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Briefing Notes:
Integration of Services

Introduction

Many not-for-profit health care delivery systems have grown or are growing through a series of mergers and acquisitions, with many of the same dilemmas of integration that confront companies is the private sector. In addition, in loosely coupled systems like health care systems, the desire for autonomy on the part of individual units often leads to redundancy. Today the imperative for health care organizations is to respond to the evolution of the marketplace by cutting costs, so the prospect of reducing costs by integrating across these different divisions is appealing.

Many providers today are engaged in a discussion about organization design that recognizes that many support services are duplicated across their networks. (This dilemma foreshadows the same issue of redundancy across a new set of partners.) We hope that this note will provide some structure for your thinking about how best to integrate support services. We also looked through the published health care literature to find recent cases that might illuminate this issue; there are only a few, but they are included here. Finally, we conclude with some of our thinking on why it has been so difficult for integrated delivery systems to get costs out, by way of suggesting some general rules to keep in mind as you work to reduce costs.

Structure Follows Strategy

It is appropriate to begin any conversation about organizational structure by remembering the dictum that "structure follows strategy." This is particularly true for health care systems because of the rapid changes occurring within them. Ideally, you want to design tomorrow's organization in health care rather than today's, so you need to keep in mind where your business is heading. The following framework for thinking about structure and strategy is adapted from Jay Galbraith.

A Display of Organization Structure and Strategy Choices

Strategy	*Structure*	*Degree of Centralization*
Single business (R > 95%)	Functional	High
Dominant business 75% < R < 95%)	Functional + profit centers	High/moderate
Related businesses	Multidivisional profit center	Moderate
Unrelated businesses	Holding company	Low

The strategies represent increasing amounts of diversity. A single business strategy means that 95 percent of sales revenue (R) comes from that one business. A dominant business is one in which a little diversification has taken place to the extent that the revenue from the dominant business is less than 95 percent but more than 75 percent of total sales. This is the category that describes most hospital-driven health care networks today, with the hospital creating about 80 percent of the system's revenue. The third group consists of organizations that have diversified so that no one business accounts for as much as 75 percent of company revenue. This may describe the health care system of tomorrow, with the hospital's revenues reduced in favor of other parts of the system.

Traditionally, the dominant business strategy is implemented by a mixed structure. In this frame, the hospital itself is managed by a functional structure, and the diversified businesses are managed as separate, individual profit centers. (This describes the structure of many hospitals today pretty closely.) What does the next stage look like? The related business strategy has traditionally been managed through the classic decentralized multidivisional, profit-center form. *In summary, the more diverse the strategy the more decentralized the structure. As diversity increases, central functions decrease in importance and size.* (The one exception to this rule is the finance function that tends to stay centralized for policy and often for operational responsibilities as well.)

Thinking About Centralization vs. Decentralization

Centralizing and then decentralizing businesses has been something of a "fad" in American business, with the popularity of first one and then the other in vogue. Based on our review of the case material, the trend in health care today is toward centralization. The key is to understand that all organizational design choices involve tradeoffs. There is no one right way to structure all organizations, but there is one best way to structure a particular organization, based on what one knows about choosing between the tradeoffs. Ultimately, the goal is to improve overall productivity, which is a combination of efficiency and effectiveness.

The following dimensions should be kept in mind:

- ***Efficiency:*** A centralized, functional organization creates efficiency because it creates economies of scale and the opportunity to standardize practice and reduce duplication. This is the promise of centralizing support services in health care organizations with the hope that it will reduce costs. This kind of organization also makes it possible to be highly specialized since a specialized resource can be shared with the entire organization.
- ***Effectiveness:*** A decentralized organization is able to respond rapidly to internal and external customers; therefore, it is usually more effective. Effectiveness here is defined as "doing the right things." The case material we found suggests that internal customers are more satisfied with decentralized staff services.
- ***Control:*** The other side of the support coin is control. Operational control is easier to achieve with a centralized, functional structure. With a more decentralized structure management can only exert strategic control. (Galbraith defines operational control as tracking costs and strategic control as tracking profits.)
- ***Coordination:*** Coordination of support services for different business units is easier when support services are centralized and functional. To achieve coordination of support services between diversified business units you need to develop lateral processes like cross-functional teams that cut across the divisions.
- ***Vertical distribution of power:*** This dimension refers to whether power is concentrated "high" or "low" in the organization. The trend is toward decentralization of decision-making power, pushing power down to people with direct product or customer contact.
- ***Horizontal distribution of power:*** This dimension gets a lot less attention but is arguably more important. It refers to whether or not power is concentrated centrally or pushed "out" to the department dealing with critical issues. For example, in competitive industries like health care where the power to influence prices, terms and conditions is shifting to the customer, decision-making power can be shifted to areas that deal directly with customers. (Be careful about defining who the health care customer is today, however, since in a managed care environment the customer is the managed care contract purchaser, and the power would therefore shift to the contracting office.) Another example is in industries where purchasing goods and services is increasingly important; the purchasing function is given increased decision making power.

Think for a moment about patient-centered care as an illustration of these tradeoffs. The movement to patient-centered care was motivated by a desire to increase the effectiveness of service to customers (patients). In most hospitals decision-making power was pushed down and services were decentralized to the unit. It has been very difficult to attach cost savings to patient-centered care even though that was its early promise (and where cost savings have occurred it has generally been because of skill-mix changes or broader spans of control). In many

settings we see some of the predictable problems that arise with decentralization: activities are more difficult to understand and, therefore, control and coordination problems occur within the unit and between nursing and other functions. Many of our clients' experience also proves the point about effectiveness since customer satisfaction with patient-centered care has been high.

A Model to Consider: The Distributed Organization

Galbraith also presents an alternative to the classic centralize/decentralize tradeoff that is worth thinking about. In the distributed organization a company-wide activity is moved from headquarters to an operating unit. The operating unit then performs that activity for the entire organization as well as its own operating unit. The matrix below illustrates the options:

	Centralize	***Decentralize***
Core model	#1 Headquarters	#2 Simple system with one operating unit
Distributed model	#3 One unit performs service for the whole system	#4 Every unit has every service

Most health care systems could be described by box #4, with much duplication of services in different divisions or units. In the distributed model, Galbraith proposes moving services to a single location to capture the efficiencies of centralization, but moving it out of the core so that it is closer to the customer. Where do you locate the service? He recommends placing it where competency is highest. In his example, if one division purchases more widgets than the others, put them in charge of purchasing widgets for the entire company. Some questions to begin thinking about to explore the parallel for a health care provider network might be:

1. Where does most patient scheduling originate?
2. Which division will need the tightest control over information systems in the future?
3. Where is the volume of billing greatest? Where is billing competency highest?
4. Where are the customers for training concentrated?

The downside of the distributed model is the loss of neutrality or perceived loss of neutrality. He recommends dealing with this by creating "substitute reciprocity." This means giving each unit one headquarters function. (In other words, "Don't mess with my budget or I'll retaliate by messing with your hiring.")

Learning from Cases

A review of the literature yields this conclusion: There is not much specific information about the reorganization of support services in health care. Several articles mention that systems are centralizing selected services, and no article mentions decentralizing services. One ongoing study, the Health Systems Integration Study conducted by Gillies and Shortell et al., and sheds some light on the question of integration.

The study measured perceived levels of clinical integration, physician-system integration and functional integration in 12 organized delivery systems across the United States. We will focus on their results on functional integration, which included support services. The study finds that certain areas seem to be the easiest, or at least the quickest, to integrate while others lag far behind.

Easiest to Integrate	***Most Difficult to Integrate***
Financial management	Physician integration
Human resources	Support services
Culture	Information systems
Strategic planning	Clinical integration
Financial management operating policies	Marketing
Resource allocation	Quality assurance

The three areas with the lowest integration scores (meaning they were hardest to integrate) are physician integration, information systems and support services. A complete list of functions that are candidates for centralization is included in the article we append.

Why It Is Difficult to Take Costs Out of Health Care Systems

Many of our clients are engaged in efforts to reduce costs. Over time, as we have watched them encounter obstacles, we have developed these ideas about what the critical factors are for success.

1. Reengineering to make processes more efficient will not reduce costs unless it is combined with a program to shrink the workforce. Many reengineering efforts improve processes incrementally, e.g., saving .20 FTEs, without making it possible to actually eliminate positions.
2. Downsizing alone will result in one-time savings only if it is not combined with reengineering work to change processes because the rate of growth of costs remains the same and costs will creep back.
3. Reengineering efforts need to take the entire system into account if they are going to increase capacity. (In hospitals, reducing length of stay is equivalent to increasing capacity.) For example, if you improve the throughput of the ER without improving the throughput of critical care (or some next stage in the

process), you will only succeed in creating a bottleneck in a different location. The capacity of the entire system needs to expand for capacity to expand.

4. If the marketplace is constraining your growth because it is so competitive, then expanding your capacity is not going to help you generate more revenue. In that case, your only recourse is to reduce costs.
5. Watch the impact of higher levels of acuity. If you are tracking costs for the hospital alone, it may look like costs are actually increasing as acuity rises. However, costs may be flat or decreasing across your system as a whole.
6. Finally, we believe that the single most important contribution to cost reduction comes from changing physician practice. Because this is so difficult, many health care systems focus their energies everywhere else. We often remind ourselves, "It's the physicians, stupid."

Sources

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