Distributing systems level leadership to address the COVID-19 pandemic

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INTRODUCTION

COVID-19 pandemic has disrupted the political, economic and healthcare systems of most, if not all countries across the globe. As such, the COVID-19 pandemic represents another global health catastrophe similar to the Spanish influenza (1918–1920), H1N1 swine influenza (2009–2010) and West African Ebola (2014–2016) with high mortalities. Current public health measures aimed at subduing the spread of COVID-19 virus seem to be working but are not extensive enough to prevent ongoing infections and death. There is a need for leadership at the systems level, necessary because COVID-19 represents a complex problem, of a type commonly characterised as (volatile, uncertain, complex ambiguous (VUCA)) unlikely to be effectively addressed by a single agency or person. In the context of COVID-19, leadership of the system encompasses politicians, scientific experts, civil servants and front-line practitioners, where leadership is shaped by the system in which it is enacted, and its historical, political and national characteristics. We discuss systems level leadership to address the COVID-19 outbreak, with concern for recovering from COVID-19.

As our first aim, we outline three themes related to how systems level leadership might influence recovery from the COVID-19 pandemic. Second, we highlight debate about the most effective leadership configurations for addressing and recovering from COVID-19. Conceptions of leadership appropriate to address a crisis such as that presented by COVID-19, on the one hand, highlight the need for heroic individualistic leadership. Indeed, we have seen heroic leaders emerge in the political domain (Jacinda Ardern, New Zealand’s Prime Minister), among scientific experts (Chris Whitty, chief medical officer, CMO, UK), and the clinical front line: see James Stoller’s account of such hero leaders at the Cleveland Clinic in the USA where he works in a previous issue of British Medical Journal Leader. Such individualistic leadership is necessary to respond to the immediate crisis engendered by COVID-19, but contemporary leadership studies alert us to the need to complement this with distributing leadership at a systems level as we move through to a phase of recovery from such crises. A complex issue such as a influenza pandemic involves a large number of agencies, all of whom encompass discrete professional and organisational expert jurisdictions. We, thus, argue post-heroic leadership alternatives that go beyond a single, ‘heroic’ individual are needed to manage the crisis since we need to combine knowledge capabilities of a myriad of actors. This is not merely a case of having a myriad of leaders ‘around the table’, but ensuring their leadership efforts are not fragmented, rather they share the same values and their influence is synergistic and aligned in addressing COVID-19.

Finally, the initial affective leadership response to any crisis is likely to impact on the ability of any system to develop and maintain the necessary productive interactions underpinning effective leadership for recovery. During the early stages of any crisis leaders commonly distance themselves from responsibility for the crisis and exhibit defensive-ness regarding any attribution for failure. As such, the unintended consequence of blame can entrap people into established behavioural commitments and make it more difficult to recover from crisis on the basis that blame and paralysis works against collective learning, as it reduces trust, openness to information and communication.

We now consider the three themes raised in literature about systems level leadership through illustrations across our four countries, analysis of which we derived from their respected national media; for recovery from crises, nurtures the blame game and is likely to render learning following the crisis more challenging.

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example, in case of England, we reviewed headlines from BBC News, the Guardian and Financial Times. In essence, literature suggests a need for leadership to be pluralised, even as heroic leaders come to the fore and for leadership to be pointing in the same direction, with leaders creating synergy through their efforts to address crises.16

ILLUSTRATIVE EXAMPLES

England

Statistics: Using statistics produced by John Hopkins University on 15 March 2021, for comparison purposes (www.coronavirus.jhu.edu), there have been 4.23 million cases and 123 000 deaths in the UK, of which England represents the major constituent (UK population is 68 million, of which England is 55.3 million). John Hopkins University notes that statistics may be collected in different ways by countries, with considerable under-reporting in some countries, nevertheless international commentary highlights England has performed poorly relative to other countries.

Preparation for COVID-19: In England, the government was slow into lockdown, lagging some weeks behind its European neighbours, even as COVID-19 in the population became increasingly evident. The government appeared complacent. We note, for instance, Professor John Ashton, a leading Public Health expert, branded England’s COVID-19 response ‘pathetic … they’ve been doing it in a (non) smoke-filled room and just dribbling out stuff.’ (The Guardian, 12 March). Such complacency was reflected in the prime minister missing a total of five Cobra meetings (government’s main emergency committee) at the start of the outbreak. The government’s initial stance, although since denied, was one of encouraging ‘herd immunity’ through accepting large swathes of the population would become ill (Financial Times, 9 March). The economic imperative was dominant even in the early days of COVID-19, encouraged by more libertarian Ministers, seemingly at odds with others in the Government, such as the Health Minister. Following which, England lacked surveillance infrastructure for COVID-19, perhaps more crucially it lacked supplies of testing equipment and personal protection equipment for front-line professionals. The high death rate in England, in part is due to poor preparation, and likely to render recovery following the crisis more challenging than it might otherwise have been. As evident below, poor preparation fuelled allegations of blame and defensiveness across the ranks of leaders in different domains that might be expected to come together in response to COVID-19.

Individualistic and distributed leadership configuration: In the context of poor preparation outlined above, the prime minister, Boris Johnson aligned his role as one of a ‘wartime’ leader akin to Churchill, a prime minister regarded as hero by the English public. Following which, and despite poor preparation, an encouraging collective trajectory of leadership emerged. Alongside his inclusion of key ministers concerned with the economy and health, we also note inclusion of scientific experts in the leadership configuration in daily media briefings about COVID-19 alongside the prime minister. We see the government rely on a narrower range of knowledge capabilities than might be optimal, with evidence produced by epidemiologists and statistical modellers privileged, and to some extent behavioural scientists. Further, despite problems of supply chains for personal protective equipment and the challenge of mounting an effective operational response at organisational level to the delivery of health and social care, there is an absence of those front-line leaders with organisation and management expertise. Rather, the Government took a centralised, command-and-control approach, which might be characterised as symbolic to show they are doing something to address COVID-19. Large-scale exhibition centres were converted into temporary ‘Nightingale’ hospitals. When the crisis subsided with COVID-19 numbers dropping, and lockdown restrictions much reduced, this potentially allowed space for reflection and learning regarding the effectiveness of collective leadership in anticipation of the much predicted second wave of the pandemic. However, first, the prime minister pushed back against an imminent inquiry. Second, central government, despite calls for greater involvement of regional and local leaders in decision making, did not extend the leadership collective. This was apparent in the government mandating a local lockdown in June in a city in the English Midlands, Leicester, within which local health and political leaders were both surprised by the lockdown and starved of the nationally held data they needed to control infections. The leadership fractures between central government and local government were even greater as a second lockdown extended later in the year on a regional basis. Even within the Government, so-called ‘hawks’ in the ruling party, who wanted the economy opened up, were at odds with the Prime Minister’s decision making around lockdown. Rather than distributed, leadership can be characterised as fragmented at the second lockdown stage. Only during a third lockdown, which was implemented on a national basis, did leadership appear more distributed, with consensus within government and between central and local government, in the face of increasing incidence of COVID-19 and visible pressure on the National Health Service (NHS) and their staff with increasing hospitalisations. Following which, the government worked closely with NHS and public health organisations to ensure, along with Israel, England has been one of the fast movers in vaccinations, with 23.34 million of the population vaccinated by 15 March 2021, and all adults expected to have received at least their first dose of a the vaccination by end June 2021.

Affective leadership response to COVID-19: The promise of an emerging collective leadership configuration across different actors and levels of the system has dissipated. Beginnings of blame were evident in England in the immediate aftermath of emergence of COVID-19. Anthony Costello, former Director of Maternal and Child Health at WHO has been particularly critical of the English Government’s response as ‘a litany of failures’ (The Guardian, 7 April). Worryingly, rather than reflect and learn during the space afforded later on by the summer within which case numbers fell, the government showed its disposition towards blaming scientific experts for poor advice. Meanwhile, the scientific experts claimed the government didn’t follow the experts. This was starkly evident when the prime minister demanded employees return to work, but the government’s chief scientific advisor refuted the idea and emphasised employees should work from home when they could. The government also blamed other agencies for failure to effectively address the COVID-19 pandemic. Public Health England in particular was castigated for failure. Meanwhile, the head of the civil service, Mark Sedwell, was ‘stood down’ by the Prime Minister, influenced by his private chief advisor, Dominic Cummings, that the civil service proved weak in responding to the COVID-19 pandemic. While, supported by a rapid mass vaccination programme, England appears to be coming out of the pandemic quicker than many other nations, should there be a public inquiry (the prime minister has suggested there will be given time), then there is likely to be blame as well as learning derived from this.

Summary: In England, while the inclusion of scientific leaders to address volatility and uncertainty of COVID-19 is praiseworthy, given leadership fragmentation, a prevalence of
scapecoating from some of the leadership configuration, and poor leadership preparation for a pandemic, the configuration for leadership appeared to not be effectively distributed to frame the response to COVID-19 in England as well as might be desirable. While the rapid mass vaccination programme appears to underpin a recovery trajectory, in the face of COVID-19 incidence numbers and associated deaths, we suggest enactment of distributed leadership at the system level in England has proved inadequate.

INDIA

Statistics: According to the Johns Hopkins Coronavirus Resource Centre, on 15 March 2021, India, an LMIC of around 1.3 billion people, has the second-highest number of coronavirus cases (after the USA), with 11.26 million cases and 158,063 deaths (less than 2%). However, due to India’s poor health monitoring system, there could be significant under-reporting of this data. Nonetheless, it appears that India outperformed several developed countries, including the USA, in terms of COVID-19 management.

Preparation for COVID-19: Capacity issues, lack of collaborative leadership and operational feasibility have been to blame for poor preparation to manage COVID-19. The pandemic has highlighted the flaws and shortcomings of India’s response in terms of low testing rates, inadequate healthcare services and deficient social security. Supplies of necessary equipment, such as PPEs, were not provided in a timely way, and as the epidemic progressed, shortages arose rapidly. Other services, such as hospital beds, ventilators, were also below the requirements. The main purpose of the lockdown was to buy time for making preparations to deal with the pandemic effectively postlockdown through deployment of public health personnel; increasing the testing capacity; establishing a consistent strategy for tracing and quarantining contacts; and maintaining the treatment and protection of patients across critical facilities. However, there emerged criticism that central government thwarted or made efforts of state governments more complicated in absence of synergistic leadership to address the pandemic.

Individualistic and distributed leadership configuration: That India implemented a nationwide lockdown without meticulous planning and transparency fits with the highly personalised leadership style of the Prime Minister Modi. Nevertheless, the early phase of India’s response to the emergence of COVID-19 was enacted through a collective leadership configuration across a high level group of ministers (similar to emergency committee, Cobra, in England) comprising of central government ministers of Health, Civil Aviation, External Affairs, Defence and Home Affairs to review, monitor and evaluate the preparedness regarding management of COVID-19 in the country (www.pib.gov.in). Below this sat groups empowered to advise about discrete issues, such as supply chains and public communications. These were coordinated by the Ministry of Home Affairs (MHA). Guidelines were issued to all 37 states and union territories on management of COVID-19 and progress was regularly reviewed through video conferencing by high-level government officials. District Collectors were designated as the ‘nodal officers’ at field level for containment operations, who were given adequate authority to take the critical decisions in coordination with respective state governments. Meanwhile, scientific experts were involved in briefings through electronic and social media. Initially, there was little conflict in the leadership efforts of scientists and the central government, in large part because the former were drawn from central government funded and controlled institutions, such as Indian Council of Medical Research, All India Institute of Medical Sciences, National Institute of Virology. India appeared to enact the necessary collective leadership for an effective response to COVID-19, nevertheless cracks in leadership were to appear as setout in the next section.

On 16 January 2021, India launched the world’s largest vaccination campaign against the COVID-19, vaccinating about 300 million people in priority categories. To date, however, just 0.3% of the population has been completely vaccinated. The first group consisted of healthcare and front-line staff, while the second group consisted of people over 60 years and those aged 45–59 who had comorbid conditions. This second group began receiving vaccinations from 1 March 2021. The Ministry of Health set up more than 20,000 vaccination sites across the country, and launched a dedicated website (covin.gov.in) and CoWin app for registration. Surprisingly, India offers free vaccination at government hospitals and has set a price limit of Rs.500 (US$7) for two doses at private hospitals. The Ministry also drafted a ‘COVID-19 Vaccine Communication Strategy’ to ensure the success of the vaccination programme, and is now working closely with public and private health organisations, individual influencers, community groups, and social media. Like England, the vaccination programme appears underpinned by more effective distribution of leadership than previously evident.

Affective leadership response to COVID-19: We see evidence of conflict, specifically between central (‘union’) government and individual state governments, which adversely affected attempts to curb the pandemic. The MHA constituted an Inter-State Ministerial Team (ISMT) to inspect states, such as Kerala, that were potentially diverging from national lockdown. Conflict was evident with West Bengal, where state government failed to provide ISMT with sufficient data about patterns of COVID-19. Following which, the chief minister of West Bengal blamed central government for taking unilateral and undesirable actions against some state governments. In Delhi, the state government accused the central government of issuing home isolation rules alleging that it was not an epidemiological decision, but a political one, highlighting inconsistency over quarantine rules applying in the city. Meanwhile, central government accused Delhi-based state government of generating terror in the city through overestimation of numbers of cases of COVID-19, which had an adverse economic impact on the city and its region. We also see conflict emerging between scientific experts and central government. In May 2020, three medical professional bodies sent a joint statement to Prime Minister Modi criticising the handling of the COVID-19 outbreak, highlighting lack of consultation by central government with epidemiologists who had a greater knowledge of the nature of disease transmission relative to experts in statistical modelling whose views seemed privileged. Blame across different levels of government and between government and scientific experts seemed increasingly prevalent in India as numbers of COVID-19 climbed.

Summary: In India, we see an antecedent configuration of individualistic and distributed leadership across the system. Vaccinating a billion people, including hundreds of millions of adults, against COVID-19 would be a daunting and unparalleled challenge in India, and it will take at least a couple of years to reach half of the population. Health practitioners are more likely to help with recovery, but a lack of coordination between the central and state agencies has weakened India’s chances of learning and recovering from the pandemic. It appears that the implementation of distributed leadership in Indian health system has only been moderately effective in COVID-19 response.


Commentary

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Affective leadership response to COVID-19: The first wave reached its peak just before the end of March 2020 and during the second half of April, there were only a handful of infections reported daily. It seemed that Australia had successfully handled COVID-19, with just over one hundred deaths reported nationally. However, not everything seemed to have worked well. The Ruby Princess cruise ship was allowed to dock in Sydney and resulted in over one hundred infections on Australian soil and in other countries when passengers were allowed to board flights to return to their homes overseas. This has highlighted the breakdown of communication among the various authorities involved, leading to an official government inquiry being held into this incident. Another incident that essentially led to the second, more severe, wave of COVID-19 infections in the state of Victoria resulted from the hotel quarantine debacle in Melbourne. Starting in April 2020, hundreds of visitors returning from overseas were put into quarantine across a number of hotels. The security measures put in place (having multiple security guards at each hotel) were not directly handled by the state government but essentially handed over to a few security firms who then subcontracted to others to find the necessary staff, resulting in them failing to do their job effectively. It took a number of weeks before the state government stepped in to take more drastic action, bringing in the state police and the Australian Defence Force personnel. Following which, the second wave started to appear in mid-June 2020, with the number of daily infections quickly rising to well beyond the peak reached in the first wave. The state government put in place aggressive suppression measures, introducing stage 4 lockdown in Melbourne and stage 3 lockdown in regional Victoria. By mid-October 2020, the number of daily infections reported reduced to very small numbers, leading to reducing the restrictions significantly. There has been some disagreement and blame among the state and federal leaders to the extent of the measures being put in place in this respect and when the borders will be opened up, especially for Victorians. Following a small cluster of COVID-19 cases recorded at a hotel near Melbourne Airport in early February 2021, the Victorian government put in place a 5-day ‘circuit breaker’ lockdown across the whole state. This measure was considered essential and was highly effective in stopping the spread of the virus from the local area. Again, we see that Australia’s leadership response at the system level has proved responsive to emerging threats posed by COVID-19.

Australia’s COVID-19 vaccination programme started in late February 2021 and will become available in phases. The Australian Government is being advised by the Australian Technical Advisory Group on Immunisation and consistent with guidance from WHO, prioritisation of groups for the first dose has been carried out and vaccinations have began. Delays in the supplies of COVID-19 vaccine, reliant on a global supply chain, have illustrated, however, that leadership efforts may need to extend beyond a single nation’s system, and leadership requires distribution at a global level.

Summary: In Australia, while antecedent conditions for effective leadership include preparation and synergy across levels of government, the VUCA of COVID-19 means little room for error from leaders. Australian leaders seem to be learning in real-time, which might enhance prospects for recovery. The state of Victoria demonstrates that although mistakes can be made (eg, the poor handling of the hotel quarantines), a strong system-level leadership team aids an effective response and infrastructure to cope with crises.
Affective Leadership Response to COVID-19: Considerations for Systems Leadership

Prescription 1: preparation for crisis: recovery is shaped by antecedent conditions, even prior to the emergence of COVID-19. Leadership around planning for unanticipated events is crucial, since lack of preparation for such events is likely to engender blame rather than a learning response towards recovery.

Prescription 2: individualistic and distributed leadership configuration: Notwithstanding the volatile and unpredictable nature of COVID-19, the leadership trajectory for recovery is one which requires a large number of stakeholders from discrete professional and organisational boundaries to be engaged in a leadership response over time. As such, leadership needs to be distributed across political, scientific and front-line clinical domains, with synergistic, rather than fragmented, momentum.

Prescription 3: affective leadership response to COVID-19: What should be avoided in such a volatile and unpredictable situation is blame and scapegoating. Governments may find it more difficult to engage leaders where they feel they ‘may be hung out to dry’ for failing to effectively address any crisis, and thus slow to contribute to recovery efforts. In this respect, England’s system level leadership may be less aligned and synergistic in its recovery efforts.

Correction notice The affiliation “Department of Pediatrics, Dr. Horacio E. Oduber Hospital, Caya Punta Brabo, Aruba” has been added for author Jamiu Busari.

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REFERENCES