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# The Effect of Normative Social Forces on Managed Care Organizations: Implications for Strategic Management

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## EXECUTIVE SUMMARY

Drawing on institutional theory, this study examines how adherence to a number of "institutional" and "technical" environmental forces can influence the business success of managed care organizations (MCOs). The standards studied include: (1) *institutional forces*: socially accepted procedures for delivering care (access to quality care, availability of information, and delivery of care in a personal manner); and (2) *technical forces*: industry standards for cost control and efficient use of financial and medical resources.

The most significant finding is that successful MCOs must conform to *both* institutional and technical forces to be successful. MCOs that conform to either one or the other type of standard were no more successful than those that conformed to neither.

These findings have several important implications for MCO strategy. First, to be successful, MCO executives must understand the external environment in which they operate. They must anticipate and respond to shifts in that environment. Second, this understanding of the external environment must place equal emphasis on societal demands (e.g., for accessible care and information) and on technical demands (e.g., for cost-efficient care). These findings may well reflect that once managed care penetration reaches relatively high levels, marketshare can no longer be gained through cost-efficiency alone; rather, enrollee satisfaction based on societal demands becomes a key factor in maintaining and gaining marketshare.

Institutional theory provides some strategies for accomplishing these goals. Cost-containment strategies include implementing policies for cutting costs in areas that do not affect the quality of care, such as using generic drugs and reducing administrative excesses and redundancies. At the same time, MCOs must implement strategies aimed at improving conformity to prevailing societal perceptions of appropriate care, including providing patients more freedom to choose their physicians and encouraging and rewarding care providers for being friendly and personable. An MCO should work to inform the public of the organization's efforts to provide high-quality, low-cost medical care in a friendly, convenient manner.

## INTRODUCTION

In the United States, one out of seven working adults is employed in the healthcare industry, and over 14 percent of the gross domestic product is spent on healthcare services. In fact, no country has ever allocated so much of its economic activity to healthcare as the United States currently does. Consumers and politicians must increasingly make spending allocation decisions between healthcare and such other vital areas as savings and debt reduction. Many policymakers, employers, and individuals worry that the United States will soon reach the limits of what society will tolerate in allocating resources to healthcare needs (Williams 1995). In anticipation of these limits, the healthcare industry is developing new organizational strategies to help control costs. Managed care is currently the most widely practiced of those strategies.

Managed care organizations (MCOs) assume that traditional fee-for-service models do not provide adequate financial controls and utilization incentives for physicians and hospitals to contain the costs of providing healthcare. Under managed care, the needs of the patients are balanced with efforts to provide cost-effective care. Typically, MCOs enroll subscribers by promising to provide all necessary medical care in exchange for a fixed monthly premium. The MCO also contracts with hospitals, physicians, and other healthcare providers to dispense the necessary medical care to its enrollees at a discounted reimbursement rate. In

exchange for accepting reduced fees, the caregivers gain access to the MCO's enrollees.

Not surprisingly, state governments have seized upon managed care as a strategy for holding down their Medicare and Medicaid healthcare expenditures. As a portion of general spending, state Medicaid expenditures are second only to education, accounting for an average of 11.7 percent of state expenditures in 1996 (Savage et al. 1997). In an attempt to curb these costs, as of 1995, 25 percent of the nation's entire Medicaid population was enrolled in some form of managed care plan (Savage et al. 1997).

Recently, many researchers, physicians, and healthcare administrators have begun to argue that cost controls are being implemented at the expense of the provision of appropriate care (AMA 1995; Clancy and Brody 1995; Crane 1995). Managed care organizations have been accused of actions that violate accepted healthcare practices, such as undermining patients' trust of physicians' motives, recruiting only the healthiest patients and refusing care to the truly sick, forcing physicians to withhold costly treatments, purchasing poorer quality services, and even contractually forbidding physicians from disclosing the existence of services not covered by the managed care plan (Kassirer 1995; Rodwin 1995).

## CONCEPTUAL DEVELOPMENT AND HYPOTHESES

Clearly, the external environment has been playing an increasingly

prominent role in the way healthcare organizations operate (Duncan, Ginter, and Swayne 1995). To be effective, MCOs must understand their external environment, and successful strategic management must position the MCO most effectively within this changing environment (Duncan, Ginter, and Swayne 1995). Institutional theory offers a way to understand how MCOs interpret and respond to their environments and predicts which response patterns will be the most successful.

### **Institutional Theory**

While several theories have enjoyed relative popularity, institutional theory is relatively new to health services research. Because it focuses on the importance of societal standards on organizational behavior, testing predictions may provide a clearer understanding of the effect of conformity to societal standards on the performance of MCOs.

Unlike theories that seek to explain why organizations are different, institutional theory is concerned with the homogenous nature of organizations. However, to refer to institutional theory as if it were a single theory is inaccurate—institutional theory is best thought of as a collection of theories. While a common theme of these theories is the examination of the way in which institutions provide stability and meaning to social behavior, theories and theorists differ in explaining how this phenomenon occurs (Scott 1995). This study focuses on the part of institutional theory that emphasizes that institutionalized

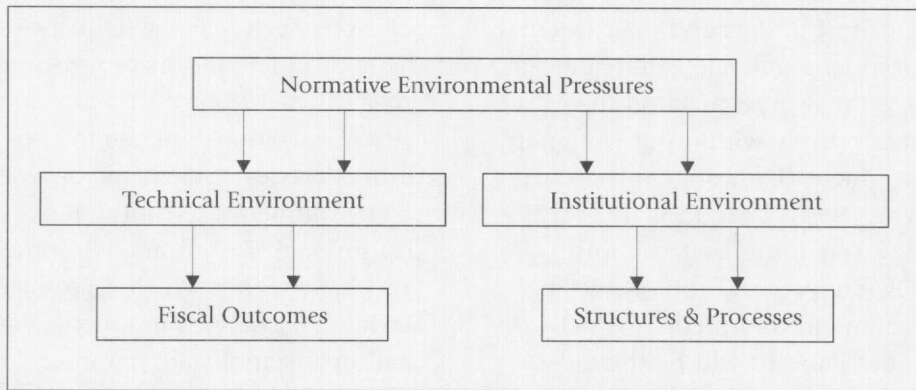
belief systems form a unique class of elements that can explain the existence or the continuation of organizational practices. Such belief systems provide the appropriate means of pursuing goals (Scott 1987).

Organizations operate in two distinct classes of elements or types of environments: technical and institutional. Technical environments are “those within which a product or service is exchanged in a market such that organizations are rewarded for effective and efficient control” (Meyer and Scott 1983, p. 140). In a technical environment, organizations are rewarded with enhanced legitimacy for promoting efficiency of production and reduction of costs. As such, technical environmental requirements typically focus on fiscal outcomes.

Institutional environments, on the other hand, are characterized by rules, requirements, values, and standards to which an organization must comply to receive legitimacy and support. In institutional environments, organizations are rewarded for following “appropriate” procedures instead of quantity and efficiency of output. Therefore, institutional environmental forces generally focus on structure and processes. The distinction between technical and institutional environmental forces is depicted in Figure 1.

Through a variety of institutional systems, society defines which goals are appropriate and how organizations should pursue them. Although prior classification schemes have identified a variety of these institutional systems (Scott 1995), this study focuses solely

**FIGURE 1**  
Impact of Environmental Forces



on the *effect* of these systems on the healthcare organizations that pursue their goals. Normative systems comprise values and standards that define desirable behavior (Scott 1995). Such normative systems place constraints on organizational actions by defining acceptable goals, such as reducing healthcare costs; they also specify appropriate ways of pursuing the goals, such as following accepted clinical practices. Normative control mechanisms are derived from the standards of society as a whole and from notions such as commonly accepted ideas of what is "right" and appropriate. They act as an alternative to costly coercive control mechanisms (Scott 1995).

Experts argue that all organizations face both institutional environmental forces and technical environmental requirements to some extent, but one generally has a stronger influence than the other (Meyer and Scott 1983). Healthcare organizations, however, are situated in a relatively unique environment in which both institutional

and technical environments have a strong influence (Alexander and Am-burgey 1987; Davis and Provan 1996). The institutional environment reflects standards that govern the provision of necessary and appropriate care, safety, easy access to care, societal welfare, and prolonged life. These standards have been a primary part of the medical care environment since Hippocrates. However, changes in the healthcare environment have brought about conditions in which cost containment, cost reduction, and improved efficiency in the use of effective services are also very important (Shortell and Kaluzny 1994). The advent of MCOs is a reflection of this increase in the strength of the requirements of the technical environment in which healthcare providers operate.

As evidence of the strength of the institutional environmental forces and technical environmental requirements facing MCOs, public-opinion surveys rate the following factors as the most important in healthcare: a choice about

doctors or hospitals, access to care when needed, and affordable prices (Taylor and Morrison 1993). The vast majority of the general public also believes that administrative costs are too high due to inefficiency and waste (Woolhandler and Himmelstein 1991) and that expensive, marginally effective medical care should be coordinated and controlled (Yankelovich, Skelly, and White, Inc. 1984).

Through a meta-analysis of public-opinion surveys, Harris (1994) noted several dominant attitudes, opinions, and preferences of Americans towards their healthcare. People believe that access to healthcare should be a "social right" and that access to high-quality healthcare should be available to everybody. They believe that they should be free to choose physicians and facilities and to obtain information explaining treatment options. Care providers should be communicative, helpful, and possess effective interpersonal skills. Additionally, they believe that out-of-pocket expenses should be minimized and bureaucratic and administrative overhead should be reduced.

These surveys reflect strong elements of the normative institutional forces and technical environmental requirements operating in the healthcare environment. Although not an exact science, evidence suggests that public opinion affects healthcare organizations (Blendon 1988). Due to the dual nature of their environment, MCOs face strong pressures from both the institutional environmental forces and technical environmental requirements.

### Hypotheses

Ability to follow appropriate standards of behavior (institutional conformity) and perform efficiently (technical conformity) helps determine an organization's success. Based on the logic developed in the discussion of institutional theory, institutional conformity can be assessed through the use of consumer satisfaction surveys. With the key institutional forces identified by Harris (1994), we examine enrollee perceptions of how well specific MCOs conform to societal standards for access to quality care, information availability, and delivery of care in a personal manner. To assess technical conformity, we examine financial and utilization data. We also analyze MCO conformity to societal standards governing administrative efficiency, control over expensive care, and efficient delivery of medical care.

Consistent with a multiple contingency approach to evaluating effective performance (Zammuto 1984), the views of many constituencies could be considered. For our purposes, MCO enrollees, care providers, administrators, and employers are the most important constituencies.

In addition, healthcare professionals increasingly emphasize the use of patient satisfaction surveys as an important measure of the performance of MCOs (Bergman 1994; Bowers, Swan, and Koehler 1994; McAlexander, Kaldenburg, and Koenig 1994). Pressures on companies to switch MCOs are coming from employees enrolled in some plans. MCOs find that employers listen to their employees when choosing providers; dissatisfied enrollees

may express their concerns directly to their employers, leading to the MCO being dropped by the employer. Thus, MCOs are paying increased attention to subscribers' satisfaction with the care they receive—both its cost and its appropriateness.

Consistent with prior research (Luft 1981) and because of the inherent difficulties in any single operationalization of enrollee satisfaction, two distinct classes of measures are used: cognitive and behavioral. Cognitive-based satisfaction measures enrollee statements of their satisfaction with their MCO. Alternatively, behavioral-based satisfaction looks at physical actions that enrollees take due to their level of satisfaction.

From a cognitive perspective, performance can be measured by asking enrollees about their satisfaction with their MCO (Provan and Milward 1995). Because normative influences on technical and institutional environmental forces originate in social beliefs, it is reasonable to think that the better an MCO is at conforming to normative institutional environmental forces and technical environmental requirements, the higher will be its level of stated enrollee satisfaction. Thus, we pose the following hypotheses:

- **Hypothesis 1:** MCOs that are superior conformers to both the institutional and technical forces of their environment will have the highest level of stated enrollee satisfaction.
- **Hypothesis 2:** MCOs that are superior conformers to either the institutional or technical forces

of their environment but are not superior conformers to the other will have moderate levels of stated enrollee satisfaction.

- **Hypothesis 3:** MCOs that are not superior conformers to either the institutional or technical forces of their environment will have the lowest levels of stated enrollee satisfaction.

From a behavioral perspective, MCO performance can be viewed through enrollee action based on their overall level of satisfaction with the MCO. For example, they might voice complaints, attempt to bring about corrective actions, or disenroll from the MCO. Therefore, the better an MCO is at conforming to normative institutional environmental forces and technical environmental requirements, the lower will be its level of enrollee disenrollment.

- **Hypothesis 4:** MCOs that are superior conformers to both the institutional and technical forces of their environment will have the lowest enrollee disenrollment rates.
- **Hypothesis 5:** MCOs that are superior conformers to either the institutional or technical forces of their environment but are not superior conformers to the other will have moderate enrollee disenrollment rates.
- **Hypothesis 6:** MCOs that are not superior conformers to either the institutional or technical forces of their environment will have

the highest enrollee disenrollment rates.

## **METHODS AND MEASURES**

The data for this study come, in part, from the National Committee for Quality Assurance (NCQA) HEDIS Pilot Project and was provided by 26 MCOs across the United States that approximate the entire MCO population's type, size, age, and geographic distribution (NCQA 1995). A series of measures represents organizations' responses to institutional and technical environmental forces. Measures of enrollee satisfaction for each MCO were from a survey administered to 10,762 enrollees of the MCOs. All information is from 1993.

### **Performance Measures**

The following measures represent cognitively based assessments of MCO performance. Gathered from enrollee satisfaction surveys using a four-point Likert-type scale, they include: (1) enrollees' willingness to recommend the plan to others, and (2) enrollees' intent to switch plans when they next have the opportunity to do so.

As a behaviorally based assessment of performance, the percentage of members disenrolling was determined for each MCO. Enrollees who are dissatisfied with an MCO's performance will tend to disenroll from that MCO (NCQA 1995). The formula is:  $[(\text{Total Enrollees in January 1993} - \text{Total Enrollees in January 1994}) / \text{Total Enrollees in January 1993}]$ .

### **Responses to Institutional Forces**

The following measures represent MCO conformity to normative institutional

environmental forces for how MCOs "should" behave. They reflect conformity to several of the key normative environmental forces identified by Harris (1994). Specifically the five measures are:

1. access to healthcare when needed by the enrollee;
2. the personal interest in the enrollee and their medical care by health-care providers;
3. ease of seeing the doctor of the enrollee's choice;
4. enrollee's perception of "how much they are helped"; and
5. enrollee's perception of the thoroughness of examinations. The measures were gathered as part of the enrollee satisfaction surveys using a five-point Likert-type scale.

### **Responses to Technical Requirements**

The following measures represent data on the MCO's conformity to technical environmental requirements for cost control and efficient use of financial and medical resources. Specifically, the four measures are:

1. medical loss ratio;
2. administrative loss ratio;
3. revenue required per enrollee to break even; and
4. average length of obstetrical (OB) hospitalization stay.

### **Analysis**

Two linear regression models using effect-coded variables test the hypotheses. The first regression uses a single

cognitive-based measure of enrollee satisfaction as the dependent variable. This measure is calculated as the sum of the two measures: (1) recommend plan to others, and (2) intent to switch plans (reverse-coded). The dependent variable for the second regression is a behavioral-based measure of enrollee satisfaction (percentage of members disenrolling).

To begin, a single measure of institutional conformity and another of technical conformity are calculated for each MCO. These two variables represent the extent to which each MCO conforms with the institutional and technical forces in their environment. Institutional conformity is calculated based on an equal weighting of the following measures:

1. access to medical care when needed;
2. personal interest shown by care providers in the enrollee and their medical care;
3. ease of seeing the doctor of the enrollee's choice;
4. enrollee's perception of "how much they are helped;" and
5. thoroughness of examinations.

Each variable is weighted equally because no prior empirical or theoretical evidence suggests they have a differential effect.

Technical conformity is calculated in the same manner as institutional conformity:

1. medical loss ratio (reverse-scored);
2. administrative loss ratio;

3. required revenue; and
4. length of OB hospital stay.

Again, because no prior empirical or theoretical evidence suggests that the variables will have differential effects, they are weighted equally.

Using these single measures of conformity to institutional and technical environmental forces, the MCOs are divided into three groups: superior conformers to both institutional and technical environmental forces (High Both), superior conformers to either institutional or technical environmental forces but not both (High One), and superior conformers to neither institutional nor technical environmental forces (High None). Superior performance is the top one-third of the MCOs in terms of the single measures of institutional and technical conformity.

Two statistical tests examine the cognitive-based and behavioral-based performance hypotheses. First, a linear regression model is calculated to determine whether group membership is related to performance. Second, a series of three *t*-tests determine where the groups' differences lie.

## RESULTS

### Descriptives

As shown in Table 1, when all of the variables used in this study are examined, a great deal of statistically significant intercorrelation among the variables represents institutional conformity. Left untreated, this conformity could cause a problem; however, multiple indicators of different facets of the



TABLE 1  
Correlation Matrix of All Variables

Variable	Mean	Std Dev	1	2	3	4	5	6	7	8	9	10	11
1. Disenrollment rate	0.20	0.11											
2. Recommend to others	90.65	3.54	-.41*										
3. Intend to switch	12.74	4.53	.56*	-.79*									
4. Access to care	86.18	5.59	-.04	.62*	-.52*								
5. Interest shown	96.33	4.77	-.04	.65*	-.42*	.85*							
6. Ease of choice	71.36	8.48	.06	.46*	-.33	.83*	.80*						
7. "How much care"	88.46	4.88	-.27	.87*	-.73*	.81*	.78*	.64*					
8. Thoroughness of exam	88.01	5.16	.12	.49*	-.23	.76*	.92*	.79*	.69*				
9. Medical loss	85.96	5.07	-.32	-.11	-.03	-.35	-.42 <sup>H</sup>	-.36	-.23	-.39 <sup>H</sup>			
10. Administrative loss	10.47	3.98	.52*	-.10	.24	.22	.33	.20	.04	.39 <sup>H</sup>	-.71*		
11. Break-even revenue	142.61	52.71	.58*	-.26	.35 <sup>H</sup>	.20	.14	.33	-.05	.29	-.35	.19	
12. Obstetrical LOS	2.32	0.37	-.27	-.01	.07	-.15	.09	.15	.02	.17	.28	-.34	-.12

\*  $p < .05$ , <sup>H</sup>  $p < .10$

**TABLE 2**  
**Correlation Matrix of Blocked Variables**

Variable	Mean	Std Dev	1	2	3
1. Cognitive perf.	177.91	7.65			
2. Behavioral perf.	0.20	0.11	.52*		
3. Inst. conformity	50.96	27.12	.34†	.06	
4. Tech. conformity	48.36	10.53	.22	.28	.24

\*  $p < .05$ , †  $p < .10$

same phenomenon are necessary for improved construct validity. Handling them as a block can help to remedy the adverse effects of multicollinearity (Pedhazur and Schmelkin 1991). In the regression analyses, the separate measures of organizational responsiveness to institutional environmental forces and technical environmental requirements are grouped into two blocks: institutional conformity and technical conformity. Therefore, Table 2 provides a correlation matrix of only those measures used in the statistical analysis; the two independent variables are not statistically significantly correlated with each other.

**Results Using the Cognitive-Based Measure of Satisfaction**

Table 3 provides the results of the linear regression using the single cognitive measure of enrollee satisfaction as the dependent variable. The overall *F*-ratio is statistically significant [ $F(2,23) = 5.55, p = .011$ ], thereby indicating that group membership is related to performance. This result allows for the meaningful comparison between group means to determine if

statistically significant differences exist (Pedhazur 1982).

The results of the *t*-tests (also shown in Table 3) show that the mean level of enrollee satisfaction for High Both is statistically significantly greater than those of both High One [ $t(16) = 3.21, p = .005$ ] and High None [ $t(11) = 3.01, p = .012$ ]. However, Table 2 shows that the results of the *t*-test between the mean levels of enrollee satisfaction for High One and High None are not statistically significant [ $t(19) = .76, n.s.$ ].

Based on the statistical results that the mean performance of High Both is greater than those of both High One and High None, Hypothesis 1 is supported. Although the mean performance of both High One and High None are significantly below High Both, they are not significantly different from each other. Therefore Hypothesis 2 and Hypothesis 3 are not supported.

**Results Using the Behavioral-Based Measure of Satisfaction**

Table 4 provides the results of the regression analysis using the behavioral measure of enrollee satisfaction. Similar to these for the first set of tests, the



**TABLE 3**  
Results of Analyses Using Cognitive-Based Satisfaction

Group	N	Mean	df	t	p
High Both	5	186.42	16	3.214	.005
High One	13	176.42			
High Both	5	186.42	11	3.006	.012
High None	8	174.43			
High One	13	176.78	19	.757	.459
High None	8	174.43			

Adj  $R^2 = .267$ ,  $F(2,23) = 5.545$ ,  $p = .011$

**TABLE 4**  
Results of Analyses Using Behavioral-Based Satisfaction

Group	N	Mean	df	t	p
High Both	5	.08	16	2.873	.011
High One	13	.22			
High Both	5	.08	11	2.842	.016
High None	8	.26			
High One	13	.22	19	.949	.355
High None	8	.26			

Adj  $R^2 = .253$ ,  $F(2,23) = 5.233$ ,  $p = .013$

results show that the overall F-ratio is statistically significant [ $F(2,23) = 5.23$ ,  $p = .013$ ]; group membership is related to performance.

The results of the *t*-tests (also shown in Table 4) are also similar to those of the first series of tests. They show that the mean level of enrollee satisfaction for High Both is statistically significantly greater than those of both High One [ $t(16) = 2.87$ ,  $p = .011$ ] and High None [ $t(11) = 2.84$ ,  $p = .016$ ]. The results also show the *t*-test

between the mean levels of enrollee satisfaction for High One and High None is not statistically significant [ $t(19) = .95$ , n.s.].

Results replicate the findings of using the cognitive-based measure of performance. Based on the statistical results that the mean performance of High Both is greater than those of both High One and High None, Hypothesis 4 is supported. Although the mean performance of both High One and High None are significantly below High

Both, they are not significantly different from each other. Therefore Hypothesis 5 and Hypothesis 6 are not supported.

## DISCUSSION AND IMPLICATIONS

Is conformity to environmental forces related to the performance of MCOs? The results of this study suggest that the answer is yes. MCOs that are superior conformers to the normative forces in their environment are superior performers whereas those that are not superior conformers are not superior performers. Alone, this finding is not significant. Organizational theorists have long held that environmental conformity is important to organizational success (cf., Lawrence and Lorsch 1967). However, this study indicates that simple conformity to the external environment is not enough to promote successful performance. Superior conformity to *both* the institutional environmental forces *and* technical environmental requirements is necessary for superior performance. MCOs that merely emphasize one environment over the other do not enjoy any better performance than MCOs that do not emphasize conformity to either environmental force. MCOs must conform to both environmental forces.

Although Hypotheses 3 and 6 were not supported, this finding might not mean that MCOs that fail to be superior conformers to either institutional or technical environmental forces (High None) may still be superior performers. Although the performance of MCOs in High None is not statistically significantly different from the performance of those MCOs in High One,

it is statistically significantly below the performance of MCOs in High Both.

## Implications for the Strategic Management of MCOs

The finding of this study—that superior conformity to both institutional and technical environmental forces is necessary to achieve superior performance—has several implications for MCO strategy formulation. First, in order to be effective, MCOs must understand the external environment in which they operate and be able to conform to its forces. They must anticipate and respond to the significant shifts that take place within their normative institutional environment (Duncan, Ginter, and Swayne 1995). Second, the findings indicate that superior conformity to either institutional environmental forces or technical environmental requirements, but not the other, is inadequate for superior performance.

A possible explanation being put forth by some health administration researchers (Koco 1991; Studin 1995) might enhance understanding of these intriguing results. For organizations operating in environments characterized by strong technical requirements, marketshare positively correlates with efficiency and lower costs (Studin 1995). As a result, to gain market share, organizations often need to pursue strategies related to cost containment. By doing so, these organizations will be able to increase their volume of business, negotiate reductions in their operating costs, fight off competitors, and maintain market domination.

The assumption behind managed care is that people will switch from

traditional fee-for-service models to managed care plans precisely because of the financial incentives to do so. As people experience the difference in premium and out-of-pocket costs between fee-for-service systems and managed care systems, they will eventually become more price sensitive. As people become more price sensitive, managed care will become more price competitive (Studin 1995). At the same time, consumers, health professionals, and policymakers still hold strong beliefs toward appropriateness of procedures and practices (Scott 1987), but they are generally interested in reducing perceived inefficiencies in exchange for reduced costs.

At some point, however, the market may be saturated to a point where little additional marketshare can be gained by continuing such aggressive cost-containment strategies. When this saturation occurs, MCOs begin to shift their strategic focus. They often try to differentiate themselves by maintaining their focus of cost efficiencies, but also pursuing policies aimed at capturing other segments of the market oriented more towards the normative institutional factors such as freedom of choice and easy access to care (Koco 1991).

This strategic transition may offer some insights into the results of this study. We might argue that because of market-penetration levels, the 26 MCOs included in this study are faced with a need to conform to greater normative institutional standards for behavior. As a result, those MCOs that are best able to do so (High Both) enjoy the highest levels of enrollee satisfaction. However, because conformity to tech-

nical requirements is necessary but not sufficient to promote differentiation and success, no advantage is to be gained by being a superior conformer to only one environmental force. As a result, no statistically significant difference exists in the levels of enrollee satisfaction between High One and High None.

MCO strategies for adjusting to these environmental forces need to include policies for cutting costs in areas that do not effect the quality of care. These could include measures such as using generic drugs, reducing administrative excesses and redundancies, reducing overhead expenses such as rent, increasingly applying automation and information technologies, and implementing continuous quality improvement programs. At the same time, MCOs could implement strategies aimed at improving conformity to prevailing normative institutional forces, including providing patients more freedom to choose their physicians, encouraging and rewarding care providers for being friendly and personable, taking the time to carefully explain treatment options to patients, and scheduling visits at times that are convenient for the patient. An information campaign aimed at current and potential enrollees would also be helpful. The goal should be to inform the public of the MCO's efforts to conform to institutional and technical standards in a superior manner. An MCO should promote how it provides enrollees with high-quality, low-cost medical care in a friendly, convenient manner.

## CONCLUSION

This study asked the question: Does conformity to environmental forces have an effect on the performance of MCOs? Conformity to environmental forces does positively affect performance to the extent that the MCO is a superior conformer to both the normative institutional forces and the technical requirements in its environment. To this, MCOs need to adopt strategies that lead to such superior environmental conformity and turn away from current trends of overemphasizing conformity to technical environmental requirements at the expense of conformity to normative institutional forces.

## References

- Alexander, J. A., and T. A. Amburgey. 1987. "The Dynamics of Change in the American Hospital Industry: Transformation or Selection." *Medical Care Review* 44 (2): 279-321.
- American Medical Association, Council on Ethical and Judicial Affairs. 1995. "Ethical Issues In Managed Care." *Journal of the American Medical Association* 273 (4): 330-35.
- Bergman, R. L. 1994. "Are Patients Happy? Managed Care Plans Want to Know." *Hospitals & Health Networks* 68 (23): 68.
- Blendon, R. J. 1988. "The Public's View of the Future of Health Care." *Journal of the American Medical Association* 259 (24): 3587-93.
- Bowers, M. R., J. E. Swan, and W. F. Koehler. 1994. "What Attributes Determine Quality and Satisfaction with Health Care Delivery?" *Health Care Management Review* 19 (4): 49-55.
- Clancy, C. M., and H. Brody. 1995. "Managed Care: Jekyll or Hyde?" *Journal of the American Medical Association* 273 (4): 338-39.
- Crane, M. 1995. "It Doesn't Pay to Short-change Managed Care Patients." *Medical Economics*, 72 (5): 95-104.
- Davis, M. A., and K. G. Provan. 1996. "A Cost-Constrained Model of Strategic Service Quality Emphasis in Nursing Homes." *Health Services Management Research* 9 (1): 24-33.
- Duncan, W. J., P. M. Ginter, and L. E. Swayne. 1995. *Strategic Management of Health Care Organizations*, 2nd ed. Cambridge, MA: Blackwell.
- Harris, J. S. 1994. *Strategic Health Management: A Guide for Employers, Employees, and Policy Makers*. San Francisco: Jossey-Bass.
- Kassirer, J. P. 1995. "Managed Care and the Mortality of the Marketplace." *New England Journal of Medicine* 333: 50-52.
- Koco, L. 1991. "Competition Spurs Growth of Point-of-Service HMOs." *National Underwriter* April 29: 7-9.
- Lawrence, P. R., and J. W. Lorsch. 1967. *Organization and Environment: Managing Differentiation and Integration*. Cambridge, MA: Harvard University Press.
- Luft, H. S. 1981. *Health Maintenance Organizations: Dimensions of Performance*. New York: John Wiley & Sons.
- McAlexander, J. H., D. O. Kaldenburg, and H. F. Koenig. 1994. "Service Quality Management: Examination of Dental Practices Sheds More Light on the Relationships Between Service Quality, Satisfaction, and Purchase Intentions in a Health Care Setting." *Journal of Health Care Marketing* 14 (3): 34-40.
- Meyer, J. W., and W. R. Scott. 1983. *Organizational Environments: Ritual and Rationality*. Beverly Hills, CA: Sage.
- National Committee for Quality Assurance. 1995. *Technical Report: Report Card Pilot Project*. Washington, DC:

- The National Committee for Quality Assurance.
- Pedhazur, E. J. 1982. *Multiple Regression in Behavioral Research (2nd ed.)*. Fort Worth, TX: Harcourt Brace Jovanovich.
- Pedhazur, E. J., and L. P. Schmelkin. 1991. *Measurement, Design, and Analysis: An Integrated Approach*. Hillsdale, NJ: Lawrence Erlbaum Associates.
- Provan, K. G., and H. B. Milward. 1995. "A Preliminary Theory of Interorganizational Network Effectiveness: A Comparative Study of Four Community Mental Health Systems." *Administrative Science Quarterly* 40 (1): 1-33.
- Rodwin, M. A. 1995. "Conflicts in Managed Care." *New England Journal of Medicine* 332: 604-7.
- Savage, G. T., E. G. Kirby, C. E. Cochran, L. H. Friedman, and D. Purtell. 1997. *Health Care at the Crossroads: Managed Care and the Two Faces of State Reforms*. Paper presented at the Academy of Management Meetings, Boston.
- Schine, E. 1995. "Meanwhile, a Public Hospital Struggles to Survive." *Business Week* September 4: 84.
- Scott, W. R. 1987. "The Adolescence of Institutional Theory: Problems and Potentials for Organizational Analysis." *Administrative Science Quarterly* 32: 493-512.
- . 1995. *Institutions and Organizations*. Thousand Oaks, CA: Sage.
- Shortell, S. M., and A. D. Kaluzny. 1994. "Organization Theory and Health Services Management." In: *Health Care Management: Organization Design and Behavior*, 3rd ed., edited by S. M. Shortell and A. D. Kaluzny, pp. 3-29 Albany, NY: Delmar Publishers.
- Studin, I. 1995. *Strategic Healthcare Management: Applying the Lessons of Today's Top Management Experts to the Business of Managed Care*. Burr Ridge, IL: Irwin.
- Taylor, H. and J. I. Morrison. 1993. "Public Opinion: Attitudes Toward Managed Healthcare." In: *Making Managed Healthcare Work: A Practical Guide to Strategies and Solutions*, edited by P. Boland, pp. 51-69. Gaithersburg, MD: Aspen Publishers.
- Williams, S. J. 1995. *Essentials of Health Services*. Albany, NY: Delmar Publishers.
- Woolhandler, S., and D. U. Himmelstein. 1991. "The Deteriorating Administrative Efficiency of the U.S. Health Care System." *New England Journal of Medicine* 324 (18): 1253-58.
- Yankelovich, Skelly, and White, Inc. 1984. *Health and Health Insurance: The Public's View*. Washington, DC: Health Insurance Association of America.
- Zammuto, R. F. 1984. "A Comparison of Multiple Constituency Models of Organizational Effectiveness." *Academy of Management Review* 9: 606-16.

## PRACTITIONER RESPONSE

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Our family disenrolled from our managed care organization recently because a lower-cost employer-sponsored plan became available. In less than three weeks, a research company located in Chapel Hill, North Carolina called to ask me if I

would respond to a series of survey questions about the service and quality experience with the HMO we had left.

The telephone surveyor asked me to rate our former plan on a Likert scale of one to ten. The survey questions dealt with a series of patient issues, including: (1) accessibility (e.g., ease of seeing the plan doctor of choice, access to care) and (2) patient satisfaction (e.g., overall satisfaction with the care provided and perception of the attentiveness of caregivers). The survey conformed to the key normative institutional environmental forces for how MCOs "should" behave.

It is not surprising that the MCO we left would spend the effort, time, and expense of interviewing us—it is demonstrably more economical and efficient to retain enrollees than to seek new members. It has been estimated that the cost to acquire one new enrollee is \$1,000.00 to \$1,500.00—in some markets, that is more than the annual revenue for a plan member. To replace the enrollment of our family of three would cost the plan \$3,000.00 to \$4,500.00. Because of these costs, retention is a critical factor for continued success and future viability in an increasingly competitive environment.

We all are well aware that MCOs must conform to our present technical environment. Broad public opinion and the competitive realities of the market dictate cost containment, cost reduction and improved efficiency in the way we deliver healthcare. Although we have seen some moderation in price increases for employers, government payors, and patients over the past few years, the cost of healthcare remains a prime concern for the patient/consumer and out-of-pocket expense remains important. It has been shown that a patient will switch plans when the cost difference in premium is as little as \$15.00 per month.

While cost remains an issue, there is increasing concern from society and consumers about quality, accessibility and the determination of what is "medically necessary"; is what we do to, and for, patients correct? Do MCOs deny needed diagnostic tests or referrals and reward physicians for withholding care? Freedom of choice, accessibility, and perceived quality are normative institutional factors increasingly valued by today's more sophisticated consumer/patient.

In their article, Drs. Kirby and Sebastian apply institutional theory to MCO performance and strategic planning. They measure the effect of technical environmental forces that affect fiscal outcome and the normative institutional environmental forces that conform to patient and societal needs. Their study demonstrates that superior performing MCOs operate in a manner that is both cost-efficient and conforms with socially accepted norms. Strategies that lead to superior performance with the normative institutional forces and still meet the technical requirements of the environment are critical for success. Just dealing with, or overemphasizing, the cost issue is not a strategy for long-term superior performance and success. MCOs must also demonstrate what patients and society increasingly expect in healthcare: freedom of choice, accessibility, and perceived quality. In other words, we must provide value to the patients we serve.