

HEALTHCARE LEADERSHIP SKILLS NEEDED FOR POPULATION HEALTH

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Abstract

Many countries and economies -- developed and emerging -- are demanding better health for their populations and workers. A population's health is determined by its environment, heredity, lifestyles, and medical care system. These factors must be improved in order to improve health, and collaboration among many organizations and sectors of society is needed to improve these factors. However, health care leaders historically have not done this. They have focused mostly on medical care services and have collaborated mostly with only other medical care providers and insurers. To meet demands for better health in their countries and economies, health care leaders must now collaborate with a broader and more diverse group of economic and social partners -- such as churches, schools, businesses, youth groups, courts, public agencies, volunteer groups, neighborhood associations, and others. To do this well, health care leaders must use skills in leadership, stakeholder management, and collaboration.

During the past decade, the United States, Canada, and other countries have increased their efforts to improve population health, and this trend is likely to continue in the future (Boufford 1999; Hancock 1999; Marmot 1999; Podger 1999). An important part of these efforts has involved leaders of health care organizations (HCOs) working to improve health in their local communities, rather than only providing acute medical care to the ill and injured. In doing so, these leaders have found that they must work with a new, wide, diverse group of organizations. When their mission was only to deliver acute medical care, health care organizations (HCOs) and their leaders worked closely with other HCOs -- hospitals, medical groups, outpatient centers, rehabilitation facilities, mental health clinics, as well as the payer and financing organizations. However, health is much broader; the World Health Organization (1944) defines it as a “state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.” Thus, to really improve health and achieve complete well-being, HCO leaders must now work with organizations in other economic sectors and parts of society (Hancock 1999).

The purpose of this paper is to explain why and how health care leaders must use specific leadership skills to form collaborative relationships with a new, wide, diverse group of partners outside the health care sector, in order to improve health in their communities and countries. Health care leaders and managers who want to improve population health -- rather than only provide medical care -- should benefit from this paper because it will help them understand what they must do to achieve that goal. The paper may also interest health planners, public health directors, community leaders, and public policy makers who wish to help improve population health. The paper first briefly explains the emerging shift from medical care to population health. It next draws from the field of public health to argue that if a population wishes to improve its health, then it must improve four factors that determine the health of a

population. The paper explains that improving these determinants will require health care leaders to collaborate with numerous social and economic organizations in their communities beyond the traditional health care organizations with whom they have interacted. The paper finishes by discussing three types of inter-related leadership skills that will be especially important for this work.

The Shift from Medical Care to Health

Powerful stakeholders of health and health care have demanded that the health care sector improve population health rather than just fix the ill and injured. Global and national leaders and futurists have urged this in order to make the world and its economies and societies livable and sustainable for all (Hancock 1999; World Bank 1994). Some scholars have urged that health reform should improve health status rather than merely improve medical care services (Boufford 1999; Cutler 1995; Fielding and Halfon 1994; Fries et al. 1998; Welton, et al. 1997). Other scholars have called on HCOs such as hospitals to adopt a different role in the changing health care system – a role that creates community health rather than just provides medical care (Griffith 1997; McNerney 1995; Shortell et al. 1996; Sigmond 1995). The healthy communities movement has added momentum to efforts to improve the health of local populations community by community (Proenca 1998; Rundall and Schauflier 1997).

Purchasers of health care and medical care – mainly governments and employers -- have demanded better health as a way of getting better value for their payments (Boufford 1999; Coye 1995; Marmot 1999; Podger 1999; Romeo 1996). No longer passive payers, they have interjected themselves into the health care system and pushed toward less use of expensive treatments and more use of basic preventive measures. Businesses and employers want healthier employees and a healthier

workforce from which to hire labor (Proenca 1998; Verranec 1999). They know that to be as competitive as possible, they must have a highly productive workforce, which can only occur if workers are healthy and if there is a healthy labor pool from which to hire. Assertive consumers have been demanding that society and the health care sector do more to prevent illness and injury rather than just treat them after they occur. In summary, health purchasers, consumers, policy makers, scholars, and other health stakeholders have emphasized that HCOs should do more to improve health.

Determinants of Health

Health care leaders who want to improve population health must understand what forces shape and determine the health of a population. The public health work of Blum (1974, 1983) and others (e.g., Hancock and Garrett 1995; McKeown 1979) shows that there are four major factors that must be considered. These are the environment in which people live, their lifestyles, their genetic endowment, and their medical care system. Blum's work gives health care leaders a framework to follow as they strive to improve the health of their respective populations.

The environment is thought to be the most powerful force and therefore the most immediate concern in undeveloped countries. It involves such elements as adequate housing, unpolluted air, clean water, sanitary waste disposal, recreational facilities, places to socialize, safe working conditions, and, the absence of war and crime. After the environment, lifestyles become the most important factor for improving health. In developed countries, people's lifestyles and behaviors will be especially important for improving health, such as reducing use of tobacco and alcohol, avoiding accidental injury, obtaining adequate nutrition and exercise, managing stress, and enhancing emotional development. Heredity is

important, but until very recently, little could be done to change it to improve health. However, with advances in genetics and the human genome project, the basic biological endowment of a population can be altered if society allows it. The final determinant of health is the medical care system, which actually has the least influence on health (Blum 1974, 1983) despite the funding and media attention directed toward it. Great progress has been made with medical advancements to treat disease, but the environment, lifestyles, and heredity exert greater influences on a population's health. These four determinants of health are presented in the health management literature (e.g., Dever 1991; Longest 1994), but they have not been fully attended to by most health care managers. Some HCOs and their leaders have improved the environment and lifestyles of their populations (Fromberg 1997; Olden and Clement 1998; Rundall and Schauffler 1997), and others should do so if they really want to improve the health of their local and national populations.

Partners for Medical Care and for Health

To create medical care, health care organizations have mostly worked with medical care providers and payers. They have coordinated their organizations with other HCOs such as physician group practices, outpatient diagnostic centers, mental health clinics, rehabilitation centers, hospitals, surgery centers, home care agencies, medical centers, nursing homes, medical supply companies, pharmaceutical firms, and other organizations in the health care sector. And of course they have also worked with the payer organizations such as health insurers, managed care plans, government health financing bureaus and agencies, and so forth.

It should be evident from the previous section that HCO leaders must now work with a wider more diverse group of economic and social partners in order to create health. These leaders and their HCOs cannot do much by themselves to improve the environment, change lifestyles, and resolve community social problems that jeopardize health. They need the help, support, resources, and expertise of others to have much effect on population health status. Recall that the medical care system in which they work is the least influential of the four determinants of health. Merely creating a better medical care system will not affect health status as much as will creating healthier environments and lifestyles. And, to improve environments and lifestyles of a population requires that health care leaders partner with organizations outside of the health care sector that are involved with these determinants of health. These partners would include religious and faith organizations, the police system and courts, human service agencies, neighborhood associations, youth groups, government agencies, volunteer groups businesses, schools, and many others. These non-medical partners are close to and knowledgeable of the people and problems pertaining to the environment and lifestyle determinants of health.

Leadership Skills for Partnering

Health care leaders should consider that the non-medical partners with whom they must now interact are different from traditional medical care partners. For example, people from community groups, neighborhood associations, and other grass roots organizations are likely to have different world views, cultural norms, communication styles, and expectations than health care leaders, professionals, and providers. These non-medical stakeholders view and use power differently, and they are likely to

perceive power and status differences that can inhibit collaboration. These non-medical people gather, use, and understand data and information differently than do the health professionals, such as relying more on qualitative data and stories than on quantitative data and graphs. Whereas health care professionals and leaders are likely to pay great attention to task assignments and goal achievement, people from community groups may be more concerned about group processes and partner relationships. This will lead them to approach community health problems differently and to work toward solutions differently. Along with all this, they will have their own communication styles, techniques, and methods.

Besides the grass roots organizations and the local community groups, there are other types of non-medical partners with whom HCO leaders must work effectively. School systems and their leaders have their own agendas, their own approaches to local social issues, and their own sets of constraints and pressures. Law enforcement agencies and the criminal justice system have their norms, expectations, methods, and views of what constitutes useful information for decisions. The same can be said for churches, synagogues, parishes, and other religious and faith groups, which may approach social issues from different ethical perspectives than would some other community health participants. Businesses of course will have their own world views, agendas, methods, and cultural norms. In summary, HCO leaders who take a role in creating health will have to work with a new, wide, diverse, and quite different set of partners. They will have to use inter-related leadership skills, stakeholder management skills, and collaboration skills to work effectively with their new partners from outside the health sector.

If the HCO leaders are leading (rather than just participating in) the effort to create population health, they will have to practice effective leadership. A fundamental responsibility of a leader is to

create shared commitment to a vision – in this case a vision of population health – and this will be an essential step toward partnering with non-medical stakeholders to create health. They will have to carefully communicate this vision of population health and gain commitment for it. To achieve lasting commitment, leaders will have to help other partners understand its importance and its effects – both positive and negative – and help them see why just providing medical care is no longer enough. The leader may have to educate stakeholders (potential partners) about benefits, such as achievement of a desired goal, expanded professional network, new resources perhaps including grant funds, favorable public image, new knowledge and competencies, service to customers and clients, and understanding of the external environment and market. Alternatively, the leader may have to overcome objections and concerns, such as use of time and resources, diversion from other goals, and possibly conflict with other goals (Lasker et al. 2001).

The leader should of course focus on tasks, goals, and outcomes, but should also monitor and manage group processes so as to integrate diverse partners for collaboration. New partners may be intimidated and perhaps even feel unwelcome because of status differentials, professional jargon, and so forth. Leaders must overcome these barriers to create collaboration, such as by meeting new partners at their level and in their settings, by demonstrating respect, by showing partners that their views and ideas are valued, and by allocating resources equitably. They will have to discern the stakes of these new partners as stakeholders, and strive to satisfy expectations. Leaders should appropriately seek and use both qualitative and quantitative data; oral and written input from partners. They must assure that it is understood by others, and, more generally, will have to monitor their own communication and that of others to assure that it is understood by all. This may involve frequent testing for understanding through questions and feedback, which may be time-consuming but will build trust and effectiveness for the

long-term. Finally, the leader must share power, decision making, and control, and must avoid dictating and controlling others.

Collaboration will be very important for HCO leaders striving to work with new partners and manage stakeholders to improve population health. Kanter (1994) explains that collaboration is people creating new value together; it is different from exchange, which is people getting something back for something that they contributed. Thus, HCOs should try to create new community health together, rather than try to get back patients, referrals, power, or something else for what they put into the effort. Health care leaders working with their new community partners and stakeholders will have to collaborate more than exchange. To do this, they should share rather than negotiate, listen rather than talk. They should try to adapt to non-medical partners rather than expect the partners to readily adopt the medical model. There will have to be shared problem solving and decision making, shared resources and power, shared accountability and rewards.

Within one's own organization, the HCO leader may have to take management steps to help develop collaborative partner relationships with new non-medical partners and stakeholders. This may include, for example, broadening the HCO's strategic planning process, re-allocating human resources, changing internal policies and procedures, modifying job descriptions, and revising some daily operations.

Finally, even if a health care organization does not take a leadership role in the community health domain, its representatives who participate in community health efforts will still have to practice many of the skills and behaviors discussed above for leaders. They still must help develop the necessary collaborative relationships with new community partners and stakeholders, so that the HCO can work with other community organizations to improve the health of the population and country as is now

demanded by many health stakeholders.

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