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Customer value and lean operations in self care

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Abstract

There has been a shift towards independence and choice for patients, as people want more information and control over their health care. Moreover, hospitals face an increasingly complex list of challenges, ranging from an aging population and cost pressures to greater concerns for patient safety. This study explores the role of the customer as specifier of value and the tension of customer wants versus patient needs in a lean healthcare environment. The role of the customer as value specifier lies at the heart of Lean principles and operations, which poses a fundamental problem when implementing Lean in healthcare due to the ambiguous notion of the patient as customer. The study is based on a survey of 40 healthcare providers. It identifies a misalignment of perceived want and need along the value chain, with associated implications. Empirically, the study offers lean implementation advice, and conceptually it expands on the debate of appropriate lean application in the healthcare sector.

Key words: lean, customer value, health care, self care

Introduction

Hospitals face an increasingly complex list of challenges, ranging from an aging population and cost pressures to greater concerns for patient safety. (Drummond-Hay and Bamford, 2007; McDermott and Stock, 2007). Due to the increased incidence of long term conditions like diabetes, asthma and heart disease society is changing, and the public's attitude to looking after their health is beginning to change. There has been a shift towards independence and choice for patients, as people want more information and control over their health care. Moreover, evidence suggests that patients' beliefs regarding their condition and the perceived role of health providers strongly predict their healthcare behaviour (Odgen, 2005). In this paper, we explore the issue of customer focus in the NHS and specifically look

at customer value and lean operations in self care. *Self care* is defined by the DoH (2007) as “the care taken by individuals towards their own health and well being. It includes the actions people take for themselves, their children and families to, maintain good physical and mental health; meet social and psychological needs; prevent illness or accidents; care for minor ailments and long-term conditions; and maintain health and wellbeing after an acute illness or discharge from hospital”. The term *self management* is often used interchangeably with self care but is related specifically to living with a long term condition. Self care has been shown to be effective in improving quality of life and promoting appropriate utilisation of services. It is for this reason that supporting patients to self manage their conditions and to use health services when appropriate has been identified as an increasingly important element in national health policies. (Cottam and Leadbeater, 2004).

Customer focus in NHS

Since the early 1980’s political pressure has driven the NHS towards a more market orientated position in a much publicised attempt to cut costs, increase efficiency, effectiveness and accountability as well as improving patient care (DoH, 1997, 1998a, 2001a). Recently focus has been on increasing the degree of patient-centered care through greater customer-orientation and partnerships (DoH, 1998b, 2001b, 2002). While such a customer orientation in private healthcare is not new in the UK or USA (Macstravic, 1999, 2003; O’Malley, 2004; Stavins, 2004; Weisbart, 2002; Whitcomb and Shafa, 2001) its introduction within an NHS whose culture is more custodial, consensual, equitable and socially driven in nature (Bolton, 2002; Antony *et al.*, 2007) as well as being change resistant (Ferlie and Fitzgerald, 2002) has potentially created serious adoption problems (Beckett, 2000; Bolton, 2002; McGuire, 2003; Wright and Taylor, 2005). Many protagonists of such a customer focus argue that the benefits to both patient organisation are multi-level including increased flexibility and diversity of staff skills (McBride *et al.*, 2005), cost cutting (Jarrett,

2006; Kendall and Lissauer, 2003) to overall patient care and positive experiences (Fillingham, 2007; Perucca, 2001; Weisbart, 2002; Whitcombe, 2001).

Clearly such a paradigm shift provides managers and front line staff with a major challenge and many managers and staff are not convinced that such a change is required, or indeed beneficial (Adams *et al.*, 2000; Bolton, 2002; McBride *et al.*, 2005; Read *et al.*, 2002). A number highlight the idea that such a stance could be seen to be not only at odds with the fundamental philosophy of the NHS (Beckett, 2000; Walsh, 1994; Wright and Taylor, 2005). This in turn raises the questions of whether increased levels of such market-led initiatives could also have contributed to plummeting employee motivation and rising levels of stress, burnout and staff turnover (Ackroyd, 1994, 1996; Burnard *et al.*, 2000; Gelsema *et al.*, 2006; Hall *et al.*, 2006; McVicar, 2003), and whether these will worsen in a Lean self care environment (Conti *et al.*, 2006; Angelis *et al.*, 2007).

In addition it has been suggested that such a move is forcing already limited resources to be focused away from patient care to areas that are perceived to be more public relations orientated that create unfair and unrealistic expectations of what can be achieved by medical, nursing and social carer staff (Drake and Davies, 2006). Indeed Bolton (2002) puts forward the argument that such a situation is damaging to the patient-nurse relationship in that it undermines the professional status of the nurse in the eyes of the patient (and these authors would suggest the patients intimate social circle) by shifting their role to more of a service provider than expert carer. Bolton goes on to conclude that the higher levels of 'emotional labour' (2002:131) involved in such a relationship will not only lead to the nurse behaving in two ways; the autonomous professional nurse vs the smiling and closely monitored service provider, but result in a situation where patients will always be unsatisfied with their care. Such an argument raises an interesting question: does being a

healthcare provider mean that you have to upset people sometimes in order to deliver quality care and what are the implications of this in a customer orientated health care?

Customer value in Lean self care

Lean thinking has wide applicability in many different countries and industries (Womack *et al.*, 1990; Womack and Jones, 2003), with demonstrated potential for achieving high productivity and quality. (Snell and Dean, 1993; Sakakibara, 1997; Lowe *et al.*, 1997; Bushell, 2002; de Treville and Antonakis, 2006). Empirical evidence by Shah and Ward (2003) and Fullerton *et al.* (2003) shows that Lean contributes substantially to the operating performance of plants. With its roots in the Toyota production system, it is increasingly implemented in both private and public services. But while lean principles have been identified as appropriate for the public sector in general, implementation and sustainability remains a challenge. (Jones, 2004; Westwood *et al.*, 2007). In health care, this is partly due to the dynamics between the different stakeholders, which may be enabling or inhibiting, depending on stakeholders views and agendas. (Papadopoulos, 2007).

This role of the customer as value specifier lies at the heart of the Lean philosophy (Womack and Jones, 2003) and yet potentially poses a fundamental problem when implementing Lean within the NHS due to the ambiguous notion of the “patient as customer” (Gillian and Wistow, 2006; Wright and Taylor, 2005). We define a customer as an individual or group who has the power to specify and pay for services or products they want and value. Value in lean operations is defined by customer value, not only in the end product, but also in the chain of processes that take place for an end service to be delivered to the customer. Hence, as Bateman *et al.* (2007) remark, for effective lean operations there needs to be a clear view of the customer without confusion of multiple customers and stakeholder pressures and requirements. Waste is defined as what costs time, money and resources but does not add value from the customer’s perspective. By identifying customer value, lean operations put

pressure on the provider to be efficient and effective in the provision of their services. (Drummond-Hay and Bamford, 2007). Customer value in healthcare may mean improvements in areas such as medical mistakes, waiting times and patient satisfaction. (Gowen *et al.*, 2006). Because lean principles and techniques were developed in the private sector, determining the customers and the perceived value may be more straightforward than for the public sector.

Customer wants and needs

A stakeholder in an organization is defined as “any group or individual who can affect or is affected by the achievement of the organization’s objectives” (Pouloudi and Whitley, 2000:46). Within a primary care context these stakeholders are multiple and often geographically and socially diverse. However, as Figure 1 shows, at the core lies the patient who the DoH (2001b, 2004) believe should be in a position to specify if not dictate the received care.

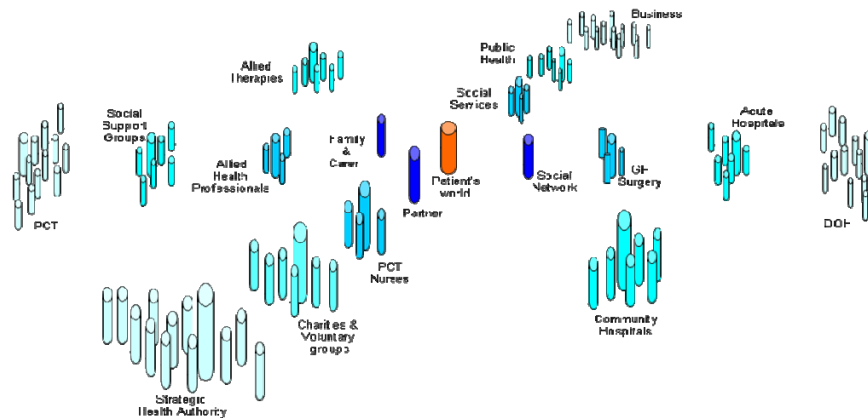


Figure 1: Patient Sphere of Immediacy, Watt and Sherry (2007)

There is tension with regard to customer wants versus patient needs. National health provision tends to be a need driven, resource starved and socially accountable process (Bolton, 2002) delivered free at the point of delivery by autonomous professionals holding expert knowledge as it is “doctors and nurses who are in the best position to know what patients need” (DoH, 1997:11). The patient receives care specified by a tightly bounded care

package formed in the main by the analysis and opinions of said professionals. Although the patient's views and needs are considered they are done so from a custodial-care perspective rather than from a buyer-supplier one. Through the mechanism of consent (DoH, 2001c) a patient is able to refuse care but they cannot dictate the care they receive. In other words, patients are not able to specify or demand what they want. Therefore they are not able to behave as a traditional customer.

Traditional customers are generally seen as autonomous, powerful and knowledgeable people, driven by aspirational wants and actual or perceived needs. They are willing and able to determine what they believe is valuable and assess, across a number of competing suppliers, who will be able to provide them with that value for a price they are happy to pay (Johnston and Clark, 2005). Relationships between buyer and supplier are in the main clearly defined and understood and buyers being "characterized by inter-dependent, collaborative and long-term relationships" (Wright and Taylor, 2005:206). If a customer is unhappy with a service refunds and exchanges can quickly occur or the customer can simply choose to buy from a multitude of different suppliers in the future. However, public sector health care patients do not fit this characterization as easily (Callaghan and Wistow, 2006). As with any Public Service with limited and politically distributed resources the NHS is there to provide services to citizens that are seen to be in the public interest, (Gilliat *et al.*, 2000) and as such it is accountable to the public as a whole not to individual customers. This is illustrated by Potter (1988:151) who notes that in the case of any public sector service "the interests of individual consumers must constantly be juggled against the interests of the community as a whole". Not only is the relationship with the organisation and the community different from the commercial sector, the individuals receiving the service also highlight key differences.

First, patients do not pay for their NHS treatment at point of delivery. They make contributions to the Health Service over their working lives through taxation. Secondly even

with the market orientation that exists today, choice of service providers is still limited so market freedom to choose only occurs to a lesser degree. However these differences pale into insignificance when the nature and disposition of the patient is taken into consideration. Although many have healthcare experience as a patient, few can be said to be knowledgeable of the stakeholders, operational processes, illnesses, clinical conditions and care options available. Patients are often frightened, unsure and vulnerable rather than powerful and autonomous (Bolton, 2002), and often lack the ability to understand their conditions and related care in depth while finding it difficult to understand their felt needs and express them clearly to other stakeholders (Bradshaw, 1994). This situation may also be compounded in a Primary Health Care context by the elderly nature of many patients, geographical dispersal, social isolation and domestic/family-derived pressures.

Results and discussion

This preliminary study is based on a survey of clinical and non-clinical NHS staff across the UK. The sample space was clinical and non-clinical NHS staff attending three five-event training seminars at the NHS Institute for Innovation and Improvement. The attendees were handed the surveys at the end of the seminars to be collected anonymously before departing. 40 surveys were returned out of 60, with a response rate of 67%. The survey asked for interviewee position and institution, identification of perceived customers, what the customer want, what the interviewee perceives the customers to need, and how the customer want and need is assessed. Space on the surveys was provided to allow for clarification of answers and time allocated as requested by the interviewees. According to the responses, customer satisfaction ratings were less influential than their expressed complaints, with information on the latter primarily being collected. This suits the DoH mechanism of consent, where patients are able to refuse care but cannot dictate the care they receive. (DoH, 2001c). Perhaps not

surprisingly, institution with greater interaction with the general public also employed a wider range of feedback mechanisms, such as focus groups and public consultations.

Lean techniques such as Value Stream Mapping seek to eliminate wasteful activities through the active participation of all appropriate stakeholders, as staff involved in the various steps along the patient journey get together to map out how the process currently operates and identify waste. Patient involvement in this process incorporates the patient perspective throughout the various process steps. (Westwood *et al.*, 2007). A commonly used method for mapping value streams has been the Rother and Shook (1998) methodology, which shows customers, suppliers, control functions, and key phases of the process, together with key quantitative pieces of information relating to operating process performance. However, the value equation involves multiple stakeholders and there is no single metric upon which to measure customer value.

The preliminary results reveal that linking the perceived patient wants and needs to the operations performance dimensions, these differ from the hierarchical sandcone model associated with lean operations, where eventual cost reduction relies on internal and external cumulative foundation of improvement in other performance objectives. (Ferdows and de Meyer, 1990; Nemetz, 2002). Patients were foremost perceived to want quality as specification of service, conforming to expected level of performance. As per Gowen *et al.* (2006), this was followed by speed in the form of timely and easy access to the health care services provided both geographically and in terms of availability, and fast throughput time. Dependability such as acquiring accurate information and limited care stoppage was less important, as was quality in terms of fit for purpose. That dependability of service was perceived to be a patient need but not a want indicates the internal performance advantage of preventing late delivery slowing down throughput speed, and in turn reducing costs. Flexibility was only stated in terms of enhancing service quality. Perhaps not surprisingly

given the context of a nationalized health care system, cost had limited impact on patient preferences.

The perceived patient needs were somewhat different. As one may expect, there was emphasis on quality as specification of service. This was followed by the effectiveness of care in terms of low cost, timely and appropriate information, and external speed in terms of the elapsed time between demanding a service and receiving it in a satisfactory condition. Flexibility in service delivery time was viewed as less vital, as was service dependability and quality in terms of fit for purpose. The latter exemplified the low value given to patient experience throughout the care process, somewhat contrasting the findings of Fillingham (2007), Weisbart (2002) and Whitcombe (2001). Immediacy to the patient of the carer as shown in Figure 1, or position in the self care chain, did not yield significant differences in responses.

Involvement, in terms of improvements suggestions, were a low priority for both patients and their carers. Patients were not perceived to desire involvement in the care provision and similarly the health care staff did not view such activity desirable for the patients. Contrary, in terms of care quality, patient participation and involvement was perceived desirable. Not for operational learning or innovation, but rather for the benefits obtained through communication and greater opportunity for patient reassurance.

Conclusion

Lean principles require that value is specified and that the customer specifies this value. The difficulties that this throws up in the health sector has not been resolved other than in simple linear system elements. Contrary to the process recommendations of Bateman *et al.* (2007) and Drummond-Hay and Bamford (2007), there is no agreement as to who the customer of the NHS environment is. In self care patients has a relatively active role which is not necessarily reflected in the value allocated to their preferences by the other stakeholders. The

care providers themselves are often better positioned to state what care ought to be given to a particular patient rather than the patient him/herself. Other care providers may see their Primary Care Trust as the customer or even the relatives of the patient who are essential and unpredictable elements of the care program. Appleby *et al.* (2003) argue that promoting patient focus within the NHS may sit uneasily in an institution that traditionally has relied on funding, structure and objectives determined by the government.

Although patients are unable to behave as a traditional customer, which appears to fly in the face of current government patient-centred care and value focused Lean, the reasons are understandable. We suggest that, contrary to the stated role of patients in self care, such individuals may not be in the best position to determine their health needs and dictate their care in an authoritative, knowledge based and clear manner and while they may be able to articulate 'wants' as a typical customer might those wants may not have any relevance to their clinical care needs. As such, the question needs to be asked as to whether viewing a patient as a customer who can specify value that will have meaning in a clinical care context is viable. In a Lean perspective the question becomes even more urgent.

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