Does Diversification Make Health Organizations Healthier?

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The Twenty-Ninth Annual George Bugbee Symposium on Hospital Affairs conducted by the Graduate Program in Health Administration and Center for Health Administration Studies of the Graduate School of Business, Division of Biological Sciences, University of Chicago, was held at the Ambassador West Hotel, Chicago, on May 8, 1987. These symposia are a reflection of strong concern of the Graduate Program in Health Administration with complex current issues in health care management.

The topic for this, the Twenty-Ninth Symposium, was chosen by a committee of the Alumni Association because of its relevance in this period of changing environment for health care institutions. These proceedings are published and distributed in the hope that they will prove useful to both practitioners and students of health care management.

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INTRODUCTION

RONALD ANDERSEN: Welcome to the twenty-ninth annual George Bugbee Symposium on Hospital Affairs. The symposium is sponsored by the Center for Health Administration Studies and the Graduate Program in Health Administration at the University of Chicago. Each year, alumni choose a subject for the symposium's topical input and generic relevance to effective health care management. The program is directed toward you: our alumni, students, and colleagues who are interested in health services management and research.

Our topic this year is diversification in the health services sector. Hospitals and other health care organizations are producing an increasing variety and range of products and services in areas such as ambulatory care, geriatric care, health promotion, home health care, and outpatient diagnostic services. They are also reorganizing the way in which services are provided, by forming various mergers, consolidations, affiliations, arrangements with health maintenance organizations (HMOs), primary care units sponsored by hospitals, and preferred provider organizations (PPOs).

In this symposium, we have asked a knowledgeable group of executives, researchers, and educators to consider with us a range of questions about this diversification. These include why it takes place, what makes it successful or unsuccessful, what should managers keep in mind when considering diversification, what role does competition play in diversification activity, and finally, what questions remain to be answered about the causes and effects of diversification.

We will begin with an overview of diversification efforts. Our presenter is Everett Johnson, Professor and Director of the Institute of Health Administration at Georgia State University. Ev is also the director of two health care consulting firms, the E&J Group and Physician Contract Services of Marietta, Georgia. He was formerly CEO of Gary Methodist Hospital. He is a long-time associate of the Graduate Program in Health Administration, where he began as a preceptor and lecturer in the early 1950s, and was its Associate Director from 1977 to 1979. He is active in many associations. He was a member of the House of Delegates in the American Hospital Association, and was Chairman of the American Congress of Health Care Executives. He also writes numerous books and articles. His most recent book, Hospitals Under Fire, was published by Aspen Systems, Inc. in 1986.

Our discussant is Mark Shanley, Assistant Professor of Policy and Organizational Behavior at the Graduate School of Business at the University of Chicago. He was previously an instructor in the School of Business at Fairfield University and also in the Wharton School of Business Administration at the University of Pennsylvania. He was also a program consultant for Macro Systems and a reference specialist for Aspen Systems Corporation. His research focuses on studies of firm acquisitions and

strategic decision making. He has also looked at the impact of hospital organization.

HOSPITAL DIVERSIFICATION -- WHAT WENT WRONG?

EVERETT JOHNSON: The popular health care phrase used to describe diversification in hospital programs is "alternative revenue sources." However, the experience of many hospitals in diversifying is contradictory: "alternative expense sources."

Fortunately, many diversifying hospitals have maintained reasonably robust bottom lines so that their entrepreneurial ventures have not generally seriously threatened their financial futures. However, this view is of limited value because it is based only on personal knowledge. Up to the present time there have been no organized data collection and overall analysis of the total results of hospital diversification in the last few years.

TWO ORGANIZATIONAL STRATEGIES

Hospitals have used two different organizational strategies for diversification. The traditional strategy has been the establishment of a new service or department, such as a Hospice Program, within the existing corporate structure.

The word diversification is now generally used in the hospital field to describe the establishment of separate corporations in a parent-subsidiary structure with a mixture of not-for-profit and for-profit subsidiaries operating at multiple sites.

This concept was initially popular as a way of side-stepping certificate-of-need regulations and restrictions in cost reimbursement formulas.

The variety of different parent-subsidiary structures used by hospitals reflects both local market opportunities and their degree of willingness to be venturesome. Usually the first step in developing a multi-corporate structure has been the establishment of a foundation. These became popular in the seventies to offset the capturing of undesignated gifts to hospitals by Medicare. Foundations functioned as fund-raisers for hospitals and in organizational entity for land acquisition both on and off campus sites.

As Medicare reimbursement became more restrictive in the late 1970s and certificate-of-need regulations more rigorously controlled new program and building efforts, additional corporate entities became more attractive. The popular corporate model became the parent-subsidiary arrangement with the hospital corporation becoming a subsidiary corporation.

These new corporate structures were promoted by hospital executives to their governing boards. Generally hospital directors responded enthusiastically but thoughtlessly. In order to demonstrate the need for a

new parent corporation, other than the hospital corporation, chief executive officers prepared lists of potential health care business opportunities in such a way that it appeared to hospital directors that several corporations would be needed to accommodate the variety of businesses proposed.

Once the parent subsidiary corporate concept was approved in principal by governing boards, several subsidiary corporations were created even though there were no immediate plans for implementation. Frequently these corporate shells have subsequently been maintained without any activity being undertaken.

MARKETPLACE COMPETITION

In 1982 the Tax Equity and Fiscal Responsibility Act was enacted and quickly followed in early 1983 with the Prospective Payment System Amendments to Medicare, which placed price caps on their services. The hospital reaction caused the daily patient census to head South as patient days per thousand population often dropped 50 percent in their primary market area.

At the same time competitive medical plans, health maintenance organizations, and preferred provider arrangements quickly increased in popularity. The net effort in 1983 and 1984 of decreased inpatient service volumes and capped or discounted prices stimulated interest in diversification and corporate restructuring.

Probably the most popular idea in 1984 to offset the reduction in hospital revenues was to develop joint ventures between hospitals and members of the medical staff through a real estate limited partnership type of organization. The basic incentive for hospitals was the belief that physicians would use the services of such an entity because physicians had an investment in its operation. It was a time of contradictions: not-for-profit hospital executives who had criticized as unethical the investor-owned hospital corporation's sale of stock to physicians using their hospitals were now actively promoting limited partnerships in the not-for-profit hospital's joint venture -- and did not recognize their hypocrisy.

Whether a hospital initiated a joint venture or a wholly-owned subsidiary corporation, in 1984 the timing was poor. It was a year of uncertainty and much effort. Hospital revenues had to be adjusted to diagnostic related groups for billing purposes, health maintenance organizations were rapidly expanding, as were prospective payment systems, and ambulatory care demand was soaring.

Not much administrative time remained for diversification. Nor was there any sense of confidence about the bottom line of the hospital. It was not a time for risk-taking --even though it was the right time.

CORPORATE COMPROMISES

What went wrong with diversifications? Not much for a very few hospitals, such as Northridge Hospital in California that eventually emerged as Health West. For the vast majority of metropolitan hospitals several major problems were never directly confronted nor resolved.

The most frequent outcome of a corporate restructuring was a failure to recognize and clearly separate the parent board of directors from the subsidiary hospital board of directors. In many reorganizations the parent board was significantly smaller than the hospital board, but was predominately staffed by influential hospital board members.

The result was a transfer of conservative hospital trusteeship viewpoints to the board of the parent corporation. These prior hospital board members did not have the perspective or skills to be venture capitalists. These existing perspectives were usually further reinforced by appointing the hospital chief executive officer to the chief executive officer positions in the parent corporation and promoting the chief operating officer of the hospital to the hospital's chief executive officer's position.

This typical corporate musical chair game prevented the acquisition of skills and experiences needed to be successful in developing new market ventures. In essence the new chief executive of the parent faced the same restraints he previously experienced in the hospital corporation: hospital funds were to be spent only for sure-fire successes and only in limited amounts. The perspective of the board members remained the same as the ones they held as hospital directors. Fundamentally, they did not know how to think and organize as venture capitalists.

Operationally, the board of directors of the parent protected the assets of the hospital corporation as if they were still hospital trustees: which is to say that insufficient resources were committed for marketing and promotion and too many resources committed to overhead before the ventures became operational.

The typical development pattern of parent-subsidiary structures that was followed was to establish a corporate office for the parent at a site away from the hospital campus, and then to hire a chief executive officer, a financial officer, a staff of two to five people for marketing and planning, and sufficient secretarial support. Expenses were immediately incurred with no offsetting revenues -- and typically revenues never expanded sufficiently to exceed expenses in the following years.

Too often in the rush to create a parent-subsidiary structure the importance of reserved rights for the parent to control the subsidiary corporations were overlooked. The size and composition of the boards of the operating companies were not carefully thought through, nor the parent board's authority to appoint and remove subsidiary directors. Little thought was given to the selection of experienced legal counsel and audit

firms to insure satisfactory operations for the multi-corporate structures.

In addition, the need for centralized control of operating and capital funds and budget approvals was ignored. Because the hospital was the major profit producer, there was typically little or no discussion at the time the hospital board approved a parent corporation of how to flow surplus funds from the hospital to the parent. To do so would have highlighted for the hospital board the extent to which they were losing control of their decision-making authority.

One of the major reasons for the failure of hospital diversification to develop substantial income producing businesses has been the lack of either insight or willingness to decide the issue of reserved rights at the time of formation. Only at a later time has this failure become apparent to governance. By then the accomplishments of the multi-corporate organization had been so limited that to raise this issue was likely to lead to a reversion to the original corporate structure.

THE PRICE OF INEXPERIENCE

The reasons for the lack of success in diversification has varied by the type of business venture a hospital tried. The lack of experience of hospital executives in planning and developing a new business venture and their reluctance to hire experienced people to direct the hospital's diversification programs has clearly been a major reason for failures.

Too often a hospital has moved into a new program without first developing a carefully worked out business plan. It frequently appears that the chief executive officer merely assigned a project to an associate with instructions to be responsible for its development without any formal assessment of market risk, actual or potential competitors, defining a market strategy or estimating the downside risk. What was defined was a range of expenditures that would be authorized for the project.

When a business plan was developed it was often less than complete and frequently not adhered to as the project developed. There was a lack of discipline and market judgment as the plan was implemented, particularly when members of the hospital medical staff became involved in or were affected by a new venture.

The price of inexperience has often been reflected in optimistic market projections that overestimate both short and long term volumes and revenues and underestimate the time required for the projected volumes to be achieved.

Another characteristic reflecting inexperience has been the over-spending on new buildings by applying the same construction standards used in hospitals. For example, a hospital purchased the practices of several physician groups and erected a new medical office building to house

them in one location. The new building is known locally as a Taj Mahal. The hospital has a large gross revenue from the purchased practices, but no profit because of excessive construction costs. What the hospital did in effect was to trade 1965 dollars for 1985 dollars and erased the profit margin of the practices in the process.

When hospitals hire a developer for a new venture they often select a developer offering the lowest fee, rather than basing their selection on the quality of the past experiences of the developer. In one case the hospital paid the lowest priced developer a fee of $750,000 to establish a retirement center. The developer did not do a thorough market study. As a result the retirement center was built in a rural area that did not attract sufficient residents to become financially successful. That hospital has now been merged into a hospital chain in order to prevent bankruptcy.

Other kinds of misjudgments have occurred when hospitals sponsored managed care ventures. A common problem is to under-capitalize either a health maintenance organization or a preferred provider organization and accommodate the shortage of start-up funds by spending less on marketing efforts than is desirable. Another element in managed care often not developed satisfactorily is the management information and utilization control systems. Frequently planned utilization targets are exceeded and management does not exercise the controls necessary to obtain physician's compliance because of the expected adverse reactions of their medical staff.

A third major problem hospitals experience with managed care programs is a lack of total coverage of the planned market area of the health insurance program. In some instances managed care programs have required exclusive contracts from physicians. This restriction operated in two ways to constrain enrollments: by arbitrarily limiting the number of physicians participating in the program as well as the number of insured willing to be limited by the physician providers available.

Hospitals that have developed free standing ambulatory care centers in the majority have been marginally profitable. Usually either the market research on locations and services was incomplete, or the recommendations of the research effort were ignored in terms of location and promotion.

In medical office buildings ventures hospitals have usually been successful in metropolitan areas and were breakeven in small towns. Generally, though, medical office buildings have been one of the better investments for hospitals.

Imaging centers are usually wholly-owned by radiologists, but are occasionally a joint venture with a hospital. In both instances they have been successful.

Many ambulatory surgery centers have not fulfilled their revenue projections when jointly-owned by a hospital and surgeons, but usually are

profitable when wholly-owned by the hospital.

Other business ventures for diversification have included ambulatory services, retailing medical equipment and supplies, apothecaries, wellness centers, health clubs, and reference laboratories. Generally, even though some of these ventures have had revenues of several million dollars, their net income has been a small loss or gain. None have been sufficiently successful to produce million dollar profits.

WHAT WENT WRONG

In medium and large size hospitals with an enthusiastic diversification program, there are typically five to fifteen subsidiary corporations. One example is a 300-bed hospital that has nine corporations in addition to the hospital corporation and the parent corporation. Last year these nine corporations had $17,500,000 in gross revenues. Three of the companies had a net profit of $524,000 while the other six had a combined loss of $798,000 for an overall consolidated loss of $274,000. For the same fiscal period the hospital had a net gain of about $5,000,000.

To produce these results there were 430 full-time equivalent employees in the nine subsidiaries. With this kind of experience the obvious questions are "was it worth it" and "what went wrong?"

The usual response about the worthwhileness of the effort is that it protected the primary market area of the hospital. A more reasonable conclusion is that hospital executives are rationalizing a lack of success.

The enthusiasm for corporate restructuring and diversification started to wane in the last year. A number of hospitals are reversing directions by closing their separate parent corporate offices and either terminating the staff or reassigning them to the hospital organization.

On the face of it the lack of success of hospitals to diversify into health-related businesses would seem to be unusual. However, it is more likely a measure of the uniqueness of the hospital marketplace and the economic protections for hospitals during the last 50 years.

The inability of hospitals to successfully diversify are the same reasons which generally affect other business ventures. Overall their focus was financial and operational rather than strategic and entrepreneurial. Their parent- subsidiary corporate structure dispersed accountability and provided no personal incentive for management to succeed.

Operationally there was a lack of specialized talent and no bonus or stock option for success. The senior managers of the subsidiaries usually also carried major management responsibilities in the hospital organization. Consequently, if the venture failed they still maintained their hospital

position. There was no penalty for failure or marginal success -- and no reward for outstanding success.

What happened was a lack of awareness that new business ventures were not the same as the hospital business. Hospital trustees went through the usual legal maneuver to establish new corporations and then expected them to take off and run like the hospital. Hospital thinking and operations were replicated for new concepts without identifying any reasons to operate in a different fashion. Even though the functions were different the form remained the same.

Conversely there are hospitals which have successfully diversified and are on the way to becoming billion dollar a year businesses. The difference seems to have been at the level of the board of directors: and particularly with one or two directors who had successful business careers. They steered their hospital boards and executives in different ways than the majority of hospitals.

Probably the most important difference was their leadership in creating a small parent board that was separate from the hospital board with a membership similar to their business experience.

These successful boards can be characterized as directors who knew how to solve problems and were willing to forcefully express their opinions; not simply to say what they were against. They were willing to be risk-takers, to occasionally be wrong, and to accept criticism and financial failures. They had the courage and persistence to hire competent executives with mature judgment and back up these executives.

The directors of these successful parent corporations routinely did their homework, were prepared for board meetings, and were objective in their thinking. They made a difference.

Successful diversification programs can be characterized by the articulation of their subsidiary corporations into an overall coordinated market strategy. Their strategic planning was carefully worked out and each business venture had a strong rationale for its creation and operation. They believed that a hospital had a right to develop an economic future for itself and were not constrained by actions of a medical staff. On the other hand, they worked hard to avoid antagonizing physicians, but did not allow a medical staff action to prevent them from entering a market.

WHERE TO FROM HERE?

What can be expected in the next few years from hospital diversification efforts? From the events now taking place it seems likely that hospitals will no longer try to start new business ventures across the health care spectrum. They appear to be learning that special expertise is needed to convert a good idea into a profitable business.

What they are now working on are the development of affiliations and consolidations in acute care services. Large, inner-city tertiary level hospitals are hard at work finding hospital partners in the suburbs and small towns to strengthen their referral base. They are also coupling these moves with the development of managed care programs to increase their attractiveness to potential partners. If other subsidiary businesses facilitate these arrangements, such as an ambulance service, or a variety of educational programs, they are also developed.

Another shift still underway is the conversion of a District or Authority hospital organization into a parent-subsidiary structure to eliminate the political restraints which exist in quasi-public institutions.

The heyday of widespread diversification has passed. However, diversification will continue at a moderate pace with more thought and careful development than in the past. Except for a few hospitals, it will never provide economic salvation, but will gradually expand to provide a broad range of coordinated health services within a community. The essential key will be control of a managed care program that articulates a variety of healthcare services in a cost effective way.

MARK SHANLEY: When I came here this morning I was very much expecting to discuss a lot of ways in which diversification health care would be different from that in business. I was surprised, and very pleasantly surprised, to find that Ev was talking about many of the points that could be made to criticize business diversification as well. I can take very little issue with many of his points. I found the talk very informative and highly insightful. I would just like to amplify a few of the points that he made.

The first point is the importance of a strategy. This gets overlooked quite often, but you will find that the successful diversifiers think in terms of skills that they can transfer and in terms of what they can provide to an acquired firm as well as what they may receive from the acquired firm or the new venture. That is frequently overlooked. It comes up in Ev's point about the lack of willingness to invest in new ventures in an acceptable way.

The second point also relates to strategy. If you do not have a strategy, it becomes very difficult to define what you are seeking and to characterize a diversification effort as a success or a failure. Without a clear strategy, it is difficult to identify what constitutes success or failure on any terms. In a sense, the whole process becomes one of experimentation where indeed you end up rationalizing your outcomes, rather than evaluating how well you made decisions in the first place.

A third point in Ev's talk which I thought very informative was his discussion about various types of separations that need to occur organizationally. You need to separate the corporate structure from the subsidiary structure. That is very important, and it works both ways. You need to recognize corporate prerogatives in managing a totally diversified organization. At the same time, you must recognize the need for autonomy at the subsidiary level. Related to this is the need to recognize differences among related subsidiaries. I'm not saying that the solution is very easy. Relatedness among new ventures has to be the key. Successfully diversified firms have to move out from carefully defined course skills. But they need to recognize that they are different from one another.

In terms of research needs, when I have talked with corporate executives about how they manage their diversification efforts, the one phrase that came up time and time again concerned planning: you need to do your homework. I cannot stress that enough. What you have in a poor diversification strategy is one that is thought up and sounds plausible, but is not checked by solid research. What happens then is that after the deal occurs, whether it is a new venture or an acquisition, there are surprises. The failure to anticipate the surprises and the failure to structure for those surprises causes many of the organizational problems that Ev talked about.

These were the basic points that struck me. Again, I have little to dispute because these were the same insights that I found in looking at business firms.

QUESTIONS AND ANSWERS FOLLOWING TALKS BY DRS. JOHNSON AND SHANLEY

QUESTION: I have a question to which both of you seem to subscribe, and I wonder if you could elaborate. Why do you keep boards separate? Why do you keep a corporate board separate from a subsidiary board? What is the purpose of doing that? Secondly, I wonder if you could comment about paying boards.

EVERETT JOHNSON: Number one, I think you have got to get a corporate board that is interested in what you are doing. Number two, I think you have to have people interested in what you are doing. The one thing that hospitals ignore that is crucial -- and we routinely ignore it -- is our need for hospital directors, (or directors in any corporation) who know the industry. We do not have people who know the industry on hospital boards. That is the one reason they are so weak today. You have got to have people that know the business you are in. From my point of view the board is there fundamentally to advise and help you think through a problem. A hospital board works by consensus decision-making, which is not the way a lot of other boards operate. They will tell the CEO "this is what we think," and never even take a vote. Then the CEO is off and running. In a hospital boardroom, what do we do? Two people object and so we delay the proposal. We send it back to committee because we want more information. Time goes right out the window. That is the problem and the reason why you need separate boards. Should you pay them? Absolutely.

MARK SHANLEY: In terms of general separation between corporate and business unit boards, I would agree completely with Ev that you have to have people who know the business. The trouble is that when you diversify, if you do not separate the boards, you get people who are familiar with the hospital but not with the new businesses. The problem there is that the corporate level has got to deal with multiple businesses: apples and oranges. At the individual level, you have to deal with the specific business. The real problem there is getting the overall view and making the people who make corporate decisions still accountable for how they work out. I do not have any simple solutions for that.

EVERETT JOHNSON: Let me add one point. When you have, for example, a parent-subsidiary board arrangement, it's very frequent that you take a hospital board and part of its leadership and place them on the parent board. Do you know what happens? They still operate to protect the profits of the hospital instead of bringing them to the parent to spend for something else. We go back and buy another x-ray machine or something else for the hospital.

RONALD ANDERSEN: I understand from you Ev, that there is nothing fundamentally unwise about going into diversification for hospitals. It is in how they do it. Is that your point?

EVERETT JOHNSON: In general. They have not been doing it well.

QUESTION: But it is wise to diversify if you are doing well.

EVERETT JOHNSON: I think so. I can give you several examples. Santa Fe Health Systems in Florida and Riverside in Norfolk are examples that are well on their way to becoming billion dollar corporations. They will make it in the next decade. They also couple diversification with some kind of a managed care program. You have to have a tool in order to help integrate your total market system.

QUESTION: Ev, you mentioned one example of a hospital maintaining its liability and making a profit, and the subsidiaries losing money. You said that one basic reason given was to protect the markets. Thinking back to the previous question, it would seem to me that that is sometimes a hard response to refute, in deciding whether or not the bottom line is a good indicator of whether diversification is working or not.

EVERETT JOHNSON: I think you're right. It is hard to refute. Except when you analyze, go into a situation and look at all the issues. I guess I cannot at the moment pick out clearly one, two, three or four factors. You get an overall impression that the response is an alibi. When you see that they did not put senior management totally into these roles, and that they did not buy the experience and talent that they need to do it, you sort of work your way back and say, "Well...". These people are still essentially, in most instances, working for a hospital board even though it is called a parent. They are also trying to protect their job. So they say, "This is what we're up to." I do not blame them for doing it if they can get away with it. But in terms of trying to get the job done, it is not going to work. At least they can protect their jobs. Everybody likes to eat.

QUESTION: Don't you think there's a major clash in the cultures between an entrepreneurial effort where you have risk takers versus a large industrial organization in which a hospital would be a typical one where you have people who are incremental managers and preservers of capital, working at the margins? Also, you have major classes of the kinds of people who like to work in different sets. How do you get those two distinct groups to work? Is it by acquisition? Is it by separate incentive systems? How do you do it?

EVERETT JOHNSON: I think your comments simply point out how difficult it is realistically to get the job done. One of the things that has always in a sense depressed or negatively impressed me is the fact that a lot of business boards do not know how to start other businesses, and they simply go on an acquisition kick. They do not know how to do it, either.

QUESTION: Before we go further, does either one of you have any suggestions on board composition? Ev, you mentioned a little bit that people should know something about the business you are in.

EVERETT JOHNSON: You're absolutely right.

QUESTION: How about adding positions?

EVERETT JOHNSON: Are we talking about parent or hospital board?

QUESTION: Hospital board.

EVERETT JOHNSON: Sure, I have no question about that. I think any hospital that does not add positions is going in the wrong direction. But I think they ought to be the key leadership roles in the medical staff because the board functions in that instance as a coordinating mechanism. At the parent, I don't think so. On the other hand, at the parent level, there's got to be a sensitivity, if we're going to do a certain business venture. How is this going to impact our medical staff? Is it worth the risk of adverse reaction from a medical staff? Or how do we limit the risk or impact on the positions? And many times I see business plans that I think are half-baked but never include in the plan how we handle or how we assess what it does to the current members of the medical staff of the hospital. They just completely ignore it. The most common example I can think of is when we start some primary care centers away from the hospital, and we staff it with newly employed physicians on a salary and ignore the economic impact on the attending staff. They are competing with the doctor's office building two blocks away. All those guys are on your medical staff and they get mad, and then people wonder why. I just do not understand this kind of thing.

QUESTION: Ev, I know you have strong feelings about board composition in hospitals. I've heard you speak less about board composition of subsidiaries. Well, basically the question is, it sounds like you have lots of concerns about the way hospital boards are structured, but aren't there even more concerns about how the subsidiary boards are structured?

EVERETT JOHNSON: Not more, but equal. I would think you can find all kinds of different types of errors when you go into this area. I guess the most typical thing is that a hospital board or the parent decides we have six little subsidiaries that we hope will go someplace. And they have a board of twenty-two people. They divide them up and put them on those boards, and the administrative staff assigns one or two administrators of their organization to that board likewise. Do you know what happens? I know some CEO's in the parent who spend over half their time in board meetings. I don't know how you get anything done when you do that. I think the most effective way to do it is to have a very small board on the subsidiary. Three, four, or five people, mostly management, maybe one from the parent board who is not management so that they would have some kind of a control, like an audit on the system. And that's the way I would go. Just to save time to get a focus on what you are doing. And I'd put them on a bonus system to get the job done.

QUESTION: When you develop that kind of a harmony, aren't you running a risk of individual subsidiary corporations doing things that will harm the parent corporation -- harm the hospital corporation -- and establishing the kind of competition that might be set up between the main business and relatively autonomous subsidiaries?

EVERETT JOHNSON: That is why you have a parent organization. I would say this, as a useful adage, decentralize decision- making, centralize coordination. That is easier said than done. But if you follow that principle, I do not think those problems occur. Or when they start to occur, you know about them and step in and take corrective action.

DIVERSIFICATION AND STRATEGY OF MULTIPRODUCT HEALTH CARE FIRMS

STEVEN LAZARUS: I have difficulty leaping into the subject of diversification. From my perspective, the perspective of a former executive of a major health care company and a present board member of a community hospital, the diversification decision is often a derivative, one possible consequence of a process, and not necessarily the best one.

Optimally the diversification decision emerges from a continuous and thoughtful planning process. I want to spend a few minutes and describe what I mean by that.

I have found that effective planning -- whether it be conducted by a corporation, a hospital, or the Department of Defense -- has three major characteristics: intent, a scanning technique, and the capacity for opportunistic modification.

By intent, I mean central purpose or central direction. I am inclined to use the metaphor of a journey, a cross-country trip. You head for Seattle and irrespective of the detours and diversions you experience, your default position always points you toward Seattle. In my judgment, the shared perception of a central tendency is the organizing principle of an institution. This has implications for a diversification strategy.

While planning intent is necessary, it is also dangerous. Habit can replace reason and activity can become robot-like. Those familiar with Shirley Jackson's short story The Lottery will recall the image of a prosaic community annually selecting one of their number to be stoned to death for a reason long forgotten.

One of the two great potential flaws in any planning system is the absence of a scanning mechanism, a well-disciplined and coherent method for gathering factual and current information on environmental change and competitive activity.

The tendency of institutions and enterprises is to be insular and inbred. It has frequently been asserted that many of the problems of the U.S. automobile industry originate in the tendency of automobile executives to believe that the entire world was composed of Grosse Pointe and Bloomfield Hills, Michigan.

Technologies change, and such change renders practices obsolete. Economics change, vastly modifying anticipated financial return. And perhaps most importantly, competitors act. Most competitive action requires response if an institution is to remain healthy.

The second great potential flaw in a planning system is the inability to take opportunistic action. A scanning mechanism will provide intelligence

regarding environmental changes and competitive activities but such intelligence is useless if it does not trigger timely mid-course corrections in the flight path of a plan. Returning to the metaphor of a plan as a journey, these would be the detours and diversions necessary to permit continued progress toward the original destination.

So much for planning abstractions. It would be useful if, in practice, planning systems operated in this fashion, but all too often they do not.

In many institutions planning systems do not even exist. This was the case with most hospitals well into the 1980s. More often they are peripheral and are treated by the decision- making apparatus of the organization as adjunctive. Decisions are consequently all too often a product of egotism, insularity, all the penalties of success. And non-decisions, a particularly virulent consequence of flawed planning systems, are more likely. In my judgment, institutions and enterprises tend to be inertial, tend to resist change, and all too often fall under the aegis of mediocre leadership.

Against this background, let me take up the subject of diversification. I have always found it to be a faddish word -- like competitiveness -- and a potential trap. It was in the name of diversification that many of the Rube Goldberg conglomerates - the LTV's, LITTONS, and ITT's of the 1960s were put together -- and these have not proven to be enduring constructs. Furthermore, diversification in my opinion, must always be examined as one of several alternative strategic responses to environmental and competitive changes. Others might be restructuring, vertical integration forward and backward, consolidation, and so forth. In part, we are dealing here with a problem of definition. The term -- diversification -- is blurred at the edges. Some use it as a rubric for all forms of enterprise modification. I will try to employ it in a narrower fashion.

Why diversification? Since I am speaking from experience and observation rather than to report the results of disciplined research, I must hypothesize.

The two primary motivations are fear -- usually prompted by identification of a perceived strategic threat, and, secondly, the appearance of opportunity. Unfortunately, all too often the opportunity is made manifest by the action of a competitor and the decision to diversify then becomes intrinsically imitative.

The involvement of ego is worthy of some research. Powerful CEOs with docile boards gain national swashbuckling reputations through aggressive acquisition programs. And by doing so they have made their companies tempting targets for takeover specialists who could calculate considerably higher breakup values.

But before I give you the impression that I believe all diversification to be unwarranted, let me hasten to say that there has been and will continue to be successful diversification.

I will try to describe what I believe to be certain critical success factors. The first is what I call "relatedness," a difficult term to define. It might be easier to illustrate what it is not. AVCO Manufacturing, since swallowed by Textron, both classic conglomerates, briefly flirted with the movie making and distribution business and failed. No one from AVCO's Industrial Manufacturing or Financial Services arms understood it. Market familiarity is enormously helpful but many enterprises trap themselves by loose definitions of markets.

During the last ten years, several large pharmaceutical companies moved into the field of medical devices and found that industrial sales to hospitals was a very different thing than drug detailing.

"Skill leverage" is often cited as a strong success factor in diversification. American Hospital Supply Corporation had a great success channelling an extraordinary heterogeneity of product lines through its enormously strong distribution system. Baxter Travenol, my alma mater, employed world class skills in sterilization and plastics packaging to develop a variety of business relating to the human blood stream.

On the other hand, the Voluntary Hospitals of America have difficulties creating an insurance entity even with Aetna as a partner. Humana has had similar difficulties and it will be interesting to see how well HCA and Equitable fare together.

I would speculate that decentralized independence of operation is a success factor in diversification -- provided there is a strong effective leadership in place. Bristol-Meyers has diversified successfully for decades using this principle and continues to do so as it moves into biotechnology with the acquisition of Genetics Systems. Abbott Laboratories is another example of effective decentrally-managed diversification.

Deep financial capability is helpful. Several years ago Dupont set out to build a health care group, largely through acquisition. If an enterprise has the resources and the stamina to ride out the inevitable early mistakes, diversification can ultimately be successful. On the other hand, Warner Lambert is a good illustration of how much a company stands to lose by not recognizing the difficulties of venturing into a new area.

While hospital diversification is not my specific topic, the present trends in both community and teaching hospitals raise the spector of managerial overload.

For example, Beverly Hospital, a 233-bed facility north of Boston, is today a mini-conglomerate operating acute, long-term, home care, medically

assisted housing, ambulatory care, a medical office building, a kidney dialysis center, and a birthing center. It has relationships with a variety of managed care entities and is exploring affiliation relationships with other provider institutions and groups. This same pattern is being repeated throughout the country and presents an enormous challenge to hospital leadership, much of which is relatively new.

As a final element of my presentation I would like to illustrate some of the material thus far discussed with three experiences from my years at Baxter:

1. ENTERING THE HOME CARE BUSINESS -- 1980

Strengths
- A good planning system in place.
- A strategic assessment showing treatment locus shifting out of the hospital.
- An existing skill set and core distribution channel developed over fifteen years for the home dialysis business.
- Strong relevant technology.

Weaknesses
- Lack of awareness of systems needs and different operating requirements.
- No experienced managers.

Assessment
- After seven years, a strong success.

2. BUILDING A HEALTH CARE INFORMATION BUSINESS -- 1981

Strengths
1. Presumed access to the buying marketplace
2. Some in-house technical skill
3. Financial capability
4. Successful models to emulate

Weaknesses
1. Late to market
2. No market selling experience
3. Effort required to integrate acquisitions
4. Time required to build infrastructure
5. Inadequately anticipated competitive reaction

Assessment
- After six years, just into the black

3. MAJOR CONSOLIDATION -- 1985

Opportunities
1. Outcome could be world's largest/strongest healthcare company
2. Enormous synergism available

Risks
1. Large debt
2. Necessity to integrate cultures
3. Still within healthcare -- an environment becoming more difficult
4. At the moment of entry -- a bet the company gamble -- putting it in play

Assessment
1. Strategically preemptive move
2. Still shaking down but looking successful
3. Market valuation has doubled

The future health care executive, like Paul Tillich's comment about 20th century man, must learn to become comfortable with ambiguity. The environment forces this executive toward a variety of economic activities such as the consideration of diversification and away from maintenance of quality of care. I maintain that this will become something of a "O sum" game, and quality will suffer. It is a matter for serious public policy consideration.

LYND BACON: Thank you, Steve, for your useful insights and views on diversification, strategy and planning. In responding to your comments, I'd like to first make some observations, some of which are speculative, on context of strategy-making in general. I'll then spend just a few moments considering strategy-making from the standpoint of the key decision-maker.

The examples of diversification that Steve just gave illustrate that some strategic issues faced by different kinds of firms in the same industry at roughly the same time can be quite similar. This is due to the fact that changes in the factors controlling market structure determine the bounds on the behavior of firms, that firms in the same distribution channel can, under many conditions, affect each other, and finally that competitors can affect each other's output decisions. In the health care industry, the inventory behavior of hospitals affects the behavior of firms that supply the inputs to the treatment production process. When major regulatory change and technological innovation began to stem the growth of the inpatient care market, many hospitals implemented strategies to reduce inventory costs (and also, parenthetically, to diversify). This undoubtedly affected the profitability of supplier firms and caused them to seek new opportunities, some of which Steve has just described. The important observation here is that strategies of firms in the same industry are intertwined.

Diversification can be thought of as either a characteristic of a particular market, or as something a firm does. Most of our discussion today has employed this latter definition. Different types of diversification can be distinguished. In the tradition of the study of industrial organization, diversification may be either "related" or "pure conglomerate" in form. This relatedness, which Steve has referred to, is usually in terms of production processes, channels of distribution, or managerial expertise.

From a marketing perspective, diversification means entering a new market with a new product, as distinguished from new product development, new market development, and market penetration. This fairly common definition is due to Ansoff (1957). All of these are a type of growth strategy. Kotler (1980) has advanced a slightly different definition. He defines what he calls "concentric" diversification as entering new product/markets where synergies may be exploited, and "horizontal" diversification, which is a new product in an existing market. Other definitions may be found.

These differing definitions may suggest to you that there can be problems with actually measuring diversification, and these problems are non-trivial. It is not always clear how much a product can be changed before it becomes a new one, nor how much the needs of consumers must change before a new market is being served. In the literature examining the relationship between the diversification of manufacturing firms and other firm characteristics, diversification has been proxied in various

studies by the number of S.I.C. codes, and the spread of total sales volumes across codes. Such measures don't obviously indicate the idea of "relatedness", which, from a strategy-formulation perspective, is an important construct. Good measures of diversification that represent economies in the production of related health care services are clearly needed to study diversification across health care firms. Generally speaking, if you have difficulty measuring a construct, you have difficulty determining its effect. It may therefore be the case that market-wide, a posteriori analyses of the effects of diversification may be less illuminating than well-planned case studies that generate useful hypotheses and suggest comparisons to firm behavior in other industries.

I think we can all agree that diversification results from some kind of decision-making process within a firm and that generally this behavior is goal-directed. Given that these decisions are a response to market characteristics, diversification is "downstream", so to speak, from a variety of factors that must be understood to understand diversification. One aspect of real markets that is little understood consists of the dynamic interrelationships between the strategies of firms.

Any firm can be thought of as having to deal with two classes of decision problems related to its environment. The first consists of managing its channels of distribution. A channel of distribution may be thought of as consisting of multiple decision-makers with separate decision variables. These variables include things like quality and price. Such a channel in health care could consist of a supplier and a hospital, a hospital and a physician, or supplier and hospital and physician. How each channel member behaves can be shown to have implications for the profitability of the other channel members. It should be noted that, generally speaking, channel profits will be submaximal if coordination in distribution is lacking. This will happen in the case where independent decision-makers act purely in their own self interests when setting the values of their decision variables.

One way of coordinating distribution is vertical integration. The conventional wisdom is that this strategy is advisable when market growth is occurring, and it was commonly discussed in health care not long ago. Vertical integration means that some channel members must give up control over their decision variables. Some potential undesirable results may be that variable costs will rise because of centralized decision- makers not having the same level of expertise as the old ones, having to buy products from competitors, and possible anti-trust violations.

Another way of coordinating distribution is by simple contracting between firms for specific performances. Here some channel members also must give up control. There may be incentives to cheat in the short run, and enforcement of contracts can be difficult.

Jeuland and Shugan (1983) have shown that cooperation amongst