POLARITY MANAGEMENT :

THE KEY CHALLENGE FOR INTEGRATED HEALTH SYSTEMS

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Executive Summary

Integrated health systems are confronted with numerous dilemmas that must be managed. Many of these dilemmas are an inherent part of the system’s structure, given the co-location of multiple competing hospitals, medical groups, and (sometimes) health plans under one organizational roof. This paper presents an analysis of these dilemmas -- referred to in the management literature as polarities -- as they are found in six integrated health systems in Illinois. The nine polarities that must be managed include: hospital systems that want to be organizations of physicians, expanding the system by growing the physician component, system centralization versus physician decentralization, centripetal versus centrifugal forces involving physicians, system objectives versus physician interests, system centralization versus hospital decentralization, primary care physicians versus specialists, physician autonomy via collectivization, and vertical versus virtual integration. For most polarities, the paper identifies some of the solutions enacted by systems. The general conclusion is that executives and physicians in integrated health systems must attend to the processes of integration as much as or more than the structures of integration.
INTRODUCTION

A great deal has been written about the integration of physicians and hospital systems. Much of this literature has focused on the structural vehicles -- such as physician hospital organizations (PHOs) -- that have been developed to enable both parties to jointly contract with managed care payers (Burns and Thorpe, 1993; Cave, 1994; Conrad and Shortell, 1996). Recent empirical evidence documents the diffusion of these structural vehicles across U.S. hospitals (AHA, 1996, Table 2; Alexander, Burns, Zuckerman et al., 1996, Table 3; Morrisey, Alexander, Burns et al., 1996, Exhibit 1; Burns, Bazzoli, Dynan et al., 1997, Table 3). These data suggest that structural vehicles for contracting are not as widespread as is commonly believed.

At the same time, there is mixed evidence regarding the outcomes of integration efforts (for a recent review see Burns, Shortell, and Andersen, 1997). Evidence suggests that these structural vehicles have not been successful in obtaining managed care contracts or covered lives (InterStudy, 1997), and are not primarily targeted at reducing costs or improving outcomes (Ernst and Young, 1995). On the other hand, recent findings point to a positive association of physician board membership on hospital financial performance (Molinari, Alexander, Morlock et al., 1995; Goes and Zhan, 1995; Mark, Evans, Schnur et al., 1996). Finally, the Health Systems Integration Study (HSIS) has reported mixed evidence regarding the impact of (a) functional and physician integration on clinical integration and (b) overall system integration on system financial performance (Gillies, Shortell, Devers et al., 1994; Shortell, Gillies, and Anderson, 1994, Exhibit 2).

Such findings suggest that it may be more appropriate (at least in the near-term) to focus on the processes of integration that may be antecedent to outcomes. Such a focus is consistent with the structure-process-outcome model articulated earlier by Donabedian (1966). It is also consistent with the emerging importance of processes in managing large-scale organizations (Ghoshal and Bartlett, 1995, 1997).
There is growing evidence that integration efforts need to focus on integrative processes in addition to integrative structures. A study sponsored by the Prospective Payment Assessment Commission (ProPAC, 1993; Bray, Carter, Dobson et al., 1994) suggests that the quality of the work relationships between physicians and hospitals helps to explain why some hospitals make profits under Medicare while others sustain losses. Such relationships as trust, communication, and decision-making participation were considered to be more important for hospital profitability than the presence of contracting vehicles such as PHOs. Indeed, several recent analyses of PHOs have concluded that these contracting vehicles are empty shells with little managed care infrastructure -- that is, structures without process (Michigan State Medical Society, 1994; Ernst and Young, 1995; Burns and Thorpe, 1997). A recent comparative case analysis of integrated systems by the Center for Health Management Research (CHMR) similarly concluded that processes of trust, physician participation in governance and management, and leadership development are critical for integration success (Zuckerman, Hilberman, Andersen et al., 1998).

The recent strategic management literature also argues that process management has an important impact on profitability. In a comparative study of the automotive and computer industries in four countries, researchers found that long-term partnerships along the value chain that involve customers and suppliers in strategic planning and product/process design are associated with firm profitability (Ittner and Larcker, 1997). The researchers conclude that greater emphasis should be given to understanding the stages of process management and how the entire value chain can be managed to achieve process improvements.

In a similar vein, Ghoshal and Bartlett (1995, 1997) argue that top management should refocus their attention from structures to processes. Their suggestion is based on an analysis of global/matrix firms such as Asea Brown Boveri (ABB), a $30 billion electrical engineering firm that (until recently) employed 65,000 workers in 1300 separate operating companies in 140 different countries (Taylor, 1991; Simons and Bartlett, 1992; Kets de Vries, 1994). Within ABB, each of the 1,300 operating company presidents reports to both a global business head (global responsibility for product line) and a regional country coordinator (local responsibility for
geographical line) -- hence the global/matrix firm. The challenge facing such firms is to balance the simultaneous needs for product standardization with geographic localization. That is, how can firms balance the need for economies of scale in production with the need to maintain local flexibility and market responsiveness?

The global/matrix firm has simultaneous needs to be both global and local, big and small, and centralized and decentralized. Ghoshal and Bartlett argue that the global/matrix structure described above can “embrace” these paradoxes and tensions by internalizing them, but it cannot resolve them. Instead, top management must focus on developing processes within and across the organization that permit a fluid balancing of these tensions. The core organizational processes they identify include managerial entrepreneurship, building competences by developing skills and knowledge and sharing them across the firm, and continuously renewing the firm and its operations.

The integrated health systems developing today resemble the global/matrix firms described above. On the one hand, they have entered into new product markets by integrating backward into insurance (in-house health plan) and ambulatory care (acquired physician practices) or forward into extended care (e.g., home health, nursing homes) (Conrad and Shortell, 1996, Figure 3). On the other hand, they have entered new geographic markets by horizontally integrating multiple hospitals and/or medical groups operating in different areas or different segments of the same metropoplitan market.

The present study argues that a key challenge in such integrated health systems is managing the tensions and conflicts inherent in such structures (Burns, 1986; Sahney, 1996). Such tensions pervade not only physician/system relationships, but also physician/physician and hospital/hospital relationships within healthcare systems. This challenge has been labelled “polarity management”: managing between dilemmas or extremes (Johnson, 1992; Stewart, 1996). Polarities are opposites or contrasts that do not and cannot function well independently of one another. Due to their interdependence, neither side of a polarity can be chosen as a solution when the other side is
ignored (Johnson, 1992). Polarity management thus becomes a critical problem-solving skill of navigating between divergent goals and interests that are important to key stakeholders. Begun, Luke, and Pointer (1990) have described similar types of paradoxes that need to be managed in quasi-firm relationships between physicians and hospitals.

This study outlines nine types of polarities that exist in physician/system, physician/physician, and hospital/hospital relationships. These polarities are illustrated using ethnographic data gathered from a comparative case analysis of six integrated systems in Illinois (Burns, Egan, and Van Duyne, 1997). The study then outlines the implications of these polarities for administrative practice. The study concludes with a description of some of the “glue” that holds the integrated systems together in the face of these polarities.

**METHOD**

**Study Background and Sites**

This study is based on intensive case analyses of six integrated delivery systems in Illinois conducted in late 1996 and early 1997. The case studies constituted part of a three-phase investigation of integration that also conducted focus groups of executives and practicing physicians in Chicago and downstate Illinois, and interviews with emerging physician groups. The three-phase investigation was sponsored jointly by the Illinois Hospital and HealthSystems Association (IHHA) and the Institute of Medicine (IOM) in Chicago.

The IHHA invited systems to participate in the study. Six systems were chosen to ensure representation from both Chicago and downstate institutions, teaching and nonteaching systems, and hospital-based and physician clinic-based systems. The six systems were: Advocate Health Care, Northwestern Healthcare Network, Rush System for Health, Carle, OSF Healthcare System, and Southern Illinois Healthcare. There is no claim that these systems are representative of all integrated systems in Illinois, or that Illinois systems are representative of systems nationwide. Several of these systems have participated in prior national studies of integration by
the HSIS and CHMR projects and have been profiled in case publications (cf. Coddington and Moore, 1994, 1996).

**Interview Conduct and Protocol**

For each site, a team of investigators from the IHHA, IOM, and the Wharton School conducted a series of on-site interviews with key administrative and medical leaders using a standardized interview protocol. The interviews inquired into nine process areas of integration between physicians and systems: partnering with physicians, representing physicians in governance, developing physician leaders, harmonizing primary care - specialist relationships, sharing risk and reward in business relationships, acquiring physician practices, adopting cost-effective strategies and practices, balancing physician independence with economic security, and adding value to healthcare delivery through integration. Interviews typically lasted one-and-a-half hours each.

The on-site visits were followed up by additional telephone interviews, using the same protocol, with active members of the medical staff at each system to ensure adequate practitioner representation. On average, 9-10 individuals were interviewed at each system, with an equal mix of executives and physicians. Interview data were supplemented with recent corporate and media reports to prepare the site case studies. The individual case studies have not yet been published. The aggregate findings across all six sites are described elsewhere (Burns, Egan, and Van Duyne, 1997).

**NINE POLARITIES IN INTEGRATED HEALTH SYSTEMS**

**Polarity #1 : Hospital Systems Want to be Organizations of Physicians**

With the exception of Carle, the systems in this study were hospital-based. Many of these hospital systems expressed the desire to become “organizations of physicians”, acknowledging that physicians are the key point of attachment with the patient and the enrolled population of covered lives. Given the historical independence and cultural dissimilarities between hospitals and physicians (Shortell, 1991; and Tucker, 1992), this desire represents a leap of faith. This desire is
also hindered by unilateral strategic moves made by the systems.

One manifestation of the difficulty of achieving this transition is the fact that the process of integration is initiated by the hospitals and, from the perspective of practicing physicians, controlled by the hospitals. This is often due to the hospitals’ perceived need to move quickly to establish an integrated system around a core set of cooperating institutions. Physicians, who are often not well informed about such initiatives, will be “brought along later on”. Such was the tactic adopted elsewhere by BJC in St. Louis. The problem posed by this tactic is that integrating systems want physician buy-in and partnership. For their part, practicing physicians don’t fully understand the system’s efforts or strategic aims. This lack of understanding is due in part to the busy office schedules of practitioners (who probably don’t have time to read corporate memos or attend meetings) as well as to short circuits in the transmission of information from the corporate office down to the physician office level. The consequence is that physicians lack the information and participation necessary to build the trust and partnership sought by the system.

Another manifestation of the difficulty in transitioning from a hospital system to an organization of physicians is the debate over the appropriate way to integrate physicians. The systems have pursued integration by linking physicians with economic contracting vehicles sponsored by their member hospitals, such as a hospital-based PHO or medical staff-based independent practitioner association (IPA). An alternative approach to integration is linking physicians with other physicians. At one institution, a large affiliated physician group has sought to be the acquisition arm (rather than the system) for new physicians brought into the system. They view this as consistent with the system’s intent to be an organization of physicians in which the system grows by “growing the physician component” (see below). However, group members expressed some concern over the system’s acquisition of other group practices. Such concern reflects not only a perceived lack of influence but also competitive threats posed by new entrants. At another institution, primary care practitioners (PCPs) have formed “physician organized delivery systems” (PODS). PODS are groups of PCPs who virtually organize into risk-bearing networks for capititated business and contract with a select group of specialists with whom they wish to share
risk and reward. These PODS exist independently of the economic contracting vehicles and are often formed by the physicians themselves. There are, nevertheless, ties between the PODS and the system. For example, the leadership of the economic vehicles must come from the PODS, and specialists who wish to contract with the PODS must belong to the specialty panel of the contracting vehicles.

**Polarity #2: Expand the System by Growing the Physician Component**

Another tension related to the first is the expressed desire of these systems to expand by growing their physician component. This strategy has proved to be problematic in several respects. First, several systems have focused much of their expansion around the acquisition and growth of large multispecialty groups. Many of these groups have been losing huge amounts of money, an experience common to other physician networks (e.g., Partners HealthCare System in Boston). One reason for the financial losses has been the lack of physician productivity and compensation systems. As a consequence, the groups’ losses have been subsidized by the acute care hospitals that have been profitable in the past but are being deemphasized in future planning.

Second, one of the requirements for growing physician groups is capital. Capital is needed for practice acquisitions, information systems that standardize data entry and link group locations, data collection for quality and cost benchmarking, etc. A major tension develops, however, when the system attempts to grow another component in addition to its physicians. Several systems sought to simultaneously grow physician groups and health plans, but found that both required substantial capital investments that competed with one another.

Third, at least part of the physician growth strategy is driven by the moves of competing systems to acquire PCPs and develop their own contracting vehicles. Thus, some systems acquire physicians in order to prevent competitors from doing so and/or to guarantee the availability of future referral sources to in-house specialists. This leads systems to invest large amounts of capital in developing integrated physician arrangements that suffer from low productivity and returns (Wall Street Journal, 1997). The dilemma arises over whether the system should lose
money on developing integrated structures or lose physicians to competitors who will then lose money on developing integrated structures.

**Polarity #3 : System Centralization and Physician Decentralization**

A third set of tensions arises due to the different organizational bases of hospital and physician office care. It is commonplace (but still important) to mention that physicians are being asked to identify with a system while they tend to despise authority and distrust bureaucracies (Goldsmith, 1993). As Shortell (personal communication) has noted, what physician wants to think of him/herself as fitting into a system? Thus, while the system is seeking interdependence, the physician may prefer independence.

Integrated systems tend to include several hospitals with an overarching corporate office, from which springs much of the system initiatives. As part of the integration effort, practicing physicians are asked to work with a central corporate office and staff that they have never dealt with and perhaps have never seen. They are also asked to share risk system-wide through system-sponsored contracting vehicles such as Super-PHOs. In contrast, physicians tend to concentrate the hospital portion of their practice at one institution. They thus only know the local hospital chief executive officer (CEO) and his/her staff; they also belong to the local hospital-sponsored PHO or other contracting vehicle and share risk with physicians whom they know.

In addition, these integrated systems seek to merge two very different types of firms. On the hospital side is a small number of large institutions; on the physician side is a large number of small office practices. This merger has proved difficult in system efforts to communicate with physicians and to represent them in governance. Some systems, for example, have thousands of affiliated physicians in offices scattered across a wide geographic area. Communicating with them is no easy matter. Similarly, with so many physicians, it proves difficult to adequately represent all constituencies in any system-level forums for decision-making. Several systems have abandoned any attempt to do so, and instead seek to represent physicians using representatives from intermediate-level bodies such as the local contracting vehicles at the hospital.
It is important to note that research on mergers and acquisitions has tended to find a negative association between merger success and the disparity in size of the firms involved (Kitching, 1967; Hunt, 1990). That is, mergers are more likely to fail when a large firm acquires a much smaller target firm. Part of this may be due to the acquiring firm’s failure to understand or harness the potential of the target firm in the post-acquisition period. Part may be due to the difficult logistics of merging activities of firms that operate on entirely different scales with different cultures and operating systems.

**Polarity #4: Centripetal vs. Centrifugal Forces Involving Physicians**

There are also centralizing and decentralizing processes at work among physicians. On the one hand, there are centripetal forces seeking to more closely bind physicians with the system; on the other hand, there are centrifugal forces seeking to separate physicians from the system. For example, most of the systems seek to develop a single signature contracting capability in which the system can speak for all hospitals and physicians and enter into global capitation agreements. At the same time, physicians (particularly specialists) are developing specialty networks on their own for carveout capitation. Ironically, systems sometimes support these specialty-oriented efforts by providing assistance with strategic planning or joint-venture capital. System executives do not see a contradiction between their efforts to obtain global capitation and specialty carveout efforts. Rather, they believe a menu approach will work best with the current diversity of payers. They also wish to have a “seat at the table” in dealing with the burgeoning specialty networks.

As another illustration, some of the systems are forming system-wide IPAs as one vehicle for payer contracting on a large geographic basis. At the same time, physicians are organizing their own IPAs at the hospital level to maintain some measure of local autonomy and control. More significantly, physicians in one system have recently organized their own metropolitan-based IPA separately from the system and its hospitals. They have organized this IPA in partial response to the system’s failure to win large managed care contracts and its recent downsizing. Group practice formation is a key method used by systems to more closely bind physicians
together and with the system. Systems have actively encouraged primary care and other physicians to form groups for several reasons: to represent physicians in governance, to facilitate professional learning, to help foster the desired collaborative culture, to help physicians to accept and manage risk, and to serve as a vehicle for physician recruitment (e.g., groups may be a more attractive partner than the system). To assist group formation, the systems have provided some organizing assistance and startup capital, as well as ongoing leadership training through the Kellogg Graduate School of Management. Ironically, after the groups go through an early maturation process (e.g., how to think and act on their own, how to handle business decisions), they frequently set off in a faster and/or different strategic direction from the system. Groups may pursue their own managed care contracts, decide to become more freestanding and independent from the system, or consider partnering with rival integrated systems. Typically, systems don’t try to block these moves but rather seek to support them financially and maintain representation in the group’s governance (i.e., seat at the table). In one system, executives likened these moves to the actions of wayward children who will someday return home.

In one respect, the systems have engendered this situation by encouraging physician leadership development. Educational programs include training in finance and entrepreneurship. In several systems, entrepreneurial physicians have formed PODS, equity models, and large PCP groups from scratch and taken these groups in new directions. The leadership programs have thus been successful: the systems have trained leaders and not just followers.

**Polarity #5: System Objectives vs. Physician Interests**

Another dilemma confronting integrating systems concerns the mismatch between system objectives and physician interests. The systems are typically developed to pursue managed care and capitated contracts. System objectives thus focus on winning contracts and assuming responsibility for more covered lives. Physicians, on the other hand, are not as interested in the number of contracts or covered lives that a system has garnered. Instead, they desire more patients and referrals. In many systems, however, there has been a serious delay in gaining capitated contracts and covered lives since payers have shown some reluctance to passing on risk
to providers (InterStudy, 1997). The result is that, with some exceptions (e.g., Carle and Advocate), these systems are “all dressed up with nowhere to go”.

This situation has spawned a number of related dilemmas. First, whatever benefits have been gained from system integration have accrued to the system. These include the development of system-wide information linkages, contracting vehicles, and medical management tools. Benefits of integration for physicians are promised down the road. This scenario is ironic, given the oft-noted distinction in time horizons of the two groups (Shortell, 1991). Thus, executives who have long-term horizons are reaping short-term advantages while physicians with short-term horizons are asked to look long-term.

Second, during the initial years of formation and development, the systems have subjected the medical staffs of their member hospitals to considerable change (e.g., the formation of hospital-level and system-level contracting vehicles). Such change has not only disrupted traditional medical staff-hospital relationships but also undermined physician trust and commitment, particularly given the failure to gain large capitated contracts. Systems are thus confronted with the difficult problem of jointly managing large-scale change and physician trust. Compounding this difficulty is the fact that the systems tend to focus on developing contracting vehicles (structures of integration), while rank-and-file physicians stressed the need to emphasize traditional skills in managing physician-hospital relations such as communication and participation.

Third, in their efforts to prepare for capitated contracting, systems are seeking to subject their affiliated and integrated physicians to various managed care measures that will enable them to jointly adapt to market forces. Such measures include system-level and hospital-level care management, capitation management, information systems, and leadership development. At the same time, opposite interests are motivating some physicians to seek integration with the systems. These include the desire to escape managed care and seek protection from market forces. Thus, systems want to assume and manage risk while many physicians wish to avoid it or flee it by selling their practices to the systems.
The disjunction between system objectives to assume/manage risk and physician interests in avoiding risk takes on other manifestations. Consistent with published national data (Ernst and Young, 1995), the systems have developed contracting vehicles to accept capitated contracts and risk, and yet the physician members in these vehicles do not financially invest in them to any significant degree. Similarly, the systems wish to pursue risk contracts by establishing and growing their physician networks, and yet the systems and groups have typically failed to develop the necessary managed care infrastructure within these networks (e.g., physician selection, medical management, contracting specialists, information systems).

**Polarity #6 : System Centralization and Hospital Decentralization**

The tensions generated between systems and physicians are paralleled by tensions between systems and their member hospitals. The systems’ *raison d’etre* is typically to prepare for global capitation and win managed care contracts. Not surprisingly, they orient their efforts around issues of system welfare such as reducing inpatient hospital utilization and regionalizing services. System welfare conflicts with the welfare of local hospital operating units, however. Member hospitals are typically oriented to increasing their own inpatient utilization and maintaining local services that increase patient access and support physicians’ practices.

In a similar vein, the systems seek to develop system-level initiatives that demonstrate their value to member institutions. These initiatives include Super-PHOs, IPAs, and management services organizations (MSOs). At the same time, the system is confronted by member hospitals which have developed their own local initiatives in these areas and have gained some learning curve advantage with them. Consequently, hospitals are not always willing to participate in system-led initiatives. Some systems, particularly those based on loosely-coupled federated models (cf. Simon, Smithburg, and Thompson, 1950), can not always compel compliance but must seek to build upon the strengths of local institutions. It is also the case that member hospitals sometimes fear the loss of local control as systems initiate these activities at the central level, and may even doubt the system’s ability to assume these functions and perform them as well.
There are also divisions between the member institutions that potentially hinder system-led efforts to act in unison. For example, consistent with national trends (Luke, Ozcan, and Olden, 1995), most systems are locally organized with members in the same metropolitan market. Oftentimes, these systems combine hospitals that historically have been rivals with one another over patient bases, referrals, teaching programs, medical staff composition, culture, etc. The system office asks hospitals that have been fierce competitors to now collaborate and cooperate with one another. Problems appear when the hospitals are asked to sign system-level contracts with payers. While the goal is to do single signature contracting as a system, the medical staffs of member hospitals don’t necessarily want to share risk with medical staffs elsewhere whom they distrust or look down upon. There is also a reluctance to share the financial surplus one’s hospital has historically achieved with other hospitals and, in effect, subsidize them. Hospitals that have been used to getting high prices in their contracts are concerned that a Super-PHO contract will negotiate a lower, standardized rate that reduces their profit margin. Across the six study sites, those systems that lacked a common bottom line linking all member hospitals typically encountered strong resistance to regionalizing services and sharing resources.

A final source of division between the system and its members lies in the fact that, despite their common location in a single market, member hospitals occupied very different environments for managed care contracting. Some hospitals were situated in areas of the market with very high managed care penetration and thus had long developed contracting vehicles to deal with payers. Other hospitals resided in areas with low managed care penetration, enjoyed considerably more commercially-insured business, and had not really embarked on a concerted strategy to deal with payers. Systems commonly found it difficult to act as systems and engage in single signature contracting when their members were not on the same page of managed care preparedness.

**Polarity #7: PCPs vs. Specialists**

PCPs and specialists have traditionally clashed over such issues as communication and return of patients. Integrated healthcare has exacerbated many of these conflicts in acute ways. First, the
physicians who are typically more “integrated” with the system — gauged by ownership/practice acquisition — are the PCPs. The non-integrated specialists view the development of contracting vehicles (often headed by PCPs) and PCP networks with two concerns: many specialists will be excluded from the specialty panels that these vehicles and networks deal with, and many will suffer a drop in referrals.

Compounding these fears is that the PCPs are increasingly viewed (by both the system and the specialists) as the “favorite son”, effectively usurping the role that specialists once enjoyed. PCPs are now viewed as the key to the system’s future success by virtue of their ability to provide primary care for a large population of covered lives. Specialists, however, are keenly aware that they have been largely responsible for the past financial success of the system and have provided the revenues used by the system to build its PCP base. Many of the PCP groups now forming in these systems are developing their own specialty and ancillary services, all of which threatens the economic livelihood of specialists on the hospital medical staff. Consequently, PCPs are becoming the “distrusted son” in the eyes of specialists. Such diminution of trust is reportedly inhibiting referrals and collaboration between the two sets of physicians.

In addition to the economic reversal of fortune, there is a political upheaval among PCPs and specialists. The emerging medical leadership in many integrated systems are the PCPs who (by stipulation in some cases) must be represented in disproportionate numbers in the governance of the managed care contracting vehicles. Moreover, the leaders of the hospital-level PHOs are typically PCPs and not specialists. These developments are in sharp contrast to the leadership of the traditional medical staff, which has been specialist dominated and controlled.

**Polarity #8 : Physician Autonomy via Collectivization**

One of the key dilemmas investigated during this study is how physicians seek to balance their traditional independence and professional autonomy with the growing need for economic security in the face of managed care pressures. Physician perceptions about balancing autonomy and security varied considerably by physician type. Solo practitioners had, by definition, avoided group practices, integrated arrangements, and employment. For them, professional independence
seemed paramount, although they expressed concerns over their incomes. Employed physicians (primarily PCPs) tended to report they had not lost clinical autonomy over referrals or prescribing patterns, but they had lost control over the functioning and administration of their offices (e.g., staffing and purchasing decisions). Specialists, on the other hand, believed they were losing both autonomy and security, particularly with the development of PCP-based contracting vehicles that might reduce the size of the panel of specialists they contract with.

In several systems, a primary means to jointly ensure autonomy and security was through “collectivization” of physicians by physicians. In essence, physicians sacrificed their individual autonomy to achieve collective autonomy, economic power, and security. Such collectives included the formation of large physician groups, multispecialty clinics, economic contracting vehicles, or PODs. Most of these collectives were organized and administered by the physicians themselves. Their large size increased physicians’ visibility, importance, and leverage in the system. In this manner, physicians hoped to achieve greater “equilibrium” in negotiations with the hospital system and large managed care payers.

Collectivization brought several immediate benefits to organized physicians that were not enjoyed by freestanding practitioners. First, physician collectives were more likely to have voice in system governance by virtue of having designated board seats for large physician groups or contracting vehicles. Second, physician collectives were more likely to receive strategic planning and financial assistance from the system to develop their networks. Collectivization also brought benefits to the systems by serving as a competitive spur to unorganized physicians throughout the system to follow their lead.

Polarity #9: Vertical vs. Virtual Integration

A major debate in the field of integrated healthcare is whether firms should vertically integrate via ownership or virtually integrate via contracting (Goldsmith, 1994; Conrad and Shortell, 1996; Walston, Kimberly, and Burns, 1996). The systems studied here did not view this as an either/or issue but rather as a delicate balancing act between both. As noted in recent studies of integrated systems (cf. Dynan, Bazzoli, and Burns, 1997; Zuckerman, Hilberman, Andersen et al., 1998),
systems typically offer their physicians a menu of integration options from which to choose, depending on the stage of their career, their specialty, and their preferences for loose versus tight coupling. Physicians who wish to maintain their independence can select the IPA or PHO option; those who desire closer economic integration can select the MSO, equity model, or salaried practice model.

In addition, physicians exhibit mobility across these integration options as their needs change and as they gain experience with a given option. Over time, some physicians transition from loosely-coupled to tightly-coupled arrangements; others move out of tightly integrated arrangements to looser forms of integration. Similar processes occur at the group level. In one system, an owned group decided to become freestanding while a freestanding group decided it wished to be acquired. The same system also pursued both ownership of groups as well as investorship in groups. The system believed that its equity position provided it with a seat at the group’s governance table and the basis for future partnerships.

One key dilemma for many systems was the make-or-buy decision regarding health plans. Several systems (and some of their acquired groups) had developed their own health plans but experienced conflict in managing them alongside the other integration components. As mentioned earlier, the health plans competed with aligned physician groups for financial resources and development. Moreover, the in-house health plans were too small to generate enough patients and market share, and potentially antagonized the other payers the systems contracted with. In many systems, the health plans were sold to external payers which provided an influx of cash to support additional physician network expansion. In other systems, however, the health plans were not only retained but also emphasized in the system’s growth strategy. In such instances, coordinated strategic planning was facilitated by overlapping governance across the system’s medical clinic, hospital(s), and health plan. Alignment of financial incentives was achieved by means of single asset ownership of all integration components.

IMPLICATIONS OF POLARITY MANAGEMENT
It has been commonplace to view these types of polarities as either/or choices. The analysis here suggests that these polarities are interdependent rather than mutually exclusive. That is, they are appropriately viewed as cross-cutting axes (90 degree angle) rather than opposite ends of a continuum (180 degree angle). Viewed from this perspective, the role of management becomes balancing the rival perspectives. On the one hand, managers must pursue the system’s interest in increasing alignment and inclusion of physicians; on the other hand, managers must accommodate the physicians’ interests in empowerment, local control, and self-determination.

Polarity management may involve more than simply balancing perspectives, however. It may entail pursuing both directions simultaneously. Similar findings have been presented in empirical studies on leadership, which in years past debated whether leaders should display theory X behaviors (also labelled initiating structure, autocratic leadership) or theory Y behaviors (consideration, participative democracy) (cf. McGregor, 1960). Blake and Mouton’s (1964) “management by grid” approach suggested that effective leaders combined both consideration and initiating structure styles. Misumi and Peterson (1985) provided more recent, supporting evidence for this view in their study of Japanese leaders, although leaders were not extremists on either set of behaviors.

Similar conclusions have also been reached in qualitative studies of successful companies. One of the eight characteristics of the “excellent firms” examined by Peters and Waterman (1982) was “value-driven organization”. Almost every successful firm had a strong CEO and an organizational culture that institutionalized his/her values. The content of these value sets mirrors the two leadership styles mentioned above. The initiating structure style is evident in such corporate values as *we want to be the best at what we do, we do the job well,* and *superior quality and service* -- all of which connote strict standards of performance and attention to detail. The consideration style is apparent in such values as *importance of people as individuals,* *informality enhances communication,* and *we want innovators at all levels* -- which connote a people-orientation, openness and accessibility, and participation.
Another attribute of these excellent firms was “simultaneous loose-tight properties”. The companies were tightly structured in terms of strongly-held values which disciplined and controlled everyone’s behavior. However, because employees were expected to adhere to these values, there was less need for overt supervision. This yielded a loosely-structured environment that permitted autonomy, flexibility, and experimentation. The organization thus built the initiating structure and consideration styles into its architecture as well as its values.

A more recent study of visionary companies likewise explains their success in terms of their ability to (a) avoid the tyranny of the ‘or’ and (b) embrace the genius of the ‘and’ (Collins and Porras, 1994). Such companies found it easier to live with paradoxes and seemingly contradictory ideas at the same time. They sought to achieve both sides of a polarity simultaneously, such as achieving high performance in both the short-run and the long-run, or preserving core values while stimulating radical change.

The essence of leadership -- from the perspective of polarity management -- thus becomes managing ambiguities and multiple directions. Confronting these seemingly contradictory ideas provides a fruitful method to sort out confusions regarding the organization’s direction and to create meaning for the organization’s participants. It can also serve to promote organizational learning in dynamic external environments and diverse internal environments. For example, by articulating the existence and nature of the polarities mentioned above, executives and physicians can begin to explore both sides of dilemmas as a means to overcome resistance to change.

According to Johnson (1992), the action steps are to:

1. Recognize that you have a polarity to manage rather than a problem to solve;
2. Recognize there is an upside and a downside to each pole;
3. Diagnose which pole the organization is currently favoring and what its upside and downside effects are;
4. Be sensitive to the downsides as they are experienced by the other parties;
5. Be willing to switch poles;
6. Anticipate the likely responses of other parties to changing poles;
7. Know how to talk to the opposite pole and mediate between opposites. The important process here is to explore both sides of the polarity or dilemma to be managed. Neither side should be ignored or avoided.

It is not surprising that many of the challenges of polarity management resemble those of leading a diverse workforce (Joplin and Daus, 1997). These include changing power dynamics, diversity of opinions, lack of empathy, tokenism, participation by diverse groups, and overcoming inertia in dealing with the foregoing issues. Such challenges now confront healthcare systems as they seek to integrate with their physicians.

WHAT IS THE GLUE?

Given the multiple polarities that exist in integrated health systems and the diversity of interests to be accommodated, what is the glue that holds these systems together? Three cohesive forces were present in the six Illinois sites: standardization, interpenetration, and culture. These forces are illustrated below.

Standardization
The HSIS identified three types of integration (functional, physician, and clinical) in their study of hospital systems. Common to each type was the notion of “pooled interdependence” (Thompson, 1967; Hrebinjak, 1994): each hospital in the system featured the same integrative elements. Thus, for example, clinical integration meant that system hospitals would share the same clinical protocols, medical record elements, outcomes data, support services, etc. In essence, regardless of the type of integration, activities were conducted in a like manner in each hospital.

Standardization also served as a major cohesive force in this study. As in the HSIS, one set of elements to be standardized concerned clinical care practices such as guidelines and care maps. Clinical activities were also standardized using a common managed care infrastructure. In one system, all of the economic contracting vehicles shared the same utilization management tools and
administrative committees; at the same time, all of the group practice sites shared the same administrative and clinical systems. Likewise, other systems sought to standardize clinical functions by means of system-wide information systems and patient records, or MSOs that could standardize physician back office functions.

Systems with educational missions also relied on common teaching programs across hospitals to provide a unifying force, oftentimes allowing one hospital with a demonstrated capability in a given clinical area to develop the system-wide educational, clinical, and research focus for other hospitals. These same systems also utilized clinical institutes of excellence and system-wide research programs to unite the various members in pursuit of common research and educational objectives.

Finally, one system sought to standardize ‘competencies’ across its member hospitals. These competencies included contracting management, care management, and capitation management. The system developed a Super-PHO to standardize managed care contracting functions (and thus contracts) across the hospital-based PHOs. In this manner, the system presented a unified face to the customer. With regard to care management, the system instituted a medical directors council to standardize referrals across PHOs, fee schedules, and guidelines. Finally, the system established a Super-MSO to standardize capitation management skills.

**Interpenetration**

Global firms such as ABB seek to develop patterns of interdependence and interpenetration among its numerous operating companies by several means. These include the use of a matrix structure whereby operating company presidents report to both a product leader and a geographic area leader — in effect, forcing the two sets of leaders to continually balance the needs for standardization and localization. In a similar fashion, several of the systems in this study utilized matrix arrangements to interweave the interests of interdependent activities: products/clinical areas, hospital markets, and operating functions.
For example, one system developed a matrix of strategic business functions and local hospital market operations. Specific hospital CEOs (with responsibility for local markets) were given additional responsibility for system-wide operating functions such as physician development, managed care, quality, continuum of care, information technology, etc. The ultimate aim was to base a portion of the CEO’s compensation on the performance of the corporate-level function, which would require hospital CEOs to cooperate with one another in order for each to achieve their corporate targets. Another system developed a matrix of local market operations and key customers. Specific directors of contracting vehicles (e.g., PHOs) at the hospital level were jointly responsible for key HMO payers systemwide. A third system developed a matrix of local market operations and product lines. Here regional medical directors were made jointly responsible for the standardization of clinical products across the system.

Interpenetration was achieved in other systems without the specific use of matrix arrangements. For example, in one system a large medical group provided the single biggest block of admissions to the system hospital, while the hospital served as the primary locus of inpatient practice, capital, and medical education for the group. There was also a dense network of contracts and financial relationships between the two entities. In one integrated system the major organizational components (medical group, hospital, and health plan) had overlapping medical leadership and governing boards to permit unified planning.

**Organizational Culture**

Finally, while the different systems had different cultures, the presence of a common culture in each served to bind the various components together. In systems with major teaching programs, the educational and research mission served as the cohesive force (e.g., collaborative research projects across institutions, joint pursuit of residency program objectives). In systems with religious foundations, the faith mission and ministry linkage provided a set of guiding values that, in some cases, were inculcated in physician leaders during formal orientation sessions. In systems with for-profit components, the for-profit orientation and the equity stake available to physicians served as a cohesive force.
Summary

There is no evidence as of yet regarding how well these cohesive forces work to unite the systems. The integration efforts depicted here are, with one exception, less than ten years old. Efforts aimed at improving cohesion are even more recent. This lack of history and development makes it difficult to observe integration outcomes, let alone evaluate them. It may be prudent for executives and fruitful for researchers to focus instead on the processes of integration that may influence such outcomes. This analysis suggests that processes such as polarity management represent a key administrative challenge that integrated systems must address in order to demonstrate their potential.
REFERENCES


