

How Is Isomorphism in the Health Care Industry Generated Across Legal
Forms, or Is It? Analysis of Australian and United States Interviews

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This paper looks anew at one of the most basic questions in the study of organizations: Where do organizational structures come from? By structures we mean recurrent patterns, from procedures to relationships, from behaviors to committees. This is purposefully a considerably broader notion of organizational structure than the conventional but important Weberian list: hierarchy, division of labor, standardized procedures, formalized rules, etc. Structures are important for many reasons, from their impacts on effective pursuit of organizational goals to their allocation of organizational resources to private agendas.

All organizational theories provide some indication of where structures come from. The answers range from efficiency and effectiveness, to uncertainty reduction, to resource dependency, to labor control, to elite power, to structural inertia, to selection forces, to legitimacy seeking. The project of which this paper is a continuation has been examining nonprofit organizations' structures as a response to their need for legitimacy, which is the central concern of neo-institutional theory. As we shall see, the inductive turn the project takes with this paper moves us into other theoretical territory.

An organization gains legitimacy (and the status, security, and resources that come with it) when it meets environmental expectations such that key actors in the environment accept the organization in a taken-for-granted way as an exemplar of the form it claims (e.g., school, bank, nonprofit organization). It is not enough to perform effectively to be legitimate; in fact, if you look like what you are expected to look like, you may not have to be effective at all. It is organizational structures that environmental actors assess in deciding whether an organization is legitimate (Meyer and Rowan, 1977).

Legitimacy seeking leads logically to structural similarity among organizations of the same form as they all try to measure up to common expectations for that form. Certain interactional processes heighten this tendency toward similarity, which neo-institutional theory calls isomorphism. Domination or dependency leads to coercive isomorphism, that is, compliance with the demands of stronger organizations. Uncertainty about goals or means leads to mimetic isomorphism or copying models that appear to have achieved legitimacy. The influence of experts leads to normative isomorphism as professionals, teachers, and consultants spread their views widely. Where these isomorphism-inducing processes operate strongly, an organizational field can be said to have coalesced (DiMaggio and Powell, 1983).

Nonprofit organizations can be expected to be subject to especially strong isomorphic processes because they tend to be dependent on other organizations for resources, to exhibit considerable uncertainty about their goal or the means to achieve their goal, and to be enmeshed increasingly in expert and professional networks. Yet, an

earlier investigation with Australian data did not find high levels of isomorphism among nonprofit organizations nor greater isomorphism where coercive, mimetic, or normative processes operated (Leiter, 2005b). This may mean that nonprofit organizations do not (yet?) constitute an organizational form about which the environment has clear expectations nor an organizational field in which the interactional processes of dominance, dependence, copying, and influence operate.

Instead, isomorphism may be generated where organizations face the same environment and use the same technology, as these factors largely determine the key conditions of dependency and uncertainty that lie behind much of the generation of isomorphism. Organizations that produce the same product or service face the same environment of suppliers, customers/clients, competitors, and regulators and they generally use the same technology to produce their product or service. Organizations that produce the same product or service are said to be in the same industry. Even if nonprofit organizations do not exhibit substantial structural isomorphism, it is nonetheless reasonable to expect that the industries in which nonprofit organizations are located may be isomorphic, with the isomorphism extending across legal forms; that is, across nonprofit, for profit, and government organizations within the same industry. Empirical investigation of the educational, community services, and health care industries, in all of which nonprofit organizations play important parts, lends some support to this expectation. That investigation, moreover, detected the strongest isomorphism in the health care industry (Leiter, 2005a).

This paper continues the inquiry by focusing on organizations in the health care industry. Going into the field, our expectations for isomorphism-inducing processes centered on the coercive and the normative (Paradis and Cummings, 1986; Potter, 2001; Sloan et al., 2001); for differences in health care across legal forms, however, see Schlesinger (2006). Specifically, health care is highly regulated (as one of our respondents would later tell us, it's up there with nuclear electricity generating and air travel), and health care organizations face powerful equipment and pharmaceutical suppliers upstream and powerful insurers and physician groups downstream. Moreover, the physician and nursing professions command longstanding expert influence in this industry, along with the influence of the newer health care administration profession. While these themes surface in our data, we have been surprised to find other themes more prominent. In the end, in order to make some sense of our data, we have had to expand our explanatory tools beyond the neo-institutional repertoire.

Neo-institutional accounts of isomorphic processes focus primarily on structural and environmental forces behind organizational behavior and operations. While we have much to gain by examining how macro-level institutions influence organizations, focusing strictly on the enabling and constraining aspects of organizational contexts would limit our understanding of how organizations may resist, redirect, or reinforce isomorphic processes. Organizations are not robotic automatons that operate according to environmental factors alone; organizations respond to powerful other organizations, to uncertainty, and to professionals actively, independently, and with agency. We fully recognize, however, that this is agency within substantial constraint.

Anthony Giddens' (1984) theory of structuration captures the duality of agency and structure in human interaction. According to Giddens, there is a bidirectional relationship between agency and structure: individual agents can influence social structures, and social structures can either enable or constrain agents. Such processes occur in continua of time and space, which are essential to an understanding of the duality of agency and structure. For our purposes, organizations can be considered agents that operate within structures including (but not limited to) larger parent organizations, external market conditions, medical regulations, legal forms, professional associations, and/or governments. These structures enact boundaries within which our organizations operate, often resulting in coercive, mimetic, or normative isomorphic tendencies (although not as we originally envisioned). Amidst pressures to conform to existing structural arrangements, the organizations we studied exercise agency in the sense that they often resist becoming identical to other firms. Through processes of competitive differentiation (Barman, 2002), they sometimes fight to establish themselves as distinct from others and tackle organizational problems in innovative ways.

Our data are semi-structured interviews with managers in ten health care organizations. The interviews are spread broadly across the industry and the globe. Both hospitals and nursing homes are included, as are nonprofit, for-profit, and government organizations. Moreover, we have completed interviews in both the Brisbane area of Queensland, Australia and the Research Triangle area of North Carolina, United States. Our effort has been to have a case in each of the 12 cells (2 sub-industries X 3 legal forms X 2 geographic regions). We have come close. Government organizations have been hardest to find as government health care organizations appear to be shrinking in number. This "sampling" design assures lots of variation, but it rules out generalization. We will search for processes and avoid making generalized inferences.

Our method has been to ask a preplanned series of open-ended questions, probing frequently to obtain full responses. While broad ranging, the questions addressed tap into the processes through which isomorphism is thought to be produced. (The question outline is available from the authors on request.) The interviewer took cryptic notes and then transcribed the notes into accounts that were as full as memory allowed, not hesitating to add the beginnings of analysis and interpretation even while typing the accounts. We have each attempted, independently, to abstract the main idea(s) and emphases from each interview. These abstracts and the interview accounts provide the materials for our analysis.

We both have found recurrent commentary and emphasis in the interviews on two factors: (1) the respondent's organization, itself, being part of a larger organization, a factor which the manager sometimes reported to be constraining and sometimes enabling; and (2) the market for the organization's services sometimes being competitive and sometimes not being competitive. Regarding the first factor, a hospital or nursing home in these interviews is typically part of a multi-establishment organization, be it a private corporation, a large nonprofit (including faith-based ones), or a governmental agency. On the constraining side, the larger organization may prescribe strategic directions or

require common procedures; on the enabling side, it may provide financial support or put local establishments that are parts of the larger organization in touch with one another to share ideas about common problems. We have sought out one nursing home that is not part of a multi-home organization to shed further light on the effect of this factor.

Regarding the second factor, how competitive the market is, we define the market in terms of the geographic locality, as is conventional. Some of our organizations face considerably more local competition than do others. We note that several of our respondents experienced competition with other hospitals or nursing homes that were part of their parent organization, which we will explore in analyzing these cases. As a further complexity, some respondents perceived the level of market competition differently from objective indicators they told us about (for example, number of empty rooms, length of waiting list). In the analysis, we will try to classify the case by the objective level of competition and remark on the respondent's perception of that competition in our analysis of the case. We will watch to see whether the reaction to perceptions of competition is isomorphism or differentiation, that is, conforming to market-wide expectations or standing out from others in the market.

Our approach to the analysis is to organize the cases in the four cells defined by cross-classifying these two dichotomies (i.e., constraining vs. enabling parent organization; competitive vs. not competitive market). Figure 1 displays the distribution of our cases (except the one without a parent organization) across these four cells. Please note that, though our cases are unevenly distributed, we in no way claim that the distribution we found is representative of any population of health care organizations. We proceed to examine managerial perceptions, strategies, adjustments, and decisions within each cell. Then, we make comparisons across the cells. We hope to shed light on the question with which we started: Where do structures (in health care organizations, including nonprofit health care organizations) come from?

(Insert Figure 1 about here.)

High Competition – Constraining Parent Organization

Two of the organizations we studied stood out as existing in a highly competitive, parentally constrained environment. The first is a non-profit community hospital in North Carolina with strong local ties. The hospital is part of an umbrella organization we refer to as the “health system,” which is comprised of many medical providers in an academic setting. Although the hospital is owned by the county, it is leased to the health system on a 20 year contract. We learned about the organization from a high-ranking business administrator who has been with the health system for over eleven years. The second is a series of state government-owned nursing homes in North Carolina. We interviewed the program manager for all the homes, who has been with his organization for fourteen years. The homes he manages are strictly controlled by the state, although contracted to a for-profit organization for operation.

The controlling parents in these two organizations are quite different from one another. In the case of the community hospital, the health system substantially limits the autonomy of hospital administrators. The highly bureaucratic character of the health system results in slow decision-making, as proposals must be approved by several persons in a hierarchy before change is enacted. The health system controls matters as important as hospital expansion and as minute as the choice of hospital software or the content of advertisements. The nursing homes are distinct from the community hospital in the sense that constraint comes primarily from the state government. Legislation and regulation limit how money can be allocated and who can be contracted on the organization's behalf. Like the health system, the state government is extremely bureaucratic, slowing down decision-making and improvements. Further complicating state control is general governmental ignorance regarding nursing homes and how they operate.

In addition to constraint at the hands of a parent organization, our respondents at the community hospital and government nursing homes also reported high levels of market competition. Our respondent at the hospital identified an industry trend towards client empowerment, through which medical patients increasingly know which hospital they want treatment from, rather than going where their doctors suggest. This is quite different from the past, when physicians guided their patients towards certain institutions for care. As a result, the hospital must attract new patients while maintaining good relationships with those doctors who continue to refer their clients. Our respondent at the nursing home confirmed that patients exercise their right to choose between different providers, stating that his organization receives few referral patients from government hospitals. Although state homes tend to be considerably more affordable than for-profit or nonprofit homes, the cost difference across legal forms is less substantial for clients who pay by Medicaid than for patients who pay by private insurance or out of pocket. Our respondent has difficulty finding new clients, and there is a short waiting list for the homes he manages. In response to the threat he perceives from private nursing homes, our interviewee plans to start advertising his organization.

The community hospital also experiences what can be considered "internal competition"; health service board members compare units within the network on measures of financial productivity. It is thus in the best interest of the hospital to set itself apart from others in the health service through innovation, although top-down constraint from administration limits the ability of the hospital to do so. Stated differently, processes of coercive isomorphism are at odds with a desire for competitive differentiation in this hospital. The government nursing homes we examined did not face doubly internal and external competitive pressures.

Although both the community hospital and government nursing homes face considerable limits on organizational autonomy, administrators in both organizations use their discretion and power to resist isomorphic tendencies and survive. For instance, community hospital management distinguishes their organization from others in the health service and outside medical caregivers with strong community ties and a customer service focus. This hospital has been operating for over 100 years, during which several

restructurings have occurred. Throughout this period of time, the hospital has developed strong roots in the area; its slogan, “friends and neighbors taking care of friends and neighbors,” sums up these roots. Workers in this organization share a sense of pride in what they do and many have been with the hospital for decades. This is quite different from what one might expect of an organization dominated by a powerful bureaucratic parent organization. Hospital administration has also launched an initiative to improve customer service through training and employee engagement. According to our respondent, focusing on customer service is a very common way of coping with environmental uncertainty; she stated, “I can’t think of a hospital out there that is not trying to improve customer service.” As hospital administrators work to maintain the organization’s standing as a community-based hospital that truly cares about patients, they differentiate the unit from others in the market and those units bureaucratically-defined within the health system. A focus on local involvement and customer service helps our respondent and her hospital resist pressures for isomorphism.

Our respondent at the nursing home takes a quite different approach to parental control and competition: he actively seeks changes in government regulations and subverts formal processes while running his organization more like a business than a public agency. As our respondent has been running government nursing homes in the area since their inception, he is a trusted authority within the state bureaucracy and has considerable discretion. When the state or legislative processes slow him down, he acts on behalf of his organization independently and then resolves bureaucratic conflict later. State bureaucrats assume that this manager’s actions are legitimate, as he has more knowledge regarding the nursing home industry than his superiors. Things he fights for typically fall into place. When our respondent is unhappy with state funding or regulations, he seeks out new funding sources and creates organizational surplus for new projects himself.

Low Competition — Constraining Parent Organization

This cell has fully five examples from our interviews. Even though this cell is much more populous than the others, we do not want to argue that this is an especially common situation because our data are not suitable for generalization. Rather, the interviews show the variety of ways in which the combination of an unproblematic market and strong corporate control can arise.

One organization in this cell is a for-profit hospital for patients with mental illness in North Carolina, one of 96 such hospitals owned by a national corporation. The interview was with the chief executive officer (CEO) of the hospital. A second is a faith-based combination of residential nursing homes with home health agencies and community social services in southern Queensland. Here the interview was with an administrator who split her time between running the combination of agencies in a small city and planning the ongoing integration process for the entire region. The third is a for-profit chain of nursing homes in Queensland that is itself a division of a privately held corporation. This interview was with a consultant who had left the position of General Manager of the nursing home division the year before. The fourth organization is a

government hospital in a small southern Queensland city that is part of the state health system. The interview was with the administrator of the hospital whose formal title is District Manager of the state health system. Finally, the fifth organization is a for-profit hospital in a large Queensland city, one of 70 hospitals in a publicly traded corporation. The interview was with the hospital's CEO.

Low market competition arises in a number of ways across these cases. The North Carolina for-profit hospital is the only free-standing, acute care psychiatric hospital within a three hour drive now that the government psychiatric hospital in the same city is being closed; of course, this description does not tell us why no other competition has arisen. The interviews with the for-profit Queensland nursing home administrator and with the integrating Queensland nonprofit organization made virtually no mention of their competitive situations, leaving the impression that this market (which these two organizations share) is non-problematic, perhaps because there are plenty of aged and poor clients in need of services. The latter respondent did suggest that her organization could secure its market even more by emphasizing the religious denomination of the organization so that potential clients of that faith would develop a preference for her organization, a kind of faith-based niche or division of the market. The Queensland government hospital, too, does not worry about competition, but its situation is uncontrollable demand, as it is required by law to accept anyone who comes for care. It has developed a cooperative arrangement with a nonprofit hospital nearby in which each accepts surgery or laboratory processing from the other at moments of overflow. The main problem of the otherwise uncontrollable demand is that government inputs have not been pegged to this demand or the resultant costs so that the hospital is always stretching resources well beyond the care they can adequately provide, but this is a problem of inadequate resources, not of too much competition. The Queensland for-profit hospital has secured its niche by a longstanding focus on veterans (contrast the United States where the government maintains special hospitals for veterans, though we were unable to secure an interview in any of them) and by an informal division of medical specializations among the city's hospitals—its own was cardiac care, a division of specializations that the CEO kept a wary eye on lest another large hospital try to compete in cardiac care.

If anything, several of these organizations see their competition as more within their corporation than within their geographic market. They have to compete for investment by headquarters. This is notably the case for the for-profit hospitals, which believe they are the recipients of increasing corporate investment because they are “making their numbers.” In North Carolina, this success has allowed the hospital a \$12,000,000 expansion. In Queensland, where the hospital accounted for fully a quarter of the parent corporation's profits, it gives the CEO special access to headquarters and the board. Another important form of competition that surfaced in these interviews was competition for highly skilled personnel. The CEO of the Queensland for-profit hospital mentioned her quick work in securing space for a promising doctor to start his work at her hospital. The administrator of the Queensland integrated nonprofit pointed to the advantage her organization's “public benevolent institution” status gives it in recruiting and retaining personnel: almost twice as much income is tax free for employees of PBIs

as it is for other nonprofits. But neither competing for headquarters investment nor competing for personnel is the same as the competition for clients other organizations in this study face.

This low level of market competition may have an important effect on emphases established by organizational leaders. Though several other interviews in the study underlined their organizations' focus on customer service, and in precisely those terms, these interviews did not. Of course, the care they give may be just as good; indeed, the Queensland government hospital, despite all its resource limitations, nonetheless undertakes "root cause analyses," adapted from airline safety practices, to solve difficult problems, and the North Carolina for-profit psychiatric hospital has very aggressively attacked the difficult problem of medication errors through daily meetings that include the CEO and other high level staff, hence a huge resource commitment. Still, to the extent that competition for customers focuses an organization's attention and resources explicitly on those customers' preferences, weak competitive pressures may focus attention and resources otherwise.

If the competitive pressures experienced by these five organizations are weak, the controls from headquarters are much stronger. These controls manifest themselves in a variety of ways. The North Carolina for-profit psychiatric hospital must submit a burdensome stream of figures on its financial and patient care performance. Uncollected accounts and "adverse patient events" put them in especially bad light. They have tried every approach they could think of to collect on delinquent accounts, and the CEO's participation in efforts to limit medication errors may arise in part from pressure from above, as well as from regulatory agencies. The CEO complained that falling into a low percentile on any of the key indicators can trigger headquarters' demand for an "action plan" and signal the kind of attention local administrators fear. This happens even if their numbers are not far below the mean (the same as the tyranny of "grading on a curve" that students so dislike). Of course, this is not the only organization in the study that must report frequently and elaborately up the line, and then deal with the consequences.

The Queensland for-profit hospital's performance is also measured by its corporate parent. The result is a CEO who, despite a nursing background, is oriented to business values and to corporate preferences rather than patient care. Cost control efforts in the face of a difficult nursing labor market, for example, have led to a higher patient to nurse ratio. More subtly, the CEO, having been successful in attracting corporate investment by virtue of her hospital's excellent performance, focuses extensively on the expansion of her building. She explains that they are now in the process of adjusting "models of care to the new building." One might have expected the reverse, that the building would be designed according to new models of care.

The Queensland faith-based integrated nonprofit faces demands from the church hierarchy for more and more business-like practices. In fact, it was the church, seeking economies, that initiated the integration that now preoccupies this organization. At the level of the three merged organizations and on the front lines of service delivery, the business-oriented integration is frequently resented. This goes beyond the elevation of

the director of one of the three organizations (and not the largest one, at that) to head the integrated conglomerate. In addition, care-oriented leaders below oppose what they see, in part at least correctly, as the imposition of business values over care values. This theme echoes in other organizations; the CEO in the Raleigh for-profit hospital has a hard time convincing many on his staff that good business and good care are compatible.

The Queensland for-profit nursing home chain has its budget carefully controlled by the owning family and the CEO it has put in place over the entire corporation. This top-down control manifests itself in the “top dogs” favoring old friends and relatives, especially men who exhibit machismo. There was no talk of such particularism in the publicly traded for-profit hospital interviews, where everything was “the numbers” and the contribution to corporate profit. The female General Manager of the Queensland nursing home division reported that she felt insecure even when she did a good job. She eventually left the organization over what she termed “values differences.”

The Queensland government hospital, as one might predict, faces, not this sort of particularism from above, but rather the constraint of rules set above. At the base is the constraint of its very mission. As the hospital for people without private insurance, it cannot control the demand for its services and is therefore usually in reactive mode. Moreover, its funding formula does not take account of its level of activity, that is, how many patients it serves and with what diagnoses. Therefore, it cannot dedicate itself to giving the best care possible, but rather has as its longstanding announced goal offering “the best care for the dollar.” Moreover, expectations for public health care have gone up in the light of recent medical errors elsewhere in Queensland, so that they are under considerable scrutiny. Thus, this hospital is always conscious of constraint. Part of its adjustment is to emphasize and call upon the loyalty of its staff and patients to their 146 year old community hospital.

Among these five cases, headquarters control seems to emphasize business values of cost, revenue, performance, and profit. Local managers’ efforts to adjust to these emphases cannot help but lean that way, even as these managers pay a bit, or even a lot, of attention to the care mission. The conflict between the two, though, can emerge despite efforts to reconcile them. Perhaps it is the weakness of local market competition that allows corporate business values to predominate in these organizations.

High Competition — Enabling Parent Organization

Only one organization in this study fell into the high competition, enabling parent cell: an urban non-profit hospital in Australia. The hospital is part of a larger group of hospitals associated with a church, which we shall refer to as the “Care Together” network. Our respondent was a business-minded financial director who works with Care Together, primarily with the hospital in question. He has been in his position for two-and-a-half years, although he has been in the health care field for much longer.

The hospital we studied is united with other urban and rural hospitals within the Care Together network. While many other organizations in our study experience their

relationship with parent organizations as constraining, this hospital has an enabling relationship with Care Together. The church encourages individual hospitals to retain their autonomy, and community focus and service are emphasized in line with church values. Units in the network run more or less independently of the Care Together network. Although hospitals in the network were initially brought together by the church for coordination purposes over six years ago, it appears that very little integration has actually occurred. While the church has made large investments in the hospital, many hospital projects have been separate from headquarters. For instance, the hospital currently has a joint venture with a university to provide in-vitro fertilization services. Although a church initiative to provide such services could be controversial (given debates about the ethical ramifications of such procedures), the autonomy of the hospital to build this program buffers the church from possible criticism.

Where our respondent reported constraint was within the hospital's external environment. Located in the middle of a city, hospital expansion is difficult, especially since there is a good deal of competition with other local hospitals who also wish to expand. The respondent named at least three major competitors, although he also indicated that a few have specialty or spatial niches. Competition among hospitals and for space is further complicated by difficulties in attracting new physicians to work out of the hospital. Physicians are in high demand, and have a great deal of power in negotiations with hospitals. In the face of substantial isomorphism, excellence in providers and care is the means by which this hospital tries to set itself apart from others in the area. However, new doctors seek employers with innovative operating theaters, which this hospital has difficulty providing due to space restrictions. Although the hospital is fighting to renovate operating theaters over time, change comes slowly.

Processes of competitive differentiation operate in this hospital. As our respondent stated, good doctors, good equipment, and unique services/specialties set hospitals apart from one another in this competitive market. Differentiation is potentially limited by the use of consultants, which the respondent feels probably results in similarity across organizations (i.e., normative isomorphism). However, our respondent stated that what sets this particular hospital apart from the competition is an emphasis on cardiac care and the in-vitro fertilization program. He is also instituting an information-sharing and accountability program within the community despite modest anticipated profits. It seems as though hospital administrators are constantly seeking ways to innovate in regard to care and services.

Interestingly, our respondent would like *more* standardization and collective mentality among those in the Care Together network. In other words, the respondent regards coercive isomorphism as potentially having a positive impact on his organization. If units within the network were to operate together, economies of scale could save the hospitals money and time. For instance, this hospital currently lacks an effective business plan. If the church were to take on the task of integrating business decisions on behalf of all units, hospital resources could potentially be used more efficiently. Depending on the collective power of the Care Together units, further integration and coordination might weed out local competitors and enhance unit reputations among physicians.

Low Competition – Enabling Parent Organization

We have a single organization in this cell. It is a nonprofit residential community for the aged in North Carolina with a continuum of care, including a skilled nursing unit, that is part of a faith-based nonprofit with several such local establishments in the state. The interview was with the local executive director.

The interview shows how powerful the process of interpretation or sense making can be. All indications point to a relatively uncompetitive market: our respondent has no problem filling all his units, with only one out of 212 currently unoccupied, plus he has a secure market niche because his residents pay much less upfront (\$75,000 to \$275,000) than residents at other, newer residential communities (\$300,000 at the minimum). The difference comes in good part from his organization having bought its land years ago when it was cheaper.

Still, this business-minded executive construed his market as quite competitive. He worries about a new and very large for-profit community being constructed in another city in the state, so large that it will realize far greater economies of scale than those he enjoys. Even more on his mind than competing providers is what he considers to be limited demand. Many people who could afford to move into his kind of residential community at an age when they were able to enjoy “independent living” wait instead until they need more assisted living or skilled nursing services. He would prefer 74 as an average age of moving in to his current 78. He sees this need-driven demand as culturally shaped by a strong preference in his region for being cared for at home by the family. He contrasts his region with another affluent region a day’s drive to the north where families with the means expect to place their elders and ultimately themselves in one of the many residential communities that flourish to meet the much more ample demand. He stated he has no reason to expect the local culture behind the need-driven demand to change as the baby boomers start to need the sort of elder care he offers.

So, while his market position is quite secure, this executive director worries and strategizes about attracting new residents. For example, he has added an adult day care center, which none of the other residential communities in his area have. He is trying in this way to distinguish his community within a market in which “all the retirement communities do the same thing; they all offer the same services.” His strategy is “competitive differentiation” in the face of overwhelming isomorphism and cultural values he cannot change. He has pushed other innovations, for example, a very broad wellness program for residents and staff and a diversity initiative that centers on move-in subsidies for those who could not afford to reside there otherwise. He does not present these as competitive tactics; indeed, he portrays them in terms more of the mission of care. Still, they, too, along with the adult day care, may help to differentiate his community from the competition and attract reluctant elders and their families.

These several innovations and strategies reflect substantial local autonomy. This executive director is hired by the parent organization and reports to “the big board” and

the state president, and he is aware that state-level policies have the potential to be constraining. That is how he feels about inflexible state-level employee benefits; he wishes he could change the mix of benefits and pay for some of his hard-to-retain employees. Still, for the most part, he does not feel constrained by state-level policies or administrators. He jokes that sometimes he “acts now and asks forgiveness later,” for example in subsidizing lower income residents. This expression is a sign that he is allowed substantial discretion, probably in part because his community is meeting its financial and care targets. But, the way he looks at the state organization goes beyond feeling largely free of its interference; he does not fight against its initiatives, but rather gets on board. A key example is a safety initiative now being pushed at all four of the residential communities. Besides safety payoffs for staff and residents, there is real money to be saved in anticipated 20 percent lower insurance premiums, about \$100,000 savings state-wide each year. This could mean holding down monthly rate increases for his residents, who complain whenever rates go up. Moreover, the central administration not only initiated the safety program, but it is involved in reinforcing the importance of the program. For example, state executives drove two hours from headquarters to one of the other communities simply to attend a safety program at a luncheon. The symbolism was not lost on local executives. Thus, this executive director sees headquarters both as not constraining, and also as enabling his own efforts. As we have seen, his efforts are aimed primarily at a fairly aggressive program of competitive differentiation.

No Parent Organization

All our cases situated local hospitals or nursing homes within a parent, be the parent a corporation, a nonprofit agency or church, or a government. These parents, both constraining and enabling ones, proved quite important to the structures of the local organizations. To highlight the importance of the parent and to understand the influence of the parent better, we sought out an organization without a parent. This case is a for-profit nursing home in North Carolina. The interview was with the owner, who is the son of the founder.

Our respondent was very much aware of how not having a parent makes a difference for his organization. When someone has a new idea, he said, all they need to do is “convince me.” His nutrition department head had brought an alternative way to structure nutrition department employment from her previous position in a corporate setting. She expected to have to fill out all sorts of forms and jump through all sorts of hoops to implement her idea but was surprised when the owner told her, “I’m convinced. Let’s do it.”

He sees the contrast in another crucial way: economies of scale and risk that in the long run, he said, will doom single site nursing homes like his. The scale economies include such frequently mentioned ones as bulk purchasing and in-house pharmaceutical and hospice care operations. He also pointed to the specialized skills that multi-unit nursing home operations can maintain at headquarters, chief among them in his thinking being skills in Medicare and Medicaid billing as well as skills in understanding, monitoring, and dealing with complex and shifting regulations. These skills, which he

cannot afford, he sees as crucial to survival in the nursing home business; interestingly, he explained his strategy in making up for his inadequacy through a personal tie: he has turned for advice to a friend who runs a chain of nursing homes and has developed the crucial billing skills in part through employing billing specialists. On the economies of risk side, he noted how easily a disaster can wipe out a single site nursing home, as happened to the longtime private owners of a nursing home in New Orleans when Katrina's flooding took the lives of some of their patients; they were bankrupted by the ensuing law suits. A chain with 20-30 homes would not be wiped out by a disaster at one of them.

These economies of scale and risk do not require nationwide chains with hundreds of homes. Regional chains with 15-80 homes are large enough to capture the economies. These regional chains have the additional advantage of typically being privately owned so that their futures do not rest on their stock prices. National chains, in contrast, are typically publicly traded, which makes them dependent on outside investors who are sensitive to short term profits. Because short term profits are shaped mostly by unpredictable government regulatory and reimbursement policies (he reported that 85 percent of nursing home revenues are determined by the government), he foresees disinvestment from publicly traded nursing homes in the future. Overall, the future in nursing homes, according to this respondent, belongs to middle-sized, usually regional, privately owned chains.

Our respondent confirmed what we heard from some other nursing home administrators: there is plenty of demand for their services, so that the market does not present important competitive challenges. Even if the many new assisted living organizations that have come into the region in the last decade expand into skilled nursing (some of them, he asserts, are already doing so without securing the required licenses), he expects the increasing demand of an aging and growing population to keep the competitive situation as is.

The problems he faces, and he came back to this over and over, are with government regulations. He displayed several very thick binders full of regulations. Not only are there a lot of regulations, but they change, and even if they do not change, their interpretations change or the technology for demonstrating compliance changes (e.g., from paper to internet). It is expensive to comply. He, and most other nursing homes, he claimed, now employ a registered nurse with additional training in the regulations, simply to make sure the 25 page "Minimum Data Sheet" (on each patient) is completed accurately and consistently (across shifts and across parts of the form). The stakes are high. Failure to complete the form correctly after repeated audits can result in penalties as high as \$30,000-\$50,000 if the Medicaid case load is large. His home, which has relatively few Medicaid patients, once was penalized about \$6,000.

He has managed to avoid certain government regulations by being small and old. Building standards for nursing homes kick in at the \$1 million dollar mark. His home by virtue of its age and gradual accretion of new facilities has never triggered these standards. Overall, however, government regulations at the state and federal levels are

the biggest constraint he talked about, certainly more so than in our other cases. Perhaps the corporate form that so characterizes the health care industry, or at least that so characterizes our other cases, buffers the individual organization, while without that buffering, the full weight of the constraints is felt locally.

Discussion/Conclusion

We began this study by asking “Where do organizational structures come from?” Our sampling design is set up to provoke contrasts across nations, across sub-industries, and across legal forms. The contrasts we are looking for are in how constraining the parent is, how competitive the market is, and how much agency the local organization and its administrator show. We must be very cautious about these comparisons because our organizations were not chosen to be representative of others in their cells. In this cautious tone, then, we report that our analyses generally reveal that large parent organizations and industry market conditions have a profound effect on the way that health care organizations are structured. The influence of parent organizations and competition overshadows other forces said to affect organizational structure, namely, legal regulations, legal forms, uncertainty, the influence of professionals, and governments.

We do not see contrasts between Australia and the United States health care organizations we studied. This echoes a quantitative comparison with greater generalizability one of the authors made between nonprofit organizations in these same countries, where the similarities exceeded the differences (Leiter, 2008). Likewise, hospitals and nursing homes do not seem to be different in these regards. There may, however, be differences by legal form. Specifically, we only found nonprofits that had an enabling parent, while all the for-profits and government organizations (with a parent) had constraining parents. This difference should not be overdone, however, given that we had nonprofit cases with constraining parents. There is only the hint, therefore, that some nonprofit health care organizations that are part of larger nonprofit organizations are allowed substantial autonomy or actually facilitated by their parents. This could happen because nonprofit parents are in fact different in strategy or capacity from for-profit or government parents, or it could happen because nonprofit parents are becoming constraining like the other parents, but haven’t arrived at the same point yet. The potential for constraint by nonprofit parents is certainly illustrated well by the North Carolina nonprofit hospital that is part of the health service and the Queensland health and social services organizations that were integrated at the initiative of their church parent.

As discussed earlier, we began our interviews from a neo-institutional point of view, alert for evidence of isomorphism to meet environmental expectations. We did find examples and patterns of isomorphism, particularly of coercive isomorphism. However, coercive isomorphism did not appear as a result of legal health care regulations as we originally expected, but rather from powerful parent organizations influencing units under their control. From the requirement to include the corporate logo in local advertising to corporate prioritizing of safety programming in all local organizations and

many other examples, headquarters often impose requirements on individual hospitals and nursing homes. Government regulatory requirements are always at hand in this industry, but, surprisingly, they were not top-of-mind for most of the administrators we interviewed. Perhaps regulation had become so routine in its impact as not to have jumped to the fore, or perhaps the corporate office handles some of the regulatory burden so as to reduce its local impact. The latter possibility is suggested by the one case we studied without a corporate parent; there, regulation was truly the center point of the interview and oriented many of the respondent's ways of looking at his organization and its business struggles. We did not find many examples of mimetic isomorphism, that is copying due to uncertainty, even though this is the form of isomorphism most frequently noted in the literature (Mizruchi and Fein, 1999). In the few instances in which mimetic isomorphism did in fact appear, it resulted from social networks between administrators within the health care industry. Nor did we find the extent of normative isomorphism, which derives from expert influence, as we expected in so thoroughly professionalized an industry. The expert influence of doctors and nurses went unmentioned, and respondents rarely mentioned the use of business consultants in creating organization structure.

Our findings indicate that while parental organizations lead to structural isomorphism among health care organizations, organizations are not entirely formed by or to conform with the expectations of their environment. Managers within organizations respond actively to other organizations, key among them their competitors, in order to maximize their agency's survival and success. Giddens' theory of structuration speaks to this duality of structure and agency in the social world (1984). We have also found support for Giddens' argument that time and space are important context dimensions that social scientists must analyze for a complete understanding of social reality. Particularly, we find that the manner in which organizations exercise agency is often influenced by their position in time and space.

For instance, the North Carolinian community hospital in the health system emphasizes local service in the face of a bureaucratic, domineering parent organization as the hospital workers have developed a reputation from serving area families for many decades. The legacy of care this hospital established over time became an avenue by which coercive isomorphic pressures from the health system could be subverted. The for-profit mental health hospital in North Carolina expanded as a result of changes in the external mental health market. Although the actions of his hospital are limited by a constraining parent corporation, local political changes that led to the closure of a large state mental hospital allowed this unit to expand and establish itself as the primary mental health provider in the region.

Interestingly, the agency with which our organizations respond to structural constraints often results in positive community change for workers and consumers of health care facilities. Organizations commonly responded to isomorphic tendencies with an emphasis on locale specificity, customer service, workplace safety, and by seeking new funding sources. These actions potentially improve patient care and employee working conditions. Innovative and efficient business operations can free up organizational resources for customer service or better equipment for staff. A question for

future researchers is whether or not blunting isomorphism in the health care industry results in better conditions for those employed therein or seeking treatment.

And equally fundamentally, future investigators might wish to examine the extent and history of umbrella parent organizations in the health care industry. How common are parent organizations? When did they first arise? What influence do they have on the structure of organizations? It may be that parent organizations have been instituted for efficiency purposes, or simply that legal changes have made such structures likely. Parent organizations may be relatively new, as our data seem to indicate, or alternatively, may have been operating for an extended period of time. Their varying impacts, both constraints and opportunities, and the ways local administrators deal with these impact are crucial for understanding emerging structures in health care.

Figure 1. Organization Classification Schema

	Enabling Parent Org.	Constraining Parent Org.
High Competition	Queensland nonprofit hospital	North Carolina nonprofit hospital North Carolina government nursing home
Low Competition	North Carolina nonprofit residential community	North Carolina for-profit hospital Queensland nonprofit combined care organization Queensland for-profit nursing home Queensland government hospital Queensland for-profit hospital

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