Healthcare Organizations in Transition

Practically everyone in America uses healthcare, or has a close associate who uses healthcare, in any given year. It is personal and sometimes frightening, but it lengthens our lives and makes them more comfortable and more enjoyable. It is also very complicated and very expensive. Healthcare is delivered by about 150 different licensed or certified practitioners, many of whom require substantial amounts of capital equipment. On the average, healthcare consumes nearly $6,000 per person per year, about one-sixth of our income, more than education, defense, welfare, pensions, and justice.\(^1\) About 20 million individuals each use several tens of thousands dollars worth of healthcare in a single year.

Such a large expense must be financed somehow; an unexpected burden of tens of thousands of dollars is beyond almost every family’s resources. Healthcare is financed by several insurance-like mechanisms, using employment benefits and both state and federal tax support. The complexity and the financing mechanism diminish the usual market forces that control cost and quality, creating a complex set of social and personal problems.

Forces for Change in Healthcare

In addition to its complexity and cost, healthcare also changes rapidly. Technology, demographics, economics, and politics drive the change, not only as individual factors but also by interacting with each other to make the rate of change faster. A trip to the doctor’s office today is noticeably different from a few years ago; a trip to the hospital is even more strikingly changed. Technology develops new drugs, tests, and procedures each year. The population is older and needs more services. These are not new forces. Technological change in healthcare has been important for over a century, and the population has been aging since public health reforms and immunization campaigns around 1900. These trends have generally accelerated in recent decades. Technology is stimulated by the continuing federal support of research through the National Institutes of Health. Partly as a result of successful healthcare, larger numbers of people are living to old age, when they need increasing amounts of care.\(^2\)
Economic and political forces for change arise from the high cost of healthcare and the complex methods of financing it. By 1990, the cost of healthcare had been rising rapidly for more than two decades, substantially exceeding the general rate of inflation or the rate of growth of the economy. Federal and state governments found the cost of healthcare eroding their available funds, and employers saw the health insurance benefit reducing their profits. In the 1990s, both acted strongly to curtail the growth of healthcare cost. The issues were value (service received for dollar spent) and access (who can count on and who is denied financial assistance). Earlier this decade health expenditures once again began to rise from about 13 percent of the gross domestic product in the 1990s to 15 percent of the gross domestic product in 2003, although by 2005 healthcare costs appear to have stabilized.

Political pressures mounted from those dissatisfied with the price and from the specter of growing numbers of uninsured citizens. At the federal level, Congress tied Medicare hospital prices to the federal budget increases and restructured Medicare doctors’ fees. Healthcare reform was intensely debated in 1994. The debate reinforced the pressures on Medicare, the largest government program, and stimulated the development of managed care for Medicare, Medicaid, and employer-assisted health insurance. Managed care became the term for a broad range of changes in the financing mechanisms for healthcare that transfer the costs back to providers (e.g., physicians and hospitals) and to users (i.e., patients and their families). Health maintenance organizations (HMOs) and other new forms of insurance introduced new processes and systems designed to eliminate unnecessary costs and, in many cases, to improve quality and acceptability of service. (Bold-faced words throughout the text are defined in the Glossary, see page 633).

Healthcare providers found themselves pressed to eliminate expenditures, demonstrate their quality of care, and improve their responsiveness to patient needs. Comparisons to competitors and to benchmarks, the best-known performance for similar processes, became routine, as employers, government agencies, and families began to look for lower-cost options. Many community hospitals and their physicians responded with far-reaching reorganizations. Healthcare organizations (HCOs), also called health systems and integrated delivery systems, arose to meet the economic and political pressures. The reason for the existence of HCOs is to address those problems—to ensure that citizens of a community can gain access to healthcare services they need, at a high quality and at an acceptable price.

The leaders in reorganization efforts soon learned that the solution lies in extensive revision of the way healthcare is delivered, with particular attention to how the parts fit together. Traditionally, most physicians worked alone or in small partnerships. They were supported by about 6,000 hospitals, mostly managed by citizens of local communities. Other professions and organizations—podiatrists, psychologists, drug stores, nursing homes, and
home health agencies, for example—were even less integrated. Critics called the situation the “nonsystem” of healthcare and “the last cottage industry.”

At the same time, a few HCOs had demonstrated that they can deliver care that is acceptable to large numbers of Americans, at a cost and a rate of cost increase that are significantly lower than the overall numbers. These organizations have a different style of relationship between the physician, the organization, and the patient, emphasizing cooperation to improve cost and quality. Many of them also have a different health insurance relationship with the patient or the employer, owning their own insurance operation and emphasizing cost management in their insurance. But these organizations have been in existence for 50 years or more. They have not been universally popular anywhere, and they have not always succeeded in new locations. It is clear that HCOs will not meet their goals by cloning the prototypes indiscriminately.

**The Premise of “The Well-Managed Healthcare Organization”**

The demands of the marketplace are central to the future development of HCOs. The clearest demand is the ability to control quality and cost of services. Public concern with the quality of care is mounting, and more Americans are convinced that better quality is better value, not necessarily more expensive. In the influential report of the Institute of Medicine Committee on Quality of Health Care, the goal is clearly stated: Healthcare should be “safe, effective, timely, patient-centered, efficient, and equitable.” The report documents a substantial shortfall and is a call to action for improvement. A second demand is for expanded financing. Strong pressures have developed to expand coverage of office and home care, mental illness, preventive services, and drugs. While most HCOs provide these services, the change to insurance-based payment stimulates new demands to integrate and improve these services.

Well-managed HCOs will meet these demands. They will start from and improve on historical models, blending acute inpatient care with new structures for outpatient care and prevention. They will offer the patient a comprehensive array of services, beginning with prevention and routine care at the doctor’s office and going through specialized intervention and surgery to rehabilitation and continuing care. They will emphasize their ability to integrate this continuum of care at higher levels of quality and satisfaction with service and value. The best will make health, rather than healthcare, their product.

Similar transitions have occurred historically in many other industries. As the business historian Alfred Chandler has noted, the shift is frequently to greater value, not just to lower cost. Greater value usually involves a transfer of responsibilities originally left to the market or the buyer to a more comprehensive organization better equipped to fulfill them. Often the new organization’s contributions are in coordinating, integrating, or improving the uniformity of the product or service. It achieves the improvements by
designing new technology or new applications. 12 So it will be in healthcare. Instead of individual arrangements with several different doctors and facilities, many Americans will choose HCOs that deliver comprehensive services for competitive package prices.

The transition will go on for decades. New models are sure to be developed. Traditional models may have surprising longevity. But the winners will integrate a broad spectrum of prevention, ambulatory care, acute care, chronic care, and end-of-life care and will work much more closely with insurance and healthcare financing agencies.

The record of the leaders indicates that success will require the improvement of basic processes by which care is delivered, ensuring the best clinical plan for each patient’s condition, flexibility to accommodate varied needs, and responsiveness to the needs of caregivers and workers as well as patients. 13

This book describes the well-managed HCO in terms of those processes. In the jargon of continuous quality improvement, it is an effort to document “best practice” on the processes critical to organizational survival—those that have to work for the organization to succeed. The processes design services, allocate resources, attract patients, ensure quality, and recruit healthcare professionals. They are described in terms of three major system groups: (1) governance and the executive, (2) caregiving, and (3) the learning system that supports the continuous improvement necessary for competitive survival.

The emphasis is on integrating these processes and their components into an effective whole. The approach is to identify what each component must do to allow the others to work effectively. That is, a caregiving organization must have processes that speed communication about patient needs; select adequately prepared professionals; allow consensus-building discussion of new methods; provide competitive compensation; and deliver the patients, tools, caregivers, and supplies to the right place at the right time. Similarly, governance must decide how big the organization will be, what markets it will serve, what kinds of caregivers it will need, and how it will affiliate with these caregivers. The governance and caregiving decisions are based on analyses prepared by planning, marketing, finance, and information processes and implemented through human resources and plant services.

The models for the processes are drawn from the experience of leading institutions—those that have built a record of both financial and market success. They are likely to be the best known practices; they almost certainly are not the best possible practices. They are under continuous improvement at the institutions that developed them, and competitors may make breakthroughs that surpass these practices. At the same time, the processes as described are consistent with the experience of many thousands of organizations in a variety of fields beyond healthcare. They build on what are now well-established theories of organizations, particularly that the organizations themselves are voluntary associations of people formed to achieve ends they cannot achieve.
Chapter One: Emergence of the Healthcare Organization

as well alone and that organizations function best when they focus deliber-
ately on identifying and meeting the needs of both their customers and their
workers. It is a fair statement that no system or process is fully described.
Whole books, indeed libraries, of information relevant to each system are
omitted by necessity. A modest start on the omissions is provided in the
“Suggested Readings” at the end of each chapter.

The Building Blocks: Healthcare Organizations

HCOs arise from two ancient and deeply valued social traditions. One is the
hospital, the place of shelter for the sick or needy. The other is the physi-
cian, or healer, the individual who possesses special talents to promote health.
These traditions have occurred in most civilized societies, changing over time
and place as needs and opportunities changed. The new HCO can be said to
be only the latest implementation of the tradition; it is unique in that it goes
further than almost any predecessor in intertwining both concepts. It also is
evolving new relationships with the other two parts of modern healthcare—a
group of associated industries that provide services to patients and health
insurance organizations that are essential to finance such a large portion of
personal expenditures.

Hospitals
The idea that a society or community should have a special place to care for
the sick and needy is almost as ancient as the “healer” tradition. It is refer-
enced in the earliest writings of major civilizations and is found in some form
in every modern society. It found root in the United States before the Revo-
lution, when Ben Franklin founded The Pennsylvania Hospital in 1760,14
and the new federal-government-constructed hospitals in several other cities.
The initial role for these hospitals, and for other hospitals before the late
nineteenth century, was to provide a safe place for the ill or impaired to live.
Those who had homes did not use hospitals. The visit of the doctor was nor-
manly to the home; he often volunteered his time at the hospital and came
only to care for the sick poor.15

Only after the explosion of medical knowledge did the hospital become an
essential partner for the physician. The hospital’s ability to provide capi-
tal equipment and trained personnel made it important. By the twentieth
century, advances in surgery required radiology and laboratory diagnostic
facilities, operating theaters, trained nurse assistants, anesthesiologists, and
postoperative care. Around the beginning of the century, some doctors at-
tempted to provide these on their own in proprietary hospitals. It soon be-
came clear that not-for-profit community hospitals had both capital-raising

The Rise of Hospitals as Community Resources
advantages and market advantages, given that the facilities could be used by many surgeons without the necessity for organizing the surgeons themselves.

As healthcare became more complex, the not-for-profit hospital continued to finance the heavy capital investments, providing facilities and equipment that were paid for by the community and available to all qualified practitioners. It recruited or trained support staff, pooling demand from many doctors who affiliated with it to provide work for a growing number of healthcare professions and technician groups. After World War II its role was recognized in the Hill-Burton Act, federal legislation that assisted hundreds of communities to build not-for-profit hospitals. Also principally in the post–World War II era, hospitals began to maintain procedures and systems that monitored quality not just among the healthcare professions they employed but also among doctors who affiliated with them while maintaining private practices. These three elements—financial capital, human capital, and quality management—constitute an organization of healthcare.

By the 1980s, 6,000 community hospitals served as society’s longest-standing commitment to organizing healthcare. At their peak, about one in ten citizens became inpatients every year, and many others visited emergency rooms or outpatient services. Hospitals consumed almost half the total healthcare expenditure. They were found in all but the smallest villages across the nation. In each community, they were the largest resource of facilities and equipment, far outstripping the investment of individual practitioners. They were, and they remain, the leading employers of many of the healthcare professions, including physicians. They provide systems and procedures that are essential to high-tech medicine. Most importantly, both the courts and the national organization recognizing good management—the Joint Commission on Accreditation of Healthcare Organizations—have established the hospital as the principal vehicle to control the quality of the healthcare transaction.

Hospitals in the United States are owned by a wide variety of groups and are even occasionally owned by individuals. Most hospitals are community hospitals, providing general acute care for a wide variety of diseases. There are three major types of ownership:

- **Government hospitals** are owned by federal, state, or local governments. Federal and state institutions tend to have special purposes such as the care of special groups (military, mentally ill) or education (hospitals attached to state universities). Local government includes not only cities and counties but also, in several states, hospital authorities that have been created from smaller political units. Local government hospitals in large cities are principally for the care of the poor, but many in smaller cities and towns are indistinguishable from not-for-profit institutions. Both are counted as community hospitals. State **mental hospitals** and federal hospitals are not classed as community hospitals.
• **Not-for-profit hospitals** are owned by corporations established by private (nongovernmental) groups for the common good rather than for individual gain. As a result, they are granted broad federal, state, and local tax exemptions. Although they are frequently operated by organizations that have religious ties, secular (or nonreligious) not-for-profit hospitals constitute the largest single group of community hospitals both in number and in total volume of care, exceeding religious not-for-profit, government, and for-profit hospitals by a wide margin.

• **For-profit hospitals** are owned by private corporations, which are allowed to declare dividends or otherwise distribute profits to individuals. They pay taxes like other private corporations. These hospitals are also called investor owned. They are usually community hospitals, although there has been rapid growth in private psychiatric and other specialty hospitals.17 Historically, the owners were doctors and other individuals, but large-scale publicly held corporations now own most for-profit hospitals. **For-profit hospitals** grew rapidly in the 1970s, and again in the 1990s, but never accounted for more than 15 percent of all hospitals. They are much more common in some southern states and can be a major factor or the sole institution in some communities.

Figure 1.1 shows community hospital statistics compiled by the American Hospital Association (AHA). Because the AHA plays a major role in collecting statistics about hospitals, its classification system is used for most purposes.18 Several measures of volume are shown in the figure, in addition to the number of institutions in each ownership class. Beds, admissions, and expenses can be used to classify hospitals by size. Discharges, which are virtually identical to admissions in the course of a year, and revenue, differing from expenses only by profit or loss, are also used.

Most U.S. community hospitals are small, but as Figure 1.2 shows, larger hospitals provide most of the service. The trend has been for smaller hospitals in urban areas to disappear. They either go out of business or are acquired by larger institutions. In rural areas, there is still a need for a convenient primary care facility, but the role of inpatient care in that facility has diminished. Many hospitals in rural areas have changed to exclusively outpatient services.19

Both for-profit and not-for-profit ownerships are sometimes referred to as private to distinguish them from public, or government, hospitals. However, as a consequence of their commitment not to distribute profits or assets to any individual, not-for-profit hospitals are legally dedicated to the collective good. Thus, for the vast majority of community hospitals in the United States, the owners, in the sense of beneficiaries, are the communities they serve. The corporation holds the assets, including any accumulated profits, in trust for the citizens of the community.
In part because of the trust relationship, but perhaps in larger part because of the need to be responsive to the same market opportunities, ownership of community hospitals is rarely critical in its overall management. Many hospitals owned by local governments are indistinguishable from not-for-profit hospitals in similar settings. Except for having the obvious right to distribute dividends and the obligation to pay taxes, for-profit owners function similarly as not-for-profits owners. In the courts, government hospitals are generally held to slightly higher standards of public accountability and conformity to the U.S. Constitution. Because they must honor any citizen’s economic rights and religious freedom, government hospitals have open medical staffs and respect staffs’ constitutional guarantees of freedom from participation in religious activities. Private hospitals are obliged simply to use due process and not to discriminate on grounds of age, sex, race, or creed. Religious versus nonreligious not-for-profit owners appear to have little difference, but religious owners may provide more services to vulnerable populations and services that represent fidelity to a larger religious social ministry.\textsuperscript{20,21}

Given the narrow range of these distinctions, it is not surprising that studies of the effectiveness of various types of ownership rarely reveal major differences.\textsuperscript{22,23} How well a hospital carries out the process of market assessment and program development depends much more on who manages it and how

<table>
<thead>
<tr>
<th>Ownership</th>
<th>Number</th>
<th>Beds (ooo)</th>
<th>Admissions (ooo)</th>
<th>Expenses ($000,000)</th>
<th>Personnel (ooo)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nongovernment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not-for-profit</td>
<td>2,967</td>
<td>568</td>
<td>25,757</td>
<td>359.4</td>
<td>3,077</td>
</tr>
<tr>
<td>For-profit</td>
<td>835</td>
<td>113</td>
<td>4,599</td>
<td>49</td>
<td>406</td>
</tr>
<tr>
<td>State and local governments</td>
<td>1,117</td>
<td>128</td>
<td>4,730</td>
<td>72.9</td>
<td>666</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>4,919</td>
<td>809</td>
<td>35,086</td>
<td>481.3</td>
<td>4,149</td>
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</table>

<table>
<thead>
<tr>
<th>Ownership</th>
<th>Number</th>
<th>Beds</th>
<th>Admissions</th>
<th>Expenses</th>
<th>Personnel</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nongovernment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not-for-profit</td>
<td>60</td>
<td>70</td>
<td>73</td>
<td>75</td>
<td>74</td>
</tr>
<tr>
<td>For-profit</td>
<td>17</td>
<td>14</td>
<td>13</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>State and local governments</td>
<td>23</td>
<td>16</td>
<td>14</td>
<td>15</td>
<td>16</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
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*SOURCE:* Reprinted with permission from American Hospital Association. 2006. *Hospital Statistics, 2006 Edition,* Table 1, pp. 4–5. Chicago: AHA. Published by Health Forum LLC.
well than on who owns the property. A community hospital can be successful under any ownership if it is effectively managed. The most significant difference is that the results of that success accrue to a community in the case of not-for-profit hospitals and to the stockholders in the case of for-profit hospitals. Healthcare systems integrating several hospitals may have an advantage. The range of necessary skills and experience is much broader in a system, and if these virtues can be translated to more effective management, systems will thrive where individual institutions fail. But, as in the comparison of for-profit and not-for-profit ownership, evidence of their superiority is not easy to develop.

Hospitals began a consolidation movement away from independently owned organizations and toward multiunit organizations in the 1980s that reached its peak about 1995 and has continued slowly since then.

There are two major forms of a multiunit organization. Alliances, or networks, are interorganizational strategic contracts between independently owned organizations. They allow members to disaffiliate relatively easily and...
quickly. As a result, the central organization can undertake only activities that the entire body consents to, even though all members do not participate, thus severely restricting its scope and flexibility. Purchasing associations are enduring forms of alliances. Joint ventures—where two or more corporations share ownership in a new corporation—are a form of alliance. Some alliances are inherently transient: either they evolve toward more centralized structures or they disappear.26

**Health systems** are organizations that operate multiple service units under a single ownership.27 Systems are much harder to dissolve and are generally intended to be permanent. The owners can exercise substantially more control over individual units. Systems can be created as mergers (where two corporations are merged into a third), acquisitions (where one corporation purchases another), or holding companies (where a new corporation acquires the assets of earlier ones but keeps them in operation).

As Figure 1.3 shows, about 334 healthcare systems were operating in 2005. Two-thirds of all hospitals, with 65 percent of beds, are now part of healthcare systems. Only about 16 percent of all hospitals are unaffiliated, either by network or by system.

Geographically scattered systems have a **market share** in each of many different healthcare regions. Many of the Catholic healthcare systems follow this model. The original for-profit corporations also followed this model, building small hospitals in a large number of cities stretching across the Sunbelt. Geographically focused systems attempt to capture substantial market share in one or a small number of geographic areas. They are often formed by merger or acquisition of previously independent institutions. Many of the larger systems following this model are also closely affiliated with health insurance organizations. Kaiser Permanente, by far the largest healthcare system in the nation, has replicated the geographically focused model in many different sites. Several other large systems are geographically focused in one or a few sites, such as Intermountain, which serves most of Utah and parts of adjacent states; Mayo,
with operations in Minnesota, Arizona, and Florida; Henry Ford in southeast Michigan; Sentara in eastern Virginia; and Geisinger in Pennsylvania. These focused systems and some of the Catholic systems have generally thrived in recent years, and many of their processes are models for this text.

**Physicians**

The notion of the healer with special powers can be traced to the witch doctor or shaman of prehistoric civilizations. Early healers provided herbal remedies, surgical intervention, and psychological support for patients and families. Their knowledge and skills were extensive, and some treatments remain in use today. Traditional medical knowledge occurs in the early writings of both eastern and western civilizations. Hippocrates began the codification of disease and treatment for western civilization in 260 BC. A long line of clinical investigators added slowly to Hippocratic knowledge.28

In the mid-nineteenth century, the discovery of anesthesia and the germ theory of disease greatly extended surgical opportunities. An explosion of surgical capability continued through the twentieth century. Beginning in the 1930s, vastly more effective pharmaceuticals were discovered for anemia, diabetes, and a wide variety of infectious diseases. In the later decades, immunizations for many serious epidemic diseases were developed and oral contraceptives became available. Radiologic, other imaging, and chemical diagnostic methods were perfected. Endoscopic diagnosis and treatment—direct visualization and manipulation of internal organs through small surgical incisions—became commonplace near the end of the twentieth century.

The rapid increase in knowledge was paralleled by a restructuring of medical education and the development of medical specialties. Although physicians are licensed by state governments to practice any form of medicine or surgery, the vast majority now practice in only 1 or 2 of more than 30 different specialties. Certification for these specialties is provided by a system of specialty boards that supervises training programs, maintains lifelong periodic examinations, encourages research and publication in their area, and stimulates continuing education for their members.29 Specialty certification is rapidly becoming a condition for practice, especially in organized medical settings.

The specialties can be grouped several ways, but the most useful for the purposes of HCOs may be that which emphasizes four main divisions—**primary care**, medicine, surgery, and diagnosis. Primary care physicians hold themselves out as the first point of contact for the patient; they are doctors who can diagnose and treat most problems and select appropriate specialists for the balance. The latter three groups, called **referral specialties**, receive many or all of their patients on referral from other physicians. Figure 1.4 shows a list of selected physician specialties in active practice in the United States. It also shows the number of multiple specialties reported by individual
physicians and the number of physicians not certified by any board. Two important generalizations are supported by Figure 1.4. First, most physicians are now certified. Second, about half are certified in primary care and half in the referral specialties. In 1999 the Council on Graduate Medical Education, an advisory group to the federal government, noted that despite the warning of a surplus made 20 years previously, only limited progress had been made in reducing the growth of the U.S. physician supply,\textsuperscript{30} with shortages projected among some specialty groups.\textsuperscript{31,32} Shortages of primary care physicians appear to have been met in part by expanding roles and availability of physician substitutes such as nurse practitioners.\textsuperscript{33}

The actual practice of the physician specialties is different on almost every dimension. Some physicians (e.g., rheumatologists) practice principally by evaluating and understanding the course of disease, while some (e.g.,...
orthopedic surgeons) make dramatic interventions with elaborate technology. Some (e.g., pathologists) rarely communicate with patients as individuals, while others (e.g., anesthesiologists) relate to patients almost incidentally in the course of treatment; still others (e.g., psychiatrists) must establish an intimate ongoing relationship. Some (e.g., hospitalists and intensivists) cannot practice outside the hospital, while others (e.g., family medicine practitioners) rarely use the hospital.

There is also a substantial difference in earnings. Until the 1990s, primary care doctors earned less than half the income of those who rely on the most expensive technology, although today that gap is narrowing. Not surprisingly, there are also substantial differences in temperament, lifestyle, and values between specialties as well as between individuals.

Figure 1.5 shows the distribution of U.S. physicians by type of practice as of 2003. The majority of those in office-based practice were in small single-specialty groups or independent practice, and most of the financial arrangement was in individual fees. While it would be wrong to say these forms are not organized, they are small organizations with limited capability. The larger, more organized models of medical practice included the following:

- Multispecialty group practices open to fee-for-service and HMO financing, such as the Mayo Clinic and Henry Ford Medical Group
- Group practices limited to HMO financing, such as Kaiser Permanente
- Independent physicians associations organized to allow doctors practicing independently for fee-for-service financing to collaborate to serve managed care contracts
- Physician-hospital organizations, including hospitals or health systems and physician organizations and those generally accepting both fee-for-service and managed care financing

<table>
<thead>
<tr>
<th>Practice Arrangement</th>
<th>Number (000s)</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office-based practice</td>
<td>530</td>
<td>70</td>
</tr>
<tr>
<td>Hospital-based practice</td>
<td>62</td>
<td>9</td>
</tr>
<tr>
<td>Residents and fellows</td>
<td>100</td>
<td>14</td>
</tr>
<tr>
<td>Teaching, administration, and research</td>
<td>41</td>
<td>6</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total active physicians</strong></td>
<td><strong>737</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

* Excludes osteopathic physicians

• Government programs, such as the Army and the Veterans’ Administration
• University medical school faculties

Other Healthcare Providers
Hospital employees and physicians provide about two-thirds of all healthcare. The balance is provided by a wide variety of other practitioners and organizations.

About 50 professions other than physicians provide health services to patients. The list of professions reported by the U.S. Department of Labor is shown in Figure 1.6. Most are licensed or certified by state agencies and have professional associations, providing evidence of appropriate training. They work as employees in hospitals, clinics, and nursing homes, but many also practice independently under fee-for-service compensation. As insurance becomes more comprehensive, the trend is for these professions to move toward employment in healthcare corporations. The greater the interaction between the profession and other forms of care, the faster this movement is likely to be. For the patient, integration offers increased assurance of quality, greater convenience, and reduced danger of confusion or conflict between caregivers. For the insurer or HCO, integration improves cost, quality, and utilization control.

Also paralleling the growth of medical technology, many other sources of care emerged in the twentieth century. They include public clinics, nursing homes, pharmacies, specialty hospitals, home care programs, home meal programs, hospices, and durable medical equipment suppliers. Many of these are affiliated with general hospitals and clinics, but many operate as independent entities. Most are small businesses operating in a single community. Some, such as the for-profit nursing home chains, are multistate corporations. The public clinics are generally operated by local government. In addition to these identifiable businesses, there are voluntary organizations and support groups that provide substantial healthcare; Alcoholics Anonymous is the oldest and one of the most successful.

Many of these care organizations became important industries themselves, while remaining a relatively small part of the total expenditure for healthcare. The prescription drug industry is a useful example. The amount spent per person per year mounted from $25 in 1970 to $359 in 1999 to about $600 in 2005. The increase paid for antibiotics; oral contraceptives; anticoagulants; hypertensive agents; vaccines for polio, measles, and whooping cough; and cancer drugs. Drugs are produced principally by a few large multinational companies and are distributed principally by hospitals and 50,000 licensed pharmacies. Although many pharmacies were independent small businesses, retail drug chains began rapid growth in the 1970s and by
2005 provided 75 percent of the nonhospital market. Drugs provided in the hospital were covered by early private health insurance plans. Traditional Medicare and private health insurance programs did not cover outpatient drugs, but managed care plans and Medicare supplements generally did. The Medicare Modernization Act of 2004 enabled prescription drug availability under Part D benefits.

The nursing home, home care, and hospice industries have important parallels to pharmacies. They generate commercial opportunities for small local businesses and national supply corporations. The local businesses are often acquired by larger, publicly listed stock companies who form geographically scattered systems. These seek economies of scale by mastering the details of

### Table 1.6

<table>
<thead>
<tr>
<th>Healthcare Professions Other than Physicians, 2004</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number (000)</strong></td>
</tr>
<tr>
<td>------------------</td>
</tr>
<tr>
<td>Providing general care</td>
</tr>
<tr>
<td>Licensed practical and vocational nurses</td>
</tr>
<tr>
<td>Physician assistants</td>
</tr>
<tr>
<td>Registered nurses</td>
</tr>
<tr>
<td><strong>Total</strong></td>
</tr>
<tr>
<td>Providing care limited to specific organs or diseases</td>
</tr>
<tr>
<td>Chiropractors</td>
</tr>
<tr>
<td>Dentists</td>
</tr>
<tr>
<td>Optometrists</td>
</tr>
<tr>
<td>Podiatrists</td>
</tr>
<tr>
<td>Psychologists</td>
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<td>Social workers</td>
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<td>Providing care limited to specific modalities</td>
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<td>Dietitians</td>
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<td>Electroencephalograph technologists</td>
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<td>Emergency medical technicians</td>
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<td>Laboratory technologists</td>
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<td>Respiratory therapists</td>
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<td>Speech language pathologists and audiologists</td>
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<td><strong>Total</strong></td>
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The Well-Managed Healthcare Organization

care delivery and supporting local operations with training, supplies, and capital. Some HCOs offer these services as well, but independent, geographically scattered organizations tend to dominate.38

Health Insurance Organizations

Modern healthcare can be financed only in the context of health insurance or related risk-sharing mechanisms. Most Americans have a mechanism to finance their healthcare. Most working families receive health insurance as an employment benefit. The aged participate in Medicare—a universal government health insurance—and most of them have supplementary private insurance. Some, but not all, poor receive Medicaid—a state and federal insurance. A few people purchase health insurance individually or through groups other than through their employment. Coming from so many different sources, it is not surprising that insurance varies widely in the details of the protection it provides or that some people fall through the cracks. About 15 percent of the population has none of these mechanisms, and an equal number of people have insurance that is inadequate for their needs.

The coverage itself is administered by about 2,000 different companies. A much smaller number are economically important in geographically specific marketplaces. These are mostly large HMOs, Blue Cross and Blue Shield Plans, and commercial insurance companies that administer many different kinds of programs for employers and government. Technically, many of these programs are not insurance because the employer or the government accepts the financial risk for the group in question and the health insurance organization acts as intermediary, seeing that care is provided according to the contracts and paying the providers. Medicare is the largest single example. The federal government holds the insurance risk, through the Medicare Trust Fund. Intermediary insurance companies administer the plan in each state. There are often two intermediaries, one for Part A (covering mostly hospital expenses) and one for Part B (covering medical and other practitioner expenses). Similar complexities describe the private market. Large employers often self-insure their groups; they frequently turn to intermediaries to administer the healthcare benefit.

Health insurance companies initially identified their function as bearing risk, marketing, subscriber billing and service, and claims payment. They often avoided any selection of providers and accepted the providers’ judgment on both appropriate treatment and fair price. The Medicare Act Preamble, which called for “reasonable costs” to pay hospitals and “usual, customary and reasonable” fees for physicians,39 was widely accepted as a model. Traditional health insurance still fulfills these functions. Under pressure to improve cost performance, managed care plans added negotiation of fees and various mechanisms to ensure quality and minimize cost. The large intermediaries offered these and even pioneered their development so that they now offer a
range of products and services, from traditional health insurance to HMOs, with several risk-sharing alternatives.

However necessary it might be, insurance itself contributes to the increase in costs. Insurance divorces the payment mechanism from the point of service and removes the economic consequence of decisions by both the caregivers and the patients. When the premium is paid by employers and is subject to tax preferences, the consequence is doubly or triply removed. The issue is how to design insurance that simultaneously provides the necessary financial protection and minimizes the inflationary consequences of the divorce.

Devices to achieve cost control have become increasingly sophisticated in the past 20 years, since the passage of the HMO Act in 1973. They fall into five major categories.

1. **Limits on premium covered.** Many employers are moving to defined-payment programs that will also require employee premium sharing. Large companies typically offer an array of alternatives at different premium levels, with a defined contribution toward the premium.

2. **Limits on payment.** To patients: **Deductibles** delay insurance participation until a specific amount has been spent by the patient, and **copayments** put the patient at some financial risk at each step of care. The deductible is a standard feature of catastrophic or major medical insurance contracts, where it serves to rule out routine medical expenses. Copayments are often a feature of indemnity insurance, which pays cash benefits for specific services received, up to a limited amount for each healthcare event. They are also used in HMOs to reduce premiums or discourage unnecessary or inappropriate use.

   To providers: Fee-for-service payment to providers is discounted below what is perceived to be the market rate. This approach has been routine in Medicaid and is used in managed care financing. Medicare payments to hospitals and physicians were restricted by Congress in the 1990s.

3. **Limits on provider selection.** Healthcare financing plans limit the patient to a panel of providers approved in advance. **Preferred provider organization** and HMO contracts are designed to favor more economical providers, but they have received limited support in the marketplace. **Point of service** (POS) plans offer unlimited choice of provider, with substantial financial incentives for the patient to use panel providers.

4. **Provider risk sharing.** Risk-sharing plans use financial devices to encourage providers to eliminate unnecessary services. They include bundled prices such as diagnosis-related groups, where payment is based on the patient’s condition rather than what was done for each patient. They also include a variety of payment mechanisms such as...
withholding a fraction of the payment to distribute if utilization targets are met or providing other incentives for meeting targets.

In its most advanced form, risk sharing pays providers capitation—a fixed dollar amount for each month the patient remains under contract. This requires an explicit selection of provider by the patient, even though the patient may not seek care at all. The provider, usually a hospital-physician group combination, accepts full risk for managing the patients’ care. Capitation has proven unattractive to physicians and patients alike.

5. Pay for Performance. Pay for performance (P4P) is used by a growing number of private and public payers as a means to improve the health of patients and to foster new behaviors from physicians.42 P4P initiatives are a collaboration with providers and other stakeholders to ensure that valid quality measures are used, that providers are not being pulled in conflicting directions, and that providers have support for achieving actual improvement. While P4P is a means to improve the health of patients, it is intended to foster new behavior from physicians by providing incentives that improve care for people with chronic diseases and conditions.

The most sophisticated insurance products use several of these devices simultaneously. HMOs frequently combine copayments, provider selection, bundled payment, and provider capitation. POS plans offer the patient a choice of provider for a price but use copayments deliberately to channel care to selected providers with whom they have risk-sharing contracts. Even traditional contracts have increasingly elaborate devices to influence both patient and provider behavior.

The health insurance market has undergone significant changes in the 1980s and 1990s. Managed care cost-controlling products grew rapidly in the 1990s but have fallen into disfavor in early 2000s. The movement to “defined contribution” reflects employers’ concern that they not bear the full costs of healthcare increases. Many employers are simultaneously stressing improvement in the quality of care. The combination of out-of-pocket costs to patients and greater emphasis on quality will provide challenge and opportunity for HCOs.

Suggested Readings


Notes


GOVERNING: MAKING HEALTHCARE ORGANIZATIONS RESPONSIVE TO THEIR ENVIRONMENT
The effectiveness of organizations to deliver modern healthcare is obvious. Hardly any disease or condition, beyond the very simplest, can be treated by a single individual; almost everything requires a systematic, coordinated effort of many different people, unique and expensive resources, and often highly specialized facilities. But a collective effort must serve collective goals. How do we, as citizens, make sure the effort goes in directions we want? The answer, in healthcare as in other enterprises, is that we delegate the question in two ways—first to individuals to make their own choice, usually between competing suppliers, and second to a group of people called the governing board. The board, sensitive to the reality that the enterprise must be the choice of a substantial number of individuals, establishes the direction of the collective enterprise. They hire an executive to implement their decisions, and the executive negotiates a series of agreements with the caregivers and others. Those agreements are made through the formal structure that we call “the organization.” Increasingly, the agreements and even the underlying direction are quantitative—goals and performance are measured. Numbers drive much of the discussion that identifies opportunities, builds consensus, and agrees on goals. Overall, the process that shapes the collective effort toward the needs of the individual patients is called governance. It is a heuristic process, where learning occurs from experience. The best organizations, in healthcare as in other sectors, stimulate learning by systematic review of their gains and losses and deliberate experiments to improve.

Part I of this text discusses the governance process, from the origins of the collective effort itself through the contributions of the governing board and the executive, the design of the organizational structure, and the measurement of performance. Hidden within the complexities of these processes is a pattern of behavior that gets repeated over and over again, from the highest levels of strategy to the care of an individual patient. The pattern describes how an HCO sets goals, selecting some objectives over others. As shown in Figure I.1, the pattern is one of search for possibilities or opportunities, discussion to build consensus among the participants, and agreement about a course of action and an expected result. The pattern begins again when the result is evaluated and the new possibilities are identified.

Leading institutions are good at implementing this pattern at all levels. They bring large numbers of people, open minds, and innovative ideas
to the search step. They conduct broad and free-ranging discussion, airing potential disputes rather than concealing them, so that a large number of people understand not only what the goal is but also what its limits are and why it was selected. Finally, they agree on actions that are realistic within the range of agreement and generally achieve them.
Defining the Healthcare Organization

Organizations are social groups created by human beings to accomplish goals they might otherwise be unable to reach. The participants define the goals, and the goals define the organization. Organizations emerged contemporaneously with civilization itself, are usually improvable, and have become noticeably more complicated as well as more effective. Healthcare organizations (HCOs) are no exceptions to these statements. This chapter provides a foundation for understanding the numerous and complicated interactions that allow the modern HCO to relate effectively to its environment, fulfilling as many goals of its supporters as possible. The chapter describes:

1. The stakeholders, those individuals and groups committed to the HCO’s success, and how they express their interests
2. The purposes or goals the HCO strives to achieve
3. How the HCO responds to stakeholder interests
4. How managers and leaders help the HCO respond

All of these topics are revisited in later chapters. The intent here is to convey the broad outline of an open system—a dynamic, ongoing interaction between the HCO and its constituencies that allows them to fulfill their goals.

Open systems theory implies that any organization can be described in terms of processes that transform resources—labor, supplies, capital, and knowledge—into products and services that meet demand. The organization is dependent on all elements of the set—customers, workers, supplies, facilities, and technological skill—and limited by the element in shortest supply. Its success depends on its ability to make the transformation. Applying the theory, an HCO is successful when it attracts and meets patient care demand by

In a Few Words

Healthcare organizations (HCOs) exist because they provide services people find useful. These people become stakeholders in the organization’s continued existence. For HCOs, the services are healthcare and health promotion. Many different stakeholders consider these services essential to a good society, but stakeholders’ specific needs are often in conflict. A second function of an HCO is to find ways to resolve these conflicts, increasing stakeholder satisfaction in total while meeting each stakeholder’s minimal needs.

This chapter defines stakeholders, provides a classification for thinking about them, describes how they make their voices heard, and identifies their common need—for care that is safe, effective, patient centered, timely, efficient, and equitable and for disease prevention and health promotion.

The chapter also gives broad outlines of the organization that best meet stakeholder needs. It identifies the managerial role in these organizations—to maintain the paths of communication; protect the rights of all stakeholders; and find the measures and facts that support reliable, evidence-based decisions and that help teams actually deliver care.
assembling doctors, nurses, equipment, supplies, and knowledge effectively and efficiently.

The transactions between the elements, such as hiring, buying, and selling, are exchanges. An exchange is a voluntary transfer of goods, services, or purchasing power that occurs when both parties believe themselves to benefit from it. Exchanges occur constantly in society, and in a certain sense they ultimately can occur only between individuals. As a practical matter, however, a great many exchanges occur through organizations. Exchange partners are individuals or organizations who have a contract or commitment to exchange with an organization. Important exchange partners are also stakeholders, and conversely, most stakeholders are also exchange partners. The relative ability of stakeholders to achieve their goals is called influence, or power—that is, the ability to change or shift the organization. Stakeholders who can affect the success of the organization are often called influencers. Exchange partners can be classified according to the nature of their exchange. One very useful classification of partners is between customers and providers. Customers are all those partners who use the services of the organization and generally compensate the organization for those services. Providers are all those who provide services and generally are compensated by the organization for their efforts. (Compensation in either case may be something other than money.)

The concept of open systems is closely related to the theory of the firm in economics. Like the theory of the firm, open systems theory forces the organization’s management to consider prices, quality, and value for the customer; and a similar list—wages, working conditions, and return on investment—for the providers. The two lists inevitably conflict; the customers want more service at lower prices, the providers more compensation for less effort. The justification for any organization is its ability to integrate these conflicting demands, finding a solution that is acceptable to all. The solution is always compared to realistic alternatives—that is, to competition. If it is not as good as competing alternatives, the organization will shrink and fail; if it is better, it will grow and thrive. Open systems theory is particularly useful in a market economy and a free society because it emphasizes the importance of satisfying people who voluntarily contribute to the exchanges.

**Critical Issues in Relating the HCO to Its Environment**

**Defining stakeholders of the HCO**
- Who they are
- Why they matter
- How they are heard
- What the value of listening to stakeholders is

**Identifying purposes of the HCO—the stakeholders’ common ground**
- Safe, effective, patient-centered, timely, efficient, and equitable care
- Health promotion
- Disease prevention
- Reduction of health disparities

**Designing the HCO**
- Strategic, clinical, and support systems
- Measures and benchmarks
- Strategic plans and annual goals

**Managing the HCO**
- Customer focus
- Worker empowerment
- Continuous improvement

**Sustaining the HCO’s values, measures, and communications structures**
- Mission, vision, and values
- Transformational management
Chapter Two: Relating Healthcare Organizations to Their Environment

Stakeholders for Healthcare Organizations

HCOs have a particularly complex set of stakeholders and exchange partners. Historically, the life-threatening and intimate nature of healthcare, the extraordinary privilege given to doctors and other caregivers, and the tradition of Samaritanism created an unusual organizational environment. More recently, these factors have been complicated by the expansion of healthcare technology and the elaborate mechanisms that finance it. Figure 2.1 summarizes the exchange partners.

Customer Stakeholders

Patients are the most important exchange partners. They expect appropriate, high-quality medical care, a safe environment, and reasonably comfortable amenities. Friends and family accompany most patients and many family members serve as informal caregivers, so HCOs must establish close and direct relations with them. Patients’ expectations include a major element of trust. Information asymmetry—the organization and its caregivers possess substantially more knowledge about the patient’s needs than the patient does—makes it impossible for many patients and families to articulate their needs. Instead, they expect the organization to do that for them, thoroughly and fairly. Much of the failure in patient relations comes from the difficulties in managing that trust.

Health insurers and fiscal intermediaries provide most of the revenue to HCOs, making them essential exchange partners. Private health insurers are agents for buyers, which include governments, employers, and citizens at large. Two large governmental insurance programs are exchange partners with most HCOs. Medicare deals with organizations through its intermediary, often the local Blue Cross and Blue Shield Plan. Medicaid, a state-federal program that finances care for the poor, is run by the state Medicaid agency or an intermediary. Representing the buyers, payment organizations attempt to keep the cost of care as low as possible and recently have begun efforts to improve the quality and safety of care.

Patients rely on a variety of mechanisms to pay for care. Much health insurance is provided through employment, making employers important exchange partners. Historically, unions played a major role in establishing health insurance as an employee benefit. Federal, state, and local governments purchase insurance for special groups of citizens and also buy as employers. Buyers, who must meet the demands of their own exchange networks, have taken action to restrict the growth of costs, acting principally through payment organizations. Their pressure is likely to continue.
Most payment organizations mandate two outside audits of hospital performance—one by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or its osteopathic counterpart, the American Osteopathic Association, and the other by a public accounting firm of the HCO’s choice. Some insurance plans are accredited by the National Commission on Quality Assurance (NCQA), which also accredits ambulatory care and disease management. HCOs have exchange relationships with these agencies.

**Government regulatory agencies** are exchange partners that at least nominally act on behalf of the patient and buyer. Licensing agencies are common, not only for hospitals and healthcare professionals but sometimes also for other facilities such as ambulatory care centers. Many states have **certificate of need** laws, requiring permission for hospital construction or...
expansion. **Quality improvement organizations** (QIOs), formerly called **peer review organizations**, are external agencies that audit the quality of care and use of insurance benefits by individual physicians and patients for Medicare and other insurers. The courts address individual malpractice liability cases, and the collective impact of these cases is a force for uniformity of care. HCOs are subject to many consumer protection laws, including the Health Insurance Portability and Accountability Act, which despite its title addresses major issues of patient record confidentiality.7

HCOs require land and zoning permits; they use water, sewer, traffic, electronic communications, fire protection, and police services and thus are subject to environmental regulations. In these areas, HCOs often present special problems that must be negotiated with local government.

HCOs make numerous, varied, and far-reaching exchanges with community agencies and informal groups. They facilitate infant adoption; receive the victims of accidents, violent crimes, rape, and family abuse; and attract the homeless, the mentally incompetent, and the chronically alcoholic. These activities draw them into exchange relations with police and social service agencies.

HCOs take United Fund charity. They facilitate baptisms, ritual circumcisions, group religious observances, and rites for the dying. They provide educational facilities and services to the community, such as health education and disease prevention programs and assistance to support groups. These activities often make them partners of charitable, religious, educational, and cultural organizations. Prevention and outreach activities draw HCOs into alliances with governmental organizations, such as public health departments and school boards, and with local employers, churches, and civic organizations.8

HCOs are frequently one of the largest employers in town, and not-for-profit HCOs often occupy facilities that, if taxed, would add noticeably to local tax revenues. The community may hold the organization to certain conditions, such as a certain level of charity care, in return for nonprofit status.9 As a result, the electorate and the local government are stakeholders. Communication with the electorate, which is also a major part of the HCO’s customer market, often involves the media—press, radio, and television coverage as well as purchased advertising.

**Provider Partners**

The second most fundamental exchange, next to patients, is between the HCO and its **associates**—people who give their time and energy to the organization. HCO associates are employees, **medical staff members**, trustees, and other **volunteers**. Employees are compensated by salary and wages. Trustees and a great many others volunteer their time to the organization; their only compensation being the satisfaction they achieve from their work.
Medical staff members receive monetary compensation either through the organization or directly from patients or insurance intermediaries. Primary care practitioners—physicians in family practice, general internal medicine, pediatrics, obstetrics, and psychiatry; nurse practitioners; and midwives—are the most common initial contacts for healthcare. Referral specialist physicians tend to see patients referred by primary care practitioners and to care for these patients on a more limited and transient basis. They are more likely to manage episodes of inpatient hospital care. Hospitalists, a new referral specialty, accept relatively broad categories of patients and manage inpatient care solely. Other professional caregivers (e.g., dentists, psychologists, podiatrists) are also medical staff members.

A successful HCO must supply the compensation its associates are seeking. Monetary compensation must be competitive with alternative opportunities. Also, whether participation is compensated or volunteer, the individual must receive some satisfaction beyond earnings. Otherwise, volunteers will stop volunteering and physicians and employees will leave for other organizations that can better fulfill their needs.

Associates are often organized into groups that manage their exchanges to some extent. Unions, or collective bargaining units, sometimes represent employed associates. Physicians often form professional associations and practice groups. Doctors specializing in neurology, for example, can become a group representing its members to the organization as a whole. Group membership is itself an exchange; individuals choose it because a group can meet some needs that would otherwise go unmet. The success of the groups depends on the set of exchanges that commits the individuals to their groups.

HCOs use significant quantities of goods and services, from artificial implants to food to banking, purchased from outside suppliers. Financing partners help HCOs acquire capital through a variety of loan and lease arrangements. HCOs often enter into strategic partnerships with suppliers and other provider partners, commitments that specify longer-term obligations of the parties.

In the course of meeting patient needs, HCOs have considerable contact with other providers, including competing organizations and agencies whose service lines may be either competing or complementary, such as primary care clinics, mental health and substance abuse services, home care agencies, hospices, and long-term care facilities. Relationships with these organizations have become increasingly formal, ranging from referral agreements through strategic partnerships and joint ventures (formal, long-term collaborative contracts often involving capital investment) to acquisition and operation of services. It is not uncommon for two HCOs to collaborate on certain activities, such as medical education or care of the poor, and compete on others. Even competi-
tors with almost exactly the same services negotiate contracts with each other. Federal and state antitrust laws regulate negotiation between competitors, but the prohibitions are specific and other communication is permitted.

Government agencies of various kinds monitor the rights of associate groups. Occupational safety, professional licensure, and equal employment opportunity agencies are among those entitled access to the HCO and its records. The HCO is obligated to collect Social Security and income tax withholding.

Sources of Stakeholder Influence

Meeting stakeholder needs is the core purpose of all organizations. Successful organizations work steadily and systematically to increase the number of loyal stakeholders. Their efforts are proactive, identifying stakeholder needs before they become points of contention, and involve extensive listening, program design, and redesign.

The ultimate source of stakeholder power is their ability to participate in the exchange. Participation is of such importance that it is carefully measured and closely monitored. Customer participation is measured as “market share,” and provider participation is measured by retention and shortages. Satisfaction of participants is also monitored; the goal is to have “loyal” or “secure” customers and associates — those whose opinions are so positive that they will not consider alternatives (“will return”) and will recommend the organization to others (“will refer”).

The stakeholders’ conflicting desires can easily lead them to become adversarial, as in the traditional relationship between unions and management. Successful HCOs strive to minimize adversarial relationships. They do this by building a record of responsiveness and truth telling, making a diligent effort to find and understand the relevant facts, maintaining respect and decorum in the debate, and searching diligently for solutions. Thus, the stakeholders leave the discussion feeling that they were heard, that the decision was fair, and that no realistic opportunity to improve the decision existed. “My (or our) concerns have been heard and met as well as anyone could” is the feeling that results from successful negotiation.

Each of the exchange partners of the HCO has relationships with exchange partners of their own. Individuals and families affiliate with schools, employers, churches, and community groups. These organizations relate to each other through contracts and agreements, creating networks of exchange relationships. The networks are based on shared values or common needs. Many are more or less permanent, while others are temporary alliances to forward a specific goal. The HCO is always located in a web of such networks.
The networks also serve to build consensus and influence on questions stakeholders view as important. They facilitate negotiation, serving as channels of communication to stakeholders with similar perspectives. Alliances, consensus, and influence allow the networks to address complicated social problems like healthcare of the uninsured or health promotion. Nurturing, understanding, and respecting these networks are keys to success for a community. HCOs both contribute to the processes supporting networks and use the networks to fulfill their mission.

Social Controls on Healthcare Organizations

Stakeholders can imbed their viewpoint into law, regulation, and contract so that agencies operating with broad scope over many HCOs may enforce their perspective. These actions are social controls on HCOs. They create the regulatory agencies that protect customers and associates outlined earlier. They almost always reflect good intentions—safety, equity, human rights, quality, efficiency. Accomplishment is another matter. Regulatory agencies have generally fallen short of expectations.

Quality of Care

Licensure and JCAHO had important impacts when they started but are no longer gaining significant results. JCAHO scores are not associated with outcomes measures for quality or efficiency. NCQA concedes

The quality of health care delivered to Americans who are enrolled in health plans that measure and report on their performance improved markedly in 2003, but the health care system remains plagued by enormous “quality gaps,” and the majority of Americans still receive less than optimal care.

Certificate-of-need programs also proved to be ineffective. Although QIOs and their predecessors have been around for decades, they obviously have not sustained high-quality care. Similarly, although the courts have re-shaped the relationship of HCOs to their medical staff members, they have not been effective in promoting quality. It is argued with some persuasiveness that many of these efforts are in fact captured by the stakeholders being regulated, a complete perversion of the original intent. Thus, licensing and certificate of need can become devices to protect monopolies, and JCAHO can serve provider rather than customer needs.

In addition to regulation and accreditation, the malpractice lawsuit is an important social control. Charitable immunity and governmental immunity protected hospitals from malpractice liability through World War II. Beginning about 1950, the courts began holding hospitals financially responsible for the consequences of their negligent acts. The number of suits won by former patients increased, but the number instituted rose even more spectacularly. By 1980, community hospitals were clearly responsible not only for any negligence of their employees but also for negligence of their physicians. Ironically, a landmark survey, the Harvard Medical Practice Study in 1990,
found malpractice claims themselves to be a clumsy weapon. Although adverse clinical events occur in about 4 percent of all inpatient hospitalizations, the study found little relation between these events and court decisions. Less than 3 percent of adverse events could be documented as malpractice claims, and “most of the events for which claims were made in the sample did not meet our definition of adverse events due to negligence.” These facts led the study group to conclude, “Medical-malpractice litigation infrequently compensates patients injured by medical negligence and rarely identifies, and holds providers accountable for, substandard care.” Malpractice remains an active social force, but its impact varies widely by state. It may work against customer needs by discouraging physicians from practicing in certain areas and by suppressing reports of seriously negative outcomes.

The use of objective measures of performance as a focus for control may provide an escape from this dilemma. Recent efforts have focused on the quality of care: the National Quality Forum (NQF), “a not-for-profit membership organization created to develop and implement a national strategy for health care quality,” was founded in 1999. The intent and style of NQF are sharply different from JCAHO’s. NQF has a board of 19 members, of whom only two are directly affiliated with provider organizations. Ten are affiliated with government, buyer, or consumer groups, and four are nonvoting “Liaison Members,” including the presidents of JCAHO and NCQA. NQF believes:

The American health care system . . . is marked by serious and pervasive deficiencies in quality. Quality problems . . . result in increased mortality and morbidity and in failure to alleviate conditions that cause pain and disability, leading to a lower quality of life, a less productive workforce, and billions of dollars in unnecessary costs.

Extensive research supports the NQF’s charge of unacceptable quality. *To Err is Human*, the Institute of Medicine’s first publication on healthcare delivery, documents that 44,000 to 90,000 Americans are killed each year by errors in healthcare. The second publication, *Crossing the Quality Chasm*, expands the documentation. A recent national survey concluded that only about 55 percent of Americans who seek care receive recommended treatment.

NQF has established a mechanism to evaluate and standardize measures of quality. The measures it accepts are recorded for public use by the Agency for Healthcare Quality and Research, which publishes them on its web site. Medicare and private insurance programs now pay for performance, offering incentives for improved quality, and JCAHO has moved to add process and outcomes quality measures to its criteria.

Laws or payment incentives mandating public release of performance information may strengthen the NQF approach. Providing public data on quality seems to promote improvement. Public data level the playing field.
The data allow all stakeholders to share a common understanding of the facts and may clarify stakeholder debates.

**Cost and Efficiency**

The amount of money devoted to healthcare is a function of income and the desire for healthcare relative to the desire for other needs such as food, defense, and education. The decision should be a function of a marketplace or political forum that balances those needs against the needs of providers. Buyers and taxpayers accepted enormous increases in healthcare costs throughout the 1970s but began to reassert their control of prices around 1980.

Advocates of economy have two serious problems: the economy they seek (1) involves the loss of somebody’s job and (2) may seriously impair service. They have pursued two approaches—regulation and competition. Over half the states had rate regulation programs in 1980; they differed markedly. Only four states (New York, Massachusetts, New Jersey, and Maryland) were rigorous in their approach and actually documented real dollar savings. Rate regulation in most other states was a less pressing issue. As a result, legislation gathered less widespread support and the programs were weaker in design and less effective in controlling costs. Price regulation has disappeared from all states except Maryland.

Difficulties in funding the Social Security Trust Fund for Medicare led the federal government to limit payment to hospitals through the prospective payment system [PPS] (Social Security Amendments of 1983). PPS is a payment program, not rate regulation. It set a price for each hospitalization based on categories of illness called diagnosis-related groups (DRGs). A similar program limiting physician fees—the resource-based relative value scale—was implemented in 1992. During the same time frame, most health insurance plans established fixed prices per cases using the DRG concept. In 2001, Medicare began paying for much ambulatory care using ambulatory patient groups and fixed prices for the services defined in each group. Home care, hospice care, and nursing home care are also paid according to negotiated prices.

The market control concept was effective. By 1996, the growth of national health expenditures, in double digits for several years in the 1980s, fell to 3 percent, only slightly more than inflation. It was held to less than 6 percent growth per year for the six years ending 1999. Although prices have risen since 1999, the price of healthcare is now set by a market, not by individual organizations. The prices offered remain significantly more generous than in any other nation.

After 30 years of experimentation, the United States appears to be implementing devices that hold HCOs accountable for quality (through NCQA, NQF, and the emerging consensus on outcomes measures) and cost (through the market). The implication is that the organizations themselves must control their operations, matching or exceeding competitive alternatives. This is
nothing new in most industries, but it is one of the major forces shaping organisational strategy.

**Purpose of Healthcare Organizations**

The open systems concept implies that to be successful, an organization must have a purpose that is attractive to stakeholders. The purpose forms the foundation for exchanges and guides the negotiations between the exchange partners. The best purposes are clear, convincing, publicly displayed, and broadly accepted.

**Historical Purposes**

The purposes of HCOs have not changed drastically over time. Benjamin Franklin, conducting the fund drive for the first community hospital in North America—The Pennsylvania Hospital, founded in 1760—eloquently built his case on five arguments:

1. We need a refuge for the unfortunate, and Christianity will reward you for your generosity to this cause. (Although Franklin did not say so, Judaism, Islam, and Buddhism also praise charitable behavior.)
2. You might need it yourself this very night.
3. Among other things, we can keep contagious people off the streets.
4. We can certainly handle this better as a community than as individuals.
5. Grants from the Crown and the Commonwealth will lower the out-of-pocket costs. (Franklin might have added that the grants were “new money” that would eventually end up in Philadelphians’ purses.)

These purposes still motivate most hospitals. Four of these arguments appear in most modern fund-raising literature. The fourth—control of contagious disease—is now the contribution of HCOs to public health. Contagion was reduced in importance when antibiotics and vaccines came into widespread use, but the broader concept—disease prevention and control—has become a major opportunity to reduce costs.

In fact, the history of hospitals and the emergence of HCOs clearly reveal multiple and powerful motivations in the communities that built them. Although other taxonomies could be created, it is useful to think of these motivations in Franklin’s five groups:

1. **Samaritanism and support of the poor**—a desire to aid the sick and needy because the aid itself has value or intrinsic merit. In advanced industrial nations, Samaritanism has two forms: tax-supported government programs and voluntary charity.
2. **Personal health**—a desire to improve the health of oneself and one’s loved ones to deal more effectively with disease, disability, and death.

3. **Public health**—a desire for health as a collective or social benefit to prevent illness, ensure a healthy workforce and military force, and reduce the social burdens associated with disease, disability, and death.

4. **Economic gain for the providers and the community**—a desire to use the HCO as a source of income and employment and a desire to make the community as a whole economically successful and attractive as a place to live.

5. **Control of costs and quality of healthcare**—a desire to ensure certain levels of quality and costs for healthcare, recognizing that poor quality and inefficiency impair the achievement of the other four goals.

These five motivations are the permanent support for community HCOs. The debates that occur from community to community and from generation to generation are about the relative importance of each rather than the introduction of new ones.

**Ethical Values**

The best-managed HCOs begin by reinforcing ethical concepts that most potential stakeholders share. Seeking stakeholders who share a common vision minimizes conflicts and provides a foundation for constructive debate and conflict resolution. Excellent HCOs seek associates who share these values:

- **A love of human life and dignity**, expressed as a willingness to give service and to respect each person’s rights and desires. Respect must be extended regardless of age, sex, race, sexual orientation, social status, or religious belief. Respect for patients must be extended regardless of the cause of the patient’s problem. Respect for associates must be extended regardless of rank.

- **A commitment to quality of service to the patient** that is taken as primary and inviolate. The well-run HCO satisfies all reasonable expectations of quality and requires adequate quality as the immutable foundation of any activity it undertakes.

- **An understanding that quality of service is multidimensional**, including access, satisfaction, continuity, comprehensiveness, prevention, and compliance as well as accurate diagnosis and effective treatment. The well-managed HCO attempts to fulfill the holistic concept of wellness, rather than simply provide treatment.

- **A belief that healthcare services can be measured and improved**, a commitment to look honestly at evidence in the search for improvement, and an expectation that associates of the organization will derive satisfaction from identifying and achieving these improvements.
Well-managed HCOs strive to attract and encourage people who share these values. They announce their ethical commitment through their mission, vision, and value statements and reinforce it through their actions. They praise acts of kindness and foster a caring environment. They avoid and discourage those who disagree with their values, particularly people who are unable to express love and respect for individual dignity and those who cannot deal honestly with evidence. A broad spectrum of incentives, including recognition, encouragement, praise, promotion, and monetary compensation, rewards dedication to these values. Sanctions are used rarely—mainly in cases where the individual’s behavior threatens the quality of care or the continued effectiveness of the work group.

**The Future Part One—New Goals for Personal Healthcare**

The Institute of Medicine’s Committee on Quality of Health Care in America proposed a challenging vision of healthcare that has received widespread stakeholder attention and acceptance. The Committee’s goals of safe, effective, patient centered, timely, efficient, and equitable care and 10 “Simple Rules” (see Figure 2.2) provide a vision for care in the twenty-first century that almost all stakeholders endorse. But the rules are far from simple, and current practice falls far short of the goals. The rules and goals deal with three broad topics:

<table>
<thead>
<tr>
<th>Current Approach</th>
<th>New Rule</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Care is based primarily on visits.</td>
<td>1. Care is based on continuous healing</td>
</tr>
<tr>
<td></td>
<td>relationships.</td>
</tr>
<tr>
<td>2. Professional autonomy drives variability.</td>
<td>2. Care is customized according to patient</td>
</tr>
<tr>
<td></td>
<td>needs and values.</td>
</tr>
<tr>
<td>3. Professionals control care.</td>
<td>3. The patient is the source of control.</td>
</tr>
<tr>
<td>4. Information is a record.</td>
<td>4. Knowledge is shared, and information flows</td>
</tr>
<tr>
<td></td>
<td>freely.</td>
</tr>
<tr>
<td>5. Decision making is based on training and</td>
<td>5. Decision making is evidence based.</td>
</tr>
<tr>
<td>experience.</td>
<td></td>
</tr>
<tr>
<td>6. Do no harm is an individual responsibility.</td>
<td>6. Safety is a system property.</td>
</tr>
<tr>
<td>7. Secrecy is necessary.</td>
<td>7. Transparency is necessary.</td>
</tr>
<tr>
<td>8. The system reacts to needs.</td>
<td>8. Needs are anticipated.</td>
</tr>
<tr>
<td>9. Cost reduction is sought.</td>
<td>9. Waste is continuously decreased.</td>
</tr>
<tr>
<td>10. Preference is given to professional roles over</td>
<td>10. Cooperation among clinicians is a</td>
</tr>
<tr>
<td>the system.</td>
<td>priority.</td>
</tr>
</tbody>
</table>

**FIGURE 2.2**

Simple Rules for the Twenty-first Century Health System

SOURCE: Reprinted with permission from *Crossing the Quality Chasm: A New Health System for the 21st Century*. © 2001 by the National Academy of Sciences courtesy of the National Academies Press, Washington, DC.
(1) an increased reliance on information and communication, (2) a fundamental change in the patient-caregiver relationship, and (3) a new culture of collaboration among caregivers. Meeting the vision will require greater integration and coordination, from the individual patient’s care to the size and design of the organizations. It will require profound changes in caregiver attitudes and care processes and a shift from “healthcare” to “health” as a central goal.

**Safe**

Society generally expects HCOs to be safe, and the historic ethical precept of medicine is “First do no harm.” However, according to a detailed and conservative study of medical errors and injuries in 2003:

18 types of medical injuries may add to a total of 2.4 million extra days of hospitalization, $9.3 billion excess charges, and 32,591 attributable deaths in the United States annually. ... [T]he total national health care costs ... could be $4.6 billion.44

Safety has been shown to be a function of system and process design. Attention to design allows caregivers to reduce error to levels substantially below current performance.45

**Effective**

Unnecessary care and “futile medicine” are at issue in effectiveness. The study cited earlier that concluded that only about 55 percent of patients have appropriate care was based on a large sample of citizens from 12 metropolitan areas in 1998–2000. It compared actual care to established national guidelines for leading acute and chronic disease. Its conclusion means that almost half the patients either received less care than they should, or care that they did not need.

The level of performance according to the particular medical function ranged from 52.2 percent ... for screening to 58.5 percent ... for follow-up care.47

We found greater problems with underuse (46.3 percent of participants did not receive recommended care ... ) than with overuse (11.3 percent of participants received care that was not recommended and was potentially harmful ... )48

**Evidence-based medicine**—agreement that scientific evidence will prevail whenever it is available—will replace these practices. The use of computerized records, agreed-on plans of care, and closer attention to patient needs will increase the effectiveness of care, with concomitant improvements in health, particularly for those with chronic disease.

**Patient Centered**

Today’s successful HCO emphasizes the basics of customer satisfaction as the best way to build and retain market share. Direct measurement of satisfaction is detailed, comprehensive, and commonplace. Failure to satisfy patients on simpler elements of customer satisfaction, like sensitivity to patients and waiting times, is as serious as departures from technical quality.
Chapter Two: Relating Healthcare Organizations to Their Environment

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The Committee’s vision of customer satisfaction takes on a deeper meaning. Much medical care involves choices between alternatives, sometimes with enormous consequences. Through most of the twentieth century, responsibility for these choices was vested solely with physicians. The trend toward informing the patient about his disease and its management alternatives began with informed consent for surgery in the 1960s and has grown steadily since. In its first three rules (see Figure 2.2), the Committee has recognized the patient’s right to comprehensive, continuous care, adapted to individual needs and wishes. These rules mean that patients must be taught the choices open to them; guided about the implications of those choices; and encouraged, but never forced, to select the option they will find most satisfactory or least unsatisfactory. Patient choice is likely to become a major part of managing care of aging and chronically ill patients, resulting in the expanded use of hospice care and more deaths occurring outside the acute hospital.

Timely care suggests prompt response to patient requests, immediately for emergencies, quickly for urgent problems, and within patient expectations for routine care. Leading organizations now track these responses and improve them.

Timeliness also suggests reaching the patient at the optimal clinical time, which is often before illness strikes. Many illnesses and problems can be prevented. Tobacco usage adds about $100 billion a year to national expenses, in both healthcare and lost wages. Alcohol abuse, domestic violence, traffic accidents, unplanned pregnancy, immunization failures, workplace accidents, other substance abuse, obesity, lack of exercise, and unprotected sex also contribute substantially to the cost of care. Thoughtful community leaders recognize the cost and the potential contribution of HCOs in reducing unnecessary illness. It is imbedded in the Committee’s rules 8 and 9—anticipating needs and reducing waste.

Leading HCOs developed mechanisms to control costs in the 1980s and 1990s. Government and commercial buyers increased their commitment to efficiency as the mechanisms proved effective. Inevitably, future HCOs will compete on price as well as on service.

Equitable care requires service to all sectors of society. Samaritanism suggests this as an important goal; efficiency and cost concerns will reinforce it. Because organizations and even individual physician providers have high fixed costs, high volumes lead to lower costs. Both economies of operation and marketing advantages accrue to the organization that actively recruits all possible patients, even though some of them may be financed at less than full cost. The best organizations will have specific programs for access by low-income groups. They will include convenient clinics for primary care, emergency and walk-in care, and outreach activities emphasizing early treatment and prevention. (The burden of uninsured and underinsured care does not fall equally on hospitals.)
Those who have higher volumes of uncompensated care are called *disproportionate share hospitals* and receive extra compensation under Medicare.)

**The Future Part Two—New Emphasis on Prevention and Health Promotion**

Not-for-profit HCOs are legally incorporated for the benefit of the community they serve and are usually granted tax advantages in return for the service. They are often called community HCOs. It is often argued that these organizations and America’s healthcare system in general have made a fundamental error, emphasizing cure rather than prevention, handling the most immediate stakeholder needs but overlooking longer-term solutions. This argument holds that care, even care that meets the Committee’s goals and rules, is not enough. Community organizations of all kinds, but especially HCOs, must promote health and prevent disease. The argument has gained strength in this century. Demographic trends show an aging population that will need more care and a shrinking workforce that will have difficulty meeting healthcare needs. This combination will drive up the cost of care, making U.S. industries less competitive and overtaxing the workforce that must support it. One major contribution to solving that problem is health promotion and disease prevention, to improve health and reduce the underlying need for care.

*Healthy People 2010*, a publication of the U.S. Department of Health and Human Services, shows that the prevention approach has enormous potential. The two goals of the Healthy People 2010 initiative are to increase the length and quality of life and to eliminate disparities in health. The work identifies ten “Leading Health Indicators,” areas where preventive activity can be focused to improve longevity and the quality of life:

1. Physical activity
2. Overweight and obesity
3. Tobacco use
4. Substance abuse
5. Responsible sexual behavior
6. Mental health
7. Injury and violence
8. Environmental quality
9. Immunization
10. Access to healthcare

The work also contains specific goals for 28 disease or industry risk areas, identifying specific applications of the opportunities and estimating the potential impact. The argument is that collaboration across the community as a whole is essential to address these opportunities.
Leading HCOs have taken this challenge seriously, using a variety of approaches to reduce the risk of disease or injury. For example, leading HCOs do the following:

- Discourage tobacco use, forbidding any use within their buildings and promoting smoking cessation for patients and associates
- Promote worker and patient safety by redesigning work processes
- Promote child health with parent education about car seats, smoking in the home, sudden infant death syndrome, vaccination, appropriate diet, and anger management
- Promote healthy patient behavior with diet, exercise, and sexuality education; substance abuse management programs; and early detection and early management of disease

The most advanced work follows the Healthy People 2010 approach of seeking broad community participation. For example, in Kearney, Nebraska, a Catholic Health Initiatives (CHI) hospital, has established a community health partnership with employers, government, schools, and social agencies. In 1996 the partnership established 15 specific goals, dealing with housing, substance abuse, violence, obesity, immunizations, healthcare, and the environment. By 2002, they had achieved four and made substantial progress on seven goals. Kearney won a “Healthy Cities” award.55

CHI’s mission to “build healthy communities” reflects the concept of an integrated health system (IHS), an organization that strives deliberately to meet all the health needs of its community at minimum cost. (The terms “integrated health network” and “integrated delivery system” are also used.) IHSs have integrated horizontally by incorporating many traditional hospitals and vertically to incorporate more kinds of healthcare. As Figure 2.3 shows, services of a vertically integrated IHS begin with those aimed at keeping the community well and continue through several levels of disease or condition management. At each stage, the objective is to return the patient to the well population at the lowest possible cost. Thus, the bulk of a disease is treated on an ambulatory basis. The services of a fully integrated IHS extend through continuing nursing home care (where the goal is to maintain the patient’s independence as much as possible) to palliative care at the end of life (where comfort replaces cure and the patient is encouraged to determine the outcome as much as possible).

**Designing and Building the Healthcare Organization**

People rarely design and build new HCOs, but they often redesign and rebuild existing ones. In fact, leading organizations redesign and rebuild
continuously, implementing a philosophy of continuous improvement. An organization pursuing continuous improvement will set expectations that it can and will achieve but that will meet stakeholder needs better each year, even changing the organization’s central purpose if necessary.

**Establishing the Mission**

The mission of an organization is the most central agreement between the stakeholders, and it tends to be the most permanent. It establishes the specific purposes of the organization. It should identify a distinctive competence, a contribution to stakeholder needs that, when done well, justifies the organization and distinguishes it from others that are similar. Missions are frequently limited geographically—service to patients in a specific county or metropolitan area—or to selected kinds of healthcare—for less complicated disease, for children, or for mental illness. A profile of Ben Franklin’s motives must be developed. How much charity care? Which services? What commitment to prevention and health promotion? What cost? Who pays? Who gets the benefit? These are profound questions, and well-managed HCOs address them carefully.

Successful HCOs build and maintain consensus around their mission using the following process:
1. Generate a periodic dialog about “What are our motivations?” and “What should be our distinctive competence?” The dialog deliberately involves broad stakeholder participation. It serves two major functions:
   a. It reminds stakeholders of the historic reasons for the organization’s existence, recalling previous discussions and agreements and, in most cases, reaffirming them.
   b. It encourages stakeholders to express their current needs or desires, stimulating debate on possible changes, and thus keeping the organization current with its community’s needs. New concepts, such as the “Simple Rules” and Healthy People 2010 are introduced.
2. Formally approve a mission statement reflecting the stakeholder dialog and summarizing the consensus.
3. Summarize the arguments supporting the mission in formally approved statements of vision and values. The vision is usually a simple statement of the contribution of the mission to universal goals. The values often call for respect, safety, quality, honesty, compassion, and other virtues. They establish a moral foundation for the enterprise.
4. Publicize the mission, vision, and values broadly and consistently, using multiple media and endeavoring to keep the agreement prominent everywhere and at all times.

Most leading HCOs revisit the mission, vision, and values annually and reopen broad debate every few years. Once adopted, the mission, vision, and values are central to decision making. Any proposal must pass the test of being consistent with the mission; any action must be consistent with the vision and values. New exchange partners are carefully informed about the mission, vision, and values and told that they are expected to adopt them and abide by them. Serious disagreement or noncompliance with the mission, vision, and values leads to termination of exchange relationships.

Examples of mission, vision, and value statements are readily available; most organizations post them on their web sites. A few mission statements are shown in Figure 2.4. Missions reflect differences in corporate ownership. Secular community HCOs tend to commit to universal access and high quality of care. Faith-based HCOs generally incorporate their spiritual commitment. For-profit HCOs recognize their stockholders’ right to a return on investment. But because the statements must be acceptable to a broad stakeholder constituency, missions tend to be similar, even across ownership.

Creating the Organized Response
Fulfilling modern healthcare missions effectively requires three different kinds of operating systems, as shown in Figure 2.5:

1. Strategic systems—stakeholder listening and environmental scanning, identifying common themes, exploring alternatives, promoting
### FIGURE 2.4
Representative Missions of HCOs

<table>
<thead>
<tr>
<th>Organization</th>
<th>Mission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Catholic Health Initiatives</td>
<td>To nurture the healing ministry of the Church by bringing it new life, energy and viability in the 21st century. Fidelity to the Gospel urges us to emphasize human dignity and social justice as we move toward the creation of healthier communities.</td>
</tr>
<tr>
<td>Intermountain Health Care</td>
<td>A mission of excellence and the pursuit of ever-higher standards of quality. As a Salt Lake City-based nonprofit organization with no investors, our commitment is to provide clinical excellence, quality and innovation rather than stockholder profit.</td>
</tr>
<tr>
<td>SSM Health Care</td>
<td>Through our exceptional health care services, we reveal the healing presence of God.</td>
</tr>
<tr>
<td>University of Michigan Health System</td>
<td>Excellence and Leadership in Patient Care/Service, Research, Education</td>
</tr>
<tr>
<td>St. Luke’s Health System</td>
<td>Committed to enhancing the physical, mental, and spiritual Health of the communities we serve. Supported by education and research, our Health System partners with others to achieve our goals.</td>
</tr>
<tr>
<td>Sentara Health Care</td>
<td>To provide our patients with innovative services to treat illness and disease and promote the improvement of personal health.</td>
</tr>
<tr>
<td>HCA Health Care</td>
<td>Above all else, we are committed to the care and improvement of human life. In recognition of this commitment, we strive to deliver high quality, cost effective healthcare in the communities we serve.</td>
</tr>
</tbody>
</table>

**Source:** Websites of each organization. Web addresses are current as of 9/15/04.
consensus, acquiring resources, coordinating the systems and their components, maintaining measures of performance, and monitoring overall effectiveness

2. **Clinical systems**—identifying and meeting the needs of individual patients and providing care

3. **Technical and logistic support systems**—ensuring the availability of personnel, supplies, equipment, amenities, capital, and knowledge resources required by the operating systems

This chapter provides an overview of these systems, and each is described in depth in the following chapters. Integrating the activities within the systems so that they work effectively together is critical. Most activities are carried out by teams, or **microsystems**—groups of individuals who work closely together, usually face to face. The individuals in the microsystems interact minute by minute. They must often relate to other teams within or outside their system to succeed. All the teams participate in continuous improvement.
Functions of the Strategic System
The strategic system must design the network of microsystems, build stakeholder participation and loyalty, and create a culture that supports the vision and values. These functions are achieved by listening, establishing strategies, and pursuing continuous improvement.

Listening
An HCO relates itself to its stakeholders through environmental assessment or stakeholder listening—a deliberate program to identify the changes in the environment, specifically including the opinions of present and potential stakeholders. The mission, vision, and values provide focus to scanning, shaping it to a manageable set of questions:

- Are there opportunities to improve mission achievement?
- Do certain or potential stakeholders have unmet needs that the organization could fulfill?
- Does the mission need modification?

Scanning and listening are pervasive in a well-managed HCO. They occur at every level, down to the smallest microsystem. A wide variety of devices is used to identify trends in stakeholder positions, ranging from monitoring the federal government to direct surveying of individuals and small groups of customers and providers to tracking the sometimes secretive actions of competitors. Many issues are clarified by benchmarking—comparing to the best-known performance on a given question. A final question deals with continuous improvement of the listening function: Are there ways to identify and evaluate stakeholder needs more effectively?

This question forces review of the stakeholders—who they are, how their voices are heard, and how the information from the environmental scanning is integrated for analysis and discussion. It permits the organization to improve its scanning and listening processes. Figure 2.6 shows the scanning and listening processes.

Developing Strategies and a Business Plan
The organization must translate the stakeholder desires into effective responses. It begins this by crafting a business plan—an integrated set of strategies to achieve the mission, developing each strategy as a multiyear plan for a set of processes with specific objectives. The strategies are carried out by a governance team, a senior management team, and the technical and logistic functions working with the clinical teams.

Each strategy includes the following elements:

- The contribution of the strategy to the mission and stakeholder needs
- Specific quantitative goals—the number of patients to be treated, the minimum standards for clinical outcomes and patient service, the levels of associate satisfaction, the cost of service, and the revenue expected
• The resources that will be required and their sources—the capital, facilities, equipment, supplies, and skilled personnel needed and their availability.
• The organization and accountability—the individuals and teams who will implement the strategy and their assignments
• The timetable and interim checkpoints
• Evaluation of the risks involved in implementing the strategy—potential failures of demand or recruitment of personnel, the implications of competitor actions, possibilities of changing technology and obsolescence—and plans to minimize these risks

For a new and untried strategy, these elements are all forecasts about the future and are subject to uncertainty. As the strategy moves forward, the teams gain knowledge and confidence and the uncertainty is reduced. The strategies for leading HCOs now focus on service lines—coordinated programs of care for groups of diseases that require similar knowledge, treatment approaches, and resources. Cardiovascular care, women’s health,
cancer care, and neurological and stroke care are the largest service lines because those groups are the most common. Mental illness and chemical dependency service lines are also common, but for historic reasons they tend to be in freestanding organizations rather than integrated ones. Trauma, orthopedics, endocrinology and diabetes, and rheumatology (arthritis) are service lines that require larger supporting populations because the diseases are rarer. Two other service lines—hospitalists for other nonsurgical inpatient diseases and general surgical care for other surgery—are growing in popularity. Leading institutions are now moving beyond acute care, creating service lines for long-term care, palliative care, preventive care, and health promotion.

The clinical service lines share a need for several specialized patient care resources that help with diagnosis and treatment. These clinical support services include emergency departments, operating rooms, clinical laboratories, imaging services, and rehabilitation services. Their use is arranged patient by patient, as needed. The clinical support services have strategies as well.

Within the service lines and the support services, teams accept accountability for specific parts of the strategy. They, too, create plans with quantitative goals, resource needs, and timetables. These small units are also called accountability centers; they are the smallest building blocks of the organization.

Each accountability center and all larger aggregates, including the organization as a whole, routinely monitor measured performance against goals. Annually, the units identify new, improved goals and incorporate them into an annual plan, or budget, for the coming year. In a successful organization, strategies are carefully developed and evaluated, budgets develop realistic near-term goals, and actual performance conforms closely to the plan.

Excellent organizations improve continuously and systematically. The strategic system supports improvement with policies requiring measured performance and explicit goals, training opportunities to improve associate skills, rigorous attention to accurate measurement, and rewards for achievement. Maintaining continuous improvement is a distinguishing characteristic of leading organizations.

If stakeholder needs were unchanging, organizational goals would not change. The exchange partners would be in a stable, more or less permanent equilibrium. Permanence is even more unrealistic today. The relative influence of various stakeholders changes, their desires change, technology changes, and the strategies of the organization must change in response. So pervasive is change in modern society that successful organizations expect to change constantly. They actively seek change in their scanning activities. The organization is designed around continuous improvement.

The continuous improvement concept arose from continuous quality improvement (CQI)—a movement that became popular in the early 1980s as
a way to keep U.S. industry competitive in world markets. W. Edwards Deming is recognized as the founder of the movement, which spread to the larger hospitals and healthcare systems within a few years. CQI is a critical component of leading commercial and industrial organizations. It is embedded in the Malcolm Baldrige National Quality Award, an annual competition with prizes for large and small commercial organizations, HCOs, and educational organizations. Many states also offer prizes using criteria similar to the Baldrige award. CQI emphasizes carefully measured performance with benchmarking, customer-oriented goals, empowered workers, and process focus.

“Improvement” as an idea implies measurement. CQI measures as much as possible. Having a measure and improving performance against it raises the question of “best possible.” That is the concept of the benchmark. An organization using CQI has measured thousands of processes and situations, and each has three values—actual, goal, and benchmark. Often it has several benchmarks—“best in company,” “best in nation,” and “best in world.” The annual goals can move up the ladder of benchmarks, keeping each annual goal realistically achievable. “Actual” will show an improving trend.

The measures are so critical to success, both to the organization and to the individual, that they must be safeguarded like any other valuable asset. There is constant pressure to distort or falsify them. One task of the strategic system is to maintain control of the measurement processes, using rules, audits, and sanctions to ensure that the measures remain accurate.

“Quality” in CQI is broadly defined as any characteristic that improves the product or service in the eyes of the buyer. That places the customer—the one who starts with the money—in the position of defining the good or service the organization supplies. Many healthcare teams do not work directly with patient customers. They have “internal customers” such as the clinical microsystems. Without in any way ignoring the needs of other stakeholders, customer focus recognizes that success depends on convincing people to use the service (and part with their money). This concept has three advantages. First, it clarifies boundary spanning and expectation setting. Second, it gives a rule for settling disputes between stakeholders. Third, and most important, the focus and the rule are consistent with free market and democratic principles. All of us are both customers and servers; we should serve as we would wish to be served.

Servers are not ignored, however. Continuous improvement empowers workers, encouraging them to take control of the operating system and revise it as necessary to meet or improve on customer expectations. Workers are empowered when they know that they can change their operating environment. Empowering workers in HCOs and other organizations with complex arrays
of microsystems requires a unique style of management. The things workers need for empowerment—adequate training, effective logistics (supplies, tools, equipment, and information), and answers to questions—must be supplied by management. Rewards must be offered for achievement. Management’s responsibilities are derived from worker needs, rather than the other way around. Managers must explain and coach, rather than give orders and demand compliance. Coordination is achieved through process design, not by fiat.

**Process Focus**

Improvement itself focuses on revising process—the series of actions or steps that transform inputs to outputs. Most processes are revised by teams, called performance improvement teams (PITs) established to address a specific process. Some PITs are from a single microsystem, but most processes involve coordinating two or more microsystems. The PITs should contain membership from all microsystems involved. They are often augmented with specialists from technical and logistic functions. PITs follow the Shewhart cycle, called “Plan Do Check Act” or PDCA (see Figure 2.7). PDCA approaches process revision by careful study of the problem with a deliberate effort to uncover the most fundamental possible corrections (Plan), then followed by the development of an idea or proposal for revision to attack the problem (Do), the performance of a trial to systematically field-test the idea (Check), and implementation of the idea (Act).

Process focus emphasizes factual analysis. Management, like medicine, is evidence based. The search for facts is far ranging. Empirical evidence resolves debate among the PIT members. The analytic tools of science are brought to the process, and statistics figure heavily in the analysis. The organization will strive to do what is factually sound, statistically significant, and scientifically proven.

**FIGURE 2.7**

Shewhart Cycle for Process Improvement

<table>
<thead>
<tr>
<th>ACT</th>
<th>PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implement the best solution and return to Plan.</td>
<td>Identify the real problem. Analyze causes.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>A</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Analyze causes.</td>
<td>Plan.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>C</th>
<th>D</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHECK</td>
<td>DO</td>
</tr>
<tr>
<td>Test the solution. Evaluate the result. Consider further improvements.</td>
<td>Develop improved systems. Select the best improvement.</td>
</tr>
</tbody>
</table>
Using facts to make choices between alternative goals and processes is a critical philosophical commitment of continuous improvement. There are competing philosophies, such as religion or ethics (which may forbid certain businesses entirely or under certain circumstances), authority (whatever the boss says), power (a test of wills between stakeholders), and simply tradition (we’ve always done it this way). The theory of continuous improvement is that the more reliance on facts, the greater the organization’s chance of success. Most people are unwilling to make a complete commitment to follow facts blindly and therefore make certain religious or ethical constraints. The successful organization integrates these effectively into its mission, vision, and values and uses facts to identify the best solutions within a domain defined by religion, ethics, and law.

The organization that follows continuous improvement theory is a learning organization. It quickly comes to know more about its business than anyone else does. It is likely to be the first to discover or invent new opportunities that go beyond the customers’ range of knowledge but that will fill customer needs. Apple’s iMac is an often-cited example, but Henry Ford’s Model T is the most striking. Nobody was asking for an iMac or a Model T before they were built. After people saw them, tried them, and became convinced that they worked, the market for them exploded. Organizations deeply knowledgeable about their products and the markets involved are positioned to make these kinds of advances.

**Functions of Clinical Systems**

Almost all healthcare is delivered by teams; even primary care (the “visit to the doctor”) usually involves a team. Although the frontline primary care practitioners provide a critical point of contact and comprehensive case-management function, they need nurses, laboratories, pharmacies, imaging, and more to practice medicine today. More complex patient needs expand the list. A patient with a serious heart problem is likely to encounter teams in emergency care, angiography and angioplasty, surgery, intensive care, rehabilitation, and primary care, which amount to several dozen people working in six or seven different teams. The clinical system must accomplish two basic functions:

1. Assist each team to its optimal achievement
2. Integrate the teams effectively to optimize patient care

Many researchers have studied the design and operation of excellent clinical teams, which they called “microsystems.” Their conclusions from several case studies and interviews reaffirm the basic principles of continuous improvement, relating them directly to the clinical teams:

A microsystem’s typical developmental journey toward excellence entails five stages of growth—awareness as an interdependent group with the capacity to
make changes, connecting routine daily work to the high purpose of benefiting patients, responding successfully to strategic challenges, measuring the microsystem’s performance as a system, and juggling improvements while taking care of patients.67

Excellent planned care requires that the microsystem have services that match what really matters to a patient and family and protected time to reflect and plan. Patient self-management support, clinical decision support, delivery system design, and clinical information systems must be planned to be effective, timely, and efficient for each individual patient and for all patients.68

Case studies by Batalden and colleagues show that team excellence requires systematic surveillance of customers, associates, processes, and patterns of measured performance. Improved patient outcomes result from process redesign to reduce unnecessary variation, ensure informed clinical decisions, remove waste and rework, and provide support to staff.69 To progress, the microsystems need support from the larger organization to supply the resources, maintain the culture, support the flow of information, and provide leadership.70,71

Batalden and colleagues identify five critical themes for clinical leadership—trust making, mitigating constraints and barriers among departments and units, creating a common vocabulary, raising microsystem awareness, and facilitating reciprocal relationships. These themes are elements of the organizational culture that are strengthened by training, repetition, reinforcement (i.e., reward for appropriate behavior) and, when necessary, correction of inappropriate behavior.72

Clinical leadership and strategic leadership must also meet the teams’ need for providing adequate supplies, equipment, personnel, information, and knowledge. Excellent HCOs use the process of continuous improvement to build both the culture and the integrated processes that support the microsystems. As they do this, they make the organization a preferred place to work, removing the “hassle factors” that frustrate many clinicians. The result is well-designed, smoothly operating processes that please both customers and providers, meeting Institute of Medicine goals and individual workers’ needs simultaneously.

Functions of Technical and Logistic Support
The third system set of an effective HCO provides the resources for the strategic and clinical systems. Its components are built around the kinds of resources required—personnel, knowledge, supplies, equipment, and facilities. Technical and logistic support provides the following:

1. Information and knowledge. Care requires a thorough understanding of each patient’s needs, including the medical history. As the plan of treatment is developed and implemented, the team members need current
information to stay coordinated. Errors and failures in patient information can be life threatening. Accurate financial records are also essential.

Knowledge is now as critical as the information that describes individual care. Clinical teams need knowledge that is described in **protocols**—the normal steps or processes in the care that the team has agreed on. PITs and strategic activities require a great deal more knowledge—historical performance statistics, benchmarks, cost analysis, bibliographies, and special studies.

The information and knowledge systems include finance, accounting, and **information services**. Internal consulting services in planning, marketing, and process analysis support the PITs and strategic analyses. Their services are an important part of knowledge management.

2. **Personnel with the right training to complete each task.** Clinical teams are led by physicians or others with postbaccalaureate training. They include a variety of highly specialized skills that are acquired from educational institutions or in-house training. Strategic systems require skilled managers, lawyers, accountants, and clerical workers. All these personnel need an orientation, compensation, and a competitive benefits package. They must be recruited, often in shortage situations. Retaining them and keeping them safe, healthy, and productive require providing counseling and services like day care. PIT leaders need training in improvement processes and team leadership, while managers need training in management. These functions are provided by a **human resources system**.

3. **Supplies, equipment, and facilities.** Associates, patients, and visitors require a safe, attractive environment that includes food service, parking, conveniences, and even entertainment. Clinical teams need supplies, sometimes with critical timing and handling conditions, as well as sophisticated equipment and specialized environments. These logistic needs are met by a plant service system and a materials management system.

Like the clinical teams, most of the strategic, technical, and logistic activities are built from small teams—**responsibility centers** that supply specific needs and have measured performance. All of these units must function effectively and coordinate with each other to create excellent care. Much of the recent activity in healthcare management has been devoted to understanding and improving the ways in which these teams and the clinical Microsystems are organized. Healthcare systems, for example, can be understood as efforts to centralize strategic, technical, and logistic systems to make them more cost-effective. A large organization has opportunities to negotiate with stakeholders that a smaller one does not. It can seek returns to **scale** by centralizing...
technical and strategic systems, and it can develop a knowledge resource more easily than a smaller organization can.

At the same time, it is possible to acquire some resources through contracts with independent vendors. Logistic services such as food and sanitation are usually purchased by contract. Knowledge services such as benchmarking, consultation, surveying, and data processing are available from outside vendors. Consultants frequently assist with strategic issues. Clinical support services such as imaging and clinical laboratory are often arranged through local firms of specialist physicians; joint ventures are common with these groups and the service lines themselves. The HCO must provide the full array of systems; it does not need to own them to do that. It can also use a wide variety of contracting, ownership, subsidiary, and joint venture structures.

The Managerial Role

To summarize, HCOs are created by stakeholders to meet a broad spectrum of purposes around health and community needs. They are shaped by stakeholder interaction. They respond to stakeholders by building consensus about purpose (mission), shared visions, and values. They achieve their purposes and vision by continuous improvement; reliance on measured performance in multiple dimensions; and establishment of specific, achievable short-term goals for their microsystems.

Management’s role is to make all this happen. Managers identify issues, collect facts, and arrange discussions. They participate directly in many types of listening. They control the measurement systems so that the data reported are accurate. They train and encourage learning. They monitor the culture for conformance to values, encouraging appropriate behaviors and discouraging inappropriate ones. They work with stakeholders to achieve consensus and resolve disagreements. They are directly involved in designating leaders for system components. They monitor actual performance against goals and manage the distribution of rewards.

Managers start as team leaders and rise to greater responsibility and more complex issues. Their skill is often critical in the organization’s success. Managers at all levels relate to stakeholders, although in different ways. Some of the ways managers relate to stakeholders, at senior and starting levels, are shown in Figure 2.8. Excellent managers constantly seek ways to increase total stakeholder value, studying processes and policies; forming and leading teams; and overcoming obstacles and objections by careful listening, debate, and redesign. The activities shown in Figure 2.8 reflect a style of management called “transformational,” which will be discussed further in Chapter 4. In all reported cases, excellent HCOs rely on transformational management.
### FIGURE 2.8
Examples of Managerial Roles in Stakeholder Relations

<table>
<thead>
<tr>
<th>Relationship Activity</th>
<th>Senior Managers</th>
<th>First-Line Managers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Listening</td>
<td>Conduct community surveys and focus groups</td>
<td>Talk with patients, families</td>
</tr>
<tr>
<td></td>
<td>Meet with community leaders and spokespersons</td>
<td>Observe work processes</td>
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<td></td>
<td>Participate in community activities, service clubs, etc.</td>
<td>Talk informally with associates</td>
</tr>
<tr>
<td></td>
<td>Ensure open-door and on-call availability to associates</td>
<td>Participate in community activities, service clubs, etc.</td>
</tr>
<tr>
<td></td>
<td>Walking rounds</td>
<td>Review satisfaction surveys</td>
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<tr>
<td></td>
<td></td>
<td>Assist associates with work</td>
</tr>
<tr>
<td>Ensuring accurate data</td>
<td>Monitor performance reports</td>
<td>Enter data for reports</td>
</tr>
<tr>
<td></td>
<td>Train new associates in information policies</td>
<td>Retrieve information</td>
</tr>
<tr>
<td></td>
<td>Respond to audit requests</td>
<td>Explain information policies to new associates</td>
</tr>
<tr>
<td></td>
<td>Attest accuracy of financial and quality-of-care reports</td>
<td>Encourage complete, accurate reporting</td>
</tr>
<tr>
<td>Training and publicizing</td>
<td>Establish training programs</td>
<td>Train new associates</td>
</tr>
<tr>
<td></td>
<td>Work with high schools and community colleges</td>
<td>Train all associates in new procedures</td>
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<td></td>
<td>Speak to interested groups</td>
<td>Put up posters for celebrations</td>
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<td></td>
<td>Prepare and issue reports</td>
<td>Report associate achievements</td>
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<tr>
<td>Improving work processes</td>
<td>Identify variation and benchmarks</td>
<td>Identify variation and benchmarks</td>
</tr>
<tr>
<td></td>
<td>Establish and guide performance improvement teams (PITs)</td>
<td>Participate in PITs</td>
</tr>
<tr>
<td></td>
<td>Identify strategic possibilities</td>
<td>Establish informal PITs</td>
</tr>
<tr>
<td></td>
<td>Participate in PITs</td>
<td>Celebrate performance improvement</td>
</tr>
<tr>
<td></td>
<td>Plan performance improvement celebrations</td>
<td></td>
</tr>
<tr>
<td>Building consensus</td>
<td>Discuss differences with stakeholders</td>
<td>Discuss differences with associates</td>
</tr>
<tr>
<td></td>
<td>Establish and maintain an evidence-based, honest culture</td>
<td>Maintain an evidence-based, honest culture</td>
</tr>
<tr>
<td></td>
<td>Guide associates and stakeholders to opportunities for debate</td>
<td>Negotiate solutions to specific problems</td>
</tr>
<tr>
<td></td>
<td>Negotiate solutions to specific problems</td>
<td></td>
</tr>
</tbody>
</table>
Questions to Debate

How do stakeholders’ needs differ? By age—old versus young? By income—rich versus poor? By role—buyers versus providers? By geography—Jackson, Mississippi, versus Jackson, Michigan?

The chapter adopts a specific theory of operations and a set of values for a well-managed HCO. There are other theories, such as “3-legged stool” (stakeholders are the board, management, and medical staff), “satisficing” (meeting all stakeholders’ minimum, as opposed to optimum, needs), and “profit maximization” (totally or partially excluding the values of both IOM and Healthy People initiatives). How would these theories change operations in a hospital, and would the change be better or worse?

How does an HCO hear its stakeholders? How does it resolve conflicting stakeholder views? What would happen if only some stakeholders owned an HCO and others were simply users or buyers of service?

Must an HCO always have three component systems—governance, clinical, and support? What would happen if it didn’t? Are there ways to have a system without owning a system? How can an HCO decide what it should own?

What is the managers’ role in HCOs? How is the role different from the folk tradition of managerial roles (like Donald Trump in the television show The Apprentice or “the boss” in popular literature)? Why has this difference developed?

Suggested Readings

On Organization Theory

On the History of Hospitals and Healthcare
Chapter Two: Relating Healthcare Organizations to Their Environment


**On the Future of Healthcare**

**Notes**


23. Ibid.


47. Ibid.

48. Ibid.


56. See, for example, the credo of Johnson & Johnson at www.jnj.com/who_is_jnj/cr_index.html. The company has a century-long history of exceptional profitability and argues that its record is *because*, not in spite, of its credo.


