

By treating clinical departments as business units, hospitals can transform their approach to management—and achieve considerable clinical, operational, and financial results.

How service-line management can improve hospital performance

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A hospital's managerial practices strongly influence how well it performs clinically, operationally, and financially. But around the world, hospitals—particularly those in public health systems—have often proved to be slow adopters of good practices. A common problem at many hospitals is that clinicians play only a limited role in the management of their departments; most decisions are made centrally. Yet clinicians are responsible not only for direct patient care but also for the majority of all hospital spending, so decisions made in the boardroom without their input are frequently ineffective. The absence of clinicians from the ranks of management also discourages them from suggesting ways to improve performance, because they often perceive centrally mandated “improvement initiatives” as nothing more than simple cost-cutting exercises.

The UK's National Health Service (NHS) hospitals are a case in point. The NHS was designed to be run centrally (see sidebar, “Overcoming a command-and-control legacy”), and only recently have NHS hospitals—and the clinical departments within them—been encouraged to take on greater autonomy. As a result, some of the managerial practices at NHS

hospitals are less than optimal (see “Management matters,” in this issue).

These practices can be improved through the use of an approach called service-line management (SLM), which is designed to devolve decision making and accountability to the front line—that is, to the clinicians

responsible for patient care. SLM was developed jointly by McKinsey and Monitor, the independent regulator of the NHS foundation trusts.¹ It is based on a simple assumption: that a hospital's clinical departments can be regarded as equivalent to the business units, or service lines, in a commercial organization. Each department functions as a service line responsible for the quality of the product delivered, the customer's satisfaction with that product, the productivity of the people who work in the department, and the department's economic performance. For hospitals, the product is patient care, and economic performance is the degree to which a department provides that care within the limits set by a country's reimbursement system.²

Clinical departments can function as service lines only if they have the power to make decisions. Thus, SLM allocates autonomy to the front line: the clinicians in each department, particularly the clinical directors, have greater control over its activities and greater input into its long-term goals. Of course, this autonomy must be earned. Clinicians must accept greater accountability for the functioning of their departments, and all departments must be monitored regularly to ensure that performance problems are corrected.

Implementing SLM is challenging because it requires a number of important changes to the way a hospital works; the key elements include its organizational model, culture and capabilities, and its approach to strategic planning. Implementation also requires robust systems for managing performance and information. However, hospitals that have implemented SLM have found the effort worthwhile. Clinicians can indeed drive operational effectiveness, so their hospitals can deliver higher-quality health care, provide patients with a better experience, and perform more efficiently.

Common challenges

Pilot projects we conducted in NHS hospitals have identified several challenges common to SLM implementations. First, as noted, most such hospitals are centralized organizations that have little experience with devolved decision making. Second, few of them have ever developed long-term strategies, and even their short-term planning suffers from poor data collection and insufficient performance-management systems. Third, there is often a significant capability gap between the managers who look after these hospitals' financial efficiency and the clinicians responsible for health care delivery:

¹ National Health Service (NHS) hospitals that meet certain governance, managerial, and financial-viability criteria are allowed to become foundation trusts, a status that gives them much greater operational independence.

² In the United Kingdom, for example, reimbursement depends on the tariff the NHS sets for each HRG (health care resource group).

the managers lack a deep understanding of the health care processes they oversee, and the clinicians lack training in basic management.

Lack of empowerment at the front line

Until recently, managerial decisions in NHS hospitals were made by the chief executive and board of directors, with little input from clinicians. Furthermore, the activities of these hospitals were heavily influenced by how the organizations obtained funds. Each hospital's overall budget was determined by block contracts based on the previous year's activities, and the budget for each department was based on its previous year's budget, adjusted for inflation. Recent reforms have changed the NHS and its funding mechanisms a good deal, but managerial decision making remains centralized at many hospitals.

Under this type of management, roles and responsibilities are often misaligned. For example, the clinical decisions made by doctors—whether a patient should undergo surgery, say, or receive an expensive drug—account for about 80 percent of all hospital spending. Yet when hospitals are managed centrally, doctors have neither the incentive nor the authority to find ways of delivering care more cost-effectively.

Lack of strategic focus

Because of the budgeting process just described, NHS hospitals have historically had little ability to make independent, long-term strategic

decisions. Planning has instead focused on year-by-year budgeting or cost-cutting exercises, and there has been little impetus to consider the relative profitability, quality, and efficiency of different service lines. Even when performance pressures have spurred interest in such issues, a hospital's management often lacks the information and decision support systems required to make sound operational and financial decisions. In some cases, there may be a wealth of data but little usable information; in others, the staff may be unable to translate the existing information into meaningful action.

In addition, many NHS hospitals seem to lack robust performance-management systems. The chief executive responds to centrally set targets, and we find little evidence that individual departments (or the people within them) understand the overall strategy of their hospitals, are measured against their ability to achieve those goals, or have any other incentive to do so.

Capability gap

At the center of each hospital's operations are highly qualified deliverers of care—doctors, nurses, and allied health professionals. In contrast, the general managers in NHS hospitals do not undergo any sort of formal qualification process, and their competence varies dramatically, both among and within hospitals. Often general managers have difficulty

earning the respect of their clinical colleagues not only because of their individual deficiencies, but also because they are frequently perceived as barriers to excellent care rather than its enablers.

NHS hospitals employ doctors directly; they do not use fee-for-service arrangements, unlike hospitals in many other countries. Thus, the doctors (and other clinicians) in NHS hospitals could be asked to assume greater managerial responsibilities. To date, however, two factors have limited the clinicians' role in management. First, many of them view their accountability solely through a professional (that is, medical) lens; some, in fact, believe that their responsibility for delivering high-quality patient care is incompatible with a responsibility to help the hospital achieve financial efficiency. Second, most clinicians have received only limited instruction on how to manage people, operations, and finances; even the senior doctors, with responsibility for managing their junior colleagues, typically get little training or support for this aspect of their role. However, all clinicians share traits that could serve them well if they took on expanded managerial responsibilities: they have been trained to make independent decisions and have a highly developed sense of professional excellence and accountability.

Key components of implementation

Service-line management can help hospitals overcome the challenges we

have just outlined—for example, by providing clinical leaders with a management tool kit and training in how to use it—and can help these leaders adapt to, and then learn to foster, a performance culture. As noted, SLM generally requires significant change in five areas: a hospital's organizational model, culture and capabilities, approach to strategic and annual planning, performance-management systems, and information-management methods.

Organizational model

Each service line must be set up as a “natural unit”—a team to which accountability can be delegated and within which improvement efforts can be focused. Because hospitals vary in the size and scope of their departments, there is no single correct organizational model for SLM; the structure should be tailored to the characteristics and culture of each hospital. Nevertheless, all hospitals should consider several issues. The most important are the number and size of the service lines, decision rights, and leadership.

Determining the right number of service lines can be difficult. Too many of them places unnecessary demands on the planning and budgeting processes and on the chief executive's management capacity. Too few can force unnatural groupings of clinical activities and put excessive pressure on service-line leaders.

Several criteria can help a hospital determine how many service lines it should have. First, each service line should be self-contained. It should have discrete patient and staff groups, its own infrastructure (for example, wards and equipment) wherever possible, separate profit-and-loss accounts, and minimal external interactions.

Within each hospital, all service lines should be relatively comparable in size (staff, budget, and income), and all should use a common measure of success. Most NHS hospitals have 10 to 20 service lines.

Decision rights lie at the core of SLM because they determine each service line's role and responsibilities. At the hospitals where we have piloted SLM, we have often found that before the transformation, the staff members did not understand where decisions were made or what decision rights they themselves had. However, they almost unanimously agreed that decision making should occur at lower levels of the organization, by people closer to the actual delivery of patient care. After the transformation, all staff members clearly understood which decisions they were entitled to make.

We strongly believe that each service line should have a single point of accountability, so we recommend that each be headed by one clinical leader. If a hospital wants a clinical leader and a general manager to share service-line leadership, it must make sure that both parties understand who is responsible for making final decisions.

Culture and capabilities

For many hospitals, an organizational transformation on the scale of SLM requires a significant shift in the beliefs and behavior of the frontline staff, especially the senior doctors, many of whom will become service-line leaders. Thus, when planning a shift to SLM, the executives of a hospital cannot focus solely on its organizational structure, systems, and processes. They must also consider the human aspects of managing change.

Devolved decision making and increased accountability will alter the roles and responsibilities of all frontline staff, but the changes will be felt most acutely by the service-line leaders. These clinicians will need to understand the broader challenges their hospitals face, to accept ownership of their service lines, and to be capable of making decisions that take into account many financial, operational, clinical, and human factors.

Service-line leaders should be able to demonstrate leadership in four ways. First, they ought to be effective role models who can inspire the staff and help it perform at its best. Second, they should display a strong commitment to patients, the quality of care, and good outcomes. Third, they should show an equally strong commitment to their managerial role by understanding the drivers of financial performance, identifying and prioritizing opportunities to improve operational excel-

EXHIBIT 1

Motivating the leaders

Average of all respondents,¹ on a scale of 1 to 4, where 1 = 'not motivating' and 4 = 'extremely motivating'

How successful do you think each of the following incentives would be in motivating you personally to become a service-line leader?

	Clinical directors	General managers
Shape future of service	3.7	3.8
Learn new skills	3.3	3.3
Career development	3.0	3.5
Greater remuneration	3.0	3.1
Shape hospital's future	3.0	3.3
Involvement with hospital at executive level	2.8	3.3

¹Based on 2007 McKinsey survey of 39 clinical directors and general managers across four National Health Service (NHS) foundation trusts.

lence, and developing service-specific strategies and objectives. Finally, they should be able to communicate and collaborate effectively with other service-line leaders, to engage appropriately with the chief executive, and to interact with external stakeholders when necessary.

Because of the way most NHS hospitals have been run, few service-line leaders have all these capabilities today. In our work to date, the most critical gaps have involved managing the performance of others (particularly other doctors), understanding the drivers of financial performance, and engaging effectively with external stakeholders.

To attract the right candidates for service-line leadership, a hospital must have a value proposition tailored to the factors most likely to motivate them. Our research suggests that the biggest motivators for potential service-line leaders are the ability to shape the future of the service and the possibility of learning new skills (Exhibit 1).³

Strategic and annual planning

Each service line needs to develop its own strategy within the context of a hospital's overall strategy, so the staff at all levels, and particularly the service-line leaders, must clearly understand the hospital's goals in undertaking the transformation to

³In 2007, we surveyed 39 clinical directors and general managers at four NHS foundation trusts.

SLM. In our experience, a transformation story—the CEO’s personal account, including clear guidance about the path of change—is a powerful tool for communicating the hospital’s goals.

What’s more, a hospital-wide analysis of the relative size and contribution margin of each service line can help the CEO and senior executives review their overall portfolio. This exercise can in turn help define the strategic options open to specific service lines. Hospitals in other countries have used this method to refine the scope of the services they provide. For example, a hospital might aspire to increase

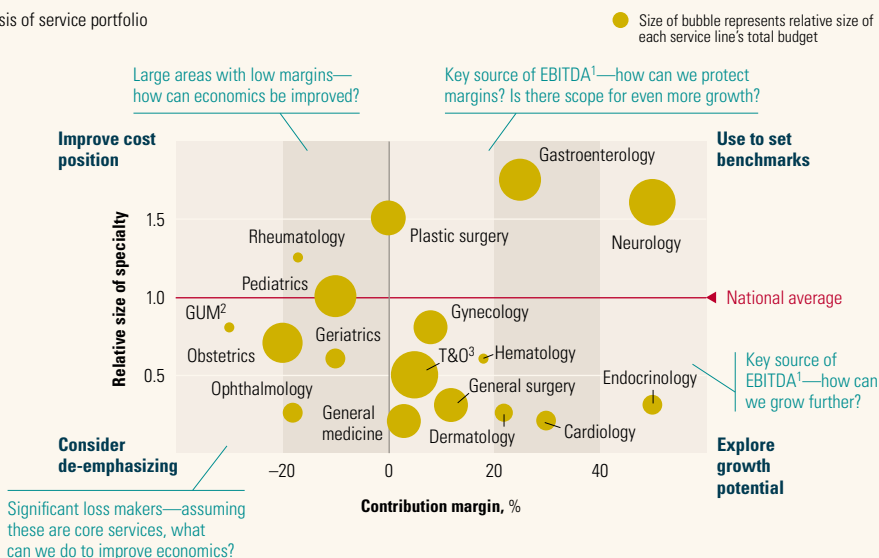
its market share in profitable but low-volume service lines and to reduce costs in high-volume, high-cost ones. Plans for low-volume, high-cost service lines should be considered carefully because a hospital must balance its need to improve efficiency with its obligation to provide high-quality care to the local community.

Information about the relative size and contribution margin of all service lines can be depicted on a strategic portfolio matrix, which helps highlight the key questions hospitals must consider (Exhibit 2). However, the matrix should not be used in isolation; it must be reviewed with

EXHIBIT 2

Defining options

Analysis of service portfolio



¹Earnings before interest, taxes, depreciation, and amortization.

²Genitourinary medicine.

³Trauma and orthopedics.

a clear understanding of where a hospital is distinctive, the quality of the services provided, and the external landscape. Thus, to develop a robust strategy that can be translated into annual objectives, the leaders of a service line must understand its current performance (clinical, financial, and operational) and all the external market factors that will affect its performance in the future (demand growth, competitive position, and so on).

Performance-management system

A well-functioning performance-management system is essential for SLM. Such a system enables the service lines to earn autonomy because it creates a clear view of, and accountability for, progress toward agreed-upon objectives. Equally important, it allows the executive team to intervene if a service line's performance remains or becomes poor. The performance-management system must include several elements: a scorecard with a set of clear and balanced key performance indicators (KPIs) for each service line, regular review meetings including effective conversations about performance, and rewards and consequences that reinforce the desired behavior.

A scorecard should be developed both top-down and bottom-up: its KPIs must be aligned not only with a hospital's goals and objectives but also with the service line's clinical, operational, and financial performance. The staff of each

service line should select which KPIs to prioritize, and its leader should take responsibility for ensuring that the chosen metrics reflect both its strategic plans and the hospital's overall strategy. Once established, the KPIs ought to be measured regularly, and each service line's performance in meeting agreed-upon targets ought to be monitored. The results should enable the leader of the service line to understand how its performance varies from those targets and to manage that performance more effectively through review meetings and conversations.

Everyone at a hospital, from the chief executive to the frontline staff, should participate in review meetings to ensure that appropriate information travels up and feedback passes down. The CEO and senior executives should meet regularly with service-line leaders, who in turn should meet regularly with the teams in their departments. In addition, the leaders of a team ought to meet regularly with each of its members. The frequency of review meetings should be linked to performance; poorly performing service lines, teams, or individuals should be monitored more often than high performers. Performance conversations ought to focus on identifying the root causes of problems rather than their symptoms. Just as a doctor cannot treat a patient who has suffered a stroke without first determining its cause, so too must these performance conversations

identify the underlying causes of specific problems (say, that surgeons are inflexible in their scheduling) and not their symptoms (operating theater utilization is low). Participants in these conversations should focus on improving performance rather than assigning blame or challenging data.

Rewards and consequences must be linked transparently to performance, with an appropriate balance of team and individual rewards and of financial and nonfinancial rewards. Our research in hospitals implementing SLM suggests that the most attractive incentives are increased managerial autonomy and the ability to access

a portion of the surplus/profit pool of money for the service line (Exhibit 3). In many cases, team incentives are more attractive than individual ones. These findings resemble those we have obtained in other industries: many people are motivated primarily by the chance to make their own decisions and shape their areas of influence, while financial rewards are secondary.





Information management

Timely, accessible information is fundamental to well-informed decision making. Thus, the management and financial information available to the frontline staff—particularly the

EXHIBIT 3

The most attractive incentives

Incentives for potential service-line leaders, average of responses, on a scale of 1 to 4, where 1 = 'not motivating' and 4 = 'extremely motivating'

		Clinicians	Managers	Total
Top 5 nonfinancial incentives¹	Further autonomy in decision making (for whole service line)	 2.8	 3.5	 2.8
	Increased opportunities for development (eg, taking on more responsibilities or new projects)	 2.8	 3.1	 2.8
	Operational performance-based awards, akin to clinical-excellence awards	 2.8	 2.8	 2.8
	Performance transparency (for whole service line—compared to other service lines in trust)	 2.7	 3.2	 2.7
	Training opportunities	 2.6	 3.0	 2.6
Top 5 financial incentives¹	Ability for service line to access part of a 'surplus pool' of funds proportional to achievement of agreed objectives	 3.1	 3.7	 3.3
	Individual performance-based pay increases	 2.9	 2.9	 2.9
	Further control over budgets and investment decisions (for the whole service line)	 2.8	 3.4	 3.0
	Fee-for-service Saturday lists	 2.8	 2.2	 2.5
	Individual performance-based annual bonuses	 2.7	 3.2	 2.9

¹Based on 2007 McKinsey survey of 39 clinical directors and general managers across four National Health Service (NHS) foundation trusts.

Overcoming a command-and-control legacy

From its beginnings, in 1948, the UK's National Health Service (NHS) was designed to have central command-and-control systems. Indeed, Aneurin Bevan, founder of the NHS, once declared that if a bedpan fell in a hospital ward, its echo should reverberate in the Palace of Westminster. Over the next half century, progressive waves of change were imposed in a top-down manner, giving rise to the perception that managing performance requires ever-larger cohorts of administrators implementing centrally developed policies and procedures, with little room for flexibility or local decision making.

In 2000, however, the UK government published its NHS Plan, which was designed to increase investment and drive reform in the service. A second phase of reform followed in 2003, with the goal of giving patients more choice and health care providers more independence. These reforms included the establishment of foundation trusts; hospitals that could meet

certain financial and clinical requirements would be allowed to become nonprofit organizations independent of the central NHS hierarchy (and reporting instead to an independent regulator). In the foundation trusts, performance management is driven by strong, accountable boards. NHS hopes that all hospitals will eventually become foundation trusts.

Another important reform was the creation of health care resource groups (HRGs, which are conceptually similar to the diagnosis-related groups used in other countries) and the decision to base the reimbursement of hospitals on them. An HRG-based reimbursement system allows hospitals to track productivity at the front line.

These reforms have, in turn, strengthened the forces of decentralization and underscored the importance of clinical leadership. As a result, the service line has emerged as the most appropriate center for driving performance improvements within hospitals.

doctors—must be intuitive, easy to use, and presented in a format tailored to its needs. All users should be trained in how to interpret and act upon the information.

The implementation of SLM has led many NHS hospitals to adopt two innovations for information management. The first is activity-based costing. Profit-and-loss statements for each service line are being used as an interim step, but the ultimate goal is to make the cost of each case,

as well as the income derived from it, more transparent. The second innovation is the use of business intelligence systems, which can create a single reporting structure from the legacy databases (for patients, the pharmacy, finance, and HR, among other things) that proliferate in many hospitals.

Unleashing the potential of clinicians to lead their service lines is the

key to improving the performance of hospitals. However, clinicians cannot become effective service-line leaders unless those hospitals have the appropriate organizational structure, culture, and capabilities, as well as effective approaches to strategic planning and to the management of performance and information. Often, a radical transformation is the only way to ensure that these elements are present.

Hospital executives should not underestimate the challenge of the transformation to SLM. For most hospitals, this type of management represents a fundamentally new way of working, and it is unrealistic to expect people to change overnight. Considerable leadership from the top is vital: the board and senior executives must be sure that they agree on all changes

and be careful not to aim for a degree of transformation that the organization cannot deliver. They must also display an ongoing commitment to change and lead the overall effort. As Stephen Ramsden, the chief executive at one of the hospitals where we piloted SLM, recently wrote, “If the chief executive is not leading transformational change there is a good chance no one is.”⁴

Finally, hospital executives should keep in mind that there is no single correct starting point; different hospitals have begun their journey to SLM in different ways, depending on their culture and appetite for change. But considering that SLM enables hospitals to control costs, increase productivity, and provide higher-quality care, the journey is well worth making. +

⁴ Stephen Ramsden, “On being a good chief executive,” *Health Service Journal*, 2007, Volume 117, Number 6073, p. 34.