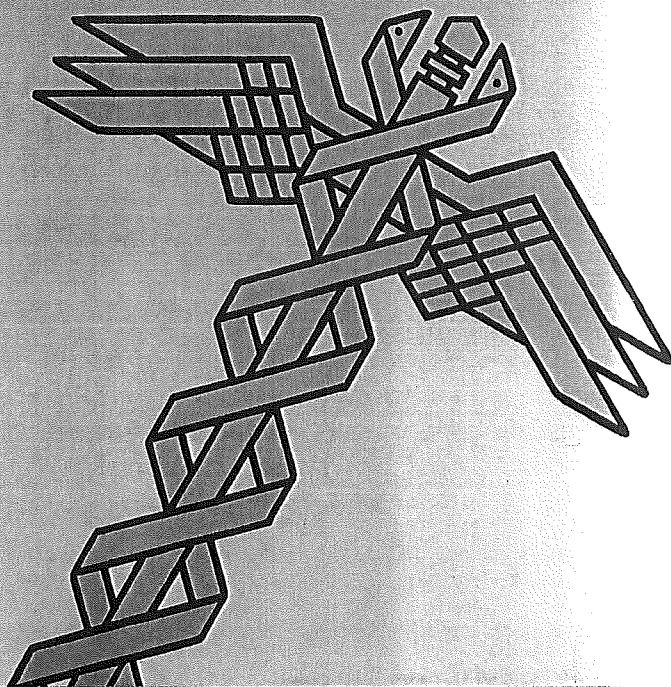


Stephen S. Mick and Associates

Innovations in Health Care Delivery

*Insights for
Organization
Theory*





Health Care Organizations and the Development of the Strategic-Management Perspective

Stephen M. Shortell

Edward J. Zajac

The rapidity and pervasiveness of changes occurring within the American health care system are widely acknowledged. For students of organizations, these changes have four important implications. The first is the need to examine the process by which organizations within an industry transform themselves to meet the demands of a radically new environment. The second is the need to expand concepts of organizational effectiveness based on a few stakeholders (for example, physicians and patients) to include a broad array of diverse stakeholders (for example, third-party payers, large employers, regulatory bodies, and legal and licensing agencies). The third is the need to change the primary focus of analysis from internal operations and performance to the organization's relationships to external stakeholders and its environment. The fourth implication is the need to move beyond the study of individual health care organizations to the study of strategic alliances involving systems or networks of health care organizations. In addressing these issues, research on health care organizations has generally kept pace with parallel developments in the organizational sciences at large and, in a few cases, may even be at the cutting edge.

In this chapter we provide a brief overview of strategic-management theory and the contributions of health care organizational research to that theory. The main focus, however, is on two

subareas of investigation: strategic change and adaptation, and the development of strategic alliances. These areas are selected because of their importance both to the health care sector and to the study of strategy in general. In each area we draw on recent research to illustrate its potential contributions for further theory development.

The State of Strategic-Management Theory

Strategic-management theory has its origin in Chandler's (1962) seminal work on strategy and structure. This work is reinforced by the conceptual work of Ansoff (1965), Andrews (1971), and Schendel and Hofer (1979), and more recently by Porter's insights into competitive strategy (1980, 1985). Although disagreements exist in the literature about what should be included in the definition of strategy—some favoring a broad definition that includes the goals and objectives of the firm (Chandler, 1962; Andrews, 1971) and others favoring a narrow definition limited to the plans and activities of the organization (Ansoff, 1965; Schendel and Hofer, 1979)—all agree that strategy involves positioning the organization relative to its environment and competitors in order to achieve its goals and assure its survival. This formulation of strategy has led to two main streams of investigation: issues and questions of strategic content, and issues and questions of strategic process. The content research has focused primarily on the relationship among the firm's strategies, its environment, and its performance. It has addressed issues of diversification, generic-strategy taxonomies, strategic groups, and the evolution of markets, among other topics (Fahey and Christensen, 1986). The process-oriented research has focused on issues of strategy formulation and implementation. Attention has been paid to planning methods, decision-making processes, the alignment of strategy and structure, and their effects on performance (Huff and Reger, 1987).

Ansoff (1987) has suggested the emergence of a paradigm centered around the idea that the strategic behavior of an organization should be examined as a function of the interplay among environmental forces, internal organizational configurations and processes, and strategic content. Along similar lines, Kimberly and Zajac (1985) call for an examination of the connections among environ-

ment/strategy, strategy/structure, and structure/behavior. These approaches attempt to integrate strategic-content and strategic-process research while taking into account the nature of the organization's relationship to its environment.

For further progress to be made, however, it is necessary to address several issues and questions that have received relatively little attention in either the content or process literature to date. Among these are:

- The role strategy plays in achieving the nonfinancial goals of the organization, particularly in regard to diverse stakeholder groups. Almost without exception, the current literature is focused on accounting and financial indicators as measures of the success of a firm's strategy.
- Examination of the conditions under which some firms are likely to change their strategy and which types of strategic change are more likely than others to be effective.
- Emerging cooperative strategies and strategic alliances that go beyond the current preoccupation with a single firm's competitive strategies.
- Studies that explore in depth the relationship between the corporate office and the division in the strategy-making process of multidivisional organizations.
- What happens in the strategy formulation and implementation process when power bases are diffuse and when key leaders lack formal position, power, or authority.
- Examination of the extent to which strategy formulation and implementation are intertwined processes and the conditions under which strategies are likely to be generated out of the implementation process rather than formulated in advance.
- Further investigation of the role of internal transaction costs and benefits in strategy implementation and performance.

Health care is a particularly attractive area for addressing these issues. Because of the broad mission of most health care organizations and the fact that the industry is composed of both for-profit and not-for-profit firms, a wide range of performance issues (both financial and nonfinancial) can be addressed. In addition, one

can examine the extent to which the objectives of a diverse array of stakeholders are met. Given the significant changes occurring within the industry, it also serves as a fertile ground for examining the extent to which organizations change their strategies, the conditions under which certain strategies are more effective than others, and the process by which new strategies are successfully implemented. It also provides an opportunity for observing the implementation of cooperative strategies (for example, strategic alliances and networks) and of acquisition and divestment strategies (for example, hospital and clinical as well as support service consolidations and closings). The growth of hospital systems affords excellent opportunities for studying various aspects of the corporate office/division relationship, ranging from strategic-planning processes to the centralization versus decentralization of decision making to transaction-cost economics.

In addition to these content issues, the health care sector also serves as a laboratory for examining process-oriented issues. For example, the prominent role played by diverse groups of health care professionals opens up new opportunities for studying the nature of strategic planning and implementation. How are these processes conducted when power among key actors is dispersed and when members of one of the key groups (physicians) are usually not even employees of the organization? Health care organizations also can provide rich insights into the growing normative assertion that strategy formulation and implementation are highly interrelated processes because a health care organization's ability to implement many of its strategies depends on early and significant involvement of physicians and other key professional groups. The diffuse power base along with the rapidity of change also provide opportunities for studying the relationship between formal and informal planning and between induced and autonomous planning (Burgelman, 1987).

Current Research

The push for an economical and cost-effective health care system means that organizations must consider health care as both an economic and a social good. To learn how these different ideologies are

balanced requires an explicit examination of the strategies pursued by health care organizations and the processes by which they are formulated, implemented, and evaluated (Kimberly and Zajac, 1985; Shortell, Morrison, and Robbins, 1985).

A small but growing literature has emerged that addresses the strategic behavior of health care organizations and provides some insights into the development of strategic-management theory at large. A sample of relevant conceptual and empirical work from the 1980s is highlighted in Figure 6.1. Works are classified according to the content categories suggested by Kimberly and Zajac (1985). Although there is reasonable coverage of each category, empirical examination of the connections among the three categories has only begun.

Longest's (1981) resource-dependence perspective on the strategy-making process gives a prominent role to the organization's leaders as the "key strategists." They are charged with the responsibility for perceiving the environment and aligning the organization's distinctive competence with the demands of the environment. The important role played by the top-management team in the strategy-making process is only beginning to appear in the strategic-management literature (Hambrick and Finkelstein, 1987). Further research on health care organizational leadership can make an important contribution to understanding the top-management team's role in the overall strategy-making process.

Longest also emphasizes that implementation is influenced by a complex interplay of strategies, tasks, structures, technologies, and people; relatively little is known about this process. A major question that emerges is the extent to which implementation can be or should be structured through the formal strategic-planning process or left fluid. Burgelman (1987) takes up this issue by contrasting the role played by induced (structured) versus autonomous (fluid) approaches in the process of strategic adaptation.

The work of Peters and Tseng (1983) and Shortell, Morrison, and Friedman (1990) highlights some of the behavioral dynamics associated with strategic adaptation. They emphasize the importance of five factors: the role of precipitators of change—events or circumstances that make the status quo uncomfortable; the need to articulate desired alternative states; the importance of the organiza-

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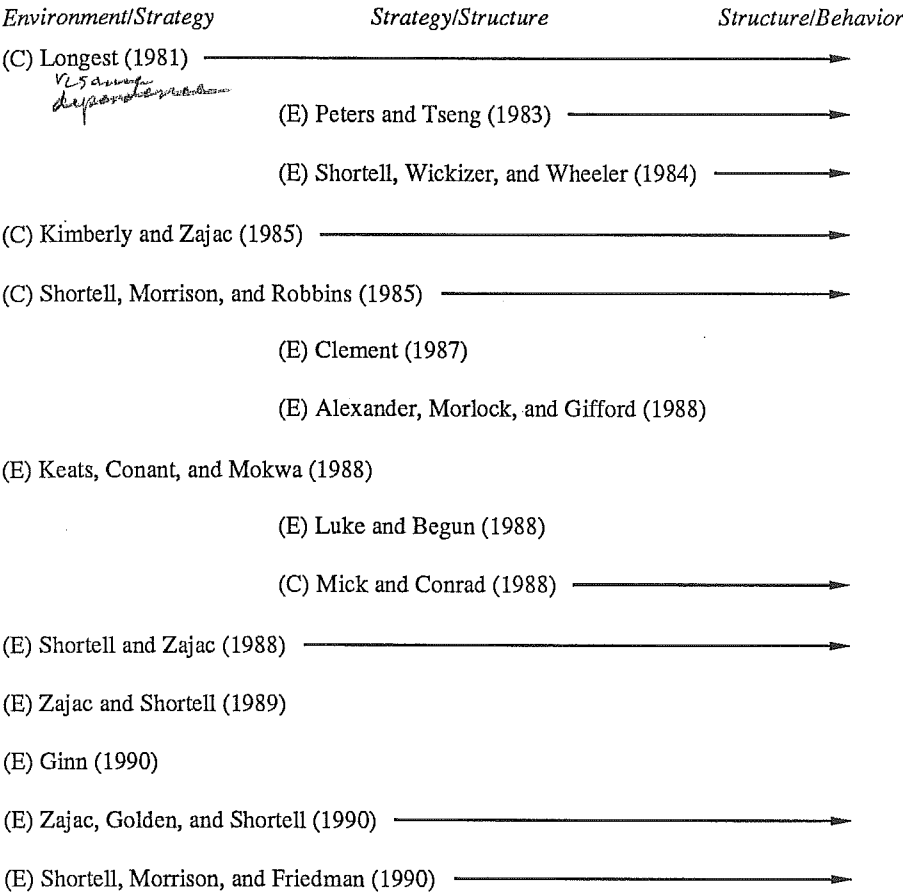
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Figure 6.1. Classification of Selected Health Care
Organizational-Research Contributions to Strategic-Management Theory



Note: C = conceptual, E = empirical.

tion's culture and value system in successfully initiating such change; the need to take risks; and the need to manage the timing and pace of change. In studying the problems associated with the implementation of one strategy—hospital/physician joint ventures involving primary-care group practices—Shortell, Wickizer, and Wheeler (1984) and Shortell and Zajac (1988) highlight the impor-

tance of balancing autonomy needs and integration needs in structuring relationships between the parent organization and new units. Zajac, Golden, and Shortell (1990) also discuss the role of such relationships in enhancing innovation. These findings have added to a growing literature on new venture developments and organizational spinoffs.

The conceptual pieces of Kimberly and Zajac (1985) and Shortell, Morrison, and Robbins (1985) lay out a number of issues, questions, and hypotheses requiring attention. Subsequent work has addressed some of these areas. The most productive stream of research (Ginn, 1990) has been that examining the changes in the health care environment and strategic content, particularly in reference to Miles and Snow's (1978) typology of prospectors (consistently innovative), analyzers (market niche oriented), defenders (protective of current domains), and reactors (lacking a consistent strategy) (Keats, Conant, and Mokwa, 1988; Luke and Begun, 1988; Zajac and Shortell, 1989; Shortell, Morrison, and Friedman, 1990). Most of these studies (Luke and Begun did not examine performance) have found generally consistent findings pertaining to the degree of strategic change initiated by health care organizations—approximately 38 to 50 percent in various samples; the direction of change—from a defender orientation to an analyzer and prospector orientation; the importance of prior strategy in initiating strategic change; and the general superior performance of organizations adopting an analyzer or prospector strategy versus those adopting a defender or reactor strategy. Shortell, Morrison, and Friedman (1990) examine some of the underlying factors that account for these findings, including the requirements for managing the different strategic orientations. This stream of health care organizational research has made important contributions to the strategic-management literature at large by suggesting that in turbulent environments a proactive analyzer or prospector strategy appears to be preferable to a defender or reactor strategy and is associated with superior performance. The health care organizational literature also provides some empirical data relevant to the frequency with which firms change strategies and the direction in which those changes occur.

Other work noted in Table 6.1 has examined the effects of

specific strategies or structural elements. For example, Clement's (1987) data indicate that diversification has not paid off for most hospitals, although more recent research suggests some of the factors that may distinguish the more successful diversifiers from the less successful (Shortell, Morrison, and Hughes, 1989). Alexander, Morlock, and Gifford (1988) document how hospital restructuring has resulted in corporation-like hospital boards rather than philanthropic boards and a consequent increase in the strategic orientation of such boards. Mick and Conrad (1988) provide useful guidelines for considering vertical-integration strategies based on Williamson's (1975) transaction-cost perspective. Of particular note is the emphasis they give to internal behavioral impediments such as goal displacement, poor communication, and poor conflict resolution, which can increase "internal" transaction costs.

Strategic Adaptation

In a world in which change is common and continuity uncommon, the study of strategic adaptation is of particular importance. It also provides a lens for studying many organizational phenomena because it is under conditions of change that new issues and processes arise, underlying assumptions are exposed, and new insights are uncovered. Among the more important and interesting aspects of strategic change are the prevalence, direction, magnitude, pace, duration, and effects of the process. In particular we are interested in the circumstances (external and internal to the organization) surrounding the process. For example, under what circumstances and conditions do organizations change or not change their strategies? Two studies of strategic change in health care organizations specifically address some of these issues. They provide a departure point for developing an integrative framework to guide future theory development and testing.

Prevalence of Change. Using different samples of hospitals, both Ginn (1990) and Zajac and Shortell (1989) observed strategic changes (as measured by the Miles and Snow typology of prospectors, analyzers, defenders, and reactors) to occur with some frequency—in 38 percent of the 77 Texas hospitals studied by Ginn

from 1976 to 1980 and from 1981 to 1985, and in 54 percent of 510 hospitals belonging to eight hospital systems nationwide studied by Zajac and Shortell from 1983 to 1985. Subsequent work indicates that 50 percent of system hospitals changed their strategic orientations between 1985 and 1987 (Shortell, Morrison and Friedman, 1990). Both Ginn and Zajac and Shortell found that prior strategy (specifically, being a defender) was the strongest predictor of the probability of a change in strategic orientation. These findings suggest that, at least in industries or sectors undergoing significant environmental turmoil, organizations are more likely to change their strategies than is suggested by some of the literature (for example, Hannan and Freeman, 1984). The failure to observe a greater prevalence or frequency of strategic change in the past may be due to the selection of industries that were relatively stable. ✓

Direction of Change. Ginn (1990), Zajac and Shortell (1989), and Shortell, Morrison, and Friedman (1990) all find a consistent shift in strategy from the more passive defender category to the more active analyzer and prospector categories. It appears that not all strategies are equally preferred for given environmental states. In the face of significant environmental change, active market-oriented responses involving the analyzer and prospector approaches are favored. This response appears to be due to the belief that the organization needs to develop new products or services (needs to diversify) to compete in new markets; in the case of health care, these new services and products include outpatient diagnostic centers, home health care, and sports medicine. In this way, a hospital can both protect the acute-care business and develop new revenue sources. ✓

Magnitude of Change. If one accepts the Miles and Snow (1978) continuum of the defender strategy as the least change-oriented and the prospector strategy as the most change-oriented, then the magnitude of switching from a defender to a prospector strategy would be greater than that of switching from a defender to an analyzer or an analyzer to a prospector. In Ginn's (1990) work, of the seventeen defenders who switched their strategies, five became reactors, eight became analyzers, while only four became prospec-

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tors. Of the four analyzers who switched strategies, two became prospectors and two reactors; none became a defender. All four of the prospectors who switched strategies became analyzers. These results suggest that hospitals seldom move more than one category away from their base orientation on the Miles and Snow strategic continuum. ✓

These results are confirmed by national studies finding that 65 percent of all strategic changes were made within adjacent categories (Shortell, Morrison, and Friedman, 1990). The authors suggest that this observation might be explained by the notion of a strategic comfort zone within which organizations wish to operate even when recognizing the need for a significant degree of strategic reorientation. The idea of the strategic comfort zone involves the extent to which the new strategy requires a significant departure from the organization's current culture, values, behavioral norms, practices, policies, and mix of abilities and skills. In brief, to what extent does the organization feel comfortable about the new strategy and capable of implementing it? The leap from defender to prospector (or the reverse) is beyond most organizations' comfort zones and, therefore, is likely to be resisted. Empirical support for this notion is also found in studies of other industries (Topping and Rudolph, 1989).

Pace of Change. None of the existing health care literature explicitly addresses the rapidity with which strategic changes are initiated and implemented. The shorter time interval studies (Zajac and Shortell, 1989; Shortell, Morrison and Friedman, 1990) suggest that the changes occurred within at least a two-year period as evidenced by both chief executive officers' perceptions and the hospitals' actual market behavior. Some evidence also suggests that organizations staying within their strategic comfort zone had fewer problems in implementing the needed changes and, therefore, were able to do so more quickly than those that did not stay in their comfort zones. At the same time, the content of the new strategy adopted influenced the pace of change. For example, strategies emphasizing an experimental, proactive stance toward the market (for example, the prospector stance) required careful involvement of physicians and ongoing monitoring of the pace of change. At times the implementation processes needed to be accelerated through the formation of task forces and committees. At other times, the process

needed to be slowed down as pockets of resistance arose and necessitated regrouping and reeducation tactics.

Duration of Permanence of Change. Once established, how long do new strategies persist? Although the existing studies cover periods of several years, none are of sufficient length to directly address this question. However, 60 percent of those in the national study of system hospitals reported that they planned to continue with present strategies for at least two years (Shortell, Morrison, and Friedman, 1990). (Of the 40 percent who planned to change their strategies, the vast majority intended to become analyzers, again reflecting the strategy makers' beliefs that proactive strategies rather than defensive strategies will better meet evolving environmental demands.) In general, the permanence of an organization's strategy is likely to be a function of the extent to which it continues to help the organization meet and anticipate environmental changes and competitive threats, achieve goals and objectives, and make use of capabilities while remaining consistent with the organization's mission and values. This area requires increased attention.

Effects of Change. On average, little evidence suggests that those who changed their strategies outperformed those who did not in regard to a variety of financial and nonfinancial indicators (Zajac and Shortell, 1989; Shortell, Morrison, and Friedman, 1990). This finding may be due to the relatively short time frame in which performance effects were examined. However, evidence suggests that prospectors and analyzers outperform defenders, particularly in regard to financial indicators and market share. These findings are significant in that they provide empirical support for top management's belief that in the rapidly changing health care environment the analyzer and prospector strategies appear to be the "correct" ones.

The Process of Strategic Adaptation: Building Blocks of a Theory

As shown in Figure 6.2, strategies are a function of the interaction among environments, organizations, managers, markets, and performance. These elements are the building blocks for understanding

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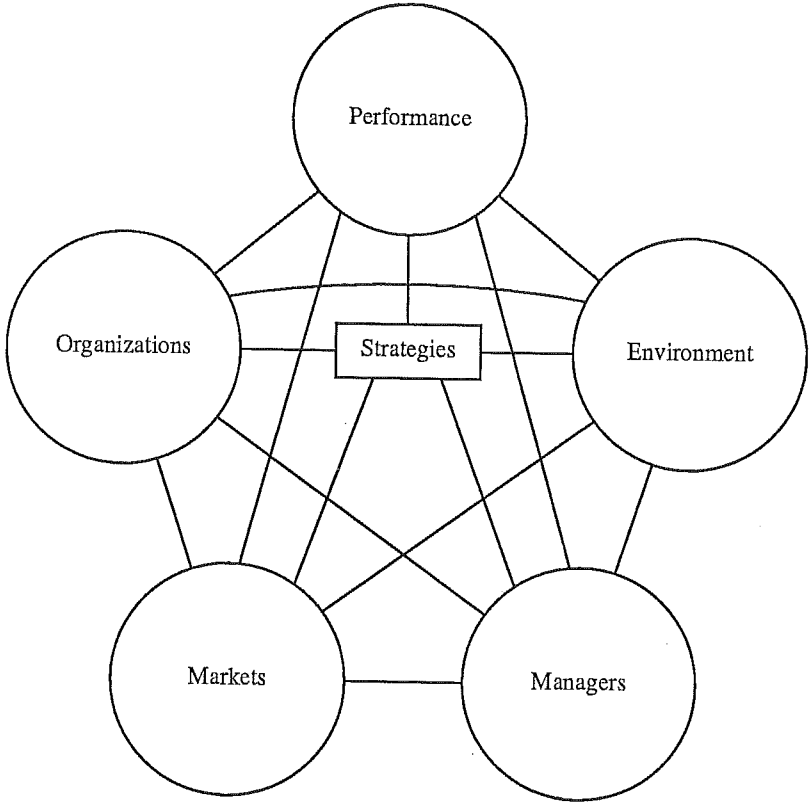
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Figure 6.2. Elements of a Theory of Strategic Adaptation.



strategy formulation, implementation, and change. Thus, a “the-
ory” of environments, a “theory” of organizations, a “theory” of
managerial behavior, a “theory” of markets, and a “theory” of per-
formance are required. Understanding strategic change is an inher-
ently multidisciplinary process in which interdisciplinary research
is likely to provide the greatest guidance. The most important ele-
ments of each of these building blocks are highlighted and then
pulled together into an integrative framework that may be used to
guide future research.

Role of Environment. From the perspective of strategic ad-
aptation, the most important characteristic of environments is the

nature of change within them—the extent to which change is structural or cyclical in nature (Martell, 1986). Structural changes are relatively permanent qualitative changes in the environment. Cyclical changes are relatively temporary, largely quantitative changes in the environment. The introduction of the Medicare prospective-payment system in 1983 is an example of a structural change in that it resulted in a qualitatively different relationship between hospitals and one of their major payers—the federal government. Faced with condition-specific payment caps, hospitals for the first time had an incentive to provide efficient, less costly care. Examples of cyclical change include a change in the interest rates for financing capital expansion or changes in the rate of inflation in the overall economy. Some periods may be more favorable for expansion of services than others, but the up and down changes are just that—reversible. They may require some adjustment in the organization's behavior but not radical change.

Table 6.1 provides further insight into structural versus cyclical change by summarizing some of the key implications for the strategic-adaptation attributes discussed in the previous section. As shown, structural changes in the environment are likely to have far more important and pervasive implications for strategic adaptation than are cyclical changes. Cyclical changes cannot be ignored but do not require the degree of reorientation or realignment demanded by structural changes. — depends on how well they can be predicted, one would think

The distinction between structural and cyclical change applies to both the organization's institutional and its task environment. Some institutional-level changes are structural in nature, such as the increase in the number of women entering the medical profession, while others are cyclical, such as fluctuations in capital markets. Similarly, some changes in the organization's task environment are structural, such as the growth in the out-of-hospital services, while others are cyclical, such as the number of competitors entering or leaving the market. Whether it is dealing with the institutional environment or the task environment, top management's perception of environmental change as structural or cyclical and the implications for the organization are of particular importance.

Role of Managers. It is generally agreed that the organization's top-management team or dominant coalition plays a key role

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Table 6.1. Implications of Structural and Cyclical Environmental Change for Strategic Adaptation.

Implications for Strategic Adaptation	Structural	Cyclical
Prevalence	Higher probability of significant and widespread strategic change	Lower probability of significant and widespread strategic change
Direction	In the direction of fitting or matching the perceived requirements of the changed environment in an ongoing fashion	In a direction that can be easily reversed
Magnitude	Substantial; new and different resources and capabilities required	Small; minor adjustments in current resources and capabilities required
Pace	As rapid as possible; each day lost cannot be made up	Slow, no overreacting
Duration	Long-term and relatively permanent	Short-term and temporary
Performance Effects	Substantial and long-lasting	Minor and reversible

in both perceiving the need for change and organizing to implement change (Hambrick and Finkelstein, 1987). Success often depends on accurately perceiving the nature of the environmental change as structural or cyclical, understanding the demands that the environmental change places on the organization, and accurately assessing the organization's capabilities to cope with these demands. By misperceiving structural change as cyclical change, managers can underreact to environmental change. In contrast, mistaking cyclical change as structural change can lead to overreaction. For example, hospital executives who thought that Medicare prospective payment (structural change) would be a temporary blip on the screen (cyclical change) made a significant mistake in underreacting and failed to accurately diagnose the qualitatively different implications of this new form of payment. Their hospitals were ill-prepared to deal with the challenges and have largely played catch-up in attempting to cope with the new payment environment. At

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the same time, other hospital executives overreacted to increases in competition (cyclical change) by offering every diversified service possible; they made the mistake of assuming that every competitor would stay in business and exert long-lasting and permanent influence (structural change).

In general, the perception of the environment as structural or cyclical depends on top management's experience and abilities, the visibility of the change itself, the pervasiveness of the change, and the organization's recent performance. The greater top management's experience and the greater the extent to which top management has been exposed to external events and circumstances and worked outside the current organization, the more likely they are to be able to distinguish between structural and cyclical change. One might also expect that the greater the experience they have had with the organization's core technology and their competitors, the better they will be at perceiving the difference between structural and cyclical change in the task environment.

The more visible the environmental change, the easier it is to detect and to decide whether it is structural or cyclical. For example, a change in the way in which physicians are paid is a highly visible change. In contrast, the changing demographics of a hospital's local community may be less discernible because the change may occur in increments over a period of many years.

The number of groups affected by the change and the importance of these effects (that is, their pervasiveness) also influence management's perception. The greater the degree to which suppliers, customers, and competitors are affected by the environmental change, the greater likelihood that the change will be noticed and perceived as significant by management. For example, many hospitals that initially underestimated the effect of prospective payment eventually saw the impact it was having on other hospitals, major employers, and even suppliers. Recognizing the ripple effect, many hospitals saw the need for significant strategic adaptation and initiated responses that included the joining of systems, consolidation or merger, corporate restructuring, and diversification of services.

Management's recognition of the importance of environmental change will also be influenced by the organization's performance

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over time and, in particular, in recent years. In general, the more successful the organization has been in the past, the less likely is top management to recognize the need for change. This response may be due less to top management's failure to recognize the importance of the environmental change than to their confidence in the organization's ability to deal with the change with its current strategies. This mind-set is particularly dangerous when the environmental change is structural. Thus, as ironical as it may seem, poor performance in recent years may be a blessing in disguise if it causes top management to reexamine the organization's strategic orientation and ability to deal with the changed environment. In current failure may be sown the seeds of future success.

In addition to accurately assessing the nature of the environmental change, top management must be adept at understanding the demands that the change places on the organization. What are the specific implications for the organization? Simply recognizing prospective payment as an important structural change was not sufficient. It was also necessary to diagnose what it meant for "treating" the organization. For those operating in highly competitive environments, prospective payment might mean the need to develop new services and new revenue streams, and, in turn, to develop new skills and new relationships with physicians. For those operating in a highly regulated environment, it might mean the need to emphasize cost containment and consolidation of staff and services. This response, in turn, might call for considerable education of physicians and nurses and reassurance that the quality of care will not be compromised by cost-cutting efforts. Accurately diagnosing the demands of environmental change is particularly important when the change is structural because of its generally enduring and pervasive nature.

Role of the Organization. As noted, an important top-management responsibility is assessing the capability of the organization to deal with the environmental change. This task involves systematic consideration of the organization's current mission and goals, strategies, design, information-processing abilities, skill mix and experience, and, of course, financial resources. Some hospitals do not change their basic strategic orientation even when they think

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it is the "correct" thing to do because top management does not believe the organization has the ability to do so (Shortell, Morrison, and Friedman, 1990).

The organization's mission and overall goals provide a starting point for assessment. Has the environment changed so radically that it is beyond the scope of the organization's mission? Does the mission need to be expanded? For example, a hospital that has served the local community for seventy-five years may suddenly need to expand its mission to become a regional health care provider. Conversely, a hospital that has identified itself for years as a regional medical center may need to refocus and downsize its services to a few centers of excellence rather than trying to compete with others across the board.

It is also useful to distinguish between the core and peripheral aspects of the organization's mission. The core comprises the organization's identity—its heart and soul and reason for existence. Typically, this core will not be subject to change even in the face of bankruptcy or closure. In contrast, the peripheral features of the organization's mission are malleable. Not only can they be changed to meet environmental demands, but they often must be in order to protect the organization's core mission.

Existing health care organizational research also suggests that an organization's current strategy is one of the best predictors of whether a switch in strategies will occur. The ability of the organization to deal with the environmental change with its current strategy must be assessed. Among the most important characteristics of the current strategy are its ability to handle complexity, diversity, divisibility, and reversibility (Zaltman, Duncan, and Holbek, 1973; Shortell, Morrison, and Friedman, 1990). If the current strategy can embrace complexity and diversity, then the organization may be able to handle a marked change in its environment. Thus, an analyzer strategy that encompasses the development of new markets and new services (characteristics of a prospector) and that emphasizes efficiency and cost containment (characteristics of a defender) may be complex and diverse enough to deal with a significant environmental change for which it is difficult to predict the ultimate consequences. In this regard, it is of particular interest to note that the

most frequently selected strategy in the health care industry has been the analyzer.

The ability of the organization's current strategy to be divided into subcomponents or parts and to be reversed is also important. If the organization's current strategy can be subdivided, it may be able to deal with environmental change without a strategic shift because the ability to subdivide suggests a "loose coupling" (Weick, 1976) of strategic components that permits flexibility in the adaptation process. Similarly, if an organization's current strategy can be undone or retraced to some extent, a major strategic reorientation may be unnecessary. In both cases however, structural environmental change will be a stronger test than will cyclical change. In fact, organizations whose current strategy can be subdivided and reversed should be particularly adept at dealing with cyclical changes in their environments. Precisely for this reason cyclical changes are less likely than structural changes to generate significant strategic shifts.

The organization's current strategy interacts with the organization's design, information-processing practices, and overall skill mix in determining the organization's ability to respond to the changing environment. We refer to the organization's design (functional, divisional, matrix, the level at which decisions are made) its information-processing practices, and its skill mix as the organization's capability. The organization's current strategy and its associated capability combine to determine its strategic comfort zone (Shortell, Morrison, and Friedman, 1990), as previously defined. Making switches to adjacent strategies requires less radical alterations of an organization's current capability and, thus, increases the likelihood of a successful transition. The characteristics of complexity, diversity, divisibility, and reversibility that tend to be associated with different strategies also play a role here. For example, a defender strategy is generally associated with a relatively low degree of complexity and diversity, while a prospector strategy is generally associated with a relatively high degree of complexity and diversity. Once again, structural environmental change rather than cyclical change is likely to place the greater demand on the organization to expand its strategic comfort zone.

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fort zone will depend largely on its financial resources or its degree of slack. The greater the available slack, the better the organization's ability to upgrade its information-processing capabilities, reconfigure its decision-making processes and design, retrain workers, and purchase new skills. The existence of slack is particularly important when change is structural. In fact, organizations with little slack may subconsciously misread or redefine structural environmental change as cyclical in order to obtain a match with their existing resources and capabilities. Such redefining is precisely what some hospitals may have done in the mid-1980s in response to the Medicare prospective-payment system. Also, organizations that have enjoyed recent financial success without a large capital endowment or long-standing surplus of slack may accurately diagnose the environmental change as structural but, as previously noted, overestimate their ability to handle the change.

Role of Markets. Markets are usually treated as part of the organization's task environment and thus included under the analysis of the environment. But we believe the interaction of organizations and markets to be of sufficient importance to deserve separate attention. Although many characteristics of markets are relevant to strategic adaptation, we focus on two of particular importance: entry and exit barriers, and an organization's ability to create and sustain competitive advantages. Competitive advantage will be determined largely by the organization's position in the marketplace relative to current competitors and new competitors and its ability to exit from markets that are no longer attractive. The role played by exit barriers is relatively underemphasized in the literature to date (Porter, 1980).

In health care, there is almost a bimodal distribution of entry and exit barriers. On the one hand, entry barriers for the development of new hospitals and high-priced, high-technology services are relatively high. Such developments usually require considerable capital, knowledge, and expertise, and often have to meet strict regulatory requirements. On the other hand, entry barriers for low-tech services such as health promotion, home health care, and sports medicine are relatively low, usually requiring little capital and encountering few regulatory constraints. Exit barriers for hospitals are

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high not only because of their investment in capital and people but also because of their political and social legitimacy. The outcry caused by hospital closures attests to this fact. In contrast, exit barriers for services such as health promotion, home health care, and sports medicine are low because they are less capital intensive and, in some cases, are easily replaced with alternative services.

The key lies in assessing the impact of environmental change (whether structural or cyclical) on the entry and exit barriers for the market in which the organization operates. If the environmental change increases the barriers to entry on the part of other organizations, then there may be less need for a given organization to change its strategies. If the change lowers the barriers to entry, then there may be pressure on the organization to change its strategies in order to respond to the new competitors.

Exit barriers may operate in a more complex fashion than entry barriers. If exit barriers are raised for the firm as a whole, it may be faced with having to make a major strategic reorientation because leaving the business altogether is simply not a viable alternative. If exit barriers are lowered, then dissolution may be a viable strategic alternative. More likely, entry and exit barriers exist for specific units or for product or market segments, and decisions to divest or expand are made at this level. When an exit barrier for a given service is lowered, it may be possible for the organization to divest the service without fundamentally changing its overall strategic orientation.

The most important implication of markets is the ability of the organization to create and sustain a competitive advantage. The challenge is to develop new products and services that meet consumer needs and desires more effectively than those of competitors. Ideally, an organization wants to be the first or at least one of the first to develop a new product or service and then works continuously to erect barriers to prevent others from entering the market. One of the lessons, however, that health care holds for other industries is that the gains that may be achieved from using the "first-mover" strategy (Lieberman and Montgomery, 1988) are short-lived and difficult to sustain without constant differentiation of the product or service. The key lies in developing products and services that are difficult for others to imitate (Barney, 1988) and then to contin-

uously refine or extend the products or services so as to assure their uniqueness in the minds of the consumer.

Role of Performance. It has already been mentioned that the failure to meet performance objectives or poor performance relative to competitors or industry standards is often a trigger for strategic change. However, much of the current literature focuses on traditional financial and accounting indicators of performance such as profit margins, cash flow, and return on equity. Although in the long run these are relevant measures by which the success of many firms' strategies ought to be evaluated, they may not be the most appropriate set of indicators for evaluating short-run strategic effects. Furthermore, they may be too limited to encompass all strategic objectives. Some strategies have short-run objectives, such as preempting a competitor from entering the market or repositioning the organization to deal with future change, that in the short run may be associated with decreased financial performance. In the case of health care organizations, other objectives include improving the quality of services, improving patient care, and meeting the needs of those without the ability to pay for their care. It may be as important to consider the failure to meet these objectives as a cause for initiating strategic change as it is to consider the failure to meet financial goals.

Performance gaps are particularly likely to be triggers for strategic change when the top-management team interprets them as the result of a poor alignment of the organization's current strategy with the nature of the changed environment rather than as the result of a failure in execution or implementation. If a gap is interpreted as a failure in implementation, the tendency will be to redouble the effort or to work smarter but not to change the game plan. Here again, the consequences of misinterpretation are likely to be more serious if the environmental change is structural than if it is cyclical.

Putting the Blocks Together: A Framework for Further Research

Advances in our understanding of strategic change and adaptation can be made by examining the relationships among the building

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blocks of environment, organizations, managers, markets, and performance. Central to this examination are the processes of perception, interpretation, and comparison (Ginsberg and Grant, 1985; Dutton and Duncan, 1987; Thomas, 1990). People in organizations, particularly leaders, combine information with their own knowledge and experience in perceiving whether environmental change is structural or cyclical. They also interpret the meaning of the change for their organization, taking into account their internal assessment of the organization's capabilities and their strategic comfort zone and making an external assessment of how the market in which the organization operates—particularly in regard to entry and exit barriers—is influenced by environmental change. They make these interpretations and assessments by comparing the organization's performance with its goals and objectives, stakeholder expectations, and the performance of immediate competitors as well as the industry at large. The overall process is one of comparing the organization's strategic direction with the demands of the environment to arrive at a decision to continue with the current strategic orientation or to adopt a new orientation.

Given our discussion to this point, we can suggest some relationships among the components of the framework in regard to the probability and magnitude of strategic change. These examples are hypotheses to be tested rather than a single integrated theory.

Hypothesis 1: The greater the degree to which environmental change is perceived as structural rather than cyclical, the greater the probability and magnitude of strategic change

Hypothesis 2: The greater the degree to which poor performance is attributed to environmental demands rather than to internal operations, the greater the probability and magnitude of strategic change

Hypothesis 3: The greater the organization's perceived capability of managing a new strategy, the greater the probability and magnitude of strategic change

Hypothesis 4: The greater the degree to which an organization's current strategy lacks characteristics (that is, complexity versus simplicity or diversity versus homogeneity) consistent with environmental demands, the greater the probability and magnitude of strategic change

Hypothesis 5: The greater the extent to which the organization's current strategy is unable to sustain a competitive advantage across an altered set of entry and exit barriers, the greater the probability and magnitude of strategic change

These hypotheses are first-order relationships. In addition, a number of second-order relationships can be suggested involving the factors most likely to be associated with the perceptual, interpretative, and comparative processes that underlie these hypotheses. For example, in regard to the accuracy of perceiving the external environment the following are suggested.

Hypothesis 6: The more varied the skills and experiences of the top-management team, the more accurate their perception of the external environment

Hypothesis 7: The more visible the external change, the more accurate the top-management team's perception of the external environment

Hypothesis 8: The more pervasive the effects of the external environment, the more accurate will be the top-management team's perception of the external environment

Hypothesis 9: The greater the organization's performance gap, the more accurate will be the top-management team's perception of the external environment.

Similarly, in regard to assessing the organization's strategic comfort zone, the following might be suggested:

Hypothesis 10: The more widely shared the organization's mission and goals, the more accurate the assessment of the organization's strategic comfort zone

Hypothesis 11: The greater the understanding of the current strategic orientations requirements in relation to the requirements of alternative strategic orientations, the more accurate the assessment of the strategic comfort zone

Hypothesis 12: The greater the knowledge of current decision practices, information-processing systems, and skill mix, the more accurate the assessment of the organization's strategic comfort zone

Hypothesis 13: The greater the availability of slack resources, the greater the ability to expand the organization's strategic comfort zone.

A number of hypotheses related to performance can also be suggested. These include:

Hypothesis 14: The greater the accuracy of the top-management team's perception of the environment, the better the organization's performance

Hypothesis 15: The greater the degree of match or fit between the organization's capabilities and environmental demands, the better the organization's performance

Hypothesis 16: The greater the degree to which strategic change is undertaken within the organization's strategic comfort zone the better the organization's performance in the long run

A number of interactive hypotheses can also be examined. For example, the relationship between the accuracy of environmental diagnosis and performance is likely to be stronger when change is structural rather than cyclical.

The advantage of the proposed framework is that it integrates a variety of issues and approaches associated with strategic adaptation. It recognizes that adaptation involves the study of relationships and comparative processes. Among the most important of these relationships are those between environmental characteristics and demands and organizational capabilities, between environmental demands and the organization's recent performance and between environmental demands and local market characteristics. In addition, the ability of the top-management team to diagnose accurately the nature of these relationships and interpret their meaning for the organization is important. Thus, strategic adaptation is seen as a dynamic, interactive process between the organization and its environment, a process mediated largely by the organization's leaders. In this regard, one way in which managers can expand their strategic comfort zone and increase organizational capabilities is through participation in interorganizational networks and strategic alliances.

Strategic Alliances

The growth of interorganizational networks and strategic alliances appears to be associated with turbulent environments. In recent years, it has become fashionable to use the term *turbulent* to depict

environments of organizations. Originally coined by Emery and Trist (1965) to depict highly complex and rapidly changing environments, turbulence has been somewhat loosely used to describe almost every industry in transition. However, a close inspection of the Emery and Trist definition reveals two general conditions under which the term is appropriate: high interconnectedness of organizations and substantial interdependence between society and the focal organization.

Organizational researchers studying today's turbulent American health care system have tended to neglect studying the interconnectedness and interdependence among organizations and instead have overemphasized amorphous and powerful environmental "forces." We contend that the emphasis on immutable forces, while understandable, may implicitly shape the way that organizational researchers view organization/environment interactions. For example, both the population-ecology and the institutional perspectives in organization theory typically conceive of organizational environments in broad, depersonalized terms as forces that impose either organizational conformity or death. In this vein, Scott and Meyer (1983, p. 149) define an *institutional environment* as "the elaboration of rules and requirements to which individual organizations must conform." It should also be noted that institutional theorists have begun to "move away from a conception of the institutional environment to one of multiple institutional environments" (Scott, 1987, p. 498).

We prefer to demystify the discussion of organizational environments by viewing the environment of a health care organization as simply the collection of other specific organizations that are interconnected to or interdependent with it. This health care organization, in turn, is part of the environment for the other organizations. In other words, when a health care organization "looks out" with concern at its turbulent environment, what it sees are other organizations "looking out" at it!

An important implication of this perspective is that the analysis of organization/environment relations shifts away from the question of how an organization fares under the pressures of institutionally demanding or "naturally" selecting environments or both, and moves toward the question of how an organization inter-

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acts (for example, competitively or cooperatively) with other relevant, specific organizations. Stated differently, there is value in focusing less on turbulent environments and more on the specific strategic actions of health care organizations that are aimed at confronting—and sometimes contributing to—the overall turbulence in organizational environments. (We do not advocate ignoring relevant environmental issues that are nonorganizational in nature, such as demographic trends. Our view is simply that most relevant environmental forces are, in fact, organizationally created and sustained, and thus are subject to organizational influence.)

However, even here, we suggest that the strategy literature's emphasis on the adaptation efforts of single organizations should be complemented with an increased focus on the strategic adaptation efforts of the collective set of interdependent organizations (Astley and Fombrun, 1983). The following discussion investigates one such organizational innovation whose growth has coincided with increased environmental turbulence—namely, health care strategic alliances. Formation of these alliances can be viewed as one way in which organizations expand their capabilities and extend their strategic comfort zones.

A health care strategic alliance can be defined as any formal arrangement between two or more health care organizations for purposes of mutual gain. Historically, a variety of multi-institutional arrangements have been found in health care (see DeVries, 1978, or Starkweather, 1971, for basic comparisons of a wide range of such arrangements). However, changes in the health care environment suggest the need to consider additional new forms of alliances as well as to reexamine traditional types of alliances and the motives that drive their formation, growth, and success. Stated differently, we are interested in examining the implications of the forms, functions, and effectiveness of contemporary health care strategic alliances. Before proceeding, however, it is important to discuss the conceptual contributions of the existing health care literature on multi-institutional arrangements.

Previous Views of Multi-Institutional Arrangements. The earliest approaches usually attempted to establish a continuum on which multi-institutional arrangements could be located (Stark-

weather, 1971; Brown and Lewis, 1976; DeVries, 1978). DeVries (1978, p. 82), for example, arrays multi-dimensional systems on a continuum from "less commitment, more institutional autonomy" to "more commitment, more system control," in the following order: formal affiliation, shared or cooperative services, consortia for planning or education, contract management, lease, corporate ownership but separate management, and complete ownership.

In conceptual terms, Longest (1980) views the growth of multi-institutional systems as the result of an "external dependency relationship" between the hospital and its environment. In doing so, Longest is applying the resource-dependence perspective (put forth by Pfeffer and Salancik, 1978, in the organization-theory literature) to the health care industry. Although Longest uses the term *stabilization strategy* to characterize multihospital arrangements, his view of strategy is somewhat restricted. He states (1980, p. 19): "It is formulated by people for a hospital that exists in relation to an external environment upon which the hospital is highly dependent." When Longest asserts that certain environmental circumstances lead to predictable strategic responses, his deterministic view of hospital actions appears to go even beyond the original notions of Pfeffer and Salancik, although he retreats somewhat from this position in his later work (Longest, 1981).

Fottler, Schermerhorn, Wong, and Money (1982), although also using an "environmental-dependence" approach, do not assume a purely reactive hospital and allow for attempts by hospitals to influence environments. Reviewing the conceptual literature, the authors are rather critical and note that there continue to be limitations to the understanding of interorganizational phenomena. Regarding the state of empirical research on the impact of multi-institutional arrangements, Fottler, Schermerhorn, Wong, and Money (1982, p. 72) view most of the studies as "only semi-empirical, often based on expert testimonies rather than scientific inquiry."

Provan (1984) discusses interorganizational relationships within one type of multihospital system, a consortium. Provan focuses on the single issue of decision-making autonomy, using solely a resource-dependence framework, and acknowledges that he makes "no attempt . . . to relate decision-making autonomy to hospital effectiveness" (p. 498). Despite having limited the scope of the

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paper, Provan (1984, p. 494) states the interesting view that "although other perspectives are available, they tend to be narrower than resource-dependence as a general framework for understanding interorganizational activity." We suggest that the strategic-management perspective provides a broader and more general framework for understanding interorganizational activity than does the resource-dependence perspective.

D'Aunno and Zuckerman (1987) offer an interesting discussion of how hospital federations may follow a life-cycle model of development. The article, in taking a longitudinal perspective, is an original theoretical contribution to the existing literature on interorganizational arrangements, which has tended to take a static perspective. (Shortell and Zajac, 1988, and Zajac, Golden, and Shortell, 1990, have also attempted to use health care data to examine longitudinal issues in interorganizational arrangements.) One question that arises is whether federations need to progress in the sequence hypothesized by D'Aunno and Zuckerman, or whether managerial actions can substantially alter their evolution. (This question is general to all research that invokes life-cycle models of organizational, product, or industry evolution.)

Luke, Begun, and Pointer (1989) apply Eccles's (1985) notion of the quasi firm to analyze interorganizational arrangements in the health care industry. They also attempt to construct their own "classification of interorganizational relationships" based on two dimensions: tightness of coupling and degree of strategic purpose. The typology is somewhat confusing, however, in that one of their types is the firm, which is not an interorganizational relationship. Another type, called a "latent" firm (an organization that is tightly coupled but has a low degree of strategic purpose), is also not an interorganizational relationship. In addition, the examples given for a latent firm include organizations such as large public utilities whose top managers would probably take exception to having their organizations characterized as not having a high strategic purpose. Another difficulty is that Luke, Begun, and Pointer equate permanence with degree of importance. This need not always be the case.

To summarize, the prominent feature of most of the existing literature has been the development of typological approaches, similar to those offered by Starkweather (1971), Brown and Lewis

(1976), and DeVries (1978). These typologies have been useful in documenting and describing the common and different features of a wide range of interorganizational arrangements in health care. Researchers now need to explore the significance of these commonalities and differences. For example, what differences should an organization expect if it were to choose one form rather than another? We argue that the existing health care—and general organization-theory—literature has not yet developed an adequate response to this question. We further argue, however, that there may not be a clear-cut answer, and that the question itself may be misleading. More specifically, we believe that several of the forms of conventional wisdom about strategic alliances should be challenged.

Myths About Multi-Institutional Arrangements. As noted, DeVries (1978) and others have arrayed multi-institutional systems on a continuum of autonomy to control. Almost without exception, however, these rank orderings reflect the degree of ownership, with complete ownership being equated with the highest form of control. We argue that to equate ownership with control can often be misleading, and we use a simple, publicly visible example from a non-health care setting to demonstrate our point.

Myth #1: Degree of ownership equals degree of control. It is well known that McDonald's Corporation is interested in maintaining control over its raw materials to ensure that quality is highly consistent. In dealing with its suppliers, one might therefore expect that McDonald's would prefer an interorganizational arrangement that would involve ownership of suppliers in order to have substantial control. This is not the case however. With no ownership interests, McDonald's simply communicates its quality requirements to the supplier organizations, and the organizations are quick to oblige.

How can this be? Two factors seem to be relevant. The first is obvious: McDonald's, by virtue of its size, enjoys substantial relative power in its relationship with suppliers (McDonald's represents a large portion of any food supplier's business). Having this power obviates, in large part, the need for McDonald's also to own some or all of its suppliers' assets. Ownership and control are es-

have been useful in different features of health care. Some of these common differences should be taken into account rather than care—and general developed an adequate however, that there question itself may be that several of the alliances should be

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entially separated in this case. The second reason involves the establishment of a tradition of mutual gain and cooperation. Specifically, McDonald's has made it a policy to be loyal to high-quality suppliers and to use its size to protect suppliers from dramatic swings in sales revenue. In this way, both parties have incentives to ensure a long-term cooperative relationship with no ownership interests. Some parallel is apparent in the relationships that currently exist between hospitals and physicians.

This simplified example is not intended to show that ownership and control are usually uncorrelated. Rather, it demonstrates that tight control can exist even when there is no ownership. In other words, the theoretical continuum that is popularly used for locating different types of health care strategic alliances may be in need of reevaluation.

This reevaluation of the forms of strategic alliances brings us to a second popular misconception.

Myth #2: Form equals function. Researchers, by focusing on the different types or forms of health care strategic alliances, have implicitly assumed that certain forms imply certain functions and even certain outcomes. If a single form could serve multiple functions, researchers would have no interest in discussing the differences among forms. Zajac (1986) addresses this issue, in part, in his analysis of contract-management arrangements. He argues that organizations choosing to engage in a similar type of strategic alliance may have widely varying intentions and that expected performance will vary correspondingly. He thereby suggests that it may not be reasonable to expect a particular form of interorganizational arrangement to translate into a particular performance result. And, in fact, Zajac found that the performance outcomes of similar contract-management arrangements differed depending on the strategic intentions or orientations of the organizations involved.

This finding suggests a general neglect of the concept of strategic orientation in previous research on interorganizational arrangements. The form of alliance used may be much less important in suggesting particular performance outcomes than the strategic intentions, as articulated by key decision makers, that motivate that choice of alliance. In other words, the form of the alliance is not a good predictor of what the alliance can achieve. Outcomes will also

be influenced by key decision makers' perceptions of environmental change as being cyclical or structural. The implication of this line of argument is that it is important for researchers to consider the strategic intentions of participant organizations when deciding which performance outcome(s) to include in their analysis of health care strategic alliances.

The issue of performance arises in the third misconception about strategic alliances.

Myth #3: Strategic alliances are inherently risky. Some researchers have argued that strategic alliances, by their very nature, are risky endeavors (Harrigan, 1985). From this perspective, the cooperative links between two or more organizations are viewed as somewhat fragile, exposing each party to the risk that the other party or parties may not continue to cooperate as expected. Luke, Begun, and Pointer (1989) also characterize their quasi firms as inherently unstable. And the business press has had a penchant for describing, in detail, particular joint ventures or other alliances that failed (for example, one of us was recently approached by a reporter who wanted to do a story on the five biggest joint-venture failures).

We argue that this fixation on riskiness may be misguided. Specifically, we contend that any assessment of the risk of strategic alliances should be balanced with an assessment of the expected returns of the alliance in financial performance, political influence, innovation, and organizational learning, and an assessment of the opportunity cost of not engaging in a strategic alliance. Regarding the expected returns, although financial performance is an obvious outcome to consider when analyzing the success or failure of a strategic alliance, it is not clear that it should be considered the most important outcome. For example, innovation may be a driving force behind strategic alliances (Zajac, Golden, and Shortell, 1990), and, more generally, alliances may be viewed as a desirable way for organizations to learn about new markets, services, and ways of doing business. These outcomes may be negatively correlated with financial performance, at least in the short run (Shortell and Zajac, 1988).

Regarding opportunity cost, the baseline for comparison when considering a joint venture is not Is it risky?, but What is riskiest: going it alone, doing nothing, or engaging in an alliance?

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What is likely to expand the organization's capabilities and strategic comfort zone? Riskiness is not necessarily a problem per se. For example, the virtues of entrepreneurship are often extolled, despite the high risk involved. Strategic alliances may appear risky when the baseline comparison is not made explicit, but when compared with attempting a de novo entry into a new market or ignoring the market altogether, entering an alliance may seem like a relatively low-risk proposition.

Advantages of a Strategic-Management Perspective. We would contend that the debatable logic underlying these three myths becomes obvious when one takes a strategic-management perspective. Perhaps a historical overemphasis on the structural features of strategic alliances is responsible for each of the three myths. In any event, gaining an understanding of the strategic objectives driving such cooperative activities is the first and most important step toward understanding the effectiveness of strategic alliances.

We hope that our discussion of strategic alliances and strategic adaptation in general has demonstrated the advantages of complementing population-ecology and institutional-theory perspectives with a strategic-management perspective. In this regard, we would like to end our discussion on a provocative note by making an observation and posing a question. When we look at health care, we see flourishing new organizational and interorganizational forms and activities. Which theory seems best suited for explaining these developments: the standard population-ecology approach, which, as Astley (1985) notes, is limited to observing selection and retention (rather than variation) in a given population of organizations over time; the institutional approach, which stresses the conformity and homogeneity of organizations (DiMaggio and Powell, 1983); or the strategic-management approach, which emphasizes organizational adaptation and change? We hope that this chapter, and other chapters in this book, will stimulate further discussion of this issue.

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