure to achieve health goals during decentralization. New funding mechanisms give the call for leadership and management a new global urgency.

"We in the health sector have a history of accidental managers. Breakthroughs will be tough because there is little history of competence building in management in low-resource settings. For instance, Global Fund Country Coordinating Mechanisms[6] are a whole new ballgame. Managing such entities requires very high levels of leadership and management skills. Some mythical thinking exists, which is the feeling that those with medical and nursing training should automatically be good leaders/managers."[7]

—Bob Emrey, Chief, Health Systems Division, Bureau for Global Health, USAID, Washington DC

These are extremely challenging yet exciting times for public health in the developing world. In 2002, all 191 member nations of the United Nations agreed to eight Millennium Development Goals (MDGs) by signing the UN Millennium Declaration. Designed to cut poverty in half by 2015, nearly half of these time-bound, quantifiable MDGs and targets concern health issues, such as the reduction of HIV/AIDS, tuberculosis (TB), malaria, malnutrition, maternal, child, and infant mortality.

African leaders met in Abuja in May 2006 to renew their commitment to enable Africa to

meet the MDGs and targets set for HIV/AIDS, TB, and malaria in the Abuja Declarations of 2000 and 2002. They formed multisectoral and sectoral partnerships to fight these and other diseases. New actors in health emerged at the community, regional, and national levels, while debt relief freed resources for public health efforts.

In the past three to five years, donors have offered unprecedented levels of funding to prevent and fight particular diseases through the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM), the Bill and Melinda Gates Foundation, the President's Emergency Plan for AIDS Relief, and numerous other multilateral, bilateral, and national initiatives. Together the MDGs and sources of megafunds call for the massive scale-up of health services to fight HIV/AIDS, TB, and malaria, as well as for more general improvements in maternal and child health.

In Africa, these opportunities come at a time when the prevalence of common diseases has outstripped the capacity of national health systems, and, in some countries, the supply of human resources for health is collapsing.

Even so, low-income countries are responding to the opportunities offered by these funds. Although far from achieving necessary levels of access to services and drugs, they have made some progress, including increasing access to antiretroviral therapy from 1% of AIDS patients to more than 17%, and, in some countries, decreasing the prevalence of HIV.

The Global Fund and MDGs represent a huge shift in perspective. Enhanced global connectivity, education, and advocacy efforts have helped policymakers understand the dispropor-

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[6] A Country Coordinating Mechanism (CCM) is a multisectoral partnership within a country that develops grant proposals for the Global Fund to Fight AIDS, Tuberculosis and Malaria, based on high-priority national needs. After approval of a grant, the CCM oversees its implementation. A CCM includes representatives from both the public and private sectors, including governments, nongovernmental organizations, faith-based organizations, private businesses, and communities affected by the diseases. For more information on CCMs, see http://www.globalfund.org.

[7] Bob Emrey, in discussion with Joseph Dwyer, Aug. 21, 2003.

tionate burden of poverty and disease faced by the developing world. At the same time, country sovereignty and leadership require that country leaders define country priorities and approaches for national responses to health and take responsibility for meeting commitments they have made. Most ministries of health, including those in smaller countries, recognize the importance of management in carrying out their responsibilities. For example, at the last World Health Assembly, the Minister of Health from East Timor stated that he needs to develop the management capacity of district health officers.

Managers and health institutions need strong leadership, governance, and management systems and procedures to effectively:

- administer these new monies;

- scale up services rapidly;

- maintain fledging multisectoral partnerships;

- oversee the dispersal of funds to implementing partners;

- maintain transparency and accountability.

These times urgently call for strong leadership and effective management in health institutions. Yet one of the most significant challenges in public health and health care services today—a challenge much less frequently cited than the need for drugs and personnel—is the lack of basic preparation for those who must lead and manage in health institutions and programs, from the community to the national levels.

As Adam Wagstaff and Miriam Claeson of the World Bank state:

"Health providers in both the public and private sectors and in both the formal and informal sectors play a key role in delivering interventions of relevance to the Millennium Development Goals. Many are efficient, deliver high quality care and are responsive to their patients. But many are not. As a result, resources—public and private—are wasted and facilities sit underused. Two things can make a difference: One is the quality of management. Better management means a clearer delineation of responsibilities and accountabilities inside organizations, a clearer link between performance and reward. . . . Management (also) means getting accountabilities right within the organization . . . and between the organization and the public."

NECESSARY LEADERSHIP AND MANAGEMENT SKILLS

To meet these new commitments as well as their ongoing commitments, health leaders and managers must continuously search for ways to do things better, faster, easier, and with greater transparency—with a constant focus on quality and results. With effective preparation in leadership and management, doctors and nurses learn to ask two questions over and over again:

- First, are we providing the best possible care, given the resources we have to achieve our goals?

- Second, where do we currently have performance gaps that impede our efforts to reach our goals?

Among recent trends is the recognition that health providers need to be *engaged* in making service improvements in order for the quality of

health services to improve. Engagement has been defined as "The extent to which employees commit to something or someone in their organization, how hard they work, and how long they stay as a result of that commitment" (Corporate Leadership Council 2004). Health program managers learn how to engage other health care workers in the work of addressing service delivery challenges to create efficiencies and produce higher quality services that clients will use (Research into Practice).

What are the leadership and management skills that entry-level, mid-level, and senior managers urgently need in this era of great opportunity and responsibility? A district medical officer has different learning needs and must apply somewhat different knowledge, skills, and tools than a minister of health. The following box offers examples of specific skills that would make a difference at various managerial levels. Any large-scale program to develop leadership and management would have to tailor its efforts to the needs of each managerial level through a customized, user-friendly process.

Examples of Leading and Managing Skills at Different Levels

Managers at all levels need skills for managing people, information, supplies, and funds. By involving teams in their activities, they can gain commitment and build the capacity of others.

Entry-Level Skills

Scan and focus / plan and monitor (information)
- Analyze service statistics, survey data, and comments of clients and staff
- Prioritize local health challenges and link to service tasks and resources
- Plan simple improvements to address health challenges
- Develop a framework to monitor implementation of improvements

Align and inspire / organize (people)
- Lead groups to address challenges (clinical and nonclinical staff, client committees)
- Align staff and stakeholders capacities with planned activities
- Develop a positive work climate
  - communicate commitment, expectations, and achieved results
  - improve staff-client communications
  - engage and motivate individual staff

Mobilize / implement (supplies and funds)
- Estimate resource needs for improvements
- Mobilize resources (space, in-kind contributions, funds)
  - make requests, advocate, and negotiate locally and with the next level
- Use resources efficiently
- Optimize use of commodity ordering systems
  - prevent stockouts of needed pharmaceuticals (antibiotics)
  - expedite orders of supplies (specialized light bulbs)
- Use equipment systems for repairs (microscope repair)

Mid- and Senior-Level Skills

As managers become managers of managers, their perspective shifts to coaching managers below them. They expand their time horizon to plan eventually 10 to 20 years ahead for resources. They form supportive external relationships. While the skills below are key for all managers, they are critical at the mid- and senior levels.
- Set strategic program priorities
- Ensure the flow of adequate resources (human resource management, supply management, quality assurance, financial management, and revenue generation)
- Improve staff performance
  - communicate program priorities and clear expectations
  - offer supportive supervision and coach team leaders
  - acknowledge good performance
- Ensure the flow of accurate information for decision making (data collection, analysis, use in decisions, and feedback)
- Model values

The importance of leadership and management to achieving health goals has been recognized for decades, yet progress in developing leadership and management has been slow. In 1951, a WHO expert committee assessed the state of the world's health services and noted that "in general, health services throughout most of the world but especially in developing countries were administered in a fragmented manner. There was insufficient coordination horizontally between different agencies responsible for different aspects of health or vertically between central, middle, and peripheral levels of administration" (WHO 1998).

The Declaration of Alma Ata, which came out of the worldwide WHO conference on primary health care in 1978, indicated the importance of management:

"For primary health care to succeed, it will require the support of the rest of the health system, and of other social and economic sectors concerned. Health systems support includes facilities for consultation on health problems, referral of patients to local and more specialized health institutions, provision of supportive supervision, and guidance, logistics support, and supplies."

In the late 1980s, most countries routinely began preparing national health plans as part of their national development plans or as separate documents. Health planning training, initially directed at national officials, was extended to staff at the intermediate and service delivery levels. For many participants, it was the first time they had been asked to articulate goals and objectives related to health.

Developments in the early 2000s raise questions about the current capacity of leadership and management in the health sector, yet distract from a much-needed focus on building public health capacity and infrastructure. It is difficult for health managers in low-income countries to balance expanding access to quality integrated primary health care services while simultaneously spending, accounting for resources, and rushing to achieve results in order to meet requirements of the high-cost, highly visible programs to combat major causes of morbidity and mortality (Barks-Ruggles 2001, World Bank 2005).

The performance of the high-stakes programs (including those funded by GFATM, the President's Emergency Plan for AIDS Relief, the Global Alliance for Vaccines and Immunization, and STOP TB) reveals major bottlenecks. For example, while the Global Fund approved funding for thousands of insecticide-treated bednets to reduce malaria, government procurement in some African countries has been so complex that the governments have not yet purchased the nets for their national malaria programs to distribute to households (Dugger 2006). Such experiences re-ignite concern about health systems' capacity to effectively absorb and manage resources, including the funds pouring in.

WHO is reorganizing to refocus on health systems management support, and in 2006 they are focusing on the human resource crisis. The Global Health Workforce Alliance could be a vehicle for effectively building sufficient leadership and management capacity in low-income countries to give donors, funders, and

governments greater confidence that limited resources will be well used to reach health goals. The Health Metrics Network, funded by the Bill and Melinda Gates Foundation, and the Health Systems Action Network represent two other efforts to initiate a focus on strengthening health systems performance and management.

INTERNATIONAL HEALTH TRAINING EFFORTS

WHO and the World Bank have ongoing efforts to address deficiencies in leadership and management capacity through management-related courses. Most WHO programs are embedded in specific technical programs, for example, immunization, management of the sick child, malaria, or tropical disease research. From time to time, WHO has also offered general management training. Currently, the Organization and Management of Health Services unit oversees health management strengthening as a part of health systems development. It focuses on low-income countries and is crafting a "management needs assessment tool" to help tailor management training in each country.

The World Bank Institute currently focuses a key part of its training and capacity development on monitoring and evaluation. Through its "Introduction to Monitoring and Evaluation" course, participants learn sequential steps to design and implement a monitoring system or evaluate projects, programs, or policies. The World Bank also offers off-site courses in such areas as public management, financial management, and health sector reform and has begun to deliver courses virtually.[8]

LEADERSHIP AND MANAGEMENT TO ACHIEVE SERVICE EXCELLENCE IN INDUSTRY

While attention to leadership and management in health care is relatively recent, particularly in low-income countries, their combined use in business and industry is well recognized as a key to client satisfaction and financial performance. In fact, according to economist and former founding partner of DRI/McGraw-Hill, Dr. Robert Gough, the number one factor that financial investors use in deciding whether to invest in a business idea is the quality of the leadership and management team—not the product or the market.[9]

Empowered staff drive excellence in service. Service businesses like Ritz-Carlton, Walt Disney, and Nordstrom have repeatedly won the coveted Malcolm C. Baldridge Award because of simple leadership-inspired management practices that evangelize staff and gain customer loyalty. At Ritz-Carlton, any employee, without exception, is empowered to spend resources to put right any customer dissatisfaction problem. At Disney, where 80% of 42,000 staff interact face-to-face with customers, managers teach staff that there are 10 million "moments of truth" each day, where staff can personally affect customer loyalty. The staff handbook at Nordstrom has one rule: "Use your best judgment in all situations," and all sales staff behave as if they are entrepreneurs (Service Excellence Experience 2006).

This push for customer loyalty can benefit health care as well. For example, the Baptist

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[8] For more information on the World Bank Institute's courses, please see http://web.worldbank.org/ WBSITE/EXTERNAL/WBI/0,,pagePK:208996~theSitePK: 213799,00.html.

[9] Robert A. Gough, Jr., PhD, Managing Director of Lexington Partners in Lexington, MA, in discussion with Michael Paskavitz, Oct. 17, 2004.

Hospital in Pensacola, Florida won the Baldridge Award in 1999 when it rose from the 18th to the 99th percentile nationally in patient satisfaction in just one year. Their secret, according to Baptist's Chief Medical Officer Dr. Craig Miller, was "Be really, really nice to everybody." They also reduced staff turnover from 30% in 1999 to less than 12% (Huseman and Bilbrey 2005).

Bottom-up accountability transforms culture. What if commercial airlines filled 95% of leadership and management positions with pilots, especially pilots who have received only flight training and have little or no preparation in leading teams to achieve results? The lessons of leadership and management in commercial aviation began in the 1970s, when airlines were deregulated. For the first time, they competed for passengers based on value—the best flying experience for the best price.[10] But many people were concerned that the more competitive environment would prompt airlines to compromise safety. This did not happen.

The airline industry began to study high-risk errors in aviation and learned that human error contributed to more than 50% of aviation accidents. Naval aviation research learned that 59% of serious accidents were due to failures by air crews, typically breakdowns in sharing information. Root-cause analyses revealed that the culture of flight crews—where pilots, like doctors, were given unquestioned authority regardless of their leadership capability—greatly contributed to the likelihood of errors and acci-

dents. This knowledge led to a revolution in the way airlines lead and manage. Now, if any employee at British Airways sees a failure or a breakdown of any type and does not report it, the employee can lose his or her job. And if the employee reports the problem, he or she can receive a reward (Pizzi et al. 2001).

Tapping staff's extra effort improves performance. In the late 1990s, when the highly competitive oil giants Mobil and Exxon merged, their union caused great strife and a cultural crisis among staff, which profoundly affected the company's leading indicators. Employees withheld their best efforts as a way of asserting their feelings and influencing the realignment. Brian Baker, Mobil's president of North American Marketing and Refining remarked, "There's a piece of us that we all sort of hold in reserve and we give it only when we are truly committed to what we are trying to achieve. You get 30% of most people's effort in a normal sense, but there's another 70% that is discretionary and is only given if people really want to give it. Real leadership is somehow trying to tap that extra 70%." Dr. Richard Huseman, who was hired as an executive coach and Director of Global Knowledge, said that tremendous efforts to improve corporate performance through leadership and management development have made Mobil/Exxon one of the world's leading companies (Huseman and Hayes 2002).

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[10] In the area of leadership and service excellence, Singapore and Southwest airlines have consistently held best places in independent surveys of airline service. The president of Southwest created a culture of empowerment among employees to push service benchmarks, such as reducing the 20-minute flight turnaround time to 15 minutes by having staff behave as if they are a race-car pit crew (Snow 2006).

EDUCATION INTEGRATES LEADERSHIP INTO TEACHING AND DIRECTING SCHOOLS

Leadership, as a revolutionary principle, changed business dramatically in the last 30 years of the 20th century. The education sector in developed countries has just begun to embrace its value. Growing interest within US education is driven by two factors: first, appreciation for the idea that strong leadership qualities in teachers raise the standards for classroom performance, and second, the national shortage of school principals and of those who are training to become principals. For example, in the state of Minnesota, 70% of school principals will have retired by 2010 (Hay Group 2000, Villani 1999).

In the past few years, an increasing number of publications and initiatives have emphasized the importance of scaling up leadership and management in public education:

- In 2001, the book *Awakening the Sleeping Giant: Helping Teachers Develop as Leaders* was published; the concept of "teacher-leader" began to take root.

- The National Staff Development Council published its seminal report "Learning to Lead, Leading to Learn"

- about its program to develop school principals.

- New York City rolled out its Leadership Academy, a rigorous 14-month leadership course for aspiring principals of the city's 1,400 schools serving 1.1 million students. After this program, standardized test scores for elementary schools led by these principals improved; the number of fourth-graders who could read at grade level increased from one-third to two-thirds in one year ("In NYC, Model Emerges for Fixing Urban Schools," p. 12A).

- The state of Tennessee launched a "Teacher-Leader Development" program that describes Teacher Leaders as "accomplished teachers who inspire students to learn and achieve and who see themselves as change agents for excellence within the classroom, the community, and beyond."

- In 2004, the state of Louisiana amended its teacher certification structure to include a new category, Teacher Leader. The St. Charles Teacher Leader Institute was founded with a $50,000 grant from the BellSouth Foundation.

SECTION IV: New Paradigms for Improving Leadership and Management in Health Care

To raise the quality of leadership and management in health care to the level in business and industry would entail deliberately putting bright young doctors and nurses, early in their careers, in positions where they can learn the managerial and leadership ropes under the supervision or mentorship of seasoned professionals. Richard Feeley, Clinical Associate Professor at Boston University School of Public Health, notes that current practice of valuing clinical over managerial and leadership skills means "people do not get introduced to planning and management issues until they are relatively senior, and consequently the job of good planning doesn't get done because there is nobody to do it. There is no one to sit and think through what has to be done and how."[11]

Despite the pressing need to strengthen the capacity in managers, the vast majority of training conducted in health service delivery institutions today continues to be clinical and public health training. While this training is important, it is not sufficient to face the challenges of health care today. To close the gap between the need for results-oriented management and leadership in health institutions and what is currently done requires more than traditional training programs.

Promising initiatives to develop management and leadership exist, however. The following examples reflect a paradigm shift to *valuing* leadership and management capabilities and *requiring* them for positions that badly need these abilities. For the most part, they involve all levels of man-

agement and link improved leadership and management to improved services. Drawn from different countries, the examples illustrate:

- meritocracy for promotion (Brazil);

- civil service prerequisites (Mexico);

- outreach to staff in their workplace (Mozambique);

- learning while overcoming real challenges (Egypt in-service and pre-service, Virtual Leadership Development Program);

- senior-level coaching and mentoring (worldwide).

A MERITOCRACY OF GOVERNMENT LEADERS AT ALL LEVELS: CEARÁ, BRAZIL

In the late 1980s, the governor of the state of Ceará in Brazil wanted competent people with good technical and management qualifications to lead state secretariats, the equivalent of ministries at the state level. Very few people had the experience and ability to lead teams and achieve the results needed to pull Ceará up from its position as one of the lowest in Brazil in terms of social-sector indicators.

He and others created a new paradigm in government for selecting people to promote into leadership positions.

- First, people had to apply to be accepted into a leadership development program.

- They needed references from two current or former supervisors.

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[11] Management Sciences for Health, Focus-group discussion on leadership and management in health care, Boston University School of Public Health, June 22, 2005.

- Finally, they had to successfully complete the government's leadership development program.

The governor kept his commitment and selected people from this leadership pool for key assignments. The new approach replaced the traditional system of promoting people according to seniority or less transparent criteria, whether they wanted leadership positions or not.

In the Secretariat of Health, this new approach has stimulated significant improvements in child health–related indicators. For example, the health secretaries of municipalities who took the leadership development program worked with teams of mayors, community leaders, health care managers, and providers to address high infant mortality rates. The implementation of their action plans resulted in decreases in infant mortality.[15] Overall, 70% of 37 municipalities succeeded in decreasing infant mortality rates, some by as much as 50%; see the table below for examples. The program has been institutionalized in collaboration between the Secretariat and the State School of Public Health and has also been expanded to other states.

Changes in Infant Mortality after Leadership Development Programs

Municipality	*Infant Mortality (Deaths per 1,000 live births)*	
	Before program	After program
Maranguape	36	13
Aquiraz	32	10

CIVIL SERVICE REFORM AND EDUCATIONAL OPPORTUNITIES: THE MINISTRY OF HEALTH, MEXICO

In 2003, a new civil service law in Mexico reformed the recruitment of civil servants. The law mandated that all government employees (including those from the Ministry of Health) be selected and hired based on competencies for the job through an open, transparent process. [12]

Each Secretariat now has a "professionalization committee" in charge of developing job descriptions and profiles. It also has a training program to bring employee's credentials up to date. Each job profile includes knowledge, skills, attitudes, and values related to the behaviors necessary to carry out the job's responsibilities and tasks. The profile contains four sets of basic competencies:

- public service vision, including ethical values;

- management and leadership competencies;

- general technical competencies (e.g., administration, languages, and management of software);

- specialized technical competencies.

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[12] Management Sciences for Health, "A Paradigm Shift in Public Health: Professionalizing Leadership and Management in Ceará, Brazil," draft, Leadership, Management, and Sustainability Program (Boston: MSH, 2006).

According to these profiles, all leaders and managers, from the mid- to senior level, must have credits (obtained through master's degree programs, courses, seminars, and forums) and pass an accreditation process. The Secretariat of Education took charge of evaluating employee credits and making sure the accreditation process works. Employees who fail the accreditation have one year to try again. If they fail a second time, they lose their jobs.

As a complement to this accreditation, the National Institute of Public Health now offers a postgraduate program: Master's in Management and Executive Leadership in Health. This new program introduces management and leadership competencies into the health sector in Mexico, including the ability to:

- set strategic directions to provide services efficiently, effectively, and equitably;

- make decisions, negotiate, and resolve conflicts using organizational dynamics;

- apply principles of quality to health services;

- develop new directives in management and leadership in health and use these in training and leading others;

- participate in and manage applied research projects in health services.

OUTREACH TO STAFF THROUGH A FOCUS ON STANDARDS: MOZAMBIQUE

In 2002, the Ministry of Health in Mozambique, with support from MSH and funding from USAID, introduced an initiative designed to improve care and service in the health sector by fostering a culture of "leadership at all levels." With the prospect of continued and perhaps greater funding from donors, the Ministry

needed to demonstrate that it could improve the leadership and management capacity and accountability within the central office and in the provinces, districts, and village medical clinics.

As part of this program, MSH introduced its Challenge Model to all levels in the health sector. (This model is a systematic approach for working together as a team to identify and face one challenge at a time and achieve results.) Workshops were held to train staff how to apply the Challenge Model in their workplace, while involving their key stakeholders and even local communities. Staff identified and prioritized their organization's most difficult challenges and then used the model to reveal solutions that could be implemented with minimal resources. In teams, staff developed key indicators associated with their biggest challenges, made plans to fix them, and monitored their progress over time.

Performance—as defined locally—was improved with no additional resources. For example, in the village of Lumbo, the use of important hygiene practices, such as decontamination of work surfaces and good sterilization techniques, improved from 20% to 88% in one year. On the Isle of Mozambique, biosecurity practices such as correct disposal of biomedical waste rose from 16% to 83% in a year. Similar achievements were observed throughout Mozambique; the Challenge Model became a standard management tool.[13]

Concurrently, the health sector embarked on a new MOH quality initiative, where staff at the clinic level participated in workshops to assess

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[13] Cary Perry, "Working at All Levels to Improve Health Services: Evaluation of the Management and Leadership for Health Support in Mozambique," Evaluation report, Management & Leadership Program (Boston: MSH, Aug. 2005).

their facility's level of compliance against 161 national quality standards. Staff formed action plans to raise the level of compliance with these standards. In the villages of Mossuril and Carapira, staff improved compliance with standards from 26% to 35% and from 11% to 44%, respectively, with no new resources.

Since both programs achieved results, the MOH of Mozambique is integrating their approaches into its operations.

IN-SERVICE LEADERSHIP AND MANAGEMENT DEVELOPMENT OF TEAMS: ASWAN, EGYPT

In 2002, the Aswan Governorate, a rural, underdeveloped area in Upper Egypt, launched a process to improve the quality of and accessibility to health services in three districts. The health units in these districts faced the challenge of improving health status for their population. To do this, they wanted to increase client satisfaction and use of health services and to make a commitment to serve their clients better. Staff from six health facilities and three districts participated in a four-month leadership development program sponsored by the Ministry of Health and Population and MSH. The program focused on increasing the capacity of managers to produce organizational results.

Doctors, nurses, and midwives (41 in all) from health centers, a hospital, and districts were grouped into 10 working teams. Through bimonthly one-day workshops, participants committed to a shared vision of the future and used MSH's Challenge Model to frame specific challenges. Through "owning" their challenge and applying the leading and managing practices and skills they had learned, they were able to implement their action plans. Between workshops, they met as teams in their facilities to continue their work. Their engagement with making service improvements was so strong that the doctors and nurses expanded the program to the entire Aswan Governorate without additional donor funding. From a few local Ministry facilitators, the program expanded to 35 facilitators who are bringing the program to other governorates using Ministry of Health resources. As a result of women having more access to family planning services, making more antenatal and child care visits, and having more deliveries by trained medical staff, health care outcomes improved.

Changes in Aswan Governorate Service Statistics after Leadership Development Program

Indicator	Change in indicator
Infant mortality	12% decline (2001–2005)
Maternal mortality	35% decline (2000–2005)
Contraceptive prevalence	17% increase (2001–2005)

The program's impressive success across the whole governorate has led ministries of health from other countries to adopt its principles and approaches to empower health care workers to lead and manage teams with their own resources.

VIRTUAL LEADERSHIP AND MANAGEMENT DEVELOPMENT: WORLDWIDE

Large-scale innovation in management requires reaching large numbers of people in their workplaces around the world with practical skills. To help fill this need for short, applied learning programs, MSH has developed and implemented virtual programs, including the Virtual Leadership Development Program (VLDP).

Like the leadership development program in Egypt, the VLDP strengthens the leadership capacity of health teams to produce improved organizational results, but it uses a blended approach of on-site team meetings and virtual individual work on a website. The program materials, workbooks, and CD-ROMs sent to all participants before the course make it possible for them to participate even if they do not have good connectivity.

Expert facilitation is vital to the program's success. Two co-facilitators, experts in leadership and organizational development as well as facilitation, engage participants by making daily announcements, drawing attention to a topic in the readings or on the online discussion in the cafe, and raising provocative questions. They also review each team's homework, provide feedback on the teams' action plans, and coach them in addressing identified organizational challenges. The VLDP guides teams through modules in identifying and addressing real organizational challenges while strengthening their leadership practices and competencies.

After completing the program, the teams can participate in LeaderNet, a virtual leadership network where they access materials, exchange ideas, and participate in virtual seminars with others who have completed a leadership development program. Designed for both public- and private-sector managers, and offered in five languages, the VLDP has been delivered to more than 150 teams (more than 1,200 participants) in more than 30 countries in the developing world, resulting in enhanced individual leadership, stronger and more cohesive work teams, and improved organizational results. Health care results differ with the challenge that each team selects. Sample results follow.

Performance of Teams after Virtual Leadership Development Programs (9–11 months after the end of the programs)

Organization	Challenge	Results
Joint Clinical Research Centre, Uganda	Expand antiretroviral access	▪ Reduced stockouts of antiretrovirals from 20% to 2% ▪ Opened 27 new clinics
Marie Stopes, Uganda	Institute effective work plans	▪ Provided 50% more family planning methods, as defined by UNFPA
San Juan Hospital, Guatemala	Increase filled drug prescriptions for hospital patients	▪ Filled 90% of all prescriptions and 98% of basic drug prescriptions (vs. 75% previously), after reorganizing hospital pharmaceutical supply system

Sources: Amber Oberc, Cary Perry, and Karen Sherk, "Evaluation of the Africa 1 and 2 Virtual Leadership Development Program (VLDP)," Management & Leadership Program (Boston: MSH, Aug. 2005). Nancy LeMay, "Follow-up Evaluation: Three Latin American Cohorts in the Virtual Leadership Development Program," Management & Leadership Program (Boston: MSH, Oct. 2004).

This innovative program to engage groups to achieve results has been adapted for teams working in TB control, HIV/AIDS services, reproductive health, child health, and improvement of management systems.

EXECUTIVE COACHING AND MENTORING TO IMPROVE CLIENT SATISFACTION

Both coaching and mentoring can be successful pathways for increasing management and leadership capacity. Coaching is a learning approach that helps people discover new possibilities and increase their capacity for effective action. MSH and other organizations have successfully used executive coaching techniques and methods to support clinic directors and other managers in the change of culture and the learning of new practices aimed at achieving financial sustainability.

The purpose of coaching is to increase the professional effectiveness and personal satisfaction of individuals, and to achieve the strategic results of the organization.

People are naturally inclined toward personal growth if they receive appropriate feedback and support, which coaching can provide. The coachee is the client and the process takes place through self-correction. The coach is a "different observer" who helps the managers see a different perspective and explore new interpretations that open up new possibilities for action.

Coaching has shown tremendous ability to affect organizational performance and deliver results. For example, by engaging 49 leaders and managers in an intensive one-year performance coaching initiative, Florida Hospital in Orlando, Florida (the largest provider of services to elders in the US) was able to improve patient satisfaction scores from the 45th to the 80th percentile and clinical performance from the 45th to the 85th percentile, nationally (Paskavitz 2006).

Pre-Service Training: Menoufia University and Alexandria University, Egypt

The pre-service initiative of MSH's Leadership, Management, and Sustainability (LMS) Program emerged from the need for physicians and nurses to acquire management and leadership knowledge and practices prior to assuming their managerial roles in health units. (It draws on work from the previous Management & Leadership Program.) Collaborating with the Medical Faculty of Menoufia University and the Nursing Faculty of Alexandria University, the pilot program integrated leadership and management principles, frameworks, and tools[14] into pre-service learning for nurse and physician interns.

The goal was to create a program that can be institutionalized in medical faculties across Egypt and later transferred to other developing countries. The program's design was coordinated with the USAID mission in Egypt and Health Workforce Development Team, which is reforming medical curricula in pre-service education.

The pilot was successfully completed at both the Menoufia medical school and the Alexandra nursing school. Modules included: Leadership Overview, Scanning, Focusing, Aligning & Mobilizing, Inspiring, Implementing, Over-coming Obstacles, and Sustaining Results.

Participants worked in teams that included interns, faculty, head nurses, and hospital administration. Teams worked to address priority challenges in their hospitals, including infection control and rational use of resources.

All the teams participating in the program learned how to lead others to improve performance in their hospital units. Faculty members

observed decreases in the rate of infection in most departments, and nurses reported working toward results without additional resources. At the end of the pilot, the Supreme Council of Universities voted to include a leadership program in the medical and nursing curricula. The Nursing Faculty in Alexandria made the program part of the nursing curriculum in September 2005.[15]

Educational Progress over 25 Years: The Ministry of Health, Morocco

Where countries began professionalizing decades ago, progress is noticeable. In 1982, there were almost no trained public health physicians in the Moroccan Ministry of Health. Through a focused, strategic effort, the MOH identified key staff for training in public health (including management) and over 10 years professionalized the doctors and nurses working in positions of leadership within the MOH. In the MOH today, the number of professionally trained public health physicians in senior management roles is staggering compared to 25 years ago.

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[14] For materials of the LMS Program, refer to http://www.msh.org/projects/lms/AboutUs/index.html.

[15] Tawhida Khalil and Ersin Topçuoglu, "Evaluation of the Pre-service Developing Managers Who Lead Programs at the Alexandria Nursing School and Menoufia Medical School, Egypt," evaluation report, Management & Leadership Program (Boston: MSH, Sept. 2005).

"This is leadership—that our health personnel do not wait for instruction from the highest levels, but rather make decisions that enable them to do what they need to do to serve their communities."

—Margarita Gurdián, Minister of Health, Nicaragua

There is a view in some international health circles that the best way for developed countries to help developing countries to attain their health goals is to provide ample drugs, resources, and short-term health and technical assistance workers. We believe that these inputs are important but need to be augmented to produce sustainable results. We propose that doctors, nurses, and, increasingly, nonclinical managers be better prepared to lead teams to achieve results and effectively lead change, so they, themselves, are able to succeed in achieving health goals. A real paradigm shift is needed to stop the slide toward less effective health care in countries that face critical threats to their whole health system.

A "Band-Aid" approach to strengthening management and leadership capacity has high costs, including wasted or lost resources; lack of results; poorly led and inadequately supported staff; and, most important, failure to save lives, reduce illness, and achieve the health results pursued in all countries.

We propose a clear objective to be shared with all who are concerned about the future of health care: All current and future health managers are well prepared to lead and manage to achieve results.

To realize this objective, the following actions must be taken:

- Develop a clear proposition of the value for leadership and management in health care that interested countries can identify with.

- Adapt and use indicators to measure the effectiveness of leadership and management performance at the national, regional, district, and local levels.

- Work with others to identify factors that successfully link improved leadership and management with improved health and sustainable systems and with evidence of results.

- Gain clarity on the real nature of the job of a doctor and of a nurse at various levels to ensure that practical preparation for meeting current job demands becomes part of pre-service and in-service learning.

- Share learning methods and models so that relevant leadership and management programs can be efficiently adapted and applied.

- Work with in-country champions—both individuals and institutions—to integrate the basics on leading teams and leading change into curricula for doctors, nurses, and new managers.

- Engage in dialogue with various professional associations to scale up cost-effective leadership and management development and to build alliances with accrediting bodies in order to establish recognized credentials, including continuing education requirements.

- Research and share guidance on effective approaches for individual and organizational accountability and on the rewards related to improved leadership and management.

- Clearly link the paradigm shift of improved leadership and management with the work of the Global Health Workforce Alliance capacity-building initiative.

- Communicate the evidence that demonstrates the relationship between improved leadership and management and improved outcomes; and support policy efforts to raise the profile and credibility of leadership and management development.

FORM ALLIANCES

Alliances among, for example, medical and nursing schools, schools of public health, business schools, and professional associations will all be useful to expand leadership and management development.

Business schools across Africa, Latin America, Asia, Europe, and the US have much to offer in building the capacity of health managers in health services institutions and in working with pre-service institutions to bring management and leadership skills to medical, nursing, public health, and other students. One of the leaders in Africa is the Eastern and Southern Africa Management Institute (ESAMI), a pan-African regional management development center owned by 10 member governments from eastern and southern Africa. As a service and market-oriented institution, ESAMI offers high-level specialized management training and development programs, consulting, and action-oriented research services to clients and institutions. These range from central and local governments, regional and international institu-

tions, NGOs, and parastatals, to private-sector institutions, including health service professionals and organizations. In May 1997, the UN Economic Commission for Africa officially designated ESAMI "The African Centre of Excellence in Management Development." Another influential business school is the Institut Supérieur du Management in Dakar, which has integrated a US-oriented approach to management training into its educational programs.

Professional associations in medicine, nursing, public health, and hospital administration can promote accreditation and continuing professional development to motivate improvements in leadership and management in health care organizations. Being awarded a continuing education credential from a professional association offers individuals the opportunity to continue work in their fields while learning new competencies they may not have learned in their previous education.

State, national, and international professional associations, such as the World Medical Association, World Council of Nursing, World Association of Public Health Associations, and the International Pharmaceutical Federation can help lead efforts to bring management and leadership development programs to health service institutions at this critical time. These associations are concerned about meeting the needs of practitioners who want and need better preparation.

Use Indicators

It will be important for countries to know when they are making progress in developing professional health care managers. To assess their progress, countries can select and measure changes in indicators. Sample indicators could include:

- schools of medicine, nursing, and public health have leadership and management programs in their curricula;

- senior positions require credentials in leadership and management development;

- a countrywide network of health care leaders and managers exists within the country.

It is ironic that health care, which has as much or more human capital than any other industry in the world, has not yet fully embraced the importance of the impact that leadership and management can and will have on organizational performance. Those charged with leading and managing health services want to be prepared to succeed in their important roles. It is time to join together and support them as they strive to lead and manage for results.

Professor Sam Luboga, Deputy Dean of the Faculty of Medicine at Makerere University in Uganda, summarizes well the case for leadership and management:

"The many projects generated by new funding opportunities, such as the Global Fund, are exposing weaknesses in existing systems, from monitoring and evaluation to internal controls. We need leadership and management development if the full benefits of these initiatives are to be achieved."

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We welcome feedback on this paper. If you have experience with preparing doctors and nurses for managerial positions in health care in low-income countries, please direct your comments to Joseph Dwyer (c/o bookstore@msh.org). Thank you in advance.