



RURAL HOSPITALS' VIABILITY AND STRATEGIC RESPONSES

Decreasing numbers of paying patients, inadequate supplies of healthcare personnel, changing utilization patterns, and inadequate compensation from third-party payers are among the factors combining to threaten the stability of the rural healthcare delivery system.¹ More than 250 rural community hospitals have closed since 1980,² and as many as 600 are at risk of closure in the next few years.³

Survival in this environment requires adaptation and innovation by rural communities and their healthcare providers.⁴ To maintain viability, rural hospitals must shift from a product to a market orientation, from a care-taking to a risk-taking mentality, and from operational to strategic management.⁵ The successful implementation of appropriate strategic behaviors in a timely manner has become an essential element of rural hospital management.

To examine the viability of rural hospitals and the strategic behaviors rural hospitals have undertaken to maintain their viability, the Catholic Health Association, in conjunction with the University of Iowa Center for Health Services

A Study Finds a Relationship Between the CEO's Optimism And the Number of Strategic Changes Implemented

Research, conducted a national survey of short-term community general hospitals located in non-metropolitan statistical areas.⁶ An extensive questionnaire was mailed to the chief executive officers (CEOs) of all Catholic, all other religious

Summary In 1989 the Catholic Health Association, in conjunction with the University of Iowa Center for Health Services Research, surveyed chief executive officers (CEOs) of rural hospitals regarding their hospital's viability and strategic behaviors and orientations. An extensive questionnaire was sent to the CEOs of all Catholic, all other religious not-for-profit, and all investor-owned rural hospitals, as well as to a 50 percent random sample of government and other not-for-profit rural hospitals.

CEOs on average perceived that their hospital's viability relative to that of other rural hospitals was higher in 1989 than it had been in 1987. Ninety-four percent of hospitals whose CEOs perceived an increase in viability had been medium- or low-viability hospitals two years earlier. Thus, despite reports of deteriorating conditions for rural hospitals, rural hospital CEOs appeared to be relatively optimistic regarding their institution's viability.

Changes in strategic direction accompanied these perceived increases in viability. The predominant strategic orientation adopted by rural hospitals in 1987 was that of the defender, but many hospitals that used this approach switched to the analyzer orientation by 1989. Significant shifts also occurred toward the reactor orientation from the analyzer and defender orientations.

A greater percentage of hospitals with a perceived increase in viability between 1987 and 1989 altered their organizational role. The most common change for these hospitals was from limited care to basic care.



Dr. Ludke is associate professor at the Graduate Program in Hospital and Health Administration and Center for Health Services Research, University of Iowa, Iowa City. Ms. Westhoff is senior associate in member services, and Ms. Flood is director of member relations, Catholic Health Association, St. Louis.

BY ROBERT L. LUDKE, PhD; LOLA J. WESTHOFF; & BRIDGET McDERMOTT FLOOD



not-for-profit, and all investor-owned rural hospitals, as well as to a 50 percent random sample of government and other not-for-profit hospitals. The questionnaire requested information on the hospital's viability; role and composition of the board of trustees; implementation of 80 specific strategic behaviors; strategic orientation and organizational role; and perceived threats, opportunities, and problems. The 80 strategic behaviors were compiled from the literature to represent possible actions a rural hospital might undertake, in light of its environmental conditions, to pursue its goals and objectives. A total of 640 usable questionnaires were returned, for a 43 percent response rate. Of these, 119 were Catholic and 521 non-Catholic hospitals.

CHANGE IN PERCEIVED VIABILITY

CEOs on average perceived that their hospital's overall viability relative to that of other rural hospitals was higher than it had been in 1987 (see **Figure**). More than 52 percent of respondents rated their hospital's viability higher than it had been two years before, while only 30 percent perceived a decrease in viability and 18 percent reported no change.

This change in viability was strongly related to the hospital's perceived viability in 1987. Of those respondents who perceived an increase in viability, 36 percent had hospitals with low viabil-

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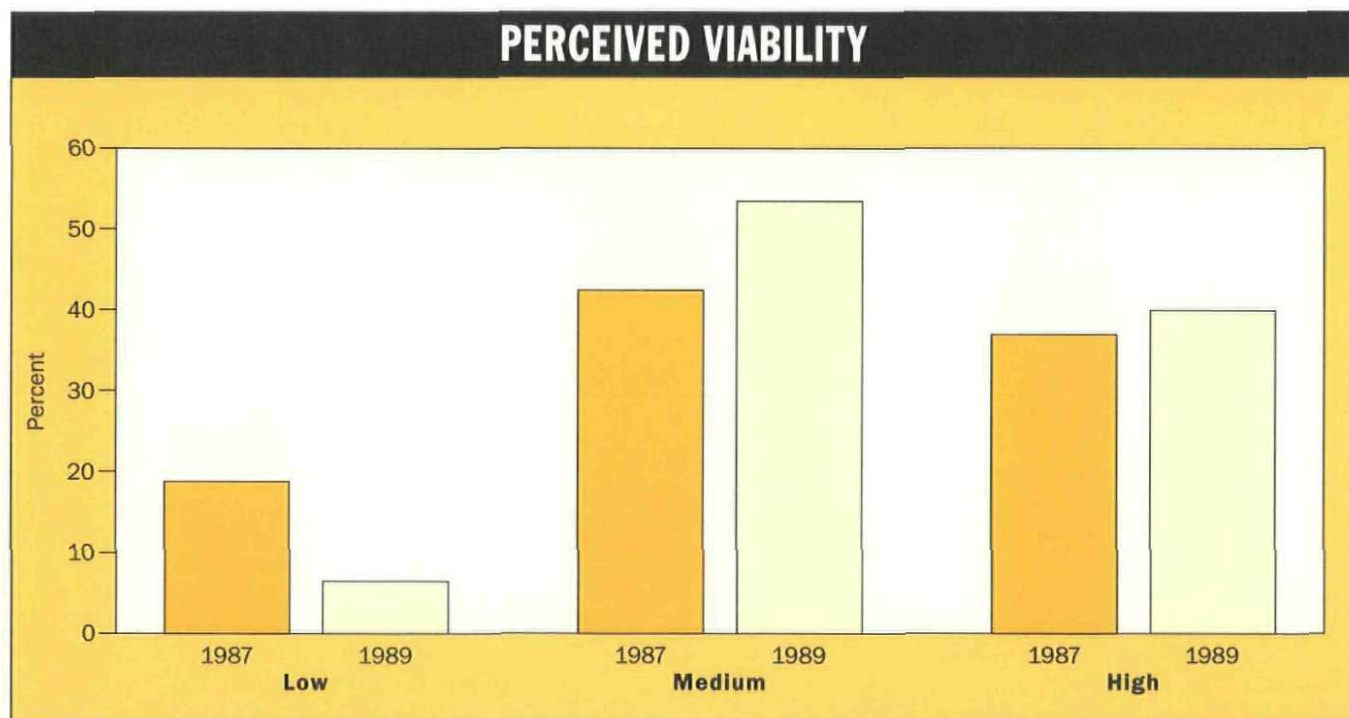
ity in 1987, 58 percent had medium-viability hospitals, and 6 percent had high-viability hospitals. Almost all (95 percent) CEOs of hospitals with low viability reported that their institutions had improved in overall viability. No significant differences existed between Catholic and non-Catholic hospitals.

Thus, despite numerous reports of deteriorating conditions for rural areas and hospitals, rural hospital CEO respondents appeared to be relatively optimistic regarding their institution's viability. Except for those at hospitals which had high viability in the past, the majority of rural hospital CEOs actually perceived an improvement in their institution's overall viability over the two-year period.

CHANGE IN STRATEGIC ORIENTATION

Stephen Shortell and colleagues postulate that hospitals adopt different strategic orientations that define their strategic behaviors and overall performance (see **Box**, p. 52).⁷ They also suggest that hospitals will change their strategic orientation to adapt to changing environmental conditions when they perceive the need for change and have the ability to change.

The predominant strategic orientation adopted by the rural hospitals in 1987 was the defender (36 percent), followed by the analyzer (31 percent). However, a larger proportion of Catholic





than non-Catholic hospitals adopted the reactor (34 percent versus 22 percent) and prospector (14 percent versus 7 percent) orientations, and a smaller proportion were defenders (22 percent versus 39 percent).

For both Catholic and non-Catholic rural hospitals, the strategic orientation adopted in 1987 was strongly associated with their past viability. Fifty-seven percent of the hospitals with low viability in 1987 were defenders, compared with 41 percent of medium-viability and 19 percent of high-viability hospitals. Approximately 34 percent of high-viability hospitals were analyzers, and 33 percent were reactors, compared with 24 percent and 12 percent, respectively, of the low-viability hospitals. These results are consistent with the findings of Shortell and colleagues that defenders do worse than other hospitals in almost every financial area, particularly operating margin and after-tax income.⁸

For both Catholic and non-Catholic facilities, hospitals whose CEOs perceived an increase in their overall viability were more likely to have changed strategic orientation between 1987 and 1989 than were other hospitals (49 percent versus 26 percent). The predominant change in strategic orientation for these hospitals was from the defender to the analyzer, with a greater proportion of non-Catholic hospitals (38 percent) than Catholic hospitals (27 percent) adopting this strategic change. These results are again consistent with the findings of Shortell and colleagues, who suggest that it is more comfortable for defender hospitals to change to the analyzer orientation than to other orientations.⁹

Significant shifts also occurred toward the reactor orientation. Approximately 38 percent of Catholic hospitals whose CEOs perceived an increase in viability switched to the reactor orientation from the analyzer (21 percent) or defender (17 percent) orientations. Also, 34 percent (15 percent and 19 percent, respectively) of non-Catholic hospitals made these changes. These findings do not agree with those of Shortell and colleagues, who indicate that hospitals will not easily change to a reactor orientation.¹⁰ However, in light of rural economic uncertainties and other factors such as federal regulations and third-party payment policies, rural hospital administrators may believe that their viability depends on adopting this transitory strategic position while searching for a more consistent, coherent strategy.

Dramatic shifts away from the defender orientation and toward the analyzer and reactor orientations also occurred for many hospitals whose CEOs perceived no change or a decrease in their

IMPORTANT FINDINGS

- Despite numerous reports of deteriorating conditions for rural areas and hospitals, rural hospital CEOs appear to be relatively optimistic about their institutions' viability.
- For Catholic hospitals, higher levels of perceived viability may facilitate greater strategic activity, possibly because of greater availability of resources.
- The hospitals tended to avoid strategic behaviors that could damage employee morale, create substantial expenditures, or alter the organizational structure significantly. At the same time, they tried to maintain a commitment to providing charity care and high-quality care with existing staff.
- Rural hospitals' most common organizational role in 1987 was to provide basic care, followed by advanced and limited care. However, Catholic hospitals tended to adopt a broader service orientation than non-Catholic hospitals.
- Hospitals with increased viability were more active than other hospitals in implementing changes in the administrative structure. Almost two-thirds of hospitals changed CEOs.
- Hospitals tended to offer more, rather than fewer, services to achieve improved viability, a strategy that may not be consistent with changes in the rural environment.

Hospitals have all moved toward the analyzer and reactor orientations, regardless of perceived changes in viability.

facility's viability. As a result, hospitals have all moved toward the analyzer and reactor orientations, regardless of perceived changes in viability. However, in 1989 the Catholic and non-Catholic hospitals in this study continued to differ in their current strategic orientation, although the differences were not as large as they had been in 1987. Catholic hospitals more frequently adopted the reactor orientation and less frequently selected the defender orientation. Similar proportions of both types of hospitals continued to choose the analyzer and prospector orientations.

LEVEL OF STRATEGIC ACTIVITY

Hospitals with a perceived increase in viability implemented on average 34 of the 80 strategies listed in the study (42 percent), which was about the same as the number implemented by hospitals perceived to have either the same or decreased viability. However, Catholic hospitals engaged in a greater amount of strategic activity than non-Catholic hospitals, implementing on average 50 percent of the strategies versus 41 percent.

For non-Catholic hospitals, the perceived level of past viability did not appear to be related to the level of strategic activity. However, Catholic hospitals perceived to have low viability in 1987 implemented on average 44 percent of the strategies, compared with 51 percent for medium-via-



STRATEGIC ORIENTATIONS

Defender This hospital offers a stable set of services to well-defined markets. It concentrates on excellence in its existing offerings. It does not quickly adopt innovations in the healthcare marketplace.

Analyzer This hospital offers a stable set of services to well-defined markets but also devotes resources to the development of promising services or markets. By monitoring other hospitals, it attempts to provide new services that are proven to be efficient and effective.

Prospector This hospital often modifies its services or markets. It consistently tries to be a leader in providing new services or developing new markets. It responds quickly to new market needs and opportunities.

Reactor At different times, this hospital operates like all three of the hospitals described above. Sometimes it will change only in response to external pressures, and at other times it will adopt proven innovations or be the first to offer a new service.

bility and 70 percent for high-viability Catholic hospitals. Thus, at least for Catholic hospitals, higher levels of perceived viability may lead to greater strategic activity, possibly because of a greater availability of resources. On the other hand, CEOs may view strategic activity as a requirement to maintain current levels of viability.

STRATEGY IMPLEMENTATION

Most Frequently Used Strategies The strategies most frequently implemented by all hospitals, regardless of level of perceived viability, are as follows:

- Participate in group purchasing agreement 99%
- Improve quality assurance program 94
- Increase use of part-time employees 90
- Cross-train employees 88
- Improve utilization review program 86
- Use temporary help 81
- Implement or increase strategic planning 80
- Implement or participate in a program 79
to recruit physicians in family or general practice
- Initiate community educational activities 78
and/or support groups
- Assist physicians in building their practices 77

The strategies appear to focus on four areas:

1. Cost control through group purchasing and effective utilization of available human resources
2. Strategic planning and performance control
3. Physician recruitment and retention
4. Community bonding through educational and support programs

In general, strategy implementation was not

associated with the level of past viability with three exceptions. A smaller percentage of hospitals perceived to have low viability in 1987 undertook strategies to cross-train employees (83 percent), initiate community educational activities and support groups (70 percent), and help physicians build their practices (69 percent) than did hospitals with medium or high viability (91 percent, 83 percent, and 82 percent, respectively).

Least Frequently Used Strategies The strategies that were least frequently implemented by all hospitals were the following:

- Sponsor or cosponsor an HMO 5%
- Budget to provide less charity care 6
- Decrease benefit package for full-time employees 9
- Decrease benefit package for part-time employees 9
- Discontinue contracts with an HMO or PPO 10
- Merge with another hospital or corporation 11
- Contract to provide administrative services to other healthcare providers 13
- Initiate capital expenditures in plant or equipment in an amount greater than or equal to 20% of the hospital's total assets to expand administrative areas 14
- Transfer sponsorship or ownership 16
- Acquire physician practices 17

Hospitals
tended to avoid
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significantly.

Compared with other hospitals, a greater proportion of hospitals with increased viability transferred sponsorship or ownership (16 percent versus 10 percent) and a lesser proportion initiated capital expenditures in plant or equipment to expand administrative areas (14 percent versus 22 percent). Thus the hospitals in this study tended to avoid strategic behaviors that could damage employee morale, create substantial expenditures, or alter the organizational structure significantly. At the same time, they tried to maintain their commitment to providing charity care and high-quality care with existing staff.

With one exception, the implementation of these strategies was not associated with perceived past viability. A smaller proportion of hospitals with low viability in 1987 (8 percent) expanded administrative areas than did hospitals with high or medium viability (17 percent).

Differences in Strategy Implementation Hospitals perceived to have increased their viability implemented certain strategies more frequently than did other hospitals. All these strategies involved changing the hospital's administrative structure.



Hospitals with a reported increase in viability were more likely to:

- Change the CEO (66 percent versus 44 percent)
- Restructure administrative responsibilities to decentralize decision making (41 percent versus 31 percent)
- Change the role of the board of trustees, particularly from advisory to decision making (35 percent versus 25 percent)
- Contract for management services (35 percent versus 25 percent)

On the other hand, hospitals with increased viability were less likely than other hospitals to:

- Update information systems (70 percent versus 79 percent)
- Increase percentage of registered nurses in direct patient care (59 percent versus 68 percent)
- Implement or participate in a program to recruit physicians in general surgery (50 percent versus 63 percent) and orthopedics (45 percent versus 55 percent)
- Participate in a healthcare network (45 percent versus 54 percent)
- Create a foundation (36 percent versus 44 percent)
- Share employees with other employers (29 percent versus 38 percent)

CHANGE IN ORGANIZATIONAL ROLE

Several authors suggest that rural hospitals must change their organizational role to remain viable.¹¹ As costs increase, service area populations decrease, and supplies of essential healthcare personnel dwindle, rural hospitals may no longer be able to maintain a full-service orientation. To realign their services to basic community needs and resources, rural hospitals may have to adopt a less service-intensive orientation, especially in acute inpatient care services. Making this change can be one of the most dramatic strategic behaviors a hospital can undertake.

For the purposes of this study, the organizational role was defined according to the four categories presented in the **Box**. Rural hospitals' common role in 1987 was to provide basic care (68 percent), followed by advanced care (21 percent) and limited care (11 percent). Catholic hospitals tended to adopt a broader service role than non-Catholic rural hospitals. Whereas 41 percent of the Catholic hospital CEOs perceived their institutions to be advanced care hospitals and 53 percent perceived them as basic care hospitals in 1987, 16 percent and 71 percent of the non-Catholic hospital CEOs, respectively, reported that their facilities adopted these roles.

As costs increase, populations decrease, and supplies of essential personnel dwindle, rural hospitals may no longer be able to maintain a full-service orientation.

A strong association existed between the hospital's perceived viability in 1987 and its organizational role. Approximately 22 percent of the low-viability hospitals were limited care hospitals in 1987, compared with 13 percent of the medium-viability and 4 percent of the high-viability hospitals. On the other hand, 33 percent of the high-viability hospitals had advanced care roles, compared with 16 percent of the medium-viability and 8 percent of the low-viability hospitals. This was the case for both Catholic and non-Catholic hospitals in the study.

A greater percentage of hospitals with increased viability made changes in their organizational role than did other hospitals (14 percent versus 8 percent). The most common change for hospitals with increased viability was from limited care to basic care (57 percent), followed by the change from basic care to advanced care (22 percent). The most frequent changes for hospitals with no change or a decrease in viability was from basic care to either limited care (38 percent) or advanced care (29 percent). Thus a perceived increase in viability was associated with a broader service orientation for several hospitals, while a perceived decrease in viability was related to a decrease in services for some other hospitals. In all cases, no differences existed between Catholic and non-Catholic hospitals.

Overall, these changes did not affect the current distribution of hospitals across the four role types. Basic care continued to be the most fre-

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ORGANIZATIONAL ROLES

Long-Term Care This hospital is primarily involved in long-term care. With no full-time physician available, medical assistance is generally provided by a physician assistant or nurse practitioner in consultation with a physician at another hospital. Services are provided to local residents.

Limited Care This hospital offers limited acute care with no obstetrics, surgical, or emergency medical services. The hospital participates in the swing bed program. Patients requiring care by medical specialists are referred to other hospitals. Services are provided to local residents.

Basic Care This hospital offers services for uncomplicated obstetrics cases, general surgical services, and emergency services. It participates in the swing bed program, but places more emphasis on ambulatory and outreach services. Services are provided to local residents and to patients referred by doctors outside the local area.

Advanced Care This hospital offers a broad range of inpatient and outpatient services, often using advanced technologies. Most medical specialties are available. Services are provided to local residents, but the hospital also serves as a major referral center.

RURAL HOSPITALS' VIABILITY

Continued from page 53

quent role for 53 percent of Catholic hospitals and 72 percent of non-Catholic hospitals. This was followed by advanced care for 43 percent of Catholic hospitals and 19 percent of non-Catholic hospitals. Also, a strong association continued to exist between perceived viability and organizational role. In 1989 approximately 33 percent of low-viability hospitals had a limited care role, 57 percent had a basic care role, and 8 percent had an advanced care role. This compared with 8 percent, 74 percent, and 18 percent, respectively, for medium-viability hospitals and 3 percent, 64 percent, and 33 percent, respectively, for high-viability hospitals.

REASON FOR CAUTION

Despite the "doom and gloom" associated with healthcare delivery in rural areas, the majority of rural hospital CEOs who responded to the survey said they believed the viability of their institutions actually improved from 1987 to 1989. Some of this optimism may be related to the strategic actions these hospitals had undertaken.

Hospitals with increased viability also were more active than other hospitals in implementing changes in the administrative structure. Almost two-thirds of the hospitals with increased viability changed their CEO; their perceived increase in viability may simply reflect the new CEOs' optimism.

Although the level of optimism among rural hospital CEOs regarding the viability of their institutions, particularly those with past low viability, is encouraging, the dramatic shift toward the reactor strategic orientation suggests a degree of uncertainty and confusion regarding appropriate strategic directions. Also, some evidence shows movement toward offering more, rather than fewer, services to achieve improved viability, a strategy that may not be consistent with changes in the rural environments. These possible trends suggest that rural hospitals may need to devote more attention to environmental scanning; to identification and evaluation of strategies appropriate

to the local environment, community needs, and available resources; and to development and assessment of organizational roles and structures that will enhance and support institutional viability. □

NOTES

1. See American Hospital Association, *Environmental Assessment for Rural Hospitals 1988*, Chicago, 1987; I. S. Moscovice, "Rural Hospitals: A Literature Synthesis and Health Services Research Agenda," *Health Services Research*, vol. 23, no. 6, 1989, pp. 891-930; Office of Technology Assessment, *Health Care in Rural America*, Washington, DC, undated; "Saving Rural Hospitals Is Not the Question; Providing Healthcare Is," *Catholic Health World*, vol. 4, no. 2, 1988, pp. 1-3.
2. American Hospital Association, *Hospital Closures, 1980-1989: A Statistical Profile*, Chicago, 1990.
3. U.S. Senate Special Committee on Aging, *The Rural Health Care Challenge*, Washington, DC, 1988.
4. Robert L. Ludke, "Surviving in Rural America: Providers Must Adapt to the Changing Healthcare Environment," *Health Progress*, August 1991, pp. 60-64.
5. Stephen M. Shortell, E. M. Morrison, and B. Friedman, *Strategic Choices for America's Hospitals*, Jossey-Bass, San Francisco, 1990.
6. Catholic Health Association, *Rural Healthcare Study Summary*, St. Louis, 1990.
7. Shortell et al., p. 35.
8. Shortell et al., pp. 120-123.
9. Shortell et al., pp. 35-37.
10. Shortell et al., pp. 35-37.
11. Ludke; L. F. Pounds and J. C. Bauer, "The Future of the Rural Hospital: Assessing the Alternatives, Trustee, March 1987, pp. 18-21; S. Rosenberg, *The Changing Rural Health Care Delivery System: Development of Alternative Models*, National Rural Health Association, Kansas City, MO, 1989.

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