Organizational Forms of the Provision of Health Care: An Institutional Perspective

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In Thompson, T., Dorsey, A., Miller, K., & Parrot, R. (eds.). (2003) *Handbook of Health Communication* (pp. 319-346). Hillsdale, NJ: Lawrence Erlbaum Associates.

Authors' Note: We would like to thank Professor Katherine Miller for her helpful comments on an early draft of this paper. Contact the first author at 244 Lincoln Hall, MC-456 Urbana, IL 61801 jclammer@uiuc.edu

Health organizations are among the largest, most complex, technologically rich, and value-infused of any human arrangement. As such, the field of health and medical care in North America—and indeed the world over—provides a diverse and dynamic arena for communication and organizational research. The organizations we refer to as *health organizations* today include forms whose structures have changed little in one hundred years, such as hospitals. But health organizations also include forms that proliferate today but barely existed one hundred years ago, such as HMOs, hospice, and prepaid multi-specialty medical groups. It is therefore appropriate that we turn our attention to these changing settings.

Even a cursory glimpse at changes in health care in North America over the last century will convince the observer that a view of the health organization as the container (Putnam, Phillips, & Chapman, 1996) within which communication occurs is an insufficient approach for the study of health organizations. In the U.S., the health care sector has witnessed the rise of new organizational forms, the growth of professional norms (Abbott, 1988; Freidson, 1970, 1986), myriad connections to other sectors of society (Meyer & Scott, 1983), and changes in arrangements for the delivery of medical care (Sharf & Street, 1997). An adequate survey of communication in health organizations therefore requires a perspective that will recognize the *settings* (both organizational and institutional) where individuals recognize and create meaning as well as the *processes* by which these organizations and institutions take shape and change.

We approach our survey of organizational forms in this chapter from an institutional perspective (Meyer & Scott, 1983; Scott, 1995; Scott, Ruef, Mendel, & Caronna, 2000). Generally, the institutional perspective emphasizes the rules, values, and beliefs that surround organizations and their members as critical components of behavior and communication practices within organizations. This approach to organization studies has its roots in the work of Selznick (1948, 1949, 1957), but has a well-developed history in research on organizations more recently (Meyer & Scott, 1983; Meyer, Scott, & Deal, 1983) as well as on health organizations (Alexander & Fennel, 1986; Alexander, Fennell, & Halpern, 1993; D'Aunno & Zuckerman, 1987; Mick & Associates, 1990; Scott, et al., 2000). The institutional perspective recognizes that as organizations develop, they take on lives of their own, and that the symbolic environments external to organizations

have determinant effects on the shape, behavior, culture, climate, and even survival of organizations.

In the pages that follow we first lay out several tenets of the institutional perspective that will guide our identification of organizational forms in health care and help explain the changes we are witnessing. Second, based on the institutional perspective, we turn to a taxonomy of organizations engaged in the funding and regulating of health and medical services, organizations that represent health professionals and other health organizations, and organizations that deliver health services. With this inventory of forms complete, in the third section we review trends and change forces at work in contemporary healthcare including demographics, disease chronicity, technology, and managed care. Finally we address future research by considering ways that theory building in organizational communication could make common cause with research in health communication.

An Institutional Approach

Four themes characterize institutional analysis (Scott, Meyer, & Associates, 1994, pp. 2-3). First, the observable structures and routines that make up organizations are reflective of rules and structures in wider environments. Institutional analysis argues that the existence of organizations such as hospitals, health maintenance organizations, or health advocacy groups depends at least partially on the institutionalization of such forms, that is, the prior development of beliefs, values, and behavioral expectations. Second, the institutional perspective looks to the external environment for the logic of organizational structures rather than to the internal, local functional requirements of production. Third, institutionalized meanings—those portable beliefs we have about how organizations should look and what they typically do—pervade organizations. As Scott, Meyer, and Associates explain, "environmental patterning is not only narrowly legal and economic, but also broadly social and cultural as well" (1994, p. 3). So, despite our expectations to the contrary, hospitals in the profit-making, nonprofit, and governmental sectors look and operate very similarly, and the meaning of professionalization—autonomy and ethical standards—cuts across occupations from physicians to nurses to radiological technicians. Finally, the institutional perspective on organizations recognizes the drift toward the "rationalization" of organizational forms. Scott, Meyer, and Associates write, "the creation of cultural schemes defining means-ends relationships and standardizing systems of control over activities and actors" (1994, p. 3). Organizations—including health organizations—emerge as means to accomplish culturally valued ends.

In addition to these themes, institutional analysis also employs a number of concepts in explaining trends across organizations as well as behavior and communication processes within organizations. We will use three of these concepts in this chapter: a sectoral view of society, rational myths, and isomorphic processes. First, institutional analysis views organized activity in terms of societal sectors where decision-making rights tend to be hierarchically distributed. Decision-making rights range from resource-oriented funding decisions at higher levels, through programmatic decisions at middle levels, to instrumental decisions at the lowest levels of any given sector. In addition, *institutional* and *technical* influences may be observed to characterize sectors of organized activity. Heavily institutionalized sectors are guided by pervasive beliefs about appropriate conduct that are idiosyncratic to organizations in a particular sector. Technical sectors, on the other hand, are characterized by the exchange of easily defined goods or services. Educational organizations, for example, are highly institutionalized, that is, infused with beliefs and values about their appropriate operation irrespective of the empirical evidence about those processes. Many manufacturing industries, in contrast, are highly technical, not because of complexity in their production processes, but because their core processes are well understood and because their products are rationally exchanged in marketplaces (Meyer & Rowan, 1977). The usefulness of these concepts becomes evident when one considers the health services sector that is highly institutionalized yet shifting toward technical norms of efficiency (Navarro, 1999).

A second concept used in institutional analysis that is especially appropriate in understanding the communication in and of health organizations is the *rational myth* (Meyer & Rowan, 1977). A rational myth is a belief generated in and through organizations about the legitimacy of certain actions leading to desired outcomes of organized processes. For example, Meyer and Rowan cite the use of affirmative action offices and guidelines as a rational myth (p. 343). Because U.S. federal funding and contracting laws require certain fair hiring and recruiting practices, organizations go to considerable lengths to indicate to their environments that such practices are the local norm, while actual practices and outcomes might suggest very different processes (Meyer & Rowan, 1977). Geist and Hardesty (1992) document the creation of such myths (while not using that term) in their study of hospital staffs' responses to the imposition of Diagnosis Related Groups (DRGs) in the mid 1980's.

Third, isomorphic processes in organizational fields such as health care contribute to the uniformity we can observe across organizations. DiMaggio and

Powell (1983) identified three isomorphic forces. Coercive isomorphism refers to the adoption of a particular organizational form or process because of a dependency of one organization on another. For example, Medicare reimbursement rules require hospital accreditation making hospitals dependent on the accrediting organization. Mimetic isomorphism refers to the adoption of practices and structures based on observations of successful practices in other organizations or even in other fields. Ritzer's (1996) work on the "McDonaldization of society" discusses examples of mimetic isomorphism at work in many sectors including health care. Normative isomorphism comes about through the adoption of practices deemed appropriate by trade, industry, and professional associations. The rapid spread of the health care quality improvement movement (Berwick, Godfrey, & Roessner, 1990) is an example of normative isomorphism at work.

In sum, an institutional perspective allows an integrated method of exploring the diverse and complex field of health organizations. It views organizations as products of the rules, values, and beliefs of their environments, and offers concepts useful in understanding both the traditional forms organizations in the health care field have taken as well as newer developments in the field. Finally, an institutional perspective provides an opportunity for health communication researchers to tie individual, micro-level phenomena in health organizations to wider, macro-level changes. In the section below, we turn to an inventory of the forms of health organizations by sector. These organizational forms are the sites where interpersonal health communication takes place and the contexts of peri-consultative communication (Street & Real, 2000).

An Inventory of Health Organizations

This inventory of organizational forms follows patterns in the health services sector. We begin with an overview of the sector. We then turn to a description of the organizations that provide or channel funding in the sector, continue with organizations that programmatically stipulate activities in the sector, and end with organizations that deliver services in the sector.

Overview of the Health Care Sector

As an institutional sector, health care in the U.S. is a major domain of activity, accounting for 7.3% of total employment and 13.5% of the Gross Domestic Product (roughly 1.1 trillion dollars) in 1997 (U.S. Census Bureau, 2000a). The health sector is characterized by elements of centralization as well as elements of decentralization. The federal government's Centers for Medicare and Medicaid (CMM), formerly the Health Care Financing Administration (HCFA), is the largest single payer of health care services in the country, accounting for 43.6% of total national health care expenditures (U.S. Census Bureau, 2000a). This represents a substantial central position in the field. In contrast to this centralization, over 777,000 physicians practiced medicine in the U.S. in 1999 (two thirds of whom were in office-based practices; see Table 1), and there were in excess of 19,000 medical groups delivering health services (Havlicek, 1999). Adding to the sheer size of the sector is considerable complexity; therefore, it may be inappropriate to describe health care in the U.S. as a single system. Williams and Torrens (1998) identify four separate systems of care: a well-financed system of care for insured persons; a public system of care that primarily serves the poor; the Veterans' Administration Health Care System that since the Civil War has provided care to retired military personnel; and the U.S. Department of Defense system of care. Our inventory of organizational forms will understate this complexity. Nevertheless, as sites of health communication events, such an inventory should be helpful.

Organizations Concerned with Financing and Regulating Health Services and Products

Centers for Medicare and Medicaid. The Centers for Medicare and Medicaid (CMM) is the U.S. agency that provides health insurance coverage to about seventy-four million persons, and, as mentioned above, accounts for about 43.6 % of the national health care budget for personal health expenditures (U.S. Census Bureau, 2000a). The CMM came into existence in 1965, when Medicare and Medicaid legislation was signed. It is fair to say that the CMM are connected in a meaningful way to almost every physician and hospital in the U.S. Because of its economic power, both individual and corporate providers have adopted many uniform procedures and standards. For example, in 1983, the introduction of DRGs standardized much hospital record keeping. The rules and regulations imposed by the CMM for reimbursement have likely contributed to the corporatization of health care, "…[stimulating] hospitals to hire planners, lawyers, and financial advisors, who then found new functions for themselves in arranging mergers and acquisitions" (Starr, 1982, p. 434).

Chappelle, Blanchard, Ramirez-Williams, and Fields (2000) describe how Medicare rules promulgated by CMM constrain how physicians can teach medical students to enter patients information into medical charts. Data entered into a chart by a student cannot then be used as a record justifying reimbursement (Chappelle, et al. , 2000, p. 37). The uniformity of practices following CMM rules, regulations, and guidelines seems a powerful example of coercive

isomorphic pressures in the health care field (DiMaggio and Powell, 1983).

The same 1965 legislation that created Medicare also created Medicaid, a jointly funded venture between the Federal and State governments to provide medical care to the needy in the U.S. Each of the fifty states establishes its own eligibility standards; determines the type, amount, duration, and scope of services; sets the rate of payment for services; and administers its own program (CMM, 2001b). While Medicaid provides a safety net for poor persons in the U.S., it is criticized by advocates of the poor for being too stingy with benefits, by fiscal conservatives as being too costly, and by providers, particularly hospitals and physicians, as providing insufficient reimbursement. Policy researchers indicate that the divide between insured and uninsured is growing and that the U.S. is headed for a two-tier health care system (Reinhardt, 1996).

Insurance organizations. Health insurance organizations are important in the U.S. because they fund about one third of all expenditures for personal medical services. (33.1 % in 1998 according to the National Center for Health Statistics, 2001). While this role is smaller than the government (43.6%) it is larger than out-of-pocket payments (19.6 %). According to the U.S. Census Bureau (2000b), 944 firms provided health and medical insurance in the U.S. in 1997. These firms took in revenue of $203.1 billion in that year, employing about 328,000 workers at 3,209 establishments including organizations that operate as HMOs or own HMOs.

Organizations that Play a Programmatic Role in the Health Sector

Accreditation organizations. The Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) is the nonprofit organization that accredits hospitals, health care networks, home care organizations, long term care facilities, assisted living residencies, commission health organizations, ambulatory care providers, and clinical laboratories. Though the organization has operated since 1951, 1965 Medicare legislation provided substantial additional authority by stipulating that government reimbursements would only be paid to hospitals and clinics that were accredited.

In general, accreditation indicates that an organization meets certain formal and performance standards. To earn and maintain accreditation, an organization must undergo an on-site survey by a Joint Commission survey team at least every two or three years. Since 1997, the JCAHO has used performance measures in the accreditation process. The Joint Commission's organizational members include the American College of Physicians, the American Society of Internal Medicine, the American College of Surgeons, the American Dental Association, the American Hospital Association and the American Medical Association. As mentioned above, JCAHO accreditation is important to health organizations because it is required by many third-party payers, state licensing agencies; managed care organizations; and financial institutions (JCAHO, 2001a).

In addition to organizations that accredit hospitals and other care facilities, are the organizations that accredit schools of medicine and public health. As Pfeffer (1981) has noted, it is the curricula of academic organizations that form the domain of a field. A leading function of academic accrediting organizations is the standardization of curricula in colleges and universities. Among the more important accrediting organizations in the health sector are the Association of American Medical Colleges (AAMC), founded in 1876, and the Association of Schools of Public Health (ASPH), founded in 1953. The AAMC accredits and lobbies for 125 U.S. medical schools and sixteen Canadian medical schools, while the ASPH represents twenty-nine schools of public health and nine educational programs in public health.

Like the CMM, the accrediting organizations may be seen as an isomorphic force in the health sector. The rules imposed by JCAHO, for example, reach far into the clinical practice of medicine in ways that are a mystery to some providers (Yost & Serkey, 1999), and its methods of measuring for quality improvement are adopted from industrial efforts begun in the 1970s (Brennan, 1998). The presence of such organizations adds force to the institutional argument that beliefs and values at the field level influence behaviors and structures at the organizational level.

Trade and professional associations. The Gale Directory of Associations (Gale Research Company, 2001) lists 3,381 national associations serving the health services industry in the U.S., and an additional 3,651 operating at the regional state and local levels. These associations—of professionals, organizations, and/or patients—make up the warp and woof of occupations, organizations, and clients in the healthcare industry. In this section, we consider to just three associations: the American Medical Association, the American Nursing Association, and the American Hospital Association. These associations have several features in common. They each admit both individual members and organizational members. They each provide services to their members including advocacy, and each is over a hundred years old. As such these three represent the institutional aspect of the field of health organizations.

The American Medical Association (AMA) reported that it had just under 300,000 members in 1999 (AMA, 2001), accounting for roughly 38% of American physicians. Compare this to the over 82% represented in 1962. The Association describes itself as "the patient's advocate and the physician's voice"

(AMA, 2001). Founded in 1847, the AMA's "agenda remains rooted in [its] historic commitment to standards, ethics, excellence in medical education and practice, and advocacy on behalf of the medical profession and the patients it serves" (AMA, 2001). But with less than one-half of U.S. physicians among its members, the Association has recently struggled to define itself as relevant.

Several issues put the American Medical Association in difficulty at this historic juncture. First, the organization of medical practice has changed drastically. As an association primarily of individual members, the AMA is not as relevant as it once was because so many physicians are now employed or members of medical groups. Second, physicians are not as unified about policy matters as they once were. For example, the Association's membership includes physicians in favor of national health insurance and those opposed. In an effort to increase its revenues in the face of dwindling membership, the Association endeavored to offer a series of product endorsements in 1998, that created great controversy (Tye, 1999). However embattled it may be, from an institutional point of view.

As of 1996, The American Nurses Association (ANA) represented the interests of 2.5 million U.S. nurses (82.7% actively employed as nurses). In 1897, the directors of training at ten Eastern and Midwestern hospitals founded the Association. Aside from the traditional status difference between physicians and nurses, their associations and work situations also contrast sharply. The ANA is formally composed of the 53 state associations, 13 affiliated associations, and approximately 70 other organizations that represent aspects of professional nursing in the U.S. As an organization, it is more integrated and federated than the AMA. Individual members of the ANA are automatically enrolled as members of constituent associations at the state level.

The American Hospital Association (AHA) was founded in 1898 (AHA, 2000a). Its members include nearly five thousand hospitals, health care systems, networks, and other providers of care. The AHA also maintains affiliations with state and metropolitan associations and an additional 37,000 individual members. The AHA also plays a major role in the standardization of hospital services through its education and publishing functions (AHA, 2001). The AHA also acts as an advocate for hospitals regarding issues of concern to owners, managers, and workers, as well as for patients. AHA advocacy issues currently include concerns about hospital worker shortages, reimbursement for care provided to uninsured patients, and reducing the regulatory maze that hospitals must navigate.

Organizations Instrumental in the Delivery of Health Care

Physicians' offices. The simplest organizational form for the delivery of health services is the office of the solo-practicing physician. This site of medical communication episodes has undergone fairly rapid alteration. The number of physicians practicing in the U.S. has increased steadily over the last two decades from 153 per 100,000 persons in 1975, to 245 per 100,000 in 1997 (Havlicek, 1999), but the percentage of physicians practicing as solo providers has declined. For example, the percentage of family practitioners in solo-practice shrank from 54% in 1980 to 25% in 1997 (American Academy of Family Practice, 2001). In spite of these trends, the most common practice type, and the one that remains a cultural icon, is the solo practice.

As a setting for health communication episodes, the solo physician's office will typically employ three or four non-physicians (Community Health Care, 2001). A single individual that works closely with the physician generally carries out the nursing function; the appointments and records function concern another staff person; and the billing function may be shared or handled by a single staff person. Today these functions are frequently further removed from the control of the physician, as practice management firms contract with physicians to provide all of the ancillary services involved in the traditional medical practice (Robinson, 1997).

Medical groups. As reported in Scott and Lammers (1985), the medical group as we know it today was non-existent at the turn of the century. Not only did the vast majority of physicians practice as independent providers, but also medical groups were seen as a threat to the practice of medicine and the quality of medical care (Starr, 1982, p. 213). The first medical groups (for example, the Mayo brothers clinic in Rochester Minnesota) provided contract services to industry (in the Mayo case, to railroads). But suspicions about the ethics of group practice lingered until nearly World War II, when economies of scale and burgeoning specialization made practice combinations more feasible and increasingly popular (Starr, 1982, p. 213). As of 1996, there were nearly twenty thousand medical groups in the U.S. (see Table 1), accounting for 206,557 physician positions (Havlicek, 1999). The mean size of medical groups appears to have leveled off or fallen slightly from a high of 11.5 physicians in 1990 to 9.3 physicians in 1996 (see Table 1).

A number of researchers have commented on the transition of physicians from solo to group practices (Freidson, 1970, 1986; Scott & Lammers, 1985; Wolinsky & Marder, 1985). Some argue that the corporatization of medicine (Relman, 1998) lead to proletarianization of the occupation (McKinlay & Arches, 1985), while others argue that neither a professional stratification approach (Freidson, 1986) nor a Marxist analysis correctly captured the changes underway in medical practice (Annendale, 1989). For example, Gross and Budrys (1991), in

a study of physicians' interaction in a prepaid group, found that the physicians they studied had entered into prepaid practice with the understanding that their professional autonomy would be independent of administration. The same physicians later discovered, however, that their professional autonomy had not been preserved. As administrative controls over their practice increased, their satisfaction with professional aspects of practice declined. Lammers (1992) reported similar findings.

The institutional perspective points to an isomorphic process in the changes underway in group practices. Medical practice management firms conform to market principles and share management philosophies. Medical groups grow more similar as more of them are managed by these firms. For example, the Medical Group Management Association reported that median salaries of physician-executives and other administrators of physician-owned medical groups fell by as much as 17% in 2000, while those of executives of non-physician-owned groups rose by between 5 and 22% (Medical Group Management Association, 2000). Concurrently, as managed care firms put pressures on communities of physicians, physicians are more likely to join with others to reduce the costs of practice (Robinson, 1998).

Hospitals. According to the AHA, in 1998, there were a total of 5,606 non-federal hospitals in the U.S. (see Table 1). Of the total shown in Table 1 for 1998, state and local governments owned 1,218 (21.7%), and investors owned 771 (13.8%). The federal government controlled an additional 275 (4.9%) hospitals, and the remaining 3,342 (59.6%) hospitals were non-governmental, nonprofit hospitals, classified by federal laws as tax-exempt charitable entities (AHA, 2000b). There are two major differences between nonprofit hospitals and investor-owned hospitals. The first is the exemption from taxes granted to nonprofit hospitals by local governments (property taxes), state governments (income taxes), and the federal government (income taxes and postage rates). Second, investor-owned hospitals are expected to distribute dividends or profits to their owners/investors (Hansmann, 1981) while the operating surpluses of nonprofit hospitals must be reinvested in the hospital's activities.

The funding environment of investor-owned and nonprofit hospitals is otherwise largely similar. Both types rely largely on third-party payments to reimburse the $11,294 median cost of a hospital stay in 1997. The majority of hospitals are members of a network or system of hospitals (AHA, 2000b). This network means that many hospitals share similar management structures, indicating further isomorphic pressure toward conformity. Investor-owned and nonprofit hospitals (as well as government hospitals) are subject to the accreditation policies of the Joint Commission for the Accreditation of Health Organizations. Finally, roughly one-third (35%) of all personal medical care expenditures are made by the federal government, contributing to the similarity of hospitals as an organizational form.

A distinguishing feature of hospitals noted by a some communication researchers (Geist & Hardesty, 1992) is its dual hierarchy: physicians are organized in one hierarchical staff, and other hospital personnel—including nurses and other departments and staff—are organized in a second chain of command. Geist and Hardesty have noted that this arrangement leads to the problem of "multiple subordinates" (p. 37). This structure has few counterparts in other western organizations and may account for why hospitals have changed little during a century of dramatic technological and financing changes. But, as they point out, this structure also contributes to the nature of the hospital as a negotiated order (see also Strauss, 1978; Strauss, Fagerhaugh, Ruczek, & Wiener, 1985).

Also notable, most U.S. hospitals offer services much more intensive than room, board, personal services, and general nursing care. The hospital is continuously open and staffed to provide care for persons requiring "medical, surgical, psychiatric, testing, diagnosis, and treatment for illness, injury, deformity, infirmity, abnormality, disease, or pregnancy" (JCAHO, 1994, p. 366). Clinical laboratory services, diagnostic X-ray services, and treatment facilities for surgery or obstetrical care have become standard features of hospitals accredited in the U.S. (JCAHO, 1994).

Nursing homes. The National Center for Health Statistics (NCHS) identified 16,700 residential nursing facilities in the U.S. in 1995, with an average size of 106 beds (NCHS, 1997) (see Table 1). Gubrium (1975) provided an early analysis of life in this organized health setting that sets it apart from hospitals or clinics. Nursing homes are unusual among medical contexts because of the extremely high rates of mortality after institutionalization (Thorson & Davis, 2000). Also, patients and providers in nursing homes, as contrasted with hospitals and other settings, interact almost entirely within the organizational context and in isolation from other social influences (Nussbaum, 1990).

Hospice. While today hospice is seen as a common part of the health care landscape in American communities, it is an organizational type that has emerged in the U.S. in only the last twenty-five years. According to the Hospice Association of America (HAA) (2001), prior to 1974, there were no hospices in the U.S. Today there are 2,273 hospices approved to receive Medicare payments (see Table 1). There are also an estimated 200 hospices staffed by volunteers (HAA, 2001). Hospices in the U.S. are organized in four different ways: as both proprietary and nonprofit home health agencies (providing care in homes rather

than in inpatient facilities); as operating units or departments of hospitals; as operating units or departments of a nursing facility; and as freestanding, independent, mostly nonprofit organizations (HAA, 2001).

As a health care organization, the hospice is distinguished by three characteristics. In contrast to most other health organizations, the purpose of hospice is to provide exclusively palliative rather than curative care. Hospices provide "medical, social, emotional, and spiritual services to terminally ill patients and their family members" (HAA, 2001). Second, care provided in the hospice setting is interdisciplinary, involving the coordinated work of physicians, nurses, medical social workers, therapists, counselors, and volunteers (Berteotti & Seibold, 1994). Third, hospice relies heavily on a volunteer workforce. According to industry data, volunteers outnumber paid workers: 46,793 employees to 47,671 volunteers (HAA, 2001).

Though hospices account for a small portion of expenditures for health care in the U.S., they are important sites for the delivery of care. For example, in 1998, hospice services accounted for 0.2% of total Medicaid payments. Yet in that year (1998), hospices provided care to 401,140 Medicare patients throughout the U.S. (National Association of Home Care, 2000). The rise of hospice in America is a signal of our aging population. It represents a shift in our values about palliative and curative services. Hospice, as a newer form of health organization, have had less exposure to normative pressures and exhibit more variety and flexibility than hospitals.

Parish nurse programs. Koch (1998) reports that an estimated 2,500 nurses in the U.S. work in parish nursing programs. The typical program links a hospital and a religious parish with an individual nurse. A nurse working in the context of the church is not a new concept, but the profile of the role has changed considerably over the last two decades. Parish nursing is a health promotion, disease prevention role that incorporates spiritual care but also entails an important boundary-spanning role (Tushman & Scanlan, 1981). The breadth of parish nursing has grown considerably since 1984, from six nurses working in the northwest suburban areas of Chicago in partnership with six local churches, to nurses working within all mainline denominations in 48 states, Canada, Australia, and Korea by 1997 (McDermott, Solari-Twadell, & Matheus, 1998).

Departments of public health. In the U.S., there are 3,169 local public health agencies (NACHO, 1991). Local government structures directly influence local public health departments' activities and services. As Shonick (1981) has argued, local governments lack the relative power of the Federal and state governments to tax and therefore fund expensive enterprises such as personal medical services, so public health departments tend to be fiscally stressed and less visible than private hospitals and clinics. Nonetheless, county governments are the most common type of local government structure that house local public health agencies (U.S. Department of Health and Human Services [USDHHS], 1991). Services provided by local health agencies most commonly include immunizations; health tuberculosis screening; sexually transmitted diseases screening and treatment; chronic diseases screening; care for women, infants, and children; family planning services; prenatal care; HIV/AIDS testing and counseling; and home health care.

Pharmaceutical and biotechnology organizations. According to industry data, 1,283 companies comprise the biotechnology industry sector, although the U.S. Census Bureau (2000b) lists 1,767 firms engaged in the manufacture of drugs. The sector employs 153,000 people and in 1998, recorded $18.6 billion in revenues. The sector, like many others in health care, has been characterized by recent waves of mergers and acquisitions. In 1995, prescription drug sales amounted to just over $80 billion in the U.S. The major firms that manufacture and develop drugs are headquartered in the U.S., the U.K., Sweden, Germany, France, Japan, and Switzerland. Despite the size and complexity of the sector, the pharmaceutical industry is not highly centralized (Kanavos, Mrazek, & Mossialos, n.d.). The market tends to be broken into segments by therapeutic classes of drugs.

Compared to the highly institutionalized hospital field, the drug industry in the U.S. is much more decentralized and operates as a technical sector (Meyer & Scott, 1983). It follows market-driven norms of efficiency, pursuing the manufacture of products and services that generate profits for investors and have measurable effectiveness. Even as the hospital field is being pressured to develop more technical efficiencies, however, the pharmaceutical industry is pressured to adopt pro-social policies with respect to certain classes of drugs such as d4T, an antiretroviral drug desperately needed by people in Africa (Prusoff, 2001).

Trends and Change Forces in Health Organizations

Having completed our review of organizations in the health services sector, we turn our attention to forces influencing changes in these organizations. While many factors could be identified, this section focuses on four developments in health care: the changing demography of the U.S. population, the rise of chronic diseases, changes in the material technologies, and the development of managed care and associated management innovations. Each of these change forces has implications for health organizations.

Demographics

Health service organizations and activities—and the communication issues arising from them—reflect the age, gender, and ethnic composition of society. Demographic forces influence the nature of the population served by health organizations, the diseases and ailments treated by health organizations, and the resources available for health organizations. The single most notable feature of demographic changes facing health organizations in the U.S. is the increasing size of the aged population. At the beginning of the 20th Century, the portion of the population sixty years of age and over was 6.4%. In 2000, that figure had risen to 16.4%, and by 2050, it is estimated that 25.0% of the population will be over sixty-five (Dowd, Monaco, & Janoska 1996). These population trends translate directly into demand for health services, as over one-half (52.5%) of older Americans report living with some disability, and one-third (33.4%) report living with a severe disability (Administration on Aging, 2000). Additionally, according to the U.S Administration on Aging, chronic conditions are most frequent among the older population. In 1996, the most frequently occurring conditions were arthritis, hypertension, hearing impairments, heart disease, cataracts, orthopedic impairments, sinusitis, and diabetes (Administration on Aging, 2000).

Implied in the population shift figures reported above is the shrinking size of a healthy workforce on whose shoulders the care of elderly will rest. By 2050, the portion of the population that will be between twenty and sixty will be at its lowest since 1900 (48.1%). With more than one-half of the population dependent on this group, we may expect concerns about efficiency to be especially severe in health organization management.

Disease Chronicity

Chronic diseases are those "that are prolonged, do not resolve spontaneously, and are rarely cured completely"(U.S. Centers for Disease Control and Prevention, 1999). Chronic diseases are now the leading cause of illness, disability, and death in the U.S., and attract the majority of health care resources (Institute of Medicine, 2001, p.27). Care for a chronic disease typically involves a variety of clinicians and health care settings over extended periods. Strauss, et al. (1985) first noted the importance of disease chronicity for health services. Their concept of "trajectory" (which Strauss originally applied to the dying process) involves health events shaped by social interaction. From this point of view, chronic diseases or health conditions are not only clinically different from acute diseases or health conditions, but also they are socially distinct. The trajectory of a health event is marked by interaction between the patient and a multitude of others, including but not limited to physicians, nurses, social workers, pharmacists, and family members.

Presently the U.S. Institute of Medicine is encouraging providers to recognize the importance of improving chronic care services as a part of overall quality improvement in U.S. health care systems. Health care for chronic conditions is different from care for acute episodic illnesses. Care for the chronically ill frequently requires a collaborative, multi-disciplinary approach. Effective methods of communication among caregivers and between caregivers and patients are critical to providing high-quality care. Personal health information must accompany patients as they transition from home to clinical office setting to hospital to nursing home and back (Institute of Medicine, 2001, p.9). But physicians, hospitals, and other health organizations typically work so independently that they frequently provide care without the benefit of complete information about patients' conditions, medical histories, or treatment received in other settings (Institute of Medicine, 2001, p.9). Moreover, the collaboration and teamwork called for by the rise of chronic diseases seems to occur more frequently among non-physicians than among physicians, whose training and socialization prepares them for roles as autonomous and independent practitioners rather than as collaborators.

Technology

Recent innovations and improvements in communication technologies have opened many channels for health education and delivery (President's Information Technology Advisory Committee, 2001). Applications of information technologies are found in patient scheduling, clinical and financial records, telemedicine, imaging, web-based instruction, clinical decision support, quality improvement, biomedical research, robotics, remote visualization, and video-assisted endoscopic surgical procedures, to name only a few. And, the rapid adoption of a wide range of technologies has given rise to new occupational groups including specialized operators (such as radiological technicians—see Barley, 1986) and more general clinical engineers. The complexity of communication technologies has also contributed to the rise of the field of medical informatics (Greenes & Shortliffe, 1990).

Clearly, information technologies hold great promise in health organizations, but their potential is as yet unrealized for a number of reasons (President's Information Technology Advisory Committee, 2001). Currently public and private payers of medical services do not reimburse providers for many applications that have demonstrated value such as tele-medicine or patient-provider interactions over the internet. In addition, decision-support tools can

provide critical links between a current patient's condition and previous clinical studies, but such systems await investment. Finally, the biomedical community "has tended to rely on information technology innovations that are produced by investments in other industries and other parts of government" (President's Information Technology Advisory Committee, 2001).

Managed Care

Ten years ago, the words "managed care" had barely entered the parlance of health communication research. Today, managed care arrangements dominate the health care scene in the U.S. This section describes what managed care commonly refers to, provides a picture of its growth over the last decade and a half, and lays out opportunities and implications for health communication research (see also, Apker & Ray, this volume).

Managed care refers to a financial and organizational arrangement for the provision of health care services (almost always but not exclusively medical services). The roots of managed care can be found in early, prepaid group practices such as the Ross Loos Clinic in Los Angeles in the 1920s and the Kaiser plans of the 1940s (Starr, 1982). Both of these prepaid health plans charged industrial workers a few cents a day for medical coverage and both were controversial plans. Ross Loos, through a variety of mergers and acquisitions over the years is today known as CIGNA. By the year 2000, CIGNA covered 13.4 million lives in its managed care plans (U. S. Security and Exchange Commission, 2000). Kaiser is the acknowledged leader in nonprofit prepaid health plans, covering about 8 million lives. Neither of these plans were originally known as Health Maintenance Organizations. That term came into common use under the federal government's HMO Act of 1973 (Kongstvedt, 1989; Mayes, 1999). This legislation did much to spur the development of managed care. It required employers with over twenty-five workers to make an HMO health care plan available, and provided $375 million dollars in subsidies to create HMOs. After this legislation the numbers of HMOs and enrollees grew rapidly, as shown in Table 1. Although the number of plans rose and fell after the late 1980s, the number of enrollees has climbed steadily since the 1990s, to include 65.1 million Americans and 668 HMOs by 1997 (see Table 1).

One consequence of the HMO act of 1973 and subsequent legislation was an increase in profit making in health care. Although for-profit *hospitals* remain a small minority of the hospital population in the U.S., for-profit HMOs represent a substantial percentage of all HMOs. The 1997 Census of businesses in the U.S. identified 262 HMO medical centers subject to federal income tax and 510 HMO medical centers exempt from federal income taxes. Profit making in health care has concerned a number of health service researchers (Gray, 1983, 1991; Schlesinger, Gray, & Bradley, 1996), but has not informed health communication research to date.

A number of the features of managed care organizations might be of interest to health communication researchers. First, managed care organizations (for example, HMOs, IPAs, PPOs) can be characterized by their existence in a triad of contractual arrangements (see Figure 1). Consumers (or more specifically, their representatives in the form of employers or governments) purchase memberships in plans from plan administrations. Plan administrations may be operated by organizations that bear close resemblance to the federally chartered HMOs of the 1970s. Alternatively, they may be operated on a for profit basis, or they even may be operated by private insurance corporations or government agencies. The key characteristic of consumers in managed care is that they are almost always members of a population, either employed persons (typically at large organizations), or beneficiaries of government sponsored plans such as Medicare or Medicaid. The key characteristic of plan administrations is that they represent pure administrative structures. They arrange for the access of populations to health services and the access of providers to clients, but the plan administrations provide no direct services. The central characteristic of providers in these plans is that individual physicians, medical groups, hospitals, laboratories, and/or pharmacies have entered into an agreement with the plan administration on the basis of competitive bidding. Without the formal relationship of the provider to the plan, there would be no possibility for the provider to be reimbursed for the service provided to patients.

Tying these three parties together are highly specific and binding contracts. For the patient population, these contracts specify with minute detail the nature of services and manner of their provision which the patient may request of the provider. For the plan, the contracts specify the obligations and duties of the plan toward both provider and patient. For the provider, the contracts specify not only what services may be reimbursed, but also the limits of referrals, hospital admissions, financial incentives, and controversially, what the provider may or may not disclose to the patient about the contract. The contracts represent a set of structures for patient-provider communication that are specified beforehand.

This over-arching structure now dominates patient-provider communication in the U.S. Little health communication research (Lammers & Duggan, 2002; Lammers & Geist, 1997; Miller, 2001) has recognized the pervasiveness and influence of these structures, although health services researchers have devoted increasing attention to them (for example, Gross &

Budrys, 1991; Robinson, 1997, 1998; Scheffler, 1999).

Several features of managed care plans are significant for health communication researchers. The stability of the patient-provider relationship is a staple of organized medicine's view of good practice as well as communication researchers' assumptions about the nature of the dyad. But, because the plans structure the patient-provider relationship as a contract, the relationship is pre-defined by the conditions of the contract, potentially threatening this stability. Patients may be unable to continue to see certain providers because the parties (providers, administrators, patients, or employers), may elect not to renew contracts. This was the case for 934,000 Medicare recipients dropped from managed care plans in 2000 (Cawley, Chernew, & McLaughlin, 2001). As a contract, the relationship can be bought and sold like a commodity. Thus, disruption in the patient-provider relationship can occur when plans fail due to market forces, as in the case of FPA Medical Management, a physicians management group that collapsed in 1998 leaving more than 400,000 patients without an arrangement for medical service (Brewster, Jackson, & Lesser, 2000). But disruption can also occur when the contracts are transferred, as in the case of the purchase of FHP by Aurora Health Plans in Milwaukee, WI and the subsequent elimination of 11 physicians' jobs (Trewyn, 2001).While the reorganization can be explained in business terms it nonetheless has consequences for the patient-provider relationship. The separation of technical (or clinical) control from administrative control in prepaid medical practices (Gross & Budrys, 1991) ultimately subjugates physicians' control of their practices to administrators. This could decrease the attractiveness of medical careers, and perhaps threaten quality of care.

From an institutional perspective, managed care represents the rise of norms of efficiency and market values in what until recently was a sector defined by sacred intangible and untestable beliefs about the importance of the patient-provider relationship and public trust, precisely what Meyer and Rowan (1977) referred to as rational myths. Hospitals and physicians, largely in groups, are now brought under the logic of market efficiencies and the commodification of every aspect of the sector, from procedures to relationships (Lammers & Geist, 1997). The development of the field very much follows the pattern of institutionalization outlined by Lawrence, Winn, and Jennings (2001). Thus, we would expect the content, style, and nature of patient-provider communication to change as managed care develops and gradually comes to dominate a community.

Theorizing Organizations in Health Services[1]

In Kreps's and Thornton's (1992) widely-used text, contextual features of health communication are described using a series of concentric circles to show how patient-provider communication is surrounded by organizational and societal factors. Similarly, the Health Belief Model (HBM) (Rosenstock, 1974) and the Behavioral Model of Health Services Use (Andersen, 1995) offer frameworks that suggest socially influenced patterns of health care use. But as Mattson (1999) has pointed out, models like the HBM need much additional specification of their communication elements. Each of these models could also benefit from additional specification of the concepts involving the providers of health services (see Table 2 for an enumeration of such concepts).

Occupational Identification

Writers in health communication have struggled for years with terms that are inclusive enough to acknowledge that physicians are in the minority among those mainstream professionals who see patients, while avoiding the thorny problem of identifying just what distinguishes one caregiver from another. Problems with access to and costs of care have placed more and more registered nurses, physicians' assistants, and nurse practitioners in front of patients. While many provide preliminary screening, in a number of settings, patients may not see a physician at all over a period of years. For example, nurse practitioners or physicians' assistants often handle routine gynecological exams instead of gynecologists.

Status distinctions among physicians may lead to differential outcomes in the experience of care for the provider that in turn might be expected to contribute to differences in the patients' experiences. Patients in the U.S. have access to a wide range of specialists whose training and professional identity may be quite different from that of generalists. Practitioners work in increasingly complex organizations where managerial concerns become a part of the organizational culture (Barr, 1997). The financial pressures placed on providers increasingly put the patient in a room with an employee of an organization.

Group Context

As group researchers have exited the laboratory and entered the field in search of more realistic group processes (Frey, 1994), some new concepts have entered the language of group analysis that should be of particular use to health communication researchers. The key features of the bona fide group perspective include stable but permeable boundaries and interdependence with context (Putnam & Stohl, 1990; Stohl & Putnam, 1994). For example, Lammers and

Krikorian (1997) applied the concept to surgical teams. They suggested that structural relationships among pools of potential members of any given surgical team could predict communication outcomes. Berteotti and Seibold (1994) raised questions about role coordination among hospice team members of differing status. Consider also the role of formal and emergent authority in health care groups. Given the increasingly interdisciplinary nature of health care teams, cross-disciplinary communication, authority, and interdependence could be vital. For example, the U.S. Agency for Healthcare Research and Quality has placed a special emphasis on medical errors in its requests for proposals; measurable medical error may be due to certain, specifiable group communication patterns (Berwick, et al., 1991).

Organizational Context

Health communication research routinely fails to control for standard organizational variables of size, complexity, formalization, climate, and history. Yet these are precisely the kinds of distinctions that are of concern to policy makers and investors in other sectors. Barr (1997) argues persuasively that service quality is a function of organization size and complexity, and in turn affects organizational outcomes. Formalization, the extent to which organizational procedures are codified and have law-like qualities, is today rampant in health organizations. Yet formalization itself is problematic. Hacker and Marmor (1999) contend that the term *managed care* (and many terms associated with it) "…is a confused assemblage of market sloganeering, inspirational rhetoric, and managerial jargon that sadly reflects the more general state of discourse about American medical institutions" (p.1033). They persuasively argue that the whole alphabet soup of HMO, PPO, MIP, EPO, POS, and the like are misleading, inaccurate, and confusing. They urge analysts to avoid using the industry labels for these managed care entities and to replace the jargon with more empirically descriptive terms. The climate of health organizations has been the subject of health communication investigations (Klingle, Burgoon, Afifi, & Callister, 1995), but like much climate research, has not been tied to valued outcomes, like organizational success or health status. Given the levels of burnout among health care workers (Miller, Birkholt, Scott, & Stage, 1995), organizational attributes like size, complexity, formalization, climate, and history are critical to the success of health services (Aiken, Sochalski, & Lake, 1997).

Institutional Context

Whereas organizational variables are often overlooked in health communication research, institutional variables are invisible. Institutions can be best thought of as macromorphic patterns of behavior, beliefs, and structures within which organizations have life and much dyadic communication can be taken for granted. Scott (1995) defines institutions as follows: "Institutions consist of cognitive, normative, and regulative structures and activities that provide stability and meaning to social behavior. Institutions are transported by various carriers—cultures, structures, and routines—and they operate at multiple levels of jurisdiction" (p. 33). Most writers on the subject of institutions in both sociology and economics will agree that regulation and control are defining characteristics of these large structures. As such, ownership rules, control, and decision making rights that cut across organizations are institutional characteristics. Accreditation patterns in hospitals, unionization of nurses, and the distribution of rights regarding funding, categories of services, and instrumental choices are all shaped by institutional forces in health care.

Organizational Change

Health organizations have participated in the waves of change brought on by popular management thinking, such as the Total Quality Management and Re-engineering Movements. Organizational communication scholars have offered perspectives that could improve efforts to accomplish change (Lewis & Seibold 1998), but health communication scholars have not employed these ideas to understand how providers like physicians and nurses respond to these planned changes. Labor studies researchers and nursing scholars, however, have begun to study the effects of planned organizational changes—like job redesign and hospital mergers—on the climate for patient care (Clark, Day, & Shea, in press). Studies that include purposive organizational change could be employed usefully in health communication research.

Scott, et al. (2000) employ structuration as a "master process" (p. 26) to understand how the profession of medicine was transformed in the 20th century from one with widespread autonomy to one where managerial rules govern. In a conceptual move that has relevance for health communication research, Scott, et al. refer to changes underway in medical care today as "destructuration and restructuration" (2000, p.27). Lammers, Duggan, and Barbour (2000) consider the relationship of organizational type and managerial communication to physician satisfaction as part of a structuration process.

Researchers may find applications of emerging perspectives in health communication research at the macro level. Although self-organizing systems theory (Contractor & Seibold, 1993) is aimed at explaining systems that are in states of disorder (a debatable claim in the case of U.S. health care systems),

certain of its tenets apply. For example, supply and demand for health care seem linked in mutually causal ways that have always baffled economists (Feldstein, 1993). Complex Adaptive Systems theory seems applicable to problems of understanding the trillion-plus dollar health care system and efforts to reform it (Plesk, 2001).

Finally, health communication research could also benefit from observing that the population of health organizations is changing from an ecological point of view (Aldrich, 1979; Hannan & Freeman, 1977). The population ecology perspective suggests that organizations themselves live in a dynamic environment ruled by ecological principles like births, deaths, and transformations (Aldrich & Fish, 1981). The most amazing example of organizational birth in the health arena is the medical group (not in existence at the beginning of the 20th century) that dominates medical practice today. An institutional perspective directs our attention to these macromorphic structures that influence behavior at the micromorphic level.

Conclusions

In this chapter, we have identified an institutional approach to communication in health organizations. Throughout we have applied the institutional ideas including sectors, isomorphic forces, and rational myths to sort out the population of organizations we think of as health organizations. This approach can tie traditional patient-provider research to larger issues. The central idea has been context, but issues remain. First, we have not found in the *health* communication literature much development of ideas *organizational* communication scholars traditionally work with, such as structuration, communication climate, communication or decision making in groups, leadership, workplace democracy, dialogue, network studies, public goods, technologies and organizations, or organizational identification (Jablin & Putnam, 2001). Each of these areas could be applied to issues in health organizations.

Second, in this chapter, we have accepted the patient-provider relationship as a central problem in health communication research, leaving off the population or mass audience as a legitimate focus for organizational health communication research. A shift in focus would favor more studies like Backers and Rogers's (1993) work concerning the organizational issues associated with health communication campaigns. This shift could also be tied to an institutional approach, and could draw schools of public health and the public health service into the framework.

Variation in contexts should be introduced as a variable in health communication studies. Too many studies assume a hospital or physician's office. The links between professionals and their changing status with the advent of managed care seems a promising area for further research. Changes over time in the context of patient-provider communication may also influence the validity and reliability of health communication studies. Certainly the institutional environment of health organizations has changed drastically in just the last 20 years (since the introduction of DRG's, for example). As of January 1, 2001, 933,687 Medicare enrollees (Ferris, 2000) were dropped from HMO's that claimed that federal reimbursements did not sufficiently cover the costs of care (LaTourette, 2001). Certainly disruptions in the continuity of care would influence the quality and tenor of individual health communication episodes.

An institutional approach provides a framework in which we can consider both the micro-level interactions and issues in health care as well as the organizational environment of health services. For example, physician satisfaction is a personal issue that affects individual providers, but in the aggregate, it may be an expression of shifting macromorphic forces and arrangements. If, as we observed in our introduction, organizations are expressions of culturally valued ends, there may be few better places to study changes in our culture than in health organizations.

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Footnotes

[1]This section draws on material from Lammers, J. (2001, November). *The organization of health communication and the health of organizational communication*. Paper presented at the annual conference of the National Communication Association, Atlanta, GA.

Table 1. US Health Organization Statistics: 1965-1998

Year	National health expenditures (% of GDP)	Physicians practicing in the U.S.	Medical groups in the U.S.	Mean Medical group Size	Non-Federal hospitals (NFH)	Beds per NFH	HMOs	Nursing homes	Total Medicare certified hospices
1965	5.1[a]	268,040	4,289	6.6	n.a.	129	≈0	n.a.	≈0
1970	7.1	334,000	6,371[b]	6.3[b]	n.a.	145	37	15,700[e]	≈0
1980	8.9	467,700	10,762	8.2	6,606	189	236	23,065[f]	31[g]
1985	10.3	552,700	15,485[c]	9.1[c]	6,529	184	393	19,100	158
1990	12.2	615,400	16,576[d]	11.5[d]	6,312	176	556	n.a.	806
1995	13.7	720,300	16,787	10.5	5,992	172	562	16,l700	1,857
1996	13.6	737,800	19,820	9.3	5,911	167	630	16,197	2,154
1997	13.4	756,700	n.a.	n.a.	5,812	167	652	16,052	2,274
1998	13.5	777,900	n.a.	n.a.	5,606	167	651	n.a.	2,215

Note. The data in column two are from *National Health Expenditures*, by the Health Financing Administration, 2001, Retrieved December 5, 2001 from http://www.hcfa.gov/stats/nhe-oact/tables/t1.htm. The data from columns three, six, and seven are from the *Statistical Abstract of the United States*, by the U.S. Census Bureau, 2000, Retrieved December 5, 2001 from http://www.census.gov/prod/www/statistical-abstracts-us.html. The data in columns four and five are from *Medical Group Practices in the U.S.: A Survey of Practice Characteristics*, by Havlicek, P.L., Chicago, IL: The American Medical Association. The data in column eight for years 1965 to 1980 are from *Managed Care: A Decade in Review*, by Kraus, N., Porter, M., Ball, P., 1980, St. Paul, MN: InterStudy; the data in column eight for years 1985 to 1998 are from the *The HMO Trend Report*, St. Paul, MN: InterStudy. The data in column nine are from *Advance Data*, by Strahan, G.W., 1997, Washington, DC: U.S. Department of Health and Human Services. The data in column nine are from *Hospice Facts and Statistics*, by the National Association of Home Care. Retrieved December 5, 2001 from http://www.nahc.org/Consumer/hpcstats.html

a for 1960
b for 1969
c for 1984
d for 1991
e for 1973-1974
f for 1977
g for 1984

Table 2. Organizational constructs useful in health communication

Construct	Concepts
Occupational identification	professionalism managerialism role identity employment status
Group context	membership boundaries leadership authority membership pools
Organizational context	size complexity formalization climate history
Institutional context	ownership control sector characteristics decision making rights
Change processes	purposive structurational (destructuration) births, deaths, transformations growth

Figure 1. The Structure of Managed Care Communication. The diagram is similar to Mackintosh's (1978, p. 38) which refers only to physicians, third parties in general, and resource flows, not plan administrations, populations, or contractual communication.