Interorganizational Arrangements In Academic Health Centers: A Profile Of The Eighties

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Abstract

Continual regulatory changes and new managed care options are influencing profitability and growth in the health care sector. This paper investigates the variety of interorganizational arrangements which are used by academic health care centers to cope with environmental uncertainty, and finds that these arrangements, when initiated, tend to remain stable rather than progress in formalization over time.

Introduction

Competition and regulatory changes have profoundly influenced health care institutions, and have resulted in a variety of organizational arrangements within the past decade. In 1983, the Tax Equity and Fiscal Responsibility Act was passed by Congress. This law established a prospective payment system for the payment of Medicare services, and provided financial incentives to hospitals to treat patients within a specific time period at a predetermined rate (Malloy and Skinner, 1984). During the same period, state legislatures also initiated experiments with a variety of cost containment programs to curtail hospital expenditures. Prospective payment systems and managed care plans were introduced by many state governments in an attempt to contain the escalating costs associated with the care of the indigent (Regula, 1987).

While government regulations have directly influenced inpatient services, managed care options such as Health Maintenance Organizations (HMO) and Preferred Provider Organizations (PPO) have also challenged traditional assumptions about medical care delivery. Patients who enroll in these plans tend to use less inpatient services and rely more extensively on primary care services. As a result, these plans have demonstrated the feasibility of delivering cost effective care on an outpatient basis without unduly compromising quality or patient satisfaction (Ermann, 1986).

Initially, many of these plans were viewed with some skepticism by the corporate community and the consumer. However, their ability to deliver comprehensive and efficient services appears to have contributed to their dramatic growth in the past decade. By 1989, there

were over 600 HMO plans which provided benefits to 35 million individuals and 700 PPO plans with 33 million beneficiaries (Ermann & Gabel, 1985).

Due to an increase in managed care plans and an array of cost containment regulations, the significance of inpatient services as a revenue source has declined. In 1980, the national average occupancy rate in the hospital industry was 80 percent. By 1988, the national average occupancy rate had declined to 70 percent.

As a result, hospital administrators, and particularly those involved in the delivery of services to indigent populations, were compelled to investigate new strategies to insure institutional survival. Although an array of internal management strategies may be deployed by administrators, many hospital executives are increasingly aware of the need to cooperate with other health related organizations to insure growth and profitability in the future (Shortell, 1988).

The Interorganizational Field

Research on interorganizational relationships has proliferated in the past thirty year period. In part, this interest in the field can be attributed to government regulations such as Public Law 93-641 which mandated increased coordination in the public sector, as well as private sector initiatives which acknowledged the scarcity of organizational resources to meet complex societal needs.

As a result of these regulations and initiatives, research in the interorganizational field has become

interdisciplinary in nature. Sociologists and those involved in the public administration sector have been primarily concerned with the identification of those variables which enhance the delivery of services, while those involved in business administration have attempted to identify those variables which ultimately provide economies of scale and result in increased efficiency and profitability for the firm (Whetten, 1981).

Despite the prevalence of various multi-disciplinary approaches to the study of interorganizational relationships, most theorists emphasize the significance of the organization as an "open system" which is continuously involved in a series of organizational interchanges which contribute to the internal stability of the firm. Since these interchanges occur within an environment with limited resources, organizations are constantly negotiating issues related to the coordination of tangible resources such as patients or personnel as well as intangible agreements related to organizational domain, legitimacy, and power in the community (Levine and White, 1961).

As a consequence, organizational effectiveness is not assessed through the use of traditional performance measures but rather by the organization's ability to negotiate environmental linkages which will contribute to resource stability and enhance future organizational growth (Yuchtman and Seashore, 1967).

While the concept of interdependency is intrinsic to the study of interorganizational relationships, the concept of conflict is also crucial to understanding the underlying dimensions of the interorganizational relationship. In general, most organizations strive to maintain their autonomy rather than develop interorganizational relationships with another organization. This behavior may be partially related to a desire to preserve organizational domain or it may be due to the exigencies involved in coordinating relationships with another organization (Aiken and Hage, 1968).

Decisions to cultivate interorganizational relationships, therefore, are often pursued in an incremental manner. Initially, the organization may attempt to modify those environmental conditions which influence productivity and growth. Efforts to negotiate new rates with third party payors or increased collaboration with area legislators, for example, are increasingly used during this phase by administrators. These strategies are typically directed toward external groups with some vested interest in the organization and usually have minimal impact upon the organizational structure of the institution.

If external strategies fail, the organization may resort to modifications in the organization's internal structure through decisions to curtail capital expenses or delay

recruitment of key administrative positions. Often administrators are reluctant to implement internal strategies because they invariably alter organizational structure and may affect employee morale and productivity.

Instead, proactive strategies which focus on the design of new products and services may evolve. Hospital administrators may attempt to capture market share through the use of backward vertical integration strategies which focus on new ambulatory care products or through forward vertical integration strategies which target the aged market with innovative long term care products (Jaeger, Kaluzny, and Magruder-Habib, 1987).

If these proactive strategies cannot sufficiently renew the organization, the administrator will need to investigate interorganizational relationships with other organizations in the region. Often these relationships may evolve through a series of transitional strategies which enable managers to evaluate the benefits of future relationships with another organization. Decisions to forge an interorganizational relationship with another organization are usually evaluated through a series of positive exchanges with another institution. Most institutions rarely proceed from relative autonomy to complete fusion with another organization. Rather the decision to enter a relationship with another organization usually proceeds along a continuum characterized by varying degrees of informal and legal arrangements.

In the initial stage of an interorganizational arrangement, organizations may attempt to reduce environmental uncertainty by engaging in cooperative activities which involve no legal or formal arrangement between the institutions. If these efforts are successful, more formalized interorganizational agreements may ensue. Usually, these initial interorganizational relationships involve consensus about the appropriate organizational domain of each institution, and some agreement may explicitly require the exchange of products and services at some future time. As relationships develop further, organizations may pursue coalition strategies which involve unilateral decisions in relation to bipartisan goals, or one organization may decide to relinquish autonomy and merge with another organization (Starkweather, 1971).

Obviously, most organizations will not progress through the entire spectrum of arrangements, and some will enter and depart at various points along the continuum. Decisions to forge or sever an interorganizational relationship may be influenced by the internal characteristics of the organization. Warren (1967) suggests that organizational interaction may be mediated by an institution's governing structure. Organizations such as those which are involved in federations or coalitions with other organizations may be able to exercise consid-

erable discretion in forging relationships despite their multiple affiliations while organizations which are part of a unitary structure may have their goals and objectives delineated by a parent corporation.

Other studies contend that internal variables such as capital requirements and leadership may influence the evolution of an interorganizational relationship. In particular, the need for capital may profoundly influence organizational transactions. Those organizations with access to financial markets are usually perceived as attractive partners for "cash poor" hospitals which are always in need of funds. Moreover, those organizations which possess considerable financial resources are often highly regarded within the community network, and are able to easily develop linkages with other organizations in the community (Whetten and Leung, 1979).

Executive involvement or organizational leadership has also been cited by (Akinbode and Clark, 1976; and Perruci and Pilisuk, 1970) as an essential component in the interorganizational process. Akinbode and Clark (1976) found that the type of organizational leadership which existed during the initiation of the interorganizational relationship as well as the status of the interorganizational leaders influenced transactions. Those leaders who had reached the pinnacle of their careers as well as those leaders who relied upon a democratic management style were more involved in cooperative activities.

Informal relationships which exist among executives may also facilitate interorganizational relationships. Perruci and Pilisuk (1970) found that leaders with multiple organizational affiliations were more likely to be identified as influential within their community than executives with limited relationships. Moreover, many of these interorganizational leaders were found to have extensive social ties and share greater value consensus than organizational leaders.

Conversely, environmental variables have also been defined in the literature as crucial mediating variables which can influence interorganizational relationships. Resource scarcity or abundance within a community, power distribution, and the prevailing control mechanisms which exist to disperse resources may all affect the preservation of an existing interorganizational relationship (Benson, 1975).

Although environmental and internal organizational variables may influence the evolution of an interorganizational relationship, most organizations prefer to explore a series of interorganizational relationships prior to considering consolidation which would ultimately result in the loss of organizational autonomy.

Design

Data from the American Association of Medical Colleges indicates that there are 119 academic health care centers in the nation. In order to study the nature and evolution of the interorganizational relationships which were pursued by administrators in academic health centers, a group of potential strategies was identified. The strategies which were selected are currently classified in the Guide to Hospital Words, Terms, and Phrases. This guide was developed by hospital administrators as a reference for those who had some, but not necessarily extensive, experience in the health care industry (Snook, 1987).

Since issues of face validity remained, a pretest of the questionnaire was administered to several executives in the health care field. Individuals in this group had five to ten years of experience in the health care industry, and had diverse educational backgrounds in fields such as law, accounting, marketing and management. In many ways, they closely resembled the respondents who would actually complete the survey. Although the original constructs were substantially revised as a result of the executive pretest, concerns about the universality of the terms remained. Consequently, the revised list of terms was included with the questionnaire (Table 1).

Individual strategies were further classified according to the nature of the interorganizational arrangement with another institution. In order to assess the nature and progression of the strategic options pursued by management, strategies were grouped along a continuum ranging from informal to formal arrangements.

Consequently, diversification, internal development, and subsidiaries were classified as internal organizational arrangements. Academic health centers which used these strategies basically functioned on an autonomous basis, and were not involved in relationships with other organizations.

In contrast, strategies such as affiliation, joint ventures, limited partnerships, shared services, venture capital and venture nurturing were categorized as preaffiliation organizational arrangements. These strategies effectively limited the legal liability of the institution to the specific terms of the agreement yet provided a mechanism to explore organizational compatibility.

Institutions involved in alliances and consortiums typically have common by-laws or written agreements which govern the relationships of the parties. These strategies tend to suggest greater interdependence and were, therefore, classified as intermediate interorganizational arrangements.

Table 1
DEFINITIONS OF TERMS

AFFILIATION: An agreement (usually formal) between two or more independent institutions, programs, or individuals which defines how they will relate to each other. Affiliation agreements may specify the following procedures for referring or transferring patients from one facility, medical staff appointments, teaching relationships, or provision of consultation between programs.

ALLIANCE: A formal agreement between several hospitals and/or hospital systems for specific purposes. These arrangements usually operate under a set of bylaws or other written regulations.

CONSORTIUM: (1) Formal membership organization/arrangement that functions under a set of bylaws or other written rules to which each member agrees to abide. It may or may not be incorporated. The control of assets also resides with each member although some freedom to act independently may be prescribed in the organization's bylaws. (2) When a group of hospitals agree to multiple affiliations, this often includes shared services (for example, two hospitals sharing a clinical laboratory or a laundry service.)

DIVERSIFICATION: A formal strategy whereby hospitals expand functions through setting up different corporations, limited partnerships, foundations and joint ventures to offer services.

INTERNAL DEVELOPMENT: Exploit internal resources as a basis for establishing a business new to the institution.

JOINT VENTURE: An organization or association formed by two or more parties usually formed for a single purpose or undertaking. Such organizations may make its membership liable for the organization's debt.

LIMITED PARTNERSHIP: A certain type of partnership which limits the liability of certain partners (inactive) to their investment in the enterprise only. At least one member of the partnership must be fully responsible for all debts.

MERGER: The resulting condition after one business or corporation secures the capital stock of another business. The merged corporation stock is usually then dissolved.

PARTNERSHIP: A legal form of business organization. It consists of two or more individuals with each individual assuming full personal liability for the debts of the business.

SHARED SERVICES: Clinical or administrative services offered by two or more hospitals in a joint arrangement for their mutual benefit (e.g. a centralized data processing system or a cooperative organ transplantation program are two examples of shared services.)

SUBSIDIARY: A company controlled by a "parent organization" which owns all or most of the subsidiary's shares. Although the subsidiary supports the parent company financially, they do not always engage in the same line of business.

VENTURE CAPITAL: Capital funds subject to considerable risk which are generally used in the development of new business activities. Synonym: Risk Capital.

VENTURE NURTURING: The investing company provides managerial assistance & capital to the recipient of the venture.

Finally, those relationships such as partnerships and mergers which result in diminished autonomy or no autonomy for an individual institution were classified as formal relationships (Table 2).

Since many studies have noted the significance of monitoring strategic decisions over a longitudinal period, administrators from academic health centers were asked to identify strategic alternatives pursued within the past five year period (1983-1988) and to select those strategic options which they intended to pursue within the next five year period (Fowler and Schmidt, 1988). Current and future strategies were subsequently analyzed to determine the nature of the interorganizational arrangements which were likely to evolve in the future.

Due to the time constraints imposed on administrators, a three page, self administered questionnaire was mailed to the hospital executives. Closed questions were used to insure greater reliability in interpretation, and ordinal measures were used in fifty percent of the questions. Since closed questions often preclude the inclusion of significant information, a category labeled "other" was also listed on the questionnaire. A transmittal letter, explaining the nature of the study, was also attached to the questionnaire. Respondents were asked to reply within a one month period, with follow-up letters and questionnaires sent to non respondents after a 30 day period. Due to the limited size of the population, questionnaires were mailed to each academic health center.

Findings

Forty Chief Executive Officers from 119 not for profit and public academic health care centers completed the survey resulting in a 34% response rate. In most cases, respondents pursued more than one strategy. In order to develop a mutually exclusive set of categories, the highest strategy level selected by the executive was used to classify the interorganizational arrangement with another institution. Using this criterion, a current profile of the 40 hospitals was developed.

The same criterion was used to classify the future interorganizational arrangements which management intended to pursue. Future organizational arrangements were subsequently contrasted with current organizational arrangements (Table 3).

Three hospitals indicated that they were not involved in any type of interorganizational relationship. Two of these institutions also did not intend to pursue any strategies in the future while one administrator indicated a desire to develop an intermediate relationship with another health care institution.

Internal development strategies were used by only two hospitals in the survey. One hospital planned to pursue a similar strategy in the future while the other institution indicated a desire to develop a preaffiliation agreement in the future with another organization.

Table 2
INTERORGANIZATIONAL ARRANGEMENTS IN ACADEMIC HEALTH CENTERS

STRATEGIES

Diversification
Internal Development
Subsidiaries

Affiliation
Joint Venture
Limited Partnership
Shared Services
Venture Capital
Venture Nurturing

Alliance
Consortium

Partnerships
Mergers

INTERORGANIZATIONAL ARRANGEMENT

Internal Arrangement: No contractual relationship or agreement exists with another institution. Characterized by autonomous relationship.

Pre Affiliation: Separate corporation and by-laws prevail. Contractual arrangements limit the legal responsibility of the hospital to the specific agreement.

Intermediate Arrangement: Common bylaws or written agreements govern the relationship of the parties. Contractual agreements support these relationships.

Formal Relationship: Contractual relationships which result in diminished autonomy (partnership) or no autonomy (merger) for the institution.

Table 3
CURRENT AND FUTURE INTERORGANIZATIONAL ARRANGEMENTS*

CURRENT (n = 40)		FUTURE (n = 40)	
NO ARRANGEMENT	3	SAME ARRANGEMENT	2
		INTERMEDIATE	1
INTERNAL DEVELOPMENT	2	SAME ARRANGEMENT	1
		PREAFFILIATION	1
PREAFFILIATION	7	SAME ARRANGEMENT	4
		INTERMEDIATE	1
		UNCLEAR	2
INTERMEDIATE	19	SAME ARRANGEMENT	15
		PARTNERSHIP	2
		MERGER	1
		UNCLEAR	1
FORMAL	<u>9</u>	SAME ARRANGEMENT	<u>9</u>
TOTAL	40		40

* Previous interorganizational relationships were not explored in the study.

Seven hospitals were involved in preaffiliation arrangements, and over half of the respondents indicated a desire to pursue similar strategies in the future. Two hospital executives currently involved in a preaffiliation agreement were unclear about future strategies while another executive indicated that an intermediate strategy would be adopted by his academic health center.

Intermediate strategies dominated interorganizational relationships in the academic health care environment. Nineteen academic health centers, which comprise 47.3% of the respondents in the survey, were involved in intermediate organizational arrangements. Although one hospital administrator was unclear about future organizational arrangements, fifteen executives planned to pursue similar interorganizational arrangements in the future. Only three executives planned to develop a formal relationship. Two of these executives intended to develop partnerships, while another executive planned to investigate merger strategies in the future.

Nine hospitals in the study were currently involved in a formal relationship with another institution. This group was also extensively involved in a variety of affiliation and intermediate relationships with other institutions, and indicated a desire to pursue multiple

strategies in the future. (Table 3).

Despite the variety of interorganizational arrangements which could be pursued by administrators of academic health centers, only eight executives considered an incremental move the next interorganizational stage. In contrast, 31 administrators, which constitute 78% of the respondents in the study, planned to maintain their current interorganizational relationship within the next five year period.

Discussion

Few academic health care centers in the study were involved solely in autonomous relationships, and few relied extensively upon internal development as their primary strategy. Those institutions which adopted these arrangements may be in an area in which market share is guaranteed due to the absence of competitors or they may have resources supplied through contractual agreement with a public agency. Other studies have suggested that affiliation with a parent corporation as well as resource rich environments may diminish the need to cultivate interorganizational relationships. Those variables which influence autonomy were not within the scope of this study. It appears, however, that

a small percentage of institutions may remain autonomous due to organizational structure or optimal environmental conditions (Levine and White, 1961).

Conversely, the majority of institutions were involved in an intermediate relationship with another institution. These strategies may be particularly attractive to administrators since they limit the legal liability of the institution to the specific contractual agreement, yet provide a mechanism for administrators to explore organizational compatibility without necessarily relinquishing organizational control.

Only nine institutions, which represent 22.5% of the respondents in the survey, were participating in formal relationships, and the majority of these institutions had been merged with another institution. Some of these institutions may have been compelled to merge with another institution due to their inability to survive in a competitive environment, or these mergers may actually reflect a continuous relationship which eventually culminated in a merger agreement.

Although the majority of respondents did plan to pursue similar interorganizational strategies in the future, this finding may be influenced by the time parameters which were imposed in the survey design. Respondents were asked to identify strategies which would be pursued within the next five year period rather than to identify future strategies which may evolve over an extended time period.

While some interorganizational models recognize the incremental nature of interorganizational relationships, no study has examined the temporal dimension involved in the evolution of these strategies or the criteria which organizations use in evaluating the benefits of an existing relationship. Consequently, it is difficult to predict when an institution will begin to consider a more formal type of interorganizational arrangement. Those factors which affect the progression and stability of interorganizational arrangements within academic health care centers should be explored in future studies.

Conflicting legal interpretations relating to the Clayton Act and the Sherman Antitrust Act may have also influenced the stability of the interorganizational relationships reported in this study. At present, there are several cases in various stages of litigation which are related to competitive or monopolistic activities in the health care industry. Many administrators may be reluctant to pursue more formal interorganizational relationships until legal precedents emerge in this area. Subsequent research will, therefore, need to explore the impact of regulatory statutes upon interorganizational arrangements.

Moreover, additional research should be conducted to

explore the structural as well as process dimensions of interorganizational relationships in academic health centers. Studies which examine the nature of resource flows between organizations as well as the degree of formalization and complexity associated with these agreements may yield valuable information which can be utilized by health administrators to initiate relationships with other organizations in the future (Akinbode and Clark, 1976).

Suggestions for Future Research

Decisions to forge or curtail an interorganizational relationship are often influenced by the internal characteristics of the firm. Future research should examine those internal firm variables which motivate interorganizational transactions. In particular, capital requirements, board member affiliations, and leadership style should be assessed to determine how these variables influence interorganizational relationships.

Resource investments as well as frequent coordination may also affect the process dimensions of the interorganizational relationship. Consequently, research should also be conducted to assess how the nature and frequency of resource transactions affect the stability of the interorganizational relationship.

References

1. Aiken, M. and Hage, J., "Organizational Interdependence and Intraorganizational Structure," *American Sociological Review*, Vol. 33, pp. 912-930, 1968.
2. Akinbode, I. and Clark, R., "A Framework for Analyzing Interorganizational Relationships," *Human Relations*, Vol. 29, pp. 101-114, 1976.
3. Benson, K., "The Interorganizational Network as a Political Economy," *Administrative Science Quarterly* Vol. 20, pp. 229-249, 1975.
4. Ermann, D., "HMO's: The Future of the For Profit Plan," *Journal of Ambulatory Care Management*, pp. 72-83, 1986.
5. Ermann, D. and Gabel, J., "Preferred Provider Organizations: Performance, Problems, and Promise," *Health Affairs*, Vol. 4, pp. 25-40, 1985.
6. Fowler, K. and Schmidt, D., "Tender Offers, Acquisitions, and Subsequent Performance in Manufacturing Firms," *Academy of Management Journal*, Vol. 31, pp. 962-974, 1988.
7. Jaeger, J., Kaluzny, A. and Magruder-Habib, K., "A New Perspective on Multi Institutional Systems Management," *Health Care Management Review*, Vol. 12, pp. 9-19, 1987.
8. Levine S. and White, P., "Exchange as a Conceptual Framework for the Study of Interorganizational Relationships," *Administrative Science Quarterly*, Vol. 5, pp. 583-601, 1961.
9. Malloy, J. and Skinner, D., "Medicare on the Criti-

- cal List," *Harvard Business Review*, Vol. 62, pp. 122-135, 1984.
10. Perruci, R. and Pilisuk, M., "Leaders and Ruling Elites: The Interorganizational Bases of Community Power," *American Sociological Review*, Vol. 35, pp. 1040-1057, 1970.
 11. Regula, R., "National Policy and the Medically Uninsured," *Inquiry*, Vol. 24, pp. 48-57, 1987.
 12. Shortell, S., "The Evolution of Hospital Systems: Unfulfilled Promise and Self Fulfilling Prophecies," *Medical Care Review*, Vol. 45, No. 21, pp. 177-211, 1988.
 13. Snook, D., *Guide to Hospital Words, Terms, and Phrases*, Philadelphia, Ephraim, 1987.
 14. Starkweather, D., "Health Facility Mergers: Some Conceptualizations," *Medical Care*, Vol. 9, pp. 468-478, 1971.
 15. Warren, R., "The Interorganizational Field as a Focus for Investigation," *Administrative Science Quarterly*, Vol. 12, pp. 396-419, 1967.
 16. Whetten, D., "Interorganizational Relations: A Review of the Field," *Journal of Higher Education*, Vol. 52, pp. 1-28, 1981.
 17. Whetten, D. and Leung, T., "The Instrumental Value of Interorganizational Relations: Antecedents and Consequences of Linkage Formation," *Academy of Management Journal*, Vol. 22, pp. 325-344, 1979.
 18. Yuchtman, E. and Seashore, S., "A System Resource Approach to Organizational Effectiveness," *American Sociological Review*, Vol. 32, pp. 891-903, 1967.