STRATEGIC DECISION-MAKING IN HEALTHCARE ORGANIZATIONS: IT'S TIME TO GET SERIOUS

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SUMMARY

New and continuing environmental demands and competitive forces require healthcare organizations to be increasingly careful in thinking about their strategies. They must do so in a highly unusual (multi-actor) marketplace, where a variety of system interdependencies complicate decision-making.

A good strategy requires an attempt to understand the *real,* as distinct from the *perceived,* environment, and is characterized by explicit tradeoffs along three dimensions: service or program variety, patient needs, and patient access. The quality of these tradeoffs can be assessed in terms of whether the strategy is (a) attuned to critical success factors in the organization's environment, (b) highly focused, (c) linked to the organization's capabilities, and (d) accompanied by an activity set that is difficult for competitors to imitate.

An organization also must be capable of adapting appropriately to changes in its environment. Thus, even the best strategy must be reviewed constantly if it is to remain viable. A strategy's sustainability can be adversely affected by increased buyer or supplier power, lowered barriers to entry, growing rivalry, the threat of substitutes, and increased slack in resource usage.

By thinking more creatively in the future than they have in the past, healthcare organizations can make tradeoffs and choose a focused strategic position. They then can design an activity set that is appropriate for that position, and that will assist them to achieve both financial viability and superior programmatic performance. A well-designed activity set also will assist them to sustain their performance in the face of changing environmental demands and competitive forces.

Keywords: Strategy, sustainability, activity set, financial viability, SWOT analysis

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During the next several decades, healthcare organizations in much of the industrialized world will be confronting a variety of environmental and competitive demands. As a result, they will need to think carefully about their strategies and how they wish to position themselves for success.

The environmental demands are multidimensional. In part, as Exhibit 1 indicates, the recent entrance of "baby boomers" into the 55-60 year age group suggests that, without some significant changes in healthcare delivery patterns, there will be an exponentially increasing demand for inpatient care, with concomitant cost increases. Moreover, as the data from a large United States employer indicate (Exhibit 2), unless there are some radical changes in lifestyles or public health programs, many of the health problems that are likely to emerge (primarily cancer and heart disease) are not ones that lend themselves easily to a shift to outpatient care. Finally, as Medicare data from the U.S. suggest (Exhibit 3), a small fraction of the elderly will likely require a disproportionately large percentage of healthcare resources.

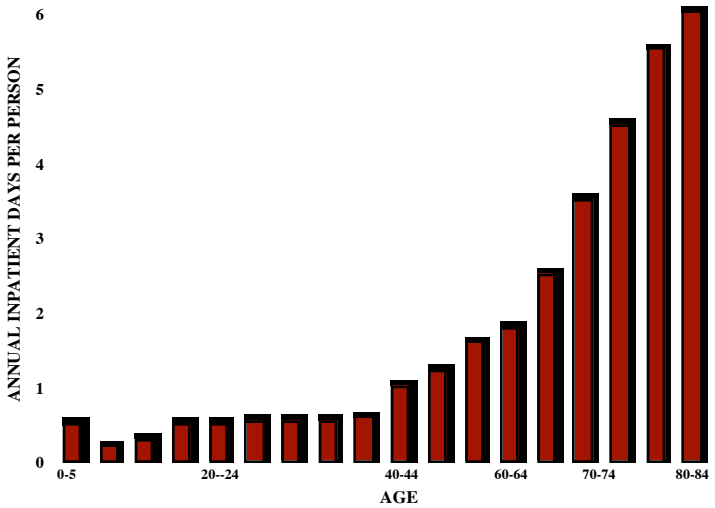
The patterns in these exhibits are not unique to the U.S. Indeed, the health systems of many other industrialized countries, especially those in Europe, face similar if not exaggerated demands. For example, as Exhibit 4 shows, in ten years' time, the percentage of the population over 60 years of age will be higher in many European countries than in the U.S.

THE HEALTHCARE MARKETPLACE

These environmental demands take place in the context of a marketplace that is unlike any other we know, and certainly not well described in any economics textbooks. As Exhibit 5 shows, there are multiple actors in almost all health systems: Person A (a patient) who receives services from Person B (a hospital or clinic) that are ordered by Person C (a physician), both of whom have their fees paid (or costs reimbursed) by Person D (a health plan or other insurer), which has its premiums paid by Person E (an employer in the U.S. or a government agency elsewhere), sometimes with cost sharing by Person A.

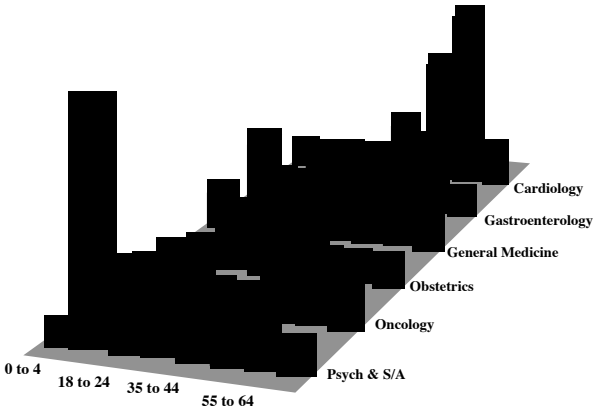
In each of the "submarkets" shown in Exhibit 5 there is a price. In all but the submarket between insurers and providers, the price is relatively simple. In this latter submarket, however, the pricing structure can be quite complex. Some managed care plans pay hospitals on a per diem basis, for example, while others pay by DRG. Some government payers, such as those in Canada, pay a fixed amount per fiscal year. In some instances physicians have their fees "bundled" with the payment to a hospital, and in others their fees are paid separately. In many instances the fees of all

Exhibit 1. The Demographic Problem



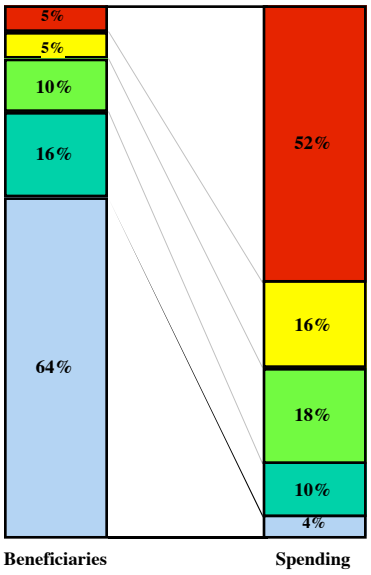
Source: The Crimson Group, Inc., Cambridge, Massachusetts.

Exhibit 2. The Morbidity Problem



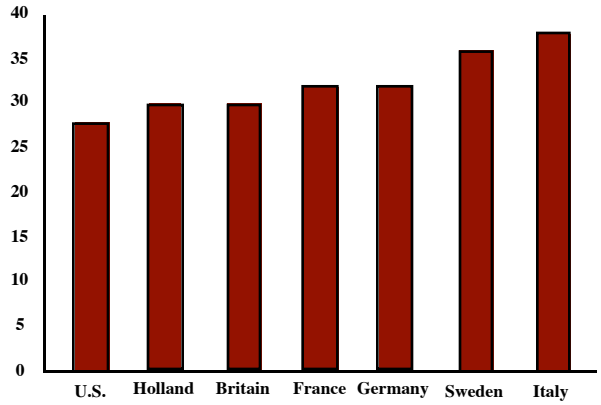
Source: The Crimson Group, Inc., Cambridge, Massachusetts.[1]

Exhibit 3. Medicare's Financing Problem



Source: United States Health Care Financing Administration, 1998.

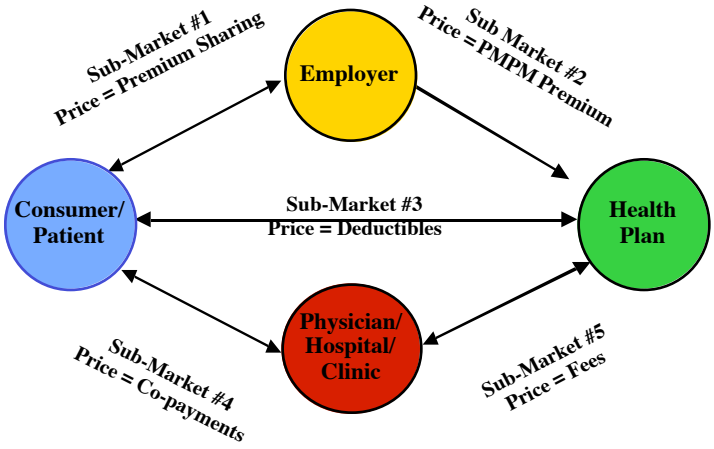
Exhibit 4. Percent of Population 60 and over in 2015



Source: Jagadeesh Gokhale and Berndt Raffelhuschen, 2001

[1] There are two aspects to Exhibit 2 that need clarification. (1) This employer had a disproportionately large number of employees who had teenage children with substance abuse problems. This is not typical of the population at large. (2) The low bars in the 65 and over category are not because there were no health problems, but rather because the cost of treatment was shifted from the employer to Medicare (the federal insurance program for the over-65 population).

Exhibit 5. The Market Problem



Source: The Crimson Group, Inc., Cambridge, Massachusetts.

physicians (primary care and specialists) are discounted by a managed care plan on the basis of "usual, reasonable, and customary." There are many other variations that serve to further complicate this submarket.

To the extent that there is price elasticity of demand in a submarket, the seller's price will have an impact on the relevant purchaser's buying behavior, resulting in decisions that can have repercussions on other aspects of the healthcare system. This phenomenon was seen in the U.S. some years ago, when the introduction of a $1 copayment for California's MediCal (indigent) patients led to a substantial reduction in their use of primary care services. Unfortunately, some of these same patients were hospitalized several months later with conditions that could have been avoided had they been treated with timely primary care. The result was an increase in *total* MediCal expenditures [Roemer, 1975].

Beyond these and similar system interdependencies lies the distinction between improving the population's health status and implementing disease management strategies. The first comprises public health programs, lifestyle changes, and improved primary care interventions, all of which can help to lower the bars in Exhibit 2, such that fewer individuals need inpatient care. The second is designed to lower the bars in Exhibit 1, such that patients admitted to a hospital consume fewer resources. The use of improved diagnostic technology (such as magnetic resonance imaging), the development of clinical pathways, and the introduction of laproscopic surgical procedures are all examples of new approaches that have assisted in this effort.

ASSESSING ENVIRONMENTAL DEMANDS

One result of the mixture of environmental demands, market forces, and system interactions is that healthcare delivery organizations need to think carefully about their strategies. They must assess the unique set of environmental threats and opportunities they face, and couple that assessment with an analysis of their capacity to develop appropriate responses. The same is true for the private sector insurers (such as health maintenance organizations) that pay healthcare providers, and for public sector organizations (such as departments of public health and government health ministries). All will need to think more strategically in light of budgets that will be under increasing scrutiny owing to the many demands that will be created by the "demographic bubble" of an aging population. In short, the time for making difficult strategic decisions has arrived.

The essence of the strategy-formulation process frequently is described in terms of a "SWOT" analysis, or an assessment of internal strengths and weaknesses (SW) combined with an analysis of environmental opportunities and threats (OT). However, a SWOT analysis can never consider *real* organizational strengths and weaknesses or *real* environmental opportunities and threats, since these are never known. Thus, an organization's senior managers are able to focus only on *perceived* strengths, weaknesses, opportunities and threats as filtered through their own lenses

and those of middle managers, physicians, nurses, and other key members of the organization. These individuals' perspectives affect at least some of the information available for strategic decision making, and thus can inhibit senior management's ability to see the organization's real SWOT. The result is a potential for sub-optimal strategic decisions [Prahalad and Bettis, 1986; Starbuck and Milliken, 1988].

A telling example of the difference between the real and perceived environments took place a few years ago in Novo Industri, a Danish manufacturer of porcine and bovine insulin. Novo had developed a very robust strategy that focused on having the lowest level of impurities of any insulin available. It devoted substantial resources to research and development so as to continually reduce impurities in its product. It also had designed a complex logistical network that assured it of a constant flow of the pig and cow pancreases needed for its production effort (where 10,000 pounds of animal pancreases were required to make one pound of crystallized insulin). Novo had an unmatched capacity to provide consumers with the purist possible porcine and bovine insulin.

This strategy was disrupted in a significant way when Eli Lilly introduced genetically-engineered (GE) insulin, a product that had no impurities whatsoever and was less expensive to produce than animal insulin. Perhaps Novo was unaware of the impending disruptive technology, or perhaps its senior managers were convinced, erroneously, that the impact of GE insulin would not be significant. Either possibility is a clear illustration of the difference between the perceived and real environments.

Closing the Gap Between Perceived and Real

Our research has identified seven techniques that successful firms outside the healthcare arena have used to close the gap between the perceived and real environments. All of these have potential applicability for healthcare organizations:

1. *Generate conflict*. Under the leadership of Michael Eisner, Disney Company invested considerable resources in meetings that brought large numbers of creative (and highly salaried) employees together for several hours at a time. They would argue (usually productively) about new film ideas and their potential impact on Disney's "profit multiplier," i.e., its theme park characters, retail and video sales, and other related activities. Among others, the movies *Pocahontas* and *The Little Mermaid* emerged from this process [Wetlaufer, 2000].

2. *Encourage employees to question existing rules and assumptions*. The Toyota Production System (TPS) encourages low level line workers to think about how to improve the production process and to suggest potential improvements to their supervisors. The TPS includes a process that allows a new idea to be tested to demonstrate its value or lack thereof. If the test shows that it can improve the production process, the TPS has a mechanism to introduce it into the manufacturing effort [Spear and Bowen, 1999].

3. *Develop a culture that embraces new ideas and differing points of view*. At General Electric under the leadership of Jack Welch, no manager was allowed to keep a good idea to him or herself. GE invested significant resources in a "learning culture" that promoted the sharing of ideas across-divisions. One result was that a good idea in, say, the aircraft engine division found applicability in what might have appeared to be an unrelated division, such as home appliances [Welch, 2001].

4. *Reward innovation*. At 3M Company, a scientist can obtain an internal grant to finance the development and experimentation of a new idea. A significant portion of each individual's compensation is based on the new ideas that he or she has developed into a marketable product. [Leonard and Swap, 1999].

5. *Expect (and embrace) failure*. Microsoft's professional staff is expected to fail some of the time. Otherwise, in the view of the company, they are not pushing themselves hard enough [Thielen,1999].
6. *Require exposure to ideas from outside the firm*. Chaparral Steel employees are required to

take a sabbatical every few years, and, when so doing, are encouraged to spend some time working with a customer to learn about how Chaparral's products might be improved [Goldman, Nagel, and Preiss, 1995].

7. *Distinguish between available resources and customer needs*. Canon was able to take market share away from Xerox when it developed a product that did not need servicing, or that could be serviced by the customer. Canon did not invest (as Xerox had) in an extensive service network for malfunctioning machines. Contrary to Xerox's assumption, customers did not want a service network; they wanted functioning photocopiers.

WHAT IS A VIABLE STRATEGY?

Regardless of the difficulty it has in undertaking a SWOT analysis, every organization has a strategy. Sometimes it is quite explicit, and sometimes it must be inferred from observing the organization's actions. The following is an explicit strategy statement prepared by Crown Cork an Seal some years ago [Andrews, 1971]:

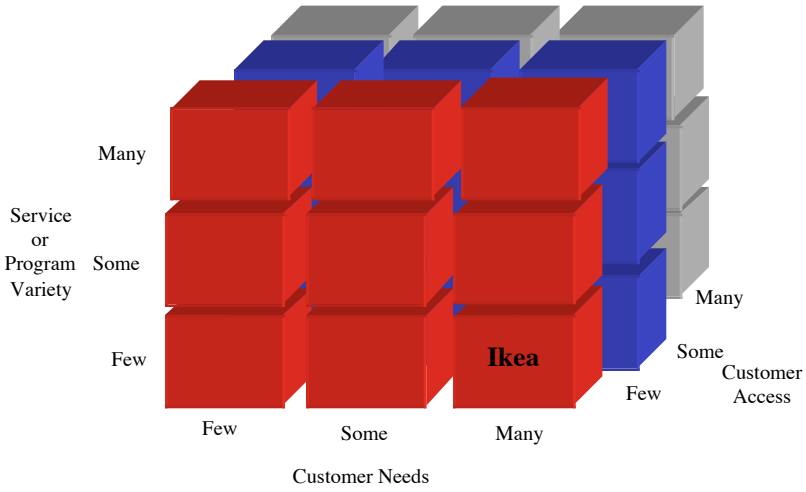
> Crown Cork and Seal aims to be a stripped-down and increasingly profitable manufacturer of specialty high-margin rigid containers for its position in bottling machinery and crowns. Its domestic growth will come from increasing the number of geographically decentralized small plants equipped and located to provide fast delivery at low transportation cost and to secure 20 to 40 percent of each local market. Customer service is led by a technically trained sales force alert to customer needs and by a technical "research" and manufacturing engineering organization which is solving current customer process and packing problems rather than doing basic research.
>
> Its current investment in innovation is kept small, but an aggressive marketing and a flexible manufacturing organization are alert to promote advances pioneered by major suppliers and competitors. Domestic operations are intended to be the stable base from which the company can expand internationally. The developing countries to which crown manufacture has already been introduced are expected to be the company's major growth opportunity in containers.
>
> Operations will be financed through retained earnings and full use of the debt capacity and are expected to return 25¢ additional profit per share per year. The organization will reward drive, energy, and accomplishment and accept rapid turnover in management ranks whenever results fall below expectations.

Note that many possible activities are *excluded* from the strategy. There is no basic research and no attempt at innovation. There also is a limit on centralized decision-making and clear expectations for employees. The exclusions reinforce the notion that the quality of an organization's strategy can be assessed in terms of the "tradeoffs" it has made [Porter, 1996]. That is, a viable strategy requires an organization to decide what it is *not* going to be as well as what it intends to be.

Few healthcare organizations have been willing to make these sorts of tradeoffs, preferring instead to attempt to be all things to all patients (or all potential patients). As the lessons from other industries suggest, however, for hospitals and other healthcare organizations to survive in the upcoming decade, they will need to consider how they wish to focus their services and programs so as to become especially good at some activities while avoiding others entirely.

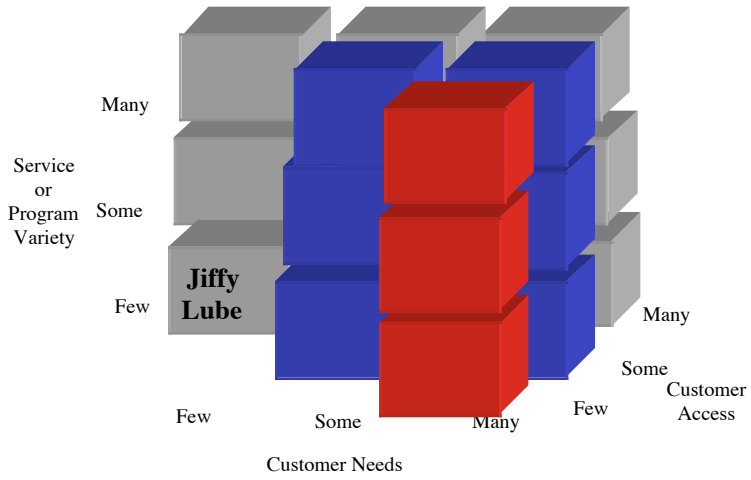
Our research suggests that there are three dimensions to strategic tradeoffs: service or program variety, customer needs, and customer access. To see how these tradeoffs get made, consider Ikea (Exhibit 6), a company that sells unassembled furniture, and that focuses on many customer needs (furniture for lots of rooms), but offers limited access (only a few stores in each market) and has a limited range of products for any given room. By contrast, Jiffy Lube (Exhibit 7), focuses on broad access (many drive-in shops) to some limited services (lubrication and oil change for an automobile) that meet very few customer needs. In contrast, most hospitals have attempted to meet a wide variety of healthcare needs by offering an extensive range of programs to as many potential patients as possible (Exhibit 8). Nothing could be more strategically misguided.

Exhibit 6. Ikea's Tradeoffs



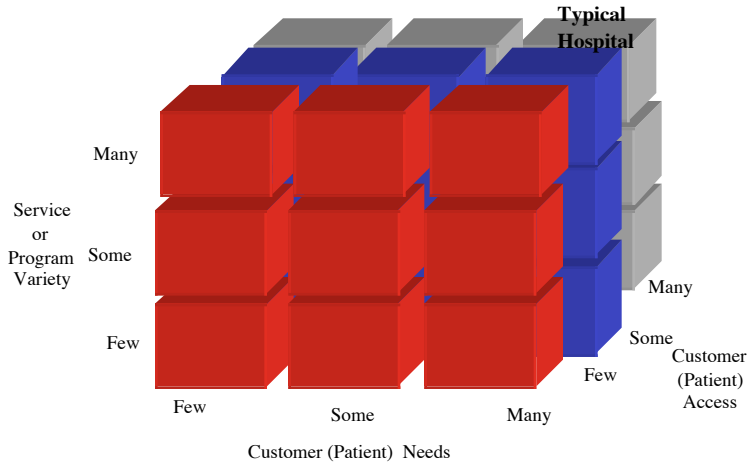
Source: The Crimson Group, Inc., Cambridge, Massachusetts.

Exhibit 7. Jiffy Lube's Tradeoffs



Source: The Crimson Group, Inc., Cambridge, Massachusetts.

Exhibit 8. Absence of Hospital Tradeoffs



Source: The Crimson Group, Inc., Cambridge, Massachusetts.

Hospitals are not alone; other healthcare organizations also have unfocused strategies. Rural Health Associates (RHA), a small (13-physician) group practice, is illustrative. Until it ceased to exist, RHA had the following broadly-focused strategy [Adler, 1982]:

> RHA aims to be the largest provider of comprehensive, quality, health care services to the entire 80,000 member population in the 27 townships in and surrounding Farmington, Maine. The organization is committed to serving this population's health care needs through extensive community involvement, research and development, and the provision of primary medical care services. Furthermore, RHA will provide and maintain financially accessible services to Farmington's poor communities via a prepaid group practice, and geographically accessible services via the operation of a central Farmington clinic and several satellite centers.
>
> Clinical care will be offered by board-certified physicians who will provide services in one of RHA's three divisions: Rural Group Practice (RGP), a fee-for-service group practice; Franklin Area Health Plan (FAHP), a health maintenance organization; and a separate research and development (R&D) group. Each division will be financially self-sufficient. The three divisions together will provide an integrated network of complementary services to meet RHA's above-stated objectives.
>
> Financial stability and growth will be achieved through the continued expansion of employer group contracts, and the growth of FAHP membership to 40 percent of the Farmington target population. Third party payer (public and private) revenue will be aggressively sought, as will independent grant revenues to assist the financing of RGP and R&D respectively. R&D staff will be directly responsible for generating overhead cost recovery from federal grants whenever possible.
>
> Remuneration above base level salaries will be directly linked to productivity and quality measures, as well as the overall financial solvency of RHA. Quality of care standards will be applied by an internal utilization review system, resulting in monthly "quality of care" reports.
>
> RHA will grow in response to the identified health care needs of the community. Needs identification will be achieved through community input and research and development activities, in the areas of health education, illness prevention, and alternative health care delivery systems.

Note the almost total absence of tradeoffs in RHA's strategy. Because the organization had not chosen between fee for service and managed care patients, its physicians needed to function with two distinct mind sets: one that focused on people who were sick and another on helping people stay well. Moreover, its compensation system, by emphasizing visit productivity, ignored the managed care goal entirely. At the same time, its focus on wellness had led it to develop a home insulation program—clearly a highly unusual activity for a healthcare organization. Finally, because of its research focus, RHA needed to generate a continuous flow of funding for its physician researchers. For a small group practice in rural Maine, the demands of this unfocused strategy were overwhelming; in the end, the organization was unable to survive.

By contrast, consider Hardy Healthcare Associates (HHA), a small (2-person) practice in the U.S. HHA focuses on Autism, Asperger's Syndrome, Pervasive Developmental Disorders, and Rett's Syndrome, along with the associated neuro-psychiatric disorders, such as ADD and ADHD, and a variety of anxiety, mood, and tic disorders. As its Web page indicates, HHA has made some explicit tradeoffs, thereby having a strategic position that is the antithesis of RHA's [Hardy, 2004]:

> In an age of managed care where providers generally see a large volume of patients in a day, we at Hardy Healthcare Associates strive to provide personalized service and care to our patients, especially since the problems we work on are often extremely complex. [We] share call nights and weekends so that you do not have to interact with professionals who are unfamiliar to you or your care. In order to provide this high quality personalized service, we have developed a fee-for-service financial policy similar to the legal profession where the professional relationship is not intruded upon by a third party insurance company.
>
> Problem-solving has become an important aspect of our work as so many patients come to us with problems that have eluded others. We do this not because we are smarter but because we are willing to take the time to think about and research problems. In order to make this possible we have declined participation in any managed care programs which may control costs but which often undermine quality of care.

HHA uses the Bio-psychosocial Model, the primary model for integrating genetic, environmental, social and emotional influences into a broader consideration of a person's state of health and well-being. In so doing, we cross sub-specialties since in fact the functioning of the brain and nervous system are integral to all organ systems; an important example of this being the immune system and the gastrointestinal system. [However], because we cannot specialize and be experts in every field, we orchestrate the coordination of services to ensure integration of care for the individual patient.

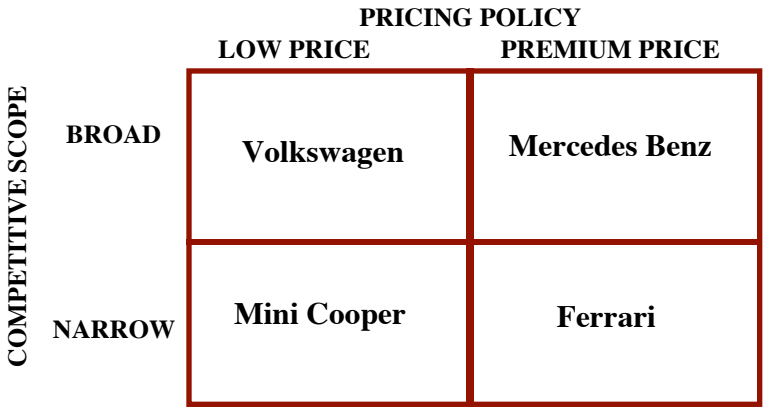
The Tradeoff Process

Making strategic tradeoffs does not require that every hospital become a "focused factory"[Herzlinger, 1997]—offering only one service to a large number of patients. Shouldice Hospital, in Canada, is perhaps the only hospital (or one of very few) that is focused in this way. Its only service is a hernia operation, and it draws patients from long distances for its cost-effective, high-quality surgical procedures.

Organizations in the U.S. such as M.D. Anderson Cancer Center, Cincinnati Children's Hospital, and Massachusetts Eye and Ear Infirmary—by focusing on patients with particular disease conditions (cancer) or particular characteristics (children), or who have problems with particular organs (eyes, ears, nose, and throat)—have made similar tradeoff decisions, None has been quite as specific as Shouldice, however.

In addition to the three dimensions discussed above, strategic tradeoffs can be assessed in terms of competitive scope (broad versus narrow) and pricing policy (low price versus premium price). The automobile industry is illustrative. As Exhibit 9 indicates, there are four general ways that firms in this industry—and, more generally, firms in mature markets with capable competitors—obtain competitive advantage [Porter 1980]: They offer a low-cost product or service to a broad market, such as Volkswagen, or to a more narrow market, such as Mini-Cooper. Or they offer a differentiated product at a premium price to a broad market, as does Mercedes Benz, or to a more narrow market, such as Ferrari.

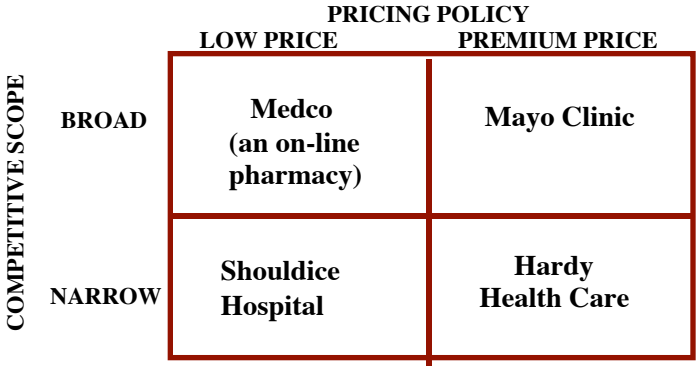
Exhibit 9. Strategic Positioning in the Automobile Industry



Source: The Crimson Group, Inc., Cambridge, Massachusetts.

Exhibit 10 shows a similar set of examples in the healthcare field. As it indicates, some healthcare organizations have made tradeoffs along these two dimensions. As with the three-dimensional model, however, healthcare organizations that have made strategic tradeoffs of this sort are difficult to find. Yet, by not making these sorts of tradeoffs an organization has potentially compromised its ability to remain financially viable.

Exhibit 10. Strategic Positioning in the Healthcare Industry



Source: The Crimson Group, Inc., Cambridge, Massachusetts.

Making tradeoffs requires courage, in large part because it means denying service to some existing patients or telling former patients to go elsewhere the next time they need care. Yet, doing so can have powerful positive consequences. For instance, at Lan and Spar, a small Danish bank, senior management decided to focus its strategy on white collar workers rather than corporations. The bank then sent letters to its corporate customers asking them to move their accounts to another bank—a courageous step, indeed. Lan and Spar is now the most profitable bank in Denmark, in part because of its highly focused strategy [Markides, 2000].

OPERATIONAL CONSEQUENCES OF STRATEGIC TRADEOFFS

Making tradeoffs has important operational consequences. For example, organizations that offer a low-cost product must have a capital budgeting process that ensures investments in assets that lower operating costs, rather than ones that help to differentiate their product. The goal of these organizations is to deliver a product of acceptable quality, but at a price (and therefore a cost) that is significantly below its competitors.

By contrast, organizations that offer a premium-priced product select narrow market segments with unusual needs, and offer them products and/or services that are widely acknowledged as superior on at least one dimension: They then invest in assets that assist them to create superiority along that dimension.

There are multiple dimensions where premium-priced differentiation can take place. They include durability (Energizer batteries), speed (Federal Express), variety (Amazon.com), ease of use (Macintosh), image (Mont Blanc pens), overall experience (Starbucks), safety (Volvo), exclusivity (American Express Black card), and no doubt many others. In general (assuming there is a sufficiently large market segment that wants the differentiated product), the greater the differentiation, the greater the gap between the organization's price and the industry's average price.

There has been increasing differentiation in the non-hospital arena of the healthcare sector over the past several years. One need only read the ads in any magazine that caters to people in the over-50 age bracket to see offerings for cosmetic surgery clinics, laser hair and cellulite removal centers, liposuction facilities, hair restoration clinics, and the like. Many cosmetic surgery centers have focused on patients (e.g., actors) who have few price constraints and a great need for a differentiated product. In the U.S., "boutique" physician group practices now cater to individuals who are willing to pay a price premium for more personalized care and shorter appointment queues. In the U.K., United Surgical Partners International has surgery centers that charge premium prices to individuals who wish to avoid queues in the National Health Service for non-urgent procedures (such as joint replacements) that can be performed on an ambulatory basis.

In the U.S. hospital sector, the Mayo Clinic is a good example of this sort of differentiation. Mayo focuses on patients (especially international ones) who are not constrained by insurance limits on payments. Similarly, some hospitals have differentiated themselves by offering supplemental

services for which the patient pays out of pocket, such as private rooms or gourmet meal service. Others have begun to focus on services for geriatric patients.

In general, however, most hospitals are stuck in the middle. They are constrained by third-party or governmental payment rates (which usually make them low-price providers) and yet they must contend with medical staffs (and sometimes patients) who demand resources and services more appropriate to a premium-priced provider. For example, some orthopedic surgeons, largely due to personal preference, use comparatively expensive joint replacement devices when less expensive devices would suffice. Other hospitals allow physicians to admit their patients with little or no advance notice, even when the need for hospitalization is not urgent. One consequence is volatility in the demand for nurses, and a frequent need to use expensive "agency" nurses. Other hospitals remain at low occupancy during weekends and holidays because physicians do not wish to work during these time periods, or because potential patients wish to be with their families. Still others succumb to physician demands for cutting-edge technology when less-expensive technology would do an acceptable job without compromising quality.

It thus would appear that hospitals could make better strategic tradeoffs than they have to date by recognizing that they function in the low-price column of Exhibit 10 and therefore need to change their operating policies to be consistent with that strategic position. An emphasis on *adequate,* rather than cutting-edge, technology, for example, would be consistent with this focus, as would the development of policies to keep occupancy high during weekends and holidays so as to provide additional financial contribution to the hospital's high fixed costs. In short, there is considerable room for hospitals to think more carefully about their strategic positions, and the assets and other operating activities needed to support it.

ASSESSING THE QUALITY OF AN ORGANIZATION'S TRADEOFFS

Just because an organization has made some tradeoffs, does not mean that it has done so appropriately. Nor can the quality of an organization's strategic tradeoffs—in the healthcare field or elsewhere—be assessed in terms of short-term financial results. U.S. companies like Amazon.com and Yahoo, and Spanish firms such as Línea Directa Aseguradora and ING Direct, had poor financial results in their early years, but by staying with their strategies they ultimately reached profitability.[2] This, of course, raises the question of what criteria other than short-term profitability can be used to assess the quality of an organization's strategic tradeoffs. Our research suggests that there are two broad criteria.

Criterion #1. Consistency with Environmental Demands

An organization's strategy must be consistent with the factors that are critical to success in its environment. These factors will differ from one country or region to the next, depending on a variety of legal and payment requirements, and other constraints. What will work well for a nursing home in Germany, for example, may be quite inappropriate for one in Italy. Similarly, a clinic in Cataluña faces different constraints and requirements from one in Andalucía. In the U.S., a large, urban, teaching hospital in the Northeast must contend with a vastly different set of environmental factors than a small, rural, community hospital in the Southwest.

In some instances, achieving this consistency requires what Kim and Mauborgne (2005) call a "breakthrough innovation," or a genuinely creative approach to a difficult set of environmental demands. A good example is Novo Industri's response to the dilemma it faced when GE insulin replaced its animal-based insulin. Novo teamed up with Nordisk to develop innovative methods to administer insulin and other diabetes-related products.

Criterion #2. Presence of a Well-Designed Activity Set

An activity set [Porter, 1996] is an internally-consistent collection of structures, systems and processes that assist an organization to implement its strategy successfully. A well-designed activity

[2] The ING Direct strategy has been replicated by Abbey (a subsidiary of Grupo Santander) in its entry into the United Kingdom, thereby reinforcing the idea of a focus on something other than short-term results.

set contributes to successful strategy implementation and also makes the organization's strategy difficult for competitors to imitate. In effect, it helps to assure the organization of attaining and sustaining superior performance.

Our research suggests that, at a generic level, an activity set comprises seven processes [Young, 2000; 2003b]:

1. *Authority and influence*. The design of responsibility centers (such as profit centers), as well as the way that both formal and informal decision making takes place.

2. *Management control*. A process that includes programming, budgeting, measuring, and reporting, which, when combined, helps to assure that strategy implementation is consistent with the organization's financial capabilities.

3. *Motivation. A* process that helps to generate a commitment to work toward achieving superior performance, and that rewards employees for behavior that is in the organization's best interest.

4. *Conflict management*. The design of mechanisms (e.g., task forces, ongoing committees) to addresses the many kinds of conflict that can arise between and among operating managers, which must be resolved successfully if the organization is to be successful.

5. *Customer management*. A complex set of activities that helps to assure the organization that it is both attracting new customers (e.g., patients) and serving existing ones in accordance with its strategy.

6. *Cultural maintenance*. Activities (such as hiring, firing, and training) that help to create and sustain a common culture and set of values that, among other things, engender an emotional commitment from employees to achieve the organization's strategic goals.

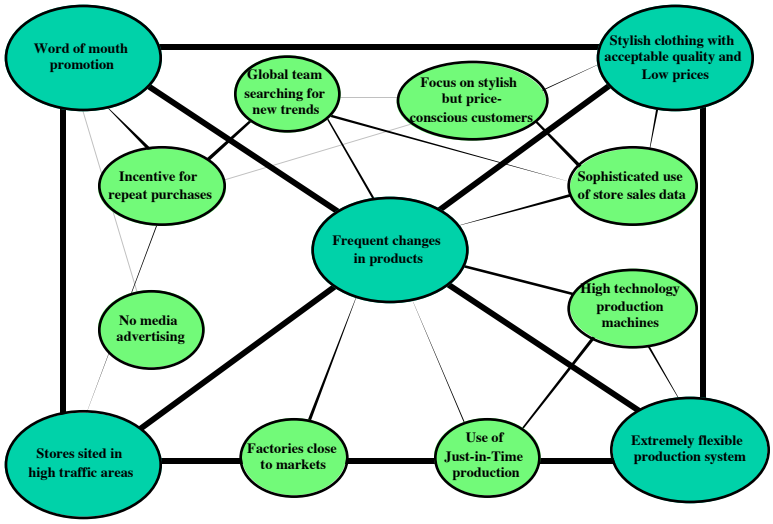
7. *Strategy formulation*. A process in which senior management continually examines the organization's overall direction and goals to see if they are appropriate, and makes changes when necessary.

Exhibit 11 shows how one of these seven processes (customer management) has been designed by Inditex (a Spanish textile firm best known by the commercial name of Zara). Of considerable importance is the fact that the set is so tightly linked that copying one or two of its elements would be of little value to a competitor. For example, many companies could have a just-in-time production system in factories located close to retail stores. But this is of little value unless there also is a global team that is identifying new trends, a sophisticated IT system that uses store data to inform senior management of which products are selling well (and which are not), the presence of stores in high-traffic sites, and an incentive system for customers to make repeat purchases. To compete effectively with Zara, a company must copy its customer management process in its entirety.[3]

It is quite likely that Zara has complemented its customer management process with a variety of activities, such as the designation of its stores as profit centers (authority and influence), the payment of significant bonuses to store managers who meet or exceed profitability goals (management control and motivation), the use of a permanent committee of senior managers that meets regularly to discuss which global trends are important to adopt and which are not (conflict management), an emphasis on constant change, requiring managers who are anything but complacent (cultural maintenance), and an ongoing process of assessing how the company might establish additional barriers to competitors that are attempting to imitate its activity set (strategy formulation).

[3] For additional details, see Ferdows, Lewis and Machuca, "Rapid Fire Fulfillment," *Harvard Business Review,* November 2004.

Exhibit 11. Zara's Activity Set



Source: Eduard Ballarin.

Few hospitals have made a strategic choice, and then developed a robust activity set to support it. Yet, imagine the competitive advantage that a hospital operating in the low-cost arena could have if it linked its strategy of low-cost inpatient care services to an activity set that included: (1) a capital budgeting process that focused on adequate but not cutting-edge technology, (2) an operational policy, supported by an operating budget, that required the use of standardized surgical devices, (3) an information system that used an electronic medical record to permit the rapid retrieval of diagnostic information, (4) an operational policy that required admissions for non-urgent care to be scheduled several weeks advance,[4] (5) a clinical pathway for orthopedic surgery that required rehabilitation care to begin several weeks prior to admission so as to shorten the length of stay, (6) an in-home after-care program, supported by an operational budget, that allowed an earlier-than-average discharge, and (7) an incentive system that rewarded physicians and others for meeting clinical pathway targets, budget goals, and other performance goals, including non-financial ones.

SUSTAINING A SUCCESSFUL STRATEGY

Designing a strategy that is consistent with environmental demands and internal strengths is not a one-time undertaking. Even the most cleverly crafted strategy must be reviewed constantly if it is to adapt to changes in environmental demands and shifting organizational strengths and weaknesses. In undertaking such a review, an organization treads a thin line between being capricious and whimsical, on the one hand, and rigid despite overwhelming evidence suggesting a need for change, on the other. For example, in many countries, despite overwhelming evidence of the care demands that will emerge from an aging population, many hospitals, and indeed entire healthcare systems, have not even begun to invest in geriatric programs or infrastructure assets (such as nursing homes) needed to care for the elderly. Denying the impending impact of this demographic bubble portends the same sort of calamity that befell Polaroid and Kodak when they denied the impending impact of digital photography.

A strategy's sustainability can be affected by changes in any of Porter's [1980] five forces of buyer power, supplier power, barriers to entry, rivalry, and substitutes. To these, Ghemawat [2005] has added the concept of slack.[5] Clearly, these factors will differ considerably from one country to the next, perhaps within regions of a single country, and quite likely among different types of healthcare providers located in the same region.

[4] This idea is not as far-fetched as it may seem. Several years ago, the Massachusetts Eye and Ear Infirmary developed an admission-scheduling system that required several weeks advance notice for non-urgent procedures. The result was that the hospital could plan admissions in such a way as to function with a full-time nursing staff that used little overtime, required minimal part-time or agency nurses, and was fully occupied during each day.

[5] Ghemawat's other threats to sustainability (imitation, substitution, and holdup) essentially are derivatives of Porter/s five forces.

Buyer Power

As buyers, governmental payers have considerable power. Most do not negotiate payment rates; they dictate them. Healthcare providers must either accept these rates or give up a significant portion of their business. Managed care plans, although not having dictatorial power over rates, nevertheless can exert control over where patients receive care, and hence have a great deal of power. For example, in the last ten years, digital imaging, which allows radiological films to be sent anywhere in the world to be read, has greatly increased the power of all buyers of radiologists' services. The resulting power shift has had an enormous impact on the strategy of many departments of radiology, causing some of them to rethink their fees and other prices.

Patients also are gaining power as buyers. The availability of information on the Internet has allowed them to learn a great deal about the quality and cost of hospitals and physicians. In some countries, patients are beginning to exercise this newfound power by becoming more proactive in choosing their providers. When cost-sharing is present, some have even begun to negotiate with providers about fees.

Supplier Power

Suppliers have considerable power when they have the ability to withhold their products or services, and thereby impede an organization's smooth functioning. One of the most common forms of "supplier holdup" is a strike. Failed negotiations with nursing unions, for example, have prevented some hospitals from moving forward with their strategies. Similarly, impasses in negotiations between hospitals and their payers have occasionally affected one or both parties. Recently, a group of hospitals in the United States obtained some large price increases from one of the region's largest health managed care plans by threatening to refuse admission to the plan's non-urgent patients.

Barriers to Entry

Barriers to entry vary considerably from one country to the next, depending on legal requirements, licensing policies, charitable giving, capital availability, and other matters. In most countries it is relatively easy for a physician to set up a practice, or for an alternative provider (such as a herbalist) to hang out a shingle. On the other hand, building a new hospital is a complex undertaking—and one that has significant cost implications. As a result, in many countries, new hospital construction, and even hospital expansions above a threshold amount, are controlled by a government agency. Thus, there can be both barriers to *entry* and also barriers to expanding into new market segments.

Rivalry

Historically, many hospitals have developed programs that are just like those of nearby facilities, and have then begun to compete with them for patients. Oncology centers, heart centers, and the like have proliferated in the U.S. In a particularly telling example, Stanford Medical Center awakened some years ago to the fact that it had been training physicians to provide competitive services in nearby community hospitals, and to do so at lower cost (since they did not have the overhead associated with teaching programs and other attributes of an academic medical center). Stanford struggled to redesign its strategy to deal with the presence of rival forces that it had created itself.

Substitutes

Substitutes have been particularly disruptive over the history of heath care. In the recent past, laser eye surgery has substituted for prescription lenses, cardiac stents for open heart surgery, and laproscopic surgery for more traditional surgery. The list is long and growing. And, even outside of hospitals, the healthcare field has seen a variety of new products and services that have attempted to substitute for more traditional ones. Acupuncture, homeopathy, yoga, health spas, and herbal medicines are all examples of substitutes that have influenced individuals' use of more traditional healthcare services.

Slack

Slack is especially prevalent in settings where professionals have wide discretion over resources. This certainly is the case in hospitals and other health care organizations, where clinical decisions by physicians, nurses, and other professional caregivers have a major impact on resource usage.

In response to this threat, many healthcare organizations have attempted to institute systems of cost control and performance measurement. This effort has been given impetus in many countries by payment systems (e.g., DRGs, global budgets) that have forced hospitals to think more carefully about the mix of services they provide to patients in the treatment of a disease, as well as the cost of providing each of those services. The creation of clinical pathways was in no small way an attempt to eliminate "slack," as it is broadly defined in the healthcare sector.

This sort of thinking has extended beyond the inpatient arena. Consider the two emergency-room treatment patterns shown in Exhibit 12. Here, as with clinical pathways, slack can be defined as the avoidance of unneeded resources (e.g., an inpatient stay) for a patient's condition.

Exhibit 12. Example of New Inpatient Utilization Pattern

48 YEAR OLD PRESENTING WITH ATYPICAL CHEST PAIN, POSITIVE SMOKING AND FAMILY HISTORY , AND NORMAL EKG

CURRENT PATTERN		OPTIONAL PATTERN	
Admit to Telemetry ALOS = 2.2 days	$2,800	Admit to Observation Unit ALOS = 23 hours	$1,000
Daily EKG x 3	$225	EKG x 2	$150
Enzymes and Full Bloods	$175	Enzymes and Limited Bloods	$75
Cardiology Consult	$150	Cardiology Consult	$150
Echo	$350	Echo	$350
Thallium Stress Test	$450	Non-Thallium Stress Test	$125
TOTAL COST	$4,150	TOTAL COST	$1,850

AT AN INCIDENCE RATE OF 5/1000, THE PURCHASER WOULD SAVE $3.5 MILLION ANNUALLY

Source: Robert Galvin, M.D., The General Electric Company.

Most hospitals have only skimmed the surface of slack-eliminating possibilities. Operating rooms, for example, are clear candidates for slack reduction. In one hospital, the use of a computerized tracking and data reporting system assisted the operating suites to move from 55 to 85 percent utilization (since the hospital held back one of its 20 ORs for emergency trauma cases, the best it could do was 95 percent), and to increase its financial contribution to the hospital's bottom line from zero to about $15 million [Young, 2004]. Yet, few U.S. hospitals have undertaken such a move.

On the non-clinical front, few hospitals have extended the concept of clinical pathways to non-clinical areas. Yet it would be relatively easy to establish "administrative protocols" for providing a medical record, washing a pound of laundry, preparing a meal, cleaning a square meter of floor space, and so on.

CONCLUSIONS

Given the threats that the above six factors pose to sustainability, senior management must monitor and assess them continually, and, where appropriate, modify their organization's strategy accordingly. Importantly, however, modifying the strategy may create a need to redesign the organization's activity set, which, although not considered to be part of strategy by many organizational theorists, is essential for successful strategy *implementation*.

Many healthcare organizations have used their nonprofit status and the importance of their missions as excuses to dismiss some or all of these six factors as irrelevant, or to avoid making difficult strategic tradeoffs. Indeed, some healthcare professionals have been critical of organizations that have made strategic tradeoffs. For-profit hospitals or ambulatory surgery centers that are selective in the patients they serve, or entities such as cosmetic surgery centers, boutique physician practices, freestanding dialysis clinics, and the like, all have been looked on with some considerable disdain by many observers. Yet, the essence of strategy rests in these sorts of tradeoffs.

Ironically, most healthcare organizations have been making tradeoffs—usually by default rather than by design—for decades. Hospitals have not extended their service lines to include embalming their deceased patients, for example. Primary care clinics do not sell questionable elixirs. Most hospital pharmacies do not stock Chinese herbs. Some hospitals have refused to merge with others that perform abortions. And so on.

But these sorts of tradeoffs are minor compared to the more serious ones that a hospital or other healthcare provider will need to make if it wishes to be successful in the years ahead. These more serious strategic tradeoffs do not need to be mercenary, however. Nor do they need to result in lower quality care or a compromise in the hospital's nonprofit mission. Rather, they address the reality that no organization can be all things to all people, and that by thinking more creatively in the future than they have in the past, hospitals and other healthcare organizations can determine which tradeoffs they wish to make so as to establish a strategic position. They then can design an activity set to support that position—one that will allow them to be financially viable while simultaneously achieving and sustaining their clinical and programmatic performance goals. The future is now!

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