

# Lessons from the other side: What can we learn from the private sector?

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## Abstract

*Business has reacted in an impressive manner to increasing globalisation, short-term stock market pressure for performance, emerging industries and new technologies. While the private sector has become increasingly competitive, the public sector has not adopted this commercial rigour.*

*Funding pressures on health services will continue, as will increasing consumer and staff demands and the blurring of public and private health care provision. As a result, there are lessons and techniques the public and private health sectors should learn from each other. I have drawn the issues that follow from my experience in the steel and food industries.*

## Competitive structure

The two most unusual features about public health care are that in general the customer does not pay you and you cannot go out of business. In the private sector, businesses that do not satisfy the customer will not prosper. Without a threat to business (and job) survival and the need to satisfy the customer (two of the most fundamental and motivating elements that the private sector utilises for improving performance), organisational motivation and change is difficult to achieve. Creating a sense of urgency, having the ability to focus on adding direct economic value to the customer and other factors, such as organisational culture, compound the difference between effecting change in the private sector compared to the public sector.

The culture of the public hospital system has some unique features. The three distinct professional groups of which the system is comprised (doctors, nurses/allied health staff and management) create a sort of tribalism. Each group has its own motivational factors, which often conflict, making a unified organisational culture difficult to achieve. This complicates organisational development. It can be argued that to make any organisational change, doctors in particular must acquiesce or 'loan' the right for

management to implement these changes. This indicates the 'federal' nature of many public health organisations (Handy 1990, p 93)

A non-paying customer, guaranteed business survival and a federal structure make significant organisational change in the public health sector difficult to achieve. An analogy could possibly be drawn with other highly specialised businesses such as the airline industry, research laboratories, or software development companies. However the fact that some doctors work part time for the public sector as well as part time for competing private hospitals complicates the issue further. Furthermore, in New Zealand there are no direct rewards to public hospitals for improving clinical quality or patient satisfaction.

## **Incentive systems**

Most incentive systems for the public health system are poor at best and often perverse. Lack of direct customer feedback is a major disadvantage. There is no direct financial 'value creation' mechanism between provider and patient. Purchasing and reward systems are woefully inadequate at defining and recognising quality improvement. In New Zealand, public hospitals can raise private sector debt to finance capital programs but there is no ready means of raising equity, other than through retained earnings, which are fully taxable. Currently the purchaser wishes to share in efficiency gains, thereby giving hospitals an incentive to minimise retained earnings! The extraction under the casemix funding system by the inlier adjustment is also a disincentive to improving productivity. Couple this with an absence of financial benefit in the purchasing model for customer satisfaction, or the quality of service, and it becomes exceedingly difficult to improve quality, change organisational culture and achieve productivity gains which could lead to surpluses for non-debt-funded reinvestment. The private sector has none of these impediments.

Most hospitals have an inadequate capital structure. Financing all capital via debt may be useful for minimising agency costs (Pringle & Harris 1984, p 499) but this makes for an exceptionally risky and inefficient capital structure (Brealey & Myers 1984, p 391). The public hospital incentive structure is inward-looking. It does not reward productivity and encourages a poor capital structure. It could also be argued that it supports the poor performer at the expense of the efficient, which makes expanding the business very difficult indeed.

## **Market analysis**

The private sector spends immense time and effort analysing its markets. Understanding market segmentation and buyer behaviour is fundamental for a firm's survival (Kottler 1984, p 252).

Many health providers carry out very little of this analysis. Indeed, little research is available into what drives health market demand, particularly acute demand. In

addition, few health providers segment their market population by disease groups, demographics, geography or primary referrers (general practitioners). The inability to analyse against these criteria results in a limited ability to forecast and understand what drives demand.

As we move to integrated care and capitated health models, market segmentation and demand analysis are becoming more prevalent in the public health sector. As providers take on more population risk, they must increase their market understanding. That is refreshing.

## **Competitive analysis**

Competitive analysis in the private sector is extremely important as it can mean the difference between success and failure. It is also very relevant to the public health sector as there is always competition for funds, and for services in certain markets such as maternity and elective surgery. Hospitals' traditional market domination will come under increasing pressure.

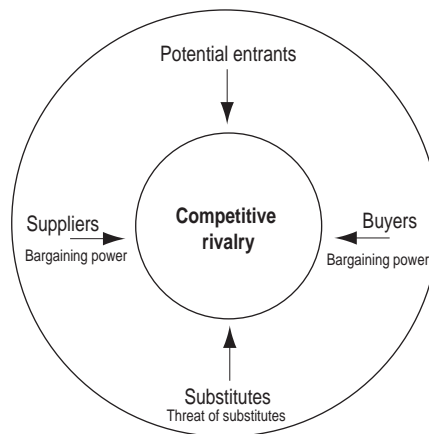
The private sector offers lessons in classical strategic competitive analysis. The requirement for public sector performance will only increase with growing purchaser capability. Certainly, in New Zealand, fee-for-service arrangements in the maternity market create a market share game; and let us not forget that many general practitioner groups believe they should hold secondary care budgets. Similarly, analysis can determine the right strategies, particularly with regard to cost structure. Michael Porter (1985, p 4) clearly identifies that success depends upon two factors: what business you are in, and how good you are in it.

What business you are in is determined by positioning (that is, the services you supply). How good you are in that business is determined by operational effectiveness. The measurement of operational effectiveness is critical, yet many health providers address this solely in terms of financial performance and, by so doing, greatly over-simplify the issue. South Auckland Health gauges operational effectiveness against four key areas (clinical quality, delivery quality, productivity and finance). Any major strategy or entry into any service line must improve all four. Mere bean-counting is detrimental to the delivery of good health care.

The competitiveness of an industry or service is defined by four key elements:

- the bargaining power of suppliers
- the bargaining power of purchasers
- substitutes for new products, and
- the threat of new entrants (see Figure 1).

These elements determine 'industry rivalry' (Porter 1980, p 4). The degree of industry rivalry has a significant impact on profitability. In general, the less intense the rivalry, the greater the profit margin. Very little competitive analysis is undertaken in the public health sector. Accordingly, market shares may suffer a decline.



Source: Johnson & Scholes 1993, p 88 (adapted from Porter 1980)

**Figure 1: Model for industry analysis**

A good business strategy will include an analysis of industry structure. ‘A firm is not a prisoner of its industry structure’ (Porter 1985, p 7). The large public health providers should concern themselves with changing the industry structure in the health system as well as their own internal strategic options. In the long term very little is uncontrollable. I would contend that very few hospitals in the public sector spend enough time considering the overall structure of the health system and how it can be changed to improve their own performance and competitive position.

Porter offers an analysis of various generic strategies that can be employed by businesses, ranging from narrow strategies (for example, focusing on different niche services) to broader strategies (for example, differentiation or cost leadership). A focus on cost leadership is critical for most services in the public health sector. Within the New Zealand public health sector there are some narrow niche services that allow people to compete on the basis of quality. There is, however, constant pressure to achieve efficiency gains and, in response to this, a great deal of effort is oriented towards cost reduction. This has major strategic implications. One of them is that a health provider must clearly understand its full cost structure and the key elements that give sustainable cost leadership.

Cost leadership has ten key determinants (Porter 1985, pp 72–83), the three most important being economies of scale, capacity utilisation and institutional (historic) factors. Cost drivers are the structural causes for cost and activity, some of which can be controlled by the business. Those that cannot need to be managed well. This is critical with regard to the supply chain of major hospitals, which have to deal with near-monopolistic supply sources, such as those for pharmaceutical goods. Analysis of each component in the supply chain, from the supplier through to the end product, can lead

to increased efficiency, reduced inventory, fewer steps in the chain and a fuller understanding of the costs added by each component along the chain.

Product costing and cost analysis are central to cost leadership. This is a strategy that has been employed by South Auckland Health, in conjunction with the other Auckland hospitals. Emphasis has been given to generic substitution, parallel importing, pushing inventory back from the hospitals to the suppliers, e-commerce systems and consolidating orders to give economies of scale in purchasing.

This supply or more general 'value' chain analysis is becoming increasingly important as market commoditisation increases. Suppliers now need to add value to their end customers rather than just treating them as simple purchasers of goods and services. Suppliers must show the end buyer that there is significant gain to be made by utilising their service. It is now common practice in the chemical supply industry for a supplier to guarantee to reduce the buyer's overall purchasing costs, which often includes decreasing use of the surplus product!

## **Core competencies**

Another key concept in strategy development is that of core competencies. The practice of industry giant 3M serves as a good example. 3M relies on only a few strategic capabilities, or core competencies, for its success. It is a company known for its innovation and its wide range of seemingly unrelated products. However, its fundamental competitive advantage is determined by its core competency in polymer chemistry (broken down into two key areas; coatings and adhesives) (Robert 1983, p 82). A further core competency of 3M is the ability to trade with culture and innovation, which I will deal with later in this article.

How many hospitals understand and build on their core competencies? At South Auckland Health our competencies revolve around three main areas: trauma/acute management, scheduling and disease management, and we are still learning to optimise these competencies. These core competencies and the processes surrounding them determine the ability of South Auckland Health to achieve its strategic objectives. It is this analysis of service competitiveness – focusing on the value chain, understanding cost drivers, maximising capacity and concentrating on core competencies – that allows us to achieve low-cost production and high utilisation of assets, and allows innovation to occur alongside our key strategic directions. Having a strategic framework is common in large, successful private sector firms but it is rarely seen in a public sector organisation.

Many hospitals have a monopoly in their local market. However forward integration (by general practitioners, suppliers, such as pharmaceutical companies, and new entrants in the market) will place increasing pressure upon these monopolies. Major public hospitals must have strategies to justify their dominant positions (Brown 1990, p 43). Market share is vital, particularly when one relates it to the ability to maximise capacity utilisation, the limited ability of market/product substitution to fill capacity gaps and the need to use market power to contest the purchaser's monopolistic position.

## **Operational effectiveness and the balanced scorecard**

Closely related to our multiple view of operational effectiveness is the more commonly known view of the balanced scorecard (Kaplan & Norton 1993). The scorecard is a multi-level performance analysis of a firm or organisation's success that measures operational effectiveness. The balanced scorecard concept is currently being developed in New Zealand. It has been applied for many years at South Auckland Health using four elements – clinical quality, delivery quality, productivity and financial performance. In the study by Collins and Porras of 18 enduring companies, organisational success is measured by more than just profits (1997, p 14).

Another time-honoured view of the private sector is that a business must take into consideration all of its stakeholders when developing and implementing strategies. This is particularly critical because implementation may be hindered if stakeholders misunderstand those strategies (which is often the case). There is no point developing business strategies if they cannot be implemented.

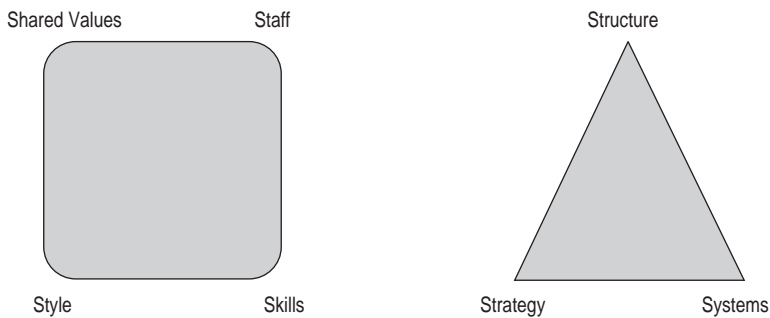
The health market is dominated by a multitude of stakeholders, political agendas and interest groups. The ability of a health provider to analyse key stakeholders, determine the factors that motivate them and then appropriately manage this large number of diverse stakeholders, is vital for success. Many multinational companies, especially those operating in different cultures, use stakeholder analysis (Johnson & Scholes 1993, p 156). Hospital managers must deal with a variety of social and organisational cultures in an increasingly competitive environment. It is therefore critical to analyse organisational culture when implementing change. In practice, however, organisational culture is rarely measured, particularly in quantifiable terms, and when it is, a framework is seldom developed to improve the culture.

## **Leadership and culture**

Understanding organisational culture and motivating people to improve performance needs leadership.

Many private sector companies devote significant amounts of senior management time to achieving this understanding. Several methods can be used to measure culture, such as the dimensional scales of socialisation and solidarity, the cultural web (Johnson & Scholes 1993, p 62), or the 12-scale organisational culture inventory, as developed by Robert Cooke & Clayton Lafferty of Human Synergistics (1986).

These methods are intended to identify the current organisational culture and the desired organisational culture, as determined by both management and key staff. The ability to close the gap between 'current' and 'desired' is fundamental for creating an organisation that empowers and encourages employees to improve performance and implement business strategy. Another means of analysing core capabilities and culture



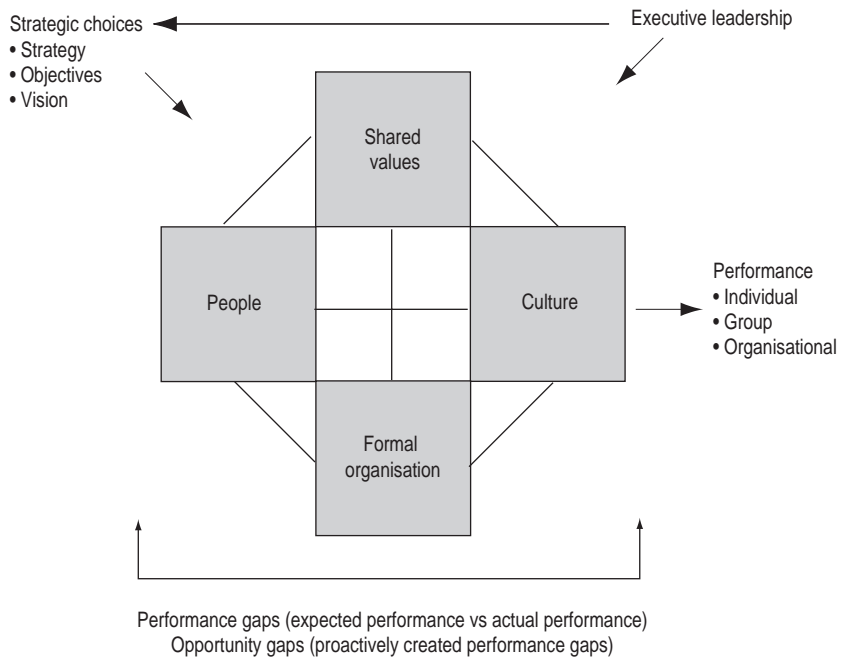
**Figure 2: McKinsey 7-S – The ‘soft square’ and ‘hard triangle’**

is embodied in the McKinsey 7-S framework (Peters 1984, p 11), which is further refined into what is called the ‘soft square’ and ‘hard triangle’ (see Figure 2).

The hard triangle represents the structure, systems and strategy; the soft square represents the firm’s shared values, styles, staff and skills. It is the strength, match and fit of these elements that can determine the firm’s success (that is, the business strategy and the firm’s ability to implement that strategy). This framework is commonly used in many industries. Health managers often concentrate on the hard triangle, which is comparatively easy to determine. Governments, and many of us, place emphasis on changing structure, hoping it will result in increased organisational performance. Most often it does not! Concentration on the soft square is sadly lacking, and often results in ineffective strategic implementation. The lesson is simple – organisational culture is the key to both short-term success and (unless managed properly) to long-term failure (Tushman & O’Reilly 1997, p 35).

A model that is more advanced than the McKinsey 7-S is based on the fit between four key organisational elements: critical tasks, culture, formal organisational structure and people (see Figure 3). When coupled with exemplary leadership and strategic choices, this indicates a strong context in which to improve organisation performance (Tushman & O’Reilly 1997, p 54). Firms such as BOC Industrial Gases and CIBA GEIGY use these models to analyse the gap between the actual and desired organisational fit of these elements (Tushman & O’Reilly 1997, p 70). The importance of leadership and the development of human capital cannot be overemphasised. There is a common misconception that hospitals are capital-intensive. Health provision is, in fact, people and knowledge-intensive.

Leadership and leadership development are fundamental for an organisation to improve performance (Kouzes & Posner 1995, p 18). Not only is the ability to inspire a shared vision critical, but the ability to create a set of core values that accompany the vision is also vital (Kouzes & Posner 1995, p 91). Collins & Porras (1997) list firms such as Asea Brown Boveri (ABB), BMW, Marks & Spencer, Nestlé, Shell and Unilever as having placed significant emphasis on leadership and, in particular, building a strong



From Tushman & O'Reilly, page 59

**Figure 3: Organisational Architecture**

vision that is linked to a set of shared core values. They maintain that long-term success needs both a vision and a set of shared values.

For many years South Auckland Health has had a vision and set of values, that have been critical for determining the organisation's and its individuals' required behaviours. The core values are obviously closely linked to development of culture and leadership and the vision is often synonymous with strategic direction or strategic intent. It is the matching of these (similar to Tushman & O'Reilly 1997) that provides the glue between strategy and organisational capability that in turn ensures successful strategic implementation.

## Patients and processes

Traditional hospital structures are dominated by the professionalism of the three main hospital tribes; doctors, nurses/allied health staff and managers. These tribes operate under traditional, hierarchical, military-type organisational lines of command that are dominated by 'silos' of professional work (that is, operational units). But patients do not adhere to just one silo. Rather, they move across them and across the boundaries between the primary and secondary health care sectors. Many hospitals still lack a system-wide view that can follow the patient across these silos (Lathrop 1993, p 45).



This compartmentalisation restricts improvement in patient processes. The ability to analyse processes and develop a systems view of the organisation has come to the health sector only recently. Many in the health sector (and elsewhere) deride techniques such as re-engineering, with its activity and process-mapping techniques. Many also belittle standard techniques, such as total quality management, which exist in many industries. While there are many failures using these 'process' views of the organisation, there are also many successes.

Ghoshal & Bartlett (1997, p 264) point out that the link between purpose, people and processes is displayed well by the General Electric Corporation (GE). The GE model successfully captured the culture of a small business (that is, speed, urgency and innovation) with the economics and benefits of size of a large corporation. GE has around 400 000 employees. These techniques are directly applicable to large hospital systems. They focus on integrating the various components of businesses, thus ensuring that the knowledge and skills dispersed across various operational units (the silos) are linked. This is also a key component of ABB Corporation; one of the most successful companies in the world (Ghoshal & Bartlett 1997, p 200).

A systems view is particularly suited to disease management and integrated care models of business. Public hospitals, with their traditional bureaucratic structure, could do well to adopt many features of this GE 'culture of small business' concept.

## **Production planning**

While there is a view that health care demands are difficult to predict, many industries also deal with stochastic processes. The retail sector, agricultural industry and most industries in general have significant degrees of variability, not only in consumer demand but also in raw material supply. Many major commodity industries face difficult patterns of demand, which is compounded by global movement in markets and exchange rates.

The application of manufacturing techniques such as demand management, demand forecasting, resource matching and production planning is rare within the hospital sector. In all but the most difficult demand periods (for example, peak winter), it is entirely possible to match patterns of demand in emergency department presentations with probability models that can determine the likely presentation patterns. This, in turn, enables scheduling of resource and demand to at least a weekly, and sometimes a daily, pattern. Forecasting in the health sector is still embryonic. At South Auckland Health we have developed many forecasting models, some of them based on time-series analysis, others based on regression analysis, and linked to such things as deprivation indexes and even temperature. These forecasts help give us sufficient lead-time to bring in resources and predict the demand pattern. This has significant implications for labour market analysis, labour market demand and the flexibility of labour to supply the

required resources. Materials requirement planning and the more recent enterprise-wide scheduling are becoming commonplace in industry.

Standard production techniques, such as simulation, are rarely used in health. At South Auckland Health we have recently used simulation models with probable distribution of arrivals and resources to design our new emergency department.

No manufacturing plant in the world operates without standard operating procedures, and scheduling is a key competency in many industrial firms, such as the steel industry. Scheduling is, however, in its infancy in the health sector. While we have an increased emphasis on using clinical pathways to give standard protocols for the treatment of various classes of patients, the day-to-day scheduling of beds, diagnostics and labour-to-demand (particularly in an acute setting) is still a complex and difficult process. These techniques, however, are commonplace in the private sector (Radford & Richardson 1977, p 44). The ability to manage inventory is partially linked to this. Many industries, particularly highly industrialised ones, have utilised the Japanese 'just in time' technique to minimise inventory. Other firms have utilised the practice of outsourcing, which allows concentration on only those aspects that are core competencies. This technique is often successfully applied to non-core health processes such as hotel services, warehousing and inventory control. British Airways now utilises administration systems for its entire global operation from India. Dealing with operational challenges such as demand modelling, scheduling lead times and matching resources to requirements in the hospital setting is well described by Lathrop (1993, pp 67–89).

## **Information technology**

Distance is dead. Carrying a call from London to New York costs virtually the same as carrying it from one house to the next. The death of distance will probably be the single most important economic force shaping society in the first half of the next century. GE, with its US\$100 billion annual revenue, is passionate about the Internet. A senior executive claimed recently that '...this is clearly the biggest revolution in business in our lifetimes – and I've got all the tools to go after it' (Stewart 1999, p 82).

How many public hospitals have Internet business groups focused on new opportunities or on reducing competitive risk? It is likely that new competitors (for example, on-line triage nursing offered by IT companies rather than traditional health providers) and the new power and control structures of the Internet and e-business will seriously alter the system as we know it.

Information technology, particularly the Intranet and e-commerce, are key drivers of much of the private sector's modern business strategic intent. Indeed the Intranet revolution has yet to happen.

The health sector is remarkably passionate for the panacea of the electronic medical record, however many industry players would see this as a false dawn. I know of no industry that has the philosophy of simply computerising all the paper that exists within that industry or business, simply because it exists. The real strategy should be to use

information technology as a means of reinforcing the business direction, not computerising paper for the sake of it.

The information technology industry is a leader in outsourcing. This technique is employed not only in the information systems field, but also, as mentioned earlier, in non-core business systems. Jack Welch best exemplifies this non-core business definition. He says that '...if you ain't number one or number two, you either fix it or get out of it' (Slater 1999, p 59). Outsourcing has become a global business, not only for information technology services, but also for industries such as component supply in the computer sector and apparel and garment supply in the retail sector. Manufacturing can now simply relocate to the location with the lowest overall cost of production, regardless of sovereign ownership of the firm.

## **Cost behaviour**

In the private sector (especially the manufacturing and heavy industry sectors) it is almost impossible to run a business without understanding the costs. Product costing in the health sector, however, is in its infancy and there are major issues with standard management accounting, as indicated by Johnson and Kaplan (1987, p 183). Management accounting information in the health sector is often too late, too aggregated and too distorted to be relevant for key decision-making.

It is an indictment on New Zealand's health sector that it still cannot calculate its long-run sustainable costs of production or how to treat and recover capital costs. This has significant implications for negotiations with the purchaser. Product-line management (margin and volume analysis by product) is a standard private sector technique, but far less common in the public health sector. Similarly, there is an especially poor understanding of the cost of capital in the health sector, options analysis for decision-making, and an understanding of cost drivers. Cost driver analysis is critical, particularly when it relates to movement in volumes and mix. As I said previously, volume (demand) will fluctuate. It is a given that if you cannot understand what drives your costs, you cannot control your costs. As most major hospitals provide a monopolistic supply, and use cost leadership as a key strategy, understanding costs is absolutely critical. While techniques such as utilisation review and benchmarking are still in their early days in public health care provision, some firms, such as Xerox, have had benchmarking as a core competency since the 1970s.

## **Conclusion**

My background is predominantly in the steel and food industries. The techniques discussed in this article are taken from that background and from recent experiences with private sector colleagues. There are some applications of these and more competitive techniques that are emerging as relevant for the health sector. There is a

lot to be learnt, particularly if we truly seek improved performance on a balanced scorecard and a multiple stakeholder basis. We need to challenge our industry structure – consider ‘clock building, not telling the time’ (Collins & Porras 1997, p 22).

We should remember that different businesses have different rates of return. In the United States the return on equity for the best-performing transport industry is lower than the worst-performing pharmaceutical company. It does indeed matter what business you are in, and how good you are in it. It is also critical to remember that the most important factors in business success – customer and staff satisfaction – are not in your accounting system. There is no silver bullet. Organisations are ambidextrous and paradoxical. We have to manage both the long and short term.

Running a hospital is an incredibly complex and difficult business. As well as the unique tribal nature of its professional structure, it also feels the impact of political factors. While these factors make change more difficult in the public health sector, the degree and speed of change required is often not as rapid as that required by private sector firms, which operate in a highly competitive environment. The overriding difference between the private and public health sectors is that in the public system the customer doesn’t pay you, you can’t really go out of business and there is no reward or ‘value creation’ system for increased clinical quality and customer satisfaction. Purchaser measurement of clinical quality is rudimentary. It is no wonder, with these misaligned factors and other perverse incentives, that improved performance is difficult. The differences between the public and private sector are often conveniently easy to find but there are also many similarities. That is why there are many lessons we can learn from the other side. We need to rebuild the clock.

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