ANALYSIS

As medicine struggles to cope with the costs of an ageing population, David Brindle investigates whether organisational science could cure the world's healthcare problems

The business of making healthcare work

Across the globe, the soaring costs of healthcare are shaping up as one of the key challenges of the 21st century. The combined impact of ageing populations, rising patient expectations, and expensive drugs and technologies is driving a search for new models of care capable of delivering both better results and greater value while retaining the essential ingredient of human compassion. As experience in the UK has shown, that can be something all too easily lost in the quest for productivity gain.

Delegates from 67 countries gathered in December 2013 in Qatar to discuss this challenge at the World Innovation Summit for Health. Lord Ara Darzi, the acclaimed surgeon and former English Health Minister who was Executive Chair of the event, told them that innovation was the key to sustainable healthcare systems. But too often, he lamented, public policy failed to support innovation and practice struggled to keep up with it.

A principal speaker at the summit was Simon Stevens, the new Chief Executive of NHS England who was then concluding his term as President for Global Health with UnitedHealth Group, the US-based healthcare company. Intriguingly, he forecast that breakthrough innovations would in future come not so much from within the healthcare world, traditionally via bench-based medical research, but from beyond it.

Transformative opportunities

"My hunch is that it is going to be capabilities developed outside the health sector, particularly the so-called general purpose technologies, that will unleash many of our most transformative opportunities over the next decade or so," Stevens said. "A lot of opportunities are going to come from innovation at the interface of business, engineering, and information science. We are likely to see, as a result, major change in the type of care, the place of care, and the care provider, as mobile sensors, cloud computing and data inter-operability connect."

Business schools are ideally placed to play a major role in such a scenario. They have the potential to bring to the often insular healthcare world insights from other sectors, to forge creative partnerships with those sectors and, perhaps most significantly, to apply a practical approach to problem solving that has hitherto been lacking.

"Healthcare is not just about using clinical evidence, and arguably there's an abundance of that out there, but about how you organise and manage it more effectively and efficiently," says Graeme Currie, Professor of Public Management at Warwick Business School (WBS) and Head of its Organising Healthcare Research Network. "The problem is getting clinical evidence into practice – I always say, moving from what you know to what you do – and that's where a business school has a clear perspective."

Currie is leading a growing WBS involvement in healthcare, both in the UK and overseas. It's an important emerging source of work and revenue for the School, but it can also be seen as making a significant statement about values, and about business in society, in the wake of the financial crash and some of the excesses that were then exposed in the business world.

"A major part of the WBS mission is focused on social responsibility, and health and healthcare is a key part of that," says Currie. "It's good for the reputation, good for the brand, to be contributing to the bottom line of health outcomes as well as wealth outcomes. When you look at the ageing population, for example, we already have a good deal of knowledge. Let's play into that field and try to make a difference."

Breaking down the silos

Penetrating the healthcare sector has not been easy, however. And that would be no surprise to critics who see it as the most siloed of any sectoral silo, resistant to overtures from the outside world and dominated by strong and fiercely defensive professional interests.

Several business gurus who have sought to take on such interests in the past have ended up in undignified retreat, licking their wounds. After a bruising attempt to initiate change at Rotherham General Hospital in South Yorkshire for a television series, former Granada Chairman Sir Gerry Robinson reflected: "Anything that involved more than two disciplines was pretty well guaranteed either not to happen or to happen very slowly."

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Eivor Oborn, Professor of Healthcare Management at WBS, might not go so far. But she observes: "People outside healthcare often don't understand the difference of the healthcare cosmos. If you walk into a hospital and talk to a surgeon, you find they are thinking differently from people on the street. They want things in neat and concise boxes – tick, tick, tick. Their training has a lot to do with it."

Ruth McDonald, a former senior National Health Service (NHS) Manager who has recently joined WBS as Professor of Governance and Public Management, thinks this characteristic is often mistaken for resistance to change. "It's more that they don't have a mindset around systems and organisation," she says. "I've got shelf-loads of books about so-called medical power, but in my experience doctors often feel powerless. They can see what needs to be done, and what would make things better, but they don't know how to go about it."

Transferable insights

The very complexity of healthcare – its professional tribes, its history and traditions, its supposed mystique –makes it an attractive proposition for academic study. As Currie argues, if you can find management approaches that work in health, they are likely to be applicable in a

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range of complex organisations in other settings. But research, however insightful, has typically stayed rooted to the printed page: translating findings into practice has usually proved an insurmountable barrier.

Working with healthcare managers is the key to overcoming this barrier, Currie thinks. By 'managers' he does not mean simply general managers, perhaps three per cent of the total staff of a hospital, but what he describes as 'hybrid middle managers' those who may sit within clinical groups but who exercise some budgetary or supervisory responsibility. All told, he reckons they account for about one in three hospital staff.

"They have some purchase on delivery of clinical services, though we might debate how much, but critically they have an almost unrivalled ability to share knowledge within and between healthcare organisations," Currie says. "They have the ability to act as a two-way mirror, capable not just of assimilating top-down management knowledge but also of translating ideas arising from clinical practice back up into their organisation."

Another, overlapping, group identified as central to efforts to affect knowledge transfer and embed change, at least in the early stages, is that of 'boundary spanners'. These, Oborn explains, are individuals operating within professional tribes with a designated – and funded – role to mediate between those who create knowledge and those who deliver care.

Learning from Canada

Oborn has been involved in the evaluation of the Improving Access to Psychological Therapies (IAPT) programme in mental health services in England, in the implementation of which boundary spanners have often played an influential role. The concept of more formally developing the role of boundary spanners in healthcare services was developed in Canada, but was undermined there when central R&D funding ran out and local services refused to foot the bill. The same issue dogs the model in the NHS.

"Given the budget problems that healthcare organisations currently have," Oborn says, "in order to convince them to allow a person who is a boundary spanner to come to a meeting, say, you need to be able to say you will make up for their time. Without the funding to do that, it's not a self-sustaining model."

Austerity hangs heavy over this agenda. The NHS in England is focused on achieving four per cent annual efficiency savings, leaving no room in its 'protected' budget for the rising costs of an ageing population or technology and drugs, while healthcare spending across the 34 Organisation for Economic Co-operation and Development (OECD) countries has slowed markedly since 2008 and fell in 11 of them between 2009 and 2011. Only Israel and Japan increased spending during that period.

An ageing population

Throughout the OECD countries, however, numbers of older people – the biggest consumers of healthcare – are spiralling. The proportion of people aged 65 or over is projected almost to double from 15 per cent to 27 per cent between 2010 and 2050, with the proportion aged 80 or over projected to increase from four per cent to nine.

At least half of all hospital admissions worldwide involve older people: in England, as many as 65 per cent of admissions are of people aged 65 or over, while people aged 85 or over account for 25 per cent of bed days – and rising.

Currie keeps in mind the illustrative case of a 78-year-old who falls and breaks her hip, requiring admission through A&E for surgery at a cost in excess of £15,000. At her age, she runs a 30 per cent risk of later dying as a consequence of the trauma and about the same risk again of ending up in residential care. Reconfiguring services around her needs could help prevent the fall in the first place, but, as he says: "If I am a hospital Chief Executive, or a powerful medical Consultant, am I going to give up resource for that?"

It's a question very much on the mind of Annette Benny, Managing Director Delivery at Northern, Eastern and Western Devon Clinical Commissioning Group (CCG), which arranges healthcare for 890,000 people. That includes, in some localities, numbers of very elderly residents that already match the projected profile for the rest of the country 20 years hence.

"We've done some work around frail elderly care pathways and, as a result, non-elective admissions to hospital are holding steady," Benny reports. "But where do we go next?" To help answer that, the CCG is working with WBS to gain a better understanding of the issues surrounding patient flows and behaviours. Because it is one of only a handful of CCGs to have retained in-house its business or commissioning support function – rather than delegated it to an NHS commissioning support unit – the analysis will be fully rounded."

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Use business intelligence

"What we want to know is how we become really slick," says Benny. "How can we really raise our game by becoming better at using our business intelligence to add value to the commissioning process?"

Having undertaken a personal development programme at what is now the NHS Leadership Academy; Benny is comfortable with what she calls a "research-y" business school approach. "We are absolutely open-minded," she insists.

"We are passionate that what we create here has got to be the right thing, so if what comes out is something very different, then yes, we will learn."

Currie's team has already completed a project with Nottingham University Hospitals NHS Trust, looking at reducing the number of falls within the hospital environment itself. Treating people who fall, which means mainly older people, costs the NHS more than £2billion a year and the trust, the fourth biggest in the UK, was dealing with 10 falls by patients every day. It had been trying for 15 years to get the numbers down.

Dr Rob Morris, Consultant Geriatrician at the Trust, says he and his colleagues had undertaken root cause analysis of the problem but were failing to convey any learning to staff working in falls "hot spots". What the WBS intervention brought was a fresh pair of eyes on the issue and an ability to make information "edible" by busy colleagues.

Part of the answer turned out to be much improved information analysis and dissemination, principally a system of brief, bullet-point reports on all more serious falls causing fracture, head injury or death – some 10 a month.

The simple innovation has succeeded in focusing minds on the issue. Thanks to this and other initiatives, the number of falls recorded by the trust fell in 2013 by eight per cent and, strikingly, the number causing fracture fell by as much as 35 per cent.

Business is a critical friend

"The role that Graeme and his colleagues played was something of the critical friend," says Morris. "We had lost our way a bit and were struggling to see the wood for the trees. Sometimes in healthcare settings, someone coming in with a blank sheet of paper can be really powerful."

Back to that 78-year-old. What would a reconfigured healthcare system look like if it were to work in her best interests? "Well", says Currie, "it would educate her about the risk of falls as part of a primary care package; it would trigger home improvements such as grab rails to boost her stability; it would arrange regular checks on her wellbeing through the social care system; and it would ensure through her local pharmacy that she was taking correctly any medication she was prescribed.

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"So you have got a truly system-wide approach to this problem of a frail elderly person living at home on her own. That's the dream."

A dream, but perhaps still not enough. Such is the enormity of the challenge facing healthcare systems that even total and universal redesign, in line with best principles, might not meet demand. "If you do the numbers, it doesn't work," warns Oborn, who believes the ultimate solution lies in us all taking more responsibility for our own health.

"It's not just about transforming knowledge into practice; it's about rethinking what healthcare is and about a different kind of contract between the citizen and the state," says Oborn. "There has to be more understanding of the citizenship role. As taxpayers, we are part of the solution ourselves. We can't leave it all to the NHS." ■

Watch Graeme Currie's short film 'Business schools and healthcare' at wbs.ac.uk/go/graeme-currie