Exhibit 1–2: ♦ Major Health Care Cost and Control Events

Year	Health Care Cost and Control Events	Major Concern
1906	Pure Food and Drug Act passed	Quality of Care
1910	Managed care born in Tacoma, Washington when two physicians contract to provide medical care to a lumber company	Access to Care, Cost of Care
1910	First group health insurance policy is issued covering Montgomery Ward retail employees	Access to Care, Cost of Care
1910	Abraham Flexner publishes *Medical Education in the United States and Canada* setting standards for medical schools	Quality of Care
1913	The American College of Surgeons is founded and creates minimum standards for hospitals	Quality of Care
1918	The American College of Surgeons begins hospital inspections – only 89 of 692 inspected met minimum standards	Quality of Care
1921	Federal Veterans' Bureau (now the Department of Veterans Affairs) is created	Access to Care
1929	First Blue Cross plan is formed by 1,250 teachers in Dallas for hospital care from Baylor Hospital	Access to Care, Cost of Care
1932	Not-for-profit Blue Cross and Blue Shield organizations begin offering group health insurance	Access to Care, Cost of Care
1933	The organization to become Kaiser Permanente is created based on prepayment of medical insurance per covered life	Cost of Care
1935	Social Security Act passed	Access to Care
1943	IRS rules that employer contributions to group health insurance premium are not taxable to employees	Access to Care, Cost of Care
1945	Kaiser Permanente HMO is opened to public enrollment	Cost of Care
1946	Centers for Disease Control (CDC) is created	Quality of Care
1946	The Hill-Burton Act passes, creating public-backed financing for hospital construction	Access to Care
1951	The Joint Commission on Accreditation of Hospitals is formed	Quality of Care
1954	Disability benefits are included in Social Security Coverage	Access to Care
1963–1969	During the Johnson administration Congress enacts 51 pieces of health care legislation	Cost and Quality of Care, Access to Care
1964	Surgeon General releases landmark report on dangers of smoking	Quality of Care
1965	Medicare and Medicaid programs enacted to provide health care for elderly and low-income Americans	Access to Care
1970s	State legislatures enact certificate of need (CON) legislation	Access to Care, Cost of Care
1972	Senate creates peer standards review organizations	Cost of Care, Quality of Care
1974	HMO Act designed to promote growth of health maintenance organizations takes effect	Cost of Care
1977	VHA established by 30 hospital CEOs – first national cooperative of not-for-profit health care organizations	Cost of Care
1979	"Healthy People" released, the Surgeon General's first report on health promotion and disease prevention	Quality of Care
1980	National health care spending as a portion of GDP is 8.9 percent	Cost and Quality of Care, Access to Care
1980	HMO enrollment at 9.1 million	Cost of Care
1982	Medicare risk-contract legislation enacted for HMOs	Cost of Care
1983	Prospective Payment System (PPS) based on diagnosis-related groups (DRGs) mandated for hospitals under Medicare	Cost of Care

Exhibit 1–2: ♦ (*cont'd*)

Year	Health Care Cost and Control Events	Major Concern
1989	"Stark I" legislation prohibits physician self-referrals for lab services	Cost of Care
1989	Medicare represent's 68 percent of physicians' income	Cost of Care
1989	Omnibus Budget Reconciliation Act reforms Medicare physician payment	Cost of Care
1990	National health care spending as a portion of GDP is 12.2 percent	Cost of Care
1990	Ryan White Act passes providing federal assistance for low-income AIDS patients and for AIDS testing and counseling	Access to Care
1991	National Committee for Quality Assurance begins accrediting managed care organizations	Quality of Care
1992	HCFA adopts resource-based relative value scale (RBRVS), which increases payments to primary care physicians and reduces payments to specialists	Quality of Care, Cost of Care
1992	Buyers Health Care Action Group, an employer purchasing group, forms in Minneapolis	Cost of Care
1993	Managed care enrollment exceeds 50 percent of those with job-based coverage	Cost of Care
1993	Oregon's Medicaid health care rationing "experiment" approved	Cost of Care
1993	Family and Medical Leave Act passed	Access to Care
1993	President Bill Clinton introduces American Health Security Act, a health-reform plan based on managed competition	Access to Care, Cost of Care
1994	Oregon passes Death with Dignity Act giving residents the right to obtain prescriptions for self-administered lethal medications from physicians	Quality of Care
1995	Blue Cross of Washington and Alaska becomes the first major insuror to reimburse for alternative medical treatments such as acupuncture and homeopathy	Cost of Care, Quality of Care
1995	Major federal crackdown on health care fraud begins	Cost of Care
1996	Health Insurance Portability and Accountability Act passes	Cost of Care, Access to Care
1997	An estimated 44 million Americans are uninsured	Access to Care
1997	Balanced Budget Act slashes Medicare budget by $115 billion over five years and authorizes Medicare + Choice to provide broader coverage options, includes CHIP (Children's Health Insurance Program)	Cost of Care, Access to Care
1998	First HMO malpractice lawsuit filed by a consumer under landmark Texas law	Quality of Care
1998	HMO enrollment at 78.8 million	Cost of Care
1998	PPO enrollment hits 90 million surpassing that of HMOs	Cost of Care
1999	Aetna Inc. purchases Prudential HealthCare giving it coverage of one in ten Americans	Managerial Efficiency
2002	Almost 50 percent of major teaching hospitals lose money because of Medicare cuts	Managerial Efficiency, Cost of Care
2006	Projected national health care spending as a portion of GDP to be 15.8 percent	Cost of Care, Quality of Care, Access to Care
2015	More than 150 million Americans are expected to be enrolled in HMOs	Cost of Care

Source: ♦ VHA, Inc. and Deloitte & Touche, *Health Care 2000: A Strategic Assessment of the Health Care Environment in the United States* (Irving, Tex. and Detroit, Mich.: VHA and Deloitte & Touche, 2000), pp. 2–11.

Exhibit 1–3: ♦ Strategy Formation Schools of Thought

School of Thought	Basic Process	Brief Description
Design School	A conceptual process, simple, judgmental, deliberate (prescriptive)	Strategy formation as a process of informal design, essentially one of conception, process of fitting the organization to its environment
Planning School	A formal process, staged, deliberate (prescriptive)	Formalized the design approach, describing strategy as a more detached, sequential, and systematic process of formal planning
Positioning School	An analytical, systematic process, deliberate (prescriptive)	Focuses on the selection of strategic positions considered generically, emphasizes the content of strategy, selection of the optimal strategy
Entrepreneurial School	A visionary process, intuitive, largely deliberate (descriptive)	Strategy is associated with the vision of single leader, focuses on personal intuition, judgment, wisdom, experience, insight
Cognitive School	A mental process, overwhelming (descriptive)	Strategy is viewed as a cognitive process of concept attainment, an understanding of the strategist's mind, how individuals handle information to develop strategies
Learning School	An emergent process, informal, messy (descriptive)	The world is too complex to develop clear plans or visions, hence strategies must emerge in small steps or stages, strategy is a process of doing and learning
Political School	A power process, conflictive, aggressive, messy, emergent (descriptive)	Strategy is a process of exploiting power within organizations and by organizations with regard to their external environment
Cultural School	An ideological process, constrained, collective, deliberate (descriptive)	Strategy is rooted in the culture of the organization and thereby depicts it as collective, cooperative, and based on the beliefs shared by the members of the organization
Environmental School	A passive process, emergent (descriptive)	Strategy formation is a passive process and power over it rests not in the organization but the force in the environment
Configurational School	An episodic process, integrative, sequenced (descriptive)	Strategy is composed of behavioral typologies, stages, episodes, or cycles

Source: ♦ From Henry Mintzberg, "Strategy Formation Schools of Thought," in *Perspectives on Strategic Management*, James W. Frederickson ed., pp. 105–197.

Exhibit 1–4: ♦ Thinking Map of the Strategic Management Process in Health Care Organizations

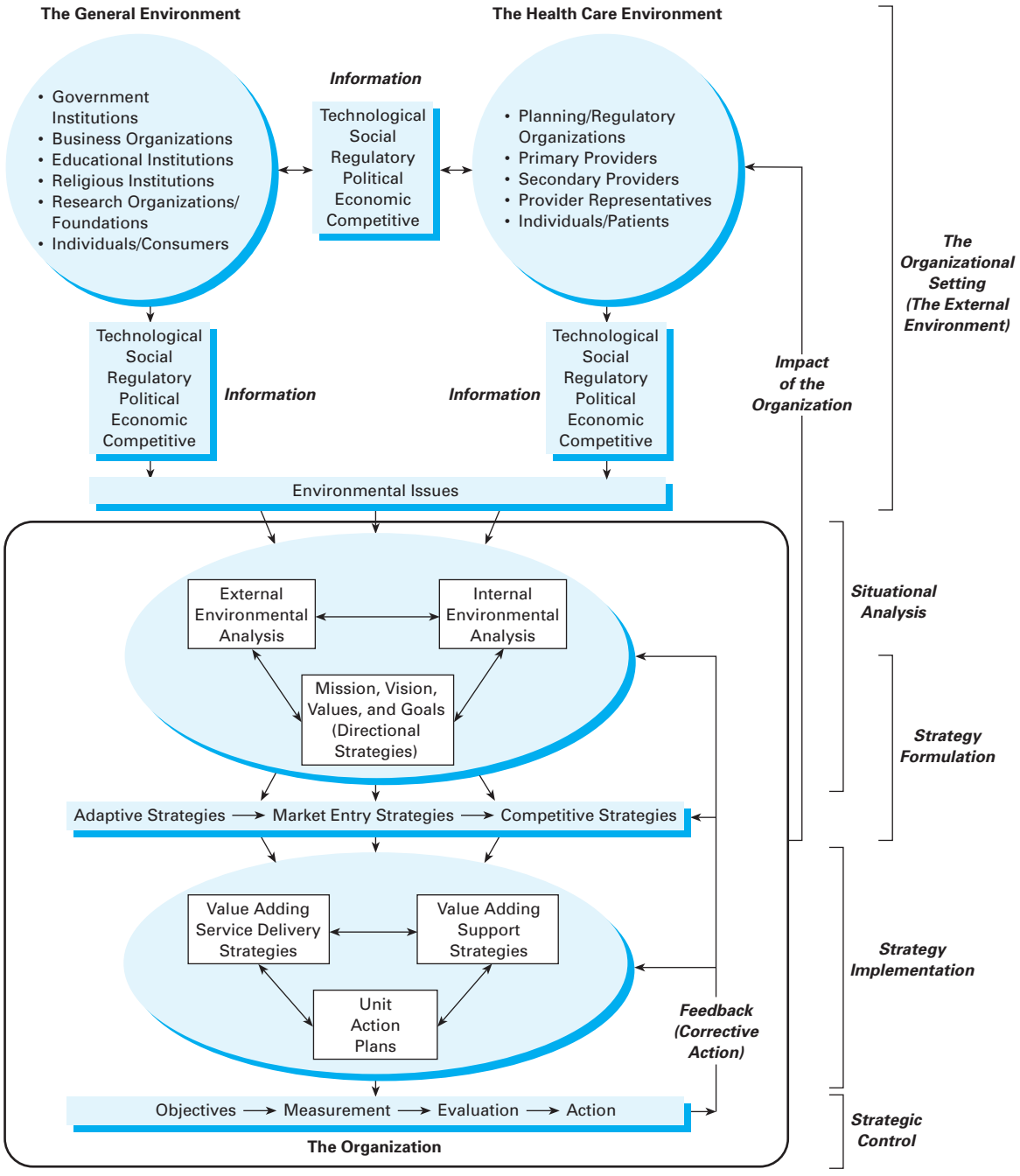
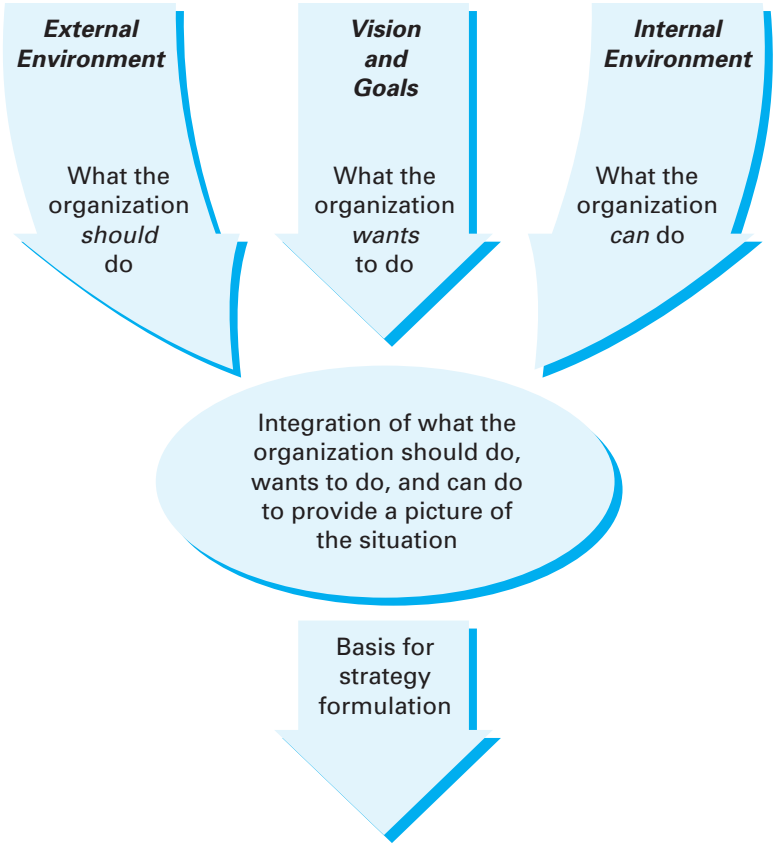
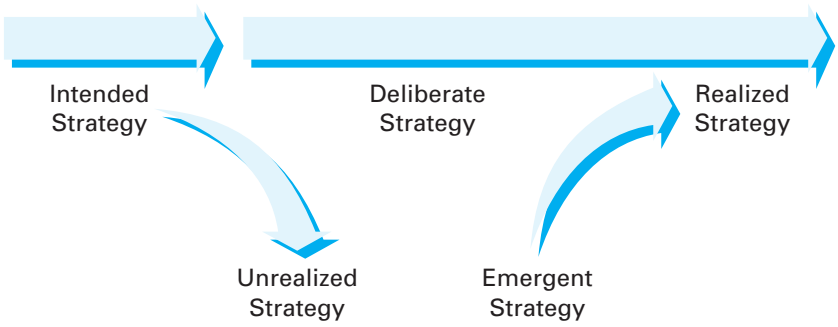


Exhibit 1–5: ♦ Analyzing and Understanding the Situation



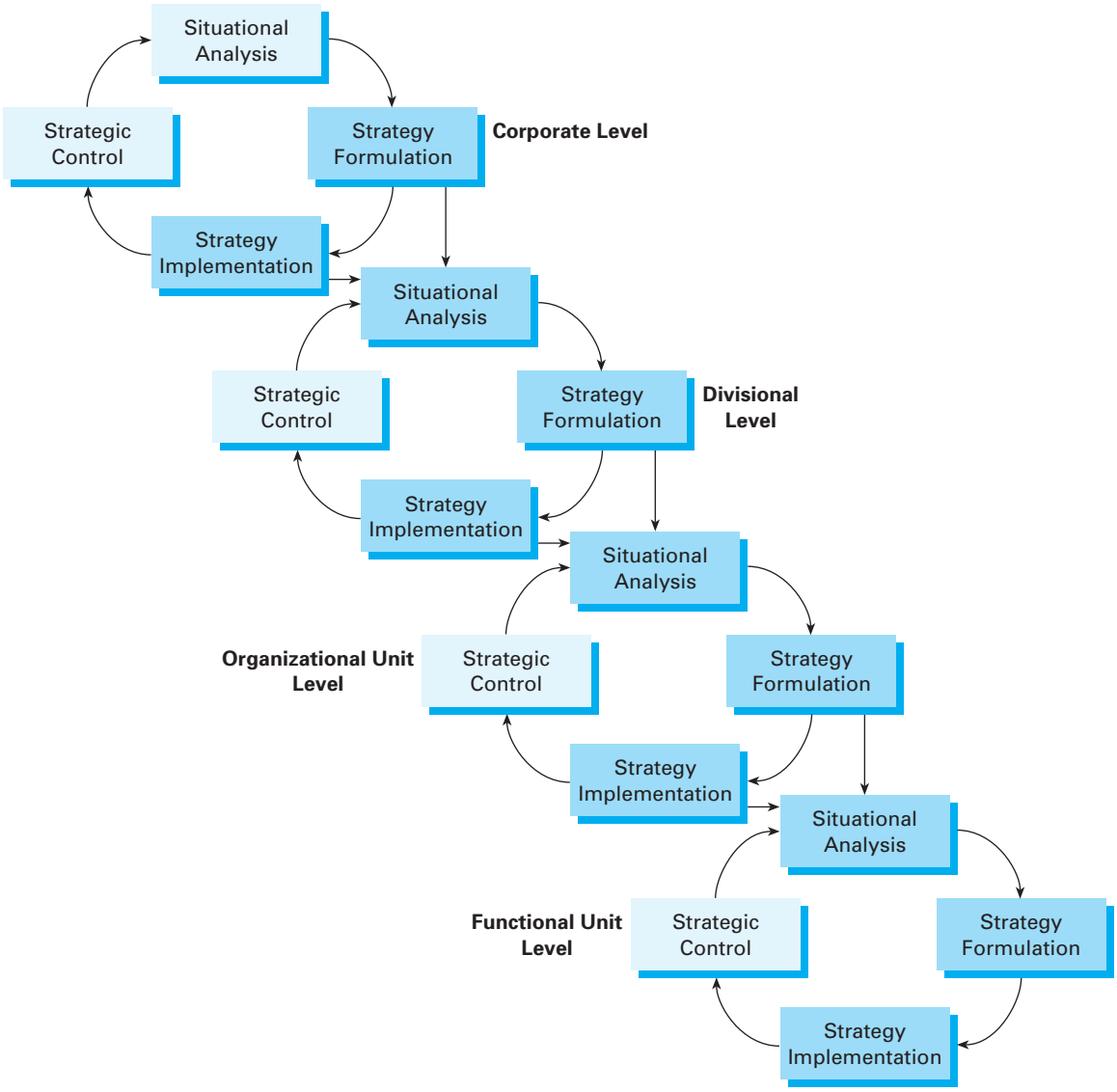
Source: ♦ Adapted from Fred Luthans, Richard M. Hodgetts, and Kenneth R. Thompson, *Social Issues in Business: Strategic and Public Policy Perspectives*, 6th edn. © 1990, p. 13. Adapted by permission of Prentice-Hall, Inc., Upper Saddle River, NJ.

Exhibit 1–6: ♦ Intended Versus Realized Strategy



Source: ♦ Henry Mintzberg, "Patterns in Strategy Formation," *Management Science* 24, no. 9 (1978), p. 934.

Exhibit 1–7: ♦ The Link Between Levels of Strategic Management



Source: ♦ Peter Lorange, *Corporate Planning: An Executive Viewpoint*, p. 61. © 1980. Adapted by permission of Prentice-Hall, Inc., Upper Saddle River, NJ.

Exhibit 2–1: ♦ The External Environment of a Health Care Organization

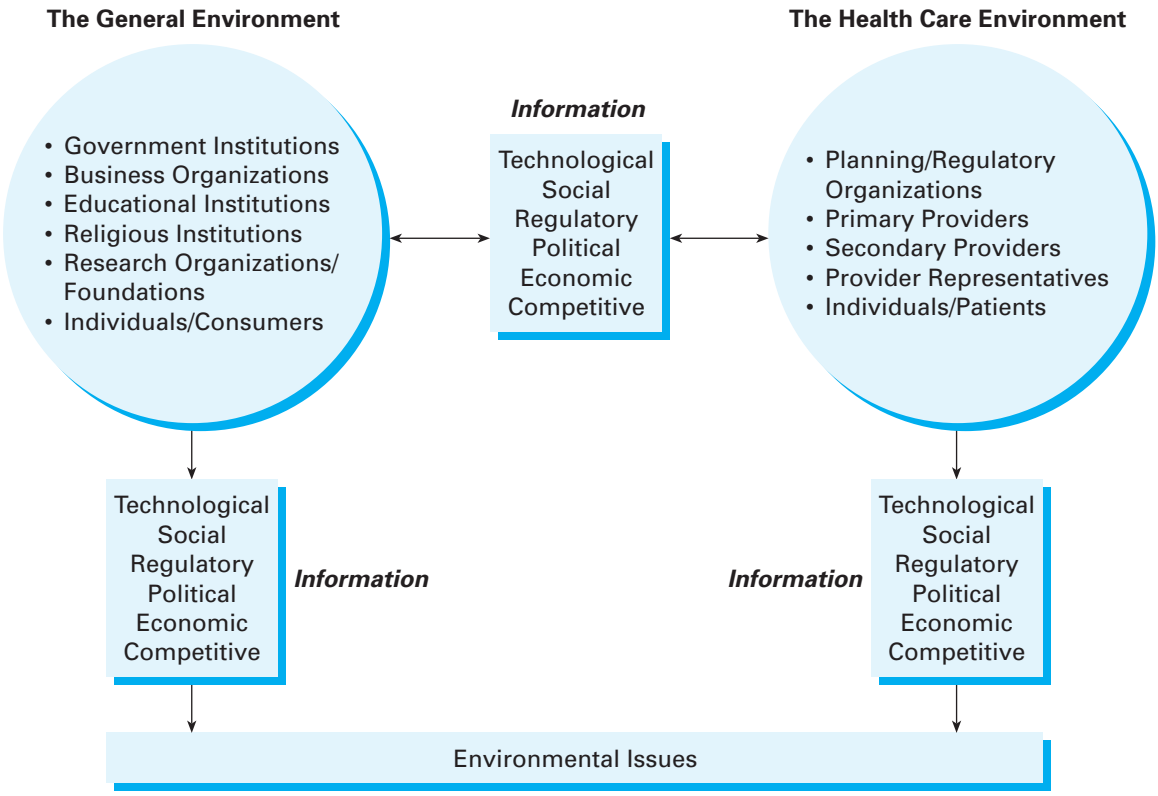


Exhibit 2–2: ♦ Organizations in the Health Care Environment

Organizations that Regulate Primary and Secondary Providers

- Federal regulating agencies
  Department of Health and Human Services (DHHS)
  Center for Medicare and Medicaid Services (CMS)
- State regulating agencies
  Public Health Department
  State Health Planning Agency (e.g., Certificate of Need [CON])
- Voluntary regulating groups
  Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
- Other accrediting agencies (ACEHSA, CEPH)

Primary Providers (Organizations that Provide Health Services)

- Hospitals
  Voluntary (e.g., Barnes/Jewish/Christian Health System)
  Governmental (e.g., Veteran's Administration Hospitals)
  Investor-owned (e.g., HCA–The Healthcare Company, Tenet)
- State public health departments
- Long-term-care facilities
  Skilled nursing facilities (e.g., Beverly Enterprises, Mariner Post-Acute Network, ManorCare)
- Intermediate-care facilities
- HMOs and IPAs (e.g., Care America, Aetna Health Care, United Healthcare)
- Ambulatory-care institutions (e.g., Ambulatory Care Centers, Ranchos Los Amigos Rehabilitation Center)
- Hospices (e.g., Hospice Care, Inc., Porter Hospice, Grace House of Minneapolis)
- Physicians' offices
- Home health care institutions (e.g., CareGivers Home Health, Arcadia Home Health Care, Visiting Nurses Association [VNA], Interim Home Care)

Secondary Providers (Organizations that Provide Resources)

- Educational institutions
  Medical schools (e.g., Johns Hopkins, University of Alabama at Birmingham [UAB])
  Schools of public health (e.g., The University of North Carolina at Chapel Hill, Harvard)
  Schools of nursing (Presbyterian School of Nursing)
  Health administration programs (University of Washington, The Ohio State University)
- Organizations that pay for care (third-party payors)
  Government (e.g., Medicaid, Medicare)
  Insurance companies (e.g., Prudential, Metropolitan)
  Businesses (e.g., Microsoft, Ford Motor Company)
  Social organizations (e.g., Shriners, Rotary Clubs)
- Pharmaceutical and medical supply companies
  Drug distributors (e.g., Bergen Brunswig, Walgreen, McKesson)
  Drug and research companies (e.g., Bristol Myers Squibb, Merck, Pfizer, Hoffman-LaRoche, Eli Lilly, Upjohn, Warner Lambert)
  Medical products companies (e.g., Johnson & Johnson, Baxter International, Abbott Labs, Bausch & Lomb)

Organizations that Represent Primary and Secondary Providers

- American Medical Association (AMA)
- American Hospital Association (AHA)
- State associations (e.g., Illinois Hospital Association, New York Medical Society)
- Professional associations (e.g., Pharmaceutical Manufacturers Association [PMA], American College of Healthcare Executives [ACHE], American College of Physician Executives [ACPE], Medical Group Management Association [MGMA])

Individuals and Patients (Consumers)

- Independent physicians
- Nurses
- Nonphysician professionals
- Nonprofessionals
- Patients and consumer groups

Source: ♦ Adapted from Beaufort B. Longest, Jr., *Management Practices for the Health Professional*, 4th edn (Norwalk, Conn.: Appleton & Lange 1990).

Exhibit 2–3: ♦ Strategic Thinking Map of the Environmental Analysis Process

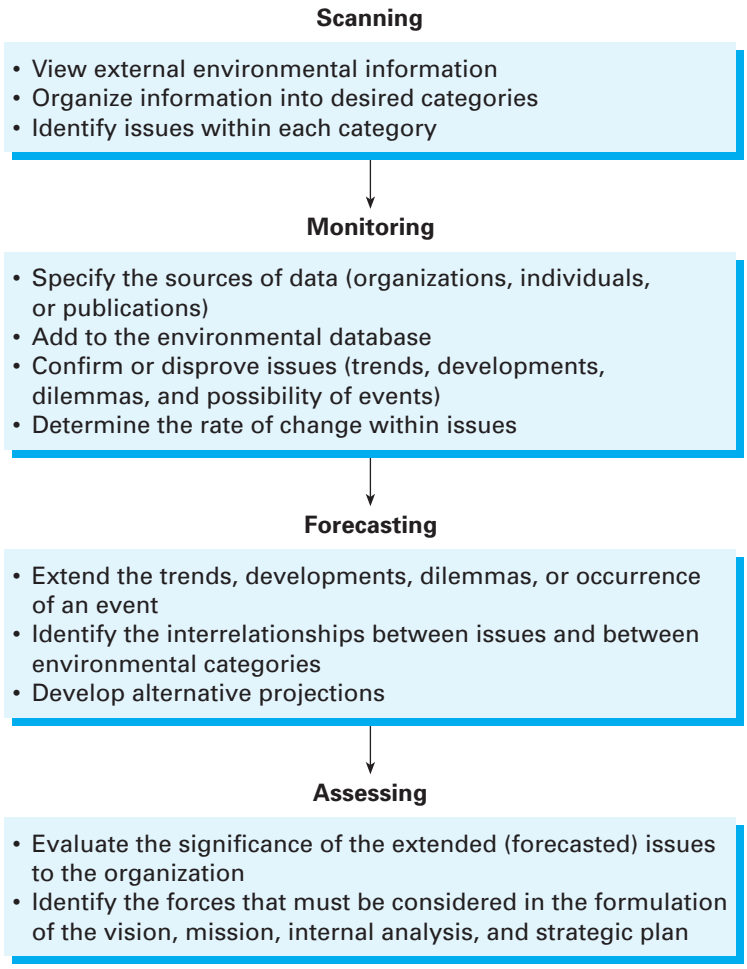
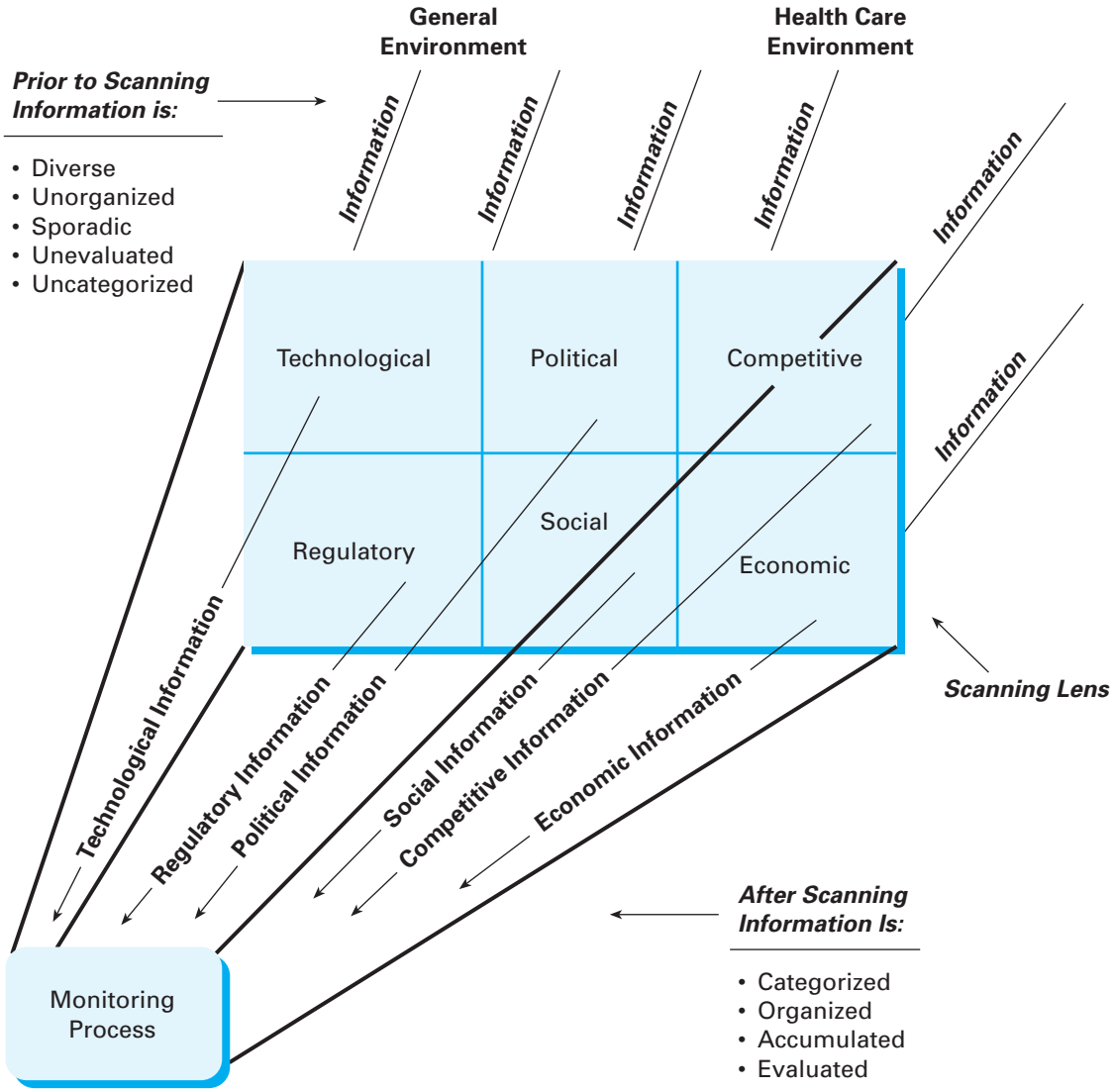


Exhibit 2–4: ♦ The Concept of Scanning the External Environment



Scanning As the Organization's Lens

The scanning process allows the organization to focus on technological, political, competitive, regulatory, social and economic issues, trends, dilemmas, and events important to the organization. The "viewing process" must sort diverse, unorganized information. This process also filters out information not relevant to the mission of the organization.

Exhibit 2–5: ♦ Information Sources

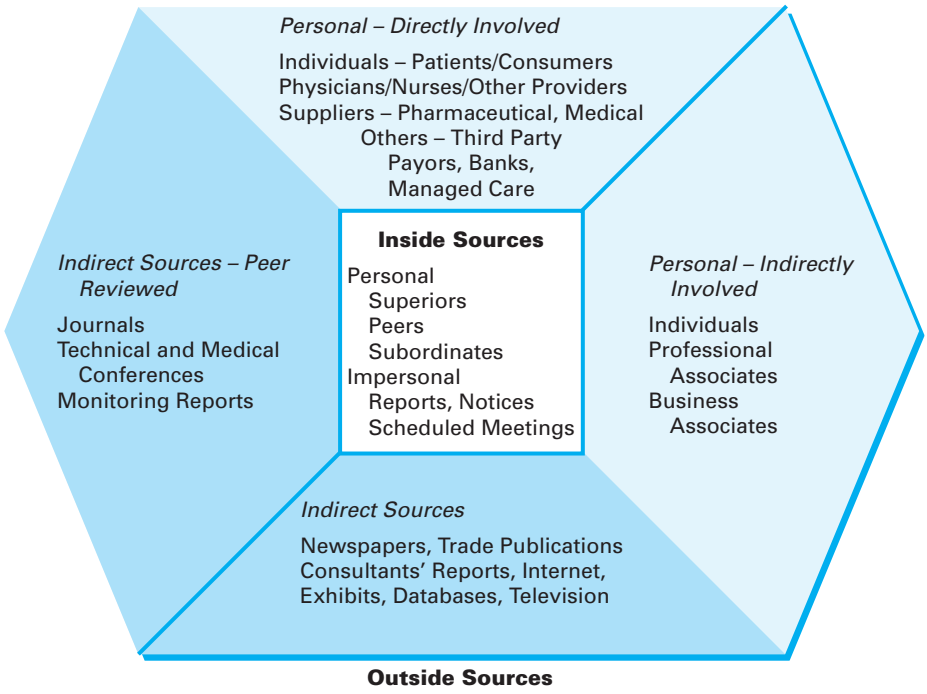


Exhibit 2–6: ♦ Trend/Issue Identification and Evaluation by Lake Villa Nursing Home

Trend/Issue	Opportunity/ Threat	Evidence	Impact on Our Organization (1–10)	Probability of Trend Continuing (1–10)
Aging Population	*Opportunity*	*1 in 5 Americans will be at least 65 by 2030*	*9*	*9*
Wealthier Elderly	*Opportunity*	*Income of those 60+ has increased 10% faster than any other group*	*7*	*6*
Local Competition	*Threat*	*Oven past 5 years, number of nursing homes in the service area has increased from 5 to 7*	*7*	*9*

10 = High probability of occurring
1 = Low probability of occurring

Exhibit 2–7: ♦ Environmental Trends/Issues Plot

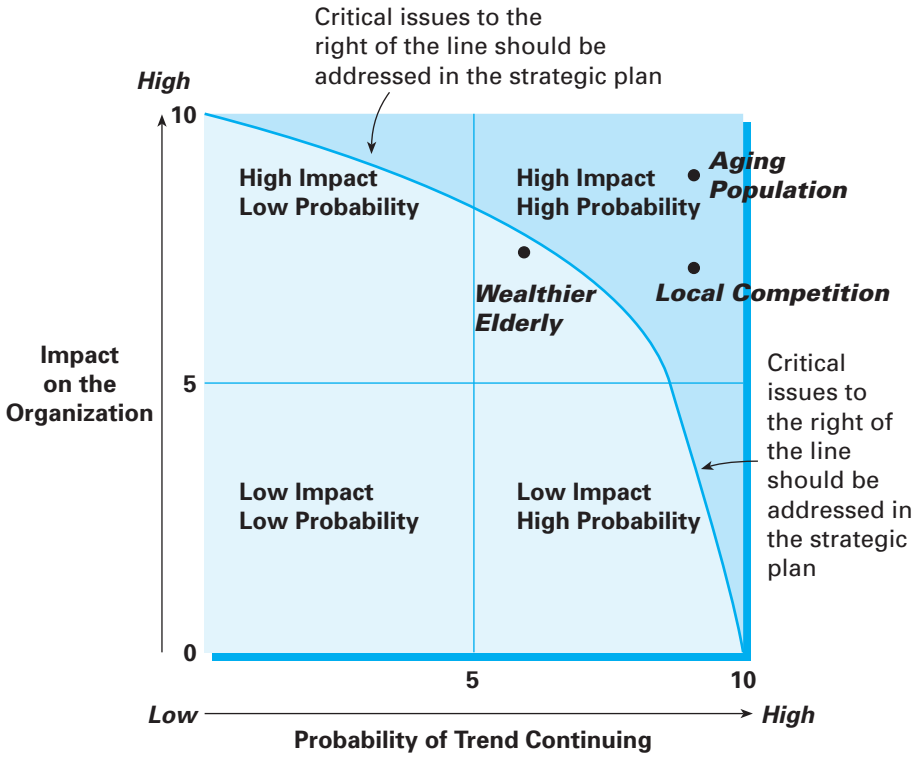


Exhibit 2–8: ♦ A Stakeholder Map for a Large Multispecialty Group Practice

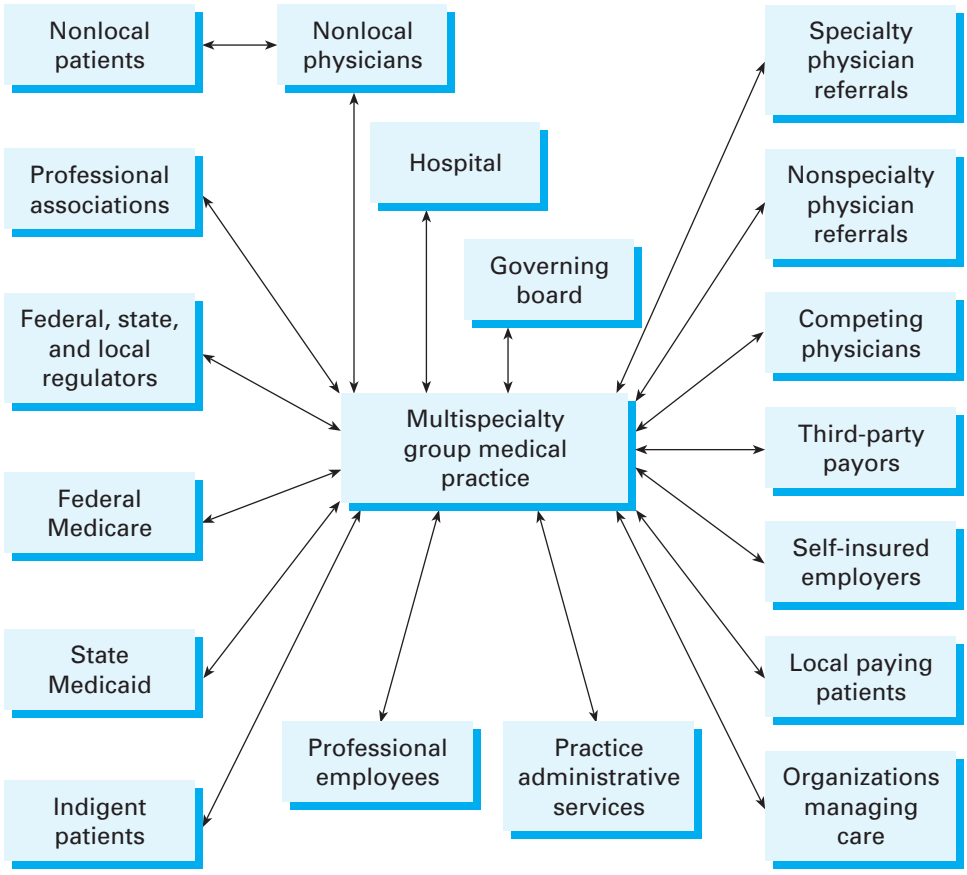


Exhibit 2–9: ♦ Three Future Health Care Scenarios

Scenario One: **Stormy Weather**
None of the fundamental problems of cost, quality, or access are resolved by 2005. Between 2005 and 2010, managed care fails to deliver reduced costs or push quality resulting in a backlash by consumers and providers. Legislation is enacted to negate the authority of managed care. Medicare cherry-picking by risk insurance plans leaves the sickest patients to be covered by conventional indemnity plans. A few major provider groups emerge; physicians and hospitals fear leaving their group. In a tight labor market, large employers continue to offer health benefits to employees; smaller employers are less able to pay for the increased costs. Health care spending reaches 19 percent of GDP and 22 percent of the population is uninsured. New technology continues to offer improved, less invasive alternatives and is demanded by baby boomers – a knowledgeable group that expects to participate in their own health care decisions. No social consensus develops to limit end-of-life care. Information technologies require huge investment but lead to disappointing results in terms of cost savings. The public health sector minimally meets its mandated functions. People worry about losing health benefits and most are unhappy with the increased out-of-pocket costs. Medicaid strains state budgets; Medicare strains the federal budget – especially as early boomers begin to access the system in 2010. Health care reform is in the forefront of public policy once again.

Scenario Two: **Long and Winding Road**
Large employers maintain price pressure on health plans and require greater contribution by employees. The increased out-of-pocket costs cause employees to reduce their use of health care services. Health plans tighten control through closed networks that pressure providers for clinical price controls. Providers attempt to resist the insurance "hassles" with very limited success. The 1998 federal budget bill includes Medicare and Medicaid cost containment as it does each year following. The public health system continues to compete with the private sector on health service delivery. Health care costs reach 16 percent of GDP and 16 percent of the population is uninsured. The system remains tiered with 20 percent in public coverage or uninsured, 60 percent in restrictive managed care, and 20 percent in high-end, indemnity insurance programs. Cost-based reimbursement is curtailed; large integrated providers have not materialized. Physicians tend to practice in small groups (although there are no solo practices). Comprehensive health care reform does not rise to the top of the public policy agenda because the system is managing to "muddle on through . . ."

Scenario Three: **Sunny Side of the Street**
Competition drives excess capacity from the system and providers and patients work together to improve health. Newly trained physicians have lowered income expectations. Providers with best practices survive; consolidation occurs and excess capacity (especially hospital beds) is eliminated. Prospective payment covers all outpatient services. Clinical information systems improve care processes and outcomes. The electronic patient record becomes a reality. Technology focuses on improved outcomes and reduced costs. Therapy trade-off can be made based on cost-effectiveness. Public health will engage in public–private partnerships and will focus on assessment, development of policy, and assurance. Health care costs are 15 percent of GDP, and 10 percent of the population is uninsured. The systems are in place to minimize unnecessary variations in health care practices, operate efficiently, track outcomes to lead to further improvements, and handle the aging of baby boomers. Insurors are rewarded for improving the health of a population and focusing on long-term health care decisions.

Source: ♦ Institute for the Future, *Health and Health Care 2010: The Forecast, The Challenge* (San Francisco: Jossey-Bass Publishers, 2000), pp. 10–14.

Exhibit 2–10: ♦ Primary Focus, Advantages, and Disadvantages of Environmental Techniques

Technique	Primary Focus	Advantage	Disadvantage
Simple Trend Identification and Extension	Scanning Monitoring Forecasting Assessing	• Simple • Logical • Easy to communicate	• Need a good deal of data in order to extend trend • Limited to existing trends • May not foster creative thinking
Delphi Technique	Scanning Monitoring Forecasting Assessing	• Use of field experts • Avoids intimidation problems • Eliminates management's biases	• Members are physically dispersed • No direct interaction of participants • May take a long time to complete
Nominal Group Technique	Scanning Monitoring Forecasting Assessing	• Everyone has equal status and power • Wide participation • Ensures representation • Eliminates management's biases	• Structure may limit creativity • Time consuming
Brainstorming	Forecasting Assessing	• Fosters creativity • Develops many ideas, alternatives • Encourages communication	• No process for making decisions • Sometimes gets off track
Focus Groups	Forecasting Assessing	• Uses experts • Management/expert interaction • New view points	• Finding experts • No specific structure for reaching conclusions
Dialectic Inquiry	Forecasting Assessing	• Surfaces many subissues and factors • Conclusions are reached on issues • Based on analysis	• Does not provide a set of procedures for deciding what is important • Considers only a single issue at a time • Time consuming
Stakeholder Analysis	Scanning Monitoring	• Considers major independent groups and individuals • Ensures major needs and wants of outside organizations are taken into account	• Emerging issues generated by other organizations may not be considered • Does not consider the broader issues of the general environment
Scenario Writing	Forecasting Assessing	• Portrays alternative futures • Considers interrelated external variables • Gives a complete picture of the future	• Requires generous assumptions • Always a question as to what to include • Difficult to write

Exhibit 3–1: ♦ Service Area Competitor Analysis

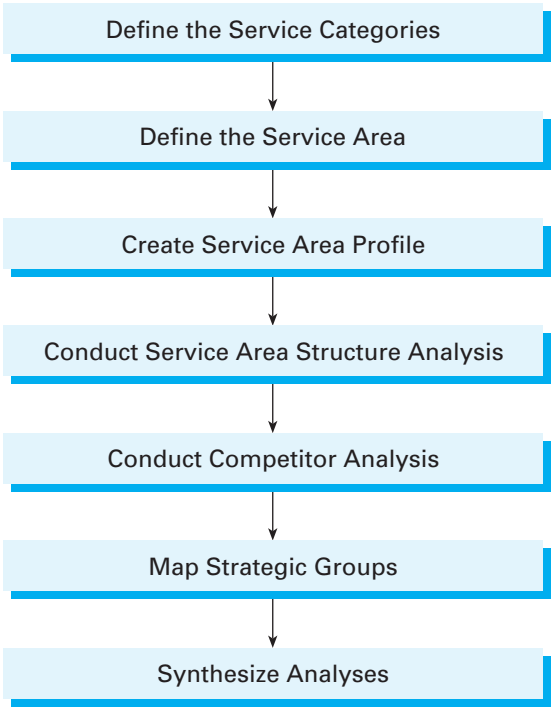


Exhibit 3–2: ♦ Service Area Determinants

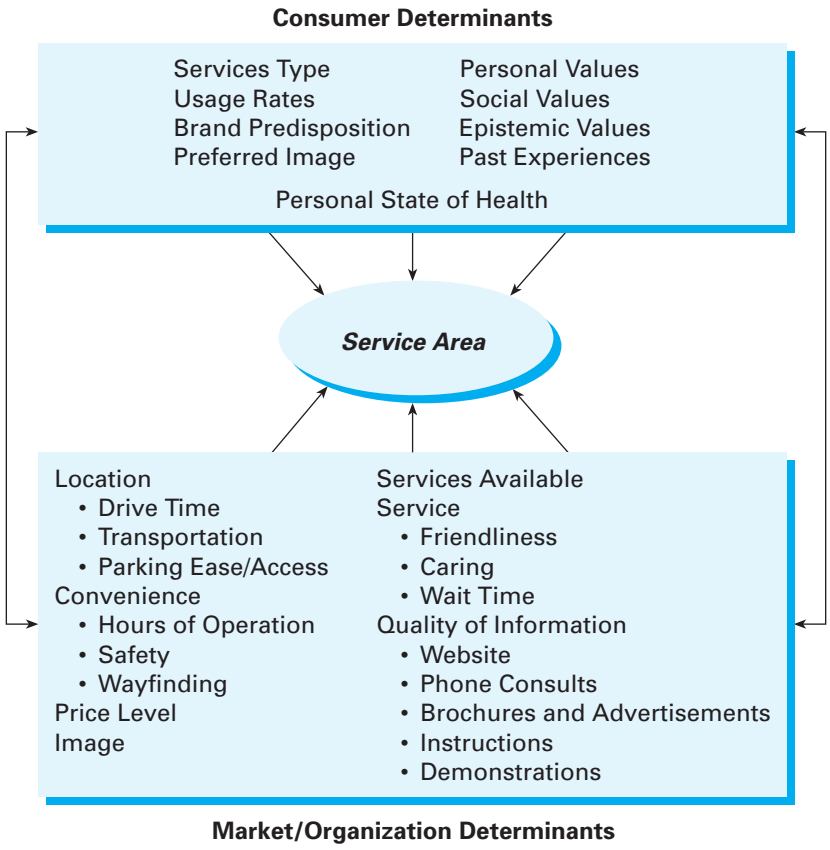


Exhibit 3–3: ♦ Service Area Profile Variables

Economic
- Income Distribution
- Foundation of Economy
- Major Employers
- Types of Businesses
- Growth Rate
- Seasonality
- Unemployment

Demographic
- Age Profile
- Sex
- Average Income
- Race Distribution
- Marital Status
- Education Level
- Religious Affiliation
- Population Mobility
- Stage in Family Life Cycle
- Occupational Mix
- Residence Locations

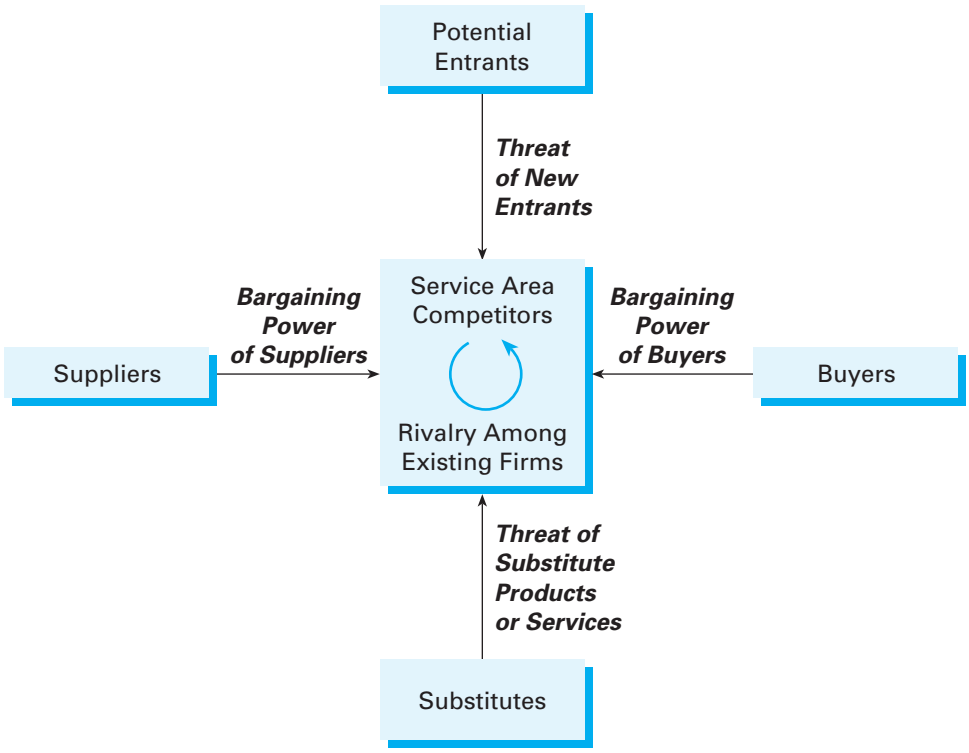
Psychographic
- Medical Conservatives
- Medical Innovators
- Medical Dependent
- Personal Health Controllers
- Youthfulness
- Sociability

Health Status Indicators
- Mortality
- Deaths from all causes per 100,000 population
- Motor vehicle crash deaths per 100,000 population
- Suicides per 100,000 population
- Female breast cancer deaths per 100,000 population
- Stroke deaths per 100,000 population
- Cardiovascular deaths per 100,000 population
- Work-related injury deaths per 100,000 population
- Lung cancer deaths per 100,000 population
- Heart disease deaths per 100,000 population
- Homicides per 100,000 population
- Infant deaths per 1,000 live births

Notifiable Disease Incidence
- AIDS incidence per 100,000 population
- Tuberculosis incidence per 100,000 population
- Measles incidence per 100,000 population
- STD incidence per 100,000 population

Risk Indicators
- Percentage of live-born infants weighing under 2,500 g at birth
- Births to adolescents as a percentage of live births
- Percentage of mothers delivering infants who received no prenatal care in first trimester of pregnancy
- Percentage of children under 15 years of age living in families at or below the poverty level
- Percentage of children under 15 years of age without all childhood inoculations
- Percentage of women over 50 without a mammogram
- Percentage of population more than 50 pounds overweight
- Percentage of persons living in areas exceeding the US EPA air quality standards
- Percentage of persons who do not wear seatbelts

Exhibit 3–4: ♦ Service Area Structural Analysis: Forces Driving Service Area Competition



Source: ♦ Michael E. Porter, *Competitive Strategy: Techniques for Analyzing Industries and Competitors*. Copyright © 1980. Adapted with the permission of The Free Press, a division of Simon & Schuster.

Exhibit 3–5: ♦ Using Porter's Industry Structure Analysis

The Hanover House Nursing Home, a skilled-nursing facility, used differentiation as its major competitive advantage. In its early years, in a less regulated environment, the home was very profitable. As the facility began to age, and with increasingly stricter regulations for long-term care, profit margins began to deteriorate. The administrators of Hanover House used Porter's Industry Structure Analysis to better understand the forces in their external environment. The following is a summary of their analysis.

Threat of New Entrants

The supply of nursing homes and other long-term care facilities is currently limited because there is a moratorium on additional beds within the geographic area. Competition is based on process or quality. If the moratorium is lifted, it will remain costly to enter the market because it is highly regulated. The greatest threat as a new entrant (when the moratorium is lifted) will be hospitals attempting to compensate for decreasing occupancy rates. Switching costs are low for hospitals (the same bed can be used for acute care or long-term care). Access to the distribution channel is high as hospitals have many of the required resources, including access to nurses, familiarity with the regulations, and capability to enter quickly (by converting acute care beds to long-term care).

Intensity of Rivalry Among Existing Organizations

Although there is competition, the long-term care industry is not fiercely competitive. Hanover House has six competitors – Mary Lewis Convalescence Center, Hillhaven, Altamont Retirement Community, St. Martins in the Pines, Lake Villa, and Kirkwood – that have relatively stable market shares. Because the service has both quality and dollar value, there is the opportunity to differentiate, and switching costs are high for the consumer. It is a highly regulated area and, therefore, not a great deal of diversity among competitors is apparent. The long-term care industry is maturing but remains a rapid-growth industry driven by demographic and social trends (the graying of America and the deterioration of the extended family). The most significant factor creating rivalry is the high fixed assets, which make exit difficult and success important.

Threat of Substitute Products and Services

There are few substitute products for nursing home care. Home care is a substitute but an increasingly less available alternative because of the mobility and dissolution of the family unit. Other alternatives include nonskilled homes, retirement housing, and domiciliaries. Increased costs and DRGs have virtually eliminated hospitals as an alternative. On balance, substitutes do not appear to be a strong force in the nursing home industry.

Bargaining Power of Customers

The power of the customer in the industry is generally high. The major consumer, the government, purchases over 45 percent of nursing home care and regulates reimbursement procedures as well as the industry. Therefore, significant levels of information are available. In addition, for private-pay customers, the purchase represents a significant investment and comparison shopping is prevalent. Product differentiation tends to reduce buying power but relatively low switching costs and government involvement make nursing home care a buyers' market.

Bargaining Power of Suppliers

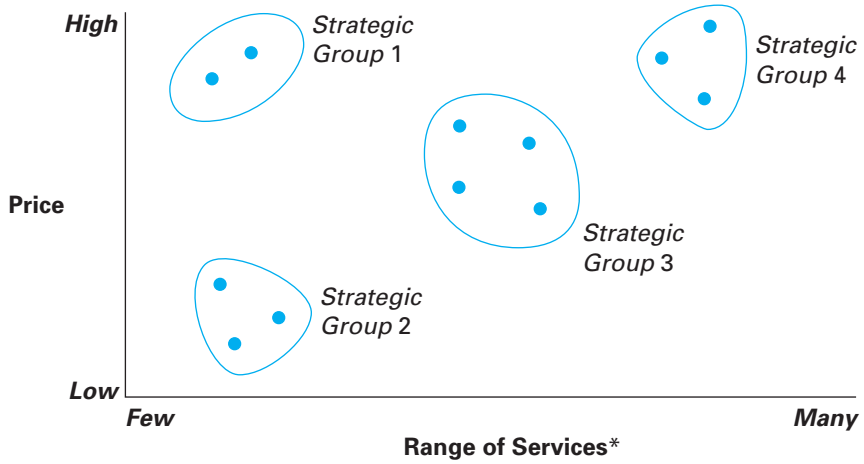
Because the product is simultaneously produced and consumed in service industries, labor is the major supplier in the nursing home industry. Although Hanover House is unionized, it has maintained good labor relations, and the union is not particularly powerful. Most who work in long-term care have selected the field to satisfy their need to care for others or make a contribution rather than to earn large salaries. Suppliers are not a dominant force in the nursing home industry.

Source: ♦ Elaine Asper, "Hanover House Nursing Home," an unpublished case study.

Exhibit 3–6: ♦ Potential Competitor Strengths and Weaknesses

Potential Strengths	Potential Weaknesses
• Distinctive competence	• Lack of clear strategic direction
• Financial resources	• Deteriorating competitive position
• Good competitive skills	• Obsolete facilities
• Positive image	• Subpar profitability
• Acknowledged market leader	• Lack of managerial depth and talent
• Well-conceived functional area strategies	• Missing key skills or competencies
• Achievement of economies of scale	• Poor track record in implementing strategies
• Insulated from strong competitive pressures	• Plagued with internal operating problems
• Proprietary technology	• Vulnerable to competitive pressures
• Cost advantages	• Falling behind in R&D
• Competitive advantages	• Too narrow a product/service line
• Product/service innovation abilities	• Weak market image
• Proven management	• Below-average marketing skills
• Ahead on experience curve	• Unable to finance needed changes in strategy
	• Higher overall costs relative to key competitors

Exhibit 3–7: ♦ Service Area Assisted Living Competitors



For this service area, assisted living organizations are pursuing four basic strategies: high price with highly specialized services (*Strategic Group* 1), low price with few ancillary services (*Strategic Group* 2), medium price with some (selected) services (*Strategic Group* 3), and high price with many services (*Strategic Group* 4). The primary (direct) competitors for these organizations are other organizations within their own strategic group. Customers who seek the attributes of one strategic group, such as highly specialized rehabilitation services, are unlikely to be attracted to another strategic group. These assisted-living organizations should change strategy cautiously as a decision to add services may move an organization to a new strategic group and therefore a new set of competitors. Note that in this example there may be an opportunity to enter or move toward a medium-cost, many services niche and become a strategic group of one.

*Range of services includes skilled nursing, organized social activities, outings, physical therapy, education, rehabilitation, speech therapy, Alzheimer's care, nutritional services, infusion, pharmacy, homemaker services, live-ins, companions, and so on.

Exhibit 3–8: ♦ Analysis of the Charlotte, North Carolina, Eye Care Market

Service Category Eye Care Services, Refractive Surgery
Service Area Charlotte, Mecklenburg County, North Carolina

	Competitively Relevant Issues	Comments
Service Area – General	• The largest city in either of the Carolinas, located on the border. The nearest city, Winston-Salem is more than 90 miles away.	Not much need to travel outside of Charlotte for health care, especially routine care
	• Many people come to Charlotte for their health care. People travel to Duke University for extraordinary care as there is no medical school in Charlotte.	
	• Insurance covers injury to the eye, diseases of the eye, and malfunctions of the eye, but does not typically cover correcting vision (although it can be covered)	Typically there are few employers that offer eye care insurance
	• Nearly 60 percent of all Americans need corrective lenses	60 percent in a growing market is an opportunity
	• Cataracts and glaucoma are eye diseases that occur with aging	Laser surgery has been used for cataracts
Service Area – Economic	• Median household income in Charlotte is $45,360 (compared to $35,350 in NC and $37,005 in US)	Charlotte has a population that can afford the procedure
	• Percentage below poverty at 9.7% is less than the state and nation (NC: 12.6%; US: 13.3%)	
	• Retail sales per capita $13,867 (NC $9,740 and US $9,190)	
	• Healthy economy, number of jobs increasing, very low unemployment (<3%)	Entrepreneurs are often innovators and early adopters
	• Identified as one of the top cities for entrepreneurs	
	• Nearly 80 percent of residents work in businesses of less than 100 employees	Big business tends to require the corporate "look"
Service Area – Demographic	• More than 500,000 people live within Charlotte's city limits; 648,000 in Mecklenburg County; 1.2 million in the Charlotte MSA	A growing population may mean there's more room for a new provider using LASIK surgery
	• Mecklenburg County has high population growth – 26.8% from 1990–99 (compared to 15.4% in NC and 9.6% in US)	A younger population is more likely to adopt the new surgery
	• Population over 65 at 9.1% is lower than the state and nation (12.5% in NC and 12.7% in US)	Better educated consumers are more likely to pay for the surgery
	• Population over 25 with college degree: 28.3%	
	• Ethnic mix is 67.8% white (NC: 73.3%; US: 71.9%), black 26.5% (NC: 22%; US: 12.8%), native American 0.4% (NC: 1.3%; US 0.9%), Asian 2.8% (NC: 1.4%; US 4.0%), Hispanic 2.7% (NC 2.3%; US 11.5%).	The black population has been slower to adopt the new surgery, but as more experience occurs, it presents an expanding market

Exhibit 3–8: ♦ (*cont'd*)

	Competitively Relevant Issues	Comments
Service Area – Psychographic	• Younger, upwardly mobile population, significant banking center for US, seeking world-class city status • Business-oriented community • Bible belt – 73% church or synagogue members • Youthful orientation • Outdoor activities at the beach or mountains; both in easy driving distance	Population wants to "look" successful and not be hindered by glasses or wearing contacts. Religious question: is surgery for cosmetic reasons the right thing to do? Outdoor activities are easier without having to keep up with glasses or search for a lost contact LASIK is generally surgery for lifestyle and cosmetic reasons
Service Area – Health Status	• Generally healthy population • Diabetes occurs more frequently in the South and contributes to problems with the eyes often leading to blindness	

Exhibit 3–9: ♦ Service Area Structure Analysis

Five Forces	Forces Driving Service Area Competition	Conclusion
Threat of New Entrants	• Existing providers have already climbed the learning curve – experience level is important in successful surgeries (need more than 500 performed to be "experienced") and established economies of scale • Capital requirements are high – the laser equipment costs more than $500,000, requires frequent and costly maintenance, and a $250/eye royalty fee • Barriers to entry – only ophthalmologists (MD degree) who have been trained on excimer laser equipment and have access to it can perform the procedure • Existing service differentiation – perceived differentiation (high image) for Christenbury Eye Center as the first provider of LASIK and he performs the most each month	**Low** Threat of new entrants into market is presently low primarily because of the existing providers' economies of scale and the high equipment costs. The threat may increase over time because there are few providers for the size of the population and equipment costs are likely to decrease
Intensity of Rivalry	• Seven fairly evenly balanced providers (including the two largest) have physicians that perform laser eye surgery • Capacity is augmented in large increments (laser costs more than $500,000) • Diverse competitors – competitors employ distinctly different strategies (also diverse personalities) • High strategic stakes – focusing primarily on refractive surgery increases risks (narrow product line) • High exit barriers – once the equipment commitment is made, it is difficult to alter strategy or move in new direction	**High** Rivalry is likely to remain intense in this market as the competitors are well balanced, strategic stakes are high, and it is difficult to exit the market
Threat of Substitutes	• Do not bother to correct vision that is less than 20/20 • Nonsurgical vision correction – contacts and glasses • Radial keratotomy (RK) – the oldest surgical method • Laser PRK – resculpts the surface of the cornea • In the future substitutes will likely be implantable lenses, LTK (laser thermokeratoplasty), CK (conductive keratoplasty), Custome LASIK – the new technologies are predicted to improve vision to 20/10	**High** Currently there are a number of low-cost substitutes and the number of substitutes is likely to increase
Bargaining Power of Customers	• Elective surgery – rarely covered by insurance and consumer can defer procedure to later time • Can obtain enough information to gain bargaining leverage – some customers are traveling to Canada where the procedure is as much as $1,200 per eye less expensive • Consumers can "shop" for price and service (low switching costs before procedure)	**High** Consumers have high bargaining power because of elective nature of the procedure. Consumers can opt for a much less expensive substitute, shop price or wait for prices to decline.
Bargaining Power of Suppliers	• Few suppliers of equipment – Visx manufactures the Visx Star that is used in 70 percent of all LASIK surgery; Summit Technologies manufactures the Apex Plus laser that is used in nearly 30 percent of LASIK procedures (Visx and Summit share the patent) • There are few equipment substitutes – in the near future several new players will introduce excimer lasers: Autonomus is developing LADARvision; Bausch & Lomb is developing Technolas 217A; Nidek (a Japanese firm) is introducing Nidek EC-5000 (none have FDA approval as of 2001) • Equipment is essential to the business	**High** Currently suppliers can keep prices for equipment high as there are few suppliers. New technologies and increased number of suppliers will likely reduce the power of suppliers in the near future.

Exhibit 3–10: ♦ Strengths and Weaknesses

Competitor	Strengths	Weaknesses
Christenbury Eye Center	• Personality and energy of Dr. Christenbury • First to do Lasik surgery in Charlotte • General manager who's responsible for strategic planning • Extensive marketing by a Marketing manager and Dr. Christenbury • Systematic marketing research • Longevity and loyalty of the 25-member staff • Number of procedures done per month: 300 all by Dr. Christenbury • Three satellite offices with five staff each • Cost based on severity of impairment from $1,800/eye to $2,000/eye, financing available • Ad agency that creates and places ads in TV, radio, direct mail, Yellow Pages, and Internet • Good information systems, budgeting and billing procedures • Locally owned	• Dr. Christenbury is a sole provider of the procedure • Clients feel "herded" to "keep the doctor on schedule" • So much advertising that it diminishes the image • Very fast-paced, sometimes stressful work environment • No discounts • Non-FDA approved equipment, although involved with FDA-approved clinical trials, each patient has to consent
LCA Vision Laser Center	• National organization, headquartered in Cincinnati, Ohio, 30 centers in US, Canada, and Finland • Four employees operate the Center, all area ophthalmologists are invited to use the facilities • All employees are cross-trained and can substitute for each other • Visx excimer laser used – FDA approved • Number of procedures is growing from 100/month to 200/month • LCA co-markets with local ophthalmologists • Cost $2,250/eye, one seminar attendee will be given a free procedure (drawn from a hat), financing available • Lifetime Continuous Care Program (no additional charges) • Good information systems, budgeting and billing procedures	• Less "local" orientation • Employees are consistently asked to work overtime • Markets Center to clients and ophthalmologists • Ophthalmologists generally have older patients • LCA does little marketing for the Center; rather it expects physicians to market themselves and use the Center • General manager often has to make appointments and handle phones • Scheduling of independent physicians to perform the procedure on their clients

Exhibit 3–10: ♦ (*cont'd*)

Competitor	Strengths	Weaknesses
TLC Laser Center	• National organization, headquartered in Canada, 48 centers in North America • Ten employees plus three staff ophthalmologists • Performs 160 procedures per month (from 60/month 18 months ago) • Advertises in radio, magazines, Yellow Pages, and Internet with personal calls on local optometrists • Customer satisfaction = 96% • Lifetime Commitment Program (no charge for additional procedures forever) • Developed a network of optometrists who refer to the Center (140 optometrists in the area; 88 in Charlotte) • Financing available, $250/eye discount if procedure can be watched by others, $100/eye discount if attended a seminar prior to surgery • Visx excimer laser used – FDA approved • Good information systems, budgeting and billing procedures	• Less "local" orientation • Marketing handled by corporate, with local coordinator • Near capacity at current location • Referrals are primarily from optometrists who will be responsible for follow-up and are owed $400/eye for referral • Cost is $2,400 per eye

Exhibit 3–11: ♦ Competitor Analysis – Mapping Competitors

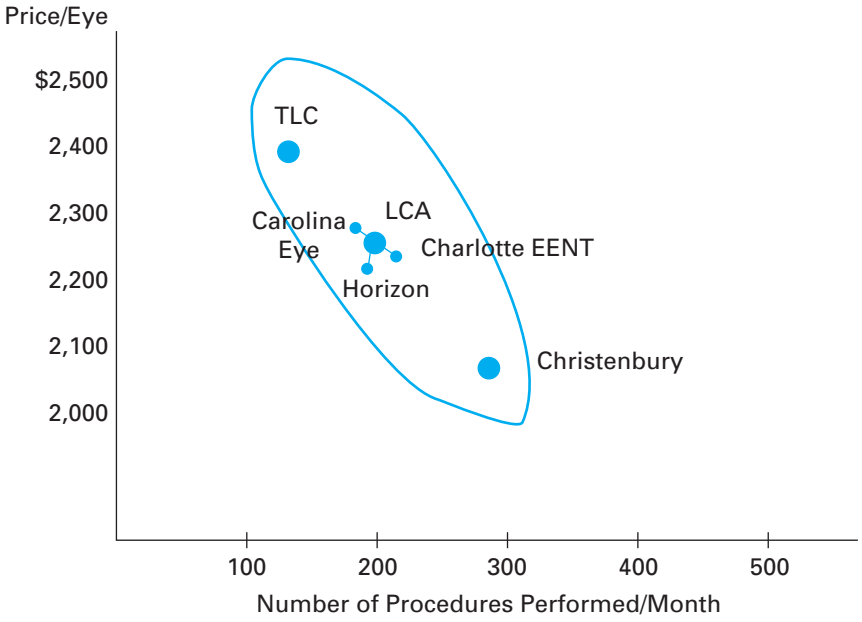
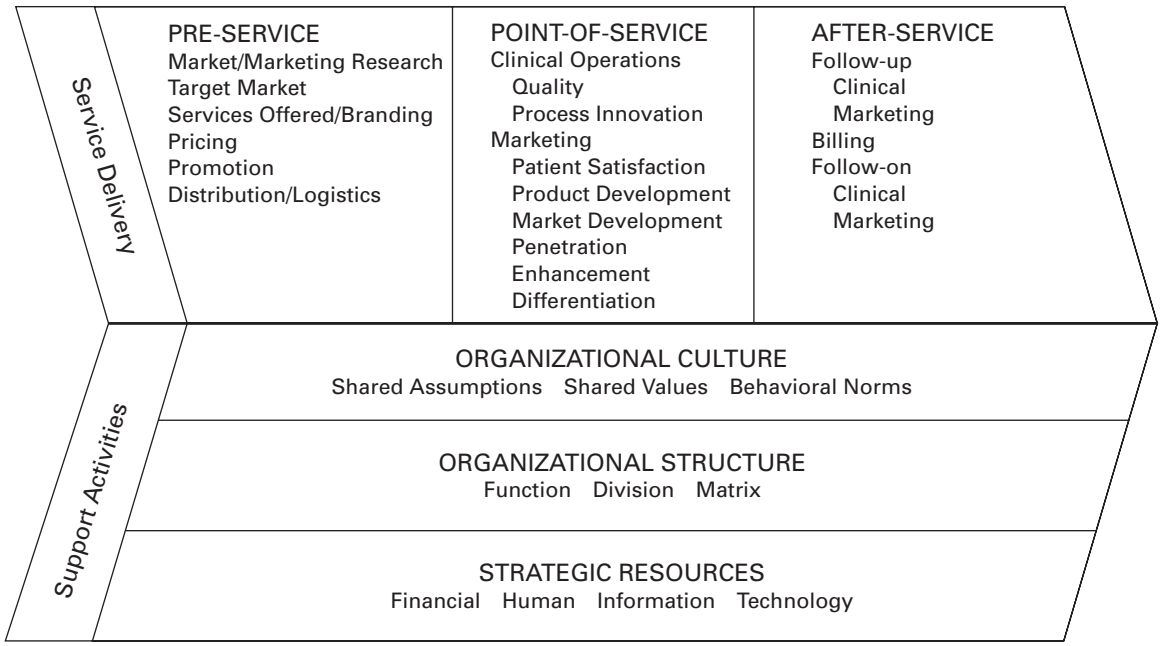


Exhibit 4–1: ♦ The Value Chain



Source: ♦ Adapted from Michael E. Porter, *Competitive Advantage: Creating and Sustaining Superior Performance* (New York: Free Press, 1985), p. 37.

Exhibit 4–3: ♦ Strategic Thinking Map for Discovering Competitive Advantages and Disadvantages

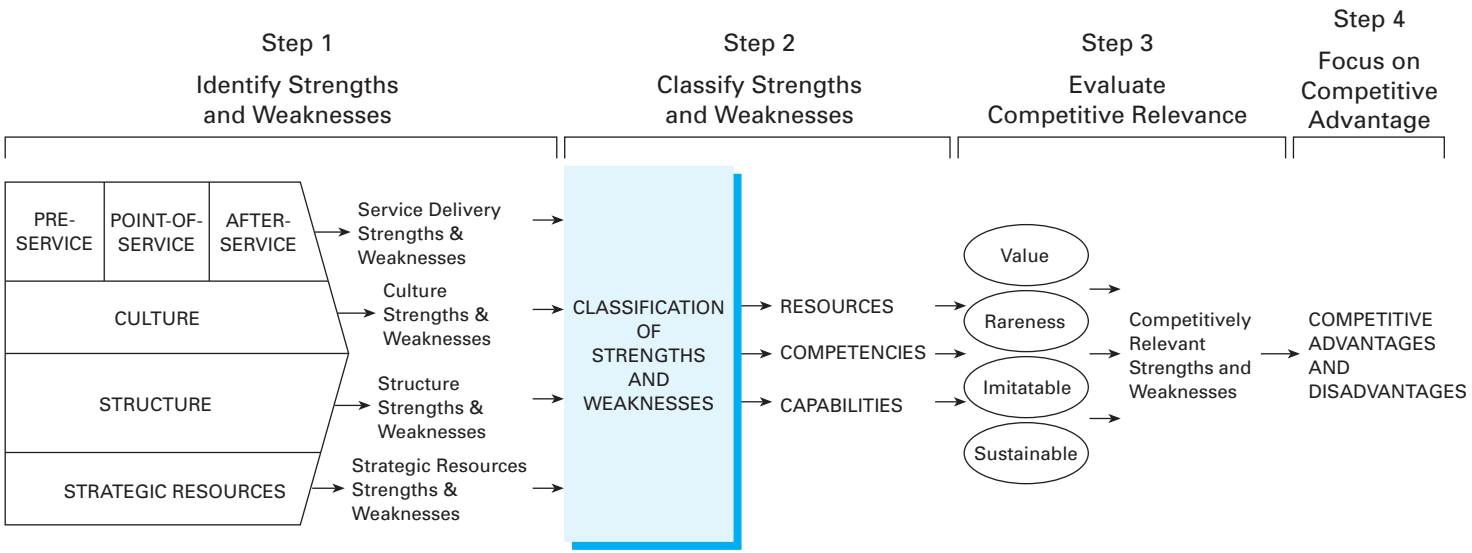


Exhibit 4–5: ♦ Evaluating the Competitive Relevance of Strengths

Strength	Type of Strength	Is the *Value* of the Strength High or Low? High/Low	Is the Strength *Rare*? Yes/No	Is the Strength Easy or Difficult to *Imitate*? Easy/Difficult	Can the Strength be *Sustained*? Yes/No
Service Delivery:					
Convenient clinics	Resource	H	N	E	Y
Adequate parking	Resource	H	N	E	Y
Accessible buildings	Resource	H	N	E	Y
Patient-oriented appointment system	Resource	H	N	E	Y
Patient-oriented providers	Competency	H	Y	D	Y
Accessible specialists and ancillary personnel	Resource	H	N	D	Y
Equivalently qualified staff on all shifts	Competency	H	N	E	Y
On-site pharmacy	Resource	H	N	E	Y
Assistance in validating parking	Competency	L	N	E	Y
Payment options effectively communicated	Competency	H	N	E	Y
Organizational Culture:					
"Can do attitude" by medical staff	Competency	H	Y	D	Y
Rewards based on performance	Capability	H	Y	D	Y
Informal team orientation	Capability	H	Y	D	Y
Organizational Structure:					
Cross-trained and multiple skilled staff	Competency	H	Y	D	Y
Decentralized decision making	Capability	H	N	E	Y
Well-understood two-way communication	Capability	H	N	E	Y
Strategic Resources:					
Balance in debt and equity financing	Capability	H	Y	D	Y
Integrated financial information system	Capability	H	N	E	Y
Creative and aggressive marketing staff	Competency	H	N	E	Y
Appropriately trained medical staff	Competency	H	N	E	Y
Adequate and appropriate facilities	Resource	H	N	E	Y
Contractual agreements with other providers	Capability	H	Y	D	Y
Modern, clean, and well-maintained facilities	Resource	H	N	E	Y
State-of-the art medical equipment	Resource	H	Y	D	Y

Exhibit 4–6: ♦ Strategic Thinking Map of Competitive Advantages Relative to Strengths in General

Is the *Value* of the Strength High or Low? High/Low?	**Is the Strength *Rare*? Yes/No**	**Is the Strength Easy or Difficult to *Imitate*? Easy/Difficult**	**Can the Strength Be *Sustained*? Yes/No**	**Implications**
H	N	E	Y	No competitive advantage. Most competitors have the strength and those that do not can develop it easily. All can sustain it. Maintenance strategy.
H	N	E	N	No competitive advantage. All competitors have the strength which is easy to develop. Strength is not sustainable so it represents only a short-term advantage.
H	N	D	Y	No competitive advantage. Many competitors possess the strength but it is difficult to develop, so care should be taken to maintain this strength.
H	N	D	N	No competitive advantage. Many competitors possess the strength but it is difficult to develop, and those who do possess it will not be able to sustain the strength. Only a short-term advantage.
H	Y	E	Y	Not a source of long-term competitive advantage. Because it is valuable and rare competitors will do what is necessary to develop this easy-to-imitate strength. Short-term advantage, should not base strategy on this type of strength but should obtain benefits of short-term advantage.
H	Y	E	N	Not a source of competitive advantage. The strength is easy to imitate and cannot be sustained. Short-term advantage. Do not base strategy on this type of strength but obtain benefits of short-term advantage.
H	Y	D	Y	Source of long-term competitive advantage. If value is very high may be worth "betting the organization" on this strength.
H	Y	D	N	Possible source of short-term competitive advantage but not a strength that can be sustained over the long run.

Exhibit 4–7: ♦ Evaluating the Competitive Relevance of Weaknesses

Weakness	Type of Weakness	Is this Characteristic of High or Low *Value*? High/Low	Is this Weakness *Common* (not rare) among Competitiors? Yes/No	Is it Difficult or Easy to *Correct* This Weakness? Easy/Difficult	Can Competitors Sustain Their *Advantage*? Yes/No
Service Delivery:					
Inadequate number of telephone lines at peak demand	Resource	H	Y	E	N
Poor signage and office directories	Resource	H	Y	E	N
Inadequate security at facilities	Resource	H	N	D	Y
Rude and inconsiderate receptionists	Competency	H	Y	E	N
Inadequate levels of staff to handle demand	Resource	H	Y	D	N
Cluttered examination rooms	Resource	H	N	E	Y
Lack of caring follow-up after receipt of services	Competency	H	Y	E	Y
Inadequate staffing of business office	Resource	H	Y	E	N
Complicated and confusing billing system	Capability	H	Y	E	N
Organizational Culture:					
Resistance to change by some personnel	Capability	H	Y	D	N
Reluctance to think of patients as customers	Capability	H	N	D	Y
Organizational Structure:					
Centralized business processes that slow down clinic operations	Capability	H	Y	E	Y
Centralization of purchasing	Capability	H	Y	E	Y
Lack of well-defined management succession plan	Capability	H	Y	D	Y
Strategic Resources:					
Lack of integration of clinical and administrative systems	Capability	H	Y	D	Y
Centralized human resources system	Capability	H	Y	E	Y
Financial office staff that is reluctant to share information	Capability	H	Y	E	Y
Clinic design that inhibits patient flow	Capability	H	N	D	Y
Inaccurate patient medical records	Capability	H	N	D	Y
Lack of online access to medical information	Resource	L	Y	D	Y

Exhibit 4–8: ♦ Strategic Thinking Map of Competitive Disadvantages Relative to Weaknesses

Is this Characteristic of High or Low *Value*? High/Low	**Is this Weakness *Common* (not rate) among Competitors? (Yes/No)**	**Is it Difficult or Easy to *Correct* This Weakness? Easy/ Difficult**	**Can Competitors Sustain Their *Advantage*? Yes/No**	**Implications**
H	Y	E	Y	No competitive disadvantage in short run. Weakness of our organization but others are also weak. Weakness is easy to correct. Competitors will work to correct weakness. If we fail to correct, competitors could achieve an advantage
H	Y	E	N	No competitive disadvantage. Weakness of our organization but also a weakness of competitors. Easy to correct weakness
H	Y	D	Y	No short-term competitive disadvantage. Competitors also possess the weakness, but it is a dangerous situation that must be addressed to ensure competitors do not overcome this difficulty and correct it first. Competitors' ability to sustain advantage could become long-term competitive disadvantage
H	Y	D	N	No competitive disadvantage. Weakness is common and is difficult to correct. Competitors cannot sustain any advantage represented by this weakness
H	N	E	Y	Short-term competitive disadvantage. Competitors are not weak in this area but the weakness is easy to correct. The organization should move quickly to correct this type of weakness
H	N	E	N	Not a competitive disadvantage. Competitors are not weak in this area but the weakness is easy to correct. Competitors cannot sustain any advantage provided by our weakness. Should correct even though any advantage will be short term
H	N	D	Y	Weakness represents a serious competitive disadvantage. The weakness is valuable, most competitors do not have it, it is difficult for us to correct, and competitors can sustain their advantage. Attention is demanded
H	N	D	N	A serious competitive disadvantage in the short term. Attention directed toward difficulty of overcoming weakness relative to the ability of competitors to retain the advantage

Exhibit 4–9: ♦ Strategic Implications of Competitively Relevant Strengths and Weaknesses

Competitively Relevant Strength or Weakness	Basis of Competitive Advantage or Disadvantage	Strategic Implication
Strengths:		
Competency – Patient oriented Providers	Uniqueness Driver	Relatively few health care organizations treat patients like customers
Competency – "Can Do" Attitude by Medical Staff	Uniqueness Driver	Willingness of staff to respond to patient needs creates pleasant environment
Capability – Rewards Based on Performance	Cost Driver	Pay for performance improves productivity
Capability – Informal Team-Orientation	Uniqueness Driver	Teamwork results in better service
Competency – Cross-Training and Multiple Skilled Staff	Cost Driver	Less specialization can lead to lower costs and higher job satisfaction
Capability – Balance in Debt and Equity	Cost Driver	Balanced financial structure reduces cost of capital
Resource – Contractual Agreements with Other Providers	Uniqueness Driver	Contractual agreements may increase efficiency of operations
Resource – State-of-the-Art Medical Equipment	Cost Driver	High-technology can contribute to improved medical care
Weaknesses:		
Competency – Reluctance to Think of Patients as Customers	Uniqueness Driver	People go elsewhere for care
Resource – Inadequate Security at Facilities	Uniqueness Driver	Patients avoid facilities where safety is in doubt
Resource – Clinic Design that Inhibits Patient Flow	Cost Driver	Poor clinic designs increase waiting time and promote inefficiency
Capability – Inaccurate Patient Medical Records	Cost Driver	Inaccurate records reduce and slow down reimbursements and cash flow

Exhibit 5–1: ♦ From Organizational Mission to Unit Objectives

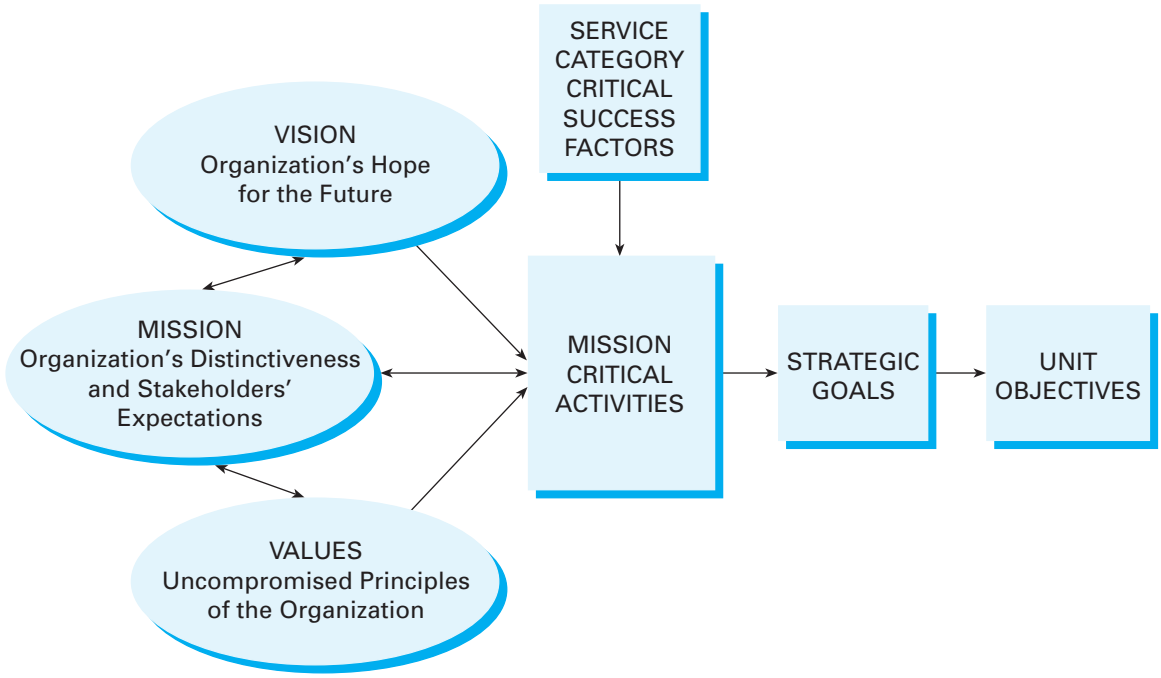


Exhibit 5–11: ♦ Strategic Thinking Map for Writing a Mission Statement

Component:	**Key Words Reflecting Component**		
1. Target customers and clients: "*The individuals and groups we attempt to serve are . . .*" Do not be limited to only the obvious.			
2. Principal services delivered: "*The specific services or range of services we will provide to our customers are . . .*"			
3. Geographical domain of the services delivered: "*The geographical boundaries within which we will deliver our services to our customers are . . .*"			
4. Specific *values*: "*Specific values that constitute our distinctiveness in the delivery of our services to customers are . . .*"			
5. Explicit philosophy: "*The explicit philosophy that makes us distinctive in our industry is . . .*"			
6. Other important aspects of distinctiveness: "*Any other factors that make us unique among competitors are . . .*"			

Exhibit 5–15: ♦ Strategic Thinking Map for Writing a Vision Statement

Component:	**Key Words Reflecting Component**		
1. Clear hope for the future: *"If everything went as we would like it to go, what would our organization look like five years from now? How would we be different/better than today?"*			
2. Challenging and about excellence: *"When stakeholders (patients, employees, owners) describe our organization, what terms would we like for them to use?"*			
3. Inspirational and emotional: *"When we think about the kind of organization we could be if we all contributed our best, what terms would describe our collective contributions?"*			
4. Empower employees first: *"How can we ensure that employees understand and are committed to the vision? What needs to be done to get everyone's buy in?"*			
5. Memorable and provides guidance: *"What types of words should be included to ensure all organizational members remember and behave in accordance with the vision?"*			