

The Critical Role of Management in the Delivery of Healthcare Services

Stephen M. Davidson, PhD

Hidden in the article by Litvak and Long¹ is a very important point: Managers are critical to the success of healthcare organizations in the contemporary United States. The reason is simple. Healthcare organizations—including, but not limited to, managed care organizations (MCOs)—are responsible for furnishing quality healthcare, but they must do so while operating under difficult financial constraints. As a result, they need to emphasize efficiency in providing services. Although managers can reduce some costs on their own, they need to work together with clinicians to maximize efficiency.

Healthcare organizations can save money by streamlining “business” functions such as purchasing, accounting, and maintenance, but the organizations’ ultimate success, especially over the long haul, depends on how well they conduct their core business—delivering care to people who are sick. The goal is to provide that care “better” than in the past, by which we mean diagnosing a patient’s condition accurately and promptly using modern technology, choosing a useful treatment, and providing it effectively to the patient—using the fewest steps, the least time, the most appropriate methods, and the fewest dollars. Since responsibility for making these choices must rest with the clinician who is face-to-face with the patient, what role do managers play? They neither deliver the care nor make clinical decisions about an individual patient. Instead, their task is to increase the probability that the clinicians’ decisions will result in better care at lower cost. How?

Managers’ Decisions and Clinical Care

Managers make several types of decisions to accomplish the goal of better care at lower cost. Some decisions involve the selection and purchase of equipment and technology for clinicians to use. Analytic tools such as variability analysis, the main subject of the Litvak and Long article, can help managers to assess the value of devices before deciding whether or not to purchase them. But managers need to do more.

In their MCOs, hospitals, and other healthcare organizations, managers must create conditions under which clinical professionals actually provide services to patients. Managers want to help clinicians make the optimal choice for each patient without being in the room with them, so these managers must understand the factors that can influence clinical decision makers positively. Financial incentives and clinical information are 2 such factors that managers may be able to affect.

Financial incentives can be very useful tools. Economists demonstrated a long time ago that, other things being equal, physicians who are paid on a fee-for-service basis deliver more services than those paid by salary. (The extent to which fee-paid physicians deliver too many services or salaried physicians deliver too few is less clear.) Although by avoiding fee-for-service payment, managers can influence physicians to do less, that is not the same as promoting efficiency because efficiency incorporates the concept of benefit as well as cost. It can be thought of as “doing the right thing well at the right time and using the fewest dollars.” Moreover, managers need to be concerned about the entire clinical episode, not just the services provided by a particular physician following his or her own incentives. Inadvertently, some clinical choices may result in the need for additional services provided by others. Further, the treatment of many conditions requires services from multiple clinicians, often practicing in

From Boston University School of Management, Boston, MA.

Address correspondence to: Stephen M. Davidson, PhD, Management Policy Department, Boston University School of Management, 595 Commonwealth Avenue, Room 625, Boston, MA 02215.

different sites—a primary care physician (PCP), a specialist, and staff in a hospital, for example. If an MCO is at risk, it has an interest in the patient's receiving the needed services in the most appropriate, lowest cost sites without service duplication, but the integration needed to produce that result does not occur spontaneously.

This idea is made more concrete by an example. Over an 8- or 10-week episode, a patient, who was a member of a health maintenance organization, had a heart attack and was treated in an emergency room, as a hospitalized inpatient, and in an extended care facility (ECF). On the advice of the physician who examined him in the ECF, after returning home, he saw his primary care physician about a continuing irregularity; and on referral by the PCP, he saw a cardiologist as well. Before the patient was able to keep a second appointment with the cardiologist, to whom the patient was supposed to bring his medical records, he died.² The primary care physician was uninvolved and apparently uninformed about his patient's condition and treatment in the hospital and ECF. During the entire period, no succeeding provider had access to the patient's prior records or history, nor is there evidence that any clinician communicated directly with a colleague practicing in another setting. The result was not only the repetition of a number of tests, but also the loss of considerable time.

Although the patient may not have survived in any event, the processes of care were anything but seamless. Numerous opportunities to make them more efficient and, perhaps, more effective were missed. To improve the care reported in this story, standard procedures are needed so that succeeding segments of extended episodes are linked; it is a managerial role, working with clinicians, to facilitate the development of those procedures.

Automated information systems, too, have the potential to improve clinical decisions. To work, these systems must be accessible to clinicians as they treat patients and the software must permit the clinicians to use information about a particular patient in ways that improve efficiency (by avoiding duplicate tests, for example). When a patient has a condition with which the physician has little personal experience, clinical information systems can also increase the probability of a clinically appropriate decision by importing guidelines or protocols based on aggregated national data from groups of similar patients. Typically, it is managers who make the decisions to acquire the necessary hardware and software,

and in doing so, Litvak and Long's statistical methods can be useful.

Constraints on Effective Managerial Decisions

If these are examples of decisions that can positively affect clinical practice, however, it must also be recognized that, in making them, managers face important constraints. Some of these constraints may lead managers to make decisions that undermine their best intentions and that fail to achieve the desired outcome. These constraints include (1) pressures from competitors; (2) the limits of technological development; (3) the lack of needed funds or credit; (4) inexperience; and (5) a failure to recognize the full value of engaging in the hard work of finding better ways to deliver care.

Although competition is expected to stimulate innovation among firms to produce higher quality and lower prices in order to attract or retain needed customers, sometimes it creates pressures that make achieving the underlying goal more difficult. For example, in response to competitive pressures, many MCOs removed utilization constraints and freed patients to self-refer to specialists, thus making it harder to contain utilization rates and costs. Similarly, to avoid losses to competitors, many MCOs grew their organizations by adding physicians and subscribers before the MCOs had systems in place to help them manage utilization and costs effectively. As a result, costs began to rise again, and a backlash occurred.³

Second, although employers are pushing MCOs to measure quality of care so that subscribers can choose plans on the basis of quality, the fact is that to date, measures of an organization's quality are fairly primitive. Similarly, clinical information systems are still evolving and have not reached their full potential. Undoubtedly, both quality measures and information technology will improve, but for now, consumers can more easily understand the cost of a plan's coverage than its quality⁴ and plans can more easily track their costs than their care.

Third, improvements (eg, the purchase of new technology and the development of quality-enhancing standard procedures) can be expensive, and an MCO must be able to afford them. Many healthcare organizations have been losing money recently, so their capacity for such investment has suffered. This difficulty is compounded when an organization needs to make multiple investments, which compete among themselves for limited resources. Further, to maximize the value of any technological

enhancement takes time, yet another cost. Indeed, the time of clinicians and managers can be a major cost when the goal requires them to work together to develop methods for increasing the probability of service integration, as discussed earlier.

Fourth, the new environment depends on managers engaging physicians in collaborative efforts, but this is a task with which most managers have little experience. In fact, the traditional job of healthcare managers was to create the conditions that made it possible for physicians to apply their skills and knowledge in the service of patients. Responsibility for patient care rested with physicians acting independently as ethical professionals even when the work occurred in a hospital. In that context, healthcare managers learned their physicians' needs for equipment, facilities, and staff and tried to provide them. In the current environment, managers need different, more collaborative skills.

Finally, the first task in building such an alliance with physicians is to gain their attention and then their agreement that collaboration is important. Many do not see that their clinical work has much impact on a large MCO or hospital, especially as their connection to the organization often appears to be distant, if not tenuous. Many physicians continue to practice in community-based offices with a few colleagues and technical staff and tend to see MCOs as insurers who pay the physicians for services provided and hospitals simply as places where the physicians treat some of their patients. Moreover, most practitioners have contractual relationships with several MCOs, so even if they recognized value in developing procedures that improved quality or efficiency, these physicians could not reasonably be expected to work with managers and clinicians in multiple plans. The scope of the problem may be reduced to some degree when physicians combine into a large group that contracts with insurers,⁵ but fundamentally, the issue remains the same because then the group's managers must engage physicians in unfamiliar and unpopular collaboration.

Conclusion

Managers may indeed be "poor cousins" to professional providers, as Litvak and Long assert. Certainly, the managers' roles in healthcare are poorly understood and unappreciated by others in the system. If care provided under the auspices of organizations, whether MCOs, hospitals, or others, is to have value beyond that which is provided by individual clinicians acting alone, then it is managers who will cause that value to be created. The result will be care that is better because the power of information systems is brought to bear; care that is integrated because standard procedures are in use; and care that is more efficient because sources of waste can be identified and steps can be taken to reduce it. Managers will not deliver that better care themselves, but they will create the conditions under which expert clinical professionals can.

The job is a difficult one, partly because of the constraints outlined above and partly because it is so new that even the best managers are just learning how to do it well, often through a painful process of trial and error. Until they get it right and learn to engage the clinicians in such productive processes, however, the full value of MCOs and other healthcare organizations will still be in the future.

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