The More Things Change, The More They Stay the Same

Barbara Bigelow and Margarete Arndt

For decades, the hospital environment has been described as turbulent and hostile. At the same time, the transfer of business practices into hospitals has been advocated, accompanied by the largely untested assumption that these practices are crucial to performance and even survival. As this pattern became entrenched, the accumulated knowledge gained within the industry of managing in a hostile and turbulent environment has been overlooked. We argue that it is time to question the pattern.

The hospital industry faces extraordinary challenges. There is an "urgent need for more control over rising hospital costs" (p. 11) and "unprecedented public agitation over the ill's of the American health delivery system." (p. 14) The entire field of health is pervaded by "a sensational and intolerable paradox of soaring costs and deepening dissatisfaction." (p. 77) The health care climate "is almost frenetic" (p. 22) and an "atmosphere has been created in which new and untested ideas are welcome if they promise immediate cost reduction." (p. 80) Increasing and conflicting pressures are placed on hospitals by "consumer, producer, and educational interests" while "increasingly stringent financial controls are acting to paralyze hospital management." (p. 133) The rate of change "has increased dramatically," (p. 92) leaving hospitals in an "unprecedented period of tension within the industry." (p. 52) In this "increasingly turbulent environment," (p. 31) hospitals have to "make a commitment to cost containment, with all that such a commitment entails," (p. 66) and "get very realistic about dealing with the cost concerns that are out there." (p. 26)

We would like to pose a challenge to the reader. When would you guess each of the above quotes was written? Are they recent? Or perhaps they are reflective of the last 10 or 20 years? In fact, they are drawn from the past 4 decades. In the past, the environment faced by hospitals was described and experienced much as it is today. In the 1960s it was described as "changing rapidly," (p. 49) in the 1970s it was wrought with "financial uncertainty" (p. 130) and created "an ever-tightening vise," (p. 66) and in the 1980s it was "rapidly changing and often threatening." (p. 63)

Throughout this time, hospitals have been criticized for lagging "behind industry in managerial sophistication" (p. 113) and have been urged to adopt a variety of management practices from private industry. In the 1960s they were told to "use the production and management skills developed in the business community." (p. 61) and in the 1980s "adopt a more

Key words: environment, hospital management, strategy

Barbara Bigelow, Ph.D., is Associate Professor, Graduate Department of Management, Clark University, Worcester, Massachusetts.

Margarete Arndt, D.B.A., is Associate Professor, Graduate Department of Management, Clark University, Worcester, Massachusetts.
businesslike approach. The specific practices advocated for hospitals have differed over the years—from cost accounting to corporate restructuring to reengineering—but the claims are similar. Hospitals that adopt the practice will reap significant strategic or operational benefits: costs will go down, efficiencies will be achieved, and market share will improve. Hospitals that do not adopt will fail to thrive, or at worst, will not survive.

A consistent pattern of behavior has emerged. The same strategy (adopting practices from business) is used repeatedly to achieve a desired end (lower costs, survival). Repeatedly it fails to achieve that end; yet it is used again and again, each time with the claim that this time will be different. This time it really addresses fundamental issues; this time hospitals will achieve sustainable savings and efficiencies and will become more competitive. In the case of total quality management (TQM) and reengineering, proponents at least acknowledged that organizations often fail to achieve the desired end. However, this is not attributed to any flaw in the practice itself or with its appropriateness for any and all industries. Rather, the reason is that management did not do it right.

In this article we suggest that it may be time to take a different look at the hospital industry. Much will be written about the future of hospitals as we enter the millennium, and we believe that it will enhance the understanding of health care management if the pattern of repeated transfers of business practices into hospitals and the assumptions that maintain it are recognized and questioned. Perhaps then we will not be saying 10 years from now what has been said for the last 40 years and is still being said today: The environment is hostile and pressures unprecedented, and unless hospitals adopt such and such a practice from private industry they will not survive. This article draws heavily upon articles published in Hospitals (renamed Hospitals & Health Networks in 1993) because, as the official publication of the American Hospital Association, it is reflective of trends in the industry and of the type of information widely available to hospital managers.

The article is organized into four sections. The first one focuses on the persistence of environmental pressures on hospitals about their cost and the need to be more businesslike. The second section reviews our research to shed light on the pattern of behavior that has emerged over time. In the final two sections we look at forces that may have reinforced the behavior and suggest how we might begin to reflect on rather than automatically operate within this well-entrenched pattern.

THE CONTINUING COST CRISIS

Over many decades now, perhaps the single biggest and most enduring concern has been health care costs, described in a journal title in 1966 as “The Continuing Cost Crisis.” Throughout this time, the sense of urgency has been pervasive: there is an “urgent need for more control over rising hospital costs,” costs are “spiralizing,” buyers are “fed up with the waste and inefficiency of the health care system,” and consumers “believe that the United States is in a medical care cost crisis.”

Rising health care costs led to the ongoing threat of intervention by “an expanding number of external forces that dictate decisions in the hospital.” A critical question addressed at a symposium on hospital affairs in 1965 was whether “hospitals exercise adequate control over their activities for the protection of the public and their own future,” or if “the public will turn to government.” Similarly, a concern dominating the meeting of the Midwest Hospital Association in 1968 was that

If hospitals fail to take the initiative now—for lowering costs, experimenting with reimbursement plans, communicating with the public and originating other improvements internally—their laxity will turn the specter of government control of health care administration and facilities into a reality.

Hospitals have long perceived the threat of external controls. They were “threatened by the ever-increasing involvement of the government in health care,” and insurers even in the 1960s were seen as having the power to “dictate the type of services that will be provided by telling their clients what services they will or will not pay for.” Regulations in the early 1970s were described as “the most economically stringent controls in the history of the health care industry,” threatening “virtual paralysis of hospital management,” and 1982 was “the year when hospital regulations reached the high-water mark.”

While the hospital industry has been described consistently as turbulent and volatile, it has certainly changed since 1960. Among the changes have been the growth of the managed care industry with its reduced emphasis on the hospital and the changes in attitude toward competition. In the 1960s hospitals were seen as
the heart of the health care continuum. No longer was
the hospital "just for the acutely ill... the increased use
of hospital outpatient department reflects that [hospi-
tals] have become the center of the community’s entire
health care system." In contrast, these days hospitals
no longer are expected (or allowed) to view
themselves in the central position in which they once
envisioned themselves. As the president and chief exec-
tutive officer (CEO) of one hospital said, "The payers
are in charge and have taken the initiative away from
hospitals to date." 

The view of competition in the health care industry
has also changed dramatically. Competition among
hospitals was anathema to many in the 1960s. "Suicidal
competition" was viewed as hurting patients and lead-
ing to "extremely bad planning at local and regional
levels." Hospitals were urged to seek "an inte-
grated community approach in an effort to eliminate
competition and waste in the hospital field." 

Area-wide planning was designed to correct the "dis-
organized, competitive group of institutions, agencies,
and individual deliverers of care" that contributed to
"significant duplications of services and increas-
ingly high costs." A decade later, in the early 1980s,
competition came to be viewed not as a problem but as
part of the solution. Now it was "necessary for hospi-
tals to compete to survive." 

Economic competition will separate the sheep from the
goats in hospital management. Those who survive will
be seasoned, tough-minded hospital executives who
thoroughly enjoy taking risks in an environment where
winners and losers easily can be identified.

Increasingly, reliance was placed on market forces
and costs, and to enforce an atmosphere of efficiency.
However, eventually disillusionment began to set in.

What goes around comes around. Twenty years ago,
joint ventures and collaboration were the hot buzzwords.
Now executives will be driven to these measures—not by
a desire to be more effective or to be more collegial but by
the absolute imperative of lessened resources. . . .
The whole competitive model is in and of itself a barrier
to collaboration.

Reminiscent of the advice given to hospitals in the
1960s, they are again advised to "move beyond just
competing to capture markets and begin to collabor-
ate among and between hospitals." 

In retrospect, it may appear that today the cost pres-
ures and the environmental uncertainty and com-
plexity faced by hospitals are greater than ever. There
are new players and the competitive environment has
changed. Yet a hospital administrator in the 1960s
experienced the pressures as "unprecedented" as well. It
was a "volatile period of health history," a "period of
crisis," a "changing health environment" in which "the basic economic foundation
of the hospital world began to shift." From the
point of view of the hospital, the environment and the
pressures brought to bear on the organization at any
one time always appeared worse than they seemed to
have been in the past. The term "unprecedented" is
used throughout the decades; costs have been de-
scribed as skyrocketing and the American public has
been reaching the "threshold of its tolerance of rising
hospital bills" for over 30 years.

Throughout these decades the mandate to hospitals
has been the same: "make a commitment to cost con-
tainment" and "get very realistic about dealing with the cost concerns that are out there." For
example, in its annual report for the year ending Sep-
tember 30, 1961, a typical community hospital devoted an
entire section to a discussion of efficiency. According to
this hospital:

When the need for efficiency is recognized by an organi-
zation, then that organization is basically sound. The
most compelling reason for obtaining greater efficiency is
to combat the yearly rise in hospital operating expenses.
[Our] Hospital along with the majority of hospitals the
country over, is plagued with the ever present problem of
rising costs. . . . Whatever the reasons for increased ex-
enses, steps had to be taken with the hospital to ensure
the most efficient utilization of every expenditure. . . . At
[Our Hospital] the need for efficiency is recognized and
patients can expect efficient service without a reduction in
the quality of the medical care they receive.

Hospitals have been admonished to meet this obliga-
tion to improve efficiency and control costs through
a generic strategy: adopt values and practices from

In retrospect, it may appear that today the cost pressures and the environmen-
tal uncertainty and complexity faced by hospitals are greater than ever.
private business. The practitioner literature suggests that hospitals have followed this advice.

Hospitals "have looked toward industry to help some of their hospital management problems" for some time.42(p.139) During the 1960s, external pressures and changes required "multiple adjustments in hospital administration,"21(p.47) and there "has never been a time when it was as necessary as it is now for these hospitals to be conducted in a businesslike fashion."43(p.32) Patients became consumers,44 and marketing became a necessary tool for hospital administrators.45 Hospitals also needed to apply sophisticated techniques for financial management,46 systems analysis,47 and management engineering.48 By the 1980s some felt that "the idea of viewing hospitals as business as well as social service organizations has taken hold."49(p.76) However, success seems to have been elusive, as hospital administration continued to be described as "derelict in not keeping abreast of the times."14(p.113) and managers still needed to "adopt a more businesslike approach."16(p.75) Nonetheless, by the end of the 1980s the assumption that business practices were necessary and appropriate continued to be well entrenched, culminating in the incorporation of TQM into the accreditation requirements of the Joint Commission on the Accreditation of Healthcare Organizations.

WHAT IS KNOWN VERSUS WHAT IS ASSUMED

A basic theme of our own work has been disentangling what is known from what is assumed. As we researched a wide variety of management practices, always questioning whether we actually know something or if it had simply assumed the status of fact, the pattern we described above emerged. We began by trying to understand if the outcomes ascribed to practices were real. On finding time and again no evidence to confirm or disconfirm intended outcomes, we began to question why hospitals would adopt them and thus to understand the pattern we observed.

Our work began in the late 1980s when we conducted research to determine whether ambulatory care centers increase market share and inpatient admissions.50 This belief was well entrenched at the time. However, a literature search showed that it was not based on empirical evidence but seemed to have taken on a life of its own through repeated telling. Common sense suggested that the claim was questionable (visits to ambulatory care centers were unlikely to result in hospital admissions), and our empirical work showed that, in fact, the centers had no such impact.

We were curious to know if this was an isolated incident, and if not, to understand why hospitals would adopt management practices that may be costly to implement and are unlikely to deliver the specific benefits that are promised. A pattern emerged in our analysis of cost accounting, product line management, vertical integration, and corporate restructuring.51,52 Each was described as a necessary response to the environment, and hospitals were often warned that their very survival would be jeopardized if they did not adopt. For example, product line management was described as "the only possible response for institutions that plan to survive this latest upheaval."53(p.55) Diversification (in this instance into the long term care market) would enable hospitals "to gain control of their immediate markets, spread financial risks over several businesses and provide quality care at a profit."54(p.74) A cost accounting system would allow management to "position the hospital to increase market share and profitability."55(p.36)

We observed a continual promotion of management practices, each promising improvements in performance but none ever demonstrating the ability to achieve its promises. To the contrary, in our own study of corporate restructuring we found that hospitals did not realize the benefits they had anticipated.56 Nonetheless, despite the cost involved in implementation and the ambiguity concerning its impact, the promotion of each followed exactly the same pattern. We turned to institutional theory to help us understand what we were seeing. Hospitals operate in an environment characterized by elaborate rules and requirements: laws, regulations, normative expectations of professional organizations, and peer pressure. In such environments organizations increase their legitimacy and thus survival chances if they adopt practices and procedures that conform to prevailing beliefs (in this case, that hospitals should be more businesslike), "independent of the immediate efficacy of the acquired practices and procedures."57(p.340) We described the nature of institutional environments and argued that hospitals face considerable pressure to adopt management practices imported from private industry.

TQM provides a powerful example. There was no empirical evidence that it achieved the many benefits ascribed to it, but there were large numbers of normative articles from consultants and practitioners, as well as many anecdotes from individual institutions. Common sense suggested that there were inherent conflicts between TQM as it was advocated and the structure and functions of hospitals, conflicts that
were not addressed in the literature and that could impede the success of the practice. Yet, the practice became completely institutionalized at great expense to hospitals, and once institutionalized, adoption of TQM became critical to maintaining organizational legitimacy independent of its impact on quality of care or financial outcomes.

During the early 1990s, the first articles began to appear in the health care literature promoting reengineering. Unlike TQM, which was now called by some “just another management fad,”58 reengineering would really enable hospitals to succeed in today’s competitive environment. As in the case of TQM, there were obvious aspects of reengineering that suggested it would not be effective in hospitals. However, proponents argued that if it does not fulfill its promise, the failure is not due to any shortcomings with reengineering. To the contrary, its “success is virtually guaranteed” to those who go about it right.590,171 Its very high failure rates were not attributed to any inherent problem with reengineering but due to failures of leadership.

In our article on reengineering we used our previous research to provide some guidance for hospital managers under pressure to adopt these practices.50 We did not believe that failure was due automatically to poor leadership but could just as likely be due to a lack of fit between the practice and characteristics common to most hospitals. We again turned to institutional theory and argued that even if the assumptions did not fit and the claims made no sense, it could still be worth adopting symbolically, thus signaling to key stakeholders a desire to be more businesslike but without the investment of time, resources, and energy required of “true” reengineering.

THE TRANSFER OF BUSINESS PRACTICES AS STANDARD OPERATING PROCEDURE

For many decades the basic scenario has been the same. First, the environment is declared hostile, turbulent, and unprecedented with respect to the pressures that threaten hospitals’ very survival. Next, hospitals are encouraged to be more businesslike and to adopt specific practices from the for-profit sector. The specific practices have changed over the years, but all promise some combination of greater efficiency, improved competitiveness, lower costs, and growth. Anecdotal evidence and normative appeals are used to convince hospital management of the vital necessity of adopting each practice. The practice disseminates widely, although substantive data documenting that the practice realizes its promise are lacking.

What has emerged is a standard operating procedure in the hospital industry. The practices may differ but the pattern is always the same. A new practice is advocated not necessarily based on its actual merits (for these are not substantiated) but by virtue of renewed hope and promise. The newest one, unlike its predecessors, really will improve efficiency, control costs, increase competitiveness, and even improve quality. Yet inevitably the underlying problem it is promised to address will persist. In time the practice is supplanted by yet another one, holding out similar hope. Two interrelated forces help to explain the embeddedness of this pattern: the assumption that business does it better and a lack of disconfirming evidence.

First, the assumption that management in private business is inherently superior and is the appropriate model for hospitals is well entrenched, dating back to the early part of the century. Even as early as the 1910s, it was widely claimed that hospitals were poorly managed,50,61 and hospitals were admonished that they should run on the same basis as other businesses.62,63 This assumption has itself become institutionalized in the most profound and enduring sense as a taken-for-granted belief.

Second, the preponderance of articles in the practitioner literature are limited to normative exhortations to adopt a practice and anecdotes from individual hospitals. The latter provide little hard evidence but promote the practice by explaining why a hospital chose to adopt it (i.e., what benefits it expects to get) and by outlining its implementation. Although the appropriateness of adoption is never questioned, cautionary notes are raised occasionally concerning implementation. However, they invariably conclude that all difficulties can be overcome by attention to general principles such as clear communications, demonstrations of top management support, and involvement of people.

Strikingly absent is disconfirming evidence, both from practicing managers and empirical research. Certainly with the latest round of practices—TQM and reengineering—there is a considerable disincentive to report implementation problems because such difficulties are so clearly attributed to poor leadership. Yet the reticence to report that a practice does not live up to expectations is not limited to these two instances. A similar pattern existed for corporate restructuring, for product line management, and all the other business practices we have studied. No one questions its appropriateness or whether it justifies the resources
often required. It merely sinks from view as a new one is introduced and declared more effective. Unfortunately, the voices of managers who experienced difficulties, or who questioned the wisdom of adopting in the first place were absent throughout, at least from journals and periodicals. Valuable information that could have helped other hospitals decide whether and how to implement is not heard.

We can only speculate on the reasons for all this. The original assumption about the appropriateness of business practices for hospitals during the early years of this century may have simply grown out of the need to find a way to manage this new type of organization, as thousands of community hospitals were founded in a relatively short period of time. The assumption of the superiority of business to other types of endeavor is also consistent with our overall culture. Firms in the "private sector" are looked upon as the appropriate agents to deal with many issues that would be handled by government or other social agents elsewhere. Examples are the provision of health insurance, involvement in managed care, or support of the arts and other charitable activities. The belief that organizational survival equates to organizational efficiency supports continued application of business practices to organizations that are labeled a priori inefficient precisely because they are not like other businesses. Lastly, in a climate in which the heroic leader is admired, individual managers whose experience does not match what they were told to expect from a business practice have little reason to believe that their experience is an indication not of their incompetence but of a fundamental lack of fit between hospitals and that practice.

We also can only speculate on why there is such a lack of empirical research into the efficacy of these practices as they diffuse in the hospital industry. It may reflect the institutionalized belief in the efficacy of business practices. However, it may also be that the life cycle of many of these practices is short. There may literally not be time to study a practice adequately during a period of rapid diffusion, and results are not published until after diffusion has occurred and interest has moved on—too late to use the results for decision making. If this is the case, it becomes all the more important that anecdotal evidence reflect all experiences, both successes and failures.

THE CHALLENGE

We suggest that the start of the new millennium is as good an opportunity as any to step back and take a new look at how we evaluate the efforts of health services managers. Three topics seem particularly pertinent. First, why is it assumed that private business is the appropriate model for managing hospitals? Despite decades of admonitions that hospitals emulate manufacturing plants, hotels, or retail establishments, they are still viewed as inefficient, bungling, and uncaring. What forces sustain the belief that the perceived shortcomings of the hospital industry can be remedied by further application of management practices from private industry? What role do consultants, normative pressures, and even inertia play in the persistence of this pattern? Do societal expectations of hospitals' purposes and function conflict with societal pressures that they be more businesslike, limiting hospitals' ability to respond to symbolic compliance and thus undermining the efficacy of some practices? A converse, but related question is whether the persistent application of business practices in hospitals has over time altered hospitals' functions and deepened societal conflict about hospitals' role and function.

Second, is it possible that the pro-business bias that has driven our assessment of hospital management has the effect of diminishing the management knowledge that could or does develop in the hospital industry? Hospital executives have more experience than executives in most industries with managing in a hostile, turbulent environment; with managing in organizations where management does not have control over much of the organization's work; and with managing in organizations where customers are vulnerable and idiosyncratic in their response to the organization's minions. Is it possible that managers everywhere lose when the knowledge of hospital managers is marginalized and devalued?

Third, we believe it would be beneficial for practicing managers and management research alike if we learned about experiences in all their variety. Success stories certainly can offer insights. However, even in the case of success stories we need to understand the contribution made by the features of a particular man-

---

Has the adoption of managerial practices that signal both a concern with cost and less caring approach to patient care served to deepen societal conflict about hospitals' role?
agement technique, the characteristics of the organization, the approach to implementation, and the interactions between these factors. At the same time, stories about difficulties or failures could provide equal opportunities for learning because they, too, offer insights into the assumptions underlying a practice, organizational features that were in harmony or conflict with those assumptions, and the management techniques that supported or hindered implementation. If such negative experiences were valued together with the success stories, and if empirical research investigated the claims made for business practices in health care, the overall understanding of management work in the health care sector would be greatly improved.

We suggest that a focus on these topics will move us out of the one way street in which management knowledge and expertise flow in only one direction into an arena where it can flow in all directions.

REFERENCES

30. Cerne, P. "Tampa, Florida: Battles are Won and Lost as Managed Care Gradually Moves In." Hospitals & Health Networks 68, (October 20, 1994): 82-83.