PART I

The Setting
Chapter 1
An Evolving Role in a Changing Environment

Nothing in progression can rest on its original plan. We might as well think of rocking a grown man in the cradle of an infant.
—Edmund Burke

CHAPTER OBJECTIVES

- Identify the dimensions in which the healthcare manager’s work environment is changing most significantly, and develop an awareness of the major factors contributing to the evolution of the manager’s role.
- Review the principal paradigm shifts that are contributing to major change in the management and delivery of health care.
- Develop an awareness of the major changes wrought by the advent of managed care and the impact of the Balanced Budget Act of 1997.
- Review the changes in the managerial role that have occurred in recent years, and offer some projections about future changes in how healthcare managers will approach their work.
- Highlight the importance of flexibility and adaptability as significant determinants of managerial success.

SITUATION: REINVENTING THE HEALTHCARE ORGANIZATION

You work for a healthcare organization or are at least somewhat familiar with how some healthcare providers work. Assume also that your organization is a community hospital and that you have been asked to participate in an activity intended to produce suggestions for redesigning the ways in which your hospital delivers care. For your purposes consider the desired outcome of the hospital’s processes to be the preservation of life and the restoration of health through medical and surgical interventions in both inpatient and outpatient settings.

Instructions

In either words or diagrams, or perhaps both, develop an organizational structure for accomplishing the foregoing objective, designating the functions you believe will have to be performed. You can do this individually, but this activity may be more fruitful when undertaken by small groups (perhaps three or four people). Spend 10 minutes or so identifying functions for your redesigned hospital, and then consider the following three questions as you proceed through this chapter:

1. Did you find yourself using the names of so-called “traditional” hospital activities (emergency, medical records, admitting, etc.) to describe the functions of your redesigned hospital? Why might you have done so?
2. Why do you suppose you can experience considerable difficulty trying to envision new ways of achieving a hospital's desired outcomes?

3. Desired outcomes were previously described as including “preservation of life and restoration of health.” In what ways might we hear this phrase challenged in describing the apparent purposes of the healthcare system of the early twenty-first century?

THE (WHIRL)WINDS OF CHANGE

It seems as though you have more work facing you than ever before. Your hospital’s occupancy has been falling steadily, but outpatient volume has been increasing on all fronts. You have lost some of your more effective employees and have attempted to replace them. However, because of periodic “hiring freezes” and other delays that remain frustratingly beyond your control, your department has been chronically understaffed for months. On your last attempt to obtain approval for replacement hiring, you were told that the open positions would probably be eliminated. As if that were not enough, you just learned that the middle manager you have reported to for several years is leaving under circumstances unknown to you and that the position is being eliminated.

Does the foregoing scenario describe your present working circumstances in some respects? Or does it reflect any of what you might have gone through in recent years or that you have reason to believe might await you and your organization just around the corner? If so, you are far from being alone. First-line managers, those who supervise the people who do the hands-on work, are caught up in a continuing period of bewildering change that some, whether by choice or involuntarily, will not survive. It is a period during which the supervisor’s role is transformed in ways that most of today’s working managers could never have anticipated when they entered the healthcare work force.

THE BROADEST SHIFTING PARADIGMS: A WHOLE NEW ENVIRONMENT

As far as the world of work is concerned, the paradigms of the generations of workers who entered the American work force during the 1940s, 1950s, and 1960s have come under severe attack. To these generations, specialized higher education or employment in certain kinds of settings were principal requisites of job—and thus income—security.

One message that young people were bombarded with for decades concerned higher education: for a secure job with a good income, get a college education. There is, of course, still much truth in that advice; in the long run the well educated still fare better than those who are not as well educated. However, in recent years it has become apparent that a college education is not nearly as effective as it once was in ensuring employment that is both well paid and stable.

Another widely held belief was that securing a job with a large corporation would usually lead to employment security. For years it was assumed that getting a job with one of the major manufacturing firms could secure one’s income
for 20 or 30 or more years and lead to a comfortable pension. This was true for many who entered the manufacturing work force as early as the middle to late 1930s or during World War II. A significant number of these people put in their 30 years and retired comfortably during a time when all were being encouraged to aspire to retirement at younger and younger ages. Why wait until 65? Many retired by 60, and those who followed were primed to expect the retirement age to drop to 55 in time for them to take advantage of it.

Take a close look at the overall status of college graduates in today's job market, and look as well at the numbers of people presently employed in manufacturing. With the exception of a few occupations, college graduates have been out beating the bushes for employment rather than being recruited on campuses as they were in earlier decades. A great many of the people presently seeking jobs in manufacturing count themselves lucky to find steady work—"steady" meaning that it might last a few years—and are overjoyed should they also be able to obtain benefits such as health insurance.

In brief, to a generation or two of Americans the control was perceived to be in the hands of the individual: Get into a good company, follow the rules, and be loyal, and you were set for life. However, the paradigms of these past generations are crumbling. Products and even entire technologies come and go, companies come and go, and when economics and the need for survival prevail, the rules mean less than they once meant; loyalty, both personal and organizational, comes in at a far second after the bottom line.

ORGANIZATIONAL PRIORITY NUMBER ONE: THE BOTTOM LINE

It is a common contention of many healthcare workers today that top management cares only about the bottom line. The critics point accusingly at even the most prestigious of the not-for-profit, supposedly humanely motivated, healthcare organizations and charge that patient care has taken a back seat to financial viability. They also can and do point at the government and the other major third-party payers and accuse them of compromising healthcare quality by cutting back on reimbursements and by applying other pressures to reduce costs. Changes in many organizations have prompted some to claim that the concern for money has grown out of proportion to concern for the public's health.

There is really no question that healthcare costs, the growth of which has at times far outpaced so-called "normal" inflation, need to be brought under control. As a solution, however, outright resistance to all cost-control pressure is neither practical nor sustainable. For long-run viability a healthcare organization—or for that matter, any business organization—must balance bottom-line concerns with human concerns. An organization that pays no heed to fiscal concerns will not survive long. An organization that focuses mostly on the bottom line may last longer, but a constant, all-fiscal approach leads to morale problems, increased turnover, and decreasing productivity, all of which can take the organization toward failure as business goes to others. Failure via this route is more gradual but fully as certain. Without balance between financial and human concerns, any organization is headed for problems. In recent years the swing of the pendulum has favored the bottom-liners, making itself felt first in businesses other than health care but later in health care as well.
Mergers, acquisitions, affiliations, and other combinations have frequently created an organizational distance in which layers of structure separate profitability issues from people concerns. This condition ensures that some of the more exploitative employers will exercise the upper hand in work relationships. The management attitude frequently suggests that if you are unhappy with the way the place is being run, there are others out there willing to do your job. This exclusive bottom-line focus uses up people.

THEN CAME REENGINEERING

Today most organizations call it “reengineering.” A few have called it “repositioning.” Some might still call it “downsizing,” “rightsizing,” or simply “reorganizing.” Regardless of the label applied, however, the intended result is the same: the systematic redesign of a business’s core processes, starting with desired outcomes and establishing the most efficient possible processes to achieve those outcomes.

There has been much talk of reengineering, and there have been a considerable number of exercises that have borne that label. Many of these, however, have been little more than cursory exercises in reorganizing, as a few functions are combined, some functions are eliminated here and there, and a number of positions are done away with. In some instances, there are actual layoffs; in others, sufficient planning and thought have gone into the process to allow the decision makers to manage normal attrition over a period of time and thereby reduce the work force without involuntary separations. In either case, however, it sometimes appears as though the only constant in all of these reengineering efforts is the inevitable reduction in the work force.

True reengineering, beginning with a clear focus on desired output and working backward to determine how best to achieve that output, consumes large amounts of time and energy. It also frequently requires considerable amounts of money in the form of consultant costs and other expenses. But more often than not it is embarked upon when financial circumstances are poor and there is an anxiously perceived need to do something quickly to stave off disaster.

As numerous management consultants have discovered, rarely has there come a need that makes outside consultants’ services as valuable as does reengineering. It is not, however, any special wisdom or experience that makes the outsider important in reengineering. Rather, it is perspective; the outsider can see what the insider cannot see. The person inside of the organization is hampered by the internal perspective, and is frequently unable to see much beyond the processes of which he or she is an integral part and in which he or she has a significant personal stake that can be as basic as continued employment.

There is also a lurking dread in the supervisor’s knowledge that “reengineering is coming.” This is the fear that one’s own position is going to be eliminated, a fear often borne out as reengineering proceeds. Can one expect a supervisor to plunge willingly into a reengineering effort when it might mean the loss of his or her job? How many people will honestly and enthusiastically work themselves out of their jobs?
Faced with the reality of reengineering, today’s healthcare managers are hampered in three significant dimensions: (1) they are at risk in the process, and this manifests itself as fear and uncertainty; (2) they are internal to the organization and cannot step back and objectively view what so intimately involves them; and (3) they are affected far more than they might ever be able to acknowledge by some long-held paradigms that are presently under concentrated—and largely successful—attack.

Further implications of reengineering are discussed in Chapter 25.

**CAN WE “REINVENT” THE HOSPITAL?**

What you have been encouraged to recognize and to think about in “Situation: Reinventing the Healthcare Organization” is the difficulty involved in true reengineering. Most who ponder this exercise will discover that they cannot avoid using names of a number of so-called traditional activities to describe the redesigned organization. Although true reengineering calls on us to begin with the desired outcome and find the apparently most efficient path to that outcome, we are swayed by our familiarity with the path that already exists. It is as though our present knowledge and understanding form walls around us—walls we cannot readily see beyond. We are in a box, as it were, giving rise to the often-heard admonition of the need to “think outside of the box,” a phrase that long ago attained cliché status. Yet thinking outside the box can be difficult because we so often fall victim to the implicit assumption that “the box” represents the limits of our world. We do not readily see a new path to our desired outcome because of the existence of the path already utilized.

Certainly the “preservation of life and restoration of health” may presently be challenged in a number of ways. Although it must remain a primary outcome of the system as a whole and of most individual organizations, it is seen by some as secondary to, or at best equivalent to, a financial purpose that may be as basic as organizational survival. Like it or not, finances are a major driving force in health care. There are those who will say, not completely without justification, that patient care concerns are secondary to financial considerations, and this feeling will prevail as long as limits exist on resources available for health care. For-profit healthcare providers cannot be expected to provide care if there is no profit in doing so, and even not-for-profit providers, comprising the majority of hospitals and a significant percentage of long-term-care facilities, need to stay financially solvent to continue serving their purpose in achieving their desired outcomes.

**THE MANAGED CARE “SOLUTION”**

**The Beginning of Restricted Access**

Aside from technological advances, most of what has occurred in recent years in the organization of healthcare delivery and payment has been driven by concern for costs. Changes have been driven by the desire to stem alarming cost increases and, in some instances, to reduce costs overall. These efforts have been variously focused. Government and insurers have acted on
health care’s money supply, essentially forcing providers to find ways of operating on less money than they feel they require. Provider organizations have taken steps to adjust expenditures to fall within the financial limitations they face. These steps have included closures, downsizing, formation of systems to take advantage of economies of scale, and otherwise seeking ways of delivering care more economically and efficiently. It was in this cost-conscious environment that managed care evolved. Managed care, consisting of a number of techniques intended to reduce costs and improve quality, seemed, at least in concept, to offer workable solutions to the problem of providing reasonable access to quality care at an affordable cost. Managed care included economic incentives for physicians and patients, programs for reviewing the medical necessity of specific services, increased beneficiary cost-sharing, controls on inpatient admissions and lengths of stay, cost-sharing incentives for outpatient surgery, selective contracting with providers, and management of high-cost cases. The most commonly encountered form of managed care is the Health Maintenance Organization (HMO). The HMO concept was initially proposed in the 1960s and formally promoted as a remedy for rising healthcare costs by the Health Maintenance Organization Act of 1973.

The introduction of managed care placed, for the first time in the history of American health care, significant restrictions on the use of services. The public was introduced to the concept of the primary care physician as the “gatekeeper” to control access to specialists and various other services. Formerly, an insured individual could go to a specialist at will and insurance would usually pay for the service. But with the gatekeeper in place, a subscriber’s visits to a specialist were covered only if the patient was referred by the primary care physician. Subscribers who went to specialists without referral suddenly found themselves billed for the entire costs of specialists.

By placing restrictions on what services would be paid for and under what circumstances they could be accessed, managed care plans exerted control over some health insurance premium costs for employers and subscribers. In return for controlled costs, users had to accept limitations on their choice of physicians, having to choose from among those who agreed to participate in a given plan and accept that plan’s payments, accept limitations on what services would be available to them, and, in most instances, agree to pay specified deductibles and co-payments.

Managed care organizations and governmental payers brought pressure to bear on hospitals as well. Hospitals and physicians were encouraged to reduce the length of hospital stays, to reduce the use of most ancillary services, and to meet more medical needs on an outpatient basis. Review processes were established, and hospitals were penalized financially if their costs were determined to be “too high” or their inpatient stays “too long.” Eventually, payment became linked to a standard or target length of stay so that a given diagnosis was compensated at a predetermined amount regardless of how long the patient was hospitalized.

As managed care organizations grew larger and stronger they began to negotiate with hospitals concerning the use of their services. Various plans negotiated contracts with hospitals that would provide the best price breaks.
for the plan’s patients, and price competition between and among providers became a reality.

During late 1998 and early 1999 approximately 160 million Americans were enrolled in managed care plans, encompassing what may well have been the majority of people who were suitable for managed care. In-and-out participation of some groups, such as the younger aging and Medicaid patients, was anticipated. However, the bulk of people on whom managed care plans could best make their money were supposedly already enrolled. But managed care continued to grow. According to the trade association America’s Health Insurance Plans, as recently as 2007 approximately 90 percent of insured Americans were enrolled in plans with some form of managed care.¹

Much of the movement into managed care was driven by corporate employers attempting to contain healthcare benefit costs. However, during this same period of growing managed care enrollment, the number of managed care plans experiencing financial problems also increased steadily.

It appears that managed care was able to slow the rate of health insurance premium increases throughout most of the 1990s. As the decade ended, however, the cost of insurance coverage was again climbing at an alarming rate. The climb continued; it was reported in 2005 that health insurance premiums would increase in some areas by more than 12 percent for 2006, making 2006 the fifth straight year of double-digit premium increases for many.² This grim prediction was fulfilled, and the trend has continued; increases for 2011 averaged well in excess of 10 percent.

By the end of the 1990s it appeared that the majority of average middle-class subscribers had reached a negative consensus about managed care. This caused some damage to the political viability of for-profit managed care and hurt managed care overall. Indeed, it seemed increasingly likely that managed care might not be financially affordable in the long run.

The year 2000 was a grim 12 months for the relationship between managed care plans and Medicare. As a result of decisions made during the year, on January 1, 2001, nearly a million beneficiaries in 464 counties of 34 states lost their coverage when 118 HMOs withdrew from Medicare. In addition, many of the plans that remained in Medicare increased premiums and reduced benefits, in response to what were described as continually rising costs and the effects of cuts in reimbursement rates. In December 2000 Congress voted for billions of additional dollars for Medicare HMOs, supposedly to reduce premiums or increase benefits to subscribers. However, wording of the legislation also allowed HMOs to pay more to their networks of hospitals and doctors, thus consuming the majority of the additional funds. As a result, only 4 of the 118 HMOs that withdrew returned to Medicare.

It is reasonable to say that although managed care had its benefits at least for a time, it is evident that managed care plans have not been able to sustain their promises of delivering efficient and cost-effective care. An aging population, newer and more expensive technologies, newer and higher priced prescription drugs, new federal and state mandates, and pressure from healthcare providers for higher fees have essentially wiped out the savings from managed care for employers and subscribers alike.
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THE BALANCED BUDGET ACT OF 1997

Major Cuts Affect Medicare Providers

The Balanced Budget Act (BBA) of 1997 was adopted in part because of: the increased fiscal pressure caused by the growth of Medicare payments, concern over Medicare over-payments, the desire for more rational payment methods, and a stated wish to offer beneficiaries greater choice. By mandating that federal revenues and federal expenditures be balanced each fiscal year, the BBA fundamentally altered the rules of fiscal policy-making in the United States. (It perhaps need not be said that the mandate to balance the federal budget has been dramatically over-ridden in recent years.) A balanced budget would of course be sensible, but it was the manner in which budget balancing was implemented that forced disproportionate reductions in healthcare reimbursement. In terms of its overall effects, the BBA became the most significant piece of healthcare legislation since Medicare and Medicaid were established in 1965.

The reductions required to balance the budget were not taken uniformly from all elements of the budget. More than half of the federal budget—specifically the very large piece of the budget including Department of Defense spending, Social Security, and interest on the federal debt—was insulated from cuts, meaning that the entire balancing reduction would have to come from the remaining less-than-half of the budget. Medicare had some time earlier attained the position of the nation’s largest third-party payer for healthcare services. As a direct result of the BBA, drastic cuts occurred in Medicare reimbursement, therefore affecting the income of healthcare providers. The BBA required $122 billion in spending cuts over a 5-year period beginning with 1998, with the overwhelming majority of reductions—95 percent or $116 billion—coming from one single source: Medicare. And most of the reductions were attained by eliminating or reducing payments to actual providers of health care.

Widespread Hardship

The elements of the healthcare system most affected by the BBA were a matter of opinion, specifically the opinion rendered according to where one was situated in the provider population. According to some sources, the reductions of the BBA clearly targeted post–acute care services, especially skilled nursing facilities and home health agencies. Certainly a number of health care professionals were affected by the BBA, including physical therapists, occupational therapists, and speech pathologists whose reimbursement was severely capped. The BBA cap on combined rehabilitation services, effective January 1, 1999, had the effect of dramatically reducing the number of rehabilitation professionals employed in long-term care facilities and also resulted in the closing of some facilities.

Those in post–acute care who felt specifically targeted were not alone; persons responsible for operating a great many hospitals likewise felt singled out for significant reductions in reimbursement. For most hospitals, Medicare had much earlier become a significant source of income; for a great many, it had become their largest third-party payer. Depending on various reimbursement systems in place in some states, for years Medicare had been the single
significant payer that essentially contributed the full cost of care and helped these institutions remain financially viable. However, the BBA's arbitrary reimbursement reductions forced many acute care institutions into the red, increased pressures for cost reductions, brought about closures, and prompted an increased number of mergers and other affiliations.

Some degree of relief from the BBA arrived in the form of the Balanced Budget Refinement Act (BBRA) of 1999, arising perhaps out of recognition that the act itself went too far in reducing reimbursements. The BBRA became law in November 1999, and it suspended the cap that had been placed on outpatient rehabilitation services and paved the way for the design of a new payment mechanism. Also contributing some relief for providers was Congress's December 2000 infusion of cash in recognition of many managed care plans' abandonment of Medicare participation. Regardless of these positive steps, however, the BBA brought some irreversible consequences to healthcare providers.

HEALTHCARE PARADIGMS AND THEIR EFFECTS

In terms of how one handles incoming information, as a set of rules or beliefs or expectations, a paradigm can be both a clarifier and an obstacle. Incoming information that fits within our paradigms is seen clearly because it confirms our expectations. Information that is inconsistent with our paradigms, however, cannot be seen nearly as readily and, in some instances, can hardly be seen at all. The inconsistencies disturb our equilibrium with our environment, and our reactions include fear, uncertainty, frustration, resistance, and the inability to imagine any good resulting from the pressures we are experiencing.

Today's healthcare managers are caught up in some dramatic paradigm shifts. Consider just a few of the long-held beliefs that are crumbling under present-day pressures:

- The acute care hospital will always be the heart of the healthcare system (clearly no longer true as the “system” takes over).
- The way we presently deliver care is the best, most cost-effective way available (only to those who cannot see another way).
- We work in an essential industry; times might get tough, but we will never be allowed to disappear (tell that to the former employees of all the hospitals that have merged, downsized, or just plain closed).
- All people have a right to the latest and best that medicine has to offer (contradicted by the steady increase in rationing forced by economics).
- Free choice must always prevail, so managed care—HMOs and such—can go only so far (contradicted by the growth of managed care options).
- Physicians will (and should) always control the use of the healthcare system (but they too are being swept along by the same changes affecting everyone else).
- "But we can’t reduce cost without adversely affecting quality,” is a reflection of perhaps the strongest paradigm of all, and certainly it is the one causing the most frustration on the part of persons subject to the pressures of change.
In true reengineering it is necessary to begin with the determination of necessary outcomes and work backward to determine what should be put in place to achieve those outcomes. In any organization—in this respect health care is no different from any other business—the people within its systems are limited in their ability to see the possibilities because their paradigms are products of their individual experiences and beliefs.

In working backward from desired outcomes to appropriate processes, at times it is necessary to force our thinking along different paths, to deliberately turn away from what we know and follow a line of thought that feels wrong and that causes discomfort. Assistance from outside the organization, whether from professional consultants or others, can be helpful in forcing us to get out into the uncomfortable territory where the creative solutions are to be found.

Managers working in health care can best ensure their futures by becoming paradigm breakers and by refusing to remain satisfied with the status quo for very long. We have heard repeatedly that necessity is the mother of invention. Perhaps so, although if this were strictly true we would be seeing the world’s greatest advances coming out of the areas of most dire need, and this certainly is not happening. Perhaps instead the parent of invention, or at least of innovation, is dissatisfaction. Dissatisfaction with the status quo appears to be the strongest force available for breaking out of our paradigms.

**MARKETING HEALTH CARE**

Opinions concerning the place of marketing in health care run the gamut from complete acceptance to total rejection. The range of attitudes perhaps exists in part because to many people “marketing” is simply “advertising,” and for many years the principle professions, especially the health professions, did not advertise. True marketing, of course, consists of more than advertising, but to a significant portion of the population these terms are likely to remain synonymous.

The marketing process essentially guides potential customers in differentiating the organization’s products and services from those of competing organizations. Accepting this as a thumbnail definition of marketing, we might then proceed to ask: Is this sort of differentiation necessary in health care? At one time in the recent past many would have said that such differentiation was not particularly necessary. Today, however, marketing is a fact of business life in many healthcare organizations. As health care becomes more volatile, as medical practice changes and some providers strive to fill unused capacity, as payment mechanisms and forms of provider organizations proliferate, competition will continue to intensify between and among elements of the healthcare system.

Competition in health care essentially involves access, cost, and service quality. What becomes complex is the consideration of who is being courted for their favor at any given time. Patients are the ultimate consumers of health care; it is for them that the system exists. But since most patients neither select their own health care nor directly pay for their care, a number of different relationships enter the marketing equation, including the following:

- Physicians admit patients to hospitals, so hospitals have a stake in getting a certain number and kind of physicians on their admitting staffs.
The Evolving Role of the Healthcare Manager

Changes in Healthcare Management Lead the Way

One could argue at great length whether management skills in and of themselves are most important in managing in health care or whether one should have a solid grounding in one of the various healthcare disciplines. It is the age-old and generally irresolvable controversy: Who makes the better manager, the functional specialist or the management generalist?

The specialist-versus-generalist argument has probably been more prevalent in health care than in other arenas, although for many years the external view of health care did not especially recognize that conflict. Rather, much of the external view of health care held that almost anyone could manage there and that the “real” managers managed in “industry,” primarily in manufacturing but certainly in the for-profit sector (see Chapter 2).

Of course there is nothing new about this tendency to look down on other fields as somehow lesser than one’s own. Thus, for-profit looks down on not-for-profit; within for-profit, manufacturing looks down on banking while banking looks down on insurance and real estate; within for-profit and not-for-profit, almost everyone looks down on the public sector (government); and so on. What is significant, however, is how past general perceptions of health care as

- The diminishing use of inpatient hospitalization has brought some hospitals into direct competition with each other as unused capacity grows.
- Hospitals supply patients to rehabilitation and long-term care facilities, which thus have an interest in cultivating relationships with hospitals.
- Managed care plans (HMOs, etc.) and traditional insurance plans, both for-profit and not-for-profit, attempt to sell themselves to employers, individuals, and care providers.
- Providers, in turn, endeavor to sell themselves to the plans they feel will best serve their needs.
- An increasing number of medical group practices, free-standing surgical centers, clinics, and the like, most being products of the recent three decades, vie with each other for patients either directly or through physicians’ referrals.
- Pharmaceutical companies vigorously promote their products with the physicians who prescribe medications for patients. Since the late 1990s pharmaceutical companies have also engaged in widespread advertising aimed at encouraging patients—those ultimate consumers—to ask their physicians for specific medications.

All of the foregoing suggest that marketing is becoming increasingly important to the healthcare organization and that the rapidity of change occurring within health care is subjecting providers to the same uncertainties that most other industries face in the normal course of business. Today’s healthcare organization cannot afford to go forward without the benefit of a well-thought-out and regularly updated marketing plan.
a “lesser” field have led some people to assume an expertise they have never possessed. Perhaps because they remember the days of health care of 40 or so years ago, health care pre-1970 when people of greatly varying backgrounds and qualifications managed healthcare organizations, countless displaced managers with no healthcare expertise whatsoever have offered themselves to health care with the attitude that anyone can do it. (“I managed in XYZ Corporation for years, so I’m obviously qualified to manage a hospital or one of its departments.”)

The perception external to health care severely lags the internal reality. The years when “industry dropouts” could gravitate to health care’s management ranks are decades past. In fact, in recent decades a cycle of sorts has been experienced. Specialized graduate-level training in health administration grew and expanded, which furnished many master’s-degree–trained managers to health organizations. Such programs proliferated to a point where colleges were turning out many more master’s-prepared, would-be managers than the system could absorb. Yet hospitals continue to receive applications from new master’s-degree holders who are attempting to enter at general administrative levels but are finding that opportunities are dwindling while the competition is intensifying; they find themselves competing with an increasing number of experienced—and unemployed—healthcare managers.

For the foreseeable future, the best preparation and background for the new manager within health care will include training and experience in one of the various healthcare specialties, or at least in one of the few nonhealth specialties regularly applied within health organizations (finance, for example) plus graduate-level education in health administration. The days when a newly graduated master of hospital administration (MHA) could count on entering directly into an administrative position are largely gone. Rather, one should expect to spend some time in the ranks and in management at the department level. Because of the current healthcare climate and the dramatically increased competition for administrative positions, a pure health administration education (without benefit of prior, specialized education and experience) is no longer as valuable as it once was.

The Flattened Organization

Healthcare managers are in a period when one of the most prominent indicators of change is the elimination of layers of management in their organizations. This reduction can be difficult for many to deal with because it is a change that occurs abruptly when compared with the growth of the condition it is correcting.

The management hierarchy usually develops gradually over a period of time. This growth always happens for what are apparently good reasons: in times of success or at least of financial stability, top managers react to what seem to be valid needs, and positions are created to serve certain purposes. Each position created becomes interrelated and, to some extent, interdependent with others in the hierarchy. Some tasks accrue to the new position from other positions in the hierarchy; some develop solely as functions of the new position.
There is always some useful purpose served by a newly created management position. However, the process of establishing multiple layers of management has some negative and sometimes extremely damaging effects. The multiple layers breed duplication of effort as the same problems and issues are addressed at succeeding levels. Responsibility is diluted and diffused as these levels become involved. Communication needs—not to mention the potential for communication breakdowns—expand and intensify as levels proliferate.

The presence of multiple levels of management tends to push decision making up the chain of command. This is in direct contradiction with one of the tenets of Total Quality Management (TQM) and with today’s prevailing management belief in general that decisions are most effectively made at the lowest possible organizational level. The manager who makes few real decisions because of the presence of two or three higher levels of management can hardly be described as capable of feeling ownership of the job.

For years many healthcare managers had the benefit of job titles and position perks without having to worry a great deal about accountability. They simply “played supervisor” to the extent that they were visible members of management who could count on their supervisors to relieve them of the responsibility of making difficult decisions or dealing with troublesome issues. Now, however, this condition is rapidly changing. First-line managers are assuming—and will continue to assume—increased responsibility as layers of management are removed and the organization is flattened (a term that is best appreciated when one views organization charts of the same structure in “before” and “after” circumstances).

A frequent victim of reorganizing that involves flattening is the middle manager, the occupant of that intervening layer of management between the supervisor and the top. In reengineering or reorganizing, middle managers sometimes disappear from the organization as their positions are eliminated. Sometimes they remain within the structure but at a lower level, becoming first-line managers.

Middle management might have multiple layers (for instance, consider the nursing department run by a vice president, four directors, two dozen nurse managers [head nurses], and a number of assistant nurse managers, not to mention staff who, on occasion, are assigned as charge nurses). Or middle management might be a single layer (as in the case of the billing supervisor [first line] reporting to the business office manager [middle] who in turn reports to the director of finance).

Middle management is frequently the last level created in the hierarchy, evolving from apparent necessity as the spans of supervisory control broaden to seemingly intolerable dimensions. As middle-management positions are cut, a few duties flow upward, but the bulk of what remains—that is, the essential part of what remains—flows downward to the first-line manager. At first, it would seem that the span of first-line control is again increasing as middle management thins out, but what is primarily happening today—or at least should be happening, in organizations that have reengineered sensibly—is that the properly empowered supervisors (always considering the term supervisor as synonymous with first-line manager) are empowering their employees and spreading authority and responsibility across the work group.
In any case, a flatter organization means a broader scope of responsibility for the individual supervisor and often also means more employees to manage.

**Some Constants to Hang On To**

Although this discussion deals primarily with ways in which the supervisory role is changing, it is necessary to point out some fundamentals that should never change in the relationship between manager and employees.

It will always be important for the manager to be visible and available to the staff. The employees need to know that their primary source of job guidance and organizational communication is readily accessible when needed.

Closely related to visibility and availability is the matter of the manager’s organizational orientation: Does this person face upward or face downward? The temptations to face upward, that is, to orient oneself in the direction from which recognition and rewards are perceived as coming, are numerous. However, the upward-facing supervisor is usually perceived as aloof and unapproachable. It is the downward-facing supervisor, the one who identifies with the work team and behaves as part of the team, who will be most successful in moving the group in productive directions.

The individual must be a practitioner of a true open-door policy. We are all aware that there hardly exists a manager at any level who has not said, “My door is always open.” This is, however, more readily said than accomplished. The open door is largely an attitude, once again related to visibility and availability. Too often the door may be physically open but the manager’s attitude suggests that one had better make an appointment through proper channels before approaching. The manager who is not readily reachable by direct-reporting staff for a few minutes now and then is sending a message of self-importance, saying through actions that he or she is more important than the staff.

The manager should accept a role as a key team member and resist the temptation to behave as though he or she is the most important team member. Terms that accurately describe the present first-line supervisor include the likes of “coach” and “counselor.” In fact, the term coach suggests a strong similarity between the coach-and-team relationship and the supervisor-and-group relationship. A team can play without a coach; it may play raggedly and without unified purpose or direction, but it can nevertheless play. But a coach cannot coach without a team. Thus a team without a coach is still a team, but a coach without a team is without a job. Similarly, a counselor with no one to counsel is unneeded.

If the manager is no more important than the team members, then why is this person paid more than the team members? The answer to this lies in the amount of responsibility borne. Regardless of how far staff empowerment progresses and how much decision-making is done in the ranks, the person who directly supervises the staff remains responsible for what is done and for instructing, coaching, and leading the staff in getting it done. A leader should never set himself or herself above the employees except in one critical dimension—the bearing of responsibility.
Self-Motivation and the First-Line Manager

Because of the ways in which the supervisory role is changing and because of the dramatic changes in health care that are causing the alteration of that role, the individual is caught in a classic motivational crunch. Many hospitals are cutting back their staffs and thinning out the ranks of management. Attendant to this, employee morale is worsening in some places. This contributes to declining productivity; employees can hardly be expected to give their undivided attention to high-quality output at a time when they fear for their employment. All of this—declining morale and decreasing productivity—tends to occur at precisely the time when productivity should be expected to increase for the sake of organizational survival.

The supervisor occupies a difficult place in today’s healthcare organization because he or she is susceptible to the same negative pressures on morale as the nonsupervisory staff. Yet he or she is expected to be sufficiently self-motivated to help lift the employees’ level of motivation. As a key team member and the one most responsible for the output of the group, the supervisor can have a significant effect on the group’s outlook and effort. It is important that the supervisor do everything possible to be “up” when the group members are “down.” This leader must be a cheerleader at a time when the employees might feel there is nothing to cheer about.

Surely this seems like one is expected to put up a false front for the employees. Why, one might ask, should the supervisor not feel the same frustration and lack of confidence in the future that the employees feel? Simply stated, trying to be optimistic is necessary for all concerned. If the supervisor’s behavior reflects only the doom and gloom the staff members feel, you can be guaranteed that this will dramatically affect employees’ behavior—and not in positive directions.

Improving morale is presently an uphill struggle in many healthcare organizations. Poor morale has more than once been cited as the worst human resources problem in the hospital industry, with the main cause of the problem being layoffs. Morale and motivation are, of course, complex considerations that at any time can depend on a variety of factors. It is fairly safe to say, however, that the attitude and approach of the leader can have significant effects on the attitude and approach of the group. It is part of the leader’s responsibility for the entire group to recognize that the group can be influenced in either positive or negative directions by the attitude brought to the job every day.

This is easily said, but not so easily accomplished. We can readily say, “Cheer up!” but if you are gloomy it is not so easy to force a reversal of mood. So much of what is related to the supervisor’s ability to self-motivate will depend on that individual’s personal relationship with the elements of the job. If you genuinely like the work, and if you can find satisfaction and fulfillment in the tasks you must perform, then you have a running start on successfully motivating yourself and serving as a positive example for the group members. If, however, one has been lured into the role primarily by title, status, pay, and perks, in all probability this person will not rise to the challenges of the shrinking organization and the flattening management structure.
Some Honest Empowerment

In management circles and in the literature there is always a great deal of attention paid to the “flavor of the month.” Since the TQM movement arose, one of the principal “in” terms has been “empowerment.” In all that we do concerning reengineering and total quality management—somewhat curiously, because these are concepts that frequently work against each other—we speak of appropriately empowering employees.

In terms of a supervisor empowering employees, empowerment is no more than that old standby delegation—but delegation performed properly (see Chapter 5). The problem has been that most of what we have called delegation was not delegation performed properly, so delegation as both a term and an observed management practice has acquired a tarnish that no amount of polishing can remove. However, it is pointless to engage in controversy over what such a term might mean. What is important is that any group’s leader must truly be empowering in relationships with employees by delegating properly to the fullest extent of his or her capacities.

In these days when management structures are becoming leaner, empowerment is essential. Empowerment stands as the only practical way to expand and extend the leader’s effectiveness and to pursue the constant improvement that is expected in the present environment. When it comes to seriously improving the ways the group’s work is accomplished, empowerment acknowledges the fact that no one knows the details of the work better than the person who performs it every day. The leader needs all the help that can be gotten from the group because chances are the group will be larger than in the past. Leaner management structures will mean more employees within a supervisor’s responsibility, thereby automatically increasing the potential for employee problems and expanding the supervisor’s involvement in personnel management issues. More time on such matters means less time to devote to other concerns.

New concerns and involvements are arising. In the emerging environment, the supervisor may be called on to undertake tasks that were never before part of the role, such as actively participating in a reduction-in-force and actually designating individuals for layoff.

For the most part, first-line supervisors have traditionally been seen as doers, the working leaders of groups of people whose concentration is on getting today’s tasks accomplished. In the leaner, flatter organization, especially the organization that has eliminated its middle-management positions, the first-line supervisor will take on much more of a planning role than previously experienced. This provides even more reason for the supervisor truly to be empowering staff: while the employees look after today, the leader will spend more time preparing for tomorrow.

JOB SECURITY IN THE NEW ENVIRONMENT

As pointed out earlier in this chapter, the old paradigms of job security involved education, loyalty, and stability. These paradigms have shifted; education does not guarantee employment, loyalty has lost its meaning in terms of organizational attachment, and it is impossible to pursue a stable career and
employment relationship when entire technologies and occupations can come and go within a few years, and organizations can vanish almost overnight. The only things that will give an individual job security in a changing environment are skills. Job security—at best a relative commodity, if it exists at all in any absolute sense—no longer lies in constancy and predictability. Rather, job security today lies in one's flexibility and adaptability. The manager who can continually learn and grow and change is most likely to survive to work in the new environment.

It has been said repeatedly that the primary thrust of TQM involves the determination to always do the right things and always do them right the first time. This is a highly appropriate belief for both the individual and corporate entity. After all, whether for an individual or an organization, the best security for continuing success lies in performance.

QUESTIONS FOR REVIEW AND DISCUSSION

1. How does true “reengineering” differ from “reorganizing,” “downsizing,” and other concepts of organizational restructuring?
2. What is the significance of a supervisor’s visibility and availability?
3. What is meant by the claim that job security now resides in flexibility, adaptability, and performance?
4. What are the forces encouraging a supervisor to “face upward”?
5. Define “paradigm.”
6. How do you believe “empowerment” is differentiated from “delegation,” if at all?
7. Why has “marketing” become so prominent in health care today?
8. In reengineering, what is the primary purpose of working backward from desired outcomes to establish new processes?
9. How is competition affecting the delivery of some forms of health care?
10. What was the principal effect of the Balanced Budget Act of 1997?

EXERCISE: RESPONDING TO EXTERNAL PRESSURE

“Due to concerns over quality and access to care, the move to shorter (inpatient) stays is being monitored by patient-advocacy groups and legislators. It is imperative that facilities turn their attention to tighter control over the cost of ancillary services to meet the expectations for controlling the costs of health care.”

Exercise Questions

1. Why do you believe ancillary services might be specifically targeted for cost reduction?
2. In your view, what impact will the significant reduction in the use of ancillary services have on the quality of care? Why?

NOTES