KPMG

Value walks

Successful habits for improving workforce motivation and productivity in healthcare

KPMG International

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People create value for patients

Preface

For decades now, much of the health policy being debated across the world has focused on laudable but technocratic changes aimed at influencing the way in which healthcare is delivered. As a result, reform has tended to concentrate on payment systems, governance practice, organizational structures, regulation, better purchasing and the welcome explosion of clinical information to patients and citizens alike.

But anyone who has ever managed a healthcare provider will tell you that the most important and sustainable differences to the quality and cost of patient care actually result from the design of the clinical care process, the degree of innovation in the business model, and the motivation of staff. Indeed, all too often, pushing a single-minded focus on productivity ends up demoralizing professionals and other staff. With this in mind, we have developed this report to examine how health system leaders can create a seemingly paradoxical synergy: enhancing productivity while simultaneously increasing work attractiveness and professional motivation.

It is easy to become anxious about the future of healthcare. In some parts of the world, economic crisis has forced countries to make sweeping changes — politically, economically and socially. In its wake, funding for healthcare services, both public and private, has come under pressure and retrenchment has begun. But the simple truth is that, even once the global recession passes, countries will never be able to return to the golden days when healthcare expenditure outstripped GDP growth by between 0.5 percent and two percent per annum for decades at a time. This deal has changed forever.

A new era has clearly dawned, whether we like it or not. In the West for example, the combination of slower economic growth, ageing populations, smaller tax-paying workforces and rising healthcare demands is already forcing countries to address some deep seated, pernicious problems. Against this backdrop, many pundits suggest that demography has become our destiny.

Dr. Mark Britnell
Chairman & Partner,
Global Health Practice,
KPMG in the UK

Dr. Marc Berg
Partner,
Global Health Practice,
KPMG in the US

Looking back, the casual observer would be inclined to agree; hindsight shows that healthcare has almost always tried to ignore these vexed issues, choosing instead to demand a higher share of economic growth and ramp up staffing levels to respond to immediate 'pain-points'. But the reality is that this approach is simply not sustainable. A more radical approach that can deliver both better quality and lower cost must be found if we are to fundamentally address the challenges that are already upon us.

With deeper analysis, it becomes clear that while for the past 60 years or more technical, therapeutic and professional advances have revolutionized many clinical procedures, the truth is that the underlying business and care models have remained largely unaltered. Unlike most other industries, healthcare has proved to be particularly stubborn when faced with radical change.

In part, this is because many of the new care processes have become imprisoned in the wrong physical infrastructure. Some hospitals lack specialist skills for some of the work they do, even while they provide an over specialized service to patients with multiple chronic conditions. Frequently, different care pathways collide in an uncoordinated fashion and produce sub-optimal quality and cost. At the same time, many primary care systems are underweight and need to be 'bulked up'. Indeed, the growing elderly population and explosion of patients with long-term physical and mental conditions are a painful reminder that while today's health systems need different care models fit for the twenty-first century, the day-to-day reality threatens to swamp existing institutions designed for the last century. Clearly, entrenched views make for slow change.

There is a better way. We firmly believe that the five successful habits that we have identified for improving workforce motivation and productivity can produce better quality at lower cost. Christensen, Porter and others have articulated a clear case for clinical and business model change. Their work has demonstrated that the pursuit of better patient value will necessitate care model change that is based on the simultaneous achievement of better segmentation, stratification and integration.

Our own work suggests that key ingredients are: the use of sophisticated population modeling techniques that predict risk and assemble a new primary care system focused on supporting wellness and monitoring illness tele-medically; bigger solution shops embedded in local communities and packed with diagnostic capability; integrated services for long-term conditions that create new value-adding businesses; and actively managed and facilitated networks that separate predictable elective procedures from 'hot' emergency work, much of which can be both centralized and networked to improve outcomes.

As is increasingly being found in other industries, involving customers (or in our case, patients) in co-production and co-design can dramatically reduce costs, improve satisfaction and enhance outcomes. There are ample examples of those approaches being successfully harnessed throughout the world. Dedicated trauma facilities in Canada and Australia, centralized stroke facilities in England, mass production facilities in India (eyes and hearts) and dedicated orthopedic centers in Scandinavia all show what is possible. In America, Kaiser Permanente's new 'cyber care' approach points to what the empowered patient, when facilitated by technology, can achieve. Experience in South America and Africa tell a clear story of how new and extended non-traditional models of community care can produce substantial health gains.

Our research demonstrates that organizations that are able to achieve these types of transformative changes can increase productivity and work attractiveness simultaneously by adhering to five basic habits. For one, successful organizations tend to have a **strategic focus on value for patients**.

And when this is driven by **empowered professionals** with considerable autonomy to achieve outcomes, it produces real benefits. We have also found that by combining the **intelligent and systematic application of business and care process re-design** with a greater level of discretion to change staff roles, adjust deployment and 'crew' staff teams, organizations can achieve more stringent adherence to agreed protocols and collective responsibilities. This will require improved management information to support **steering staff performance using outcome measures** rather than process and input targets. Indeed, the reduction of clinical variation is often controlled, designed and directed by these teams once high-level goals have been agreed with management. Finally, **active staff performance management and accountability** built on robust dialogue, supportive development and clear lines of responsibility can produce superior levels of discretionary effort.

Underlying these habits is a strong body of evidence that demonstrates that higher staff morale and motivation has a beneficial effect on the patient experience. At the same time, the active maximization of clinical time and the reduction of non-value activities is a central tenet to achieving better quality at affordable costs. Sadly, this is an overwhelmingly neglected area, especially in the public sector.

Based on our experience in the sector, we believe that the development of new models and forms of clinical education and training in developing

countries represent a great opportunity for educational and healthcare organizations in the West to create mutually beneficial relationships for a sustainable future. If we are to achieve the levels of change necessary then it will be vital that Professional Organizations, Trade Unions, and patient groups are included in the ongoing debate on how policy approaches can be implemented in specific countries and contexts.

If one were to truly believe that demography is destiny then it stands to reason that healthcare is in serious trouble. Already, we are witnessing significant workforce shortages in many developing countries and ageing populations in developed countries. And with fewer staff and more people to care for, we can expect to experience both unaffordable labor costs and further global migration of skilled staff from poor to rich countries. Take, for example, Africa where more than 30 percent of the world's disease burden is concentrated, but only three percent of the workforce. Clearly, raising staff productivity is absolutely crucial for the wellbeing of billions of people.

Our research also demonstrates that — all too often — staff is seen as a cost to the system. The old mind-set that subscribed to the belief that 'cost walks on two legs' needs to be replaced with a new one: 'value walks on two legs'. This is not just a philosophical nuance. While the current financial climate has led many organizations to opt for 'quick fixes' through blunt staff retrenchment and redundancies, the reality is that, in the long run, mass redundancies in healthcare almost always turns out to be unproductive.

Indeed, evidence suggests that dramatic and unsophisticated cost cutting does not last and that costs bounce back. Simply put, the recruitment and training of staff is a costly affair, particularly when all evidence points to the fact that we will need all of the workforce we currently have, and more. Surely the better path, therefore, is to enhance our health workforce's ability to create more value, efficiency and productivity, meaning that — in the short-term — flexible right-sizing may be the better option. For example, rather than redundancies, health systems may instead focus on the temporary adjustment in working hours coupled with clinical re-design to effectively reduce costs without impacting on quality.

We would like to thank our clients and all of those that participated in this valuable research. Those seeking more detailed analysis of our findings can read the full report at kpmg.com/healthcare.

We hope that this report raises the profile of what is currently a relatively neglected issue, and that workforce considerations will become a more prominent component of the debate on maximizing value and reducing costs in health systems around the world.

Dr. Mark Britnell
Chairman & Partner
Global Health Practice

Dr. Marc Berg
Partner
KPMG in the US
Global Health Practice

The workforce challenge

Introduction

The healthcare systems of the developed world are coming under serious long-term pressure. Populations are ageing and demand for health services is ballooning. At the same time, it is becoming increasingly clear that the quality of care being provided is highly inconsistent. Healthcare's workforce stands at the heart of these issues. To meet rising healthcare demand, more people are needed to do the work — while as a whole nations' workforces are or will be declining. To deliver high quality care, a highly motivated and skilled workforce is essential. Finally, and paradoxically in the light of these long term trends, to reduce costs, workforce productivity is a core focus: workforce, after all, constitutes the largest single cost factor of healthcare systems.

The workforce challenge is far from simple, and we will need to rethink common assumptions to tackle the issues at stake. When the issue is reduced to discussing the 'numbers' of professionals needed, we will miss the point. The truth is that in developed countries, projected shortages in the past has usually failed to materialize — we have always just spent our way out of the problem. Theoretically, we could do this again. The problem, however, is that we simply cannot afford to do this anymore — whether in developed or in developing countries.

Simply pushing for more productivity is also not going to be a long-lasting solution. Pushing productivity too unidimensionally will hurt the very motivation of the workforce that we need so urgently to drive quality improvement efforts and face the pressures building up on the system.

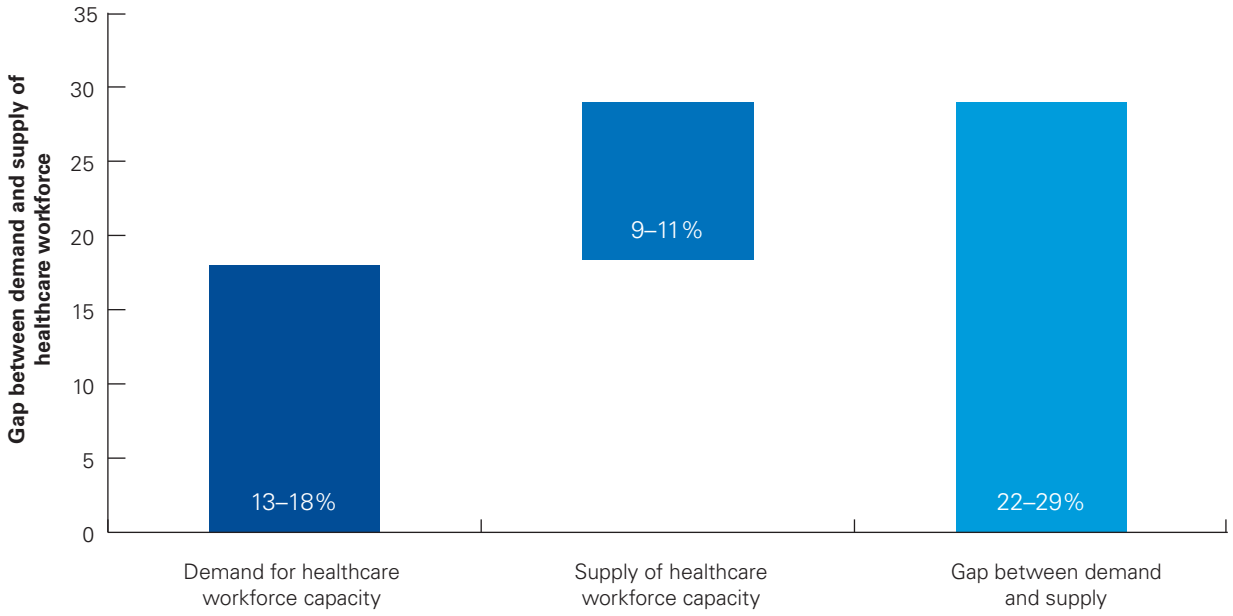
So how do we solve the dilemma of increasing demand for health services while our resources are dwindling? Can quality be enhanced in the process? Can we make healthcare workers more productive while making the work more attractive?

To answer some of these questions, we have examined a range of inspiring examples from around the world to demonstrate that with concerted effort and transformative change there is a solution. The examples that we have used are proven and come from real provider organizations. And in most cases, they have shown to have a direct and simultaneous impact on workforce productivity, quality of care and employment levels. By combining the lessons learned from these organizations, we hope to show how the optimal synergy between these three — often conflicting — objectives can be achieved.

Please mind the gap

There is little doubt that health systems in the developing world are approaching a widening chasm between the rapidly growing demand for health services and a steady decline in the quantity of health workers. Indeed, our analysis shows that by 2022, the OECD countries will be facing a workforce shortfall of somewhere in the region of 22 to 29 percent (see Figure 1).[1,2]

Figure 1: Gap between demand for and supply of healthcare workforce capacity by the year 2022



Source: OECD data, Analysis: KPMG International, 2012.

Is demography our destiny?

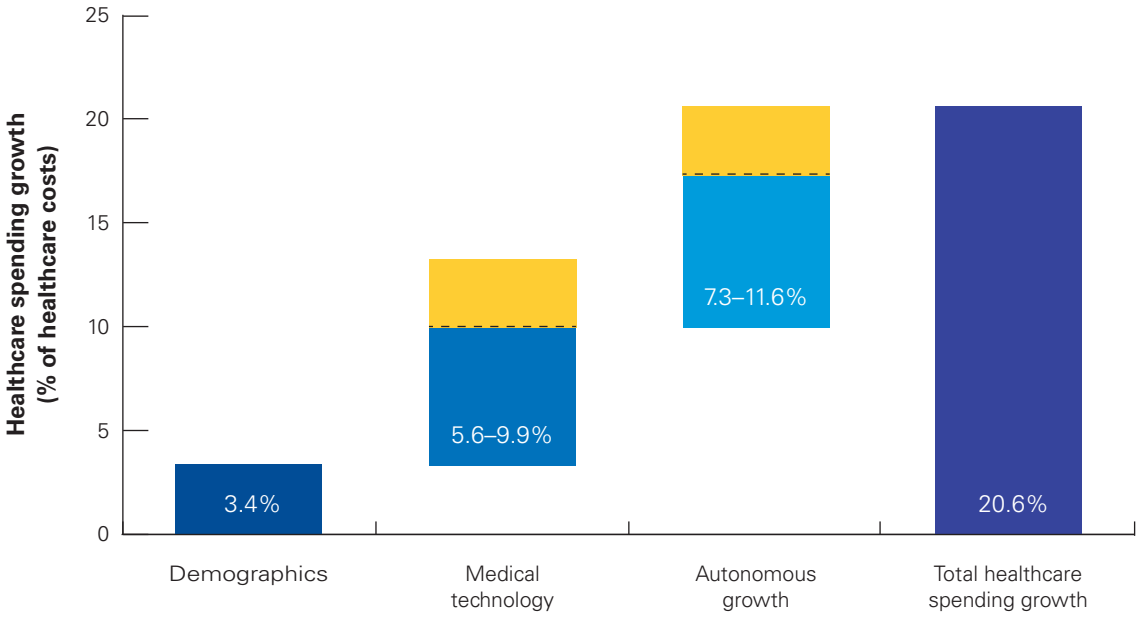
The causes of this gap are fairly clear. Demography plays a role: as shown in Figure 2, over the last decade demography explains 3.4 percent of the growth of 20.6 percent in costs in OECD countries. Larger parts of spending growth of the last decade are caused by medical technology (5.6-9.9 percent) and autonomous growth (13–18 percent) due to factors such as prosperity (which is associated with higher spending on healthcare) and supply induced demand.

Over the next decade we expect an additional demand caused by demography of 6.1 percent and, assuming autonomous growth continues for the next decade, we can expect a total demand for the healthcare workforce of 13 - 18 percent (see Figure 1). In this estimation we downplayed the effects of medical technology development because these are primarily seen in healthcare expenditure. New medical technologies will however require additional healthcare professionals or professionals with new skills.

[1] Included in this report are the EU-15 countries and the US, Canada, Japan and Australia. Other economies like India, Singapore and China are not members of the OECD and are not included in this report due to unavailable internationally comparable data.

[2] For more details, please see chapter 2 and 3 of the background report, available on our website kpmg.com/healthcare

Figure 2: Breakdown of healthcare spending growth as percent of GDP between 2000 and 2009 in OECD countries



Figures on Medical technology and Autonomous growth are ranges indicated by dashed lines.

Source: OECD data, Analysis: KPMG International, 2012. For more details see full report at kpmg.com/healthcare.

Where are all the health workers going?

Demography also plays a part in the steady decline in the number of healthcare professionals in the developed world. In part, this is because as ageing populations retire, economies experience an overall decrease in the number of people of working age. For the healthcare sector, this will result in a decline of between four to six percent over the next ten years.

Yet again, there is more to the story than simple demography. Overall, employees are putting in fewer hours every year. Our research shows that part-time employment has risen from 16 percent in 2000 to 19 percent in 2009. The average number of hours worked per week has also dropped by almost seven percent over the past twenty years. If this trend is allowed to continue for another decade, we estimate that the average work week will shorten by an extra 5.6 percent to just under 34.5 hours. The combined effect of these developments is a drop in healthcare workforce capacity of between nine and 11 percent by the year 2022 (see Figure 1).

Building the bridge: Can we afford it?

On face value, it would seem certain that a 22 to 29 percent shortage of healthcare workers in developed countries would signal that healthcare systems are set to suffer from a massive shortfall of qualified healthcare professionals. However, while these numbers seem threatening, there are a number of potential policy measures available that could increase the number of professionals and significantly close the gap.

The most obvious relates to the setting of retirement ages and the number of hours worked per year which differs greatly among OECD countries. Indeed, if all countries shared Japan's high retirement age and Greece's work hours, OECD countries could, in theory, enjoy a 35 percent gain in total labor capacity (see Figure 3). Another policy-level measure that could help close the gap lies in increasing female participation rates. Differences between OECD countries are substantial, and could represent a 10 percent labor capacity gain if the average OECD country achieved Northern European standards on female participation.

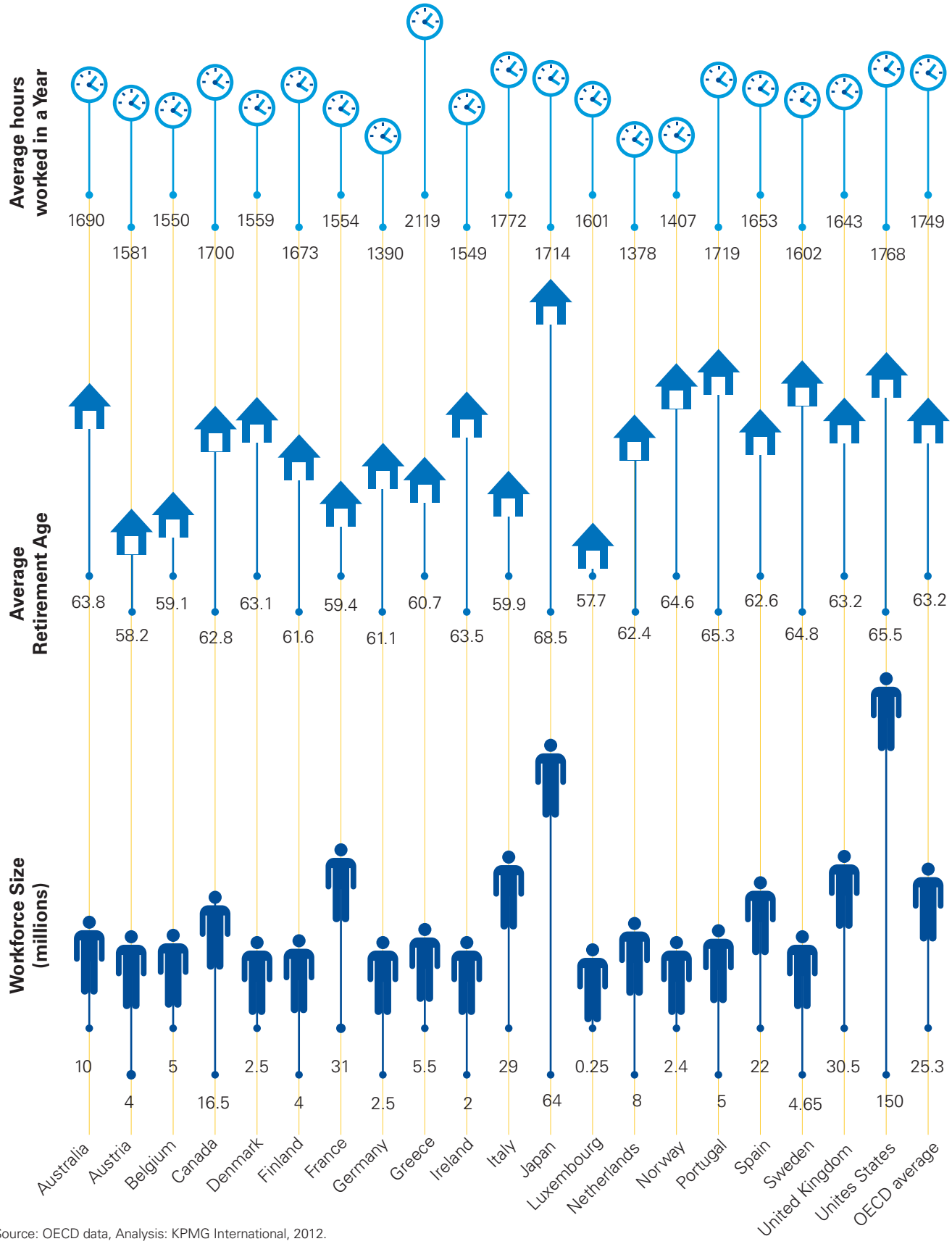
Significant variances between OECD countries also emerge when comparing the size of the total healthcare workforce as a share of total employment. While the average rate for the OECD countries is currently 10 percent, there are significant differences across the board: Greece has one of the lowest participation rates with just five percent of the total workforce employed in the healthcare field, whereas in Norway, 20 percent of total workers are healthcare employees. If all OECD countries would achieve the rates of Norway, we would see a 100 percent capacity increase as participation rates move from 10 to 20 percent. As can be seen in Figure 4, the combination of these policy measures could result in an almost 300 percent increase in the healthcare workforce.

The point here is not to argue that a 300 percent increase in healthcare workforce is realistically possible. We cannot maximize all policy levers at the same time (even if we wanted to): Greece's long working hours, for example, are partly caused by low female participation in the Greek economy. In addition, maximizing all these levers may not work wonders on the productivity of the overall workforce available. The point here, however, is that in the light of this, overcoming the potential gap of 22 to 29 percent is not unfeasible. The core question is whether we can afford it.

While a dramatic shortage of healthcare professionals may not fully materialize, it is clear that health systems cannot afford to keep throwing money at the problem. This will force a radical change in the way we approach 'the workforce challenge'. In the developing world, the problem is even more severe; the WHO estimates that some 60 African and Asian countries will face a critical shortage of healthcare workers but will not have the economies to allow them to spend their way out.

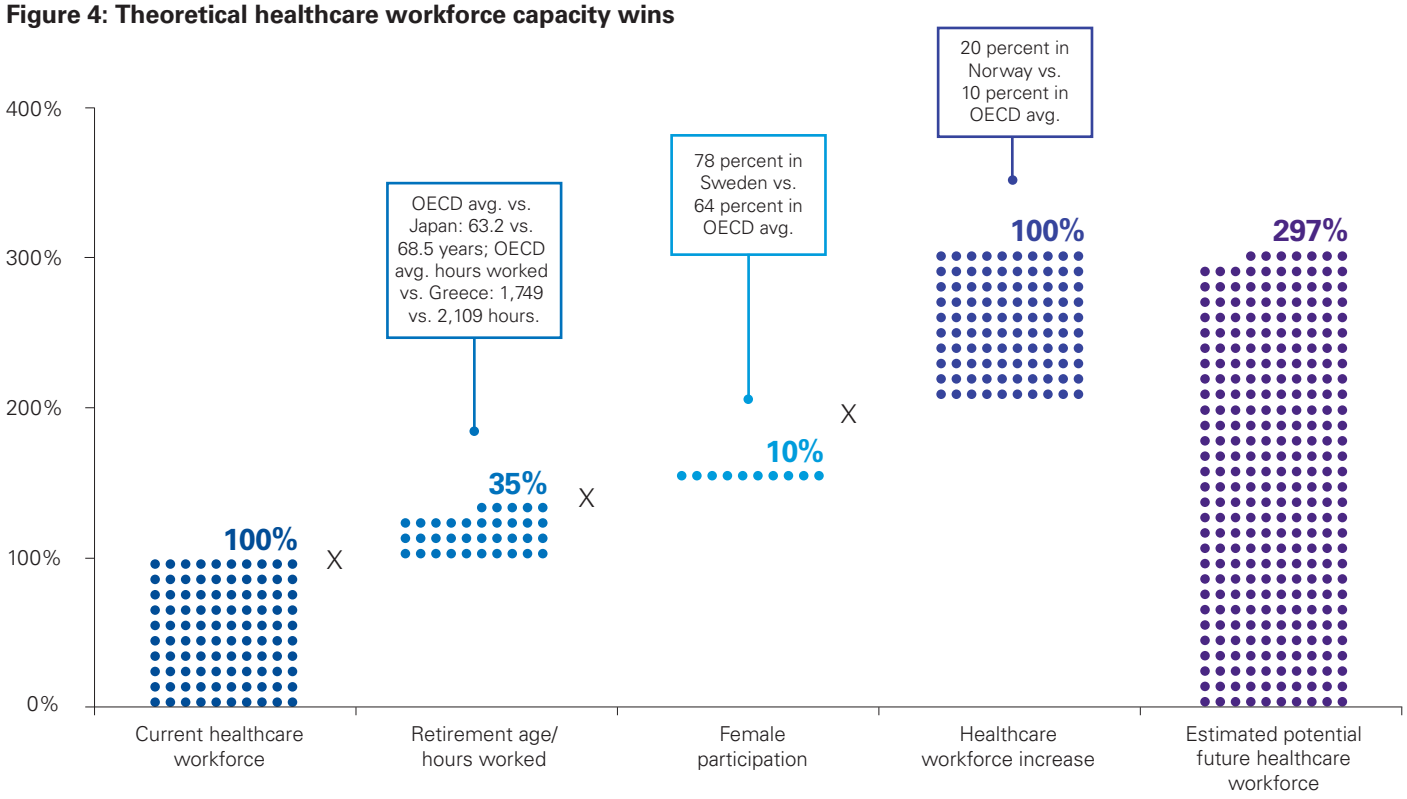
The simple truth is that to meet this challenge there really is only one solution: to make substantial improvements in the productivity and capacity of the healthcare workforce. This is, in our opinion, the only way that countries can simultaneously reduce the cost of healthcare and the need for more healthcare workers. In our global search for best practices, we found a number of providers that have been able to increase the productivity of their professionals, while also improving the quality of care and the attractiveness of the work. By broadly applying the lessons provided by these (sometimes surprising but equally inspiring) examples from around the world, we believe healthcare systems can develop a truly sustainable route to addressing the global workforce challenge.

Figure 3: The average number of hours worked per year and the average effective retirement age of countries, compared by workforce



Source: OECD data, Analysis: KPMG International, 2012.

Figure 4: Theoretical healthcare workforce capacity wins



Source: OECD data, Analysis: KPMG International, 2012.

Labor shortages: demography is not destiny

Most experts agree that the labor market is dynamic, involving dozens of moving pieces that interact together to affect economic growth and the labor supply. It is far from a simple equation that measures the number of available jobs against the available workforce. Indeed, by focusing solely on the number of jobs and the number of workers, one risks ignoring important complexities, such as the changing levels of immigration, the retirement age and productivity. Simply put, demography is not destiny and the number of potential workers in each age bracket is only one potential factor in the complex equation that determines the supply of available labor.

Labor shortages in developing countries

Our research shows that the predicted shortages of healthcare professionals will probably not materialize in OECD countries, assuming they have the funds to 'spend their way out'.

However, according to estimates by the World Health Organization (WHO), many developing countries now face severe shortages of healthcare professionals and, as a result, the provision of essential health services is at risk. Clearly, funding is a major challenge and, while increasing the productivity of the existing workforce will be a key objective for those countries, even more imaginative solutions are going to be needed if the developing world hopes to bridge the potential workforce gap.

Importing workforce from overseas

Although the quantity of personnel available in any given country is largely dependent on national labor market conditions, there are a number of examples of countries importing large numbers of healthcare professionals from other countries to close the workforce gap. However, if one were to examine global healthcare labor markets, it seems clear that importing healthcare personnel is not the most desirable way to deal with a national labor shortage (Crisp 2010). Importing healthcare professionals only relocates the potential labor shortage in healthcare, often to less developed countries where wages are lower. Importing personnel from less developed countries also means taking highly educated people away from countries that may have struggled to pay for their education in the first place.

Enhancing the productivity of healthcare providers

While 'solving' the workforce problem by raising overall costs to unacceptable levels is not a viable solution, pushing hard on productivity also carries clear dangers.

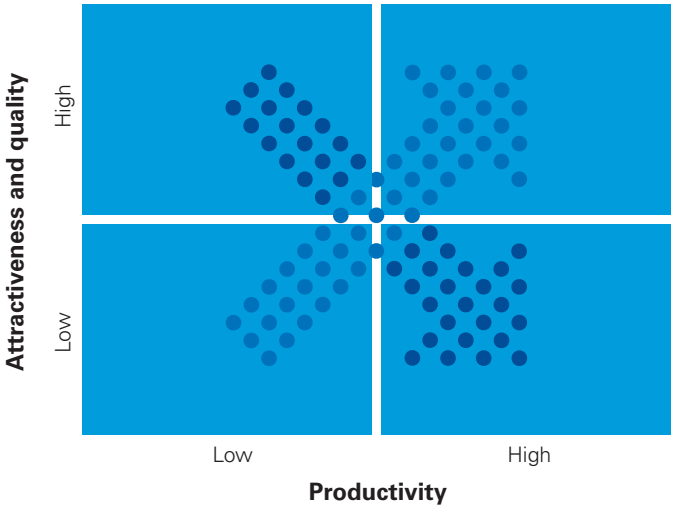
Healthcare providers could simply slash their costs, as many businesses do in times of economic shortfall. But this is not advisable for two reasons. First, research shows that cost reductions made during financially difficult times are often not sustainable. On average 93 percent of costs cut are believed to return when businesses refocus on growth after a period of cost cutting (KPMG, 2011). Indeed, sustainable cost-efficiency programs tend to require businesses to engender a clear focus and vision, increase transparency and enhance employee engagement: capabilities that are lacking in many businesses and particularly difficult for healthcare organizations.

Second, blunt cost-cutting measures are often shown to have a negative impact on both the quality of care and the engagement of professionals and other workers. Simply put, asking employees to work harder is not a proven recipe for success. Requiring professionals to see more patients per day could lead to diminished quality and a higher risk of medical errors. What is more, such measures generally decrease workforce satisfaction, leading to increased levels of absenteeism and decreased employee retention rates (see the red arrow in Figure 5). Clearly, if the healthcare sector were to lose focus on quality and attractiveness, then the significant potential of labor supply will be lost, leading to a downward spiral that we cannot afford.

The challenge therefore, is to close the potential workforce gap in a new and radical way: by enhancing the productivity of healthcare personnel while at the same time improving the quality of care and improving the attractiveness of healthcare work. Our research clearly shows that this approach can result in cost savings, quality gains and a more satisfied workforce (as illustrated by the green arrow in Figure 5).

Figure 5: The challenge: enhance productivity, quality and work attractiveness.

All too often, pushing productivity reduces workforce motivation and work attractiveness, which negatively affects the quality of the work delivered: the red arrow. The challenge lies in finding the habits behind the green arrow: enhancing productivity while simultaneously increasing quality, workforce motivation and work attractiveness.



Source: KPMG International, 2012.

The five successful habits for improving workforce motivation and productivity

As we examined the world's healthcare systems to find best practices, we identified many providers that had successfully increased the productivity of their professionals while also achieving gains in quality and enhanced attractiveness of healthcare work.

What we found was that, while providers vary in structure, resources and culture, there were a number of commonalities that characterized the systems that had found a recipe for productivity, quality and attractiveness gains. We call these the five successful habits for improving workforce motivation and productivity.

The first characteristic is that successful organizations tend to exhibit a **strategic focus on value for patients**, accompanied by **empowered professionals** who are responsible (often jointly with line management) for the organization of the care delivery process. Successful organizations also demonstrate strong capabilities in intelligent **task and business process redesign**. This means that care tasks for patients are re-allocated in a way that allows the different skills of professionals to be maximized in an environment where no task is seen as 'out of bounds' for some professions because of boundary disputes. As a result, decisions and responsibilities are handed to those who are best equipped for the task regardless of ingrained customs. This empowerment of different professionals goes hand in hand with the fourth habit of successful organizations which sees the control of these professionals over the outcomes of their work enhanced through increasingly sophisticated ways of **steering on outcomes** by leveraging available management information.

Indeed, with the proper information, professionals are often able to monitor their own work processes and improve quality and productivity performance. In addition, access to management information has been shown to help create greater levels of accountability between the professionals and organizational leadership. Finally, successful organizations also tend to **actively manage staff performance** in a way that empowers staff to flourish through the adoption of a variety of policies such as developing clinical leadership and accountability, training and education, intelligent absentee management and so forth.

1. Strategic focus on value for patients

Writing in the New England Journal of Medicine Dr Tom Lee of Massachusetts General Hospital says: '"Value" is a word that has long aroused skepticism among physicians, who suspect it of being code for "cost reduction." Nevertheless, an increasing number of healthcare delivery organizations now describe enhancement of value for patients as a fundamental goal'. It is clear from our case studies that this is the key first step to unlocking improved quality, reduced costs and increased productivity.

Organizations need to have a clear view about what constitutes value for patients and use this to set its strategy, measure success and as the basis for conversations with front line staff. Having a strong sense of purpose based on what matters to patients and ensuring that there is a focus on this at all levels of the organization means that it is much more likely that there will be alignment between professional and managerial goals. This is a crucial requirement for success in the other key habits we have identified and makes difficult conversations about the redesign of work processes, performance, etc easier and more constructive.

Our global research shows that successful organizations need to embed the search for value for patients in all aspects of the organization including their goals, management information, recruitment methods, reward systems, strategies and the behavior of staff at the frontline.

2. Empowered professionals

Command and control methods do not work well in complex environments. Staff that have limited discretion will be less able to solve problems, identify improvements or exercise initiative: worse, low levels of autonomy have been found to have a negative impact on patient mortality and the retention and recruitment of staff. Daniel Pink's summary of the research in this area has found some surprising results. For simple tasks, standard monetary motivators work, but they may not work at all for complex and cognitively demanding tasks. Staff need pay that meets their needs and feels fair but once this is in place, three additional factors are required:

— Autonomy — the ability to direct the course of one's own work.

— Mastery and self-challenge — The overarching desire for people to improve themselves, gain experience and get better at what they enjoy.

— Purpose — The reasons staff do what they do. Doing tasks merely for money and profit is not very motivating, but doing tasks to make someone's life better, to make the world better, to have a well defined purpose to work and to make money — that is motivating. This is why the first habit is so important.

There are some additional steps to ensure that empowerment is effective. Firstly, if professionals are to be in the lead they will need to learn leadership and team working skills and be coached and supported as they learn.

This needs to include improvement skills and the time to use them. Secondly, as the Virginia Mason case study (see page 24) shows there often needs to be an explicit discussion about what is expected from staff and how they will be held to account. There needs to be a change in the traditional relationship between physicians and their organization. In the past there has been little accountability and autonomy was interpreted as the freedom to practise medicine in a wide variety of different ways unconstrained by cost considerations. A new model of responsible autonomy needs to be negotiated in which professionals are held to account for outcomes and where decisions to depart from evidence based pathways of care are recorded and discussed. For nurses and other staff more autonomy and control, supported by high quality front line leaders is important. Thirdly, empowerment is supported by improved team working which is also associated with fewer errors, lower nurse burnout and higher quality care — including possibly reduced mortality.

Team working does not just happen and needs to be developed and nurtured.

3. Task and process redesign

Many tasks and processes in healthcare have not been systematically designed and often have more to do with the convenience of the staff and tradition than with the needs of the patient. The widespread use of methods to improve efficiency through the standardization and systematic redesign of care is a key habit of the organizations we studied. The best embed continuous improvement in the work of their staff as well as more radical redesign of staff roles and work processes. A surprising finding is that improved efficiency, which may also mean seeing more patients, can increase job satisfaction by removing the pointless work staff have to do to fix broken systems, look for missing equipment or deal with failure to get care right first time.

As we see in the case study from Mozambique, sometimes quality and costs can be improved by training workers to take on tasks that have only previously been done by doctors.

While there are many opportunities to shift tasks to lower paid and less extensively trained staff it is a mistake to assume that this is always the answer. In emergency care it seems that having the most skilled and experienced decision maker as early in the process as possible produces better results and lower costs. In the example from Buurtzorg efficiency is maximized by integrating tasks. The extra costs incurred by using better educated professionals for tasks that could be done by lower paid and less qualified staff are offset by the reduction in travel times, the costs of hand offs and the improved decision making by staff who can use their judgment to decide what is required and identify problems. There are unexpected benefits from this, for example, while the home care nurses are doing less demanding tasks they can talk to the patients and identify risks and issues that can reduce future costs.

The need to match the right skills to the task is one of the reasons why the use of pathways is a key strategy for improving processes. As the case studies from Aravind Eye Care and Circle show they are also important as tools for improving performance, eliminating waste and in engaging clinical staff in design and improvement. This is an example of how leading organizations have started to treat knowledge management as a key organizational competence. Best practice can be designed into processes rather than having to rely on hiring the most knowledgeable individuals.

4. Steering by outcomes: measurement and feedback

Richard Bohmer of Harvard Business School identifies a number of habits of high performing organizations including: the measurement and oversight of clinical work and self-study. The best organizations are collecting more information about processes and outcomes than those required by regulators and other external reporting and they use this to drive improvement. The end point is to steer the organization by outcomes — for example measuring infection rates rather than adherence to hand hygiene policy. There is some way to go before this is a reality.

The best organizations use their internally generated data to test ideas for improvement and to generate new knowledge about what works and change their practice. This requires staff that are clear about value (habit 1), empowered and trained to make improvement (habit 2) and have the tools to specify and design high quality care (habit 3). The measurement and feedback habit re-enforces this culture of improvement.

In the case studies we can see how Circle and Avarind use the monitoring and sharing of outcomes with professionals to create a drive for improved outcomes. Similarly, by monitoring patient satisfaction and overall costs of care, Buurtzorg have managed to demonstrate to payers that their business model (employing more expensive nurses, in self-steering teams) is more cost effective and works.

5. Active staff motivation and management

Human resource management is underdeveloped in many healthcare organizations. It is often transactional, traditional and risk averse. It often lacks a strategic perspective and is generally not prepared to challenge current practice. While many of the high performing organizations featured in this report have taken an innovative approach, they also appreciate that these initiatives must be built on a platform of basic good practice. Failure in this area can fatally undermine staff commitment to the values of the organization and their support of its leadership. These practices must start right at the recruitment stage by ensuring that staff not only have the right skills but that they understand and support the values of the organization. The recruitment of people who are resilient in the face of change seems to be an important factor. Induction into the organization is taken seriously and is compulsory, even for top managers.

In our case studies, staff have clearly defined roles supported by systems for ensuring that they get high-quality feedback and appraisals that are linked to rewards and based on metrics that are meaningful. As well as recognizing and rewarding good performance, the best organizations are also rigorous about dealing with poor performance, behavior at odds with the values of the organization and absenteeism. There is a strong business case for a focus on staff well-being and the experience of staff.

These foundational processes need to be part of a wider approach to quality governance found in the best organizations where the Board plays a key role in setting objectives and values and ensure that these are upheld and permeate the organization.

We now look at some of the detailed experience from around the world where these five approaches have been effectively applied.

Figure 6: The five habits shared by providers that successfully address the workforce challenge

Source: KPMG International, 2012.

Netherlands:
Buurtzorg empowered nurses focus on patient value

Background

In the Netherlands, the financing and delivery of home care is highly fragmented with various tasks — such as washing the patient, serving meals and putting on elastic compressions — paid through different reimbursement schemes and, more often than not, executed by different professionals. As a result, patient care tends to lack coordination, making it difficult for the care providers to respond appropriately to changing patient conditions, which in turn leads to compromised continuity of care and low patient satisfaction.

At the same time, many home care service providers have cut costs by fine-tuning the minimum skill level required to accomplish each task. Dutch home care also tends to be focused on responding to patients' current problems rather than preventing deterioration, meaning that interventions are generally added on only once the patient's condition has already worsened.

To respond to these challenges, the home care organization Buurtzorg (meaning neighborhood care) was created to focus on patient value by putting professionals in the lead through reverse task shifting. Essentially, the program empowers nurses (rather than nursing assistants or cleaners) to deliver all the care that patients need. And while this has meant higher costs per hour, the result has been fewer hours in total. Indeed, by changing the model of care, Buurtzorg has accomplished a 50 percent reduction in hours of care, improved quality of care and raised work satisfaction for their employees. In fact, in 2011, Buurtzorg was chosen as the Dutch employer of the year.

How it led to productivity improvement

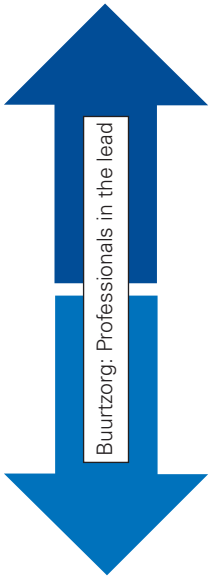
One of the keys to the program's success is that Buurtzorg's home care nurses organize their work themselves. Moreover, rather than executing fixed tasks and leaving, they use their professional expertise to solve the patient's problem by making the most of their clients' existing capabilities, resources and environment to help the patient become more self-sufficient. Simply put, Buurtzorg professionals' aim is to make themselves superfluous as soon as possible, versus other providers who tend to execute the subtasks without truly focusing on the patient's overall situation.

Habits Utilized

- Staff are asked to focus on prevention of future problems
- Give staff permission to solve problems
- Train staff in improvement
- Measure whether patients' needs are met
- Develop self managing teams

Buurtzorg uses small self-steering teams (with a maximum of 12 nurses) who attend to an area of approximately 15,000 inhabitants and work together to ensure continuity of care. As a result, the professionals build durable relationships with their community, which further strengthens their ability to find local solutions for patients' problems. Although the teams are independent and self-steering, they are supported by a centralized service organization which provides management information to both the team and the organizations' leadership in order to minimize local overhead and maximize the professional's face-to-face time with patients.

Figure 7: Results of Buurtzorg methods



More/higher:

- Productivity
- Work satisfaction
- Supply of professionals
- Revenue
- Quality
- Motivation

Less/shorter:

- Costs
- Resources per patient
- Cycle time
- Unplanned care
- Absence through illness
- Staff turnover

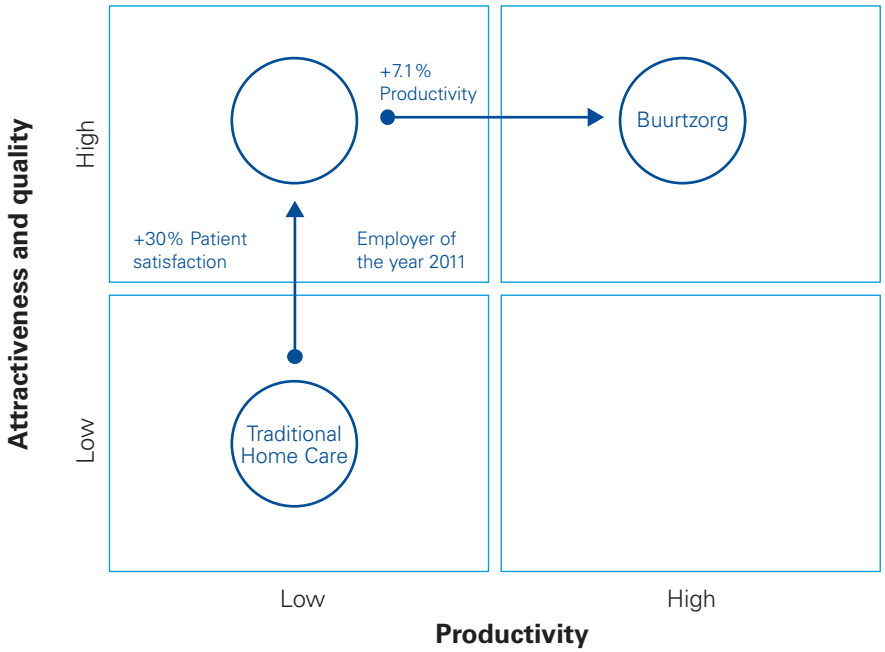
Key results

In just two years, more than 2,000 nurses have joined the program despite the increasingly tight labor market for nurses in the Netherlands. Indeed, by 2011 Buurtzorg employed 4,000 nurses and nurse assistants working in over 380 autonomous teams.

Preliminary results show that Buurtzorg's patients consume just 40 percent of the care that they are entitled to and half of the patients receive care for less than three months. As a result, patient satisfaction scores are 30 percent above the national average and the number of costly episodes requiring unplanned interventions has dropped. The company's financial revenue has also dramatically increased from €1 million to €40 million in a period of five years.

The Buurtzorg approach to healthcare delivery has also led to higher workforce productivity and reduced rates of absence through illness. Indeed, the total Buurtzorg organization requires overhead of just eight percent, compared to more than 12 percent within the regular home care services sector in the Netherlands. In 2010, the company achieved a 58 percent time actually spent with patients, versus a national average of only 51 percent. Given that 45 million hours of home care were provided in the Netherlands in 2010, the higher productivity level represented by Buurtzorg could potentially free up almost 7,000 full time employees nationwide (CVZ, 2011).

Figure 8: Buurtzorg increases productivity, quality and work attractiveness



Source: Buurtzorg, Analysis: KPMG International, 2012.

US:
Changing relationships with physicians at Virginia Mason Medical Center

Background

Virginia Mason is well known for its application of the Toyota Production system to healthcare but its work in changing the relationship between the organization and its doctors is just as impressive. Without the active engagement of doctors healthcare organizations have little chance of implementing radical improvements. The problem in many places is that the expectations and demands made on doctors, increasing accountability and requirements to work in more organized and systematic ways has challenged the basis of their traditional relationships with the hospital. The privileges that doctors had enjoyed including a high level of freedom, protection from the rigors of the market and toleration of behaviours not permitted in other staff have been gradually under attack. The old deal has been replaced without any explicit conversation and across the world this has been manifesting itself in discontent amongst many doctors. The antidote is to openly discuss what's changing and why with physicians, then creating a shared vision that truly has meaning and, also jointly, defining a new and explicit deal that supports both the organization's success and physicians' professional pride and satisfaction. This approach is based on research on the idea of the psychological contract adapted for healthcare by Amicus Inc.

Gary Kaplan MD the president and CEO of Virginia Mason Medical Center decided to address this head on and to develop a new 'compact' between Virginia Mason and the physicians who worked for it. The initial reason for this was a period of financial challenge leading to Gary's appointment as CEO and the development of a new vision and strategy for the organization.

How it led to productivity improvement

The first phase consisted of interviews with physicians by Jack Silversin of Amicus. Dr. Kaplan says, Jack quickly uncovered that a big part of the frustration our doctors were feeling was their sense that Virginia Mason was not the same organization they had joined. The deal they had been promised — and that they had enjoyed — was, in their eyes, violated.

A retreat was organised for the physicians and managers. Gary identifies this as a key turning point. Helped by a long serving physician leader the staff took time out to think about the issues. Dr. Kaplan says 'They candidly talked about the old deal which was characterized by autonomy, protection and entitlement. And, they shared their sense of loss and frustration. There was actual mourning for the aspects of the past that were not going to come back. I know that the emotional catharsis that some — not all — experienced during the retreat had a huge impact on readiness to move forward. The group that attended the retreat (most of the medical staff) brainstormed some elements of what a new compact should look like.'

The next phase of compact development took more than six months. First, a group was set up to take the idea forward. This was a broad group of enthusiasts and skeptics. The CEO joined the committee but was clear that he did not want his comments to influence others. His role was to help ensure that the "asks" of the organization were not going to be outside the scope of what the organization was prepared to give.

Department meetings were held in which the draft compact was vetted, discussed and improved. Feedback from many meetings was collected and a second draft went out for more discussion. This happened through the Spring of 2001. It was summer by the time the compact was finalized and shared with all physicians in departmental meetings.

Key results

Dr. Kaplan says: 'Was there resistance to this new set of reciprocal expectations? Less than one would anticipate. If we had come out of the retreat and circulated the draft that emerged as a done deal I guarantee there would have been push-back. In the end, a very small number of doctors did leave our organization because they didn't agree with the idea of such clear cut expectations or didn't like what it obligated them to. My entire career had been at Virginia Mason Medical Center so seeing physicians leave on my watch wasn't easy. But if the match between our expectations and an individual physician's isn't a good one, everyone is better off when that physician chooses to practice elsewhere. The culture that has evolved out of our compact is helping all our improvement efforts to succeed.

Dr. Kaplan reflects that 'looking back it is fortunate that we undertook the compact work when we did. It preceded our learning about Toyota Production and I believe is a significant contributor to the progress we've made in adopting our Virginia Mason Production System. One key lesson for me is how essential transparency is in all that we do. It's critical to know your current state so you can improve any value stream or process. And being absolutely transparent regarding what physicians can expect of VMMC and what, in turn, is expected of them is the only way to succeed and have physicians who are professionally fulfilled and contributing 100 percent every day.

Last, the Japanese word, "nemawashi" captures why our compact work has been successful. It means "tilling the soil" which was taking the necessary time to have deep conversations. The reflection we did and the compact change that resulted has allowed us to move further and faster than we otherwise could have. The compact has proved to be an extremely useful way of aligning physician behavior with what the organization needs from them to achieve our shared vision — "to be the quality leader and transform healthcare."

Habits Utilized

- Clear vision of improvement
- Involve physicians in thinking about how they work with the organisation
- Use an improvement methodology

Virginia-Mason Medical Center Physician Compact

Organization's Responsibilities

Foster Excellence

— Recruit and retain superior physicians and staff

— Support career development and professional satisfaction

— Acknowledge contributions to patient care and the organization

— Create opportunities to participate in or support research

Listen and Communicate

— Share information regarding strategic intent, organizational priorities and business decisions

— Offer opportunities for constructive dialogue

— Provide regular, written evaluation and feedback

Educate

— Support and facilitate teaching, GME and CME

— Provide information and tools necessary to improve practice

Reward

— Provide clear compensation with internal and market consistency, aligned with organizational goals

— Create an environment that supports teams and individuals

Lead

— Manage and lead organization with integrity and accountability

Physician's Responsibilities

Focus on Patients

— Practice state of the art, quality medicine

— Encourage patient involvement in care and treatment decisions

— Achieve and maintain optimal patient access

— Insist on seamless service

Collaborate on Care Delivery

— Include staff, physicians, and management on team

— Treat all members with respect

— Demonstrate the highest levels of ethical and professional conduct

— Behave in a manner consistent with group goals

— Participate in or support teaching

Listen and Communicate

— Communicate clinical information in clear, timely manner

— Request information, resources needed to provide care consistent with VM goals

— Provide and accept feedback

Take Ownership

— Implement VM-accepted clinical standards of care

— Participate in and support group decisions

— Focus on the economic aspects of our practice

Change

— Embrace innovation and continuous improvement

— Participate in necessary organizational change

Compact Checklist

The process of developing an explicit compact is facilitated when the following conditions are in place:

☐ Sufficient trust between doctors and administrators to be able to have candid conversations

☐ Education for doctors about market and economic changes that are driving the need to change the way healthcare is delivered

☐ Development: wide and deep ownership of a shared vision — a picture of where the organisation is heading — that resonates with all

☐ A guiding coalition or committee that can champion a compact change process with the physician body

☐ Sufficient patience to allow a process that touches every doctor — NOT a "roll out" from senior leaders

☐ Ample time for doctors and administrators to engage in dialogue about what behaviors are needed

☐ Will from the top to hold both administrators and physicians accountable for living the compact commitments once a document is created that is broadly supported

☐ Top leaders demonstrate they are NOT exempt but are standard bearers for new behaviors and open themselves to feedback about how their behaviors are or are not consistent with the new compact

Source: Amicus Inc. with permission

Mozambique:
Better access and quality of obstetric care through task-shifting

Background*

Like many African countries, Mozambique is experiencing a critical shortage of healthcare workers. After independence in 1975, the country had only 80 doctors to serve a population of 14 million and precious few staff capable of providing emergency obstetric care[3]. However, starting in 1984 Mozambique began to explore a partial solution to this immediate challenge by training non-medical staff to undertake obstetric surgery.

How it led to productivity improvement

While obstetric surgery is traditionally conducted by gynecologists, many obstetric surgical interventions (such as caesarean sections) can also be performed by trained non-physicians. Starting in 1984, the country began to recruit healthcare workers from rural areas to be trained in performing these kinds of interventions.

Candidates were required to have at least a three-year degree as either a nurse or a medical assistant and then had to complete a two-year course, which was followed by 12 month internship under supervision of a surgeon (Kruk et al. 2007). After completing the course, recruits became 'Tecnicos de cirurgia' (a role comparable to surgically trained assistant medical officers), and were allowed to perform obstetric surgeries.

Habits Utilized

- Improve maternal mortality and other outcomes
- Train staff to undertake complex tasks
- Rethink training

*This case illustrates how in developing countries unorthodox solutions have to be found given the immense shortages of skilled healthcare professionals. It is not intended as an example of how every healthcare system should be run, but of how developed countries can learn from developing countries.

[3] Krkr et al, 2007.

Key results

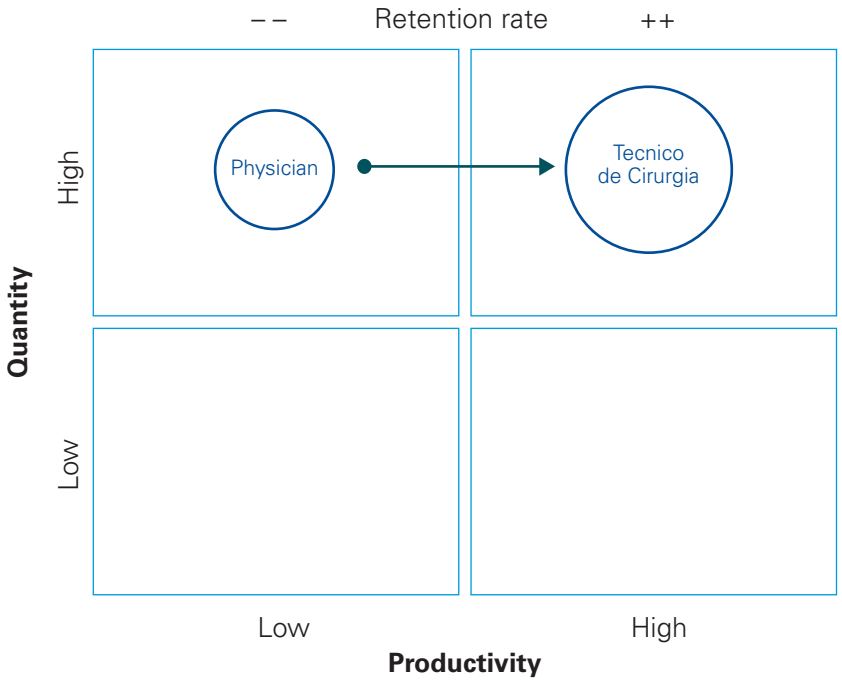
Over the years, the Tecnicos have become a vitally important part of the delivery of obstetric care in rural areas of Mozambique. Indeed, according to a 2007 study, fully 92 percent of all obstetric surgeries in all district hospitals were being carried out by Tecnicos de cirurgia (Kruk et al. 2007). Moreover, Mozambique enjoys a high retention rate for these Tecnicos, 88 percent of which were still working in the country seven years after graduation. This achievement is made even more significant when juxtaposed against the retention rate for physicians which had fallen to zero after seven years.

Studies into the Tecnicos success also reveal that, after reviewing 2,071 caesarean sections performed by Tecnicos and gynecologists (Kruk et al. 2007), there had been no clinically significant difference in outcome measures between the two: "decision making and quality of care as gauged by indications for surgery, postoperative deaths, and major complications were comparable to obstetricians" (Kruk et al. 2007).

The Tecnicos initiative also proved to be exceptionally cost-effective. Research shows that the training of one Tecnico cost US$19,465 as compared to US$74,130 per physician. Equally, the annual cost of deployment was also much lower with each Tecnico requiring US$3,859 versus US$10,367 per physician (Kruk et al. 2007).

This example shows that by expanding the pool of skilled workers, demand for healthcare can be met without compromising the quality of care. Mozambique's experience proves that non-traditional measures can reduce healthcare costs and enhance staff retention.

Figure 9: Task-shifting Tecnicos de Cirurgia



Source: KPMG International, 2012.

India:
Aravind Eye Care System: Optimizing the flow of patients

Background

India is home to 9 million of the world's 45 million blind people. Recognizing an unmet need, a retired ophthalmologist, Dr. Govindappa Venkataswamy, founded a specialized eye care clinic in 1976 with just 11 beds. Today, the Aravind Eye Care System (AECS) is the world's largest provider of eye care services focused on the mission of eliminating preventable blindness.

How it led to productivity improvement

Aravind Eye Care System operates as a network of eye care facilities where doctors are encouraged to spend approximately 60 percent of their time on clinical work, 20 percent on teaching and 20 percent on research. The system is focused on enabling doctors to be as productive as possible by limiting their responsibilities to initial diagnoses, verifying routine test results and performing surgeries using an 'assembly-line' approach, thereby ensuring that the most expert and expensive professionals are used to their maximum capacity. To manage the variety of other responsibilities such as administrative work, diagnostics, nursing and assisting, young women (aged 17 to 19 years), are recruited from local villages by word of mouth and trained extensively in a variety of skills.

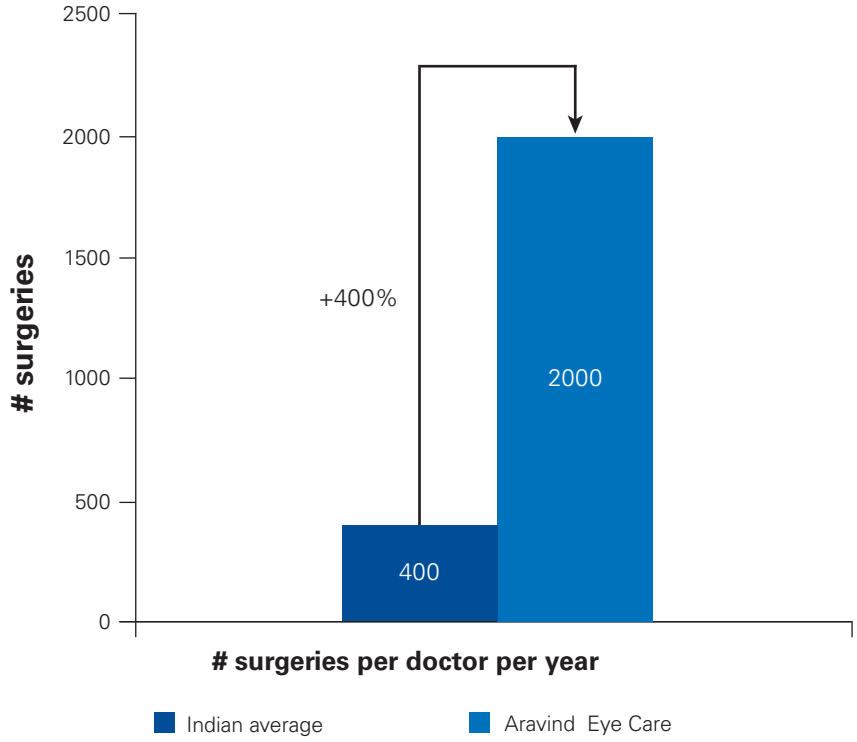
Habits Utilized

- Making top level care affordable and accessible
- Standardised work allowing new types of staff to be used
- Measure whether patients' needs are met

AECS has also focused on optimizing the flow of patients throughout the clinic which has resulted in faster throughput times and a decreased number of patient visits. Notably, the clinic largely operates on a walk-in system which means that demand for care tends to fluctuate from day to day and hour to hour. To manage these demand peaks, the clinics constantly project expected patient numbers and adjust manpower accordingly. For example, the clinics maintain a real-time dashboard that shows how many patients in each clinic have exceeded the standard throughput time and extra staff are then transferred to that location from nearby clinics.

While the AECS focuses on 'assembly line' models, the quality of care is of the upmost concern and is monitored extensively and reported transparently. The clinics follow a 'no secrets' rule where complication rates are presented on a monthly basis by clinic as well as by individual surgeon allowing leadership to actively strive to improve the complication rates at every level. In addition, ophthalmologists are rotated between free and paying hospitals in order to ensure an equal level of quality between the different patient categories.

Figure 10: Comparative results Aravind Eye Care System



Source: Aravind Eye Care, Analysis: KPMG International, 2012.

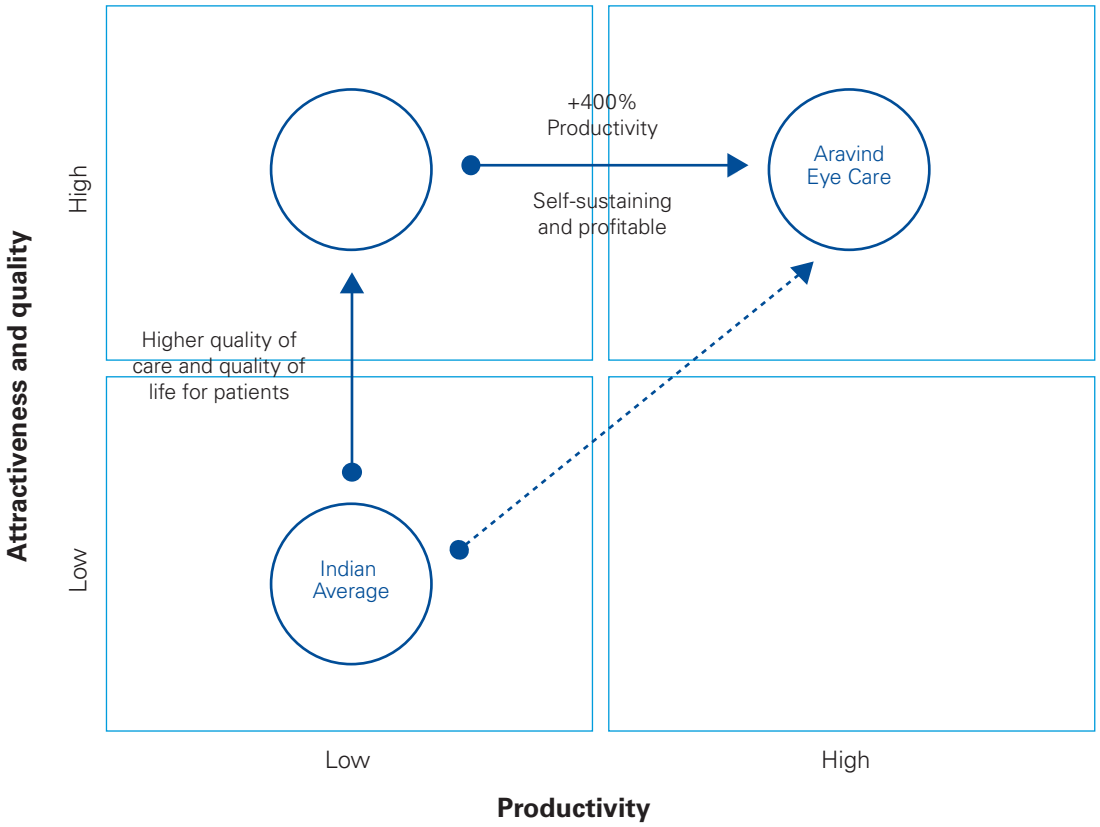
Key results

Starting from just eleven beds, the clinic now treats more than 2.6 million out-patients and performs more than 300,000 ophthalmic high-volume surgeries per year. Not only is Aravind Eye Care System the largest provider of eye care services in the world, it has also achieved the highest national productivity rate while delivering world-class outcomes. Indeed, Aravind doctors perform on average 2,000 surgeries per doctor each year, versus an average annual rate of 400 surgeries by other Indian doctors.

AECS also rivals leading providers in the developed world. When compared to the UK, for example, Aravind Eye Care handles slightly less than two thirds of the volume of the NHS at just one percent of the cost, with complication rates of half of the British standards.

And while Aravind treats most of its patients for free or at a deeply subsidized rate, the organization is not only fully self-sustainable, but is also one of the few not-for-profit organizations that achieve a financial surplus through revenues alone (only six percent of its operating budget comes from grants).

Figure 11: Aravind Eye Care System



Source: Aravind Eye Care, Analysis: KPMG International, 2012.

South Africa:
Helen Joseph Hospital improves efficiency and nurse empowerment through stock control

Background

Situated in Johannesburg, South Africa, the Helen Joseph Hospital is a designated regional academic facility and, with 530 beds, is the third largest teaching hospital in Gauteng Province. However, the hospital, which also offers tertiary services, was experiencing challenges related to stock control and stock staging, particularly for ward supplies. Facing high costs for expired ward stock, the hospital recognized the need to improve their stock utilization and budget in order to submit their budget requests for the following year.

How it led to productivity improvement

With a renewed focus on maximizing stock efficiency on a minimal budget, the Helen Joseph Hospital began a stock efficiency improvement project in 2011 with the goal of achieving rational drug use and improved stock control.

The project began by mapping the stock processes and identifying areas of inefficiency in order to develop targeted interventions. As a result, inefficient ward stock processes were improved by moving stock ordering and planning from a reactive process to a proactive one. All areas of the hospital charged with storing pharmaceutical stock were also cleaned up and the layout of the ward store area was optimized.

Project leaders also focused on building the nursing staff's capabilities by offering continuous support and advice in stock management. Regular meetings with pharmacists and therapeutics added to the sense of urgency for the nursing staff.

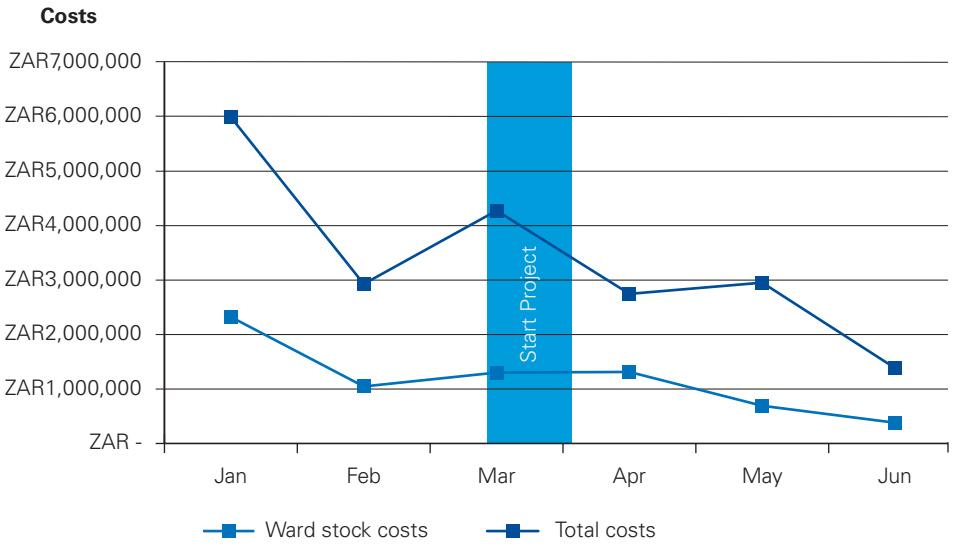
Habits Utilized

- Give staff permission to solve problems
- Provide tools and techniques to support this
- Involve staff in designing improvement
- Provide quick feedback to show staff their results

Key results

While the project is only in its first year, the results are already becoming evident in both the productivity of the organization and staff motivation. The improved pharmaceutical management processes have led to decreased total stock costs and enhanced efficiency with nurses spending less time waiting for stock at the pharmacy due to more efficient cross-functional teams. Ordering efficiency was also improved by allocating pharmacists to specific wards and, with more time to visit the wards to due improved efficiency, communication was enhanced between physicians, nurses and pharmacists leading to a higher quality of care.

Figure 12: Costs per month before and after the pharmacy project



Source: Helen Joseph Hospital, 2011.

With the gap between the pharmacy and the nursing staff effectively bridged, staff motivation also improved. Pharmacy staff reports feeling more empowered and, having provided input on improving processes, felt that they now played a more vital role that allowed them to be more involved in the whole process. Early results show that the nursing staff now feel better supported by the pharmacy and have a much better understanding of the process and, as a result, are more supportive of the stock process and their role in it.

UK:
Circle improves patient experience, quality and value of care through active staff performance management

Background

Frustrated by the perception that professionals had largely been left out of leadership and decision-making positions in UK healthcare, the founders of the British healthcare provider Circle developed an employee-owned partnership that now operates five facilities in the UK. The group provides both NHS and private health services through a model that is led and managed by clinicians supported by hospital boards consisting primarily of consultants and nurses.

How it led to productivity improvement

At Circle, the primary focus is on the patients' needs and therefore incentives for productivity and quality are aligned throughout the organization. The Circle model is characterized by five main differentiators: ownership; clinical units and leadership; continuous quality measurement and improvement; recruitment and reward.

Ownership: With the belief that clinicians cannot deliver excellent healthcare on their own, all employees who work directly or indirectly in clinical services are offered entry into the partnership. All new clinical professionals are provided with a one-time loan to purchase a fixed amount of shares, after which additional shares are allocated each year based on performance. These partners own 49.9 percent of the company with the remaining portion owned by Circle International plc.

Clinical units and leadership: Circle's hospitals are divided into individual clinical units consisting of between 50 to 100 people and directed by a lead consultant, nurse and administrator. Each unit has a seat on the hospital board and is solely responsible for all decisions that impact patient care including the cost and quality of care, activity volumes and balance sheets. By becoming closely engaged and developing a strong understanding of the goals and performance of their units, employees are afforded high levels of autonomy. Circle also offers clinical leaders a two-year leadership development program that aims to provide all of the necessary skills for managing a unit.

Staff performance management: Each clinical unit actively manages their staff performance on a monthly basis and measures results against four key indicators: clinical results, patient experience, value for money, and staff engagement. To support this activity, patient feedback forms are reviewed to identify potential bottlenecks which, when identified, are responded to with action plans that are generally followed up within six weeks. Patient feedback is also published — uncensored — on the Circle company website.

Figure 13: Circle purpose parameters

Purpose:
To build a great company dedicated to our patients

Focus exclusively on:

- What we are passionate about
- What we can become best at
- What drives our economic sustainability

Employee rewards: Circle also operates an individual reward program that, on an annual basis, determines employee compensation based on performance. Two separate appraisals take place each year and are largely based on feedback from five to ten colleagues (both upward and downward) which determines the pay and share allocation for the coming year.

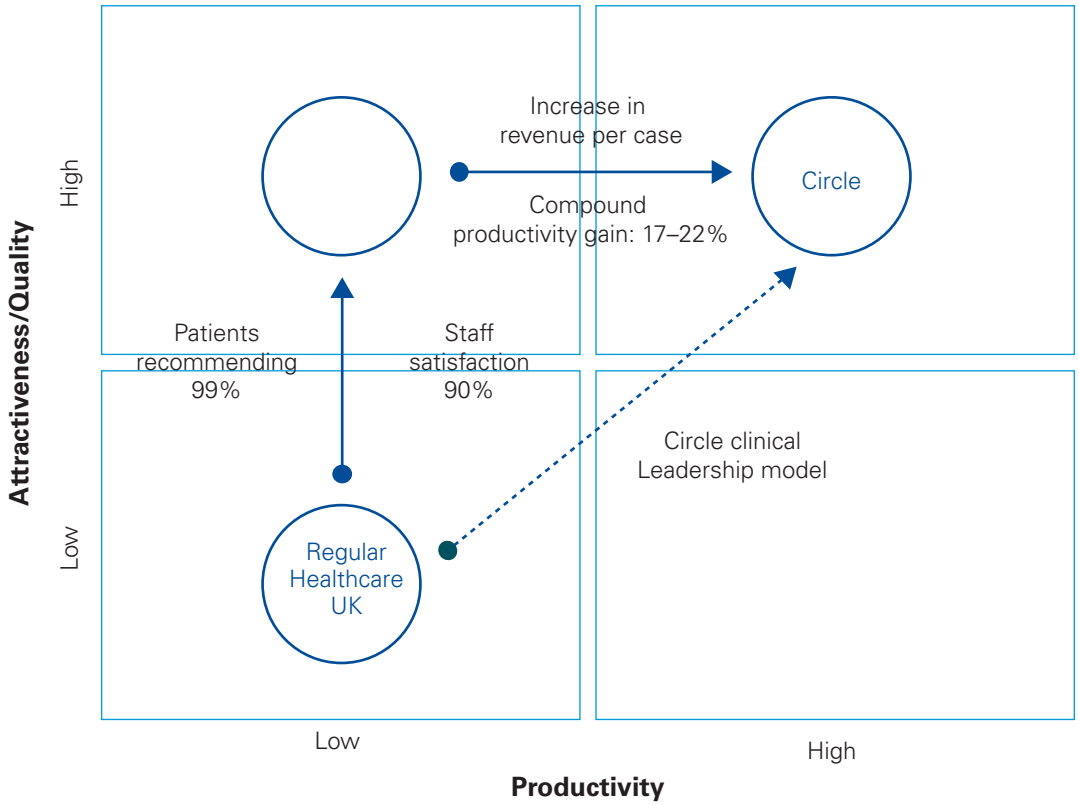
Key results[4]

As a result of their employee-focused operating model, employee engagement and involvement has successfully been embedded into the culture of the organization and its ways of working which, in turn, has impacted all key outcome metrics. For example, the organization has experienced a productivity gain of 22 percent in a single year within their Nottingham treatment centre, and a 17 percent gain in the Midlands. At the same time, Nottingham achieved an employee satisfaction rating of 90 percent and Midlands achieved 91 percent which has greatly impacted the organization's ability to recruit new staff.

Importantly, patient satisfaction has also improved with 99.6 percent of patients from Nottingham saying they would recommend their services, and the Midlands and Bath locations received similar results (99.1 and 98 percent respectively). And while all services and specialties maintain their own unique clinical outcome data, both the Nottingham and Midlands centers have shown a 'return to surgery' rate that is four times lower than the national average. Indeed, in 2010, readmissions to the Nottingham center were 5.7 times lower than the Independent Sector Treatment Centers (ISTCs) target and almost 100 percent better than the national average.

Moreover, Nottingham achieved growth in revenue per case of 7.8 percent in 2009 and 9.2 percent in 2010, helping the organization's gross profit increase from 22 to 28 percent in 2010.

Figure 14: Circle results



Source: KPMG International, 2012.

[4] Circle, UK.

Circle's Vascular Surgery:

Problem: Patients forced to make several visits. Long wait times and inefficient service.

Solution: One-stop access to vascular and cardiac testing in a convenient clinic environment. Work on efficient scheduling of lists.

Result:

— Waiting times reduced from 12 to 4 weeks.

— 38 percent productivity gain in day-case throughput.

Circle's Hernia Pathway:

Problem: No standard GP pathway from GP to surgery. Uncertainty and long waits for patients.

Solution: Bespoke hernia service with dedicated clinics and surgeons accessible via a Choose and Book system.

Result:

— Hernias undertaken at the Treatment Centre increased by 78 percent (to 571 in 2010) from 320 in 2009.

— Waiting times reduced by 12 days in the same period.

Habits Utilized

Patient value as a key goal

Devolved management model

Using clinical results, patient experience, value for money and staff engagement as performance metrics

Create a feeling of ownership

Very active performance emanagement

Conclusion

Demography is not destiny
All evidence points to the fact that, in the coming years, the combination of demographic changes and increased healthcare usage per capita will continue to increase demand for healthcare services. At the same time, the supply of healthcare professionals is facing a sharp decline and there will be growing international competition for the best talent. The combined effect of demographic change, increasing demand and changing working habits will be a shortage of healthcare professionals of between 22 and 29 percent in OECD countries[5]. The situation in other parts of the world is even more stark.

Having analyzed the potential range of options available to policy makers, it seems clear that the number of healthcare professionals can be increased, thereby allowing most (but not all) countries and specialties to avoid the predicted shortfall. By leveraging measures such as raising the retirement age, stimulating people to work more hours per year, increasing the participation of women in the sector and raising the total share of people working in healthcare, governments can effectively bridge the looming workforce gap, but will need to spend to do so. But this is simply not a feasible option. With workforce costs constituting the single largest cost in healthcare expenditure, the funding of an additional 10 to 20 percent increase in workforce is virtually impossible, particularly in the current economical climate.

The reality is that, rather than hiring more people, we must find approaches that utilize the current workforce in a smarter and more efficient way. In our study we show that there are providers that successfully manage the workforce challenge.

These providers share five distinguishing habits that help them make a difference. First, they have incorporated a ***strategic focus on value for patients*** into the DNA of their organizations. This means ensuring that this concept is built into recruitment, staff objectives, appraisal and reward systems and these are directly aligned to the organization's goals. From the Board to front line managers, actions are governed by this focus on value.

At the same time, they ***empower professionals*** by giving them the freedom to take responsibility for creating value. Team work, appropriate autonomy and control over work processes and high quality front line leaders with the skills to support and coach their teams provide an important part of a strategy to drive productivity. In particular it supports the deployment of a third key component, the use of ***task and process redesign*** to transform care processes to ensure that everyone in the care pathway (including the patient) is adding value to the patient's journey and that problems with their flow through the system can be identified, dealt with and the process improved as a result. Redesign is well understood in non-clinical areas but its application to clinical processes and pathways still has much further to go. In the best organizations this includes processes that anticipate problems rather than simply respond to them and goes beyond the boundaries of the institution by, for example, ensuring that patients can be discharged as quickly and safely as possible.

A key strategy which supports these approaches is that the best organizations actively ***manage staff performance using outcome measures*** which also promotes safe culture and continuous improvement. Many of the successful organizations discussed in this report have embedded their strategic focus on value for patients into the development of concrete and clear management information. And so rather than measuring input parameters or publishing process indicators, these organizations tend to hold their staff to account for the value actually created, such as optimal outcomes at reasonable costs and margins.

Finally, there is more to do in many organizations to ***ensure high quality staff management practices***, as all of the innovative practices can be undermined by a failure to address this. Recruitment, induction, training, reward strategy, appraisal, feedback and the active management of poor performance are often surprisingly poorly managed in healthcare.

Taken together, these five characteristics can enable providers to outperform their peers in terms of quality of care delivered, attractiveness of work and productivity of professionals. There is a strong ethical and business imperative to do this. All these measures need to be executed together, rigorously and continuously. If done well they have the potential to buy healthcare organizations enough time and staff support for much more fundamental changes to their business models of which the changes, redesign initiatives and innovations we feature here are just the beginning.

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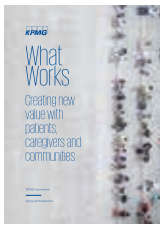

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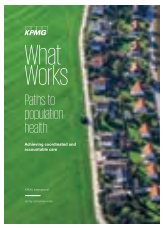

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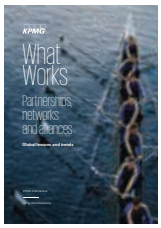

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Contacts for healthcare services

Chairman
Global Health Practice
Mark Britnell
T: +44 20 7694 2014
E: mark.britnell@kpmg.co.uk

Angola
Fernando Mascarenhas
T: +244 227 280 102
E: femascarenhas@kpmg.com

Argentina
Mariano Sanchez
T: +5411 4316 5774
E: marianosanchez@kpmg.com.ar

Australia
Liz Forsyth
T: +61 2 9335 8233
E: lforsyth@kpmg.com.au

Austria
Johann Essl
T: +43 732 6938 2238
E: jessl@kpmg.at

Belgium
Emmanuel De Moyer
T: +32 2 708 4486
E: edemoyer@kpmg.com

Brazil
Marcos A. Boscolo
T: +55 11 2183 3128
E: mboscolo@kpmg.com.br

Bulgaria
Iva Todorova
T: +35 95 269 9650
E: itodorova@kpmg.com

Canada
Georgina Black
T: +1 416 777 3032
E: gblack@kpmg.ca

Central/Eastern Europe
Miroslaw Proppe
T: +48 604 496 390
E: mproppe@kpmg.pl

China
Jenny Yao
T: +86 108 508 7074
E: jenny.yao@kpmg.com

Chile
Santiago Barba
T: +562 2 798 1507
E: santiagobarba@kpmg.com

Czech Republic
Vlastimil Cerny
T: +420 22 212 3389
E: vcerny@kpmg.cz

Denmark
Jakob Blicher-Hansen
T: +455 215 0128
E: jabhansen@kpmg.com

Finland
Minna Tuominen-Thuesen
T: +35 820 760 3565
E: minna.tuominen-thuesen@kpmg.fi

France
Benoit Pericard
T: +33 1 55 68 86 66
E: benoitpericard@kpmg.fr

Germany
Volker Penter
T: +49 30 2068 4740
E: vpenter@kpmg.com

Hong Kong
Marcello de Guisa
T: +85 22 685 7337
E: marcello.deguisa@kpmg.com

Hungary
Andrea Nestor
T: +361 887 7479
E: andrea.nestor@kpmg.hu

Iceland
Svanbjorn Thoroddsen
T: +354 545 6220
E: sthoroddsen@kpmg.is

India
Nilaya Varma
T: +91 98 100 85997
E: nilaya@kpmg.com

Indonesia
Tohana Widjaja
T: +62 21 574 2333
E: tohana.widjaja@kpmg.co.id

Ireland
Frank O'Donnell
T: +35 31 700 4493
E: frank.odonnell@kpmg.ie

Israel
Haggit Philo
T: +972 3 684 8000
E: hphilo@kpmg.com

Italy
Alberto De Negri
T: +39 02 6764 3606
E: adenegri@kpmg.it

Japan
Keiichi Ohwari
T: +81 3 5218 6451
E: keiichi.ohwari@jp.kpmg.com

Luxembourg
Patrick Wies
T: +352 22 51 51 6305
E: patrick.wies@kpmg.lu

Malaysia
Yeekeng Lee
T: +60 3 7721 3388
E: leeyk@kpmg.com.my

Mexico
Andrés Aldama Zúñiga
T: +01 55 5246 8589
E: aaldama@kpmg.com.mx

Netherlands
Anna van Poucke
T: +31 20 656 8595
E: vanpoucke.anna@kpmg.nl

New Zealand
Richard Catto
T: +64 4 816 4851
E: rcatto@kpmg.co.nz

Nigeria
Kunle Elebute
T: +23 41 280 9267
E: kunle.elebute@ng.kpmg.com

Norway
Wencke van der Meijden
T: +47 406 39345
E: wencke.vandermeijden@kpmg.no

Philippines
Emmanuel P. Bonoan
T: +63 2 885 7000
E: ebonoan@kpmg.com

Portugal
Jorge Santos
T: +35 121 011 0037
E: jorgesantos@kpmg.com

Romania
Maria Elisei
T: +40 37 237 7800
E: melisei@kpmg.com

Russia
Victoria Samsonova
T: +74 95 937 4444
E: vsamsonova@kpmg.ru

Saudi Arabia
Khalid Yasin
T: +96 611 874 8500
E: kyasin@kpmg.com

Singapore
Wah Yeow Tan
T: +65 641 18338
E: wahyeowtan@kpmg.com.sg

South Africa
Dalene van Greune
T: +27 82 719 0587
E: dalene.vangreune@kpmg.co.za

South Korea
Kyung Soo Park
T: +82 2 2112 6710
E: kyungsoopark@kr.kpmg.com

Spain
Candido Perez Serrano
T: +34 914 513091
E: candidoperez@kpmg.es

Sweden
Andreas Endredi
T: +46 8 723 9743
E: andreas.endredi@kpmg.se

Switzerland
Michael Herzog
T: +41 44 249 31 53
E: michaelherzog@kpmg.com

Taiwan
Jarret Su
T: +88 628 101 6666
E: jarretsu@kpmg.com.tw

Thailand
Chotpaiboonpun Boonsri
T: +66 2 677 2113
E: boonsri@kpmg.co.th

Turkey
Raymond Timmer
T: +90 216 681 9000
E: raymondtimmer@kpmg.com

UK
Jason Parker
T: +44 207 311 1549
E: jason.parker@kpmg.co.uk

US
Ed Giniat
T: +1 312 665 2073
E: eginiat@kpmg.com

Vietnam and Cambodia
Cong Ai Nguyen
T: +84 83 821 9266
E: acnguyen@kpmg.com.vn

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