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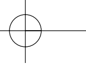

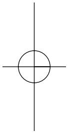

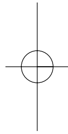

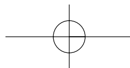

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CHAPTER 3

The Health Care Industry: A Managerial Model

Health care organizations can generally be classified into three basic groups, depending on their financial sponsorship: (1) for-profit, (2) non-profit, or not-for-profit, or (3) governmental. This classification results in a significant number of anatomical and physiological differences that to a great extent affect the organization's management processes.

THE PROFIT SECTOR

The for-profit sector encompasses a wide range of organizations. At one end of the spectrum, at least in terms of staff and revenues, are the independent practices of physicians, dentists, optometrists, chiropractors, and other providers' organizations such as independent pharmacies. In the past two decades these small businesses have reached a level of managerial sophistication rivaling that of larger organizations. Even the smallest practices have computerized appointment and billing systems, and many have payroll systems, accounts receivable and payable systems, and even marketing plans. Other practices find it more efficient to use the omnipresent consultant services to perform these functions. At the most sophisticated end of the range of for-profit direct care providers are large group practices, which are likely to be organized as partnerships, employ hundreds of professionals and nonprofessionals, and own real estate and a host of other business ventures (often under separate corporate entities).

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Inpatient facilities are a more complex form of for-profit organization. The recent history of many of these large organizations, particularly in the areas of hospitals and nursing homes owned by large chains and publicly held corporations, has been quite interesting, albeit unstable. All of those activities that we have traditionally associated with big business we now see in the health industry: mergers, acquisitions, divestitures, leveraged buy-outs, and unfortunately bankruptcy. For example, one giant of the hospital field is HCA, formerly known as Hospital Corporation of America. This company started in Nashville, Tennessee as a single hospital by Dr. Thomas Frist, Sr. (father of U.S. Senator Bill Frist) and grew through a series of mergers and acquisitions to 465 hospitals in 1987. The company still remains a giant corporation. As of December 31, 2002, HCA owned and operated 171 hospitals with over 41,000 beds, 6 psychiatric hospitals with 1,925 beds, and a host of other organizations, including day surgery centers, therapy centers, and rehabilitation programs employing 178,000 staff (52,000 part-time).[1] The nursing home industry, once the darling of Wall Street investors, went through a period of enormous growth and integration that led to companies like Beverly, Manor Care, Kindred (previously Vencor), and Mariner. Changes in financing and reimbursement, the litigation environment, and general problems in the economy in the first few years of the 21st century resulted in a dramatic shake-up in the long-term care industry. For example, financial losses due to insurance costs and the litigious environment in Florida cost three of the big chains, Beverly, Extendicare, and Kindred, to sell their holdings in the "Sunshine State." On a national scale, between January 2002 and April 2003, the top 10 nursing home chains downsized almost 18%, from 338,684 beds to 277,960 beds.[2] Perhaps most important, in terms of loss of investor confidence, was that five of the largest publicly traded nursing home companies were forced into bankruptcy in order to restructure their organizations and debt.

Health maintenance organizations (HMOs) are one of the most recent and interesting organizational development in the health care industry. Although they have been around since the 1930s, their remarkable growth did not occur until the last two decades of the 20th century. In 1984 they cared for 15.1 million people, and by 2000 the number had grown to

[1] "Desperate families embrace unapproved Alzheimer drug," *The New York Times*, June 15, 2003, p. 1.

[2] "CMS Health Care Industry Market Update," *Nursing Facilities* (May 20, 2003), p. 6.

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80 million.[3] Back when the HMO industry was in its relatively infantile stages with 10 million enrollees, 88% of enrollees were in nonprofit plans. Over the next two decades not only do we expect to see significant growth in addition to the 80 million of the year 2000 but we also expect to see a shift in ownership, with approximately 64% of enrollees now in for-profit plans. Equally important is that many of these for-profit plans started their life as nonprofit organizations. In their analysis, the organizational model of a for-profit enterprise provided significant advantages over the nonprofit model. For example, it was argued that for-profits had easier access to capital markets and tended to manage themselves more efficiently and effectively.

A final group of for-profit organizations that are often forgotten, although they are clearly forces for development and change in the health care field and offer a wealth of managerial challenges, are the commercial firms. Examples are chain pharmacies, drug manufacturers, clinical laboratories, investment bankers, and insurance companies. It is tempting to include in this group virtually any organization that employs a large number of people and thus is obligated to expend significant resources on health benefits. For example, as noted in Chapter 2, General Electric's stake in health care is so large that it is focusing on obesity in its workforce as one strategy for controlling its health expenditures.

THE NONPROFIT SECTOR

The nonprofit organizations are those most often associated with the health field. Nonprofit does not literally mean that the organization should not make a profit but rather that any surplus of revenue over expenses should not inure or be passed on to any group of stockholders or owners. Rather, all "profit" should be reinvested in the organization for its growth and development. Such organizations are classified by the Internal Revenue Service as 501(c)(3), which means nonprofit and tax-exempt. They can be the recipients of tax-deductible contributions and usually do not pay sales or real estate taxes (although there are many challenges to the real estate tax exemption). The significance of this 501(c)(3) exemption should not be understated. Nonprofit hospitals, for example,

[3] "CMS Trends and Indicators in Changing Health Care Marketplace," *2002-Chartbook*, Table 1.18.

often sit on prime real estate that would generate significant dollars for a community, which still must provide the organization with community services such as fire and police protection. The sales tax exemption is also real dollars. The organization I headed spent about $21 million per year that was not taxed at the regular 6% rate, saving the organization $1.2 million per year, which the community had to find in other ways (or cut services). Most community hospitals, health system agencies, hospital councils, and voluntary health-related organizations, such as the American Cancer Society, MS Society, or the Association for Voluntary Sterilization, are in the nonprofit category, as are 90% of the Blue Cross and Blue Shield Plans throughout the United States.

The mixed for-profit and nonprofit situation of some organizations within this framework is somewhat confusing. Kaiser presents one of the simplest examples. The nonprofit Kaiser hospitals work hand in glove with for-profit Permanente medical groups. A different example can be observed within a community hospital, where a snack bar or gift shop is run on a for-profit basis and the surplus from this unit is used to subsidize the operations of other parts of the institution. In some instances, such as when an organization has a highly visible business spun off from the original nonprofit, the subsidiary may be a for-profit venture. This typically occurs when a hospital or health system has a for-profit consulting business or thrift shop. The idea is that the for-profit organizational vehicle is more flexible and less likely to run into regulatory constraints, and if the subsidiary corporation does make a profit, it will be returned to the parent nonprofit.

GOVERNMENT

The federal government, state governments, and even local governments own and operate a staggering array of facilities and programs. At the Department of Veterans Affairs (VA) there are 138 hospitals with 45,000 beds, a size rivaling that of the large private chains such as Beverly, Quorom, or Tenet. Theoretically the average size VA hospital is 326 beds, which happens to be the exact bed count at the VA in the Bronx. Obviously there are larger VA hospitals, but also far smaller ones, such as the 60-bed facility in White River Junction, Vermont. The Department of Defense operates 18 Navy hospitals, 18 Air Force hospitals, and 25 Army hospitals. Some, such as the Army's Tripler Army Medical Center in

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Hawaii, have a moderate number of beds (209) but huge outpatient loads (in excess of 596,000 visits per year). Another federally funded hospital and health care operation is the U.S. Public Health Service's 50 Indian Health service hospitals with a total of 2062 beds and active ambulatory clinics. Official health agencies such as health departments or the U.S. Department of Health and Human Services (HHS), the Center for Disease Control, and state and local health departments are also important organizational components of the health systems. The importance of governmental health agencies was well demonstrated in 2003 during the SARS outbreak in China and Toronto. Finally, there is a range of state health-related or programs that often do not belong to official "health" agencies, such as family planning services, Medicaid management programs, and health care in prisons and jails.

MANAGERIAL MATRIX

The managerial matrix is a way of considering the issues in this chapter. Across the horizontal axis of the matrix are the three previously discussed classifications: for-profit, nonprofit, and government. The vertical axis lists a range of managerial functions and structural elements that relate to a manager's ability to organize and direct an organization.

Organizational Function

Delivery of Services

The first question considered in this matrix is that of primary function: What is it that the organization is supposed to do? One function is the delivery of services to individuals, which clearly can and does occur in all three organizational forms. Abortion services are perhaps a simple illustration. An individual desiring such a service can usually find it in a nonprofit hospital, a for-profit abortion clinic, and in some states a government-owned hospital. Whether potential customers recognize the particular financial status of the organization they are dealing with is a matter of conjecture, as are some of the implications of the organizational form. In some cases, however, it is an important distinction. For example, a for-profit organization that is responsible to stockholders may refuse to accept the patient who is unwilling (or whose insurer is unwilling) to pay

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the bill. On the other hand, if the deliverer of care is a governmental agency or nonprofit organization, it might view its responsibilities in such a way as to essentially require the delivery of care to the uninsured patient.

The blurring of distinctions between organizations is well illustrated in the hospital field. Decades ago, the federal government owned and ran hospitals for the indigent or for specific beneficiaries such as the military and their dependents. The nonprofits tended to be the community hospitals, which took a share of the indigent as well as the insured. In this group of community institutions we also found the teaching hospitals, with their internship and residency programs, and medical school hospitals. The private hospitals were oftentimes the "Doctors' Hospitals" and were used primarily by practitioners for their privately paying patients. For example, in 1929 two brothers established the for-profit 59-bed maternity and pediatric Madison Park Hospital on Kings Highway in Brooklyn, New York. In 1972, because of financial problems, the hospital converted its ownership form to nonprofit. Today, the hospital, now known as New York Community and part of the 11-hospital New York-Presbyterian Healthcare System, is a 125-bed general medical and surgical hospital that no longer offers maternity or pediatric services. In discussing the management of this facility, Lin Mo, its president and CEO, suggests that in many ways it has to be run like a bottom-line-oriented business: "[T]here is a constant and continuing process of striking the right balance between providing the best patient care we can afford to give; meet the regulations and not loose our shirt in the process through unnecessary services such as an MRI that may not be required or unnecessary overtime. This is a constant balancing act that requires continual attention to our budget and education of staff and physicians."[4]

While the conversion of proprietary to nonprofits has blurred one line, there has also been a blurring due to the conversion of traditional community hospitals into components of private chains. Illustrative of this state of affairs is St. Mary's Hospital in West Palm Beach, Florida and Good Samaritan Hospital in Palm Beach, Florida. These hospitals, formerly part of the nonsectarian Intracoastal System, were sold to Tenet Healthcare in 2001 for $244 million. The sale was precipitated by losses during the previous years, including a $40 million loss in 2000. As of

[4]Interview with Lin Mo, July 25, 2003.

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2003, Tenet has been able to manage the hospital in a profitable manner while continuing to provide the same level of charitable care that was given by its nonprofit predecessors. (This was also a condition of sale.) How have they been able to do it? First, they are careful in their admitting process, ensuring that uninsured patients have properly applied for either Medicaid or county support. As part of this admission system, they aggressively collect copayments and deductibles. Finally, they engage in intensive organizational management practices, such as careful shift staffing management and inventory control. In the simplest terms, they have introduced a level of careful bottom-line management heretofore unknown.

The buying and selling of these institutions and the movement between for-profit and nonprofit status has one additional dimension. For example, when a for-profit hospital less than a mile from New York Community was sold to be part of a different system, the owners were able to get an asking price in excess of $40 million. But, it also goes the other way. The Intracoastal Hospitals were sold to Tenet for a price of $244 million, with an apparent net proceeds of $50 million going to the establishment of the Palm Healthcare Foundation. This foundation generously provides in excess of $2 million each year to improve health care in Palm Beach County.

Planning

In the context of this discussion, I am referring to community planning for health services rather than individual organizational planning. The issue, then, is to what extent is an organization responsible for the planning of health services on a community basis? Most community planning in the United States is carried out by governmental and nonprofit organizations. Indeed, to some extent, government defines a major role for itself as that of planning. For example, the state of Florida, like most states, has a comprehensive health plan with clear implications for the providers of care. Goals such as "Enhance and improve the Emergency Medical Services (EMS) system," or "Increase the availability of health care in underserved areas" clearly affect the size and shape of the system. How government uses various points of leverage to achieve the desired outcome is essentially a political decision. Some years ago, Massachusetts decided to do something about health care cost, quality, and access by passing a balance billing law that made it illegal for physicians to bill Medicare patients for more than their approved coverage. The law was

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also expanded to cover other groups such as state employees and Blue Cross and Blue Shield subscribers. What is most interesting is that the power to enforce this law came through the licensure system; that is, as a condition of obtaining a license to practice medicine in Massachusetts, a physician must agree not to balance bill. Another Massachusetts example comes from the General Laws of the State, which give considerable planning and management power to the board of registration in medicine. Two quotations from the General Laws illustrate this point:

> The board is hereby authorized and directed to develop and implement, without cost to the commonwealth, a plan for a remediation program designed to improve physicians' clinical and communication skills.
>
> There shall also be established within the board of registration in medicine a risk management unit. Said risk management unit shall provide technical assistance and quality assurance programs designed to reduce or stabilize the frequency, amount and costs of claims against physicians and hospitals licensed or registered in the commonwealth. The board shall promulgate regulations requiring physicians to participate in risk management programs as a condition of licensure; provided that such regulations shall provide for an exemption from such requirements for physicians who are participating in pre-existing risk management programs that have been approved by the board.[5]

Clearly, government, because of its power of licensure and control over vast sums of money, has the greatest potential leverage in planning health services. Private firms do enter the world of planning, but usually as consultants to voluntary and government agencies that have the responsibility and authority for planning.

Some states have the power of "Certificate of Need"; that is, they can approve or disapprove any major project through a governmental review process. Failure to receive a certificate effectively blocks financial reimbursement for the project. For example, in Virginia, the state Department of Health has a Division of Certificate of Public Need, and that Division is part of the Center for Quality Health Care and Consumer Protection. The preface to its 2002 annual report to the governor and General Assembly of Virginia on the Certificate of Public Need (COPN) provides a useful statement about such programs:

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[5]ALM GL ch. 112§ 5 (2003).

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> The COPN is a regulatory program administered by the Virginia Department of Health (VDH). The program was established in 1973. The law states the objectives of the program are (i) promoting comprehensive health planning to meet the needs of the public; (ii) promoting the highest quality of care at the lowest possible cost; (iii) avoiding unnecessary duplication of medical care facilities; and (iv) providing an orderly procedure for resolving questions concerning the need to construct or modify medical care facilities. In essence, the program seeks to contain health care costs while ensuring financial and geographic access to quality health care for Virginia citizens at a reasonable cost. . . .
>
> During FY02 . . . [t]he Commissioner issued 103 decisions. . . . [N]inety-six of these requests were approved or conditionally approved, for a total authorized capital expenditure of $629,138,592. Seven requests were denied. These seven denied projects had a proposed total capital expenditure of $54,370,371.[6]

It would be a mistake to assume that because so few projects were disapproved that such programs were not successful. The political reality is that in many instances projects are simply not submitted because proponents know that they will not fare well. In the case of Virginia, the state received letters of intent for 27 other projects, but for various reasons they never got to the level of a COPN decision.

Monitoring and Evaluation

A third broad function is related to the monitoring and evaluation of health services. Although this is a function that all organizations perform, the question really is whether this is a primary function of the organization. Does the organization in part exist in order to monitor and evaluate other health care organizations? The function is typically a governmental responsibility that may be handled directly by government or delegated to a nongovernmental organization. When delegation occurs, the agent of government is typically a nonprofit but may also be a for-profit organization. Its organization form is less significant than its clearly delegated and delineated function.

Consider this example from the field of criminal justice. Since 1983, the Corrections Corporation of America (CCA), a for-profit company that is traded on the New York Stock Exchange, has been empowered to

[6]Commonwealth of Virginia, Annual Report on the Status of Virginia's Medical Care Facilities Certificate of Public Need Program Fiscal Year Ending June 30, 2002, pp. 1–2.

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manage 60 jails and prisons in the United States that house approximately 55,000 inmates.[7] This company, which also owns 40 prisons, contracts with governmental agencies to house prisoners who have been sentenced by the government. While obviously the inmates must received medical treatment and the prison run within a variety of governmental guidelines, we see here a significant blurring of the traditional lines between the role of government and the role of the private sector. And so it is in health care!

Thus, while the function of monitoring and evaluating health care is usually considered governmental in nature, it sometimes is taken on in quasi-governmental organizations or voluntary organizations that receive most (if not all) of their funding from the government and thus are in one way or another accountable to government. Professional review organizations (PROs) are an example of non-governmental organizations that contract with the federal government, and sometimes state governments, for the purpose of reviewing Medicare and Medicaid medical claims as well as state health insurance programs for the medically indigent. In Massachusetts the PRO, known as MassPRO, is a "wholly owned subsidiary of the Massachusetts Medical Society . . . [and] is a nonprofit organization governed by a Board of Directors comprised of physicians, health care administrators, researchers, academicians, and consumers."[8]

There are many instances in which proprietary organizations, particularly consulting firms, get into the business of monitoring and evaluating health services. Recently, many of the large public accounting firms and management consulting firms have developed significant capabilities in the areas of health services. No longer do these firms limit themselves to the roles of auditor and occasional advisor, but bid on requests for proposals from Washington or any state capital. Indeed, many of these firms have developed a remarkably strong record of excellent evaluations of health services.

Regulation

A fourth broad function is that of regulation. Government at the local, state, or national level has maintained essential control; it could even be argued that this control can never be totally delegated or transferred. To a limited extent, however, governmental agencies do transfer or allow

[7]Data retrieved (July 30, 2003) from www/correctionscorp.com/main/media.html.
[8]Data retrieved (July 23, 2003) from www.masspro.org.

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voluntary agencies to "regulate." With Medicaid, for example, one level of government subcontracts with another level. This is illustrated by the fact that the auditing of the performance of nursing homes is handled by state inspectors operating under the direction of federal regulations. At the national level, the federal government has also essentially transferred one of its major control devices for Medicare to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO, pronounced "Jayco"). If a hospital chooses to be inspected by JCAHO and passes, it receives a "deemed status." This deemed status means that the organization has met the federal Medicare standards and the government will accept that JACHO inspection as a certification. (In a small number of cases the government will go in to verify the survey.) Medicare-certified home health agencies and hospices can also go the voluntary survey route of JCAHO rather than the federal inspection route. Other JCAHO inspections, such as for nursing homes, do not result in deemed status and do not preclude the state surveyors from visiting. This pattern of cooperation among various levels of government and voluntary agencies appears to function as an organizational analogue of professional self-policing, and for the most part abuses have been limited.

Proprietary, voluntary, and governmental organizations all pay for services, but each approaches payment with a rather different philosophy. The largest group of payers are the commercial insurance companies, whose primary responsibility is to their stockholders. This "bottom line" approach, which takes into account the fact that insurance coverage is not marketed solely as a social good but also as a means for a commercial organization to make a profit, results in a somewhat hands-off attitude toward the health system and its consumers. The insurance company is duty bound to charge premiums in accordance with likely risks; if the costs of doing business go up, so do the premiums.

In the past several decades, the health insurance industry has gone through many changes. For example, to most outsiders, it appears that the big payer for health services is the Blue Cross Blue Shield organization. The "Blues" were originally all nonprofit organizations, very much tied into the hospital industry. A significant number of the remaining 43 Blue Cross and Blue Shield plans today are nonprofit entities who compete with other commercial insurers and HMOs for the health insurance dollar. For-profit Blue Cross organizations currently exist in numerous states, including California, Georgia, Missouri, Wisconsin, Indiana, Kentucky, Ohio,

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Connecticut, New Hampshire, Colorado, Nevada, Maine, and Virginia. Many insurers are also in the business of being fiscal intermediaries for the government. According to the Blue's trade association, "In 2002, Blue Cross and Blue Shield Medicare contractors processed more than 90% of the claims from hospitals and other providers (Part A) and nearly 67% of the claims from physicians and other health care practitioners (Part B)."[9]

GOAL CLARITY

Another basic question is: How clear or diffuse are goals for organizations under these three classifications? In the for-profit organization, regardless of its function, the goal clearly is to make a profit. While it is evident that a for-profit organization may have "lines" that do not make a profit but serve a public good, the organization's overall viability is quite clearly related to its ability to generate profits. A proprietary hospital or group practice cannot continue in existence if its income is less than its costs; further, it will have significant difficulties if it cannot offer a balance sheet or profit-and-loss statement attractive enough to bring in additional capital.

The nonprofit organization has goals that are somewhat less clear. If asked what the goals of the hospital are, a typical teaching hospital administrator is likely to respond, "We have a threefold mission—teaching, research, and service." These days, administrators talk of fiscal integrity, return on investments, and market penetration, but there is also the possibility of fundraising, endowment incomes, and the often not-very-remunerative goals of teaching and research

At another point on the spectrum of clear to diffuse goals are those of government health care organizations. These organizations are partly constrained (or facilitated) because they are governmental agencies and must to a great extent be responsive to an elusive constituency; additionally, they are constrained as public health organizations by the myriad problems that health care organizations of all types encounter.

In operational terms, these differences can be seen in the staffing ratios of proprietary hospitals versus those of government institutions. For example, in New York City in the mid-1970s, municipal hospitals had a ratio of seven staff to each bed (7.5), which was more than 100% higher than

[9]Data retrieved (July 30, 2003) from www.onlinepressroom.net/bcbsa.

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that of comparable proprietary or voluntary institutions. Analyses of the functioning of these institutions did not reveal any significant differences in patient mix or intensity of service; they did reveal lower productivity in the public sector, less control of productivity, more politically motivated appointments, and, finally, the anathema of all government programs—civil service, or what some view as the protection of incompetent or unnecessary staff. Return on investment decisions were not made on any basis other than political expediency. Another way of viewing this was offered by a former director of a government hospital when he referred to his institution as an employer of last resort in the community.

Revenues

How do these organizations earn or acquire their operating and capital funds? Proprietary organizations have only one significant source of operating capital: those who utilize their services. Fundamentally, these organizations become directly responsible to consumers, who, in classical market terms, vote with their dollars. Here it is necessary to recognize the clear imperfections of the medical care marketplace, in that effective demand is for the most part determined by the providers, since consumers have quite limited knowledge of the costs and benefits of the various options. A group practice that is poorly located or offers services at inconvenient times may find itself out of business simply because it depends on clients for revenue and has no opportunity to generate revenue from nonclient sources.

Capital funds are a somewhat different matter, since proprietary organizations can readily avail themselves of a range of private investors who willingly offer capital if they envision a good return on their investment. Perhaps the best example of this are health care stocks and bonds. Despite the vagaries of the stock market, health care companies still rank as reasonable investments and bond offerings still tend to be in the investment range.

Nonprofit organizations derive their operating funds from two major sources: consumers and philanthropy. In a very real sense, they, too, must satisfy their constituency; otherwise, their major source of operating income could be jeopardized. They have important ways of supplementing their accounts, however, such as fund-raising and gifts of various sorts. Such donations are rarely made to a proprietary organization, partly because these organizations do not solicit donations and partly because

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such a gift not only has no tax benefits for the donor but is also considered taxable income for the recipient. Further, few charitable organizations will provide money to for-profit organizations, since such gifts could jeopardize their own charitable status.

Capital sources for nonprofits are fourfold. First, like all organizations, they can attempt to have surplus revenues and then invest those funds for future capital projects. Second, because of their tax-exempt status, they can actively solicit donations from individuals and foundations for building projects. Third, they can go into the bond market and offer tax-exempt bonds, which typically sell at lower rates than corporate bonds offered by for-profit companies. The quality of their bond offering is a function of their balance sheet, so it is imperative that even the most community-minded nonprofit organizations be managed almost as if they are for-profit entities. Finally, they can attempt to borrow money from any number of lenders. The issue for the lender, once again, will be the strength of the organization's balance sheet.

A third source of income is really not income at all but is essentially a bonus to nonprofit organizations, and this is the often debated tax exemption. Depending on location and quality of facility, a small community hospital may be worth millions of dollars. What would that amount to in terms of real estate tax? What about sales tax? A hospital or health system typically will save millions of dollars each year as a result of their tax exempt status.

Government organizations and, to some extent, quasi-governmental organizations, acquire their money from three primary sources: consumers, philanthropy, and taxes. A state health department, for example, does not have to generate any funds itself (although some enrich their operations by seeking additional project money from foundation or governmental funding); its dollars flow from the state budget, which is in turn related to taxes. Many government-funded programs, including those that are direct service programs, are removed from direct responsibility for generating their budgets. The conceptual notion of a service responsibility predominates, although even in government programs, accountability is required; but this accountability is usually upward to a field or regional office as opposed to downward to the consumer.

A related question with regard to resources is: To what extent can managers affect the flow of resources into an organization? In other words, how much freedom does a manager have in developing programs to

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attract new clients or new dollars? Despite the range of controls exercised on health organizations, there is some degree of freedom; the extent varies between the three major types of organizations.

Managers in for-profit operations probably have the greatest flexibility within their organizations for expanding revenue sources, since the clear mission of these organizations is related to their ability to generate adequate (and increased) revenues. Nonprofit organizations have certain constraints, the most significant of which is (as was noted earlier) their tax-exempt status. While this is fundamentally a benefit, it is also a potential problem in that it may preclude the development of new and profitable services. This is not to suggest that nonprofit organizations cannot or do not go out and market their services; indeed, they do in a variety of ways. Perhaps the major conceptual constraint is related to the somewhat more diffuse mission of the nonprofit organization. A nonprofit organization might knowingly develop a program that is clearly unlikely to be self-supporting simply because there is a community need for it or because it is viewed as part of the organization's service responsibility. Rarely is such benevolent behavior seen in for-profit organizations.

Government organizations are usually much more constrained than either of the two other types of organizations. Government organizations may be prevented by law or custom from offering services to "non-eligible" recipients. To put it another way, the programs in which they are engaged are developed solely to satisfy certain clearly defined constituencies. To go beyond those constituencies is an encroachment on someone else's territory and may be beyond their scope of responsibilities and likely reimbursement. If an organization does go beyond its jurisdiction, there are often disincentives to provide the service. It is interesting to note how many municipal hospitals that had limited themselves to indigent patients decided to open their doors to insured or privately paying patients when faced with budget crises. As President Clinton was fond of saying, "It's the economy, stupid."

Expenses

While resources are one managerial headache, costs are no doubt the major headache of managers of all health care organizations. The question of concern here is: To what extent can managers in these various organizations control costs? To address this question properly, it must be recognized that the typical health care organization has two types of costs: fixed

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and variable. The fixed costs are those that, for the most part, are beyond the scope of the organization's, or at least the manager's, ability to control, and may be considered overhead. Of course, even this concept is a bit illusory, since there is a certain latitude within fixed costs; for example, energy costs might be considered fixed, and yet through careful analysis of alternative systems a manager might find satisfactory substitutes. The variable costs are simply those attached to each specific patient visit. As an illustration, a family planning clinic has fixed costs for its land and building (mortgages and interest), regardless of the number of visits of patients per week, month, or year; however, each visit generates other costs directly related to the visits, such as supplies that are consumed.

The single largest item in virtually any health care budget is salaries, typically running upwards of 60% in a hospital or nursing home. How can a manager affect that item? In a for-profit enterprise, the traditional solution is careful attention to productivity and hiring. Control of this critical section of the budget has been more difficult, however, in government and voluntary agencies, where hiring has historically been used to provide a safety valve for unemployment.

Community organizations, simply because of their "closeness" with the community, must be more circumspect in how they deal with this issue of staffing. Perhaps one of the best examples is the Hunterdon Medical Center in Flemington, NJ. In the mid-1970s, in response to a declining census, the hospital closed off beds that logically would have dictated laying off workers. Yet, as one of its largest community employers, the company felt a responsibility to the community and decided not to lay off workers, hence putting itself into a difficult financial situation. Would a for-profit company have acted in such a way?

Some years ago, one of the nation's largest tire manufacturers negotiated a 50 cents per hour pay decrease with its union so that the plant would not follow other companies that moved to the Sun Belt and abandoned workers in the "decaying" industrial East. Could this happen in the health care field? How can the Health and Hospitals Corporation of New York close hospitals or hospital beds without losing jobs? Many managers admit that their health care organizations are overstaffed, but what can they do about it? In the for-profit organization, the answers seem simpler, perhaps because the self-interest of the organization is more clearly identified than the amorphous "public interest" that the government or voluntary organization must serve.

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Feedback and Action

Assuming that the problem has been diagnosed, what can be done? This is perhaps one of the most perplexing problems facing the line manager. In the context of the matrix, this is termed the feedback loop and action. To what extent will data and analysis result in some type of corrective action? Assume that a particular program area is not achieving its goals because an individual worker is simply and blatantly unproductive. Attempts at assisting the worker have been to no avail, and the manager has come to the distasteful conclusion that the worker must be fired. In the for-profit organization, it is usually the manager's prerogative to discharge the worker; if justification is required, it is to a higher-level manager or perhaps a union. In the voluntary agency, additional constraints may be imposed because of community pressure; discharging an informal community leader may bring unacceptable consequences. In government, the obvious problem is the civil service, a system that was designed to protect the worker from arbitrary and capricious "bosses" and that now functions, in part, to protect arbitrary and capricious workers from the reasonable and often difficult economic decisions of management.

Many other examples can be used to illustrate the differences among these three major organizational types when they are faced with data and information. In New York City, the president of the Health and Hospitals Corporation "buried" a report on one of his hospitals because he felt the community would be outraged if it was known that "their" hospital was threatened with closing. A for-profit management company "cleaned house" at one New York voluntary hospital by laying off hundreds of employees and thus brought a measure of fiscal stability to that institution. Is it possible that the former hospital director, one of the nation's most thoughtful and knowledgeable professionals, had simply not been aware of the solution? Hardly! Rather, as the agent of a charitable organization, he was not empowered to make the "hard-nosed" business decisions that were acceptable under the regime of a proprietary business firm.

Action, then, is in large part related to the number of constituencies and constraints that must be satisfied. Certain organizations have fewer constituencies than others, and the goals of some are sharper than others. Action for the for-profit organization relates to the bottom line, either today or in the foreseeable future. At the other extreme, action in government relates to an unclear and oft-debated public good, as well as to the prospect of reappointment or reelection.

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A final example: During the time I was a CEO of a nonprofit, I decided for a number of legitimate reasons to discharge a senior staff person. I offered him the option of resigning or being fired. He selected the option of an immediate resignation. Later that day I was discussing this with my brother, who was then the dean of a major medical school. At the other end of the phone line I heard his astonishment and perhaps envy. He, too, wanted to fire some staff and faculty, but organizational rules and tenure made such personnel actions time consuming and not always possible. In this case, each organization operated with different constraints, and the university's constraint of tenure represented a major stumbling block to change.

MANAGERIAL TIME FRAME

The time frame in which management must act may differ in these various organizational arrangements. In for-profit and voluntary organizations, it is postulated that both top and middle management have and can afford a time frame long enough to plan and implement properly. In essence, they can emulate the model of private industry, such as the automobile industry, in which up to a decade may pass from the time of a new model's inception to the time of its introduction. Both top and middle management have a sense of stability that allows them to plan, develop, and, in some cases, test alternatives. They simply do not have to make a "splash" to survive the next political purge or election.

For the middle manager in government, who is often protected by civil service, the time frame may also be long. On the other hand, top management in governmental agencies and programs are continually asked to produce results by absurd deadlines. A governor is elected in November and asked to produce a multibillion dollar budget in January. A member of Congress complains, and a secretary or commissioner is asked to solve a complicated social problem within a few days.

The press both facilitates and complicates these public management positions. Most people cannot name the heads of the Fortune 500 companies but can easily identify senior government officials. Why? Because these officials are always in the spotlight and, in many senses, are being asked for "action." A government agency must act in order to develop a constituency both within and outside of government and thus ensure its

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own managerial well-being. Because they have their own resources, private and voluntary organizations can afford more independence in both planning and action.

The reward structure for management is rather diffuse and sometimes confusing. In the private and nonprofit organizations, income, benefits, and privileges are usually directly related to the quality and quantity of work, or, to put it another way, to the value or esteem in which the organization holds a person. A top manager in one of these two organizational types has considerable latitude in how or when people are rewarded; sometimes a day off, a small bonus, or a new title can be given. For top management in the government organizations, however, degrees of freedom are severely limited, particularly with nonprofessional staff. With so little latitude, managers may find themselves not only unable to motivate employees but also unable to prevent them from being dissatisfied because of those tremendous trivialities that so often irritate employees and prevent them from doing a reasonable day's work.

THE MANAGEMENT ROLE

In both private and voluntary organizations, individuals become managers and remain managers because of their loyalty and performance. Most organizations want people who are loyal to their ideas, concepts, and goals. Loyalty is not enough, however. The manager must have needed skills, which can range from being a financially technocratic whiz to being a skilled negotiator. Organizations have natural histories and needs for different types of people at different times. The manager's skills must contribute to the organization, and the possessor must be recognized as the integral implementer of the skills.

In a theoretical sense, it could be argued that effective health administrators are those who have an understanding of the health system within which they have to operate, the skills to manage it, and the knowledge to apply those skills judiciously. Some, on the other hand, argue that "management is management" and is a totally transferable skill. Others say that "management is a bunch of crap" and that what a manager really needs is to know something about how health services are organized and to have a feel for the "people."

The most costly and possibly most unfortunate natural experiment on this issue has been the New York City Health and Hospitals Corporation.

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In 1978, for example, the newly appointed president of this billion-dollar corporation was described by the mayor as a man with top-flight management skills gleaned from his experiences as the number-two man in the New York City Police Department. The official health establishment in New York City mumbled under its breath and did nothing. Who did this management expert replace? A former Catholic priest and college chaplain who, by a series of accidents, became president of the corporation with less than five years in health administration (not one day of which amounted to anything approximating hospital administration). Who had he replaced? An outspoken activist physician without a day's worth of hospital administration experience, who in turn had replaced a psychiatrist with federal government experience but no hospital administration experience.

In this natural experiment, it has been demonstrated that the road to the top in government has nothing to do with a logical model of managerial competency and experience but only political expediency. Those appointed for such reasons are obligated to those with the appointment power. Thus, in order to stay on the top in a political position, those appointed must pay extremely careful attention to constituencies, not only their own, but, perhaps more importantly, those of the individuals who have the power to appoint (and no doubt) remove them.

CONCLUSION

Each of the three types of organizations appeals to different constituencies, has different possibilities to offer to the public, and, in this author's opinion, has an appropriate role in the health system. Ideologues would claim that the poor can be served properly only in the public general hospital because that is the institution where there is accountability. How has this accountability been brought into play? Certainly not in the accessibility, availability, or even quality of services. If there is accountability in these institutions, it appears to be related more to the workers than to the patients. Private health care organizations are criticized for "skimming the cream" of the system; however, they have also reacted much more rapidly and in some respects more sensitively to public needs. When laws were passed legalizing abortion, for example, where were the public clinics and voluntary agencies? The "Medicaid mill" is criticized—but who else is willing to go into Washington Heights or the South Bronx and provide care?

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Finally, voluntary organizations are criticized for virtually everything, but it must be remembered that they have made major contributions to progress in clinical medicine and to the advancement of health care.

In sum, the United States has a pluralistic system that has many edges and angles that disturb and perturb. But, before we throw it out, it behooves us to understand it and make it work in the most effective way for the special needs of our society.

Case Study 3-1

THE CABINET MEETING

Every Tuesday and Thursday morning, the senior management of the Central Valley Medical Center, a 411-bed hospital, meet to discuss a broad range of managerial issues. A major subject of concern for the past several weeks has been the declining Medicare census, and discussions have revolved around strategies to increase the census. At today's meeting, the following conversation takes place:

CEO: Any progress on the census initiatives?

COO: One new thing we are exploring is a telemedicine initiative that may develop better relationships with practitioners in rural areas and result in their sending us patients.

CFO: Have you costed the project yet?

COO: No, but we are working on it. Besides, if it smells viable I am going over to development and seeing if they can get some state, federal, or foundation money to pay for the deal.

CEO: Anything else?

COO: Yes, I've been approached by the Revere brothers, who are interested in doing a deal with us.

CFO: Who are they?

(*continues*)

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Case Study 3-1

COO: They are two guys who own and run two private nursing homes with a total of 500 beds, mostly Medicare. Anyway, they want to work a deal whereby we would be their only referral hospital. I suspect they could put between 10 and 20 patients a day into the hospital.

CEO: Sounds good, but what's the deal?

COO: They want a guaranteed $75,000 per year for the referrals.

CFO: It's certainly worth it, but we don't want to run afoul of the Medicare regs. Maybe we could give them a job or responsibilities for the money?

CEO: Right! See if they would be interested in being Chief of Gerontology.

COO: I doubt if they want to do anything, but I'll talk to them.

CEO: Great!

DISCUSSION QUESTIONS

1. What is wrong with this picture?
2. What type of moral and intellectual leadership is being offered by the CEO?
3. What do you suspect will be the likely scenarios in this case?