

Healthcare Leadership Failures Require Metrics and Meritocracy Reforms; Olumuyiwa Bamgbade, Salem Pain Clinic BC Canada

Canada's Healthcare Leadership Requires Major Reforms, Including Meritocracy and Performance Metrics; Olumuyiwa Bamgbade, Salem Pain Clinic, BC, Canada

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confirm that Canada's healthcare system is in crisis, partly due to underfunding and understaffing, but primarily because of leadership failures. Healthcare leadership is vital for system effectiveness, equity, and sustainability. However, in Canada, leadership appointments are decided by subjective likability,

politics, nepotism, and exclusion, rather than merit, skills, or vision. Leadership roles are often filled without transparent, merit-based processes. Many healthcare administrators and

physician-leaders lack formal education in organizational leadership, systems thinking, or health policy.

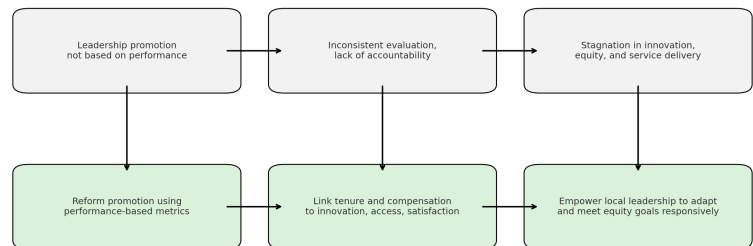


Healthcare leaders should complete accredited leadership training, mentorships, and regular formal assessments."

Dr. Olumuyiwa Bamgbade

The healthcare system is entrenched in a rigid bureaucracy that values compliance and control over innovation and agility. Leaders often prioritize risk avoidance and status quo preservation rather than addressing systemic issues such as access delays, workforce burnout, or Indigenous health disparities. There are insufficient mechanisms for

assessing healthcare leadership performance. Unlike in the corporate sector, where outcomes and returns on investment are monitored, poor healthcare leadership persists for years without evaluation or consequence, weakening the system's capacity to evolve. Despite Canada's multiculturalism, systemic xenophobia or ethnocentrism limits the inclusion of talented foreign-trained doctors or immigrant administrators in leadership roles.



Healthcare Leadership

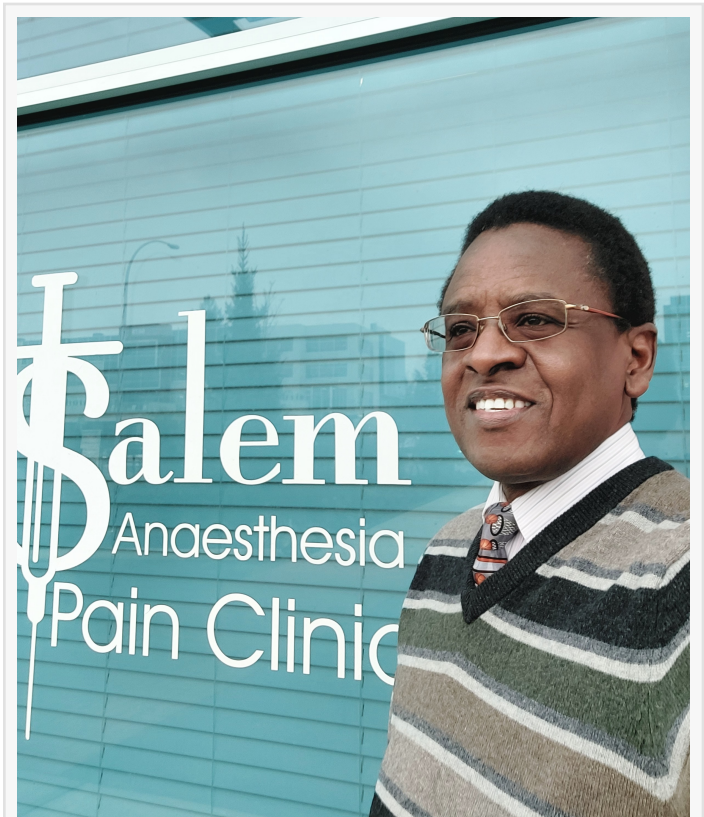
Poor healthcare leadership causes widespread workforce burnout, low morale, and early exit of talented professionals. Leadership inertia deepens health inequities, particularly for Indigenous populations, rural communities, and low-income immigrants. Opaque decision-making and unresponsiveness to community needs reduce public confidence in the system and its stewards. Indeed, these problems weaken social solidarity and compliance with public health initiatives.

Canada's socialized healthcare system requires deep reforms of its leadership. Leadership recruitment must be based on merit and transparency. Publicly advertised positions, independent selection panels, and standardized competency assessments must be embraced to mitigate favoritism and increase public trust. Health administrators and clinical leaders must be required to complete accredited leadership programs emphasizing systems thinking, equity, crisis management, and strategic innovation. Leadership reforms should include mentorship programs and leadership fellowships.

Leadership promotion must be based on performance metrics. Reforms must establish metrics and consistent evaluations for health system executives, linking tenure and compensation to outcomes in innovation, staff satisfaction, and patient care access. Performance evaluations must incorporate stakeholder feedback and external audits. Hospitals and health authorities should be allowed to innovate independently while maintaining accountability for equity and service delivery objectives by relocating decision-making closer to communities. Additionally, local leaders must be empowered to facilitate contextual adaptation and responsiveness.

Canada's healthcare system cannot be resilient or equitable without transforming how its leaders are chosen, trained, and evaluated. Entrenched practices such as favoritism, exclusion, and neglect of formal leadership development have yielded a system strained by inefficiency and inequity. Meaningful reform requires embedding merit, transparency, inclusion, and accountability into leadership pipelines. By doing so, Canada can restore trust and workforce vitality and align its healthcare institutions with the diverse, evolving needs of its population.

Dr. [Bamgbade is a healthcare leader](#) with an interest in [value-based healthcare](#) delivery. He is a [specialist physician](#) trained in Nigeria, Britain, the USA, and South Korea. He is an adjunct professor at institutions in Africa, Europe, and North America. He has collaborated with researchers in Nigeria, Australia, Rwanda, the USA, Kenya, Armenia, South Africa, Britain,



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