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Healthcare Strategy and Corporate Finance

In the cold light of day

10 demanding tests for hospital strategy

February 2015

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In the cold light of day: 10 demanding tests for hospital strategy[1]

What is your strategy? Will your hospital merge with another, continue alone or even form a chain? Which service lines, in which locations will you choose to invest in and which services lines will you divest? How will you balance resources across service, research and education? Where will you focus your capital investment? How will you manage vertical integration? Will the Trust seek an international footprint or focus on domestic operations?

Hospital strategy matters. It is the path organisations plan to navigate to achieve their clinical, financial and other goals – a set of integrated decisions in service of delivering strategic objectives. Strategy's importance is reflected in the prominence its development and execution is given in both chief executive job descriptions and in board responsibilities.

While there are many examples of good hospital strategies, there have also been striking examples of major strategic decisions that have gone wrong: mergers that have not delivered benefits; major capital investments that have not yielded sufficient returns; integrated-care pilots that have not taken off. As well as sins of commission, there have been sins of omission: difficult decisions kicked into the long grass. All this is causing some to question how their existing approaches to strategy have allowed them to get into such difficult positions in the first place.

Getting strategy right is becoming more urgent. Underlying pressure from changes in health needs and ever-advancing technology are combining with an increasing focus on quality, a constrained financial environment and a failure regime that makes the consequences of strategic missteps very real.

This paper seeks to provide the guidance hospital leaders need—relevant to navigating through the present challenge, but also timeless in nature—in the form of 10 tests. These tests distil generations of McKinsey thinking across multiple industries, tempered in the world's toughest markets, into a single document.

The traditional guidance to strategists outlines the best processes, tools and frameworks to be used—on the assumption that their thoughtful application will necessarily result in a good strategy. It often has. But this approach also has its challenges. And, independent of the process, boards and senior teams need to be able to evaluate the resultant strategy to determine whether it is fit for purpose.

Here, rather than focusing on inputs, we define what characterises the outputs of a truly distinctive strategy, in the form of 10 tests. Chief executives, chairs and boards can then ask:

- Does my strategy pass all the tests?
- And working back from the desired end, by what means can I develop strategies that do pass the tests?

1 The content of this paper is primarily taken from "Have you tested your strategy lately?" and has been tailored to a healthcare context. The original article was authored by Chris Bradley, Martin Hirt, and Sven Smit in the January 2011 edition of the McKinsey Quarterly

Test 1: Does your strategy create the maximum healthcare value?

In its original military conception, strategy sets the preconditions for victory before the army takes to the battlefield against those whose interests are opposed to ours. In a typical business setting, victory is determined by profits and opponents consist of all rivals in the marketplace. So strategy, in a business context becomes an integrated set of choices—made ahead of time and in the face of uncertainty—to create and capture economic surplus.[2]

The objective of profit maximisation is not an appropriate one for not-for-profit organisations or organisations that have an explicit social mission. Hospitals need to think in terms of clinical quality, access, research, teaching and financial goals.

For a hospital, playing a collaborative role in the health economy, the definition of strategy becomes: an integrated set of choices—made ahead of time and in the face of uncertainty—to create the maximum healthcare value. Hospital executives will need to think hard about the appropriate balance between competition and collaboration, and therefore the amount of the value created that they will capture for their organisation.

Healthcare value should be thought of in terms of health outcome per pound spent. Michael Porter articulates this as:

> "Achieving high value for patients must become the overarching goal of health care delivery, with value defined as the health outcomes achieved per dollar spent.
>
> Since value is defined as outcomes relative to costs, it encompasses efficiency. Cost reduction without regard to the outcomes achieved is dangerous and self-defeating, leading to false 'savings' and potentially limiting effective care."[3]

Value is not shorthand for profit. As well as financial performance, value creation encompasses making improvements in quality, in access, in education and in research as these can and should, lead to improved outcomes. Conversely, value can be destroyed even when a hospital's financial performance is improving if, for example, clinical outcomes worsen or access is restricted.

Despite not being profit-maximising entities, all hospitals, and most services within those hospitals, do operate in a competitive environment. Intense competition exists to deliver patient care – often locally between primary and secondary care, regionally between hospitals for acute care and nationally for tertiary care between specialist centres. Competition for resources is also intense – whether for scarce capital to fund development, for the highest-quality nurses, doctors and managers or for research and education funding.

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2 This definition focuses on business-unit strategy which is about winning in the market for products and services. Corporate strategy, on the other hand, focuses on winning in the market for corporate control.

3 Porter, M.: "What is value in health care?" *New England Journal of Medicine,* 2010.

The concept of beating the competition or beating the market can be helpful for hospitals if it is understood to mean competing to create value in the health system.

Porter and Teisberg describe a cycle of value creation based on positive-sum competition that:

> "... drives relentless improvements in quality and cost. Rapid innovation leads to rapid diffusion of new technologies and better ways of doing things. Excellent competitors prosper and grow, while weaker rivals are restructured or go out of business. Quality-adjusted prices fall, value improves, and the market expands to meet the needs of more consumers." [4]

This is what hospitals should strive for – to improve quality, access, education, research and cost performance. What they must avoid is zero-sum competition where:

> "... system participants divide value instead of increasing it. In some cases, they may even erode value by creating unnecessary costs. Zero-sum competition in health care is manifested in several ways: First, it takes the form of cost shifting rather than fundamental cost reduction .... Second, zero-sum competition involves the pursuit of greater bargaining power rather than efforts to provide better care ... Third, zero-sum competition restricts choice and access to services instead of making care better and more efficient." [5]

Of course, creating value in this way is difficult, particularly day after day, year after year. Even where hospitals offer a demonstrably better service, some patients/purchasers are highly conservative, often sticking with an incumbent provider despite overwhelming evidence of suboptimal quality compared to an alternative provider. In addition, health systems do not stand still. What enabled a hospital to create value yesterday will almost certainly not be sufficient tomorrow. New entrants will enter, politicians will make new policy, regulators will introduce new regulations and enforce old ones in new ways, innovators will innovate and so forth. The approaches hospitals used to create value in the past will be superseded as others find ways to deliver better outcomes quicker, cheaper and in a manner that delights patients, regulators and politicians.

Health systems are also highly interactive. Each actor responds and reciprocates in a highly dynamic way, immediately scuppering the idea that consistent adoption of best practice is sufficient to develop value-creating strategy. Adding a further challenge, systems are turbulent and often unpredictable. Over time, sources of value dissipate and new ones must be sought.

4 Porter, M., Teisberg, E.: "Redefining competition in health care", *Harvard Business School Press,* 2004.
5 Ibid.

Strategies have to be robust to the onslaught of a myriad of forces, they have to be dynamic and responsive in nature and they have to be able to take advantage of unexpected events. Few hospitals, in our experience, ask themselves if they are maximising the value they create —the pressures of 'just keeping up with the game' seem intense enough. But playing along can feel safer than it really is. Surprisingly, weaker contenders win a war when they deploy a divergent strategy[6], and the same is true in healthcare.[7]

The first and most important test therefore becomes: does your strategy enable the hospital to create maximum value in the healthcare system? The remainder of this document lays out the nine tests into which this fundamental test can be disaggregated.

6 A divergent strategy is one that is radically different from the norm.

7 See Arreguin-Toft, I.: "How the weak win wars: a theory of asymmetric conflict", *Cambridge, UK: Cambridge University Press,* 2005.

Test 2: Is your strategy clear about the sources of the value you plan to create?

Identify sustainable sources of value that can withstand the onslaught of system changes

Know the basis of your ability to create value, and you've answered the question of why you will be able to create it (and vice-versa). But don't fall for a mirage—hold it up to the test.

Value created in a health system by a hospital typically has as its ultimate basis some advantage enjoyed by that hospital over other players. Are you the only provider able to deliver services along the entire emergency pathway within the geography? Does your size mean that you are able to staff 24/7 rotas in a cost-effective manner and can thus deliver seven-day services in a way no one can match? Are your facilities simply more modern, so that you can provide a better patient experience?

Without an advantage, some basis for creating value that other players in your health economy lack, it is unlikely the hospital can be maximising value for the health system. In fact there is a very real risk that resources will be deployed inefficiently and patients, the public and the taxpayer will be worse off than they need to be.

Advantages stem from two sources of scarcity: positional advantages and special capabilities.

Positional advantages are roosts in the system that enable major value creation. In publicly funded health systems, hospitals have often had positional advantages as a function of geography – there are no other providers capable or willing to provide services, teaching and/or research in that locality. Patient flows, referral networks, research funding and relationships with education commissioners have been sticky. Hospitals, secure in their local perches and insulated from competition, have been able to create and capture value by providing a relatively static menu of services.

Special capabilities, the second source of value creation, are scarce resources that confer unique advantages on those possessing them. The most obvious ones from other industries, such as a drug patent or a lease on mineral deposits, we call privileged tradable assets: they can be bought and sold. Another important category of special capability, which we call distinctive competencies, comprises things that an organisation does particularly well, such as innovating or managing diverse sets of stakeholders. In healthcare they are typically skills of individuals or teams or specialist equipment, though they could be business systems, software or even a brand name. These capabilities can be just as powerful as assets in creating advantage, but cannot be easily traded.

To yield true advantage, special capabilities need to be critical for generating value and exist in abundance within the organisation, while being scarce and hard to imitate outside.

Too often, hospitals have been cavalier about assuming they have positional advantages or special capabilities. Health systems are becoming more competitive: technology is reducing the importance of geography as a factor in care provision; commissioners are more aggressive in retendering, often consolidating acute services and shifting care into non-hospital settings. Yesterday's assumptions about why hospitals will be able to create value are increasingly crashing against the harsh reality of more competitive health systems. Understanding how and why competition in key service lines will change is vital.

Any source of value creation will only lead to value only if it is translated into an attractive proposition to key stakeholders. The strategy should be clear on what value the hospital will bring to each core stakeholder group. For example:

- **What is the offer to patients?** Are we providing better access? Higher quality care? A better experience? Or indeed a powerful combination of all three?
- **What is the offer to payors?** Is our cost-quality payoff better? Do we offer integrated care better along the patient pathway?
- **What is the education offer?** Do we provide a genuinely distinctive educational experience more tailored to the needs of a changing health system?
- **What is the offer to research funders?** Do we deliver more rapid translation of research to therapy? Do we more effectively incorporate our patient population into the research agenda? Do we offer a better partnership with world-class universities?

Passing Test 2—Determining the true source of advantage

- Understand the fundamental drivers of health economy and hospital performance: assess where the value is being created, why it is there and where it is moving to – for example, are volumes shifting towards non-acute settings? Is the trend towards the consolidation of tertiary care likely to continue?
- Take a dynamic view: health systems and healthcare providers are almost never static, and strategists should always assume that any point of vulnerability will be exploited
- Be precise in defining special capabilities: remember we are looking for specific and rare gaps that drive differential performance, not for best practice
- Test for competitor response: competitors are not only evolving, they are also responding to every move you make—if they have the freedom and capability to do so
- Take the user's (patient and payor/commissioner) perspective: teams that go out of their way to generate insights and experience from their customers' perspective routinely develop better and more richly convincing strategic views.

Test 3: Is your strategy coherent across clinical quality, access, research, teaching and financial goals, and set in the context of health economy priorities?

Ensure the strategy speaks to each element of the hospital's mission

As discussed above, hospitals are different to profit-driven organisations: different because embedded in the cultural DNA of each of them is a commitment to a social mission, a mission that is often characterised as being tri partite in nature: clinical care, teaching and research. Most hospitals would add two other components to this – access to care and financial sustainability. These core objectives are important because they are the mechanisms through which hospitals create value.

It is odd then that so many hospital strategies speak to only a sub set of these five core objectives. As a simple test, all hospital strategies should set coherent goals, based on evidence and real insight, across these five dimensions.

The difficulty, of course, is that income, costs and therefore financial sustainability can be measured easily, and what is measured tends to become what is managed. Of course financial performance matters – hospitals must be responsible custodians of the assets and resources they manage. But it cannot be the only objective. Hospitals must set quantifiable goals across each of the five dimensions and measure performance against them. The best hospitals already do: the Cleveland Clinic sets and tracks performance across a balanced scorecard of measures for each of its 27 institutes.

The goals must be based on real data, mined for insights and tempered with an understanding of customer (payors' and patients') intentions. Remember, the task of the strategist is not just understanding the system—it is seeing things that others don't. This might be, for example, better understanding patient flows and thereby recognising the value of strategically placed outpatient facilities and investing in appropriately sited buildings. It may be more effectively mapping the public health trends and recognising that a piece of new technology is affordable as a consequence and, based on its purchase, establishing a market leading position.

Unlike most profit-driven organisations, publicly funded hospitals do not operate in isolation. They are part of the local and sometimes national 'health economy' and must contribute to the strategic goals of that whole system. A good public hospital strategy will support the financial and clinical sustainability of the entire health system, not just that of one provider within it.

Passing Test 3—Setting evidence-based strategic goals across five core dimensions, in the context of the whole health economy priorities, with the aim of creating value

- Set strategic goals across each of the five core dimensions that are coherent and self-reinforcing and support the objective of creating value
- Be specific–put numbers against each one, define timeframes
- Find and use proprietary data to support the goal generation and the whole strategy: be adventurous in finding new data rather than recycling the same reports that everyone else does
- Seek novel ways to analyse the data: often, a new analytical technique or framework, thoughtfully used, will give new insights
- Employ creative idea-generation techniques: explore for more innovative ideas[8]
- Look for multiple viewpoints and leave space for dissent: don't rush in to confirm conventional wisdom, instead, let contrarian views be heard
- Learn from experience: often, the strongest insights are generated through learning that is generated by your hospital's experience
- Challenge implicit assumptions: look into an established business model and test how well the assumptions match the environment.

8 See: Coyne, K., Clifford, P., Dye, R.: "Breakthrough Thinking from Inside the Box", *Harvard Business Review,* December 2007.

Test 4: Is it granular about where to compete down to at least a service-line level?

Match the unit of analysis to service lines and specialties

The need to create value prompts the question: in which service lines and which specialties? This question is more nuanced and important than you might expect.

Hospital strategies must at least be defined at the service-line level and may also need to be defined at a specialty or sub specialty level (it will depend on the market you are in). Looking at this level of detail uncovers the true differences between service lines rather than averaging them away. A distinctive strategy is very specific about how to continuously shift resources to capture opportunities at this granular level in the context of a coherent allocation of effort and resources across all of the operations of the hospital.

The empirical evidence is compelling: focusing resource allocation on the right service lines and specialties is an important way to create value.

Passing Test 4—Getting granular

- Conduct analyses at the service line and specialty levels and avoid averaging out: understand system dynamics and hospital performance as granularly as possible
- Move resources between services lines, specialties and sites: make clear moves that continually out-position competitors.

Test 5: Does it put the hospital ahead of trends?

Stay ahead of the trends—recognising that value creation (and destruction) rides on the back of new forces and innovation – rather than optimising for the status quo

Anticipating change is essential for predicting where new pools of value may emerge. New technology, new clinical protocols and new payments systems all create new opportunities to create and capture value. During a period of change, market participants have a special opportunity to rethink their commitments, such as technology investments, the location of services or choice of partners in line with a reset strategy for the new environment.[9] The present financial challenges, for many hospitals, represent such a moment.

Discontinuities often seem to come out of nowhere and are usually highly disruptive and destructive. But, viewed over time, almost all industries are much more turbulent than they appear and discontinuity is, in fact, the norm. Healthcare is no exception. Many strategic reviews miss this reality because they extrapolate from the past three to five years, a timeframe too brief to capture the true violence of system change. In fact, the probability of the next three to five years continuing in the pattern of the prior years is quite low.

Sometimes industry transitions can be abrupt: a major innovation in a business model (usually driven by new entrants) or external shocks: in regulation, demand or technology. But most disruptions are caused by trends that emerge fairly slowly – so slowly that hospitals, or sometimes whole health systems, fail to respond until the painful implications are upon them. By the time emerging trends hit, it is too late to mount a strategically effective response, let alone to shape the change to your advantage.

For a hospital, successfully and rapidly incorporating clinical innovation is vital. As commissioning standards become more stringent and as outcomes become more transparent, the costs of not incorporating innovative clinical practice will rise.

When faced with disruptive trends, managers and clinicians often delay action, held back by sunk costs, an unwillingness to undermine an existing operating model or simply by being too wedded to the success formula of yesteryear. The cost of delay, however, is steep: consider the plight of major travel agency chains that were slow to understand the power of new online intermediaries. It is worth pondering whether the shift towards integrated care will leave hospitals equally stranded.

The key is to convince decision makers to move ahead of trends. Catching up with a wave that has swept past you is very difficult. Is your present strategy in line with the major trends, or are you heading cheerfully in the wrong direction?

9 See, for example: Rumelt, R.: "Strategy in a 'Structural Break'", *McKinsey Quarterly,* 2008.

Passing Test 5—Staying ahead of the trends

- Assume that continuation of the status quo is the least likely scenario: at the very least, ensure trends are in the scope of strategy development work
- Know your history and match time horizons accordingly: don't just rely on three years of data as they will hide the long-term trends
- Incorporate major macro forces: many inevitable long-term trends are already evident based on economic development, clinical and other technology, demographics and so forth
- Scan broadly to seek advance signals of change: always look to the periphery for hints of what is to come
- Drill down to specific implications and quantify impact: model the impact of the trends on quality, on operations, on access, on teaching and research and on the financials to see which ones really matter and anticipate detailed scenarios of how the trends may, in fact, manifest.

Test 6: Does it acknowledge an informed view of residual uncertainty?

Eliminate unknowns that can be resolved and define the 'residual uncertainty' that can't be removed, rather than assuming away uncertainty or being paralysed by it

A central challenge of strategy is that we have to commit to fixed choices now, and our payoffs occur in a future environment we cannot fully know or control. Therefore, an accurate view of uncertainty is central to strategy; but it is often dealt with clumsily or ignored altogether.

In our experience, hospitals oscillate between two extreme views of uncertainty. On one extreme, bold point estimates are used to paper over the real uncertainty. On the other extreme, ambiguity is perceived to be so high that it prevents clear-headed decision making, even when many factors can be subject to sensible analysis. Deeply analysing the situation usually pushes us into the middle ground of these extremes, where many things can be understood, but some variables have an irreducible uncertainty that can at least be characterised through, for example, scenarios or similar instruments.

In healthcare, we typically find uncertainties fall into two broad camps – those that are clinical or technical in nature (how will clinical protocols develop? what new technologies will develop?) and those that are more political in nature (how will government policy develop? what will happen to reimbursement rates?).

The primary step is to break uncertainty down into its core components, developing a better understanding of the uncertainty we face[10]. We do not want to eliminate or assume away uncertainty, but to compress it to its minimum and to understand this 'residual uncertainty' as well as we can. Many variables seem highly uncertain at first, yet can be clarified by proper analysis. On the other hand, some things just cannot be known, even after carefully considered analysis.

This latter uncertainty cannot be assumed away; it must be at the heart of the strategic response.

Passing Test 6—Getting the best possible view of uncertainty

- Accurately identify the driving variables: start with the specific decision you are trying to make, fully understand the variables that could influence the decision
- Compress the uncertainty: focus your early analysis on removing as much uncertainty as possible, for example, ruling out impossible outcomes, understanding the forces at work and the dynamics between them and assessing the underlying economics
- Characterise the remaining residual uncertainty: for example, by developing scenarios.

10 Many of these concepts were developed by a special McKinsey initiative in the 1990s. See: Courtney, H.: "20/20 foresight: crafting strategy in an uncertain world", *Harvard Business School Press,* 2001

Test 7: Does it balance commitment with flexibility and learning?

Focus on a few high-commitment choices that matter and leave flexibility to make advantageous commitments in the future, rather than creating rigid, detailed tactical plans

In some sense, strategy is a high-wire act. On one hand, no hospital locks in long-term ability to create value without making commitments ahead of time: major, hard to reverse investments such as building a new wing, buying expensive equipment or building a brand. But on the other hand, an uncertain and evolving landscape requires learning and adaptation, which sounds like the antithesis of commitment. Striking the right balance means making commitments at the time when the hospital has an advantageous risk-return trade-off.

Each year, at any large hospital, hundreds of people make many thousands of decisions. Only a few of these are actually strategic decisions, the ones that will be most important for determining your success. But which ones are they? The acid test is whether making a particular decision involves commitment. Commitment is the only path to sustainable advantage, setting in place the preconditions for successful execution. It is impossible to repeal existing commitments at every strategy review, whereas tactics can and should change often.

We find that a focus on high-commitment decisions is often missing from strategic planning exercises. A rush to enshrine too many decisions into a strategy results in a seemingly concrete plan. It will probably lack the structural integrity of concrete, but will definitely share its rigidity. Such planning cannot accommodate the arrival of new information and new opportunities: and you will find yourself very quickly 'off plan'. Furthermore, the few choices that really matter can become obscured by a sea of tactics.

But commitment needs to be accompanied by flexibility. The degree and nature of flexibility required goes back to an intimate understanding of the uncertainty we face (see Test 6). A portfolio of actions is required that will comprise big bets (taking an informed, high-commitment position on an uncertainty to gain significant new advantages), no-regret moves (actions that will pay off no matter what happens) and real options (initiatives that involve limited cost now, but that can be elevated to a higher level of commitment if changing conditions warrant it).

A portfolio approach preserves the right balance of flexibility and commitment. Where uncertainty is high, it enables learning over time and allows a hospital to hedge multiple future scenarios. For example, it may mean investing in additional theatre and ward capacity based on an assessment of likely consolidation of surgery; putting in place an integrated care organisation with the knowledge that commissioners will seek integrated pathways for chronic conditions under all future scenarios; and establishing options to increase A&E and inpatient medical capacity based on modular building design to be exercised dependent on the effectiveness of commissioner demand management plans. In this way, commitment can grow with observed outcomes, as you learn which choices will be most successful.

One such approach is McKinsey's Portfolio of Initiatives.[11] This is a deliberate method that multiplies learning opportunities, selects the best portfolio options over time and amplifies opportunities through a staged process of escalating commitment. A dynamic approach to strategy will frame how future high-commitment decisions will be made. Such policy choices have an important lasting impact on the direction of the hospital, so are, by definition, strategic choices. For some firms, strategy may even be represented best as a set of rules and algorithms (for instance, Exxon's capital investment processes, Tesco's distinctive merchandising procedures, or Capital One's information-based marketing).

Passing Test 7—Balancing commitment with flexibility

- Identify and order the choices to be made: remember that strategy is about making choices regarding where, how and when to compete
- Focus on the few choices involving commitment: having identified the strategic decisions, most of the analysis time should be spent on informing those choices
- Build a robust portfolio of contingent actions: combine no-regret actions with bigger bets and real options
- Enhance option value: see where you can build options into the strategy, for example, modularise projects (particularly infrastructure) or leave input flexibility
- Frame how future decisions will be made: adapt ongoing decision-making processes to drive and evolve a strategic direction.

11 See: Bryan, L.: "Just in-time strategy for a turbulent world", *McKinsey Quarterly,* 2002.

Test 8: Is your strategy contaminated by bias?

Employ decision making processes that minimise cognitive bias and careful logic that steers clear of mistaken inference, while being wary of attributing past performance to observed 'success factors'

It is evident that even the best executives, armed with the best insights and tools of strategy development, can back bad decisions. In the NHS, we have seen a large number of PFI hospital builds that, with the benefit of hindsight, were based on overly optimistic business cases. Recent developments in research suggest two important sources of such failure: decision biases and faulty inferences.

The first failure type, decision bias, stems from the limitations of the human brain. The burgeoning field of behavioural economics seeks to understand these biases.[12] The worst offenders include over-optimism (our tendency to hope for the best and believe too much in our own forecasts and abilities), anchoring (tying to arbitrary reference points), loss aversion (putting too much emphasis on avoiding downsides), confirmation bias (overweighting information that validates our opinions), herding (comfort in following the crowd) and champion bias (basing the merit of an idea on the person proposing it).

Knowing your enemy is half the battle. But, since bias is unconscious and hard to detect, the full antidote is to ensure the strategy is based on a rigorous process. Such a process will include routinely questioning all assumptions and challenging the facts on which they are based; specifying in advance criteria for evaluating options; and explicitly encouraging dissent and debate in the decision making process.

The second important failure type is faulty inference. Strategy is especially prone to faulty logic because it relies on extrapolating ways to succeed in the future from a complex set of factors observed today. This is a fertile garden for two big problems: attribution error (succumbing to the 'halo effect') and survivorship bias (ignoring the 'graveyard of silent failures').

The 'halo effect' is the false attribution of success to observed factors. It is strategy by hindsight and assumes that replicating the actions of another will lead to the same results for you.

Survivor bias refers to analysis based on the surviving population without considering what happened to those who did not live to tell their tale: this skews the view of what caused success and presents no insight into what might have caused failure. Were the survivors just luckier? While case studies are useful and have their place, understanding strategy in hindsight can be of limited use to those of us who, stuck in the present, have to make the best strategic choices we can in light of what we know today.

Hospital executives tell us it is particularly difficult to challenge the unconscious biases of clinical staff. Finding an arena in which to debate and challenge clinical biases has proven to be enormously powerful.

12 For a highly relevant summary see: Roxburgh, C.: "Hidden flaws in strategy", *McKinsey Quarterly,* 2003.

Passing Test 8—Proofing against bias and false inference

Bring a fresh pair of eyes to the issues: maintain a culture of challenge where the obligation to dissent is fostered—bring in non-executives from different industries who are willing to ask awkward questions

Develop multiple potential solutions and hypotheses: generate multiple options that illuminate the choices being made

Watch for confirmation bias: seek to disprove your hypotheses rather than prove them and let contrarian voices be heard

Make the decision-making process unbiased: develop well-thought-out processes for how decisions will be made to avoid bias

Double-check inferences and attributions: take extra care when jumping from data to conclusions.

Test 9: Is there conviction to act among management and clinicians?

Emphasise the conviction and passion of clinicians and management based on genuinely new beliefs and personal discovery, rather than relying solely on analytical exercises

Many intellectually robust strategies fall short in implementation because of a failure to build conviction in the organisation's clinical body. A unified clinical and managerial team is vital.

CEs and boards should not be fooled by the warm glow they feel after a slick presentation by management. They must check that members of the team not only actually share the new beliefs that support the strategy, understand the implications of those beliefs and are aligned on how to take the strategy forward, but also that clinicians are fully behind the strategy.

Where a change of strategy is needed, it is usually because changes in the external environment have rendered the assumptions underlying the original strategy obsolete. Typically, these assumptions will continue to be held by at least some of the managers and clinicians. To move ahead with implementation, you need a process that openly questions the old assumptions and allows managers and clinicians to develop a new set of beliefs that are appropriate for the new situation. This is not likely to be achieved by just shuffling through lengthy reports and attending presentations. Nor will the social processes required to absorb new beliefs—group formation, building shared meaning, exposing and reconciling differences, aligning and accepting accountability—occur in formal meetings. An interactive process of co-creation is needed.

Passing Test 9—Building conviction with clinicians and the management team

- Understand the ambitions and constraints: senior practitioners are all too aware that hospitals don't make decisions, people do
- Develop the strategy as a joint effort between clinicians and managers
- Connect the strategy process with personal learning: for decision makers to behave and act in the new way required by the strategy, they need a deep level of conviction and understanding
- Design interactions to create conviction, not just convey information: there are always ways to make strategy sessions more conducive to building conviction
- Build a support base of change champions: build a network of people who feel connected to the strategy, understand what it means and are passionate about driving implementation.

Test 10: Is there a credible path to impact?

Define the changes required and adapt resource allocation to reflect strategy choices, rather than issuing vague statements of intent

By definition, a strategy that is not implemented (or not implemented well) cannot be a good strategy because it will not result in the actions necessary to achieve its objectives. It is said that good companies develop great strategies, but struggle to execute them; great companies develop good strategies and execute them brilliantly. The prerequisites for good implementation need to be embedded into the strategy process early on.

Most strategies that are well-implemented have a common set of features. But the many strategies that fail in implementation do so in their own unique ways. One fruitful exercise that we recommend is to conduct a case-closed review on the implementation of past strategies in your organisation to uncover the specific execution challenges you face.

Hospitals are highly labour-intensive organisations. As a result, changes to ways of working are likely to be a big part of a hospital's strategy. To have a path to impact, the overall organisational strategy must have a parallel workforce strategy, with clarity on what it would take to see staff with new roles and working in new ways across the hospital.

Passing Test 10—Ensuring a path to impact

- Make the strategy easy and compelling to communicate: if you can't explain the strategy in a compelling way on one page, the 200-page analysis pack will be hard to translate into real action
- Clearly define the 'from to's' in the value proposition, business model, organisation and capabilities: develop a detailed view of the shifts required to move from the current state to the desired future state
- Ensure a balanced range of mechanisms is in place to affect the changes: assure yourself that each major from-to shift is matched with focused energy to make it happen and enough energy to overcome the inertia
- Create an environment that enables the change: support change through role modelling, fostering understanding, building capability and reinforcing with formal mechanisms
- Align ongoing resource allocation processes with the strategy: align complex budgeting, capital allocation, people planning, operational planning and other processes with the strategic intent.

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Tests for real strategy must be demanding and comprehensive. Examine your strategy in the cold light of day against this high bar. Then, creatively and thoughtfully think through how you are going to close the gaps. Getting hospital strategy right will improve the lives of millions of patients, make better use of scarce resources and return health systems to sustainability.

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Healthcare Strategy and Corporate Finance
January 2015
Designed by Visual Media Europe

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