
Organizational Design Consistency: The PennCARE and Henry Ford Health System Experiences

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EXECUTIVE SUMMARY

There has been much discussion of the appropriateness of various organizational strategies for today's healthcare industry. This article presents case studies of two healthcare organizations that have pursued very different configurations. PennCARE uses a virtually integrated, loose contract-based arrangement, while Henry Ford Health System employs a vertically integrated, tight ownership model. Despite these different approaches, their overall designs are strikingly similar. In essence both systems demonstrate a property called organizational design consistency; they simply approach it from different ends of the spectrum.

This article presents the notion of organizational design consistency and defines it as the steady pursuit of a single preferred configuration strategy across key elements of organizational design. To illustrate the framework the case studies target four key elements of organizational design (governance structure, organizational culture, strategic planning processes, and decision-making procedures) and explain how consistency across these components adds value to both of these differently configured healthcare systems. There is room enough for diverse configurations of organizations in the current healthcare environment. Consistency does not mandate conformity; value can be derived from both tight and loose models. Furthermore, when fashioning organizational design consistency strategies, healthcare systems should carefully choose tightly or loosely modeled configurations to appropriately suit their aims, their markets, and the capabilities and resources available to them.

In response to fundamental shifts in the U.S. healthcare industry, healthcare firms have undergone a drastic remodeling of organizational form (Kaluzny and Zuckerman 1992). Some healthcare organizations have emerged as tight, vertically integrated structures, while others have proceeded as loose, virtually integrated arrangements (Luke, Begun, and Pointer 1989). These models represent distinct organizational strategies, and each has discrete implications for incentive placement/misplacement, goals, orientations, and values (Conrad and Shortell 1996; Foreman and Roberts 1991; Goldsmith 1994, 1995; Pointer, Begun, and Luke 1988; Robinson 1997; Robinson and Casalino 1996; Shortell 1997; Tennyson and Fottler 1997; Walston, Kimberly, and Burns 1996; Williamson 1975). Consequently, there has been much discussion of the appropriateness of each of these configuration approaches for today's healthcare industry.

This article presents case studies of two healthcare organizations that have pursued very different configurations. PennCARE uses a virtually integrated, loose contract-based arrangement, while Henry Ford Health System employs a vertically integrated, tight ownership model. Despite their different approaches to integration, in looking at these two cases through a more broadly focused analytical lens, their overall designs are remarkably similar. In essence both systems demonstrate a property called organizational design consistency; they simply approach it from different ends of the spectrum.

This article introduces the frame-

work of organizational design consistency with the intention of offering health system leaders a practicable reconciliation to the ongoing vertical versus virtual integration debate. The article does not argue for one configuration over another, but shows how both the tight and loose models can be effective strategies. In reaching this conclusion the study demonstrates for practitioners the value-added benefits of bringing to bear a composite perspective, via the consistency framework, on the design of their complex organizations.

ORGANIZATIONAL DESIGN CONSISTENCY

Organizational design consistency is defined as the steady pursuit of a single preferred configuration strategy across key elements of organizational design. The case studies in this article target four key elements of organizational design: governance structure, organizational culture, strategic planning processes, and decision-making procedures. Governance structure refers to the integration mechanisms used for establishing control. A tight governance structure employs a vertical or ownership form of integration, while a loose governance structure employs a virtual or contracting-based form of integration (Robinson and Casalino 1996). Organizational culture refers to the values, styles, attitudes, and beliefs that characterize the organization (O'Reilly 1989) and form the basis for its and its members' identities. A tight organizational culture suggests an overarching corporate-level identity, while a loose organizational culture

suggests an independent business unit-level identity. Strategic planning processes refer to the determination of business priorities, objectives, and targets. A tight planning process occurs in a centralized fashion, while a loose planning process occurs in a decentralized way. Decision-making procedures refer to the manner in which strategic actions are initiated and organizational concerns are adjudicated. In a tight model, decisions are made from the top down; in a loose model, decisions are arrived at from the bottom up. In targeting these four factors the case studies do not claim to include all possible components of organizational design. Rather, this article considers a representative combination of prominent dimensions that have emerged as important in the literature on design strategy and implementation (Bartlett 1983; Doz and Prahalad 1988; Galbraith and Nathanson 1978; Hedlund and Rolander 1990; Roth, Schweiger, and Morrison 1991).

RESEARCH DESIGN

The research design combined qualitative field work with case study methodology. The data were collected during structured, open-ended, face-to-face conversations as a part of a larger data collection effort. The data include 14 interview points across the two case study sites during the summer of 1998. At each site, key figures involved in the organization's strategic development, planning, communication, and implementation efforts agreed to be interviewed. The interviewee population comprised individuals thought to be most knowledgeable about the issues

of interest and included health system and hospital CEOs, health system and hospital COOs, health system and hospital vice presidents of strategy, health system and hospital vice presidents of quality assurance/improvement, other key health system and hospital executives, the head of the health systems' insurance arrangement(s), the head of the health systems' physician group(s), and any other key physicians.

The two case study sites were chosen because they represent opposite poles of the configuration spectrum. In addition, these sites were chosen because, at the time of the interviews in the late 1990s, the popular press viewed them as examples of successful, widely well-regarded healthcare systems (Aetna 2000; Appleby 2000; Todd 1999).¹

CASE STUDY ONE: PENNCARE

PennCARE is an example of a loosely configured healthcare system. Descriptive information about PennCARE can be found in Table 1.

Governance Structure

PennCARE is a completely virtual arrangement based on a social model of connecting organizational entities. Interviewees clearly articulated the system's loose governance model by stating that "PennCARE does not own any of the system's components," "investment is completely noncapital," and "there is no merger of assets by participants." PennCARE's relationships across the complete continuum of care are entirely contract based, and ownership is kept entirely at the local level

TABLE 1
Key Descriptive Statistics

	PennCARE	HFHS
Year of founding	1996	1915
Headquarters	Allentown, PA	Detroit, MI
System hospitals	1. Abington Memorial Hospital 2. Doylestown Hospital 3. Easton Hospital 4. Gnaden Huetten Memorial Hospital 5. Grand View Hospital 6. Hazleton General Hospital 7. Hazleton–St. Joseph Medical Center 8. Lehigh Valley Hospital 9. Muhlenberg Hospital Center 10. North Penn Hospital 11. Pocono Medical Center	1. Henry Ford Hospital 2. Henry Ford Cottage Hospital 3. Henry Ford Wyandotte Hospital 4. Bi-county Community Hospital 5. Riverside Osteopathic Hospital 6. Kingswood Hospital
Total beds	2,888	1,498
Total facility admissions	119,728	70,857
Total inpatient days	773,162	405,769
Total outpatient visits	2,005,179	1,416,802
Total Medicare discharges	51,002	27,728
Total Medicaid discharges	8,627	6,133
Total emergency visits	340,073	218,200
Total inpatient surgeries	37,177	18,003

Note: Data are as of 1998.
Source: AHA 2000.

(Guadagnino 1996). One interviewee summarized the arrangement with the simple statement that “PennCARE is very consistent—it is not trying to own anyone or anything.” PennCARE is a completely voluntary arrangement built on the belief that “volunteerism can forge an integrated delivery system every bit as powerful as those built on ownership” (Hensley 1997, 82) and

the desire to provide a mechanism for maintaining the prized independence of system members. Although PennCARE hospitals, or, as PennCARE calls them, local care units (LCU), buy into membership in the PennCARE system via stock purchases, any LCU can opt out of PennCARE at any time. LCUs are also free to decline participation in systemwide initiatives, as they so

choose without being excluded from system membership.

These statements verify that PennCARE is consistently structured with arms-length contracting relationships comprising a loose model of organizational control, or a virtually integrated governance structure.

Organizational Culture

Interviewees agreed that PennCARE does not have an overarching organizational culture and that by and large cultural notions for PennCARE members remain at the local level. One interviewee explained, "PennCARE provides access to intellectual capital, managed care infrastructure, and collaborative vision, yet deliberately preserves significant aspects of the 11 cultures." Each of the 11 LCUs has its own strong and unique sense of self. Each is a cornerstone of healthcare within its own community. According to interviewees, PennCARE recognizes that it is in no position to impede the LCUs' community missions and that there is large variation in how important PennCARE is to each LCU's strategy and how committed each LCU is to the PennCARE concept. As such, PennCARE sees wisdom in declining to promote cultural standardization, preferring instead to leave system members free to follow their own traditions. Interviewees commented that the preservation of local identities makes it possible for system members to remain true to their traditional selves, engendering sensations of pride, maintaining their integrity, and preventing them from grappling with confusing crises of spirit.

PennCARE's loose approach to organizational culture is very much in sync with its loose approach to governance. Both are virtual, and by design allow for flexibility and volunteerism. Just as PennCARE does not own its component LCUs, neither does it own its culture.

Strategic Planning Process

PennCARE has a designated planning group that includes the board of directors (comprising two members from each LCU) and an executive committee. This group sets directions, identifies priorities, produces a mission statement, and oversees a monthly budget-reporting process. According to interviewees, the overall charge of this group is more to aid the PennCARE system in reacting to opportunities than to perform planning per se. In fact, this group does not produce a formal, written strategic planning document, and in truth planning largely occurs in a decentralized fashion. Each LCU makes its own strategic plan and develops its own formula for staying afloat. The planning group's input enters into these local plans only to the extent that LCUs try to consider PennCARE's mission and goals and try not to run counter to or duplicate the system's efforts in their own strategic plans.

PennCARE's strategic planning process matches well with its loose governance structure and loose organizational culture. First, because the composition of the planning group has representation from each of the system's component members, the planning process is inherently iterative rather

than based on directive principles; as such, the process clearly matches the pervasive spirit of PennCARE's mentality of loose collaboration. Second, the fact that PennCARE does not have a formal, written strategic planning document but a "virtual plan," which lays out PennCARE's implicit purpose while allowing organizational components flexibility in how they choose to achieve it, is very much in sync with PennCARE's virtual governance structure and culture. Third, having system members maintain a large degree of independent planning powers for their local operations deliberately reinforces PennCARE's dedication to preserving system members' autonomy and maintaining loose arms-length relationships.

Decision-making Procedures

Strategic decisions occur in two ways at PennCARE. Occasionally, when initiatives require substantial PennCARE support and investment or have significant risk, they are implemented throughout PennCARE with oversight by system management. A handful of these major projects have been conducted, like establishing a systemwide call center and creating standardized, computerized clinical records for the system. More common, however, are initiatives for which strategic decision making occurs at a local level and is handled in a bottom-up fashion. These projects, which are operational in scope, tend to be driven by committees and collaborative teams with representation from different levels of the LCUs, including a Medical Advisory Committee, a Managed Care Risk Allocation Committee, an Information Sys-

tems Committee, a CFOs' committee, a COOs' committee, and a nurse executives' committee, to name a few. These committees were described as "affinity groups" by one interviewee, conveying their voluntary, participatory, and collaborative nature. The committees address issues and put forth initiatives that are handled through a decentralized decision-making process, enabling jurisdiction to rest at the local level. Along these lines, initiatives for developing operating economies of scale in shared services such as food, house-keeping, insurance brokers, and group purchasing organizations are underway.

This largely decentralized decision-making structure is consistent with PennCARE's overall model of loose configuration. The fact that system members maintain autonomy yet also have voice in the system's strategic decisions reinforces the omnipresent tenets of arms-length governance and partnership modes of thinking at PennCARE.

The Value of Organizational Design Consistency at PennCARE

At PennCARE, loose models of governance structure, organizational culture, strategic planning, and decision making together provide the system with consistency of overall organizational design.

This constant theme of loose configuration across all of these key components of PennCARE's organizational design appears critical for creating value. To begin, interviewees explained that PennCARE's loose consistency approach provides value by allowing system members access to collective

intellectual capital and increased intellectual strength. In addition, interviewees gave examples of how PennCARE's organizational design has an ability to create synergy among system members by explaining that PennCARE has caused relationships to develop between hospitals that would not normally have come together or that operate in different markets. Interviewees explained that PennCARE's loose consistency approach further provides value by creating the perception that independent hospitals can survive without selling their souls to managed care corporations; this sensibility increases the system's credibility in the eyes of its customers and competitors. Interviewees also noted that PennCARE's consistently loose approach provides value with an empowering paradox that allows system members to maintain, individually, their independence, integrity, and reputation, yet at the same time fosters among them a sense that PennCARE is a coalition of equals. To this end informal discussion forums have voluntarily sprung up across PennCARE, motivated by, as one interviewee put it, the simple notion that, "Hey, we're all in this PennCARE thing together, let's see what we can do."

CASE STUDY TWO: HENRY FORD HEALTH SYSTEM

Henry Ford Health System (HFHS) is an example of a tightly configured healthcare system. See Table 1 for descriptive information about HFHS.

Governance Structure

HFHS is an example of an organization that consistently centralizes control of

its relationships and activities at the system level. As explained by Shortell et al. (2000), HFHS represents a "centralized physician insurance system" governed primarily through ownership mechanisms. HFHS's insurance plan arrangements exist primarily at the system level; its physicians are part of a large salaried medical group; and its centralized laboratory, radiology, and other service divisions are operated at the system level. In other words, almost no governance arrangements exist at the individual hospital level; instead, all are highly aggregated and integrated.

Interviewees had no trouble characterizing HFHS as having vertically integrated linkages based on an ownership model that yields a tightly controlled governance structure.

Organizational Culture

Interviewees explained that the culture of HFHS is currently going through a transition as competitive pressures in the marketplace are causing tensions, shifting power, and generally complicating the relationships among system members. As a result, interviewees noted that HFHS's overarching systemwide culture is perhaps a bit less apparent than it has been in the past. They stressed, however, that for the most part it remains solid. Along these lines, interviewees described elements of HFHS's culture as including a historically collaborative mentality, a tradition of strong ties between HFHS's hospitals and physicians, a general alignment of system members, and a deeply entrenched common vision and understanding of support.

This strong model of culture is highly compatible with HFHS's hands-on governance structure. Both the culture and governance structure are tightly arranged toward fostering clinical cohesion and administrative attachment throughout the system.

Strategic Planning Process

Strategic planning functions formally at HFHS. The ownership of strategic planning rests in an official capacity with the senior vice president of planning and strategic development. Each year a formal strategic planning process takes place whereby each major operating unit (i.e., the health plan, the medical group, each hospital) is obliged to create a strategic plan guided by and organized around broad system initiatives that are provided by key HFHS executives. For instance, at the time of the interviews each operating unit was asked to address how it would contribute to system growth, system quality, market-leading service, and the goal of being a low-cost provider. Operating units are expected to adhere to system policy and use these system-set parameters in creating their own strategic plans and meeting independent divisional goals. HFHS then has a process by which it coordinates these separate divisional plans into a cohesive plan for each of its geographic regions (e.g., Detroit Metro). Next, these regional plans are synthesized at the executive level, where possibilities for cross-level linkages, learning synergies, duplicate work avoidance, and inter-relations among regions are explored in a formal strategy review for the system.

The strategic planning process at HFHS is tightly controlled administratively and centralized at the system level. As such it is very much in sync with HFHS's consistently tight models of governance structure and organizational culture. HFHS's strategic planning process supports its overall tight organizational design. Just as tight governance and culture engender similar focus and energy among system members, the strategic planning process also facilitates their engagement by creating a sense of "systemness" as all of the operating units work from the same overarching initiatives.

Decision-making Procedures

According to interviewees, key HFHS decisions are approved centrally at the executive level and implemented at the operating unit level with corporate support, resources, and links to staff departments for purposes of coordination. Once high-level decisions are made, responsibility is delegated to the operating units to manage their budgets with system goals in mind. This top-down decision-making structure is further supported by a series of administrative rules, standard operating procedures, and systemwide sanctions.

The tightly controlled decision-making process is consistent with HFHS's centralized governance structure, organizational culture, and strategic planning process. A common understanding among HFHS employees is that centralized decisions have the authority to over-ride operating unit decisions; this knowledge ensures that initiatives, decisions, adjudication,

and culture are all coordinated and governed at the executive level.

The Value of Organizational Design Consistency at HFHS

In contrast to PennCARE, the HFHS case study describes a situation in which organizational design consistency is based on tight models of governance structure, organizational culture, strategic planning, and decision making. As with PennCARE, however, *the consistency of design across all of these key components of the HFHS organization appears to create significant value.*

Overall, tightly configured organizational design consistency benefits HFHS by ensuring system control over administrative activities, concentrating accountability at the system level, yielding a clear alignment of incentives, focusing attention on systemwide entrepreneurial opportunities, and making it possible for system members to rally behind uniform goals. Furthermore, consistency in a tightly configured design facilitates the ability of all system members to have access to the same environmental assessment data and operate on the same time lines. Interviewees explained that having this combination of administrative uniformity and centralized control yields instrumental value in that it allows for easy comparisons, internal benchmarking, and straightforward evaluation of both overall system and individual operating unit functioning. Another consequence of this consistent organizational design, interviewees revealed, is that it helps them think of themselves from

a system perspective and as system members rather than independent business units. Finally, interviewees felt that having this consistently tight organizational design provides value because it has enhanced HFHS's reputation and promoted a quality image for the system.

CONCLUSION

The two case studies discussed introduce the concept of organizational design consistency and depict its ability to promote value at both of the differently configured healthcare organizations. The case studies illustrate how each organization has effectively demonstrated an ability to manage system relationships into a coherent whole by synchronizing governance structure, organizational culture, strategic planning processes, and decision-making procedures and thereby suitably positioned itself to reap the benefits of its chosen approach to configuration.

The article offers practitioners prescriptive insights for the organizational architecture of healthcare systems by revealing that holistic approaches to design strategy seem sensible. In other words, health system leaders would be wise to address multiple contingencies (e.g., governance structure, organizational culture, strategic planning processes, and decision-making procedures) simultaneously in shaping their organizational designs.

By exploring the value-added benefits of steadily pursuing one preferred design strategy (whether a loose one, as in the case of PennCARE, or a tight one, as in the case of HFHS), the article

invites practitioners to recognize the merits of consistency. The case studies offer wisdom for positioning complex organizations in this age of nontraditional organizational designs (Podolny and Page 1997) by corroborating the claim that "in developing integrated health systems, the component organizations need to share a common understanding of how the system 'fits' together" (MacDonald 1994, 49). The studies illustrate a mechanism for such alignment by introducing organizational design consistency as an effective vehicle for engendering a sense of "systemness" among the members of the multiple entities that comprise complex health systems.

As a strategic framework for designing complex organizations the consistency approach does not mandate conformity but allows for the selection of either a tight or a loose model, depending on which better fits the competitive environment, geographic dispersion, organizational capacity, and so on of a particular healthcare system. Practitioners should be persuaded, therefore, that there is room enough for diverse configurations of organizations in the current healthcare environment and that both tightly and loosely modeled designs can be practical. In this way, when fashioning organizational design strategies, health system leaders should be comfortable focusing not only on building consistency among key internal elements but also on ensuring that their chosen configuration (tight or loose) is consistent with their aims, their markets, and the capabilities and resources available to them.

This model of organizational design consistency serves as an important exploratory instrument through which to begin much-needed examinations about important issues surrounding the "configuration, operation, and impact of emerging health organizations and markets" (Fraser 1997, 675). The case study analyses suggest the organizational design consistency model as a way of repositioning discussions of the merits of vertical versus virtual integration in healthcare. Rather than determining whether a tight vertical or loose virtual configuration is better, the case studies stress that valuable lessons can be learned from employing overarching levels of analyses rather than focusing on either/or scenarios.

The strength of these qualitative findings must be curbed by both an acknowledgment that some degree of selection bias can enter into any voluntary interview situation as well as a recognition that two case studies can justify only minimal generalization. Consequently, a large-scale primary data collection effort is necessary to address these concerns and build additional construct measures of organizational design consistency.

Nevertheless, this introduction to the concept of organizational design consistency leaves open many promising avenues for future research. To begin, it will be interesting to examine if a causal relationship between organizational design consistency and organizational performance exists. Of additional interest is the question of whether health systems display sequential patterns in their development of organizational design consistency.

This article focuses exclusively on the positive ramifications of organizational design consistency; a different direction for future research might be to explore any potential drawbacks associated with organizational consistency, such as whether its implications vary during more and less turbulent shifts in the healthcare industry, whether it limits a system's ability to change, and whether it precludes a system from pursuing innovations that do not fit neatly into its consistency design. Finally, future research is charged with the task of sorting out the broader policy effects of organizational design consistency, such as whether it makes systems more ready to accept and manage risk for healthcare delivery, whether systems with organizational design consistency are better able to take coherent action in response to external pressures, and whether systems that are designed consistently are more or less likely to enter into successful strategic alliances with others.

Note

1. Since the data collection in 1998 both of these systems have suffered financially. This article's intention, however, is to describe how organizational design consistency adds value, not to argue causally that consistency leads to enhanced performance. It is therefore beyond the scope of this analysis to address whether consistency strategies might have played a role in these recent financial setbacks.

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PRACTITIONER APPLICATION

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The discussion of organizational design consistency is very timely and applicable in today's healthcare industry. Over the last ten years the formation of health-

care networks has accelerated. These networks have taken on many forms—some have been formed through acquisition and ownership, some through sponsorship arrangements that lead to common governance, and some through looser affiliations. Different network models are used to achieve different objectives, which may include enhancing the quality of care, improving the ability to negotiate with managed care companies, coordinating strategic development activities, and improving operational efficiencies. Within each of these network models successes and failures have occurred.

In many cases the success of a network, whether it was formed through acquisition and ownership or through looser affiliations, is determined by the strength and unity of its leadership. Strong, unified leadership will set forth values and expectations that are consistent with the overall objectives of the organization. As hypothesized by this study, the organization's design from the perspectives of governance, culture, strategic planning, and decision making will be consistent. By choosing to evaluate this hypothesis from the perspectives of two large, well-regarded healthcare systems with very distinct designs, the author is able to compare multiple facets of the organizations. Additionally, she is able to demonstrate how both of these networks attained success despite the differences in their organizational design.

PennCARE's network is built more loosely, with members able to choose those systemwide initiatives in which they participate and opt out of the network at any time. By describing the retention of local identities among PennCARE's members and its decentralized planning and localized decision-making processes, the author succinctly outlines the loose organizational design employed at PennCARE. Under this design, the organization's senior leadership defines the organization's value as increasing the strength of the individual members and promoting their collaboration without depleting their individuality.

The author contrasts the description of PennCARE with that of Henry Ford Health System, a tightly designed health network. Henry Ford Health System centrally controls the network's planning, decision making, and activities. Henry Ford Health System's senior leadership defines the system's value as enhancing operational efficiency and quality, both of which promote a solid reputation.

By comparing these two networks from multiple perspectives, the author has clearly demonstrated the value that can be derived under two very different, yet consistent, organizational designs. This provides the reader with insights into the benefits and value of different organizational structures and their applicability.

