C A S E 5

Can This Relationship Be Saved? The Midwestern Medical Group's Integration Journey

OVERVIEW

Midwest Medical Group (MMG), one division of Midwestern Health System, has achieved a great deal and struggled to do so as the MMG managers attempted to integrate individual clinics within MMG and to integrate MMG's activities with other units in the Midwestern system. This case is part of a longitudinal study of organizational changes in MMG and its role in the Midwestern System. It is based on interviews with MMG managers and system-level leaders as well as observations of MMG management team meetings from 1994 to 2002.

MMG and Midwest managers experienced three recurring issues during the period from 1999 to 2002. First was the Midwestern accounting and transfer pricing system that made MMG appear (on paper) as a financial drain on the system. The second issue was a hospital-centric policy that did not allow MMG to hire specialists who might compete with specialists practicing in Midwestern hospitals. When MMG attempted to develop new specialist relationships, other Midwestern leaders demanded that MMG sever these new relationships and work with Midwestern hospital-affiliated specialists groups instead. The third issue was related to ambiguous and conflicting views of MMG's role in the Midwestern System. The Midwestern Health System had restructured several times during the past eight years. With each restructuring, repeated questions were raised about the value of MMG to Midwestern.

KEY ISSUES

1. Performance measurement systems – effects of financial accounting systems on organizational behavior.
2. Managing relationships in pluralistic organizations – challenges in managing multiple and often competing interests among organizational groups.
3. System-level vision and strategy – effects of ambiguous unit roles within a larger system.

TEACHING OBJECTIVES

After analyzing this case, students should be able to:

1. Understand how the MMG–Midwestern internal environment affected strategy implementation.
2. Understand the effect of control systems on unit action plans.

This teaching note was written by Rhonda Engleman and Jisun Yu under the supervision of Professor Andrew H. Van de Ven of the Carlson School of Management at the University of Minnesota. The case was prepared to promote class discussion and learning. It was not designed to illustrate either effective or ineffective management. Used with permission from Rhonda Engleman.

3. Identify underlying issues that lead to differences between an intended strategy and a realized strategy.
4. Determine the actions to be taken to address the three recurring issues in MMG's relationship with the other Midwestern units and to realize MMG's potential contribution to the Midwestern Health System value chain.

SUGGESTIONS FOR EFFECTIVE TEACHING

Because this case describes an organization undergoing major changes in strategies and structures at multiple levels, it is best used as a context for discussing strategic issues and challenges in managing mergers and acquisitions (M&A) as well as large-scale organizational change. Within this broad area of M&A and change, there are at least three specific topics for which the case can be especially useful. Those topics are: (1) internal environmental analysis, (2) the role of control system on unit action plans, and (3) differences between intended strategy and realized strategy.

This case may be used to demonstrate the importance of conducting an internal environmental analysis. The Midwestern Health System has assembled all of the pieces of the health care value chain – a health plan, primary care services, acute care facilities, and marketing systems. However, the support activities needed to tie the service delivery elements together are a source of weakness. The case illustrates the differences in cultural assumptions, values, and behavioral norms between MMG and other Midwestern units that have led to recurring conflict. Midwestern has struggled to find an appropriate organizational structure, creating ongoing confusion and ambiguity regarding unit roles. Midwestern and MMG leaders have continually debated the value of MMG to the system. At times, MMG is seen as a key strategic resource to the system. Yet, at other times, MMG is seen as a significant drain on the system's resources. These weaknesses in Midwestern's support activities have impeded the system's ability to integrate the activities of MMG and the other system units in a value chain that provides the organization a sustainable competitive advantage.

The case may be used to illustrate the effects of control systems on unit action plans in implementing strategy. The vision guiding Midwestern was to "offer an integrated health care system to affordably enhance the health of people living and working in communities we serve." MMG carried out the Midwestern vision initially through acquiring clinics to broaden geographic coverage. The system measured MMG's performance primarily through its financial results. These MMG acquisitions were costly and MMG's early financial performance was poor. Thus MMG shifted focus to develop management and control systems to improve the medical group's efficiency and reduce costs. Despite cost reduction efforts, MMG continued to bleed red ink. System leaders initiated several studies to understand the sources of MMG's financial problems. Despite results that showed MMG was performing as well as could be expected given system constraints on the group, system leaders continued to focus on the MMG bottom line in evaluating its performance. When MMG managers tried to overcome their financial losses by increasing revenues through expanding specialist services, system leaders intervened to cancel such initiatives when Midwestern hospital-affiliated specialists complained. As a result, MMG managers continued to focus on efficiency and cost reduction action plans within the group. MMG did not explore the potential of working collaboratively to integrate their work with other Midwestern units.

Finally, this MMG case highlights the difference between intended strategy and realized strategy. Although Midwestern leaders intended to develop an integrated delivery system in which the different delivery units would collaborate to improve services to their patients across the continuum of care, the results were far different than expected. Ongoing cultural differences between Midwestern units, repeated conflicts, and continued ambiguity about unit roles prevailed over time. Rather than collaboration across units, these unresolved problems resulted in a system of individual silos, each working to maximize its individual unit performance rather than seeking out opportunities for collaboration.

QUESTIONS FOR CLASS DISCUSSION

1. How did the realized strategy differ from the intended strategy in the MMG integration journey?

The vision guiding Midwestern was to "offer an integrated health care system to affordably enhance the health of people living and working in communities we serve." The vision implied two priorities: building an integrated health care system and improving community health. Similar to many other health care organizations during the mid-1990s, Midwestern was formed as a response to pending health care reform that would have given integrated health care systems a competitive advantage.

MMG was an important piece of Midwestern's strategy. Like many other integrated health care systems responding to the anticipated managed care environment, Midwestern secured market share for its health plan by acquiring primary care physician practices in strategic locations across the plan's geographic market. Midwestern consolidated medical group management to concentrate managerial expertise on improving the cost and quality of primary care services provided by MMG. Midwestern system executives expected the MMG management team to integrate their previously separate physician practices and clinics into a single medical group. In addition, Midwestern executives expected MMG's management team to link the medical group functions with those of other Midwestern system units to better coordinate patient care processes across the continuum of care.

However, realized strategy is often quite different from intended strategy. The environment did not move toward managed care as had been predicted, and other regulatory and insurance market changes resulted in declining reimbursement for the overall system. Midwestern developed a market business segments (MBS) business model, separating the health plan business from the delivery business and shifting the organization away from system-wide integration. Midwestern executives remained committed to integration between MMG and the other providers in the system, purposefully integrating MMG and Midwestern hospitals into one division. Midwestern executives intended this change as a means to force MMG to work more closely with the hospitals.

However, division leaders established MMG as a separate market business segment with its own cost center and financial performance targets. Although the MMG management team made great progress in integrating the group's individual clinics, the team made little progress integrating MMG activities with the other Midwestern units. In fact, over time, MMG seemed to pull away from the organization even more while system leaders repeatedly evaluated whether the

organization should dismantle or divest MMG altogether. Through a combination of environmental changes and the internal implementation process, Midwestern did not achieve the level of organizational integration originally intended.

2. How did MMG's organizational culture differ from the Midwestern system-level leadership culture? How did these differences affect strategy implementation?

The Midwestern system-level leadership group could be described as a control culture. System leaders were focused on preserving the financial well-being of the Midwestern System. Although system leaders attempted a major change in organizational structure, their actions were more indicative of maintaining the status quo. The MBS model was designed to achieve greater collaboration between MMG and Midwestern hospitals, yet the implementation of that new organizational structure maintained MMG as a separate cost center and did not create incentives for MMG–hospital collaboration. When conflicts arose between MMG and Midwestern hospitals, system leaders dealt with these conflicts in an authoritative, directive manner.

On the other hand, the MMG level leadership group could be described as a collaborative culture. Within MMG, the leadership group was focused on developing and enhancing customer relationships. Above all else, their relationships with patients were most important to the MMG leadership team. Within the MMG management team, MMG leaders acted as participative team builders.

When MMG leaders perceived Midwestern System leaders' actions to be authoritarian, they united even more strongly to protect MMG. A vicious circle developed with MMG leaders acting to preserve MMG interests, these MMG actions opposed by other Midwestern unit leaders, System leader interventions to preserve these other units' interests, escalation of undesired MMG actions, renewed opposition from other Midwestern unit leaders, and so on. As a result, MMG became locked in a destructive relationship with the rest of the Midwestern System, unable to move forward toward its desired goals, and the organization unable to decide MMG's future in the organization.

3. What are the MMG's and Midwestern Health System's strengths and weaknesses from an internal environment perspective?

The case does not provide enough information to complete a full internal environmental analysis of MMG and Midwestern, but does provide information about several strengths and weaknesses.

MMG Strengths

- Broad geographic coverage with 50 clinics in strategic locations.
- Organizational culture emphasizing continuous improvement.
- Consolidated administrative structure.
- Solid commitment to improving patient care.

MMG Weaknesses

- Financial losses.
- Strained relationships with other Midwestern System units.
- Ambiguous role in the Midwestern System.

- Frequent leadership transitions.

Midwestern Strengths

- Service providers across the continuum of care including hospitals, clinics, nursing homes, home health, and other health care services from acute to primary care.
- Health insurance products and relationships with physician groups.

Midwestern Weaknesses

- Little integration across Midwestern units.
- Frequent organizational structure changes.
- Ambiguous leadership transition process.
- Lack of vision for the System's future.

4. How did Midwestern's strategic control systems affect MMG unit plans and Midwestern strategy implementation?

From 1994 to mid-1996, the MMG leadership team focused on medical group growth through acquisition. Financial losses related to clinic acquisitions were expected during this time period. After mid-1996, MMG performance was primarily evaluated by the group's financial bottom line. MMG management attempted to improve their financial performance first by focusing on cost reduction initiatives, and then on increasing revenues by expanding specialty services. MMG cost reduction initiatives went unnoticed by System executives and other Midwestern units because they did not affect other system members. However, MMG attempts to increase revenues by recruiting specialists led to repeated high profile conflicts with other Midwestern System members. Each time a conflict erupted, Midwestern System leaders intervened in MMG specialist recruitment efforts, settling the conflict in favor of the demand by the hospitals that MMG retract its decisions and work with Midwestern hospital-affiliated specialists instead.

Midwestern System leaders were concerned about perennial MMG financial losses. Searching for an explanation for MMG losses, Midwestern leaders conducted several benchmarking studies. In each case, MMG compared favorably to similar medical groups in productivity, compensation, support staff numbers, ancillary revenues, billing practices, and referrals to other system members. One of these studies showed that MMG contributed more than $500 million in annual net revenue to the System through referrals to Midwestern hospitals. By contrast, MMG carried far more System overhead expenses compared to other System-sponsored primary care groups. Each study demonstrated that MMG was performing as best as possible given the constraints placed upon it by the Midwestern System.

Despite the results of these MMG benchmarking studies, the Midwestern System continued to evaluate MMG based on the group's financial performance. MMG leaders felt unfairly burdened by the Midwestern System overhead and System-imposed constraints on what they could do to improve MMG's financial performance. Midwestern leaders doubted the benchmarking study results, continually questioning MMG managers' abilities as the source of MMG financial difficulties.

As a result, MMG managers focused primarily on internal MMG integration and spent far less time on external relationships with other Midwestern units or other external groups. Meanwhile,

Midwestern leaders focused their attention on controlling MMG rather than exploring opportunities to leverage MMG's resources as a means to improve and expand Midwestern services and competitive position.

5. What key issues will Olsen's successor face in managing the MMG? What actions would you recommend her successor take to address these issues?

Based on this case, Olson's successor will need to address three key issues. First is the Midwestern accounting and transfer pricing system that makes MMG appear on paper as a financial drain on the system. This accounting system sets MMG up for repeated conflicts with other Midwestern units. The new MMG president should negotiate a more balanced performance measurement system that acknowledges MMG contributions to the Midwestern System as well as its stand-alone financial performance.

The second issue is the hospital-centric policy that does not allow MMG to hire specialists who might compete with specialists practicing in Midwestern hospitals. When MMG attempted to develop new specialist relationships, other Midwestern leaders often demanded that MMG sever these new relationships and work with Midwestern hospital-affiliated specialists groups instead, even when these specialists could not or would not meet MMG patient needs. Olson's successor should lobby for a more balanced approach to MMG specialist hiring decisions. MMG leaders must acknowledge that in a pluralistic organization such as Midwestern, such decisions harbor the potential for contentious conflict. Midwestern leaders must establish clear guidelines for MMG specialty relationships and communicate these guidelines to both the MMG and Midwestern specialty communities.

The third issue is the ambiguous and changing vision of MMG's role in the Midwestern System. The Midwestern System restructured several times during the past eight years. With each restructuring, repeated questions were raised about the value of MMG to Midwestern. The new MMG president should advocate for a final decision as to MMG's membership in the Midwestern System. Living in a shadow of continuous doubt about MMG's membership in the System has limited MMG's and Midwestern's ability to move forward. Whatever the decision, MMG's new president must establish a strategic direction for the medical group and move forward with a clear implementation plan.

CASE 6

Vietnam International Hospital: What Now?

OVERVIEW

Vietnam International Hospital was first envisioned in 1995 as a provider of quality health care for foreign nationals coming to do business in Hanoi after the communist government began to liberalize the economy in the early 1990s. Financed and managed by Australians, it opened in 1998 just as the full force of the monetary meltdown of the Southeast Asian economy was unfolding. As a result, the target market the hospital intended to serve not only failed to grow as hoped, but actually started to shrink. This resulted in the facility recording a string of losses following its opening. To turn things around, the hospital management hired a series of three different marketing managers/consultants to help reposition the hospital and to revive its prospects. The marketing managers attempted a number of strategies to attract the foreigners who remained in Hanoi and more effectively reach out to the indigenous upper-income Vietnamese population. The case tells the story of the hospital, its competition, and its efforts to survive in a very hostile environment.

This case was developed to provide students with an opportunity to study a classic business problem in a rather unique international setting—Hanoi, Vietnam. First, the students are asked to assess the quality of the analysis and decision making that led to the launch of Vietnam International Hospital. They are then asked to assess the future prospects of the hospital given the current circumstances. They are also asked to assess the effectiveness of the marketing efforts thus far undertaken and suggest alternatives. Finally, they are asked to make a decision regarding whether Vietnam International Hospital should be sold.

The case is intended for use in either undergraduate or graduate courses in strategic marketing/marketing management. In addition, the case could be used in international business courses and it would be appropriate for courses in health care management. The case may also be used early in strategic management courses in conjunction with discussions of doing business abroad and undertaking international joint ventures.

LEARNING OBJECTIVES

1. To learn to apply various marketing tools (SWOT, Porter's Five Forces) in the analysis of VIH's situation and be able to make recommendations based on that analysis.
2. To determine the break-even point for VIH in terms of customers and to apply this knowledge in decision-making.
3. To synthesize information in the case and to provide alternative solutions that could have been utilized to build the business.
4. To be able to suggest what should have been done before launching the venture.

This teaching note was written by Mark J. Kroll, Louisiana Tech University, and Barbara Ross Wooldridge, University of Tampa. It is intended as a basis for classroom discussion rather than to illustrate either effective or ineffective handling of an administrative situation.

SUGGESTIONS FOR EFFECTIVE TEACHING

In the following section we provide three possible pre-discussion assignments along with our analysis of those case assignments. In addition to traditional approaches for analysis, such as Five Forces and SWOT analysis, we have found (especially at the graduate level) for students to get full benefit from the case they need to "get into the numbers" and draw some conclusions about the financial viability of the business. In anticipation of class discussion, we suggest students be given one, two, or all three of the following assignments, depending upon the depth of analysis the instructor wishes to pursue. We suggest the assignments be couched in terms of the students serving as consultants to Mr. Lee, the ultimate decision maker in the case. It may be helpful to explain to them that they will have to make certain assumptions concerning the behavior of cost and revenue relationships, and be prepared to explain their basis for making them.

Assignment 1: Using Porter's five forces, what does the picture look like for success?

The threat of new entrants: The threat of entry by health care organizations offering comparable services in to the Hanoi market area was deemed low due to the following:

- The 1999 expatriate market base of approximately 4,500 is only half of what it was in 1997.
- There were fairly high capital expenditure barriers to the market (VIH's initial capitalization was US$10.5 million). VIH's initial investment was likely low relative to what it would cost others to enter because Bach Mai Hospital provided facilities that only needed to be upgraded.
- A new competitor would have had to secure contracts with international health care providers and insurors. Contracts were available for bid once a year.
- Bach Mai (being state owned) gave VIH political entree into the market that other new entrants may not have been able to access.

The bargaining power of suppliers: The threat from relative bargaining power of suppliers would have been considered low for the most part as most items could be obtained from several sources, however:

- The one exception to the absence of bargaining power may have been Bach Mai Hospital, which might be considered a supplier of physical space and political connections. It would be safe to assume given the hospital's state ownership and implicit connections with the Health Ministry, if Bach Mai's administration became unhappy, then the consequences could be severe.

The bargaining power of customers: There are three target segments: international health insurance companies and the expatriates they covered, Vietnamese employers, and the elite of Vietnamese Society. All three of these customer groups had significant bargaining power.

- The international health insurance companies had significant bargaining power. For as long as VIH lacked contracts with these insurors, expatriates would have continued to use the international insurors out-of-country services rather than VIH's local services. To obtain contracts from the insurors, VIH must convince

them that VIH provided a more cost effective alternative to evacuation while providing comparable care for the patient.

- Vietnamese employers had a strong position as they may be the most likely portal for VIH into the Vietnamese middle class.
    - Vietnamese were not accustomed to spending for health care, and may not have bought it on their own, but may have enrolled if a cost-sharing arrangement were available at work.
    - A state-run system was in place and free to all, though some bribes were usually required. The Vietnamese middle class relied on the state system for care.
    - It was politically correct to use the state system.
- The elite had moderate power, as VIH must win this important market of early adopters.

Threat of substitute products or services: Substitute products were available for all three of VIH's target segments: foreigners, employer-sponsored middle class patients, and the wealthy. Overall, one would have to conclude the threat posed by substitutes was high.

- International medical evacuation services, subacute clinics, and state-run facilities were available to foreigners living in Hanoi.
    - Evacuation Services were already in place and the many international insurance carriers had contracts with them. AEA-SOS operates two private clinics for expatriates with non-acute care needs as well as acute care evacuation services.
    - Clinics for non-acute care were in place and were staffed by expatriate doctors.
    - The state-run system was in place and expatriates could use the facilities of this system, though the facilities were not of a standard that expatriates are likely to find acceptable (see Exhibit 6/1).
- For the Vietnamese Elite, the State run system was already in place and it was politically correct to use this system.
- If any market segment wished to go outside the state system – alternatives such as evacuation plans were in place.

The intensity of rivalry among existing firms: Because of the unique nature of VIH and its partnership with Bach Mai, the other firms in the market were not in direct competition; thus, intensity of rivalry between existing firms was low.

- Expatriate Market: evacuation services did not directly compete, because the only choice was to fly out of the country for medical services. For evacuation services to compete directly they would have needed clinics that could have handled more than nonacute situations.
- Vietnamese Market: VIH was perceived to offer much better care and was much more expensive than the state run system. Its target market was a small niche, the elite of the country, and did not compete directly with the state system.

Overall Assessment

In summary, an industry analysis of the situation confronted by VIH was a mixed bag, but even when the forces were favorable, it was for the wrong reasons. Specifically,

while the threat of new entrants was low, that was primarily owing to the absence of an adequate patient base, the relative poverty of the country, and the reluctance of the native population to use the service. Two out of four of the other forces did not auger well either. The international insurors, who might have been viewed as the customer base VIH most needed to attract, had considerable bargaining power given the availability of substitute services. In fact, the availability of substitute goods provides VIH's potential customers with their bargaining power. On the brighter side, VIH had no direct competitors, though again the reason for this was likely a lack of market. Finally, VIH faced no supplier control.

Assignment 2: Undertake a traditional SWOT analysis of the case.

Strengths:

- First privately owned hospital in Hanoi, opened in 1998. A "first mover advantage" was possible.
- Only medical facility of its kind in Vietnam.
    - Allowed a person to receive treatment locally that before could only be obtained in places such as Singapore or Australia.
    - All other hospitals were state owned and deemed to be significantly inferior in quality.
- Much less expensive alternative to medical evacuation for expatriates. The typical cost of an evacuation is $5,000–6,000 for patients able to sit upright and $10,000–15,000 for those transported on a gurney. These costs were only for the transportation of the patient to the medical facility outside of Vietnam (Singapore or Australia).
- Affiliation with Bach Mai Hospital, a state-owned facility. Bach Mai's political entrée into the market was valuable, and it may have given potential patients political cover needed to use the facility.
- Private investor Mr. Lee had deep pockets. His initial funding of the project was US$6.5 million, and he has continued to keep the hospital afloat.
- Management and staff comprised of locals and expatriates gave the hospital an awareness of the unique cultural aspects and needs of both markets.
- Mr. Lee was already successful in several ventures in Vietnam.
    - Major stake in the country's leading steel producer.
    - Major stake in a leading producer of steel sheet goods.

Weaknesses:

- Sustained heavy losses throughout first year of operation.
- Success was predicated on the growth of the expatriate market, which in fact shrank.
- Cost structure required VIH to charge high prices relative to the Hanoi incomes.
- High fixed costs for providing health care.
- Has not established itself as a source for medical evacuation services.

Opportunities:

- Western style restaurants, up-scale hotels, private clubs, and apartments had been built to provide amenities the expatriate market would desire (infrastructure in place for this segment), if the economy rebounded.
- State-run medical system offered very substandard care when compared to more developed countries (see Exhibit 6/1).
- Doi Moi free market reforms should over time stimulate joint ventures and growth in the expatriate population.
- Younger Vietnamese professional couples were aware of the inadequacies of the state run system and wanted access to better health care. Half of VIH's first year inpatient volume was from Vietnamese clients even though the focus had been on expatriates.
- Potential to target high-income Vietnamese families that wanted world-class medical care.
- Hai Phong, an industrial area located 60 miles east of Hanoi, could potentially be a source of both expatriate and local clients.

Threats:

- Established substitute goods in the form of medical evacuation services. AEA International SOS had contracts with 800 health care insurors worldwide.
- Other clinics staffed by expatriate doctors could provide nonacute care.
- Vietnamese consumers did not have a history of being willing to spend heavily for health care.
- Some of the potential Vietnamese market could not use the facility due to political concerns.
- If VIH was able to effectively target the Vietnamese market, the perception of the hospital might be compromised for expatriates.
- Rumors about the hospital
    - VIH was about to close.
    - VIH was not interested in treating Vietnamese.
- Potential discontinuation of loans from Mr. Lee.
- For expatriate treatment VIH had to have international health care insurors agree to VIH as an acceptable alternative, contracting was done on a yearly basis.
- The expatriate population was dependant on free market reforms in Vietnam and a strong Southeast Asian economy. Problems with both Doi Moi and the region's economy had diminished the expatriate community.
    - In 1997 the pressure on the Thai bhat lead to currencies in neighboring countries to plummet in value.
    - The economic slow down lead to a decrease in expatriates in Hanoi falling from 9,000 to roughly 4,500.

Overall Assessment

The success of VIH in the short and mid-term depended heavily on the expatriate market. The Vietnamese market once established had the potential to help buffer VIH during the down phase of business cycles, but VIH could not exist solely on the Vietnamese market. Being the first and only medical facility of its kind in Vietnam was not enough to ensure the venture's success. There simply was not a sufficiently large enough expatriate

population in Hanoi to support VIH, and it did not appear likely that a sufficient expatriate population would move into the Hanoi area in the foreseeable future. As difficult as the decision maybe, Mr. Lee needed to cut his loses and look to other investment opportunities.

Assignment 3: Using the May 1999 profit and loss statement as a beginning point, undertake a two-part financial analysis to determine: (a) whether the original expatriate population base present in 1997 was sufficient to support the VIH project; (b) what the size of the expatriate community would have to be for the hospital to break even.

Note: Depending on the class and level (graduate versus undergraduate), the instructor may wish to provide the students with three key assumptions in addressing this assignment:

1. The patient mix found in Exhibit 6/5 would remain constant.
2. Major cost elements will behave in a linear fashion at higher volumes.
3. Salary and wage figures will remain constant at approximately $78,000 per month as these are for the most part "fixed costs."

Information needed to answer the question:

1. Patient mix of expatriates to Vietnamese would remain the same regardless of the number of expatriates.
2. Major cost elements remain constant at higher volumes, specifically depreciation charges would not increase materially with greater volume because of unused capacity.
3. Salary and wages would remain relatively constant at $78,000 per month (remember that much of the salary costs were fixed).
4. Need to remember that marginal or variable cost was about 20 percent of revenues.
5. Health care demand generated by the expat community would expand in a linear fashion. Given that expatriates accounted for 57 percent of patients, if there were twice as many expatriates, VIH's revenues should expand by 57 percent of their latest revenue figure.

Part A: Original Expatriate Population Base Sufficient for VIH to Break-Even?

To project results for VIH assuming 57 percent greater revenues, we use the May 1999 total costs as a base to which we will add 20 percent variable costs incurred to generate the additional revenues. In other words, our total monthly costs would be:

May 1999 Salaries & Wages Expense	$ 78,275
May 1999 Depreciation Expense	181,370
May 1999 Unclassified Expenses	56,171
Sub-total	$ 315,816
Plus: 20 percent of marginal revenues	12,726
Total	$328,542

Therefore, if revenues were 157 percent of their current levels (reflecting an expatriate population of 9,000), total revenues would equal to $175,264 per month (using May 1999 figures). Total costs would equal $315,816 plus marginal costs of $12,726, for a total of $328,542. Obviously, on a full cost basis (inclusive of depreciation charges), even if the number of expatriates in Hanoi had remained at 9,000 the hospital would be in trouble. On an operating cash flow basis (excluding the non-cash depreciation charge) the hospital would have its head above water with $28,092 in positive monthly cash flow. Students may be impressed by the capital intensity and high degree of operating leverage involved in the health care industry.

Part B: Size of the Expatriate Community to Break-Even

In terms of how large the expatriate community would have to be in order for VIH to break even while covering depreciation charges, revenues would have to expand to at least $366,864 a month to reach break-even (again, working with May, 1999 numbers):

May total revenues:	$111,633
May salary & wages:	$ 78,275
May operating expenses:	$ 56,176
May depreciation charges:	*$181,176*
Total costs:	*$315,627*
Uncovered costs:	$(203,994)

To cover such a loss, assuming as discussed in the case a contribution margin of 80 percent (i.e., the marginal cost of new business is 20 percent), about $254,993 in additional revenues would be required ($203,994/0.80). This would mean the hospital would have to generate $366,626 in total revenues per month (current revenues of $111,633 + $254,993). This value assumes that the present physical plant and full-time staffing could handle this greater volume and no significant fixed costs would be needed — a big assumption. To generate $366,626 in total revenues, the hospital would have to be serving an expatriate community of over 22,000 (about 18,000 more than there are at present), assuming an incremental increase in the expatriate community of 4,500 results in an increase in revenues of $63,600 ($254,993/$63,600 x 4500) (see part A above). To cover a revenue shortfall of $203,994 would require approximately 14,000 more expatriates to move to Hanoi in addition to the original 9,000 present when the hospital project was launched. The one possible mitigating factor that might lower these requirements would be if the expatriate community were larger, the hospital might not have had to lower its prices as much as it had by May 1999, and the contribution margins would obviously be much better. It is, however, difficult to estimate how much margin erosion might have been prevented.

It would appear that to simply break even, the expatriate community would have had to more than double in size from its original base of 9,000. For the hospital to earn a return for its investors commensurate with the risk they assumed in opening such a facility in a developing-world country would have required even greater growth in the expatriate

community. Given the above analysis, it appears the investor group was probably rather unrealistic about the prospects for the hospital even if the economic crisis that hit Asia had never occurred. These results also make clear that for the hospital to have any chance in the future in its present configuration, it will have to build the Vietnamese side of the business aggressively.

QUESTIONS FOR CLASS DISCUSSION

1. Based on the original concept of the hospital, do you think Mr. Lee and Dr. Tan had made a realistic assessment of the Hanoi market for private medical care when they launched the project?

This question could be approached in one of two ways, depending on which of the earlier mentioned assignment questions were used. If the SWOT analysis was applied, students should be able to discern in a qualitative way that the cons of this project clearly outweighed the pros even at the outset when the expat community was at its largest. It does not appear that our entrepreneurs ever considered doing any pre-opening assessment of VIH's ability to appeal to the expat community or their insurors. Nor does there appear to have been any thought of scaling the facility to the market's potential. The prospects for a 50-bed private hospital were wildly optimistic and reflect a surprising level of naiveté on the part of a supposedly seasoned investor such as Mr. Lee.

If the students have been asked to estimate the required break-even in hospital revenues, a very rich discussion can be developed in terms of the methodology and approach the financial analyst might use to make such estimates. In the final analysis, if the students' numbers turn out to be anything like those presented in assignment 3, it will be apparent the facility should never have been opened.

2. If you had been acting as a pre-project marketing consultant to Mr. Lee what might you have done by way of data collection to ascertain the nature of the market? Remember, this is a developing-world country, and oftentimes consumers have little conceptualization of the product you envision.

In terms of the Vietnamese market, assessing the nature of that market would have been a daunting task, as a private state of the art hospital providing high-quality health care services would truly have been a "new product" for this market. The first step would have been for the researcher to attempt to discover what, if any, were the expectations the Vietnamese had concerning private health care. Then, given these expectations, determine what the cost would have been to meet them. Having ascertained the minimum expectations and cost to fulfill them, the next step would have been to determine if there existed a large enough market to obtain minimally acceptable sales levels. If it was determined that the segment was large enough to be viable then additional research should have been undertaken to discover what sources (family, work, advertising) influenced the use and choice of health care options. It is important to remember that given the "new" product nature of VIH, the findings of this pre-launch research may not have been reliable.

For the expatriate market Porter's Five Forces should have been employed before entry. If this had been done, the power and importance of the insurance companies (bargaining power of customers) and the one-year contracting basis would have been discovered and this issue could have been addressed much earlier.

For the expatriate workers research should have been conducted to determine their perceptions of local health care: what was lacking, what would be acceptable given available facilities, along with their perceptions about air evacuation. Additionally, research should have been done on what was the major source of information about health care options in Vietnam and what was the major influence or indicator of health care option choice.

3. To build volume for the Hospital among Vietnamese, it appears that VIH not only needs to build brand awareness, but must also create need awareness in its market. How would you suggest VIH go about creating in the Vietnamese community recognition of the need for higher quality medical care without offending the government and its state-sponsored health care system?

Among the population of Hanoi (and all of Vietnam for that matter) there was a latent preference for all things not Vietnamese. The general perception was that products manufactured outside the country were inherently better than those built within the country. For example, the label on cans of "Raid" insect spray announced that it was the leading brand in the USA. Honda motorcycles assembled outside of Vietnam were more coveted and sold for higher prices than Honda motorcycles built in Vietnam. The same kind of latent belief probably existed that western health care was superior to that available in the state hospitals**.** However, as mentioned in the case, there was no real tradition of spending for health care in Vietnam. This was of course owing to the availability of the state system, but also may have been owing to a lack of awareness of modern medicine and what it could do to enhance the quality of life. Heretofore, given the primitive nature of Vietnamese medicine, there was simply nothing to spend money on in the way of health care.

In response to this lack of appreciation of what modern medicine can do, the hospital may have to work to educate those who can afford its services about the benefits of modern health care. The easiest way to do this would be to use advertising comparing and contrasting its services with those offered by the state facilities. This of course would also be extremely dangerous for a host of political reasons. Alternatively, VIH might borrow a technique from American health care providers and conduct remote site health fairs with free screenings and basic consultations. These could be held at the few upscale retail centers in Hanoi. Some advanced advertising of the fairs could help build traffic for the events.

4. What is your evaluation of the decision to discontinue the MCP program? Why do you suppose it was discontinued?

As is obvious from the data presented in Exhibit 6/10, even though the MCP program was not terribly successful in terms of the numbers of policy sales, the program was quite profitable in terms of revenues generated versus the cost of providing services covered by the plan. As of the end of September 1999, the program had generated $43,386.00 in premium revenue while only $14,437.00 had been incurred in providing benefits under the plan. The plan was even more profitable when one considers that it was estimated the marginal cost of providing care was only 20% of marginal revenues generated. Said another way, given the very high fixed-cost-structure of the hospital, it only cost the hospital an additional $2,887.40 ($14,437.00 x 0.20) in out-of-pocket costs to service the MCP patients. In addition, these patients generated an additional $10,422 in services not covered by their MCP plans.

Given these numbers, why was the plan killed? Two reasons appear likely. First, the plan generated very small numbers and never fulfilled management's or the board's aspirations. Given the small numbers, they may have felt inclined to simply forget the whole thing. Second, as mentioned in the case, a couple of relatively expensive cases (expensive in terms of billable services) occurred which frightened the board in terms of what the hospital's potential liability might be (in terms of revenues foregone) when assuming the worst. It does not appear they ever thought in terms of what it actually cost the hospital to provide the care (i.e., the actual out-of-pocket expenses), but rather focused on the revenues they had to forego by having the policies in place.

5. In addition to the steps already taken by Ms. Anh and Mr. Nguyen, what other measures could you suggest to build the business volume at VIH?

There appear to be at least five opportunities for expanding market share that VIH has not fully exploited.

- Medical evacuation market. Although VIH did list medical evacuation as a service offered, management had never really seriously pursued it the way AEA International SOS had. Obviously, this market represented something of a dilemma for VIH. On the one hand, they desperately needed to build volume through the facility but, as mentioned in the case; they were very reluctant to see seriously ill patients merely "flow through" the hospital on their way to a foreign facility. Such patients did not offer VIH much of an opportunity to sell significant medical services. On the other hand, if they did not aggressively pursue the evacuation market, many expatriates were not likely to work with VIH out of fear that VIH would try to take on more than they were capable of handling rather than evacuating the patient overseas. Additionally, there was always going to be that element of the expatriate community that would insist on evacuation when they became ill regardless of the quality of care available in Hanoi. At this point it would appear to make sense to pursue the evacuation market if for no other reason than to familiarize as many in the expatriate community as possible with VIH and its capabilities.
- Enhance the credibility and acceptance of VIH in both the expatriate and Vietnamese communities via capitalizing on the power of word-of-mouth (WOM) communication. WOM would have had several unique advantages for both expatriates and Vietnamese segments. First, WOM is generally perceived to be

more credible since it emanates from personal "impartial" sources. Often, when it comes to services (such as medical care, hairstylists, mechanics, legal) to avoid making mistakes, consumers rely on WOM in their decision making process. Word-of-mouth is vital with medical services because of the uncertainty (for expatriates of the quality of care in Vietnam as opposed to evacuation) and thus higher perceived risk for the consumer. For the Vietnamese, because of the complexity and newness of the service, WOM would have allowed them to obtain information vicariously about it – via a trusted source. One method available to take advantage of WOM would have been the use of testimonials from prominent expatriates and Vietnamese. If VIH could have secured expatriate patients' permission to use their endorsements in VIH's marketing efforts, the hospital's management may have been able to assuage the expatriate community's anxieties about relying on VIH for acute care. By securing endorsements from leading Vietnamese, VIH might have changed some Hanoi residents' minds about the merits of spending more for health care. A potential secondary source of WOM would have been to offer referral discounts to current VIH Vietnamese patients – if they recommended VIH to someone who purchased a plan, the person recommending VIH would have received a discount on future services.

- Affiliate with referring clinics located outside the immediate Hanoi district. For instance, about 80 kilometers (60 miles) to the east of Hanoi is the city of Hai Phong, a port city of at least 2 million people with no facility comparable to VIH. Pursuit of both the expatriate and Vietnamese market there would likely add marginal volume with minimal additional costs.
- Re-launch the MCP program. Although sales of the program were modest at best, it was, at the margin, a very profitable program. As long as the hospital continued to experience excess capacity, the MCP program would continue to have represented very profitable business, even if the absolute number of enrollments was not great. Additionally, the program did tie policyholders to the hospital.
- Develop a program aimed at child health care. It appeared from the case that the Vietnamese were willing to pay to obtain superior health care for their children. Of the HC 21 memberships sold, over half were for children.

6. What risks, if any, do you see in trying to market to expatriates and Vietnamese at the same time?

It is an unfortunate fact of life that at least some in the expatriate community were likely to conclude that if VIH becomes too "Vietnamese," the quality of care would not be sufficiently high to meet their needs. In other words, if VIH's patient base consisted of too many Vietnamese, it might lose its image of exclusivity. In contrast, the expatriate patient base helped VIH's image in the Vietnamese community – the thinking running along the lines of "if it is good enough for the wealthy foreigners, it must provide high-quality care." Even if some expatriates were alienated by the Vietnamization of VIH, with no major turnaround in the expatriate census in sight, VIH had no choice but to run that risk.

7. Would you recommend the current owners of VIH sell their interest to the French health care firm according to the terms offered, or continue on their own? Why or why not?

Given the fact that Vietnam International Hospital was fairly close to cash flow break-even, there might have been a temptation to hang on a while longer. A couple of realities argue against that position. First, even if the hospital broke-even on a cash flow basis, it would still be a very long way from covering depreciation charges, which were considerable. Although not covering depreciation charges in and of itself was not that troubling, it also meant VIH was a long way from generating sufficient funds to invest in the new medical technology, facilities, and maintenance that its patients and their insurors were likely to expect in the years to come. It is also very difficult to imagine the hospital ever earning any kind of profits for its investors or being able to retire any of the loans Mr. Lee had made. Far better for Mr. Lee to get some of his money back now and begin earning some kind of return, than to have it tied up for years in an investment unlikely to earn any kind of return.

The one justification for holding on might be if VIH's management were to anticipate some major shift in government economic policy toward more open trade, free market reforms, and economic development. In such an event, the expatriate community would have been likely expanded anew and more Hanoi residents would have been able to afford the kind of medical care VIH offers. As long as the government continues its piecemeal, go-slow-approach to economic liberalization, it was unlikely VIH will have a sufficient market base to allow it to economically pursue its mission.

EPILOGUE

In January 2000, the sale of VIH to the French health care provider was consummated. The terms of the sale were not disclosed at the time, but it was believed they were essentially the same as those mentioned in the case. At this writing, it is not known what plans the new owners have for the facility. As an added curiosity, VIH became "ground zero" of the severe acute respiratory syndrome crisis in Hanoi. The hospital was identified as the point of origin of SARS in Hanoi and was for a time quarantined. The new owners have worked to reposition the facility toward high-income Vietnamese. Given the rapid subsequent growth of the Vietnamese economy, the demand for the facility's services from both the Vietnamese and expat community has grown steadily.

CASE 7

Indian Health Service: Creating a Climate for Change

OVERVIEW

The Indian Health Service (IHS) was dedicated to providing comprehensive health care services to more than 1.4 million American Indians and Alaska Natives (AI/ANs). The basis for this responsibility was established and confirmed by numerous treaties, statutes, and executive orders as well as a special government-to-government relationship between the Indian tribes and the United States. The IHS had a budget of over $2 billion, over 15,000 employees, and was responsible for the operation of more than 500 facilities.

IHS Director Dr. Michael Trujillo knew that in order to accomplish the agency's mission, IHS must honor past treaties and respect the beliefs and spiritual convictions of the various tribes. The need to respect local traditions and beliefs was formally recognized in Indian self-determination. Despite the appreciation of the importance of self-determination, IHS was considered a discretionary agency in the Congressional budget process, had not developed an adequate third-party payor billing system, faced difficulty recruiting professional staff, and served a population whose health status was below that of the rest of the United States. Dr. Trujillo must decide how to lead the IHS through challenging times. He recognized the necessity to continue to increase the health status of the IHS's population to gain continued Congressional funding and support. He understood, however, based on the experience of the past four years, that the likelihood of increased funding above normal cost-of-living increases was very low. One of his most important challenges was to determine more effective ways to accomplish the IHS mission and honor his philosophical commitment to self-determination.

KEY ISSUES

1. Balancing the tension between the need for centralized planning and direction to focus resources in a manner that would increase health status in the most efficient way while allowing local communities (tribes) to define their own health needs.
2. Planning for and managing on-going organizational change in a public bureaucracy with a rigid structure.
3. Instituting innovative ways of mission accomplishment in a changing health care setting with evolving philosophical perspectives (decentralization of health needs assessment).
4. Leading the culture changes necessary to accommodate a change in philosophy away from a centralized and controlling bureaucracy to a more decentralized and facilitating organization.
5. Specifying the activities necessary to implement a new organizational strategy for mission accomplishment.

This teaching note was written by Terrie C. Reeves, University of Wisconsin Milwaukee, W. Jack Duncan, University of Alabama at Birmingham, and Peter M. Ginter, University of Alabama at Birmingham. Used with permission from Terrie Reeves.

TEACHING OBJECTIVES

After analyzing this case, students should be able to:

1. Understand and analyze the range of responses possible for the managers of governmental agencies and other bureaucratic organizations when faced with environmental changes.
2. Understand the ongoing dilemma faced by leaders and managers attempting to balance the positive and negative aspects of organizational centralization and decentralization.
3. Develop innovative ways to accomplish a mission that has become increasingly difficult to accomplish using conventional approaches because of stable or declining resources.
4. Apply strategic management concepts to bureaucratic and government entities.
5. Demonstrate the use of visionary or transformational leadership tactics.
6. Develop a strategy to accomplish the mission / vision of Dr. Trujillo.

SUGGESTIONS FOR EFFECTIVE TEACHING

The Indian Health Service case is intended for use in either a health care management course or a public health strategy and policy course. We have used the case effectively with graduate health administration students because of their ability to draw a parallel between the dilemmas faced by the IHS and other specialized health care systems such as the Veterans Administration. A familiarity with the general health care environment is needed as a basis for comparison with the situation faced by the Indian Health Service. Further, the students need to be aware of the trend in public health toward community-based health needs assessment. The case is an illustration of the potential culture change problems that will likely result from efforts to implement radical paradigm shifts in operational philosophies. It provides an immediate and concrete illustration of the ongoing dilemma between centralization and decentralization in management.

Students interested in providing health care services to American Indians and Alaska Natives should find that the case provides good background information on these groups. It is likely that students will take sides on the issue of trying to change the bureaucracy or the structure of an entity versus making changes within the existing bureaucracy or structure: the health administration students may be more likely to want to recommend wholesale change whereas public health students may be more inclined to suggest working "within the system." Students may also become partisans of either greater centralization and control of the IHS or greater decentralization.

Students may be tempted to apply strategic management principles to the IHS in a traditional way. Although these may be useful and valid, students need to realize the importance of the various IHS stakeholders, the impact the stakeholders can have on the organization, and the need for continued involvement by stakeholders. Students need to be aware of the roles other governmental units play in the strategic decisions made by IHS – the IHS must operate in an atmosphere of compromise and cooperation, it cannot "go it alone" no matter how attractive an independent alternative may appear. It is important that students understand that treaties between the United States government

and sovereign states imply policy issues far beyond the immediate problems faced by the IHS. Thus, the normal SWOT approach to analyzing the case may be an appropriate method of analysis only if it is supplemented with other analytic tools.

We have found it particularly useful to allow students to attempt these applications and struggle with issues such as the following:

1. Difficulties in identifying stakeholders for organizations such as the Indian Health Service.

Stakeholder maps often become large and complex when students begin to think seriously about the various tribal councils; other government agencies such as the Bureau of Indian Affairs; state, local, and national public health organizations; private sector health care facilities; and so on.

2. Multiple priorities present complications to rational, linear decision making.

Dr. Trujillo has a very strong personal commitment to self-determination and has the formal authority necessary to move the agency in the direction of community-based decentralization. This move, however, may not be the most direct method of achieving the concrete results lawmakers want relative to the improvement of the health status of Native Americans and Alaska Natives. Balancing his philosophical commitment to self-determination and the realistic need to produce results that will be instrumental in acquiring future resources presents Dr. Trujillo with a complex dilemma – the need for centralization to control and focus on the one hand and the need for decentralization to achieve involvement and commitment on the other.

3. Managing a large and complex bureaucracy and leading it toward a new operational paradigm.

Government bureaucracies tend toward centralization and control. Yet, the mission of IHS and the philosophy of self-determination argue for involving local communities more in the assessment of health care needs and providing the means that would be most effective for addressing the needs. This dilemma provides an opportunity to discuss topics such as transformational leadership, coalition building among local stakeholders, and culture change. In fact, our classes consistently focus more on these topics than any others.

This case provides a detailed description of the environment faced by the IHS for students to identify and discuss the major strategic issues. Further research would add depth and greater insight to the discussions.

Role playing can be used to facilitate learning and to bring out the various environmental factors. For example, students can be separated into stakeholder groups (such as the Indian tribal leaders and members of several different tribes, Congressional committees, IHS employees, and IHS leaders) and asked to discuss the environmental issues from these vantage points. Stakeholder groups might be asked to define their expectations of the IHS for the future, given environmental changes, and how the expectations of one

stakeholder group differs from or are in conflict with those of another group. Based on input from other groups, the IHS leader group can be asked to decide upon a strategic course for the IHS.

We have had particular success using a role-playing exercise whereby we have Dr. Trujillo interacting with tribal leaders in one of his frequent visits to the Southwest. In this meeting, the leaders present Dr. Trujillo with a wish list of needs including a primary care physician, a new laboratory facility, and transportation services to the clinic. The leaders continually refer to "self-determination" as the basis for their need and insist that he should provide them the resources to solve their local health problems. Dr. Trujillo is very sympathetic with their requests but emphasizes his need to use resources most effectively for the "total system" and offers to assist the leaders in building partnerships with other local public and private organizations to address their problems. The tribal leaders insist that it is his responsibility to find the resources and Dr. Trujillo struggles in his attempt to explain how he must balance ensuring results for IHS while being sensitive to local needs.

Good sources for identifying stakeholders "who really count" and managing those stakeholders are:

R. K. Mitchell, B. R. Agle, and D. J. Wood, "Toward a Theory of Stakeholder Identification and Salience: Defining the Principle of Who and What Really Counts," *Academy of Management Journal* 22, no. 4 (1997), pp. 853–886.

John D. Blair and Myron D. Fottler, *Challenges in Health Care Management: Strategic Perspectives for Managing Key Stakeholders* (San Francisco: Jossey-Bass, 1990).

Another possibility using role playing is to divide the class into two groups, one of IHS leaders and one of Indian Affairs Committee members. The IHS leaders can be asked to justify IHS programs and initiatives while the committee members search for justification for program cuts or reallocations. This approach works particularly well with students interested primarily in public policy.

The case can be used as the basis for a written analysis, either as presented, or with additional outside research required. Students can also be assigned a research topic pertaining to the case (individually or in teams) such as the legal, policy, epidemiological, cultural, or financial implications of changes in the IHS. This approach can help bring out the importance of the IHS's different stakeholders. Excellent sources include the following:

Indian Health Design Team, *Design for a New IHS: Preliminary Recommendations of the Indian Health Design Team* (Washington, DC: Indian Health Service, 1995).

Indian Health Design Team, *Design for a New IHS: Final Recommendations of the Indian Health Design Team* (Washington, DC: Indian Health Service, 1997).

F. Mullan, *Plagues and Politics: The Story of the United States Public Health Service* (New York: Basic Books, 1989).
Indian Health Service, *Trends in Indian Health* (Washington, DC: Indian Health Service, Division of Program Statistics, 1996).

The Internet is a good source for governmental statements and testimony, for epidemiological data, and for government policy. In addition, there are many excellent sources for the beliefs and practices of individual Indian tribes or Alaskan Native groups.

Finally the case lends itself to an analysis of the strategic options available to the HIS under different scenarios. For example, scenarios could be developed around the following questions:

- What will happen to the IHS with the passage of the balanced budget amendment?
- What will happen to the IHS if comprehensive health care reform is legislated?
- What are the implications for the IHS if national mandates are instituted for Medicare or Medicaid?

Students may be asked to develop realistic scenarios that might face IHS in the future. They should analyze the implications of each scenario for IHS and decide what strategic actions best fit a given scenario. Included in the analysis may be a prioritization of the various IHS programs under different scenarios. Or, students may envision new or different programs for the IHS under different scenarios. If so, they should be asked to justify the inclusion of these programs. Further reading on scenarios may be found in:

P. Leemhuis, "Using Scenarios to Develop Strategies," *Long Range Planning* 18 (1985), pp. 30–37.
A. Schriefer, "Getting the Most Out of Scenarios: Advice from Experts," *Planning Review* 23, no. 5 (1995), pp. 33–35.

Strategic analysis of the case might be centered on the following issues:

- Effective health services for American Indians and Alaska Natives must continue to integrate the philosophies and values of the tribes while remaining consistent with the overall mandates of the IHS for system-wide health status improvements.
- Alcohol and substance abuse among AI/ANs must be addressed.
- More efficient business practices are needed to maintain the IHS's viability.
- More effective philosophical approaches (community-based self-determination) to mission accomplishment must be developed.
- Empowerment at the local level to determine and act on the changes needed to best serve each tribe or community must occur.
- Lack of increases in budget allocations from the Federal government and ways of leveraging limited resources must be considered.

STRENGTHS/WEAKNESSES AND OPPORTUNITIES/THREATS

Regardless of the particular issue selected, we have found it useful to insist that the students begin with a general situation analysis as a basis of addressing the various

strategic issues. Perceptive students quickly realize that the difference between internal and external factors is not as clear in the case of the IHS as with some other organizations. Because of the heavy involvement of the tribes in Indian health care in general, and in the IHS, specifically, and because of belief differences between AI/ANs and many others in the United States, the concepts of "internal" and "external" may be different for the IHS. These differences can lead to interesting classroom discussion.

Strengths	Weaknesses
1. Reputation for quality care	1. Dependence on the political process
2. Education and training capabilities	2. Budget constraints
3. Dedicated and enthusiastic personnel	3. Staff recruitment and retention
4. Improved health status	4. Poor billing and collecting capabilities
5. Lobbying power of American Indian groups	5. Bureaucratic, top heavy organizational structure
6. Community orientation and sensitivity to Indian culture	6. Inferior pay for health professionals comparable with the private sector
7. Dr. Trujillo, a strong leader	

Opportunities	Threats
1. Tribal interest in IHS involvement	1. Increases in health care costs
2. "Reinventing government" initiative	2. "Reinventing government" initiative
3. Young service population	3. Downsizing of the Federal workforce
4. Public's interest in American Indian issues	4. "Free" nature of IHS may encourage overuse
5. Physician surplus making IHS more attractive to medical personnel	5. Increases in diabetes, cancer, and other debilitating diseases among service population
6. Advanced technology	6. Service population's economic disadvantages
7. Government-to-government relationship between Federal and tribal governments	7. Differences in socioeconomic and other factors among tribes
	8. Financial strain experienced by rural hospitals and clinics affects IHS and tribal facilities
	9. General attitude favoring decentralization and getting services closer to the people
	10. Shift from direct Federal support to "block grants" to states

We have found over time that our most productive discussions have evolved around the centralization/decentralization question at a strategic rather than an organizational level. It is critically important for Dr. Trujillo to emphasize and demonstrate his commitment to self-determination but also to communicate his responsibility for "system-wide"

performance. He correctly identifies one of his primary challenges as "managing" expectations and behaving in a manner that conveys his sensitivity to local needs while making it clear that the IHS cannot "be everything to everyone." We suggest that the class be asked to develop an outline of the philosophical position of the IHS relative to local needs. Essentially, this exercise results in a definition of the roles the agency is willing to play relative to local health needs.

The IHS should be challenged to look at the issue of Indian self-determination in much the same way as the larger public health community has looked at community-based health needs assessment. By "tuning in" to local concerns, the IHS may actually be able to more effectively leverage its limited resources than by continuing to operate as a centralized bureaucracy. However, the agency should be very careful in decentralizing its strategic decision making to avoid the creation of false expectations. Specifically, we recommend the following approach for discussion.

Dr. Trujillo's commitment to self-determination creates both an opportunity and a threat for the IHS. Ultimately, the mission of the IHS is to improve the "physical, mental, social, and spiritual health" of the American Indian and Alaska Native peoples. The mission explicitly states that this improvement should take place "in partnership" with the peoples. Interestingly, Indian self-determination is a reflection of the "community-based" movement taking place in the larger public health community. Therefore, it is possible to draw some analogies from the public health sector and apply them to Dr. Trujillo's decision making.

Public health agencies have learned, sometimes the hard way, that advocating community-based initiatives can create false expectations that central authorities will automatically and promptly respond to requests for new resources from local communities. In an era of limited resources such as that faced by the IHS, it is important to very carefully specify the role of the central authority and the roles it can perform for tribal communities.

Discussions in class suggest that the best strategy for the IHS is to avoid creating the impression that it will be able to grant all community requests but at the same time ensure local leaders that it can provide valuable assistance. It is suggested, therefore, that the following approach be implemented.

Decision 1. Determine precisely the role of the IHS in Indian self-determination and community involvement.

We suggest that the IHS carefully avoid creating the impression that it can supply all needs. Instead, there are some services it is uniquely equipped to offer.

IHS as Data Collector. There are examples of state public health agencies that have functioned essentially as data collectors for local health departments and communities. The IHS could do the same. In such a case the agency would focus its resources on assembling location-specific data sets and relevant demographics, vital statistics, and other relevant data as inputs for local communities in accomplishing their own community health needs assessments with the aid of the data supplied.

IHS as Facilitator. Some state public health agencies function as a facilitator in community health needs assessment by organizing forums, facilitating discussions, leading focus groups, and so on while distancing themselves from actually doing the needs assessment. In this case the local units and communities are responsible for all of the assessment with the state department functioning only as an objective facilitator and conflict resolver. As facilitator the state agency suggests and negotiates the appropriate process to be used. The IHS could be an extremely important facilitator of local health initiatives.

IHS as Technical Consultant. In this model the central agency is available to provide subject area experts and technical assistance in all aspects of community health needs assessment. As technical consultant the IHS would be expected to have skilled experts to assist in coalition building, survey research, interview protocols, and related areas.

IHS as Advocate of Native American Health. Although this is an important role for the IHS, it is a risky role. As the advocate, the IHS might find itself in the role of problem solver or at least the responsible party for funding the solving of problems. The proper advocacy role for the IHS is political in nature. Political advocacy for the health needs of the Indian peoples is a legitimate role of the central authority.

Decision 2. Agreeing on Philosophy.

To present a consistent message, it is important that the IHS make its philosophy of how self-determination and the health status of the Indian peoples relate to one another. We suggest that following aspects of this philosophy should be made explicit.

Focus on Community. This is the opportunity for the community to assume ownership of its own health and well-being.

Local Control and Participation. It is critical that representatives in the community conduct the actual assessment to facilitate ownership.

Power Sharing. There must be a willingness on the part of the state agency and the local units to share power in a meaningful way. Agency-wide initiatives must have a forum for expression in any health needs assessment and local uniqueness must be addressed as well. A balance between the two must be achieved.

Information and Problem Solving. Community health needs assessment should be data driven and decision making should be based on relevant and defensible information.

Decision 3. Inventorying IHS's Capacity for Community Health Needs Assessment.

If there is agreement on the role of IHS in self-determination and consensus on the philosophy, careful attention must be given to the capacity of the agency to deliver on the services it commits to provide for local communities.

Decision 4. Agreeing on a Process.

Finally, a process must be selected for guiding the community health needs assessment. Some of the more important activities are listed below:

- Identifying community leaders.
- Building coalitions among community leaders.
- Developing governing boards for coalitions of community leaders.
- Profiling the demographics of target populations.
- Inventorying community health assets (resources).
- Assessing community health risks and problems.
- Defining community health needs.
- Holding community forums and event analyses.
- Planning appropriate interventions to address community health needs.
- Providing ongoing technical assistance.
- Evaluation and process improvement.

It is possible to take an approach directed toward conventional strategic management concerns, if the discussion proceeds in this direction. An emphasis on strategy formulation would minimize the centralization/decentralization dilemma.

STRATEGIC ALTERNATIVES

Depending on which stakeholders students decide have the greatest influence, several strategic options are possible. The following have been suggested by students.

Expansion: Diversification – creation of an Indian HMO product (could be developed as a maintenance strategy in which many of the services currently provided by the IHS would be offered in an HMO format instead of piecemeal).

Maintenance: Reorganization – reorganize and re-structure the IHS to give more autonomy to the tribal and local organizations.

Contraction: Divest and Reorganize – divest hospitals and clinics and become, instead, a grant/contract administering agency.

Students may suggest privatization of the IHS. If this suggestion were made, the following points should be discussed concerning implementation. What precedents are there for privatization of government entities? Reminding students of the recurring argument about the VA medical system can stimulate discussion. Many critics suggest that it makes sense to simply pay private providers the fees needed to provide medical care to veterans. The increasingly small number of veterans reinforces the economic case for doing away with the VA medical system entirely and contracting for services with private providers. Some states such as Tennessee have experimented with subcontracting with private firms for the management of prisons. Numerous states have considered "getting out" of the mental health business and contracting with private organizations for essential services. In 1996, an ambitious experiment in school reform in Hartford, Connecticut that involved hiring a for-profit company (Educational Alternatives, Inc.) to run the public school system collapsed. However, other private companies such as the Edison Project, LP and Alternative Public Schools have continued to seek business in this

area. Finally, the 1994 Entitlements Commission of the United States government opened the door to the possibility of the eventual privatization of the Social Security System using the highly successful case in Chile as an example.

Are the treaty responsibilities between governments in effect forever? The most interesting perspective from which to discuss this question is by raising the ethical issue. Treaties are made to last forever or in some cases the treaty provides the means by which an agreement may be altered. Customarily, a treaty remains in force until one or more of the following conditions develop: (1) one or more parties to the agreement decide to cancel the treaty after a proper notice to the other parties of an intent to do so; (2) the failure of one party to carry out its responsibilities; (3) parties to the treaty agree to terminate the agreements; or (4) other reasons agreed on at the time of the ratification of the treaty. In other words, treaties may be looked on as legal contracts and may be terminated in much the same way as a contract.

QUESTIONS FOR CLASS DISCUSSION

1. Who are the stakeholders of the IHS and which are most important?

Many stakeholders of the IHS are obvious, but the relative power position of each may not be quite as obvious. Blair and Fottler suggest analyzing stakeholders in a manner similar to Porter's competitive forces model. The more powerful the stakeholder the more an organization must take the stakeholder into account. More powerful stakeholders probably mean that the organization must be more collaborative or adopt more compromise positions in order to accommodate the powerful stakeholder. Following is a list of the IHS's stakeholders taken from student analyses.

- The Indian and Alaskan Native Tribes. Individual Tribal members are providers, employees, and service population, but the Tribes acting as a unit are the most powerful stakeholders. Students should realize that a major consideration for the IHS is the vast differences between the individual tribes in both customs and beliefs and in relative power; to consider the tribes as one unit may not be the most effective way to analyze tribal importance to the IHS.
- The Congress and the Committees of Congress with oversight of the IHS.
- Other health and human services agencies that supply services (including some health services) for the AI/AN population.
- Lobbying groups such as the National Indian Health Board.
- Other government agencies, such as the Centers for Disease Control and Prevention.
- The local public health departments.
- Governments in states in which the various tribes are located.
- Regulatory, licensing, planning, and accrediting agencies (IHS hospitals and clinics are regulated and accredited like all similar facilities).
- Other primary and secondary care providers, both public and private.
- Educational institutions.
- Pharmaceutical companies.
- Health equipment supply companies.
- The American Public Health Association.

- Other professional associations, such as the AMA, the AHA, and so on.
- The employees of the IHS.
- Organizations that might compete with the IHS's facilities in a given location or nationally such as hospital chains, clinics, and other providers.

Stakeholder Analysis

Stakeholder	Stakeholder's Expectations	Possible Outcome Standards
Community (Indian and non-Indian)	• access to health care and other services • quality care • sanitary environment • job security	• access and quality of care provided • improvements in health status
Indian Health Service (including all levels and parts of the organization)	• the healthiest population possible • continued government funding • continued viability • continued support from AI/ANs • continued input in decisions	• improvements in health status • improved sanitary environment • continued viability • input into decisions
US Government	• provision of health care for the covered population • quality care • IHS to meet policy, regulatory, and treaty expectations	• regulation, policy, treaty compliance • decreased costs to fund greater health improvements
Indians and Alaska Natives	• quality care • access to care • respect of traditions • involvement in IHS decisions	• accessibility to health care • quality of care provided • numbers of complaints about lack of respect or understanding of traditions
Employees	• job security • respect and understanding of traditions • meaningful jobs	• number of lay-offs • number of complaints • amount of input into IHS changes
Physicians and other health providers	• adequate reimbursement for services • adequate patient base • input into IHS changes	• cash flow • ease of referral • input into decisions
Other health care facilities (including contract	• change in AI/AN population served	• flat or decrease in services to indigent

providers)	• no increased financial demands	or underserved AI/ANs

2. Why is the balancing of centralization and decentralization a major challenge faced by Dr. Trujillo?

Dr. Trujillo has a complicated balancing act. The mission calls for the improvement of the health status of Native Americans and he recognizes that even stable resources will demand results. At the same time, he is committed philosophically to self-determination and localized health needs assessment as the order of the day. If Dr. Trujillo allows the IHS to lose its focus by the uncoordinated pursuit of locally defined needs, system-wide results are likely to suffer. On the other hand if he does not allow local communities input into their health needs and assist in responding to local health needs, self-determination will be little more than a slogan and local communities will view the IHS as little more than another Washington bureaucracy. It is critical that Dr. Trujillo develop a statement of precisely what role the IHS is willing to play in self-determination and carefully manage expectations based on this role statement.

3. What factors could impede changes to the Indian Health Service?

Students should recognize and discuss the unique relationship between the Indian tribes, the IHS, and the Federal government regarding health care for AI/ANs. Change is most easily accomplished when those effected by the change participate in it; because there are so many groups effected by change in the IHS, participation by all may be, at best, slow and at worst, impossible. Many organizational changes may require policy, political, or legislative changes first which means overcoming all the usual political problems confronted by governmental reformers. In addition, our political system allows a place for special interest groups who may either slow, speed, or divert legislation. H. G. Rainey maintains that there must be several conditions present in order for change to occur in a federal agency: 1) a durable power center, committed to successful change, 2) appropriate timing for collective support, and 3) a comprehensive, clear, realistic alternative process. Students should be challenged to discover whether these conditions, or some similar set of conditions, are present for the IHS. Two good change sources are:

D. N. Lombardi, *Thriving in an Age of Change: Practical Strategies for Health Care Leaders* (Chicago: Health Administration Press, 1996).
H. G. Rainey, *Understanding and Managing Public Organizations* (San Francisco: Jossey-Bass Publishers, 1997).

4. How can Dr. Trujillo overcome some of the resistance to change?

Students usually realize that Dr. Trujillo could lessen resistance to change within the IHS, and will emphasize these possibilities in their answers that might include some or all of the following points. Although organizational change is usually a form of renewal for the organization, both organizations and most individuals associated with organizations feel uncomfortable with change. Often individuals make an estimate on value for the benefits to be gained from change less the costs associated with change – learning about new

situations minus time and effort needed to re-train, and compare it to the cost of not making the change – losing a job due to down-sizing. Individuals often favor the alternative with the least cost, or with the smallest negative value, for example. Organizations may also calculate the value of change: How much will changing to adapt to environmental forces cost compared to how much will be lost (usually in lost business) if the change is not made and the organization does not adapt to changes in the environment; however similar to individuals, the relative values are often based on perceptions, and perceptions can be altered by organizational leaders.

The IHS may not be able to deal with some environmental pressures it faces either because the stakeholders involved are opposed, or because it cannot absorb the cost. However, Dr. Trujillo can alter the relative values by being aware of the reasons for resistance to change; that is, the reasons for a perception that change costs more than the cost of not changing.

- Lack of "ownership" in the change.

If those affected by change feel they have no input into the change process, they may feel no "ownership" for the change. Participation and involvement in all aspects of the process – change formulation through implementation and control – may help to alleviate this resistance to change. Students can suggest ways that all those involved in a changed IHS could feel more "ownership" of the process.

- Lack of benefits.

If those affected by change cannot see the advantages or benefits they (or their constituents) will receive, they may be unwilling to support change. Clear identification of the payoffs for each group affected may help to increase support. Payoffs can be couched in financial terms or in more qualitative terms, but must be deemed valuable by the group to whom the payoff will occur. Students may use this approach to analyze any recommended strategic changes for the IHS by assessing the payoff of a strategic change for all groups involved.

- Increased burdens.

If those affected by change feel that the change consumes inappropriate or greatly increased levels of time, resources, or energy, they may be unwilling to support change. This analysis is, in a way, the other side of the payoff analysis. Students can assess the "burden," of cost of any strategic change from the point of view of each group; the key to the analysis will be to carefully define the meaning of "burden" for the group. For example, making a strategic change that requires additional time spent in caring for a segment of patients may be burdensome for some stakeholder groups such as Congressional committees, but may be beneficial for others such as the Tribes who have different concepts of time.

- Insecurity.

If groups feel threatened economically, physically, politically, or mentally (emotionally), they may not support changes. Strong, visionary leadership, negotiation, compromise, and clear enunciation of the costs and benefits of strategic changes can minimize this source of resistance. Students may wish to discuss Dr. Trujillo's abilities to perform these leadership duties.

- Fear of failure.

If groups believe that changes will not work, they are unlikely to be supportive of change. The perceptual basis for this source of resistance should be eliminated if the first four sources of resistance are dealt with properly. Students may wish to discuss what would constitute actual failure (as opposed to the fear of failure) in a strategic change, and develop contingency plans and alternatives.

Individual reactions to and perceptions of change are covered in many organizational behavior texts.

S. P. Robbins, *Essentials of Organizational Behavior*, 5th edn (Saddle River, NJ: Prentice Hall, 1997).

J. M. Kouzes and B. Z. Posner, *The Leadership Challenge: How to Keep Getting Extraordinary Things Done in Organizations* (San Francisco: Jossey-Bass Publishers, 1995).

F. Hesselbein, M. Goldsmith, and R. Beckhard (eds), *The Leader of the Future* (San Francisco: Jossey-Bass Publishers, 1996).

D. K. Hurst, *Crisis and Renewal: Meeting the Challenge of Organizational Change* (Boston: Harvard Business School Press, 1995).

5. What are some possible sources of alternative resources that the Indian Health Service might pursue?

Although students may bring up the issue that the IHS is not collecting from third-party payors as much revenue as is due to it, the primary issues in this case are not related to revenue. However, students usually want to discuss aspects of the revenue problem because it is more concrete than some of the other issues presented in the case. Congress passed the Indian Health Care Amendments of 1988, which authorized the IHS to bill, third parties for both inpatient and outpatient services. Third parties include Medicare, Medicaid, and private health insurance providers.

American Indian and Alaska Native people who are eligible for IHS services receive their health care free of personal charge from the IHS. Those individuals who do have insurance coverage (private or government entitlement) will have their policies billed. The IHS does not collect the co-payments or deductibles that are required with some policies. Those individuals who do not have insurance coverage are not charged for the services they receive. An untapped source of revenue for the IHS is an out-of-pocket fee for services provided. This IHS revenue source, for many economic and political reasons, has not been considered.

The good student will be able to find the 1995 review by the Office of Inspector General (OIG) of the Department of Health and Human Services on the Internet. In summary, that review criticizes the IHS for its inability to bill private insurors and follow up on claims effectively. The objectives of the review were to determine whether the IHS accurately billed private health insurance companies and collected for all covered services provided to patients in IHS medical facilities. To test IHS practices, the OIG looked at a 3-month period ending March 31, 1993. The OIG found that the IHS had not established the

controls necessary to ensure that the amounts billed were accurate or that all covered services were billed resulting in the under-billing of private insurers by $7,332,191 during the 3-month review period.

The OIG review found several reasons that the IHS did not file claims or filed inaccurate claims with private health insurers for covered services including:

- An absence of internal controls that allowed errors and omissions to be made and go undetected.
- Business offices that did not have sufficient resources to keep up with the workload.
- Business office staff that were not adequately trained.
- Business offices that used outdated fee schedules and pharmaceutical price lists to prepare claims.

In addition to the $7,332,191 under-billed, IHS business offices had neither contacted private health insurance companies nor followed up on an estimated $1,237,970 of unpaid claims (also during the 3-month review period). This occurred because the IHS did not identify and track the claims needing follow-up, assign sufficient staff to perform follow-up activities, or provide complete follow-up instructions. To maximize collections, the OIG recommended that the IHS should establish the necessary internal controls, assign adequate resources to its business offices, and provide additional training to business office staff to ensure that claims for all covered services are filed and accurate. One way to establish the necessary internal controls, they suggested, would be for the IHS to automate its claims processing system. In addition, the OIG recommended that the IHS distribute fee schedules in a timely manner and implement complete and timely follow-up procedures. Students may develop additional methods to ensure that under billing does not continue. They may also suggest co-payments as required by many insurors.

Depending on which strategic choice students make, other possible sources of additional revenue may be suggested. However, it is probably unrealistic for students to suggest increased budget allocations from Congress.

Students should also discuss other resources available to the IHS. People may be one of these – tribal members or other grass roots organizations – and the education functions they can provide. Other agencies such as state health agencies or authorities, city or county entities, or even entities such as water commissions or highway departments may all be resources for the IHS depending on the strategies chosen.

CONCLUSIONS AND SUMMARY

There are usually four major classroom "take away" lessons from this case.

1. Stakeholders (or constituents) and their interests are vital to the strategic management of a public organization.
2. Centralization and decentralization are not merely lessons from management history but remain an important dilemma for strategic decision makers in public as well as private organizations.
3. Leaders are needed even in government "bureaucracies."

4. Leaders and organizational stakeholders can – together – bring change to even the most structurally bound organization.

EPILOGUE
(The following information is publicly available and will probably be discovered by the good student.)

Trujillo's leadership and vision were instrumental factors in the formation of the Indian Health Design Team (IHDT). This task force of tribal leaders and IHS executives was given the duty of designing a new and more effective IHS, one that would not only have fewer levels of management, but would also direct its resources to local tribes and communities. The team used a process based on participation and involvement with the other stakeholders in Indian health care, including the National Indian Health Board, Indian people, tribal leaders, and IHS staff and professional employees.

The team followed simple, but unique, guiding principles. The IHDT felt that it was important to:

- put the patient first,
- focus on health,
- respect cultural sensitivity,
- empower local decision making,
- build accountability into the new system,
- consult with Indian people, and
- honor, uphold, protect, and advocate sovereign rights.

The team in a draft report released preliminary findings and recommendations in July, 1995. The draft received many comments and constructive criticisms from stakeholders of Indian health and the design process continued and was fueled by these new suggestions. The final report, entitled *Design for a New IHS: Final Recommendations of the Indian Health Design Team*, was released in February 1997.

The IHDT found that one design could not support all of the differences found among the various tribes at the local levels. Instead, the team decided to focus on the support functions of the organization – that is, the Area Offices and IHS Headquarters. The implementation of the redesign would occur in two phases.

- Phase One involved the restructuring of IHS Headquarters and was scheduled for completion in 1997. The plan called for streamlining the IHS Headquarters organization from over 132 divisions and branches to less than 50. These condensed units were grouped into three major offices: the Office of the Director, the Office of Public Health, and the Office of Management Support. The core functions of the new IHS Headquarters focused on advocacy for Indian health, strategic leadership, and support for the Indian Health Care System.
- Phase Two of the IHDT plan involved Area Office redesign and was scheduled for completion in 1998. The Area Offices were to be made more supportive of local health programs. By removing the controlling role of the Area Offices, funds could be saved and administrative staffs decreased. Any changes at the Area level were to involve the local tribes and Service Units.

CASE 8

Dr. Louis Mickael: The Physician as Strategic Manager

OVERVIEW

Dr. Louis Mickael is a physician who has been in solo practice for thirty years. Beginning in the early 1980s, enormous changes have taken place within the health care industry that extensively changed the process of providing care to patients. These changes have precipitated stress and extended working hours for Dr. Mickael. At this time, three problems, or concerns, face him as he nears the age of sixty, a point in life when most people are contemplating retirement.

The first problem he must face is that health care regulatory processes are making it extremely cumbersome to carry on the activities of a physician practice. Second, the average age of his patient base has increased; the outcome is that more time and resources are required to provide care needed by these older individuals as the economic base that is available to fund their care is eroding.

The third concern for Dr. Mickael is that competitive forces are beginning to dictate a change in the way he can deliver health care to his patients. His normal mode of interaction with patients is very much the old-fashioned, "country doctor" approach. Pressures brought about by the regulatory shift that have precipitated a high degree of competition between physicians are an affront to his in-grained set of values.

These issues add up to a dilemma for the Doctor, one he feels forced to address through the evaluation of strategic directions currently available to him ranging from retirement to career change.

KEY ISSUES

1. The concept of product life cycle as it is exemplified in a health services context.
2. The extent to which a clarification of organizational objectives (as reflected by Dr. Mickael's values set) are important in an analysis of financial viability.
3. Marketing in the health care sector as a function of differentiation of service(s) provided.

TEACHING OBJECTIVES

1. To provide an opportunity for students to develop strategy and policy in a small privately owned health care organization.
2. To illustrate that physicians' practices are businesses in today's health care environment and they need strategic management as much as any other health care organization.
3. To illustrate how the environmental changes in the health care industry have affected the lives of the major players – the physicians.
4. To illustrate that physicians have to work harder and longer hours and know more about business to maintain their standard of living.

SUGGESTIONS FOR EFFECTIVE TEACHING

This case portrays the physician as a reactive manager. Prior to the 1980s, this attitude was adequate because financial remuneration for services provided was not predicated on development of the objectives of the firm into a strategic plan. Health care has become more regulated, and functioning within this sector requires that physicians develop a competitive strategy to continue "doing business."

Using a textbook approach to organizational analysis and strategy formulation and implementation (this could emanate from a general management, health care administrative, or entrepreneurial focus), the student can see the multitude of ramifications that environmental (regulatory) change holds for an industry and an organization operating within that industry.

The information provided can be organized for either written or in-class presentation format at the senior undergraduate or master's level. The student is expected to develop an environmental assessment and an internal capabilities analysis using decision support tools that have been previously addressed in class (such as TOWS, IFE, EFE, Grand Strategy Matrix, and so on). It is also expected that thoughtful analysis of alternative strategies will indicate a recommended strategy, and that plans for implementation will be included.

STRENGTHS/WEAKNESSES AND OPPORTUNITIES/THREATS

A summary of Dr. Louis Mickael's internal strengths and weaknesses and external opportunities and threats is provided below.

Strengths

1. Dr. Mickael is an experienced, caring physician who is personable and well liked by his patients.
2. He is energetic, appears to be in excellent health, and is able to maintain a very hectic schedule.
3. As a hospital board member, Dr. Mickael is deeply involved in the medical community power structure.
4. He has a good awareness of the changing medical environment.
5. He shares space with another physician who provides patient coverage in his absence.
6. He has access to a competent computer systems consultant.
7. His client base is stable.
8. The office is in close proximity to the hospital.
9. Good financial condition – net working capital has remained around $35,000 in each of the past three years. All expenses are paid in the current quarter.
10. Dr. Mickael is in a position to exit the market with a minimum of loss. Other than the expenses of closing the office and the work involved to aid the other two doctors in renting the empty office, liquidation proceedings could commence immediately.

Weaknesses

1. The patient treatment process is often in disarray (i.e., runs late, doesn't adhere to schedule).
2. The office layout is inadequate in space and design.
3. Staff and organizational structure is disorganized and poorly managed (no full-time staff or well-trained office manager).
4. Inordinate amount of Dr. Mickael's time is spent on committee memberships.
5. Staff privileges are held at only one, small hospital.
6. There is no marketing plan other than word-of-mouth, and the patient base demonstrates great stability (little growth).
7. The office is located away from the growth center for the community.
8. Expenses are rising, revenues are not, and financial strength is eroding.
9. Aging patient base.
10. Dr. Mickael has a limited background in business management.

Opportunities

Threats

1. Greater emphasis on primary care as a method to control health care costs.

2. Businesses are increasingly interested in ways they can control rising health care costs as they perceive their ability to compete internationally to be threatened and to have significant impact on the bottom line.

3. Hospitals are purchasing physician practices.

4. Aging population.

1. Continuous change in reimbursement methods and governmental regulations leads to decreased revenues and increased administrative costs.

2. In the health care sector, general overhead costs are increasing faster than revenue growth.

3. Urban decline.

4. Competition from hospitals.

5. Increasing number of physicians working in specialties.

6. Economic growth of areas bordering the business district.

7. Hospitals seek to move middle-aged physicians toward retirement and replace them with younger physicians.

STRATEGIC ALTERNATIVES

Adaptive Strategies.

1. Expansion/product development – attainment of Family Practice certification.
2. Expansion/diversification – specialize in industrial medicine.
3. Contraction/divestiture – retiring from medical practice.

Market Entry Strategies.

1. Purchase/acquisition – purchasing Dr. Charles' medical practice.
2. Cooperation/joint venture – procuring a partner.

Value Adding Service Delivery/Pre Service (Marketing Strategy).

1. Locate office away from the center-city area that would offer better opportunities for growth.

QUESTIONS FOR CLASS DISCUSSION

1. How has the health care industry changed in the past decade?

Significant changes occurred for this industry early in the decade of the 1980s. Expenditures for Medicare had approached $59 billion by 1983, and in 1984 the US government initiated a prospective payment system (PPS) of reimbursement to replace the retrospective system that had previously been in use. Other private insurers soon followed suit, reflected in the emergence of health maintenance organizations (HMOs) and preferred provider organizations (PPOs). The structural and regulatory changes have led to a situation in which financial remuneration for delivering health care is declining, in large measure because of increasing administrative costs.

The environmental impact of PPS sent out "shock waves" that have changed the profile of the health care industry. With few exceptions, the industry is comprised of structures through which services are dispensed to health care consumers quite differently from those in place at the beginning of the 1980s. It is now comprised of organizations that must compete for their share of the health care market, and who need to develop the concept of competitive strategy, not just as a precursor to growth, but often simply to survive.

2. Use an analysis of the competitive power of third-party payors as buyers, direct competitors, and the threats of new entrants and substitutes to compare the industry environment experienced by Dr. Mickael prior to the early 1980s with the environment in which he now is working, approximately ten years later.

Note: Information needed should be available from the case, a general knowledge base, and material available through any hospital, academic, or public library.

Power of Buyers
Health care is unique in that receivers of services are usually not the entities responsible for paying much of the bill for those services. In the early 1980s, a prospective payment system was developed by Medicare; other insurors followed suit, and a system of coding illness diagnoses and health care procedures (DRGs) was undertaken that is still being continually refined. The regulation has drastically changed the process of fee reimbursement for health service providers.

Power of Competitors
Direct competitors are other physicians who, for the most part, were not concerned about their share of the patient market prior to the early 1980s. This is no longer true. The market is now smaller, given that funds for care to each patient are more restricted. This means that break-even and positive bottom-line figures require service to more patients than ever before. There is now competition from other private practitioners operating solo or in groups. PPOs and HMOs may serve as aggregates of peers that can capture a portion of the patient market.

Using both horizontal and vertical integration, hospitals are directly competing with private physicians. Their organizational structures have expanded to include a broad range of for-profit and not-for-profit health services offerings, such as free-standing clinics and wellness centers.

Threat of New Entrants
There are strong financial and educational barriers to entry in this profession. Depending on the specialty, setting up a practice could run into thousands of dollars before the physician recaptures the costs of education and practice setup. This has been true for quite a long time. Now, however, as revealed in the case, competition from this sector is not necessarily an individual effort as hospitals join forces with new entrants to reduce the entry barriers for an individual physician, and at the same time increase their competitive power over other hospitals.

Threat of Substitutes
Substitutes for the traditional health care practiced today have come about largely since the beginning of the 1980s. The rising medical costs for being ill have precipitated a strong focus on the business of staying healthy. Research on stress, for example, has provided evidence that a sound exercise program can help eliminate the deleterious effects of stressful work, overweight, and some of the aging processes. Fitness centers have been built to address a number of such programs, and indications are that a healthier populace is beginning to replace the original patient market.

3. What other environmental factors should be included in an analysis of this case?

Sociocultural – Patient Demographics
In the beginning stage of Dr. Mickael's practice, the typical patient was in his or her mid-thirties, and had an annual income of less than $20,000. Today, his patients average 58 years of age, and their average income of $25,000 does not reflect an increase that is commensurate with the increase in the consumer price index (CPI).

Nearly 60 percent of his patients are currently subsidized by Medicare insurance. The remaining patients are self-pay, or reimbursement is sought through memberships represented by Medicaid and PPOs.

Sociocultural – Physician Value Set
This physician is very patient-oriented. His approach resembles the "old-time country doctor" who is familiar with patients on a very personal basis and is often perceived as a family member because the physician-patient relationship is so intimate. This is a holistic approach to medical practice that traditionally has involved an inordinate amount of time spent with each patient; it has become an inefficient way to practice medicine in light of the regulatory structures now in place for reimbursement.

Industry Infrastructure
Hospital structures have changed dramatically in response to changing market demand. A shift in reimbursement protocol, along with technological advancement, has resulted in a much higher proportion of health care patients being treated through hospital outpatient services. In addition, as hospitals have attempted to acquire more market share to augment

declining patient bases, they have differentiated service offerings to encompass both not-for-profit and for-profit enterprises.

An additional element in this infrastructure is the expansion of certification and specialization offerings. The emergence of family practitioners and industrialized medicine are examples. The role and responsibilities undertaken by the general practitioner have undergone a major shift. Most obstetrics and gynecological problems are now referred to specialists, as are a multitude of other patient internal diagnostic concerns.

Technological
The advances in this sector have enabled the physician to cope with the rapidly changing medical environment. Computer technology that has created "high-tech" diagnostic and therapeutic instrumentation has also made available efficient and affordable practice management hardware and software.

Economic
From 1985 through 1989 a survey by *Medical Economics* showed practice expenses rising at a rate well above inflation. In 1989 alone, they surged 19.8 percent, the biggest one-year jump in a decade. During the 1980s, the increase in the cost of living outpaced physicians' gain in median net income.

4. What is the financial posture of this practice?

Dr. Mickael is experiencing some financial difficulty. This is confirmed by the losses of $1,827 and $1,866 in 1989 and 1990 and the income of $350 in 1991 (see Exhibit 1 in this Note, derived from Exhibit 8/5 in the case). The balance sheets for the same time periods disclose several areas of concern. Cash on hand has decreased approximately 46 percent, accounts receivable has increased nearly 50 percent, and stockholder's equity has declined (see Exhibit 2 in this Note, derived from case Exhibit 8/6). The average collection period for accounts receivable (see Exhibit 3 in this Note, derived from case Exhibit 8/6) has increased nearly 25 percent over the past three years.

Dr. Mickael's Z scores (see Exhibit 4 in this Note) have increased. This indicator, taken by itself, is optimistic, and although his profitability would indicate otherwise, he is still paying bills with current assets and does not have any debt. However, in diagnosing any case, ancillary support tools can render an invaluable "second opinion."

5. Given that Dr. Mickael prefers not to retire just now, what recommendations exist for him?

Accept City General's offer to provide financial backing for a new physician certified in family practice to join Dr. Lou's practice in anticipation of his retirement within the next few years.

Pros:

- Will increase the ability of the practice to handle a larger volume of clients.
- Will take away some of the responsibilities from Dr. Mickael.
- Will add another person to top management that will increase the objectiveness of decision making.

Cons:

- Will require additional space that does not presently exist.
- May be difficult to attract a partner considering Dr. Mickael's aging patient base and the demographics associated with the current location.
- Will add salary expense.
- Will require Dr. Mickael's adjustment to no longer being the sole decision-maker.

Buy Dr. Charles' practice.

Pros:

- Will provide room for a new physician on Dr. Mickael's staff.
- Will provide an immediate influx of new patients, many of whom are already familiar with Dr. Mickael.
- Should alter the current patient mix and improve the financial position.

Cons:

- Will require sizable investment.
- Will increase expenses, including rent, which is allocated on a square foot basis.

Reorganize the office staff in line with needs related to current industry constraints.

Pros:

- Should increase cash flow through speedier forms processing, thereby reducing accounts receivable.
- Will improve client satisfaction through more efficient handling of forms and processing of claims.

Cons:

- Will add to expenses.
- Will probably necessitate termination of one, or possibly two, of the current staff. This would not head the list of Dr. Mickael's priorities.

Rearrange the office layout in the existing structure or move to new quarters with a layout better suited to Dr. Mickael's needs.

Pros:

- Will increase office efficiency.

Cons:

- Will require considerable expenditure.

Become certified in the field of Industrial Medicine and obtain a position with a local company.

Pros:

- Will free Dr. Mickael of the "long days" in the office.
- Will reduce stress level for Dr. Mickael.
- Will allow someone else to "handle the business" so that all Dr. Mickael has to do is practice medicine.

Cons:

- Will require an investment in time and money.
- Will require that Dr. Mickael find an employer in a satisfactory location.
- Will require that Dr. Mickael leave a practice in which he has considerable time and emotion invested.
- Dilemma associated with concern about abandoning current patients.

Backward or forward vertical integration as a SPACE analysis suggests that Dr. Mickael's strategic position is in the "Competitive" sector, indicating an unstable industry, but a practice profile that has some financial stability. Therefore, another alternative that is appropriate for firms in the competitive vector is either forward or backward integration to add programs of health maintenance and illness prevention (forward), or the addition of a testing facility (backward).

Pros:

- This could add convenience for patients, and increase the marketing function as more and more individuals go through the facility.
- Offers the possibility for partnership with other physicians, thus becoming a broader marketing tool.

Cons:

- Will entail addition of staff and an increase in expenses and investment.
- Will require additional business management time and focus, neither of which Dr. Mickael has in great supply.

EXHIBIT 1 Dr. Louis Mickael: Statements of Income for the Years Ended December 31

	1991	1992	1993
Operating revenue:			
Professional fees	$172,281	$172,472	$204,910
Interest income	992	456	210
Total revenues	173,273	172,928	204,910
Operating expenses:			
Salaries	117,455	124,608	132,325
Professional dues and licenses	1,925	1,873	1,816
Misc. professional expenses	1,228	2,246	3,232
Drugs and medical supplies	2,550	1,631	2,176
Laboratory fees	2,629	524	1,801
Meetings and seminars	2,543	838	3,880
Legal and professional fees	5,525	2,057	5,400
Rent	16,026	16,151	18,932
Office supplies	4,475	3,262	4,989
Publications	1,390	406	401
Telephone	1,531	1,451	2,400
Insurance	8,876	9,629	11,760
Repairs and maintenance	3,547	4,240	5,352
Auto expense	1,009	1,487	3,932
Payroll taxes	3,107	2,998	3,780
Computer expenses	846	938	1,905
Bank charges	438	455	479
Total operating expenses	175,100	174,794	204,560
Net income (loss)	($1,827)	($1,866)	$350

EXHIBIT 2 Dr. Louis Mickael: Balance Sheets at December 31

	1991	1992	1993
Assets			
Capital equipment			
Medical equipment	$11,722	$11,722	$11,722
Furniture and fixtures	3,925	3,925	3,361
Less-accumulated depreciation	6,477	9,094	11,891
Total capital equipment	9,170	6,533	3,192
Current assets			
Cash	15,994	9,564	8,666
Petty cash	50	100	100
Accounts receivable	19,081	25,054	28,509
Total current assets	35,125	34,718	37,275
Total assets	$44,295	$41,271	$40,467
Liabilities			
Current liabilities			
Income taxes payable	639	653	123
Dividends payable	1,158	1,154	1,154
Total current liabilities	519	501	1,277
Owner's equity			
Net income (loss)	(1,188)	1,213	229
Less: dividends	1,158	1,154	1,154
Retained earnings	(2,346)	(2,367)	(925)
Capital	46,122	43,137	40,117
Total owner's equity	46,122	40,770	39,192
Total liabilities and owner's equity	$44,295	$41,271	$40,467

EXHIBIT 3 Dr. Louis Mickael: Average Collection Period in Days for the Years Ended December 31

	1979	1986	1991	1992	1993
Accounts receivable/ (annual credit sales/365)	48.95	85.54	40.43	53.02	50.83

EXHIBIT 4 Dr. Louis Mickael: Z Scores at December 31

Variable	1991	1992	1993
X1 = Working Capital/Total Assets	0.79	0.84	0.92
X2 = Retained Earnings/Total Assets	1.00	1.00	1.00
X3 = EBIT/Total Assets	(0.04)	(0.05)	0.01
X4 = Market Value of Equity/Book Value of Total	0.00	0.00	0.00
X5 = Sales/Total Assets	3.89	4.18	5.06
$Z = 1.2X1 + 1.4X2 + 3.3X3 + 0.6X4 + 1.0X5$	6.10	6.42	7.60

where EBIT = earnings before income tax