Idea Watch

FIRST

The Perils of Partnering In Developing Markets

How a health care provider addresses the risks that come with globalization

by Steven J. Thompson

Ten years ago Johns Hopkins Medicine International, where I'm the CEO, joined forces with Anadolu, a Turkish charitable foundation, to build and operate a state-of-the-art medical center in Istanbul. The project's success would depend on putting the right executives in place—managers experienced in the operational and clinical challenges that leading hospitals must face. Hopkins was prepared to draw them from within its own ranks, but Turkish law prohibits noncitizens from running hospitals. And yet finding qualified Turkish executives proved impossible. How could we manage a large, complex project in a country whose laws prevented us from hiring the right people for key leadership roles?

It's hardly the kind of problem a health care CEO expects to encounter, but issues like this are a reality in today's global market. As developing economies move up the industrialization ladder, their need for sophisticated, high-value services rises, too. But usually few, if any, local business leaders have the expertise to provide the finance, media, information technology, and other services required. That's one reason why governments and enterprises in these countries increasingly seek to form joint ventures with top U.S. and European organizations; think of J.P. Morgan and the Union Bank of India, DreamWorks and China Media Capital, or Google and UOL Busca, in Brazil. And for the foreign partner, teaming up with a local entity can ease entry into a market that has considerable growth opportunities.

However, these partnerships can turn into nightmares, as Hopkins has learned. Having worked for 15 years on projects ranging from clinics to hospitals to major medical education and research centers in more than a dozen countries, including Chile, Lebanon, Panama, Singapore, and Turkey, we've seen several efforts run off the rails, or nearly do so, for many reasons. We've emerged from these early failures and challenges with a highly flexible model for collaboration that has led to significant successes and enabled us to grow our business at a rate far beyond that of the U.S. health care market as a whole.

Hopkins collaborates with governments, insurers, foundations, and health care companies. Because we're a nonprofit, we take only a minority equity position, or none at all. We operate less like partners and more like consultants with an unusually broad range of responsibilities and a high level of authority, and in a way that keeps us involved on an ongoing basis—and often puts our name on the front door.

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Although the health care industry is unique in many ways, the challenges we've faced are likely to confront any services business seeking to expand in other countries through local partnerships. Here are some of the hurdles we encountered, along with the approaches that helped us clear them.

Filling the Local Talent Gap

In the case of the Istanbul medical center, the mandate that the chief executive be a Turkish citizen left us without much control. And before long the hospital was plagued with quality problems: Patient safety procedures weren't consistently followed, operating rooms were over- or underbooked, and some physicians failed to adopt accepted evidence-based diagnostic and treatment procedures. Everyone involved was concerned about the slow pace of improvement, and some feared that the center would never be worthy of the Hopkins imprimatur.

Even when the law doesn't require that top managers be citizens, local partners often insist on it. We've learned that fighting to put in our own top managers at the outset rarely pays. Instead we seek to strengthen our consultative position, teaming our advisers with local executives and asking that they be given roles in which they can influence the process and culture. In the Turkish project, for example, we had a seasoned U.S. manager serving as the chief nursing officer—a critical post.

Usually within a year or two, local partners recognize that their own managers can't provide the needed push for innovation and culture change, and we can start taking on top management functions. In Istanbul, the foundation soon agreed to give one of our managers the number two role—and dissolved the top position, leaving our executive in charge while remaining in technical compliance with the law. The project is now thriving.

It's important to note that we don't seek to run overseas projects long-term. It's difficult to find highly qualified U.S. personnel who are willing to accept a post in a developing nation for even a few years, let alone permanently. And it's almost impossible to find enough people to staff three or 10 or 20 projects at once, which presents a serious obstacle to growth.

The solution we've discovered is two-pronged. First, our field managers focus not only on improving operations but also on mentoring local managers, with the aim of preparing them to take over within two to five years. In many cases we bring key local managers and professionals to our Baltimore facilities to see how they run. We also push to establish local training programs in everything from nursing leadership to hospital financial management to HR. Second, we've set up a strong recruitment pipeline in Baltimore to attract more top U.S. talent to developmental health care and to provide special training.

When Best Practices Collide With Culture

In most developed countries, nurses, junior physicians, and other midlevel providers are now empowered to challenge the decisions of senior physicians when a patient's health may be at risk, and that capacity has dramatically improved the quality of care. But in most of the countries where Hopkins has partnerships, the medical culture still clings to the old model, wherein no one ever questions a doctor's judgment. We ran into this problem in Singapore (which, although not a developing country, is seeking to improve its health care delivery), in an oncology clinic we built and operated in partnership with the government. Nothing our managers said could change the situation.

The first thing we do when confronted with a culture clash is determine whether we really need to challenge the culture. Often we can find approaches that accomplish our goals within the cultural constraints. For example, after we discovered that male patients in some Persian Gulf hospitals were refusing to see female doctors, it was easy enough to inform patients of the doctor's gender when scheduling appointments. Similarly, male doctors at some of the same hospitals learned that when examining and treating a married woman, they had to conduct all conversation through her husband.

But we won't compromise when patient health and safety are at stake. We solved the problem in the Singapore clinic by seeding the staff with professionals who could lead by example—nurses from countries where those providers have more autonomy. Their willingness to stand up to doctors initially shocked and even offended many staff members. However, as people saw that patient outcomes were steadily improving, they began to come around, and the culture of deference receded.

A PROJECT CHECKLIST:
How Johns Hopkins Sizes Up International Risk

Evaluating the Opportunity

- ☐ Assess the potential partner's willingness to commit resources
- ☐ Assess regional constraints—the regulatory environment, infrastructure, and so on
- ☐ Work with the partner on a project plan and a business plan
- ☐ Ensure that the partner has a clear understanding of and realistic expectations for the project

Getting Up To Speed

- ☐ Engage experts from Hopkins to hire key personnel and to design processes
- ☐ Establish training and mentoring programs for local managers and professionals
- ☐ Set up clinical, operations, and financial performance metrics
- ☐ Establish quality, safety, and efficiency processes
- ☐ Set a timeline for accreditation

Operating Over Time

- ☐ Stabilize processes and create feedback loops
- ☐ Transfer more responsibilities to local managers
- ☐ Establish local education and recruitment pipelines
- ☐ Establish regional marketing programs
- ☐ Consider new initiatives and expansion

If There Are Signs of Trouble:

If your concerns are modest, propose a smaller, months-long pilot consulting project

If your concerns are serious, walk away

Look for cultural mismatches and adapt your processes

Increase the number of Hopkins and other expat professionals

Expand support to local managers

If problems are significant, revisit strategic plans and consider replacing management

If problems are severe, consider scaling back or killing the project

Strengthen training and mentorship

Bring in experts from Hopkins to help solve problems

Retool processes that are falling short

Reinstate key Hopkins managers if possible

Freeze or reduce the scope of activities until problems are solved

Set up problem-solving forums with partners in other countries

Mitigating Risk

Lending the Hopkins name to a hospital that delivers unimpressive care could significantly damage our 135-year-old brand—and that's a real danger in developing areas, especially in a project's early days. We have no control over many factors, including the quality of academic institutions, the sources of investment, the regulatory and judicial systems, and all the other infrastructure that can support or undermine long-term success. How do we know when a project will be worth the risk?

Choosing the right partner and learning how to read signs from the up-front negotiations are critical. Partners who are looking for a fast return on investment or merely seeking to capitalize on the Hopkins "halo" are anathema to success. We've learned how to pick up on the sometimes subtle signals that other parties' goals aren't aligned with ours. For example, in the first meeting a good potential partner will focus on sustainable quality and commitment, not financial returns. For this reason alone, more than a third of our initial conversations go no further.

When we do agree to a project, our contract specifies the goal of obtaining accreditation from the Joint Commission International or another organization that sets a high bar. We've found that in the absence of such objective judgment, partners may shrug off our exhortations for faster and greater change.

We used to plug away on projects that were heading in the wrong direction, but no more. We've become better attuned to signs that a partner isn't honoring its commitments, or that government officials are putting up too many obstacles, or that the local staff isn't likely to step up. If we see those signs, we immediately bring in outsiders, including experts from Baltimore, and rethink what we're doing. So far we've never had to kill a project that was fully under way, but we're prepared to if need be, and our contracts typically include a "termination at convenience" clause.

Make no mistake: For all the risks, partnering on complex projects in developing countries offers the potential of great rewards. For Hopkins, the rewards go beyond the considerable financial upside. Our affiliates issue press release after press release trumpeting our facilities' progress, and many local managers move on to posts in government health ministries and other influential bodies. When our projects prosper, our brand prospers, and new opportunities come our way. HBR Reprint F1206A

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