Policy Brief:

Organisational leadership

ANTICIPATORY CARE PROJECT

The Anticipatory Care Action Learning Project research team acknowledges the palawa people of lutruwita upon whose lands we have conducted our research.

This project is funded by the Australian Government through the National Partnership Agreement on Improving Health Services in Tasmania.

The research reported here was produced by a collaboration between the lead organisations and communities of the four project sites, the Tasmanian Government Department of Health, the University of Tasmania, and the Australian Prevention Partnership Centre. The report was prepared by the University of Tasmania Anticipatory Care research team: Dr Susan Banks, Dr Robin Krabbe, Ms Miriam Vandenberg and Ms Thérèse Murray. We wish to thank Professor Richard Eccleston, Dr Therese Riley, Ms Flora Dean, and Ms Sarah Hyslop for their insights and support throughout the project.

The role of organisations as leaders in the Anticipatory Care System

Be prepared to let go and do things differently

Anticipatory care (AC) connects those at risk of chronic disease with health and wellbeing services and community support networks. The Tasmanian Anticipatory Care Project (ACP) adds to the growing body of evidence that a systems thinking and citizen focused approach to connecting those at risk of chronic disease to health and wellbeing services and community support networks has the potential to:

- reduce the incidence of chronic disease over the medium to long term
- reduce costs over the longer term by addressing health and wellbeing problems before more expensive health services are required.

Taking a systems thinking approach, the ACP considered anticipatory care as a system, with interconnected system parts and the participation of multiple organisations, including many that may not be traditionally understood to be part of the "health system". By appointing deliberately diverse local lead organisations in four sites, the Tasmanian ACP gained insights into the strengths and weakness of these organisations as leaders in anticipatory care, particularly with relation to disadvantaged and hard to reach people and communities. The organisations chosen were a local council (Clarence), a General Practice (Ulverstone), two neighbourhood houses (Launceston northern suburbs), and an Aboriginal community-controlled association (Flinders Island). Each organisation was selected based on their readiness, capacity, and willingness to lead the project in their local community.

Figure 1: Map illustrating the four Anticipatory Care Project sites

Boundaries: Organisational attributes

Each of these deliberately distinct organisations plays a specific role within the AC system, bringing their own attitudes and beliefs, approaches, knowledge and relationships which are embedded in and shaped by their specific place and community. These differences in the attitudes and attributes found amongst the organisations can be understood both as organisation specific and potentially more generalisable strengths and weaknesses of leadership within AC.

Taking a systems approach, these organisational attributes also represent organisational boundaries – the values, attitudes, perspectives and attributes that define what is considered relevant, important and worthwhile, or irrelevant and excluded by and within those organisations. These boundaries have implications for the ways in which the lead organisations understand their local context; situations and people; ethical and social justice issues; marginalization; resourcing; roles; and ways of approaching and improving the AC system. The organisational boundaries act as enablers and barriers in the AC system.

The ACP has found that organizational leadership in anticipatory care is shaped by the following boundaries or attributes (Figure 2).

Figure 2: Organisational leadership attributes and roles in an anticipatory care system

Research findings and insights

Role and scope differs according to the type of organisation, its role in the AC system, external constraints, and the scope of its responsibilities and accountabilities. The lead organisations (neighbourhood houses and FIAAI) that are overtly place-based, philosophically aligned with community development principles, and with direct accountabilities to their communities through their governance structures were better placed for community engagement and for reaching an understanding how the AC system is experienced by those most at risk. FIAAI has the advantage of combining its health services focus with being directly in place and deeply involved with the wider community.

Local government is able to provide geographic and population wide reach; diverse functions and connections across communities; and policy and decision-making powers that directly impact AC and social determinants of health (SDoH). On the other hand, the general practice (GP) has responsibility primarily to their patients and so is able to provide those patients with the continuity and long term relationships that are key to successful AC.

Role and scope can also present barriers in that they exclude anything considered irrelevant to the role, or out of scope. When AC was considered non-core, activities were not prioritised or supported and this may have contributed to local government seeming to find deep rather than broad community engagement difficult.

> *The system as it is now, if you go and see your GP, generally, if you've got a healthcare card or a pension card you get bulk-billed, and that's good, at a lot of clinics. At some clinics they don't, you have to go and pay and claim the gap back afterwards anyway, which also makes the process more traumatic for people, because they really will be waiting on that rebate, for when it goes into the bank. (Ulverstone)*

The role of general practice as a commercial business, operating within the constraints of government policy and funding models, restricted bulk billing to a modest commercially viable level. This situation creates barriers to access for the few who are bulk billed, and effectively places the majority of poor community members 'out of scope'. This last is a barrier not only for the GP lead organisation but for the majority of GPs and other health professionals interviewed and encountered across multiple sites during the ACP.

Beliefs and attitudes underpin organisational approaches to AC, people and community and were expressed in the boundaries around what is considered important, relevant, and within the responsibility of the organisation. For instance, compassion and a concern for people's emotional safety underpinned successful, deep engagement, and inclusion in marginalised communities. Another key enabler identified for AC leadership was commitment to addressing the SDoH.

Organisations such as the neighbourhood houses or FIAAI, whose core concerns and values are aligned with a commitment to addressing the SDoH, were more easily able to incorporate them into an approach to AC. On the other hand, an apparent privileging of a medical model of health and quantitatively evidenced knowledge within the GP lead organisation, coupled with a belief in mainly personal responsibility for health, created barriers to approaching AC from a SDoH perspective.

Beliefs and attitudes also undepin how organisations choose to respond to system, policy, or funding constraints, and important examples of innovation suggest the value of questioning taken for granted limitations and barriers.

I think we—the strength is the fact that we look at it from an Aboriginal health perspective and they have a holistic understanding of—and a holistic definition of what is health. So, it's all those—it's not just clinically focused and they certainly, we all consider a person and their circumstances rather than the disease. (Flinders Island)

The **approach** to AC leadership taken by organisations arises in part from their role and scope, beliefs, and attitudes. Enablers for a successful approach included flexibility and adaptability, curiosity, managed risk taking, reflection and learning, collaboration, and responsiveness to local place and people and their needs as expressed by them. When opposite approaches were in place, they created barriers to leadership. Organisations with a strengths and SDoH approach to AC were better able to engage with their local communities, to see and explore the situatedness and complexity of AC, and to identify power imbalances, inequity, and opportunities for change.

... that sort of goes across the breadth of what [FIAAI] does, because there's so many facets of the work that's done here. So at every level—I think that you can physically see anticipatory care happening here. Because everyone draws on everyone else's strengths and experiences to facilitate the best care, whether they be in mums and bubs, or whether they be in aged care. And regardless of what your job title says that you are a part of, everyone works together to make all cogs work. (Flinders Island)

Within the context of the SDoH, a medical understanding of the presentation, progression, treatment, and opportunities for prevention of chronic disease was also an important component in approaching and improvement in the AC system.

But approaches that emphasised a primarily medical model of health, without consideration of the SDoH, tended to minimise system complexity. A lack of respect for other types of knowledge or action also created barriers to collaboration. Approaches that focused on personal responsibility for health contributed to marginalisation and victim blaming.

Community engagement. The most effective community engagement occurred where there was pre-existing and continuing trust based, non-judgmental, and culturally competent relationships with at risk individuals and communities.

One of the things that I think neighbourhood houses excel at is that socialisation and being that warm, friendly other home, and that's what some people will say: "This just feels like home. This is my other home." I mean, that's what you want. (Launceston)

Locally embedded organisations such as FIAAI and the neighbourhood houses, working *with* and *for* communities, used and strengthened existing networks. These organisations *trusted* community experience and knowledge, rather than imposing solutions from positions of

perceived greater knowledge or authority. The GP and local government organisations were also able to build and extend existing networks but their reach into disadvantaged communities affected by the system was significantly less than FIAAI and the neighbourhood houses.

Engagement varied by organisation and again this reflects roles and values that not only shape approaches to engagement, but also who is seen to be their community, ranging from the relatively affluent and highly engaged to people who are at high risk and marginalised. Each organisation engaged with a slice of the local community but not always deeply or with those at most risk, leaving many people "out of scope" and unheard, including those who continue to be hard to reach.

Legitimacy[3] of AC leadership is grounded in contribution to and alignment within the system and attributes that support an organisation's capacity to lead in some way. Legitimacy included perceptions and attitudes about the status of the organisation, social respect for roles, organisations and people, credibility and trust, insider/outsider status, recognition of expertise and experience, history, and political and social capital.

Each of the lead organisations has different types of legitimacy within the system. Neighbourhood houses and FIAAI are seen as legitimate representatives of their communities. Local government also represent their communities in a more overtly political sense, and they also have the power to effect change through policy, regulation and planning. Doctors have acknowledged health expertise, social status, and influence, and are trusted to provide leadership in health provision and information (Figure 4).

However, legitimacy can also be undermined by competing values. An example is the way negative perceptions of "outsiders" undermine the local legitimacy of visiting professionals on Flinders Island. Legitimacy is also undermined by perceived lack of integrity or care: if council "consultation" is believed to be just lip service or when there is a perception, rightly or wrongly, that GPs care more about money than health, for example.

The ACP has challenged our assumptions about who has a legitimate role in AC generally and a leadership role in AC specifically. Initially it was assumed that General Practices and Local Government would be the most likely and legitimate AC leaders given GPs' acknowledged expertise, and perceived health leadership, and council's legislated responsibilities, reach and resources. However, the ACP has highlighted the legitimacy of the leadership role that neighbourhood houses and FIAAI play in their local communities and that they are well placed to take a leadership role in AC.

Figure 4: Still from a telehealth informaton video, Patrick Street Clinic

Relationships, influence, and power. In addition to their engagement with target communities, all organisations have their own networks and relationships that provided opportunities for influence, communication, collaboration, and sometimes indirect connection with harder to reach people and communities. Relationships and networks were strengthened and expanded during the project and show evidence of changing and strengthening the AC system. Each organisations was also able to wield influence and power in the system, bringing diverse people together, influencing external organisations, lobbying, and advocating for change directly and via the media (Figure 5).

Barriers to effective relationships for AC include lack of diversity in networks, competition for market or funding that reduces collaboration, mistrust of outsiders, and attitudes that devalue the expertise and knowledge (often tacit) of others. Uneven power dynamics amongst organisations and individuals were also a barrier to collaboration, trust and information sharing, and a source of marginalisation within the system.

EDITORIAL

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Health model ret

NEWS

Telehealth could stay

Routes sign for roads ahead

Figure 5: Examples of media advocacy from the Launceston site

Enabling contexts support the exercise of leadership.[3] Enabling contexts for ACP leadership included a lived and practiced organisational commitment to the purpose of the project, AC, and the SDoH as approaches to health, evident not only in the ACP, but in day to day activities. Enablers also included flat structures, flexible bureaucracies, a degree of autonomy or empowerment for participating staff, a willingness and capacity to collaborate, and a bottom-up approach which trusted local communities to understand their own issues and priorities. Enabling contexts prioritised AC and therefore provided top-down support, time, space, and resources for leadership, creativity, and operational management, and had tolerance for risk. Barriers included a lack of organisation-wide support (project operating as a silo), a lack orientation to SDoH approaches, and a lack of clarity, commitment and alignment with the project and AC vision and goals.

The **knowledge, skills, and expertise** of the lead organisations in the ACP reflects their diversity. Community development knowledge and soft skills such as relationship and network building, facilitation, community engagement, communication, and collaboration were key enablers, as was deep knowledge about multiple aspects of place, community, and local expressions of the AC system. Cultural competence was also important, not only for Aboriginal people on Flinders Island, but for other communities and settings.

Why does cultural competency matter?

Attitudes about a community or a person shape how they are treated and their expectations—in life generally, and of the health system. Attitudes to Tasmania's palawa peoples (Aborigines), for instance, are an important factor across Tasmania, including on Flinders Island. Historical and continuing discrimination shape the health and wellbeing of palawa, including through dispossession, sexual and other violence, socioeconomic disadvantage, lower life expectancy, and direct (e.g., verbal abuse) and covert racism (e.g., poorer treatment, marginalisation).[4] But cultural competency is also required to understand and ensure the needs of local communities are valued.

However, technical and specialist knowledge is also needed. A broad range of medical and health related expertise; an understanding of policy, processes and systems implicated in AC and the SDoH; and skills in managing resources, time, activities, people, and projects were all necessary for effective leadership of ACP. Knowledge and skill barriers to organisational AC leadership lie in gaps in such knowledge that is bounded by the scope, role and approach of the organisation. Such barriers are mitigated by relationships and collaboration with diverse organisations and respect for different types of knowledge and expertise. For example, the neighbourhood house lacked medical expertise and knowledge of how the system "works" from a GP perspective and the GP in their area lacked knowledge about local services and people's situations, but coming together bridged gaps for both.

I wouldn't have been able to [support our clients' health] without you guys, 'cause I honestly didn't know what was out there. (Launceston)

Diversity within an organisation such as the breadth of skills provided by a volunteer workforce is also a significant source of knowledge, skills and expertise.

The other thing is a kind of professional development from a community development point of view: seeing how productive a group of people with a single focus can be. And the value of creating those connections across areas that were probably isolated before—across health, across GPs, across police, across community centres. (Launceston)

Qualities that enable leadership in Anticipatory Care

A number of organisational qualities (below) were identified as key to leadership in the ACP, and for AC more generally. The possession or lack of these qualities, along with the enabling and limiting boundaries particular to each organisation were often found to be complementary. For example, where FIAAI or a neighbourhood house may have a deep insight into a particular need of their local community, local government may be the organisation that has the power to make change in response to that need.

No one organisation has the full complement of attributes and qualities needed to be the ideal and only AC leadership organisation, so what is needed to lead efforts to strengthen the AC system are strong relationships, and collaboration amongst organisations. These leadership qualities also suggest opportunities for individual organisations to grow and enhance their own leadership capacity within the AC system by building these qualities internally.

The leadership qualities are:

- Collaborate with an openness to multiple perspectives and respect for different types of knowledge.
- Deep connection with and responsiveness to at risk communities and cultural competency in those communities.
- A lived and practiced organisational commitment to the principles of social justice, equity and compassion.
- Flexibility, adaptability, creativity, risk taking, self-reflection, and an openness to learning.
- Established networks of relationships and influence.
- Breadth of expertise, knowledge, and skills.
- Ability to manage resources, time, activities, people, and projects.
- Commitment to SDoH and an AC approach.

Policy implications

The Tasmanian Government is at the forefront of investing in new approaches for the prevention of chronic disease, informed by new research and translation methods developed with the University of Tasmania. Our analysis of leadership enablers and barriers in ACP lead organisations provides a number of insights regarding both desirable leadership qualities for AC initiatives and the design of AC programs and initiatives more generally. The ACP has highlighted the power of a model of collaborative and diverse AC leadership, distributed across the AC system. The role of government should be to practically and financially support such a model so as to significantly strengthen AC leadership and therefore the capacity to strengthen the system in a sustainable way to improve long-term health outcomes:

- Create and fund multi-organisation and long-term collaborative leadership groups that incorporate and take advantage of multiple roles, scope, perspectives, system entry points, and complementary leadership qualities.
- Ensure that collaborative leadership groups include strengths-based and place-based organisations with deep community connections and local cultural competency that can effectively engage with local communities.

Mind the Gap

The ACP involved only four lead organisations but many more were identified as participating in the AC system during the project. These organisations, and others also have the potential to fill gaps in perspective, attributes, and leadership qualities including bridging critical gaps in community connections with those people who continue to be hard to reach.

- Ensure that leadership collaborations include organisations and mechanisms that are able to engage with, and draw in, groups and communities who are affected or marginalised by the system.
- Create criteria for the selection of leadership for preventive initiatives that incorporate identified leadership qualities and enablers across key organisational attributes.

Build collaboration

Collaboration amongst diverse organisations does not just happen it needs to be built. Provide time, support, funding, and facilitation to:

- Build senior level organisational alignment amongst partners across the system with a commitment to creating a shared vision and purpose, including core project approaches such as SDoH built into funding,[5] contract, and governance guidelines.
- Create project initiation processes and events that extend organisational alignment and shared purpose further into the partner organisations.
- Build relationships, trust, and understanding across all levels of participating organisations.
- Create shared governance and dynamic multi-level collaboration mechanisms[5] and processes, which support the key leadership qualities, and provide for ongoing flexibility, self-reflection, managed risk-taking, learning, negotiation, and change.

Endnotes

[1] Williams, B., & Hummelbrunner, R. (2010). *Systems concepts in action: A practitioners' toolkit.* Stanford, CA: Stanford University Press.

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