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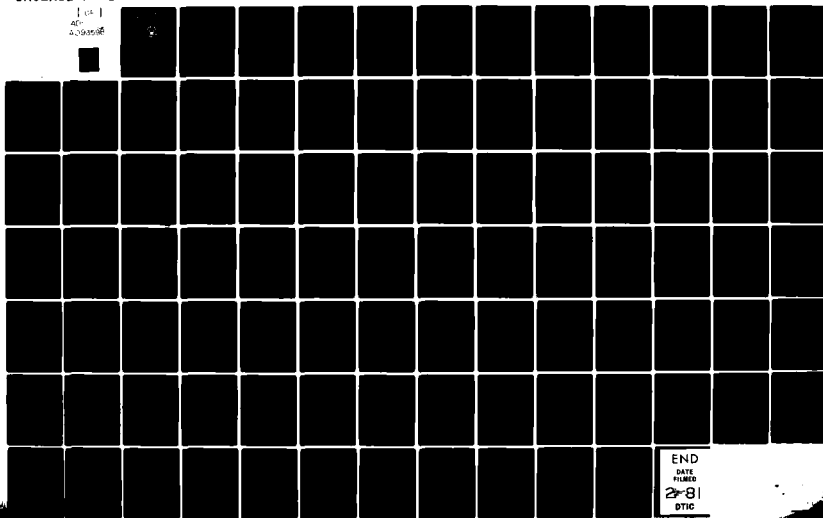
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THESIS

APPLICATION OF A HEALTH SERVICE GROWTH
MODEL TO DETERMINE THE MANAGEMENT
REQUIREMENTS OF HEALTH SERVICE PROVIDERS

by

Patrick Allen/Shannon

September 1980

Thesis Advisor:

J. K. Arima

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Application of a Health Service Growth
Model to Determine the Management
Requirements of Health Service Providers

by

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Submitted in partial fulfillment of the
requirements for the degree of

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ABSTRACT

Much has been written about whether the hospital chief executive officer/commanding officer should be a physician or an administrator. Indeed, as health care systems become more complex and diverse, physicians find themselves choosing between their status in the organizational hierarchy and their increasingly technical and specialized medical fields. Many systems have changed, or are changing, from one that is provider oriented to an administrative dominated one. There seems to be a consensus forming that the administrator dominated system is superior to others, at least in the civilian sector. However, this consensus may not take into consideration the goals, objectives, and orientations of the systems being changed. What is good for one hospital, may not be good for all. This study was an attempt to present a method by which the identification of the hospital CEO/CO can be determined through the use of a model which considers facility management requirements and orientations. The conclusion drawn was that CEO/CO selection should be based upon the respective orientations of the system rather than professional credentials alone.

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I. BACKGROUND AND INTRODUCTION

Hospitals are among the most complicated organizations in the world today. They are characterized by an extremely fine division of labor and wide variety of skills. A hospital is not only a place for the ill to seek care, it is also an arena where teaching and research often take place. It can be correctly identified as a hotel, a treatment center, a laboratory, and a school, among other things. It is most certainly a complex professional organization.

The personnel working in a hospital include physicians, nurses, managers, technicians, housekeepers, social workers, scientists that are skilled in fields allied to medicine, and clerks, to mention a few. This myriad of personnel types connected with the changing functions of hospitals, from a place where one went to die, to a place that is an entire social system in itself, demands that whomever is the chief executive officer (CEO)--or commanding officer (CO) in the case of the military--he/she must possess the necessary skills and education to be able to integrate the wide variety of personnel skills into an effective force, and do it effectively.

This paper presents a model by which one can determine the type of CEO a facility should have, based upon the orientations and management requirements of that facility. That

all facilities must either have a physician or an administrator as the CEO is not true.

The selection of the health care facility CEO/CO should also rightly depend upon the system the facility must function within. The objectives and goals of the various systems can be better suited to an individual with a background conducive to the system's goal achievement.

Perrow [Donabedian on Perrow, 1973] showed hospitals as progressing through various stages until they arrived at a stage where the survival of the organization outweighs all else. But, prior to reaching the final stage, the hospital is dominated by trustees and/or physicians whose primary concern is the patient, the provider, or a combination of both.

Early hospitals were most likely to be run by nurses, as they were nearly always present. The physician merely used the hospital as a practicing base. Indeed, MacEachern [1957] identified Florence Nightingale as the first hospital administrator.

Later, as the population grew, physicians began to spend more and more of their time at the hospital, because it was easier for the multitude of patients to meet collectively than for the provider to see each patient at a separate location. This system survives today.

The superior education and social standing of the physician eventually brought him to the forefront of the organization of the hospital. He became, at once, the provider and

the chief executive officer, overseeing the entire operation of the facility. This was before there were any educational program of any consequence in the field of hospital administration.

As technology, organizational complexity, and specialization reached higher levels, the provider found himself having to choose between practicing medicine, or managing a hospital. The need for a specialist in hospital administration had been created.

Subsequently, the field of hospital administration has become a profession in itself, although many physicians do not consider administrators to be their peers [Bellin, 1973; Sheinbach, 1974]. Accordingly, many health care systems have turned over the reins of power to professional managers. On the other hand, many have held on to the system where the physician not only treats the patient, but also rules the hospital. The Navy health care system fits the latter category.

In the face of ever increasing physician shortages that are presently plagueing the Navy, one must ask whether the utilization of physicians is a prudent use of an already scarce resource; to wit, are the budget and economic costs foregone through this practice the best use of the Navy's resources? This paper purports to provide a method by which that determination can be made. Regardless of the specific answer one derives from the model this paper presents, there is no doubt that the hospital CO/CEO will have to be increasingly well-educated and sophisticated to function effectively

in the health care environment; above all, leadership and management skills are required.

II. APPROACH

Methodology

In contemplating which methods were to be used in this study to determine whether a physician or an administrator should be the commanding officer/chief executive officer (CO/CEO) of a health care facility, it was initially decided that the most effective method would be one of comparison. That is, if one is to determine whether the Navy is utilizing its physicians efficiently, he or she must use as a criterion other health care systems. The Navy's and indeed the entire armed forces' medical systems, while being of considerable size, are only a fraction of the entire national health care system. Therefore, it is postulated that health care systems other than military are the norm, and deviations of the military health service system (MHSS) from this norm should be identified and analyzed.

Data Collection

Institutions were initially selected for comparison on the basis of close proximity to the Monterey Peninsula for economic reasons and the type of institution with regard to the teaching function, the profit motive, and whether the facility was governmentally based. The San Francisco Bay area was selected for its proximity, Stanford University Medical Center (SUMC) was selected for its teaching function,

Kaiser Foundation Hospital of San Francisco (KFHSF) was selected for its proprietary nature, and the San Francisco Veterans' Administration Hospital (VAHSF) and Public Health Service Hospital (PHSHSF) were selected for being two different systems with federal government affiliation.

Each of the above mentioned organization's CEOs were interviewed by the author, with the exception of SUMC, where an assistant administrator was interviewed. In addition, documentary information was obtained from all the organizations to allow determination of their individual organizational structures and functions.

Subsequently, requests for assistance and participation were mailed to the American College of Health Care Administrators (ACHA), the American Medical Association (AMA), the Joint Commission on Accreditation of Hospitals (JCAH), the U.S. Navy Bureau of Medicine and Surgery (BUMED), Hospital Corporation of America, Inc., Humana, Inc., Lifemark, Inc., and National Medical Enterprises, Inc. It was felt that these institutions provided a reasonable cross section of types of health care institutions found in the United States which exercise a measure of control over health care delivery systems.

Of all the administrative positions that Navy physicians occupy, that of a hospital or treatment facility commanding officer (CO) is probably the most visible and one that has the nearest direct counterpart in other systems. Therefore,

it was decided that the CO position would be examined in contrast to its civilian counterpart, the chief executive officer (CEO) of a civilian health care facility.

The Model

A model was devised within which the CO/CEO comparison could be conducted. The model basically states that the importance of administrative duties, responsibilities, and accountabilities, as opposed to clinical duties, responsibilities, and accountabilities, determines whether the CO/CEO position will be occupied by an MD or an administrator. Also, the model takes into consideration who the facility is treating, where the facility's operating funds come from, and whether the patient is the principal beneficiary of the physician/patient relationship.

The model is based on a concept of stages of organizational development that will permit the evaluation of the duties of the CO/CEO with respect to his involvement in administrative or clinical functions and responsibilities. The model is akin to Perrow's [1961] three essential states an organization goes through in its effective lifetime and Donabedian's [1973] classification of an organization's objectives.

In Perrow's model the initial stage is governed by trustees who view the organization's principal need to be acceptance and financial support. Subsequently, the primary emphasis shifts to the most skillful tasks that the

organization performs. In this stage, called medical domination, the experts who have the necessary skills become the dominant force and the most influential in setting organizational objectives. When an organization finally becomes so complex that it embraces many skills and interacts with other organizations, it has a need for skillful management and coordination. This need fosters the third stage of administrative dominance which is based primarily on the complexity of basic hospital activity. This is the final and most progressive stage [Donabedian, 1973, on Perrow, p. 36].

Donabedian's main objectives of a medical care organization are (1) client oriented, representing a humanitarian tradition of service where primary attention is given to client welfare and adoption of client wishes and desires, (2) provider oriented objectives which are meant to serve the interests of those who provide the care, among whom the physician is paramount, and (3) organization oriented objectives which primarily serve the organization [Donabedian, 1973].

It is obvious that these two models share some of the same characteristics. The model presented within this paper, while somewhat similar, is not on a one-to-one basis with the models of Perrow and Donabedian; rather, it is an integrated model which was created for the specific purpose of helping determine whether an MD or an administrator should be the CO/CEO of a given health care facility.

The CO/CEO determination model says that medical treatment facilities go through three stages, just as in Perrow's model. But, where Perrow's model speaks of stages of domination and Donabedian's speaks of objectives, the CO/CEO model simply reflects an organization's need for a particular type of leader based upon its own organizational orientation. Also, just as in Perrow's model, the CO/CEO model can show any given hospital in either of the three categories; but, unlike Perrow's model, the CO/CEO model does not state that a hospital will always move from one category to another as organizational complexity increases. Rather, the organization will move to a different category only when its organizations change enough to warrant the move. Further, the move does not necessarily have to be in one direction.

The three organizational modes of the CO/CEO model are:

1. Primary medical care orientation
2. Health care provider orientation
3. Organizational orientation

The health care system that has primary medical care as its main orientation is characterized by an emphasis on the provision of health care. Health care is of primary importance while the wants and needs of the provider and the system are secondary. Examples of this type of orientation are (1) a one doctor facility in undeveloped areas or remote locations, such as an island in Puget Sound, (2) one of the many one-doctor-owned hospitals in Japan, or (3) primitive medical

support of ground combat forces where litter bearers and aidmen serve the medical officer who treats the sick and wounded.

The system oriented on the health care provider is highly specialized and technical. It considers the physician as its chief resource, and the system practically exists to support him or her. This is a world where research, training, quality of care, professional judgment, and physician compensation are buttressed by the physician's refusal to turn over the reins of management to qualified administrators.

The system that is organizationally oriented is also highly specialized and technical. It is a system that emerges when its survival requires the organizational adoption and utilization of modern management techniques because of the increasing importance and complexity of its personnel, financial, supply, support, industrial relations, and facility upkeep functions. The patient care function remains with the physicians. "Organizational efficiency that is consistent with good health care," is the key phrase in the organizationally oriented system.

The specific characteristics of each of the three modes of the CO/CEO determination model are:

1. Primary medical care orientation
 - a. client access
 - b. client use
 - c. client dignity
 - d. responsiveness to client
 - e. client's freedom of choice

2. Health care provider orientation

- a. research
- b. training
- c. professional judgment
- d. quality of care
- e. provider compensation
- f. facility control

3. Organizational orientation

- a. efficiency
- b. profit
- c. survival

These characteristics resemble Donabedian's [p. 40-41] objectives of medical care organization to a large degree, albeit not entirely.

In the context of the care oriented mode, the client access characteristic is defined as the degree to which the patient or client is economically able to afford care at a specific institution. Where the client obtains the necessary funds is unimportant. It could be from voluntary insurance, compulsory insurance, governmental assistance, employer provision, governmental benefits, or directly from the provider in the form of charity. Client use refers to the equality of access one has at an institution, and is closely related to client access. This characteristic is asking whether equality in use exists and whether the use is adjusted for individual client need. Client dignity is relatively self explanatory. How the client is personally treated once he gains access, connected with the legal, ethical, and administrative safeguards that protect the patient, is the crux of this

characteristic. Responsiveness to the client simply means the degree to which the facility adapts to the client's wishes and desires. Freedom of choice is the ability the client has to select health care from among available institutions; if he/she does not like one facility, can he/she go to another with equal ease?

In the provider oriented mode the research and training characteristics are defined as the amount of research and training generally being conducted at any given health care facility. For the purposes of the model matrix, systems that have complete facilities devoted to research and training are not considered to be conducting research and training in a hospital, although they are undeniably closely related. However, that a system has these specialized institutions will be taken into consideration for the purpose of separating those that are engaged in research and training to a similar degree. Professional judgment means the extent to which the provider has the freedom to practice medicine without regard to other factors. Quality of care, while notoriously difficult to measure, is interpreted as the care provided; without regard to costs. Provider compensation is the extent a facility/system considers provider remuneration as an important factor. Facility control is the measure of the power or predominance providers possess within a facility or system.

In the organizationally oriented mode, the concepts of efficiency, profit, and organization survival are closely related; indeed, they are interdependent, especially in a proprietary system, or a nonprofit system with proprietary behavior.

Constraints on the Model

The CO/CEO determination model should not be applied to a health care facility that stands in isolation. It should be remembered that this model is best applied to those health care facilities that are a subsystem of a larger system, that is, those facilities that are subject to the overall guidance and direction of a larger entity. For example, the Navy clinic at Treasure Island in San Francisco Bay is a subsystem of the Naval Regional Medical Center (NRMC) at Oakland, Ca., which, in turn, is a subsystem of the Navy Medical Department.

These health care facilities that are part of a larger system do not grow or develop independently of the larger systems of which they are a part. The goals toward which the larger system strives may dictate the general direction that the subsystem takes, whether those goals are profit, self-preservation, political, growth, or whatever. The chain-of-command or organizational structure of the larger systems may dictate or constrain changes in the identity of the subsystem hospital CO/CEO--especially when rank and pay determine how and at what level one functions within the subsystem.

III. SYSTEM DESCRIPTIONS

Before any analysis was attempted, it was felt that a brief description of each of the participating organizations would provide better insight into their underlying structures. The institutions were divided into three separate categories: (1) proprietary, (2) nonprofit, and (3) governmental.

Proprietary

The proprietary category includes Hospital Corporation of America (HCA), Humana, Inc., Lifemark, Inc., and National Medical Enterprises (NME). A representative organizational diagram appears in Figure 1.

The organizational structure employed by Hospital Corporation of America is a straightforward one and is assumed to be fairly representative of a health care system that is proprietary in nature. This assumption, in conjunction with the fact that organizational diagrams of the other three previously mentioned proprietary corporations were not available, should be remembered by the reader. However, the analysis section of this paper will reveal corporate interorganizational differences, as well as attitudinal differences of the corporation executives, that were obtained through questionnaires.

There are certain characteristics of proprietary hospitals that make them readily distinguishable from other multihospital

groups [Takich & Darr, 1978]:

1. They are not necessarily or totally owned by physicians.
2. They employ corporate staffs trained in management skills.
3. They raise their capital through issuance of stocks and bonds.

These investor owned companies are publicly accountable for profits and losses; therefore, economy, efficiency, incentive to provide attractive services, effort and incentive on the part of the personnel, and responsiveness to the consumer are of the utmost importance. It should be pointed out that these attributes will be evident in a profit making sense; the facility will be responsive so long as the consumer can absorb the costs. Because the sole interest of the stockholder lies in earning the highest possible rate of return on his or her investment in that organization [Wood, 1975], the very survival of the organization depends upon its being able to make a profit. Assuming that the consumer has freedom of choice, he or she will not patronize a particular institution if a certain level of satisfaction or utility is not gained.

HCA

There are two physicians currently listed as corporate executives for HCA. One is the President and Chief Operating Officer, while the other is Vice Chairman and Chief Medical Officer (Figure 1). Both were among the original founders of the corporation [HCA questionnaire, July 1980]. The

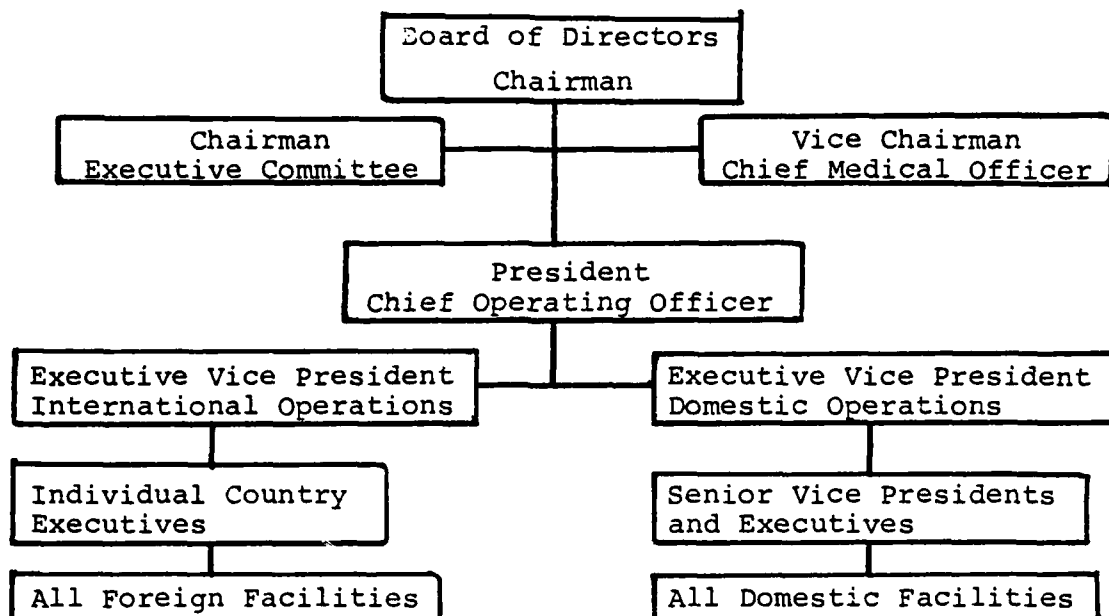


Figure 1. Organizational Structure of the Hospital Corporation of America

Chief Medical Officer position must, by its very nature, be filled by a physician. The President and Chief Operating Officer position will probably be filled by a nonphysician when the incumbent vacates the position.

Hospital Corporation of America is a leading operator of proprietary hospitals, nearly all of them general acute-care facilities. HCA owns or leases 105 hospitals in the U.S. and Australia for a total capacity of 17,000 beds. HCA also manages 43 other facilities for other owners, such as municipal governments, religious orders, and others [Value Line, May 23, 1980]. In leading financial publications, such as

Value Line Investment Survey [May 23, 1980] and Moody's Handbook of Common Stocks [Summer, 1980], one finds such descriptive phrases as ". . . is maintaining its powerful earnings momentum," "This stock is a good choice. . ." [Value Line May 23, 1980, p. 1284], "Reflecting improved productivity. . ." and "Continued growth can be expected. . ." [Moody's, pages unnumbered]. Hospital Corp. of America is clearly a leader in proprietary hospital circles and appears to be quite successful at its business.

Humana, Inc.

Humana is a leading hospital management company. It operates 93 acute-care general hospitals and one psychiatric hospital, providing a total of over 16,000 beds. The hospitals are located in the U.S., Switzerland, and England. Value Line [May 23, 1980] says Humana's earnings growth lately has been phenomenal and the stock has excellent upward momentum. Moody's [Summer, 1980] said Humana is in an excellent position for further gains. Although Humana is not as old as HCA, it appears to be just as successful and well managed.

Lifemark, Inc.

Lifemark owns or leases 17 general hospitals, representing some 1900 beds in service. It also manages 18 other hospitals, provides ancillary services to 52 client hospitals, and operates 17 dental laboratories. Lifemark's facilities are wholly in the U.S. Value Line [May 23, 1980] said Lifemark's earnings are up, admissions are up, physician

recruiting is up, and the corporation plans to double its size within five years. Although not as large as HCA or Humana, Lifemark is successful and appears to be well managed.

National Medical Enterprises, Inc.

NME owns and operates 30 general hospitals which represents 3,900 beds, most of them in California. It manages 17 other hospitals under contract, operates 113 nursing homes, distributes hospital equipment and supplies, and provides respiratory therapy services at 60 client hospitals. NME is a total health-care company. In addition, the government of Saudi Arabia selected the company to provide management consulting, personnel recruitment, purchasing, and other services for some of its health care facilities over a 5 year period. This was the fourth such contract for NME [Value Line, May 23, 1980]. Moody's and Value Line both have nothing but positive comments on this corporation. NME, like the other proprietary health care organizations mentioned, appears to be well managed as well as successful.

Nonprofit Hospitals

This category includes Kaiser Foundation Hospital of San Francisco (KFHSF) and Stanford University Medical Center (SUMC).

"Many of the nonprofit forms of organization are also profit-oriented in that they frequently engage in aggressive investment policies that increase their capital holdings.

The issue, of course, is not whether profits exist, but to what extent, but the consequences of profit-oriented motives on the workings of the system." [Mechanic, 1972, p. 26] Most nonprofit, nongovernmental hospitals have characteristics that are common to all of them, the main difference being in ownership and control [MacEachern, 1957]. This category of health care institution is comprised of, but not limited to, church hospitals, fraternal hospitals, community hospitals, nonprofit corporate hospitals, and university teaching hospitals. The last two listed in this category are really variations of community hospitals. These institutions get their financial support from fees of paying patients, earnings of departments, gifts, donations, endowments, government grants without government control, and prepaid health plans provided by an employer for his or her employees [MacEachern, 1957].

Over the past several years, many institutions that would fall into this category have been endeavoring to achieve better management/purchasing economics by making a contract with another hospital organization, such as the investor-owned Hospital Corp. of America. Financial pressures usually cause this mixing of profit and nonprofit organizations. The nonproprietary hospital hopes that the contract will result in economics, such as mass purchasing, tighter controls, and clearer accountability. On accountability it has been suggested that doctors, who make many of the cost decisions in a nonprofit hospital, understand that they are accountable

to management in the investor-owned hospital, whereas the accountability in a nonprofit system gets diluted or dissolved "in the muddy currents of the trustee-staff-administrator relationship in a nonprofit system" [Rakich & Darr, p. 72].

Kaiser Foundation Hospital of San Francisco

KFHSF is but one facility of the parent organization, Kaiser Foundation Hospitals, Inc. Originally organized in 1933 to provide health care services to Kaiser employees, the system has evolved into a nationwide health care plan that accommodates non-Kaiser patients as well as plan members. Kaiser hospitals are intended to operate as true community hospitals. Presently, there are seven regions within the overall Kaiser system; this represents 29 hospitals and 6,295 beds. The hospitals range in size from 50 to 628 beds. Additionally, Kaiser is in a cooperative effort in an eighth region in Dallas, Texas, with a major third party insurer [KFHSF interview, July 1980]. The Kaiser-Permanente Medical Care Program is the largest comprehensive, prepaid, group practice health delivery program in the United States. Many authorities in the health care field believe the Kaiser mode of health care delivery offers definite advantages over the traditional fee-for-service physician practice of independent, uncoordinated hospitals. One of the most highly regarded characteristics of the program is the fact that subscribers prepay fixed dues in return for a package of definitely available services; this per capita, fixed sum, prepayment

feature is seen as an incentive to economy and efficiency [Bower & Christensen, 1978]. Kaiser Foundation Hospital of San Francisco is but one of the previously mentioned 29 hospitals in the Kaiser system. It serves the San Francisco Bay and Northern California areas, and can be considered to be typical of a Kaiser hospital [KFHSF interview, July 1980]. Figure 2 shows the organizational structure of the Kaiser system to include KFHSF. The reason that Figure 2 shows practically the entire organizational structure rather than just to the CEO level is because the Kaiser structure is so different from others in this paper. This difference will be elaborated in the analysis section of this paper.

KFHSF, while being a nonprofit hospital of the KFH system, is a facility that has proprietary-like characteristics. The Kaiser system is considered to be one of the most efficient of its type [Bower & Christensen, 1978].

Originally designed as a Kaiser employee only, health care system, the plan was opened to the San Francisco Bay area public in 1945. By 1947, the system had spread to Oregon and was serving nearly 25,000 members [Bower & Christensen, 1978]. By the early 1950s, Kaiser operations had attained such size that it required outside debt financing.

The program had borrowed \$4.5 million to build new medical centers in Los Angeles and San Francisco. The reorganization of the plan's management system was essential in order to ensure its survival. The Kaiser system was divested into

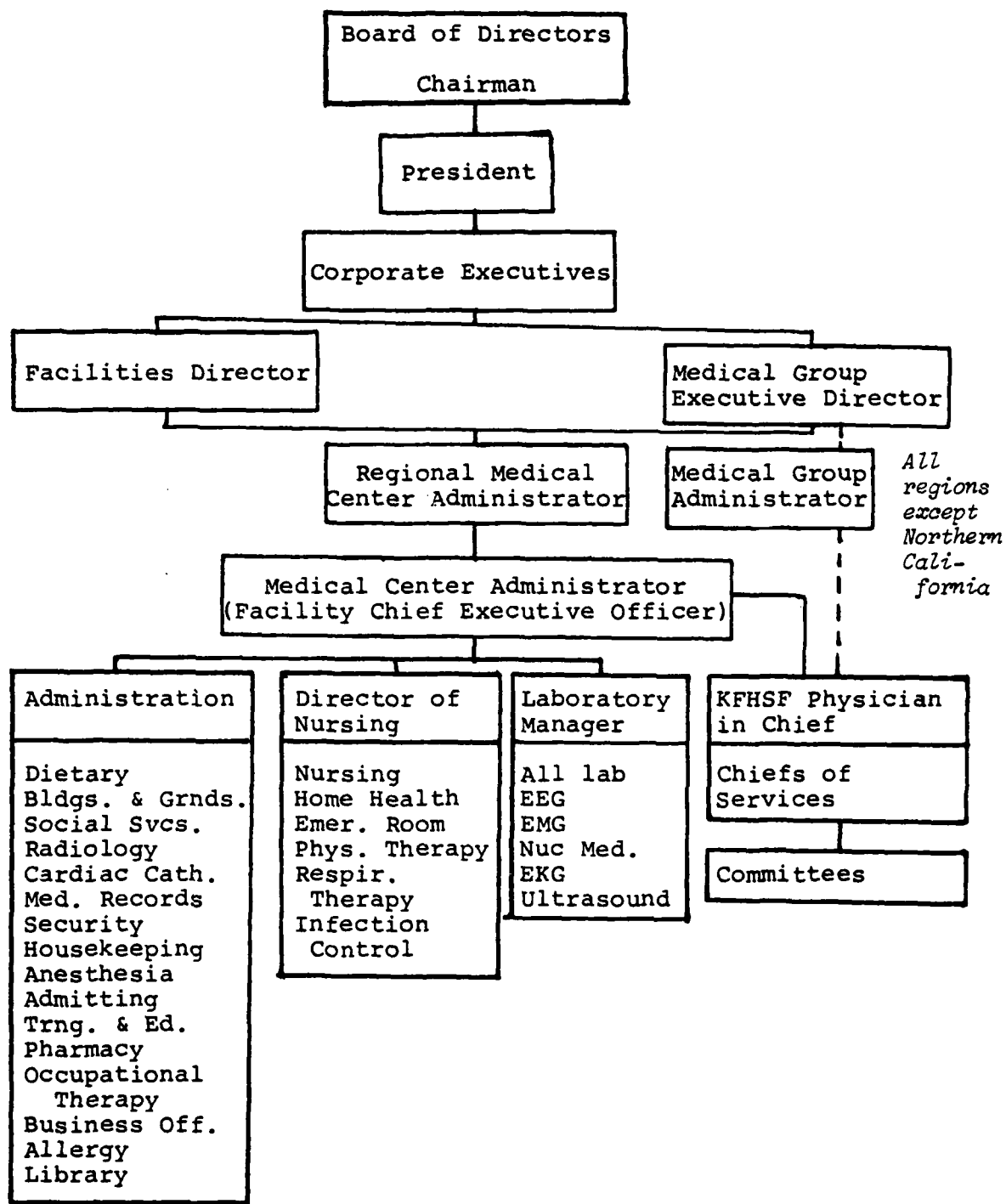


Figure 2. Organizational Structure of the Kaiser Foundation Hospitals

into three separate corporations designed to work as a team: a Health Plan Corporation, a Permanente Medical Group, and a Hospitals Corporation.

The Health Plan Organization's function was to integrate the other elements. The plan contracted with members to provide health services for fixed monthly dues, negotiated a contract with the medical group physicians to provide the professional medical services, and the plan contracted with the nonprofit Hospitals Corporation to provide the necessary facilities and ancillary services. This organizational system is illustrated in Figure 3 [Bower & Christensen, 1978].

The responsibility of the Permanente Medical Group was to provide the professional services of physicians necessary to assure the contracted for benefits of the Health plan members. The Medical Group was organized as a for-profit partnership or association and was managed separately from the Health Plan.

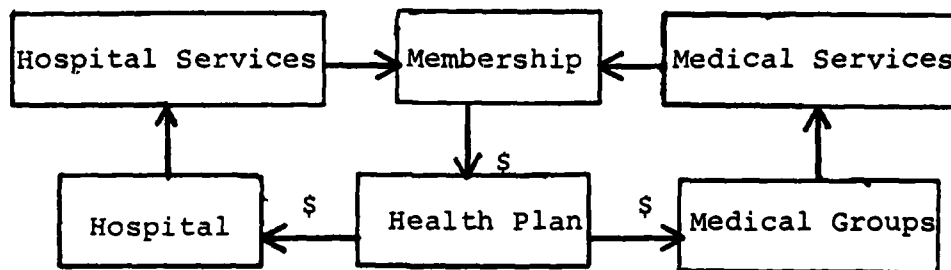


Figure 3. Intraorganizational Structure of the Kaiser Triad

The Hospitals Corporation owned and managed the facilities of the Kaiser system. Although the Health Plan and the Hospitals Corporations are different legally, they share the same board of directors. It should be noted that Kaiser physicians had no customary active staff privileges at the hospitals, that is to say they had no special employment or other contractual relationship with the hospital [Bower & Christensen, 1978].

Each of the Kaiser regions is jointly managed by two men: a regional manager who is the regional chief executive for the Health Plan and the hospitals, and a medical director who is the chief executive for the region's Medical Group. The regional manager has reporting to him a health plan manager and a regional hospital administrator. Both of these are usually nonphysicians. It so happens that as of this writing the regional medical center administrator of the Northern California region is an MD. However, this is an exception as all other regional administrators are not physicians.

Stanford University Medical Center (SUMC)

SUMC is a singular institution; that is, SUMC is not a part of a larger health care organization (Figure 4). However, it is part of Stanford University and is subject to its overall guidance. All general operations concerning the medical center are formulated and executed within the hospital proper. SUMC is an acute-care general hospital consisting of 663 beds with an average annual patient load

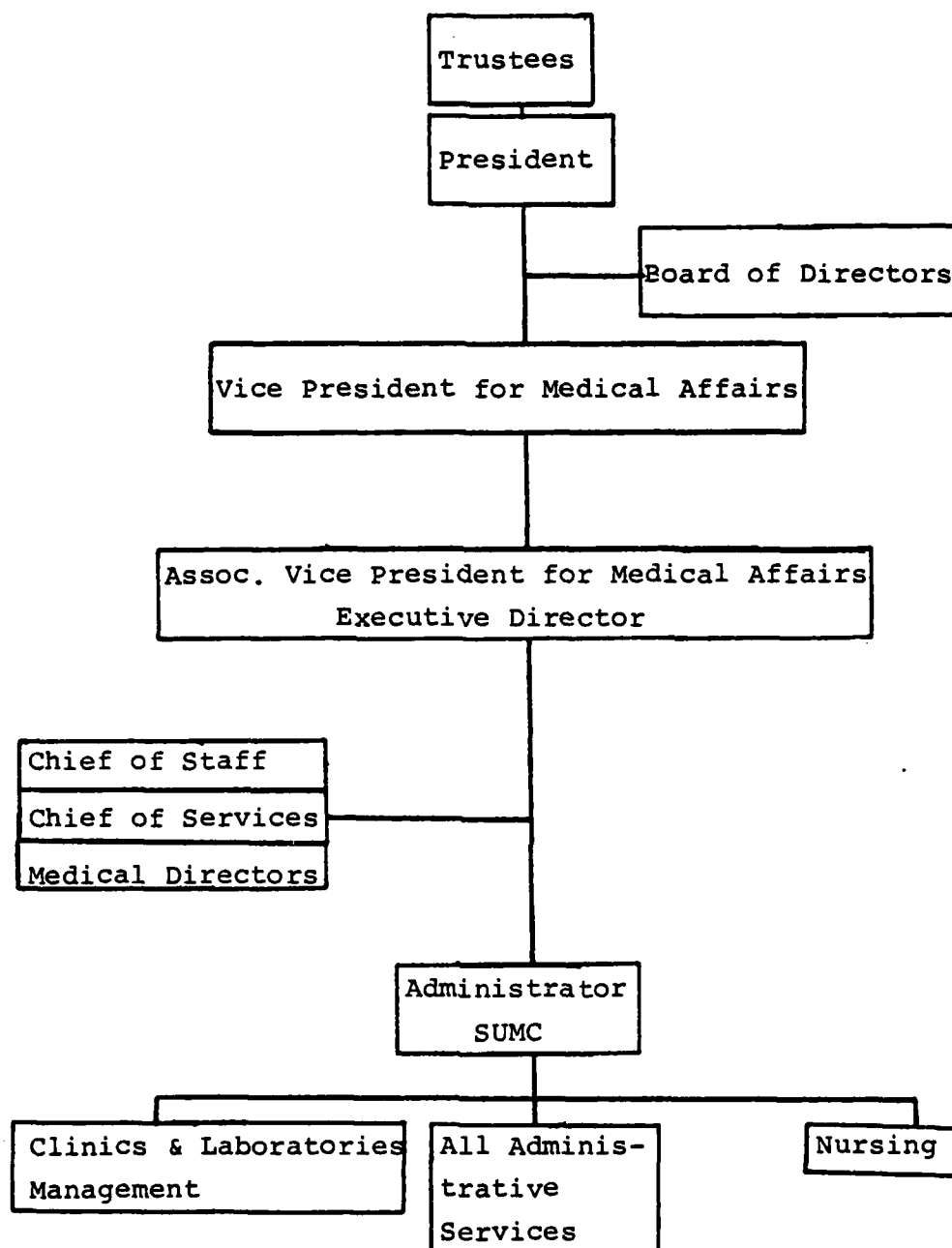


Figure 4. Organizational Structure of the Stanford University Medical Center

of about 180,000 patient days. Cardio-vascular surgery--specifically heart transplants--and radiation therapy are the Center's specialties. Additionally, SUMC played a key role in the development of the linear accelerator for medical use. This development was done with Stanford University [SUMC interview, August 1980].

SUMC's patient draw comes from an estimated 10-mile radius of the hospital. While the majority of the patients are from the immediate area, there is an international draw to the hospital's heart and radiation specialties. The international patients who seek SUMC's specialized care are primarily treated by SUMC physicians while the local populus is treated by local physicians who have practicing privileges at SUMC. The Stanford University physicians are primarily involved in research and very unusual or specialized cases.

As a hospital that is organizationally isolated from another health care system, one might conclude that SUMC should not be evaluated under this paper's CO/CEO determination model. However, the reader is reminded that SUMC is part of the Stanford University system and as such is subject to the university's overall guidance. SUMC therefore, qualifies for analysis because it is part of a larger system, albeit health care is only one part of that system's function.

One of the primary purposes of SUMC is to provide a teaching or research environment for the faculty physicians thus providing a learning environment for students in

medicine and allied science studies. In isolation, this fact could easily lead one to conclude that SUMC should fall into the provider-oriented mode of the CE/CEO model because research, teaching, and learning are characteristic descriptors of that mode. However, these three descriptors do not fully describe all of the functions of SUMC.

Although SUMC is a university hospital that is used as a teaching tool, it also functions as a community hospital for the immediate area. Local physicians are offered practicing privileges by SUMC in order to provide an up-to-date facility for area residents. These facilities are provided on a fee-for-service basis from the patient or a third-party insurer. This added income helps offset the expenses of the center while providing a state-of-the-art facility to the local population. While a certain number of the beds at the hospital are always kept available for faculty research and teaching, the majority of the beds is for general use [SUMC interview, August, 1980].

Governmental Health Care Facilities

This category is made up of the Veterans' Administration Hospital of San Francisco, the Public Health Service Hospital of San Francisco, and U.S. Naval health care facilities. No specific Naval health delivery system was selected because all of the major facilities are organized in the same manner; therefore, the organization structure as outlined in the

Manual of the Medical Department was relied upon as being representative of a single major facility.

The Federal Government provides funds, in the form of a budget, to all Federal health care facilities. In addition, the Federal Government is heavily involved in financing the care of the population at other than Federal facilities through programs, such as Medicare. This heavy financial involvement in health care causes the Federal Government to wield a profound influence upon all those that benefit from its programs and facilities, either directly or indirectly.

In government hospitals, the always present danger of political interference can materially affect efficiency and increase costs. The ideal situation would be to use government funds, but not have government control, thereby eliminating the possibility of political interference. This could be done by placing facilities under the management control of a board of trustees who can act independently of any political organization and who are free from political domination [MacEachern, 1957].

Federal health care facilities represent a huge "pork barrel" from which political constituents can draw benefits, making the possibility of a Federal sector hospital being free from politics remote at best. As long as Federal funds are used, there will probably also be the element of political domination present, and, as long as there is political domination, so will there also be interest groups at the forefront of that domination.

Veterans' Administration Hospital (VAH) of San Francisco (VAHSF)

The VAH system consists of 172 acute-care general hospitals located within six national regions. The hospitals range in size from 120 to 1300 beds.

The VAH system has a total of 84,400 beds, making it one of the largest health care systems in the world. The VAHSF complex is a 440-bed general medical and surgical facility that is affiliated with the University of California in a teaching capacity. The VAH system exists to serve Veterans' Administration beneficiaries. Other categories of patients are reviewed on an individual basis and may be accepted on a space-available basis. VA hospitals are federally funded on a yearly budget basis [VAHSF interview, July 1980]. The organizational structure of the VAH system down to VAHSF is shown in Figure 5.

VA hospitals are controlled and operated by the VA through its director, who is not a physician (Figure 5). The director of VA medicine, however, is a physician--as are most of the top level executives of the VA medical system at the VA headquarters in Washington, D.C. This is prevalent in all governmental health systems and is probably the result of established tradition as well as the influence of groups such as the American Medical Association (AMA) [VAHSF interview, July 1980].

Public Health Service (PHS) Hospital San Francisco (PHSHSF)

The PHS health care system is also a federally funded organization. This quasimilitary organization exists to serve

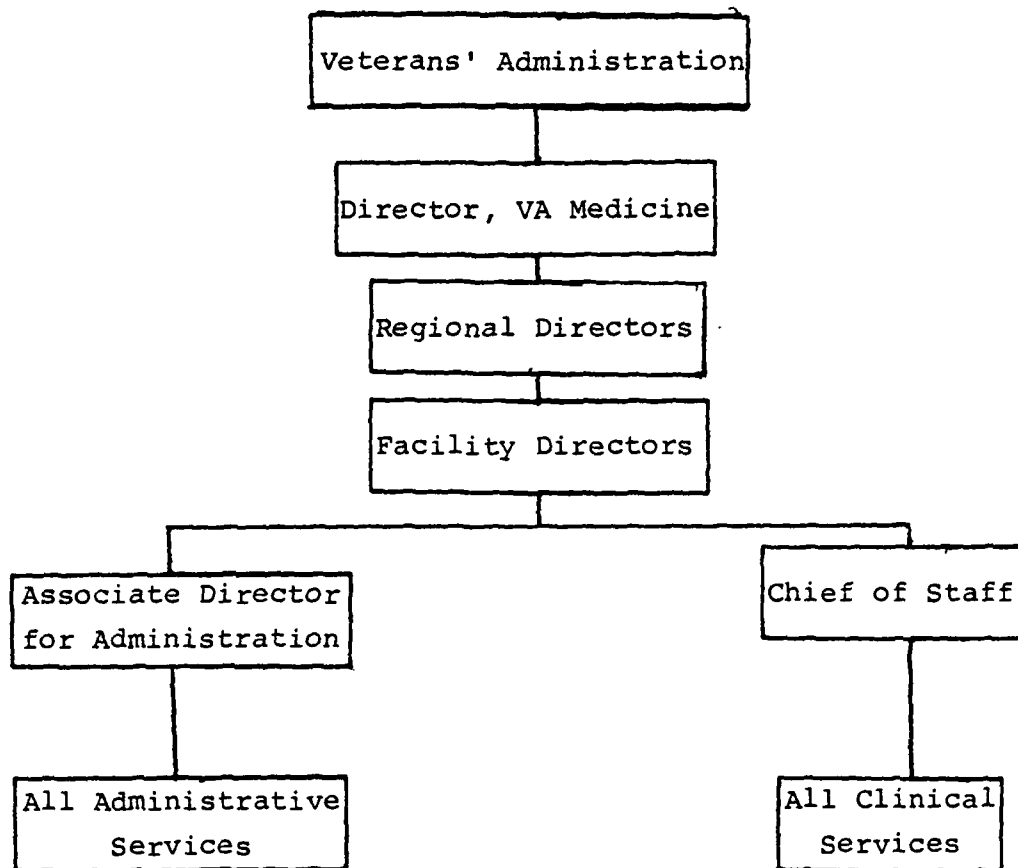


Figure 5. Organizational Structure of the Veterans' Administration Health Care System

civilians in the U.S. Merchant Marine, the U.S. Coast Guard, and other members of the uniformed services along with their dependents. Additionally, American Indians under the cognizance of the Bureau of Indian Affairs are entitled to treatment at PHS facilities. The PHS also grants care to others on a need and space available basis. The PHS health care system consists of eight hospitals nationwide. They operate outpatient clinics and one special hospital for Hansen's disease. PHS-SF is responsible for a five state area including California, Nevada, Utah, Arizona, and Hawaii. It is a medium-sized facility of approximately 300 beds and is endeavoring to broaden its operational scope commensurate with available funds; as the entire PHS health care system is. Although the U.S. Merchant Marine has declined in strength in recent years, the PHS must keep a large number of beds available for contingency purposes. The excess resources are currently being used to provide health care to the refugees from Cuba, Indo-China, and others as Congress may direct. The PHS system of organization is shown in Figure 6.

Of all the health care systems this paper takes under consideration, the PHS system resembles the U.S. Navy's the most; even to the uniforms PHS officers wear. PHS officers even have the same rank structure as Naval officers, albeit PHS uses the civil service pay system while the Navy uses the DOD system.

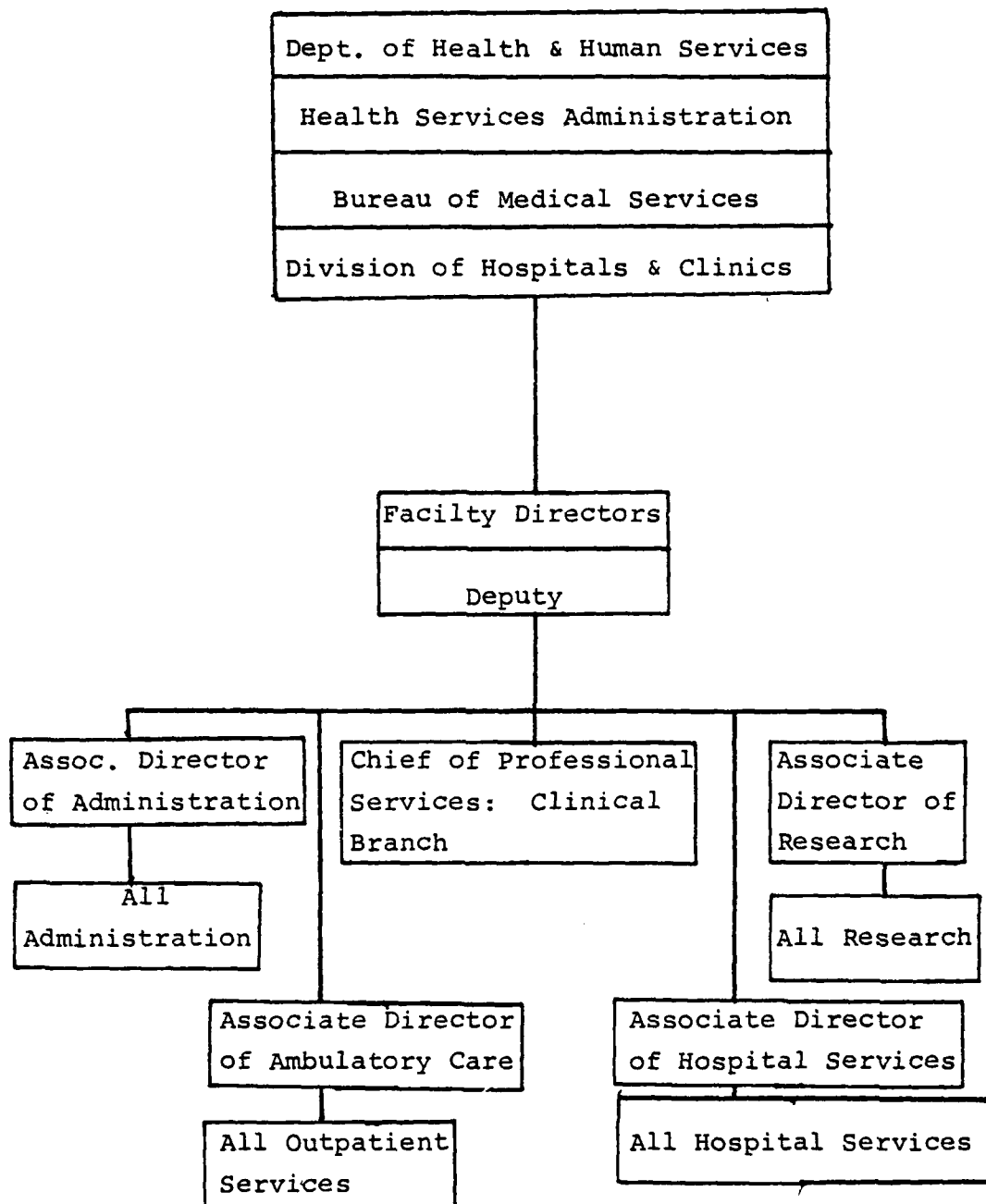


Figure 6. Organizational Structure of Public Health Service Hospitals

The United States Navy Medical Department

The USN Medical Department has been in existence in one form or another since the very beginnings of the Navy itself, which in turn goes back to the beginnings of the United States as a nation. The Medical Department of the Navy is composed of commands and facilities devoted to providing health care services. It includes the Bureau of Medicine and Surgery, Naval Regional Medical Centers (NRMC), Naval Hospitals, and medical departments of ships and stations throughout the world.

The Navy Medical Department exists to serve Navy and Marine Corps personnel and their dependents, retired members and their dependents, Federal civilian employees, and others as authorized by law [Manual of the Medical Department, 31 Oct. 73, Change 80]. The Navy Medical Department consists of a total of 807 medical facilities which is comprised of 240 fixed medical treatment facilities, such as hospitals and clinics, and 567 nonfixed medical treatment facilities, such as shipboard sick-bays, Marine Corps Fleet Marine Force (FMF) units, Construction Battalions (CB's), and other mobile units. The average daily patient load for Naval medical treatment facilities was 4,613 in 1976. In addition, there were 14,301,283 outpatient visits in 1976, excluding dental procedures [Medical Statistics, U.S. Navy, 1976]. Funds for Naval health care are provided by Congress by way of the Department of Defense (DOD) and the Navy Department. The representative organizational structure is in Figure 7.

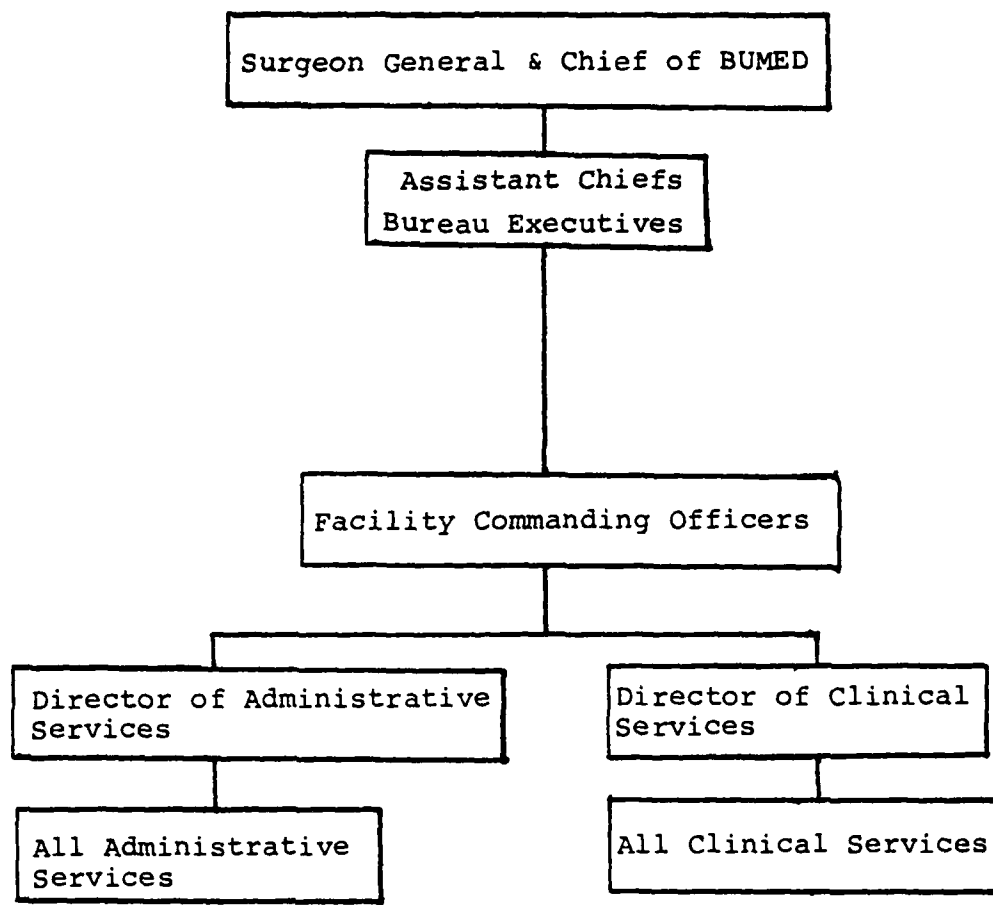


Figure 7. Organizational Structure of the U.S. Navy Medical Department

IV. ANALYSIS OF FACILITIES AND SYSTEMS

Overview

The analysis of the facilities and systems included in this paper is based upon the orientation modes of the CO/CEO determination model, which, in turn, is based upon the organizational structure and priorities of the facilities and systems themselves. In order to determine which orientational mode each of the facilities/systems would best fit, the CO/CEO determination model matrix was devised (Table 1).

The matrix is divided into the three orientational modes previously referred to in the methodology chapter of this paper. The three modes are further subdivided to include their characteristics, also mentioned in the methodology chapter.

As there are six facilities/systems being considered in this paper, it was decided that they would be ranked from 1 to 6, depending upon their relative strength in a given characteristic. The scoring was done by the author. A score of 6 in a characteristic means that the respective facility/system is strongest among the remaining facilities/systems in that particular characteristic. Alternately, a score of 1 means that characteristic is at its lowest in its respective facility/system among the other facility/systems.

The individual characteristics of each facility/system are summed up for each mode, indicating the relative ranking

Mode Characteristics	PRO- PRIETARY	<i>Nonprofit</i>		<i>Governmental</i>		
		KFH	SUMC	VAH	PHSH	NAVY
		<u>CARE ORIENTED</u>				
Client Access	1	3	2	4	5	6
Client Use	1	3	2	4	5	6
Client Dignity	6	4	5	3	2	1
Responsiveness to Client Freedom of Choice	1 <u>6</u>	3 <u>4</u>	2 <u>5</u>	4 <u>3</u>	5 <u>2</u>	6 <u>1</u>
TOTAL	15	17	16	18	19	20
		<u>PROVIDER ORIENTED</u>				
Research	1	2	6	3	4	5
Training	1	2	6	5	3	4
Professional Judgment	1	2	3	4	5	6
Quality of Care	1	3	2	4	5	6
Provider Compensation	1	6	5	2	3	4
Facility Control	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>
TOTAL	6	17	25	22	25	31
		<u>ORGANIZATION ORIENTED</u>				
Efficiency	6	5	4	3	1	2
Profit	6	5	4	2	2	2
Survival	<u>6</u>	<u>5</u>	<u>4</u>	<u>2</u>	<u>3</u>	<u>1</u>
TOTAL	18	15	12	7	6	5

Table 1. Matrix of the facilities/systems and their relative rankings across the mode characteristics of the CO/CEO determination model.

of the facilities within each mode. For example, Table 1 shows that in the care oriented mode, the Navy, with a score of 20, is the most care oriented system, relative to the others on the table, while the proprietaries, at 15, are the least care oriented. On the other hand, these positions are reversed in the organization mode totals. The score of a facility/system in any particular characteristic is not intended to indicate the quantity of that characteristic for that facility/system. Rather, the characteristic score is simply a relative ranking across all facilities/systems. As an example, the profit characteristic of the organizational-oriented mode indicates that the governmental systems all have score of 2 indicating that they are tied or equal for the lowest score for that characteristic on the matrix. This means that, of all the facilities/systems being considered, the governmentals have the least profit characteristic. Actually, it is generally known that governmental health care facilities have no profit characteristic whatsoever; but, as the sum of the row scores must be the sum of all natural numbers from 1 through 6, a score of zero is precluded for any characteristic.

While the matrix in Table 1 will be used for the analysis of how each facility/system fits into the different modes and their characteristics, the profiles graphed in Figures 8, 9, and 10 will be the basis for an overall comparison of the Navy system as opposed to the other governmentals, nonprofits, and proprietaries, respectively. The overall profile analysis

will permit an illustrative comparison with which the reader can see how the Navy contrasts with the other facilities/systems across all modes and characteristics.

Scoring for the matrix and the subsequent graphs is based on information obtained and determined during the research phase of this thesis and summarized in the preceding section.

Medical Care Oriented Mode

The Navy system, with a score of 20 out of a possible 30, ranks highest as a care-oriented system. Alternately, the proprietary systems ranked lowest at 15. It is interesting to note that the six facilities/systems fell into essentially two groups, both intrarelated.

Although the two nonprofit hospitals were rated slightly higher than the proprietaries, the matrix indicates they are closely related. This is because the nonprofit hospitals engage in practices that are similar to those of the proprietary sector; namely, the constant acquisition of real estate and capital goods. Both KFH and SUMC also offset operational costs by providing care to anyone on a fee-for-service basis. Thus, the low scores in access and use for the proprietary and the nonprofit hospitals. The government hospitals score high in these categories because virtually everyone who is eligible for care will be treated without regard to costs. In the same vein, KFH scored highest among the nongovernment group because of its obligation to its prepaid members; but,

the motive to keep costs to a minimum also forces the low group to limit care to those who are able to pay for, or in the case of SUMC, will provide an academically interesting case. The Navy is rated highest in access and use because its beneficiaries are most easily identified among the high group. Those eligible for VAH or PHS care make up a wide spectrum of beneficiaries while the Navy's beneficiaries come from the relatively limited military group.

Concerning client dignity and freedom of choice, the Navy ranks lowest and the proprietaries highest. These two characteristics are closely related because if a client is not treated with dignity and he/she has freedom of choice, he/she will probably choose another facility. On the other hand, if the client does not have freedom of choice, he/she will have to endure any indignities given, unless the care is not absolutely necessary, in which case the client only has the option of staying or leaving. The governmental facilities rank lowest as a group here, with the Navy the lowest group. Generally speaking, Navy beneficiaries have no alternatives where VA and PHS beneficiaries may be insured through employers and the like, thus making them eligible for care at a different facility. VA ranks higher than PHS in this category because PHS beneficiaries include medical indigents, such as American Indians and refugees, and as such, are probably less likely to have alternative plans. They are also less likely to demand dignified treatment. Among the high group, the proprietaries

rank highest because their clientele are paying for care at a direct fashion; therefore, they could also pay for care at a different facility with equal ease. This forces the proprietaries to please the client, lest they lose profitable business. SUMC outranks KFH here because the bulk of its patient load comes from the local population in a proprietary fashion. Kaiser, on the other hand, has a prepaid client that must use the KFH system. The fact that KFH accepts paying customers from outside the health plan in the same manner as the proprietaries, and that KFH must offer some degree of dignity to keep the prepaying contracts from year to year, separates them from the governmentals in these two categories.

Responsiveness to the wishes and desires of clients is most likely to come from the governmental group and least likely to come from the proprietaries because the governmental hospitals will endeavor to grant wishes and desires to the extent their budget permits, whereby the proprietaries will be least responsive in this category due to the profit motive. The proprietaries will provide the least the client will tolerate and the governmentals will provide the most they are able to afford. The proprietaries will exceed the governmentals only when the client is willing to bear the additional cost. The prepaid nature of Kaiser makes it most like the government hospitals; accordingly, it is ranked highest among the nongovernmental facilities. Stanford exceeds the proprietaries because SUMC has a teaching function and, as such,

will provide care to medically interesting cases regardless of ability to pay, at least to the extent the medical center is able to absorb the costs.

Health Care Provider Oriented Modes

Among all facilities/systems considered, the Navy rated highest as a provider oriented system, while the proprietaries rated lowest. As Table 1 shows, the difference between the two is maximal.

The proprietaries ranked lowest here because they are relatively devoid of any research or training, and they are totally devoid of any facilities controlled by a provider; to wit, none of the proprietaries have any physicians as a facility CEO. Professional judgment in a proprietary system is limited to what the provider is actually qualified to do; namely, medical care. All else is decided by managers, even to the extent that it may infringe upon a provider's course of treatment decision, if there is an alternate course available that is sufficiently effective and less expensive. Provider compensation is not important in the proprietaries because they do not normally employ physicians. They provide a hospital in which local physicians are granted practicing privileges. When providers are employed in some capacity, it is assumed their remuneration will be at the lowest possible level consistent with attracting the potential employee, as this is the economically prudent action. Further, the level of remuneration is most likely to be determined by compensation specialists rather than the providers themselves.

The Navy ranked highest in the provider oriented mode. Although individual facilities may not be heavily involved in research and training, most are to some degree. Also, the Navy is involved in entire facilities that are devoted strictly to research or training, such as the Armed Forces Institute of Pathology, and the Armed Forces Research Institute for research purposes; and, the Uniformed Services University of Health Sciences for training purposes. The professional judgement of a Navy provider is unquestioned, and is limited only by what the budget will bear. Even the budget is no object in special cases, where the facility can request additional funding from BUMED. Quality of care in the Navy is of paramount importance and is subject to the same constraints as the professional judgment of the provider. Provider compensation is of high importance in the Navy medical system. A Navy physician is eligible to receive additional remuneration over and above what a comparably graded administrator receives. Also, the request to Congress for special pays and bonuses for Navy providers is drafted by physicians, and they determine the amount of the additional pays and bonuses that will be requested. These requests are limited only by what the market (Congress, OSD, and the President) will bear. Facility control in the Navy is provider dominated. All Navy Regional Medical Centers are commanded by physicians, most executive level positions in BUMED are physician occupied, and medical facilities not commanded by physicians are subcommands of a larger

physician-commanded system [Appropriations Committee on Defense, 1980].

SUMC deserves special mention in the provider oriented mode because it ranks second to the Navy, in conjunction with PSHH. While this may appear inconsistent with a system that has proprietary habits, it is not totally out of character. SUMC is research and training heavy; and, provider compensation ranks second to Kaiser because it is necessary to have a high level of pay to attract the talent necessary to operate a university medical teaching and research system. Facility control while dominated by administrators at the hospital level is, in reality, in the hands of providers at the university level. It appears as though the management of the facility is left to the managers, while the general direction--in the clinical sense--of the hospital is determined by the providers. The managers must adjust their priorities to accommodate that direction.

Both the PSHH system and the Navy are heavily involved in training, albeit not to the extent of the VAH, at least on the individual facility level. Their basic participation in this mode characteristic is in local university teaching cooperation. The sheer number of VAH facilities cooperating with local institutions of higher learning justifies the VAH ranking here. The higher relative ranking in the research category for the Navy is a result of its worldwide research effort in all types of medicine. The PSHS system, while significant, does not have as large a scope.

Kaiser is rated highest in provider compensation because the Permanente Medical Group (PMG) part of the Kaiser triad is a for-profit corporation. This is as opposed to the non-profit status of the hospitals and the health plan. Kaiser physicians determine their own pay consistent with the health plan's ability to meet that determination. Also, any unspent budget funds at the end of the fiscal year are divided among the physicians and the other Kaiser entities. Provider control in a Kaiser hospital is limited to the clinical aspects; all else comes under the administrator's cognizance. Professional judgment in a KFH hospital is unquestioned, but limited to budget constraints. A Kaiser provider knows that the more he/she saves, the more he/she will receive as a saving bonus at year's end. That incentive is conspicuously absent from the other systems. The research and training characteristics of the KFH system are limited to providing a consistent throughput of new physicians to keep the PMG vacancies full and to keeping staff physicians current in state-of-the-art medicine.

Organizational Oriented Mode

The governmental hospitals ranked lowest among the group in this mode, with the Navy as the absolute low. This was not unexpected, primarily because of the profit characteristic. Governmental hospitals are in the business of expending funds rather than taking them in.

Predictably, the proprietaries scored highest in this mode, in all characteristics. As previously mentioned, the efficiency,

profit, and organizational survival characteristics of the organizationally oriented mode are extremely interdependent in proprietary and proprietary-like nonprofit systems. This explains the identical characteristic scores arrived at in the proprietary and the nonprofit columns. As the proprietaries are the only hospitals among the entire group that are stated for-profit corporations, and because profit, efficiency, and survival are so closely related, the proprietaries have to be rated as the most organizationally oriented.

The proprietary nature of the nonprofit KFH and Stanford hospitals causes them to be ranked directly below the proprietaries in this mode. This is based upon their official nonprofit status.

That KFH is rated higher than SUMC is primarily attributable to their respective source of funds. The Kaiser system must obtain operating funds through their prepaid health plan, and other nonmembers who arbitrarily elect to use a Kaiser hospital in lieu of any other. SUMC, on the other hand, procures its funds by allowing the local population to use its facilities on a fee-for-service basis; also, SUMC has access to university funds, not to mention government research grants, endowments, and other charitable type contributions. Thus, the survival of SUMC is not wholly dependent upon its own efficiency, as are the proprietaries and the KFH system, respectively.

Among the governmental hospitals, efficiency measurement is a difficult concept. How does one decide whether a governmental hospital is efficient? If their budgets and its execution are the yardstick, should the fact that a hospital spent more or less than was originally appropriated be considered? If a facility spends less than it has the right to, it is likely that the succeeding budget will be reduced by the amount previously saved. Any incentive to operate efficiently is practically nonexistent for this type of system. If a facility spends more than is originally appropriated, it must request additional funding from its parent organization. While this may be frowned upon in official circles, it may also be used as justification for a larger budget the following year. If a facility completes its fiscal year without over or under spending, it appears as though it has achieved efficiency. The facility has done exactly what it said it was going to do, and therefore, must be well managed. The formulation of a budget, in this sense, is more important than any other phase.

It was, therefore, decided that some measurement of who a hospital's clients are, connected with how a hospital uses its health care professionals, would be the best measure of efficiency. The former relates to client dignity, client autonomy, and the prevalence of the client group's influence and power. The latter refers to the extent a hospital uses its health care professionals in the same manner as the

civilian sector, where efficiency is more easily quantifiable, not to mention of more importance.

In a PHS hospital, the client's lack of freedom of choice and dignity are conspicuously present. Among its users, the merchant marine is probably the most organized and affluent. The Indians, refugees, and the remainder, are for the most part unorganized and indigent. It is felt that mariner's organizations, such as the dockworkers union, would have considerable political power and could bring pressure to bear to forego any adverse action that might result because of facility inefficiency. Further, the fact that PHS hospitals use physicians in administrative positions while paying them physician wages, rather than the opposite proprietary practice, points to further inefficiency.

A Naval health care facility is similar to a PHS facility in that their health care professionals are used in much the same manner as the PHS. That Congress can wreak its will upon the Navy to force an efficiency of sorts is attributable to the fact that the Navy's clients, while being somewhat more affluent, are generally less powerful than PHS clients because formal unions and similar organizations are prohibited, thus making the Navy beneficiary less of a political threat. It is undeniable that Department of Defense funds are among the first to be reduced during an austere budget year.

A VA hospital is most likely to be more efficient than other government hospitals. Among the government group, the

VA personnel practices are most like that of the proprietary sector. Administrative jobs are usually handled by administrators; clinical jobs are handled by physicians; and, if a provider elects to stay in or go to administration, he/she must forfeit any special provider remuneration receivable. Relatively speaking, veteran's groups enjoy acceptable client dignity and freedom of choice. While eligible for VA benefits, most are otherwise employed and are most likely to have employer sponsored health care benefits. As a group, veterans are organized into several different fraternal organizations. However, it is felt that because VA beneficiaries are a more homogeneous group, rather than the mixture of indigents, refugees, mariners, and what you that constitute the makeup of the PHS clientel, the veterans are more apt to use their political power to demand more efficiency, as opposed to holding back Congressional retribution for inefficiency.

Among the governmental hospitals, the Navy should be the least concerned with organizational survival. As long as there is a Navy, there must also be a medical department to provide health care to its members. That the organizational form of the Navy Medical Department may change is not being argued. Rather, it will exist in some form so long as the United States has a Navy. If a system had to go, or be reduced, the PHS would probably be the first system to lose its hospitals, if for no other reason than the political power of the clients involved. As a group, the governmental hospitals are relatively

secure in their survival because the political consequences of a system closure would probably be unbearable to those responsible.

Overall Profile Analysis

Figure 8 depicts the relationship between the Navy system and the other governmental systems. Predictably, the respective graph lines have similar shapes, although the points occur at different levels for all but the profit characteristic, and the VAH line turns upward towards the training interest while the Navy and PHS lines go downward. Otherwise, the three lines are practically symmetrical.

The governmental systems are all funded in a similar fashion and they also have what could be referred to as a captive clientele in that their eligible beneficiaries are more apt to use their respective facilities than bear the economic cost of using a fee-for-service system. It appears as though patient economics plays a large part in determining the demand on government health care facilities. Eligible clients seem to be willing to give up a large measure of dignity and freedom of choice in return for a high degree of access, use, and responsiveness to their needs and desires.

It is suspected that because governmental providers enjoy systems that are physician oriented, they are willing to forego wages to a certain extent. The nonmonetary aspects of a government provider's wages make up for the relatively low wages he/she receives. The Navy ranks highest in all but the training

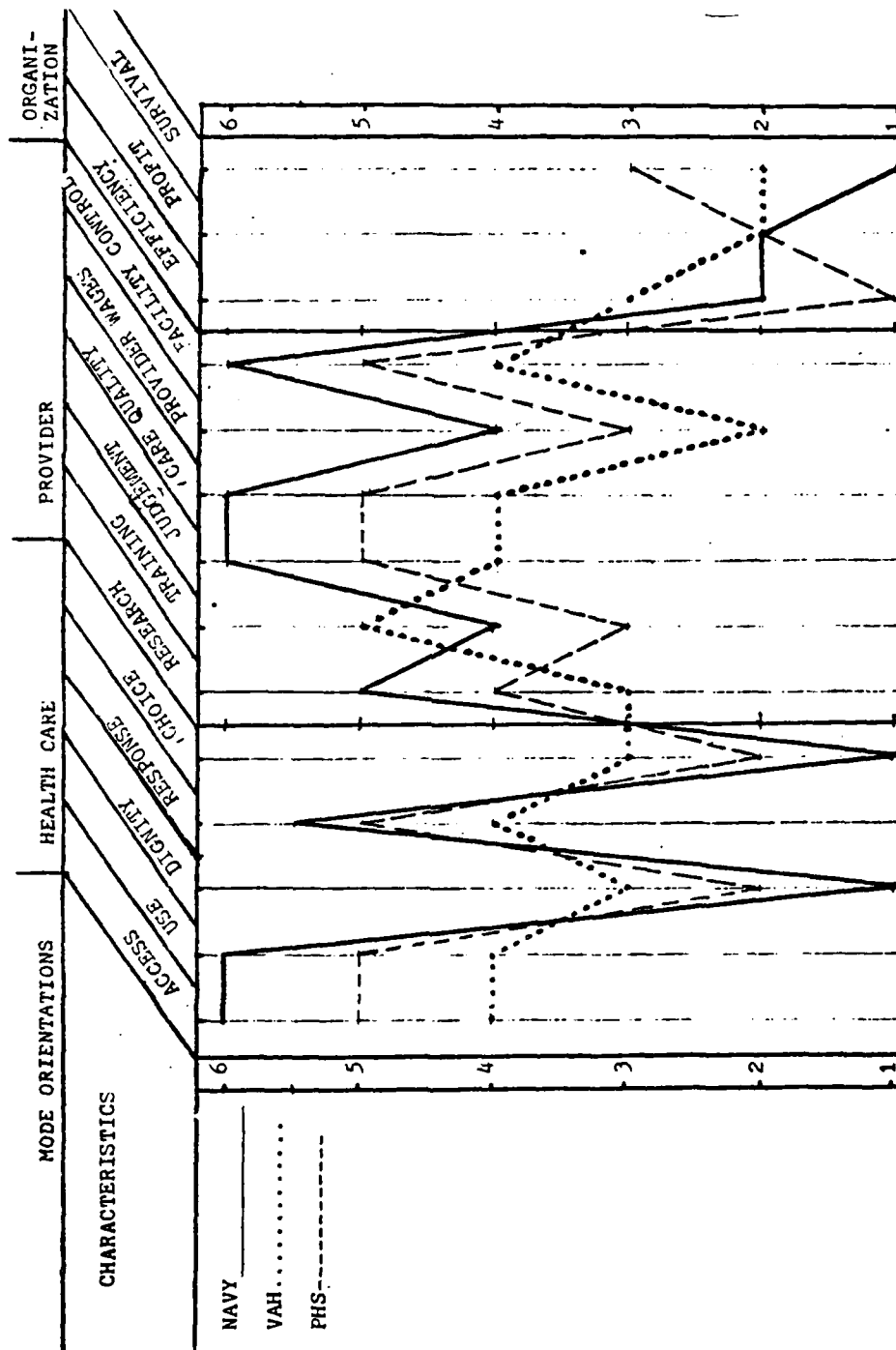


Figure 8. Profile Analysis of the Facilities and their Relative Rankings Across the Mode Characteristics of the CEO/CO Determination Model

characteristic of the provider orientation mode among the government facilities, albeit they are all close. This is a possible explanation for the relative success of provider recruiting and retention despite their relative low level of remuneration.

Figure 9 is the graphical overlay of the Navy system as opposed to the nonprofit hospitals. In contrast with Figure 8, Figure 9 shows the Navy at odds with the nonprofit hospitals in most of the mode characteristics.

The Navy system is most like KFH in the care mode. This is probably due to the captive client system that KFH and the Navy system both enjoy. The fact that the real clients of both systems have no choice, brings the systems closer together, while the KFH practice of accepting anyone who can pay keeps the systems apart.

In the provider mode, the Navy system more closely resembles SUMC. This is because of the training, research, provider autonomy, and facility control that these two systems enjoy. In this sense, KFH becomes more organizationally oriented. Indeed, were it not for the PMG sector of Kaiser, the KFH would probably be almost entirely organizationally oriented.

The relative ranking for SUMC in the provider mode puts it in a tie for second place position with PHS, and just below the Navy. That SUMC was the only nongovernment facility to score higher than a government facility in this mode attests

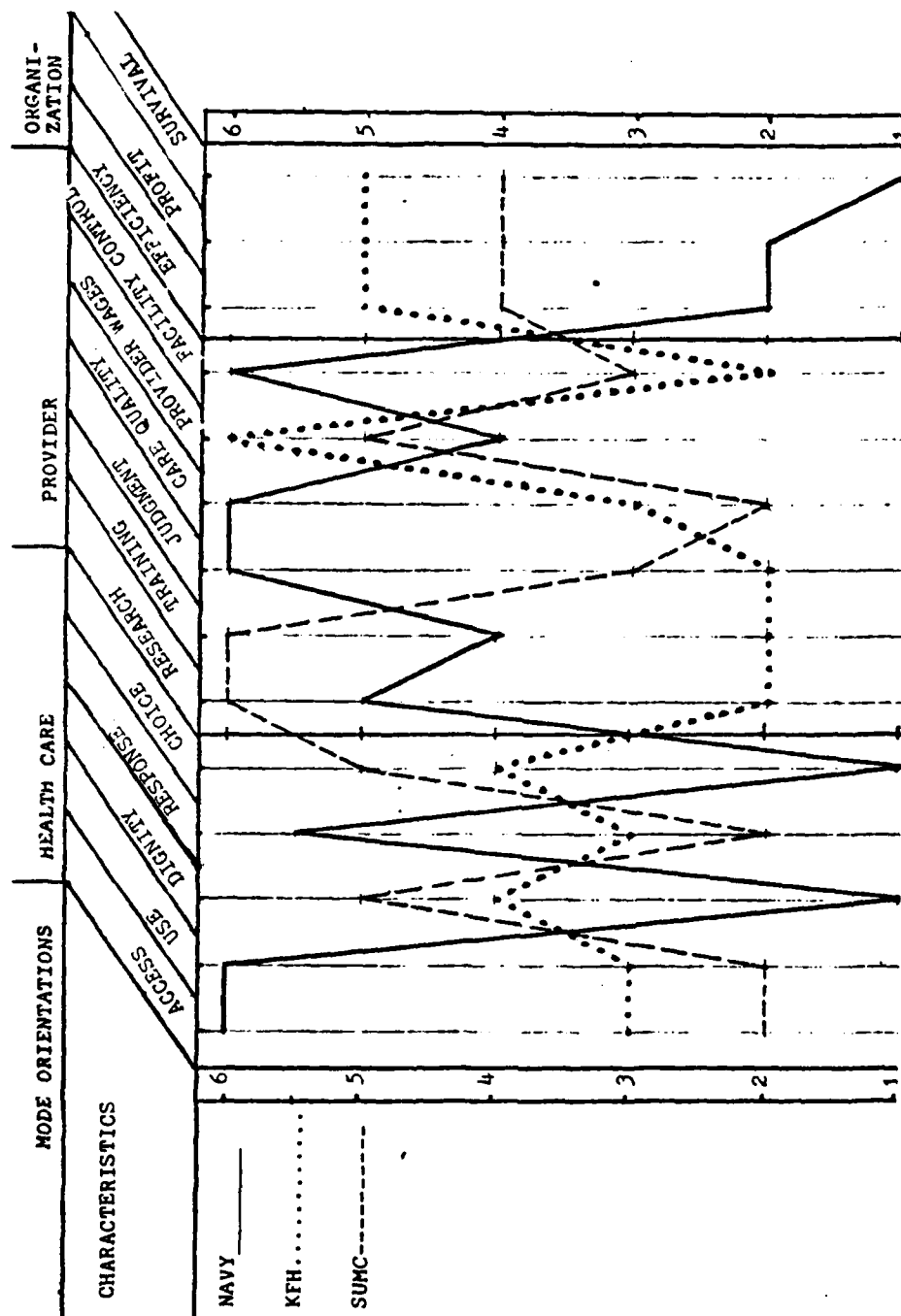


Figure 9. Profile Analysis of the Facilities and their Relative Rankings Across the Mode Characteristics of the CEO/CO Determination Model

to its similarity to the Navy's medical system in regards to a system that is oriented toward the provider.

The stark contrast of the Navy system and the organizationally oriented proprietaries is readily evident in Figure 10. Of the fourteen characteristics of the three modes, not one depicts these two systems as being even remotely similar.

The fact that a publicly owned corporation must consider profit making for its stockholders as its primary objective dictates that the proprietaries get the most from each cost dollar.

In the care mode, only dignity and choice will cause the proprietaries to increase their profits, as was previously explained. Being care oriented in the other care characteristics will only raise their costs. Therefore, these costs will be kept to a minimum, consistent with good health care, and to the degree that the facility will not drive clients away.

The provider orientation mode of Figure 10 portrays the largest difference between the Navy and the proprietaries. Where the Navy is very strong in most of these mode characteristics, the proprietaries are nonexistent. All of the provider oriented characteristics represent opportunities to spend money with little potential for profit. Providers are a scarce, expensive resource that consume other resources. Evidently, the proprietaries have discovered that the most efficient manner to deal with physicians is indirectly.

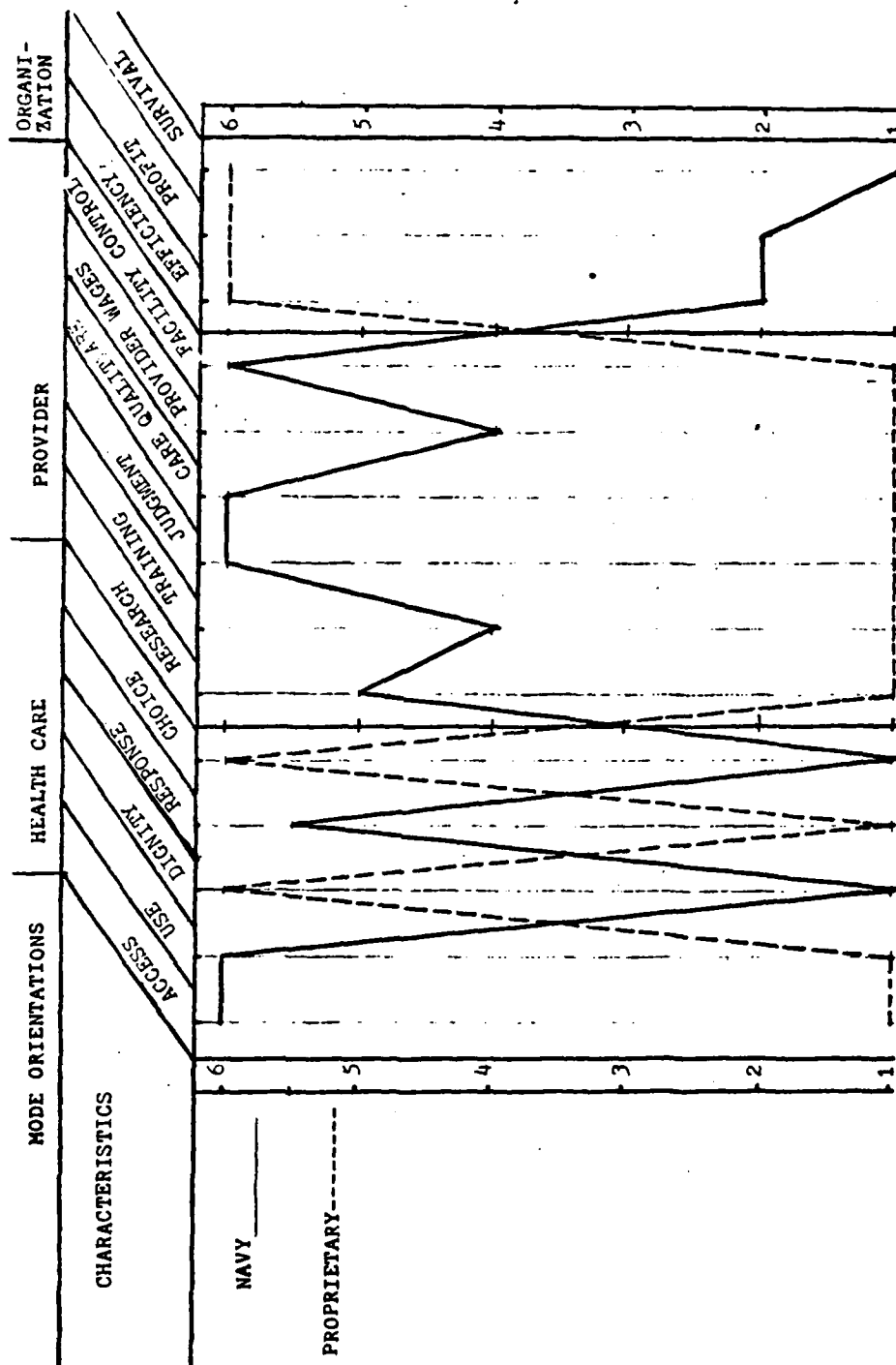


Figure 10. Profile Analysis to the Facilities and their Relative Rankings Across the Mode Characteristics of the CEO/CO determination Model

As previously stated, efficiency and profit ensure survival in the proprietary sector. The stockholders demand for a return on his/her investment dictate that a proprietary hospital do whatever is necessary to ensure profits; thus, survival. The Navy has no such problems with its funds procurement. Although subject to budget cuts in austere years, Congress will always appropriate the funds necessary for the Navy to complete its mission, and the Navy's medical mission is to spend money in support of the medical needs of the Navy itself.

A naval medical facility will be as efficient as it has to be, relative to the austerity of the fiscal budget. If efficiency, profit, and survival were paramount to the Navy, their system would logically resemble that of the proprietary sector, where those characteristics are of the utmost importance.

V. DISCUSSION

Care Orientation Mode

Careful examination of Table 1 reveals that the higher a facility/system scores in the care oriented mode, the more likely it is that the facility will have a physician CEO. If a facility/system is care oriented, it will provide the best care possible, within its budgetary limitations. Cost becomes a secondary consideration in the care mode. This extreme of the care mode is descriptive of hospitals that do not have to raise their own funds, such as government hospitals.

Both PHS and the Navy have high total scores in this mode. In fact, they score very high in every characteristic except dignity and choice, as was previously pointed out in the analysis. Their doctrine of total access and use to all eligible beneficiaries connected with responsiveness to the wants and desires of their clients to create systems whereby the quality of care is limited only by the budget, and even that is negotiable through emergency funding from the parent organization. Such is the nature of cost overruns in the Federal Government.

Systems that lean towards the care mode are almost always physician dominated. Both the Navy and PHS fit this description. While the VAHs are high in care orientation, they seem to be tracking in a new direction. This will be discussed in the final section of this chapter.

The more cost conscious a facility becomes, the more apt it is to have an administrator as the CEO. Proprietary systems and nonprofit hospitals, such as Kaiser and Stanford certainly fit this description; accordingly, they are not high in the care mode. As the score totals of the care mode in Table 1 indicate, concern for efficiency is inversely related to each score; the lower the score, the more concern for efficiency. The opposite is also true.

Provider Orientation Mode

The higher a facility scores in the provider mode, the more likely it is to have a physician CEO. SUMC stands out as an exception to this result, due primarily to the teaching and research nature of Stanford's hospital. In spite of this high provider mode score, SUMC still employs an administrator as its CEO because it must raise its own funds to a large degree, mandating an efficiency that is not absolute, but adequate to meet its needs.

It is clear that while one of the main purposes of SUMC is the teaching of Stanford University medical students, it achieves this purpose through the devotion of the bulk of its resources to the local population's use in return for a fee. This local population does not include the university students, as the university has found it more profitable to subcontract for the care of the students with another medical entity. Where one might easily conclude that a facility of

of this type would be provider oriented because of its research and teaching functions. The facility is, in reality, a combination of provider and organizationally oriented under the model because of its proprietary like practice of providing health care for a fee to the general public, and because the duties, responsibilities, and accountabilities of the CEO are management and survival oriented.

The PHSH organizational system is dominated by physicians. The Surgeon General of the United States is the PHS CEO. All regional directors are physicians. All facility directors are physicians, as are all of their deputy directors (Figure 5). The closest any administrator comes to being anywhere near a facility CEO position is the associate director of administration. In the absence of the CEO, the deputy becomes acting CEO [PHS interview, July 1980].

As a provider care oriented system, the PHS works very well. Physicians are accountable only to other physicians. There is no interference from managers, as the system has designed them out of any position with a respectable power base. It is known that the physician is the central figure in a hospital, for without his special skills and knowledge, the hospital merely becomes another building. Indeed, the most important function of a hospital is to treat patients, and that task would be impossible without physicians [Opp, 1962]. Paul Opp, in his paper on hospital administration and the medical staff, points out that some of the most frequent

sources of administrative-medical staff conflict are [Opp, 1962]:

- a. Physicians resent any type of control or direction by anyone other than physicians.
- b. Physicians resent any real or imagined encroachment upon affairs considered by physicians to be purely medical.
- c. Physicians have feelings of superiority and want freedom from administrative interference. They view the administrator as a threat to their freedom and superiority.
- d. Physicians seem to think that the hospital exists entirely for them rather than the patient. They tend to forget that the hospital is for the patient.
- e. Physicians have an "omniscience complex" which causes resentment in underlings.

As the PSHS system has no administrators with any real authority, the physicians of the PHS system should feel relatively free from interference by administrators. The director of PSHSHSF states that he believes that only physicians can effectively relate to other physicians on hospital matters and that in his opinion, physicians make the best CEO's, regardless of management function [PSHSHSF interview, July 1980]. The PSHSHSF CEO said that he felt that many of the PHS physicians would quit if the career path to CEO were opened to administrators rather than physicians because the opportunity to be CEO enhanced their overall compensation [PSHSHSF interview, July 1980]. One must ask at this point whether the PHS physician would accept the CEO position in lieu of special physician pay as previously discussed in the VA section of

this paper. Further, if a physician does quit because he or she is no longer eligible to be a facility CEO, one must also ask whether the system will not function more efficiently because it is less expensive to hire an administrator rather than a physician as a CEO, not to mention the opportunity costs of having a physician in management and the fact that administrators are better qualified to be a hospital CEO because of their experience and educational background.

The accountabilities of a PHS CEO are to other physicians from the bottom of the organizational hierarchy to the top. Physicians understand physicians better than anyone else; that point is inarguable. Their education, desires, and priorities are basically the same, thus making it easy for one to relate to another regardless of their place in the hierarchy. This is, of course, as opposed to a physician/administrator relationship.

The organizational structure of the Navy Medical Department is illustrated in Figure 6. As in the PHS system, it is also dominated by physicians.

Of the 23 Naval Regional Medical Centers (NRMC), not one is commanded by other than a physician. Administrators of the Medical Service Corps do command medical department facilities that are not clinical in nature, such as the Hospital Corps School. They also command some of the smaller medical facilities that are subcommands of a larger physician-commanded entity [House Appropriations Committee hearings, 1980].

Also, the overwhelming majority of the higher executive positions at BUMED are filled by physicians [BUMED Organizational Manual, 1980], even though these positions are managerial in nature and should not require a physician's skills. It appears that physicians occupy these positions because of the organizational system rather than the skills required by those positions.

Credence is lent to the belief that the Navy is provider oriented when one discovers that in the midst of the highly touted and much publicized "physician shortage" the Navy is supposed to be experiencing, there are approximately 100 Navy physicians (at any one time) that are in jobs that are primarily administrative in nature [U.S. Senate, 1979]. Further, all Navy physicians in these high administrative positions, to include facility CO/CEO, are eligible to draw physicians' inducement pay and/or variable incentive pay. Under currently proposed legislation, this could amount to some \$29,000 extra over a comparably graded MSC officer of the health care administration section [Navy Times, 1980]. This figure does not take into consideration the opportunity costs, recruitment costs, and educational costs of utilizing a physician in administration when administrators are available.

Seventy-two different military medical facilities had to curtail or completely eliminate some normally available services to eligible beneficiaries during fiscal year 1978. The service cutback covered some 12 different specialties

[Congressional report, 1979]. Using the Navy as the model and examining the Naval Hospital at Quantico, Va., this writer has personal knowledge that while OB/GYN services were closed at that facility, there was a board certified OB/GYN specialist assigned to an administrative position at the Bureau of Medicine and Surgery some 20-odd miles away. Additionally, the cost difference between physicians and administrators grows dramatically when recruitment costs of \$5,000 to \$6,000 per physician and/or educational costs of \$37,000 to \$190,000 per physician enrolled in a Navy sponsored program [Cost Effective Analysis, 1976] are figured in to compensate for the new physician who must be brought on board to replace that physician who is out of clinical medicine and into executive medicine.

As in the PHS system, the Navy CO/CEO of a major health care facility will be replaced by the Chief of Clinical Services rather than the Chief of Administrative Services when the CO/CEO is unable to be present (Figure 6) [MAN MED Chapt. 11]. The Navy CO/CEO sees his duties, responsibilities, and accountabilities as provider oriented; and rightfully so because he is a provider who is striving to keep his institution within the organizational framework of a provider oriented system.

The Navy's heavy involvement in research and education offers further evidence that its system is provider oriented. Institutions, such as the Armed Forces Institute of Pathology

and the Armed Forces Research Institute are world famous for their research efforts and accomplishments. Educational programs that subsidize health profession students, and the recently establishment of a medical school that exists solely to provide physician input for the Armed Forces (United States University of Health Sciences) are referred to. As pointed out in an earlier section of this paper, commitment to research and education are two of the primary characteristics of the health care provider oriented system.

Organization Oriented Mode

The proprietary systems stand as the ultimate example of a system that is organizationally oriented. Their very existence depends upon success in this mode.

There are those who argue that the profit motive debases the system, distorts priorities, leads to exploitation of the poor and powerless, and encourages unnecessary resource proliferation. The issue is not whether profits stimulate abuse or exploitative behavior, as they may often do; rather, it is necessary to consider whether the anticipated gains that result from the profit incentive outweigh these abuses.

It is assumed that those people who elect to patronize a for-profit health care institution do so of their own free will. They are paying for that health care either directly or through a third party insurer, rather than being told what organization or institution they must go to because their care

was being subsidized by the government or had been previously contracted for by their employer. If the proprietary hospital is making a sustained profit, then it is, to a certain degree, both successful and efficient. It has fulfilled its obligation to its share owners while providing a measure of satisfactory health care to those that must bear the cost of that care.

If the proprietaries are indeed the most efficient, one must ask what factor causes them to be that way. In the context of this paper, the four proprietaries were asked what practices they used in regard to determining who a hospital CO/CEO should be.

HCA reported that it was not necessary for a hospital CEO to be a physician, that none of its hospital CEOs are providers, and that their CEO's duties are managerial in nature [HCA communication, July 1980].

Humana, Inc., reported that it is not necessary for the CEO of a hospital to be a provider, that none of its hospital CEOs are physicians, that the CEO position is managerial in nature, that none of its corporate executives are physicians, and that administrators make the best CEOs [Humana communication, July 1980].

Lifemark, Inc., reported that it is "absolutely not" necessary for the CEO of a hospital to be a physician, that none of its hospital CEOs are physicians, that the governmental health providing agencies "use of MDs in administration" is

a complete waste of an already scarce resource, that physicians should be used only in roles requiring and MDs skills, that trained administrators should be used in administrative positions, that there is nothing in the education and training of a doctor that "in any way" prepares him to direct a hospital organization, that generally speaking, non-MD administrators do a decidedly better job than MDs in all respects in administration, including staff relationships. Lifemark went on to say that the military's use of physicians as CO/CEOs

. . . goes back many, many years to the time when physicians were the Medical Corps (sic), before hospital administration as a profession was ever thought about. With the advent of collegiate programs in hospital administration, the opportunity presented itself for the services to introduce trained administrators into the role of hospital and health facility director, but the opportunity was refused. The MAC (sic) was introduced, but MAC officers (Army) and similar categories in other services were never privileged to assume the CEO role. The AMA, in particular, and vast corps of retired medical officers carried sufficient weight to always forestall any change in that direction. Since physicians occupy all principal positions in the medical arms of all armed services, it is unlikely that any change will ever come from within [Lifemark communication, July 1980].

NME, Inc., reported that it is not necessary for the CEO of a hospital to be a physician, that none of its hospital CEOs are physicians, that the CEO position is administrative and managerial in nature, that .01% of its top executives are providers, and that, generally speaking, administrators make the best CEOs. NME went on to say that "I do not agree

with the use of physicians in positions which are primarily administrative in nature, for the primary reason that physicians are not trained in managerial skills necessary to effectively function in these positions" [NME communication, July 1980].

Of the four proprietary hospital corporations mentioned, none are controlled by physicians. Of all the individual institutions that these four corporations own or operate, none have a physician as a CEO. This is in keeping with the CO/CEO determination model of this paper. All of the four organizations' facilities have nonphysician administrators as their CEOs. These CEOs are, in turn, responsible to other administrators all the way up the corporate ladder. The goals and orientations of the individual facilities are organizational in nature, in that the very survival of the organization depends upon the effective and efficient management of each individual facility. If a specific facility is inefficient and/or unprofitable for a period of time, it will not survive. The corporate entity may absorb losses for a short period of time, but cannot do so for an extended period if it expects to survive.

It is the duty and responsibility of the facility CEO to maximize profit, consistent with acceptable health care. He is accountable to administrators for that duty and responsibility. Therefore, the CEOs of all the facilities represented by the four proprietary corporations are, and should be, nonphysicians.

The more provider or care oriented a facility is, the less organizationally oriented it will be. Indeed, Table 1 shows a continuum of organizational orientation that rises as the system becomes more and more proprietary in nature.

It is suspected that the governmental hospitals will acquire more of the organizational characteristics as their budgets come under ever increasing scrutiny from dollar conscious Congressmen/women and taxpayers.

A System in Transition

Organizationally speaking, the VAH system begins to take on the complexion of a proprietary system below the level of the director of VA medicine. All regional directors are administrators rather than physicians, and the majority of the CEOs of individual facilities are also not physicians. While the facility director at VAHSF is a physician, he states that he is the exception to the rule and that the only reason he is presently serving in that position is that the CEO experience will better qualify him for an executive position at VA headquarters in Washington, D.C. The VAHSF CEO also said that the reason most VA hospitals have administrators as their CEO is because VA physicians cannot draw any special remuneration if they are in an administrative position. This recent VA ruling caused most physicians who were working as administrators to return voluntarily to clinical medicine. The annual pay difference is in the thousands of dollars and it appears

as though they were unwilling to forego that pay for the privilege of being in "executive medicine" [VAHSF interview, July 1980].

The VAH system, according to the CO/CEO model, appears to be in a transition phase. That is, it is in the process of making the move from a patient/provider-oriented system to one that will incorporate some organizational characteristics. This observation is based on the fact that nearly all CEO positions are now filled by administrators, whereas they were formerly filled by physicians. Further all regional directors are administrators.

VI. CONCLUSIONS

The CEO/CO of a health care facility should be a physician if a relatively high score is obtained in the care oriented mode of the CEO/CO determination model, such as the score of the Navy system in Table 1. Alternately, a lower score in this mode indicates that an administrator might be the appropriate choice. The proprietaries represent the opposite extreme of the Navy's score in the care oriented mode. The more care oriented a hospital is, the more apt it is to have a physician as the CEO/CO.

The most effective CEO/CO for a health care facility that is provider oriented would be a physician. The governmental hospitals scored high in this category, with the Navy the highest; and, they are physician oriented. That Stanford scored high was attributable to its research and training characteristics; but, its proprietary-like nature dictates that SUMC have an administrator as CEO.

Administrators are the most effective choice for CEO/CO in facilities that are organizationally oriented. Institutions, such as the proprietaries, are administrator dominated, and the facilities are quite efficient. The relatively high score of KFH, a non-profit facility, is derived from its proprietary nature. The Navy scored lowest here, giving added credence to its present CEO/CO assignment policy.

Systems and facilities whose orientations may be in a transition phase from one mode to another, such as the VA, should use administrators--even though the system executives continue to be physicians--if the direction of the move is towards organizational orientation. However, as long as the primary orientation of the facility is care oriented, and the move is towards provider orientation, the physician is still the most appropriate choice.

In regards to the Navy, this writer is forced to conclude that physicians should continue to hold the CO/CEO positions, as well as other executive medicine billets, so long as the Navy Medical Department continues to be a provider/care oriented system. This conclusion may change if Congress and the tax-paying public demand efficiency in Federal health care systems, thus mandating Navy medicine to assume an organizationally oriented mode.

APPENDIX A
INTERVIEW QUESTIONNAIRE

1. Describe your area of cognizance.
2. What do you perceive are your most important duties or responsibilities?
3. What duties or responsibilities take up most of your time?
4. Is there a person or persons that you are directly responsible to? (Is there someone you have to keep happy?)
5. What do you perceive that a person believes is the most important thing you need to do?
6. What sort of leverage or control does that person have over you?
7. How do those controls affect your effectiveness of operation?
8. How do you ensure that this organization is operating effectively and still meet your patients', staffs', and superiors', expectations?
9. Describe your service population. Is there anything about them that requires special or extraordinary measures in order for you to achieve full operational effectiveness?
10. Is there a conflict between your superiors' wants and your service population's wants? If so, you do you resolve the conflict?
11. Do you believe that the chief executive officer position is primarily administrative or managerial in nature?
12. Do you believe that a physician makes a more effective C.E.O. than a non-physician?
13. If so, explain what qualities or qualifications a physician has that makes him a better C.E.O.

14. If not, can you explain why most governmental hospitals, such as PHS and the Armed Forces use M.D.s as C.E.O.s rather than non-physician administrators?
15. Considering all factors of the duties involved, such as war, peace, the physician shortage, etc., who do you think should be the C.E.O. or Commanding Officer of a military hospital; a physician or a non-physician administrator?
16. If physician, then do you think a non-physician would be feasible or could function effectively within the military health care system?

APPENDIX B

VAH INTERVIEW RESPONSES

1. Director of the VA Medical Center and of the fee-for-service provided by the civilian sector to VA beneficiaries for all of Northern California.
2. The director has total responsibility for everything that happens at the hospital. Everything is important. The VA Medical Center director is the CEO in the most complete sense of the word.
3. If the basic structure of the hospital is working well, the director can spend most of his time on matters that may seem trivial, such as greeting guests, veterans groups, dignitaries, and so forth, but, in reality, have great underlying importance. Detecting situations that are potential trouble spots or problems is also very important. The assistant director handles administration and the chief of staff handles clinical matters.
4. Yes, the regional director.
5. Concurs with that of the hospital director.
6. Line authority.
7. The priorities are the same, therefore, there is no conflict.
8. By holding those in control responsible for their actions. Otherwise, sound management techniques and effective communication.
9. Veterans' Administration beneficiaries, as described by law. Yes, the service population is aging at a rapid pace,

due to the World War II peak of veterans beginning to move into their sixties. This causes their consumption of care to increase as their ages rise; demand is increasing.

10. Only that the service population's demands exceed what the budget allows the center to provide.

11. Yes.

12. The VA has not found that either is uniquely better at the job. The VA is reluctant to lose all physician CEOs because the top jobs at VA headquarters are limited to physicians, and experience as a hospital director is a very desirable background for these top jobs.

13. delete

14. The VA uses administrators to a great extent. The VA has very few physicians left as directors. Otherwise, it is just a tradition extending from the purpose of a hospital.

15. The professional background of a person is irrelevant; both should be used. Of 168 hospital directors in the VA, only 6 or 7 are physicians. This limits the selection for the top positions at the headquarters, as they must be physicians. But, if a physician wants to be a hospital director, he must give up his special pay that physicians are eligible to receive. This was a negotiation factor with the Office of Management and Budget (OMB). Special pay for physicians would only be given to those in positions that require physician's skills. The hospital director's position does not require an

M.D.; therefore, any M.D. serving in that capacity does not receive any special pay.

16. (delete)

APPENDIX C

KFH INTERVIEW RESPONSES

1. Administrator of the San Francisco KFH, which is one of 13 in the Northern California region. This includes all KFH and PMG activities in San Francisco, and represents a work force of approximately 1500 people. The administrator works with the physician-in-chief, who has the overall professional responsibility of the hospital in terms of quality of care, physician matters, and so forth.
2. Keeping the operation within its budget. Negotiating an adequate budget with his superiors.
3. Trivia does not bother him unless he chooses to be bothered by it, because he has sufficient staff support to take care of everyday problems. However, he does spend about 20% of his time on incidental matters because he does not want to lose touch with the everyday operations of the hospital. Planning and review occupies the majority of his time.
4. Yes, the regional director, who is an administrator. He also happens to be a physician but, this is an exception because regional directors are generally administrators.
5. Concurs with the priorities of the administrator.
6. Line authority, the regional director has the authority to hire or fire the hospital administrator.
7. They do not affect the operations because their priorities are the same.

8. Sound management techniques and businesslike practices.
9. Twenty-one percent of the population of San Francisco.
Eleven percent are age 65 or over. The language requirement of the multi-national makeup of the population causes problems.
10. No (essentially).
11. Yes
12. No, but the cooperation of the physicians is important.
13. (delete)
14. No, other than tradition.
15. If qualified administrators are available, there is no reason why they should not be able to occupy those positions provided that there are physicians available to take care of physicians' problems, and provided that there would be a high spirit of cooperation between the administrator and the physician-in-chief.
16. (delete)

APPENDIX D
PHSH INTERVIEW RESPONSES

1. A five state responsibility including California, Nevada, Utah, Arizona, and Hawaii.
2. Develop hospital services and deliver health care to our (PHS) beneficiary population.
3. Administrative duties take up most of his time, clinical duties come next.
4. Yes, the beneficiaries in a positive sense. In the context of "keeping someone off his back," the director of hospitals and clinics in the line authority above him.
5. Concurs with that of the hospital director.
6. Line authority.
7. The "bureaucracy" is the big problem, not his superior. Everything gets tied up in the operation of the system, it's not flexible enough.
8. The effectiveness of the hospital and the expectations of those involved are not mutually exclusive. These two factors go together. Internal review and efficiency are the foremost factors.
9. Seamen have special needs such as quick turn around times between in-port and at-sea operations. This limits case follow-up. The unique social and cultural aspects of the American Indian population require special appreciation. The refugees are a special group with stressful problems.

10. No, they are very responsive and supportive. Within the context of national priorities, the beneficiary problem has been instrumental in keeping PHSHSF open. There is no doubt that that the loud, free expression by the beneficiaries has foregone the closure of the hospital.

11. Yes.

12. (I) do, but (my) standpoint is not unbiased.

13. Although the attributes a person brings to a job are more important than the professional degree the person has, the organization the PHS currently has is more conducive to administration by a physician. Control over the medical staff is best handled by a M.D. because responsiveness to and control over the medical staff must be based on mutual understanding of needs and professional respect. The medical staff feels that a physician CEO more readily identifies with the problems concerning recruitment and retention. They feel that their value systems will be attended to more effectively by a physician. Physicians, in a system such as the PHS, are better able to compete for medical needs than nonphysicians.

14. (delete)

15. The use of physicians as CEOs is not a waste. The same reasons as were provided in question number 13 apply here, also.

16. The issue here is the individual rather than the profession. An individual from either profession could bring certain attributes to a CEO job that would make him/her an

excellent CEO, provided the necessary support was available and forthcoming.

BIBLIOGRAPHY

Bellin, Lowell E., "The Health Administrator as a Status Seeker," Journal of Medical Education, v. 48, p. 896-940, October 1973.

Bower, Joseph L. and Christensen, Charles J., Public Management: Text and Cases, Richard D. Irwin, Inc., 1978.

Cost Effective Analysis of Two Military Physician Procurement Programs: The Scholarship Program and the University Program: A Report to the Congress of the United States. Office of Management and Budget. May, 1976.

Donabedian, Avedis, Aspects of Medical Care Administration: Specifying Requirements for Health Care, Harvard University Press, 1973.

Hospital Corporation of America, Inc., personal communication with H. F. Cooney, Director of Public Relations, July, 1980.

Humana, Inc., personal communication with H. H. Phillips, Vice President of Human Resources, July, 1980.

Lifemark, Inc., personal communication with R. W. Carithers, Vice President of Public Affairs, July, 1980.

MacEachern, Malcolm T., Hospital Organization and Management, 3rd ed., Physicians Record Company, 1957.

Manual of the Medical Department, Department of the Navy, Bureau of Medicine and Surgery, G.P.O., 1952.

Mechanic, David, Public Expectations and Health Care, Wiley-Interscience, 1952.

National Medical Enterprises, Inc., personal communication with G. A. Smith, Sr. Vice President and Chief Hospital Operations Officer, August, 1980.

Organizational Manual of the Bureau of Medicine and Surgery, Department of the Navy, Bureau of Medicine and Surgery, January, 1980.

Rakich, Jonathan S. and Darr, Kurt, Editors, Hospital Organization and Management: Text and Readings, 2nd ed., SP Medical and Scientific Books, 1978.

Sheinback, Jerry, "The Health Administration as a Status Seeker," Journal of Medical Education, v. 49, p. 314, March 1974.

United States House of Representatives, Appropriation Subcommittee on Defense Hearings, 96th Congress, May 12, 1980.

United States Senate, Armed Services Committee, Subcommittee on Manpower and Personnel, Hearings on Tuesday, March 20, 1979.

Wood, Adrian, A Theory of Profits, Cambridge University Press, 1975.

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