



SOPHIE BIJLOOS

Building a License to Lead

**Hoe zorgbestuurders
bouwen aan draagvlak
om te besturen**

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How healthcare executives build support to lead

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BUILDING A LICENSE TO LEAD

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en volgens besluit van het College voor Promoties.
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door

Judith Sophia Maria (Sophie) Bijloos

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9 Summary

Healthcare executives are the target of criticism, and yet executives in particular need trust and leeway to do their jobs properly. The importance placed on healthcare makes the lack of trust in the people in charge of healthcare even more worrying. In the last five years, the level of healthcare executives' remuneration, the desirability of introducing an executive test, mergers, staff shortages in nursing home care, fraud cases and bankruptcies in healthcare are some of the issues that have given rise to debate in the Dutch House of Representatives about healthcare executives and attracted media attention. Research by NIVEL into trust in healthcare insurers, comparing it with trust in other players such as healthcare executives, reveals that just 9% of the population has trust in healthcare executives. This lack of public trust in healthcare executives has pushed the issue of governance onto the policy agendas of politicians and regulatory authorities in recent years. The outcome has been tighter legislation with regard to what is and is not allowed, and more sweeping powers of intervention for the minister and external regulators. Good governance is also higher on the agenda of healthcare executives, leading among other things to the development of an accreditation system for healthcare executives and a new version of the Governance Code for Healthcare drafted by healthcare executives themselves.

The key question in this dissertation is: what are healthcare executives doing to consolidate their license to lead? Having a license to lead means having the support of relevant stakeholders to lead.

Where feasible and relevant, this study examines three levels:

| Support for... | Support from... |
|---|---|
| 1 individual executives | 1 the executive's immediate environment |
| 2 the executive board as a body | 2 the relevant stakeholders within and outside the organization |
| 3 healthcare executives collectively | 3 society at large |

Figure 37: the relationship between the recipient and the giver of the license to lead.

The research question has been answered on the basis of a literature review, a longitudinal survey of healthcare executives involving three hundred respondents, started in 2000 and then repeated every five years, interviews with twenty-two healthcare executives, searchers, executives' secretaries, the director of the NVZD – Dutch association of healthcare executives and an advisor and a focus group of ten healthcare executives, which met roughly every six months over a five-year period (**chapter 2**).

In practice (**chapter 3**), how healthcare executives design the process (throughput legitimacy) is of paramount importance in gaining sufficient legitimacy to lead. Process

guarantees are enshrined in law and appear to be an important aspect of an executive's day-to-day work. They are also factored in when recruiting a new executive, for example by involving internal and external stakeholders and undertaking recruitment with a public profile. In this dissertation moral virtues based on the work of Aristoteles are formulated which are extrapolated from research into institutional texts. The moral virtues which the legal standards dictate for this throughput legitimacy are responsibility, fairness and diligence.

Most important of all in obtaining approval is the ability of healthcare executives to draw upon their own professionalism and character to create a shared moral framework (input legitimacy). It is by developing their profession that healthcare executives (collectively within the NVZD) build a shared set of standards for professional governance. A number of things make this difficult. Healthcare executives set great store by experience and informal learning in their endeavors to professionalize. In terms of demonstrating their own professionalism, it is harder for them to provide visible evidence of informal learning and accumulated knowledge.

The moral virtues which, based on professional standards derived from the literature and the accreditation process, are associated with input legitimacy are reflection, self-discipline and flexibility.

When it comes to earning the requisite trust, it is most important that healthcare executives demonstrate that their actions are effective and purposeful and that, in consequence, their work contributes to taking the organization forward (or keeping the organization stable) and to the provision of good, accessible and affordable care for the institution, the region or the system (output legitimacy). In practice, the guiding principle of 'good care' encapsulates the role of executives and of the organization. The executive ensures the provision of good care both in liaison with the organization and outside the confines of the organization. Sometimes, the executive's idea of what constitutes good care is at odds with that of the stakeholders within and outside the organization. To get stakeholders on board with their proposed approach, executives must be able to shape changes while building support and powers of influence. In practice, one of the ways in which they increase their powers of influence is upscaling. The process can be conducted so as to 'anchor' the changes, which is the case when a new organizational form or governance structure is chosen. Moral virtues that are necessary in practice to achieve output legitimacy are courage, tenacity and pride.

Based on the theory, various system characteristics, organizational characteristics and personal characteristics of a healthcare executive can be identified which can affect the

license to lead (**chapter 4**). Looking at the system, the semi-public setting to a degree dictates the tasks of healthcare executives, influences who can formally revoke the license to lead and provides the framework within which legal standards are set for healthcare executives. At the system level, healthcare executives themselves can collectively influence their license to lead, by developing their profession and designing the recruitment process in a certain way.

At the organizational level, power structures within the organization and the organization's current "stage of life" determine how healthcare executives within the organization can consolidate their license to lead. Healthcare executives themselves decide how they will handle the changing context, influenced by public policy among other things, in which healthcare institutions operate. The way they lead their organization through this influences the license to lead.

Lastly, where personal characteristics are concerned, the healthcare executive's intellectual and moral knowledge, choices and actions also influence his license to lead.

Based on this research, it can be stated that the building blocks of a healthcare executive's license to lead are as follows:

- The executive's good character (intellectual and moral knowledge, choices made and actions taken in the best intentions, arising from the capacity for self-discipline);
- The creation by the executive of acceptance^[65] of himself;
- The creation by the executive of support for the organization;
- The creation of acceptance by the executive of healthcare executives collectively;
- The construction by (the) healthcare executive(s) of a moral framework (more or less intersubjective views about what constitutes good outcomes, good methods and good motives);
- The contribution made by the executive to the organization's future;
- The contribution made by the executive to good, accessible and affordable healthcare with respect to his own institution, the region and/or the national system.

The diagram below summarizes how these building blocks roughly relate to each other.

65 When the other person perceives legitimacy, this creates support. Justification is a means that can be used to legitimize actions. Therefore, support is the point at which legitimacy meets justification.

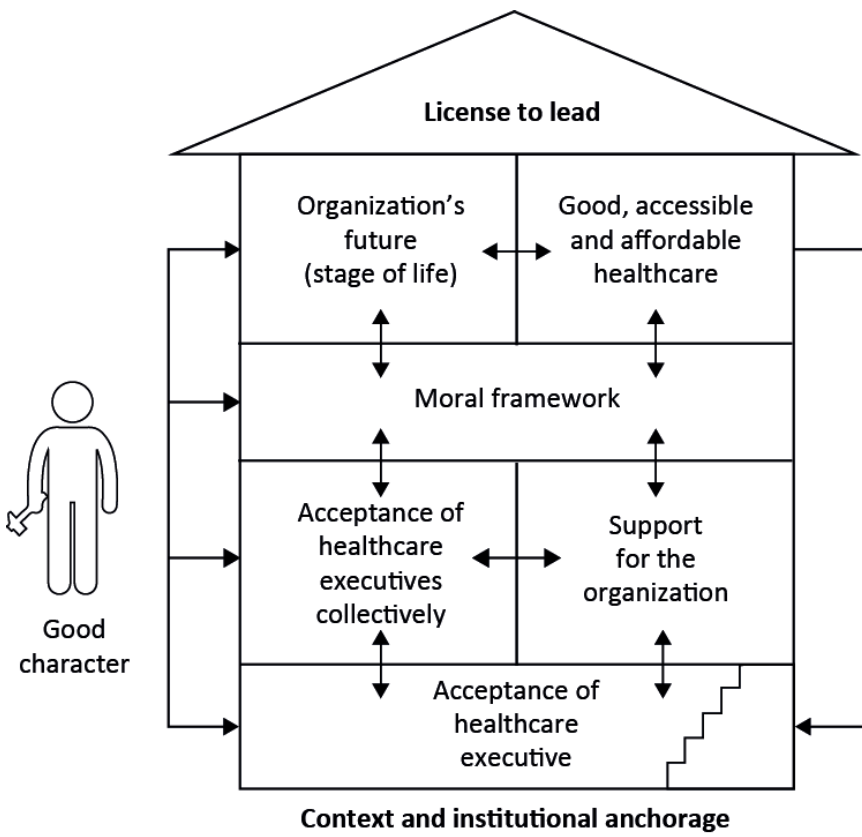


Figure 38: Building blocks of the license to lead.

Figure 38 represents the ideal: in practice, some building blocks of the license to lead are always missing (**chapter 5**). Thus, despite having become less ambiguous in recent years, the standards applied to good governance in healthcare vary greatly. In practice, the standards and values of executives and stakeholders can also clash or be weighted differently. The lack of a clear idea of what constitutes good governance in healthcare is another major factor behind the lack of a recognized training pathway for healthcare executives. Moreover, in practice there are incompetent executives or executives who gain support by, for example, giving jobs to friends on the management team. And not all executives and healthcare institutions will always contribute to good, affordable and accessible healthcare.

Each building block individually may contribute for a time to the license to lead, as long as the executive enjoys some support from a key stakeholder. The license to lead is forfeited when the foundation, the acceptance, is lost.

In practice, executives find themselves juggling many balls. Even without everyone's support or without moral consensus, they work to advance the organization and provide good, accessible and affordable care in the institution, their own region and nationwide. The various building blocks also influence each other: delivering good results leads, in turn, to greater support and moral consensus. If the outcome is prioritized over the process ('the ends justify the means'), there is a risk of failing to achieve positive results, because of stakeholder 'obstruction'. Nor are the building blocks fixed in place: legitimacy can be lost during the process. Support and a shared moral framework are two of the keys to solidifying the results achieved for the long term.

All the building blocks mentioned are important to maintaining the license to lead on a lasting basis, both as an individual and as a group. Lasting support can be achieved if due effort is made in all these aspects. The degree of support may vary. Legitimacy, approval or trust may be gained, legitimacy being the lower threshold for support and trust the highest level. Executives can use themselves as an instrument here: their personality (input legitimacy), the way they design the process (throughput legitimacy) and the result they are able to achieve (output legitimacy) engender varying amounts of support.

The work done by healthcare executives themselves to consolidate their license to lead is a key focus of this research. How lasting that license to lead is will depend on how those executives approach that task. A more lasting license to lead can be achieved through institutional anchorage, be that in legislation, codes of conduct, models created by healthcare executives themselves, the government or other parties, and so on. The context and institutional arrangements are instrumental in bolstering or undermining healthcare executives' license to lead.

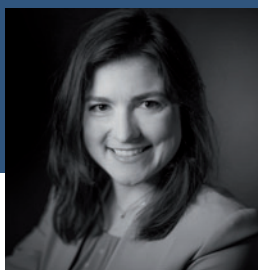
In conclusion (**chapter 6**), healthcare executives collectively seem to now be enjoying a more robust license to lead: the accreditation system, for instance, has staved off further government intervention such as the imposition of a suitability test. Furthermore, due in part to initiatives by healthcare executives, a set of standards for good governance is emerging. Healthcare executives collectively behave as a profession in the making. Because of this, they are not assessed by, or held to, a set of common standards. Healthcare executives do not have the distinct right of professionals to perform acts that people are otherwise forbidden to do (internal regulation and quality control). Informally, gatekeepers have emerged who do play a role in the selection and assessment of healthcare executives. These are supervisory boards, searchers, educational establishments (which set entry requirements for their courses) and co-determination bodies (which, increas-

ingly, have a say in the appointment of executives). However, the role of these gatekeepers is not very visible to the general public.

In recent years, both healthcare executives themselves and legislators have devoted a lot of attention to throughput legitimacy, with the result that healthcare executives now share their power with stakeholders in the organization. The challenges faced by the healthcare system call not only for a sound decision-making process, but also the knowledge and skill needed to deliver the right outcomes. Based on this research, recommendations can be made to help healthcare executives consolidate their license to lead. The key recommendations are:

- Make clear arrangements at system level about the sharing of responsibility.
- Use incidents (dismissal of an executive, tighter supervision, negative media reporting) as learning opportunities.
- Ensure a meticulous recruitment process, which specifies and evaluates the executive's personal qualities and match with the organization.
- Define professionalization pathways for healthcare executives, which involve formal and informal learning;
- Identify high potentials within the healthcare organization and train them along those professionalization pathways;
- Consider adding an aptitude test to the accreditation process and (if there is enough public support) making this a license to practice;
- As well as discussing decisions, also discuss motives and choices. This paves the way for achieving a moral consensus.
- Always base decisions on the best available evidence.

Zorgbestuurders hebben draagvlak nodig om hun werk goed te kunnen doen. De afgelopen jaren heeft het aan dit draagvlak vaak ontbroken. Daarom is een belangrijke vraag hoe zorgbestuurders kunnen bouwen aan draagvlak (oftewel hun license to lead). Deze vraag wordt in dit proefschrift beantwoord. Daarbij is gekeken naar drie niveaus: individuele zorgbestuurders, raden van bestuur en zorgbestuurders als collectief.



Sophie Bijloos studeerde af in geschiedenis, wijsbegeerte en rechten. Vanaf 2011 werkt zij als juridisch beleidsmedewerker bij de NVZD. In 2019 is zij haar eigen adviespraktijk gestart.

