BECAUSE WE CARE –

Tackling the looming healthcare blackout

by Katharina Janus
Professor of Healthcare Management
President and CEO of ENJOY STRATEGY, Paris

As the pandemic becomes endemic in its third fall on earth people have largely returned to "normal" habits, or rather "new" normal routines considering the permanent change of how we interact, work together, and **take care of each other**. So far, the dramatic wave of new infections and subsequent hospitalizations that came with colder weather, indoor activities, and a lack of safety measures such as masks, disinfection, and vaccination, has not materialized. However, while the general population's attention has moved on to other economic worries and political warfare, healthcare systems and their respective providers are continuing the fight – now to **retain and recruit personnel**. Critical care is – again - in the spotlight, but other specialties are raising alarming voices as well. The aftermath of the pandemic paired with the long overdue reforms of payment, working conditions, and changing roles and responsibilities have now resulted in a **conundrum of human resources management** that is faced by other industries as well – but with one major difference: the impact on life-or-death of members of our society. In Germany for example, material infrastructure and beds are available, but the **scarcity of personnel** in critical care has resulted in the situation that emergency departments in some cities are going off-duty and not accepting ambulances anymore. I heard similar stories pre-pandemic only in the US under the heading of "ER diversions" – mostly due to payment and profitability reasons. But in Germany? This is a new era, and we must **act quickly to avoid a healthcare blackout**.

This summer I was pleased to support ANAP France (National Agency Supporting Performance Improvement of French Healthcare and Medico-Social Facilities) in collaboration with the European Association of Hospital Managers (EAHM) and under the auspices of the French Presidency of the European Union with the organization, preparation, and thought leadership of the conference **"Critical care and the healthcare crisis: organizational lessons at the European level"**. As a healthcare manager and professor, I was intrigued to hear first-hand from critical care experts about their experiences and draw conclusions to tackle the situation as it represents itself. We discussed approaches to adapting critical care supply to demand in the European Union, reflecting on experiences from France, Germany, Ireland, and Italy. From the bird's eye perspective, we zoomed into the topic of rethinking the organization of critical care teams and heard about experiences from France, Germany, and Spain. Finally, we envisioned what a future collaboration in critical could look like and how to translate existing evidence for good collaboration into practice and establish ongoing efforts to accomplish a vision for tomorrow.

At the end of the day, we had to ask: what have we learned? We have a vision, but what does it mean? It is the ability to think about or plan the future with imagination or wisdom. We concluded that all (European) countries are dealing with the same issue, so a joint approach to a common framework

would make sense. But what is preventing countries from accomplishing this vision? Maybe it is because countries are not making those decisions, but **people do**. Collaboration is an **innate human undertaking**. It is the action of working with someone to produce something. Consequently, we must ask "What is preventing people from accomplishing the vision of collaboration and a unified framework?"

We learned from David Morgan of the OECD that **a joint definition is key** – if we have no joint definition, we cannot be sure to talk about the same issue at any given point in time. This is particularly important as far as **standards** and **quantifiable resources** are concerned. It is also essential to allow for **information to be shared** and **communication to happen** which serves as a basis for wise decision-making in medicine and policy. This then allows for an objective discussion of "what kind of" and "how many" resources are needed. We exchanged different opinions about how many resources we need and how to ensure valid and reliable data sources. I believe it is essential to "walk the corridor" and "talk to people". Michael Power of Beaumont Hospital Ireland mentioned that not the pure data capturing is important but also the **follow-up call to investigate how healthcare professionals are coping** with the situation as it presents itself.

The **"care reserve concept"** in France is an interesting approach which might also be developed further into a European pool of resources. Jean-Paul Mira of Cochin Hospital France mentioned that **the thought process had stopped**, and that it was a challenge to just "capture the correct numbers of nurses" nowadays. What would it take to engage in a possible further discussion to revitalize the thought process? We all know that **long-term thinking** is required to be prepared for the future.

However, even the best and unified standards that address resource availability do not provide us with answers **"how" to use a possible pool of resources**. As Marc Leone of Marseille University Hospital France mentioned "just comparing numbers is insufficient" – **cultural and structural differences must be considered, and processes improved. *We need healthcare managers.*** I'd like to highlight here from our own work the different cultural dimensions to be considered: **national, organizational, and professional cultures**. We must develop a strategy to deal with and leverage cultural dimensions as they are key for collaboration. Many speakers talked about great collaboration in critical care teams in crisis mode, but in normal times healthcare professionals fall back into their **old habits** and **silo mentalities** that are defined by their respective specialties as Leticia Moral of Quironsalud Spain mentioned rightly. Julien Poettecher of the Hautepierre Hospital Strasbourg France pointed out that positive and long-lasting examples of **collaboration** are usually **driven by the human and personal experience**. Again, it is **the human factor that is key**.

Flexible staffing could increase efficiency and effectiveness – we learned that high capacities and sophisticated infrastructure do not necessarily translate into lower mortality as the comparison between Spain and Germany has shown. **Reskilling, retraining and the repurposing of hospital units** was pointed out by Olivier Joannes-Boyau of Bordeaux University Hospital France and Leticia Moral. We must **"work with what we have"** is Ralf Kuhlen's (Helios Health Germany) approach. Of course, this is not only related to human resources but also materials and drugs for which Pierre Albaladejo of the University Hospital Grenoble France suggested a **strategic sourcing on the European level**.

We heard about great national examples that have the chance to be transferred to other countries, regions or even to the European level. Gernot Marx of the University Hospital Aachen Germany elaborated on the **use and impact of telemedicine approaches** and Michael Power showed us how **collaborative capacity management** can work. Again, my question is how to **make it work and then scale it up as a joint undertaking**?

Speakers agreed that **communication is key** and must be improved. Myriam Combes of Elsan France raised issues on the lack of information exchange and consequently the adoption of **best practices and training**. Marc Leone pointed towards the **positive effects of social media** for information

exchange among professionals during the pandemic which would have to be analyzed in more detail and possibly employed in a more targeted way. Quirino Piacevoli of San Filippo Neri Hospital Italy was rather pessimistic with respect to the current state of exchange and collaboration. Although the resource question seems to be the most pressing, we must not underestimate the **underlying cultural, societal, and economic values that impact successful change**. Together with this come **ethical questions** that are deeply ingrained in the histories of different healthcare systems.

What is needed today is a comprehensive assessment with respect to patient needs, resources, cultures, and a possible implementation that also includes lobbying and a clear definition of roles and responsibilities that can drive change. This discussion in critical care today is essential as it is just the prelude for what is hitting the healthcare system in general and could serve as a role model for change on a higher level. To accomplish our vision, we first must propose ways to collaborate and facilitate communication among different countries and cultures. We can then develop joint strategies and approaches to implementation.

BECAUSE WE CARE and we are concerned with the practical implications & implementation of the issues raised above we have launched the CARE-TANK initiative that aims at extending the generic idea of "care" to today's healthcare management practice. **Healthcare nowadays is increasingly about caring, and substantially less so about curing**. An ageing population paired with multiple chronic diseases has turned the classical **"one-shot" acute patient** for which today's hospitals were designed into a **"subscriber" who requires ongoing care** and will most likely not be cured entirely. This patient also requires **more communication, interaction, care management and many other non-billable activities** that most health systems are not designed for and only sluggish to adopt.

Interestingly, medicine's focus on "curing" is like management's approach to set objectives, implement, control, and measure the accomplishment in terms of "performance". In this way, **"healthcure" and management are the "perfect match"**. However, if we intend to manage "healthcare" resources, this fruitful liaison begins to fall apart and we must acknowledge that the mission to cure cannot always be accomplished – in fact, most of the time, the result of medical care cannot be measured easily, but it is an **ongoing process of caring that is carried out by people**.

We extracted from the above-mentioned conference and from another event that we were commissioned to organize for the Commonwealth Fund New York a couple of key learnings that underline the urgency of the current initiative:

- We do **not have enough people** to provide necessary health **CARE**; we will have even fewer healthcare professionals as they **exit the workforce**; and we have **no idea/plan/strategy** how to fill the widening supply-demand-gap. The belief that technology will mitigate the issue is a **fallacy**.
- We are **not providing an appealing perspective to the next generation** of healthcare professionals – many career beginners are even encouraged by their friends & families to rethink their interest and choices as **the profession does not seem attractive** enough.
- We believe that **pushing content and engaging more/better healthcare managers** to "manage the issue actively" can do the job because unifying regulations on the political level will be unlikely and time-consuming. And **a solution is needed rather quickly/now**. But how?

The essential existence of **people as care providers** has not been recognized sufficiently by management and medicine because it was – and still is – much easier to deal with redesigning organizations in which people work and adding technological solutions (which have their added value but do not solve the key issue above). It is also because budget planning and healthcare expenditures determine the thinking on both the macro and micro levels. **Money flows easily when reputation is high, transparency is low, but "something" can be measured.**

Approaches to medical error management, standard operating procedures – just to name a few – follow

these "measurable" management principles that have been introduced by Frederick Taylor more than a century ago. His "principles of scientific management" were, however, **designed to optimize factory work** that could be **defined, split in individual tasks, and easily monitored**. Certainly, there exist elements of medicine that are easy to define, and that can be standardized, optimized, and controlled. **Taylorism provided easy answers to manage factory work**. The "problem" (and the advantage) is that **medical work is carried out by people and that providing health care is – in many instances – not comparable to factory work**. Therefore, the **human side** of healthcare systems is essential as Douglas McGregor stated already in 1960.

Management and medicine seem to be **stuck in the age of modernistic approaches** which have been fueled by the medical revolution and the desire to simplify and standardize operations. However, a **postmodernist approach will be essential to address the human resources challenges** global healthcare systems are facing. Healthcare must develop strategies to recruit and manage people – or rather professionals - who provide care and who are experts in their field. Experimenting solely with managing peoples' performance in work processes is necessary, but insufficient. We must have the **courage to give up the mythos that everything can be quantified and controlled** as Matthew Stewart postulated in his book the "management myth" and **rediscover people's stories and intrinsic motivations**.

To improve **healthcare system performance** in a post-pandemic world we must address the **human element of healthcare** urgently and therefore **we have launched the Care-Tank initiative to evaluate the following essential factors and help organizations and systems to better address them**:

Objectives and lead questions of the current initiative:

- **Listen to healthcare professionals in-person** to understand **burn-out and exit** from the profession. **Why** are people leaving and **where** are they going? **Which** healthcare professionals are predominantly leaving?
- Better understand the **underlying needs** of professionals' motivations and how these could be **rediscovered and mobilized**. Why did professionals choose the profession in the first place? How can we address **emotions** in organizations such as **fear**?
- **Cultivate the professional culture** by clearly defining roles, norms, and values. How can we **reinvent the image/branding** to make the healthcare profession **attractive for the next generation**?

Approach:

- We employ our **proven investigative mixed methodology** that relies on personal interviews and multi-staged evaluation (quantitative and qualitative).
- Depending on the level of stakeholder involvement our depth and scope of investigation varies.

If you care, how can you and your organization get involved in the current initiative?

- We have already gained the support of stakeholders in **several medical and medico-social specialties**.
- Beyond healthcare a diverse range of supporters from other industries are facing the same issues and are in the process of **joining the consortium** we are putting together.
- Every Care-Tank supporter has **individual interests** and questions that we will address as part of the interviews in specific organizations.
- All Care-Tank supporters **commit to an aggregation of results on the macro level** to allow for conclusions and comparisons on an international and cross-specialty level.
- We will **communicate results to make the public aware** of the situation and **develop a concrete strategy and recommendations** to tackle the looming healthcare blackout.

The pandemic has been and still is a terrible human drama but at the same time an opportunity for management because necessary change became more easily possible. In the same way as it applies to medicine, management also must address **the human(istic) approach that carries us into the future:**

show leadership; **make the workforce feel safe, appreciated, recognized,** and part of the community; and empower people. **Inclusion** and **diversity** will be key in this strategy as well as **communication** – using simple messages and every form of media. We must make **staff well-being** a priority to obtain buy-in and a lasting effect… **IF WE CARE**!

If you or your organization would like to be part of this global initiative, please email me at janus@enjoystrategy.com.

Prof. Dr. Katharina Janus
President and CEO, ENJOY STRATEGY, Paris
Founder, Center for Healthcare Management

Headquarter: Paris, France
Email: janus@enjoystrategy.com
Web: www.katharinajanus.com
LinkedIn: https://www.linkedin.com/in/katharina-janus-b391321/
twitter: @katharinajanus

Biographical Summary

Prof. Dr. Katharina Janus is the president and CEO of ENJOY STRATEGY (formerly the Center for Healthcare Management) a global healthcare market expertise firm that provides privileged insights, access, and implementation advice, consistently engaging key opinion leaders. Services range from due diligence, creating collaborations, to post-merger integration, repositioning, and value shaping. Over the last twenty years she has held multiple positions as an entrepreneurial executive, tenured full professor in Germany and several professorial appointments at Columbia University, New York. She has authored more than 150 publications and convened global executives and leading thinkers in her forums. As a German-born global citizen she has chosen France as her home and base camp for her world-wide undertakings.

Having worked in many Western European countries, the US and China, Prof. Janus is well-known for her global market expertise, strategic analyses, and cultural sensitivity. As a tri-lingual keynote speaker and moderator she frequently contributes her global domain expertise and in-depth knowledge of healthcare markets and trends. She has helped a range of market players from large multinationals to mid-sized not-for-profits, foundations, senior executives, governments and private equity companies with strategic endeavors. Prof. Janus has taken on roles as advisory and supervisory board member at for-profit (for example Allianz, EFESO), not-for-profit (such as the French Hospital Federation) and public organizations (Steering Committee of the Swiss National Fund).

Dr. Janus earned her Master's Degree in Business Administration at the Universities of Hamburg and Université Panthéon-Sorbonne Paris and holds a PhD in Business and Social Sciences from Helmut-Schmidt-University in Hamburg as well as the German qualification as a full professor. She was a post-doc visiting scholar and visiting professor at UC Berkeley and is certified in behavioral change and motivational interviewing techniques. Dr. Janus is the recipient of awards by the Commonwealth Fund, the Rockefeller Foundation, the Brocher Foundation and the European Union. ■