



GLOBAL LEADERSHIP FORECAST 2008 | 2009

HEALTH CARE HIGHLIGHTS

> Ann Howard, Ph.D. > Richard S. Wellins, Ph.D.

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A Welcome from DDI

We are pleased to present this profile of the current status of leadership and leadership development within the United States health care community. This report grew out of a larger study, the *Global Leadership Forecast 2008|2009*, the fifth in DDI's research series on global leadership issues and practices. The results presented here compare and contrast the responses from HR professionals and organizational leaders in health care with their counterparts in other U.S. industries.

Here are some of the reasons why this study is so relevant and timely:

- Nearly 1,400 associates from health care organizations participated and were compared to more than 2,400 leaders and HR professionals from other U.S. industries. The health care study is comprehensive.
- We often hear that health care is different. You'll see some of those differences in the data. The business priorities in health care are different from those in other industries. The most respected leadership competencies are different in health care. There are significant variations that provide opportunity for interpretation and change.

- Finally, there are some striking similarities between the *Health Care Highlights* and the *Global Leadership Forecast*. An example of this is the level of confidence that HR professionals have in senior leaders in health care or in other industries.

The current *Global Leadership Forecast* and this report address several issues in addition to the state of leadership today. Both consider what's working and what's not in developing tomorrow's leaders. They also look at how organizations build their leadership pipeline and plan for successions.

Although no single approach to leadership development is right for every organization, DDI believes there are sound practices that work in most situations. I am confident that this report will offer you new ideas and insights into leadership development. Hopefully, it will also stimulate your own ideas about ways that you can significantly enhance the capabilities of leaders in your health care organization.

I welcome your insights and reactions and look forward to discussing the research with you.

Debra D. Walker

Debra D. Walker, Vice President, Health Care

ABOUT DDI



In today's grow-or-die marketplace, having the right talent strategy is crucial for an organization's success.

Development Dimensions International will help you systematically and creatively close the gap between today's talent capability and the people you will need to successfully execute tomorrow's business strategy.

We excel in:

- **Competency models** that are linked directly to your business strategies.
- **Screening and assessment**, enabling you to hire the right people with a full range of validated tests and assessments.
- **Behavior-based interviewing**, helping hiring managers and recruiters make accurate hiring decisions.
- **Performance management** to foster individual accountability and superior execution of your strategic priorities.
- **Succession management** expertise and assessment systems to help you make critical placement and promotion decisions.
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DDI has precisely the kind of resources needed to implement your talent initiatives effectively and consistently throughout your organization.

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DDI TREND RESEARCH

Global Leadership Forecast 2008|2009 is part of the continuing series of trend research by DDI's Center for Applied Behavioral Research (CABER).

In alternate years our research has focused on recruiting and selecting talent as reported in the *Selection Forecast*. CABER also investigates special topics around optimizing human talent in the workplace.

Executive summaries of research reports are available at www.ddiworld.com. To order full reports, call DDI Client Service at 1-800-944-7782 (U.S.) or 1-724-746-3900 (outside the U.S.).

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SYMBOLS USED IN THIS REPORT



Reported by Human Resource (HR) Professionals



Reported by Leaders



Key Finding

STUDY PARTICIPANTS

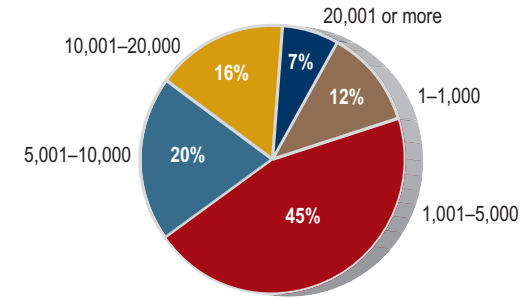
This report is based on survey responses from human resource professionals and leaders in U.S. health care organizations. An HR professional completed a survey for each organization or major organizational business unit. The HR professionals then invited representative samples of their organization’s leaders to complete leader surveys. The health care respondents are compared in this report to HR professionals and leaders in other U.S. industries who responded to the *Global Leadership Forecast* (see **Table 1**).

TABLE 1 Sample Size

	Health Care	Others
HR Professionals	82	384
Leaders	1,297	2,061
TOTAL	1,379	2,445

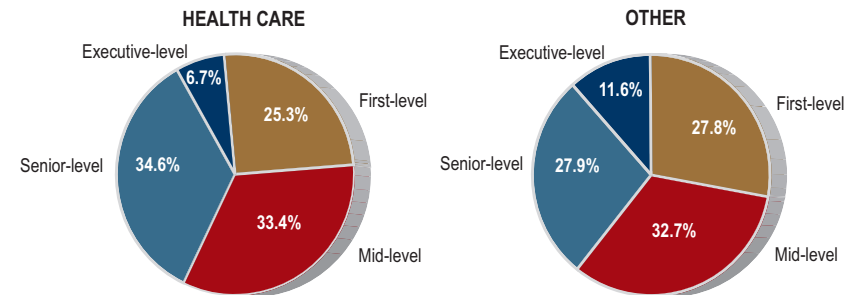
Almost half the health care organizations had 1,001 to 5,000 employees (see **Figure 1**). A handful of health care organizations (5 percent) were multinational (i.e., they owned, operated, or had affiliate offices in multiple countries).

FIGURE 1 Organization Size



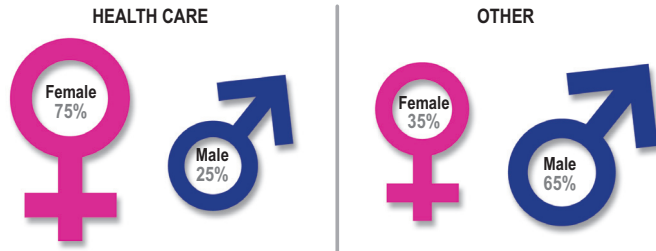
Leaders were distributed similarly among first-level, mid-level, and higher-level positions for both health care and other organizations. However, the higher-level leaders in health care were more likely to be in senior rather than executive positions (see **Figure 2**). This might be because a rather small group typically formulates strategy in health care organizations.

FIGURE 2 Management Level of Leaders



A much more significant difference was that health care leaders were overwhelmingly female, whereas leaders in other organizations were predominantly male (see **Figure 3**).

FIGURE 3 Gender of Leaders



Additional information about the health care organizations and leaders is in the demographics section of this report.

LEADERSHIP TODAY

Business Priorities

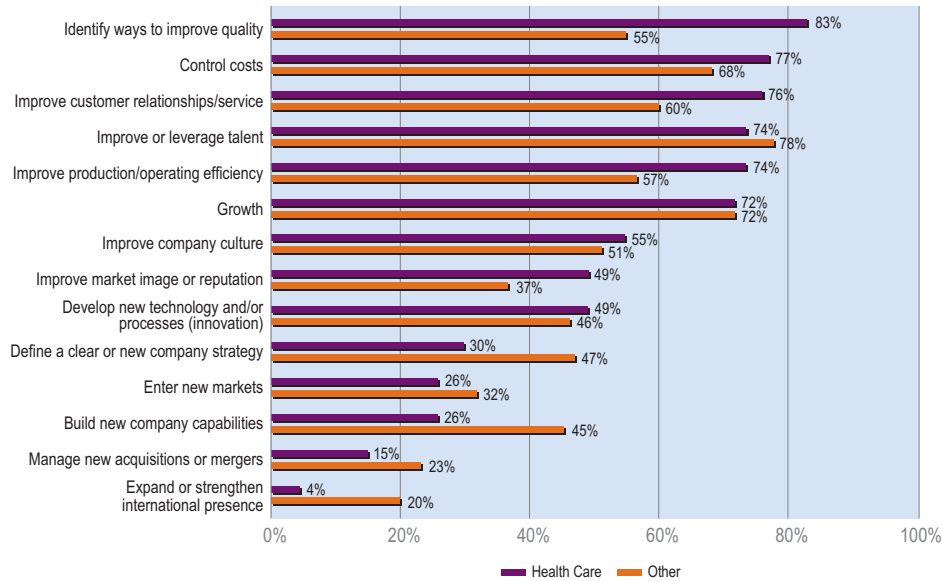
Leaders were asked to identify the most important business priorities for their particular organization; they could check any of the items that applied. We focused on the perspectives of executives, whose thinking best represents where their organizations are headed. **Figure 4** lists the items from highest to lowest priority according to the health care executives.

Health care's top priorities were quality, costs, and customer relationships.

With all constituencies pressuring health care to improve quality, it should come as no surprise that health care executives saw quality as their top priority. Hospitals are being pushed from all sides to control costs: by savvy patients and their families, who expect safe, effective, and affordable care; by the federal government, which regulates policy; and by public and private funding entities, which control the purse strings. Finally, the third highest priority cited by executives—improving customer relations and service—is being driven by industry competition and initiatives such as HCAHPS® (Hospital Consumer Assessment of Healthcare Providers and Systems).

Health care leaders were overwhelmingly female, whereas leaders in other organizations were predominantly male.

FIGURE 4 Executives' Business Priorities



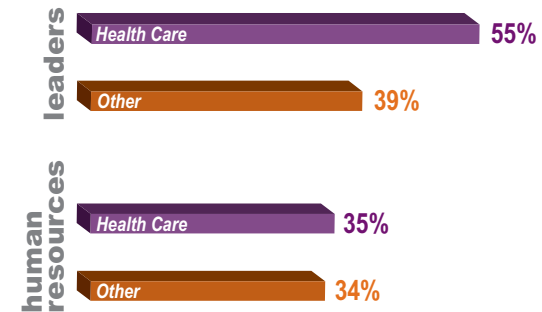
Not far behind on health care executives' priorities were improving or leveraging talent, improving operating efficiency, and growth. Other organizations had talent and growth at the top of their lists, but they were less concerned with operating efficiencies than was health care. This is likely related to the impact of operational inefficiencies on patient safety/quality and the cost of delivering care. Many health care organizations are involved in process improvement efforts like Six Sigma and Lean.

Evaluating Leaders

HR's confidence in leaders' ability was lukewarm.

Only slightly more than one-third of HR professionals in health care or other industries indicated high confidence in leaders' ability to assure the success of the organization (see **Figure 5**). This suggests that most organizations have a long way to go in developing top-notch leaders.

FIGURE 5 Confidence in Leaders' Ability to Assure Organization Success



However, considerably more health care leaders (55 percent) had high confidence in their leadership than either the health care HR professionals or leaders in other types of organizations. The higher confidence of health care leaders was due most likely to the nature of the sample: The HR professionals represented 82 health care organizations, but the leaders represented only 18 organizations. The leaders' organizations had disproportionately more effective leadership development programs (see **Table 2**). Thus, their responses tended to be, on average, more positive than the responses from the HR professionals.

TABLE 2 Leadership Development Effectiveness

	Organizations of HR Sample	Organizations of Leader Sample
Most Effective	39%	58%
Typical	41%	31%
Least Effective	20%	11%

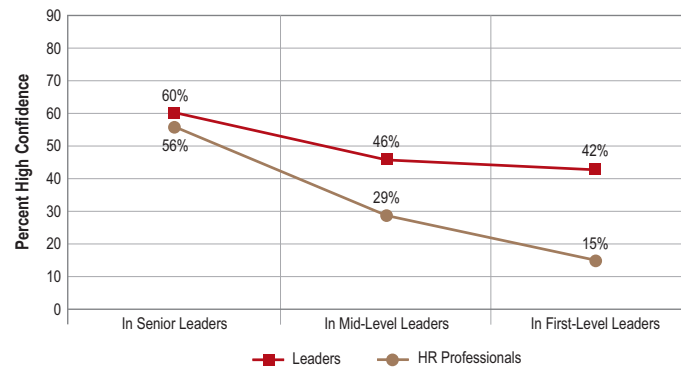


Confidence slumps for lower-level leaders.

Confidence in leadership varied significantly according to the level of leader considered (see **Figure 6**). Both health care groups felt the most trepidation about the abilities of first-level leaders—a common finding for other *Leadership Forecast* organizations—although the health care HR professionals were significantly more negative.

Because of the tremendous growth in the health care industry, the demand for leaders exceeds the pool of those who are ready to take on the role. Many individuals are being thrust into leadership roles without the appropriate screening or

FIGURE 6 Confidence in Leaders by Level



training, leaving them ill-prepared to meet day-to-day challenges. A DDI study (Paese & Wellins, 2007) found that less than 30 percent of U.S. leaders considered their organizations effective at supporting new leaders. To increase the success of frontline leaders, it is imperative that health care organizations, like others, not only select the right people from the start, but find ways to develop them more effectively during the transition from one position to the next.

Many individuals are being thrust into leadership roles without the appropriate screening or training, leaving them ill-prepared to meet day-to-day challenges.

DEVELOPING LEADERS

This section looks at how health care organizations try to develop leadership skills and how well leadership development programs are executed.

Evaluating Leadership Development Programs

Health care's leadership development programs surpassed others in quality.

Fifty-two percent of health care leaders were satisfied with what their organizations offered to develop their leadership capabilities, a significantly higher figure than that for leaders in other industries (see **Figure 7**). The HR professionals in health care shared the leaders' sentiments: Their ratings of the quality of their leadership development programs also were higher than the ratings from those in other industries. The health care organizations should feel some pride in besting their peers on leadership development. However, nearly half of the leaders are not satisfied with opportunities to develop their skills, indicating that there is still plenty of room for improvement.

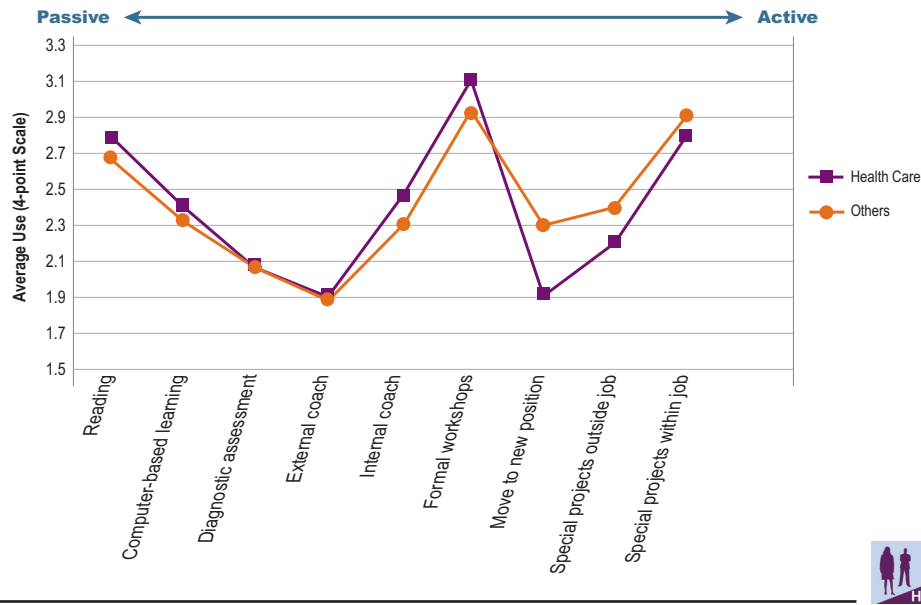
FIGURE 7 Evaluating Leadership Development Programs



Development Methods

HR professionals were asked to review a list of development methods and indicate how often they used them on a four-point scale ranging from “not at all” to “extensively.” **Figure 8** shows the average ratings for each method for the health care and other respondents. The methods are arranged on a continuum that ranges from passive, external activities to active methods integral to the job.

FIGURE 8 Use of Leadership Development Methods



Health care organizations need more on-the-job leadership development.

Compared to organizations in other industries, those in health care made less use of two development methods: moving to a new position and special projects outside the job. Leaders in the global sample typically found the on-the-job methods on the right side of the graph more effective. This does not mean

that off-site activities are not helpful, only that they are unlikely to ensure development on their own. Thus, health care organizations should consider adding more on-the-job types of development activities to complement their current programs.

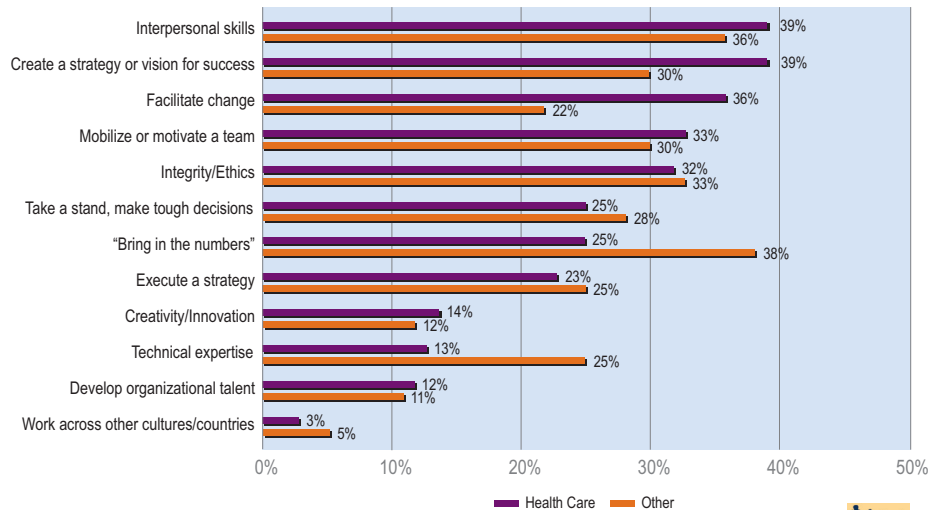
Development Focus

Although the *Global Leadership Forecast 2008|2009* did not ask about the content of development programs, the health care leader sample shed some light on where organizations focused their development efforts. Survey respondents were asked to review a list of leadership competencies and identify the top three that currently get the most respect in their organization.



Health care organizations should consider adding more on-the-job types of development activities to complement their current programs.

FIGURE 9 Most Respected Leadership Competencies



Health care organizations respect leaders who visualize success and facilitate change.

Leaders from both health care and other industries considered interpersonal skills one of the top two ways to get the most respect. However, more health care leaders reported respect for those who create a strategy for success and facilitate change. By contrast, more leaders in other industries identified “bring in the numbers” and technical expertise as important ways to gain respect. This is not surprising because the vast majority of hospitals put their mission of care ahead of “bringing in the numbers.”

Weak execution undermined the potential impact of leadership development.

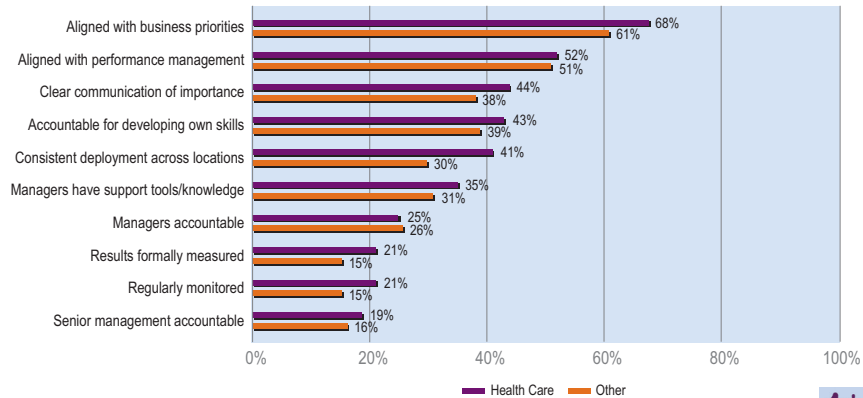
Figure 10 shows the percentage of HR professionals who agreed or strongly agreed with key questions around execution. The items are listed in order from the highest to lowest endorsement by the health care sample.

As Figure 9 indicates, health care leaders saw a greater need to facilitate change than did their counterparts in other industries. Today’s health care leaders are confronted with far-ranging reform efforts, extensive technology and equipment updates, and draconian changes in reimbursements, all of which is occurring in an environment that is becoming more transparent to public view and oversight.

Executing Leadership Development Programs

DDI advocates actions in five key areas to assure that a development program is executed in a manner that will lead to desired business results. Items relating to five areas—communication, accountability, skills, alignment, and measurement—were included in the *Global Leadership Forecast* surveys. Respondents were asked to indicate whether important steps to assure sound execution of development programs were taken; they rated each item on a five-point scale ranging from “strongly disagree” to “strongly agree.”

FIGURE 10 Leadership Development Program Execution



In comparison to those in other world regions, U.S. organizations—whether in health care or other industries—did a notably poorer job of executing development programs. However, health care organizations significantly exceeded their counterparts in other industries in consistently deploying programs across locations, due perhaps to the many consolidations and the subsequent need to create systems from multiple independent hospitals. They also were somewhat better at aligning with business priorities, perhaps because there is greater consistency in health care priorities than in other industries.

For eight of the ten items depicted in Figure 10, less than half of the health care or other organizations were taking the necessary actions to assure effective program execution. Only 44 percent of health care organizations communicated the importance of leadership development and its business

purpose, and only slightly more than a third made sure that managers have the tools and support to help develop their direct reports. These data don't bode well for the success of leadership development programs. HR-created learning programs might be powerful, but they will have little impact on the organization unless they are implemented in a way that will reinforce and sustain them over time.

Health care organizations lag in accountability and measurement.

The most serious deficiencies of health care organizations in executing leadership

development programs were in accountability and measurement. Only one-fourth of organizations hold managers accountable for leadership development, and less than one-fifth hold senior managers accountable. On the other hand, many health care organizations are initiating efforts to create cultures of higher accountability—efforts that will, hopefully, extend to leadership development programs.

Only about one-fifth of health care organizations regularly monitors or formally measures the results of their development efforts. Without concrete knowledge of the outcome of their efforts, organizations will not be able to determine whether aspects of their programs need to be redirected nor will they be able to establish whether they have achieved their leadership development objectives.



The most serious deficiencies of health care organizations in executing leadership development programs were in accountability and measurement.

HIGH-POTENTIAL LEADERS

High-potential employees were defined as those designated by the organization as having the potential to assume high-level leadership roles and who are put into a special pool. Typically, these employees are placed in accelerated development programs to prepare them for their future roles.

Identifying High-Potential Leaders

Only one in three health care organizations has a high-potential program.

Compared to those in other industries, a much smaller proportion of health care organizations had a process for identifying high-potential leaders (see Figure 11). Also, the percentage of health care leaders in a high-potential program was approximately half the proportion in other organizations. This lag represents a lost opportunity for most health care organizations, which won't be able to assure that the best leaders are available and ready to fill higher-level openings.

FIGURE 11 Identifying High-Potential Leaders

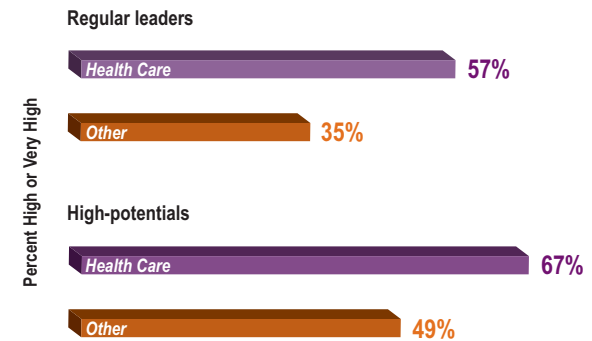


Evaluating High-Potential Development Programs

High-potential leaders were more satisfied with their development than other leaders.

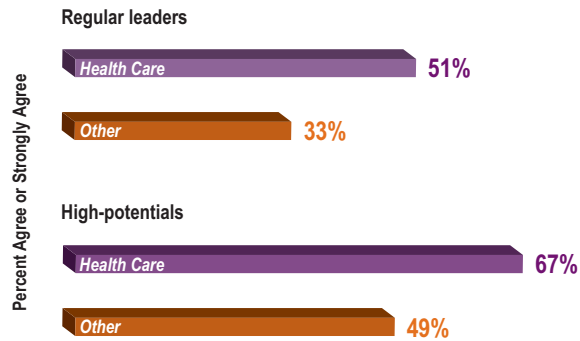
Only 31 percent of health care organizations had a program to accelerate the development of their high-potential leaders (compared to 37 percent of those in other industries). Worldwide, leaders in high-potential programs were more positive about their developmental experiences than leaders who were not in a special group. This finding held true in health care as well (see Figures 12 and 13).

FIGURE 12 Quality of Leadership Development Programs



Whether asked about the quality of their development programs or how satisfied they were with their leadership development offerings, health care high-potential leaders were more positive than leaders who were not in a special group. Moreover, the health care high-potentials were more positive than their counterparts in other industries, although this could be because the health care leaders who responded often came from organizations with highly rated programs.

FIGURE 13 Satisfaction with Development Offerings

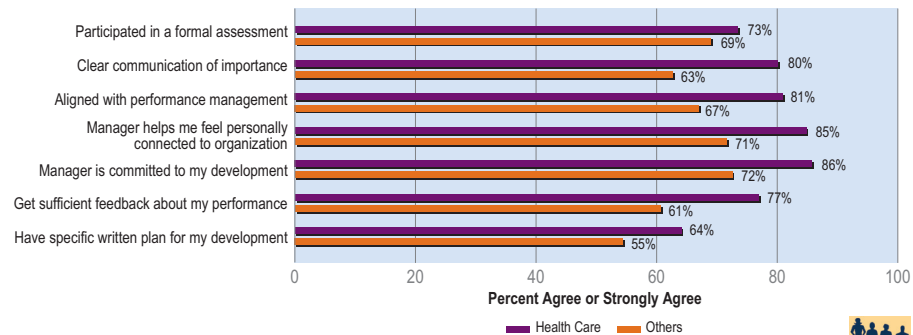


Executing High-Potential Development Programs

High-potential programs are better executed than others.

Health care high-potential leaders were more positive than high-potentials in other industries about many key aspects of execution (see **Figure 14**). More than 80 percent of the health care high-potentials reported that the business importance of their development was clearly communicated and the competencies to be developed were aligned with the performance management system. Moreover, their managers were committed to their development and helped them to feel personally connected to the organization.

FIGURE 14 High-Potential Program Execution



Compared to those in other industries, a much smaller proportion of health care organizations had a process for identifying high-potential leaders.

However, more than one-third of high-potential health care leaders did not have a specific written plan for their development. This is a significant oversight if organizations want a means to assure that development takes place. The lack of a specific plan might be a manifestation of the general lack of accountability and measurement practices for leadership development reported by HR professionals (Figure 10).

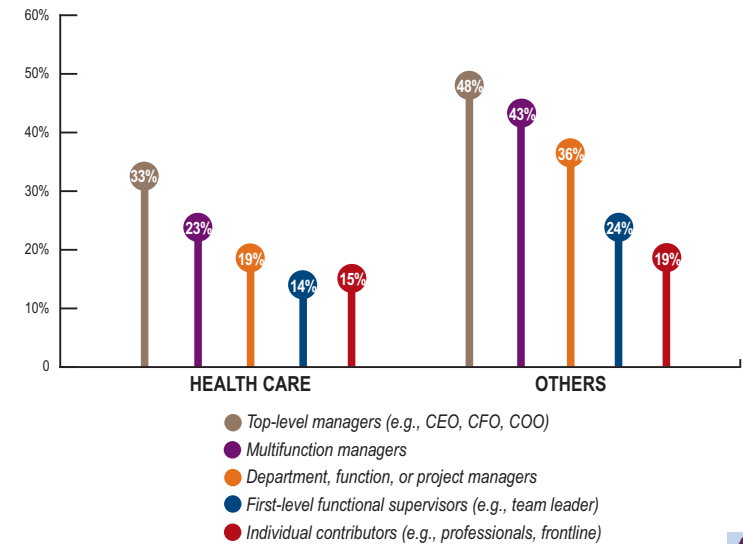
Succession Planning

Health care organizations seriously lag behind others in succession planning.

A high-potential program often is one aspect of an organization's succession-planning process. Health care organizations were significantly less likely than those elsewhere to have succession plans at all levels of leadership (see **Figure 15**). They were particularly remiss at implementing succession-planning programs at lower levels. An Aberdeen Group study found that organizations considered "best in class" in succession planning (the top 20 percent) were 20 times more likely than other organizations to have formal plans for employees at the lower levels (Martin, 2007).

Health care's low rate of success in building a leadership pipeline through succession planning is a significant deterrent to assuring their future success. As organizations grow or experience turnover, they need to be able to draw on a pool of talent to fill key positions. Also, health care leaders were, on average, older (24 percent were age 56 and higher) than their counterparts in other industries (16 percent were 56 and higher), which creates even greater urgency for succession planning.

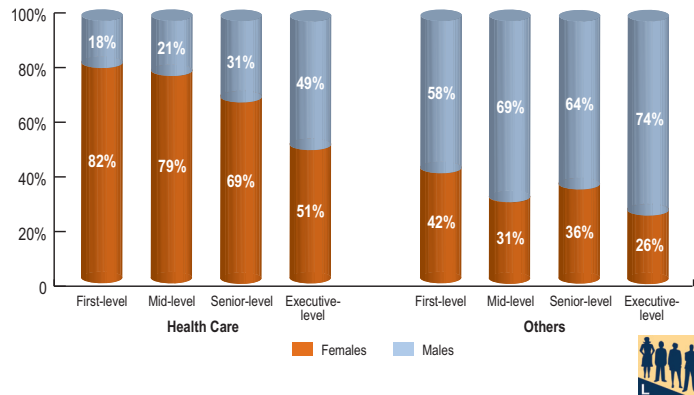
FIGURE 15 Prevalence of Defined Succession Plans



Succession decisions disadvantage women.

Over half of executive-level leaders in health care are women, far more than in most other industries. However, there is a considerable gap between the proportion of women who are frontline leaders and the proportion of women who are executive-level leaders (see **Figure 16**). Whereas 82 percent of first-level managers in health care were women, only 51 percent of leaders at the executive level were women. The gap between women's representation in the first and executive levels also was apparent in other industries, but it was particularly glaring in health care, where the proportion of women in the total leadership population is so large.

FIGURE 16 Gender by Management Level



The American College of Health Care Executives (ACHE, 2006) reported a recent upturn in the proportion of women achieving chief executive officer (CEO) positions. In three previous studies women were achieving CEO positions at about 40 percent of the male rate, but in 2006 that figure grew to 63 percent. Although there was understandable pleasure at this progress, these rates need to be interpreted in light of the ratio of men and women in health care leadership positions. If gender parity existed, women's promotion rate would be at 100 percent of the male rate; that is, if women are 75 percent of all health care leaders, as in this sample, then they should be 75 percent of the CEOs. However, the American Hospital Association estimates that only about 24 percent of hospital CEOs are women (*Modern Healthcare*, 2007).

There are several possible explanations for the smaller proportion of women in executive positions. Traditionally, top-level executives in health care often had degrees in business or finance, whereas the majority of women in health care come from a clinical tradition. However, this tradition is changing. The ACHE (2006) study found that among health care executives, about half of each gender group had degrees in health care management.

Conflict with family responsibilities and career interruptions also might have created barriers or lowered women's aspirations for the top jobs in health care organizations. The ACHE (2006) study found that only 40 percent of women aspired to the CEO job in the next 15 years compared to 70 percent of the men. Women are even beginning to shun the chief nursing officer (CNO) position—a role few men occupy because of their relative small number in the nursing population—because of the intense pressure resulting from a national focus on quality of patient care, chronic nursing staffing shortages, an emphasis on cost containment, fast-paced technology implementation, and a complicated regulatory atmosphere (Rollins, 2008).

Other explanations of the shrinking proportion of women in higher rungs of management look to stereotypical perceptions of women's qualifications and leadership abilities or outright discrimination. The ACHE (2006) finding that female health care executives earn 18 percent less than men in such



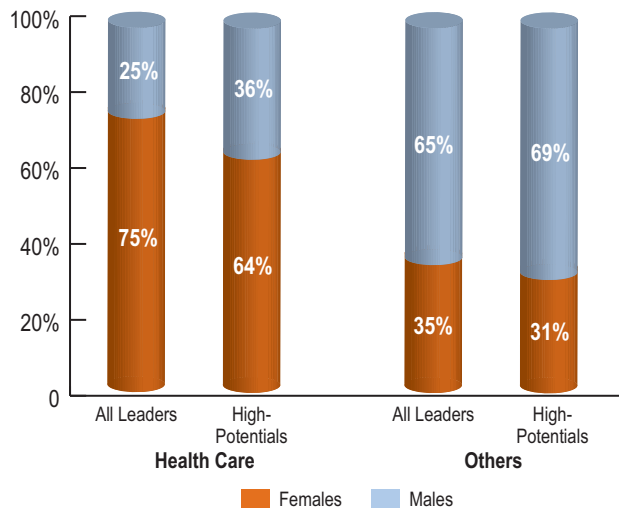
There is a considerable gap between the proportion of women who are frontline leaders and the proportion of women who are executive-level leaders.

positions suggests inequitable treatment at work. The study found that 81 percent of the women favored efforts to increase the proportion of women in senior health care management positions, but only 42 percent of the men did.

Women get fewer opportunities for accelerated development.

The experience of high-potential programs offers a glimpse at whether efforts to increase women’s presence in senior positions are being made. **Figure 17** shows the gender composition of high-potential programs among U.S. organizations participating in the *Leadership Forecast*. To provide perspective, these programs are compared to the gender composition of the total number of leaders.

FIGURE 17 Gender of All Leaders and of High-Potential Leaders



If there were gender equity, the proportion of women in the high-potential programs would be equivalent to the proportion of women in the organization’s leadership ranks. In Figure 17, all organizations showed greater proportions of men in high-potential programs than in the overall leadership ranks. However, the disparity was much more pronounced in the health care organizations. This means that in health care, proportionately more men than women are being groomed to advance to high levels in the organization.

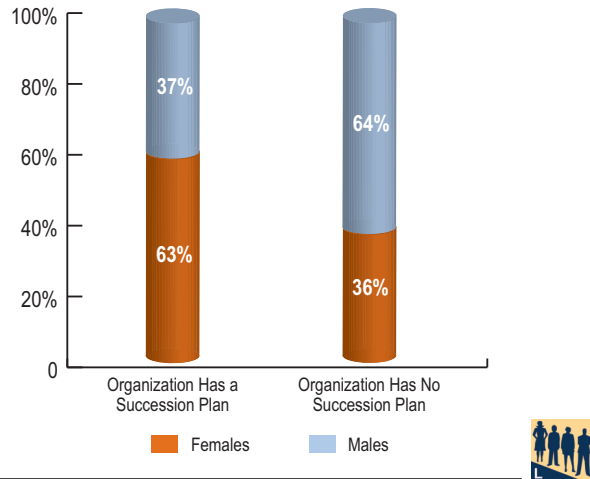
Formal succession plans promote gender equity.

Discriminatory actions are not necessarily deliberate. The ACHE (2006) study indicated that 86 percent of men (and 69 percent of women) believed there was gender equity in their organization. Yet, where promotions and high-potential pool decisions are made one at a time, it might not be apparent that an undercurrent of bias is operating.

Formal succession plans typically focus on high-potential leaders as a group, which can illuminate gender disparities. To test whether having a formal succession plan makes a difference in the elevation of women to executive-level positions, we compared two types of organizations: those with a formal succession plan at the executive level and those without (see **Figure 18**).

These data clearly show that women are much more likely to be in executive positions when an organization has a formal succession plan. Where a formal succession plan was in place, nearly two-thirds (63 percent) of the executives were women. In organizations that did not invest in a formal succession plan, only a little over one-third (36 percent) were women.

FIGURE 18 Presence of Executive Succession Plans and Gender of Executives (Health Care Only)



Formal succession plans usually entail a series of objective evaluations of leaders' competencies and other characteristics to determine their potential. Using objective indices of potential and readiness for promotion can eliminate unconscious gender biases about performance and leadership characteristics. This could serve to help more women get to the executive level.

As shown previously, health care organizations have been slow to institutionalize formal succession management plans. The scarcity of such plans might be compromising health care's future not only because organizations risk not having strong leaders when they need them, but also because they make it very difficult for women to reach the top levels of the organization. This threatens the organization's reputation and also wastes valuable talent.

CONCLUSIONS AND RECOMMENDATIONS

Health care organizations in the United States face several serious and sometimes competing priorities. Patients, their families, and the government are pushing for safe, affordable, high-quality care. Operational efficiencies and cost control are critically needed at the same time that customer relations and good service are essential to staying in business. Given the urgency and multiplicity of their priorities, it is extremely important that health care organizations select and develop first-class leaders who can carry out these missions with skill and passion.

The health care leaders in the *Global Leadership Forecast 2008|2009* disproportionately represented organizations with effective leadership development programs. Their high-potential programs were well regarded and better executed than those in other industries. In addition to acknowledging leaders who demonstrate deft interpersonal skills and the ability to motivate a team, these organizations also reward leaders who create a vision or strategy for success and skillfully facilitate change. These leader incentives suggest that many health care organizations are on the right road to achieving their business objectives.

However, the typical health care organization, as represented by HR professionals, showed some weaknesses in leadership development. Particular concerns were raised about the abilities of leaders at the first level of management. Selection

Women are much more likely to be in executive positions when an organization has a formal succession plan.

into these positions needs to be scrutinized, and more development work needs to be done to shore up these leaders' skills.

Health care's leadership development programs were generally better regarded than those in other U.S. industries. However, health care programs would benefit from including more on-the-job learning and opportunities for practice, which leaders worldwide claimed to be most effective for enhancing their leadership skills.

There are two other areas where health care organizations need to enhance their leadership development practices:

1. **Improve program execution.** U.S. organizations were weaker than the typical global firm in executing leadership development programs, and health care organizations were no exception. In particular, health care organizations need to hold senior management accountable for leadership development. They also need to make sure that the managers of developing leaders are held accountable for development results. Organizations can help ensure that this happens by providing appropriate resources and tools to managers and by formally monitoring and measuring the outcomes of leadership development initiatives.

2. **Build a robust leadership pipeline.** Only one in five health care organizations had formal succession plans and only one in three had a high-potential program. Most health care organizations are simply not planning for their future, despite having a population of leaders that is likely to be older and closer to retirement. *Global Leadership Forecast* organizations with the most effective development initiatives are two times more likely to have leadership pipeline practices in place. Health care should follow their example.

A sound pipeline approach focuses on early identification of those who have both the motivation and ability to be future leaders. It further ensures that there are leaders at all levels ready to meet the organizational demands of the future, and it provides these leaders with accelerated support and development to ensure their success.

Succession planning also can have the added benefit for health care organizations of taking an objective look at women's performance and potential and accelerating their movement into top leadership positions. Women's progress to the top echelons of health care organizations has been far less than would be expected based on their overwhelming numbers in the health care industry. Formal succession planning can provide the objectivity needed to remedy this situation while at the same time helping secure health care organizations' journey to the future.

APPENDIX

Demographics

Organizations

82 Number with HR professional response

Number of Employees	
2%	1–200
2%	201–500
7%	501–1,000
45%	1,001–5,000
20%	5,001–10,000
16%	10,001–20,000
6%	20,001–50,000
1%	50,001 or more

Presence in the Global Market	
95%	National
5%	Multinational (own, operate, or have affiliate offices outside own country)

Leaders

1,297 Number in sample

Management Level	
25%	First-level (supervisor, team leader, foreman, etc.)
37%	Mid-level (leader of first-level leaders)
28%	Senior-level (leader/manager of mid-level leaders)
9%	Executive-level (leader in a policy-making position)

Organizational Tenure	
3%	Less than 6 months
5%	6–11 months
9%	1–2 years
17%	3–5 years
19%	6–10 years
12%	11–15 years
35%	More than 15 years

Age

1%	Less than 25
12%	26–35
25%	36–45
39%	46–55
19%	56–65
5%	More than 65

Gender	
25%	Male
75%	Female

Note: Numbers may not add up to 100 percent because of rounding.

Participating Organizations

Adventist Health System
All Children's Hospital
Alta Bates Summit Medical Center
American Red Cross of Greater Chicago
Ashland Community Hospital
Banner Health
Baptist Health South Florida
Baptist Outpatient Services
Barnes-Jewish Hospital
Bassett Healthcare
Bon Secours St. Francis Health System
Children's Health System
Children's Hospital and Health System
Children's Hospital of Omaha
Children's Hospitals and Clinics of Minnesota
Children's Medical Center
Choctaw Nation Health Services Authority
Christus Health System
City of Hope
Community Memorial Hospital
Continuum Services, Inc.
Covenant Woods
Cummins Behavioral Health Systems, Inc.
East Alabama Medical Center
EMHS
Emory Healthcare
Florida Hospital
Frankfort Regional Medical Center
Greenville Hospital System
Group Health
Gwinnett Hospital System

Hamot Health Foundation
Health Alliance of Cincinnati
HealthEast Care System
INTEGRIS Health, INTEGRIS Physicians Services
Iowa Health—Des Moines
Jewish Hospital & St. Mary's Health Care
JPS Health Network
Kaiser Permanente—Colorado
Kettering Health Network
Kindred Healthcare
Kootenai Medical Center
Lakeland Regional Medical Center
Licking Memorial Health Systems
Los Alamitos Medical Center
Martin Memorial Health Systems
Medical Center of Plano
MediCorp Health System
Memorial Healthcare System
Memorial Medical Center
Methodist Health System
Methodist Le Bonheur Healthcare System
Mount Sinai Medical Center
Northeast Georgia Health System
North Florida Regional Medical Center
North Shore LIJ Health System
Norton Healthcare
NYU Medical Center
Oregon Health & Science University
OU Physicians
Owensboro Medical Health System
Parkland Health & Hospital System
Philadelphia Corporation for Aging
Pocono Medical Center

Porter Health System
Presbyterian Healthcare Services
Provena Health
Providence Health & Services
Rockford Health System
St. Elizabeth Medical Center
Saint Joseph's Hospital
St. Mary's Hospital
St. Patrick Hospital
St. Vincent Regional Medical Center
Sanford Health
Saratoga Hospital
Southwest Washington Medical Center
Spartanburg Regional Healthcare System
Sweetser
Texas Children's Hospital
Texas Health Resources
University of Kentucky Healthcare
University of Missouri HealthCare System
University of Texas M.D. Anderson Cancer Center
Valley Health

Note: When completing the HR survey, each respondent was asked to type the full name of the organization he or she represented. In publishing the list of participating organizations, DDI cannot assume responsibility for errors in spelling or other errors in the information provided by these individuals. This list does not include organizations that wished to remain anonymous.

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