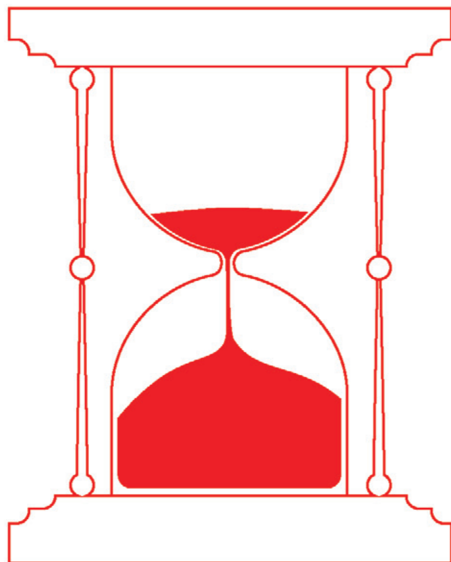
European Health
Management in Transition



Developing and Engaging Clinical Leaders in the "New Normal" of Hospitals

Why it Matters, How To Do It

Federico Lega
and Angela Pirino

DEVELOPING AND ENGAGING CLINICAL LEADERS IN THE "NEW NORMAL" OF HOSPITALS

European Health Management in Transition

Series Editors:

Federico Lega, Full Professor of Health Management and Policy, Director of the Research and Executive Education Center in Health Administration, University of Milan.

Usman Khan, Visiting Professor, KU Leuven Healthcare, is currently undergoing an unprecedented period of change, which is presenting a challenge to the fundamental tenants of health management and policy established over the last decades. The differentiated nature of the change agenda and the pace of change has been such that there has been limited space or time to provide a structured or comprehensive response, or to consider at a strategic level how health management teaching and practice should evolve and develop. This then is the focus for the *European Health Management in Transition* series, published in alliance with the European Health Management Association (EHMA).

Books in the series investigate how changes to the health and social care environment are leading to innovative and different practices in health management, health services delivery design, roles and professions, architecture and governance of health systems, patients' engagement and all other paradigmatic shifts taking place in the health context.

The books provide a roadmap for managers, educators, researchers and policymakers to better understand this rapidly developing environment.

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Why It Matters, How to Do It

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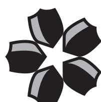

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FOREWORD

Foreword. Why Clinical Leadership Is no Longer Optional

Here we will explain why clinical leadership is not a passing issue but rather the key to the future of health systems, their sustainability, performance, quality, and other dimensions of success.

Leadership is a buzzword for health policymakers. The development of clinical leadership and managerial skills is a priority in healthcare reforms across the globe.[1,2] Framework programmes for teaching physicians management skills have attracted increasing interest through the initiatives of health departments, medical societies and medical schools. While clinical leadership is clearly a global policy priority worldwide, it is less evident whether it has real substance. Based on in-depth analysis of the recent literature and an empirical survey, we argue that clinical leadership is the (necessary, inevitable) response to challenges and trends ahead.

Clinical needs are changing. Today's patients have multiple comorbidities and the average age of the population is steadily rising. Patients struggle to find adequate answers from healthcare organisations, where service is fragmented along medical specialty boundaries. Integrated care pathways and multidisciplinary treatment approaches are now needed. This means that the current healthcare organisation, with its

professional clans, autonomous hierarchies and guarded areas of practice and working rules, is no longer adequate.

Reforms in most Western countries have called for cost containment in response to spiraling healthcare expenditure for the ageing population and for new technologies. Efficiency and efficacy were introduced to provide physicians in charge of medical staff with performance parameters. Similarly, evidence-based medicine and accountability for treatment outcomes have replaced informal, peer-based non-standardised performance appraisal. Hospitals now measure performance, collect data and report it. Organisations are compared according to the results they achieve, as are individuals and groups working within an organisation. This shift has generated new managerial needs and calls for new competences such as performance management, value-based approaches and operations management.[5] Finally, patient expectations (e.g. quality of nonclinical services, hospitality, waiting times, flexibility, customer support) have all changed. Healthcare services are subject to societal pressures that demand more streamlined and patient-centred organisations.[6]

Hybrid doctor–manager roles are often seen as the solution to these challenges, to 'bridge the gap' between the old and new. While clinical leadership is not a panacea for all of healthcare's problems, it is much needed, as clinical leaders will have to be better equipped to improve clinical governance, develop multidisciplinary and interprofessional collaboration, and achieve cost savings without compromising the quality of care.[7]

There is recent international evidence that good management and clinical leadership have an impact on healthcare performance.[2,8,9] Despite political enthusiasm for medical managerial roles in healthcare organisations, the actual practice of medical management varies. International comparative research on the involvement of doctors in

management shows a rather diversified picture of the timing of healthcare managerial reforms. Denmark, the United Kingdom and the Netherlands were among the pioneers of such reforms back in the 1980s and early 1990s, whereas Italy, Germany and France only more recently implemented similar processes, which is why they lag behind the others.[1]

Comparative research has identified a number of factors at the system and the organisational level that may explain the degree of development of managerial roles and the engagement of doctors in such roles, for instance, the extent to which these roles are endowed with authority and autonomy for decision-making (e.g. budgeting and investment planning). National policies supporting clinical management are in place the United Kingdom and Italy in contrast to Germany, where the healthcare sector is fragmented into numerous local and private providers and where hospital owners critical toward the development of clinical leadership have sought to limit physician empowerment.[10]

Another important factor is the availability of financial and career incentives for doctors to get involved in management, e.g. whether the doctor is a hospital employee or works on a contractual fee-for-service basis. In the Netherlands, for example, there is wide variability in the development of clinical leaders in large university hospitals and smaller local hospitals, also because the latter employ staff on a contractual basis.

But there also exists the paradox and the risk of wasting capacity and capability. If we have an extraordinary medical doctor, he/she should be allowed to practice as a physician or surgeon as much as possible. Anything less would mean denying patients access to the best care. According to evidence from the last 20 years, great doctors often (if not always) place medical practice above their managerial duties. A possible solution might be to identify a second tier of physicians and,

after evaluation of their potential, train them as managers so that doctors could focus solely on clinical practice. In healthcare organisations (as in other professional contexts) there is an unwritten rule by which top management and clinical leadership are one and the same. Doctors are legitimised (and accepted) by their peers if they are recognised as clinical leaders. Consequently, clinical leaders have to be great doctors.

It's up to us to support top clinicians in their managerial roles so they can reserve as much of their time as possible for clinical practice. This involves training them in various fields, making them charismatic leaders that provide vision, sense-making and problem-solving, while coaching and supporting them in operational functions. Most likely we will need to develop leaders that act as organisational designers and operations managers. Operations managers do not necessarily have a medical degree, since their job is to serve as project managers, change agents and administrators.

For the past 100 years, organisational studies have reported that organisations change when someone pursues their vision to bring about improvement. This is what makes the difference between good and great (healthcare) organisations, between those stuck in their "comfort bunker" and those who innovate and evolve. In this light, co-management by two types of leaders might benefit healthcare organisations. Leadership training should be developed within this framework. These are the "big" items on the clinical leadership agenda.

Complex issues are ambiguous as evidence. For instance, strong non-clinical managerial roles in a system have been found to hamper the development of hybrid leadership. In the United Kingdom, many decisions are taken by general managers, who are numerous and hold a strong position in Britain's National Health Service (NHS), whereas in Italy doctors

employed with the public health system have historically been in charge of hospitals; therefore, developing clinical leadership to its full potential was seen as less urgent.[1,11] The influence of professional bodies in policymaking is also relevant. In France, for example, hospital management models were implemented under the guidance of powerful medical associations.[12,13]

Many contextual factors can influence medical involvement in management.[14] Research has shown that choices can be made to foster clinical leadership. Policymakers and executive managers should show courage and allow medical managers ample autonomy and space to work within. Clinical leadership is an exercise in problem-solving management through administrative and budgetary accountability. It has much more to do with doing the right things rather than just doing things right. Without the genuine engagement of clinical leaders, decisions about which services should be delivered, to whom, when, where and how, will be difficult to deliver when they contend with the challenges posed by new technologies and drugs, therapeutic alternatives, turf wars, defensive medicine and inappropriate use of diagnostics to name just a few. Executives should not shy away from the risks inherent to such decisions and should be ready to support clinical leaders effectively by delegating power, ensuring adequate staffing and training and giving individuals the opportunity to best perform in their role.

Clinical leadership is not only about clinical leaders; it is also about how clinical leaders are led.[11] The specifics of healthcare must be taken into account when selecting, training and evaluating clinical leaders. Healthcare organisations are complex professional bureaucracies, especially those in the public or not-for-profit sector. Healthcare organisations are also tightly interconnected with external stakeholders and politics. As a consequence, healthcare leaders face highly

complex problems that cannot be solved with linear, analytical approaches.[15]

Moreover, leaders rely on their capability for network management: not only to steer their organisation but also to connect, build consensus, balance and compromise in their effort to overcome conflicting objectives.[16] Clinical leadership applies a structured method to address problems, as well as sensitivity to cope with complex dynamics through a strategic management approach. Finally, professionals and professional associations should understand that clinical leadership is not about dismantling professionalism but rather about reconfiguring it, incorporating new values and logic into medical culture to make it more responsive to societal changes and expectations from patients and citizens.[17]

Summarising, medicine and management are not incompatible. Management entails taking clinical problems to a higher level, not focusing exclusively on specialty-based treatment of individual cases. Accordingly, healthcare can become more interconnected and organised, more responsive to the demands of the external environment. If this is what we know, what is it then that we don't yet appreciate and need to understand? There are few comparative studies on the challenges, impact and effect of clinical leadership. The time has come to do serious research and assemble evidence. If the next decade is about taking a value-based approach to working inside the black box, then clinical leadership is no longer optional. The correlations between effective clinical leadership, professional background, training schemes, organisational design, decision-making and governance models, skills mix and leadership strategies are just some of the areas that need to be fully investigated. This needs to be done now, quickly and in depth. Our patients are waiting.

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Thank you all, I could not have done it without you.

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CLINICAL LEADERSHIP IN CONTEXT: NEW PUBLIC MANAGEMENT, HORIZONS OF THE 'NEW NORMAL', AND CORPORATISATION OF HEALTH ORGANISATIONS

Why health systems and organizations cannot be investigated and understood without considering the context in which they operate. They adjust to the new normality through policy and organizational actions. Here we briefly discuss what is taking place at the policy level before analyzing the trajectories of change at the organizational level, where new designs, new roles, and leadership responsibilities are emerging and redefining the need for stronger clinical leadership.

THE RISE OF PROTO-MANAGERIALISM

Health system security and health organisation sustainability have dominated the public debate for the past 30 years (1). The new public management approach many European countries implemented in the 1990s placed emphasis on the financial management of healthcare organisations. Finances came under closer scrutiny, and austerity measures were widely adopted in the aftermath of the 2008 recession.

Though of no surprise – *primum vivere, deinde philosophari* – according to the Romans, the predominance of economics led to a cultural shift, an inversion of ends and means, in which cost management was 'the one and only issue'. As a consequence, healthcare systems and organisations were often reconfigured, transformed, downsized, merged, redesigned and streamlined in an effort to improve their cost management capacity, and basically to reduce costs.

It was in this environment that proto-managerialism entered healthcare systems and organisations in the 1990s. Before then, the model of professional bureaucracy described healthcare organisations well, with their functional specialities-based internal design that accommodated specific needs driven largely by the interests of medical professionals:

1. the need to develop a specific expertise and skills set: the allocation and ownership of resources and logistics (e.g. beds, operating theatres, outpatient clinics, nurses, staff)
2. the need to delineate (and position) the 'turf' of physicians working in the same or other hospitals, a common path in professional contexts
3. staff self-interest, whereby the distribution of doctors and medical work was influenced more by professional

interests, financial inducements, rivalries and career prospects than by patients' needs

In general, the influence of power and politics in organisational design choices is well documented. The common roots and progress of medical knowledge and specialties led to striking similarities in hospital organisation throughout the world: market-oriented countries (e.g. the United States and Latin America) versus public system-based countries (the United Kingdom and Europe). Additionally, healthcare management tended to be passive and custodial in deference to professional groups – especially physicians – who exerted considerable control over healthcare demand in all contexts.

In the 1990s, the model underwent two major revisions:

1. the introduction of top-layer management (CEO, COO, CMO etc.) to better guarantee unitary management and strategic development of the organisation
2. the development of a stronger 'technostructure' that would serve management needs. Planning, budgeting, management control, quality and strategic human resource management are some of the functions for developing and running operational services that supported clinicians' decision-making and accountability.

These features marked proto-managerialism. In spite of more structured decision-making processes for planning, investment, budgeting, and performance evaluation, the results were not very satisfying. Research has shown that clinicians often did not play the game but rather responded by: Circumvention – involvement in management to legitimise existing behaviour and power, consistent with the idea of

purely self-serving leadership; Custodial orientation – involvement limited to minimum necessary reporting and budgeting. When senior professionals reluctantly took on administrative roles, their approach was often predominantly 'custodial', wedded to the concepts of practice held by the service providers themselves (Kirkpatrick et al., 2013). The focus was not on serving the organisation but rather the interests of the professional base; Partial hybridisation – when clinicians became 'finance doctors' and (unfortunately) financial viability determined clinical choices explicitly or implicitly. Those who simply didn't play the game were classified as 'fugitives'.

During the proto-managerialism phase, healthcare managers, an organisation's top managers, implemented management practices in their hospital and health organisation assisted by accounting systems and output measures (i.e. diagnosis-related groups [DRGs]) which often resulted in cost management and financial micro-management. Though necessary, it was insufficient to support management in an increasingly turbulent and dynamic environment. Indeed, healthcare is the prototype of a volatile, uncertain, complex, ambiguous (VUCA) context.

During the austerity years, external pressures further reinforced this approach. There was a lack of strategic planning and thinking. Management was reactive. Innovation was often adopted randomly or according to professional or political interests. Discipline of operations was weak. The same symptoms affected all European countries.

Acknowledgement of the situation spurred renewed attention to the process of health service delivery managerialisation. Recent studies and debate indicate that management can enhance the value produced by healthcare systems, organisations, professionals (Lega et al., 2013). Many healthcare systems pondered how to improve the

managerialisation of their organisation (Lega, 2008; Lega et al., 2013). But which kind of management should be employed? Which managers? How could professionals become engaged in the game? How could management be reconciled with ethics when confronted with sensitive decisions?

FROM ROWING TO STEERING

The second wave of managerialisation started when, under the pressure of sustainability, healthcare systems began to recognise that they had to shift their attention to cost management if they were to survive and retain legitimacy. This phase started around the last years of the first decade of this century.

Two major goals were envisaged: Operations and Outcomes. Until the 1980s, healthcare systems were controlled mainly by input allocation; then, in the 1990s output measures were introduced, followed by outcome measures in the late 1990s and into the early years of this century. Only very recently has attention been directed to patient-reported outcome measures (PROMS) and patient-reported experience measures (PREMS). Clinical/critical pathway tools, process re-engineering approaches and lean management techniques emerged in the 1990s, though their implementation has been patchy and limited to date. Clinical governance tools and audit methods have gained acceptance only during the last decade (ccc).

During the recession years, decision-makers tried to establish their control over healthcare system costs through a renewed focus on input. Limits were imposed on recruitment and personnel replacement, purchasing and borrowing

policies, and new technology implementation. Payments and rates for treatments were re-negotiated and reduced. Whatever the strategy to keep expenditure from spiralling out of control, all healthcare systems were focused on short-term input control. This scenario clearly prefigured the risk of rationing and a lack of focus on quality and outcomes. Slowly but steadily operations and outcomes became more evident (Lega & Calciolari, 2012).

Appropriate sustainability demanded a new focus of managers and the professional system. Operations and clinical choices became the target. A fresh management approach was needed that would help to address prioritisation issues arising in decision making at the strategic and the shop floor level. Something to support the improvement of delivery processes through a better understanding of and interaction with the 'black box' of clinical processes. Inappropriate use of diagnostics, drugs and therapies, defensive medicine, artificial variability, turf wars among specialists, and waste of resources could no longer be sustained. Sensitive decisions (e.g. when to use expensive bio-drugs, prostheses or medical devices in patients with a low probability of positive outcome or which prosthesis or drug to prescribe for patients with limited life expectancy) were appearing on the agenda of public and social insurance-based systems. Outcome became the North Star for guiding decisions with ethical implications. Managers and professionals found a new focus at the top of their agenda. Meanwhile, the value-based healthcare paradigm was replacing previous mantras, such as total quality management, process re-engineering, lean and patient-centred organisations.

Recent studies and debate indicate that good management can indeed enhance the value produced by healthcare systems, organisations and professionals (Bloom et al., 2009; Goodall, 2011; Spurgeon et al., 2011). The value of management as a

means to better manage value was being addressed. Evidence increasingly demonstrating that management does matter. Not just the proto-managerialism of the first phase, which supported healthcare organisations in improving their rowing capability: the aim of 'doing things right'. The time had also come for more effective steering. Managers were acting as leaders and helping their organisations to 'do the right things'. Doctors were turning into clinical leaders, fully engaged in sustaining their organisation's efforts to improve operations, clinical choices and strategic development. This was effectively hybridisation, where managerial values were assumed and integrated with professional values: the mix generated better strategic orientation (Goodall, 2011).

As a consequence, two new functions within the techno-structure grew significantly: clinical governance and operations management to serve the new focus. The same path, albeit at a different pace and different in 'translation', was observed throughout Europe. While management was evolving in this direction, recession hit Europe and with it new challenges emerged. Healthy perspiration was not enough for managers and clinical leaders, inspiration was also demanded. A 'new normality' was redefining the healthcare sector. Understanding what type of leadership was needed and which skills to develop and put into practices set the agenda for the next level of management: management 2.0.

THE NEW NORMALITY

To answer the question of leadership and how to develop it within healthcare organisations, it is necessary to have a good understanding of the contents and requisites generated by the 'new normality'. Two clusters of changes in the healthcare

sector are reshaping the context for management (Lega et al., 2013).

The first cluster concerns current ‘evolutions’. Healthcare organisations face several challenges due to:

1. Changes in epidemiology

    - an aging population needs differentiated care
    - more and more ‘frail’ patients (chronic, frequent-user, not self-sufficient) need an integrated continuum of care
    - more highly dependent, critical patients are not so unstable as to require intensive care
    - post-acute surgical patients need a medical tutor (orthogeriatric patients)
    - more and more elderly patients have cognitive problems, complex social backgrounds

2. Technical and technological innovations in service delivery

    - new treatment opportunities derived from new skills
    - operations with quick recovery (day surgery, one-day surgery, week surgery)
    - freestanding surgery, mini-invasive techniques, robotics
    - risk of ‘turf wars’ due to the overlapping of ‘catchment’ areas in medical, surgical and interventional diagnostics (cardiovascular, neuroscience, oncology)

3. Expectations of improved flow and quality of care

    - building patient-centred hospitals designed around patient needs