Chapter 6

Strategic Management of Stakeholder Relationships

John D. Blair, G. Tyge Payne, Timothy M. Rotarius, Carlton J. Whitehead, and E. Gordon Whyte

The health care environment is undergoing fundamental and somewhat revolutionary changes. Even without the proposed government changes, reform is occurring. The ultimate effect of this reform—whether mandated by the government, driven by private sector initiatives such as managed care, or produced by the demands of powerful buyer groups for more health care for less money—is unknown. It is certain to affect the future of the industry, however, by leading to increasingly complex, integrated organizations and networks.

The leaders of these new organizations must manage an increasingly complex web of relationships with a growing number of active, powerful, and sometimes competing stakeholders (i.e., any individuals, groups, or organizations that have a stake in the decisions and actions of an organization and attempt to influence those decisions and actions). These stakeholders exert an influence on every health care management issue, and managers must recognize and evaluate these relationships for their potential to support or threaten the organization and its competitive goals.

Much of the emerging health care literature champions the development of organized health care networks and systems as the fundamental strategy for facing the uncertain future created by health care reform. Managers, seeking to position their organizations for optimal strategic responsiveness to a still poorly understood future, have turned to linkages with others that have often been competitors or adversaries. Thus, hospitals, physicians, and health care plans are creating vertically integrated organizations and systems. This emergence of rapidly growing organized delivery systems and networks has changed the strategic web, that complex set of interrelated relationships, within which health care organizations find themselves. Therefore, because the nature of those relationships is constantly changing, the need for managers to engage in effective strategic management of stakeholder relationships is more crucial now than ever before.

Today's strategic stakeholder management tools must be sophisticated and powerful if executives are to lead their health care organizations effectively, as the strategic web of health care relationships can become extremely complicated. For example, Figure 6-1 depicts a private, tertiary care hospital (Hospital A) that, as part of an integrating system (System A), is contemplating a strategic alliance with a cardiology group (Group...
Figure 6-1 The Evolving Strategic Web for the Tertiary Care Hospital within an Integrating Regional System, a Simplified Model
E). Strategic alliances of this sort often are formed to allow for the attainment of some overall competitive goal. Also identified in Figure 6–1 is a myriad of other relationships that come into play because of this contemplated strategic alliance. What initially would have been viewed as a simple, dyadic relationship has mushroomed into a large number of key relationships (notice that only key relationships are shown in this strategic web figure, not all the relationships) that need to be acknowledged, addressed, and managed.

Figure 6–1 shows many key relationships. Those relationships that are highlighted with question marks are used as examples throughout this chapter. These are relationships that need to be examined in light of a strategic alliance between Hospital A and Cardiology Group E. As can easily be seen, there is an array of relationships between the hospital and the stakeholders that can be changed or called into question through the formalization of just one specific strategic alliance. The key relationships that Hospital A has with its stakeholders represent a pattern of formal and informal, interconnected stakeholder relationships.

Many hospitals already are forming or have formed one or more strategic alliances with physicians—both in primary care and in medical or surgical specialties. Some hospitals have even formed alliances with both physicians and health care plans in order to present a more fully organized health care system. Many of these newly created relationships have forced organizations to match the ever-changing environment. Unique opportunities exist to explore the consequences of creating and managing relationships among key hospital, physician, and health care plan stakeholders.

Few organizations have a fully developed, articulated strategic approach for managing their key stakeholder relationships. In most organizations, the stakeholder management perspectives of the executives are incomplete at best, and their approaches to stakeholder relationship assessment and management are haphazard. At worst, organizations have absolutely no systematic and effective stakeholder management approach. (Health care leaders require a detailed, overall approach, however, along with specific tools and techniques.) The strategic relationship management approach to stakeholders provides a means of properly identifying all the players, their roles, and their level of stake in the network. In other words, it can help identify those areas in which there are likely to be significant opportunities for cooperation or risks of conflict among key network stakeholders.

Health care executives can develop more productive relationships with the key people—employees, physicians, community leaders, hospitals, competitors, managed care organizations, and others—who hold a stake in the management decisions of health care organizations. The examples used throughout this chapter are those varied and complex relationships that affect a specific type of health care organization—hospitals. The steps in this approach to strategic stakeholder management include the following:

- Identify all relevant external, interface, and internal stakeholders.
- Diagnose each stakeholder in terms of potential for threat and potential for cooperation.
- Ensure that the diagnosis for each stakeholder relationship is relevant for the specific issue facing the organization (e.g., the emerging issue of increasing hospital-physician integration through an alliance with a specialty physician group).
- Classify each stakeholder relationship as
mixed blessing, supportive, nonsupportive, or marginal.
- Formulate generic strategies for the management of each stakeholder relationship: involve the supportive stakeholder; collaborate with the mixed blessing stakeholder; defend against the nonsupportive stakeholder; and monitor the marginal stakeholder.
- Implement these generic strategies by developing specific implementation tactics and programs for each strategy-stakeholder combination.
- Evaluate the managerial implications of effectively managing stakeholder relationships from a strategic point of view.
- Identify which employees, as internal stakeholders, should be involved in the implementation process.

IDENTIFICATION OF ORGANIZATIONAL STAKEHOLDERS

Exhibit 6-1 provides a listing of the typical stakeholders for a large U.S. hospital, divided into three distinct stakeholder groups: external, interface, and internal. Whereas the internal and interface stakeholders often are at least partly supportive of the hospital, many of the external stakeholders may be neutral, nonsupportive, or even openly hostile. A health care organization must respond to a large number and a wide variety of external stakeholders. They fall into three categories in their relationship to the organization: (1) those that provide inputs into the organization, (2) those that compete with it, and (3) those that have a particular special interest in how the organization functions. The first category includes suppliers, patients, third-party payers, and the financial community. The relationship between the organization and these external stakeholders is a symbiotic one, as the organization depends on them for its very survival. (The degree of dependence of the organization on these stakeholders depends on the number and relative attractiveness of alternative providers of similar services.) In turn, these stakeholders depend on the organization to take their outputs. Without the organization or others like it, the stakeholders providing inputs could not survive. Consequently, the relationship between the organization and the stakeholders that provide necessary inputs is one of mutual dependence. As such, the two parties cannot, or do not want to, do without one another. They may experience conflict in finding ways to cooperate, however. For example, conflict may develop between a hospital and its patients over the price charged for certain services, but neither wishes to sever all relationships with the other.

The competing external stakeholders seek to attract the focal organization’s dependents. These competitors may be direct competitors for patients (e.g., other hospitals), or they may be competing for skilled personnel (e.g., related health care organizations). Competitors do not necessarily need one another to survive. While cooperation between hospitals and their competitors has increased in recent years, so, too, has competition. Competitiveness, rather than cooperation, best defines the nature of the relationship most of the time.

External stakeholders in the third category, special interest groups, are concerned with those aspects of the organization’s operations that affect their interests. The major special interest groups that relate to hospitals are government regulatory agencies, private accrediting associations, professional associations, labor unions, the media, the local community, and various political action groups. Because of the nature of the special interest, conflict most often defines the nature of this relation-
Exhibit 6–1 Stakeholders for Typical Large Hospital

A. External Stakeholders

1. Competitors
   • Other hospitals
     Private, not-for-profit
     Public
     Investor-owned
   • Physician practices (for outpatient services)
   • Other alternatives, e.g., freestanding outpatient surgery, diagnostic, or instant care centers

2. Related Health Care Organizations
   • Other hospitals in region (noncompetitors)
     Private, not-for-profit
     Public
     Investor-owned
   • Physician practices
     Solo
     Single-specialty medical group
     Multispecialty medical group

3. Government Regulatory/Licensing Agencies
   • Federal
   • State
   • Local

4. Private Accreditation Associations
   • e.g., Joint Commission on Accreditation of Healthcare Organizations

5. Professional Associations
   • e.g., for certification of hospital professionals
     National
     State
     Local

6. Unions
   • National/international
   • Local

7. Patients
   • Private pay patients
   • Insured patients
     Direct contract with employer
     Through contract with managed care organization
     Pay through prospective payment
     Pay at full rate
     Pay at discounted rate
     Pay through capitation

8. Third-Party Payers
   • Governments
     Federal
     State
     Local
   • Regional employers
     Through indemnity insurance
     Through managed care contract
     Through direct contract
   • Business coalitions
   • Insurance companies
   • Managed care organizations (as purchasers of hospital services)

9. Hospital Suppliers

10. Media
   • Local
   • National

11. Financial Community
   • Including joint venture investment partners

12. Special Interest Groups
   • e.g., American Association of Retired Persons, veterans’ organizations for VA hospitals, or Alcoholics Anonymous for psychiatric/substance abuse programs

13. Religious Organizations
   • Denominational organizations, e.g., synods or dioceses
   • Local churches/synagogues
   • Pastors/priests/rabbis

continues
### Exhibit 6–1 continued

14. Local Community

#### B. Interface Stakeholders

1. Nonmanagement Medical Staff
   - On staff only at this hospital
   - Also on staff at other hospitals
   - Partners in joint-venture with hospital

2. Hospital Board
   - Trustees with policy authority
   - Advisory only

3. Parent Companies/Organizations/
   Religious Orders

4. Stockholders/Taxpayers/Contributors

5. Related Health Care Organizations (e.g.,
   as part of integrated delivery system)
   - Other hospitals in regional network
     - Private, not-for-profit
     - Public
     - Investor-owned
   - Physician practices as strategic
     partners in alliance
   - Solo

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**Source:** Adapted from *Challenges in Health Care Management: Strategic Perspectives for Managing Key Stakeholders* by J.D. Blair and M.D. Fottler, pp. 81–83, with permission of Jossey-Bass, Publishers, © 1990.

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The organization must offer each interface stakeholder sufficient inducements to continue to make appropriate contributions, but the lack of such things as a structured human resource system or adequate management authority can make it difficult to provide such inducements. Even so, the organization may offer professional autonomy (medical staff), institutional prestige or political contacts (hospital board), good financial returns (corporate office), access (taxpayers), and special services or benefits (contributors). Specific examples of interface stakeholders for Hospital A on Figure 6–1 include: System A Health Plans, Group A, the Hospital Board, and System A Affiliated Regional Hospitals.

Finally, internal stakeholders operate almost entirely within the generally accepted bounds of the organization and typically in-
clude management, professional, and non-professional staff. Management attempts to provide internal stakeholders with sufficient inducements to gain continual contributions from them. The stakeholders determine whether the inducements are sufficient for the contributions that they are required to make, partly on the basis of alternative inducement/contribution offers received from competitive organizations. Unless both the organization and the stakeholder believe an agreement will be mutually beneficial and of fair value (relative to alternatives), there will be no agreement. When resources are scarce, the exchange partners can be expected to attempt to obtain as high an inducement as possible while giving as low a contribution as possible. The organization may restructure the situation (i.e., offer a better compensation and benefit package) to induce or persuade employees to make the needed contribution. Alternatively, individuals in the organization may engage in manipulation, bargaining, and coalition activity in order to protect both their own interests and that of the coalition (including unions or professional associations) to which they belong. In Figure 6–1, the rounded corners on the boxes identify internal stakeholders to their respective focal organizations. The internal stakeholders to Hospital A include the Clinical Staff, the Hospital-Based Management Service Organization, and the Administrative Staff.

Clearly, health care organizations do not face just one or a few stakeholders. Rather, health care executives must learn to manage a portfolio of stakeholder relationships. It is vital that the leaders of health care organizations see the strategic implications of these stakeholder portfolios. No longer can specific functional managers be concerned only with those stakeholders that fall within their functional responsibilities. Instead, these manag-
ers must be cognizant of all the other relationships that are influenced by their one-on-one specific stakeholder episodes. The challenge facing health care organization executives is the creation of consistency and effectiveness in all of these individual stakeholder episodes.

DIAGNOSIS OF KEY STAKEHOLDER RELATIONSHIPS

To manage stakeholder relationships strategically, health care managers must be involved in a continuous process of internal and external scanning. They must go beyond the traditional issues in strategic management, such as the likely actions of competitors or the attractiveness of different markets. They must also look for those external, interface, and internal stakeholders that are likely to influence the organization's decisions. As noted earlier, managers must make two critical assessments about these stakeholders: (1) their potential to threaten the organization and (2) their potential to cooperate with it.17,18

Stakeholder's Potential for Threat

Hostility or threat appears as a key variable in several formulations of organization–environment–strategy relationships.19 Physicians, for example, are often explicitly identified as a group that does or could apply extensive pressure on hospitals, thereby having an impact on the hospital's effective strategic management.20,21 Looking at the current anticipated threat inherent in the relationship with a particular stakeholder or group of stakeholders is similar to developing a worst case scenario and protects managers from unpleasant surprises.

Stakeholder power and its relevance for any particular issue confronting the organizat-
tion’s managers determine the stakeholder’s potential for threat. Power is primarily a function of the dependence of the organization on the stakeholder. Generally, the more dependent the organization, the more powerful the stakeholder. For example, the power of physicians is a function of the hospital’s dependence on those physicians for patients, alternative sources of patients, the use of hospital beds, and the provision of hospital services. Such power introduces a clear potential to threaten the organization by denying it needed resources and providing them to another, such as a competitor.

A health care organization’s managers need to anticipate and evaluate systematically the actual or potential threats in its relationships with stakeholders and, in some cases, evaluate threats that face their supportive stakeholders. These threats may focus on obtaining inducements from the organization that may or may not be provided. The desired inducements may include financial resources, participation in decision making, and enactment of particular organizational policies. Alternatively, these threats may focus on undermining the fundamental viability of the organization.

**Stakeholder’s Potential for Cooperation**

The level of cooperation in an organization’s relationship with its stakeholders clearly directs attention to potential stakeholder management strategies that go beyond the merely defensive or offensive in confronting stakeholder pressures. Diagnosing this dimension suggests the potential for using more cooperative strategies that focus on the actual or potential contributions that are valued and needed by the organization. For example, two competitors who are facing a common threat of discontributions from a given stakeholder, such as a third competitor who has purchased a helicopter to aid in rural market penetration, may well be potential allies in countering such a move through a joint venture helicopter of their own.

Similarly, competitors may join together to reduce the bargaining power of preferred provider organizations (PPOs), which have been able to demand price concessions from hospitals in markets where several hospitals compete for market share. With unprofitable hospitals falling by the wayside, however, the remaining hospitals can merge. Such a merger leaves the PPO in a very weak position since there is only one dominant organization with which to negotiate and the PPO cannot threaten to send its members elsewhere. While the Antitrust Division of the Department of Justice is carefully monitoring these types of mergers, both the public and regulators are increasingly aware that in order to meet the three criteria of reasonable cost, high quality, and ready access, these types of mergers may be necessary. Health care executives need to anticipate the likely reaction of regulators—who represent the public’s stake—regarding prospective mergers.

The stakeholder’s dependence on the organization and its relevance for any particular issue facing the organization determine the stakeholder’s cooperative potential. Generally, the more dependent the stakeholder on the organization, the higher the potential for cooperation. Often, however, the organization and the stakeholder are very interdependent. For example, in a small town with one hospital and a limited number of physicians, the hospital and the physicians usually have high levels of mutual dependence. Although the hospital may encounter potential threats from some physicians who send patients to another hospital in a larger city, it may also have cooperation from most other physicians who want to keep their patients in the community.
Factors Affecting the Potentials for Threat and Cooperation

Health care executives should examine a variety of factors that can affect the level of a stakeholder's potential for threat or cooperation. Table 6–1 focuses on four major factors: relative power, control of resources, coalition formation, and likelihood and supportiveness of potential stakeholder action. For each factor, two different basic situations are possible. Generally, only one situation from each will apply to a given organization's relationship with a particular stakeholder, unless the stakeholder is likely to take both supportive and nonsupportive actions or is likely to form a coalition with both the organization and other stakeholders that are potentially non-supportive to the organization. After looking at the probable impact of the relevant situation on overall threatening or cooperative potential, a manager must make a qualitative judgment to weigh the relative importance of the four factors in making the final stakeholder relationship diagnosis most appropriate for that organization at that time.

Exactly how a factor will affect the potential for threat or cooperation depends on (1) the specific context and history of the organization's relations with that stakeholder and (2) the historical and contextual relations with other key stakeholders in the organization. For example, a hospital manager may be able to assess the threatening or cooperative

<table>
<thead>
<tr>
<th>Relationship Assessment Factor</th>
<th>Stakeholder's Potential To Threaten Your Organization</th>
<th>Stakeholder's Potential To Cooperate with Your Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>If stakeholder is more powerful than your organization, then...</td>
<td>Increases</td>
<td>Either</td>
</tr>
<tr>
<td>If stakeholder is less powerful than your organization, then...</td>
<td>Decreases</td>
<td>Increases</td>
</tr>
<tr>
<td>If stakeholder controls key resources (needed by your organization), then...</td>
<td>Increases</td>
<td>Increases</td>
</tr>
<tr>
<td>If stakeholder does not control key resources, then...</td>
<td>Decreases</td>
<td>Either</td>
</tr>
<tr>
<td>If stakeholder is likely to form coalition with your organization, then...</td>
<td>Decreases</td>
<td>Increases</td>
</tr>
<tr>
<td>If stakeholder is unlikely to form coalition with your organization, then...</td>
<td>Either</td>
<td>Decreases</td>
</tr>
<tr>
<td>If stakeholder is likely to form coalition excluding your organization, then...</td>
<td>Increases</td>
<td>Decreases</td>
</tr>
<tr>
<td>If stakeholder is unlikely to form coalition excluding your organization, then...</td>
<td>Decreases</td>
<td>Either</td>
</tr>
</tbody>
</table>

potential of the medical staff only in the context of how competing institutions are managing their medical staffs and how the organization has treated its medical staff in the past. By carefully considering the factors in Table 6–1, executives can fine-tune their analyses and management of stakeholders.

Federal, state, and local governments can influence organizations in at least two different ways: through political actions and through regulations. Governments use political activities to alter the strategic decisions that organizations make (e.g., antitrust issues vis-à-vis physician–hospital alliances). On the other hand, regulations cause organizations to change operational activities (e.g., Medicare forms and rules).

EMERGING LEVELS OF INTEGRATION IN HEALTH CARE DELIVERY

A wide range of possible organizational forms exists in today's turbulent health care environment. A model by Coddington, Moore, and Fischer highlighted six basic structural forms of both vertically and horizontally organized systems (1) physician–physician, (2) physician–hospital, (3) physician–health plan, (4) hospital–hospital, (5) hospital–health plan, and (6) physician–hospital–health plan. Each form occurs at different stages of integration—early-stage, mid-stage, or later-stage. According to this model, integration among physicians ranges from early-stage independent practice associations (IPAs) and physician-only management service organizations (MSOs) to mid-stage integration of large single-specialty or multispecialty groups (which may serve as a basis for fully organized systems). Integration between hospitals and physicians ranges from hospital-based MSOs (early-stage) to shared equity physician–hospital organizations (PHOs). Integration forms among hospitals are considered primarily early-stage integration. These three forms of integration (i.e., physician–physician, physician–hospital and hospital–hospital) are useful for classifying typical health care delivery systems in the United States. One other major player must be added to the integration puzzle in order to reach the fully organized health care system, however. That third player is the health plan. Only when the health plan is integrated at a high level with the PHO-type organization will an organizational form be created that can meet all the health care needs of a given population.

The final three forms of integration in the model developed by Coddington and associates include the health plan—hospital—health plan, physician—health plan, and physician—hospital—health plan. In each case, the addition of the health plan in the health care delivery system increases the extent of integration. Most hospital–health plan forms occur at early- to mid-stage levels; physician—health plan and physician—hospital—health plan forms, at mid- to later-stage levels of integration.

As physicians become more integrated among themselves and as health plans begin to integrate with hospitals and/or physicians, the necessity of effective strategic stakeholder management becomes apparent. For example, what happens when physicians initiate their own physician–physician integration? Their power relative to the hospital becomes stronger, and they become more of a threat to the hospital. Hospital management must understand this phenomenon fully in order to manage their strategic issues effectively.

In addition, hospital executives need to understand how their direct competitors use these new organizational forms to their own best interests. For example, as competition
becomes more and more integrated, all the organizational players need to have carefully designed stakeholder management strategies in order to stay competitive. The closer a hospital moves toward the fully integrated health care system, the better prepared that hospital is, both strategically and opportunistically, to deal with the environment.

TYPES OF STAKEHOLDER RELATIONSHIPS

The two dimensions—potential for threat and potential for cooperation—make it possible to characterize four types of health care stakeholder relationships (Figure 6-2). There is a dynamic process occurring at all times, however. Stakeholder relationships initially categorized in one cell might be moved to another cell as a result of what the organization does or does not do, what stakeholders do or do not do, what new information the organization has that would change the classification, and what issue currently faces the organization and its stakeholders.

One stakeholder can be both a direct and an indirect stakeholder. A direct stakeholder deals directly with the organization. An indirect stakeholder is still a stakeholder, but exerts influence through an intermediary. In Figure 6-1, there are several stakeholders who hold this double distinction. For example, Regional Hospitals and Cardiology Group E are both direct and indirect stakeholders of Hospital A.

**Type 1: The Mixed Blessing Stakeholder Relationship**

With mixed blessing stakeholder relationships, the health care executive faces a situation in which the stakeholder ranks high on both types of potential: threat and cooperation. Normally, relationships of the mixed blessing type include not only those with the medical staff, but also those with other physicians not on the staff, insurance companies, insured patients, and hospitals with complementary, but not competing, services. Physician–hospital relationships probably are the clearest example of this type of relationship. Although physicians can and do provide many services that benefit hospitals, physicians also can threaten hospitals because of their general control over admissions, the utilization and provision of different services, and the quality of care. In addition, physician–entrepreneurs can create organizations and alliances that threaten the hospital.

Some special interest group relationships also are a mixed blessing. For example, groups such as Alcoholics Anonymous influence substance abuse programs at hospitals. These groups have a significant stake in the hospital’s program and its therapeutic ap-
Such groups can either enhance referrals to the program or can undermine the program, thereby having a great impact on its clinical and financial viability.

Figure 6–2 also shows a question mark and two arrows under the mixed blessing relationship type. One arrow is directed toward the type 2, supportive relationship. The other is pointed at the type 3, nonsupportive relationship. These arrows imply that a mixed blessing relationship could become either more or less supportive. Later in this chapter, appropriate relationship management strategies for each type are discussed.

Some of the relationships highlighted in Figure 6–1 (highlighting refers to those relationships that have a question mark) are those between Hospital A and mixed blessing stakeholders. In this example, Hospital A recognizes two different kinds of mixed blessing stakeholders: direct and indirect. Cardiology Group E is a classic example of a direct mixed blessing stakeholder for Hospital A. Even though Hospital A is contemplating a strategic alliance with Group E, the physicians are still of the mixed blessing variety of relationships.

Relationships with competing institutions such as regional hospitals also can be mixed blessings. These regional hospitals represent the rural-type health care provider facilities in the region surrounding Hospital A. Because of their referral ties, affiliated regional hospitals indicate potential for cooperation. Because the regional hospitals also compete directly with Hospital A, they also are a potential for threat, even if the regional hospitals happen to be relatively minor competitors.

Relationships of health care providers with government agencies and patients are indirect mixed blessing relationships. Since each of these relationships is often supportive in a direct sense, the introduction of an intermediary (i.e., a managed care organization) obvi-

ously creates some potential for threat that does not exist when these stakeholders are dealing directly with the provider. This potential for threat may arise from the historical conflict of interests between the hospital and the managed care organization; it may come from the very nature of the intermediary, which attempts to control or influence this indirect stakeholder relationship.

**Type 2: The Supportive Stakeholder Relationship**

The ideal stakeholder relationship is one that supports the organization's goals and actions. Managers wish all their relationships were of this type. Such a stakeholder is low on potential threat, but high on potential cooperation. For example, the relationships of a well-managed hospital with its board of trustees, its managers, its staff employees, its parent company, the local community, and nursing homes are of this type. In many large medical centers with multiple health care facilities, a common support facility such as a power plant, laundry, or parking consortium typifies the concept of the supportive stakeholder relationship.

In the continuing example of Hospital A, several supportive stakeholder relationships surface. Assuming Hospital A does not have its own rehabilitation facility, Hospital F, which is a rehabilitation specialty hospital, would be in a supportive relationship because Hospital A feels little or no direct competitive threat from Hospital F. In fact, Hospital F has every reason to be supportive to Hospital A in the hopes of maintaining a good referral contact. However, if Hospital A did have a rehabilitation facility or was planning on adding one, then Hospital F would cease to be a supportive relationship and would likely become a nonsupportive one due to the competitive nature of their relationship.
Although government agencies and patients may have mixed blessing relationships with hospitals in the indirect sense, they have supportive relationships with hospitals from the perspective of their direct relationships. Both groups desire to have available the services that the hospital provides when they need them. Therefore, governments and patients tend to be supportive, because they have everything to gain by being supportive. Clearly, the same stakeholder can assume different stakeholder postures, according to the contextual or situation attributes of the stakeholder issue.

Type 3: The Nonsupportive Stakeholder Relationship

The most distressing stakeholder relationships for an organization and its managers are the nonsupportive ones. They are high on potential for threat, but low on potential for cooperation. Typical nonsupportive relationships for hospitals include those with competing hospitals, freestanding alternatives such as urgicenters or surgicenters, employee unions, the federal government, other government regulatory agencies, indigent patients, the news media, and employer coalitions. Special interest groups may often prove to be nonsupportive, as in the case of pro-life demonstrations that have slowed or halted normal business, particularly for ambulatory women’s centers.

Figure 6–1 shows several examples of major nonsupportive relationships, including that with the Medical School Practice Group and competing Hospital B, which is part of its own integrating network. Both of these stakeholders have similar types of relationships with Hospital A. For example, they both try to manage the same key stakeholders as Hospital A, which sets up confrontational types of behaviors. The Medical School Practice Group is clearly a nonsupportive relationship through its strategic partnership with the Public Teaching Hospital C. While not in direct competition, as is the case with Hospital B, it principally refers patients to a competing hospital (which is a high threat to Hospital A largely due to its strategic relationship with the competing network), leaving little room for any cooperative agreements.

If, however, agreements could be made with the Medical School Practice Group to partner with Hospital A instead, a new referral source could be established and the competition’s network simultaneously damaged. This presents the major strategic issues facing today’s health care executives: how to manage nonsupportive relationships effectively today so that those same stakeholders will be less threatening and more cooperative in the future.

Type 4: The Marginal Stakeholder Relationship

Although marginal stakeholders may have a stake in the organization and its decisions, most issues do not affect them. Thus, marginal stakeholder relationships are high on neither threatening nor cooperative potential. For a well run hospital, typical relationships of this kind may include those with volunteer groups in the community, stockholders or taxpayers, and professional associations for employees. Certain issues such as cost containment or access to care could activate one or more of these stakeholders, however, increasing their potential for either threat or cooperation.

Figure 6–1 shows a marginal stakeholder relationship in that between Hospital A and Hospital E. This investor-owned hospital is a small-scale general facility that does not directly compete at the large-scale tertiary care level with Hospital A. It should be noted that
Hospital E is not affiliated or identified as a key relationship with any other stakeholder shown on the web figure. Therefore, it is not perceived as being either cooperative or threatening. For reasons such as geographic location, quality of medical staff, and deteriorating physical plant, Hospital E is not viewed as playing an important part of the strategic plans of any other organization depicted in the figure. This more than likely resulted from Hospital E's mismanagement of its relationships or its lack of unique strategic value as a partner.

**Issue-Specific Stakeholder Relationship Diagnosis**

The most important issues facing organizations and their managers at a given time change constantly. Of all the possible stakeholders for a given health care organization, the particular ones that are relevant to its managers depend on the corporate/competitive strategies being pursued, as well as on the specific issue. The stakeholders concerned with cost containment will be different from those concerned with access to health care. The diagnosis of the relevant stakeholder relationships in terms of the four types will probably be different on these two issues as well.

For example, System A Medical Group performs important duties to maintain the vital links between Hospital A and the patients being seen by group physicians. In this capacity, System A Medical Group is clearly in a supportive type of relationship with Hospital A, acting as a “supplier” to Hospital A. Given the issue-specific scenario of Hospital A’s attempt to form a strategic alliance with Cardiology Group E, however, System A Medical Group now faces the introduction of Group E into its company’s (Systems A’s) network. The introduction of the physicians from Group E may threaten the smooth operations and referral patterns of System A Medical Group, since Cardiology Group E may have previously been viewed as a direct competitor. In other words, the potential strategic alliance between Hospital A and Group E may challenge the way that the System A Medical Group traditionally conducts business. Therefore, the System A Medical Group may react harshly and choose to become a less supportive stakeholder regarding this specific issue.

The inherent issue in classifying stakeholder relationships into a typology suggests that relationship diagnosis is an ongoing activity for health care managers. They cannot assume that a stakeholder supportive on one issue will be supportive on every issue, nor that a stakeholder nonsupportive on one issue will be nonsupportive on another. Moreover, whatever the classification of a particular relationship on a specific issue, explicitly classifying stakeholder relationships brings inadvertent managerial biases to the surface. For example, if a manager identifies all relationships for any particular issue as nonsupportive, then the manager should critically examine his or her assessment of the relationship between the organization and its stakeholders. If a manager always thinks of a particular stakeholder as threatening, the manager may be missing opportunities for capitalizing on potential for cooperation; similarly, a manager who always sees a stakeholder as cooperative may be running the risk of underestimating the potential for threat on a specific issue.

**GENERIC STRATEGIES FOR STAKEHOLDER RELATIONSHIP MANAGEMENT**

Stakeholder relationship diagnosis of the type attempted in Figure 6-2 suggests some generic strategies for managing relationships with different levels of potential for threat.
and for cooperation. Each of the strategies presented in Figure 6–3 can be either proactive or reactive. Since executives continually manage a wide variety of stakeholder relationships (in terms of their potential for threat and cooperation), all executives need to use a combination of strategies at any one time.

**Strategy 1: Collaborate Cautiously in the Mixed Blessing Relationship**

The best way to manage the mixed blessing relationship, high on the dimensions of both potential threat and potential cooperation, may be cautious collaboration. The goal of this strategy is to turn mixed blessing relationships into supportive relationships. If executives seek to maximize their stakeholders’ potential for cooperation, these potentially threatening stakeholders will find their support.

![Table: Stakeholder’s Potential To Reduce Stakeholder Threat](image)

<table>
<thead>
<tr>
<th>Stakeholder’s Potential To Enhance Stakeholder Cooperation</th>
<th>Stakeholder’s Potential To Reduce Stakeholder Threat</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>Low</td>
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<tr>
<td>Collaborate Cautiously in the Mixed Blessing Relationship</td>
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**Figure 6–3 Strategies for Managing Stakeholder Relationships. Source:** Reprinted with permission from J. Blair and M. Fottler, *Strategic Leadership for Medical Groups: Navigating Your Strategic Web*, © 1998, Jossey-Bass, Publishers.

Supportive endeavors make it more difficult for them to oppose the organization.

For example, the proposed strategic alliance between Hospital A and Cardiology Group E (see Figure 6–1) represents a collaborative strategy. If this alliance took the form of a joint cardiology diagnostic and care center, such collaboration effectively stops the cardiology physicians, with whom the hospital has a mixed blessing relationship, from building a center themselves and, thus, competing with hospital-based invasive cardiology or diagnostic procedures. The hospital can contribute its name and capital resources, while the physicians will presumably send their patients to the hospital when inpatient services are needed. Both the hospital and the physicians potentially will benefit.

If Hospital A can use creative contracting covenants to ensure some form of referral pattern from the regional hospitals, Hospital A has again effectively used the collaborative strategy. However, these contractual covenants could be viewed as a defensive posture of the organization. The use of this kind of collaborative strategy requires caution because of the inherent instability of mixed blessing stakeholder relationships vis-à-vis the organization. Therefore, the collaboration strategy used with them may well determine the long-term stakeholder–organization relationship. In other words, if this type of stakeholder relationship is not properly managed through the use of a cautious collaborative strategy, the unstableness of these types of relationships could turn a mixed blessing relationship into a nonsupportive one.

**Strategy 2: Involve Trustingly in the Supportive Relationship**

Because supportive stakeholders pose a low potential for threat, they are likely to be
ignored as a relationship to be managed; therefore, their cooperative potential may be ignored as well. By involving supportive stakeholders in relevant issues, however, health care executives can maximally capitalize on these stakeholders’ cooperative potential.

It is important to distinguish between collaborating with a stakeholder and involving a stakeholder. Collaboration and “win–win” strategies often are prescribed as the basic solution to problems in health care management, but the collaborative relationship is often confused with the involving relationship. Involvement and collaboration are different, however. Involvement further activates or enhances the supportive capability of an already supportive stakeholder; the emphasis is not on reducing threat, since its potential is low. It has a higher level of trust (and lack of risk) on the part of the organization. Collaboration, on the other hand, involves much more of a give and take on the parts of the organization and the stakeholder. It includes an element of caution due to the high potential for threat inherent in mixed blessing stakeholder relationships and may require the organization to give up or expend certain key resources or change important policies to gain stakeholder support either by decreasing threat and/or by increasing cooperation. Collaboration may even have a defensive element to protect the organization against potential threat.

Managers can operationalize the involvement strategy by using participative management techniques, by decentralizing authority to clinical managers, or by engaging in other tactics to increase the decision-making participation of these stakeholders. For example, hospital management may invite clinical managers to participate in the analysis and planning for the elimination of redundant programs. The clinical managers are more likely to become committed to achieving such an organizational objective if they have been involved in establishing it. The success of this type of strategy requires managers to enlarge their vision of ways to further involve supportive stakeholders in higher levels of cooperation.

Nonmanagerial professional and support employees represent another class of relationships that belong in this category and for whom an involving strategy might be effective. Employees do not pose a great deal of direct threat to the organization, although union activism, the perception of poor third-shift conditions, or human resource shortages can make their continued service problematic under certain circumstances. Yet, their cooperative potential may not have been fully tapped.

At this time, many group practices and hospitals are explicitly involving their supportive employees and in-house volunteer stakeholders in strategies by training them to manage mixed blessing relationships, such as those with funded patients, patient families, and physicians. Guest or customer relations programs are designed to enhance the management of one or more potentially threatening stakeholders by increasing the cooperative potential of a key internal stakeholder. Another involving relationship management technique is the “womb to tomb” marketing approach to caring for patients.

Another explicitly strategic utilization of involvement systematically links human resource management systems and practices to overall strategic management. Called strategic human resource management, the technique has only recently been introduced into the field of health care management. It is very consistent with the strategic relationship management approach, because it increases
involvement of a generally supportive internal stakeholder (employees) in furthering the strategic goals of the organization.

Hospital executives need to be aware of physician perceptions when entering into alliances with physicians. From a hospital perspective, relationships with physicians generally are considered to be mixed blessing relationships, and hospital executives often use involvement strategies to manage them. This can strain the hospital–physician relationship. For example, if a hospital buys a physician practice, all the physicians become employees of the hospital. If hospital executives try to exert typical hierarchical authority and typical involvement strategies over the physicians in the newly acquired practice, the physicians will most likely rebel. Even if the physicians have become employees of the hospital, they may view themselves as partners in the venture. As such, they would expect to be involved in strategic decision making at the highest levels. This is a classic case of the hospital misdiagnosing the physician–stakeholder relationship as nonthreatening and supportive, when, in fact, it is a powerful mixed blessing.

Strategy 3: Defend Proactively in the Nonsupportive Relationship

Stakeholder relationships with high threatening potential but low cooperative potential are best managed through a proactive defensive strategy. Relationships with the federal government and indigent patients are nonsupportive stakeholder relationships for most health care organizations. In terms of Kotter’s framework on external dependence, the defensive strategy tries to reduce the dependence that forms the basis for the stakeholders’ interest in the organization.29 In stakeholder terms, a defensive strategy involves proactively preventing the stakeholder from imposing costs—or other disincentives—on the organizations. Health care executives should not attempt to eliminate totally their dependence on nonsupportive relationships, however. Such efforts are doomed, either failing outright or creating a negative image for the organization. For example, trying to sever all ties with the federal government is counterproductive if a hospital hopes to market to older patients. Also, the public and the local government will almost surely take a negative view of a public hospital that tries to deny access to all indigent patients.

For example, given the regulations hospitals face, their most appropriate defensive tactic in dealing with the federal government’s regulatory agencies is to explore ways of complying with the demands imposed by the federal government at the least possible cost. Diagnosis-related groups (DRGs) that produce a surplus for the hospitals define their areas of distinctive competence. Hence, hospital executives might adopt a case-mix approach to the delivery of health care, modifying the services they offer based on cost and process accounting. Investing in more effective management information systems and specialized medical records “grouper” software, and recruiting and paying for more highly skilled medical records personnel are all part of this defensive strategy vis-à-vis a nonsupportive, demanding third-party payer and/or regulator.

This generic strategy also can drive out or reduce competition. For example, Hospital A (Figure 6–1) might be able to drive out competition from Hospital B (another private tertiary care hospital) by securing a monopoly over a particular market segment through further PPO contracting. On the other hand, to reduce competition with urgicenters or surgicenters, Hospital A could
build new ambulatory facilities or restructure existing facilities. In these examples of the defensive strategy, the connection of stakeholder management to broader strategic management is very clear, involving many traditional marketing and strategic notions for handling competitors.

Relationships with indigent patients often are thought of as nonsupportive with hospitals, especially county facilities. As a defensive strategy to reduce the use of expensive emergency department facilities by these types of patients, a county hospital could open more primary care clinics in surrounding regions and inform the indigent population about the services provided at the clinics. Such an approach might change these nonsupportive relationships to mixed blessing relationships. While the stakeholders still would be high on threatening potential, at least there would now be some element of cooperative potential.

Strategy 4: Monitor Efficiently in the Marginal Relationship

Monitoring helps manage those marginal relationships in which the potential for both threat and cooperation is low. For example, numerous special interest groups are opposed to certain procedures, such as abortion or the placement of artificial implants, or are concerned about certain patient groups, such as the aged. Typically, these groups have only a marginal stake in the activities of the organization and affect operations only indirectly by advocating a specific moral or ethical viewpoint. Relationships with taxpayers and stockholders are also marginal. In essence, marginal relationships are unstable; they can move into any one of the other three types of relationships if the particular issue is of enough importance to the organization.

Often, relationships with patient families are considered marginal. Leaving this key marginal relationship unmonitored ignores the possibility of developing a supportive relationship that can make a decisive difference in the course of patient care. In addition, dissatisfied patient families that go unnoticed potentially can cause significant problems for an organization. Assigning specific responsibility for monitoring this relationship to a member of the patient care team can avert disaster for the organization's management.

The underlying philosophy for managing these marginal relationships is proactively maintaining the status quo, while keeping the use of financial resources and management time to a minimum. Executives address issues on an ad hoc basis, and their general thrust is to "let sleeping dogs lie." Keeping them asleep, however, may require an organization to engage in ongoing public relations activities and to be sensitive to issues that could make these groups an actual threat.

Stakeholders in marginal relationships should be minimally satisfied in most cases. What it takes to keep a particular marginal stakeholder minimally satisfied may increase over time, thus necessitating greater involvement of managerial time and other organizational resources. Managers must monitor such expenditures of inducements or disincentives to determine whether they have become excessive or whether they are perhaps inadequate because the marginal stakeholder has become a key stakeholder, in general or on a particular issue.

An Overarching Relationship Management Strategy

In addition to using the four strategies specifically tailored for relationships in the four diagnostic categories, health care ex-
ecutives may employ an overarching strategy to move the relationships from a less favorable category to a more favorable one. Then the relationship can be managed by means of the generic strategy most appropriate for that new diagnostic category. For example, rather than simply defending itself against the news media as a nonsupportive relationship, a hospital could implement an aggressive program of external relations to foster openness with the media. If successful, the program could change the news media relationship to a less threatening category, such as a marginal relationship, and allow it to be managed by means of a monitoring strategy. If the hospital is willing to invest enough time, energy, skill, and money in the effort, the media relationship might even become a supportive one.

In the continuing example of Hospital A (Figure 6–1), the proposed strategic alliance with a mixed blessing stakeholder (Cardiology Group E) can present an opportunity for Hospital A. If Hospital A effectively manages Group E with a collaborative strategy, such as building a cardiology center for the group of physicians, Hospital A also may have successfully turned a mixed blessing relationship into a less threatening supportive one.

Even if mixed blessing relationships are collaboratively managed, they may not become supportive relationships. Every player in this new era of health care delivery is not voluntarily becoming involved and integrated. Thus, stakeholders do not always react as the strategy suggests. Furthermore, although organizations can create structural integration (i.e., strategic integration) fairly early, the new structure may not work without social and cultural integration (i.e., tactical integration) as well.

Of course, stakeholders generally do not just sit still and allow themselves to be managed. Stakeholders who are powerful and, hence, threatening are as likely to try to manage organizational relationships as vice versa. Many organizations and their stakeholders engage in continuous management and countermanagement strategies. To manage these relationships prudently and effectively, executives should periodically repeat the procedures to identify stakeholders and match their relationship diagnoses with appropriate strategies.

STRATEGY IMPLEMENTATION AND OUTCOMES

Given the importance of key stakeholder relationships for an organization’s overall business strategy, the successful implementation of the stakeholder management concept should provide the organization with a competitive advantage. At best, the relationship management perspectives of hospital executives are incomplete, and their approaches to stakeholder assessment are underdeveloped and haphazard. At worst, these executives display a total lack of explicit awareness of, and involvement in, a systematic and effective relationship management approach. It is essential to develop systematic and strategic stakeholder approaches—integrated with still broader relationship management issues. A key issue in all strategic action is the implementation of the planned and articulated strategy.

With a consistent and conscientious relationship management implementation strategy, a quite fully organized health care system can develop. For example, the three necessary components of organized delivery networks are shown in Figure 6–1: a hospital, a large multispecialty physician group, and a health plan. A fourth component, the System A Headquarters, is the coordinating centerpiece for the primary system components.
The shading of the boxes (as the legend shows) represents the hospital’s different stakeholders and the nature of their relationships, given the strategic alliance among the components of Hospital A, Group A, and System A Health Plans. Assuming all the various stakeholder relationships are effectively managed and formalized into this specific vertical integration, the original patterns (prior to system integration) of informal, but interconnected, stakeholder relationships now serve to structure network relationships and systems.

The organized delivery system still has embedded within it many formal and informal networks (Figure 6–1). Even with the formal development of this organized health care delivery system, however, sophisticated health care executives know that new stakeholder challenges have been raised. Stronger competitors (by virtue of the network), and new and varied partners have emerged. The health care delivery system is more complex and complicated than ever before. The number of relationships has grown geometrically. No longer do the old, internally oriented human resources approaches to solving production problems suffice.

Executives at Hospital A do not have the same level of hierarchical control, and the hospital can no longer be independent as a result of developing alliances. The overall power of the hospital has increased, but at significant cost to independence and control. Executives must coordinate with and be acceptable to strategic partners. All of this requires the development of additional tactics and stakeholder management strategies to manage these more complex and radically changing relationships.

In Figure 6–1, the formation of systems and networks has effectively divided the entire health care delivery system for the area represented into three components: those organizations affiliated with System A; those organizations affiliated with the emerging Network B; and those organizations that have yet to be included in either system/network, but that are possible partners for either system/network. As a direct competitor and nonsupportive stakeholder for Hospital A, Hospital B has attempted to imitate the successful strategic alliance of System A by establishing its own strategic alliances. Hospital A is not content with being the first to form a health care network, however. On the contrary, Hospital A hopes to maintain that lead in strategic alliance formation.

In contemplating a strategic alliance with Cardiology Group E (an independently owned and unaffiliated specialty group), Hospital A executives should consider the impact such an alliance would have on internal system relationships (System A owned and affiliated) and on direct competitors (Network B owned and affiliated). They should also consider the possibility that if Hospital A does not make an alliance with Cardiology Group E, Hospital B might do so. If the proposed strategic alliance is formalized, a joint strategy team composed primarily of administrative staff from Hospital A and Cardiology Group E should be developed to facilitate the smooth transition of Hospital A and Group E from a mixed blessing stakeholder relationship to a strongly supportive one. Additionally, representatives from the other system components, primarily from the System A Medical Group, should be part of this team to ensure that the real and important issues of System A, as a whole, are being met.

With the consummation of a strategic alliance, the administrative staffs are in mutually supportive relationships and are now strategically involved in each other’s organizations. The formalization of a strategic alliance does not mean that all the employees and managers of each respective organization will in-
constantly function as supportive stakeholders, however. Rather, relationship management tactics such as joint strategic teams composed of players from both fields are necessary in order to begin the process of jointly facing the new challenges in the environment.

MANAGERIAL RESPONSIBILITY FOR STAKEHOLDER RELATIONSHIPS

It would be a mistake to assume that the chief executive officer or any other single individual manages all the diverse stakeholder relationships in today’s health care system. Instead, the evolution of some of these organizations has seen the development of management specialists whose major purpose is to manage particular relationships. In some organizations, for example, a medical staff director or Vice President for Medical Affairs has the major responsibility for managing the medical staff relationship. Nonetheless, others, including the chief executive officer, are available to help handle nonroutine problems.

In the continuing example shown in Figure 6–1, four executives typically devote much of their time to managing several key relationships. Their roles are typical of managers who have responsibilities for several stakeholder relationships. The Director of Physician Practice Management Services, for example, is responsible for developing a physician–provider network capable of delivering health care to the insured patient base in an efficient, cost-effective manner. This person also is integrally involved in medical staff development and recruiting. The Director of Regional Services can work collaboratively with the Director of Physician Practice Management Services to provide service to regional physicians affiliated with rural hospitals in Hospital A’s regional network.

The chief financial officer and the Vice President of Marketing will work closely with Hospital A’s network partner, the health plan, which functions as a managed care organization. By forming this health care delivery network, Hospital A has assumed a much greater portion of the system’s financial risk than it previously had. For example, with capitation, the hospital agrees to treat all the patients in a given population for a preset amount of money. If a patient’s medical bills exceed this preset amount, the health care providers absorb the excess cost. As a result of this increased financial risk, the chief financial officer is quite involved with the network risk management functions. The Vice President of Marketing has direct responsibility for promoting Hospital A’s interests (both individually and in the network). The “all-in-one” concept of health care delivery is still new to the purchasers of health care, and a key responsibility of the Vice President of Marketing is to counter any actions by competing health care networks. Each of these specific hospital executives must let go of the old hospital mentality of “filling beds” and thinking, “If we own it, we can control it.” Instead, they must embrace the new health care network mentality of providing the highest quality, easiest access, and most cost-effective health care for a given population.

Stakeholder webs that show the potential opportunities and responsibilities of each stakeholder manager can aid in managers’ understanding of the strategic stakeholder process. Based on the general stakeholder web developed during stakeholder assessment, this technique provides a way to incorporate relationship management into an executive’s job description. It aids in clarifying and communicating unique and overlapping managerial roles and responsibilities. Obvi-
 ostensibly, the development of these webs requires some agreement among the various managers concerning who will manage which stakeholders on which issues. This process typically involves internal negotiations and the development of organizational policies and procedures.

CONCLUSION

To survive the turbulent and revolutionary changes facing the health care industry, health care executives must better manage their external, interface, and internal stakeholder relationships. Organizations have to rethink their strategies and operations as they face increasing and potentially conflicting demands for effectiveness and efficiency from these stakeholders.

To satisfy key stakeholders, managers must make two critical assessments about these relationships: their potential to threaten the organization and their potential to cooperate with it. When determining the stakeholder’s orientation, managers should account for factors such as control of resources, relative power, likelihood and supportiveness of potential stakeholder action, and coalition formation. These factors should be interpreted in light of the specific context and history of the organization’s relations with it and other key stakeholder relationships influencing the organization as well as that stakeholder.

Incorrectly categorizing a stakeholder relationship into the wrong classification type is, in itself, indicative of a lack of stakeholder relationship expertise. If a relationship is incorrectly classified, the chosen strategy for managing that relationship will be wrong also. Using the wrong strategic stakeholder relationship strategy can be very detrimental to an organization. Incorrectly classified relationships will be more likely to move from whichever type they are to a type that has a greater potential for threat, coupled with even less potential for cooperation.

As an overarching strategy, managers should try to change their organization’s relationships with each stakeholder from a less favorable category to a more favorable one. Then, the relationship can be managed using the generic strategy most appropriate for that “new” diagnostic category.

Executives need to do more than merely identify stakeholders or react to stakeholder demands. They must proactively develop or enhance their organization’s capacity for the strategic management of stakeholder relationships. They need to satisfy their key relationships by offering appropriate inducements in exchange for essential contributions. Executives also should monitor their marginal relationships so that they do not become key nonsupportive relationships and confront the organization with undesired discontributions.

In order to manage stakeholder relationships effectively, health care executives must recognize that the implementation of strategic stakeholder management strategies requires a thorough understanding of negotiation strategies. Clearly, to survive in the future, organizations should establish goals for their relationships with current and potential stakeholders as part of the strategic management process. Such goal setting should include clear analyses and consideration of both the organization’s and the stakeholder’s goals.

Even with effective strategic management of stakeholder activities, health care executives will face many challenges. The unpredictable and, yes, exciting times are not over for the health care industry. Government reforms will continue; employer coalitions will gain in strength and demand concessions
from health care providers and administrators; managed care will become a stronger force. Those health care organizations that take an active lead in managing their stakeholder relationships and that consciously build stakeholder relationships into their strategic plans will increase the accuracy of their relationship diagnoses and will begin to gain from the effectiveness of their strategies for managing stakeholder relationships.

NOTES


16. Blair and Fottler, Challenges in Health Care Management.


18. Freeman, Strategic Management.


24. Blair and Whitehead, "Too Many on the Seesaw."
25. Blair and Fottler, Leadership Challenges and Strategic Choices.
30. Blair and Fottler, Challenges in Health Care Management.
31. Blair and Fottler, Challenges in Health Care Management, Chapter 5.
34. Blair and Boal, "Strategy Formation Processes in Health Care Organizations."
37. Shortell et al., Strategic Choices for America's Hospitals.

John D. Blair, PhD, is the Trinity Company Professor in Management and Health Care Strategy for the College of Business Administration (and the School of Medicine) at Texas Tech University. He currently serves as the Coordinator of the Area of Management (Department Chair). He is also the founding Director of the Center for Health Care Strategy and an editor of Advances in Health Care Management, a new JAI Press series. He has also served as the chair of the Health Care Administration Division of the National Academy of Management. His most recent books include Strategic Leadership for Medical Groups: Navigating Your Strategic Web (1988); Challenges in Military Health Care (1993); and Challenges in Health Care Management: Strategic Perspectives for Managing Key Stakeholders (1990). He received his PhD from the University of Michigan in 1975.

G. Tyge Payne, MBA, RPh, is a PhD student in Strategic Management in the College of Business Administration at Texas Tech University. He serves as the Project Coordinator for the Center for Health Care Strategy, a joint venture of the College of Business Administration and School of Medicine at Texas Tech University. He also is the assistant editor of Advances in Health Care Management, a new JAI Press series. In addition to his service as the Assistant Field Experience Director for the Health Organization Management (HOM) graduate program at Texas Tech, he has held positions as a registered pharmacist in both institutional and retail settings. He received his MBA from Texas Tech University.

Timothy M. Rotarius, PhD, is Assistant Professor of Health Services Administration at the University of Central Florida. Dr. Rotarius does research on integrated delivery systems and other complex structural relationships between health care organizations. He has numerous publications and research awards, and he has been a medical group administrator. Dr. Rotarius received his PhD in strategic management from Texas Tech University.