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Commentary

Balancing Management and Leadership in Complex Health Systems

Comment on "Management Matters: A Leverage Point for Health Systems Strengthening in Global Health"

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Abstract
Health systems, particularly those in low- and middle-income countries (LMICs), need stronger management and leadership capacities. Management and leadership are not synonymous, yet should be considered together as there can be too much of one and not enough of the other. In complex adaptive health systems, the multiple interactions and relationships between people and elements of the system mean that management and leadership, so often treated as domains of the individual, are additionally systemic phenomena, emerging from these relational interactions. This brief commentary notes some significant implications for how we can support capacity strengthening interventions for complex management and leadership. These would necessarily move away from competency-based models focused on training for individuals, and would rather encompass longer-term initiatives explicitly focused on systemic goals of accountability, innovation, and learning.
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John Kotter, the American business thought-leader, has famously pointed out that most organisations are "over-managed and under-led."[1] This is a statement pointing to many things. First, it indicates the inter-relation, yet distinction between management and leadership, that there can be too much of one, and not enough of the other. Secondly, it speaks to the fact that within these elements of organisational steering, organisations have classically been guided more by management, perhaps to the detriment of leadership. Third, it subtly suggests that management, in its abundance, may be an easier thing – to see, to accept, to correct – than leadership. The mandate given to those in management positions is frequently on stewarding operational inputs, and less on creating enabling environments to support systems change. Meanwhile, leadership is considered to be the remit of those at the strategic peak of the organisation. The World Health Organization (WHO) combines the elements of inputs and inspiration to define good management and leadership as: *"providing direction to, and gaining commitment from partners and staff, facilitating change and achieving better health services through efficient, creative and responsible deployment of people and other health resources."*[2] In the context of increased global focus on health systems strengthening, Bradley and colleagues[3] recently noted the need for renewed focus on management as a critical way of making progress on pressing health challenges. This author agrees with them that *"despite a renewed focus on strengthening health systems, inadequate attention has been directed to a key ingredient of high performing health systems: management."* Indeed,

health management and its related competencies come with a technical edge, requiring abilities to link inputs to performance, control budgets, and harness resources. Yet, in complex adaptive health systems, managing and leading people is a critical but often little understood dimension. Complexity theory explains that complex systems have a non-predeterminable nature and are defined by holistic, nonlinear, emergent feedback interactions between components of the system. This means that input-output models of management risk overlooking the systemic interactions which in fact *give rise* to what we call management and leadership. As this journal has now featured editorials on management,[3] health policy and management,[4] and leadership[5] as distinct elements of health systems strengthening, this commentary presents an opportune moment to underscore their continuity: management without leadership is "dead works"; given the interactive nature of these complex phenomena, the two must be considered together. This commentary builds on Bradley and colleagues' arguments, and offers added depth by considering issues of management and leadership through the lens of complex systems.

The art and science of people-centred management and leadership, especially in low- and middle-income country (LMIC) health systems, has lagged behind.[6] Much of the focus on management and leadership has been informed by bureaucratic forms of governance[7] in country health systems – that is, forms of decision-making which emphasise hierarchy, alignment and centralised planning and thinking. Often, pyramidal structures with power accrued at the top

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have meant that leadership has been associated with position, and management derived from efficiency models. However, such approaches have not sufficiently accounted for the unpredictability of human action which results in systems emergence and novelty.[8] When we view management and leadership through the prism of complexity, it moves us towards understanding that management and leadership are beyond individual competencies and attributes solely, and are in fact systemic phenomena.[9] This is because management and leadership are interactive and context-specific, and as such are influenced by more than what emerges from an individual alone (whether innate or trained), to include what emerges from the interactions between individuals, and between individuals and the organisational contexts they are embedded in. This also means that the discrete meanings of management and leadership in a given system, and more importantly their role (ie, what are management and leadership for; what are they doing in this system?), will be determined by these relational interactions: whether management and leadership tend towards bureaucratic controls or enabling creativity will stem from here. So, while it is widely acknowledged that management and leadership style give rise to organisational culture, it should also be understood that organisational cultures and structures give rise to management and leadership capacities. This is especially true at subnational levels where middle managers must operationalise policies through particular strategic frameworks.[10]

Wide-ranging perceptions of managerial weakness and lacking leadership have been recurrent themes in analyses of poor performance and low achievement of health outcomes.[11] Yet organisational cultures and structures greatly determine the degree of managerial influence which manifests throughout the health system, and this is little commented upon. Challenges of top-down planning as a "a blunt instrument of control"[12] limit managerial responsiveness and suppress a leadership of creativity, innovation, and learning. Elsewhere, it has been noted that stagnation within health systems can be attributed to the inability to learn in order to support systemic responsiveness.[13] What is more, these challenges are not new, and appear in both high- and low-resource settings, as cases from the United Kingdom[14] and Niger, Zimbabwe, and Guinea[15] demonstrate. The main difficulty with such bureaucratic orientations, especially in resource-constrained settings, is that they result in mismatches in managerial accountability, that is, the degree to which managerial authority can be made answerable for achieving agreed-to performance targets.[16] Middle managers are regularly tasked with mandates within organisational contexts of uncertainty, which in turn limit decision-spaces, and make these mandates very hard to meet. This *rhetoric of accountability* – the distance between managerial responsibility and scope for autonomy – begs the question of whether in fact health system middle managers are often being held accountable for health system performance unfairly. The thinness of literature on health system bureaucratic accountability – an important oversight given the need for middle managers to balance upwards and downwards systemic power – points to the need for further study.[17]

How can health managers be sufficiently empowered, from a complex systems perspective, to better enact their managerial roles, their leadership capacities and release greater creativity into the system to improve health performance? It is important to note that traditional strategic management approaches do not sufficiently reduce organisational uncertainty or complexity. Furthermore, strategic management is most often packaged only at the strategic formulation stage, not significantly enough on strategic thinking, nor strategic implementation, and therefore remains limited to national-level leadership.[18] The implications of understanding management and leadership in a complex adaptive health system as an emergent property of relational interactions would begin with considering management and leadership capacities as a systems phenomenon.[19] Because the bulk of capacity strengthening approaches to date have not understood the adaptive, creative and emergent character of complex systems, they have tended to remain based on cause-and-effect, technical transfer change models.[20] As a systemic trait, this would make individual, competency-based trainings, currently the norm, insufficient, as systems in essence cannot be trained. Keeping in mind that the interactions within a complex system give rise to its character, capacity strengthening would then become about strengthening the organisational relationships that engender innovation and resilience,[21] not simply diffuse new skills. A complexity perspective on management and leadership also has the added effect of erasing the linear flow of hierarchy, and with it the notion that leadership happens at the top-level, and management somewhere thereafter; it allows management and leadership to emerge from anywhere in the system. However, the character of such management and leadership will be determined by the interactions and relationships within the system. In maintaining the balance between individual and organisational capacity strengthening approaches, the two should be considered complementarily, not mutually-exclusive.

Next, how could such strengthening occur in practical terms? Management and leadership interventions which are more long-term in scope can allow for the development and transformation of organisational relationships to be the focus. This is particularly key given the evidence that organisational context can modulate short-term and medium-term management and leadership programme outcomes over time.[22] With explicit management change goals crafted beyond individual skills acquisition (towards, say, shifting organisational incentives, values, and beliefs, as well as support from the broader environment), this implies that if the organisational context changes, then the scope for management and leadership within the organisation can change too. Secondly, focusing on systemic learning (variously called systems thinking or action learning[23]) enables the evolution and adaptation of the system. Systemic learning denotes an emphasis on exposing underlying assumptions such that new ways of thinking can lead to new behaviours and organisational structures, thus fuelling systemic change. Such an approach provokes systems change from diverse parts of the organisation – not just the top – and accepts unpredictability as part of the process. A final focus would be unambiguous attention to innovation and creativity: original and imaginative ways of thought and

decision-making to support management and leadership. Innovation is known to be important organisationally, yet it remains a minority feature in health systems strengthening. While an organic process, it must be led somehow, whether top-down or bottom-up. In this light, one might say that continued top-driven change is inefficient and expensive: it remains underpinned by principles of organisational control, which do not always allow for new organisational roles and relationships to emerge. The innovation literature has overlooked the role of middle managers in bridging between policy and practice,[24] and thus this is a field which requires greater analysis.

And so, while issues of management will continue to be critical for strengthening health systems, it is especially important that within complex adaptive health systems, management and leadership be well-balanced, and perhaps even re-balanced: understanding the workings of management and leadership – how they interact and emerge from their contexts to lead to particular outcomes – especially at operational levels of the health system, remains an important area of practice and policy research. Because of the urgency to perform, many LMIC health systems, especially in sub-Saharan Africa, have been locked on management while leaving behind or separating out leadership. We should not allow ourselves to be enticed by the allure of management's easy visibility and tempting order. Greater focus on systemic approaches to management and leadership capacity strengthening, such as interventions which are longer-term in scope, and address organisational relationships, systemic learning and innovation, is in fact the greater challenge. Ultimately, however, this challenge can help us to move past the existing bureaucratic status quo, and nudge our health systems towards enabling greater leadership, and thus greater change.

Ethical issues
Not applicable.

Competing interests
Author declares that she has no competing interests.

Author's contribution
AK is the single author of the manuscript.

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