AN EXAMINATION OF THE RELATIONSHIP BETWEEN THE ECONOMIC ORIENTATIONS AND STRATEGIES OF ORGANIZATIONS WITHIN THE HEALTH CARE INDUSTRY

by

William B. Carper

Dissertation submitted to the Graduate Faculty of the
Virginia Polytechnic Institute and State University
in partial fulfillment of the requirements for the degree of
DOCTOR OF PHILOSOPHY
in
Business Administration

APPROVED:

R. J. Litschert, Chairman

M. S. Wortman, Jr.

T. W. Bonham

K. B. Monroe

S. K. Paulson

December, 1979
Blacksburg, Virginia

ACKNOWLEDGEMENTS

The writer wishes to acknowledge the support, encouragement, and constructive comments provided by the chairman of his committee, Dr. Robert J. Litschert. The author is also appreciative of the meaningful association which he has enjoyed with the other members of his committee, Dr. Max S. Wortman, Jr., Dr. T. W. Bonham, Dr. Kent B. Monroe, and Dr. Steven K. Paulson.

Words cannot adequately express the debt which the author owes to his wife, , and to his children, ., for the many times that they have quietly accepted a back seat position relative to this dissertation. Without their understanding, forgiveness, patience, and sacrifices, this study could not have been completed. The enduring encouragement of various other individuals has also contributed greatly to the successful completion of this project. In particular, the author has been blessed to have such loyal supporters as and and in his corner throughout this long endeavor.

Finally, thanks are extended to who suffered through the typing of both the original manuscript and its numerous revisions.

TABLE OF CONTENTS

TABLE OF CONTENTS (continued)

LIST OF TABLES

LIST OF TABLES (continued)

LIST OF TABLES (continued)

CHAPTER I

INTRODUCTION

In the past, business and economic literature has focused almost exclusively on private sector, profit oriented organizations. As a result, a somewhat chauvinistic attitude that whatever takes place in these "business" enterprises is the norm and should serve as the model for all other organizational forms. This belief that the managerial expertise acquired and developed in the business sector can be transferred in toto to other types of organizations has been accepted virtually without question or empirical support (Cartwright, 1975; Hardy, 1973; Hussey, 1974; McKay & Cutting, 1974; Newman & Logan, 1976; Steiner & Miner, 1977; Webber & Dula, 1974).

The post-World War II period has witnessed the rapid growth of governmental operations at all levels and the emergence of many nontraditional types of organizations. Today, the traditional model of a single sector economy based primarily upon privately owned, profit-oriented organizations is being increasingly viewed as an overly simplistic representation of reality. In its place, Ginzberg, Hiestand, and Reubens (1965, p. 2) have posited that "a more realistic model suggests that there are three principal sectors of enterprise: profit-seeking, nonprofit, and government." This approach, which has been advocated by many authors in the past, is currently accepted by

most authorities (Copeland & Smith, 1978).

Although various political scientists and public policy analysts have recently begun systematic investigations of the governmental sector (Allison, 1969, 1971; Bailey, 1950; Kaufman, 1976; Wholey, 1975), very little empirical research has been conducted on nonprofit organizations, their employees, or their operations. In fact, there are few comprehensive data available which describe the size and organizational composition of the nonprofit sector. This absence of research has caused many important questions to remain unanswered. Among these are: How should the sector be defined? What organizations should be included within it? What is its relationship to the profit and governmental sectors? Can management techniques and procedures developed for profit oriented enterprises be applied directly and without modification to nonprofit ones? Do similar types of profit and nonprofit organizations establish similar goals and strategies and do they use similar types of goal setting and strategy formulation processes?

This dissertation presents an exploratory examination of some of these unresolved issues by comparing similar types of profit and nonprofit organizations in terms of their goals, goal structures, power relationships, and goal setting processes. The overall objective is therefore to provide an empirically based analysis of the effect which an organization's economic orientation has on one specific strategic management activity, namely that of goal setting.

Chapter I is divided into seven sections. First, because the

nonprofit sector has not received the intensive study which has characterized its profit oriented counterpart, a brief overview is presented which examines the not-for-profit sector in terms of its growth, size, composition, and importance. Second, the nature of the problem is considered. Third, the objectives of the study are summarized. Fourth, important terms which are relevant to the dissertation are defined. Fifth, the research hypotheses used to guide the course of the investigation are identified. Sixth, the conceptual foundation for the study is developed. Finally, an outline of the contents of the entire dissertation concludes the chapter.

Overview of the Nonprofit Sector

The greatest problem in attempting to study the nonprofit sector of our economy relates to the fact that virtually no one, including the United States government, is really sure how to define it (Weisbrod & Long, 1977). One of the best estimates of the size of this sector which is currently available has been made by Hiestand (1977) who combined data from the Department of Commerce and the American Hospital Association. According to his calculations, the nonprofit sector accounts for approximately 5.9 percent of our total national employment, almost double the level it was in 1950. When compared with the percentage gain in total employment for this same period, this means that employment in the nonprofit sector has increased over four times faster than total employment since 1950. Today, the total value of the goods and services provided by not-for-

profit organizations makes up roughly five percent of the U. S. gross national product or some $95,000,000,000 (Department of Commerce, 1978, p. 51; Hiestand, 1977, pp. 334, 336). In what almost amounts to an understatement, Copeland and Smith (1978, p. 154) have concluded "that nonprofit organizations represent an important part of the total economic system."

During the same period that the nonprofit sector has been making these impressive gains in size, the more traditional profit oriented sector has been losing ground. Manufacturing operations, which had long been the mainstay of the profit sector, now account for less than one fourth of all nonagricultural employment. Contract construction and mining have also suffered heavy employment losses in recent years. Tables I-1 and I-2 contain a summary of the changes in employment which have taken place in the last 20 years and if current projections (Department of Labor, 1976) are valid, these increases in nonprofit, as well as in governmental and service related, employment will continue in the future.

As indicated above, the absence of a clearly and universally accepted definition of the nonprofit sector makes any estimate of its size anything but precise. Although the Internal Revenue Service currently lists almost 300 categories of nonprofit organizations (IRS, 1976a) and ultimately determines which activities qualify for tax exempt status (IRS, 1976b), public inspection of IRS Form 990's (Tax Exempt Organization Returns) is not allowed under the present freedom of information laws. This has had the effect of eliminating one of

Table I-1

Number and Percentage of Workers Employed in Nonagricultural Establishments: 1958 to 1978

Item and Year	Total	Manufacturing	Wholesale and retail trade	Government	Services	Transportation and public utilities	Finance, insurance, and real estate	Contract construction	Mining	Goods related[a]	Service related and all other
NUMBER (1000)											
1958	51,423	15,945	10,750	7,893	6,811	3,976	2,519	2,778	751	19,474	31,949
1968	68,146	19,740	14,111	12,202	10,504	4,348	3,357	3,259	625	23,624	44,522
1978	84,365	20,109	18,808	15,504	15,830	4,663	4,661	4,031	759	24,898	59,466
PERCENT											
1958	100.0%	31.0%	20.9%	15.3%	13.2%	7.7%	4.9%	5.4%	1.5%	37.9%	62.1%
1968	100.0%	29.0%	20.7%	17.9%	15.4%	6.4%	4.9%	4.8%	0.9%	34.7%	65.3%
1978	100.0%	23.8%	22.3%	18.4%	18.8%	5.5%	5.5%	4.8%	0.9%	29.5%	70.5%

[a] Combines manufacturing, contract construction, and mining.

SOURCE: Statistical Abstract of the United States (1978, p. 412; 1969, p. 215; 1963, p. 223).

Table I-2

Change in Percent of Workers Employed in Nonagricultural Establishments: 1958 to 1978

Item and Year	Total	Manufacturing	Wholesale and retail trade	Government	Services	Transportation and public utilities	Finance, insurance, and real estate	Contract construction	Mining	Goods related[a]	Service related and all other
PERCENT											
1958	100.0%	31.0%	20.9%	15.3%	13.2%	7.7%	4.9%	5.4%	1.5%	37.9%	62.1%
1978	100.0%	23.8%	22.3%	18.4%	18.8%	5.5%	5.5%	4.8%	0.9%	29.5%	70.5%
PERCENT CHANGE 1958 TO 1978		-23.2%	+ 6.7%	+20.3%	+42.4%	-28.6%	+12.2%	-11.1%	-40.0%	-22.2%	+13.5%

[a] Combines manufacturing, contract construction, and mining.

SOURCE: Statistical Abstract of the United States (1978, p. 412; 1963, p. 223).

the most logical and potentially credible sources of data on the nonprofit sector available today. Furthermore, if one turns to other federal agencies and departments for assistance, they are of little help since these same freedom of information laws also prohibit one office from sharing much of its data with another. This causes different offices of the same federal government to use widely varying criteria for identifying and reporting about the nonprofit sector and leads to "official" size estimates which are more often than not significantly different.

Regardless of this inability to achieve consensus on how many of what type of organizations are, or even should be, included in the nonprofit sector, there appears to be little disagreement that it does contain such major components as nonprofit: hospitals; elementary and secondary schools; colleges and universities; religious organizations; welfare organizations; research organizations; cultural activities; fraternal, professional labor, and service clubs and associations; and all charitable organizations (Heistand, 1977; Tideman, 1977; Weisbrod & Long, 1977). An alternate, but highly similar typology of nonprofit activities has been proposed by Newman and Wallender (1978) who have grouped these enterprises according to the services they perform for the larger society. Among their headings are health services, education, social services, arts and culture, cooperatives, and other.

As can be seen from even a cursory inspection of the types of organizations just listed, the nonprofit sector has not only become

an important part of our total economic system, it is also intrinsically related to our social and cultural milieu. In one way or another the vast majority of Americans are dependent upon these not-for-profit organizations from their birth in a nonprofit hospital to their burial in a community cemetery. In between, nonprofit operations provide most of us with our primary, secondary, and higher educations, our artistic and cultural opportunities, our fraternal, professional, and service related associations, our religious experiences, and even our future through nonprofit medical and scientific research. Clearly our contemporary society would be vastly different were it not for the many services and opportunities provided for us by the nonprofit sector.

The Nature of the Problem

The problem to be investigated in this dissertation stems directly from the lack of research and comparative analysis which has characterized the nonprofit sector for years and relates to the importance of planning as an essential element of strategic management for all types of organizations. Although various researchers have attempted to analyze the planning process found in profit oriented organizations (see Dobbie, 1972, and Steiner & Miner, 1977, for reviews of the more significant of these efforts), and even a few have claimed to have examined the planning processes of certain nonprofit institutions (Webber & Dula, 1974), there have not been any published reports of the simultaneous comparative analysis of the

planning processes of similar profit and nonprofit enterprises. A major reason for this has been because many researchers, such as Cartwright (1975), Hardy (1973), Hussey (1974), McKay and Cutting (1974), Newman and Logan (1976), Steiner and Miner (1977), and Webber and Dula (1974), have accepted a premise which is neither supported nor refuted by the current literature. According to Newman and Wallender (1978, p. 24; italics in the original), "the presumption is that basic management concepts can and should be applied to not-for-profit activities just as diligently as to profit-seeking companies." They go on to say (p. 25) that, "the pertinent question is: Do not-for-profit enterprises have particular characteristics which make inappropriate some managerial concepts that are beneficial in profit-seeking enterprises?"

This should not be taken to mean that such basic management practices as those identifieid by Fayol (1916/1949) over 60 years ago and popularized by Koontz and O'Donnell (1976) are not valid for non-profit organizations. Rather, while acknowledging that all purposive activities will of necessity engage in some form of planning, organizing, staffing, directing, and controlling, the issue here is whether or not these functions are all performed in the same manner and result in the same outcomes regardless of the economic orientation of the focal organizations. If they are, then the conventional wisdom is valid. If they are not, then the practice of trying to fit nonprofit organizations into the profit oriented mold must be reexamined and

the contingent nature of these management functions acknowledged.

Purpose of the Study

The purpose of this dissertation is to determine if there is a relationship between an organization's economic orientation (i.e., whether it is profit or nonprofit oriented) and its strategy as operationalized in its goals. The following three-fold question serves as a basis for this research: Do organizations which use the same basic technology, but which have different economic orientations: (1) establish different strategies (i.e., goals) to guide their operations; (2) exhibit different power relationships among those who are involved in making these strategic decisions; and (3) utilize different processes for making these strategic decisions? The information needed to answer these questions will be obtained from surveys of and interviews with top level decision makers in selected profit (proprietary) and nonprofit hospitals located in the states of Virginia, West Virginia, and North Carolina.

In attempting to answer the relationship question posed above, the following will be considered: (1) the current literature dealing with profit versus nonprofit differences and organizational goals and goal setting processes; (2) the operative goals and goal structure of each of the organizations studied, as perceived by its respective top level decision makers; (3) the presence of any statistically significant differences between the perceived operative goal structures of each type of hospital (i.e., profit versus nonprofit); (4) the

relative power structure of each of the hospitals studied, as perceived by its respective top level decision makers; (5) the presence of any statistically significant differences between the perceived power structures of each type of hospital (i.e., profit versus nonprofit); and (6) the presence of any statistically significant differences between the organizational goal setting processes used by each type of hospital (i.e., profit versus nonprofit).

Significance of the Study

The research which is reported in this dissertation provides a much needed empirical analysis of the issue of profit versus nonprofit similarities and differences that was discussed above. Based upon this analysis, tentative conclusions are made as to the usefulness of the profit/nonprofit dichotomy in organizational research. In addition, this study is viewed as having relevancy for practitioners in what has been traditionally referred to as the nonprofit sector since it provides them with their first empirically based justification for adopting profit oriented management practices. Finally, this research will be of interest to many health care planners and public policy analysts since it demonstrates the extent to which proprietary and not-for-profit hospitals such as those surveyed here have similar goals and goal structures

Definitions of Terms

In order to facilitate the reading of the remainder of this

dissertation, selected terms which are either peculiar to the literature or operationalized for this research are defined as follows.

Economic orientation refers to whether an organization is owned by a group of investors and operated in such a manner as to generate a profit (profit oriented) or qualifies as a nonprofit institution according to the criteria established by the Internal Revenue Service (nonprofit oriented). The economic orientation of any particular hospital in this study has been determined by reference to the American Hospital Association's Guide (1978).

Proprietory hospitals are those which are investor owned and profit oriented.

Nongovernment, nonreligious, short-term, general hospitals are those which: (a) are not owned or operated by any branch, agency, department, or level of government; (b) are not owned or operated by any religious denomination or order; (c) treat acute rather than long-term or chronically ill patients; and (d) treat patients with a wide variety of medical problems rather than only those relating to a specific medical specialty.

Organizational goals are future outcomes which an organization attempts to achieve and which serve as guides for its operations. The terms "goals" and "objectives" are considered to be synonymous and, hereafter, will be used interchangeable as suggested by Cyert (1975), Glueck (1977), Katz and Kahn (1978), Koontz and O'Donnell (1976), Richards (1978), and Steers (1977).

Official organizational goals are those which the organization

professes to be striving to achieve and/or which are formally stated in its publications, correspondence or public statements (after Perrow, 1961).

Operative organizational goals are those which the organization actually attempts to achieve as evidenced by its day-to-day operations (after Perrow, 1961).

Goal areas are collections of goal statements which relate to similar types of activities or desired future outcomes.

Goal structures are the hierarchical orderings of the goals or goal areas for particular organizations or types of organizations according to their perceived importance (after Granger, 1964, and Gross and Grambsch, 1968, 1974).

Strategy relates to what an organization wants to accomplish and is operationalized herein in terms of an organization's operative goals and goal structures. This view of strategy reflects the works of such authors as Chandler (1962) and Andrews (1965, 1971) who have defined the concept broadly to include an organization's goals and who do not differentiate between the goal formulation and strategy formulation processes. (Obviously not all writers agree with this conceptualization. See Hofer and Schendel (1978) for a review of the concept of strategy and the strategy formulation process.)

Top level decision makers are those individuals and/or groups who regularly participate in determining the strategy of a given organization.

Power, as used herein, is defined as the ability and willingness

of an individual or group to influence or determine the strategic decisions of an organization (after Richards, 1978).

Power structures are the hierarchical orderings of individuals and/or groups according to the amount of power which they are perceived to be able to exert over the strategic decision making processes of particular organizations or types of organizations.

Hospital privileges refer to the right conveyed to a physician by a hospital which allows him/her to practice medicine in and/or admit patients to that particular institution.

Hypotheses

The hypotheses to be tested in this dissertation can be grouped into three major categories. Since a detailed consideration of the theoretical and/or research foundation for each of the following hypotheses will be presented in Chapter III, only the name(s) of the researcher(s) whose work(s) provides the primary basis for each hypothesis is included here.

Goals and Goal Structures

The effect of an organization's economic orientation on its goals and goal structure will be operationalized in terms of the following multiple hypothesis.

H1: Compared to the top level decision makers in proprietary hospitals, the top level decision makers in nonprofit hospitals will perceive significantly different operative

goal structures for their hospitals (Wortman, 1979) and:

a. rank community service goals significantly higher in importance for their hospitals (Rushing, 1974, 1976);

b. rank patient care goals significantly higher in importance for their hospitals (Rushing, 1974, 1976); and

c. rank economic goals significantly lower in importance for their hospitals (Rushing, 1974, 1976).

Power Structures

The effect of an organization's economic orientation on its power structures will be operationalized in terms of the following multiple hypothesis:

H2: Compared to the top level decision makers in proprietary hospitals, the top level decision makers in nonprofit hospitals will perceive significantly different power structures in their hospitals (Mintzberg, 1979; Ruchlin, Levey, and Cannedy, 1973) and:

a. rank the medical staff significantly lower in terms of its perceived power in their hospitals (Pauly & Redisch, 1973);

b. rank the board of trustees significantly higher in terms of its perceived power in their hospitals (Pfeffer, 1973);

c. rank the hospital administrator significantly lower in terms of his/her perceived power in their hospitals (Pfeffer & Salancik, 1977; Rushing, 1974, 1976).

Goal Setting Processes

The following multiple hypothesis will be used to examine the effect of an organization's economic orientation on its overall goal setting activities.

H3: Compared to the goal setting processes used in proprietary hospitals, the goal setting processes used in nonprofit hospitals will:

a. take place significantly more frequently (Rushing, 1974, 1976);

b. involve significantly more participants (Elling, 1963; Rushing, 1974, 1976);

c. be characterized by significantly more conflict among participants (Rushing, 1974, 1976);

d. place significantly less emphasis on considerations relating to costs versus potential income in making decisions (Rushing, 1976);

e. place significantly greater emphasis on the needs and medical welfare of the community in making decisions (Rushing, 1976);

f. be characterized by the formation of significantly more coalitions among the participants (Duncan, 1976; Mintz-

berg, 1979; Richards, 1978; Rushing, 1974, 1976); and

g. take significantly longer to complete from initiation to approval (Rushing, 1974, 1976).

Conceptual Foundation for the Study

Recently a symposium, held as part of the national meeting of the American Institute for Decision Sciences, focused on the "Conceptual Foundations of Strategic Management." During this session, papers were presented which identified and discussed four frameworks for the study of strategic management in applied settings. These four theoretical-conceptual approaches were based upon the policy sciences (Wortman, 1978), the behavioral sciences (Lang, 1978), systems theory (Callaghan & Comerford, 1978a), and organizational theory (Callaghan & Comerford, 1978b).

This dissertation will employ the organizational theory approach to the study of strategic management as an overall framework. More specifically, this research will rest on the theoretical foundation provided by contingency theory. The following section contains an overview of the development of the contingency approach in organizational analysis, as well as a discussion of how this conceptual framework can be used to examine the proposed relationship between an organization's economic orientation and its strategy.

Although profit and nonprofit forms of organizations are not recent phenomena, it has only been in the last few years that serious consideration has been given to their potential differences. This

circumstance can be traced to the way in which management theory has developed. Until the mid 1950's, organizational theory was primarily the province of what can be called the universalist school of thought which can be traced through the writings of Fayol (1916/1949), Gilbreth (1911), Gulick and Urwick (1937), Mooney and Riley (1931), Taylor (1911), Urwick (1943), and Weber (1922/1947). These universalists argued that there were certain fundamental principles of management which applied to all organizations regardless of their size, function, or form of control. Since this school claimed that these principles could be used by all organizations, any discussion or organizational differences was held to be unnecessary.

All observers, however, did not agree with the universal approach to management. Among these critics were such people as Barnard (1938), Merton (1940), Selznick (1949), Gouldner (1954), and Simon (1957). In essence, this group focused on either the various unintended consequences which were caused in organizations by the myopic application of a rigid set of management principles or the various environmental factors which affected how organizations used these principles, but which were generally ignored by management.

Building on the works of Barnard (1938) and Selznick (1949) and using the framework described by von Bertalanffy (1951, 1956) and Boulding (1956), general systems theory was developed in the late 1950's and early 1960's as a new paradigm for organizational analysis. According to this philosophy, organizations were viewed as open systems which interacted with and obtained feedback from their

various environments. Contrary to the closed system approach of the universalist school which refused to consider environmental influences, general systems theory thus represented a much more realistic approach to the study of organizations.

Owing much of its philosophical foundation to general systems theory, contingency theory has evolved as the most recent paradigm for the analysis of organizations. Although a contingency approach can, in retrospect, be identified in the works of such researchers as Woodward (1958, 1965) and Burns and Stalker (1961), Lawrence and Lorsch (1967) are generally credited with coining the term "contingency theory." In a later discussion, Lorsch and Lawrence (1970, p. 1) described the development of this theory as follows:

> During the past few years there has been evident a new trend in the study of organizational phenomena. Underlying this new approach is the idea that the internal functioning or organizations must be consistent with the demands of the organization task, technology, or external environment, and the needs of its members if the organization is to be effective. Rather than searching for the panacea of the one best way to organize under all conditions, investigators have more and more tended to examine the functioning of organizations in relation to the needs of their particular members and the external pressures facing them. Basically, this approach seems to be leading to the development of a "contingency" theory of organization with the appropriate internal states and processes of the organization contingent upon external requirements and member needs.

Outline of the Study

Chapter I

Essentially Chapter I has presented an introduction to the dissertation by presenting a brief overview of the nonprofit sector and stating the nature of the problem to be investigated along with the objectives of the research. In addition, terms were defined, research hypotheses were outlined, and a conceptual foundation for the study was developed.

Chapter II

Chapter II contains a review of the literature which deals with: (1) reported differences between profit and nonprofit organizational forms; and (2) the nature and importance of organizational goals and goal setting as part of the strategic management process.

Chapter III

Chapter III presents a detailed consideration of the theoretical and/or research foundation for each of the hypotheses to be tested in this dissertation.

Chapter IV

Chapter IV describes the methodology which has been used in this study. In particular, the sample will be identified, the data collection instruments and procedures will be discussed, the data

analysis techniques to be employed will be designated, and the limitations inherent in the methodology will be enumerated.

Chapter V

Chapter V relates the results of the surveys and interviews which have been conducted to obtain the data necessary for testing the research hypotheses. The statistical analysis of each of these hypotheses constitutes the major portion of this chapter.

Chapter VI

Chapter VI restates the problem examined in this dissertation in light of empirical data presented in Chapter V. The implications of this research for the study of strategic management in profit and nonprofit organizations are discussed and directions for future investigations in this area are proposed.

CHAPTER II

THE LITERATURE

Since the purpose of this dissertation is to analyze the relationship between an organization's economic orientation and its goals and goal setting process, the following literature review considers both of these areas. First, distinctions which have been reported between profit and nonprofit operations are discussed. Questions examined as part of this discussion include: What makes nonprofit enterprises different from profit oriented organizations? Why has there been so little comparative research on these two organizational types? Where can such comparative research be undertaken?

Second, the nature, function, and importance of goals and goal setting as generic concepts applicable to all types of organizations are surveyed in terms of their relationship to the overall strategic management process. In addition, this section examines the major definitional and usage problems associated with organizational goals as well as many of the goal typologies which have been proposed. The section concludes with a review of the more significant theoretical and empirical literature which has focused on the goal formulation process.

Profit/Nonprofit Distinctions

Given the three sector model presented in Chapter I, how does one determine in which sector a particular organization belongs? Over the years, several methods for differentiating organizational forms as either profit, nonprofit, or governmental have been proposed by various authors. Four of these are considered below.

Without question the most intuitive and widely applied criteria for categorizing operations has been the presence or absence of a profit motive. Ginzberg, et al. (1965, p. 25) argue that "the designation of an institutional form as profit, nonprofit, or governmental reflects primarily its legal ownership and only secondarily its economic operations or social purpose." They go on to state (p. 30) that "the key difference between the private sector and the not-for-profit sector is [thus] not the economic activities which they undertake, but is whether they are organized in order to seek a profit from their efforts." Reliance upon the existence or nonexistence of this singular standard has provided the basis for most discussions of profit versus nonprofit operations (MacLeod, 1971; Newhouse, 1970; Rawls, Ullrich, & Nelson, 1975; Reder, 1965; Ruchlin, Pointer & Cannedy, 1973a, 1973b; Taylor, 1955) and is even used by the Internal Revenue Service (1976a, 1976b) as a primary yardstick for judging the validity of an organization's application for tax exempt status.

Copeland and Smith (1978) have taken exception to the use of profit seeking behavior and IRS tax exempt status for categorizing

organizations because, like nonprofit organizations (NPOs), public sector operations are not based on the principle of profit maximization and are also given an IRS tax exemption. Thus, these criteria do not adequately differentiate between NPOs and public sector enterprises even if they work well when comparing NPOs and governmental activities to more traditional private sector ones. In summarizing their analysis, they state (pp. 149-150):

> Three possible differences between NPOs and the private and the government sectors come to mind: one, the tax-free status of NPOs; two, the semipublic nature of the goods and the services which they provide; and three, their sources of funds. . . . The feature which to us most accurately differentiates NPOs from organizations in the private and the government sectors is the percentage of external funds which arise from contributions. . . . Those organizations with higher percentages can be viewed as closer to a true NPO; while those with lower percentages are closer to business firms in the private sector or to public sector organizations.

Declaring the profit/nonprofit dichotomy to be "too general to be useful," Newman and Wallender (1978) have labeled the not-for-profit designation as an impotent tool for organizational research. Rather than relying on whether or not a particular enterprise seeks a profit, these researchers have identified six "constraining characteristics" which they feel account for the unusual management problems found in various types of not-for-profit organizations. These are (p. 26, italics in the original):

1. <u>Service is intangible</u> and hard to measure. This difficulty is often compounded by the existence of <u>multiple</u> service objectives.

2. Customer influence may be weak. Often the enterprise has a local monopoly, and payments by customers may be a secondary source of funds.

3. Strong employee commitment to professions or to a cause may undermine their allegiance to the enterprise.

4. Resource contributors may intrude into internal management--notably fund contributors and government.

5. Restraints on the use of rewards and punishments result from 1, 3, and 4 above.

6. Charismatic leaders and/or "mystique" of the enterprise may be important means of resolving conflict in objectives and overcoming restraints.

Although Newman and Wallender believe that the not-for-profit label is not suited to comparative organizational analysis, they never really offer any alternative definition to use. Rather, it is their conclusion that the presence or absence of one or more of their "constraining characteristics" is more critical in explaining macro level organizational behavior than are the more traditional profit versus nonprofit distinctions. Consequently, one is left to make the assumption that organizations which exhibit any or all of the "constraining characteristics" qualify as something other than traditional profit oriented enterprises. In addition, how these "other than profit" operations might be further subdivided into governmental and nongovernmental categories to fit the three sector model presented above is not discussed.

A final explanation for the observed differences in profit and nonprofit organizations has been suggested by Tideman (1977) who has

focused on the role of entrepreneurship. It is his belief (pp. 326-327) that "the incentive for efficiency in profit-oriented firms comes from the fact that the persons who are responsible for directing production are 'residual claimants.' They receive what is left of income after expenses are paid, so that they receive the gains of efficient innovations and bear the losses of poor ones. . . . A nonprofit organization, on the other hand, has by definition no residual claimant. . . . The concentrated financial incentive of entrepreneurship is absent." In the same context, Weisbrod and Long (1977, p. 341) have noted that "the role of the entrepreneur in the [nonprofit] sector is another little-understood concept." Their discussion (p. 341) goes on to pose, but does not answer, a very basic question: "What is it that motivates entrepreneurs in this context, if not conventional monetary and economic rewards?"

A partial answer to this question may have been indirectly supplied by Rawls, Ullrich, and Nelson (1975) who administered 13 different personality and psychological tests to a group of 142 graduate management students planning to enter or reenter either the profit or nonprofit sector. Following a statistical analysis of the results of the two groups on these measures, Rawls, et al. reported (p. 620) that

> individuals preferring the nonprofit sector [were] more dominant and flexible than were those favoring the profit sector. Nonprofit sector subjects were characterized as having greater capacity for status, social presence, and concern for personal relations. They place less value on obedience, responsibility, ambition, a comfortable life, cleanliness, and economic wealth, and place greater

> value on helpfulness, cheerfulness, and forgiveness. Non-profit sector subjects also expressed a greater need for power and a lesser need for security.

It was their conclusion (p. 622) that "individuals preferring one sector over the other are significantly different along certain personality, value, and behavioral dimensions." If these results can be generalized from the entry level graduate students on which they were obtained to those who have top level positions in each sector, then Rawls, et al. have made a major contribution to the explanation of managerial motivation in nonprofit organizations. More research of this type using top level executives in each sector as subjects is obviously needed before any definitive answer can be made.

Profit/Nonprofit Distinctions: Specific Examples

When attempting to compile a list of studies and discussions which relate to specific comparisons of profit and nonprofit organizational differences, the dearth of available literature quickly becomes apparent. A major reason for this lack of reported research is that it is extremely difficult to find technologically comparable profit and nonprofit enterprises to analyze since most organizations in the nonprofit sector do not have any similar profit sector counterparts. As Newman and Wallender (1978, p. 26) have noted, "in a comparative management study, differences in the nature of business undertaken predominate over ownership differences."

The most significant exception to this situation is currently found in the research which has focused on the health care industry. In order to understand this exception, it is helpful to consider the nature of the largest organizational component of this industry, namely hospitals.

Thompson (1967, pp. 14-18) described hospitals as being characteristic of what he termed an "intensive" form of technology (as opposed to either a "long-linked" or "mediating" form of technology which he used to describe mass production assembly line operations and organizations such as banks, insurance agencies, or telephone companies respectively). According to his discussion (p. 17), the intensive label was used "to signify that a variety of techniques is drawn upon in order to achieve a change in some specific objectives; but the selection, combination, and order of application are determined by feedback from the object itself." For a hospital, the "objects" are the patients, the desired "change" involves a cure for, or relief from, some type of illness or physical damage, and the organization represents a place where a wide array of services and technicians are assembled to affect the desired therapeutic changes in the patients. The exact way in which the resources of the hospital are employed for any given patient depends upon how that individual has responded to previous treatments. This therapeutic process, which Thompson referred to as the organization's "core technology," would remain basically the same for all hospitals, regardless of their individual economic orientations.

Looking specifically at hospitals as a particular organizational type which thus exhibits a single technology, Pfeffer (1973, p. 351) identified four intraorganizational forms based upon their modes of ownership or control. These were:

1. Hospitals funded and operated by governmental units, either city, state, hospital district, federal, or some combination of these;

2. Hospitals operated for profit such as those owned and operated by the Hospital Corporation of America;

3. Hospitals owned and operated by religious denominations; and

4. Private, nonprofit hospitals without religious affiliation.

Using this typology, it is possible to easily classify hospitals according to their economic orientations with groups one, three, and four being composed of various kinds of nonprofit institutions while group two represents profit oriented, investor owned, proprietory units.

The research of Thompson and Pfeffer has shown that hospitals exhibit a single basic or core technology and can be categorized according to their economic orientations. The ability to, in effect, control for variations in an organization's technology, makes it possible to thus eliminate one of the major problems which has plagued previous attempts to compare profit and nonprofit organizations. This greatly simplifies the comparative analysis of profit and nonprofit enterprises as many of the obvious problems which would be associated with a comparison of such technologically diverse or-

ganizations as General Motors and the American Heart Association immediately become irrelevant. Hospitals, therefore, constitute one of the most appropriate types of organizations to examine for differences related to profit and nonprofit orientations.

Hospital Studies

Although the relative merits of the profit versus nonprofit approach to managing health care institutions had been debated since at least the mid 1950's (Taylor, 1955), these discussions were primarily of the philosophical or "arm chair" variety. It was not until the early 1970's that researchers began seeking empirical support for their arguments.

One of the first of these empiricists was Ferber (1971) who analyzed the annual reports, press releases, and prospectuses of for-profit health care corporations as well as statistics compiled by the American Hospital Association for his report on the status of profit and nonprofit hospitals. Trying to provide a baseline for future comparative analyses rather than a formal evaluation of profit versus not-for-profit operations, Ferber found (pp. 51-59) that not-for-profit hospitals were larger in terms of their total number of beds, had higher personnel to patient ratios, paid their employees higher salaries, had higher costs per patient day and per admission, and had higher overall occupancy rates. In addition, a greater percentage of the nonprofit institutions in his study were accredited, had internship programs, were certified for Medicare reimbursement,

and provided such specialized services as organized outpatient departments, emergency departments, home health care programs, premature nurseries, inhalation therapy departments, and intensive care units. The data also showed that the vast majority of for-profit hospitals were located in urban areas (i.e., those with populations of 50,000 or more) of the Pacific, West South Central, East South Central, and South Atlantic regions of the United States. The average length of a patient's stay in these profit oriented hospitals was found to be over a day and a half less than it was in nonprofit institutions.

It was Ferber's conclusion that profit hospitals, particularly those which belonged to a multi-hospital chain, were better able to realize economies of scale, served a somewhat different patient mix, and used their personnel in a more efficient manner. Ferber believed that the role of the for-profit hospital would continue to expand and felt (p. 60) that "socially responsive capitalism, given a reasonable profit incentive, has the potential of making a vital contribution to the improvement of the hospital and medical care delivery system."

Approaching the issue from a managerial rather than an organizational perspective, Davis (1972, p. 1) focused the motivational question posed above by Weisbrod and Long (1977) on the behavior of "those who control major decisions in nonprofit hospitals." Using American Hospital Association data from nonprofit, private hospitals for the years 1961 through 1969, Davis empirically analyzed five economic theories of organizational behavior which had been proposed

as alternatives to profit maximization. These included recovery of costs, output maximization, output and quality maximization, utility and cash flow maximization. She concluded (p. 12) that

> the basic assumption that nonprofit hospitals breakeven--which is a direct goal in the recovery of cost model and a constraint in the output maximization, quality-quantity maximization hypothesis, and the utility maximization hypothesis--is not substantiated by the available evidence. Nonprofit hospitals, in fact, make rather sizable profits and these profits have been growing over time.

Davis' analysis thus provides support for Newman and Wallender's (1978) contention that the nonprofit label is impotent for classifying organizations since the "nonprofit" institutions in her study were guided primarily by the profit motive and did make substantial profits. While showing the "nonprofit" designation to be a misnomer, Davis did not find the hospitals identified as either profit or nonprofit by the American Hospital Association to be identical. According to her summary (p. 12), the

> comparison of nonprofit and for-profit hospitals provides some interesting insights into the principle points of divergence in behavior between the two types of organizational control. Among the most important findings are the following:
>
> 1. Although nonprofit hospitals serve more patients per hospital than do for-profit hospitals, this is largely a consequence of their larger average size.
>
> 2. For-profit hospitals in the same bed-size category as nonprofit hospitals serve more patients (and render more patient days of care) per bed than do nonprofit hospitals.
>
> 3. For-profit hospitals have increased output in the last decade at a faster rate than have nonprofit hospitals.

4. For-profit hospitals have expanded capacity for treating patients at a more rapid rate in the last decade than have nonprofit hospitals.

5. Nonprofit hospitals employ more capital per day of care rendered than do for-profit hospitals.

6. Small for-profit hospitals have more employees per day of care than do nonprofit hospitals. As bed size exceeds one hundred beds, nonprofit hospitals tend to employ more personnel per patient day.

7. Nonprofit hospitals have almost three times as high a ratio of plant assets to beds as do for-profit hospitals.

8. A greater proportion of nonprofit hospitals than for-profit hospitals possesses such specialized facilities as blood bank, pharmacy, physical therapy department, pathology, laboratory, premature nursery, postoperative recovery room, radioactive isotope therapy, and intensive care units.

In a recent unpublished study of 12 investor owned and 32 not-for-profit hospitals in Virginia, Carper (1977) found various institutional differences which were statistically significant ($p < .05$) even when size was controlled. Among these were number of beds, number of employees, operating budget, total assets, and staff/patient ratios (see Table II-1). Similar results have also been reported by the American Hospital Association (1978) based upon its annual national survey of health care institutions (see Table II-2).

Although the contingency approach to organizational analysis, which was briefly outlined in Chapter I, has provided the conceptual foundation for a myriad of research efforts in recent years, it has not been utilized to any extent to compare organizations based upon

Table II-1

Comparisons of For-profit and Nonprofit Hospitals on Selected Organizational Dimensions

Organizational Dimensions Examined	Overall Means for		Means per 100 Beds		Significant Differences ($p < .05$)
	For-profit Hospitals	Nonprofit Hospitals	For-profit Hospitals	Nonprofit Hospitals	
Number of Beds	125.5	211.7	--	--	*
Number of Employees	219.4	583.6	174.8	275.7	*
Operating Budget (000)	$4,839.0	$11,868.0	$3,855.8	$5,606.0	*
Total Assets (000)	$4,335.9	$13,177.6	$3,454.9	$6,224.7	*
Staff-Patient Ratio	2.24:1	3.77:1	224.0	377.0	*

SOURCE: Carper, William B. "The Characteristic of Hospital Administrators and Their Relationships to Intraprofessional Differences." Unpublished paper, Virginia Polytechnic Institute and State University, Blacksburg, VA, 1977.

Table II-2

Comparisons of For-profit and Nonprofit Hospitals on Selected Organizational Dimensions (AHA Data) for 1977

Organizational Dimensions Selected	Overall Means for		Means per 100 Beds	
	For-profit Hospitals	Nonprofit Hospitals	For-profit Hospitals	Nonprofit Hospitals
Number of Hospitals	751	3371	--	--
Number of Beds	106.5	201.7	--	--
Number of Admissions	3,793.6	7,203.8	3,561.3	3,571.2
Occupancy Rate (%)	64.6	76.3	--	--
Length of Stay (Days)	6.6	7.8	--	--
Number of Employees	211.7	552.7	198.8	274.0
Staff-Patient Ratio	2.79:1	3.16:1	279.0	316.0
Cost per Patient Day	$176.99	$174.64	--	--
Total Assets (000)	$4,652.5	$13,849.3	$4,368.5	$6,866.3

SOURCE: American Hospital Association, American Hospital Association Guide to the Health Care Field, 1978 ed. Chicago: American Hospital Association, 1978, p. A-9.

differences in their economic orientations. The most notable major exception to this veritable lacuna in the literature has been the work of Rushing (1974, 1976) which presented empirically based, substantive discussions of the effect which an organization's economic orientation has on its macro level behavior rather than merely descriptive summaries of organizational statistics.

Using a mail questionnaire, Rushing (1974, 1976) obtained responses from the administrators of 21 profit and 40 nonprofit general, short-term hospitals with less than 96 beds in the Tennessee Mid-South region which were members of the American Hospital Association. In his initial report (1974), Rushing analyzed the effect of a hospital's economic orientation upon its efficiency and effectiveness as an organization. He concluded (1974, p. 483) that "the differences in the correlates and probable determinants of efficiency and effectiveness between profit and nonprofit hospitals stem from the fact that one type is primarily an economically oriented organization and the other is not." Commenting on the possible significance of his research, Rushing (1974, p. 483) stated that "it would appear that the profit-making orientation of hospitals, and possibly other types of organizations as well, is a significant organizational property that influences the relationship between intraorganizational variables."

Two years after his first report, Rushing (1976) presented a further analysis in which he found a significant relationship between a hospital's economic orientation and the kind and amount of differ-

entiation and coordination which it exhibited. This time Rushing (1976, p. 689) went on to discuss the implications which the results of his research held for the study of organizational theory:

> They [the results] are thus consistent with the general framework of contingency theory (cf. Lawrence and Lorsch, 1967), which views the existence of intraorganizational relationships as contingent on other conditions (e.g., nature of the environment, type of technology). [The] results extend the contingency framework in that they indicate that organizational orientation, specifically profit versus nonprofit orientation, may be a significant contingency for intraorganizational relationships. . . .
>
> Finally, it is worth noting that the results for profit hospitals conform more closely than results for nonprofit hospitals to expectations based on organizational theory. This raises the general question of whether most organizational theory is more appropriate for understanding organizations in which the primary goals are economic than for understanding organizations in which the primary goals are community service and community welfare.

While not all observers (Murray, 1975; Newman & Wallender, 1978; Ruchlin, Pointer, & Cannedy, 1973a) would agree that the distinctions between profit and nonprofit organizations are either as clear cut or as significant as Rushing has argued, others believe that more research is needed before any firm conclusions are justified. One of these is Wortman (1979, pp. 372-373) who, in summarizing his extensive review of the literature on strategic management for nonprofit organizations, has not only cited the need for more research but has also indicated where this research should begin:

> Throughout this study, there seems to be a major recurring theme--that of the need for simple exploratory studies of goals and goal structures in all types of not-for-profit organizations. Although some would argue that goals and goal structures in not-for-profit organizations are sig-

> nificantly different than those in profit-oriented organizations, there is little or no evidence that they are similar or dissimilar. Therefore, studies of the strategic management process in not-for-profit organizations must begin at the very earliest stages of that process-namely goals and goal structures.

Organizational Goals and Goal Setting

Wortman's 1979 identification of organizational goals and goal structures as the logical place for the comparative analysis of strategic processes in profit and nonprofit organizations to begin is hardly accidental. For years, organizational researchers (Ansoff, 1965; Barnard, 1938/1968; Chandler, 1962; Christensen, Andrews, & Bower, 1978; Dent, 1959; Perrow, 1960, 1961, 1963, 1965; Richards, 1978, Steiner, 1969; Steiner & Miner, 1977) have recognized the fundmental and intrinsic relationship between an organization's goals and the strategies and policies it adopts. Even with all this attention, it would appear that the in-depth study of organizational goals is much like the famous statement attributed to Mark Twain concerning the weather: Everyone talks about it but no one does anything about it. The following section begins with a brief consideration of the nature, importance, and function of organizational goals as generic concepts applicable to all types of organizations and then discusses several reasons for the lack of rigorous analysis which has plagued the field. It concludes with an examination of the more important theoretical and empirical studies which have focused on organizational goals and goal setting.

Nature and Importance

The definition of organizations as a collectivities of individuals which engage in purposive, goal directed activities has had a long history in the organizational theory literature. Weber (1922/1947, p. 151) held that "an 'organization' is a system of continuous purposive activity of a specific kind." Barnard (1938/1968, p. 73 italics in original) saw "a formal organization as a system of consciously coordinated activities or forces of two or more persons." Gibb (1954, p. 879) characterized an organization as "two or more organisms interacting, in the pursuit of a common goal, in such a way that the existence of many is utilized for the satisfaction of some needs of each." Etzioni (1964, p. 3) claimed that "organizations are social units (or human groupings) deliberately constructed and reconstructed to seek specific goals." Definitions such as these, as well as similar ones found in the writings of others (Azumi & Hage, 1972; Cyert & March, 1963, Gross, 1969; Hrebiniak, 1978; Simon, 1964), have caused Richards (1978, p. 9) to conclude that "an organization would not exist unless it undertook the satisfaction of some common objective. By definition, an organization has a goal or goals."

This inherent relationship between an organization and its goals has been a basic part of the business policy (or what has more recently become known as strategic management) literature for many years. Almost two decades ago, Chandler (1962, p. 13) described strategy as "the determination of the basic long-term goals and objectives of an enterprise, and the adoption of courses of action and the allocation

of resources necessary for carrying out these goals." More recently, Christensen, Andrews, and Bower (1978, p. 125) have defined it as "the pattern of decisions in a company that (1) shapes and reveals its objectives, purposes, or goals, (2) produces the principle policies and plans for achieving these goals, and (3) defines the business the company intends to be in and the kind of economic and and human organization it intends to be."

Since an organization's goals and strategy are so closely related (Chandler, 1962; Andrews, 1965, 1971) one of the best ways to study the latter is by a careful examination of the former. In this regard, it is important to understand the functions or purposes served by organizational goals.

Functions and Dysfunctions of Organizational Goals

As a practical matter, any enterprise which is considering the formulation, revision, or widespread dissemination (either internally or externally) of its organizational goals is facing a major strategic decision. All too often, only the positive aspects of such a decision receive attention as evidenced by the many exhortations of how the establishment and/or publication of organizational goals can benefit both an institution and its members (Ackoff, 1970; Ansoff, 1962, 1965; Blankenship, 1977; Cantley, 1970; Christensen, Andrews, & Bower, 1978; Drucker, 1958; Granger, 1964, 1970; Hunger & Stern, 1976; Huston, 1962; Kotler, 1975; Mankin & Glueck, 1977; Redwood, 1977; Richards, 1978; Skibbins, 1974; Thierauf, Klekamp, & Geeding, 1977;

Thompson & Strickland, 1978). A smaller number of authors (Cartwright & Zander, 1968; Cotton, 1962; Cressey, 1958; Georgion, 1973; Gross, 1965; McCaskey, 1974; Quinn, 1977; Steers, 1977; Warner & Havens, 1968) have taken the alternate approach of presenting discussions of the dysfunctions as well as the functions of organizational goals. The recognition of both the advantages and disadvantages of organizational goals is necessary for either an organization or a researcher to obtain a balanced perspective.

A summary of three of the more cogent statements about the relative merits and problems associated with organizational goals is presented in Table II-3. Without going into a lengthy recitation of the table, it should be noted that quite often it is possible for a given aspect of a goal to be both functional and dysfunctional at the same time. Thus while a highly explicit goal may serve to provide organizational members with an end to strive for (as in the case of a output goal), it may also create conflict between and among individuals and groups within the organization if they begin to fight over the control of resources essential to the achievement of the goal. Likewise, this same goal may simultaneously serve to focus the attention of opposing external factions on the activities of the organization as was the case in many situations during the Viet Nam War (e.g., Dow Chemical and its napalm production).

This does not mean that organizations do not or should not have goals. As described above, organizations are by definition goal directed. Rather, it means that the form and kind of goals which

Table II-3

Functions and Dysfunctions of Organizational Goals
Cited By Selected Authors

Author	Functions	Dysfunctions
Quinn (1977, pp. 22-29)	Limited and vague goals can: 1. Aid organizational security by not giving competitors "free" information. 2. Promote cohesion by being general enough to allow for consensus. 3. Create an identity an alan for the organization's members. Specific goals can: 1. Provide a challange for the members of the organization which can be easily understood. 2. Help signal a major change from the past. 3. Decrease frustration and aid in building the confidence of the members of the organization. In general, goals can help: 1. Build morale. 2. Settle conflicts by establishing priorities. 3. Define problem areas that need attention.	Highly explicit goals can: 1. Cause unwanted centralization, regidity, resistance to the goals themselves, and eliminate creative initiative. 2. Focus a previously fragmented opposition onto specific issues. 3. Create conflict among members of the organization. 4. Create conflict among units or departments within the organization. 5. Become ends in themselves.

Table II-3 (Continued)

Functions and Dysfunctions of Organizational Goals
Cited By Selected Authors

Author	Functions	Dysfunctions
Steers (1977, p. 21)	For the organization, goals can: 1. Focus attention. 2. Provide a rationale for organizing. 3. Provide a standard for assessment. 4. Provide a source of legitimation. 5. Aid in recruitment by providing an organizational identity. For the individual, goals can: 1. Focus attention. 2. Provide a rationale for working. 3. Provide a vehicle for personal goal attainment. 4. Provide a sense of personal security. 5. Provide a feeling of identity and status.	For the organization, goals can: 1. Cause the means to an end to become the real goals. 2. Place so much emphasis on measurement that quantitative goals are stressed at the expense of qualitative ones. 3. Create a goal specificity problem in that ambiguous goals may fail to provide direction while highly specific ones may constrain action and creativity. For the individual, goals can: 1. Show that rewards may not be tied to goal attainment. 2. Create difficulty in determining relevant performance evaluation criteria. 3. Make it hard for him/her to identify with abstract and/or global goals. 4. Become incongruent and thus in conflict with personal goals.

Table II-3 (Continued)

Functions and Dysfunctions of Organizational Goals
Cited By Selected Authors

Author	Functions	Dysfunctions
Warner and Havens (1968, pp. 543-545)	Intangible goals can: 1. Allow the organization to accommodate diverse and even inconsistant subgoals. 2. Facilitate flexibility and adaptation. 3. Lead to action. 4. Allow one to accept the assumption that the organization is effective.	Intangible goals can: 1. Cause frustration, anxiety, and role conflict among members of the organization. 2. Lead to disillusionment with the organization. 3. Make it difficult to have "success experiences" which tend to build confidence and increase job satisfaction and morale.

any collectivity will establish is contingent upon such factors as management philosophy, the internal climate, and the external environment. Furthermore, as these factors change over time, so will an organization's goals evolve and be revised to reflect the new contingencies.

In essence then, organizational goals can have both positive and/or negative aspects at any given point in time. It is therefore up to top management to weigh these and decide on the type of goal or goals which will be established. Regardless of whether the goals are vague or explicit, closely held or widely publicized, Richards (1978, pp. 8-9) is quite justified in concluding that "goals and objectives permeate the whole management process, providing an underpinning for planning efforts, direction, motivation, and control."

An understanding of these goals and goal setting processes is therefore of great importance in the evaluation of an organizations strategy. Because of this, one might logically expect to find a great number of in-depth research efforts aimed at clarifying the field and providing a common basis for research. Such has not been the case. Several of the reasons for this situation are considered next.

Definitions and Usage of Terms

An organizational goal is an elusive concept which has often in the past been taken for granted by policy/strategy researchers as something which everyone intuitively understands. Recently, however,

a number of observers (Granger, 1964; Gross, 1968, 1969; Hall, 1975; Morasky, 1977) have come to realize that this assumption is not valid. Commenting on this situation, Morasky (1977, p. 85) has concluded that one

> . . . is often assured of the necessity of goals without being clearly informed of the definition of the thing which is so necessary. This situation leads to a variety of conditions for organizations and programs; the most common of which seems to be that goals are often haphazardly derived, poorly understood, and limited in function.

Similarly, based upon his review of the literature on goals, planning, and management in general, Granger (1964, p. 74) found it strange

> . . . that so many discussions of management begin with exhortations to clarify objectives, and then, as if the nature of objectives were well known, proceed to explore some other aspect of the matter at hand. In reality we know very little about the nature of objectives.

A primary factor which has contributed to this current condition relates to the general lack of agreement among organizational scientists as to how many of the key terms should be defined and operationalized.

Almost twenty years ago in his insightful analysis of what he referred to as "the management theory jungle," Koontz (1961, p. 13) argued that "the variety of approaches to management theory has led to a kind of confused and destructive jungle warfare." It was his belief (p. 13) that these various approaches were clearly

> . . . not drawing greatly different inferences from the physical and cultural environment surrounding us. Why, then, have there been so many differences between them and why such a struggle, particularly among our academic brethern to obtain a place in the sun by denying the approaches of others? Like the widely differing and

> often contintious denominations of the Christian religion, all have essentially the same goals and deal with essentially the same world.

Not content to merely identify a problem, Koontz proceeded to list various causes for the conflict and confusion in the field. Two of these causes related to semantic problems associated with the meaning of key words and the unwillingness of management theorists to understand each other. Koontz concluded (pp. 16-19) by calling for: (1) the establishment of a generally accepted definition of the field of management which could serve as a basis for subsequent research; (2) the integration of management and other disciplines; (3) the clarification of management semantics; and (4) an increase in the willingness on the part of management theorists to try to distill and test the fundamental principles of the field.

Apparently Koontz's call for synthesis and integration has had little if any effect on the field of management theory especially with regard to the need to clarify its semantics. For example, there is considerably less than unanimous agreement on how the terms "goals," "objectives," and "purposes" should be defined (see Table II-4). Although Etzioni's (1964, p. 6) definition of goals as "desired state[s] of affairs which the organization attempts to realize" is perhaps the most frequently quoted, it has not achieved the status of an axiom. Thus, other writers have argued that goals are "value premises" (Simon, 1964, p. 3), "long range purposes" (Blankenship, 1977, p. 8), "near-term organizational performance targets" (Thompson & Strickland, 1978, p. 15), or "imagined states of affairs"

Table II-4

Definitions of Organizational Goals
Which Have Been Offered By Selected Authors

Author	Definition
Ackoff (1970, pp. 23-24)	Goals are objectives whose attainment is desired by a specified time within the period covered by the plan.
Blankenship (1977, p. 8)	The term goal, as used here, is defined as the Long Range purpose toward which a business endeavor is directed.
Etzioni (1964, p. 6)	An organizational goal is a desired state of affairs which the organization attempts to realize.
Gross (1969, p. 293)	By an organizational goal . . . we understand a state of the organization as a whole toward which the organization is moving, as evidenced by statements persons make (intentions) and activities in which they engage.
Hall (1975, p. 13)	Organization goals are the desired ends or states of affairs for whose achievement system policies are committed and resources allocated.
Hill (1969, p. 198)	This paper uses the terms goals, objectives, aims, and purposes interchangeably. This phenomenon is defined as the motives of executives which serve as value premises in the decision process.
Mohr (1975, p. 475)	An organizational goal is the gola of a program occurring within the organization and under its auspices whose direct referent is either the organization itself as an institution or some aspect of the organization's environment.
Redwood (1977, p. 2)	Corporate objectives are a set of basic principles defining the purpose of corporate activity.

Table II-4 (Continued)

Definitions of Organizational Goals
Which Have Been Offered By Selected Authors

Author	Definition
Simon (1964, p. 3)	By goals we shall mean value premises that can serve as inputs to decisions.
Thompson (1967, p. 127)	We use goal to refer . . . to some imagined state of affairs which may be conceivably attained or approached (if not finite) at some future time.
Thompson and Strickland (1978, p. 15)	Goals are the near-term organizational perfromance targets which an organization desires to attain in progressing towards its objectives.
Vancil (1976, p. 3)	A goal is an achievement attained at some future date.
Warner (1967, p. 5)	By an organizational goal I mean a state of affairs or situation which does not exist at present but is intended to be brought into existence in the future by the activities of the organization.

(Thompson, 1967, p. 127), to mention only a few of the variations.

Not only is there a lack of consensus on how the concepts of goals, objectives, and purposes should be defined, there is also a major schism in how these terms should be employed. This has led one group (Ackoff, 1970; Thierauf, Klekamp, & Geeding, 1977; Thompson & Strickland, 1978; Vancil, 1976) to claim that these three terms are separate and distinct, while another (Christensen, Andrews & Bower, 1978; Hill, 1969; Pfeffer & Salancik, 1978; Price, 1968; Richards, 1978) holds that they may be used interchangeable, and still a third (Cyert & March, 1963; Katz & Kahn, 1978; Koontz & O'Donnell, 1976; Steers, 1977) finds that only the terms "goals" and "objectives" are synonymous. This and other similar situations have caused Wortman (1977, p. 3) to conclude that the "terminology in the business policy field is in a shambles."

This inability to achieve consensus on even the basic definitions and usages of the terms which are central to any discussion of goals has created many problems for those interested in doing research in the area. In addition, the "intellectual debate" which has taken place has generally done little more than divert attention from more substantive areas of research, retard the development of comparative organizational analysis, and, on the whole, waste a good deal of time and paper. It is obvious that the field is still wandering through the "management theory jungle" which Koontz (1961) described almost twenty years ago.

Goal Typologies

Another factor which has inhibited research on organizational goals and which is closely related to the semantic problems just discussed pertains to the construction and use of goal typologies. There are almost as many typologies of organizational goals as there are writers in the field. Table II-5 summarizes 23 "different" classificatory schemes which have been proposed by 18 authors. This listing is hardly exhaustive and is certainly not mutually exclusive. The table also shows that some authors, such as Perrow and Etzioni, have used different terminology for the same ideas in different publications--a situation that again creates problems for comparative analysis and synthesis (Hannan & Freeman, 1977).

Perhaps the most useful macro-level typology is the one set forth by Perrow in 1961. According to his dichotomy (p. 855), organizational goals can be differentiated according to whether they are official or operative with

> official goals [reflecting] the general purposes of the organization as put forth in the charter, annual reports, public statements by key executives and other authorative pronouncements. . . . [while] operative goals designate the ends sought through the actual operating policies of the organization; they tell us what the organization actually is trying to do, regardless of what the official goals say are the aims.

The basic philosophy found in this approach has been adopted in one form or another by many of the authors cited in Table II-5. Consequently, because of the great influence which this schema has had on the field together with its simplicity and intuitive appeal, Perrow's

Table II-5

Organizational Goal Typologies
Which Have Been Proposed By Selected Authors

Author	Terminology Used	Explanation of Terminology (If Necessary)
Ackoff (1970, pp. 24-41)	1. Stylistic objectives	Qualitative descriptions of desired outcomes which have intrinsic value and enable an organization's management to reach consensus on the kind of business it would like to be in and the way (style) in which it would like to conduct it.
	2. Performance objectives	Identifiable, tangible and measurable desired outcomes which have instrumental value and operational definitions.
Ansoff (1962, pp. 41-46)	1. Pseudo-objectives	Restatements of external constraints that business has to accept, whether it likes it or not.
	2. Realistic objectives	Either (1) economic objectives such as those aimed at profit maximization and the continued survival of the organization or (2) noneconomic or social objectives such as management's personal objectives, the organization's enlightened self-interest objectives, or the organizaiton's philantropic objectives.
Barnard (1938/ 1968, pp. 91-92)	1. General purposes 2. Specific purposes	Abstractions about what the organization does. Realistic, concrete statements about what the organization does.
Catton (1962, p. 32)	1. Stated goals 2. Unstated goals	

Table II-5 (Continued)

Organizational Goal Typologies
Which Have Been Proposed By Selected Authors

Author	Terminology Used	Explanation of Terminology (If Necessary)
Cressey (1958, p. 49)	1. Official or formally stated goals 2. Informal or unstated goals	
Drucker (1958, p. 84-87)	Survival objectives	1. The enterprise needs, first, a human organization designed for joint performance and capable of perpetuating itself. . . . It must be able to survive the life span of any one man. 2. The second survival objective arises from the fact that the enterprise exists in society and economy. . . . here is need for objectives which anticipate so as to enable the business to adapt and which at the same time aim at creating the most favorable conditions. 3. Then, of course, there is the area of the specific purpose of the business, of its contribution. The purpose is certainly to supply an economic good and service. This is the only reason why business exists. 4. Every business, to survive, must strive to innovate. 5. Profitability at a minimum or survival level.
Etzioni (1960, p. 259)	1. Public goals 2. Private goals	The goals an organization claims to pursue. The goals it actually follows.

Table II-5 (Continued)

Organizational Goal Typologies
Which Have Been Proposed By Selected Authors

Author	Terminology Used	Explanation of Terminology (If Necessary)
Etzioni (1964, p. 7)	1. Stated goals	Goals which are stated but command few resources.
	2. Real goals	Those future states toward which a majority of the organization's means and the major organizational commitments of the participants are directed.
Etzioni (1975a, pp. 104-105)	1. Order goals	Those aimed at preserving social order by segregating social deviants.
	2. Economic goals	Those oriented toward the production of goods and services for outsiders.
	3. Culture goals	Those oriented toward the preservation or creation of culture.
Gordon and Babchuk (1959, pp. 25-26)	1. Instrumental goals	Those aimed at social influence and designed to maintain or create some normative condition or change.
	2. Expressive goals	Those aimed at doing specific things for the organization's members and which become ends in themselves.
	3. Instrumental-Expressive goals	Those which may serve either function.
Gross (1969, p. 287)	1. Output goals	Those which are reflected immediately or in the future in some product or service, skill or orientation which will affect (and is intended to affect) a given society.
	2. Adaption goals	Those which reflect the need for the organization to come to terms with the environment in which it is located.

Table II-5 (Continued)

Organizational Goal Typologies
Which Have Been Proposed By Selected Authors

Author	Terminology Used	Explanation of Terminology (If Necessary)
Gross (Cont.)	3. Management goals	Those which reflect decisions on who should run the organization, the need to handle conflict, and the establishment of priorities on which output goals are to be given maximum attention.
	4. Motivation goals	Those which seek a high level of satisfaction on the part of the organization's members and clients, and which emphasize loyalty to the organization as a whole.
	5. Positional goals	Those which serve to help maintain the position of the organization in terms of the kind of place it is in comparison to other organizations, and in the face of attempts or trends which could change its position.
Hage and Aiken (1970, p. 125)	1. Formal goals	Those embellished in the formal statements of management.
	2. Operative goals	Those which are actually pursued.
March and Simon (1958, pp. 156-157)	1. Operational goals	Those which provide a means of testing possible alternative courses of action.
	2. Nonoperational goals	Those which do not provide for a means of testing possible alternative courses of action.
Mee (1956, p. 65)	1. Profit objectives	Those which will motivate management.
	2. Service objectives	Those aimed at providing the desired economic values to the customers of the organiz-tion.
	3. Social responsibility objectives	Those which are in line with the ethical and moral codes established by the society in which the industry resides.

Table II-5 (Continued)

Organizational Goal Typologies
Which Have Been Proposed By Selected Authors

Author	Terminology Used	Explanation of Terminology (If Necessary)
Mohr (1973, pp. 475-476)	1. Transitive goals	Those whose referent is outside of or in the environment of the organization in question and which thus relate to the intended impact of the organization upon its environment.
	2. Reflexive goals	Those which are internally oriented and designed to provide sufficient inducements that will in turn evoke adequate contributions from all organizational members with the ultimate aim being the continued survival of the organization.
Parsons (1960, p. 45-46)	1. Adaptive goals	Those which allow the organization to change and adapt to changes.
	2. Implementive goals	Those which are means to specific ends.
	3. Integrative goals	Those which are aimed at creating harmony through a sense of common purpose.
	4. Pattern-Maintanence goals	Those which are aimed at the continued existence of the organization.
Perrow (1961, p. 855)	1. Official goals	Those which represent the general purposes of the organization as put forth in the charter, annual reports, public statements by key executives and other authoritative pronouncements.
	2. Operative goals	Those which designate the ends sought through the actual operating policies of the organization; they tell us what the organization is actually trying to do, regardless of what the official goals say are the aims.

Table II-5 (Continued)

Organizational Goal Typologies
Which Have Been Proposed By Selected Authors

Author	Terminology Used	Explanation of Terminology (If Necessary)
Perrow (1967, p. 200)	1. System goals	Those which relate to the characteristics of the system as a whole, independent of its products.
	2. Product characteristic goals	Those which relate to the characteristics of the products the organization decides to emphasize.
	3. Derived goals	Those which refer to the uses to which power generated by organizational activities can be put, independent of system or product goals.
Perrow (1968, pp. 306-309)	1. Societal goals	Those which express the function of the organization for society.
	2. Output goals	Those which refer to the general product of the organization and the public in contact with the organization.
	3. System goals	Those established by key executives regarding the size, growth, stability, market share, domain, and so forth, of the organization.
	4. Product goals	A subcategory of output goals; they are most useful for comparisons of similar organizations and include such things as the type, quality, cost, styling, and availability of the goods or services produced.
	5. Derived goals	Those which are derived from the existence and behavior of the organization but which are considered essential to its conduct.
	6. Investor goals	Those which relate to the investors in the organization.

Table II-5 (Continued)

Organizational Goal Typologies
Which Have Been Proposed By Selected Authors

Author	Terminology Used	Explanation of Terminology (If Necessary)
Perrow (1970, pp. 135-136)	1. Societal goals	Referent: society in general. This category deals with large classes of organizations that fulfill societal needs.
	2. Output goals	Referent: the public in contact with the organization. This category deals with types of output defined in terms of consumer satisfaction.
	3. System goals	Referent: the state or manner of functioning of the organization, independent of the goods or services it produces or its derived goals.
	4. Product goals	Referent: the characteristics of the goods or services produced.
	5. Derived goals	Referent: the uses to which the organization puts the power it generates in pursuit of the other goals.
Redwood (1977, p. 4)	1. Financial objectives	Those which are easily quantifiable and directly related to the growth, efficiency, and profitability of the organization.
	2. Nonfinancial objectives	Those which are not a part of the above, and including such areas as job satisfaction, social responsibility, safety, and environmental concerns.
Steers (1977, p. 24)	1. Official goals	Those which represent formal statements of purpose made by executive management concerning the nature of an organization's mission.
	2. Operative goals	Those which represent the real intentions of an organization; i.e., what the organization is

Table II-5 (Continued)

Organizational Goal Typologies
Which Have Been Proposed By Selected Authors

Author	Terminology Used	Explanation of Terminology (If Necessary)
Steers (Cont.)		actually trying to do irrespective of what it claims to be doing.
	3. Operational goals	Those for which there are agreed upon criteria for evaluating the extent to which organizational activities contribute toward goal attainment.
Warner and Havens (1968, p. 540)	1. Tangible goals	Those which are stated by the organization in concrete terms.
	2. Intangible goals	Those which are expressions of intended states of affairs that do not adequately describe the desired states or the activities that would constitute their achievement.

official-operative typology has been selected for use in this dissertation.

Previous Research on Goals and Goal Setting

Theoretical Studies

Although a myriad of works have dealt with the subject of organizational goals in one way or another, most of these have done so only in a very superficial manner. At the same time, only a few researchers have ever attempted to discuss the largely ignored area of goal formulation in any detail. Several reasons for this lack of in-depth analysis have already been presented above. As a result of this deficiency, the theoretical literature which has appeared on goals and goal setting has failed to provide a comprehensive conceptual model for the study of this important topic. Consequently little progress has been made in the past decade since Hill (1969, p. 198) observed that "no universally accepted theory has evolved which explains the process of goal formation."

Two of the first works to consider goal formulation appeared in 1958 (March & Simon; Thompson & McEwen). March and Simon's approach to goal setting was in terms of a satisficing model rather than the traditional maximizing model of the classical economists (Smith, 1937). Viewing organizations as collections of individuals engaged in decision making, satisficing was regarded as the only logical way that the necessary decisions could be made because of the constraints imposed by the "boundaries of rationality." Since no one could, therefore,

ever obtain everything which he or she desired, an optimal solution was out of the question and the organization was required to set satisfactory levels of desired outcomes (goals) and select the "best" strategy from a variety of feasible alternatives.

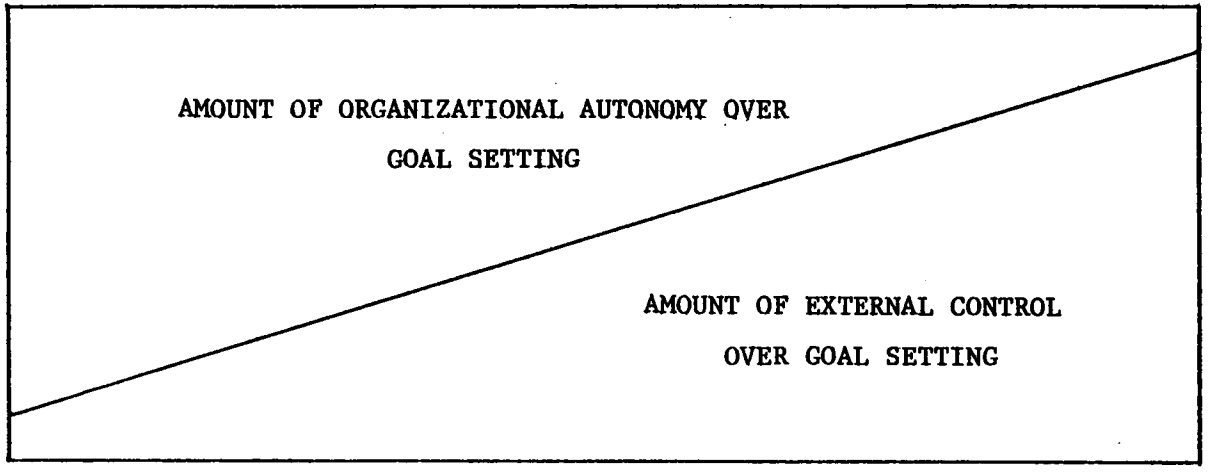
The goal formulation process outlined by Thompson and McEwen (1958) was much more complex and involved a reconciliation between the desires of the organization and the opportunities and constraints imposed upon it by the external environment. These authors described organizations as basically open systems which depend upon their external environments for input resources and/or output consumption. The survival of the organization was thus dependent upon adaptation to environmental contingencies which was seen as being accomplished primarily through the process of goal formation and revision.

Thompson and McEwen's model (see Table II-6) focused on a trade-off between the amount of organizational autonomy and external control present in the goal setting process. The left end of their continuum, labeled "competition," was where the organization had almost complete control over goal formulation and the environmental influence was primarily exercised through indirect means. This represented the ideal situation from the organization's point of view. Moving across the horizontal axis from left to right, the amount of external control increases and becomes more direct. This general relationship was termed "cooperation" and subdivided into three types: "bargaining;" "cooptation;" and "coalition."

Bargaining represented the lowest level of cooperation with the

Table II-6

Thompson and McEwen's Goal Setting Model



COMPETITION — COOPERATION

BARGAINING — COOPTATION — COALITION

SOURCE: Adapted from Thompson, James D. and William J. McEwen. "Organizational Goals and Environment: Goal-Setting as an Interaction Process." American Sociological Review, Vol. 23 (February 1958), 23-31.

environment and was described by Thompson and McEwen (p. 26) as "the negotiation of an agreement as for the exchange of goods and services between two or more organizations." Cooptation occured when an external actor was actually absorbed "into the leadership or policy-determining structure of an organization as a means of averting threats to its stability or existence" (p. 27). This significantly increased the amount of external control over goal setting because

> not only must the final choice be acceptable to the co-opted party or organization, but to the extent that co-optation is effective it places the representative of an "outsider" in a position to determine the occasion for a goal decision, to participate in analyzing the existing situation, to suggest alternatives, and to take part in the deliberation of consequences (p. 27).

Finally, at the opposite extreme from competition, was a coalition or joint venture type of alliance whereby two or more organizations would unite in order to achieve a common purpose which none of them was able to do singularly. Not only was external control maximized in coalitions, the necessity of finding other organizations which were also willing to coalesce acted as an additional constraint on the activities of the focal organization.

Although Thompson and McEwen never explicitly stated a contingency relationship between the goal setting strategy an organization should use and the type of external environment which it faces in a given situation, it is implied throughout their article that the environment determines the goal setting strategy and that as the environment changes, so will the goal setting strategy used by the organization. Furthermore, in their discussion of goal setting

as a process of organizational-environmental interaction, Thompson and McEwen never really deal with how any particular goal is established or what specific aspects of the external environment are relevant for a given goal. Thus, while an organization is said to set its goals through either bargaining, coopting, or coalescing with the external environment, the specific manner in which these processes might actually operate in real organizations is not discussed. Left unanswered, therefore, are such questions as: Who exactly is involved in the goal setting process? How are relevant environmental forces identified? How is the relative importance of each of these forces evaluated once they are identified? The model is also incomplete in that it does not consider the roles of the internal environment of the organization or the personal characteristics, aspirations, desires, and biases of the organizational goal setters.

Three additional models of goal formulation which have been widely referenced in the recent literature evolved out of studies published in the 1960's. These have been identified by Hall (1975) as the bargaining model of Cyert and March (1963), the problem solving model of Simon (1964), and the dominant coalition model based upon the collected works of Perrow (1961), Thompson (1967), and Hill (1969). (The following discussion of these three models is based largely upon Hall's analysis (1975, pp. 14-23).)

Cyert and March (1963) introduced the concept of "side payments" in their discussions of how organizations achieve agreement on what goals to establish. Since their model viewed goal setting as essen-

tially a process of negotiation between and among the various active members of the organization who have differing and often conflicting ideas as to what should be done, it was through use of side payments that conflicts are resolved and a modicum of consensus was obtained. Thus, it was

> primarily through bargaining within this active group that what we call organizational objectives arise. Side payments, far from being the incidental distribution of a fixed, transferable booty, represent the central process of goal specification (p. 30, italics in the original).

Bargaining for Cyert and March was, therefore, a continuous process in organizations since conflict could never be completely eliminated even through the use of side payments. Furthermore, it was recognized that as the desires of the active group change over time, so would the bargaining process and hence the goals of the organization. A summary of the major assumptions of this model is found in Table II-7.

A problem solving approach to goal setting was proposed by Simon (1964) who described goals as input constraints on the rational and programmable process of decision making. Whereas, previous approaches had acknowledged that external forces could directly enter the actual decision making of the organization, Simon did not entertain this possibility, although he did make some provision for indirect control in the form of imposed constraints.

Using what amounted to a linear programming (LP) model of decision

making, Simon held that an objective function as well as constraints can be identified and assigned priorities by the policy makers of the organization who retain direct control over the process. As in his earlier work with March (1958), Simon concluded that it was not possible to achieve a maximization of goal outcomes and instead opted for satisficing solutions even though this was counter to the traditional linear programming model (Lee, 1972). (See Table II-7 for a listing of Simon's major assumptions.)

The interest in developing a programmable model for goal formulation is still strong as indicated by several recent reports. Like Simon, Hill (1969) has also looked at goal setting in organizations in terms of a linear programming model and has discussed the ways in which various power groups might form coalitions to affect goal outcomes. A more promising approach has been described in separate articles by Lee (1972) and Tersine (1976) who have proposed the use of goal programming (GP) as an alternative to the linear programming models of Hill and Simon. Commenting on the advantages of GP over LP, Tersine (1976, p. 31) finds that the former can handle multiple conflicting goals, use ordinal rather than cardinal rankings, obtain a solution even if its constraints are violated, and produce a satisficing solution if an optimizing decision is not possible. Although more application oriented research using GP models in organizational goal setting is needed, the flexibility and broader systems perspective of this approach would seem to make it a preferred choice

Table II-7

Basic Assumptions of Three Goal Setting Models

BARGAINING MODEL Cyert and March (1963)	PROBLEM SOLVING MODEL Simon (1964)	DOMINANT COALITION MODEL Perrow (1961), Thompson (1967), and Hill (1969)
1. There is an active group of participants (internal or external) who impose demands on the organization.	1. Policy commitments are made within a set of constraints or requirements that are known to decision makers.	1. There are many persons or groups who hold goals for an organization. These goals are frequently in conflict and cannot all be accommodated.
2. These demands are conflicting. They cannot [all] be accommodated simultaneously.	2. These constraints can be ranked and a preferred set accommodated.	2. One individual or group does not have sufficient power alone to act unilaterally. Power is dispersed. Collective behavior is required to secure support for goals.
3. The individuals or groups are interdependent.	3. The goals of different individuals or groups can be simultaneously satisfied.	

SOURCE: Hall, Francine S. "Organizational Goals: The Status of Theory and Research." In J. Leslie Livingstone (Ed.), Managerial Accounting: The Behavioral Foundations. Columbus, OH: Grid, Inc., 1975, pp. 17, 20, 23.

over the older LP models.

The third of the models from the 1960's represents an integration of the works of Perrow (1961), Thompson (1967) and Hill (1969) and is referred to as the dominant coalition model. In this conceptaulization of goal setting, the goals of an organization must be acceptable to a sufficient number of both internal and external individuals and groups if the organization is to obtain the resources and support it needs to survive. With regard to this approach, Hall (1975, p. 22) observed that

> . . . sufficient power and control may not, initially, be concentrated in any single group (such as the policy making body) or individual administrator. . . . policy makers may coalesce with each other or other individuals or groups in order to establish the concentration of power necessary to solve dependency problems, insure goal acceptance, and gain support.

Although the dominant coalition model does not presuppose that all members of the coalition will hold the same goals for the organization, it does require that a superordinate goal be established which the various members can support (Hunger & Stern, 1976). In addition, as long as the coalition maintains its power position vis à vis other groups and/or individuals, it does not have to accommodate the desires of these less powerful actors. This does not mean, however, that once a coalition is formed all internal conflict ceases. In fact, Thompson (1967, pp. 138-143) discussed at some length how conflict may increase within the coalition and how it can be managed. The major assumptions of this approach are contained in Table II-7.

Using the dominant coalition model as a foundation, several authors (Duncan, 1976; MacMillan, 1973, 1978; Mintzberg, 1979; Quinn, 1977; Richards, 1978; Saunders, 1975) have recently described the formulation of organizational strategy as a political process. Defining the strategy of an organization in terms of its goals, these analysts have basically argued that the organization is in reality a political arena in which various internal and external actors attempt to influence the goals of the organization either individually or through the formation of coalitions with each other. The amount of influence which any of the individuals or coalitions is able to exert at a given point in time is dependent upon his, her, or its intra-organizational power at that moment (Hickson, et al., 1971; Perrow, 1963). According to Mintzberg (1979, pp. 64-65), "organizational goals . . . are the results of the play of power." Perrow (1963, p. 114) also observed this relationship between an organization's goals and its power distributions and concluded that "the power structure will generally dictate the operative goals of the organization."

An example of this political or power model is the work of Quinn (1977, pp. 34-36) which has described the goal setting process of various actual organizations in terms of what he calls "logical incrementalism," a process consisting of the following seven stages. First, top management must continuously scan the environment for strategic changes which might require the revision of organizational goals. Next a committee, staff group, or consultant is used to

identify the various problems, options, contingencies, and/or opportunities are identified, the executive seeks to broaden the support for the alternatives he or she favors without expressly stating his or her desires and thereby unduely restricting meaningful analysis by subordinates. According to Quinn (1977, p. 35), the executive's "main purpose is to begin constructive movement without threatening major power centers."

In the fourth stage, the executive begins to create "pockets of commitment" for what he or she perceives as the most desirable strategy. The crystallization of this desired strategy culminates with the selected goal or goals formal appearance in various places such as public statements or company policy guidelines. Having gone public with his or her desired goal, the executive next seeks to build a real commitment to the goal (or goals) among the members of the organization. Finally, the entire process is started again so as to insure that the organization will not become static and complacent.

The goal setting process which Quinn outlines is continuous and dynamic. It would also appear to be calculative or even Machiavellian in the way it describes how the executive "uses" his or her subordinates in order to accomplish what he or she wants. The impression remains, however, that in terms of describing actual practice, Quinn's comments may be closer to the reality of the situation (Maccoby, 1976) than many of the more philosophical descriptions which have preceded it.

Despite this contemporary emphasis on what can be termed the power or political approach to organizational goal setting, no empirical research utilizing this conceptual framework has yet been reported. In fact, very little empirical research on organizational goals and goal setting has been conducted regardless of the conceptual framework used and even when a broad definition of the field is employed.

Empirical Studies

Of the handful of empirical studies which have focused directly on organizational goals and goal setting processes (see Table II-8), four stand out as being the most significant based upon the robustness of their methodologies, analyses, and conclusions. Three of these four (Dent, 1959; Gross & Grambach, 1968, 1974; Hambrick & Brown, 1978) have been efforts to identify the goals of organizations by means of interviews with and/or surveys of top level managers. In each investigation, perceptual measures were used to determine the operative goals of the organizations studied. The fourth report, (Dobbie, 1972), represents the only empirically based analysis of actual organizational goal setting processes currently available in the literature. A brief discussion of each of these major works follows.

Dent (1959) interviewed 145 chief executive officers (or their deputies) of business organizations in his pioneering study of the goals of business managements. Using responses to the question "What are the aims of top management in your company?," Dent attempted "to

determine how various goals are related to the size of the business, the nature of ownership, unionization, and the composition of the labor force (p. 367)." His analysis indicated that the goal orientations of top management were related to these factors and led him to conclude that: businesses had multiple goals; profits were the most salient single goal; and businesses respond to the interaction of forces which originate both inside and outside the organizations (pp. 390-392).

The most extensive research on goals which has been reported to date was conducted by Gross and Grambsch (1968, 1974). These investigators used mail questionnaires sent to 15,584 faculty members and administrators in 68 American universities in their 1968 study and to 9,130 similar individuals in their 1974 research. Together these two studies provide the only attempted longitudinal analysis of organizational goals, goal structures, and power relationships to be found in the literature.

In both investigations, respondents were asked to evaluate a list of 47 goal statements deemed relevant for universities in terms of (1) how important they perceived each goal to be in their particular institutions and (2) how important should it be. Additionally, the questionnaires contained items which required the respondents to indicate how much "say" or influence they felt various individuals or groups had in determining the overall goals of their institutions.

Table II-8

A Summary of the Current Empirical Literature
Which Has Examined Some Facet of Organizational Goals

Researcher	N Used	Organizations Studied	Type of Respondents Used	Basic Methodology Employed	Type of Analysis Employed	Major Focus of the Research	Major Conclusions of the Research
Catton (1962)	293	National Voluntary Associations	General Membership	An Expert Panel; Mail Surveys; Examination of Organizational Records	Correlation Analysis; t-Tests	The unstated goals of the organizations.	Organizations have unstated goals which both help and hinder it in trying to achieve its stated goals.
Dent (1959)	145	Business Organizations	Chief Executive Officers or their Deputies	Structured, Standardized Personal Interviews	Correlation Analysis; Percentages	The goal orientations of business managers.	Goals reflect the organization as a whole rather than just its manager's personal values. Organizations have multiple goals.
Dobbie (1972, 1974)	55	Large Industrial Corporations	Senior Level Executives	Unstructured, Standardized Personal Interviews; Questionnaires	Kendall's W; gamma; Stepwise Multiple Regression; Mann Whitney U-Test	The formal long-range goal setting procedures used by large organizations.	Various organizational variables (e.g., size and experience with planning) affected the type of goal setting procedures used.

Table II-8 (Continued)

A Summary of the Current Empirical Literature
Which Has Examined Some Facet of Organizational Goals

Researcher	N Used	Organizations Studied	Type of Respondents Used	Basic Methodology Employed	Type of Analysis Employed	Major Focus of the Research	Major Conclusions of the Research
England (1967, 1975)	1,072 and 2,556	Private Sector Corporations	Top Level Managers	Mail Surveys; Structured, Standardized Personal Interviews	Correlation Analysis; Factor Analysis; Chi square; Percentages	The personal value systems of practicing managers.	Organizations have multiple goals which are more a function of the personal characteristics of their managers than of organizational characteristics.
Graham (1968)	315	Manufacturing Organizations	Top and Second Level Managers	Mail Surveys	Chi square; Percentages	The perceived importance of organizational objectives by members of the organization.	Various organizational and/or personal variables may affect one's goal perceptions.
Grimes (1973)	29	Hospitals	Administrators	Structured, Standardized Personal Interviews; Mail Surveys; Examination of Organizational Records	Correlation Analysis; Multiple Regression; Factor Analysis	The relationship between environmental dependency, strategy, structure, and organizational effectiveness.	The organizational patterns associated with effective hospitals were found to be different than the patterns associated with successful industrial firms.

Table II-8 (Continued)

A Summary of the Current Empirical Literature
Which Has Examined Some Facet of Organizational Goals

Researcher	N Used	Organizations Studied	Type of Respondents Used	Basic Methodology Employed	Type of Analysis Employed	Major Focus of the Research	Major Conclusions of the Research
Gross (1968, 1969) and Gross and Grambsch (1968)	7,224	Universities	Administrators and Faculty	Mail Surveys	Correlation Analysis; gamma; Percentages; Rankings	The identification of the goals of American universities, what these goals should be, and the centers of power in the universities.	Although faculty and administrator perceptions of IS and SHOULD BE goals were similar, goal structures and power relationships differed according to type of control (e.g., public versus private).
Gross and Grambsch (1974)	3,155	Universities	Administrators and Faculty	Mail Surveys	Correlation Analysis; gamma; Percentages; Rankings	Same as in their 1968 study. Also sought to measure changes since their first report.	Basically the same as in their 1968 study. No major changes were found over time using longitudinal comparisons.
Guth and Taguri (1965)	988	Business and Industrial Organizations	Business Managers; Research Managers; Scientists	Questionnaires	Presentation of means for questionnaire items.	The effect of personal values on corporate strategy	The personal values of managers are important determinants in the choice of corporate strategy.

Table II-8 (Continued)

A Summary of the Current Empirical Literature
Which Has Examined Some Facet of Organizational Goals

Researcher	N Used	Organizations Studied	Type of Respondents Used	Basic Methodology Employed	Type of Analysis Employed	Major Focus of the Research	Major Conclusions of the Research
Hambrick and Brown (1978)	83	Hospitals	Administrators; Trustees; Physians	Mail Survey	Correlation Analysis; Two-way ANOVA	The identification of the goal profiles of strategic decision makers	Using perceptual measures of top level decision makers, it is possible to identify the operative goals of a hospital.
Reimann (1975)	19	American Manufacturers	Top Level Executives	Interviews; Examination of Company Documents; Questionnaires	Correlation Analysis; Canonical Analysis	The relationship between management's public values and organizational effectiveness.	The public values of top decision makers appear to be strongly related to organizational effectiveness and seem to influence the organization's strategy.
Zald (1963)	366	Correctional Institutions	Administrators and Staff	Interviews; Questionnaires; Examination of Institutional Records; Observation of Behavior	Percentages	The measurement of vaguely defined goals and the effect which different goals have on the internal structure of organizations.	Goals affect organizational norms, departmental structure, and power balances. Goals are a principle determinant of social organization. Multiple measures should be used to study organizational goals.

Among the findings of Gross and Grambsch which are relevant for this dissertation are the following: (1) the goal structures of the universities in the studies varied according to type of control (public versus private institutions); (2) the diversity of these goal structures indicated that it was no longer appropriate to treat all universities as a single organizational form for analysis; (3) the power structures also contained variations which were related to a university's type of control; (4) the power structures pitted insiders (administrators, faculty, students) against outsiders (regents, legislators, governments, citizens); and (5) a strong relationship was identified between the power structures and the goal structures of the universities sampled (1974, pp. 197-201). In general the most important contribution of these research efforts lies in the methodology which they developed for use in analyzing the goals and power relationships found in real organizations.

Hambrick and Brown (1978) recently attempted to measure the goal orientations of the top level decision makers in three general hospitals. Using the traditional "top management triangle" (Gordon, 1961, 1962; Perrow, 1963) composed of the administrators, board of directors, and medical staff of each hospital for their sample, Hambrick and Brown conducted comparative research based upon what they called the "goal coalition model of strategic decision making" (1978, p. 8)--a variation of what was referred to above as the political or power model. According to their argument, strategy is a function of

the power of the individuals who participate in the goal setting process and their goal orientations (1978, p. 4). Therefore, if one could determine who the organizational power holders are, how much power each possesses, and what their individual goal orientations are, then it should be possible to predict the strategy of the organization.

Since the research of Hambrick and Brown only attempted to measure the goal orientations of an a priori group of potential power holders and did not seek to identify empirically the actual top level decision makers or assess their relative power relationships, it represents only a partial test of the coalition model. Their exploratory investigation did indicate that it was possible to create scales to measure the goal orientations of individuals. Furthermore, they found that the top level decision makers of the three hospitals studied possessed a wide variety of goal orientations which varied both within and between hospitals (1978, p. 12).

The only research which has attempted to empirically analyze the actual goal setting processes used by real organizations has been reported by Dobbie (1972) who examined 55 large corporations with regard to how they established their long range goals. Based upon his analysis of interviews with and surveys of top executives in these organizations, Dobbie concluded that organizations use different goal setting procedures in response to variation in size,

years of experience with formal organizational planning, diversity of operations, and management style. Although it was not labeled as such, this research would certainly qualify as an example of the contingency approach to the analysis of organizational goal setting which was discussed above.

Dobbie offered five models to describe the goal formulation processes used by the organizations in his sample. These models are all basically variations of either the "top-down" or "bottom-up" approaches which have been widely discussed in the literature (Dale, 1967; Granger, 1970; Huston, 1962; McCarthy & Ginn, 1970; Steiner, 1962, 1969). Dobbie concluded that, while a majority (67.5 percent, N = 37) of his sample used the bottom-up method of goal setting, there was an increasing trend toward the top-down model, especially as an organization's size and experience with planning increased.

Summary

The literature which has been reviewed in this chapter and which will serve as a basis for this dissertation has focused on two major areas. First, reported distinctions between profit and nonprofit organizations were discussed and four ways of identifying nonprofit organizations were described. These included (1) the absence of an organizational profit motive as defined by the Internal Revenue Service through the granting of tax exempt status; (2) the percentage of external funds which come from contributions; (3) the presence or absence of one or more of a list of "constraining characteristics;" and (4) the absence of traditional entrepreneurial rewards.

In trying to compile a list of specific differences between profit and nonprofit enterprises, a lack of published research was discovered. An exception was found in hospital related literature. After demonstrating that hospitals represent a single form of technology and could be easily classified according to their mode of ownership or control as either profit or nonprofit, various studies were presented which detailed distinctions between the two types of institutions. Although most of these studies dealt with basic structural, size, financial, and/or personnel related differences, two recent reports by Rushing (1974, 1976) were found to be more substantive.

After analyzing how the hospitals in his study scored on various measures of efficiency, effectiveness, differentiation, and coordination, Rushing concluded that the observed differences were primarily due to the profit or nonprofit orientation of the institutions. According to his interpretation, this indicated additional support for the contingency approach to organizational analysis and an organization's economic orientation was identified as yet another contingency variable which appeared to effect intraorganizational relationships.

The need to conduct further research on profit and nonprofit organizations was cited by Wortman (1979) as a necessary prerequisite to making any definitive statements as to their similarities or dissimilarities. A logical place for this research to begin was

identified as the goals and goal structures of profit and nonprofit enterprises.

The second part of this chapter considered the nature, importance, and function of organizational goals as well as various theoretical and empirical analyses of the topic. Since organizations have long been defined in terms of their goals, it was shown that one of the best ways to understand an organization's strategy is to examine its goals, goal structures, and goal setting processes. Although this relationship between an organization's goals and its strategy is basic to the strategic management process, the point was made that organizational goals can have both positive and negative consequences for the institution, its employees, and its external environment. Thus, the nature and type of goals established by an organization at a given point in time will be contingent upon various organizational and environmental factors.

The review of the theoretical and empirical literature on organizational goals and goal setting processes which was presented here indicated that while many have talked about the subject, few have actually attempted to quantitatively analyze it. Among the reasons cited for this dearth of rigorus study were a lack of agreement on the definition, operationalization, and use of many basic terms and an inability or unwillingness to adopt a reasonable typology for classifying organizational goals. In addition, the theoretical literature currently available has failed to provide a

generally acceptable conceptual model of the goal formulation process which could be used as a framework for analysis. Five early attempts to explain the organizational goal setting process were discussed. These included the satisficing approach of March and Simon (1958), the competition-coalition continuum of Thompson and McEwen (1958), the bargaining model of Cyert and March (1963), the problem solving model of Simon (1964), and the dominant coalition explanation based on the works of several authors. The contemporary approach was described as a political or power model in which one or more of the participants to the process attempt to exercise his, her, or their intraorganizational power in such a way as to get others to do or accept what he, she, or they want. It follows that were one able to identify the power elite of an organization and determine their goal preferences, then it should be possible to predict the goals, and hence the strategy, of the overall organization.

The empirical literature also reflects the youthfulness of the field and the lack of well developed conceptual models. Exploratory rather than definitive or even replicative studies are and will continue to be the norm until a substantial research foundation has been established. Of the handful of empirical efforts which have been reported, to date, the methodologies which have been employed to gather and analyze the data remain their most significant contributions to the field. In this regard, perceptual surveys of and personal interviews with top level participants in the goal setting process

are used most frequently and appear to provide the best results given the state-of-the-art.

In conclusion, it is felt that the literature examined here supports the following. First, the contingency approach of organizational theory, as defined by Lorsch and Lawrence (1970) above, is an appropriate framework for comparative policy analysis at the organizational level. Second, there are differences in the economic orientations of organizations which can be identified and which may be of value in explaining strategy differences. Third, hospitals represent a convenient and appropriate organizational form for use in comparative analyses based upon differences in economic orientations. Fourth, organizational goals are a fundamental component of strategy and serve as a logical place for such comparative analyses to begin. Fifth, research on organizational goals and goal setting processes has been severely retarded by a lack of agreement on basic definitions and forms of usages, as well as by a lack of well developed conceptual models. Sixth, current discussions of organizational goal formulation processes emphasize the relationship between the power relationships of an organization and the goals which it establishes. And seventh, the empirical research which has been conducted on organizational goals and goal setting has emphasized the use of interviews with top level decision makers, as well as questionnaires which seek to obtain the perceptions of these individuals with regard to what are the goals of their organizations and how they are established.

This dissertation will use this literature as a foundation for a

study of how the economic orientations (i.e., profit versus nonprofit) of a specific type of organization (i.e., nongovernment, nonreligious, short-term, general hospitals) affect the strategy (i.e., goals) of these institutions. The relationship of an organization's power distribution to its strategy will also be investigated. Since organizational goals and goal setting processes are almost universally acknowledged as being intrinsic to the field of strategic management, this study is seen as providing a much needed examination of this widely discussed but infrequently researched area of importance.

CHAPTER III

HYPOTHESES

This dissertation is by its nature and intent an exploratory study of the relationship between an organization's economic orientation and its strategy and power relationships. According to Kerlinger (1973, p. 406), "exploratory studies have three purposes: to discover significant variables in the field situation, to discover relations among variables, and to lay the groundwork for later, more systematic and rigorous testing of hypotheses."

Since the pioneering nature of such investigations allows the researcher considerable latitude in terms of how he or she defines the problem to be examined and the methodology to be used (Festinger & Katz, 1953), it is necessary that the theoretical and research foundation for the study to be carefully developed. Chapter III presents this foundation for each of the hypotheses which will be examined in this study. Taken together, these hypotheses are intended to provide a much needed insight into "why organizations that are presumably the same (e.g., churches, schools, hospitals, business organizations) pursue very different goals" (Hall, 1975, p. 30).

Goal and Goal Structure Hypotheses

H1: Compared to the top level decision makers in proprietary hospitals, the top level decision makers in nonprofit hospitals will perceive significantly different operative goal structures for their hospitals.

Chapters I and II identified the contingency approach to organizational analysis as the basic conceptual framework for this research. According to contingency theory, organizational properties such as structure, social systems, patterns of bureaucracy, and strategy are functions of other conditions. The most frequently analyzed of these "other conditions" have been size (Blau & Shoenherr, 1971; Child, 1972, 1973; Kimberly, 1976; Pugh, et al., 1968), technology (Aldrich, 1972; Perrow, 1967; Thompson, 1967; Trist & Bamford, 1951; Woodward, 1958, 1965), and environment (Burns & Stalker, 1961; Emery & Trist, 1965; Lawrence & Lorsch, 1967; Pfeffer & Salancik, 1978; Thompson, 1967).

Recently, Rushing (1976) proposed that the economic orientation of an organization is another variable which strongly influences macro level organizational behavior. The results of his comparative study of profit and nonprofit hospitals (p. 689) "indicate that profit-nonprofit orientation is a significant factor in hospital functioning. . . . [and] extend the contingency framework in that they indicate that organizational orientation, specifically profit versus nonprofit orientation, may be a significant contingency for intraorganizational relationships."

If the economic orientation of a hospital is as important as Rushing has argued, then one might reasonably expect it to be reflected in such a basic organizational dimension as the institution's goals. Consequently, it is hypothesized (H1) that the operative goal structures of profit and nonprofit hospitals will be statisti-

cally different.

In addition to extending Rushing's (1974, 1976) conclusions to the area of strategic management, this hypothesis uses Perrow's (1961) official-operative goal dichotomy and the research of Gross (1968, 1969), Gross and Grambsch (1968, 1974), and Hambrick and Brown (1978), which demonstrated that it was possible to identify and measure an organization's operative goals by means of perceptual mail surveys sent to top level decision makers, to examine the goals and goal structures of profit and nonprofit organizations. The need for an exploratory comparative analysis of this particular aspect of the strategic management process has been cited by Wortman (1979) as a necessary prerequisite to the study of strategic management in not-for-profit organizations.

Three Specific Comparisons

> H1a: Compared to the top level decision makers in proprietary hospitals, the top level decision makers in nonprofit hospitals will rank community service goals significantly higher in importance for their hospitals.
>
> H1b: Compared to the top level decision makers in proprietary hospitals, the top level decision makers in nonprofit hospitals will rank patient care goals significantly higher in importance for their hospitals.
>
> H1c: Compared to the top level decision makers in proprietary hospitals, the top level decision makers in nonprofit hospitals will rank economic goals significantly lower in importance for their hospitals.

In addition to merely examining the overall goal structures of

the hospitals in this study, three specific types of goals will be considered in terms of their importance for each economic orientation. As indicated in the wording of the above hypotheses, a positive relationship is proposed between an institution's emphasis on community service and patient care goals while a negative one is expected when this emphasis is compared to the importance placed on economic goals. In providing research support for these proposed relationships, each hypothesis will be considered separately.

H1a: Economic Orientation and Community Service Goals

Twenty years ago, Saunders (1960, p. 231) determined that the community relations ratings of a group of Mississippi hospitals which he examined were related to the way that the institutions were founded and controlled. "Hospitals rated high in community relations were generally founded by a group of community leaders, financed at least in part by the community, and devoted to its service as publically owned facilities. Hospitals rated low in community relations [however] were generally founded by medical doctors and still operate under the direction of these practitioners. They are operated privately and are owned either by individuals or partnerships or are incorporated."

This relationship has also been noted in several more recent research reports. In their analysis of the "major issues regarding the relative merits and demerits of nonprofit and for-profit control," Ruchlin, Pointer and Cannedy (1973b, pp. 13-14) argued that "the social commitment of for-profit investor-owned chain hospitals is

often open to question." Rusing (1974, p. 478) concluded that "profit hospitals are in business to make a profit first and to provide a service second. The reverse is the case for nonprofit hospitals." Rafferty and Schweitzer (1974, p. 308) felt that "proprietary hospitals, by acting in a profit-making manner, do not appear to serve a community's total needs for hospital services." In the second report on his study of profit and nonprofit hospitals, (Rushing (1976) held that a proprietary institution's lack of concern with community needs was relative rather than absolute. Commenting on earlier essays which had been very negative with regard to a proprietary hospital's position vis à vis the community, he (1976, p. 680) stated that

> . . . it is doubtful if many profit hospitals are totally unconcerned with the medical needs of the community. They must be responsive to community needs to some degree before they will be accepted and, hence, supported by the community. As profit organizations, however, they are not as interested as nonprofit hospitals in the good of the community. . . .

Based upon reports such as these, it is hypothesized (H1b) that top level decision makers in nonprofit hospitals will rank community service goals as being more important for their institutions than will similar individuals in for-profit hospitals.

H1b: Economic Orientation and Patient Care Goals

The preponderance of the current literature indicates that the

emphasis which a hospital places on patient care goals is a function of the institution's economic orientation. Gordon's (1962, p. 67) examination of the management triad (i.e., trustees, administrators, and doctors) in voluntary hospitals concluded that "the primary purpose of the voluntary (i.e., nonprofit) hospital is patient care." Many other (Durbin & Springall, 1969; Hepner & Hepner, 1973, Klarman, 1965; Moorehead, 1964; Newhouse, 1970; Ruchling et al., 1973b; Rushing, 1974; Somers & Somers, 1967; Steinwald & Newhauser, 1970; Trussell, 1965) have argued that, because of their emphasis on cost cutting and refusal to provide services which are not financially self supporting, proprietary hospitals sacrifice patient care for greater profits. In this context, Goss (1970, p. 265) proposed that the "absence of profit-making as a hospital goal (as indicated by nonprofit voluntary or governmental ownership status) facilitates better medical care than does hospital commitment to profit making (as indicated by proprietary hospital status)."

Although Davis (1972) would take exception to Goss' assertion that "profit making as a hospital goal" is absent in nonprofit institutions, the belief that proprietary hospitals provide a lower quality of care is widespread. Most past research on this issue has concentrated on comparisons of staff-patient ratios and the number and types of services offered. Hypothesis H1c is intended to test Goss' proposition by examining the level of importance which top level decision makers in each type of hospital attribute to patient care goals in their respective hospitals.

H1c: Economic Orientation and Economic Goals

Many observers, such as those cited above, have argued that economic goals are much more important for proprietary hospitals than they are for not-for-profit institutions. Although Davis (1972) has presented evidence to support her position that nonprofit hospitals are just as motivated by the profit motive as are their proprietary counterparts, the consensus of the published research in the area is in line with Rushing's (1974, pp. 478-479) conclusion that "profit hospitals are primarily economic organizations and nonprofit hospitals are not."

The most frequently identified and investigated indicator of the emphasis which proprietary hospitals place on generating profits has been labeled as "cream-skimming." According to Steinwald and Neuhauser (1970, pp. 832-833),

> The essence of the cream-skimming argument is that proprietary hospitals can and do profit by concentrating on providing the most profitable services to the best-paying patients, thereby skimming the cream of the market for acute hospital care and leaving the remainder to nonprofit hospitals.
>
> There are two basic types of cream-skimming. First, with regard to the range of services offered, proprietary hospitals allegedly eliminate, wherever possible, the more expensive and less heavily utilized services which tend to be unprofitable to most hospitals.
>
> Second, proprietary hospitals are accused of skimming the cream by excluding so far as possible patients with complex illnesses who require expensive and time-consuming treatment and patients who do not pay their full charges.

Several examinations of the two types of skimming cited by Steinwald and Neuhauser (1970) have been conducted in recent years. After comparing the medical characteristics, educational offerings, and financial characteristics of profit and nonprofit hospitals and the demographic characteristics of their patients, Ruchlin, et al. (1973b) reported that their results provided some support for the existence of profit and nonprofit differences as well as for the practice of financial skimming in proprietary institutions. Responding to Ruchlin, et al's (1973b) analysis, Rafferty and Schweitzer (1974, p. 304) argued that "the Ruchlin results provide stronger evidence of proprietary hospital skimming than the authors contend." Finally, Bays (1977) examined actual case-mix data for a group of California hospitals (19 proprietary and 22 not-for-profit) and concluded (p. 21) that "the available data on case-mix and complexity differences between for-profit and nonprofits are consistent with the cream skimming hypothesis."

If for-profit hospitals do in fact consciously engage in the type of skimming activity described above, then various economically or financially related goals should be perceived as being more important for them than would be for nonprofit institutions. Hypothesis H1d is intended to test for this relationship.

Power Structure Hypotheses

H2: Compared to the top level decision makers in proprietary hospitals, the top level decision makers in nonprofit hospitals will perceive significantly different power structures in their hospitals.

The arguments in support of this hypothesis are largely the same as were developed earlier with regard to hypothesis H1a and are thus based on contingency theory. It is felt that if an organization's economic orientation is as significant as some believe (Bays, 1977; Ferber, 1971; Rafferty & Schweitzer, 1974; Ruchlin, et al., 1973a, 1973b; Rushing, 1979, 1976; Steinwald & Neuhauser, 1970), then there should be a relationship between that orientation and the individuals or groups which are perceived as having the greatest amount of power or influence. Or, as proposed by Etzioni (1975b, p. 281), "different types of hospitals--municipal, proprietary, voluntary, etc.--are expected to vary in the groups they respond to most readily and in the kinds of power base which has the greatest leverage."

In addition to the general test for this relationship which is proposed in hypothesis H2, three specific analyses will be conducted which focus upon the top management triad found in hospitals. This triad has been identified by numerous authors (Brady, 1970; Durbin & Springall, 1969; Elling, 1963; Gordon, 1961, 1962; Lentz, 1957, Perrow, 1960, 1963; Rakich, Longest, & O'Donovan, 1977; Schulz & Johnson, 1976), as consisting of the hospital's administrator, its board of trustees, and its medical staff. It is proposed that the relative power positions of these three groups will vary depending upon the profit or nonprofit status of a given institution. The hypotheses which will serve as the basis for these specific analyses are:

H2a: Compared to the top level decision makers in proprietary hospitals, the top level decision makers in nonprofit hospitals will rank the medical staff significantly lower in terms of its perceived power in their hospitals.

H2b: Compared to the top level decision makers in proprietary hospitals, the top level decision makers in nonprofit hospitals will rank the board of trustees significantly higher in terms of its perceived power in their hospitals.

H2c: Compared to the top level decision makers in proprietary hospitals, the top level decision makers in nonprofit hospitals will rank the hospital administrator significantly lower in terms of his/her perceived power in their hospitals.

H2a: Economic Orientation and Medical Staff Power

Traditionally, for-profit hospitals have been the province of physicians which nonprofit institutions have been dominated by community leaders. In his discussion of proprietary hospitals, Rushing (1974, p. 477) noted that their "ownership and control are more likely to be lodged in the hands of one group, physicians." Steinwald and Neuhauser (1970, p. 829) have determined that a major reason for this pattern of proprietary ownership and control can be traced to the fact that "individual doctors or small groups of doctors have become dissatisfied with the lack of availability of beds for admitting their private patients and have responded by financing the construction of their own proprietary hospitals."

Although the dominant power position of the medical staff in proprietary hospitals has been discussed by these and other observers

(Dolson, 1969; Saunders, 1960), most of the support for these discussions has been either historical or from secondary sources. Hypothesis H2b attempts to determine if the medical staff is regarded as more powerful in proprietary hospitals by specifically asking the top level decision makers to evaluate the amount of influence which they perceive the medical staff as having in their particular hospitals. If the literature is correct, the medical staff should be rated as being more powerful in for-profit than in not-for-profit hospitals.

H2b: Economic Orientation and Board Power

The other side of the argument presented above with regard to the strong power position of the medical staff in proprietary hospitals was that community leaders dominate nonprofit institutions. The main way that this community domination occurs is through membership on the board of the nonprofit hospital. According to Newhouse (1970, p. 65), "one characteristic of nonprofit hospitals is that usually control formally resides in a board of trustees."

The function and composition of hospital boards of directors has been analyzed in some detail by Pfeffer (1973) who concluded that these boards provide an important organization-environmental linkage through which the organization attempts to coopt and gain greater control over those parts of the local environment upon which it is most dependent. The results of his study indicated (p. 362) that

> the differences between types of hospitals with respect to linkages with their environments [through their boards] are consequences of the different contingencies the organizations face in obtaining resources. The private nonprofit hospitals were the most closely linked to the local environment because they needed to be, drawing relatively more of their resource support from the local community.

The greater dependency of not-for-profit hospitals on their local communities stems largely from the fact that deficits in their operating budgets are compensated for with subisies from the local populace who want the institution to continue functioning (Newhouse, 1970). Belknap and Steinke (1963), Elling (1963), Elling and Halebsky (1961), Gordon (1962), and Perrow (1960, 1963) have all described actual instances of how nonprofit hospitals have used their boards to provide them with financial support, prestige, business and legal advice, or even political clout at critical points in their organizational lives.

The price which the nonprofit hospital has to pay for this cooptation of the local environment is in terms of a loss of organizational autonomy (Thompson & McEwen, 1958). As a hospital continues to provide representation on its board to those who control important environmental resources, the power of the board members increases (Emerson, 1962). Conversely, the proprietary hospital, which requires that its operations pay for themselves, is much less dependent on the local environment to support its continued existence through subsidies and thus faces less pressure to give up part of its autonomy. It is, therefore, hypothesized (H2c) that the board will be perceived

as having more power in nonprofit hospitals than it will in proprietary institutions.

H2c: Economic Orientation and Administrative Power

The evolution of the administrator into a coequal part of the management triad has been the most recent and least examined segment of the triangle (Rakich, et al., 1977; Schulz & Johnson, 1976). Consequently, there is only a limited amount of published research available which can be used as a basis for a hypothesis dealing with the relative power position of the administrator vis à vis the board and the medical staff.

One of the more plausable philosophical descriptions of the administrator's role in the triad has been presented by Etzioni (1975b) in terms of a contingency relationship. It is his contention (p. 281) that "the administrator's actions are . . . almost totally determined by various partisan interest group pressures; predicting the behavior of the administrator then is a matter of knowing the coefficients of strength of the various groups."

In this regard, Pfeffer and Salancik (1977) noted that the administrators of a majority of the hospitals which they examined tended to be selected by the boards of trustees because they possessed specific qualifications that the institutions needed at a particular point in time. The researchers also reported that as these situations changed, so did the type of administrator needed to deal with the new contingencies. The administrators in this study thus served at the

pleasure of the boards which represented local community interests. Since 55 of the 57 hospitals examined by Pfeffer and Salancik were of the nonprofit variety, it can be implied that the not-for-profit administrator is in a subordinate position to the board and the power position of such an administrator is therefore expected to be weak.

The administrator in for-profit hospitals is, in contrast, generally viewed to be in a much stronger position vis à vis the other two components of the triad. Because proprietary hospitals are primarily considered to be business organizations (Rushing, 1974), their administrators tend to be looked on as professional managers whose functions closely resemble those of corporate executives (Lentz, 1957).

Because of reports such as these, it is hypothesized (H2d) that the administrators of for-profit hospitals will be perceived as possessing a greater amount of power than will their counterparts in nonprofit institutions.

Goal Setting Hypotheses

The contingency approach to comparative organizational analysis will again be utilized to examine seven specific aspects of the goal setting processes (GSPs) of the hospitals in this study. The multiple hypothesis which will be used in this examination is as follows:

> H3: Compared to the goal setting processes used in proprietary hospitals, the goal setting processes used in nonprofit hospitals will: (a) Take Place Significantly More Frequently; (b) Involve Significantly More Participants; (c) Be Characterized by Significantly More Conflict Among the Participants; (d) Place Significantly

> Less Emphasis on Considerations Relating to Costs versus Potential Income in Making Decisions; (e) Place Significantly Greater Emphasis on the Needs and Medical Welfare of the Community in Making Decisions; (f) Be Characterized by the Formation of Significantly More Coalitions Among the Participants.

Each component of this multiple hypothesis is considered separately below.

H3a: Take Place Significantly More Frequently

The consensus of the literature, much of which has already been cited above, is that nonprofit hospitals tend to have multiple goals which seek to provide something for everyone while the goals of proprietary hospitals are more tightly focused on primarily economic considerations. Consequently, as contingencies change over time the nonprofit institution will be required to change or revise its goals more frequently than will for-profit organizations so as to placate the many individuals and groups upon which it is dependent (Elling, 1963; Pfeffer, 1973; Rushing, 1974, 1976).

H3b: Involve Significantly More Participants

The previous discussion of the role and function of the board of trustees in nonprofit hospitals (see hypothesis H2b above) alluded to the fact that these boards are generally larger than those of for-profit institutions. This is because nonprofit hospitals attempt to coopt their local environments by granting representation on the board

to important elements upon which the organization is dependent Belknap & Steink, 1963; Elling, 1963; Pfeffer, 1973; Thompson & McEven, 1958). This view is consistent with Thompson's (1967, p. 129) proposition 9.10 which states that "the more sources of uncertainty of contingency for the organization, the more bases there are for power and the larger the number of political positions in the organization."

Proprietary hospitals, because they are not as dependent upon the local environment and are thus more closely held, would be expected to have smaller boards. In addition, because of the greater power of the medical staff in for-profit hospitals (Rushing, 1974; Steinwald & Neuhauser, 1970), the boards of these institutions are expected to be composed of more physician members than those of nonprofit hospitals.

Since the board of trustees is repeatedly identified as one of the three major components of the decision making triad in hospitals (Elling, 1963; Gordon, 1961, 1962; Lentz, 1957; Perrow, 1960, 1963; Rakich, et al., 1977; Rushing, 1974; Schulz & Johnson, 1976), it is anticipated that a larger board will mean more participants in the goal setting process. With nonprofit hospitals expected to have larger boards than proprietary hospitals, it is hypothesized that there will also be more participants in the goal setting processes used by these not-for-profit institutions.

H3c: Be Characterized by Significantly More Conflict Among the Participants

One consequence of involving more participants in the goal setting

process of nonprofit hospitals was noted earlier as the establishment of multiple goals. Another is an increase in the amount of conflict which is experienced. Perrow (1963, p. 132) has described these problems in nonprofit hospitals as follows:

> Multiple leadership, as a stable system of goal determination and policy setting, is most likely to be found in organizations where there are multiple goals and where these goals lack precise criteria of achievement and allow considerable tolerances with regard to achievement. Organizations with a single goal [i.e., proprietary hospitals] or a clear hierarchy of goals provide little basis for multiple leadership. Multiple leadership arises because important group interests diverge, and each group has the power to protect its interests.

Rushing (1974, pp. 476-477) placed the conflict issue in sharper perspective by noting that "it is plausable to assume that there is less conflict between these groups [i.e., administrators, boards, and physicians] in profit than in nonprofit hospitals. . . . because competing criteria for making decisions are more apt to be systematically subordinated to only one criterion, the economic interest of the hospital." Hypothesis H3c is thus intended to provide a test of Rushing's assumption and the implication contained in Perrow's description.

H3d: Place Significantly Less Emphasis On Considerations Relating to Costs Versus Potential Income in Making Decisions

H3e: Place Significantly Greater Emphasis On the Needs and Medical Welfare of the Community in Making Decisions

Hypotheses H3d and H3e are grouped together for discussion because they represent what have been identified in the literature as the primary decision making criteria for profit and nonprofit hospitals respectively. According to Rushing (1976, p. 680), "in comparison to profit hospitals, nonprofit hospitals are more apt to make decisions that are more concerned with the perceived health-care interest of the community and less with how much particular services cost in relation to the income they can be expected to produce."

Decision criteria like these also contribute to the conflict hypothesis (H3e) proposed above. Economic criteria such as cost versus revenue analyses are highly specific and leave little room for interpretation. In contradistinction, such abstract statements as "the needs and medical welfare of the community" are vague and easily debatable with regard to what they mean. If economic criteria are in fact used by profit making organizations to the extent postulated by Rushing (1974, p. 483), then these for-profit enterprises should also experience less decision making conflict.

H3f: Be Characterized by the Formation of Significantly More Coalitions Among the Participants

If the involvement of more actors in the goal setting processes

of nonprofit hospitals and the use of more abstract and debatable criteria for decision making by these institutions leads to the predicted higher frequencies of conflict, then it is logical to assume that there should also be more efforts in these organizations to resolve this conflict. A frequently cited way of accomplishing this in triadic relationships is through the formation of coalitions (Caplow, 1956, 1968; Flanagan, 1973; Gamson, 1961a, 1961b; Komorita & Chertkoff, 1973; Mills, 1954). Duncan (1976, p. 28) described coalitions as "goal oriented alliances among individuals with different interests that are formed to mobilize joint resources so as to influence the outcome of a contest and divide the spoils of victory."

The nonprofit hospital with its many competing power groups is most likely to make use of coalitions in its decision making activities. Since it will be impossible for each faction to achieve all it wants, various groups will tend to unite in concerted action to achieve what they find to be the most attractive alternative (Cyert & March, 1963). The proprietary hospital, guided by a more singular motive and controlled by a more homogeneous group (i.e., physicians), will conversely have less need to revert to coalition formation in order to achieve consensus.

H3g: Take Significantly Longer to Complete From Initiation to Approval

The preceding sections have argued that as compared to proprietary

hospitals, the goal setting processes of nonprofit hospitals will involve more participants, be characterized by more conflict, emphasize more debatable decision making criteria, and be characterized by the formation of more coalitions. As a result of these factors, it is hypothesized that the goal setting processes found in nonprofit hospitals will take longer to complete than will those in proprietary institutions.

Summary

Because of the exploratory nature of the research contained in this dissertation, a carefully constructed theoretical foundation was deemed to be necessary. Chapter III has provided this foundation by individually considering the basis for each of the hypotheses which will be examined in this study. The methodology which will be used to analyze these hypotheses is described next in Chapter IV.

CHAPTER IV

METHODOLOGY

The preceding chapters have presented literature to support the basic premise of this dissertation which states that the goals, and hence the strategy, of an organization are closely related to its economic orientation. This literature indicated that the most appropriate types of organizations to use for testing this relationship are found in the health care industry in the form of profit and nonprofit hospitals. In addition, various hypotheses which were developed to examine specific aspects of this relationship were discussed.

Chapter IV completes the foundation building part of this dissertation by describing the methodology which was used to identify the particular organizations studied, gather the data necessary to test the proposed hypotheses, and analyze the results. It concludes with a brief consideration of some of the more significant inherent weaknesses of this research design.

The Sample

The specific hospitals which were examined in this dissertation were selected using a combination of purposive and convenience sampling techniques (Bellenger & Greenberg, 1978; Kerlinger, 1973;

Warwick & Lininger, 1975). The following purposive or judgmental criteria were used to initially restrict the institutions considered, thereby reducing variability and increasing homogeneity.

First, only hospitals with from one to three hundred beds were held to be relevant for this research. Restricting the size of the potential sample organizations to this range had the effect of controlling for variations associated with either extremely large or small institutions. The specific range was established after consultations with several professional health care administrators and planners to be representative of "average" size hospitals. These would be large enough to be viable but not so large as to have become overly bureaucratic. The use of "number of beds" as a measure of size and the practice of limiting hospital organizational research to institutions of a particular bed size is an accepted practice which has been well documented (Georgopolus, 1972, 1975).

Second, the decision to use only nongovernmental and nonreligious hospitals was made to exclude those institutions that have their operations completely underwritten by an external body. Although governmental and religious hospitals would certainly qualify as nonprofit organizations under the Internal Revenue Service guidelines, they are not considered here to be "pure" forms of the nonprofit genre (Copeland & Smith, 1978). For this reason, the classification schemes of both Pfeffer (1973) and the American Hospital Association (AHA) (1978) contain separate categories for these organizations and do not

include them with the "true" nonprofit institutions.

Third, only short-term, general hospitals are included for this analysis. A short-term institution is one in which the "average length of stay for all patients is less than 30 days or over 50 percent of all patients are admitted to units where [the] average length of stay is less than 30 days" (AHA, 1978, p. A-2). General hospitals are those "with an organized medical staff that provide permanent nursing services and both surgical and nonsurgical diagnoses and treatment of patients with any of a variety of medical conditions" (Department of Health, Education, and Welfare, 1977, p. 427). By excluding long-term and specialty hospitals, many problems peculiar to those specific types of institutions are eliminated, thus, making the resultant samples more homogeneous. For much the same reason, only nonteaching hospitals (i.e., those not associated with university sponsored medical or nursing school programs) were considered.

Finally, only hospitals listed in the 1978 edition of the American Hospital Association's Guide to the Health Care Field were included in the relevant universe. Although it is possible that this publication does not list every hospital in the nation, the probability is extremely low since it contains all AHA registered hospitals, all osteopathic hospitals affiliated with the American Osteopathic Hospital Association, and all hospitals accredited by the Joint Commission on Accreditation of Hospitals. Furthermore, the AHA's annual guide is accepted by both the hospital industry and the United States government as the authoritative listing of currently

operating hospitals in America.

In addition to the preceding restrictions placed on the relevant universe, two convenience oriented requirements were also imposed on the selection process. First, because of the data collection procedure which will be discussed below, it was necessary to identify hospitals with administrators who would be willing to complete two mail questionnaires, supply the names of other top level decision makers, and consent to a personal interview. Since it was vital to the study that all data be collected, the willingness of the administrator to participate over an extended period of time (ultimately five months) was an important sample selection criterion.

The second convenience related requirement involved the limited amount of time and especially money which was available for the data gathering phase of the research. The scarcity of these important resources meant that the geographic proximity of the sample was another critical factor in the institutional selection process which was used.

Although the sample selection process employed here makes any inferences beyond the scope of this study extremely tenuous, it is not uncommon for research in this area to be characterized by similar non-probability sampling techniques. In fact, purposive and/or convenience samples appear to be the rule rather than the exception in much of the empirical policy research which has been reported to date (see Hofer, 1975 and 1976, for extensive reviews of many of these studies). For example, Dobbie (1972, xiii) limited his study of long-range goal

setting practices to "large corporations which could be readily approached by the researcher in California."

The greatest restriction imposed on research using such sampling techniques is in terms of the external validity or generalizability of the results. This does not mean that these studies are worthless. As long as the reader is cognizant of this inherent limitation and does not attempt to apply indiscriminantly the results to other organizations and/or situations, the research maintains its usefulness.

The organizational selection process described above ultimately yielded eight hospitals which agreed to participate in this study. Four of these institutions were located in Virginia, one in West Virginia, and three in North Carolina. Five were operated as not-for-profit hospitals while three were profit oriented facilities. A more detailed description of these organizations is presented in Chapter V.

Data Collection

The data needed to test the various hypotheses presented in Chapter III were obtained by means of mail questionnaires and personal interviews. The following sections describe these data collection procedures.

The Organizational Data Questionnaire (ODQ)

Once permission to use a given hospital in this study was obtained, an organizational data questionnaire (ODQ) was sent to its administrator (see Appendix A). This questionnaire asked for information concerning: the age and size of the hospital; the number and type of doctors who have privileges in the hospital; the number and type of nonphysician personnel directly employed by the hospital; the name of the hospital's parent organization (if applicable); and the kind of activities in which the hospital engages. In addition, the ODQ also requested the names, positions, and mailing addresses of all hospital administrators, medical staff members, board members, and others who regularly participate in the top level decision making activities of the hospital.

The ODQ thus served two important functions in this research. First, it provided background information on each of the eight participant hospitals. It was felt that the type of data requested might be of value in explaining variances in the final results. Second, the ODQ provided the researcher with the names and mailing addresses of those individuals who were considered by the hospital's administrator as being regularly involved in his organization's top level decision making processes. These names in turn constituted the mailing list for the next questionnaire. In addition, by totaling the number of decision makers for each hospital, the ODQ supplied the data necessary for testing hypothesis H3b (see Chapter III). All

ODQs were completed and returned between the middle of March and the first week of May, 1979.

The Perceived Organizational Goals Questionnaire (POGQ)

Using the names of the top level decision makers provided by the ODQ as a mailing list, a second questionnaire was sent directly to these individuals. The purpose of this second instrument (hereafter referred to as POGQ, see Appendix B) was to obtain the perceptions of these decision makers with regard to the goals and power distributions of their particular organizations. In order to accomplish this, the procedure employed by Gross and Grambsch (1968, 1974) was utilized as follows.

Based upon an extensive review of the literature on hospital goals, annual reports of hospitals, and conversations with health care educators and professionals, a list of 56 goal statements which were potentially relevant for hospitals was developed. These 56 statements were in turn assigned to one of six goal areas (Community Service Related, Economic or Financially Related, Employee Related, Medical Staff Related, Patient Related, and Prestige Related) based upon the primary intent of the statement and/or its usage in other studies.

As a cross check of the resultant classification of these goal statements, 43 individuals not otherwise involved in this study but who are closely associated with the health care field in either an

academic/research, administrative, planning, or other professional capacity were asked to also categorize the statements (see Appendix D). Twenty of these individuals (46.5 percent) responded to this separate survey and thus served as an expert panel. Overall 78.6 percent of the goal statement classifications of the expert panel agreed with those based upon the literature. When only those goal statements that 60 percent or more of the expert panel agreed belonged to a particular goal area were considered (i.e., 41 of the 56 original statements), the correlation with the literature increased to 0.951.

This high level of agreement between the classifications of the goal statements obtained from a review of the literature and those of the expert panel is viewed as providing strong support for the procedure used in this study. The goal areas which were produced by these classifications represent six scales which were used in later analyses (see Chapter V) to measure the goal orientations of the identified decision makers and the goal structures of their respective hospitals.

The recipients of the POGA were asked to respond to two specific questions about each of the 56 goal statements. First, they were requested to evaluate each statement in terms of how important the goal actually IS for their particular hospital in terms of its day to day operations. Second, these decision makers were asked to evaluate the goal in terms of how important it SHOULD BE for their hospital.

The simultaneous use of these two questions represented an

attempt to isolate the operative goals of the organization by allowing the respondents to give their perceptions of both what IS and what SHOULD BE. The IS responses were used to indicate the perceived operative goals of the hospital while the SHOULD BE responses indicated the goal preferences (orientations) of the respondent. Goal structures for each type of hospital were constructed by averaging the responses of this part of the POGQ across all organizations with similar economic orientations and then ranking the averages (Gross and Grambsch, 1968, 1974).

The second part of the POGQ was designed to determine the power relationships in an organization as perceived by its top level decision makers. Again following Gross and Grambsch (1968, 1974), a list of groups and individuals who might be able to exert influence on a hospital's goal setting process was formulated from the literature and conversations with health care professionals. Respondents were asked to indicate the amount of influence which each of the individuals or groups are actually able to exert on their organization's goal setting process using a five point Likert type scale. By ranking the average scores for each potential power holder across each type of hospital (i.e., profit versus nonprofit), a power structure for each economic orientation was obtained.

In both the first and second parts of the POGQ, the respondents were encouraged to add any other goal statements or potential power holders to those which were listed and to evaluate these additional entries. This was done to allow for personalized input and thus

keep the POGQ from being merely an a priori listing which would force the respondents to only consider alternatives that had been preselected by the researcher. Since previous research efforts had relied exclusively upon a priori listings of goal statements and/or power holders, it was felt that this approach provided an improvement in design.

The final sections of the POGQ requested information concerning: the identity of the three most powerful groups or individuals in the overall goal setting process; the amount of conflict present in the process; the identity of the individuals or groups which are most frequently involved in this conflict; the frequency of coalition formation during the process; the identity of the individuals or groups which seem to form coalitions most frequently; and the criteria which are used to evaluate alternative goals.

A cover letter explaining the general nature of the project and informing the respondents that permission for the survey had already been obtained from their hospital's administrator accompanied the POGQ. Anonymity was assured and a stamped, preaddressed return envelope was included. Each questionnaire was coded for follow-up purposes (a fact which was also explained in the cover letter) and two follow-ups were sent to non-respondents at two week intervals after the initial mailing. A cutoff date for the return of usable responses was established for approximately two weeks after the last follow-up mailing. All POGQs analyzed in this study were received between May 14 and June 28, 1979.

The Personal Interview Schedule (PIS)

The last phase of the data collection process involved the completion of semi-structured interviews with the administrator of each hospital in the study. The semi-structured interview format was chosen for use in this research because it combines the advantages of both structured and unstructured interview techniques while minimizing many of their disadvantages (Kerlinger, 1973). This meant that the researcher therefore had an interview schedule to guide the overall course of the interview but was still free to alter the sequencing of the previously specified questions to fit each particular situation and/or follow-up on unexpected or what seemed to be incomplete answers. Because of the exploratory nature of this investigation and the lack of availability of previously used interview schedules, the semi-structured format thus supplied maximum flexibility while still providing predetermined bounds for the interview session.

All interviews were conducted and subsequently coded by this researcher. Consequently, many obvious problems that might have been associated with a possible lack of consistency in the interviewing and coding phases of the investigation were avoided. Standard interviewing techniques, as discussed by Backstrom and Hursh (1963) and Hennessy (1965), were followed during all interviews and anonymity was assured in an effort to elicit candid responses. Because of the amount of confidential and/or proprietary information which was obtained during the interviews, this researcher is convinced that a good rapport was established with each of the interviewees and that

their responses and comments were truthful and accurate.

The personal interview schedule (PIS, see Appendix C) used in this investigation concentrated on the organizational goal setting process (GSP) employed by each of the hospitals. In addition to having the administrator describe the overall process by which goals are established in his hospital, probing was used to make sure that as complete a description of the process as possible was obtained. All interviews were conducted during the first two weeks of July, 1979. (Since all of the hospital administrators who participated in this dissertation were male, masculine pronouns are used throughout whenever reference is made to these individuals.)

Data Analysis

Four nonparametric statistical techniques were used to test the hypotheses proposed in this study. These were the Spearman rank order correlation, the Mann-Whitney U test, the Fisher exact test, and the Goodman and Kruskal gamma. Nonparametric tests were selected for the data analysis phase of this investigation for two major reasons. First, since the sampling procedure described above is not problematic, the parametric assumptions of a normal distribution and equal variance cannot be made. Second, since the number of organizational units is small ($N = 8$), nonparametric tests are more appropriate for analyzing the proposed organizational relationships. The use of nonparametric techniques thus dictated that the analysis of these data had to be based upon either rankings created by ordering the average

raw scores for various groups of items or ordered contingency tables. (Blalock, 1972; Hollander & Wolfe, 1973; Siegel, 1956).

Spearman's rank order correlation (r_s) is the nonparametric equivalent of the parametric Pearson product moment correlation (Blalock, 1972; Leedy, 1974). This statistic was selected for use in testing hypotheses H1a and H2a which relate to possible differences between the goal and power structures (i.e., rankings), respectively, of the profit and nonprofit hospital in this study. The correlation obtained from this technique (see Appendix E for the computational formula used) would be +1.0 if perfect positive correlation were obtained, -1.0 if perfect negative correlation were obtained, and 0.0 if absolutely no association were present in the rankings. In order to determine the statistical significance of the correlations which were obtained, a z value was calculated for each r_s (see Appendix E).

The Mann-Whitney U test is the nonparametric counterpart of the parametric t-test. The major distinction between these two procedures is that the U test compares the medians of two samples to determine if they are significantly different while the t-test compares the sample means. The formula for computing the test statistic is contained in Appendix E. For small N's (i.e., $N \leq 20$) pre-computed tables are available which indicate the statistical significance of the test statistic (Blalock, 1972, pp. 561-567). The Mann-Whitney test was used with hypotheses H3b and H3g which compared profit and nonprofit oriented hospitals in terms of the number of participants in their GSPs and the amount of time needed to complete these processes,

respectively.

Originally the Mann-Whitney test had also been proposed for use in examining the frequency with which the GSPs of proprietary and not-for-profit hospitals took place (hypothesis H3a). Upon collection of the data needed to test this relationship it was discovered that only two types of responses were given. Since this resulted in a 2 x 2 contingency table (i.e., proprietary versus not-for-profit by the two response categories) and the N was small (N = 7), it was determined that Fisher's exact test (a special case of the chi-square statistic) provided a much better measure of association for this hypothesis than did the Mann-Whitney procedure.

The Fisher test calculates the probability of obtaining an exact frequency distribution under the null hypothesis that there are no differences in the population proportions (Blalock, 1972, p. 287). The computational formula used to calculate this probability is found in Appendix E.

The remainder of the hypotheses in this study (i.e., H1b, H2c, H2d, H2b, H2c, H2d, H3c, H3d, H3c, and H3f) relate to the comparative ordering or ranking of particular goals, power groups, and decision criteria, and the frequency of GSP conflict and coalition formulation. For testing these hypotheses, Goodman and Kruskal's gamma was deemed to be the most appropriate measure of association (Goodman & Kruskal, 1954, 1963). The primary reason for the selection of gamma was that it provides a proportional reduction in errors (PRE) measure of association for ordered categories in the same way that $\underline{r}^2$ does for

interval level data in a linear regression (Costner, 1965).

According to Mendenhall, Ott, and Larson (1974, p. 363), "gamma attempts to answer the question: If we know the order of ranks on one variable [e.g., economic orientation] for a pair of individuals can we predict the order or ranks for that pair on a second variable [e.g., a specific goal statement]." The calculated value of gamma which can range from -1.0 to +1.0, indicates the strength of the association between the predicted and predictor variables while the absolute value gives the percentage of guessing errors which can be eliminated by knowing the order of the cases on the predictor variable. The reader is cautioned to remember that gamma predicts the order of pairs of cases and does not predict the rank of a given case vis á vis all other cases.

The statistical significance of gamma is obtained by calculating an appropriate z value and using a table for the standard normal distribution. The formulae used to calculate the reported gammas and the z value for the significance test are contained in Appendix E. A summary of the statistical analyses which were used to test each of the proposed hypotheses is found in Table IV-1.

Significance Levels

The selection of a significance level for use in empirical research appears to be most often based upon convention with the result being that the .05, .01, and 001 levels have achieved an almost mystical quality. Skipper, Guenther, and Nass (1967, p. 18) have

Table IV-1

Statistical Analysis Summary

Hypotheses to be Tested[a]	Statistical Procedure to be Used	Data Source
1. Compared to profit hospitals, nonprofit hospitals will perceived different goal structures; and	Spearman's Rank Order Correlation	POGQ[b]
a. rank community service goals higher;	Goodman and Kruskal's Gamma	POGQ
b. rank patient goals higher;	Goodman and Kruskal's Gamma	POGQ
c. rank economic goals lower.	Goodman and Kruskal's Gamma	POGQ
2. Compared to profit hospitals, nonprofit hospitals will perceive different power structures; and	Spearman's Rank Order Correlation	POGQ
a. rank the medical staff lower;	Goodman and Kruskal's Gamma	POGQ
b. rank the board of trustees higher;	Goodman and Kruskal's Gamma	POGQ
c. rank the hospital administrator lower.	Goodman and Kruskal's Gamma	POGQ

[a]See Chapter III for the exact wording of all hypotheses.

[b]POGQ: Perceived Organizational Goals Questionnaire.

Table IV-1 (Continued)

Statistical Analysis Summary

Hypotheses to be Tested[a]	Statistical Procedure to be Used	Data Source
3. Compared to the goal setting processes (GSPs) used in profit hospitals, the GSPs used in nonprofit hospitals will:		
a. take place more frequently;	Fisher's Exact Test	PIS[c]
b. involve more participants;	Mann-Whitney U Test	ODQ[d]
c. be characterized by more conflict among participants;	Goodman and Kruskal's Gamma	POGQ[b]
d. place less emphasis on costs versus revenue considerations;	Goodman and Kruskal's Gamma	POGQ
e. place more emphasis on the needs and medical welfare of the community;	Goodman and Kruskal's Gamma	POGQ
f. be characterized by a greater use of coalitions;	Goodman and Kruskal's Gamma	POGQ
g. take longer to complete	Mann-Whitney U Test	PIS

[a]See Chapter III for the exact wording of all hypotheses.

[b]POGQ: Perceived Organizational Goals Questionnaire.

[c]PIS: Personal Interview Schedule.

[d]ODQ: Organizational Data Questionnaire.

argued against the use of these conventional levels and "suggested that a more rational approach might be to report the actual level of significance, placing the burden of interpretive skill upon the reader." Labovitz (1968), using Skipper's, et al. thesis as a point of departure, has presented eleven criteria which he feels should be considered when selecting a level of significance. Without repeating his discussion, these are (pp. 220-222):

1. Practical consequences
2. Plausibility of alternatives
3. Power of the test-sample size
4. Power of the test-size of true difference
5. Type I vs. type II error
6. Convention
7. Degree of control in design
8. Robustness of test
9. One-tail vs. two-tail tests
10. Confidence interval
11. Testing vs. developing hypotheses.

Combining Skipper's, et al. admonitions against blindly using conventional levels with several of Labovitz's guidelines for selecting an appropriate level of significance, it was decided to report the actual level of significance obtained for each measure and use the .15 level for rejecting or failing to reject the proposed hypotheses. By reporting the actual significance level, the reader is able to apply either a more or less stringent test of significance

to the obtained results as he or she wishes.

Limitations of the Methodology

Several limitations in the methodology described above have already been noted. These relate primarily to the sampling procedure and the data collection methods and instruments employed in this study.

Considering the sampling procedure first, the use of purposive and convenience oriented selection techniques makes any generalization to organizations not included in the study extremely tenuous. Such a lack of external validity is not uncommon in exploratory research and should not be interpreted as making the study unusable. In order to increase the external validity of this type of research, future investigations should make use of probabilistic sampling techniques and a less restrictive definition of the relevant universe.

The limitations of the data collection methods and instruments relate in large measure to the issues of validity and reliability. The overall validity of the research instruments used here must of necessity rest on their face and content validities which are judgmental decisions (Kerlinger, 1973; Nunnally, 1967). Similarly, because of the pioneering nature of this investigation and the construction of the instruments, classical empirical reliability measures are not appropriate for the most part.

The one exception to this is with regard to the six goal area constructs. Item analyses were conducted using zero order inter-item and item-total correlations to determine the contribution of each

goal statement to the overall goal area. Although it was not the purpose of this dissertation to construct the best possible measures for these goal areas, this type of analysis did provide insights into the appropriateness of including the various goal statements in each particular goal construct.

In addition, Cronbach's coefficient alpha was employed to measure the internal reliability of each of the six goal area scales (Cronbach 1951). This test has been described by Nunnally (1967, p. 197, italics in the original) as "the expected correlations of one test with another test of the same length when the two tests purport to measure the same thing. Coefficient alpha can also be derived as the expected correlation between an actual test and a hypothetical alternative form, one that may never be constructed." Nunnally (1967, p. 226) also argued that in the early stages of research on untested hypothesized measures of constructs, instruments with even "modest" reliabilities in the .50 to .60 range are acceptable and deserve further consideration and testing. The results of the item analysis and the calculated values for the coefficient alphas are presented in Chapter V.

Summary

Chapter IV has described the research methodology used in this dissertation and identified some of its more significant limitations. In particular, five areas were discussed.

First, the sample selection process was examined and shown to

have been guided by nonprobabilistic (i.e., purposive and convenience) considerations. Second, each of the three data collection instruments were discussed in terms of how it was developed and administered. Third, the various nonparametric statistical techniques which were used to test the proposed hypotheses were identified and briefly described. Fourth, arguments in support of the level of significance which was selected for use in determining the statistical significance were presented. Finally, several of the more important limitations placed on this investigation by the methodology which was employed were considered. These dealt primarily with problems of assessing the validity and reliability of the sampling procedure and data collection instruments which were used. However, because of the exploratory nature of this research, it is felt that these limitations do not unduly compromise the worth of the results.

CHAPTER V

RESULTS

Using the methodology detailed in Chapter IV, data were collected from respondents associated with eight hospitals and used to test the hypotheses developed in Chapter III. This chapter presents the results of the study in three parts. First, characteristics of both the organizations and the individuals who participated in this investigation are discussed in order to provide the reader with an overview of the sample. Second, each hypothesis is considered individually and its statistical analysis is reported. And third, the internal reliabilities of the six goal area constructs used in the POGQ are examined.

Characteristics of the Sample

The Organizations

The administrators of eight hospitals initially agreed to have their institutions participate in this study. Of these, three were profit oriented while five were operated as nonprofit organizations. Information requested on the ODQ and POGQ forms (see Appendices A and B) was obtained from the administrators and top level decision makers of each of these hospitals. Personal interviews were only obtained from seven of the eight administrators because the eighth administrator refused to be interviewed claiming that he had already

"wasted" too much of his time in responding to the ODQ and POGQ. In the subsequent analyses which were conducted, all eight hospitals were included whenever the data source was the ODQ or POGQ. When the data source was the PIS, only seven hospitals were analyzed (see Table IV-1 for the data source for each hypothesis).

Each of the three proprietary hospitals in the study exhibited a different ownership pattern. One was owned and operated by a national hospital chain. Another was owned by a private stock company consisting primarily of physicians and civic leaders from the local community. The third was owned by a limited partnership composed of the family of the hospital's founder and the physicians who held privileges in the hospital.

The five nonprofit institutions had similar forms of public ownership with each being operated under a charter issued by its local community to serve in the public interest. In no case, however, did the local government administer the hospital or attempt to dictate its policies.

Table V-1 lists selected organizational characteristics of the eight hospitals examined as abstracted from their respective ODQs. In general, these hospitals exhibited patterns which would be expected for their particular economic orientations based upon the current literature.

The Individual Respondents

The administrators of the eight hospitals identified a total of

Selected Organizational Characteristics of the Sampled Hospitals

Organizational Characteristic	For-Profit Hospitals[a]				Not-For-Profit Hospitals[a]					
	MCH	SCH	MPH	Mean	JMH	SMH	KDH	APH	MMH	Mean
1. Age of hospital (years)	8	49	8	21.7	60	22	83	46	22	46.6
2. Number of beds	146	120	136	134	112	103	243	152	150	152
3. Number of physicians holding privileges per bed	.260	.192	.478	.310	.250	.320	.210	.178	.167	.225
4. Number of nurses per bed	.678	.542	.721	.647	.866	.990	.720	.454	.440	.694
5. Number of other personnel per bed	1.308	1.750	1.118	1.392	2.000	1.883	1.214	1.638	1.073	1.562
6. Occupancy rate	.694	.800	.720	.738	.732	.850	.674	.770	.580	.721
7. Number of total personnel per patient	2.862	2.865	2.553	2.760	3.915	3.381	2.870	2.717	2.609	3.098
8. Average cost per patient day ($)	136.81	123.00	175.00	144.94	122.69	158.13	130.80	119.51	128.00	131.83
9. Operating budget per bed ($000)	54.8	55.8	51.5	54.0	48.2	51.5	34.2	38.2	34.0	41.2
10. Average length of patient stay (days)	5.8	5.1	4.6	5.2	6.7	8.0	8.1	7.2	6.5	7.3

[a]All hospitals were assigned a three letter coded identifier in order to provide anonymity of responses.

Table V-2

Usable Response Rates by Hospital and Position of Respondent

Position of Respondent	For-Profit Hospitals[a]				Not-For-Profit Hospitals[a]						Position Total
	MCH	SCH	MPH	Total	JMH	SMH	KDH	APH	MMH	Total	
Administrators											
Number Sent	1	2	2	5	3	2	2	7	3	17	22
Number Returned	1	2	2	5	3	1	2	3	2	11	16
Percentage	100%	100%	100%	100%	100%	50%	100%	43%	67%	65%	73%
Medical Staff											
Number Sent	2	1	5	8	5	1	3	27	6	42	50
Number Returned	2	1	2	5	4	0	0	7	2	13	18
Percentage	100%	100%	40%	63%	80%	0%	0%	26%	33%	31%	36%
Board Members											
Number Sent	5	6	3	14	6	30	17	19	11	83	97
Number Returned	5	2	1	8	3	18	10	5	7	43	51
Percentage	100%	33%	33%	57%	50%	60%	59%	26%	64%	52%	53%
Others											
Number Sent	5	4	14	23	0	3	5	0	2	10	33
Number Returned	5	4	14	23	0	2	4	0	1	7	30
Percentage	100%	100%	100%	100%	0%	67%	80%	0%	50%	70%	91%
Hospital Totals											
Number Sent	13	13	24	50	14	36	27	53	22	152	202
Number Returned	13	9	19	41	10	21	16	15	12	74	115
Percentage	100%	69%	79%	82%	71%	58%	59%	28%	55%	49%	57%

[a]All hospitals were assigned a three letter coded identifier in order to provide anonymity of responses.

202 individuals who were involved in the top level decision making processes of their respective hospitals. These individuals were categorized by the administrators as being either administrators, medical staff members, members of the hospital's board of trustees, or "other," with the latter category being used primarily for functional department heads (see Table V-2).

The initial mailing and subsequent follow-ups which were sent to these top level decision makers ultimately produced 115 usable responses (56.9%). A breakdown of these usable responses showed that the response rate from for-profit hospitals was 82 percent while from not-for-profit hospitals it was only 49 percent. By position, the medical staff had the lowest overall response rate (36%) followed by the board (53%), the administration (73%), and the "other" category (91%).

The low response rate for the medical staff is not new to hospital oriented survey research (Georgopoulos, 1972, 1975) and was not viewed with alarm here. Although the survey had the approval of all eight administrators, several of whom made repeated appeals for their medical staff's cooperation, the head of the hospital has little real power to compell a doctor not directly employed by that institution to participate in any research investigation. In light of this, even the low response rate obtained from this group was gratifying.

Conversely, the extremely high response rate obtained from the "other" category was unexpected. After discussions with the eight administrators, the most plausable explanation for this seemed to be

that although these individuals were listed as being "active" participants in the GSPs of their hospitals, they personally do not feel that their input is given the same consideration as that of the traditional triad. The POGQ thus provided the members of this "other" group with a convenient and anonymous way for them to comment on the GSPs of their hospitals. The anxiousness of the "others" to reply was similarly noted in the fact that, as a group and across all hospitals, their responses were returned to the researcher sooner than were those of any other respondent category.

Analyses of the Goal Related Hypotheses

The primary purpose of this dissertation was to determine if there is a relationship between an organization's economic orientation and its strategy as operationalized in its goals. The following pages report the statistical analyses of the three hypotheses which were developed to test for this relationship.

> H1: Compared to the top level decision makers in proprietary hospitals, the top level decision makers in nonprofit hospitals will perceive significantly different operative goal structures for their hospitals.

Hypothesis H1 was designed to test for differences in the overall goal structures of the profit and nonprofit hospitals surveyed. In order to establish the goal structures for each type of hospital, the mean responses to the IS goal statements of the POGQ were summed across each economic orientation and then rank ordered. The goal which thus

had the largest value for each economic orientation was assigned a rank of one while the goal which received the lowest mean response was ranked 56. Although space was provided on the POGQ form for the respondents to add additional goals, none were noted.

The goal structures which resulted from this procedure (see Table V-3) were analyzed by means of the Spearman rank order correlation procedure. The results of this analysis showed the perceived operative goal structures of the two types of hospitals examined to be highly correlated ($r_s = 0.852$) and extremely significant ($p < .001$) from a statistical standpoint. Similarly, based upon the converstations held with each administrator during the personal interview phase of this research, the goal structures of these institutions were not found to differ to any extent from a practical point of view. Hypothesis H1 was therefore not found to be supported by the data collected during this investigation.

> H1a: Compared to the top level decision makers in proprietary hospitals, the top level decision makers in nonprofit hospitals will rank community service goals significantly higher in importance for their hospitals.

In addition to the overall goal structure analysis presented above, the literature also indicated that differences in the amount of emphasis placed on particular kinds of goals might be expected in hospitals with different economic orientations (see Chapter III). One of these areas related to community service goals.

Using the typological procedure described in Chapter IV, the 56

Table V-3

Comparative Evaluation of Goal Statements by Top Level Decision Makers in For-Profit and Not-For-Profit Hospitals

Goal Statements From POGQ[a]	For-Profit			Not-For-Profit			Gamma	P (Two-Tail)	Goal Area[b]
	Rank	Mean	SD	Rank	Mean	SD			
1. To provide a full complement of services	42	3.10	1.16	29	3.50	0.84	.247	.276	PR
2. To lessen the pain of humanity	15.5	4.05	0.85	11	3.94	0.77	-.138	.569	PTR
3. To improve employee benefits	40	3.18	0.71	40.5	3.13	0.58	-.044	.873	ER
4. To provide doctors technical and administrative support	8	4.20	0.68	10	3.96	0.64	-.310	.201	MSR
5. To participate in the affairs of the local community	43	2.98	0.95	46	2.92	0.74	-.008	.976	CSR
6. To provide health education programs for the public	48	2.60	1.06	49	2.64	0.71	.098	.682	CSR
7. To insure financial stability	5	4.29	0.96	6	4.18	0.72	-.232	.332	EFR
8. To have the most modern equipment and facilities in the area	34	3.46	0.84	32	3.40	0.89	-.048	.841	PR
9. To maintain accreditation and licensing	1	4.68	0.52	1	4.54	0.58	-.263	.332	PR
10. To minimize the length of patient stays, given quality treatment	6.5	4.27	0.95	17.5	3.78	0.71	.520	.008	PTR
11. To provide inservice education	28	3.61	0.70	31	3.37	0.76	-.216	.379	ER

Table V-3 (Continued)

Comparative Evaluation of Goal Statements by Top Level Decision Makers in For-Profit and Not-For-Profit Hospitals

Goal Statements From POGQ[a]	For-Profit			Not-For-Profit			Gamma	P (Two-Tail)	Goal Area[b]
	Rank	Mean	SD	Rank	Mean	SD			
12. To have good relations with doctors in the local area	18	4.00	0.84	17.5	3.78	0.75	-.240	.308	MSR
13. To make all members of the local community feel welcome	10.5	4.17	0.77	16	3.82	0.75	-.382	.085	CSR
14. To sponsor home health care	52	2.11	0.90	54	2.12	0.76	.015	.952	CSR
15. To provide offices for doctors within the hospital complex	51	2.18	1.43	50	2.54	1.38	.207	.358	MSR
16. To survive	3	4.61	0.76	2	4.51	0.71	-.216	.435	EFR
17. To provide the highest quality medical care possible	2	4.63	0.62	3	4.36	0.71	-.386	.107	PR
18. To be a place where new medical techniques are developed	50	2.29	1.09	53	2.14	0.95	-.067	.780	PR
19. To modernize, expand, and grow	36	3.41	0.88	21	3.71	0.82	.253	.276	PR
20. To efficiently use our staff	17	4.02	0.82	20	3.76	0.84	-.271	.230	EFR
21. To keep in mind community health care costs in making decisions to add new services	14	4.05	0.76	23	3.68	0.76	-.401	.073	CSR

Table V-3 (Continued)

Comparative Evaluation of Goal Statements by Top Level Decision Makers in For-Profit and Not-For-Profit Hospitals

Goal Statements From POGQ[a]	For-Profit			Not-For-Profit			Gamma	P (Two-Tail)	Goal Area[b]
	Rank	Mean	SD	Rank	Mean	SD			
22. To lower the mortality rate in the local area	22	3.89	0.91	13	3.90	0.87	.005	.984	CSR
23. To provide high rewards for our employees	45.5	2.87	0.92	45	2.96	0.82	.126	.603	ER
24. To provide a friendly and pleasant environment for the patients and their families	19	4.00	0.81	24	3.62	0.81	-.364	.099	PTR
25. To provide the highest quality medical care at the lowest possible cost	4	4.39	0.67	5	4.23	0.71	-.197	.424	PTR
26. To add new services even if they are expensive and have a low potential utilization rate	53	1.85	1.07	55	2.04	1.04	.174	.465	PR
27. To be concerned with cost cutting techniques	10.5	4.17	0.86	14	3.86	0.76	-.334	.131	EFR
28. To provide the medical staff with a well equipped, smooth running place to perform its professional services	6.5	4.27	0.67	8	4.04	0.78	-.240	.312	MSR

Table V-3 (Continued)

Comparative Evaluation of Goal Statements by Top Level Decision Makers in For-Profit and Not-For-Profit Hospitals

Goal Statements From POGQ[a]	For-Profit			Not-For-Profit			Gamma	P (Two-Tail)	Goal Area[b]
	Rank	Mean	SD	Rank	Mean	SD			
29. To allow representatives of the community a voice in major decisions affecting the type of health care provided by this hospital	47	2.73	1.22	35	3.33	0.96	-.417	.046	CSR
30. To recruit, train, and retain a highly qualified and competent staff at all levels	21	3.93	0.79	9	4.03	0.81	.149	.529	ER
31. To have a low patient-staff ratio	37.5	3.31	0.98	40.5	3.13	1.00	-.146	.549	PTR
32. To have a large number of specialties represented on the medical staff	41	3.14	1.16	43	3.05	0.83	-.091	.704	PR
33. To engage in the training of medical, nursing and/or allied health care students	45.5	2.87	0.86	42	3.07	0.83	.184	.447	PR
34. To generate a financial surplus or profit	13	4.13	0.84	47	2.91	1.20	-.715	.000	EFR
35. To only provide services that are self-supporting	39	3.19	1.26	52	2.30	1.06	-.479	.017	EFR

Table V-3 (Continued)

Comparative Evaluation of Goal Statements by Top Level Decision Makers in For-Profit and Not-For-Profit Hospitals

Goal Statements From POGQ[a]	For-Profit			Not-For-Profit			Gamma	P (Two-Tail)	Goal Area[b]
	Rank	Mean	SD	Rank	Mean	SD			
36. To make the hospital a part of the doctor's practice	24	3.76	1.04	39	3.16	1.17	-.366	.099	MSR
37. To educate people about preventative medicine	44	2.95	1.10	48	2.69	0.89	-.138	.545	CSR
38. To create good employee relationships	35	3.46	0.97	22	3.70	0.86	.219	.337	ER
39. To help with the advancement of medical science	49	2.42	0.86	51	2.54	0.86	.153	.529	PR
40. To be the hospital with the highest prestige in the area	30	3.53	1.01	44	2.99	1.15	-.337	.119	PR
41. To increase the utilization of existing services and facilities	23	3.83	0.64	26	3.58	0.67	-.345	.162	EFR
42. To realize that this hospital is in competition with other area institutions for patients, doctors, nurses, and money	32	3.50	0.80	38	3.24	0.84	-.226	.352	EFR
43. To meet the health care needs of the local area	10.5	4.17	0.74	4	4.26	0.62	.077	.764	CSR

Table V-3 (Continued)

Comparative Evaluation of Goal Statements by Top Level Decision Makers in For-Profit and Not-For-Profit Hospitals

Goal Statements From POGQ[a]	For-Profit			Not-For-Profit			Gamma	P (Two-Tail)	Goal Area[b]
	Rank	Mean	SD	Rank	Mean	SD			
44. To provide a pleasant working environment for our employees	29	3.54	0.78	27	3.57	0.74	.072	.764	ER
45. To remember that our entire operation should be organized to best serve our patients	10.5	4.17	0.70	7	4.14	0.75	-.018	.944	PTR
46. To attract doctors with national reputations	54	1.81	0.75	56	1.93	0.91	.089	.726	PR
47. To be more business-like in our activities	37.5	3.31	1.01	34	3.34	0.94	.070	.772	EFR
48. To be able to influence decisions which affect local health care	33	3.49	0.91	37	3.24	0.77	-.258	.276	CSR
49. To have good relations with other health care organizations in the area	25	3.76	0.89	28	3.53	0.80	-.231	.312	CSR
50. To review the medical activities of our medical staff in order to insure the continued high quality of care that our patients deserve	26	3.75	0.81	12	3.90	0.80	.150	.529	MSR

Table V-3 (Continued)

Comparative Evaluation of Goal Statements by Top Level Decision Makers in For-Profit and Not-For-Profit Hospitals

Goal Statements from POGQ[a]	For-Profit			Not-For-Profit			Gamma	P (Two-Tail)	Goal Area[b]
	Rank	Mean	SD	Rank	Mean	SD			
51. To provide effective channels for communication and information exchange within the hospital	31	3.51	0.81	30	3.43	0.85	-.054	.818	ER
52. To give major consideration to potential revenues and costs when deciding to add or delete services	20	4.00	0.72	15	3.84	0.79	-.174	.478	EFR
53. To not interfere with the relationship that exists between a doctor and his/her patients	15.5	4.05	0.93	19	3.77	0.89	-.292	.201	MSR
54. To protect the patient from the risk and/or cost of unnecessary procedures	27	3.67	1.03	25	3.59	0.97	-.068	.772	PTR
55. To actively seek contributions, gifts, and bequests from local sources	56	1.40	0.65	36	3.25	0.91	.954	.000	EFR
56. To actively seek grant or foundation support for hospital programs	55	1.46	0.82	33	3.34	0.86	.908	.000	EFR

Table V-3 (Continued)

Comparative Evaluation of Goal Statements by Top Level Decision Makers in For-Profit and Not-For-Profit Hospitals

Goal Statements from POGQ[a]	For-Profit			Not-For-Profit			Gamma	P (Two-Tail)	Goal Area[b]
	Rank	Mean	SD	Rank	Mean	SD			
$r_s = .852$ $p < .000$									

[a]Response alternatives to the goal statements ranged from "0 = Don't know or can't say" to "5 = Of absolutely top importance" using a six category Likert-type format.

[b]Goal Area Codes: Community Service Related = CSR; Economic/Financially Related = EFR; Employee Related = ER; Medical Staff Related = MSR; Patient Related = PTR; Prestige Related = PR.

goal statements were assigned to one of six goal areas (see Table V-3 for these assignments). Eleven goal statements were included in the community service related (CSR) goal area.

Table V-4 lists the 11 CSR goals along with their profit and nonprofit rankings, gammas, and one-tail probabilities (since the direction was predicted). Before discussing the results of the analysis of this hypothesis, the reader is urged to again review the discussion of gamma contained in Appendix E. In particular, it should be remembered that gamma does not test the ranking of an item vis a vis a group of other items. Rather the reason for using gamma here was to determine if a relationship existed between the ordering of an individual's response on one variable (e.g., economic orientation) and his or her response on a second variable (e.g., a specific goal statement). If such a relationship were found to be present, then it should be possible to predict an individual's response on the latter item (a specific goal statement) by knowing his or her answer on the former (the economic orientation of his or her hospital).

Gamma indicates the strength of this relationship and is positive when the response pattern is concordant or the same for both variables and is negative when it is discordant. If there is absolutely no association present between the two variables, then gamma will be zero. Finally, the absolute value of gamma represents the proportional reduction in errors (PRE) which can be achieved in subsequent predictions of a dependent variable by knowing an individual's response pattern on a previous independent variable.

Table V-4

Comparative Evaluation of Community Service Related (CSR) Goals
(H1a: Not-For-Profit Hospitals Will Rank CSR Goals Higher in Importance)[a]

Goal Statements From POGQ	Predicted Direction Observed	Gamma	P (One-Tail)	Significant[b]
5. To participate in the Affairs and activities of the local community	No	-.008	.488	No
6. To provide health education programs for the public	Yes	.098	.341	No
13. To make all members of the local community feel welcome in this hospital	No	-.382	.043	Yes
14. To sponsor home health care programs	Yes	.015	.476	No
21. To keep in mind community health care costs in making decisions to add new services	No	.401	.037	Yes
22. To lower the mortality rate in the local area	Yes	.005	.492	No
29. To allow representatives of the community a voice in major decisions which affect the type of health care provided by this hospital	Yes	.417	.023	Yes
37. To educate people about preventative medicine	No	-.138	.278	No

Table V-4 (Continued)

Comparative Evaluation of Community Service Related (CSR) Goals
(H1a: Not-For-Profit Hospitals Will Rank CSR Goals Higher in Importance)[a]

Goal Statements From POGQ	Predicted Direction Observed	Gamma	P (One-Tail)	Significant[b]
43. To meet the health care needs of the local area	Yes	.077	.382	No
48. To be able to influence decisions which affect local health care	No	-.258	.138	Yes
49. To have good relations with other health care organizations in the local area	No	-.231	.156	No

[a]See text for the exact wording of this hypothesis.

[b]$p \leq .15$.

Returning to the question at hand, a review of Table V-4 demonstrates that there is very little support for the relationship proposed in hypothesis H1a. Although the rankings of five goal statements (i.e., numbers 6, 14, 22, 29, and 43) were found to be in the predicted direction, only one of them (number 29) yielded a gamma which was statistically significant for this research. In addition to this, when the responses to all eleven of the CSR goal statements were averaged and ranked against the other five summated goal areas for each type of hospital (see Tables V-5 and V-6), the direction of the observed responses was again not as predicted.

> H1b: Compared to the top level decision makers in proprietary hospitals, the top level decision makers in nonprofit hospitals will rank patient care goals significantly higher in importance for their hospitals.

Patient care goals were another area which the literature suggested might receive different levels of emphasis in profit versus nonprofit hospitals. In particular, it was proposed that nonprofit institutions would rank patient care goals higher in perceived importance.

Seven goal statements were categorized as being patient related (PTR). Table V-7 presents these goals using the same format found in Table V-4 above. Again the data do not support the proposed relationship since none of the PTR goal statements were ranked in the predicted direction. In fact, when the entire PTR goal area ranking obtained from for-profit hospitals was compared with that of the

Table V-5

Comparative Summary Evaluation of Six Goal Areas in For-Profit and Not-For-Profit Hospitals

Goal Areas[a]	For-Profit			Not-For-Profit		
	Rank	Mean	SD	Rank	Mean	SD
1. Community Service Related Goals (CSR)	4	3.58	0.63	5	3.44	0.62
2. Economic/Financially Related Goals (EFR)	3	3.84	0.87	3	3.67	0.63
3. Employee Related Goals (ER)	5	3.53	0.72	4	3.53	0.64
4. Medical Staff Related Goals (MSR)	2	3.87	0.66	2	3.81	0.66
5. Patient Related Goals (PTR)	1	4.10	0.60	1	3.92	0.59
6. Prestige Related Goals (PR)	6	3.36	0.85	6	3.24	0.69
$r_s = .943$						
$p = .035$ (Two-Tail)						

[a]The specific goal statements which comprise each goal area are identified in Table V-3.

Table V-6

Comparative Evaluation of Six Goal Areas in
For-Profit and Not-For-Profit Hospitals

Goal Areas[a]	Predicted Direction Observed	Gamma	P (One-Tail)	Significant[b]
1. Community Service Related Goals (H1a predicted CSR goals to be ranked higher in importance in not-for-profit hospitals)	No	-.271	.151	No
2. Economic/Financially Related Goals (H1c predicted EFR goals to be ranked lower in importance in not-for-profit hospitals)	Yes	.030	.456	No
3. Employee Related Goals (no prediction made)	N/A	.016	.952[c]	No
4. Medical Staff Related Goals (no prediction made)	N/A	.032	.897[c]	No
5. Patient Related Goals (H1b predicted PTR goals to be ranked higher in importance in not-for-profit hospitals)	No	-.290	.115	Yes
6. Prestige Related Goals (no prediction made)	N/A	-.046	.857[c]	No

[a]The specific goal statements which comprise each goal area are identified in Table V-3.

[b]$p \leq .15$

[c]Two-Tail probability.

Table V-7

Comparative Evaluation of Patient Related (PTR) Goals
(H1b: Not-for-Profit Hospitals Will Rank PTR Goals Higher in Importance)[a]

Goal Statements From POGQ	Predicted Direction Observed	Gamma	P (One-Tail)	Significant[b]
2. To lessen the pain of humanity	No	-.138	.284	No
10. To minimize the length of patient stays, given quality treatment	No	-.520	.004	Yes
24. To provide a friendly and pleasant environment for the patients and their families	No	-.364	.049	Yes
25. To provide the highest quality medical care at the lowest possible cost	No	-.197	.212	No
31. To have a low patient-staff ratio	No	-.146	.274	No
45. To remember that own entire operation should be organized to best serve our patients	No	-.018	.472	No
54. To protect the patient from the risk and/or cost of unnecessary procedures	No	-.068	.386	No

[a]See text for the exact wording of the hypothesis.

[b]$p \leq .15$.

nonprofit hospitals, it was found that the former type rated it significantly more important than did the latter (see Tables V-5 and V-6). Hypothesis H1b was therefore rejected and it was concluded that for-profit hospitals in this study were not any less interested in the welfare of their patients than were their nonprofit counterparts.

> H1c: Compared to the top level decision makers in proprietary hospitals, the top level decision makers in nonprofit hospitals will rank economic goals significantly lower in importance for their hospitals.

The final specific comparison of the ranking of a particular kind of goal was made with regard to what have been labeled economic or financially related (EFR) goals. Based upon the current literature, it was predicted in hypothesis H1c that proprietary hospitals would place more importance on EFR goals than would similar nonprofit organizations.

Table V-8 shows that nine of the twelve EFR goal statements (i.e., numbers 7, 16, 20, 27, 34, 35, 41, 42, and 52) exhibited the predicted differences in how they were ranked by each type of hospital. Although five of these nine (i.e., 20, 27, 34, 35, 41) were found to be statistically significant ($p \leq .15$), only partial support can be claimed for the hypothesis. This is particularly true since no significant relationship was observed when the entire EFR goal was examined (see Table V-6).

However, two of the goal statements which were not ranked in the predicted direction (i.e., numbers 55 and 56) did have gammas which

Table V-8

Comparative Evaluation of Economic/Financially Related (EFR) Goals
(H1c: Not-for-Profit Hospitals Will Rank EFR Goal Lower in Importance)[a]

Goal Statements From POGQ	Predicted Direction Observed	Gamma	P (One-Tail)	Significant[b]
7. To insure financial stability	Yes	-.232	.166	No
16. To survive	Yes	-.216	.218	No
20. To efficiently use our staff	Yes	-.271	.115	Yes
27. To be concerned with cost cutting techniques	Yes	-.334	.066	Yes
34. To generate a financial surplus or profit	Yes	-.715	.000	Yes
35. To only provide services that are self-supporting	Yes	-.479	.009	Yes
41. To increase the utilization of existing services and facilities	Yes	-.345	.081	Yes
42. To realize that this hospital is in competition with other area institutions for patients, doctors, nurses, and money	Yes	-.226	.176	No
47. To be more business-like in our activities	No	.070	.386	No
52. To give major consideration to potential revenues and costs when deciding to add or delete services	Yes	-.174	.239	No
55. To actively seek contributions, gifts, and bequests from local sources	No	.954	.000	Yes
56. To actively seek grant or foundation support for hospital programs	No	.908	.000	Yes

[a]See text for the exact wording of the hypothesis.

[b]$p \leq .15$.

were extremely large and highly significant. Both of these goal statements dealt with whether or not the hospitals should actively seek external funding in the form of grants, gifts, bequests, and contributions.

The fact that the nonprofit hospitals ranked these goals so much higher than did the proprietary institutions has at least one particularly interesting interpretation. The nonprofits may have begun to realize that guaranteed subsidies, traditionally used to balance deficit operations, can no longer be counted on from any given source. To counter this, the nonprofit hospitals may be starting to look more closely at alternate sources of capital such as those mentioned above. The use of these alternate sources would probably be more palatable to a nonprofit organization than would the outright adoption of more direct profit-oriented approaches.

Summary of the Goal Related Hypotheses

Overall, the analyses of the four hypotheses considered above which dealt with the goals and goal structures of the hospitals examined in this research indicate that there are no significant statistical differences between these profit and nonprofit oriented institutions. In no case was unequivocable support obtained for any of these hypotheses, although limited support was observed for the economic or financially related (EFR) goal area.

There also appears to be little if any difference in the goals and goal structures of proprietary and not-for-profit hospitals from

a practical standpoint. This conclusion is based upon the discussions which were conducted with the seven administrators during the personal interview phase of the research. Even in the EFR goal area, one would be hard pressed to identify the economic orientation of the administrator who made any given comments. Across both types of hospitals, the administrators interviewed in this study were unanimous in their belief that it is now mandatory for their institutions to operate in the black if they are to remain viable, long-term providers of health care. They were furthermore in agreement that, in the future with increased governmental and consumer awareness of rising health care costs, the need to streamline their operations so as to become more cost efficient will be one of their greatest challenges.

The results of the research conducted on the eight hospitals in this study thus fail to provide any meaningful statistical or practical support for the goal related hypotheses developed above in Chapter III. If differences in the goals and goal structures of profit and nonprofit oriented hospitals did exist in the past, they are not measurable in this sample of today's institutions. More will be said about the possible reasons for this change and its consequences for the field of strategic management in the next chapter.

Analyses of the Power Related Hypotheses

Knowing the identity of those individuals and/or groups which are able to influence or even control the goals of an organization is extremely valuable in attempting to understand the strategy of that

entity. In order to identify the loci of power in the hospitals examined in this research and determine their relationships to the institutions' economic orientations, four power related hypotheses were analyzed.

> H2: Compared to the top level decision makers in proprietary hospitals, the top level decision makers in nonprofit hospitals will perceive significantly different power structures in their hospitals.

In addition to the goal related items dealt with above, the POGQ also requested respondents to evaluate various potential loci of power with regard to their own hospitals. The results of this portion of the POGQ were summed across all hospitals of each type and then rank ordered according to their mean responses. Table V-9 presents these results.

When the rank orderings of these potential power holders were compared using Spearman's rank order correlation, it was found that the lists for profit and nonprofit hospitals were highly correlated ($r_s = .851$) with the test statistic being extremely significant ($P < .001$). Hypothesis H2 was thus not supported by the data and it was concluded that economic orientation has little, if anything, to do with the distribution of power in the organizations which were examined.

As a backup to this analysis and in order to provide an alternative to the forced evaluation procedure used to obtain the above rankings, the respondents were also asked to allocate 100 "units of influence" to any potential power holder(s) that they wished.

Table V-9

Comparative Evaluation of Potential Power Holders by
Top Level Decision Makers in For-Profit and Not-For-Profit Hospitals

Potential Power Holders[a]	For-Profit			Not-For-Profit			Gamma	P (Two-Tail)
	Rank	Mean	SD	Rank	Mean	SD		
1. Federal level politicians and/or legislators	6	4.17	1.81	10.5	3.78	1.26	-.253	.258
2. Local and state level politicians and/or legislators	14	3.76	1.09	18	3.21	0.90	-.440	.046
3. Third party providers	7.5	4.00	1.16	8	3.83	1.08	-.150	.582
4. Sources of private contributions, grants, and research money	27	1.32	0.65	22	2.79	0.82	.913	.000
5. Accreditation and licensing boards	3	4.39	0.80	1	4.62	0.68	.334	.180
6. Professional standards Review Organizations	7.5	4.00	0.84	7	4.00	0.99	.041	.865
7. Health Systems Agencies	12	3.84	0.89	9	3.79	0.92	.030	.904
8. Federal agencies, departments or offices	5	4.20	0.97	4	4.25	0.82	.008	.976
9. State and local agencies, departments, or offices	15	3.65	1.00	13	3.61	0.83	-.076	.749
10. The local community as a whole	17	3.33	0.89	15	3.54	0.84	.186	.430
11. Local bankers and/or businesspersons not on the board or staff of the hospital	23	2.55	1.06	24	2.53	0.71	.047	.841

Table V-9 (Continued)

Comparative Evaluation of Potential Power Holders by
Top Level Decision Makers in For-Profit and Not-For-Profit Hospitals

Potential Power Holders[a]	For-Profit			Not-For Profit			Gamma	P (Two-Tail)
	Rank	Mean	SD	Rank	Mean	SD		
12. The hospital's parent organization (if any)	9	3.94	1.58	27	1.94	1.06	-.753	.001
13. The hospital administrator	1	4.60	0.50	2	4.58	0.55	.000	1.000
14. The associate and/or assistant administrator(s) as a group	13	3.80	1.08	10.5	3.78	0.89	-.052	.826
15. The board of trustees as a group	4	4.37	0.80	3	4.49	0.65	.113	.660
16. The chairperson of the board	10	3.90	0.81	6	4.22	0.75	.329	.144
17. The medical staff as a group	2	4.41	0.55	5	4.25	0.76	-.158	.529
18. The chief of the medical staff	11	3.85	0.82	12	3.67	0.73	-.194	.418
19. The nurses as a group	21	2.85	0.99	16	3.41	0.68	.452	.029
20. The head of nursing service	18	3.32	1.11	14	3.58	0.75	.221	.322
21. Other professional staff as a group	20	2.93	0.92	19	3.13	0.75	.210	.373
22. Functional department heads as a group	19	2.98	0.76	20	3.13	0.85	.136	.575

Table V-9 (Continued)

Comparative Evaluation of Potential Power Holders by
Top Level Decision Makers in For-Profit and Not-For-Profit Hospitals

Potential Power Holders[a]	For-Profit			Not-For Profit			Gamma	P (Two-Tail)
	Rank	Mean	SD	Rank	Mean	SD		
23. The nonprofessional staff as a group	24	2.29	0.68	23	2.70	0.80	.410	.064
24. The students your hospital trains (if any) as a group	26	1.50	0.67	26	2.11	0.76	.627	.002
25. The patients as a group	16	3.37	1.07	17	3.25	0.87	-.108	.638
26. Other hospitals in the local area	22	2.78	0.85	21	2.94	0.72	.164	.509
27. Local religious leaders	25	2.02	0.76	25	2.18	0.68	.192	.497
r_s = .851								
p <.000								

[a]Response alternatives ranged from "1 = No influence at all" to "5 = A great deal of influence" using a five category Likert-type format.

(Although the respondents were encouraged to list other potential power holders, none were recorded.) After obtaining the average allocations for each individual or group, the averages were again rank ordered and compared using the Spearman statistic (see Table V-10). This analysis also indicated that the rankings were highly similar ($r_s = .752$, $p < .001$) across all hospitals and thus it too failed to support hypothesis H2.

In general, the "units of influence" type of sociometric measure used here to determine the power distributions in the hospitals surveyed provided a clearer reflection of reality than did the above forced choice procedure since it allowed the respondents complete freedom in terms of how they evaluated each alternative. The units of influence approach also resulted in the management triad being ranked as the three most powerful influences regardless of economic orientation. (The order of the individual rankings did vary however according to hospital type, see Table V-10.) For consistency, the following analyses of the remaining power related hypotheses report results using both the forced-choice and the open-ended approaches.

> H2a: Compared to the top level decision makers in proprietary hospitals, the top level decision makers in nonprofit hospitals will rank the medical staff significantly lower in terms of its perceived power in their hospitals.
>
> H2b: Compared to the top level decision makers in proprietary hospitals, the top level decision makers in nonprofit hospitals will rank the board of trustees significantly higher in terms of its perceived power in their hospitals.

Table V-10

Allocation of "Units of Influence" to Potential Power Holders
By Top Level Decision Makers in For-Profit and Not-For-Profit Hospitals

Potential Power Holders	For-Profit			Not-For-Profit		
	Rank	Mean	SD	Rank	Mean	SD
1. Federal level politicians and/or legislators	8	5.77	12.33	7	3.97	13.89
2. Local and state level politicians and/or legislators	9	3.08	9.50	13	1.03	5.76
3. Third party providers	6	7.31	14.68	5	6.35	14.35
4. Sources of private contributions, grants, and research money	-	-	-	-	-	-
5. Accreditation and licensing boards	7	6.67	13.97	6	5.79	11.99
6. Professional Standards Review Organizations	16	0.38	2.40	12	1.11	4.87
7. Health Systems Agencies	10	1.92	6.85	10.5	1.35	7.08
8. Federal agencies, departments, or offices	4	11.79	21.23	4	13.02	19.04
9. State and local agencies, departments, or offices	-	-	-	9	1.51	6.20
10. The local community as a whole	12	1.03	5.02	16	0.63	3.97
11. Local bankers and/or businesspersons not on the board or staff of the hospital	-	-	-	-	-	-
12. The hospital's parent organization (if any)	5	9.74	20.49	-	-	-
13. The hospital administrator	2	16.28	21.94	1	23.41	21.21
14. The associate and/or assistant administrator(s) as a group	3	15.13	22.40	2	18.83	19.20

Table V-10 (Continued)

Allocation of "Units of Influence" to Potential Power Holders
By Top Level Decision Makers in For-Profit and Not-For-Profit Hospitals

Potential Power Holders	For-Profit			Not-For-Profit		
	Rank	Mean	SD	Rank	Mean	SD
15. The board of trustees as a group	3	15.13	22.40	2	18.83	19.20
16. The chairperson of the board	16	0.38	2.40	8	2.30	7.34
17. The medical staff as a group	1	16.67	19.91	3	16.81	18.99
18. The chief of the medical staff	18	.38	2.40	15	0.79	4.51
19. The nurses as a group	13	.77	4.80	-	-	-
20. The head of nursing service	-	-	-	-	-	-
21. Other professional staff as a group	-	-	-	-	-	-
22. Functional department heads as a group	14	.51	3.20	-	-	-
23. The nonprofessional staff as a group	-	-	-	-	-	-
24. The students your hospital trains (if any) as a group	-	-	-	-	-	-
25. The patients as a group	11	1.54	7.09	10.5	1.35	6.73
26. Other hospitals in the local area	-	-	-	-	-	-
27. Local religious leaders	-	-	-	-	-	-

$r_s = .752$

$p < .000$

H2c: Compared to the top level decision makers in proprietary hospitals, the top level decision makers in nonprofit hospitals will rank the hospital administrator significantly lower in terms of his/her perceived power in their hospitals.

The three remaining power related hypotheses which are restated above will be considered together since each predicts the ranking of a part of the management triad. Based upon the results of the analyses based upon the forced-choice evaluation procedure (Table 11), the predicted direction of the proposed relationships was obtained in each case, although none of the results was statistically significant. This lack of empirical support for hypotheses H2a, H2b, and H2c was not totally unexpected in light of the high correlation which was observed between the overall power rankings of the profit and nonprofit hospitals.

Turning to the analyses based upon the open-ended units of influence approach, Table V-12 shows very little change. (It was necessary to use the t test in these analyses since the data obtained were interval level rather than ordinal.) The greatest difference in the results presented in Tables V-11 and V-12 is in terms of hypothesis H2c which related to the evaluation of the hospital administrator. Contrary to the forced choice results, the open-ended procedure indicated that the respondents from nonprofit hospitals not only ranked the administrator higher in perceived power, but that the degree of difference was significant. This conflicting situation again emphasizes the lack of support which was observed for these particular hypotheses.

Table V-11

Comparative Evaluation of Three Specific Power Groups Based Upon Their Perceived Ability to Influence Organizational Goals[a]

Power Related Hypotheses	Predicted Direction Observed	Gamma	P (One-Tail)	Significant[b]
H2a: Compared to the top level decision makers in proprietary hospitals, the top level decision makers in nonprofit hospitals will rank the medical staff significantly lower in terms of its perceived power in their hospitals.	Yes	-.158	.264	No
H2b: Compared to the top level decision makers in proprietary hospitals, the top level decision makers in nonprofit hospitals will rank the board of trustees significantly higher in terms of its perceived power in their hospitals.	Yes	.113	.330	No
H2c: Compared to the top level decision makers in proprietary hospitals, the top level decision makers in nonprofit hospitals will rank the hospital administrator significantly lower in terms of his/her perceived power in their hospitals.	Yes	.000	.500	No

[a]Forced choice approach. See text and Table 7 for clarification.

[b]$p \leq .15$.

Table V-12

Comparative Evaluation of Three Specific Power Groups
Based Upon Their Perceived Ability to Influence Organizational Goal[a]

Power Related Hypotheses	Predicted Direction Observed	t Value	P (One-Tail)	Significant[b]
H2a: Compared to the top level decision makers in proprietary hospitals, the top level decision makers in nonprofit hospitals will rank the medical staff significantly lower in terms of its perceived power in their hospitals.	Yes	-.04	.486	No
H2b: Compared to the top level decision makers in proprietary hospitals, the top level decision makers in nonprofit hospitals will rank the board of trustees significantly higher in terms of its perceived power in their hospitals.	Yes	-.85	.198	No
H2c: Compared to the top level decision makers in proprietary hospitals, the top level decision makers in nonprofit hospitals will rank the hospital administrator significantly lower in terms of his/her perceived power in their hospitals.	No	-1.62	.055	Yes

[a]Open end approach. See text and Table 8 for clarification.

[b]$p \leq .15$.

Summary of the Power Related Hypotheses

The above analyses failed to provide any support for the power related hypotheses which were tested in this investigation. Therefore, economic orientation has little, if anything, to do with the way power or influence is distributed in the profit and nonprofit organizations studied here. Although some variation in rankings was noted across hospitals, this can be primarily attributed to such factors as the particular evolutionary history of the given institution and/or its organizational-environmental relationships rather than specifically to its economic orientation.

Analyses of the GSP Related Hypotheses

> H3: Compared to the goal setting processes used in proprietary hospitals, the goal setting processes used in nonprofit hospitals will: (a) Take Place Significantly More Frequently; (b) Involve Significantly More Participants; (c) Be Characterized by Significantly More Conflict Among the Participants; (d) Place Significantly Less Emphasis on Considerations Relating to Costs versus Potential Income in Making Decisions; (e) Place Significantly Greater Emphasis on the Needs and Medical Welfare of the Community in Making Decisions; (f) Be Characterized by the Formation of Significantly More Coalitions Among the Participants.

Each component of this multiple hypothesis is considered below.

H3a: Take Place Significantly More Frequently

Data used to test for the relationship proposed in hypothesis HBa were obtained from an open-ended question contained in the

personal interview schedule. This question asked each administrator to consider the GSP used by his hospital and indicate how frequently the process takes place. Although each administrator was free to state any interval he wanted, all responses could be categorized as either "continuously" or "annually." Of the three for-profit administrators, one said his hospitals' GSP took place annually while two indicated that it was a continuous process. The four nonprofit administrators split two to two between the dichotomy.

Since these data could be organized as a 2 x 2 contingency table and the number of observations was small (N = 7), a Fisher's exact test was used to test hypothesis H3a. The probability of obtaining exactly the distribution which was observed was calculated by the Fisher test to be 0.5143 thus indicating no significant difference between the frequencies with which goal setting takes place and the economic orientation of the institutions analyzed.

H3b: Involve Significantly More Participants

To test the proposition that nonprofit hospitals involve more participants in their goal setting processes than do profit oriented institutions, the total number of top level decision makers in each hospital as identified by the administrator (see Table V-13), was analyzed using the Mann-Whitney procedure described in Chapter IV. The calculated test statistic for this particular analysis (U = 2) was found to be significant (p = .071) and the relationship proposed

Table V-13

Number and Type of Top Level Decision Makers Identified
By the Administrator of Each Hospital Surveyed

Types of Top Level Decision Makers	For-Profit Hospitals				Not-For-Profit Hospitals					
	MCH	SCH	MPH	Total	JMH	SMH	KDH	APH	MMH	Total
Administrators	1	2	2	5	3	2	2	3	7	17
Medical Staff	2	1	5	8	5	1	3	6	27	43
Board Members	5	6	3	14	6	30	17	11	19	83
Others	5	4	14	23	0	3	5	2	0	10
Column Totals	13	13	24	50	14	36	27	22	53	153
Average Number of Top Level Decision Makers in Each Type of Hospital				16.7						30.6

in hypothesis H3b was therefore held to have been supported by the data.

H3c: Be Characterized by Significantly More Conflict Among the Participants

It was suggested in the literature (see Chapter III) that decision making in not-for-profit hospitals is characterized by greater conflict than it is in proprietary institutions. The reason cited for this is that while the proprietaries are guided primarily by economic interests, the nonprofits must accommodate many varied and often competing desires. Hypothesis H3c was included to test for this relationship.

The initial analysis of the data with regard to this hypothesis produced a gamma which was significant ($p = .106$) and thus supported the predicted association (see Table V-14). However, since the nonprofit hospitals were shown in hypothesis H3b to have larger decision making bodies than the for-profit institutions, the differences noted here might have been due primarily to size variations rather than economic orientations. Such a relationship would be consistent with current organizational behavior literature (e.g., Harrison, 1975; House and Miner, 1969) which has found the level of conflict in problem solving groups to be a function of the size of the group.

Although the small organizational sample size used in this research did not allow for a rigorous test of the effect of size on hypothesis H3c, two sub-analyses were conducted which attempted to

Table V-14

Comparative Evaluation of Four Aspects of the
Goal Setting Processes (GSP) Used by For-Profit and Not-For-Profit Hospitals

GSP Related Hypotheses	Predicted Direction Observed	Gamma	P (One-Tail)	Significant[a]
H3c: Compared to the GSP used in proprietary hospitals, the GSP used in nonprofit hospitals will be characterized by significantly more conflict among the participants.	Yes	.298	.106	Yes
H3d: Compared to the GSP used in proprietary hospitals, the GSP used in nonprofit hospitals will place significantly less emphasis on considerations relating to costs versus potential income in making decisions.	Yes	-.217	.201	No
H3e: Compared to the GSP used in proprietary hospitals, the GSP used in nonprofit hospitals will place significantly greater emphasis on the needs and medical welfare of the community in making decisions.	Yes	.176	.242	No
H3f: Compared to the GSP used in proprietary hospitals, the GSP used in nonprofit hospitals will be characterized by the formation of significantly more coalitions among the participants.	No	-.056	.409	No

[a] $p \leq .15$.

control for the size of the decision making bodies. The first of these sub-analyses examined two proprietary (MCH and SCH, see Table 13) and one nonprofit (JMH) hospitals which had either 13 or 14 participants in their goal setting processes while the second compared one proprietary (MPH) and two nonprofit (KDH and APH) institutions which had between 22 and 27 participants.

The results of these analyses indicated that in each case, the GSPs used in nonprofit hospitals were still characterized by more conflict than were those used in proprietary institutions and the differences remained significant ($p = .007$ and $p = .109$ respectively). Based upon these results, it was concluded that the primary basis for the observed differences in perceived frequency of conflict which was reported was the economic orientation of the organization and not the size of its decision making body.

H3d: Place Significantly Less Emphasis On Considerations Relating to Costs Versus Potential Income in Making Decisions

H3e: Place Significantly Greater Emphasis On the Needs and Medical Welfare of the Community in Making Decisions

As was done earlier in Chapter III, hypotheses H3d and H3e are considered together here since they represent what have been identified in the literature as the primary decision making criteria for profit and nonprofit hospitals respectively. Table V-14, which contains the results of the analyses of these hypotheses, shows that although the predicted direction of the proposed relationship was

observed in each case, neither of the calculated gammas was statistically significant.

While no statistical support can thus be claimed for either hypothesis H3d or H3e, the fact that the predicted direction was observed in the data implies that there may be some basis for assuming that an organization's economic orientation does influence its decision making criteria. Obviously more research using other measures, particularly multi-item measures, is needed before any definitive statement can be made.

H3f: Be Characterized by the Formation of Significantly More Coalitions Among the Participants

This GSP related hypothesis was included to examine a possible result of several of the previously proposed relationships. Briefly, it was felt that if a non-profit organization did use a larger, more heterogeneous, decision making body which was characterized by more conflict and employed more ambiguous decision making criteria, then it might make greater use of coalitions as a means of obtaining agreement on any given course of action.

Again, Table V-14 presents the results of the analysis of this hypothesis. As can be seen, the calculated value of gamma was not significant and the proposed direction of the relationship was not observed. Since the probability associated with this gamma was high ($p = .409$), not only is there no significant difference in the frequency of coalition formation reported here but that proprietary

hospitals are almost as likely to use coalitions as are their non-profit counterparts. Hypothesis H3f is, therefore, rejected.

H3g: Take Significantly Longer to Complete From Initiation to Approval

The last hypothesis which focused on the goal setting processes used by the hospitals surveyed in this dissertation predicted that various factors, such as those included above in hypotheses H3b through H3f, would combine to make the GSPs employed by the nonprofit hospitals take longer to complete. The data needed to test this hypothesis were obtained during the personal interview phase of this research.

As part of the personal interview schedule (PIS), each administrator was asked how long the GSP used by his hospital took from the time a proposed goal was brought up for consideration until it was either approved or rejected. Since the most frequently obtained response was "it depends on the goal you are talking about," a follow-up question was inserted into each PIS. This follow-up question asked the administrator to use his organization's budget as a standard for the GSP and indicate how long it took to complete the annual budgetary process. The budget was selected for use here as a benchmark because (1) each of the hospitals had one and (2) by listing the allocation of the organization's financial resources, a budget provides a surrogate measure of an organization's goals for the period which it covers.

The responses obtained from this question were analyzed using the Mann-Whitney test. Contrary to the results predicted by hypothesis H3g, this analysis indicated that the nonprofit institutions completed their budgetary process significantly faster ($p = .028$) than did the proprietary hospitals. In absolute terms, the nonprofits took from one and a half to two and a half months to complete the process while the for-profits required from three to six months. These results thus do not support the hypothesized relationship stated in H3g.

Summary of the GSP Related Hypotheses

Seven hypotheses were tested in this study which related to the goal setting processes used by the profit and nonprofit oriented hospitals surveyed. While statistical support can be claimed for only two of these (i.e., H3b and H3c), the directions predicted by two of the other hypotheses (i.e., H3d and H3e) were also observed in the data. The overall results of these analyses are therefore not strong enough to warrant any definitive judgment as to the uniqueness of the GSPs used by each type of hospital. For now, the best which can be done is to say that, based upon the data collected in this research, there may be variations in the GSPs which can be related to differences in the economic orientations of the focal organizations. The exact nature of these relationships however is still not clearly understood.

Goal Area Reliabilities

As discussed in Chapter IV, the research instruments used in

this investigation did not lend themselves well to traditional quantitative measures of validity and reliability. The one general exception to this was noted to be the six goal area scales which were used in several of the analyses discussed above. The internal reliability of each of these goal area constructs was examined using both item analyses and Cronbach's coefficient alpha. Since it was not the purpose of this disseration to construct the best possible measure of these goal areas, the zero order inter-item and item-total correlations which were obtained have not been included in this report, although they are available from the author if the reader is interested in this aspect of the research.

The results of the analyses using Cronbach's coefficient alpha are germane to the current discussion since they indicate the degree to which the goal area constructs employed here contain items that have a great deal in common and thus succeed in providing an appropriate measure of each particular goal area. Table V-15 contains these coefficient alphas for all hospitals and each type of economic orientation. It furthermore compares these values to the alphas reported by Hambrick and Brown (1978, p. 11) for four similar constructs used in their recent study.

Nunnally (1967, p. 226) has argued that "in the early stages of research on predictor tests or hypothesized measures of a construct, one saves time and energy by working with instruments that have only modest reliability, for which purpose reliabilities of .60 or .50 will suffice." Applying this guideline to the results in Table V-15,

Table V-15

Goal Area Reliabilities Using Cronbach's Coefficient Alpha

Goal Areas[a]	Coefficient Alphas			
	For All Hospitals	For For-Profit Hospitals	For Not-For-Profit Hospitals	From Hambrick and Brown (1978)
1. Community Service	.695	.612	.742	.58
2. Economic/Financially Related Goals	.749	.797	.736	.46
3. Employee Related Goals	.783	.806	.769	Not Used
4. Medical Staff Related Goals	.524	.621	.475	.58
5. Patient Related Goals	.577	.588	.561	Not Used
6. Prestige Related Goals	.807	.816	.806	.51

[a]The specific goal statements which comprise each goal area are identified in Table V-3.

all of the goal area scales used in this research either met or exceeded the minimum criterion except for the Medical Staff Related area in not-for-profit hospitals which was only .025 below the .50 cutoff. Furthermore, except for the Medical Staff Related area, there was a marked improvement observed in the coefficient alphas obtained for the measures used in this study as compared to the corresponding constructs used by Hambrick and Brown (1978).

The generally high coefficient alphas obtained for the goal area measures employed in this dissertation were viewed as most encouraging. For each construct, additional analyses not included here indicated that its internal reliability could be increased through the selective deletion of specific goal statements based upon the results of the inter-item and item-total correlations mentioned above. The possibility of thus refining these measures for use in future research should not be ignored.

Summary

Chapter V has presented the results of the research conducted for this dissertation. A summary listing of each hypothesis and the outcome of the statistical analysis which was employed to test it is contained in Table V-16.

Based upon the analyses conducted, the following general conclusions can be made. First, no significant differences were observed between the goals and goal structures of the proprietary and not-for-profit hospitals in this study. Second, no significant

Table V-16

Summary of the Results of the Hypotheses Tested

Hypotheses Tested[a]	Results[b]
H1: Compared to proprietary hospitals, nonprofit hospitals will:	
a. Exhibit different perceived goal structures;	H1: Not Supported
b. Rank community service related goals higher;	H1a: Not Supported
c. Rank patient related goals higher;	H1b: Not Supported
d. Rank economic/financially related goals lower.	H1c: Supported in Part
H2: Compared to proprietary hospitals, nonprofit hospitals will:	
a. Exhibit different perceived power structures;	H2: Not Supported
b. Rank the medical staff lower;	H2a: Not Supported
c. Rank the board of trustees higher;	H2b: Not Supported
d. Rank the hospital administrator lower.	H2c: Not Supported

[a]See Chapter III for the exact wording of each hypothesis.

[b]See Chapter V above for the exact nature of the results for each hypothesis.

Table V-16 (Continued)

Summary of the Results of the Hypotheses Tested

Hypotheses Tested[a]	Results[b]
H3: Compared to the goal setting processes (GSP) used in proprietary hospitals, the GSP used in nonprofit hospitals will:	
a. Take place more frequently;	H3a: Not Supported
b. Involve more participants;	H3b: Supported
c. Be characterized by more conflict among the participants;	H3c: Supported
d. Place less emphasis on costs versus revenue considerations;	H3d: Not Supported
e. Place more emphasis on the needs and medical welfare of the community;	H3e: Not Supported
f. Be characterized by a greater use of coalitions;	H3f: Not Supported
g. Take longer to complete	H3g: Not Supported

[a]See Chapter III for the exact wording of each hypothesis.

[b]See Chapter V above for the exact nature of the results for each hypothesis.

differences were observed in the power structures of the proprietary and not-for-profit hospitals surveyed in this study. Third, there may be some inherent differences between the goal setting processes used by the proprietary and not-for-profit hospitals surveyed in this study although the exact nature of these differences cannot be clearly determined from this research alone. Fourth, the generally high internal reliabilities of the six goal area constructs employed here indicate that they were appropriate for use in this study and the ability to increase these reliabilities even further means that they may prove to be of additional value in future investigations.

The purpose of this dissertation was to test for a possible relationship between the economic orientation of an organization and its strategy as operationalized in its goals. To this end, three major hypotheses were developed which focused on the organization's goals and goal structures, its power distributions, and its goal setting processes. The minimal amount of support which was obtained for these hypotheses leads to only one conclusion: In terms of the eight hospitals examined as part of this dissertation, the proposed relationship between an organization's economic orientation and its strategy is not supported by the data.

CHAPTER VI

DISCUSSION

The purpose of this dissertation was to provide an empirically based examination of the relationship between an organization's economic orientation and its strategy as operationalized in its goals. Three multiple hypotheses were developed to aid in this analysis. These related to: (1) the goals and goal structures of the organizations which were studied; (2) the power structures and relationships exhibited by these organizations; and (3) the goal setting processes used by these organizations. In order to obtain the data needed to test these hypotheses, top level decision makers in three proprietary and five not-for-profit short-term, general hospitals were surveyed. The results of the statistical analysis which were conducted using the survey data were presented in Chapter V. Based upon these results, it was concluded that the proposed relationship between an organization's economic orientation and its strategy was not supported by the data.

This chapter discusses these results in light of the current literature and considers possible reasons for the lack of congruity observed between the two. Next, the implications of these research findings for the field of strategic management are presented. Finally, various directions for future research in this area are identified.

The Results and the Literature

Based upon the statistical analyses reported above, it was concluded that two of the three multiple hypotheses tested in this research were not supported by the data while the third was only supported by two of its seven parts. Since a theoretical foundation was developed for each of these hypotheses in Chapter III using the available literature, it is relevant to ask why there was such a large disparity between the outcomes predicted by this literature and the actual empirically based results.

Perhaps the easiest and most obvious explanation for this lack of congruity would be to criticize the research methodology and claim that the data were in effect aberrations of reality and hence not valid. Clearly, such an argument could be made here, in light of the nonrandom sampling procedure which was employed and the small number of organizations which were subsequently surveyed.

There are two major problems with this explanation, which cause it to be rejected. First, nonrandom sampling techniques and/or small sample sizes do not per se invalidate a research project, although they may certainly be reasons to restrict its generalizability. Many examples have already been cited above which demonstrate that, in exploratory research, particularly in the business policy/strategic management field, the use of methodologies similar to the one employed

here have been the rule rather than the exception. In addition, the reader has been cautioned throughout against any generalization of these findings to organizations not included in the sample because of the inherent weaknesses of the methodology.

Second, by accepting the easiest explanation, the search for alternate and frequently more complicated interpretations of any given phenomenon is generally not undertaken. Since the methodology employed here had some merit, the search for alternative interpretations of why the results of this research did not support the literature must be sought. Several of these are considered below.

Old Literature

An examination of the major studies used to build the foundations for the research hypotheses presented in Chapter III indicates that, virtually all of them are either quite dated or at least used data which are. For example, Rushing's 1974 and 1976 reports are based upon survey data collected in 1969, the two 1973 articles by Ruchlin, et al. used data obtained in 1970, and Newhouse's 1970 discussion of nonprofit institutions contained secondary source data from 1965 and 1966.

Although it might be possible to excuse some of this by acknowledging that it often takes an inordinate amount of time to get studies published, there is still a definite absence of contemporary research in the literature. When this is combined with the rapid rate of

change which has characterized the entire health care industry in the last decade, it becomes apparent that the current literature does not provide an adequate view of current reality. This is particularly disturbing when one considers that these same outdated writings are not only used by graduate students as bases for research hypotheses, but are also relied upon by policy makers in both government and the health care industry to provide justification for future strategies.

Changes in the Regulated Environment

One of the main reasons why this literature does not provide analysts with a useful representation of the contemporary reality can be traced to the multitude of regulatory changes which have taken place in the last decade. Increasingly government agencies and departments at all levels, but particularly at the federal level, have become active participants in the health care process. This was clearly evidenced in the power rankings described in Chapter V (see Tables V-9 and V-10).

Two specific examples of the regulatory changes which have been imposed on the industry in recent years are the creation of Health Systems Agencies (HSA) and the requirement that made institutional planning a mandatory prerequisite for participation in federal Medicare/Medicaid programs. Both of these federal actions became effective in 1975 as the results of Public Laws 93-641 and 92-603 respectively and apply to all health care institutions regardless of size, type, or affiliation. In each instance, standard

procedures and structures were established to handle various institutional activities.

Over the years this has led to a decrease in organizational heterogeneity and an increase in homogeneity. Since both PL 93-641 and PL 92-603 established guidelines to be used by the health care industry in conducting its strategic planning, it was not surprising to find no major differences in the strategies of the profit and nonprofit hospitals surveyed here.

Similar types of legislation and administrative actions in various other governmental areas have also impacted upon the health care industry to decrease the amount of organizational variation which was present even just a few years ago. While this change may not as yet have been incorporated into the current literature on profit versus nonprofit differences in health care operations, it has become a topic of special interest to practicing administrators. Regardless of economic orientation, the administrators interviewed in this study unanimously identified government regulation as being their biggest external problem area and, with the continuing debate of such new programs as national health insurance, they also see it as being the major constraint on their future activities.

Changes in the Economic Environment

Another factor which can be related to the disparity noted between the literature and the current reality has to do with the large scale changes which have recently taken place in the general

economic environment. Inflation has become a way of life in the last few years and the cost of virtually everything, including health care has increased as a result. The old argument that nonprofit organizations are inherently inefficient because they lack the profit motive (Rushing, 1974; Tideman, 1977) may no longer be valid, at least not for those nonprofit organizations which plan to continue as viable, long-term entities.

It matters little whether the new emphasis on efficiency and cost effectiveness which characterizes today's nonprofit institutions has been adopted voluntarily or has been forced upon them. Rather, as demonstrated above, the ultimate effect has been that many profit and nonprofit organizations have acquired similar operating characteristics resulting from the influence of an external factor. Since a logical place for these organizations to exhibit this increasing motivational similarity is in their goals and goal structures, it is again not surprising to find no significant differences between what have traditionally been referred to as profit and nonprofit organizations.

Discussion

If profit and nonprofit organizations of the type examined in this study are, in fact, becoming more similar, then there must be factors other than those related to economic orientation which are responsible for the differences that have been reported in the literature. Two of these factors are briefly discussed below.

Twenty years ago, Perrow (1960) concluded that hospitals go

through evolutionary cycles in which they face various threats and challenges imposed upon them by changes in their internal and external environments. He argued that a hospital changes its management group, goals, and power distribution in order to best cope with the new environmental contingencies. Similar observations were made in separate subsequent studies of community-hospital relations conducted by Belknap and Steink (1963) and Elling (1963). More recently, Pfeffer (1973) and Pfeffer and Salancik (1977) found that the composition of hospital boards and the characteristics and tenure of hospital administrators respectively were contingent upon demands imposed by their internal and external environments.

Although none of these five studies considered possible profit versus nonprofit differences, in light of the current findings, it seems reasonable to at least suggest that potential differences might be more a function of varying environmental contingencies than of economic orientation. This would mean that regardless of their economic orientations, organizations might exhibit similar behaviors in response to similar environments and that any observed differences would be primarily the result of comparing organizations from dissimilar environments.

A recent report by Newman and Wallender (1978) provides the basis for the second alternative approach to explaining organizational differences. These authors have argued that the traditional usage of the profit/not-for-profit dichotomy is too general to be of any real value in comparative organizational research. In its place, they

have suggested that the researcher look for one or more "constraining characteristics," discussed above in Chapter II, which provide the basis for explaining organizational variations. Although several problems associated with the use of Newman and Wallender's list of constraining characteristics have already been noted in this report, future research may show their approach to be superior to the continued use of the current dichotomy.

In summary then, the fact that the research results obtained do not conform to the hypotheses made using the available literature is not viewed with alarm. Rather, it is felt that recent changes in the external environments of the organizations studied, including particularly to government regulation and worsening general economic conditions, have contributed to similar operating characteristics among these organizations. Because of the age of most of the available literature, these recent changes have not been discussed in terms of their potential effects on profit-nonprofit differences.

If this analysis is valid and if present trends continue, future studies should reveal the same similarities between the two types of institutions examined in this research. Such results would furthermore strengthen the argument suggested above that the "nonprofit" label has lost its practical value in organizational research, at least with regard to the particular types of institutions examined here.

Implications

While it is not possible to make any sweeping generalizations

from this investigation because of the inherent problems in the research design, this dissertation has nevertheless provided a much needed analysis of the relationship between an organization's economic orientation and its strategy. While further research will be needed in this area before any conclusive statements can be made about the similarities and/or differences between what have traditionally been referred to as profit and nonprofit organizations, this research is seen as having three major implications for the field of strategic management.

First, as was noted in Chapter II, there has been a recent call (Wortman, 1979, pp. 372-373) for "simple exploratory studies of [the] goals and goal structures [of] all types of not-for-profit organizations" which can in turn be used to determine if these basic strategic elements are similar or dissimilar to those of profit oriented enterprises. The ultimate function of this type of investigation of the strategic management processes found in profit and nonprofit organizations.

The research which has been reported here was designed to serve as one of these exploratory studies. The results of this investigation demonstrated that there were no significant overall differences in the goals, goal structures, power structures, or goal setting processes of the particular profit and nonprofit organizations surveyed. This conclusion thus provides the first, albeit tentative, empirical support for those (Cartwright, 1975; Hardy, 1973; Hussey, 1974; McKay & Cutting, 1974; Newman & Logan, 1976; Steiner & Miner,

1977; Webber & Dula, 1974) who have been making the basic assumption that there are no major differences in how profit and nonprofit organizations are, or should be, managed.

If future research of this type on both hospitals and other kinds of not-for-profit organizations were to obtain similar results, it would reinforce the conclusions made here. It could then be argued that perhaps nonprofit organizations are merely variants of the traditional profit oriented organizational model rather than totally new forms which require their own specially designed management concepts. Again, this would support the position of such authors as those cited above, and greatly simplify the comparative analysis of organizations.

Second, it has been argued in this dissertation that most of the available literature on profit/nonprofit distinctions in hospital organizations is woefully out of date. Consequently, any research based upon it would probably be misdirected. A new body of both theoretical and empirical literature is needed in this area which adequately reflects the current environment and acknowledges the effects which the many recent changes have had on the entire health care field.

Finally, it is reasonable to question the value of the profit/nonprofit typology in light of Newman and Wallender's (1978) analysis and the results of this study. As discussed above, if the traditional differences, be they real or only apparent, between profit and nonprofit organizations are lessening because of such factors as increas-

ing government regulation and changing economic conditions, then the continued use of the "nonprofit" label is neither appropriate nor justifiable. The very issue of strategic management in what have been referred to as nonprofit organizations would thus be moot. There is a definite need to reconsider the terminology which is being used here and if it is determined that it is no longer valid, then the field must be willing to move forward and deal with more substantive issues instead of straw men. Based upon the analyses conducted here, it is felt that the nonprofit designation has little value except for use by the Internal Revenue Service, and even that is questionable when the specific activities of the organization are considered.

Future Research

This dissertation represents the first empirical analysis of the relationship between an organization's economic orientation and its strategy. Because of its acknowledged exploratory nature, no pretense has been made or even attempted that the results and conclusions obtained provide the definitive statements on this association. While there may not have been any significant differences observed between the strategic processes of the particular profit and nonprofit hospitals examined here, it does not necessarily follow that this would be true for other organizational comparisons based upon economic orientations or for even other profit and nonprofit hospitals. More research is obviously needed before this can be done. Several

of the more important areas which should be examined by this future research are discussed below.

First, the methodology used here must be reevaluated in terms of its applicability for use in future research. Because of the pioneering focus of this project and the small sample size employed, it would not be totally unreasonable to consider this investigation a pre-test for a second study which would incorporate the lessons learned here. While various problems with the methodology have been previously identified and discussed, it is felt that the basic approach used here is appropriate for this type of inquiry and deserves further refinement.

Second, the problems associated with the identification of a sufficient number of organizational units which would participate in this dissertation were particularly disturbing. In order to increase the participation rate, it is felt that future researchers who want to examine hospitals should first obtain endorsements for the project from the appropriate local, state, and/or national hospital associations of which the institutions are members.

Third, since many of the ways the research instruments used in this study could be improved have already been noted above, only two of these will be repeated here. By means of various scale construction techniques it should be possible to not only improve the internal reliabilities of the six goal area constructs but to shorten the overall length of the questionnaire as well. In addition, other questionnaire items which were not shown to be necessary to the analyses con-

ducted here could also be eliminated.

There are other areas, however, in which additional questions might be warranted. This is particularly true with regard to the items examined as part of hypothesis H3 where each sub-hypothesis was evaluated on the basis of a single question measure. It may be that the responses sought were too complex to be obtained with single item measures. Consequently, future examinations of these issues might do well to consider the use of multiple item approaches.

Fourth, since economic orientation did not affect the strategic processes of the eight organizations examined here, future investigations should consider the possibility that other factors might be responsible for the variations which have been observed. One of these "other factors" has already been discussed above and relates to the organization's external environment. A second might be the size of the organizations studied. Since only hospitals with from one to three hundred beds were analyzed in this study, it is not known if comparisons based upon either larger or smaller institutions would have yielded similar results. As was the case with Woodward's 1958 study, an expansion of the size of the organizations included in the sample might lead to other explanations and conclusions. Dobbie (1972) identified three other variables which accounted for differences in his study and which might also prove to be relevant here. These were the diversity of the organization's operations, its experience with formalized planning activities, and the management style of its executives. Future investigations should definitely examine the

effects of these and other variables on the GSPs of various types of organizations.

Fifth, the type of organization studied should be varied in order to determine if similar results can be obtained across all organizations. Among the many types of organizations which have been traditionally classified as "nonprofit" and which would provide fertile ground for such investigations are those identified in Table VI-1.

Finally, the entire area of terminology deserves closer attention. The short comings of the nonprofit label have been discussed at several points in this dissertation and do not need to be repeated here. Similarly the entire vocabulary of the strategic management field needs to be reformulated in terms of its current usage. "Buzz-words" and other terms created only to serve their inventors should be eliminated and a standard vocabulary based upon widely accepted and meaningful substantive definitions should be established. Indeed, the fact that such noted authors as Steiner and Miner (1977) have had to resort to use of a phase such as "strategy/policy" in their recent book indicates the seriousness of this problem.

The results of this dissertation have challenged much of the current literature on profit versus nonprofit distinctions in hospitals. In addition, it has been argued that the nonprofit label is of little practical use in organizational research. Finally, based upon the analyses of the data collected in this study, it was concluded that there are essentially no differences in the strategic

Table VI-1

A Typology of Different Types of Not-For-Profit Organizations

I. Public Organizations	II. Third Sector Organization
A. Executive agencies and departments (other than urban and environmental) Federal, state, and local governments Military	Public-private agencies (COMSAT, AMTRAK, etc.) Not-for-profit consultants Research institutes Consumer cooperatives
B. Urban Organizations	III. Institutional Organizations
Fire Police and law enforcement Public housing authorities Social services and welfare Transportation Human resources (manpower)	Education Hospitals and health care Trade unions Political parties Churches Libraries Performing arts Voluntary associations Organized charities
C. Environmental Organizations	
Conservation Water resources Air resources Energy resources	

SOURCE: Wortman, Max S., Jr. "Strategic Management: Not-for-Profit Organizations. In Dan E. Schendel and Charles W. Hofer (Eds.), Strategic Management: A New View of Business Policy and Planning. Boston: Little, Brown and Company, 1979, p. 354.

processes of the eight hospitals studied which could be traced specifically to their respective economic orientations. The greatest challenge which this dissertation thus leaves for future researchers is to either provide support for or repudiation of these findings.

REFERENCES

Ackoff, Russell L. A Concept of Corporate Planning. New York: Wiley-Interscience, 1970.

Aldrich, Howard E. "Technology and Organizational Structure: A Reexamination of the Findings of the Aston Group." Administrative Science Quarterly, Vol. 17 (1972), 26-43.

Allison, Graham T. Essence of Decision: Explaining the Cuban Missile Crisis. Boston: Little, Brown, 1972.

Allison, Graham T. "Conceptual Models and the Cuban Missile Crisis." American Political Science Review, Vol. 63 (September 1969), 689-718.

American Hospital Association. American Hospital Association Guide to the Health Care Field, 1978 ed. (Chicago: American Hospital Association, 1978).

Andrews, Kenneth. The Concept of Corporate Strategy. Homewood, IL: Dow-Jones-Irwin, 1971.

Andrews, Kenneth, Edmund Learned, C. Roland Christensen, and William Guth. Business Policy: Text and Cases. Homewood, IL: Richard D. Irwin, 1965.

Ansoff, H. Igor. "Company Objectives: Blueprint or Blue Sky?" Management Review, Vol. 4 (September 1962).

Ansoff, H. Igor. Corporate Strategy. New York: McGraw-Hill, 1965.

Azumi, Koya and Jerald Hage, eds. Organizational Systems: A Text Reader in the Sociology of Organizations. (Lexington, MA: D. C. Heath and Company, 1972).

Backstrom, Charles H. and Gerald D. Hursh. Survey Research. Evanston, IL: Northwestern University Press, 1963.

Bailey, Stephen K. Congress Makes a Law. New York: Columbia University Press, 1950.

Barnard, Chester I. The Functions of the Executive. (Cambridge, MA: Harvard University Press, 1968).

Bays, Carson W. "Case-Mix Differences between Nonprofit and For-Profit Hospitals." Inquiry, Vol. 14 (March 1977), 17-21.

Belknap, Ivan and John G. Steink. The Community and Its Hospitals: A Comparative Analysis. Syracuse, NY: Syracuse University Press, 1963.

Bellenger, Danny N. and Barnett A. Greenberg. Marketing Research: A Management Information Approach. Homewood, IL: Richard D. Irwin, Inc., 1978.

Blankenship, J. E., II. "Goal Setting in the Diversified Company," Managerial Planning, Vol. 26 (November-December 1977), 8-14.

Blau, Peter M. and Richard A. Schoenher. The Structure of Organizations. New York: Basic Books, 1971.

Boulding, Kenneth E. "General Systems Theory--The Skeleton of Science." Management Science, Vol. 3 (April 1956), 197-208.

Brady, N. A. "The Corporate Hospital." Hospitals, Vol. 44 (February 1970), 51-53.

Bureau of the Census. Statistical Abstract of the United States. Washington, DC: Government Printing Office, 1963, 1968, 1978.

Burns, Tom and G. Stalker. The Management of Innovation. London: Tavistock, 1961.

Callaghan, Dennis W. and Robert A. Comerford. "An Alternative Approach to Organization Theory/Business Policy Research." Unpublished paper presented at the "Conceptual Foundations of Strategic Management" symposium of the American Institute for Decision Sciences' 1978 National Meetings, St. Louis, October 31, 1978a.

Callaghan, Dennis W. and Robert A. Comerford. "An Argument for General Systems Theory Structure of Business Policy Research." Unpublished paper presented at the "Conceptual Foundations of Strategic Management" symposium of the American Institute for Decision Sciences' 1978 National Meetings, St. Louis, October 31, 1978b.

Cantley, M. F. "The Choice of Corporate Objectives." Long Range Planning, Vol. 3 (September 1970), 36-41.

Caplow, Theodore. Two Against One: Coalitions in Triads. Englewood Cliffs, NJ: Prentice-Hall, 1968.

Caplow, Theodore. "A Theory of Coalitions in the Triad," American Sociological Review, Vol. 21 (1956), 489-493.

Carper, William B. "The Characteristics of Hospital Administrators and Their Relationships to Intraprofessional Differences." Unpublished paper, Virginia Polytechnic Institute and State University, Blacksburg, VA, 1977.

Cartwright, Dorwin and Alvin Zander, eds. Group Dynamics Research and Theory, 3rd ed. (New York: Harper and Row Publishers, 1968).

Cartwright, John. "Corporate Planning in Local Government -- Implications for the Elected Member." Long Range Planning, Vol. 8 (April 1975), 46-50.

Cotton, William R., Jr. "Unstated Goals as a Source of Stress in an Organization," Pacific Sociological Review, Vol. 5 (Spring 1962), 29-35.

Chandler, Alfred D., Jr. Strategy and Structure: Chapters in the History of the Industrial Enterprise. Cambridge, MA: The MIT Press, 1962.

Child, John. "Organization Structure and Strategies of Control: A Replication of the Aston Study." Administration Science Quarterly, Vol. 7 (1972), 163-176.

Child, John. "Predicting and Understanding Organizational Structure." Administrative Science Quarterly, Vol. 18 (June 1973), 168-185.

Christensen, C. Roland, Kenneth R. Andrews, and Joseph L. Bower. Business Policy: Text and Cases, 4th ed. Homewood, IL: Richard D. Irwin, 1978.

Cohen, J. "An Alternative to Marasuilo's 'Large-sample Multiple Comparisons' for Proportions." Psychological Bulletin, Vol. 67 (1967), 199-201.

Copeland, Thomas E. and Keith V. Smith. "An Overview of Nonprofit Organizations." Journal of Economics and Business, Vol. 30 (Winter 1978), 147-154.

Costner, Herbert A. "Criteria for Measures of Association," American Sociological Review, Vol. 30 (June 1965), 341-353.

Cressey, Donald R. "Achievement of an Unstated Organizational Goal: An Observation on Prisons," The Pacific Sociological Review, Vol. 1 (Fall 1958), 43-49.

Cronbach, L. J. "Coefficient Alpha and the Internal Structure of Tests." Psychometrika, Vol. 16 (1951), 297-334.

Cyert, Richard M., ed. The Management of Nonprofit Organizations: With Emphasis on Universities. Lexington, MA: D. C. Heath and Company, 1975.

Cyert, Richard M. and James G. March. A Behavioral Theory of the Firm. Englewood Cliffs, NJ: Prentice-Hall, Inc., 1963.

Dale, Ernest. Long-Range Planning. London: British Institute of Management, 1967.

Davis, Karen P. "Economic Theories of Behavior in Nonprofit, Private Hospitals." Economic and Business Bulletin, Vol. 24 (Winter 1977), 1-13.

Dent, James K. "Organizational Correlates of the Goals of Business Management," Personnel Psychology, Vol. 12 (August 1959), 365-393.

Department of Commerce. Survey of Current Business, Vol. 58 (July 1978). Washington, DC: Government Printing Office.

Department of Health, Education, and Welfare. Health, United States, 1976-1977. Washington, DC: Government Printing Office, 1977.

Department of Labor. Occupational Outlook Handbook. Washington, DC: Government Printing Office, 1976.

Divine, Robert A., ed. The Cuban Missile Crisis. Chicago: Quadrangle Books, 1971.

Dobbie, John W. "Formal Approaches to Setting Long-Range Goals." Long Range Planning, Vol. 7 (June 1974), 75-80.

Dobbie, John W. "A Comparative Analysis of Long Range Goal Setting Procedures in Large Corporations in California," unpublished Ph.D. dissertation, University of California at Los Angeles, 1972.

Dolson, Miriam T. "MD - Administrators are Older, Earn More Money, Run Bigger Hospitals: Survey." Modern Hospital, Vol. 110, No. 2 (1969), 96-98.

Drucker, Peter F. "Business Objectives and Survival Needs: Notes on a Discipline of Business Enterprise." Journal of Business, Vol. 31 (April 1958), 81-90.

Duncan, W. Jack. "Organizations as Political Coalitions: A Behavioral View of the Goal Formation Process. Journal of Behavioral Economics, Vol. 5 (Summer 1976), 25-44.

Durhin, Richard L. and W. Herbert Springall. Organization and Administration of Health Care: Theory, Practice, and Environment, 2nd ed. St. Louis: C. V. Mosby, 1974.

Elling, Ray H. "The Hospital-Support Game in Urban Center," in E. Freidson, ed. The Hospital in Modern Society (New York: The Free Press, 1963), pp. 73-111.

Elling, Ray H. and Sandor Halebsky. "Organizational Differentiation and Support: A Conceptual Framework." Administrative Science Quarterly, Vol. 6 (September 1961), 185-209.

Emerson, R. M. "Power-Dependence Relations." American Sociological Review, Vol. 27 (February 1962).

Emery, F. E. and E. L. Trist. "Causal Texture of Organizational Environments." Human Relations, Vol. 18 (February 1965), 21-32.

England, George W. "Organizational Goals and Expected Behavior of American Managers." Academy of Management Journal, Vol. 10 (June 1967), 107-117.

England, George W. The Manager and His Values. Cambridge, MA: Ballinger Publishing Company, 1975.

Etzioni, Amitai. "Two Approaches to Organizational Analysis: A Critique and a Sugguestion." Administrative Science Quarterly, Vol. 5 (September 1960), 257-78.

Etzioni, Amitai. Modern Organizations. Englewood Cliffs, NJ: Prentice-Hall, Inc., 1964.

Etzioni, Amitai. A Comparative Analysis of Complex Organizations, revised and enlarged edition. New York: The Free Press, 1975a.

Etzioni, Amitai. "Alternate Conception of Accountability: The Example of Health Administration," Public Administration Review, Vol. 35 (May-June 1975b), 279-286.

Fayol, Henri. General and Industrial Management. Translated by Constance Stores. London: Pittman and Sons, 1949. (Originally published, 1916.)

Ferber, Bernard. "An Analysis of Chain-operated For-Profit Hospitals," Health Services Research, Vol. 6 (Spring 1971), 49-60.

Festinger, Leon and Daniel Katz, eds. Research Methods in the Behavioral Sciences. New York: The Dryden Press, 1953.

Flanagan, S. C. "Theory and Method in the Study of Coalition Formation." Journal of Comparative Administration, Vol. 5 (November 1973), 267-275.

Gamson, W. W. "A Theory of Coalition Formation," American Sociological Review, Vol. 26 (1961a), 373-383.

Gamson, W. A. "An Experimental Test of A Theory of Coalition Formation," American Sociological Review, Vol. 26 (1961b), 565-573.

Georgiou, Petro. "The Goal Paradigm and Notes Towards a Counter Paradigm," Administrative Science Quarterly, Vol. 18 (1973), 291-310.

Georgopoulos, Basil S., ed. Organization Research on Health Institutions. Ann Arbor, MI: Institute for Social Research, 1972.

Georgopoulos, Basil S. Hospital Organization Research: Review and Source Book. Philadelphia: W. B. Saunders, 1975.

Gibb, C. A. "Leadership," in G. Lindsey, ed. Handbook of Social Psychology, Vol. 2, Reading, MA: Addison-Wesley, 1954.

Gilbreth, Frank B. Motion Study. New York: D. Van Nostrand Co., 1911.

Ginzberg, Eli, Dale L. Hiestand, and Beatrice G. Reubens. The Pluralistic Economy. New York: McGraw-Hill, 1965.

Glueck, William F. Management. Hinsdale, IL: The Dryden Press, 1977.

Goodman, Leo A. and William H. Kruskal. "Measures of Association for Croso Classifications." Journal of the American Statistical Associations, Vol. 49 (December 1959), 732-764.

Goodman, Leo A. and William H. Kruskal. "Measures of Association for Cross Classifications: II. Further Discussion and References." Journal of the American Statistical Association, Vol. 54 (March 1959), 123-163.

Goodman, Leo A. and William H. Kruskal. "Measures of Association for Cross Classifications: III. Approximate Sampling Theory." Journal of the American Statistical Association, Vol. 58 (June 1963), 310-364.

Gordon, C. Wayne and Nicholas Babchuk. "A Typology of Voluntary Associations." American Sociological Review, Vol. 24 (1959), 22-29.

Gordon, Paul J. "The Top Management Triangle in Voluntary Hospitals (I)." Journal of the Academy of Management, Vol. 4 (December 1961), 205-214.

Gordon, Paul J. "The Top Management Triangle in Voluntary Hospitals (II)." Journal of the Academy of Management, Vol. 5 (April 1962), 66-75.

Gross, Mary E. W. "Organizational Goals and Quality of Medical Care: Evidence from Comparative Research on Hospitals." Journal of Health and Social Behavior, Vol. 11 (1970), 255-268.

Gouldner, Alvin W. Patterns of Industrial Bureaucracy. Glencoe, IL: The Free Press, 1954.

Graham, Gerald H. "Approaches to Organizational Goal Formation." Southern Journal of Business, Vol. 4 (1969), pp. 1-11.

Granger, Charles H. "The Hierarchy of Objectives." Harvard Business Review, Vol. 42 (May-June 1964), 63-74.

Granger, Charles H. "How to Set Corporate Objectives." Management Review, Vol. 59 (July 1970), 2-8.

Grimes, Richard M. The Impact of Structure on Hospital Effectiveness. Unpublished Ph.D. dissertation, University of Missouri-Columbia, 1973.

Gross, Bertram M. "What Are Your Organizations Objectives?," Human Relations, Vol. 18 (August 1965), 195-215. Reprinted in Walter R. Nord, ed., Concepts and Controversy in Organizational Behavior Pacific Palisades, CA: Goodyear Publishing Company, 1972, pp. 297-319.

Gross, Edward. "Universities as Organizations: A Research Approach," American Sociological Review, Vol. 33 (August 1968), 518-544.

Gross, Edward. "The Definition of Organizational Goals," The British Journal of Sociology, Vol. 20 (September 1969), 277-294.

Gross, Edward and Paul V. Grambsch. University Goals and Academic Power. Washington, DC: American Council on Education, 1968.

Gross, Edward and Paul V. Grambsch. Changes in University Organization, 1964-1971. New York: McGraw-Hill, 1974.

Guluk, Luther and Lyndall F. Urwick, eds. Papers on the Science of Administration. New York: Columbia University Press, 1937.

Guth, William D. and Renato Taqiuri. "Personal Values and Corporate Strategy," Harvard Business Review, Vol. 43 (September-October 1965), 123-132.

Hage, Jerald and Michael Aiken. Social Change in Complex Organizations. New York: Random House, 1970.

Hall, Francini S. "Organization Goals: The Status of Theory and Research," in J. Leslie Livingstone, ed., Managerial Accounting: The Behavioral Foundations. Columbus, OH: Grid, Inc., 1975, pp. 9-32.

Hambrick, Donald C. and Gordon D. Brown. "Toward Operationalizing the Goal Coalition Concept for General Hospitals." Unpublished paper presented at the 1978 National Meetings of the Academy of Management, San Francisco, August 1978.

Hambrick, Donald C. and Charles C. Snow. "A Contextual Model of Strategic Decision Making in Organizations." Proceedings of the Academy of Management (1977), 109-112.

Hannan, Michael T. and John Freeman. "Obstacles to Comparative Studies." In Paul S. Goodman and Johannes M. Pennings, eds., New Perspectives on Organizational Effectiveness. San Francisco: Jossey-Bass, 1977.

Hardy, James M. Corporate Planning for Non-Profit Organizations. New York: Association Press, 1973.

Harrison, E. F. The Managerial Decision Making Process. Boston: Houghton Mifflin, 1975.

Hennessy, Bernard C. Public Opinion. Belmont, CA: Wadsworth Publishing Co., 1965.

Hepner, James O. and Donna M. Hepner. The Health Strategy Game: A Challenge for Reorganization in Management. St. Louis: C. V. Mosby, 1973.

Hickson, D. J., C. R. Hinings, C. A. Lee, R. E. Schneck, and J. M. Pennings. "A Strategic Contingencies' Theory of Intraorganizational Power." Administrative Science Quarterly, Vol. 16 (June 1977), 216-229.

Hiestand, Dale L. "Recent Trends in the Not-For-Profit Sector." In the Commission on Private Philanthropy and Public Needs, Research Papers (Vol. 1). Washington, DC: Department of the Treasury, 1977.

Hill, Walter. "The Goal Formation Process in Complex Organizations," The Journal of Management Studies, Vol. 6 (May 1969), 198-208.

Hofer, Charles W. "Toward a Contingency Theory of Business Strategy," Academy of Management Journal, Vol. 18 (December 1975), 784-810.

Hofer, Charles W. "Research on Strategic Planning: A Survey of Past Studies and Suggestions for Future Efforts," Journal of Economics and Business, Vol. 28 (Summer, 1976), 261-286.

Hofer, Charles W. and Dan Schendel. Strategy Formulation: Analytical Concepts. St. Paul, MN: West Publishing, 1978.

House, Robert J. and John B. Miner. "Merging Management and Behavioral Theory: The Interaction Between Span of Control and Group Size," Administrative Science Quarterly, Vol. 14 (1969), 451-466.

Hrebiniak, Lawrence G. Complex Organizations. St. Paul, MN: West Publishing Co., 1978.

Hunger, J. David and Louis W. Stern. "An Assessment of the Functionality of the Superordinate Goal in Reducing Conflict," Academy of Management Journal, Vol. 19 (December 1976), 591-605.

Hussey, David E. "Corporate Planning for A Church," Long Range Planning, Vol. 7 (April 1974), 61-64.

Huston, Charles L., Jr. "Setting Corporate Objectives," Dun's Review and Modern Industry, October 1962.

Internal Revenue Service. "Activity Code Numbers of Exempt Organizations." Washington, DC: Government Printing Office, 1976a.

Internal Revenue Service. How to Apply for Recognition for Exemption for an Organization. Washington, DC: Government Printing Office, 1976b.

Katz, Daniel and Robert L. Kahn. The Social Psychology of Organizations, 2nd ed. New York: John Wiley and Sons, Inc., 1978.

Kaufman, Herbert. Are Government Organizations Immortal? Washington, DC: The Brookings Institution, 1976.

Kerlinger, Fred N. Foundations of Behavioral Research, 2nd ed. New York: Holt, Rinehart and Winston, Inc., 1973.

Kimberly, John R. "Organizational Size and the Structuralist Perspective: A Review, Critique, and Proposal." Administrative Science Quarterly, Vol. 21 (December 1976), 571-597.

Klarman, Herbert E. The Economics of Health. New York: Columbia University Press, 1965.

Komorita, S. S. and J. M. Chertkoff. "A Bargaining Theory of Coalition Formation." Psychological Review, Vol. 80 (1973), 149-162.

Koontz, Harold. "The Management Theory Jungle." Journal of the Academy of Management, Vol. 4 (December 1961), 174-188.

Koontz, Harold and Cyril O'Donnell. Management: A Systems and Contingency Analysis of Managerial Functions, 6th ed. New York: McGraw-Hill Book Company, 1976.

Kotler, Philip. Marketing for Nonprofit Organizations. Englewood Cliffs, NJ: Prentice-Hall, 1975.

Kruskal, William H. "Ordinal Measures of Association." Journal of the American Statistical Association, Vol. 53 (December 1958), 814-861.

Laboritz, Sanford. "Criteria for Selecting a Significance Level: A Note on the Sacredness of .05," The American Sociologist, Vol. 3 (August 1968), 220-222.

Lang, James R. "Behavioral Science Frameworks in Strategic Management." Unpublished paper presented at the "Conceptual Foundations of Strategic Management" symposium of the American Institute for Decision Sciences' 1978 National Meetings, St. Louis, October 31, 1978.

Lawrence, Paul R. and Jay W. Lorsch. Organization and Environment. Boston: Harvard Graduate School of Business Administration, 1967.

Lee, Sang M. Goal Programming for Decision Analysis. Philadelphia: Auerbach Publishers, Inc., 1972.

Lentz, Edith M. "Hospital Administration -- One of a Species," Administrative Science Quarterly, Vol. 1 (March 1957), 444-463.

Lorsch, Jay W. and Paul R. Lawrence. Studies in Organizational Design. Homewood, IL: Irwin-Dorsey, 1970.

Maccoby, Michael. The Gamesman. New York: Simon and Schuster, 1976.

MacLeod, Roderick K. "Program Budgeting Works in Nonprofit Institutions." Harvard Business Review, Vol. 49 (September-October 1971), 59-69.

MacMillan, Ian C. Strategy Formulation: Political Concepts. St. Paul, MN: West Publishing Co., 1978.

"The Political System in Business," Journal of General Management, Vol. 1 (Autumn 1973), 81-90.

Mankin, Douglas C. and William F. Glueck. "Strategic Planning," Hospital and Health Services Administration, Vol. 22 (Spring 1977), 6-22.

Marascuilo, Leonar A. and Maryellen McSweeney. Nonparametric and Distribution-Free Methods for the Social Science. Monterey, CA: Brooks/Cole Publishing Co., 1977.

March, James G. and Herbert A. Simon. Organizations. New York: John Wiley and Sons, Inc., 1958.

McCarthy, J. F. and A. Ginn. "A Systematic Approach to Setting and Implementing Product Objectives." Management Review, Vol. 59 (January 1970).

McCaskey, Michael B. "A Contingency Approach to Planning: Planning with Goals and Planning Without Goals," Academy of Management Journal, Vol. 17 (June 1974), 281-291.

McKay, Charles W. and Guy D. Cutting. "A Model for Long Range Planning in Higher Education." Long Range Planning, Vol. 7 (October 1974), 58-60.

Mee, John F. "Objectives in a Management Philosophy," in William E. Schlender, William G. Scott, and Alan C. Filley, eds., Management in Perspective: Selected Readings. Boston: Houghton Mifflin, 1965, pp. 59-61.

Mendenhall, William, Lymann Ott, and Richard F. Larson. Statistics: A Tool for the Social Sciences. North Scituate, MA: Duxbury Press, 1974.

Merton, Robert K. "Bureaucratic Structure and Personality," Social Forces, Vol. 18 (May 1940), 560-568.

Mills, T. M. "Coalition Patterns in Three Person Groups," American Sociological Review, Vol. 19 (1954), 657-667.

Mintzberg, Henry. "Organizational Power and Goals." In Dan E. Schendel and Charles W. Hofer, eds. Strategic Management: A New View of Business Policy and Planning. Boston: Little, Brown and Company, 1979.

Mohr, Lawrence B. "The Concept of Organizational Goal." The American Political Science Review, Vol. 67 (June 1973), 470-481.

Mooney, James D. and Alan C. Reiley. Onward Industry! New York: Harper and Brothers Publishers, 1931.

Moorehead, M. A. A Study of the Quality of Hospital Care Secured by a Sample of Teamster's Family Members in New York City. New York: Columbia University School of Public Health and Administrative Medicine, 1964.

Morasky, Robert L. "Defining Goals--A Systems Approach." Long Range Planning, Vol. 10 (April 1977), 85-89.

Murray, Michael A. "Comparing Public and Private Management: An Exploratory Essay." Public Administration Review, Vol. 35 (July/August 1975), 364-371.

Newhouse, Joseph P. "Toward A Theory of Nonprofit Institutions: An Economic Model of a Hospital." American Economic Review, Vol. 60 (March 1970), 64-74.

Newman, William H. and Harvey W. Wallender. "Managing Not-for-Profit Enterprises." Academy of Management Review, Vol. 3 (January 1978), 24-31.

Newman, William H. and James P. Logan. Strategy, Policy, and Central Management, 7th ed. Cincinnati, OH: South-Western Publishing Company, 1976.

Nunnally, Jum C. Psychometric Theory. New York: McGraw-Hill, 1967.

Pauly, Mark and Michael Redisch. "The Not-for-Profit Hospital as a Physician's Cooperative." The American Economic Review, Vol. 63 (March 1973), 87-99.

Parsons, Talcott. Structure and Process in Modern Societies. New York: The Free Press, 1960.

Perrow, Charles. Authority, Goals, and Prestige in a General Hospital. Unpublished Ph.D. dissertation, University of Calfifornia, Berkeley, 1960.

Perrow, Charles. "The Analysis of Goals in Complex Organizations." American Sociological Review, Vol. 26 (December 1961), 854-866.

Perrow, Charles. "Goals and Power Structures: A Historical Case Study," in Eliot Freidson, ed. The Hospital in Modern Society. New York: The Free Press, 1963, 112-146.

Perrow, Charles. "Hospitals: Technology, Structure, and Goals," in James G. March, ed. Handbook of Organizations. Chicago: Rand McNally, 1965, pp. 910-971.

Perrow, Charles. "A Framework for the Comparative Analysis of Organizations." American Sociological Review, Vol. 32 (April 1967), 194-208.

Perrow, Charles. "Organizational Goals," in David L. Sills, ed., International Encyclopedia of the Social Sciences, Vol. 11. New York: The MacMillan Company, 1968, 305-311.

Perrow, Charles. Organizational Analysis: A Sociological View. Belmont, CA: Wadsworth Publishing Company, 1970.

Pfeffer, Jeffrey. "Size, Composition, and Function of Hospital Boards of Directors: A Study of Organizational-Environment Linkage," Administrative Science Quarterly, Vol. 18 (1973), 349-364.

Pfeffer, Jeffrey and Gerald R. Salancik. "Organizational Context and the Characteristics and Tenure of Hospital Administrators." Academy of Management Journal, Vol. 20 (1977), 74-88.

Pfeffer, Jeffrey and Gerald R. Salancik. The External Control of Organizations: A Resource Dependence Perspective. New York: Harper and Row, Publishers, 1978.

Price, James L. Organizational Effectiveness: An Inventory of Propositions. Homewood, IL: Richard D. Irwin, 1968.

Pugh, Derek S., David J. Hickson, Christopher R. Hinings; and Christopher Turner. "Dimensions of Organization Structure." Administrative Science Quarterly, Vol. 13 (June 1968), 65-105.

Quinn, James Brian. "Strategic Goals: Process and Politics." Sloan Management Review, Vol. 19 (Fall 1977), 21-37.

Rafferty, John and Stuart O. Schweitzer. "Comparison of For-Profit and Nonprofit Hospitals: A Re-evaluation." Inquiry, Vol. 11 (December 1974), 304-309.

Rakich, Jonathan S., Beaufort B. Longest, Jr., and Thomas R. O'Donovan. Managing Health Care Organizations. Philadelphia: W. B. Saunders Company, 1977.

Rawls, James R., Robert A. Ullrich, and Oscar Tivio Nelson, Jr. "A Comparison of Managers Entering or Reentering the Profit and Nonprofit Sectors." Academy of Management Journal, Vol. 18 (1975), 616-623.

Reder, M. W. "Economic Theory and Nonprofit Enterprise: Some Problems in the Economics of Hospitals." American Economic Review, Vol. 55 (May 1965), 472-480.

Redwood, R. "Setting Corporate Objectives." Long Range Planning, Vol. 10 (December 1977), 2-10.

Reimann, Bernard C. "Organizational Effectiveness and Management's Public Values: A Cononical Analysis." Academy of Management Journal, Vol. 18 (June 1975), 224-241.

Richards, Max D. Organizational Goal Structures. St. Paul, MN: West Publishing Co., 1978.

Ruchlin, Hirsch S., Dennis D. Pointer, and Lloyd L. Cannedy. "Administering Profit and Nonprofit Institutions." Hospital Progress, Vol. 54 (October 1973a), 67-69, 80.

Ruchlin, Hirsch S., Dennis D. Pointer, and Lloyd L. Cannedy. "A Comparison of For-Profit Investor Owned Chain and Nonprofit Hospitals." Inquiry, Vol. 10 (December 1973b), 13-23.

Rushing, William A. "Differences in Profit and Nonprofit Organizations: A Study of Effectiveness in General Short-Stay Hospitals." Administrative Science Quarterly, Vol. 19 (December 1974), 474-484.

Rushing, William A. "Profit and Nonprofit Orientations and the Differentiations-Coordination Hypothesis for Organizations: A Study of Small General Hospitals," American Sociological Review, Vol. 41 (August 1976), 676-691.

Saunders, Charles B. "Strategy Formation as a Political Process." Journal of General Management, Vol. 2 (Spring 1975), 80-86.

Saunders, J. V. D. "Characteristics of Hospitals and of Hospital Administrators Associates with Hospital-Community Relations in Mississippi." Rural Sociology, Vol. 25 (1960), 229-232.

Schulz, Rockwell and Alton C. Johnson. Management of Hospitals. New York: McGraw-Hill, 1976.

Selznick, Philip. TVA and the Grass Roots. Berkeley: University of California Press: 1949.

Siegal, Sidney. Nonparametric Statistics. New York: McGraw-Hill, 1956.

Simon, Herbert A. Administrative Behavior. New York: The Free Press, 1957.

Simon, Herbert A. "On the Concept of Organizational Goal." Administrative Science Quarterly, Vol. 9 (June 1964), 1-22.

Skibbins, Gerald J. "Top Management Goal Appraisal." International Management, Vol. 29 (July 1974), 41-42.

Skipper, James K., Jr., Anthony L. Guenther, and Gilbert Nass. "The Sacredness of .05: A Note Concerning the Uses of Statistical Levels of Significance in Social Science." The American Sociologist, Vol. 2 (February 1967), 16-18.

Smith, Adam. The Wealth of Nations, Cannan Edition. New York: The Modern Library, 1937.

Somers, Herman M. and Anne R. Sommers. Medicare and the Hospitals: Issues and Prospects. Washington, DC: The Brookings Institution, 1967.

Steers, Richard M. Organizational Effectiveness: A Behavioral View. Santa Monica, CA: Goodyear Publishing Company, 1977.

Steiner, George A., ed. Managerial Long-Range Planning. New York: McGraw-Hill, 1963.

Steiner, George A. Top Management Planning. New York: MacMillan, 1969.

Steiner, George A. and John B. Miner. Management Policy and Strategy: Text, Readings, and Cases. New York: MacMillan, 1977.

Steinwald, Bruce and Duncan Neuhauser. "The Role of the Proprietary Hospital." Law and Contemporary Problems, Vol. 35 (August 1970), 817-838.

Taylor, Frederick W. Scientific Management. New York: Harper and Brothers, 1911.

Taylor, Keith. "Comparative Analysis of Hospital and Industrial Executives." Hospitals, Vol. 29 (September 1955), 100-103.

Tersine, Ricard J. "Organizational Objectives and Goal Programming: A Convergence." Managerial Planning, Vol. 25 (September-October 1976), 27-32, 39.

Thierauf, Robert J., Robert C. Klekamp, and Daniel W. Gelding. Management Principles and Practices. Santa Barbara, CA: John Wiley and Sons, 1977.

Thompson, Arthur A., Jr. and A. J. Strickland, III. Strategy and Policy: Concepts and Cases. Dallas: Business Publications, Inc., 1978.

Thompson, James D. Organizations in Action. New York: McGraw-Hill Book Company, 1967.

Thompson, James D. and William J. McEwen. "Organizational Goals and Environment: Goal-Setting As An Interaction Process." American Sociological Review, Vol. 23 (February 1958), 23-31.

Tideman, T. Nicholaus. "Employment and Earnings in the Nonprofit Charitable Sector." In the Commission on Private Philanthropy and Public Needs, Research Papers. Washington, DC: Department of the Treasury, 1977.

Trist, E. L. and K. W. Bamforth. "Some Social and Psychological Consequences of the Long-Wall Method of Getting." Human Relations, Vol. 4 (February 1953), 3-38.

Trussell, Ray E. "The Problems of Maintaining Quality in Hospitals." In John H. Knowles (ed.) Hospitals, Doctors and the Public Interest. Cambridge, MA: Harvard University Press, 1965.

Urwick, Lyndall F. The Elements of Administration. New York: Harper and Brothers, 1943.

Vancil, Richard F. "Strategy Formulation in Complex Organizations." Sloan Management Review, Vol. 17 (Winter 1976), 1-18.

Von Bertalanffy, Ludwid. "General Systems Theory: A New Approach to the Unity of Science." Human Biology, Vol. 23 (December 1951), 303-361.

Von Bertalanffy, Ludwig. "General Systems Theory." General Systems, Vol. 1 (1956), 1-10.

Warner, W. Keith. "Problems in Measuring the Goal Attainment of Voluntary Organizations." Journal of Adult Education, Vol. 19 (Fall 1967), 3-14.

Warner, W. Keith and A. Eugene Havens. "Goal Displacement and the Intangibility of Organizational Goals." Administrative Science Quarterly, Vol. 12 (March 1968), 539-555.

Warwick, Donald P. and Charles A. Lininger. The Sample Survey: Theory and Practice. New York: McGraw-Hill, 1975.

Webber, James B. and Martha A. Dula. "Effective Planning Committees for Hospitals." Harvard Business Review, Vol. 52 (May-June 1974), 51-60.

Weber, Max. The Theory of Social and Economic Organization, translated by A. M. Henderson and Talcott Parsons. New York: The Free Press, 1947. (Originally published, 1922.)

Weisbrod, Burton A. and Stephen H. Long. "The Size of the Voluntary Nonprofit Sector: Concepts and Measures." In the Commission on Private Philanthropy and Public Needs, Research Papers (Vol. 1). Washington, DC: Department of the Treasury, 1977.

Wholey, Joseph S., et al. Federal Evaluation Policy: Analyzing the Effects of Public Programs. Washington, DC: The Urban Institute, 1975.

Woodward, Joan. Management and Technology. London: HMSO Department of Scientific and Industrial Research, 1958.

Woodward, Joan. Industrial Organization: Theory and Practice. London: Oxford University Press, 1965.

Wortman, Max S., Jr. "Conceptual Foundations in Strategic Management: The Policy Science." Unpublished paper presented at the "Conceptual Foundations of Strategic Management" symposium of the American Institute for Decision Sciences' 1978 National Meetings, St. Louis, October 31, 1978.

Wortman, Max S., Jr. "Strategic Management: Not-for-Profit Organizations." In Dan E. Schendel and Charles W. Hofer (Eds.), Strategic Management: A New View of Business Policy and Planning. Boston: Little, Brown and Company, 1979.

Zald, Mayer N. "Comparative Analysis and Measurement of Organizational Goals: The Case of Correctional Institutions for Delinquents." The Sociological Quarterly, Vol. 4 (Summer 1963), 206-230.

APPENDICES

APPENDIX A

ORGANIZATIONAL DATA QUESTIONNAIRE (ODQ)

ORGANIZATIONAL DATA QUESTIONNAIRE

1. In what year was your hospital founded? _____

2. How many total beds does your hospital have? _____

3. How many physicians have privileges at your hospital? _____
   a. How many of these are full time employees? _____

4. Not counting the medical staff, how many full time equivalent (FTE) employees does your hospital have? _____
   a. Of these, how many are: Nurses (RN or LPN) _____
      Allied Health _____
      Administrative/Clerical _____
      Nonprofessional Staff _____
      Other _____

5. What is your hospital's:
   a. average occupancy rate? _____%
   b. average cost per patient day? $_____
   c. total operating budget for the current fiscal year? $_____

6. What is the average length (in days) of a patient's stay in your hospital? _____

7. If your hospital is part of a larger organizational system, please indicate the name and address of its parent organization.

   _____
   _____
   _____
   _____

On the following pages, please list (or attach a list of) the names, titles, positions with your hospital, and mailing addresses for members of each of the groups listed below.

1. All administrators (include yourself and any assistant and/or associate administrators) who regularly participate in the top level decision making in your hospital.
2. The chief of your medical staff, any heads of medical or surgical departments or services, and/or any other physicians associated with your hospital who regularly participate in its top level decision making processes.

3. All members of your hospital's board of trustees who regularly participate in its top level decision making processes.

4. All other individuals who regularly participate in the top level decision making processes of your hospital. These might include such people as functional department heads, the head of nursing service, or members of the local community not on the board or otherwise associated with your hospital.

---

1. ADMINISTRATORS

Name and Title	Position with Hospital	Mailing Address

2. MEDICAL STAFF

Name and Title	Position with Hospital	Mailing Address

3. BOARD OF TRUSTEES

Name and Title	Position with Hospital	Mailing Address

4. OTHERS

Name and Title	Position with Hospital	Mailing Address

APPENDIX B

PERCEIVED ORGANIZATIONAL GOALS QUESTIONNAIRE (POGQ)

PERCEIVED ORGANIZATIONAL GOALS
QUESTIONNAIRE

SECTION I

The first section of this questionnaire deals with hospital goals. The next several pages contain a list of various organizational goals which a hospital might try to achieve. For each goal statement, you will be asked to make two responses.

First, read the goal statement and respond in terms of how important that particular goal IS for the hospital with which you are currently associated. Your response to this question should be based upon what your hospital is actually trying to accomplish in its day to day activities at this point in time. Please do not respond to this first part based upon your belief that the goal is desirable or that it is something you would like your hospital to do.

The second response opportunity for each goal statement allows you to state how important each goal SHOULD BE for your hospital. Here you are asked to indicate how you personally feel about each goal alternative. Please do not feel that your responses to the IS and SHOULD BE parts have to be identical. In many instances, identical responses may well be the exception rather than the rule. Also, please do not feel constrained in giving your SHOULD BE response because the goal statement may never be attainable in your hospital.

The response alternatives available to you are as follows:

[5] = of absolutely top importance
[4] = of great importance
[3] = of medium importance
[2] = of little importance
[1] = of no importance
[0] = don't know or can't say

Consider the following example:

Goal Statement	How important IS it?	How important SHOULD it BE?
to care for the sick	[3]	[4]

An individual answering as above would be indicating that this goal IS "of medium importance" in terms of the day to day activities of his/her hospital and believes that it SHOULD BE "of great importance."

GOAL STATEMENTS	How important IS it?	How important SHOULD it BE?	
1. to provide a full compliment of services	☐	☐	1.
2. to lessen the pain of humanity	☐	☐	2.
3. to improve employee benefits	☐	☐	3.
4. to provide doctors with the technical and administrative support they request	☐	☐	4.
5. to participate in the affairs and activities of the local community	☐	☐	5.
6. to provide health education programs for the public	☐	☐	6.
7. to insure financial stability	☐	☐	7.
8. to have the most modern equipment and facilities in the area	☐	☐	8.
9. to maintain accreditation and licensing	☐	☐	9.
10. to minimize the length of patient stays, given quality treatment	☐	☐	10.
11. to provide inservice education programs	☐	☐	11.

POGQ-2

[5] = of absolutely top importance
[4] = of great importance
[3] = of medium importance
[2] = of little importance
[1] = of no importance
[0] = don't know or can't say

GOAL STATEMENTS	How Important IS it?	How important SHOULD it BE?	
12. to have good relationships with doctors in the local area	☐	☐	12.
13. to make all members of the local community feel welcome in this hospital	☐	☐	13.
14. to sponsor home health care programs	☐	☐	14.
15. to provide offices for doctors within the hospital complex	☐	☐	15.
16. to survive	☐	☐	16.
17. to provide the highest quality medical care possible	☐	☐	17.
18. to be a place where new medical techniques are developed	☐	☐	18.
19. to modernize, expand, and grow	☐	☐	19.
20. to efficiently use our staff	☐	☐	20.
21. to keep in mind community health care costs in making decisions to add new services	☐	☐	21.
22. to lower the mortality rate in the local area	☐	☐	22.
23. to provide high rewards for our employees	☐	☐	23.
24. to provide a friendly and pleasant environment for the patients and their families	☐	☐	24.
25. to provide the highest quality medical care at the lowest possible cost	☐	☐	25.
26. to add new services even if they are expensive and have a low potential utilization rate	☐	☐	26.
27. to be concerned with cost cutting techniques	☐	☐	27.
28. to provide the medical staff with a well equiped, smooth running place to perform its professional services	☐	☐	28.
29. to allow representatives of the community a voice in major decisions affect the type of health care provided by this hospital	☐	☐	29.
30. to recruit, train, and retain a highly qualified and competent staff at all levels	☐	☐	30.
31. to have a low patient-staff ratio	☐	☐	31.
32. to have a large number of specialties represented on the medical staff	☐	☐	32.
33. to engage in the training of medical, nursing, and/or allied health care students	☐	☐	33.
34. to generate a financial surplus or profit	☐	☐	34.
35. to only provide services that are self-supporting	☐	☐	35.
36. to make the hospital a part of the doctor's practice	☐	☐	36.
37. to educate people about preventative medicine	☐	☐	37.
38. to create good employee relationships	☐	☐	38.

POGQ-3

[5] = of absolutely top importance
[4] = of great importance
[3] = of medium importance
[2] = of little importance
[1] = of no importance
[0] = don't know or can't say

GOAL STATEMENTS	How important IS it?	How important SHOULD it BE?	
39. to help with the advancement of medical science . . .	☐	☐	39.
40. to be the hospital with the highest prestige in the area	☐	☐	40.
41. to increase the utilization of existing services and facilities	☐	☐	41.
42. to realize that this hospital is in competition with other area institutions for patients, doctors, nurses, and money	☐	☐	42.
43. to meet the health care needs of the local area . . .	☐	☐	43.
44. to provide a pleasant working environment for our employees	☐	☐	44.
45. to remember that our entire operation should be organized to best serve our patients	☐	☐	45.
46. to attract doctors with national reputations	☐	☐	46.
47. to be more business-like in our activities	☐	☐	47.
48. to be able to influence decisions which affect local health care	☐	☐	48.
49. to have good relations with other health care organizations in the area	☐	☐	49.
50. to review the medical activities of our medical staff in order to insure the continued high quality of care that our patients deserve	☐	☐	50.
51. to provide effective channels for communication and information exchange within the hospital	☐	☐	51.
52. to give major consideration to potential revenues and costs when deciding to add or delete services . .	☐	☐	52.
53. to not interfere with the relationship that exists between a doctor and his/her patients	☐	☐	53.
54. to protect the patient from the risk and/or cost of unnecessary procedures	☐	☐	54.
55. to actively seek contributions, gifts, and bequests from local sources	☐	☐	55.
56. to actively seek grant or foundation support for hospital programs	☐	☐	56.

IF YOU FEEL THAT THERE ARE GOAL STATEMENTS WHICH ARE RELEVANT FOR YOUR HOSPITAL BUT WHICH HAVE BEEN OMITTED FROM THE ABOVE LIST, PLEASE IDENTIFY AND EVALUATE THEM BELOW.

57. _____	☐	☐	57.
58. _____	☐	☐	58.
59. _____	☐	☐	59.
60. _____	☐	☐	60.

POGQ-4

SECTION II-A

This section of the questionnaire deals with the amount of influence which various groups have in terms of affecting the overall goals of your hospital. Please indicate how much influence you personally feel each of the following individuals or groups has in terms of actually affecting the goals of your hospital. Remember, we are asking about the goals of your hospital as a whole and not about the goals of any particular individual or department. If you feel that there are other individuals and/or groups which affect your hospital's goals but which are not included below, please list them at the bottom of the page and indicate their level of influence in the same manner.

HOW MUCH INFLUENCE DOES EACH OF THE FOLLOWING HAVE ON YOUR HOSPITAL'S GOALS	a great deal of influence	quite a bit influence	some influence	very little influence	no influence at all
1. Federal level politicians and/or legislators					
2. Local and state level politicians and/or legislators					
3. Third party providers					
4. Sources of private contributions, grants, and research money					
5. Accreditation and licensing boards					
6. Professional Standards Review Organizations (PSRO)					
7. Health Systems Agencies (HSA)					
8. Federal agencies, departments, or offices					
9. State and local agencies, departments or offices					
10. The local community as a whole					
11. Local bankers and/or businesspersons not on the board or staff of the hospital					
12. The hospital's parent organization (if any)					
13. The hospital administrator					
14. The associate and/or assistant administrator(s) as a group					
15. The board of trustees as a group					
16. The chairperson of the board					
17. The medical staff as a group					
18. The chief of the medical staff					
19. The nurses as a group					
20. The head of nursing service					
21. Other professional staff as a group					
22. Functional department heads as a group					
23. The nonprofessional staff as a group					
24. The students your hospital trains (if any) as a group					
25. The patients as a group					
26. Other hospitals in the local area					
27. Local religious leaders					
28.					
29.					
30.					

POGQ-5

SECTION II-B

Using the list of potential influencers found on the preceding page, please identify the three most influential individuals or groups in terms of their ability to affect your hospital's overall goals. If 100 "units of influence" were to be divided among these three individuals or groups, please indicate how you think they should be allocated based upon your personal experiences in your current hospital.

Individual or Group	Rank	Units of Influence
_____	Most Influential	____
_____	Second Most Influential	____
_____	Thrid Most Influential	____
	TOTAL	100

In any situation where there are several parties involved in a decision making process, it is possible for there to be conflict among them or for two or more of them to unite in some type of joint action. Based upon your personal experiences in your current hospital, please answer the following questions.

During the goal setting process used by your hospital, how frequently do you feel that there is conflict present among those who participate?

All the time	Most of the time	Some of the time	Rarely	Never
☐	☐	☐	☐	☐

If you feel that there is any amount of conflict present during your hospital's goal setting porcess, which individuals and/or groups do you see as being involved most frequently (refer to the list on the preceding page)?

_____ _____

_____ _____

_____ _____

During the goal setting process used by your hospital, how frequently do you see two or more of the participants unite to form an alliance either in support of or against a particular issue?

All the time	Most of the time	Some of the time	Rarely	Never
☐	☐	☐	☐	☐

If you have ever seen an alliance of two or more of the participants in your hospital's goal setting process, please identify the individuals and/or groups which most frequently join together (refer to the list on the preceding page).

_____ _____

_____ _____

_____ _____

How much influence do you personally have in terms of being able to affect the goals of your hospital?

Quite a lot of influence	More than an average amount	An average amount	Less than an average amount	Very little or none
☐	☐	☐	☐	☐

FOR OFFICE USE ONLY: ☐☐☐ - ☐☐☐ - ☐☐☐

POGQ-6

Using the format described on the first page of this questionnaire, please evaluate the following items in terms of: (1) how important each factor IS in making decisions about the goals of your hospital; and (2) how important each factor SHOULD BE in making these decisions. The IS response should indicate how much weight is given to the factor by those involved in the goal setting process as a group. The SHOULD BE response provides you with an opportunity to indicate how much weight you personally feel should be given to the factor. The response alternatives available to you are again the following:

[5] = of absolutely top importance	[4] = of great importance
[3] = of medium importance	[2] = of little importance
[1] = of no importance	[0] = don't know or can't say

POSSIBLE DECISION FACTORS	How Important IS it?	How important SHOULD it BE?	
1. the costs to implement the proposed goal versus the potential revenues which might be derived from it	☐	☐	1.
2. the probability that the proposed goal can or will ever be achieved	☐	☐	2.
3. the impact which the proposed goal might have on your hospital's competition	☐	☐	3.
4. the personal goals, aspirations, and/or desires of any of the participants in the goal setting process	☐	☐	4.
5. the needs and medical welfare of the local community	☐	☐	5.
6. the potential public relations value of the proposed goal	☐	☐	6.
7. the effect which the adoption of the proposed goal might have on the existing goals of the hospital	☐	☐	7.
8. the desires of the hospital's employees who are not directly involved in the goal setting process	☐	☐	8.
9. the feedback which ahs been received from present and past patients	☐	☐	9.
10. the potential prestige value of the proposed goal for your hospital	☐	☐	10.

1. Does your hospital have a formal list of its organizational goals (check one)?

   YES ☐ NO ☐

2. If your answer to the preceding question was YES, please answer "a" and "b" below. If you answered NO, you have completed the questionnaire.

   a. When was the last time you actually read the list of your hospital's goals?

Within the last week	Within the last month	Within the last year	Over a year ago	Never
☐	☐	☐	☐	☐

   b. How would you describe the relationship between this list of your hospital's goals and the goals it actually seeks to achieve in its daily operations?

They are the same	There is a strong relationship	There is a moderate relationship	There is very little relationship	There is no relationship
☐	☐	☐	☐	☐

APPENDIX C

PERSONAL INTERVIEW SCHEDULE (PIS)

PERSONAL INTERVIEW SCHEDULE

Hospital Code _____

Date of Interview _____

Time of Interview: Start _____; Stop _____

Location of Interview _____

Anyone Else Present: YES _____; NO _____

If YES, who: _____

_____

_____

I would like start off by asking you a few questions which relate to your hospital's goals and goal setting activities.

1. How important do you personally feel that it is for an organization such as this hospital to have a set of well defined goals? (Show interviewee Response Alternatives Card #1.)

VERY IMPORTANT _____

SOMEWHAT IMPORTANT _____

NEITHER IMPROTANT NOR UNIMPORTANT _____

SOMEWHAT UNIMPORTANT _____

VERY UNIMPORTANT _____

If the interviewee's answer to the above was other than VERY or SOMEWHAT IMPORTANT, ask why he/she does not view goals as being important.

REASON: _____

_____

_____

_____

2. Would you please describe the process by which your hospital's organizational goals are established, reviewed and revised.

Before leaving this question, make sure you have obtained answers to the following:

a. How and by whom is the goal setting process usually initiated?

b. How often does the process take place?

c. Who reviews the proposed goals?

d. Who votes on or approves the proposed goals?

e. In addition to the regular participants, who else usually provides inputs for the process?

f. What are the major criteria used in making decisions about your organizational goals?

g. How long does the goal setting process usually take from initiation to final adoption?

How about with regard to preperation and approval of you hospital's budget?

h. How many times in the last 5 years has your hospital changed its goals or the emphasis it has placed upon them?

i. How do you know if your hospital is achieving or has achieved a particular goal? _____

_____

_____

j. How long has the goal setting process which you have just described been used in this hospital? _____

_____

k. When did your hospital adopt its current organizational goals?

_____

3. Would you say that the goal setting process currently used by this hospital is: (Show interviewee Response Alternatives Card #2)

VERY FORMAL _____

SOMEWHAT FORMAL _____

NEITHER FORMAL NOR INFORMAL _____

SOMEWHAT INFORMAL _____

VERY INFORMAL _____

4. Would you say that the general atmosphere in meetings which deal with the establishment, review, and/or revision of your hospital's overall goals is: (Show interviewee Response Alternatives Card #3)

VERY GOOD _____

GOOD _____

AVERAGE _____

POOR _____

VERY POOR _____

If the interviewee's answer to the above was either POOR or VERY POOR, ask why he/she believes this is the case.

REASON: _____

_____

_____

_____

_____

5. When there is conflict on a particular goal alternative, how is it usually settled? _____

_____

_____

Is this method usually successful? _____

_____

_____

6. Does this hospital publish a list of its organizational goals?

YES _____ (Go to "a" below.)

NO _____ (Go to "c" below.)

a. If YES, to whom is this list distributed? _____

_____

b. If YES, is this distribution:

AUTOMATIC _____

BY REQUEST ONLY _____

c. If NO, ask the interviewee why his/her hospital does not publish a list of these goals.

REASON: _____

_____

APPENDIX D

EXPERT PANEL QUESTIONNAIRE

COLLEGE OF BUSINESS

VIRGINIA POLYTECHNIC INSTITUTE AND STATE UNIVERSITY

Blacksburg, Virginia 24061

DEPARTMENT OF BUSINESS ADMINISTRATION (703) 961-6596

As part of a research project on hospital goals which I am currently directing, it is necessary for me to know how certain organizational goals are perceived by various individuals and groups within the health care industry.

I would like for you to assist me in this endeavor by taking a few minutes to classify the following goal statements as being either: (1) Community Service Related; (2) Economically or Financially Related; (3) Employee Related; (4) Medical Staff Related; (5) Patient Related; (6) Prestige Related; or (7) Other. Please do not use the "Other" category unless you cannot possibly fit the statement into one of the first six categories. If you do use "Other," please specify what you feel would be an appropriate title for a new category containing such a goal statement.

Thank you very much for your help in this research.

GOAL STATEMENTS

1. to provide a full compliment of services . . . . . ☐
2. to lessen the pain of humanity . . . . . ☐
3. to improve employee benefits . . . . . ☐
4. to provide doctors with the technical and administrative support they request . . . . . ☐
5. to participate in the affairs and activities of the local community . . . . . ☐
6. to provide health education programs for the public . . . . . ☐
7. to insure financial stability . . . . . ☐
8. to have the most modern equipment and facilities in the area . . . . . ☐
9. to maintain accreditation and licensing . . . . . ☐
10. to minimize the length of patient stays, given quality treatment . . . . . ☐
11. to provide inservice education programs . . . . . ☐

[1] = Community Service Related
[2] = Economically/Financially Related
[3] = Employee Related
[4] = Medical Staff Related
[5] = Patient Related
[6] = Prestige Related
[7] = Other (Please specify a title)

GOAL STATEMENTS

12. to have good relationships with doctors in the local area . . . . . [ ]
13. to make all members of the local community feel welcome in this hospital . . . . . [ ]
14. to sponsor home health care programs . . . . . [ ]
15. to provide offices for doctors within the hospital complex . . . . . [ ]
16. to survive . . . . . [ ]
17. to provide the highest quality medical care possible . . . . . [ ]
18. to be a place where new medical techniques are developed . . . . . [ ]
19. to modernize, expand, and grow . . . . . [ ]
20. to efficiently use our staff . . . . . [ ]
21. to keep in mind community health care costs in making decisions to add new services . . . . . [ ]
22. to lower the mortality rate in the local area . . . . [ ]
23. to provide high rewards for our employees . . . . . [ ]
24. to provide a friendly and pleasant environment for the patients and their families . . . . . [ ]
25. to provide the highest quality medical care at the lowest possible cost . . . . . [ ]
26. to add new services even if they are expensive and have a low potential utilization rate . . . . . [ ]
27. to be concerned with cost cutting techniques . . . . [ ]
28. to provide the medical staff with a well equiped, smooth running place to perform its professional services . . . . . [ ]
29. to allow representatives of the community a voice in major decisions affect the type of health care provided by this hospital . . . . . [ ]
30. to recruit, train, and retain a highly qualified and competent staff at all levels . . . . . [ ]
31. to have a low patient-staff ratio . . . . . [ ]
32. to have a large number of specialties represented on the medical staff . . . . . [ ]
33. to engage in the training of medical, nursing, and/or allied health care students . . . . . [ ]
34. to generate a financial surplus or profit . . . . . [ ]
35. to only provide services that are self-supporting . . [ ]
36. to make the hospital a part of the doctor's practice . . . . . [ ]
37. to educate people about preventative medicine . . . . [ ]
38. to create good employee relationships . . . . . [ ]

[1] = Community Service Related
[2] = Economically/Financially Related
[3] = Employee Related
[4] = Medical Staff Related
[5] = Patient Related
[6] = Prestige Related
[7] = Other (Please specify a title)

GOAL STATEMENTS

39. to help with the advancement of medical science . . . ☐
40. to be the hospital with the highest prestige in the area . . . . . ☐
41. to increase the utilization of existing services and facilities . . . . . ☐
42. to realize that this hospital is in competition with other area institutions for patients, doctors, nurses, and money . . . . . ☐
43. to meet the health care needs of the local area . . . ☐
44. to provide a pleasant working environment for our employees . . . . . ☐
45. to remember that our entire operation should be organized to best serve our patients . . . . . ☐
46. to attract doctors with national reputations . . . . . ☐
47. to be more business-like in our activities . . . . . ☐
48. to be able to influence decisions which affect local health care . . . . . ☐
49. to have good relations with other health care organizations in the area . . . . . ☐
50. to review the medical activities of our medical staff in order to insure the continued high quality of care that our patients deserve . . . . . ☐
51. to provide effective channels for communication and information exchange within the hospital . . . . . ☐
52. to give major consideration to potential revenues and costs when deciding to add or delete services . . ☐
53. to not interfere with the relationship that exists between a doctor and his/her patients . . . . . ☐
54. to protect the patient from the risk and/or cost of unnecessary procedures . . . . . ☐
55. to actively seek contributions, gifts, and bequests from local sources . . . . . ☐
56. to actively seek grant or foundation support for hospital programs . . . . . ☐

APPENDIX E

STATISTICAL FORMULAE

Goodman and Kruskal's Gamma

The following discussion of gamma is based largely upon the writings of Costner (1965), Goodman and Kruskal (1954, 1959, 1963), Gross and Grambsch (1968, 1974), Kruskal (1958), and Mueller, Schuessler, and Costner (1970). It is intended to clarify the technique for those readers who are not familiar with its use.

Gamma is unique in that it not only provides a nonparametric ordinal measure of association which can be used with ordered contingency tables of any size, it also can be interpreted as a proportional reduction in error (PRE) measure which allows one to determine the proportion of guessing errors which can be eliminated in predicting an individual's response on a dependent variable by knowing his or her response on a given independent variable. Gamma thus considers pairs of responses and does not predict the specific rank of a particular case vis à vis all other cases. The ability to give gamma this PRE interpretation makes it similar to r^2 in regression analysis.

Consider the following example taken from an actual analysis performed for this study. Viewing the economic orientation of the hospital with which the respondent is associated as the independent variable (X) and his or her response to a given goal statement as the dependent variable (Y), it was possible to construct the ordered contingency table presented in Table E-1. Gamma then considers each pair of cases in this table in order to determine if they are: (1) concordant (C) or have the same order on both variables; (2) discordant (D) or have the reverse order on both variables; or (3) tied on one or both of the variables. Since gamma ignores ties on the ground

Table E-1

Ordered Contingency Table Example for Gamma

IS Goal Statement 56: How important is it to actively seek grant or foundation support for your hospital's programs?	Economic Orientation of the Respondent's Hospital		Row Totals
	For-Profit	Not-For-Profit	
1. of no importance	24	2	26
2. of little importance	8	7	15
3. of medium importance	1	29	30
4. of great importance	2	26	28
5. of absolutely top importance	0	4	4
Column Totals	35	68	103

that they result from crude measurement procedures, the third possibility becomes irrelevant. According to Goodman and Kruskal (1954, 1963), the actual value of gamma can be computed by summing the number of concordant and discordant pairs and applying the formula

$$\text{Gamma} = \frac{C - D}{C + D} .$$

The resultant value of gamma can range from -1.0 to +1.0 depending upon whether the concordant or discordant pairs dominate the table. A value of +1.0 would thus indicate a perfect positive correlation between the two variables (i.e., the same response ordering) while a gamma of -1.0 would signify a perfect negative association (i.e., the reverse ordering of responses). Should there be exactly the same number of concordant and discordant pairs in the analysis, gamma will have a value of 0.0 thereby indicating no association between the independent and dependent variables.

In this research, economic orientation was coded "1" for proprietary hospitals and "2" for nonprofit institutions and the response alternatives for each goal statement were coded "1" for "of no importance" to "5" for "of absolutely top importance" (see Table E-1). Since a nonprofit hospital was therefore "ranked" higher than a for-profit one and "of absolutely top importance" was "ranked" higher than "of no importance," a positive gamma meant that individuals who were from nonprofit institutions tended to rank the goal statement as more important than did those respondents from for-profit hospitals. Similarly, a negative gamma indicated that the respondents from the higher ranked nonprofit facility perceived the

goal statement to be of less importance than did their for-profit counterparts and vice versa.

The calculated value of gamma for the example presented above was 0.908. This indicated a very strong positive correlation between the economic orientation of a respondent's hospital (the independent variable) and his or her evaluation of goal statement number 56 (the dependent variable). More specifically, this gamma showed that respondents from nonprofit hospitals consistently ranked goal statement 56 higher in perceived importance than did respondents from proprietary hospitals, or conversely, that the respondents from proprietary hospitals consistently ranked it lower.

In addition to indicating the direction and strength of the association, the absolute value of gamma can be interpreted as a PRE measure similar to the r^2 in regression analysis. For this example, the absolute value of gamma was 0.908. This meant that by knowing the economic orientation of the respondent's hospital, over 90 percent of the guessing errors could be eliminated from predictions about his or her response to goal statement 56. Using a r^2 type of interpretation, this is the same as saying that over 90 percent of the unexplained variation in an individual's response pattern can be accounted for by knowing the economic orientation of his or her hospital.

As a final caution to the use and interpretation of gamma, the reader is urged to remember that gamma does not predict the rank of an item vis à vis a host of other items. Instead it uses ordered pairs of cases to examine the response patterns of individuals so as to determine if there is an association between a given indepen-

dent and dependent variable. In addition, the absolute value of this association shows the proportion of guessing errors which can be eliminated in predicting a response pattern on an independent variable by knowing the response pattern on a dependent variable.

The significance of any given gamma can be determined by means of the following transformation to the z statistic:

$$z = G\sqrt{\frac{C + D}{N(1 - G^2)}}$$

where: G = the computed value of gamma;

C = the number of concordant pairs in the analysis;

D = the number of discordant pairs in the analysis;

N = the number of cases.

The two page vita has been removed from the scanned document. Page 1 of 2

The two page vita has been removed from the scanned document. Page 2 of 2

AN EXAMINATION OF THE RELATIONSHIP BETWEEN THE ECONOMIC ORIENTATIONS AND STRATEGIES OF ORGANIZATIONS WITHIN THE HEALTH CARE INDUSTRY

by

William B. Carper

(ABSTRACT)

This dissertation reports an empirical investigation of the relationship between an organization's economic orientation (i.e., whether it is a profit or not-for-profit organization) and its strategy as operationalized in its goals, goal structure, power structure, and goal setting process. The comparative analysis of these fundamental strategic elements in actual profit and nonprofit organizations is viewed as a necessary prerequisite to the understanding of the strategic management process in what has traditionally been referred to as the not-for-profit sector.

Based upon a review of the current literature, three multiple hypotheses were formulated to guide the research. These hypotheses related to whether or not organizations which use the same basic technology and are of the same general size, but which profess to have different economic orientations,: (1) establish different strategies to guide their operations; (2) exhibit different power relationships among those who are involved in making these strategic decisions; and (3) utilize different processes for making these strategic decisions.

The data needed to test the research hypotheses were obtained from surveys of and interviews with the top level decision makers in three proprietary (for-profit) and five not-for-profit hospitals located in the states of Virginia, West Virginia, and North Carolina. Only short-term, nongovernment, nonreligious, nonteaching, general hospitals were studied in order to increase the homogeneity of the sample. Various problems associated with the identification of the sample and the methodology employed to collect the data are discussed and the research instruments used are included as appendices. Because of the exploratory nature of this research, the inherent limitations of the methodology which was used, and the small sample size, the reader is cautioned against generalizing the findings and conclusions reported here to organizations not specifically examined as part of this study.

A measure of the overall strategy of each organization was obtained using a mail questionnaire which asked its top level decision makers to evaluate the importance of 56 goal statements that were viewed as relevant for hospitals. The mean responses to all goal statements were in turn rank ordered for each economic orientation to obtain its particular goal structure. The power structure for each economic orientation was developed in a similar manner by having the respondents evaluate the amount of influence which 27 potential power holders might be able to exert with regard to his or her organization's goal setting process. Both the mail questionnaire and personal interviews with the administrators of each hospital were used to provide data about the particular goal setting process of each institution.

Statistical analysis of the resultant data led to the following conclusions. First, no significant differences were observed between the goals and goal structures of the proprietary and not-for-profit hospitals surveyed in this study. Second, no significant differences were observed in the power structures of the proprietary and not-for-profit hospitals surveyed in this study. Third, there may be some inherent differences between the goal setting processes used by the proprietary and not-for-profit hospitals surveyed in this study, although the exact nature of these differences cannot be clearly determined from this research alone. Fourth, the generally high internal reliabilities of the six goal area constructs employed here to examine specific types of related goals indicated that they were appropriate for use in this study and the ability to increase these reliabilities even further indicates that they may prove to be of additional value in future investigations of this type. Finally, the minimal amount of support for the research hypotheses which was observed in the data analyzed here failed to provide an empirical basis for the argument that there are fundamental differences in the strategic management processes of profit and not-for-profit organizations.