Shortell and Kaluzny’s
Health Care Management
Organization Design
and Behavior
Sixth Edition
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For twenty five years and five editions we have attempted to provide an integrative perspective to the organization and management of health services; presenting the major management theories, concepts, and practices of the day. We have also provided practical illustrations and guidelines to assist managers and prospective managers in the provision of health services in a variety of settings.

As we go to press we have entered the era of health care reform, presenting new and perhaps not so new challenges and opportunities. Under the leadership of Rob Burns, Elizabeth Bradley and Bryan Weiner, the invited chapter authors have provided a thoughtful and in-depth analysis of the theories, concepts and approaches that managers and prospective managers need to address the critical issues in the provision of health services as well as meet the challenges and opportunities resulting from health care reform.

The passage of health care reform brings a great deal of uncertainty as it attempts to address the long standing problems of access, quality, cost containment and significant disparities under unprecedented economic conditions. Much has changed as reflected in the mandates regarding access to coverage, coverage itself, the role of public and private programs and health insurance exchanges as well as the role of comparative effective studies, payment reforms, accountable care organizations and patient-centered medical homes.

While these represent significant changes in the operation of the delivery system, the fundamental managerial challenges remain and will continue to require skillful attention if health care and the various delivery organizations are to realize their potential. Issues of maintaining a motivated workforce, assuring state of the art practice patterns, coordinating various disciplines and specialties to the benefit of patient care and accommodating an ever expanding technology within a market economy that would benefit the patient and the larger community have been and will continue to be the major responsibility of management.

This 6th edition provides readers with the relevant theories, concepts, tools, and applications to address operational issues that managers face on a daily basis. As described in the lead chapter the key challenge facing organizations and their managers is to deliver “value”—the ratio of quality to cost. While this has always been a concern, the reality of present day economics and the developing science has made this imperative.

The book is divided into three sections. The first section provides two insightful introductory chapters presenting the challenges of providing health services and some of the conceptual maps necessary to help guide managers in the decision making process and providing a framework for understanding the role and contributions of management and leadership within a variety of health care settings.

The next section focuses on the Micro Perspective—Managing the Internal Environment. This perspective addresses the classic issues of organization design, motivation, communications, power, organizational learning, performance/quality improvement and managing groups and teams. Each chapter provides an “In Practice” scenario that sets the scene for the concepts and tools for effective management.
The last section, the Macro Perspective—Managing the External Environment, focuses on the organizational context and addresses the challenge of achieving competitive advantage, and managing alliances. Four new chapters will help prepare managers for the uncertainty of the years ahead. These include the challenges of managing an ever expanding information technology, consumerism, an increasingly complex regulatory environment and finally the recognition that we live in a globalized world.

Health services management has come of age and Burns, Bradley and Weiner and their colleagues have presented the theories, concepts and guidelines that future managers will need to succeed in the years ahead.

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INTRODUCTION
This book is intended for those interested in a systemic understanding of organizational principles, practices, and insights pertinent to the management of health services organizations. The book is based on state-of-the-art organization theory and research with an emphasis on application. Although the primary audience is graduate students in health services administration, management, and policy programs, the book will also be of interest to undergraduate programs, extended degree programs, executive education programs, and practicing health sector executives interested in the latest developments in organizational and managerial thinking. It is also intended for students of business, public administration, medicine, nursing, pharmacy, social work, and other health professions who will assume managerial responsibilities in health sector organizations or who want to learn more about the organizations in which they will spend the major portion of their professional lives. Previous editions have been translated into Polish, Korean, Ukrainian, and Hungarian, and we look forward to the book’s continued use by our international colleagues.

TEXT APPROACH
The sixth edition broadens the view of health care sector beyond the traditional focus on hospitals and other provider organizations to include suppliers, buyers, regulators, public health and financing organizations. It offers a more comparative, global perspective on how the United States and other countries address issues of health and health care. Additionally, the book discusses managerial implications of emerging issues in health care such as public reporting, pay for performance, information technology, retail medicine, ethics, and medical tourism. Finally, this sixth edition expands upon a major theme of the fifth edition: health care leaders must effectively design and manage health care organizations while simultaneously influencing and adapting to changes in environmental context. Managing the boundary between the internal organization and its external environment is therefore a central task of healthcare leadership.

ORGANIZATION
The organization of the book reflects this expanded theme. Part 1 provides an overall perspective on the health care sector, discusses the distinctive challenges facing health care organizations, and examines the roles of leaders and managers in influencing organizational culture, performance, and change. Part 2 focuses on core leadership and managerial tasks within organizations. These include motivating people, guiding teams, designing structure, coordinating work, communicating effectively, exerting influence, resolving conflict, negotiating agreements, improving performance, and managing innovation and change. Part 3 describes the broader context in which health care organizations operate and discusses the managerial implications of several emerging trends and issues. These include the growth of strategic alliances in the health sector, the expansion and complexity of health law and regulation, the uses and challenges of health information technology, the rise of consumerism in health care, and the global interconnectedness of health systems.

The sixth edition includes a new introductory chapter (Chapter 1) and new chapters focusing on improving quality
of concepts and principles to practical managerial and organizational issues. Second, a glossary appears at the end of the book, which includes all of the key terms and their definitions.

INSTRUCTOR RESOURCES

Instructor Companion Site

The Instructor Companion site for this text offers many valuable support materials. To access the Instructor Companion site, go to http://login.cengage.com.

If you have a Cengage SSO account: Sign in with your e-mail address and password.

If you do not have a Cengage SSO account: Click Create My Account and follow the prompts.

The following support materials are included:

• Electronic Instructor’s Manual—The Instructor’s Manual that accompanies this book includes an overview of the In Practice and Debate Time material from the text; suggested solutions to the end-of-chapter discussion questions and case studies; teaching tips and exercises; complimentary reading lists; suggested solutions to the Vignette material in the study guide; and an overview of additional Debate Time material from the study guide.

• PowerPoint presentations—This book comes with Microsoft PowerPoint slides for each chapter. They’re included as a teaching aid for classroom presentation, to make available to students on the network for chapter review, or to be printed for classroom distribution. Instructors, please feel free to add your own slides for additional topics you introduce to the class.

• ExamView®—ExamView®, the ultimate tool for objective-based testing needs, is a powerful test generator that enables instructors to create paper, LAN, or Web-based tests from test banks designed specifically for their Cengage Course Technology text. Instructors can utilize the ultra-efficient QuickTest Wizard to create tests in less than five minutes by taking advantage of Cengage Course Technology’s questions banks, or customize their own exams from scratch.

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**STUDENT RESOURCES**

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The Student Companion site for this text provides the following support materials:

- **Electronic Study Guide**—The Study Guide includes Vignettes which present additional case study material followed by critical thinking questions; assignments for the students to complete either in class or on their own to help them practice the skills they will need on the job; and additional Debate Time scenarios.

**ABOUT THE AUTHORS**

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ACKNOWLEDGMENTS

We believe that the major strength of this text is the diversity of the talented authors, who contributed multiple perspectives, experiences, skills, and expertise to each chapter. The new and substantially revised chapters reflect the breadth and depth of the authors' expertise, as well as their fresh perspectives. We wish to acknowledge with gratitude the immeasurable contribution that Stephen Shortell and Arnold Kaluzny have made in the fields of health care management research and education. As scholars, advisors, mentors, and colleagues, they have deeply influenced our work and our professional lives. Through the five editions of this book, over the past twenty-five years, they have helped educate a generation of health services researchers, policy makers, managers, and health professionals. We hope that the sixth edition sustains the tradition of excellence that these gentlemen have established.

Finally, we wish to acknowledge Lauren Taylor and Rachelle Alpern for their excellent editorial assistance.

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PART ONE

Introduction
Chapter 1

The Management Challenge of Delivering Value in Health Care: Global and U.S. Perspectives

Lawton Robert Burns, Elizabeth H. Bradley, and Bryan J. Weiner

CHAPTER OUTLINE

• The Challenge: Deliver Value
• Challenge of Rising Health Care Costs: Supply- and Demand-Side Drivers
• Other Challenges Exacerbating the Value Challenge
• Complexity of the U.S. Health Care System
• Why Changing the Health Care System Is So Difficult
• Systemic Views of U.S. Health Care
• Organization and Management Theory
• Summative Views of Organization Theory
• Organization Theory and Behavior: A Guide to This Text

LEARNING OBJECTIVES

After completing this chapter, the reader should be able to:
1. Understand the challenge of delivering value in health care
2. Identify the major forces affecting the delivery of health services
3. Distinguish the similarities and differences in the forces shaping health services globally
4. Understand why it is difficult to change the health care industry
5. Develop a system view of health care delivery
6. Understand the different types of firms operating in a health care system
7. Identify, understand, and apply the major perspectives and theories on organizations to real problems facing health care organizations
8. Develop mental agility in analyzing problems from multiple theoretical lenses
CHAPTER 1 • The Management Challenge of Delivering Value in Health Care: Global and U.S. Perspectives

KEY TERMS

Ambidexterity
Bending the Cost Curve
Bounded Rationality
Bureaucracy
Classical School of Administration
Complex Adaptive System
Contingency Theory
Decision-Making School
Evidence-Based Medicine
External Environment
Health Systems
Hospital-Physician Relationships
Human Relations School
Institutional Theory
Iron Triangle
Macro Perspective
Micro Perspective
Open Systems Theory
Population Ecology
Resource Dependence Theory
Scientific Management School
Social Network Approach
Strategic Management Perspective
System Perspectives
Triple Aim
Value
Value Chain

IN PRACTICE: The GAVI Alliance

The Global Alliance for Vaccines and Immunization (GAVI) was launched at the World Economic Forum on January 31, 2000. GAVI was a partnership of developing countries, organizations involved in international development and finance, the pharmaceutical industry, and philanthropic organizations. The Bill and Melinda Gates Foundation provided seed funding of $750 million for GAVI, followed by funding from several countries. GAVI was established to improve the distribution of new and underused vaccines to low-income countries and thereby reduce childhood mortality and morbidity, and increase the health status of these populations (Martin and Marshall, 2003; Milstien et al., 2008; GAVI Alliance, 2010).

A number of managerial challenges faced the GAVI Alliance in achieving its goals. First, the vision of the GAVI Alliance had to motivate local countries to participate in this vaccination program and gradually increase their own funding for it. Second, local countries needed to accept the responsibility to deliver the vaccine programs and the attendant results. Third, these countries had to help develop and manage local infrastructure to deliver the vaccines to rural populations—often referred to as the last hundred yards or miles of the supply chain. This meant the countries needed not only transportation and distribution networks but also a cadre of local health care workers with training in vaccine storage and administration. Fourth, the GAVI Alliance had to manage diverse stakeholders including the World Health Organization (WHO), the World Bank, UNICEF, large pharmaceutical firms that manufactured the vaccines, and the Gates Foundation. Fifth, the GAVI Alliance had to operate with a lean structure such that bureaucracy did not slow its progress. Sixth, the alliance had to develop leverage over pharmaceutical firms to purchase the needed drugs at a lower cost which local countries could afford. Last, the GAVI Alliance needed a clear governance structure with defined responsibilities for partners.

Between 2000 and 2009, GAVI directly supported the immunization of 256.7 million children for Hepatitis B, Haemophilus influenzae type B (Hib), and yellow fever. GAVI also speeded up population access to underused vaccines, strengthened health and immunization systems, and helped spawn innovative public-private partnerships (PPPs) in financing to expand vaccine coverage in 72 developing countries (GAVI Alliance, 2010). In January 2010, 10 years after the initiation of the GAVI Alliance, The Gates Foundation committed an additional $10 billion over the next 10 years.
IN PRACTICE: The GAVI Alliance (Continued)

Despite its success, GAVI has not been without its problems. Although the alliance necessarily focused heavily on developing partnerships and initiating vaccine coverage, less attention was paid to implementation of plans and mobilization of resources for ongoing treatment (in-country follow-up). One reason may be that vaccine costs have risen both absolutely and as a percentage of the total health expenditures, and vaccinations may not be the top priority of developing-country governments (Milstein et al., 2008; Muraskin, 2004). Finally, the alliance partners need to grapple with the large supply chain “system costs” required to handle, transport, and store the drugs (Lydon et al., 2008) and the issue of securing long-term financial commitments from its partners.

CHAPTER PURPOSE

A central challenge in delivering health care services in the new millennium is the challenge of delivering value. Value is created when additional features of quality or customer service desired by a customer can be provided at the same cost or price, or when a given set of features of quality or customer service can be delivered at a lower cost or price relative to other producers. Although investments in health care delivery can improve health status, which in turn can support economic growth and political stability (Burns, D’Aunno, and Kimberly, 2003; Esty et al., 1999; Sachs, 2001), still the value of health investments are not always transparent. For instance, despite evidence of the benefits of immunization coverage (Martin and Marshall, 2003; World Health Organization, 1996) and a steady increase globally during the 1970s and 1980s, immunization coverage declined sharply in the 1990s due to curtailed government funding in low-income countries. The GAVI Alliance entered in 2000 and, during its first 10 years, averted four million deaths and immunized a quarter of a billion children against deadly or disabling diseases (GAVI Alliance, 2010).

Why was this approach not already taken? To effect major changes in health care delivery and increase value, as the GAVI Alliance has, organizations require extraordinary approaches. Such approaches critically hinge on several management competencies. These include assembling (global) alliances, clarifying the governance structure of the alliance, developing the local health care infrastructure to deliver the needed services, balancing global and local commitments, and developing local ownership of health initiatives. Managerial skills (including but not limited to developing alliances, negotiating governance and roles, conflict management, managing change, forging strategic plans and leadership) are critical components of the manager’s “tool kit” in any health care system.

THE CHALLENGE: DELIVER VALUE

The key challenge facing health care firms is to deliver value, defined as the quotient of quality divided by cost. That is, firms are asked to deliver a higher level of quality at the same cost, the same level of quality at a lower cost, or higher quality at a lower cost. This challenge has been proposed to (a) providers, in the form of accountable care organizations (ACOs) and pay-for-performance, (b) suppliers, in the form of demonstrating the comparative clinical effectiveness of their products (versus alternate therapies), and (c) insurers and providers, in the form of value-based purchasing. In order to create and deliver value, health care organizations must find a way to address three health policy goals of our health care system since the late 1920s: improve the quality of care, improve access to care, and reduce cost and cost acceleration—e.g., bending the cost curve, or the reducing of health spending relative to projected trends (Commonwealth Fund, 2007a).

Numerous health services researchers have questioned whether all three goals are simultaneously attainable (Chen, Jha, Guterman et al., 2010; Katz, 2010) or require a balancing act (Berwick et al., 2008). The achievement of these three goals is sometimes referred to as the iron triangle of health care (Kissick, 1994). Picture an equilateral triangle, with three equal angles of 60 degrees, and assume that each angle is one of these three policy goals. Any effort to address one policy angle...
CHAPTER 1 • The Management Challenge of Delivering Value in Health Care: Global and U.S. Perspectives

widens that angle (e.g., access) at the expense of one or both of the other two angles (e.g., quality or cost). For example, the recent health insurance reform in the United States—the Patient Protection and Affordable Care Act—expands insurance coverage to 30 million citizens, but its savings will reportedly be more than offset by higher expenditures (and escalating costs) resulting from the expansion of coverage (CMS, 2010).

Provider organizations in the health care industry have nevertheless been periodically challenged to accomplish the quality and cost goals at the same time. In July 2009, providers from 10 U.S. markets convened in Washington to discuss how they deliver care to the Medicare population that is above average in quality and below average in cost, compared with national data contained in the Dartmouth Atlas (Institute for Healthcare Improvement, 2009). In past decades, providers have been asked to demonstrate a similar value (quality/cost) proposition using a series of management techniques, such as total quality management (e.g., reducing process variation and simultaneously raising the level of process performance), supply chain management (e.g., standardizing products to achieve consistency in use and lower unit cost), and clinical integration (standardizing care paths and protocols to reduce clinical practice variations and improve quality of care). In this past decade, the Institute of Medicine (2001) articulated six “aims for improvement” in a high-performing health care system: care should be safe, effective, patient-centered, timely, efficient, and equitable. The balancing of broad health policy goals is apparent on a global scale as well. The World Health Organization (WHO, 2000) uses three criteria to rank national health systems: health status (similar to quality), responsiveness to the expectations of the population (similar to access), and social and financial risk protection (similar to cost).

Health costs in the United States have been rising at roughly 3–4 percent annually (net of inflation) for the past six decades (Altman, 2010). Some have argued that public and private sector efforts work to temporarily rein in this rate of increase, only to see the cost escalation return (Altman and Levitt, 2002).

Why do costs rise inexorably? Many experts argue that the underlying driver of rising costs is technology and its broad application to new patients and patient indications (Aaron and Ginsburg, 2009; Commonwealth Fund, 2007b; Congressional Budget Office, 2008). Following Weisbrod (1991), technological improvements spur higher prices, higher demand, and higher costs—all of which call for greater insurance coverage for the new technology, which then drives further technological innovation. Technology contributes to rising costs in other ways. In contrast to other industries, health care technology is often a complement rather than a substitute for labor—e.g., requiring many technicians to utilize the new equipment. Moreover, providers often compete for patients based on the sophistication of the services and equipment they offer, leading to expensive excess capacity and duplication in a local market (“technology wars”). Insurance is another driver of rising costs, as broader coverage (e.g., for more people, or more benefits) increases demand and thus health spending, as well as the attendant problem of moral hazard (Arrow, 1963) whereby the insured utilize more health care than they would if they paid for services out of pocket (i.e., from their own resources without insurance).

There are several supply- and demand-side drivers of rising health costs. On the supply side, costs are driven by imperfect information markets whereby purchasers and consumers of health care are not able to discern quality differences perfectly among health care providers, make few repeat purchases, and enjoy less transparency of pricing, which allows great variation in the economic rents earned by providers of the same product or service. Such rents also result from provider market power. Costs are also driven in part by providers’ practice of defensive medicine, providers’ focus on acute rather than chronic care or prevention, and poor coordination of services among providers. Finally, costs are driven by geographic variations in the supply of hospital beds and specialist physicians, which may induce demand (Roemer, 1961).
GEOGRAPHIC VARIATION IN HEALTH CARE SPENDING: A CLOSER LOOK

Health care expenditures in the United States have been rising for years, but per capita spending on health care varies widely across the country. In 2004, for example, Medicare expenditures per beneficiary ranged from roughly $4,000 in Utah to $6,700 in Massachusetts. Even greater differences appear in comparisons of smaller geographic units and individual medical providers. Some estimate that Medicare spending would decrease by 29 percent if spending in medium- and high-spending areas matched spending in low-spending areas (Wennberg, Fisher, and Skinner, 2002).

Why does health care spending vary so much across the country? The reasons are complex and difficult to tease apart. Differences in prices of health care services and severity of illness play an important role, but together these factors account for only half of the geographic variation in spending. Regional differences in the supply of specialist physicians and health care facilities are also thought to play a role. Regional differences in provider willingness to adopt new technologies or provide costly treatments that might or might not improve health care outcomes are also thought to increase costs.

Scholars and policy makers looking to slow the rate of growth in health care expenditures (“bend the cost curve”) point to organized delivery systems that focus on coordinated care and prevention as a promising way to reduce the costs associated with the efficiencies, misaligned incentives, and poor quality attributed to the highly fragmented nature of the health care system that currently exists in the United States. In his efforts to promote health reform, for example, President Barack Obama praised the Mayo Clinic in Minnesota and the Cleveland Clinic in Ohio as examples of hospitals providing the highest-quality care at costs well below the national norm, and suggested that all providers in the country practice their type of medicine.

DEBATE TIME: Defensive Medicine

Do physicians order unnecessary tests out of fear of being sued by patients? If so, how much does “defensive medicine” contribute to the escalating costs of medical care in the United States? These issues are hotly debated. On the one hand, physicians practicing in high-liability specialties like obstetrics report that they routinely order more tests than are medically necessary in order to reduce the risk that they will end up in court (Studdert et al. 2005). In a recent Wall Street Journal article, a physician noted, “Doctors get sued for failure to diagnose and not ordering tests... It’s something that I do think about and in some cases it does influence my decision” (Searcey and Goldstein 2009). Pointing to escalating malpractice insurance premiums, some professional associations and lawmakers argue that significant cost savings could be achieved in the U.S. health care system through the passage and enactment of tort reform (e.g., limiting the size of malpractice liability awards). Others, however, argue that defensive medicine and malpractice liability do not contribute significantly to overall health care costs. According to a recent study, total spending on medical malpractice was $30 billion in 1997, a substantial amount to be sure, but less than 1 percent of total U.S. health care spending (Towers Perrin, 2008). Estimating the cost of defensive medicine is especially difficult because physicians order tests and procedures for many reasons that are difficult to disentangle. For example, fear of being sued can be mixed with the desire to provide the best care possible. Also, physicians can increase their incomes by ordering more tests and performing more procedures.

What do you think?

- How much defensive medicine occurs? How much do you think it contributes to health care spending? What, if anything, should be or could be done about it? What are the costs and benefits of the strategies you propose?
- Medical malpractice liability insurance is increasing at an alarming rate for some specialties and in some states. What, if anything, should or could be done about it? What are the costs and benefits of the strategies you propose?
On the demand side, costs are driven by the tax-free treatment of health care benefits (which contributes to richer health benefit packages and induces moral hazard), as well as public and private sector financing of health care through a third-party payment system of insurers and other fiscal intermediaries outside the patient-provider relationship. Favorable tax treatment and a third-party payer system combine to insulate the consumer/patient from the true cost of the health care services they demand. In addition, demand is driven by a country’s national wealth, the expectations of its population, the highly technological nature of health care services, and the health behaviors of its population. These supply and demand drivers are listed in Table 1.1.

There are a handful of axioms governing the demand side of this vast system that may be peculiar to health care. The first is that technological innovations and their application are desired by providers, desired by patients, and drivers of rising health care costs (“the technological imperative”) (Fuchs, 1986; Gelyns and Rosenberg, 1994). A second axiom is that technology drives specialization in the medical (and nursing) field, which further drives up health care costs. A third axiom is that every citizen deserves the finest health care now made available by these technological developments (often defined as the product or service offered by my firm) as long as someone else pays for it. Another axiom following from the technological imperative is that cost and price are the key issues germane to all parties. Indeed, the one issue that currently unites the entire value chain in health care is reimbursement; many analysts anticipate that it will be the patient/consumer that unites the chain in the future. Finally, technological innovation and its attendant costs spur the spread of insurance coverage for such innovation, which increases spending on innovation, which fuels yet more innovation (Weisbrod, 1991).

OTHER CHALLENGES EXACERBATING THE VALUE CHALLENGE

Complicating the difficulty of providing value, health care systems face a number of other challenges. These include: increasing patient demand and expectations, increasing payer and societal demands for accountability, unexpected epidemiological shifts, calls for greater patient safety, increasing complexity, strains on federal and state government budgets, inadequate supply of primary care practitioners, reported shortages of specialists and other health personnel, erosion of the public’s trust in physicians and hospitals, growing concerns over privacy of personal health information, lack

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<td><strong>Supply-Side Drivers</strong></td>
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<td>Provider market power</td>
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<td>Technology and its diffusion</td>
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<td>Geographic variations</td>
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<td>Poor coordination among providers</td>
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<td>Fee-for-service payment systems</td>
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<td>Excess capacity</td>
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<td>Acute care focus of delivery system</td>
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of transparency in prices and information, conflicts of interest and incentives, lack of consumerism, lack of efficient and effective use of information technology, and provider resistance to change (Porter and Teisberg, 2006; Herzlinger, 2006; Dranove, 2008).

On top of these challenges one can lay a series of delicate balancing acts that health care firms (and society as a whole) must deal with beyond the value equation. These include: meeting rising demand and expectations with finite resources (both capital and labor), addressing chronic care needs with an acute care–based delivery system, fostering population-based models of care amidst a system based on physicians in small groups or solo practice, sharing information while respecting patient privacy, incorporating modern therapeutic and technological advances while restraining the rate of growth in cost, and promoting wellness behaviors in a system which finances acute care seeking.

THE CHALLENGES ARE GLOBAL

The problems, issues, and challenges facing the health care industry are global, confronting health care systems in many countries (see Chapter 15). As an illustration, Table 1.2 identifies some of the common issues and problems facing the health care systems of India, China, and the United States. These countries have populations that are quickly aging—true especially of China, and increasingly so for both India and the United States. All three countries face a huge epidemiologic transition from acute care to chronic illness, with underdeveloped systems for dealing with chronic care (especially true in the East). Populations in all three countries have developed more sedentary lifestyles, with increasing incidence of diabetes, obesity, and hypertension. All three countries have populations with substantial national wealth that are now demanding more health care services and thereby increasing health care costs rapidly. Not surprisingly, all three countries also report that health care costs are a major source of personal and family bankruptcy. Finally, all three countries face the common issue of how to balance the demand for technological innovation by providers and patients with its high cost.

At the same time, there are several major divergences between these health care systems (see Table 1.3). The U.S. health care system compared with India or China spends a much higher proportion of its gross domestic product on health care and provides a higher level of insurance coverage to its population. While health insurance programs are now spreading across India (increasingly private sector) and China (mostly public sector), they provide coverage for a limited range of services (e.g., focused until recently on hospital inpatient care). Hospital ownership patterns also diverge widely. China’s hospital system is almost entirely public sector (although the country recently announced its intention to allow more entry by private hospitals), while India’s formerly public sector hospital system has seen the emergence of a thriving private sector comprised of multi-hospital systems (e.g., Apollo, Fortis, Wockhardt, and MaxHealthcare). By contrast, much of the U.S. hospital market is voluntary and nonprofit in character. Such differences and commonalities suggest that management strategies to meet

### Table 1.2 Parallel Concerns in the United States, India, and China

- Concern with iron triangle
- Concern with high hospital costs as cause of impoverishment/bankruptcy
- Concern with the high costs of technology
- Concern with geographic disparities in health status
- Concern with conflicts of interest and supplier-induced demand
- Concern with prices as driver of rising health care costs
- Concern with lifestyle issues and behaviors
- High number of specialists
- Hospital waste and inefficiency
- Lack of a primary care system
- Fee-for-service payment system
- Mixture of financing mechanisms: government, employer, individual
- Fragmentation in government ministries/bureaucracy
- Low consumer information
- Competing spending priorities (education, social services, health) at the local government level
the value challenge must consider the local context, but may nevertheless share many similar elements. As Chapter 15 notes, these strategies may encompass prospective payment systems, enhanced provider reimbursement rates, patient marketing and recruitment, etc.

**COMPLEXITY OF THE U.S. HEALTH CARE SYSTEM**

As of the writing of this book in early 2010, the United States still lacks a single national health insurance program (other than the Medicare program for the elderly) to pay for health care. Thus, one confronts a variety of mechanisms to finance health care by federal, state, and local governments, as well as employers, individuals, and philanthropic organizations. The U.S. system also has a fully developed *value chain* (i.e., interlinked activities among a set of firms whereby suppliers provide raw material inputs to manufacturers who process them and produce outputs for downstream markets) (Burns, 2002; Porter, 1985). For example, the United States has thousands of product manufacturers (pharmaceuticals, biotechnology, medical-surgical supplies, capital equipment, medical devices, and information technology), wholesalers and distributors, hospitals, physicians, nursing homes, pharmacies, home health agencies, insurers and insurance brokers, and employers offering health insurance coverage to their employees. It also has hundreds of group-purchasing organizations and public health agencies; 50 State Medicaid programs; a vast federal *bureaucracy* (literally, government by bureaus or offices), which finances care, delivers health care services, regulates providers, approves new innovation, funds basic and applied research, and provides public health; and lots of niche firms offering pharmacy benefit management and disease management services (see Figure 1.1). This is a huge industry with lots of stakeholders, divergent interests and perspectives, and entrenched positions.

Effective management of any one sector of this system requires not only an understanding of the competitive developments within that sector, but also an understanding of the other sectors, what is taking place within them, and how they interact with one another. Some of the health care managerial approaches and actions over the last decade reflect cross-sector understanding and efforts. Such efforts include but are not limited to managing under new pay-for-performance (P4P) systems developed by both public and private sector payers; working with outside vendors (e.g., hotel chains, consulting firms, General Electric) to improve customer service, patient flow, and revenue cycle management; working with information technology companies to develop and implement electronic medical records (EMR) systems (see Chapter 13); hospitals partnering with physicians to improve quality of care or develop new ambulatory care sites; and hospitals working with group purchasing organizations (GPOs) to lower supply costs.

**WHY CHANGING THE HEALTH CARE SYSTEM IS SO DIFFICULT**

In addition to being complex, the health care system is slow to change. There are several reasons for this. First, the industry is heavily regulated at both the state and federal levels by myriad agencies and professional associations. The federal government is also the dominant payer, reimbursing health care via administered prices. Market forces have thus given way to more regulation and piecemeal legislative action (due to legislative gridlock) at the federal level (Altman and Rodwin, 1988; Field, 2007).

Second, consumerism is a newcomer to health care. Until recently, consumerism was stifled by the prevalence of third-party payment and first-dollar coverage, the old sociological view of the patient playing the “sick role” (Parsons, 1951), the
However, in most of these areas, consumer engagement is not widespread.

Third, health care delivery is heavily influenced by the medical profession, which controls (directly or indirectly) up to 85 percent of all spending (Sager and Socolar, 2005). While physicians do compete with one another, they nevertheless enjoy a monopoly or near monopoly over most important decisions governing resource allocation, including: prescribing an ethical pharmaceutical, performing a surgical procedure, scheduling a laboratory or imaging test, and admitting a patient to a hospital bed. Freidson (1970) long ago discussed the professional dominance of physicians. Physicians are
IN PRACTICE: Does Pay-for-Performance Work? The Case of the Premier Hospital Quality Incentive Demonstration

In 2003, the Centers for Medicare and Medicaid Services (CMS) and Premier Inc., a large national GPO, launched the Premier Hospital Quality Incentive Demonstration (PHQID) to determine if economic incentives are effective at improving the quality of inpatient care. Hospitals participating in the PHQID collected and submitted data on 33 quality measures for five clinical conditions: health failure, acute myocardial infarction, community-acquired pneumonia, coronary-artery bypass graft, and hip and knee replacement. For each clinical condition, hospitals performing in the top decile (i.e., 10 percent) received a 2 percent bonus in addition to their usual Medicare payment. Hospitals in the second decile received a 1 percent bonus. Hospitals that underperformed on quality indicators were liable for a 1–2 percent financial penalty in the third year. Between 2003 and 2007, CMS awarded more than $36.5 million to high-performing hospitals (Premier, 2009). Bonuses averaged $71,960 per year and ranged from $914 to $847,227 (Lindenauer et al., 2007).

Premier has trumpeted the success of the PHQID. According to its studies, participating hospitals raised their overall quality by an average of 17.2 percent over four years (Premier, 2009). Participating hospitals saved the lives of an estimated 4,700 heart attack patients and provided 500,000 additional evidence-based clinical services and recommendations (e.g., smoking cessation, pneumococcal vaccination, and discharge instructions) to more than 1.5 million patients treated in the five clinical areas covered by the demonstration. Finally, Premier reports that, by March 2008, participating hospitals outperformed nonparticipating hospitals by an average of 6.9 percentage points on 19 quality measures also used by Hospital Compare, the federal government's scorecard for hospital quality (Premier, 2009).

Academic research tells a somewhat different story. For example, Lindenauer et al. (2007) matched 207 PHQID hospitals to 406 hospitals that did not participate in the demonstration but publicly reported the same quality-performance data through Hospital Compare. They found that, over a two-year period from 2003 to 2005, the PHQID hospitals showed significantly greater improvement than hospitals that engaged in public reporting only. However, the overall difference was modest (about 3 percent) after statistically adjusting for other factors. Using somewhat different data sources, Ryan (2009) found no evidence that PHQID had a significant effect on risk-adjusted 30-day mortality or risk-adjusted 60-day cost for acute myocardial infarction, heart failure, pneumonia, or coronary artery bypass graft.

So, did the program work? The answer depends on several questions: (1) what is the relevant time frame, (2) which comparison group is most appropriate, (3) which quality indicators matter most, (4) what statistical procedures are most suitable, and (5) what additional factors need to be considered in the analysis? In 2007, CMS approved a two-year extension of the PHQID, modified the program’s incentive payment structure, and committed $12 million per year in additional incentives.

largely autonomous, community-based entrepreneurs with (until recently) little employment relationship with hospitals in which many of these decisions are made. Due to professional training and the legal distinction between the hospital and its medical staff, hospitals have historically been challenged to alter the practice patterns and behaviors of their physicians.

Fourth, most of the nongovernmental sectors in health care have consolidated over the past two to three decades, thereby reducing competition, conferring market power and fostering higher prices. Consolidation has occurred in the following sectors (time periods): pharmaceuticals (late 1980s to the present), pharmaceutical wholesalers (1980s–1990s), medical devices (1990s), hospitals (1990s), insurers (1990s), group purchasing organizations (1990s), and pharmacy benefit managers (1990s–2000s). These trends have fostered the emergence of several bilateral monopolies (e.g., big insurers negotiating with large hospital systems) in local markets.

Fifth, the delivery of hospital care (which accounts for roughly 30 percent of national health expenditures) is heavily dominated by nonprofit institutions, such as nonprofit
community hospitals and municipal/state-owned facilities. Investor-owned facilities comprise only about 15–20 percent of the hospital sector—a percentage that has remained relatively flat for decades. Nonprofit hospital ownership and accountability to local boards and communities (rather than shareholders) may mitigate against pressures to alter their missions, strategies, and operating practices. Theory suggests that nonprofits exhibit relatively poor supply response to changes in demand, more limited entrepreneurship owing to constraints on the distribution of earnings, and choice of optimization of various outcomes (e.g., quantity of services provided, focus on physician convenience and returns) rather than profits (Hansmann, 1987). The empirical evidence here is generally equivocal outside of the nursing home industry.

Sixth, health care delivery is largely local. Physicians are licensed to practice in a given state and, like most hospitals, generally draw their patients from the local geographic area. Insurance companies are likewise licensed and regulated at the state level, and credential and contract with provider networks in local markets. Local markets have different configurations of power among key stakeholders (e.g., employers, insurers, hospitals, local government, etc.), which necessitate tailored strategies by manufacturers in order to sell their products. While there has been much talk about medical tourism, more domestic tourism (e.g., to regional centers of excellence) than foreign tourism (e.g., to Thailand or India) seems to take place (Deloitte, 2009). The largely local character of health care certainly complicates (and perhaps mitigates against) any concerted efforts to try to change the system from above.

Seventh, there is a widespread lack of valid data about quality and cost in health care. Until recently, most patient-provider transactions were captured and stored in paper-based systems (e.g., physician notes, patient charts, and medical records). This made it nearly impossible to analyze practice patterns to improve care quality and efficiency. To the extent that good patient care data existed, it rested in the hands of insurers who reimbursed providers for the care but did not share the granular information with them. This information asymmetry benefited insurers at the bargaining table with providers. In 2009, President Obama’s stimulus package included funding for the diffusion of electronic medical records (EMRs) across physician offices to begin to address problems of data capture, although the issues of data validity and complexity of interpretation remain. Eighth, and finally, efforts to change the health care system using business practices imported from the outside have repeatedly come up short (Arndt and Bigelow, 2000a; Burns and Pauly, 2002; Westphal, Gulati, and Shortell, 1997). One reason is that these practices have been adopted for normative reasons (e.g., to look efficient, to satisfy boards they are improving efficiency, and/or to imitate what other forward-looking organizations in the market are doing) as well as, or sometimes rather than, rational reasons (e.g., to remedy their operating problems). This would explain, for example, why hospitals have not invested more time and capital in the implementation of any given practice, or the coordination and integration among multiple practices, but rather pursued a series of discrete practice solutions over time (see Table 1.4) as they have come into vogue (flavor-of-the-month management) (Pfeffer and Sutton, 2006). Another reason is that such practices may not fully consider the institutional differences noted above and thus are not customized to health care settings.

Given the managerial problems that need to be confronted in health care, and given the complexity of the health care system and its peculiarities, what approaches seem fruitful for

**TABLE 1.4 Business Practices Adopted by Hospitals 1985–2010**

- Corporate restructuring/holding companies
- Corporate diversification into new businesses
- Theory Z management
- Total quality management/continuous quality improvement (TQM/CQI)
- Horizontal integration (e.g., mergers & acquisitions)
- Vertical integration (physician acquisition, continuum of care, insurance)
- Strategic alliances with physicians and hospital networks
- Reengineering / work restructuring
- Product line management / service line management
- Customer focus / patient-centered care
- Focused factories
- Lean manufacturing and the Toyota Production System
addressing them? One approach is to apply system analysis to glean insights into the behavior of complex settings. Another approach is to apply organization and management theory. The next two sections sketch out some of these perspectives and how they might be usefully applied.

**SYSTEMIC VIEWS OF U.S. HEALTH CARE**

Descriptions of the health care industry in the United States often begin with a discussion of whether it is a “system.” Webster’s dictionary defines a system as a complex unity formed of many often diverse parts subject to a common plan or serving a common purpose. Clearly, the U.S. health care industry does not meet this standard. As noted above, the multiple players have different goals (triple aim) and divergent interests (“patients need my product/service, you should pay for it,” consolidation versus competition, integrated versus niche models).

Is a system view important? We think so, for many reasons. First, from a macro perspective, health outcomes are determined by an array of forces and factors that spans much more than a nation’s health care infrastructure. There are multiple systems frameworks that describe these forces and factors (Shakarishvili, 2009). Hsiao (2003) and the World Health Organization (2000) have each developed a generic framework for the overall structure of any country’s health care system. These frameworks describe several background forces (environment, nutrition, sanitation, professional training, and others) that affect the policy levers available to a system. These levers (“control knobs”) include financing, payment, organization, regulation, and behavior. These control knobs are modeled to impact intermediate health system outcomes (efficiency, quality, and access) which in turn produce the ultimate health outcomes of health status, financial risk protection, and satisfaction (see Figure 1.2). Berwick et al.’s (2008) triple aims of any health system—improving the experience of care, improving the health of populations, and reducing per capita costs of care—resemble the intermediate outcomes described by Hsiao.

Second, as noted earlier, there are so many interdependent players that a systemic view helps to organize them and their interactions. Figure 1.1 provides such a framework for the U.S. context. Providers of health care services occupy the middle of the diagram for a specific reason: they are the main focus of everyone else. Buyers reimburse them for services rendered to

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**Figure 1.2** The Health Care System.


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their employees/beneficiaries: suppliers seek to sell them their products; regulators spend much of their time overseeing their quality/safety environment and their competitive conduct; and public health agencies seek to enhance population health by financing research and educational activities undertaken by providers as well as exercising oversight generally outside the direct provision of health care services. For the two parties in the upper-left and upper-right portions of the diagram (suppliers and buyers, respectively), two sets of intermediaries channel their services to providers.

This suggests a third reason for the importance of system views. The concept of a value chain (Porter, 1985)—i.e., a firm or industry’s input, throughput, and output activities that are served by a host of support functions—suggests that value is created along this collection of activities and requires effective partnerships. Value can be created by making the appropriate make-versus-buy decisions on how much of the value chain to occupy. For example, should providers operate their own insurance vehicles or contract with payers in the local market? Much of health care today is undertaking an analysis of make-buy decisions with this system view in mind. Pharmaceutical firms are now considering whether or not they should shed their research and development arms, allow such functions to be performed by smaller and more nimble actors like biotechnology firms, and concentrate their efforts on the sales and marketing functions. Conversely, hospitals are now considering whether they should assume more of the functions of the group purchasing organizations they have historically contracted with and do their own in-house contracting. Historically, suppliers have deliberated whether or not they should serve as their own wholesalers/distributors, while employers/buyers have experimented with operating their own provider networks.

A system view is important for a fourth reason. Management theory teaches that successful innovation requires concomitant changes among the system’s components (sectors) to achieve congruence or “fit” (Senge, 2006; Tushman and O'Reilly, 1997). Similar thinking has been applied to the U.S. health care system: payment reforms in the buyer sector must be accompanied by corresponding reforms in the provider delivery system. Thus, for proposed payment changes—pay-for-performance, gainsharing, or bundled payment—to work, provider organizations require new models of physician-hospital collaboration (Burns, Goldsmith, Muller, 2010). More broadly, efforts to reform one sector of the health care system must consider their impacts on the others to assess congruence with their interests and resources.

Fifth, as noted above, organizations within the health care industry have increasingly consolidated into systems over the past two decades with the stated objective of being more efficient, but may not operate as such. While mergers and acquisitions (M&A) have received a lot of attention (both by the merging firms and the media), post-merger integration activities have not. It is not clear that large multiunit systems can operate in a systemic fashion, extract scale economies from their operations, increase their productivity, add value, and address the multiple goals of access, quality, and acceptable cost. Systemic views of newly consolidated health care organizations and their potential (if any) to add value may thus be in society’s interest. Indeed, between 2002 and 2004, the Federal Trade Commission (FTC) and Department of Justice (DOJ) conducted a series of workshops to assess the competitive and efficiency benefits of horizontal and vertical forms of consolidation (FTC/DOJ, 2004).

Thus, for example, despite the continuation of larger mergers (Pfizer and Wyeth, Merck and Schering Plough), research suggests that pharmaceutical M&A does not improve research productivity or profitability over the long term (Burns, Nicholson, and Evans, 2005). Instead, there are now suggestions that “big pharma” needs to “get small,” perhaps by de-verticalizing their value chains, shedding their R&D activities, and focusing on a smaller set of activities. Similarly, the hospital systems that developed during the 1990s have devolved into more decentralized collections of autonomous operating units rather than centralized operations acting in concert (Burns and Muller, 2008). Indeed, the systems lens of federalism (the appropriate division of federal and state powers) suggests alternative ways for these hospital systems to organize themselves.

**ORGANIZATION AND MANAGEMENT THEORY**

Schools of management thought have evolved over the past century to provide conceptual maps of how to deal with internal and external challenges. These conceptual maps include theories of how things work, what causes what, and how to act. The theories are not mutually exclusive and can serve as multi-dimensional or multilayered models to guide managerial action. Executives benefit from being familiar with, and adept at using, many of these conceptual maps. This is no easy task; it is akin to being ambidextrous, both left-brain and right-brain, and more a fox than a hedgehog (Berlin, 1953).
Early Writings on Bureaucracy and Organization

Western management theory received its early impetus in the writings of Max Weber (1964), a German sociologist writing about the Prussian civil service in the late nineteenth century. Weber described the prominent features of this "bureaucracy" (literally, government by bureaus or offices) in terms of offices and officeholders, a vertical hierarchical ordering of these offices into organizational pyramids, a horizontal division of labor that separated offices and their functions, the use of explicit procedures to govern activities, the presence of records and files, and the selection of officeholders based on achievement rather than ascription. For Weber, bureaucracy was that form of administrative organization that operated under legal authority and was capable of the highest level of efficiency.

Research suggests that the bureaucratic model of organization is technically efficient and even superior to other forms under certain environmental, technological, and task conditions (Lawrence and Lorsch, 1967; Woodward, 1967). There is also considerable research on how to apply this model to the six common pathologies of the bureaucratic division of labor (Bacharach, Bamberger, and Conley, 1990):

- Role overlap (duplication): two roles perform the same task
- Role gap (accountability): neither role performs the needed task
- Role underuse (boredom): role not assigned enough tasks
- Role overload (burnout): role assigned too many tasks
- Role ambiguity (anxiety): role not clear what the tasks are
- Role conflict (stress): role's tasks are at cross-purposes

Bureaucracies are endemic to all organizations, including those in the health care industry. The degree of bureaucracy tends to be associated with both the firm’s size and age. Thus, bureaucracy is less pronounced in small work groups and entrepreneurial startups (e.g., biotechnology firms) and more pronounced in hospitals and large consolidated firms (e.g., pharmaceuticals). Hospitals are peculiar bureaucracies in that they feature a "dual hierarchy"—a centralized system governing the nonmedical activities and a decentralized, collegial one governing the medical staff (Begun, Luke, and Pointer, 1990; Pool, 1991). Physician group practices, the majority of which are quite small, are peculiar in that they feature consensual governance rather than a bureaucracy. As many researchers have noted, physicians dislike and distrust authority (Burns and Wholey, 2000).

There is nothing inherently evil in bureaucracy, even though in modern parlance it has taken on a negative connotation of poor service, lack of responsiveness, and inscrutable, byzantine operation. At its essence, management and bureaucracy are all about "control." The word "manage" derives from the French word manège, used in dressage, meaning to put a horse through its paces (Braverman, 1974). The challenge for the modern manager is to utilize the clarifying elements of bureaucracy (e.g., to resolve the six pathologies above) while at the same time avoiding the classic bureaucratic pitfalls of too many hierarchical levels that separate executives at the top from frontline workers down below, or too many horizontal divisions or units that effectively create boundaries inside and outside the firm, which impede interaction and the flow of information, or too many rules and regulations, which stifle creative problem-solving. Chapters 3, 4, and 8 in this book consider these issues.

IN PRACTICE: Efforts to Deal with Bureaucratic Dysfunctions

Considerable research has highlighted the dysfunctional consequences of bureaucracy including its inward focus (rather than focus on the client or the environment), its tendency to rigidity and inertia, and its stultifying effects on individual creativity and thus organizational change. Nothing has changed here: as late as the 1980s and 1990s, major firms such as General Electric (GE) used change programs like “Work-Out” to attack their bureaucracies (Ulrich, Kerr, and Ashkenas, 2002). After downsizing its workforce, GE found that the remaining managers and employees had more work and responsibilities to handle. To reduce the load, they gathered employee suggestions for how to get non-value-adding work out of GE’s processes (hence, the title of the program). The company discovered that Work-Out was more than just trimming excess work, however. It was also an “exercise” work-out for employees to study and diagram their work processes, as well as a mechanism for conflict resolution as different departments worked out their differences in how processes overlapping their areas might be simplified.
Frederick Taylor and Scientific Management
The scientific management school (Taylor, 1911) extended the Weberian model by explicitly emphasizing the “control” element of bureaucracy. Scientific management was an attempt to apply the methods of science to increasingly complex problems of controlling work in rapidly growing firms (Braverman, 1974). For example, Frederick Taylor employed time-motion studies to analyze a steelworker’s task into its simplest components and then systematically improve the worker’s performance of each component to maximize productivity and ensure conformity to the one best way of production. Such thinking became embedded in assembly-line technologies like auto making by industrialists like Henry Ford.

Scientific management had an enormous impact on management practice and theory for decades to come. Of particular importance to us are three assumptions. First, Taylor assumed that workers were guided by intuition and variable training, and thus were unable to perform their tasks in the best way. Instead, armed with scientific techniques (e.g., time-motion studies), management must control every aspect of the labor process and dictate precisely how it should be done. Workers were left with no discretion in their jobs, while managers were vested with all decision making regarding task design. This separation of decision making at the top from execution/implementation down below in the firm came to pervade all management and strategy thinking (Mintzberg, 1994). A second related assumption was that management needed to closely supervise workers to ensure adherence to standardized tasks and prevent any “soldiering” (deliberate restriction of output); rather than being intrinsically motivated, workers responded primarily to monetary incentives and external control. Third, due to the large variability in how to do one’s job (e.g., which methods, which tools), scientific management focused on reducing the variations and finding the one best way to perform the work in order to maximize productivity.

This school presaged several recent movements in management thinking. The emphasis on decomposing tasks into their constituent elements and worker training anticipated the early work on job design; later efforts to amend this approach included the job redesign approach (Hackman, 1975, 1983), human factors engineering (Herzberg, Mausner, and Snyderman 1959), and the quality of work life movement. These topics are taken up in Chapters 3 and 5. The emphasis on reducing variations in work anticipated the later work of W. Edwards Deming and total quality management movement in the United States of the 1980s—a topic taken up in Chapter 9. And the emphasis on specialized tasks and productivity anticipated the focused factories of the 1980s and 1990s (Herzlinger, 1997).

Classical School of Administration
The writings of Gulick (1937), Gulick and Urwick (1937), and Fayol (1949) took many of the concepts developed by Weber and Taylor and formulated them into general principles of management—essentially continuing Taylor’s view of “one best way” to manage. These principles included unity of command (i.e., one boss), unity of direction (one objective, one plan, one boss), subordination of individual interest to general interest, centralization, authority, span of control (optimal number of people to supervise), and departmentalization (Fayol, 1949). Such principles directed managerial practice for much of the twentieth century.

Departmentalization has been one of the most enduring principles articulated by this school. These writers identified two principal models for the firm’s division of labor: process departmentalization and purpose departmentalization. These have since been relabeled functional and divisional organization: organizing by functional area versus organizing by product line, customer, or geographic area. Alfred Chandler (1962) depicted the large-scale shift in the organization of American enterprise from the former to the latter. Twenty years later, Goldsmith (1981) described a similar transformation taking place among U.S. hospitals. Efforts to commingle the two forms of management gave rise to matrix structures utilized both in industry and in health care (Burns, 1989; Galbraith, 1973). Alternative forms of departmentalization comprise the core of thinking on organization design and coordination, the topic of Chapter 3.

Human Relations School
The human relations school developed a model of worker motivation that sharply differed from the Taylorist approach, and thus suggested a different way of management. Work conducted by Elton Mayo (1945) and Roethlisberger and Dickson (1947) at the Hawthorne plant of the Western Electric Company ironically began as a Taylorism project to assess the impact of lighting changes on worker productivity. In contrast to Taylor’s focus on individual workers and their jobs, their research anticipated Kurt Lewin’s (1951) insight about the primacy of the group in structuring individual behavior.
The findings implied that to improve productivity, management must attend to a new set of considerations beyond monetary incentives and top-down control of work. Managers must instead understand the informal organization of workers (groups, group sentiments, team work), the need of workers to be listened to and participate in the design of their work (participation, self-governance), and the importance of morale and satisfaction as motivators of worker effort. Group structure and process are considered in Chapter 5; communication skills are discussed in Chapter 6.

Mayo’s work suggested that workers are less rational than Taylor believed; guided less by financial incentives and more by human sentiments. Workers were also motivated to be accepted by their peer groups and achieve social solidarity. Finally, workers had an array of goals and needs that did not necessarily coincide with, or were subordinated to, the firm’s interests. This insight led to an entirely new managerial approach called “organization development,” which recognized the interdependence of the organization and groups of employees, and sought ways to simultaneously achieve both the firm’s goals and those of its workers. By extension, this school paved the way for later recognition of the employee as the firm’s key asset.

Subsequent research and writing expanded the human relations school’s approach. Douglas McGregor (1960) contrasted this school and its emphasis on managing human resources (Theory Y) with scientific management and its emphasis on control and coercion (Theory X). For McGregor, human relations management sought ways to integrate the firm and the worker, as well as ways to harness the worker’s creativity and imagination. Taking account of Maslow’s (1943) hierarchy of needs, McGregor argued that satisfying the worker’s higher-order needs of belongingness, esteem and self-actualization was critical. Herzberg refined Maslow’s approach and suggested that such intrinsic motivation was inherently satisfying, while extrinsic factors were merely dissatisfying if not met. These approaches led to the entire field of job-redesign (Hackman, 1981) and self-managing work teams. The topics of motivating people and developing teams are considered in Chapters 4 and 5.

**Contingency Theory of Leadership**

By the mid-twentieth century, two schools of management thought had been established. One argued for greater structure, control, top-down decision making, and reliance on extrinsic rewards (Theory X); the other argued for more participative management, self-governance, bottom-up decision making, and reliance on intrinsic rewards (Theory Y). For decades these schools were often (but erroneously) viewed as polar opposites. Subsequent research conducted during the 1960s and 1970s (summarized in Bass, 1981) suggested the choice of leadership style is not either-or. Instead, the effectiveness of specific management approaches depends on key situational factors (see Chapter 2).

**Decision-Making School**

The **decision-making school** of management—also labeled the “Neo-Weberian” model (Perrow, 1986)—developed during the 1950s and 1960s, spearheaded by researchers at Carnegie Mellon University (Cyert and March, 1963; March and Simon, 1958; Simon, 1947). This school focused as much on how decisions were made and goals were set as on the structure of the firm—but all within a context with which Weber and scientific managers were comfortable: control of the work process and the worker.

In contrast to both scientific management and human relations management, the decision-making school focused neither on top executives or lower-level workers, but rather on the large cadre of middle managers that had developed inside the large firms of the mid-twentieth century. Such managers and their decisions needed to be controlled. Because of limits on managers’ cognition—known as **bounded rationality**—decision making needed to be guided by “satisficing” behavior (limited search among alternative options, and selection of first acceptable solution) and the use of “programs” and “routines” (e.g., solutions or problem-solving paths used before) (cf. Simon, 1947; March and Simon, 1958). Such approaches served as points of stability and biases against innovation by narrowing the strategic choices available to managers. Decision making was also organized and controlled through means-ends hierarchies, in which the goal (ends) of one layer of management (e.g., increase profits) became translated into sub-goals (means) pursued by the subordinate layer of management (e.g., raise revenues, decrease costs). They also presaged the “garbage can model” of decision making, in which solutions have a life of their own distinct from the problems they are called on to solve, and may behave as answers looking for questions to solve (March, 1994).

The decision-making school had entirely different views of worker motivation as well. Rather than viewing workers as...
extrinsically or intrinsically motivated, or having goals that were shared or divergent from the firm. Researchers described "inducements-contributions contracts" through which the firm and the worker engaged in exchange (Barnard, 1938). This had implications for the goals pursued by the firm. There was no necessary harmony or consistency in the goals pursued. Instead, firms could have multiple coalitions, each in pursuit of their own sub-goals. Conflict could thus exist internally, and conflict resolution was never complete. Agreement on firm goals was thus accomplished through bargaining and negotiation. This school of thought thus presaged more political theories of the firm, which viewed organizations not as unified hierarchies but as competing coalitions pursuing self-interests (see Chapter 7).

Finally, the decision-making school introduced several new themes in organization theory and analysis. Rather than overt supervision and control espoused in Taylorism and scientific management, this school emphasized more unobtrusive controls over managerial decisions and behaviors. These controls included: standard operating procedures (SOPs), decision-making routines, socialization and training, organizational vocabularies and communication, and uncertainty absorption strategies (e.g., techniques to filter, process, edit, classify, and restrict the flow of information inside the firm).

Institutional Theory

In contrast to the scientific management and classical administration schools, which viewed organizations as rational tools for achieving purposive goals, institutional theory viewed organizations as organisms that adapt to pressures from without and within. What are these pressures? Similar to the decision-making school, firms here are limited in their degree of rationality by both the environment (which can deflect the firm's purposes) and internal members (who bring their own goals and interests that may vary from those of the firm's).

According to Selznick (1957), the early proponent of this perspective, firms develop a distinctive character through a process of institutionalization: they take on a distinctive set of values, structures, and capacities as part of a natural history of development. Selznick's (1949) history of the Tennessee Valley Authority (TVA) illustrates its strategy of cooptation of local leaders to ensure the agency's survival long after its initial goals were met, but at the expense of some of the agency's own goals. In this manner, the firm becomes endowed with values and goals from its environment as well as its initial charter. The history of hospitals shows how board members initially endowed and financed many facilities in the late nineteenth century to support charity care. They then broadened the medical staff in the early twentieth century to include many community practitioners to attract paying patients. However, by virtue of their control over patient access and medical knowledge, the medical staff came to dominate decision making within the institution and broadened its goals from charity care to provision of quality care to the middle class and supporting the physician's private practice (Perrow, 1963). Indeed, Pauly and Redisch (1973) argued that hospitals became the de facto workshop of physicians during much of the twentieth century.

The institutional view received further impetus from the work of Meyer and Rowan (1977) and DiMaggio and Powell (1983). They outlined the normative pressures in the environment that constrained the choice of organizational form and other structural elements adopted by the firm, leading to similarities across firms. Such structural similarities were not enacted for efficiency reasons but rather for sake of conformity with prevailing norms and values of what represented appropriate modes of organizing. Burns and Wholey (1993) documented the impact of local networks of influence in promoting the diffusion of matrix management among hospitals; Arndt and Bigelow (2000b) documented the impact of such normative ideologies and pressures on hospital management during the past century; D’Aunno, Sutton, and Price (1991) described the impact of such forces on the organization of drug abuse treatment centers; and Ruef and Scott (1998) examined the characteristics affecting hospital legitimacy over a 55-year period.

Open Systems and Resource Dependence Theories

The idea that organizations exist within an environmental context, from which it must secure resources, support, and legitimacy in order to survive and operate, received a more complete explication in open systems theory (Katz and Kahn, 1966). The institutional theorists described one set of (normative) constraints on the firm's structures and behaviors imposed by environmental forces. Thompson (1967) extended the decision-making view and its attempt to deal with bounded rationality by describing organizations as "open
systems, hence indeterminate and faced with uncertainty, but at the same time as subject to criteria of rationality and hence needing determinateness and certainty” (1967). At lower levels in the organization, managers would seek to seal off the firm from its environment through a host of “uncertainty absorption” techniques. At higher levels, the firm embraced and actively sought to manage its interdependence with the environment.

Additional research conducted during the 1960s suggested that the effectiveness of specific management and structural approaches depended on the firm’s environment, technology, and critical tasks. Thus, a more bureaucratic or “mechanistic” approach is suitable when the environment is stable and the tasks are routine and well understood, while a less bureaucratic or “organic” approach is more suitable when the environment is turbulent and the tasks are complex and less well understood (Burns and Stalker, 1961; Woodward, 1967; Lawrence and Lorsch, 1967). Later researchers went further to suggest the bureaucratic and participative structures are neither opposites, nor a one-dimensional linear continuum, but rather two different dimensions on which firms and their management approaches may rest. That is, the most effective approaches are not “either or” but “both and” (Blake and Mouton, 1964; Misumi and Peterson, 1985; Collins and Porras, 1994; Johnson, 1996). Indeed, recent research emphasizes the importance of **ambidexterity** in organizational performance: e.g., firms that are both centralized and decentralized, firms that have units that are both mechanistic and organic in structure, etc. (Quinn, 1988; Tushman and O’Reilly, 1997; Beer and Nohria, 2000).

The open-system view of organizations (Katz and Khan; Thomson 1967) contained within it the seeds of **resource dependence theory**. In this model, organizations depend on other firms for critical resources and engage in strategies to protect themselves. Thompson described four elements in the firm’s task environment (customers, suppliers, competitors, and regulators) and the firm’s interdependence with its task environment and technology. Subsequent scholars (Pfeffer and Salancik 1978) described the firm’s effort to manage or strategically adapt to this task environment. This research suggested that organizations were not passive recipients of environmental change but actively sought to change their environments. Inter-organizational relationships (IORs) constitute one key adaptive strategy for managing this interdependence. IORs have become a major focus of corporate activity, and can take many forms, including horizontal mergers and vertical integration (see Chapter 10), strategic alliances (see Chapter 11), lobbying and managing regulatory demands (see Chapter 12), and managing community physicians (see Chapters 4 and 11). In this manner, organization theory began to confront the emerging field of corporate strategy and the strategic management perspective.

**Strategic Management Perspective**

The field of strategic management has evolved considerably since the 1960s, when it was dominated by the logic of top-down decision making, deliberate corporate rationality, and environmental stability. The field now encompasses at least three main schools of thought, many of which have their precursors in the schools discussed above. One school of thought emphasizes industry structure and competitive forces (Porter, 1980), similar to Thompson’s articulation of the task environment. A second school of thought emphasizes the firm’s distinctive capabilities and resources, building upon the decision-making school’s discussion of organization programs and routines (March and Simon, 1958; Barney, 1991). A third school emphasizes the firm’s relational capabilities and collaboration with upstream suppliers and downstream distributors and customers (Dyer and Singh, 1998). Such relationships can be developed with other constituents as well, including competitors, regulators, or other firms in the task environment. These schools are covered in depth in Chapter 10.

**Organizational Ecology**

The school of organizational ecology, or **population ecology**, is typically associated with the work of Hannan and Freeman (1977) and Aldrich (1979) but developed out of early sociological work conducted by Amos Hawley (1950) and his mentor Roderick McKenzie (1968) on organizational forms, competition among forms for resource space, and organization-environment covariation. Borrowing from a biological metaphor, organizational ecology principles suggest that the environment selects out and retains the most appropriate organizational form from an existing population of various forms (Baum and Amburgey, 2005). Such forms are selected out due to their superior ability to compete for and acquire scarce resources. In this school, the emphasis is on (a) the population of firms rather than the individual firm, and (b) changes in organizational populations due to variation, selection, retention, and competitive forces. In contrast to the institutional school, organizational ecology focuses on diversity rather than isomorphism. It also suggests that
environmental forces make managerial choice and discretion very important for organizational survival and growth.

Research on organizational ecology has tended to focus on the economic and social conditions that affect the number and diversity of organizations, and their changing composition over time (Baum and Amburgey, 2005). Thus, some common themes studied include conditions that explain organization foundings (entries) and failures (exits), organizational inertia versus momentum, and changes to organizational niches (generalist versus specialist firms).

This perspective has been quite helpful in understanding the transition among competing organizational forms in certain sectors of the health care industry. Researchers have identified the environmental conditions under which generalist and specialist hospitals will survive (Alexander et al., 1986), the environmental selection pressures in the hospital industry (Alexander and Amburgey, 1987), the impact of size on the failure rates of health maintenance organizations (HMOs) (Whooley et al., 1992), the transition from the original group-model and staff-model HMOs to the more prevalent IPA model (Whooley and Burns, 1992), and the transition of the hospital industry from a cottage industry to a more organized industry of 600 systems and networks (Bazzoli et al., 1999).

**Social Network Perspective**

Sociologists have long taken the social network approach in describing the embeddedness of human behavior in social relationships (Granovetter, 1985). As noted by the human relations school, these social networks can operate within formal and informal work groups to shape and constrain individual behavior. As noted by the institutional theorists, they can also operate at the inter-firm level to exert normative pressures on managerial choice and organizational structure.

Social network structure can be analyzed in two ways: in terms of interaction patterns and in terms of structural similarity (Knoke, 1990). The interaction approach emphasizes the consequences of interaction and the ability to control interactions because of a central role in the network. Actors who have relationships with one another are grouped together in a network. This network has certain dimensions. "Network centrality" refers to the actor’s linkage to others within the network who themselves are connected. "Strength of ties" refers to the frequency and intensity of interaction with others in the network; such ties can be direct or indirect (mediated by another). "Network density" refers to the number of different linkages between two or more actors (Uzzi, 1999); the greater the number of linkages, the more dense the network, and the more embedded the network’s actors. Such networks may have a greater capacity for transferring knowledge and facilitating learning across network members (Gulati, 1995; Uzzi, 1997). For example, opinion leaders on the medical staff have often been utilized by hospitals to influence adoption of new practices by their colleagues, just as manufacturers have used them to sway adoption of new products.

The structural approach, on the other hand, groups actors by the similarity in their relations with others. “Structural equivalence” refers to two actors who have no direct connection but have similar ties with others. “Structural holes” refer to networks of actors who are interdependent but are not interacting; the presence of such holes has been shown to retard innovation (Ahuja, 2000). Structural holes can become filled by a third party who mediates their exchange (Burt, 1992). For example, foundation grants established “community care networks” during the late 1990s to bring a variety of local health agencies and providers together to promote primary care and health promotion activities (Bazzoli, Stein, Alexander et al., 1997). Similarly, integrated delivery networks (IDNs) can fill the structural hole between independent physician groups who can jointly develop and implement care management practices (Shortell and Rundall, 2003).

Social networks are also important for understanding team functioning and performance. Medical clinics exhibit varying levels of information provision among their professionals depending on network centrality, density, and homophily (Whooley et al., 2009). Similarly, strength of ties with academic researchers and centrality in research and development collaboratives furthers the access of biotechnology companies to labor expertise and capital as well as to promising projects and future collaborations (Powell, Koput, and Smith-Doerr, 1996). Finally, research on innovation within medical device firms suggests that new ideas are more likely to emerge from heterophilous networks with weak ties (to generate variations) but are more likely to be widely adopted in homophilous networks with strong ties (Van de Ven, Polley, Garud et al., 1999).

**System Perspectives**

In recent years, management theory and health care professionals have developed a host of new system perspectives, focused on the broader system in which individual and organizational behavior occurs. Some of these perspectives have focused on
health systems broadly conceived. Hsiao and the World Health Organization have both developed models linking the major inputs, throughputs, and outputs of health care (see Figure 1.2). The Centers for Disease Control (CDC) has likewise developed their “Health Run” model of the determinants of health outcomes (Figure 1.3). Other models have been developed to encapsulate the delivery system portion of the health care industry. During the 1990s and the rise of IDNs, Shortell and colleagues described a conceptual model of system integration based on functional, physician-system, and clinical integration. Nelson et al. (2008) described the embeddedness of patients and clinical micro-systems that treat them within a larger network of mesosystems (collection of clinical microsystems treating a shared patient population) and the larger macrosystem.

Other system analogies rest on biological metaphors. For example, interactions of insects (e.g., termites or ants) can result in self-organized, coordinated teamwork characterized as “swarm intelligence” (Bonabeau and Meyer, 2001). Such interactions promote robustness, flexibility, and adaptability without the need for central control or local supervision. More broadly, firms can employ the “wisdom of crowds” (Surowiecki, 2004) via social networks with customers and innovators, collaborative software, wikis, and other information markets to develop collective intelligence and make better decisions (Bonabeau, 2009).

Such approaches are referred to as complex adaptive systems (or, alternatively, complexity science). They are complex in that they are composed of multiple, diverse, interconnected elements; they are adaptive in that they have the capability to change and learn from their experience (see Chapter 9). Thinking on complex adaptive systems has been applied to health care in the study of clinical pathway development (Priesmeyer et al., 1996), the nursing profession’s resistance to change (Begun and White, 1999), medication errors in hospitals (Dooley and Plsek, 2001), and innovations in health care delivery such as HIV/AIDS prevention and treatment and the structure and performance of IDNs (Begun, Zimmerman, and Dooley, 2003). In the broader management literature, thinking on complex adaptive systems has been widely applied to strategic change and implementation.

**Figure 1.3** Centers for Disease Control (CDC) “Health Run.”

**SOURCE:** Adapted from the Centers for Disease Control.
SUMMATIVE VIEWS OF ORGANIZATION THEORY

The various theoretical schools reviewed above should be viewed not as competing but rather as complementary approaches for understanding and managing organizational behavior. Collectively, they provide the practitioner as well as the researcher with a rich, diverse set of lenses or frames. Some schools clearly operate at distinct levels of analysis: e.g., Taylorism focuses on structuring the tasks of individual workers, the human relations and social networks schools focus on groups, the decision-making school focuses on middle managers, the Weberian and classical administration schools focus on top executives who structure the firm and its activities, while the resource dependence, population ecology, and institutional schools focus heavily on the external environment.

In addition to the different levels of analysis, the schools also suggest different strategies for changing organizations and different competencies that managers need to develop. Thus, Weber, the neo-Weberians, and the classical administration theorists focus on how to design organization structures and control (worker and managerial) behavior. Researchers in the human relations school focus heavily on motivating workers, satisfying employee needs, promoting quality of life at work, and managing conflict. Resource dependence focuses on the development of interorganizational relationships and market strategies the firm can use to control its environment, while the population ecologists and institutional theorists highlight the environmental forces (both ecological and normative) that constrain such use. Finally, the network and complex adaptive system perspectives highlight the importance of social networks—especially network structure and interactions—for generating and diffusing new ideas, forming bonds of solidarity, and promoting adaptability.

Applying Organizational Theory to Practices: Hospital-Physician Relationships

How might the perspectives and insights of these different schools be used together? We can illustrate this with a concrete example: executives’ efforts to foster improved hospital-physician relationships (HPRs). In what ways are these relationships tied to the delivery of value in health care? Studies from the 1990s suggest that excellent HPRs are tied to hospital profitability under the Medicare program (Bray, Carter, Dobson et al., 1994; ProPAC, 1992). The Health Systems Integration Study suggests that economic integration of hospitals and physicians forms part of the bedrock for improving clinical integration (Shortell, Gillies et al., 2000). Empirical evidence suggests that a handful of models of economic integration help to control cost and improve quality (Bazzoli et al., 2000; Burns and Muller, 2008; Shortell, Gillies, and Anderson, 1994).

From the Weberian perspective, executives might seek to resolve the dual-hierarchy in hospitals that has long divided the medical staff from administration, perhaps by creating a more unified organization. For example, in many academic medical centers, the two lines of authority over (a) the medical school and its faculty and (b) the hospital and its professional and ancillary departments have been consolidated under one individual—the medical school dean. Alternatively, there are calls today to reorganize the hospital medical staff and improve its governing structure to promote greater accountability for quality of care.

From a scientific management perspective, hospitals might more vigorously pursue efforts at clinical integration, such as developing and disseminating clinical guidelines, and monitoring their physicians’ adherence to them. Such efforts are believed to promote higher quality of care. They also serve to reduce unwanted variations in clinical practice, and to promote evidence-based medicine, in which health care professionals identify and apply scientific information in order to make clinical decisions.

Classical administration’s focus on organization design orients hospital executives to develop the most appropriate structures within which their clinicians work. As an illustration, during the 1990s executives erected multiple vehicles for partnering with physicians and contracting with managed care organizations. These included the physician-hospital organization (PHO), the independent practitioner association (IPA), the management services organization (MSO), and the integrated salary model (ISM). Each model offered a different level of professional autonomy and hospital financial support that catered to the individual physician’s needs and desires. More recently, hospitals have shifted away from their process/functional structures and developed new organizational designs based on purpose departmentalization. These are alternatively called service line management models, hospitals within hospitals, and centers of excellence. Following the dictates of the classical school, they decentralize authority.
for a clinical area, along with supporting personnel and/or ancillary functions, to physicians in that specialty area.

Following the human relations approach, hospitals have long engaged in efforts to include physician representatives on their board and give them the opportunity to express their voice in governing the institution. In addition, they have long conducted surveys of the medical staff to understand trends in physician morale, to identify sources of physician satisfaction and dissatisfaction with the hospital, and to elicit physician suggestions for change. More recently, some medical schools have begun training future physicians in areas such as teamwork and analysis of the health care system, partly to satisfy new requirements from the AMA’s Committee on Graduate Medical Education (COGME).

The decision-making school emphasizes the importance of unobtrusive controls to reduce discretion and shape the premises of decisions made by managers. Leading IDNs in the United States, such as the Mayo Clinic and the Kaiser Permanente Medical Groups, have long utilized an internally developed and inculcated corporate culture of teamwork to promote collaborative medicine. During the 1990s, some community-based hospital systems sought to emulate this approach by developing questionnaires to evaluate prospective new members of the medical staff in terms of their orientation to quality and efficient health care delivery. Other hospitals utilized clinical databases to develop practice profiles of their physicians; such profiles were then disseminated to the practitioners with the aim of steering them to more cost-effective practice patterns. Some went so far as to perform “economic credentialing” for prospective or current members of the medical staff.

HPRs are a domain in which strong professional forces (e.g., the logics, values, norms, and beliefs of the medical profession) confront a host of institutional and market forces (Alexander and D’Aunno, 2003). At one extreme, medical profession desires for open medical staffs have long competed with hospitals’ financial interests to exclusively contract with one group to cover hospital ancillary services (Burns, Goldsmith, and Muller, 2010). HPRs have also been shaped by strong institutional forces such as government reimbursement systems (e.g., diagnosis related groups or DRGs, bundled payment) that have led hospitals to engage their medical staffs in more cooperative decision making. Since the 1990s, the physicians’ professional interests have been subsumed under a series of market-based arrangements—in effect, reducing the traditional loose-coupling between the hospital and medical staff. These reflect “heteronomous professional organizations” (Scott, 1982) such as the PHO, IPA, and ISM models.

Open systems theory has been applied to hospital-physician relationships in several ways. During the 1990s, hospitals located in markets subject to intense managed care pressures (or the anticipation of managed care) were encouraged by consultants and academics to develop vertically integrated delivery networks; these could include the acquisition of primary care physician practices, medical groups, or specialist practices. Conversely, hospitals in markets characterized by low managed-care penetration were encouraged to focus on more traditional activities to work with their medical staffs (APM/University HealthSystem Consortium, 1995). Later thinking suggested that hospitals develop ambidextrous approaches for dealing with their medical staffs—in effect, being both hospital-centric and physician-centric at the same time. Some IDNs in the 1990s aspired to hospital systems that were organizations of physicians, or to promote clinical autonomy through the collectivization of physicians (Burns, 1999).

Following resource dependence theory, HPRs can be characterized as external strategies engaged in by hospitals to control inputs critical to their survival. Hospitals have traditionally depended on community physicians to refer patients to their specialists, to admit patients to their inpatient areas, and to provide specialty coverage in the emergency room. More recently, they have depended on physicians to assist in the provision of efficient care (to manage under DRGs or bundled payments) and quality care (e.g., under pay for performance programs). HPRs can be viewed as efforts to partner with community physicians in strategic alliances—in effect, developing interorganizational relationships—and co-opt the desired behaviors in a variety of economic exchanges. Alexander et al. (1996) described a host of physician-organization arrangements developed by hospital systems in the 1990s to ensure these critical physician inputs.

From the strategic management perspective, some types of HPRs reflect not only a strategy of securing critical inputs (similar to resource dependence) but also a deliberate effort to foreclose competitors’ access to those inputs. Thus, during the 1990s, hospitals engaged in a bidding war with one another and with physician practice management companies to acquire the primary care physicians in the local area. This acquisition strategy was viewed as a zero-sum gain: i.e., the physicians my hospital acquired would be loyal to my institution and
direct all of their referrals and admissions to my institution (rather than yours). HPRs thus represented a classic vertical integration strategy (Porter, 1980). A smaller number of hospitals and IDNs viewed HPRs as a platform for developing strategic capabilities and resources (e.g., cooperation with the medical staff, physician teamwork, physician leadership, etc) that could be applied to solving other business problems or pursuing other economic ventures.

Ecological analysis has not been widely applied to the analysis of HPRs. Nevertheless, the health care reform debates of 1993 and 2009 pointed to particular models of delivery as being the most efficient mode of organizing. In 1993, the Clinton health plan called for accountable care plans (consortia of providers) to contract with state-based health insurance purchasing cooperatives in risk-bearing contracts. The 2010 health reform encourages demonstration projects for accountable care organizations (again, consortiums of local providers—this time, community hospitals and the physicians that utilize them) to deliver on both cost and quality metrics in contractual, risk-based agreements with the Medicare program. Tightly coupled HPRs—such as the Cleveland Clinic, the Mayo Clinic, Kaiser Permanente Medical Groups, and the Geisinger Clinic—have been touted as the model for other providers to emulate.

Research applying social network analysis to HPRs has developed several important hypotheses (Shortell and Rundall, 2003). The “strength of strong ties” among physician organizations is associated with the success of HPRs in developing economic exchange and altruism. Moreover, as social linkages (both direct and indirect) increase in a network, the network becomes more embedded, thus facilitating more weak ties and the spread of information and cost-effective opportunities for learning. Centrality in HPR networks, the presence of organizations that can fill structural holes in the network, and the strength of ties linking the physician organization to the network will facilitate adoption and implementation of clinical process innovations.

Finally, Begun et al. (2003) utilize the complex adaptive perspective to analyze the Minneapolis-based merger of HealthSpan and Medica into the Allina Health System in 1994. Rather than focus on the explicit merger strategy and intent, the researchers analyze how the merger actually unfolded and how Allina’s strategy and structure co-evolved over time. They suggest that integration of entities would be more effective if they were allowed to “e-merge” rather than “be-merged.”

In a similar vein, Cappelli et al. (2010) attribute the ascendance of Indian firms in a number of industries, including health care, to managerial practices of improvisation and adaptability. Emergent business practices and models, rather than explicit strategies or even Western theories, have enabled Indian firms to develop solutions such as micro-insurance and low-cost hospital care for the poor to address the needs of the “bottom of the pyramid.” The researchers characterize these practices and models as “the Indian way” of learning by doing, and suggest they may serve as sources of learning and reverse innovation for Western organizations.

**ORGANIZATION THEORY AND BEHAVIOR: A GUIDE TO THIS TEXT**

The challenge for managers is to understand the complexity of the health care system (e.g., Figures 1.1 and 1.2), and the interests and roles of the different actors within it, and then determine which managerial perspectives discussed above can be usefully applied, at what level of analysis, and using what levers to address the value equation. Table 1.5 attempts to summarize this and describe where the book’s chapters tackle these issues.

The book is divided into three parts. This chapter and the next introduce the reader to the issues of leadership and management in health care. The next part considers the micro perspective: the internal environment of organizations. Topics taken up here include organization design, motivation, groups and teams, communication, power/politics/conflict, organization learning and innovation, and organizational performance, improvement, and change management. The last part of the book considers the macro perspective: the external environment of organizations. Topics here include strategy, strategic alliances, policy and regulation, information technology, consumerism, and forces shaping health care throughout the rest of the world.
CHAPTER 1 • The Management Challenge of Delivering Value in Health Care: Global and U.S. Perspectives

CASE: Can Organization Theory Inform Efforts to Improve Health Care Quality?

Improving the quality of health care has proven to be an elusive and difficult task. Health care organizations have experienced considerable difficulty in grasping all of the individual-level, team-level, organization-level, and system-level factors that shape quality. They have also been challenged to measure quality, to motivate providers to change their practices, and to implement quality improvement projects. The problems have been manifest in high rates of hospital readmission, high rates of preventable deaths and medical errors, uneven quality of care for people with inadequate insurance, and the introduction of new and expensive medical technologies without concomitant gains in life expectancy.

Questions
1. Does theory and research in management offer any guidance for practitioners seeking to improve quality of care?
2. What does each school of thought reviewed in this chapter suggest about what to do?
3. Which of the schools of thought seem to offer the most useful advice?

REFERENCES


