Introduction: the current and future challenges of healthcare management

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Introduction

The aim of this second edition of our textbook is to support the learning and development of practising managers in healthcare organizations and health systems, and those undertaking postgraduate study on programmes concerned with health policy, health management and related areas. Increasingly, these two groups overlap – more and more managers are undertaking a master’s degree as part of their intellectual and career development, and we are firm believers in the power of the interaction between academic and experiential learning that this brings. No one learns to be a manager in a classroom, or from a book. Management is learnt by doing, by experiencing the challenges and opportunities of leadership (Mintzberg 2004). But the best and most successful managers are reflective practitioners – profoundly aware of their own behaviours, attitudes and actions and their impact on others and on the organization, and able to analyse and review critically their own practice and set it in a wider context, framed by appropriate theories, models and concepts (Peck 2004). The future leaders of our healthcare systems need to be able to integrate theory and practice, and to have the adaptability and flexibility that come from really understanding the nature of management and leadership.

This chapter sets the context for the book, by first describing the challenges of the political and social environment in which healthcare systems and organizations exist, and how that environment is changing. It then describes some of the particular challenges of those organizations – some of the characteristics and dynamics which make healthcare organizations so interesting and yet so difficult to lead. Then the chapter sets out the structure of the rest of the book and explains how we anticipate that it might be used, both in support of formal programmes of study and by managers who want simply to develop and expand their own understanding and awareness.

Healthcare systems, politics and society

In most developed countries, the healthcare sector encompasses anything from 8 per cent to over 15 per cent of the economy, making it one of the largest industries in any state – bigger generally than education, agriculture, IT, tourism or telecommunications,
and a crucial component of wider economic performance. In most countries, around one worker in ten is employed in the healthcare sector – as doctors, nurses, scientists, therapists, cleaners, cooks, engineers, administrators, clerks, finance controllers – and, of course, as managers. This means that almost everyone has a relative or knows someone who works in healthcare, and the healthcare workforce can be a politically powerful group with considerable influence over public opinion. Almost everyone uses health services, or has members of their family or friends who are significant healthcare users, and everyone has a view to express about their local healthcare system.

In many countries, the history of the healthcare system is intertwined with the development of communities and social structures. Religious groups, charities, voluntary organizations, trade unions and local municipalities have all played important roles in building the healthcare organizations and systems we have today, and people in those communities often feel connected in a visceral manner to ‘their’ hospitals, community clinics, ambulance service, and other parts of the healthcare system. They raise funds to support new facilities or equipment, and volunteer to work in a wide range of roles which augment or support the employed healthcare workforce. That connection with the community also comes to the fore when anyone – especially government – suggests changing or reconfiguring healthcare provision. Proposals to close much loved community hospitals, reorganize district hospital services, or change maternity services, are often professionally driven – by a laudable policy imperative to make health services more effective, safe and efficient. But when evidence of clinical effectiveness and technocratic appraisals of service options collide with popular sentiment and public opinion, what matters is usually not ‘what works’ but what people want.

For many local and national politicians, health policy and the healthcare system offer not only opportunities to shine in the eyes of the electorate when things are going well, but also threats to future electoral success when there are problems with healthcare funding or service provision and people look for someone to hold to account. Constituents bring to politicians in their local offices concerns about healthcare services, and politicians are keenly aware of the attitudes and beliefs of the public about their local health service. While they will happily gain political benefit from the opening of a new facility, or the expansion of clinical services, they will equally happily secure benefit by criticizing the plans of ‘faceless bureaucrats’ in the local healthcare organization for unpopular changes in healthcare services, and argue that there are too many managers and pen-pushers.

Finally, for the press, TV, radio and on-line media, both locally and nationally, the healthcare system is an endless source of news stories, debates and current affairs topics. From patient safety to MRSA and pandemic flu, from dangerous doctors to hospital closures, from waiting lists to celebrity illnesses, the healthcare system is news. Big healthcare stories can command pages of news coverage in national dailies and repeated presentation on TV news bulletins, while at a local level it would be rare to find a newspaper which did not have some content about hospitals, clinics or other healthcare services in every issue. Healthcare organizations can use the level of media interest to their advantage, to raise public awareness of health issues and communicate with the community, but they can also find themselves on the receiving end of intense and hostile media scrutiny when things go wrong.
In other words, healthcare organizations exist in a turbulent political and social environment, in which their actions and behaviour are highly visible and much scrutinized. Leadership and management take place in this ‘goldfish bowl’, where their performance and process can be just as important as their outcomes. But as if that were not enough, in every developed country the healthcare system is subject to four inexorable and challenging social trends:

- the demographic shift;
- the pace of technological innovation;
- changing user and consumer expectations; and
- rising costs within a context of global economic recession.

The only certainty is that if it is difficult to make the sums add up for the healthcare system today, these pressures mean it will be even harder to do so tomorrow.

The demographic challenge is that because people are living longer, the numbers of elderly and very elderly people are rising fast – and those people make much heavier use of the healthcare system. People may live longer, but they cost more to keep alive, they are more likely to have complex, chronic health conditions, and their last few months of life tend to be more expensive. A further dimension to this demographic challenge is the rising incidence of chronic disease in the wider population of developed countries. The World Health Organization suggests that this is a direct result of risk factors such as tobacco use, physical inactivity and unhealthy diets (WHO 2005).

The second challenge is related to the first in that it reflects an increasing ability to control chronic disease and thus extend life – the pace of technological innovation. Most obviously in pharmaceuticals, but also in surgery, diagnostics, telehealth and other areas, we keep finding new ways to cure or manage disease. Sometimes that means new treatments which are more effective (and usually more expensive) than the existing ones. But it also means new therapies for diseases or problems which we simply could not treat before. Previously fatal conditions become treatable, and interventions to monitor and slow the progress of disease or manage its impact become more available.

This in turn connects with and feeds the third challenge – changing user and consumer expectations. People want more from the health service than their parents did. They are not content to be passive recipients of healthcare, prescribed and dispensed by providers at their convenience. Accustomed to ever-widening choice and sovereignty in decisions in other areas of life – banking, shopping, housing, education – they expect to be consulted, informed and involved by healthcare providers in any decisions that affect their health. They are better informed, more articulate and more likely to know about and demand new and expensive treatments.

The first three challenges are in large measure responsible for the fourth – rising costs. Each of them contributes to the constant pressure for more healthcare funding, a pressure which for many countries is currently more acute as a result of the global economic recession. However much governments or others increase their spending, it never seems to be enough. In almost every other area of the economy, productivity is rising and costs are falling through competition and innovation. We have better, faster, cheaper computers, cars, consumer goods, food, banking, and so on, yet, in healthcare,
costs are stubbornly high and continue to rise, along with demand for services. In a
time of economic recession, this challenge is made more acute by real-term reductions
in the resource available for healthcare in many countries, and hence a focus on setting
priorities or rationing availability of services.

In short, the social, political and economic context in which healthcare organiza-
tions have to exist is often a hostile, fast-changing and pressured environment. Managers
and leaders strive to balance competing, shifting and irreconcilable demands from a
wide range of stakeholders – and do so while under close public scrutiny. The task
of leadership in healthcare organizations – defining the mission of the organization,
setting out a clear and consistent vision, guiding and incentivizing the organization
towards its objectives, and ensuring safe and high quality care – is made much more
challenging by the social, economic and political context in which they work.

**Healthcare organizations and healthcare management**

Organizations are the product of their environment and context, and many of the
distinctive characteristics and behaviours of healthcare organizations result from some
of the social, political and economic factors outlined above. However, some also result
from the nature of the enterprise – healthcare itself. The uniquely personal nature of
health services, the special vulnerability and need for support and advocacy of patients,
the complexity of the care process, and the advanced nature of the technologies used,
all contribute to the special challenges of management in healthcare organizations.

Of course, we should be cautious that this does not lead us to be parochial or
narrow-minded in our understanding of what we do, or of what we can learn from
other sectors and settings. We are all prone to exceptionalism, believing that our job,
organization, profession or community is in some ways uniquely different. It can give
us an excuse for why we perform less well. We may claim that our patients are sicker,
facilities less modern, community disadvantaged, and clinicians more difficult or disen-
gaged. It also provides the perfect reason for not adopting new ideas from elsewhere –
itis would not work here, because our organization or health system is different. Health-
care systems and organizations have a strong tendency to exceptionalism, something
that needs to be challenged on a regular basis. Healthcare organizations are large,
complex, professionally dominated entities providing a wide range of highly tailored
and personalized services to large numbers of often vulnerable users. But those char-
acteristics are shared in various degrees by local authorities, police and emergency
services, universities, schools, advertising agencies, management consultancies, travel
agencies, law firms and other organizations. Healthcare is nevertheless distinctive, and
three important areas of difference deserve some further consideration: the place of
professions; the role of patients; and the nature of the healthcare process.

For managers entering healthcare organizations from other sectors – whether from
other public services, commercial for-profit companies or the voluntary sector – one of
the first striking differences they notice is the absence of clear, hierarchical structures
for command and control, and the powerful nature of professional status, knowledge
and control. Sir Roy Griffiths, who in the 1980s led a management review of the NHS
in the UK, famously wrote in his report about walking through a hospital looking vainly for ‘the person in charge’ (Griffiths 1983). But to do so would be to miss the point, which is that healthcare organizations are professional bureaucracies in which more or less all the intellectual, creative and social capital exists in the frontline workers – clinicians of all professions, but particularly doctors. Like law firms and universities, it makes no sense to try to manage these talented, highly intelligent individuals in ways that are reductionist, or which run counter to their highly professionalized self-image and culture. This does not mean that they should not be managed – just that the processes and content of management and leadership need to take account of and indeed embrace the professional culture. Things get done not through instruction or direction, but by negotiation, persuasion, peer influence and agreement. Leaders need to make skilful use of the values, language and apparatus of the profession to achieve their objectives, and learn to lead without needing to be ‘in charge’.

The people who use healthcare services, whether you call them patients, users, consumers or whatever, are ordinary people, but they are not like the consumers of many other public or commercial services. First, there is a huge asymmetry of power and information in the relationship between a patient and a healthcare provider. Even the most highly educated, confident, internet-surfing patient cannot acquire the detailed knowledge and expertise which comes with clinical practice. Very few patients are prepared to go against the explicit advice of senior clinicians, and many patients actively seek to transfer responsibility for decision-making to these professionals. At some level, patients have to be able to trust that healthcare providers are competent, and take their advice on important decisions about their health. No amount of performance measurement, league tables, audit or regulation can substitute for this trust.

Second, when people become patients and use healthcare services, they are often at their most vulnerable and are much less able to act independently and assertively than would normally be the case. They may be emotionally fragile following an unwelcome diagnosis of disease, and weakened by the experience of illness or the effects of treatment. When lying flat on a wheeled trolley, nauseous and in pain, surrounded by the unfamiliar noise and clatter of an emergency department and frightened by sudden intimations of mortality, we are at our most dependent. We are not well placed to exercise choice, or to assert our right to self-determination. We want and need to be cared for – a somewhat unfashionable and paternalistic notion which does not sit comfortably with concepts of the patient as a sovereign consumer of health services. This all means that healthcare organizations, and those who lead them, have a special responsibility to compensate for the unavoidable asymmetry of power and information in their relationships with patients, by providing mechanisms and systems to protect and advocate for patients, seek their views, understand their concerns, and make services patient-centred.

Despite all the high technology medicine, complicated equipment and advanced pharmaceuticals available today, the healthcare process itself is still organized very much as it was a hundred years ago. It is a craft model of production in which individual health professionals ply their trade, providing their distinctive contribution to any patient's treatment when called upon. This is not mass production. Healthcare
organizations such as hospitals are much more like marketplaces than they are like factories, with the patients moving from stall to stall to get what they want, not being whisked smoothly along on a conveyor belt from start to finish. Fundamentally, it is an unmanaged and undocumented process. Usually, there is no written timetable or plan showing how the patient should move through the system, and no one person acts as ‘process manager’, steering and coordinating the care that the patient receives and assuring quality and efficiency. This model has endured because of its flexibility. The patient care process can be adapted endlessly or tailored to the needs of individual patients, the circumstances of their disease, and their response to treatment. But the complexity of modern healthcare processes, with multiple handovers of patients from one professional to another, the ever-accelerating pace of care as lengths of stay get shorter and shorter, and the risks and toxicity of many new healthcare interventions (the flip side of their much greater effectiveness) all mean that the traditional model is increasingly seen as unreliable, unsafe, and prone to error and unexplained variation (Walshe and Boaden 2005). More and more, healthcare organizations use care pathways, treatment plans and clinical guidelines to bring some structure and explicitness to the healthcare process. Techniques for process mapping and design, commonplace in other sectors, are increasingly used not just to describe the healthcare process but in so doing to identify ways in which it can be improved (McNulty and Ferlie 2004). Like any area where custom, practice and precedent have long reigned supreme, healthcare processes are often ripe for challenge. Why does a patient need to come to hospital three times to see different people and have tests before they get a diagnosis? Can’t we organize the process so that all the interactions take place in a single visit? Why are certain tasks only undertaken by doctors or nurses? Could they be done just as well by other healthcare practitioners? Gradually, the healthcare process is being made more explicit, exposed for discussion debate and challenge, and standardized or routinized in ways that make the delivery of healthcare more consistent, efficient and safer.

In conclusion, there is one other important feature of healthcare organizations. Whether they are government-owned, independent not-for-profits, or commercial healthcare providers, they all share to some degree a sense of social mission or purpose concerned with the public good (Drucker 2006). The professional values and culture of healthcare are deeply embedded, and most people working in healthcare organizations have both an altruistic belief in the social value of the work they do and a set of more self-interested motivations to do with reward, recognition and advancement. Similarly, healthcare organizations – even commercial, for-profit entities – do some things which do not make sense in business terms, but which reflect their social mission, while at the same time they respond to financial incentives and behave entrepreneurially. When exposed to strong competitive pressures, not-for-profit and commercial for-profit healthcare providers behave fairly similarly, and their social mission may take second place to organizational survival and growth. The challenge, at both the individual and organizational level, is to make proper use of both sets of motivations, and not lose sight of the powerful and pervasive beneficial effects that can result from understanding and playing to the social mission.
About this second edition and how to use the book

The first edition of this book received very positive and encouraging feedback from the outset, particularly in relation to the balance between academic rigour and practical application of concepts and ideas. When given the opportunity to prepare a second edition, there were a number of key areas where we wished to focus our attention, these being:

- making the book more international in its content and outlook;
- being more critical and reflective in tone and content; and
- addressing more explicitly those areas which had become more significant over time, such as the globalization of healthcare, the rising prevalence of chronic disease, priority setting within resource allocation, and the role of social and home care.

We have therefore made significant revisions for this second edition. First of all, in relation to the structure of the book, this time we organize our material within: systems; services; organizations; and management and leadership. Thus we move from macro topics such as politics, funding, resource allocation, through an examination of the issues concerned with the management of specific services such as primary, secondary, mental health and social care, to an examination of organizational concerns such as user involvement, health purchasing, and the use of IT, and focus finally on the specifics of leadership and management in a more practical context, such as finance, human resources, and the use of research.

In addressing the need for the book to be more international in its focus, we have drawn this time on a more international group of authors, including from the USA, Australia and Germany, and have included a new chapter on the internationalization of health systems and policies. All chapter authors were encouraged to draw on a wider range of international material, and this they have done, with many examples of research and practice from across the world.

In terms of adopting a more reflective and critical approach, we asked authors to draw on a wider base of evidence when exploring their topic, and, in the context of taking a more international approach, to avoid any undue focus on their own health system, and instead to question their own experience using international and critical research material. We have also added a chapter to this second edition with explores the management of knowledge within healthcare – this in itself provides the context for a more critical and reflective approach to healthcare management and leadership.

Finally, in respect of topics we felt needed to be addressed in this second edition, the new entrants are:

- Allocating resources for healthcare – setting and managing priorities (Chapter 4)
- The internationalization of health policies and systems (Chapter 7)
- Healthcare services: strategy, direction and delivery (Chapter 8)
- Chronic disease and integrated care (Chapter 10)
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- Social care (Chapter 13)
- Managing knowledge (Chapter 27).

All other chapters have been rewritten and edited to a significant degree, reflecting both the pace of change within the world of healthcare, but also our desire to ensure that the book is constantly improved in the manner that we exhort within a number of the chapters. We hope that you will appreciate the changes that we have made, and find the book to be as useful and thoughtful as ever, but with a much stronger international flavor, and a deeper base of evidence from research and practice.

The 26 chapters of the book which follow this introduction and overview are split into three main parts as follows.

**Part 1: Health systems**

Chapters 2–7 aim to set out the wider political, social and economic context in which healthcare organizations exist, namely ‘health systems’. These chapters provide the ‘big picture’ which helps to explain how health systems are shaped, and the way in which their constituent healthcare organizations behave, remembering that, as observed earlier, organizations are very much a product of their environment and context. This part covers health policy and the political process (Chapter 2); healthcare financing and funding (Chapter 3); allocating resources, and setting and managing priorities (Chapter 4); healthcare technologies, research and innovation (Chapter 5); health and well-being and the wider health agenda (Chapter 6); and the internationalization of health systems and policies (Chapter 7).

**Part 2: Healthcare services**

Part 2 aims to covers the issues and topics which are particular to the services which make up the business of healthcare itself. In other words, it explores the different care sectors of a health system, examining the management and other issues associated with each sector. It starts with a chapter on the overall strategy, direction and delivery of health services (Chapter 8). There are then five chapters about managing in different care sectors: primary care (Chapter 9); chronic disease and what is increasingly referred to as ‘integrated care’ (Chapter 10); acute care including secondary and tertiary services (Chapter 11); mental health (Chapter 12); and social care (known as disability services in some countries) (Chapter 13).

**Part 3: Healthcare organizations**

Part 3 focuses on the underlying architecture of health systems and organizations – the human resources, management mechanisms, and policy levers which are at the disposal of managers as they seek to organize, co-ordinate, and enact the delivery of services within different care sectors. It concludes with an examination of the role of the most important stakeholders within healthcare: users and patients. The first chapter in this section is concerned with how healthcare is purchased or commissioned...
(Chapter 14) – the way in which managers in a health system allocate resources to providers in a way that ensures that people’s health needs are met. This is followed by a consideration of the issues associated with buildings, facilities and equipment in healthcare (Chapter 15) and another chapter which explores the ways in which information technology and information systems are used in healthcare, and the challenges and opportunities presented by their increasing capability and complexity (Chapter 16). The array of issues associated with the healthcare workforce is explored in Chapter 17, and then the final chapter of this part (Chapter 18) considers the role and experience of patients, users and the public within health systems and organizations.

Part 4: Healthcare management and leadership

In this final section of the book, the focus shifts to the day-to-day business of healthcare management – what managers and leaders do, how they do it, and what the research evidence has to offer such practice. Part 4 opens with a chapter on leadership and governance (Chapter 19), exploring how organizations can ensure that they operate in a manner that is transparent, efficient, and accountable, and in so doing, develop a culture that is open, healthy and supportive of the provision of high quality healthcare. Chapter 20 homes in on the individual manager or leader, examining personal and organizational development, and the ways in which managers can adopt reflective practice for themselves and the teams and organizations they lead. The management of change is a constant challenge for healthcare managers, and this is considered in detail in Chapter 21. In Chapter 22, the management of resources in healthcare is explored, including issues such as budgeting, business planning, paying for activity, and the use of incentives such as pay-for-performance. The most important and costly healthcare resource – people – is the subject of Chapter 23 which explores in a very practical and direct manner what is required for effective management of people.

The final four chapters conclude the book with an exploration of generic issues that preoccupy and bedevil healthcare management throughout the world: quality and service improvement (Chapter 24); the management of performance (Chapter 25); managing across organizations in networks and partnerships (Chapter 26); and managing knowledge – research, evidence, and decision-making (Chapter 27).

While the content of each chapter has led its design, we asked our authors to follow a broadly consistent format in order to make the materials in the book as useful and readable as possible. You will therefore find each chapter is structured into around five or six sections, and we make liberal use of figures, tables, charts and diagrams to illustrate the content. Each chapter concludes with the following:

- **Summary box** containing key points drawing together the main messages from the chapter.
- **Self-test exercises** designed to help you to apply the content of the chapter and your learning to your own organizations. The exercises generally consist of a number of questions which we suggest you use as the basis either for personal reflection or for discussion with colleagues.
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- **References and further reading** with details of books, reports, journal articles and other materials referenced in the chapter or intended to provide background reading for you on the topic.

- **Websites and resources** where you might seek further information. We have done our best to ensure these are as up to date as possible, but bear in mind that content on the internet does change rapidly and so some links could no longer be current.

Finally, we would welcome comments on and ideas for improvement of this book. Whether you use it casually for your own development or more intensively as part of a postgraduate programme of study, we would like your feedback. Please email either one of us at kieran.walshe@mbs.ac.uk or judith.smith@nuffieldtrust.org.uk.

## References and further reading


