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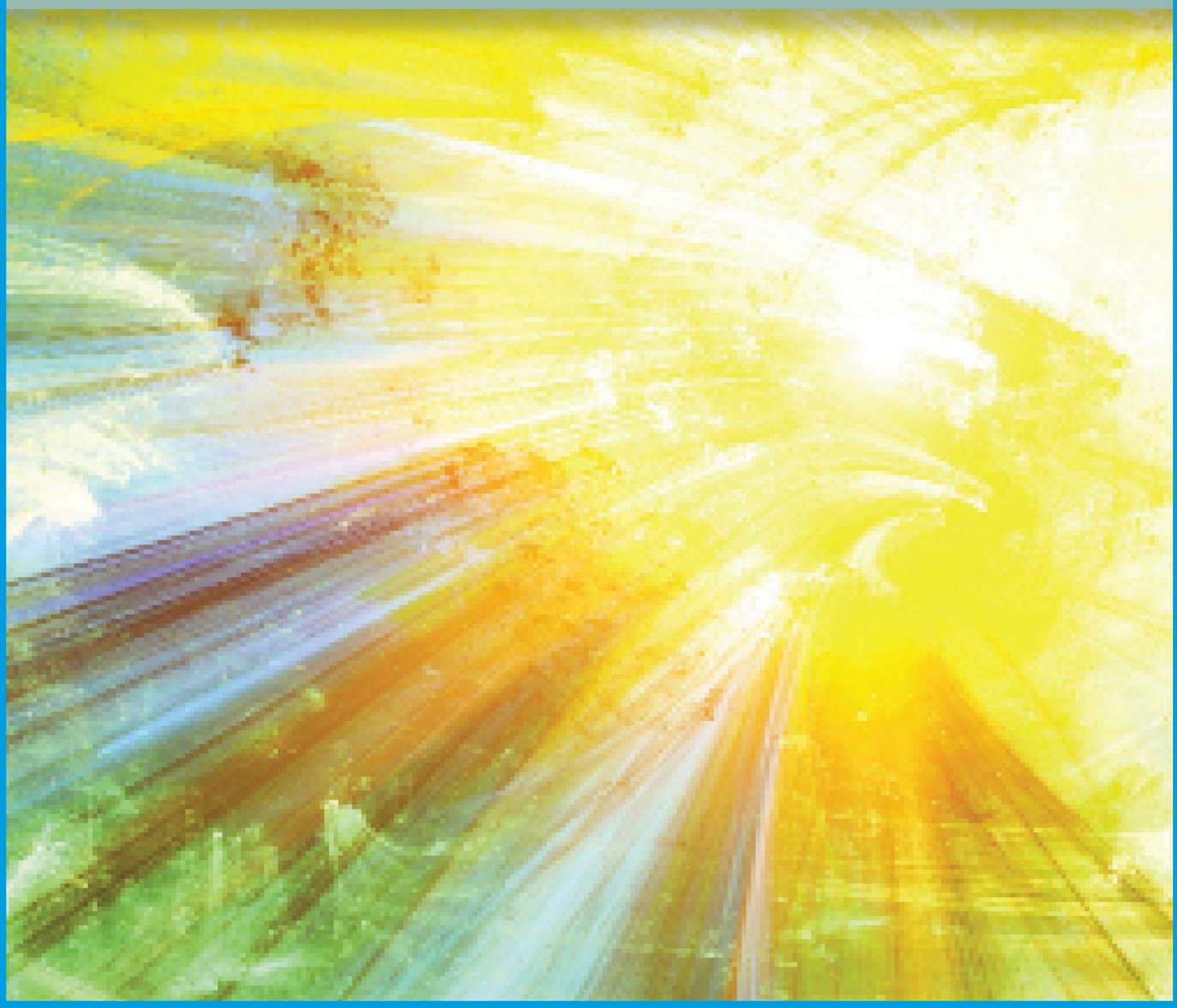
Seventh Edition

Shortell & Kaluzny's

Health Care Management:

Organization Design and Behavior

Lawton Robert Burns | Elizabeth H. Bradley | Bryan J. Weiner



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***Shortell and Kaluzny's Health Care Management: Organization Design and Behavior*, Seventh Edition**
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Foreword

For twenty-five years and six editions, we have attempted to provide an integrative perspective to the organization and management of health services, presenting the major management theories, concepts, and practices of the day. We have also provided practical illustrations and guidelines to assist managers and prospective managers in the provision of health services in a variety of settings.

As we go to press, we have entered the era of health care reform, presenting new and perhaps not so new challenges and opportunities. Under the leadership of Rob Burns, Elizabeth Bradley, and Bryan Weiner, the invited chapter authors have provided a thoughtful and in-depth analysis of the theories, concepts, and approaches that managers and prospective managers need to address the critical issues in the provision of health services as well as meet the challenges and opportunities resulting from health care reform.

The passage of health care reform brings a great deal of uncertainty as it attempts to address the long-standing problems of access, quality, cost containment, and significant disparities under unprecedented economic conditions. Much has changed as reflected in the mandates regarding access to coverage, coverage itself, the role of public and private programs, and health insurance exchanges as well as the role of comparative effective studies, payment reforms, accountable care organizations, and patient-centered medical homes.

While these represent significant changes in the operation of the delivery system, the fundamental managerial challenges remain and will continue to require skillful attention if health care and the various delivery organizations are to realize their potential. Issues of maintaining a motivated workforce, assuring state-of-the-art practice patterns, coordinating various disciplines and specialties to the benefit of patient care, and accommodating an ever-expanding technology within a market economy that would benefit the patient and the larger community have been and will continue to be the major responsibility of management.

This seventh edition provides readers with the relevant theories, concepts, tools, and applications to address operational issues that managers face on a daily basis. As described in the lead chapter, the key challenge facing organizations and their managers is to deliver "value"—the ratio of quality to cost. While this has always been a concern, the reality of present-day economics and the developing science has made this imperative.

The book is divided into three sections. The first section provides two insightful introductory chapters presenting the challenges of providing health services and some of the conceptual maps necessary to help guide managers in the decision-making process and providing a framework for understanding the role and contributions of management and leadership within a variety of health care settings.

The next section focuses on the Micro Perspective—Managing the Internal Environment. This perspective addresses the classic issues of organization design, motivation, communications, power, organizational learning, performance/quality improvement, and managing groups and teams. Each chapter provides an "In Practice" scenario that sets the scene for the concepts and tools for effective management.

The last section, the Macro Perspective—Managing the External Environment, focuses on the organizational context and addresses the challenge of achieving competitive advantage and managing alliances. Four new chapters will help prepare managers for the uncertainty of the years ahead. These include the challenges of managing an ever-expanding information technology, consumerism, an increasingly complex regulatory environment, and finally the recognition that we live in a globalized world.

Health services management has come of age, and Burns, Bradley, Weiner, and their colleagues have presented the theories, concepts, and guidelines that future managers will need to succeed in the years ahead.

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Preface

INTRODUCTION

This book is intended for those interested in a systemic understanding of organizational principles, practices, and insights pertinent to the management of health services organizations. The book is based on state-of-the-art organization theory and research with an emphasis on application. Although the primary audience is graduate students in health services administration, management, and policy programs, the book will also be of interest to undergraduate programs, extended degree programs, executive education programs, and practicing health sector executives interested in the latest developments in organizational and managerial thinking. It is also intended for students of business, public administration, medicine, nursing, pharmacy, social work, and other health professions who will assume managerial responsibilities in health sector organizations or who want to learn more about the organizations in which they will spend the major portion of their professional lives. Previous editions have been translated into Polish, Korean, Ukrainian, and Hungarian, and we look forward to the book's continued use by our international colleagues.

TEXT APPROACH

The seventh edition broadens the view of the health care sector beyond the traditional focus on hospitals and other provider organizations to include suppliers, buyers, regulators, and public health and financing organizations. It offers a comparative, global perspective on how the United States and other countries address issues of health and health care. Additionally, the book discusses managerial implications of emerging issues in health care such as public reporting, pay for performance, information technology, retail medicine, ethics, and medical tourism. Finally, this seventh edition expands upon a major theme of prior editions: health care leaders must effectively design and manage health care organizations while simultaneously influencing and adapting to changes in environmental context. Managing the boundary between the internal organization and its external environment is therefore a central task of health care leadership.

ORGANIZATION

The organization of the book reflects this expanded theme. Part 1 provides an overall perspective on the health care sector, discusses the distinctive challenges facing health care organizations, and examines the roles of leaders and managers in influencing organizational culture, performance, and change. Part 2 focuses on core leadership and managerial tasks within organizations. These include motivating people, guiding teams, designing structure, coordinating work, communicating effectively, exerting influence, resolving conflict, negotiating agreements, improving performance, and managing innovation and change. Part 3 describes the broader context in which health care organizations operate and discusses the managerial implications of several emerging trends and issues. These include the pursuit of strategies to achieve the organization's mission, the growth of strategic alliances in the health sector, the expansion and complexity of health law and regulation, the uses and challenges of health information technology, the rise of consumerism in health care, and the global interconnectedness of health systems.

FEATURES

The Seventh edition continues several popular features from the sixth edition. These include the following:

- An explicit list of topics provided at the beginning of each chapter.
- Specific behaviorally oriented Learning Objectives highlighted at the beginning of each chapter.
- A list of Key Terms that readers should be able to define and apply as a result of reading each chapter.
- An "In Practice" column describing a practical situation facing a health services organization.
- A section in several chapters called "Debate Time," which poses a controversial issue or presents divergent perspectives to stimulate the reader's thinking.
- Comprehensive Managerial Guidelines and Summary points at the conclusion of each chapter.
- Discussion Questions that help reinforce chapter concepts.

NEW TO THIS EDITION

The seventh edition updates the case studies included in the sixth edition along with the case discussion questions. It also updates the ongoing developments in health policy and regulation, as well as the research evidence in each chapter's subject matter. It also includes several new authors, expanding the community of healthcare management scholars contributing to this volume.

MINDTAP

MindTap is a personalized teaching experience with relevant assignments that guide students to analyze, apply, and improve thinking, allowing you to measure skills and outcomes with ease.

- MindTap features a complete integrated course combining additional quizzing and assignments, and application activities along with the enhanced ebook to further facilitate learning.
- **Personalized Teaching:** Becomes yours with a Learning Path that is built with key student objectives. Control what students see and when they see it. Use it as-is or match to your syllabus exactly–hide, rearrange, add and create your own content.
- **Guide Students:** A unique learning path of relevant readings and activities that move students up the learning taxonomy from basic knowledge and comprehension to analysis and application.
- **Promote Better Outcomes:** Empower instructors and motivate students with analytics and reports that provide a snapshot of class progress, time in course, engagement and completion rates.

INSTRUCTOR RESOURCES

Instructor Companion Site

The Instructor Companion site for this text offers many valuable support materials. To access the Instructor Companion site, go to http://login.cengage.com.

If you have a Cengage SSO account: Sign in with your e-mail address and password.

If you do not have a Cengage SSO account: Click Create My Account and follow the prompts.

The following support materials are included:

- **Electronic Instructor's Manual**—The Instructor's Manual that accompanies this book includes an overview of the In Practice and Debate Time material from the text, suggested solutions to the end-of-chapter discussion questions and case studies, teaching tips and exercises, complimentary reading lists, suggested solutions to the Vignette material in the study guide, and an overview of additional Debate Time material from the study guide.
- **PowerPoint presentations**—This book comes with Microsoft PowerPoint slides for each chapter. They're included as a teaching aid for classroom presentation, to make available to students on the network for chapter review, or to be printed for classroom distribution. Instructors, please feel free to add your own slides for additional topics you introduce to the class.
- **ExamView®**—ExamView®, the ultimate tool for objective-based testing needs, is a powerful test generator that enables instructors to create paper, LAN, or Web-based tests from test banks designed specifically for their Cengage Course Technology text. Instructors can utilize the ultraefficient QuickTest Wizard to create tests in less than five minutes by taking advantage of Cengage Course Technology's questions banks or customize their own exams from scratch.
- **Sample Course Syllabus**—The Sample Syllabus was developed to help instructors customize specific course titles.

ABOUT THE AUTHORS

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ACKNOWLEDGMENTS

We believe that the major strength of this text is the diversity of the talented authors, who contributed multiple perspectives, experiences, skills, and expertise to each chapter. The new and substantially revised chapters reflect the breadth and depth of the authors' expertise as well as their fresh perspectives. We wish to acknowledge with gratitude the immeasurable contribution that Stephen Shortell and Arnold Kaluzny have made in the fields of health care management research and education. As scholars, advisors, mentors, and colleagues, they have deeply influenced our work and our professional lives. Through the six editions of this book, over the past twenty-five years, they have helped educate a generation of health services researchers, policy makers, managers, and health professionals. We hope that the seventh edition sustains the tradition of excellence that these gentlemen have established.

Finally, we wish to acknowledge Lauren Taylor and Rachelle Alpern for their excellent editorial assistance.

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1

PART ONE
Introduction

Chapter 1

Delivering Value: The Global Challenge in Health Care Management

Lawton Robert Burns, Elizabeth H. Bradley, and Bryan J. Weiner

CHAPTER OUTLINE

- The Challenge: Deliver Value
- Challenge of Rising Health Care Costs: Supply- and Demand-Side Price and Volume Drivers
- Other Challenges Exacerbating the Value Challenge
- The Challenges are Global
- Complexity of the U.S. Health Care System
- Why Changing the Health Care System Is So Difficult
- Systemic Views of Health and U.S. Health Care
- Organization and Management Theory
- Summative Views of Organization Theory
- Organization Theory and Behavior: A Guide to This Text

LEARNING OBJECTIVES

After completing this chapter, the reader should be able to:

1. Discuss the challenge of delivering value in health care
2. Identify the major forces affecting the delivery of health services
3. Distinguish the similarities and differences in the forces shaping health services globally
4. Discuss why it is difficult to change the health care industry
5. Develop a system view of health care delivery
6. Discuss the different types of firms operating in a health care system
7. Identify, discuss and apply the major perspectives and theories on organizations to real problems facing health care organizations
8. Analyze in analyzing problems from multiple theoretical lenses

KEY TERMS

Ambidexterity
Bending the Cost Curve
Bounded Rationality
Bureaucracy
Classical School of Administration
Complex Adaptive System
Contingency Theory
Decision-Making School
Evidence-Based Medicine
External Environment
Health Systems
Hospital–Physician Relationships
Human Relations School
Institutional Theory
Iron Triangle
Macro Perspective

Micro Perspective
Moral Hazard
Open Systems Theory
Population Ecology
Resource Dependence Theory
Scientific Management School
Social Network Approach
Strategic Management Perspective
System Perspectives
Triple Aim
Value
Value Chain

• • • IN PRACTICE: The GAVI Alliance

The Global Alliance for Vaccines and Immunization (GAVI) is one of the largest global health initiatives (GHIs) that targets specific diseases/conditions to help meet Millennium Development Goals. GAVI was launched at the World Economic Forum on January 31, 2000, to improve the distribution of new and underused vaccines to low-income countries and thereby reduce childhood mortality and morbidity, and increase the health status of these populations (GAVI Alliance, 2010; Martin and Marshall, 2003; Milstien et al., 2008).

GAVI was a partnership of developing countries, organizations involved in international development and finance (e.g., United Nations Children's Fund, the World Health Organization, the World Bank), the pharmaceutical industry, and philanthropic organizations (e.g., the Bill and Melinda Gates Foundation provided seed funding of $750 million). GAVI lacked presence at the local level, and thus relied on its partners for planning and implementation in each country.

A number of managerial challenges faced the GAVI Alliance in achieving its goals. First, the vision of the GAVI Alliance had to motivate local countries to participate in this vaccination program and gradually increase their own funding for it. Second, local countries needed to accept the responsibility to deliver the vaccine programs and the attendant results. Third, these countries had to help develop and manage local infrastructure to deliver the vaccines to rural populations—often referred to as the last hundred yards or miles of the supply chain. This meant the countries needed not only transportation and distribution networks but also a cadre of local health care workers with training in vaccine storage and administration. Fourth, the GAVI Alliance had to manage diverse stakeholders, including its core founding members such as the World Bank, WHO, UNICEF, and the Gates Foundation. Fifth, the GAVI Alliance had to operate with a lean structure such that bureaucracy did not slow its progress. Sixth, the alliance had to develop leverage over pharmaceutical firms to purchase the needed drugs at a lower cost, which local countries could afford. Last, the GAVI Alliance needed a clear governance structure with defined responsibilities for partners.

Since its inception in 2000 through 2013, GAVI directly supported the immunization of 440 million children (e.g., for Hepatitis B, Haemophilus influenzae type B (Hib), and yellow fever), with an increase in global immunization coverage rates from 70 percent to 83 percent. Such efforts have helped to decrease the global under-five mortality rate. In addition to speeding up population access to underused vaccines, GAVI has also pursued efforts in strengthening health systems, improving vaccine storage and delivery, getting immunization onto national health agendas, and stimulating research and development for vaccines (World Bank Group, 2012).

Despite its success, GAVI has not been without its problems. Although the alliance necessarily focused heavily on developing partnerships and initiating vaccine coverage, less attention was paid to implementation of plans and mobilization of resources for ongoing treatment (in-country follow-up). One reason may be that vaccine costs have risen both absolutely and as a percentage of the total health expenditures, and vaccinations may not be the top priority of developing-country governments (Milstien et al., 2008; Muraskin, 2004). Moreover, the alliance partners needed to grapple with the large supply chain "system costs" required to handle, transport, and store the drugs (Lydon et al., 2008) and the issue of securing long-term financial commitments from its partners. An additional problem is that GAVI's single-minded focus on vertical programs such as vaccination may have diverted countries from broader efforts to develop and finance their health systems. The "Gates Foundation approach" to global health, focused on targeted technical solutions with clear and measurable outcomes, did not fit easily with broader investments needed in the social determinants of health (e.g., social and economic development) (Storeng, 2014). GAVI acknowledged this issue by adopting "health system strengthening" (HSS) as a core principle, but such support was still heavily concentrated on procuring drugs, equipment, and supplies (Tsai, Lee, and Fan, 2016). Finally, in 2008, GAVI reorganized its informal alliance model to become an independent legal entity that diluted the influence of its founding partners. World Bank interactions with and financing of GAVI immunization efforts subsequently declined.

CHAPTER PURPOSE

A central challenge in delivering health care services in the new millennium is the challenge of delivering value. *Value* is created when (a) additional features of quality or customer service desired by a customer can be provided at the same cost or price, (b) a given set of features of quality or customer service can be delivered at a lower cost or price relative to other producers, or (c) additional features of quality can be provided at a lower cost. At a societal level, health and wealth exert beneficial effects on one another. Investments in health care delivery that improve quality and/or reduce cost can improve health status, which in turn can support economic growth and political stability (Burns, D'Aunno, and Kimberly, 2003; Esty et al., 1999; Sachs, 2001). Conversely, economic development that raises the standard of living and socioeconomic conditions improves the population's health (Cutler, Deaton, and Lleras-Muney, 2006; Liu, Yao, and Du, 2015).

Nevertheless, health investments that enhance value are not always made. For instance, despite evidence of the benefits of immunization coverage (Martin and Marshall, 2003; World Health Organization, 1996) and a steady increase globally during the 1970s and 1980s, immunization coverage declined sharply in the 1990s due to curtailed government funding in low-income countries. For example, Mao's agenda to increase public health investments in China, which led to rapidly increasing life expectancy, was reversed and subordinated to economic growth under Deng Xiaoping as a part of the country's economic liberalization reforms.

The GAVI Alliance entered in 2000 and, during its first 13 years, raised over $8.4 billion, disbursed over $6 billion to 76 countries, improved the quality and safety of vaccines administered in poor countries, reduced the procurement cost of these drugs through centralized purchasing, and immunized nearly half a billion children against deadly or disabling diseases.

Why was this approach not already taken? To effect major changes in health care delivery and increase value, as the GAVI Alliance has, organizations require extraordinary approaches. Such approaches critically hinge on several management competencies. These include assembling (global) alliances, clarifying the governance structure of the alliance, developing the local health care infrastructure to deliver the needed services, balancing global and local commitments, and developing local ownership of health initiatives. Managerial skills (including but not limited to developing alliances, negotiating governance and roles, conflict management, managing change, forging strategic plans and leadership) are critical components of the manager's "tool kit" in any health care system. These skills are described in subsequent chapters in this volume.

THE CHALLENGE: DELIVER VALUE

The key challenge facing health care firms is to deliver **value**, defined as the quotient of quality divided by cost (Porter and Teisberg, 2006). That is, firms are asked to deliver a higher level of quality at the same cost, the same level of quality at a lower cost, or higher quality at a lower cost (Institute for Health Care Improvement, 2009). More expansive definitions include patient access and convenience along with quality features (Lee, 2015). In the United States, this challenge has been proposed to (a) providers, in the form of accountable care organizations (ACOs), pay-for-performance (P4P), and other types of value-based contracting; (b) insurers, in the form of value-based insurance design (VBID); and (c) suppliers, in the form of outcomes-based contracts with insurers (Barlas, 2016).

Value-based health care has recently become a global concern. In 2016, the World Economic Forum launched its "Value in Healthcare" project to stimulate national health system reforms around value. That same year, The Economist Intelligence Unit (2016) issued its global assessment of value-based health care across 25 countries. Common components of value-based health care include an ecosystem of supporting institutional and policy structures, coalitional support from broad stakeholders, support of professionals who are trained in value-based health care, quality measurement and standardization, cost measurement, integrated and patient-focused care, and payment based on outcomes.

In order to create and deliver value, health care organizations must find a way to address three health policy goals of our health care system since the late 1920s: improve the quality of care, improve access to care, and reduce cost and cost acceleration—for example, **bending the cost curve**, or the reducing of health spending relative to projected trends (Commonwealth Fund, 2007a). In past decades, providers have been asked to demonstrate a similar value (quality/cost) proposition using a series of management techniques, such as total quality management (e.g., reducing process variation and simultaneously raising the level of process performance), supply chain management (e.g., standardizing products to achieve consistency in use and lower unit cost), and clinical integration (standardizing care paths and protocols to reduce clinical practice variations and improve quality of care).

Numerous health services researchers have questioned whether all three goals are simultaneously attainable (Chen et al., 2010; Katz, 2010) or require a balancing act (Berwick, Nolan, and Whittington, 2008). The achievement of these three goals is sometimes referred to as the **iron triangle** of health care (Kissick, 1994). Picture an equilateral triangle, with three equal angles of

60 degrees, and assume that each angle is one of these three policy goals. Any effort to address one policy angle widens that angle (e.g., access) at the expense of one or both of the other two angles (e.g., quality or cost). For example, the Patient Protection and Affordable Care Act (PPACA) expanded insurance coverage to 24 million citizens but at a cost of roughly $1 trillion that needed to be recouped via taxes, lower provider reimbursements, and other programmatic savings (CMS, 2010).

Provider organizations in the health care industry have nevertheless been required to accomplish the quality and cost goals at the same time. Since the 1990s, employers have monitored health plans (and thus their provider networks) in terms of four domains of measures known as the Healthcare Effectiveness Data and Information Set (HEDIS), which resemble the iron triangle: effectiveness of care, access/availability of care, utilization and relative resource use, and experience of care. The Institute of Medicine (IOM, 2001)—now known as the National Academy of Medicine—articulated six "aims for improvement" in a high-performing health care system: care should be safe, effective, patient-centered, timely, efficient, and equitable. Most recently, providers in the United States have been encouraged to pursue "the triple aim" that builds upon the IOM's six aims: improving the patient's experience of care, improving the health of the population, and reducing the per capita cost of care (Berwick, Nolan, and Whittington, 2008). These three aims have been baked into the quality scorecard used to measure ACO performance in the Medicare program.

The balancing of broad health policy goals is apparent on a global scale as well. The World Health Organization (WHO, 2000) uses three criteria to rank national **health systems**: health status (similar to quality), responsiveness to the expectations of the population (similar to access), and social and financial risk protection (similar to cost).

CHALLENGE OF RISING HEALTH CARE COSTS: SUPPLY- AND DEMAND-SIDE PRICE AND VOLUME DRIVERS

One reason why the health system is challenged to deliver value is that the denominator—health costs—has risen steadily over time and proven difficult to restrain. National health expenditures in the United States have been rising at roughly 2.3 percent annually above the growth in gross domestic product for the past five decades (Altman, 2010; Blumenthal, Stremikis, and Cutler, 2013). Some have argued that public and private sector efforts work to temporarily rein in this rate of increase, only to see the cost escalation return (Altman and Levitt, 2002; Jost, 2012). Such rising costs make health care increasingly unaffordable to the individual and crowd out other public spending.

Why do costs rise inexorably? Many experts argue that the underlying driver of rising costs is technology and its broad application to new patients and patient indications (Aaron and Ginsburg, 2009; Commonwealth Fund, 2007b; Congressional Budget Office, 2008a, b). Following Weisbrod (1991), technological improvements spur higher prices, higher demand, and higher costs—all of which call for greater insurance coverage for the new technology, which then drives further technological innovation. Technology contributes to rising costs in other ways. In contrast to other industries, health care technology is often a complement rather than a substitute for labor—for example, requiring many technicians to utilize the new equipment. Moreover, providers often compete for patients based on the sophistication of the services and equipment they offer, leading to expensive excess capacity and duplication in a local market ("technology wars"). Insurance is another driver of rising costs, as broader coverage (e.g., for more people or more benefits) increases demand and thus health spending, as well as the attendant problem of **moral hazard** (Arrow, 1963) whereby the insured utilize more health care than they would if they paid for services out of pocket (i.e., from their own resources without insurance).

There are several supply- and demand-side drivers of rising health costs. On the supply side, costs are driven by imperfect information markets whereby purchasers and consumers of health care are not able to discern quality differences perfectly among health care providers, make few repeat purchases, and enjoy less transparency of pricing, which allows great variation in the economic rents earned by providers of the same product or service. Such rents also result from provider market power. Costs are also driven in part by providers' practice of defensive medicine, providers' focus on acute rather than chronic care or prevention, and poor coordination of services among providers (Studdert et al., 2005; Towers Perrin, 2008). Finally, costs are driven by geographic variations in the supply of hospital beds and specialist physicians, which may induce demand (Roemer, 1961).

On the demand side, costs are driven by the tax-free treatment of health care benefits (which contributes to richer health benefit packages and induces moral hazard), as well as public and private sector financing of health care through a third-party payment system of insurers and other fiscal intermediaries outside the patient–provider relationship. Favorable tax treatment and a third-party payer system combine to insulate the consumer/patient from the true cost of the health care services they demand. In addition, demand is driven by a country's national wealth, the expectations of its population, the highly technological nature of health care

GEOGRAPHIC VARIATION IN HEALTH CARE SPENDING: A CLOSER LOOK

Health care expenditures in the United States have been rising for decades (Jost, 2012), but per capita spending on health care varies widely across the country. There are well-known variations in spending across states, hospitals, and even physicians to treat the same condition. Earlier, the Dartmouth Atlas suggested that the cost and quality of the services rendered to the Medicare population were either negatively correlated or not correlated at all, suggesting that Medicare spending could be reduced by decreasing such variations without harming quality (Wennberg, Fisher, and Skinner, 2002).

Why does health care spending vary so much across the country? The reasons are complex and difficult to tease apart. Differences in prices of health care services and severity of illness play an important role, but together these factors account for only half of the geographic variation in spending. Regional differences in the supply of specialist physicians and health care facilities are also thought to play a role. Regional differences in provider willingness to adopt new technologies or provide costly treatments that might or might not improve health care outcomes are also thought to increase costs. Most recently, research has identified variations in the cost and utilization of post-acute care services (e.g., nursing homes) as a major driver (Newhouse and Garber, 2013). Researchers have also challenged the Dartmouth Atlas research findings noted above by showing that across all funding sources (e.g., Medicare, commercial payers, etc.) higher levels of spending in wealthier states may translate into higher quality of care (Cooper, 2008).

Scholars and policy makers looking to slow the rate of growth in health care expenditures ("bend the cost curve") point to organized delivery systems that focus on coordinated care and prevention as a promising way to reduce the costs associated with the efficiencies, misaligned incentives, and poor quality attributed to the highly fragmented nature of the health care system that currently exists in the United States. In his efforts to promote health reform, for example, President Barack Obama praised the Mayo Clinic in Minnesota and the Cleveland Clinic in Ohio as examples of hospitals providing the highest-quality care at costs well below the national norm and suggested that all providers in the country practice their type of medicine.

DEBATE TIME: Overuse, Underuse, and Misuse of Health Care

Researchers at the Rand Corporation suggest that the health care system suffers from three process problems in delivering quality: overuse of services, underuse of other services, and misuse of still other services (Schuster, McGlynn, and Brook, 1997). Overuse characterizes those services and procedures that are expensive and where the potential for harm to patient's health exceeds the possible benefit, such as the excessive use of antibiotics for viral infections. Underuse characterizes those services that are likewise costly to perform but increase the quality of care and produce favorable patient outcomes, such as vaccinations, preventive visits, and taking medications as prescribed. Misuse, finally, characterizes those services that add costs without necessarily harming the patient, such as extra lab tests, unnecessary screening (PSA), or avoidable complications. In early 2017, *The Lancet* devoted an entire issue to the global nature of these three problems.

What do you think?

- Which of these three problems do you think is most prevalent?
- Which of these three problems do you think is most important to address?
- What managerial strategies might you employ to address each one?

services, and the health behaviors of its population. These supply and demand drivers are listed in Table 1.1.

There are many price and volume drivers of rising costs as well. Price drivers include provider consolidation and the resulting lack of competition, development of new technologies, rising labor costs, provider cost-shifting, and consumer preferences for care in higher-cost settings. Volume drivers include fee-for-service payment, rise of chronic diseases, consumer demand, defensive medicine, lack of care coordination, and fraud and abuse.

A handful of axioms govern the demand side of this vast system that may be peculiar to health care. The first is that technological innovations and their application are desired by providers, desired by patients, and drivers of rising health care costs ("the technological imperative")

(Fuchs, 1986; Gelijns and Rosenberg, 1994). A second axiom is that technology drives specialization in the medical (and nursing) field, which further drives up health care costs. A third axiom is that every citizen deserves the finest health care now made available by these technological developments (often defined as the product or service offered by my firm) as long as someone else pays for it. Another axiom following from the technological imperative is that cost and price are the key issues germane to all parties. Indeed, the one issue that currently unites the entire value chain in health care is reimbursement; many analysts anticipate that it will be the patient/consumer who unites the chain in the future. Last, technological innovation and its attendant costs spur the spread of insurance coverage for such innovation, which increases spending on innovation, which fuels yet more innovation (Weisbrod, 1991).

OTHER CHALLENGES EXACERBATING THE VALUE CHALLENGE

Complicating the difficulty of providing value, health care systems face a number of other challenges. One key problem involves measuring and managing quality of care. Providers are confronted by multiple payers with different quality performance scorecards; moreover, many of the quality metrics are not highly correlated with one another (cf. Smith et al., 2017). Another key problem is the growing burden of chronic illness in the population (both in the United States and globally), which requires more clinician time and resources to treat. Other challenges include increasing patient demand and expectations, increasing payer and societal demands for accountability, unexpected epidemiological shifts, calls for greater patient safety, increasing complexity, strains on federal and state government budgets, inadequate supply of primary care practitioners, reported shortages of specialists and other health personnel, erosion of the public's trust in physicians and hospitals, growing concerns over privacy of personal health information, lack of transparency in prices and information, conflicts of interest and incentives, lack of consumerism, lack of efficient and effective use of information technology, and provider resistance to change (Dranove, 2008; Herzlinger, 2006; Porter and Teisberg, 2006).

On top of these challenges one can lay a series of delicate balancing acts that health care firms (and society as a whole) must deal with beyond the value equation. These include meeting rising demand and expectations with finite resources (both capital and labor), addressing chronic care needs with an acute care–based delivery system, fostering population-based models of care amidst a system based on physicians in small groups or solo practice, sharing information while respecting patient privacy, incorporating modern therapeutic and technological advances while restraining the rate of growth in cost, and promoting wellness behaviors in a system that finances acute care seeking.

Table 1.1 Supply- and Demand-Side Drivers of Health Costs

Supply-Side Drivers	Demand-Side Drivers
Imperfect information regarding price and quality	Tax treatment of health care benefits
Provider market power	Third-party payment system
Nonprice competition (e.g., technology wars)	Breadth and depth of insurance coverage
Technology and its diffusion	Moral hazard
Geographic variations	Rising national income
Poor coordination among providers	Poor healthy behaviors
Fee-for-service payment systems	Private sector financing of care, which supplements public spending, encourages greater coverage, and may promote cost-shifting
Excess capacity	
Acute care focus of delivery system	
Limited primary care	
Malpractice fears and pressures	

THE CHALLENGES ARE GLOBAL

The problems, issues, and challenges facing the health care industry are global, confronting health care systems in many countries (Burns, 2014; Burns and Liu, 2017; see also Chapter 15). As an illustration, Table 1.2 identifies some of the common issues and problems facing the health care systems of India, China, and the United States. These countries have populations that are quickly aging—true especially of China, and increasingly so for both India and the United States. All three countries face a huge epidemiologic transition from acute care to chronic illness, with underdeveloped systems for dealing with chronic care (especially true in the East). Populations in all three countries have developed more sedentary lifestyles, with increasing incidence of diabetes, obesity, and hypertension. All three countries have populations with substantial national wealth that are now demanding more health care services and thereby increasing health care costs rapidly. Not surprisingly, all three countries also report that health care costs are a major source of personal and family bankruptcy. Finally, all three countries face the common issue of how to balance the demand for technological innovation by providers and patients with its high cost.

At the same time, there are several major divergences between these health care systems (see Table 1.3). The U.S. health care system compared with India or China spends a much higher proportion of its gross domestic product on health care and provides a higher level of insurance coverage to its population. While health insurance programs are now spreading across India (increasingly private sector) and China (mostly public sector), they provide coverage for a limited range of services (e.g., focused until recently on hospital inpatient care). Hospital ownership patterns also diverge widely. China's hospital system is almost entirely public sector (although the country recently announced its intention to allow more entry by private hospitals), while India's formerly public sector hospital system has seen the emergence of a thriving private sector comprised of multihospital systems (e.g., Apollo, Fortis, Wockhardt, and MaxHealthcare). By contrast, much of the U.S. hospital market is voluntary and nonprofit in character. Such differences and commonalities suggest that management strategies to meet the value challenge must consider the local context, but may nevertheless share many similar elements. As Chapter 15 notes, these strategies may encompass prospective payment systems, enhanced provider reimbursement rates, patient marketing and recruitment, etc.

Table 1.2 Parallel Concerns in the United States, India, and China

• Concern with iron triangle
• Concern with high hospital costs as cause of impoverishment/bankruptcy
• Concern with the high costs of technology
• Concern with geographic disparities in health status
• Concern with conflicts of interest and supplier-induced demand
• Concern with prices as driver of rising health care costs
• Concern with lifestyle issues and behaviors
• High number of specialists
• Hospital waste and inefficiency
• Lack of a primary care system
• Fee-for-service payment system
• Mixture of financing mechanisms: government, employer, individual
• Fragmentation in government ministries/bureaucracy
• Low consumer information
• Competing spending priorities (education, social services, health) at the local government level

Table 1.3 Areas of Divergence: United States versus India and China

• Health care spending per capita
• Percentage of national health expenditures (NHE) accounted for by patient out-of-pocket spend
• Development of private health insurance
• Depth and breadth of insurance coverage
• Presence of centralized purchasers
• Percentage of NHE spent on drugs
• Tradition of private sector ownership of hospitals
• Development of the central government's role in health care
• Development of governance mechanisms to monitor providers