Sustainable Leadership Competency Model Leading To Business Growth and Development in Healthcare – An Introspective Study in Kolkata, India

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ABSTRACT: *This study identified a sustainable leadership competency model leading to business growth and development for developing healthcare executives in Kolkata, India based on the Healthcare Leadership (HL) Model. Eleven chief executive officers and chief medical officers were interviewed. They considered 86% of the Healthcare Leadership (HL) competencies as very important or vital and perceived a gap in the performance of these competencies. They also identified additional vital competencies beyond the scope of the model. Participants also reported that leadership development and succession planning programs were lacking. Recommendations are to design a leadership development program using the HL model as a framework and further customizing the approach as per the organization's unique mission, vision, strategy, values, and circumstances. The HL is offered as a general strategy for leader development that could be useful in the growth and development of Indian private healthcare industry, based on some "best practices" in the design and implementation of the leadership programs.*

I. INTRODUCTION

Nowadays, a hospital is conceived as a place where people receive services to recover their health or to reinforce it (Gallent, 1996). It is also a place for teaching—a learning center for future physicians, surgeons, and other professionals. Often, the hospital is also a research center where scientific knowledge of illnesses is broadened. In a sociological sense, the modern hospital is a complex organization with roles, rights, obligations, attitudes, values, and goals of their own.

The Hospital as an Enterprise

As the concept and practices of hospitals have evolved, management models have also changed, from adoption of business management models, which emphasizes in self- reliance, productivity and profitability, up to meeting the needs and expectations of all stakeholders.

According to Malagón-Londoño et al. (1996), modern hospitals are companies in which complex processes of various kinds converge, such as healthcare, hospitality services, scientific research, training and education, drug manufacturing, and the attention to the typical areas of any company: human resources, suppliers, legal issues, and finance. Notably, these tasks only can be done successfully with an efficient management.

Like any typical modern enterprise, the survival and consolidation of a hospital depends on its effectiveness to meet the expectations of its stakeholders for which it has to drive a complex system composed of elements and processes of various kinds.

Hospital stakeholders include clients, patients, employees, investors, suppliers, insurance companies, government agencies, and financial institutions.

Several obstacles face hospitals attempting to manage the institution as an enterprise. The first has been the paradigm shift of hospital from the idea of a charity entity that survives on contributions from generous individuals and institutions to a self- sustaining, productive, and profitable organization.

The second difficulty, as in any enterprise, to achieve the levels of productivity and profitability is the adoption of an appropriate modern business model. The business management models have been evolved quickly, so that the practices and models which were successful in the last half of the last century no longer produce the same results, because the environmental conditions of business have changed dramatically.

According to Aitken and Higgs (2010), the main contextual factors underpinning the increasing pressures on organizations to respond to growing complexity and environmental volatility are: increasing levels of competition, investor and stakeholder demands, globalization, changing nature of the workforce, technology, legal and regulatory changes, and societal changes. Because of these changes in the business environment, a change in the enterprise managing is also required. It is needed a change in the beliefs, values, life perspective and responsibilities and competencies of the leaders and managers.

To be a good manager is no longer sufficient to perform the traditional functions of planning, organizing, directing and controlling. According to Kouzes and Posner (1998), the main functions of a leader should be challenging the process, inspiring shared vision, enabling other to act, modeling the way and, handling the increasing uncertainty and complexity.

Purpose of the Research
This study sought to identify a leadership competency model for developing healthcare executives in India based on the Healthcare Leadership (HL) Model which would lead to growth and development of healthcare organization. Three research questions were examined:

- Is there a leadership competencies model applicable to Indian private healthcare organizations?

- How do top leaders in Indian private healthcare organizations perceive their own performance?

- What kind of framework would be helpful to develop leadership capability required by top leaders in Indian private healthcare organizations?

Importance and Significance of the Research
The exercise of effective leadership in any business is crucial to the achievement and sustainability of long-term desired results. This is even more critical for hospital companies because, by their very nature, the impact of success or failure in management is crucial.

If a company does not succeed either in production or marketing of consumer goods or the provision of certain services, it may just disappear and their stakeholders will lose something valuable. However, if a hospital does not fulfill its commitment, what is at stake, ultimately, is people's lives and health. It is, therefore, crucial that an effective leadership is necessary that attains proper coordination of people and processes. In the Indian context, there are large areas of opportunity in business management, particularly in hospital organizations. As such, this study will be a pioneering contribution in this field.

Project Setting
The information for this study was obtained from interviews with chief executive officers (CEOs) and chief medical officers (CMOs) of Indian private healthcare organizations located in Kolkata with 250 to 1,200 employees and serving 3,600 to 15,000 patients per year.

II.   LITERATURE REVIEW
This study sought to identify a leadership competency model for developing healthcare executives based on the HL Model. First, the importance of leadership in healthcare organizations is discussed. Second, leadership concept and leaders' traits, styles, and competencies are reviewed. Third, leadership competencies models are examined.

Importance of Leadership in Healthcare Organizations
Aitken and Higgins (2010) mention that an organization's environment has the following characteristics: increasing levels of competence, demands from investors and other stakeholders, globalization, evolving nature of the workforce, technology, legal and regulatory changes, as well as social changes. Hartley and Bennington (2010) point out that there are several additional reasons why an effective leadership is required in hospitals:

- There are new challenges in terms of health, amongst them the different sorts of illnesses the world confronts today.
- There exist both a new culture and new health goals.
- Due to the Internet, there is less "deification" of professionals and medical authorities and greater expectations in terms of individualized and flexible care.
- The new health techniques and technologies require new ways to interact with patients and within and among hospital teams.
- There is an increasing emphasis in radical innovations rather than mere continuous improvement. These are required to support safety, quality, and efficiency of health services.
- Health organizations are changing—not only in their structure but above all in regards of their cultures and ways of working.

Leadership Concept

Undoubtedly, there is a widespread agreement regarding the importance of leadership in the world of organizations. However, there is no consensus about the leadership concept itself and its key components. In this respect, Burns (1978) said "leadership is one of the most observed and less understood phenomena on earth" (p. 2). Yukl (2006) agreed, commenting that the investigation of leadership has experienced narrow approaches and there has been little integration of the findings emerged from different strategies.

Hartley and Bennington (2010) suggest "The Warwick Six C Leadership Framework," which comprises a structure to classify and portray different aspects of leadership. The six Cs are concepts, characteristics, contexts, challenges, capabilities, and consequences. Each one of these elements has a myriad of definitions and approaches.

Stodgill (1950) says that leadership can be considered as the process or the act of influencing the activities of a group organized to establish and achieve their goals. It considers leadership as an influential social and relational process that occurs within a group. It pays attention not only to the characteristics of the individuals but to what happens between the leader and his or her followers. This definition also highlights the importance of the group's common purposes as an important condition to be met for leadership to take place.

Homans (1961) agrees with the first part of Stodgill's definition, which says that leadership takes place in a group when a person (the leader) gives the orders in the form of suggestions, mandates, or requests and the followers act in accordance with those in return for rewards. Common purposes are not mentioned as a key motivating component, even though the achievement of that common goal might be considered a type of reward.

Burns (1978) commented, "Leadership over human beings is exercised when persons with certain motives and purposes mobilize, in competition or conflict with others, for institutional, political, psychological, and other resources so as to arouse, engage and satisfy the motives of followers" (p. 110). Competition appears in this definition as an element that detonates group cohesion which is required for the group to follow orders from that who understands the group's motivation.

Smircich and Morgan (1982) say leadership is realized in the process whereby one or more individuals succeed in attempting to frame and define the reality of others. In comparison to the previous definitions, this does not include motivations or values as a key element, although it can be implicitly understood that it is only possible to define other people's reality if they find valuable what they get from their leader.

Locke (1991) approaches leadership as the process of persuading others to undertake actions towards a common objective. Again, a common objective is mentioned as a determining factor for leadership. It is also important to note that persuasion here is understood as a process rather than a specific competence. In this context, persuasion does not mean simply talking eloquently or offering powerful rational ideas, but instead to bundle a series of personal, social, and professional conditions that make a person trustworthy increasing his or her potential to influence others.

Heifetz (1994) considers leadership as mobilizing people to tackle tough problems. Burns (1978), like Heifetz, also talks about tough problems as a leadership detonator.

In the healthcare industry, Goodwin (2006) says that leadership is a dynamic process of pursuing a vision for change in which the leader is supported by two main groups: (a) followers within the leader's own organization and (b) influential players and other organizations in the leader's wider, external environment. The leader incorporates a broader view by considering not only the influence he or she exerts in the group and on the key stakeholders within the environment.

There are substantial differences between these definitions. While some emphasize the importance of goals or purposes, others focus on the process or social dynamics. Still others center in the group, organization, or social system. While some highlight the intention of satisfying followers' needs, others include the existence of challenging situations as detonator. Despite these variations, almost all of them share the idea that leadership is mainly about the exertion of influence among and between human beings with the intention of achieving a certain purpose. Given that there is little agreement on the definition of terms, it is not the intention to carry out a comprehensive analysis of leadership based on different perspectives and approaches. Instead, the purpose of this section is to draw attention to statements by several authors and institutions about the characteristics and competencies of leadership.

Traits, Styles, and Competencies of Leadership

Stodgill (1974) pointed out that around the 1940s, the investigation of leadership was focused on primarily innate features or characteristics associated with effective leadership. Even though, for different reasons, this focus on cognitive and personality traits was not well received, in more recent times, it is possible to recognize traces of such approach. Adair (2007) identified enthusiasm, integrity, determination, justice, empathy, humility and trust as generic traits of effective leaders. Nevertheless, as commented by Parry and Briman (2006), Yukl (2006) and Jackson and Parry (2008), such kind of qualities may not be relevant to all leadership situations.

According with Hartley and Benington (2010), halfway through the last century, dissatisfaction with trait theory lead many authors to pay more attention to what leaders actually carried out rather than on their innate traits. This tendency was known as a focus on styles and behaviors commonly used by leaders. A very important change consisted in considering that such behavior could be acquired. Therefore, greater emphasis was dedicated to the development of leadership and less in the selection of leaders.

Some of the most representative studies of such approach are known as the Ohio studies by Halpin and Winer (1957), who identified two key dimensions: consideration (focus on people) and initiating structure (focus on the task). Blake and Mouton (1961) expanded the Ohio studies findings and by developing the Leadership Grid, which describes leadership styles along the dimensions of focus on people and focus on the task. Their work conceptualized leadership in five styles: impoverished leadership (low people, low task), authority-compliance leadership (low focus on people, high focus on task), middle of the road leadership, (medium focus on people, medium focus on task) country club leadership (high focus on people, low focus on task) and team leadership (high focus on people, high focus on task).

Subsequently, Boyatzis (1982) was one of the first to use the frame of reference for competencies to try to understand and improve the qualities of leaders. Boyatzis defines competence as an intrinsic characteristic of the person, which triggers an effective or above average performance at work. Hirsch and Strebler (1995) address competencies more specifically as abilities, knowledge, experience, attributes, and behavior needed by an individual to effectively develop a task or function. A crucial difference between the approach on traits and the approach on competencies focuses on qualities that are expressed in behavioral terms and implies that competencies can be learned and improved, unlike focusing on intrinsic traits.

Many authors do not distinguish between the concepts of *competence* or *capability*. Regardless of the term used, competencies or capabilities are perceived with reference to the performance of a task or function and the interaction between the context and the person is therefore acknowledged.

Boyatzis (2006) emphasized that a competence results from the interaction of a person and its context, understood as work requirements and organizational environment. He explained that leadership is affected by the current situation of the leader and that it does not only depend upon his or her qualities. He said the best fit of leadership happens within the area of maximum stimulation, challenge, and performance. This best fit occurs as the intersection of individual traits (e.g., vision, values, knowledge, competencies, interests); organizational environment (e.g., culture, structure, core competencies); and job demands (e.g., tasks, functions, roles). Hirsch and Strebler (1995) believed that skills, knowledge, experience, attributes and behavior were the basic competencies people need to effectively perform a task or function. They are always located within the context of job performance and an organizational environment.

With this frame of reference in mind, a summary of some categorizations of leadership competencies developed by different authors and organizations will be presented. It is important to note that it is not the objective to present the most accepted classifications or models of competencies, but to simply show some examples which will let perceive the amount of categorizations present in the field and the different variations stemming from them. In general terms, there are great coincidences with respect of competencies included in the different approaches; however, there are some contrasts in the way they are grouped and their particular emphasis.

Leadership Competencies Models

Generic models proposed by different authors will be presented first. Afterwards, some specific models used by different organizations and businesses including healthcare organizations also will be presented.

Generic models for leadership competencies. Adair (2005) examined various leadership perspectives, including the Qualities Approach, the Functional Approach, and the Situational Approach. He explains that the Functional Approach is when he makes more reference to what we address as competencies. He comments that the role of leaders is to help their followers to succeed at performing common tasks, create and maintain the synergy in the team, and develop individuals. To do this, activities must be carried out, including those related to (a) achieving the task (i.e., defining the task, planning, informing, controlling) and (b) building the team and developing the individual (i.e., evaluating, motivating, organizing and leading by example).

Adair (2005) established that for leaders must develop the following skills or competencies to comply with their roles and carry out their duties:

- Coordination and teamwork: ability to procure for people to work as a team towards a common goal.
- Decision making: capability to think clearly in order to solve problems and make timely decisions.
- Communication: capability to express ideas and opinions in a way others understand and also understand the ideas and opinions expressed by others.
- Self-management: capability to effectively manage time and personal organization.

The domains and competencies are defined as follows:

- Transformation. Visioning, energizing, and stimulating a change process that coalesces communities, patients, and professionals around new models of healthcare and wellness. The models include a achievement orientation, analytical thinking, community orientation, financial skills, information seeking, innovative thinking, and strategic orientation.
- Execution. Translating vision and strategy into optimal organizational performance. They include accountability, change leadership, collaboration, communication, impact and influence, information technology management, initiative, organizational awareness, performance measurement, process management, and organizational design and project management.
- People. Creating an organizational climate that values employees from all backgrounds and provides an energizing environment for them. This competency also includes the leader's responsibility to understand his or her impact on others and to improve his or her capabilities, as well as the capabilities of others. It includes competencies such as human resources management, interpersonal understanding, professionalism, relationship building, self-confidence, self-development, talent development, and team leadership.

Each one of the competencies in the model is represented in steps to describe how it emerges as positions or functions grow in scope, complexity, or sophistication. The steps are called competence levels. Each competence has from three to six performance levels.

Although this model has been used mostly in healthcare institutions, as with the case above, it does not offer special or distinctive characteristics from this sector and is applicable to any other type of business. The elements are basically the same. What changes is the scenario. Without doubt, the way to "operationalize" the different competencies will be different from business to business, always depending upon the nature of the products and services it offers.

Thus, from different angles and emphases, most of the approaches outlined address the same kinds of competencies. The HL competence model will be used as frame of reference for the following stages of the present study, given its comprehensive approach, internal consistency, and specificity.

III.   RESEARCH METHODOLOGY

This study sought to identify a leadership competency model for developing healthcare executives in India based on the HL Model. Given the unquestionable significance of counting on effective leaders in the hospital industry, it is a requirement to depend on solid competency models to guide the leadership development efforts in this sector. The research questions were as follows:

- Is there a leadership competencies model applicable to Indian private healthcare organizations?
- How do top leaders in Indian private healthcare organizations perceive their own performance?
- What kind of framework would be helpful to develop leadership capability required by top leaders in Indian private healthcare organizations?

Phase 1: Preparation

Instrument selection. In this section are described the reasons why the Health Leadership Competency Model was chosen as a basic framework. The model is an evidence-based and behaviorally focused approach for evaluating leadership skills across the professions, including health management, medicine, nursing, and across career stages. The Health Leadership Competency Model was developed from an extensive academic research and an implementation in hospital institutions and other kinds of organizations. During the initial stages of the model's development, interviews, psychometric analysis and comparative studies were carried out in different business sectors. Its implementation within the healthcare industry was based on additional reexamination of literature, good practice analysis, opinions from panels of experts, and pilot testing.

The model includes three general domains subdivided in 26 behavioral and technical competencies. Each competency is composed of behavioral indicators or levels to facilitate both development and evaluation, as individuals advance from their initial level to medium levels and advanced stages. The model allows the identification of leadership improvement opportunities in academic and practical scenarios. The Health Leadership Competency Model is substantiated in behavioral observation, in the investigation of several approaches and models, like those of Boyatzis (1998); Boyatzis, Cowen, and Kolb (1995); Spencer (1991); Spencer, McClelland, and Spencer (1994).

Subject selection. To discover the most relevant leadership competencies within the context of hospitals in India, several current leaders in the sector were interviewed. Participants had to be senior executives (i.e., CEO or CMOs) with a minimum experience of 2 years in the same or higher position. Six CEOs and five CMOs from private hospitals in the city of Kolkata, India, were interviewed in person in their own offices for approximately 60 minutes.

To protect the identities of those interviewed as well as the confidentiality of the information, no names were recorded for interviewees or institutions.

Phase 2: Data Collection

The interview was conducted in two sections: (a) competency scoring on importance and performance based on the HL Model and (b) open-ended questions.

Interviewees were asked to score each competency, using a scale from 1 (low) to 5 (high) for both importance and performance of the CEOs and CMOs. They were also asked to comment on the reasons behind the scores. The answers from interviewees were recorded and later transcribed, encoded, and organized. To make sure the competencies had the same meaning for interviewees, each competency was described in a card that was shown to them. It included a description of the competency with concrete examples to facilitate their understanding.

For the first part of the interviews, a specific script was followed:

The cards that I will present to you describe the competencies of a high performance leader. According to your experience, what's their relevance in order for a CEO and CMO of a hospital in India to be an effective leader? Observe in each card the description of the competency at issue and qualify both its importance as well as the average performance of leaders you know across the Indian healthcare industry broadly.

The second part of the interview was comprised of the following open-ended questions:

* After reviewing the HL leadership model competencies, do you think there are other additional competencies needed for the Indian context? Please name them.

* What are the main differences you find between a CEO/Top Management leader of a given company and a CEO/Top Management leader of a hospital?

* What was the specific formation and/or education that you received to become (CEO or CMO)?

* What experiences have helped you become a leader as a CEO or CMO?

* What suggestions can you make to help form/educate/train CEOs or CMOs as effective leaders for the healthcare industry?

* What are you doing to form/train your successor? What are you doing to strengthen the values, attitudes and competencies of your successor to develop him/her as an effective leader?

Phase 3: Analyzing the Data

For the first part of the interviews, the IPA method was used, originally developed by Martilla and James (1977). This method allows the evaluation of each item separately, in a double dimension: the value assigned by the interviewee and the actual reality that he or she perceives. Generally, results are plotted into a two-by-two matrix, in which the vertical axis represents importance and the horizontal axis represents performance, which gives place to four quadrants:

* Quadrant A: High importance/low performance. The items placed in this quadrant require immediate attention.

* Quadrant B: High importance/high performance. The items placed in this quadrant represent the main strengths which must be maintained and reinforced.

* Quadrant C: Low importance/low performance. The items placed in this quadrant represent weaknesses, although, given the fact that are not considered important, they are not priorities and do not require at the moment from additional efforts.

* Quadrant D: Low importance/high performance. The items placed in this quadrant represent efforts, in a certain way wasted or useless, since whatever is done in this regard does not add value.

The quadrants were configured in an asymmetric form in the specific case of this research. Another important reference consists in drawing a diagonal line, since it represents the maximum congruence possible between the importance assigned to a competency and the performance perceived in respect of the same competency.

For the second part of these interviews with the open-ended questions, the answers were recorded, encoded, grouped and analyzed in terms of frequencies and percentages.

Data were collected from two separate groups: CEOs and CMOs. Both types of leaders are considered the most influential in the healthcare industry and also share the same importance in the organization. However, due to their profiles and fundamental objectives, certain differences in their perceptions about the importance of the leadership competencies should be expected. CEOs are the responsible for the entire business but the CMOs are the responsible for everything that has to do with the patient's treatment and care.

Phase 4: Merging and Making Sense of the Data
Once the data were grouped and analyzed for frequencies, a matchmaking process was made between the data of the two parts to make sense of it. A search was made for correlations and patterns between them and the findings were used to design the model for helping actual top management and their successors develop the competencies they most need to be effective leaders in the healthcare industry.

IV. RESULTS
This study sought to identify a leadership competency model for developing healthcare executives in India based on the HL Model. First, the results of the importance-performance analysis are presented. General findings, CEO findings, CMO findings, and areas of CEO-CMO agreement are discussed. Next, the interview results are presented.

Importance-Performance Analysis Findings
General findings. The IPA helps find the gap between the competencies that are considered important and the performance perceived in those competencies by CEOs and CMOs. The action plans for improvement will reside in those competencies that have the highest importance together with the biggest gap. An overview of most important and least important are described here.

Twenty-two of the 26 competencies (84.61%) scored between 4 and 5 on a scale of 1 (low) to 5 (high). These results means the 22 competencies are considered very important to vital within the Indian healthcare industry context. Only four competencies (community orientation, information seeking, impact and influence, and organizational awareness) received an average score between 3 and 4, meaning desired to very important. None of the competencies received an importance score below 3.2.

It is worth noting that the 22 competencies considered between very important and vital have a performance below 4, which positions them in the deficit quadrant. The competencies on this quadrant demand special attention, as shown in Figure below. These competencies are very important, while simultaneously not reaching expected performance levels.


N = 11
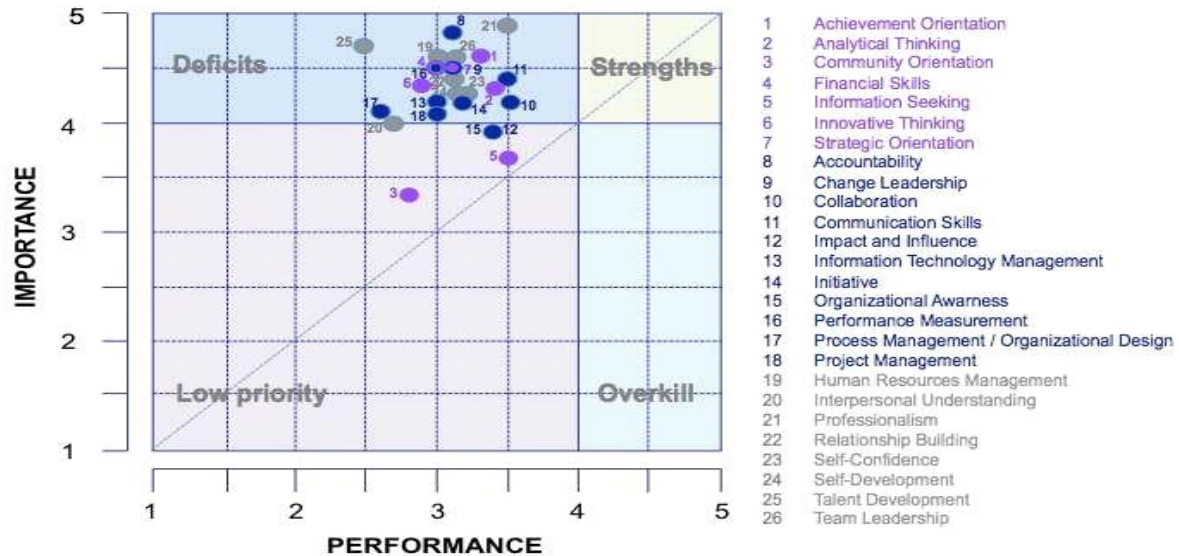
Top Leader Perceptions of Healthcare Leadership Competencies

The distance between the dot and the diagonal dotted line represents the gap between the scored importance and the perceived performance. The competencies with the greatest gaps are: talent development (gap = 2.18), accountability (gap = 1.73), and human resource management (gap = 1.64). The competency with the shortest gap between importance and performance is information seeking (gap = 0.27).

Since one of the purposes of this study consists in analyzing the degree of adaptation of the HL competencies model to the Indian context, it is particularly relevant to observe the importance assigned to each competency by the interviewees. The following figure shows teach competency in rank order by the importance followed by the corresponding levels of perceived performance.
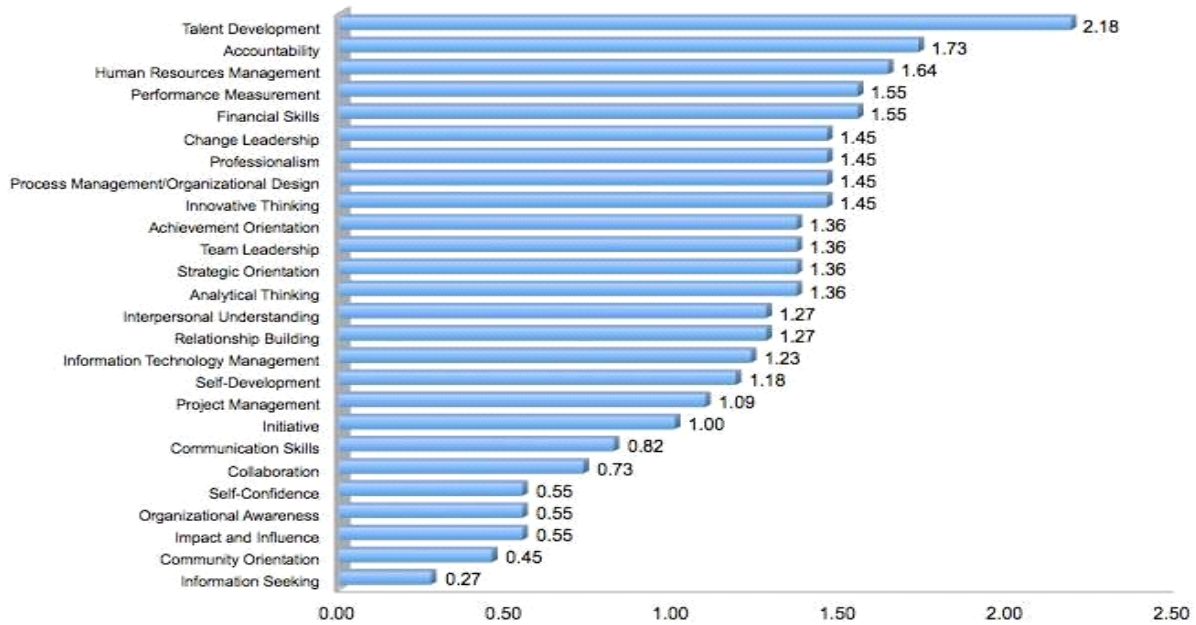

N = 11
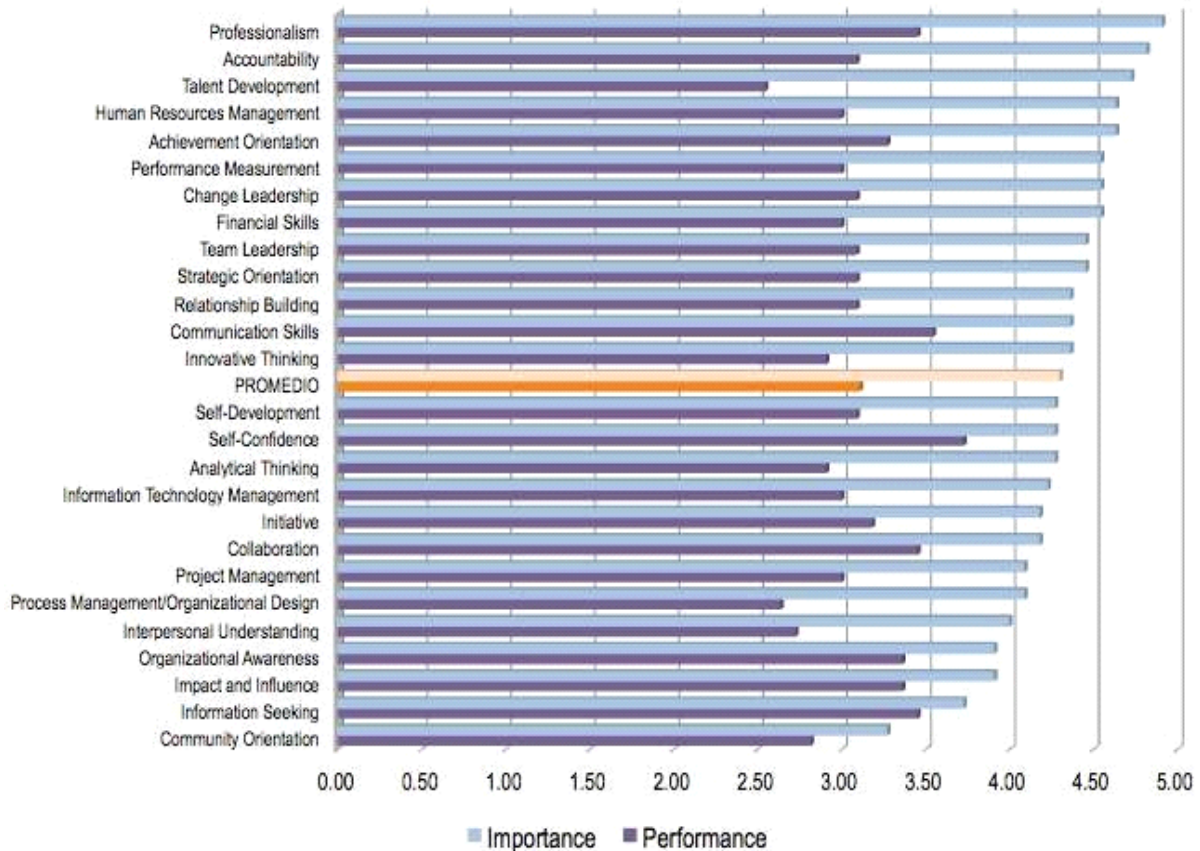
Top Leader Perceptions of Importance and Performance of the Healthcare Leadership Competencies

The competencies considered as the most important are professionalism (4.91), accountability (4.82), and talent development (4.70).Differences between importance and performance can be observed in following figure.

A way to interpret this differences is, for example, in the case of talent development, where a correspondence between perceived performance and scored importance of 54%, since its performance was graded as a 2.5 and importance with a 4.7 (2.5/4.7 = 0.54).

Differences between importance and performance and their respective percentage should be seen as complementary information, as they do not consider the overall context. For example, information seeking has been graded with an average of 3.7 for importance and 3.5 for performance, meaning they have a 93% correspondence between performance and importance. However this competency falls into the low priority quadrant.

Talent Development — 2.18
Accountability — 1.73
Human Resources Management — 1.64
Performance Measurement — 1.55
Financial Skills — 1.55
Change Leadership — 1.45
Professionalism — 1.45
Process Management/Organizational Design — 1.45
Innovative Thinking — 1.45
Achievement Orientation — 1.36
Team Leadership — 1.36
Strategic Orientation — 1.36
Analytical Thinking — 1.36
Interpersonal Understanding — 1.27
Relationship Building — 1.27
Information Technology Management — 1.23
Self-Development — 1.18
Project Management — 1.09
Initiative — 1.00
Communication Skills — 0.82
Collaboration — 0.73
Self-Confidence — 0.55
Organizational Awareness — 0.55
Impact and Influence — 0.55
Community Orientation — 0.45
Information Seeking — 0.27

N = 11

Top Leader Perceptions of Differences between Importance and Performance for Healthcare Leadership Competencies

As following figure shows, no significant differences appeared in the scores that the interviewees gave to each of the three groups of competencies of the HL Model of Transformation, Execution, and People.

1 **Transformation Competencies**
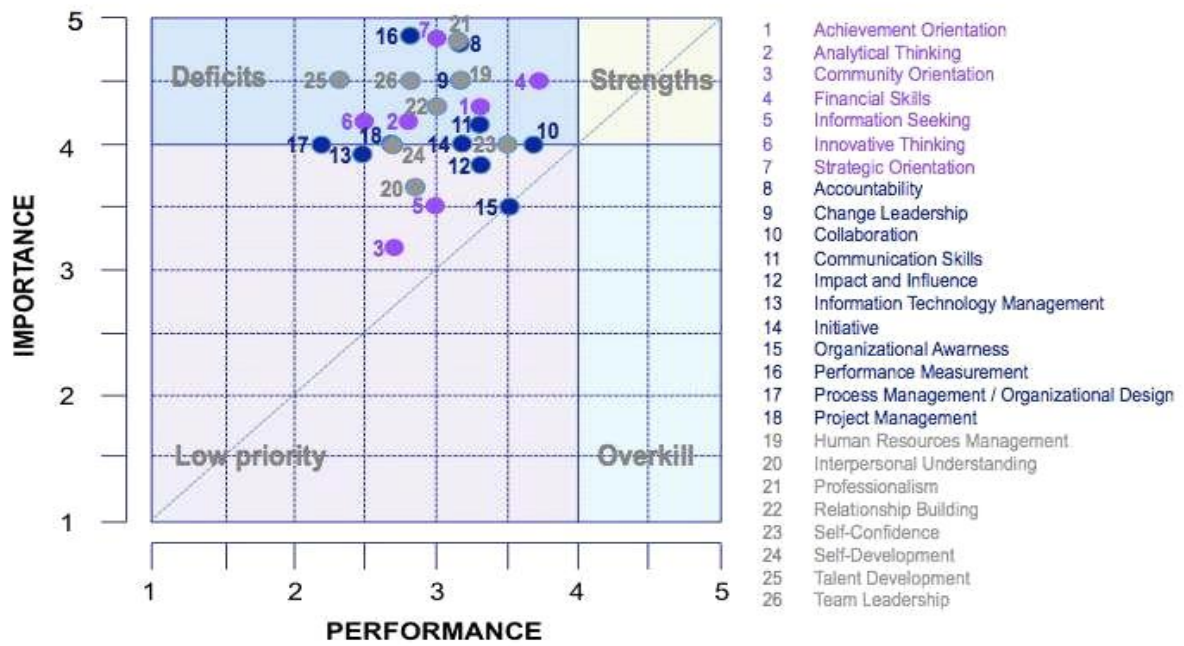2 **Execution Competencies**
3 People Competencies
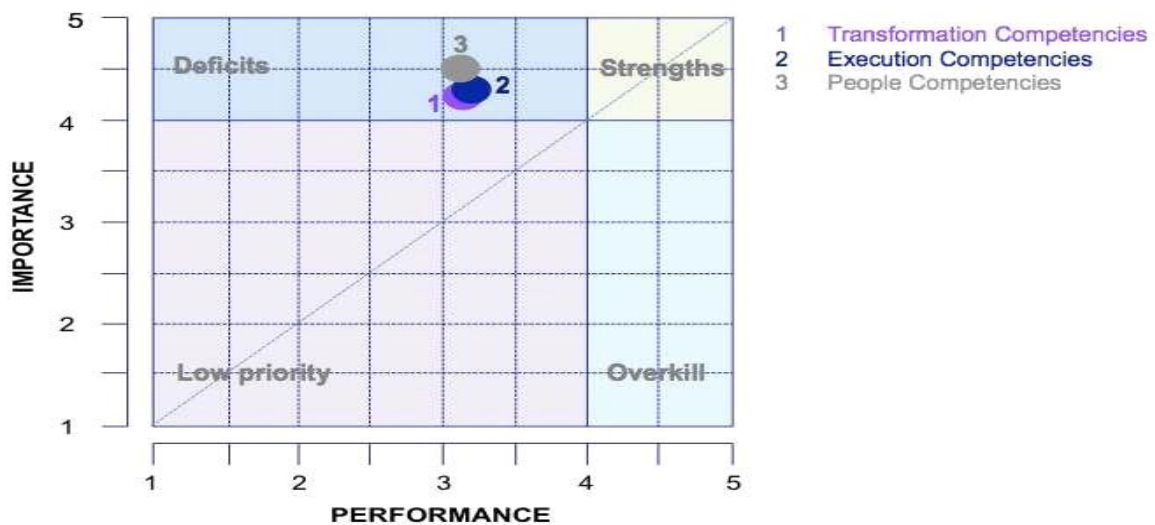
N = 11

Top Management Perception for Healthcare Leadership Competency Groups

The average scores for importance and performance regarding the three groups of competencies are located within the deficit quadrant, which means that the three groups are considered between very important and vital and have a performance that is rated between regular and good.

Chief executive officer results. Considering that based on only the six CEOs' answers, 20 out of the 26 leadership competencies of the HL Model (76.92%) are considered between very important and vital. Moreover, in all of these, the performance is closer to regular than to good, thus, locating them in the deficit quadrant (see following figure).

The six competencies that are below the very important level are community orientation, information seeking, impact and influence, information technology management, organizational awareness and interpersonal understanding.

N = 6

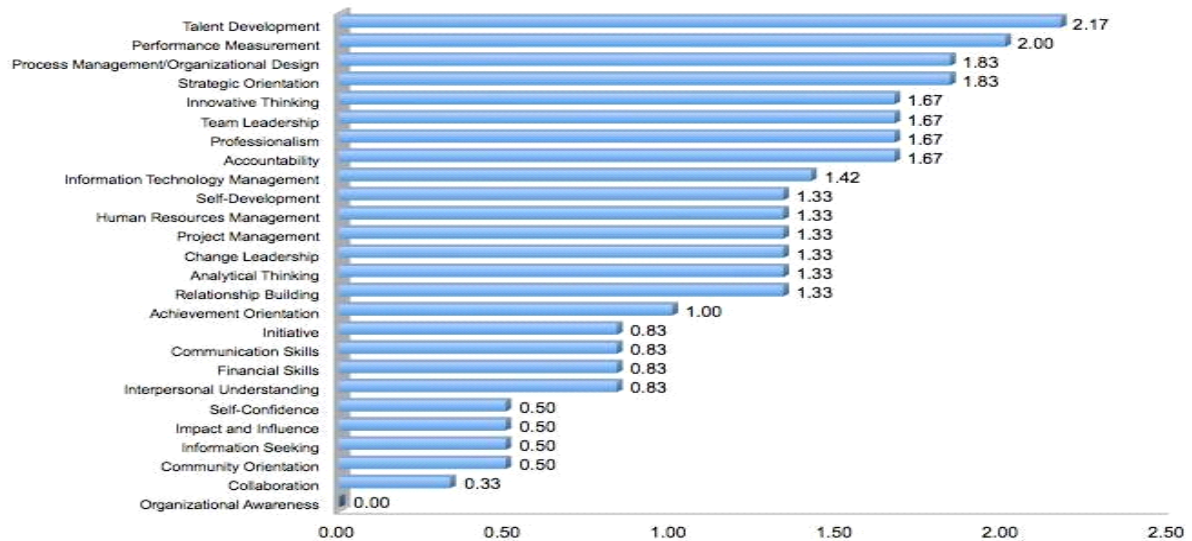**Chief Executive Officer Perceptions for Healthcare Leadership Competencies**

Leadership competencies that are considered as the most important by CEOs are: performance measurement, strategic orientation, professionalism, and accountability, with an average score of 4.83. Following figure shows the order of importance for all of the leadership competencies pictured in the HL Model with its corresponding perceived performance.
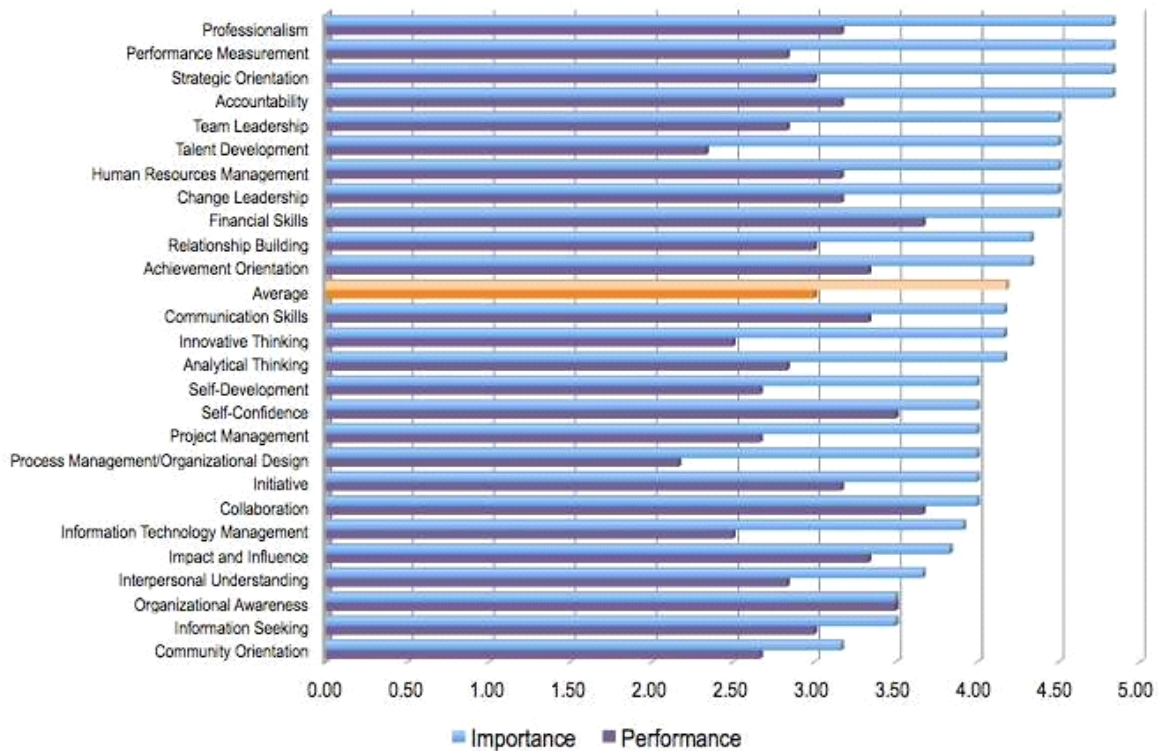
N = 6

**Chief Executive Officer Perceptions of Importance and Performance for Healthcare Leadership
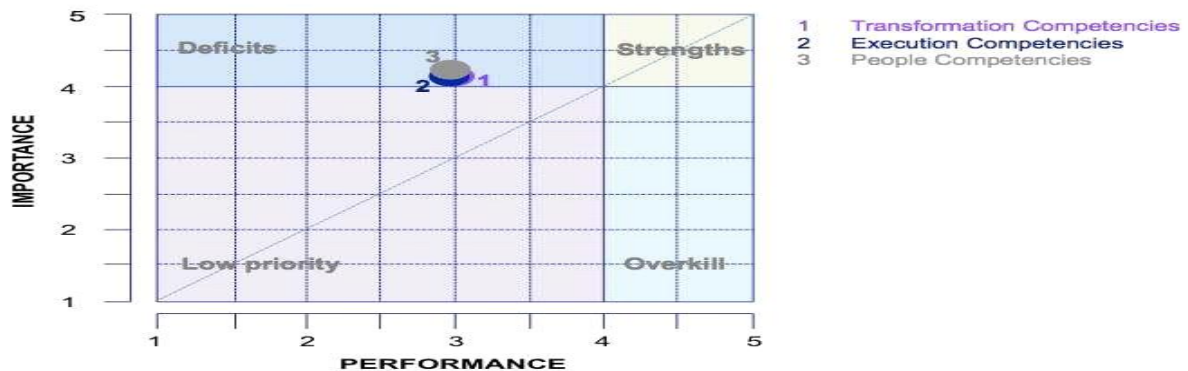Competencies**

Next figure shows the difference between the scored importance and the perceived performance of the interviewed CEOs. As it may be noticed, the competencies that have the greatest gap between scored importance and perceived performance are talent development, performance measurement, process management and organizational design, and strategic orientation.

N = 6

Chief Executive Officer Perceptions of Differences between Importance and Performance on the Healthcare Leadership Competencies

From the CEOs' point of view, there are no significant differences between the three leadership competencies pictured in the HL Model (see following figure). The three competency groups of Transformation, Execution, and People are considered on average, as very important and have a regular performance, thus locating these competencies in the deficit quadrant.


N = 6

Chief Executive Officer Perceptions for Healthcare Leadership Competency Groups

Chief medical officer results. Based on data from the five CMOs, 25 of the 26 leadership competencies pictured in the HL Model are very important to vital. It is worth noting that 23 of the competencies considered between very important and vital have a performance close to regular, thus locating them in the deficit quadrant. In contrast to the CEOs' perceptions, the CMOs believe that two competencies are located in the Strengths quadrant: self-confidence and information seeking (See red circles in Figure). Just one competency is considered desired, which means a level lower than very important: community orientation.

Chief Medical Officer Perceptions for Healthcare Leadership Competencies

Leadership competencies that are considered most important for CMOs are: talent development, professionalism and achievement orientation, with an average score of 5.

Following figure shows the order of scored importance to all the HL Competencies Model, with its correspondent level of perceived performance.
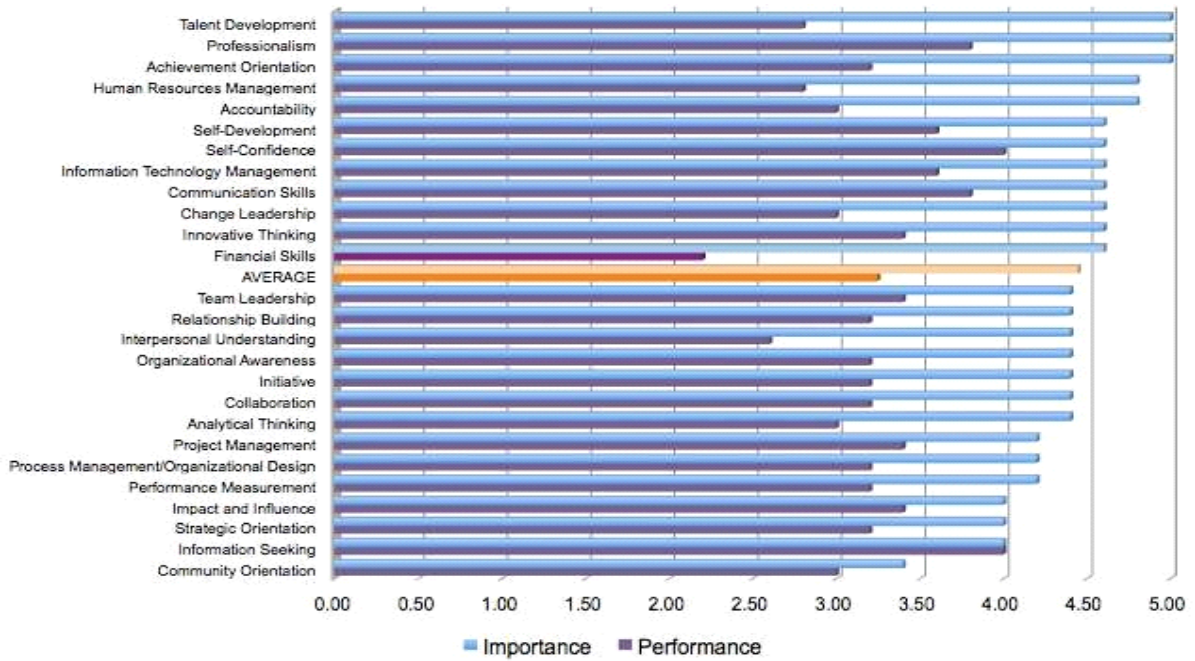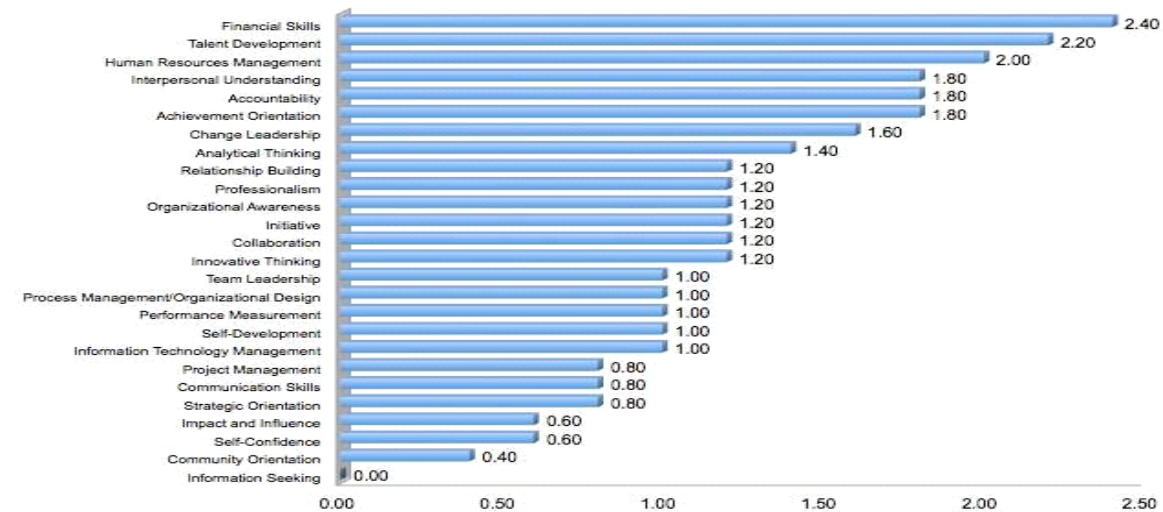
N = 5

Chief Medical Officer Perceptions of Importance and Performance for Healthcare Leadership Competencies

Next figure shows the difference between the scored importance and perceived performance of interviewed CMOs. As it can be observed, the competencies that have the greatest gap between scored importance and perceived performance are: financial skills, talent development, and human resources management.

N = 5

Chief Medical Officer Perceptions of Differences between Importance and Performance for Healthcare Leadership Competencies

Small differences were produced between the three groups of competencies; however, from the CMOs' perspective, they are not significant, as the three competency groups (Transformation, Execution, and People) are considered on average very important and have a regular performance (see next figure). These results mean the three groups are plotted in the deficit quadrant. However, it is worth noting that competencies such as people, on average, are considered the most important.
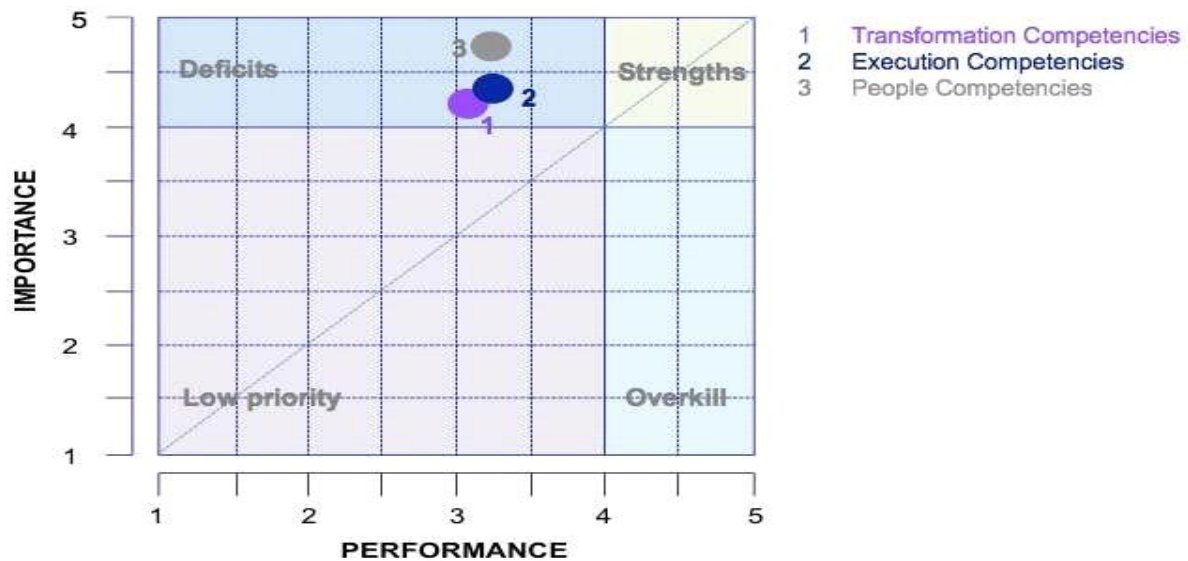
N = 5
Chief Medical Officer Perceptions for Healthcare Leadership Competency Groups

       Areas of agreement between chief executive officers and chief medical officers. Only in the case of professionalism do CMOs and CEOs concur by scoring the competencies as one of the three most important; however, in general, there exists a high level of coincidence with respect of the importance assigned to all competencies.

Regarding the gaps, the only area of CEO-CMO agreement is talent development. Both groups agree that one of the greatest gaps between scored importance and perceived performance appears in this competence.

Interview Results
       Interviewees were asked six questions to gather additional data about needed leadership competencies within the context of private hospitals in India. This section presents the interview data and differentiates the CEOs' and CMOs' perspective.

       Additional competencies needed. Participants were asked, "After reviewing the HL leadership model competencies, do you think there are other additional competencies needed for the Indian context? Please name them."

Five out of six CEOs affirm that Business Acumen is fundamental and vital.

Business acumen referred to knowledge of the business and its environment, context, or government and norms characteristic of the industry and the market. This competency by itself is not included in the HL Model; however, it may be considered as part of strategic orientation, because its description contains the following similar points: (a) conducts environmental scanning, b) develops strategy to address environmental forces,c)aligns organization to address long-term environment, and (d) shapes industry strategy.

       Other competencies that are not explicitly included in the HL Model and are considered very important to the CEOs are: stress management; conflict management; feedback; empathy; personal management; quality orientation; uncertainty management; and, especially, decision making. They repeatedly referenced decision making directly or indirectly throughout the interviews, stating that the CEO is fundamentally a decision maker.

       The CEOs also mentioned other competencies including relationship building (i.e., with medical staff and outside doctors), ethical performance, and network building.

These competencies were included in the HL Model under terms such as relationship building and professionalism.

       CMOs added other competencies such as empowerment, ownership, self- knowledge, synthesis capacity, resistance or perseverance, resiliency, and negotiation. CMOs also mentioned competencies that were included in the HL Model, such as the capacity to motivate and develop other people (talent development), self-esteem and belief in oneself (self-confidence), and financial skills. Some CMOs mentioned values or personal traits such as humility, which is not actually a competency, but rather manifests itself through specific competencies such as active listening and continuous learning.

CMOs agreed with the CEOs that there is a lack of competencies such as busines acumen, decision making and conflict management.

In summary, most CEOs and CMOs agreed that the HL Model contains the most relevant competencies for a top level leader in the healthcare industry; however, they added some competencies that are valuable and are not contemplated explicitly in the presented HL Model. The competencies list might be endless, making its implementation as a leadership model impossible. It seems important not to configure an exhaustive model of competencies but a general reference framework that each organization can complement and clearly align it to its mission, vision, values and beliefs.

Unique features of hospital chief executive officers. Participants were asked, "What are the main differences you find between a CEO/Top leader of a given company and a CEO/Top leader of a hospital?"

All of the CEOs focused on the particular attributes of the healthcare organizations. They agreed that by stating that healthcare institutions are highly complex organizations due to a series of factors: (a) they should have a continuous 24/7 operation without holidays, nonstop; (b) they service a wide variety of clients, including patients, family members, doctors, researchers, students, and insurance companies; (c) they are highly unpredictable, as a high percentage of their operation is based on emergencies; and (d) repeated operation errors translate into loss of life and health. CEOs additionally mentioned that in this set, top leaders must develop certain competencies that allow them to handle the described complexity successfully. The principal competencies they referenced directly or indirectly were complexity recognition and management, systemic thinking, quick decision making, high uncertainty and stress management, resiliency, effective delegation and empowerment.

CMOs mentioned characteristics that distinguished healthcare organizations as complex, such as managing people while they are in a vulnerable situation, the social impact that they have, and/or the great challenge of making a profit while having a humanitarian sense. In this context, the CMOs mentioned that for the top leaders of healthcare organizations, there are certain competencies that are more critical than for the leaders in other industries. These competencies include systemic thinking, complexity recognition and management, capacity to manage highly vulnerable persons, empathy and warmth in relationships, and making a profit ethically with a humanitarian sense at the same time. Both CEOs and CMOs affirm that healthcare organizations are more complex than most organizations.

Education received. Participants also were asked, "What was the specific formation and/or education that you received to become (CEO / CMO)?" From the six interviewed CEOs, two are doctors, two are engineers, one is an economist, and one is a public accountant. In addition to their professional qualification, all of them have master's degrees, business administration seminars, and masters in healthcare systems administration. However, they unanimously recognize that they have not received a proper education to be a CEO, and much less to be leaders.

They admitted that what has most helped them become CMOs and leaders is workplace experience that enabled them to learn by doing. They recognize the importance of the master's degrees and seminars; however, they view them as complementary rather than as a substitute for experience. Similarly, one can deduce from the CEOs' answers that their formation as leaders has been thanks to certain personal qualities and personal development experiences rather than to the existence of an institutional strategy that promotes it.

The two medical CEOs affirmed that it is crucial to be a doctor and have passed through several medical middle management positions to really know and understand the internal movement of a hospital, with a fresh view, free from "contamination" from other practices. The six CEOs agree that it is fundamental to deeply know and have a wide experience in hospital operations. One interviewee commented that a factor or condition that is necessary to become a leader is being successful in his or her own medical specialty, as this generates credibility and status, which are needed to be respected in the medical community, and followed by others.

One of the interviewees addressed in his answer whether leaders are born or made. He commented that leadership is part of the essence of certain persons and that formal training is only complementary. Both the CEOs and CMOs agree that they have formed themselves thanks to their experience and proven track record in the various positions they have held within the organization.

In summary, the participants commented that the master's degrees and seminars are good for strengthening their foundation and ordering their ideas; however, educational experiences were not considered to be determining factors in their formation as leaders. All the participants described themselves as self-taught in their leadership and a few of them mentioned the importance of observing and learning from internal and external models.

Developmental experiences. Participants then were asked, "What experiences have helped you become a leader as a CEO/CMO?" The CEOs' responses reinforced their answers to the previous question. They agreed that affirming their general experience in the job has been critical, particularly as it concerned exposure to multiple decision-making situations. They also mentioned the importance of frequent interaction with various persons and institutions, such as doctors, patients, suppliers, and insurance companies.

A couple of interviewees talked explicitly about the importance of being near their immediate boss to enable them to observe how he or she performs in different situations and to receive specific coaching. Others mentioned that professionalism and accountability translate into recognition, prestige, and credibility.

One CMO specifically underscored the importance of personal discovery, meaning finding and developing one's talents. He also emphasized the need to reflect systematically about one's own conduct and to identify one's successes and development opportunities. Finally, he stated that developing as a leader requires keen listening and knowing how to ask the right questions.

Both the CEOs and the CMOs mentioned the importance of the interaction with people, in both formal and informal situations. They also agreed that accepting and solving challenges and executing projects successfully were fundamental to effective leadership.

Suggestions for training. Participants were asked, "What suggestions can you make to help form/educate/train CEOs/CMOs as effective leaders for the Healthcare Industry?" The CEOs unanimously recommended that the candidates develop deeper knowledge and understanding of the healthcare environment and norms and that they experience the different problems facing a healthcare organization. Other recommendations were to (a) define what kind of leader is required for the size, characteristics, and circumstances of one's institution; (b) develop a systematic, context- based training module; (c) learn global best practices regarding organization norms and clinical issues; (d) help potential successors gain more international exposure, mainly through work practices and experiences in other countries; and (e) strengthen values formation.

Similarly, CMOs recommended that leaders strengthen their values and their knowledge of the industry, healthcare environment and norms. They stressed the importance of CMOs systematically completing a series of positions to develop as leaders, starting with front-line posts, progressing through various middle management medical posts, and culminating in executive-level positions. One specific recommendation offered was to encourage the development of transformational leadership versus transactional leadership (Bass, 1990). Transactional leaders pursue a cost/benefit-based economic exchange to meet subordinates' current material and psychic needs in return for their contracted services. Transformational leaders go further by seeking to arouse and satisfy the higher-order needs of employees. The aim of such leadership is to engage the follower's full self and support self-esteem and self- actualization, consistent with Maslow's hierarchy of needs (as cited in Bass, 1990).

Additional recommendations were to assign specific challenging projects to candidates, develop business sense, and professionalize the CMO post.

Developing successors. Participants were asked, "What are you doing to form/train your successor? What are you doing to strengthen the values, attitudes and competencies of your successor to develop him/her as an effective leader?" Findings revealed that just of the CEOs is forming his successor by making him be practically beside him so that he observes the strategy and the decision making process, and so the CEO can offer coaching to help him to relate properly with the medical staff. One of the CEOs stated that institutionally, they have clearly identified the desired profile of the successor and that they are now looking for him or her. This CEO did not mention what the hospital is actually doing to develop a specific successor. Another CEO mentioned that reaching the CEO post requires climbing through the organization rather than developing specific competencies. The remaining CEOs acknowledged the importance of forming successors; however, they limited themselves to talking about theoretical concepts such as talent identification, higher direct interaction with candidates, identification of opportunity areas, coaching, and the involvement of them in challenging projects and complex decision making situations.

CMOs discussed ideas and concepts regarding the formation of successors; however, they offered no specific and concrete actions they were actually doing for this purpose. An exception was that one of the interviewees affirmed having identified his successor and having substantial interaction with him, empowering him, exposing him to complex situations, and giving him regular coaching.

In summary, although the participants voiced good intentions and ideas, no systematic successor development process was detected.

Summary

Summarized IPA and interview results are as follows:

- HL Model competencies are well suited for the Indian private healthcare organizations' context, as 86.61% of the competencies are considered by the interviewees between very important and vital. The rest of the competencies, which add up to the 15.39%, are considered between desired and very important.

- Survey results suggested that CMOs see more room for improvement than the CEOs. Whereas 96.15% of CMOs rated the competencies as either very important or vital, CEOs rated only 76.92% of the competencies in the same range.

- In all competencies considered in the questionnaire as very important by CEOs and CMOs, a performance deficit was noted for each, meaning there is plenty of space for development. The top-ranked disparities found were talent development (gap = 46%), accountability (gap = 36%), process management and organizational design (gap = 36%), human resources management (gap = 35%), and performance measurement (gap = 34%).

- Leadership competencies considered most important by CEOs were performance measurement, strategic orientation, professionalism, and accountability (mean score = 4.83). Competencies with the greatest gap between scored importance and perceived performance were talent development, performance measurement, process management and organizational design and strategic orientation.

- Leadership competencies considered most important for CMOs were talent development, professionalism and achievement orientation (mean score = 5). Competencies with the greatest gap between scored importance and perceived performance were financial skills, talent development, and human resources management

- The interview data suggested that the CEOs and CMOs consider most of the competencies very relevant; however, they identified additional critical competencies, including business acumen, decision making, conflict management, constructive feedback, stress management, empathy, personal administration, quality orientation, uncertainty management, empowerment, ownership, self knowledge , synthesis capacity, perseverance, resiliency, and effective negotiation.

Summary, Conclusions and Recommendations

This study sought to identify a leadership competency model for developing healthcare executives in India based on the HL Model. Three research questions were examined:
- Is there a leadership competencies model applicable to Indian private healthcare organizations?

- How do top leaders in Indian private healthcare organizations perceive their own performance?

- What kind of framework would be helpful to develop leadership capability required by top leaders in Indian private healthcare organizations?

A summary of findings is presented first, followed by conclusions and recommendations for CEOs, CMOs, and organizational development practitioners. Limitations of the study and suggestions for future research also are described.

Summary of Findings

- A total of 86.61% of the leadership competencies identified in the HL Model are considered by the CMOs and CEOs as very important or vital. The most important were professionalism (4.91), accountability (4.82), talent development (4.73) human resources management (4.64), and achievement orientation (4.64).

- There is a gap in performance regarding all the HL leadership competencies. The most important areas of opportunity (mean score = with an average of 3.11) are: talent development, accountability, human resources management, performance measurement, and financial skills.

- In addition to the competencies included in the HL model, the interviewees considered as relevant for the

Indian context additional competencies such as: business acumen, decision making, stress management, conflict management, feedback, empathy, personal organization, quality orientation, empowerment, ownership, self-knowledge, perseverance, resiliency, negotiation, and uncertainty management.

- The interviewees had at least one of the following: Master's in Business Administration, Master's in Hospital Administration, and top management seminars and courses. However, none of them have received specific formation to perform as leaders. They believed their leadership competencies have been developed through their years of experience at work.

- Both CEOs and CMOs emphasized that forming their successors and strengthening their leadership competencies is of utmost importance; however, actually they don't have concrete strategies that meet that purpose.

V.   Conclusions
From the findings described above, it is possible to extract several conclusions.

These are described in the following sections.

Is there a leadership competencies model applicable to Indian private healthcare organizations?
With no doubt, there are models such as the HL Model that are good referential frames for identifying the competencies required by top leaders in the Indian healthcare industry. Different organizations, however, will most likely wish to discover their own respective "best leadership competencies model," depending on their context and purpose. The value of a model like this does not lay in its universality, but in its power to inspire.

The HL model, in particular, has the virtue of being tested in a large amount of healthcare organizations and has demonstrated its value. In this sense, it may be considered a "best practice" in the leadership competencies classification for serving as a good framework to orient the institutional efforts for leadership development.

How do top leaders in Indian private healthcare organizations perceive their own performance?
According to the IPA, all the competencies considered in this study are in the deficiency quadrant. This is because the performance of other colleagues in the same leadership position was perceived as lower than the level of importance assigned by the interviewees and hence represent areas of opportunity. This aligns with perceptions of leadership competencies among CEOs and CMOs of the Indian private healthcare industry. Being conscious of the gaps and accepting them can provide a premise for change to close the gaps between the current situation and the desired one.

What kind of framework would be helpful to develop leadership capability required by top leaders in Indian private healthcare organizations?
McAlearney (2008) asserts based on her studies that leadership development programs have a positive impact in the quality and efficiency of the healthcare industry through giving more strength to the workforce, promoting efficiency in organizational education and in the development activities, reducing turnover and related costs, and focusing organizational attention in specific strategic priorities. McAlearney (2010) later concluded that the executive leadership development programs are viewed by the healthcare executives as important tools to strengthen the healthcare system's strategic objectives, elaborate succession plans and offer development opportunities, and that it is worth to invest in them.

Groves (2011) discovered based on research from 15 nationwide healthcare administration systems in the United States hat exemplary healthcare organizations use a talent administration system composes of six factors and their corresponding success factors. These factors are:
- Establishing the business case for talent management. This phase's success depends on the right identification of the strategic priorities, the characteristics of the workforce, and the diversity of their initiatives.
- Defining high-potential healthcare leaders. Success in this phase depends mainly in the clarification of leadership competencies in the context of the organization's business strategy.
- Identifying and codifying high-potential leaders. Success in this phase depends mostly on the tools for classifying high-potential leaders as well as the evaluation process.
- Communicating high-potential designations. In this phase it is important to emphasize the importance of the continuous development and strengthening of key leadership competencies while preventing the status associated to titles getting in the way.
- Developing high-potential leaders. The key of this phase is offering high- potential leaders experiential learning opportunities, balancing them with their own needs.

- Evaluating and embedding talent management practices. Consists in developing the metrics for evaluating the effectiveness of the talent management system.

The Corporate Leadership Council (2003), an international organization that gives support to more than 16,000 leaders, from more than 6,000 organizations across 60 countries, has done a large number of studies about leadership as a topic and has accumulated a vast experience about leadership development plans. In its paper "Highlights of Effective Leadership Programs," the organization identifies the main success factors in the leader development plans. These success factors can be incorporated into a good general framework for CEOs and CMOs and are:

- Define the required leadership profiles. Analyze the organization's needs with precision for determining the most important skills and attributes for an effective leadership.
- Clarify the organization's purposes and desired outcomes. Gaining clarity about the organization's purpose is necessary with respect to leader development to allow for objective evaluation of the effectiveness of the training activities.
- Adapt the development opportunities to the leaders' needs. Maximize the development impact by creating a specific plan for each leader, offering them development activities with the highest return adapting experience, and programs and opportunities to the important gaps in the competencies for each leader and the organization's.
- Ensure top leadership support. Every effective leadership development program must have the complete support of the senior-level managers. Furthermore, leader development is most effective when senior executives participate also as instructors.
- Link competencies to results. Competencies make sense to participants if they can clearly see the relationship between a competency and the desired results in the organization.
- Visualize future leadership needs. It is important to take into account probable changes in the mix of leadership skills for the long run and manage proactively the development of leadership potential in every levels of the organization.
- Create a continuous improvement and development culture. Use organizational resources to support and strengthen the impact of leadership development program "beyond the classroom."
- Place leadership development within the specific organization's context. Programs should develop individuals in accordance to the nature of the organization, having in mind its culture, norms, values, work processes, and services.
- Build results scorecards. Scorecards can motivate individuals to focus and perform with intensity. Without scorecards, a leadership development activity can be an enjoyable exercise; however, neither the executives nor the organization can expect much result without its measures.
- Ensure managers' responsibility on leadership development. Provide managers the tools and incentives they need to accelerate leaders' development.

VI.   Recommendations

For chief executive officers and chief medical officers. CEOs and CMOs are the right people within the organization to promote the design and implementation of coordinated and systematic leader development plans. Importantly, CEOs and CMOs do not need to design of the leadership development plans, as this requires a high degree of specialization and dedication and competes with their other important tasks. However, it is very important that they ensure that the institutional leader development plans are strategically oriented and that they take advantage of the learning and best practices regarding this topic. Although organization development and human resources personnel can implement, the plans need to come from and be promoted by the top leaders.

For organization development practitioners. Organization development practitioner should study, compare, and select an appropriate leadership development model for the organization, having in mind the best practices as described. Next, this leadership development model chosen for the organization must be adapted to the specific needs and circumstances of the organization.

Limitations of the Study

The results of this study represent the particular perception of a small group of top leaders regarding the importance and performance of certain leadership competencies for CEOs and CMOs within the Indian private healthcare organizations. These results are not to be generalized to the whole healthcare system in India for several reasons.

First, a statistical formula was not used to determine the size of the sample of interviewees regarding the total population of top leaders of Indian private healthcare organizations (CEOs and CMOs). What was used is the criteria of availability and accessibility for the interviews.

Second, using these criteria, a random selection of the sample was not possible. Interviewees were chosen from a list of available candidates.

Third, the importance and performance evaluation of the leadership competencies was completely subjective. In case of importance, it does not represent a problem because the objective was to understand the interviewee's perspective regarding the importance of each competency. However, in the case of performance, the interviewees were not evaluating a specific subject but the average of their known CEOs or CMOs.

Fourth, organization development practitioners should be aware that this general strategy for leaders development in the Indian healthcare industry is a theoretical elaboration and it lacks the experimental research to confirm it.

VII.   Suggestions for Future Research

A leader development strategy for the Indian private healthcare industry has been proposed in this section, based on the findings of prior studies of best practices on leadership development. However, this particular strategy is still a theoretical elaboration whose validity only can be evaluated by the reality itself.

For this reason, the following step should be a "pilot" application of this leader development strategy in a Indian private healthcare organization. This would allow for validation on the strategy and corresponding adjustments. Afterwards, it could be offered to other institutions for its application, sharing results and impacts for further configuring a truly basic strategy that is applicable to the Indian reality.

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