Entrepreneurship in Publicly Funded Hospitals:
A Multi-Case Study of Privately Funded Rehabilitation in Ontario Hospitals

By

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A thesis submitted in conformity with the requirements for the degree of Doctor of Philosophy
Institute of Health Policy, Management, and Evaluation
Faculty of Medicine, University of Toronto

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Abstract

Ontario hospital spending represents the largest portion of the health care budget. Consequently, governments and publicly funded hospitals have implemented policies and strategies to decrease health care costs on the one hand, and on the other hand, to increase revenues from non-governmental sources. For hospitals, one revenue-generating opportunity includes partnering with privately funded rehabilitation companies or creating hospital-owned privately funded rehabilitation departments. The presence of parallel funding streams (public and private) for health care services departs from the political and organizational norms for Canadian hospitals. The primary objectives of this research are to characterize the organizational relationships between publicly funded hospitals and privately funded rehabilitation departments and companies, examine their effectiveness, and understand the benefits and/or disadvantages that these relationships afford hospitals beyond those originally anticipated. This study used mixed research methods within multiple case studies. Study results indicated that Ontario hospitals have employed numerous entrepreneurial strategies to increase revenues in addition to government funding. The relationships between hospitals and privately funded rehabilitation companies/departments allowed the relationship partners to achieve mutually beneficial goals by exploring and exploiting new and existing material and non-material resources. Nevertheless, hospital leaders have encountered
political, social, and organizational tensions when related to the presence of privately funded health care services in hospitals. This study contributes to organization and management science by examining the utility of these relationships and the factors that hinder or facilitate relationship success. From a practical perspective, the findings of this study are of value to organizational leaders who may wish to establish and maintain effective relationships between publicly and privately funded companies in the context of the Canadian health care system.
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# Table of Contents

Abstract................................................................................................................................. ii  
Acknowledgements .............................................................................................................. iv  
Abbreviations ........................................................................................................................ x  
List of Tables .................................................................................................................................... xi  
List of Figures................................................................................................................................... xii  
Table of Appendices .................................................................................................................. xiii

Chapter One: Introduction and Overview .............................................................................. 1

1.0 Statement of Issues .............................................................................................................. 1  
1.1 Contribution of Study .......................................................................................................... 5  
1.2 Definition of Terms ............................................................................................................. 6  
1.3 Research Questions ............................................................................................................. 8  
1.4 Organization of the Thesis .................................................................................................. 9

Chapter Two: Study Context .................................................................................................. 11

2.0 Introduction ......................................................................................................................... 11  
2.1 Policy Influences on Health Care Funding and Delivery in Canada ................................ 11  
2.2 Health Care Financing and Delivery .................................................................................. 13  
\hspace{1em} 2.2.1 Financing ................................................................................................................ 14  
\hspace{1em} 2.2.2 Delivery ................................................................................................................ 15  
2.3 Ontario Hospitals ................................................................................................................. 18  
\hspace{1em} 2.3.1 Hospital Funding .................................................................................................... 19  
\hspace{1em} 2.3.2 Policies Aimed at Increasing Hospital Revenues and Reducing Costs ............ 20  
\hspace{1em} \hspace{1em} 2.3.2.1 Issuing of the BOND ................................................................. 20  
\hspace{1em} \hspace{1em} 2.3.2.2 Changes to the Schedule of Benefits ......................................................... 22  
2.4 Hospitals and Private-Public Partnerships ........................................................................ 23  
\hspace{1em} 2.4.1 Relationships between Ontario Hospitals and Privately Funded Companies for Non-Health Care Services ................................................................. 24  
\hspace{1em} 2.4.2 Relationships between Ontario Hospitals and Privately Funded Companies for Rehabilitation Services ................................................................. 25  
2.5 Conclusion .......................................................................................................................... 29

Chapter Three: Review of the Relevant Literature ............................................................... 31

3.0 Introduction ......................................................................................................................... 31  
3.1 Framework for the Literature Review .............................................................................. 31  
3.2 Organizational and Hospital Responses to Environmental Stress ................................ 32  
3.3 Organizational Relationships ............................................................................................ 35  
\hspace{1em} 3.3.1 Definition of Terms ............................................................................................... 35  
\hspace{1em} 3.3.2 Organizational Behaviour Theories ........................................................................ 36  
\hspace{1em} \hspace{1em} 3.3.2.1 Motivation and Choice of Partners for Organizational Relationships ........ 37
Chapter Five: Results – Relationship Effectiveness between Publicly Funded Hospitals and Privately Funded Rehabilitation Departments/Companies .......................................................... 75

5.0 Introduction ............................................................................................................ 75
5.1 Summary of Responses .......................................................................................... 76
5.2 Findings .................................................................................................................. 77
  5.2.1 The Structure of Organizational Relationships between Publicly Funded Hospitals and Privately Funded Rehabilitation Departments/Companies ........ 77
    5.2.1.1 Structure of Relationships between Hospitals and Privately Funded Departments ................................................................. 77
    5.2.1.2 Structure of Relationships between Hospitals and Privately Funded Rehabilitation Companies ........................................... 79
  5.2.2 Perception of Relationship Effectiveness ......................................................... 83
Chapter Six: Results – Entrepreneurial Behaviour of Hospitals

6.0 Introduction ........................................................................................................... 111
6.1 Data Analyses ....................................................................................................... 112
   6.1.1 Themes ............................................................................................................ 112
6.2 Findings .................................................................................................................. 114
   6.2.1 The Motivation to Augment Funding ................................................................. 114
6.2.2 Supporting Hospital Activities ........................................................................... 115
   6.2.2.1 Patient Care .................................................................................................. 117
   6.2.2.2 Global Budget and Maintenance/Development of Hospital
       Infrastructure ......................................................................................................... 118
   6.2.2.3 Global Impact and Innovation .................................................................... 119
   6.2.2.4. Reinvestment into Business Development ............................................... 121
6.2.3 Strategies to Decrease Reliance on MOHLTC Funding ...................................... 122
   6.2.3.1 Focus on Entrepreneurship ........................................................................ 123
   6.2.3.1.1 Hospital Entrepreneurship on the Rise ....................................................... 123
   6.2.3.1.2 Focus on Business Development .............................................................. 126
   6.2.3.1.3 The Hospital “Business” ........................................................................ 128
6.2.3.2 Increase Efficiency .......................................................................................... 129
   6.2.3.2.1 Establishing and Divesting Clinical Programs ....................................... 130
   6.2.3.2.2 Increasing Operating Efficiencies ............................................................ 132
6.2.3.3 Growing Alternative Revenues ..................................................................... 133
   6.2.3.3.1 Commercializing Intellectual Expertise: “Selling Know-How” ................ 133
   6.2.3.3.2 Development of New Programs .............................................................. 135
   6.2.3.3.3 Partnerships ............................................................................................. 138
6.3 Chapter Summary .................................................................................................. 140
8.1.2 Relationships between Hospitals and Privately Funded Rehabilitation Departments/Companies

8.1.2.1 Relationship Structure

8.1.2.2 Relationship Effectiveness and Factors That Influence It

8.1.3 Institutional Tensions Related to the Presence of Privately Funded Health Care in Hospitals

8.2 Distinctive Contributions of the Study

8.2.1 Theoretical Contributions

8.2.2 Contributions to Management Practice

8.3 Study Strengths and Limitations

8.4 Future Research and Conclusion
### List of Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABF</td>
<td>Activity-Based Funding</td>
</tr>
<tr>
<td>BOND</td>
<td>Business-Oriented New Development</td>
</tr>
<tr>
<td>CHA</td>
<td>Canada Health Act</td>
</tr>
<tr>
<td>CIHI</td>
<td>Canadian Institute for Health Information</td>
</tr>
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<td>FP</td>
<td>For-Profit</td>
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<td>HBAM</td>
<td>Health-Based Allocation Model</td>
</tr>
<tr>
<td>LHIN</td>
<td>Local Health Integration Network</td>
</tr>
<tr>
<td>LHSIA</td>
<td>Local Health System Integration Act</td>
</tr>
<tr>
<td>MOHLTC</td>
<td>Ministry of Health and Long-Term Care</td>
</tr>
<tr>
<td>MVA</td>
<td>Motor Vehicle Accident</td>
</tr>
<tr>
<td>NFP</td>
<td>Not-for-Profit</td>
</tr>
<tr>
<td>OHIP</td>
<td>Ontario Health Insurance Plan</td>
</tr>
<tr>
<td>P3</td>
<td>Private-Public Partnerships</td>
</tr>
<tr>
<td>PHA</td>
<td>Public Hospitals Act</td>
</tr>
<tr>
<td>QBP</td>
<td>Quality-Based Procedure</td>
</tr>
<tr>
<td>RFP</td>
<td>Request for Proposal</td>
</tr>
<tr>
<td>WCB</td>
<td>Workers’ Compensation Board</td>
</tr>
<tr>
<td>WSIB</td>
<td>Workplace Safety and Insurance Board</td>
</tr>
</tbody>
</table>
List of Tables

Table 2.1  Funding and Delivery of Health Care in Canada  
Table 2.2  Public, Private, and Not-for-Profit (NFP) Institutions and Providers  
Table 3.1  Keywords and Search Terms  
Table 4.1  Description of Cases: Relationships between Publicly Funded Hospitals and Privately Funded Departments/Companies  
Table 4.2  Matrix of Study Participants  
Table 4.3  Data Collection  
Table 4.4  Measures of Research Rigour  
Table 5.1  Summary of Responses  
Table 5.2  Comparison of Privately Funded Rehabilitation Companies and Privately Funded Rehabilitation Departments  
Table 5.3  Concepts used to Describe Relationship Effectiveness  
Table 5.4  Top Seven Factors that Influenced Relationship Effectiveness – List of Codes and Working Definitions  
Table 5.5  Factors that Impacted Relationship Effectiveness between Publicly Funded Hospitals and the Privately Funded Rehabilitation Departments/Companies  
Table 6.1  List of Themes and Descriptions  
Table 6.2  Cited Reasons to Increase Alternative Revenues from Respondent Interviews  
Table 6.3  Strategic Focus of Hospitals from Hospitals’ Strategic Plans  
Table 6.4  Strategies Used by Hospitals to Increase Efficiency and Grow Alternative Revenues  
Table 6.5  Frequency of Terms Related to Entrepreneurship in Strategic Documents  
Table 7.1  Intended and Unintended Entrepreneurial and “Other” Consequences on Hospitals as a Result of their Relationships with the Privately Funded Rehabilitation Departments/Companies  
Table 7.2  List of Themes and Descriptions
List of Figures

Figure 5.1 Partnership Arrangements between Publicly Funded Hospitals and Privately Funded Rehabilitation Departments/Companies Examined for this Study ................................................................. 82
# Table of Appendices

<table>
<thead>
<tr>
<th>Appendix</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appendix A</td>
<td>E-mail Invitation to Participants</td>
<td>190</td>
</tr>
<tr>
<td>Appendix B</td>
<td>Participant Information Sheet</td>
<td>191</td>
</tr>
<tr>
<td>Appendix C</td>
<td>Interview Guide for Research Questions # 1.a.,b.,c.,d. and 2.b.,c.</td>
<td>194</td>
</tr>
<tr>
<td>Appendix C1</td>
<td>Interview Guide for Research Questions# 1.a.,b.,c.,d. and 2.b.,c.</td>
<td>196</td>
</tr>
<tr>
<td>Appendix D</td>
<td>Interview Guide and Survey for Research Question # 1.d.</td>
<td>198</td>
</tr>
<tr>
<td>Appendix D1</td>
<td>Interview Guide and Survey for Research Question # 1.d.</td>
<td>201</td>
</tr>
<tr>
<td>Appendix E</td>
<td>Survey for Research Question #2.a.</td>
<td>204</td>
</tr>
<tr>
<td>Appendix F</td>
<td>Participant Consent Form</td>
<td>208</td>
</tr>
<tr>
<td>Appendix G</td>
<td>Description of Social Judgment Analysis</td>
<td>209</td>
</tr>
<tr>
<td>Appendix H</td>
<td>Reported Effectiveness Factors and Assigned Codes</td>
<td>210</td>
</tr>
<tr>
<td>Appendix I</td>
<td>Factors that Influence Relationship Effectiveness – All Participants</td>
<td>217</td>
</tr>
<tr>
<td>Appendix J</td>
<td>Factors that Influence Relationship Effectiveness – Academic Hospitals and All Privately Funded Partners</td>
<td>218</td>
</tr>
<tr>
<td>Appendix K</td>
<td>Factors that Influence Relationship Effectiveness – Community Hospitals and Privately Funded Partners</td>
<td>219</td>
</tr>
</tbody>
</table>
Chapter 1

Introduction and Overview

1.0 Statement of Issues

This study examines organizational relationships between publicly funded hospitals and privately funded rehabilitation departments and companies. The primary objectives of this research are to characterize these organizational relationships, examine their effectiveness, and understand their impact on publicly funded Ontario hospitals. This study also affords opportunities to consider the potential utility of these relationships in the wider context of the Canadian health care system.

In Canada, health care falls under provincial/territorial jurisdiction. Although health care is also provided privately, each province/territory operates a public insurance program that covers most health care services. To receive federal funding, these insurance plans must comply with the terms of the national Canada Health Act (CHA), which speaks to five key principles (public administration, comprehensiveness, universality, portability, and accessibility) that govern the national health insurance system. According to the CHA, all "insured persons" (Canadian residents) must receive full coverage for "insured services," which are defined as “medically necessary”/“medically required” services provided in hospitals and/or by physicians (Government of Canada, 1984; Madore & Tiedemann, 2005). This is “a floor, not a ceiling,” as provincial/territorial insurance plans can insure beyond these requirements should they wish to do so (Deber & Mah, 2014). While provinces offer a similar range of insured services, they are able to define for themselves which services are medically necessary and which services must be performed in hospitals and/or by physicians. One implication is that changing where care is
delivered (e.g., moving from hospitals to home and/or community) or by whom care is delivered 
(moving from physician to non-physician providers) may allow health care services to shift 
outside of CHA requirements for provincial insurance coverage.

In Ontario, hospital spending represents the largest portion of the health care budget. Consequently, starting in the 1990s, the Ontario Ministry of Health and Long-Term Care (MOHLTC) implemented a number of reform strategies aimed at containing public health care costs in hospitals by re-defining the following: which procedures are medically necessary (by limiting the frequency of procedures or insuring procedures to include only certain populations, i.e., elderly, children, individuals with genetic predispositions for certain diseases); who must perform certain procedures (by allowing some procedures to be performed by health care professionals other than physicians); and where health care services are provided (by moving certain services outside of the hospital setting) (Hanlon, 2001; Madore, 2005; Madore & Tiedemann, 2005; Marchildon, 2013). Thus, some previously insured health care services were, and continue to be, “de-insured” as they have been identified as having limited medical value or not medically necessary to be provided by physicians, and/or having been moved out of the hospital setting (cost shifting).

This dissertation focuses on one cost-containment strategy by Ontario hospitals: the shift of outpatient rehabilitation services that were previously provided in hospitals, to settings outside of the hospital. The decision to move previously insured services out of the hospital into the home or community setting has provided an opportunity for a niche market for the delivery of the same services by private for-profit (FP) businesses. This phenomenon is referred to among health policy researchers as the “passive privatization” of health care (Davidson, 2006; Madore & Tiedemann, 2005; Tuohy, 2002).
There is much discussion and debate about the role of privatization in the Canadian health care system. Researchers and health policy analysts focus their discussions on value, efficiency, effectiveness, belief systems, and the sustainability of publicly funded health care if the administration and funding of health care were to be further privatized (Chados & MacLeod, 2004; Davidson, 2008; Maioni, 2010; Marchildon, 2004; Tuohy, 2008). One of the concerns associated with private funding for health care in Canada is related to the implications for preferential accessibility for certain sectors of society, and that this may contribute to the erosion of services that are funded under the public model of financing (Deber, 2009; Dhalla, 2007; Madore, 2005).

Proponents of privately funded health care focus on the lack of sustainability of the Canadian health care system and propose that an increase in privately funded health care services offers an opportunity to offset the growing costs of health care. The national report coordinated by Senator Michael Kirby (2002) proposed expanding the role of the private sector within the Canadian health care system in order to support the costs associated with operating the current public system (Senate of Canada, 2002). However, one of the biggest concerns, expressed by some with regard to the expansion of private services, is that the comprehensiveness of health care services – one of the defining features of the Canadian health care system – may not be upheld (Chados & MacLeod, 2004; Flood, Tuohy, & Stabile, 2006). The viability and desirability of solutions, like private sector services expansion to support, and possibly change, the way health care is currently funded and delivered, continue to be debated from the standpoint of economics, sustainability, and the social mores that define the Canadian health care system. While not the primary aim, this study contributes to this discussion by examining the effect of privately funded rehabilitation in publicly funded hospitals.
In acute or rehabilitation hospitals, inpatient rehabilitation services are usually provided to individuals after surgery, stroke, brain dysfunction, limb amputation, and spinal cord injuries; while outpatient rehabilitation services are provided to individuals with impairments that do not require hospitalization or after patients have been discharged from acute or rehabilitation hospitals (Canadian Institute for Health Information, 2008; Office of the Auditor General of Ontario, 2013). Rehabilitation services can include physical therapy, occupational therapy, speech-language pathology, social work, and nursing (Office of the Auditor General of Ontario, 2013).

Landry et al. (2009) analyzed the strategic responses of 47 hospitals when the Ontario Health Insurance Plan (OHIP) made funding changes by limiting the amount and eligibility for outpatient rehabilitation. According to Landry et al. (2009), some hospitals chose to reduce, or discontinue, rehabilitation services for patients discharged from the hospital, whereas others (17%) chose to partner with privately funded rehabilitation companies, or create their own FP rehabilitation departments. The privately funded departments and partnering companies offered services to a subset of individuals who paid for outpatient rehabilitation services through private extended health insurance, privately funded but government-regulated insurance plans (Workplace Safety and Insurance Board and Motor Vehicle Accident insurance plans), and out-of-pocket payments. In addition, these privately funded companies and departments offered hospitals the opportunity to generate additional revenues to subsidize government funding. Landry et al. (2009) noted that the rise of such partnerships, between publicly funded hospitals and FP departments and companies, warranted further research to examine system-wide effects.

From political and legal standpoints, the presence of privately funded rehabilitation companies and departments within the hospital setting does not infringe upon the CHA (Deber,
since outpatient rehabilitation services for most Ontario residents do not fall under the CHA requirements. However, the presence of FP rehabilitation within publicly funded hospitals has instigated much debate regarding the possible growth of practices that undermine a health care system that is predicated on equitable access to services within the hospital setting (Chados & MacLeod, 2004; Davidson, 2006, 2008; Flood & Thomas, 2010; Hurley et al., 2008b; Marchildon, 2004).

The partnerships between publicly funded hospitals and privately funded rehabilitation departments/companies in Ontario are the focus of this study; they present an opportunity to understand the relationship between two parallel (public and private) systems of funding housed under the organizational umbrella of the publicly funded hospital.

1.1 Contribution of Study

This study stands to contribute to our understanding of whether such relationships are effective, and why; the conditions under which they are effective; and what benefits and/or disadvantages these relationships afford beyond those originally anticipated. According to Barr (2007), “there are few available data regarding the success or problems of using a public-private partnership approach to improve the delivery of health and welfare services, because few published studies of successful public-private partnerships of this type are available” (p. 24). This study addresses this knowledge gap. In Canada, engagement with privately funded health care organizations that may provide additional revenues “remain uncharted territory for many hospitals, but the increasing need to obtain revenue beyond provincial funding is forcing health administrators to grapple with this new reality” (Hutchinson, 2003, p. 41). Generally, when Canadian publicly funded hospitals enter into business relationships with privately funded
organizations, these relationships are typically for non-medically related services, such as laundry, food, and retail (Silversides, 2008a).

This study aims to contribute to organization and management science by investigating emerging organizational relationships that provide the opportunity to analyse two parallel funding systems, under the same organizational umbrella, in the provision of health care services. The increasing presence of these organizational relationships in Ontario hospitals merits investigation because lessons learned may be of utility in the wider context of the Canadian health care system as publicly funded health care organizations respond strategically to funding changes by seeking alternative revenues through partnerships. Furthermore, this study examines the relationships between hospitals and privately funded rehabilitation companies/departments using two organizational theories: resource dependence theory and neo-institutional theory. The application of these complementary theories allows for an examination of the utility and relevance of the resource-based perspective (predominant in both theories) in a mostly publicly funded not-for-profit (NFP) health care environment.

1.2 Definition of Terms

Intra-organizational relationships connote relationships within companies; whereas inter-organizational relationships are alliances struck between two separate companies (Argote, 1999; Brass, Galaskiewicz, Greve, & Tsai, 2004; Parmigiani & Rivera-Santos, 2011; Tsai, 2000).

For the purpose of this study, the Workplace Safety and Insurance Board (WSIB) and Motor Vehicle Accident (MVA) insurance systems are referred to as privately funded systems. While this author acknowledges that these insurance systems are sometimes represented as quasi-public systems because they are privately funded but have government oversight, literature
suggests that the WSIB and MVA insurance systems display characteristics of private businesses with a focus on cost containment and incentives for efficiencies (Davidson, 2008; Marchildon, 2004).

The privately funded rehabilitation departments created by publicly funded hospitals are referred to in the literature, and by participants of this study, by numerous terms including: subsidiaries, clinics, privately funded departments, and units. From a legal perspective, there are specific regulations that differentiate business partners, subsidiaries, trust companies, and corporations (Government of Canada, 1994); however, even within the same hospital, study participants used a variety of different terms to identify the privately funded departments/companies that offer privately funded rehabilitation services. In this study, the term “privately funded rehabilitation department” is used, as it is the term most frequently used by study participants in reference to the privately funded rehabilitation departments created by the hospitals. These privately funded rehabilitation departments can be geographically located within and/or outside of the hospital setting. Similarly, privately funded rehabilitation companies, just like privately funded hospital departments, can be found geographically within and/or outside of the hospital. The term “under the organizational umbrella of the publicly funded hospital” refers to the hospitals’ organizational and clinical practices that are observed by the privately funded rehabilitation departments and companies in the course of their relationships with the hospitals.

Health care services are those services that promote health, prevent disease, and provide diagnostic, curative, rehabilitative, supportive and palliative services (Lamarche, Chauvette, Larouche, & Foundation, 2003).
1.3 Research Questions

This study is guided by two groups of research questions. The first set of research questions is intended to describe the relationships between hospitals and privately funded rehabilitation departments/companies, and to evaluate their utility. More specifically, this first set of questions describes the relationship, its perceived effectiveness, and the factors that influence the perceived effectiveness of the relationship. These research questions are:

#1.a. “How are these organizational relationships structured?”; #1.b. “How is relationship effectiveness defined between publicly funded hospitals and privately funded rehabilitation departments/companies?”; #1.c. “Are these relationships perceived as effective by relationship partners?”; and #1.d. “What are the factors and/or conditions that impact the perceived effectiveness of these organizational relationships?”

The second set of questions focuses on the impact of these relationships on hospitals. Research has demonstrated that the interaction between public and private systems has consequences on the organizational behaviour and entrepreneurial orientation of both organizations through knowledge exchange (Eikenberry & Drapal Kluver, 2004; Hirth, 1997; Hoskisson, Covin, Volberda, & Johnson, 2011; Macedo & Pinho, 2006). Entrepreneurial orientation of NFP organizations has been noted as an important factor in “organizational survival in the contemporary environment” (Coombes, Morris, Allen, & Webb, 2010). Given that publicly funded hospitals are seeking to augment financial resources in addition to funding provided by government sources (Hutchison, 2002; Reynolds, 2008; Tuohy, Flood, & Stabile, 2004), the entrepreneurial orientation of publicly funded hospitals, as a result of their interactions with privately funded departments/companies, warrants study. Thus, the following research questions focus on establishing the entrepreneurial orientation of hospitals; the impact
of these relationships on the entrepreneurial orientation of hospitals; and any other impact that these relationships have on hospitals. Specifically, the questions are as follows: #2.a. “How do hospital leaders describe the entrepreneurial orientation of their hospitals?”; #2.b. “What are the intended and unintended consequences of these relationships on the entrepreneurial behaviour of publicly funded hospitals?”; and #2.c. “What are, if any, the other intended or unintended consequences of these relationships on publicly funded hospitals?”

1.4 Organization of the Thesis

This study is situated within the Canadian health policy context and predicated on the organizational behaviour literature pertaining to partnerships. The study is further informed by literature on private/public funding for health care in Canada and work that has examined the strategic responses taken by hospitals to proactively mitigate organizational instability associated with funding changes. Using literature in the organization sciences as a frame, this study examines the effectiveness of relationships that publicly funded Ontario hospitals form with privately funded rehabilitation departments/companies.

The thesis is organized as follows. Chapter 2 reviews the environmental context of the Canadian health care system, the methods of funding and health care delivery, and strategic responses that hospitals have taken to reduce reliance on government funding. Chapter 3 examines theories that explain the formation of inter- and intra-organizational relationships. While the literature on inter-organizational relationships is more developed than it is in the study of intra-organizational relationships, the literature demonstrates that all organizational relationships are similar in the sense that the motivation to enter into relationships centres on the need to exploit and explore resources with the assistance of relationship partners. Chapter 4 describes the methods used in this study. Specifically, a multiple case study method is employed
to examine the relationships between hospitals and privately funded companies/departments. Alternative cases of hospitals in relationships with their own publicly funded departments, as well as cases of academic and community hospitals, are used to strengthen and contrast study findings. **Chapter 5** characterizes relationships between hospitals and privately funded departments and companies, examines their effectiveness from the perspective of study participants, and proposes a definition for relationship effectiveness. Furthermore, this chapter details the relationship factors that facilitate and hinder the interaction between publicly funded hospitals and privately funded rehabilitation departments/companies. The relative importance of these factors is presented so that leaders in publicly funded hospitals, who may want to engage in such relationships, are able to focus on the key factors that are core to the success of such relationships. **Chapter 6** focuses on the evolving entrepreneurial orientation of publicly funded hospitals. The rise in entrepreneurship is described by study participants as a direct result of the perceived need to augment MOHLTC funding. **Chapter 7** describes the intended and unintended consequences of these relationships on the publicly funded hospitals and places emphasis on the entrepreneurial orientation of hospitals as a result of these relationships. Discussion of research findings with respect to existing literature, management practice implications, limitations of this study, and suggestions for future research are offered in **Chapter 8**.
Chapter 2
Study Context

2.0 Introduction

This chapter examines the Canadian health care system with a focus on Ontario hospitals. The Canada Health Act (CHA) is reviewed and its implications on policies that influence health care funding and delivery are discussed. This chapter concludes with an overview of hospital governance, and how changes to hospital budgets, along with supporting policies, have stimulated some hospitals to augment funding provided by the government using a variety of strategies, one of which – the provision of privately funded rehabilitation services – is the focus of this study.

2.1 Policy Influences on Health Care Funding and Delivery in Canada

According to the World Health Association (WHO), health care systems present in different countries are strongly influenced by their underlying societal norms and values. Like other human service systems, health care services often reflect deeply rooted social and cultural expectations of the citizenry, and this has led to diverse institutions and a large variation in the types of social contracts between the citizens and their prospective governments (Lameire, Joffe, & Wiedemann, 1999). Accordingly, health care funding and its provision vary across societies.

In Canada, health care can be characterized in terms of organization, funding, and delivery (Detsky & Naylor, 2003; Fierlbeck, 2011; Marchildon, 2013). The CHA is federal legislation that impacts the way health care services are funded and delivered. The CHA clarifies the conditions that provincial governments must follow in order to receive the maximum federal transfer of funds for health care. The symbolic scope of the CHA is embedded deeply
into the Canadian identity (Maioni, 2010). The CHA stipulates that insured persons should have reasonable access to insured health and extended health care services, provided under the provincial law without financial or other barriers. Under the CHA, insured health services include hospital services, physician services, and surgical dental services provided to insured persons. Extended health services include nursing home intermediate care services, adult residential care services, home care services, and ambulatory health care services, such as outpatient rehabilitation (Government of Canada, 1984). Each province, should it so choose, can extend its provincial health insurance plan above and beyond the coverage of services specified in the CHA.

The five standards set in the CHA are universality, portability, accessibility, comprehensiveness, and public administration (Government of Canada, 1984). Canada’s national health insurance, Medicare, is designed to ensure that all eligible Canadian residents have reasonable access and funding for all medically necessary hospital and physician services. The CHA frames the philosophical tenets of Medicare, and is a representation of Canadian values and ideologies as they relate to health care funding and provision (Maioni, 2010). The five standards of the CHA are briefly described below:

1. Universality - Under the CHA, the health care insurance plan of a province must entitle insured persons all insured, medically necessary services provided in hospital and/or by physicians under uniform terms and conditions.

2. Portability - Given that health care insurance is under the jurisdiction of each province, the portability standard allows insured residents of each province to receive care when travelling between provinces.
3. Accessibility - Provincial insurance plans must ensure that insured persons have “reasonable access” to insured services under uniform terms and conditions that do not impede access to the insured services.

4. Comprehensiveness - The comprehensiveness requirement states that, at minimum, provinces must cover all insured health services provided by hospitals, medical practitioners, or dentists.

5. Public Administration - The CHA stipulates that provincial plans must be administered by a public authority and function as NFP agencies.

As earlier described, under the CHA the federal government sets conditions that must be upheld by the provincial health insurance plans in order to qualify for the maximum federal funding that is available through the Canada Health Transfer Plan (Fierlbeck, 2011). The next paragraphs address the possible permutations of health care financing and delivery.

2.2 Health Care Financing and Delivery

Financing of publicly funded health care services refers to the methods by which money is collected via taxes and premiums to pay for insured health care services and capital costs associated with health care services, and to subsidize some extended health care services. Financing also stipulates the service providers that will be paid, how much they will be paid, and for which health care services (Deber, 2000). With respect to health care financing, approximately 70% of Canadian health care is publicly financed through general taxation by the federal, provincial, and municipal governments (Canadian Institute for Health Information, 2013). Private insurance and out-of-pocket payments are generally used for services not covered under the CHA. Delivery of health care services refers to the ways in which health care services
are organized and provided (Deber, 2000). The next sections elaborate on health care financing and delivery.

2.2.1 Financing

Approximately 70% of health care in Canada is publicly funded to provide medically necessary hospital and physician services as well as to subsidize other types of health care, such as long-term care and prescription drugs (Marchildon, 2013). Of private spending for health care, approximately 30% accounts for services paid independently by individuals or financed by privately funded insurance plans (Deber, 2000; Fierlbeck, 2011; Marchildon, 2013; Marchildon & DiMatteo, 2011).

In Canada, provincial health care insurance plans must be administered by a public NFP agency. While private insurance is not accepted for publicly insured services, private plans can supplement those services not covered or partially covered under public plans (i.e., dental care, vision care, assistive devices, ambulance, some long-term care, and prescription drugs outside of hospitals). Furthermore, private funding is permissible to assess and treat non-insured persons, such as those individuals who may be eligible under MVA or WSIB insurance plans, as well as non-Canadian residents (Fierlbeck, 2011).

Provinces can establish for themselves any blend of privately or publicly insured services. Provinces across Canada have different rules related to how health care services are billed (under private or public insurance), what services are deemed medically necessary, and which are covered, or not, under publicly funded insurance (Fierlbeck, 2011). “The CHA is a floor not a ceiling; provinces are able to fund beyond these requirements should they wish to do so” (Deber & Mah, 2014, p. 57). While provincial variations exist in terms of health care
funding and the type of services that are publicly insured, provinces more or less closely adhere to the principles set out in CHA in order to receive the maximum transfer of health care funding from the federal government. In addition to funding, the main reason that provinces closely adhere to the principles of the CHA is the dominant public ideology regarding Canadian health care. The state of Canadian health care is highly influenced by the public voice of health care consumers. Canadians place a great deal of value on the publicly funded system and the principles that guide how health care is funded and provided (Maioni, 2010; Soroka, 2007).

2.2.2 Delivery

While the majority of Canadian health care is publicly financed, the delivery of health care can take place in public NFP and private FP facilities; care can be provided by privately or publicly funded individuals. For example, health care institutions in charge of public health are funded by the government and employ publicly funded workers. Generally, such facilities deal with community health programs, immunization programs, and health education (Fierlbeck, 2011). Ninety-five per cent (95%) of Canadian hospitals are classified as private NFP institutions (Deber, 2004; Fierlbeck, 2011; Marchildon, 2013). The FP health facilities in Canada usually provide specialized/niche services, such as some long-term care facilities, specialized non-medically urgent surgical procedures for hernias and cataracts, and addiction centres. Furthermore, privately owned and FP facilities exist for rehabilitation, diagnostics, and home care services. Table 2.1 illustrates a matrix of possible variations of health care funding and delivery in Canada (Deber, 2004).
Table 2.1

Funding and Delivery of Health Care in Canada

<table>
<thead>
<tr>
<th>Public Financing</th>
<th>Private Financing</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Public Sector Delivery</strong></td>
<td><strong>Private insurance topped up by</strong></td>
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<tr>
<td></td>
<td><strong>private user fees</strong></td>
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<tr>
<td><strong>Public Insurance, public</strong></td>
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<td><strong>hospitals, and public</strong></td>
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<td><strong>employees</strong></td>
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<td></td>
<td><strong>Private insurance and privately employed or</strong></td>
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<td></td>
<td><strong>self-employed providers</strong></td>
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<td><strong>Private Sector Delivery</strong></td>
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<td><strong>Public insurance and privately employed or</strong></td>
<td><strong>Private insurance and</strong></td>
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<tr>
<td><strong>self-employed providers</strong></td>
<td><strong>privately employed or self-employed providers</strong></td>
</tr>
</tbody>
</table>

Madore & Tiedmann (2005) elaborate on the Deber (2004) representation (Table 2.1) to
include specific examples of providers/institutions that fall under various financing and delivery
models of health care. Their adaptation, with supplementary examples of different
privately/publicly funded services added by this author, can be found in Table 2.2.
Table 2.2

Public, Private, and Not-for-Profit (NFP) Institutions and Providers

<table>
<thead>
<tr>
<th>Financing</th>
<th>Delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public</td>
<td>Public</td>
</tr>
<tr>
<td></td>
<td>• Public Health</td>
</tr>
<tr>
<td></td>
<td>• Provincial psychiatric hospitals</td>
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<td></td>
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</tr>
<tr>
<td>Private</td>
<td>• Elective non-medical (e.g. private room) and medical (e.g. lighter cast) goods and services in publicly funded hospitals</td>
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(Adapted from Deber (2004) by Madore & Tiedemann, 2005. Supplementary examples added by this author to the Madore and Tiedeman table.)
2.3 Ontario Hospitals

Ontario hospitals are NFP corporations that are designated as public entities under the Public Hospitals Act (PHA) (Ministry of Health and Long Term Care, 1990b). The PHA provides the regulations under which Ontario public hospitals operate, and the compliance to the PHA is overseen by the Minister of Health and Long-Term Care (MOHLTC). The PHA enables the Minister of Health to fund public hospitals as long as it is in the public interest. In 2006, the MOHLTC formed fourteen Local Health Integration Networks (LHINs) to plan, integrate, and fund local health care at the regional level of jurisdiction (Ministry of Health and Long Term Care, 2008). The MOHLTC oversees the LHINs through annual performance reviews and participates in the budgeting process. Under the PHA, hospitals are classified and designated into a number of groups based on the hospitals’ specialties and locations. Provincial legislation can be enacted in order to impose obligations on public hospitals. For example, the “Excellent Care for All Act” was created with the mission to improve patient care and enhance the patient experience (Ministry of Health and Long Term Care, 2010). Through this Act, hospitals are mandated to conduct employee and patient satisfaction surveys and have in place patient relations procedures. Another recent piece of legislation is the Local Health System Integration Act (LHSIA), under which hospitals are required to engage the community when developing plans and setting priorities for the delivery of health care services (Ministry of Health and Long Term Care, 2006; Ontario Hospital Association, 2013).
2.3.1 Hospital Funding

In Ontario, hospital costs are the single biggest line item in the health care budget (Canadian Institute for Health Information, 2013; Sutherland, Repin, & Crump, 2012). The spending for Ontario publicly insured hospital services was approximately $16.4 billion for 146 publicly funded hospitals in the 2012-2013 fiscal year (this represents a $2.2 billion increase from $14.2 billion in 2008-2009 fiscal year, when 149 publicly funded hospitals were registered).

Until recently, hospital budgets were allocated through a global budget based on previous spending, the actual services that were provided by hospitals, and annual increases (Ministry of Health and Long Term Care, 2012). Global funding was based on a formula that provided hospitals with funds that could be used at the hospitals’ discretion. In 2012, the MOHLTC changed the funding model to subsidize hospitals based on specific patients’ needs. In this new model, global hospital funding represents 30% of the hospital budget; 40% of funding is allocated using a Health-Based Allocation Model (HBAM); and 30% of funding is allocated to Quality-Based Procedures ( QBPs ), which are evidence-based procedures for targeted clinical groups. Small rural hospitals (those that treat fewer than 2,700 patients per year) and psychiatric facilities will continue to receive annual funding through a lump-sum global budget.

The aim of this new funding model is to streamline patient-centred care for necessary/essential procedures in order to ensure best use of limited health care funds (Ministry of Health and Long Term Care, 2014). HBAM funding uses a health-focused funding formula that takes into account past service levels and unit costs, based on (1) Population-specific health
information, such as age, socio-economic status, and geographic location of hospital users, and
(2) Diagnostic and procedural information related to treating hospital users. QBP is funding that
is provided to hospitals for specific procedures for targeted clinical groups. The price of the
procedures is structured to provide incentives and reimbursements to hospitals that are providing
such services (Ministry of Health and Long Term Care, 2012). Both funding models, HBAM
and QBP, closely align to the Activity-Based Funding (ABF) model. The main aim of ABF is to
encourage hospitals to spend money on clinically meaningful “bundles” of care by taking into
account patient characteristics, for example, age, gender, and socioeconomic status (e.g.,
HBAM) and the procedures required to treat certain diagnoses (e.g., QBP). The ABF model is
meant to encourage productivity and efficiency of hospitals, reduce hospital wait lists by
reducing length of stay, and encourage transparency related to costs and expenses within
hospitals (Deber, Hollander, & Jacobs, 2008; Sutherland, 2011). Under ABF, hospitals retain
any surplus in funding above their expenditures per case, but must also absorb any losses if
expenditures exceed reimbursement (Palmer, Martin, & Guyatt, 2013). Overall, it appears that
the objective of the MOHLTC is to provide funding to hospitals based on the number of patients
that are served, the specific services that are delivered, the quality of the services, and the
specific needs of the patient populations served by the hospitals.

2.3.2 Policies Aimed at Increasing Hospital Revenues and Reducing Costs

Policies are levers used by the government to drive specific individual and organizational
behaviours (Deber et al., 2008; Madore & Tiedemann, 2005; Marchildon & DiMatteo, 2011). In
order to contain costs incurred by hospitals, the MOHLTC has implemented various policy
responses to rein in hospital spending. Two specific government strategies, Business-Oriented
New Development (BOND) and the de-insurance of clinical services, are of importance to this
study context because they have, intentionally and unintentionally, led hospitals to participate in revenue-generating activities through partnerships.

2.3.2.1 Issuing of the BOND

The BOND policy was initially introduced by the MOHLTC in 1982 to provide incentives to hospitals to increase revenues (Ministry of Health and Long Term Care, 2008). BOND was the first policy that encouraged hospitals to expand revenues beyond Ministry funding by permitting hospitals to generate income from activities that are not necessary for the provision of patient care. Through BOND-related activities, hospitals were allowed to retain 100% of any net income or operating surplus in their yearly budgets. In 1991, the BOND was suspended due to problems associated with high-risk revenue-generating real estate projects. The moratorium was lifted in 1999 and the BOND guidelines were revised with provisions that ensured that all BOND-related projects would undergo an external review and regular evaluation by independent auditors (Durcan, 2002). The current BOND guidelines indicate that hospitals can retain any net income or operating surplus of income from BOND-related activities as long as these are directed toward hospital operations, including, new or existing programs, equipment purchases, debt retirement, or capital (Ministry of Health and Long Term Care, 2008).

Hospitals have the discretion to generate funds in ways that are consistent with their own policies, communities, and areas of expertise as long as they comply with rules set in the BOND guidelines. Over the years, hospitals have embraced the entrepreneurial spirit that BOND has afforded them and consequently have built and operated parking lots, provided treatment to out-of-country patients, offered and charged for semi-private accommodation, and retailed non-patient care services (retail pharmacy, food services, etc.) to visitors and patients (Hanlon, 2001).
2.3.2.2 Changes to the Schedule of Benefits

Marked changes to the funding of the health care sector took place in the mid-1990s with a reduction in transfer payments from the federal government to the provinces. One of the strategies used by provincial governments to address these funding constraints was the de-insuring, or de-listing, of services that were previously insured under provincial health plans (Ministry of Health and Long Term Care, 1990a). Under financial pressure and the influence of the evidence-based medicine movement, provincial governments engaged in boundary shifting by de-listing services of limited clinical value and shifting services, primarily extended health care services as defined under the CHA, out of the hospital into the community setting (Flood et al., 2006). This provided an opportunity for a niche market for the delivery of the same services in community settings by private FP businesses (Davidson, 2006). Provincial governments have considerable scope and influence in terms of organizing and providing health care in the hospital setting and each province may have a different set of insured and un-insured services. In Ontario, de-listing of health services is a relatively frequent occurrence as scientific evidence shifts, and as politics and budgets influence the definition of medical necessity (Charles, Lomas, & Giacomini, 1997; Flood et al., 2006; Madore, 2005). Furthermore, while some extended health outpatient services are identified as insured under the CHA (e.g., occupational therapy, physical therapy, and diet counselling) (Health Canada, 2014), each province may decide to limit or move these services out of the hospital setting thus making them not subject to the five conditions of the CHA.

Privatization of health care services can be achieved in one of two ways: actively, by containing public health care costs by partial or total de-insurance of previously insured services; or passively, by shifting services outside of the hospital setting. Outpatient rehabilitation has
experienced passive privatization as it has been moved outside of the hospital and into the community setting (Landry, Verrier, Williams, Zakus, & Deber, 2009).

### 2.4 Hospitals and Private-Public Partnerships

Most literature involving Ontario hospitals and privately funded companies involves infrastructure projects and uses Private-Public Partnership (P3) as the term to describe such relationships (Silversides, 2008a, b). While the focus of this study is on relationships between publicly and privately funded organizations for the provision of health care services, the literature on P3s for non-health care services may be used to inform the current study and is thus briefly reviewed.

The Canadian Council for Public-Private Partnerships defines P3 as: “A cooperative venture between the public and private sectors, built on the expertise of each partner, that best meets clearly defined public needs through the appropriate allocation of resources, risks and rewards” (Li & Akintoye, 2008). According to these authors, public-private partnerships span a spectrum of models from contracting out, as an alternative to traditionally delivered public services, to arrangements that are publicly administered but within a framework that allows for private finance, design, building, operation, and possibly temporary ownership of an asset. The next sections review the existing relationships between Ontario hospitals and privately funded companies that offer non-health care and health care services.
2.4.1 Relationships between Ontario Hospitals and Privately Funded Companies for Non-Health Care Services

As noted earlier, most P3s between hospitals and privately funded organizations are related to infrastructure projects. For example, in Ontario, hospitals have entered into P3s as one way to balance budgets (Gilbert, 2009). In 2008, 19 Ontario public hospitals were being financed and/or constructed by private sector consortia with another 7 hospitals entering similar arrangements (Silversides, 2008b). Generally, the consortia, consisting of construction firms, financiers, property management firms, and/or food or janitorial services “bid to design, build, and/or finance a hospital. These deals usually include a multi-decade contract to maintain the building and sometimes, to operate services” (Silversides, 2008b, p. 884). P3s are supported by the Canadian government, with the federal government creating a $1.2 billion fund to encourage P3s and a $25 million federal office to facilitate them (Silversides, 2008a, b).

Some hospitals have experienced successful P3s. For example, in Ontario, St. Michael’s Hospital has moved beyond a supplier-customer relationship, and partnered with Baxter Canada to produce a Health Care Partners Fellowship (Motiwala, McLaughlin, King, Hodgson, & Hamilton, 2008). Westpark Health Care Centre (Monaghan, Malek, & Simson, 2001) and University Health Network (Gray & Sinnott, 1998) have also entered into seemingly successful P3s for services such as laundry and catering. Nevertheless, given the relative newness of P3s, they also pose management challenges for hospitals. For example, Jim McCarver, the Ontario Auditor General, has widely criticized the P3 funding model utilized by the Brampton Civic Hospital because both the time and the cost associated with building the hospital was double the estimate (Gilbert, 2009). In another example of problematic P3 management, the William Osler Health System, the Ontario Health Coalition, and three unions went through four years of legal wrangling to obtain documents pertaining to the contracts between the hospital and the private
consortium. The documents were apparently not provided nor approved by the province before the onset of the partnership and various questions existed regarding the agreements between the hospital and the consortium’s multiple private partners (Silversides, 2008b).

2.4.2 Relationships between Ontario Hospitals and Privately Funded Companies for Rehabilitation Services

In response to the shift of outpatient rehabilitation services into the community, Landry et. al. (2009) found that 17% of the hospitals in their study sample demonstrated a “privatization response” by contracting rehabilitation services from private rehabilitation companies or by creating their own FP departments to offer outpatient rehabilitation services. The strategy to create a hospital-owned department “involves a process whereby a hospital may choose to create an independent for-profit clinic within the corporate structure. The subsidiary is essentially a private practice owned and operated by the hospital” (Landry et al., 2009, p. 227). In instances when hospitals chose to contract with private companies, the companies offered a variety of services that included assuming the delivery services, taking on operational responsibility, and renting space. All permutations of these arrangements involved some type of profit sharing for the hospital. According to Landry et al. (2009), contracting with private companies or creating FP rehabilitation departments allowed hospitals to create additional revenues. For example, by partnering with privately funded rehabilitation companies, hospitals were able to contain costs by having the rehabilitation company take the responsibility for costs associated with labour agreements and employee benefits. On the other hand, creating privately funded rehabilitation departments provided hospitals the opportunity to diversify revenue streams and to use profits to subsidize hospitals’ operating costs. The rehabilitation services offered by the privately funded departments/companies were paid for by MVA insurance, WSIB, extended health insurance, and through out-of-pocket payments. Landry et al. (2009) concluded that the strategic responses by
hospitals to restructure outpatient rehabilitation services into the community have ripple effects for the health care system and its users. One of the recommendations from their study is that the rise in FP rehabilitation departments and the presence of FP companies in hospitals warrant further research, as these have emerged without public debate or research to evaluate their impact. This current study specifically responds to this recommendation by examining such relationships and their impact on hospitals in such relationships.

The presence of privately funded rehabilitation departments and companies within publicly funded hospitals raises questions related to compatibility of values and how these parallel funding systems, motivated by potentially different prerogatives, co-operate within one organization. The values of publicly funded health care, as outlined in the CHA and already reviewed, are not always compatible with the values of privately funded enterprises, particularly when the intent of the private enterprise is to generate profit. The motivation for profit in the process of providing health care can create incentives for profit maximization and cost minimization, which can lead to trade-offs between quality and efficiency (Deber, 2004; Tuohy et al., 2004). For example, in a systematic review and meta-analysis, Devereaux et al. (2002) found that American FP, versus NFP, hospitals had higher rates of patient deaths. The authors attributed their findings to the fact that FP hospitals focused on achieving and exceeding profits for their shareholders. Therefore the administration of such hospitals devoted fewer trained personnel to providing patient care (Devereaux et al., 2002). In another systematic review, Devereaux (2004) found that FP hospitals in the United States of America had higher payments for care than NFP hospitals. The authors cited the necessity to generate profit for investors, higher administrative costs, and higher bonuses for executives as the reasons that the cost of FP hospital care exceeded that of NFP hospitals (Devereaux et al., 2004). They also noted that the
health care systems in the US and Canada are more alike than different, and suggested that Canadian health care administrators and policy makers exercise caution before introducing privately funded health care into Canada.

In Ontario, privately funded rehabilitation departments within hospitals appear to have traits of NFP organizations. NFP organizations can run a “surplus” of revenue over expenditures but cannot distribute the profits to individuals (the surplus can be spent on higher wages for employees, training/education/research, subsidizing less profitable services, and reinvesting back into their own operations). Ideally they are motivated by multiple objectives, rather than just profit (Deber, 2004). Overall, the NFPs operate on a cost-recovery basis and any profits are redistributed to the organization itself – in the case of this study, to the hospitals rather than to shareholders or owners. While privately funded rehabilitation companies operating within hospitals generate a profit for owners, shareholders, and the hospital, the hospital-owned privately funded departments distribute the surplus only towards hospital operations (Landry et al., 2009). Privately funded rehabilitation departments and companies have come under scrutiny because they can be perceived as a representation of an inequitable health care system that allows access to health care to some members of society and not others. A central debate in the literature has been the treatment of injured workers within the privately funded departments/companies located in hospitals (Chados & MacLeod, 2004).

Workers’ compensation in Canada predates Medicare; the system finances health care required to treat injured workers on terms and conditions different from those offered to individuals under provincial health care. “The rationale behind giving WCB cases preferential treatment is that as long as workers are off the job, it costs the compensation system considerable sums of money to support them. By speeding up their treatment (and return to work), these costs
are reduced, even if the system has to pay for their treatment at private clinics” (Chados & MacLeod, 2004, p. 22). Injured workers, in theory, should receive the same type of care as members of the public who are covered by provincial health care plans, the difference being that the funding for health care is provided by Workers’ Compensation Board (WCB), as it is known in most provinces, and Workplace Safety and Insurance Board (WSIB), as it is known in Ontario. Given that WCB/WSIB can make their own arrangements with public and private facilities outside of the Ontario Health Insurance Plan (OHIP), they tend to use a variety of methods to accelerate the provision of health care services for their workers. “The WCBs employ two basic strategies to expedite care for injured workers: new service-delivery arrangements with providers, either in-house or on a contractual basis, and financial incentives for providers to treat injured or ill workers more quickly than other individuals” (Hurley et al., 2008b, p. 10).

Provincial WCBs may be regarded as quasi-insurers because they are a form of mandatory social insurance. However, unlike providers of other forms of social insurance, WCBs manage their funds privately and are not backed by a provincial treasury (Davidson, 2008). WCBs fulfill a social contract between employers and employees by collecting premiums from employers and adjudicating these funds to employees in instances of work related injuries or diseases (Bhimji, 2008); but, according to Davidson (2008) the strategies used by WCBs typify the actions of private insurers. These strategies include initiating performance fees, penalties for not meeting timelines, incentives to motivate hospitals and physicians within them, and designating preferred provider relationships in order to expedite services for injured workers. Accordingly, and because of these characteristics, workers’ health insurance has been
referred to as parallel insurer, alternative insurer, and private insurer (Bhimji, 2008; Davidson, 2006, 2008; Hurley, Pasic, & Lavis, 2008a; Tuohy, 2008)

In Ontario, WSIB has exclusive contracts with some teaching hospitals via their “specialty clinics” for injured workers and is possibly the biggest customer for hospitals’ privately funded departments (Davidson, 2006, 2008). The expenditure by WSIB in hospitals’ privately funded departments is substantial. In 2012, WSIB of Ontario spent $457 million in health care, approximately $52 million of which was spent on the rehabilitation of injured workers in hospitals’ privately funded departments (Worker's Safety and Insurance Board, 2012). Given that WSIB chooses hospitals’ privately funded departments for assessment and treatment of injured workers, this practice has been debated as an illustration of a parallel and “two-tiered” health system (Davidson, 2008; Hurley et al., 2008b; Tuohy, 2008).

2.5 Conclusion

This chapter focused on contextualizing the Canadian health care system by examining the policies that influence funding and delivery of health care services. Furthermore, the review examined the nuances of funding, delivery, and values inherent in the Canadian health care system. Special attention was given to Ontario hospitals, their governance, funding mechanisms, and policies that have, intentionally and unintentionally, provided opportunities for hospitals to engage in relationships with privately funded companies. Governments and hospitals have implemented policies and strategies to decrease health care costs on the one hand, and on the other, to increase revenues from non-governmental sources. For hospitals, one revenue-generating opportunity is to partner with privately funded rehabilitation companies or to create hospital-owned, privately funded departments for the purpose of offering outpatient
rehabilitation services to individuals with privately funded insurance, or those who are able to pay for such services out of pocket. The presence of parallel funding streams (public and private) for health care services departs from the political and organizational norms for hospitals. Chapter 3 examines theory and literature pertaining to organizational relationships, in order to inform the analysis of relationships formed between hospitals and privately funded rehabilitation departments/companies.
Chapter 3

Review of the Relevant Literature

3.0 Introduction

This chapter highlights the literature and theory used to frame the research questions of this study. The chapter’s layout is as follows: first, the framework for the literature search is provided; second, a review of literature on inter-organizational and intra-organizational relationships sets the stage for understanding the relationships between the publicly funded hospitals and the privately funded rehabilitation departments/companies; and lastly, factors that influence relationship effectiveness are examined, with a particular focus on private-public partnerships.

3.1 Framework for the Literature Review

The literature review for this study covers the literature for the following databases, which were searched for the period 1990-2014: Medline (OVID), EBSCO, Business Source Premier, Embase, and ProQuest. The search terms and key words were searched with Boolean terms (AND, OR). Table 3.1 demonstrates the keywords and search terms that were used. Initially, the literature search yielded 257 articles. Titles and abstracts were screened and eligible articles retrieved. Overall, 63 articles were reviewed. Specific parameters were set on the publication period as the bulk of literature on private-public relationships was published after 1990 (Barr, 2007); however, the references of the 63 articles were reviewed and any relevant articles/books prior to 1990 were used. In addition, the reference sections of the obtained 63 articles were scanned and any relevant articles/books that were missed in the original searches were then obtained and used for this review.
Table 3.1
Keywords and Search Terms

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<th>Search terms:</th>
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<td>Public sector</td>
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<td>Inter-organizational relation*</td>
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<td>Alliances OR partnerships</td>
<td>Inter-institutional relations</td>
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<tr>
<td>Success* OR effective*</td>
<td>Collaborative relationships</td>
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<td>Canada</td>
<td>Intergroup relations</td>
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<tr>
<td>Public-private partnerships</td>
<td>Hospital entrepreneurship</td>
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3.2 Organizational and Hospital Responses to Environmental Stress

From an organization theory perspective, the Miles and Snow typology offers a taxonomy from which to understand how organizations respond when confronted with environmental adversities (Miles & Snow, 1978). This taxonomy has been applied to Ontario hospitals by Hanlon (2001). According to Miles and Snow, organizations develop predictable patterns of strategic behaviour in order to persevere in light of perceived environmental threats. That is, organizations adjust and adapt their strategic tactics to enhance organizational survival. The patterns of strategic behaviour are classified according to the following strategic types: defenders, prospectors, analyzers, and reactors. Organizations that use the defender strategy do not search outside of their habitual routines or products to source new opportunities. Instead, they improve efficiencies of existing operations. Prospectors are organizations that search for new market opportunities in order to respond proactively in the face of environmental uncertainty. Analyzers are organizations that are able to simultaneously establish stability and rapid adaptation. Usually such organizations are able to create an atmosphere of routine and
efficiency through formalized structures of daily operations, and at the same time scour the market for opportunities and experiment with new products/ideas. Reactors are organizations that make adjustments to their strategies and products only in the face of imminent environmental threat. Such organizations are less effective in adapting to changing environments because they do not have consistent practices/structures that would allow them to make adjustments quickly. Miles and Snow (1978) placed the strategic types on a spectrum of organizational responses, with prospectors and defenders being at the opposite ends of the continuum. Central to the Miles and Snow (1978) model is the two-way relationship between organizations and environments. For example, certain strategic types of organizations thrive in particular environments, a concept known as “strategic fit.” Where there is a “fit” between an organization and its environment, these organizations not only survive and thrive but also tend to influence or shape their environments.

Hanlon (2001) adapted the organizational strategic types from Miles and Snow and applied their typology to the Canadian hospital sector, in order to describe the strategic responses that hospitals have undertaken in the face of budgetary constraints. According to the author, hospitals have used the “protection” reaction by seeking alternative revenue sources or cutting their operations so that they may continue to offer the same products and services. The “rationalization” reaction by a hospital was more internally focused. Hospitals of this type have chosen to make decisions that focused on using efficiency strategies, cutting services/positions, or finding cost savings; these hospitals did not typically introduce new products or seek revenue-generating activities. A third hospital type that emerged in the face of financial turbulence was an “integrator.” The integrator’s strategy was to develop agreements or alliances with other organizations, “not only to reposition in the marketplace, but to change the nature of the
marketplace itself” (Hanlon, 2001, p.158). The final strategy was one of “re-engineering,” which included tactics such as discontinuing entire product lines and becoming more specialized. According to the author, the top three strategies that Ontario hospitals used in light of budgetary constraints included “protection,” by reducing non-clinical staff; “rationalization,” by targeting reductions in core services, such as closing beds or replacing inpatient care with outpatient services; and “re-engineering” investments to increase efficiencies, such as employing new accounting systems (Hanlon, 2001).

From a theoretical perspective, Hanlon (2001) was the first to categorize Canadian hospitals in terms of organizational responses in the face of perceived budgetary constraints. However, an analysis of the study demonstrates that the author did not take into account the possibility of hospitals being able to use more than one strategic response at one time. That is, according to Hanlon, hospitals strategically chose and maintained a specific set of actions in response to budgetary constraints.

In summary, Miles and Snow (1978) and Hanlon (2001) described various responses of organizations to environmental stress and resource scarcity. The response of significance to this study and research questions is the formation of relationships with other organizations. The next sections of this chapter contain a review of the literature related to organizational relationships.
3.3 Organizational Relationships

The literature on organizational relationships can provide context for understanding the relationships between hospitals and privately funded rehabilitation departments/companies. This literature is situated in the field of organization and management science. Several definitions offer the background for understanding organizational relationships.

3.3.1 Definition of Terms

Organizations are defined as “(1) social entities that are (2) goal oriented, (3) designed as deliberately structured and coordinated activity, and (4) linked to the external environment” (Daft & Armstrong, 2009, p. 9). Lukas et al. (2007) focused the definition to address health care organizations, describing health care organizations as comprising four components, “(1) mission, vision, and strategies that set its direction and priorities; (2) culture that reflects its values and norms; (3) operational functions and processes that embody the work that is done in patient care; and (4) infrastructure such as information technology, human resources, fiscal services, and facilities management that support the delivery of patient care” (Lukas et al., 2007, p. 314).

Within the organization science literature, relationships are defined as linkages formed for specific reasons between sets of actors (individuals, groups, organizations), and are described using various terms, including alliances, collaborations, networks, and partnerships (Brass et al., 2004; Oliver & Ebers, 1998; Oliver, 2001; Parmigiani & Rivera-Santos, 2011; Tsai, 2002). Generally, organizational relationships are seen as strategically important, cooperative relationships between partners to share or exchange resources with the goal of improved performance (Parmigiani & Rivera-Santos, 2011).
Inter-organizational relationships are those that are founded between two separate organizations; these relationships usually connote geographic separateness between the companies (Oliver & Ebers, 1998; Oliver, 1991; Oliver, 2001; Parmigiani & Rivera-Santos, 2011). Intra-organizational relationships are those that are founded between organizational units, groups, or individuals, usually within the same organization (Argote, 1999; Brass et al., 2004; Tsai, 2000, 2002).

Given these definitions and the description offered by Landry et al. (2009) of privately funded departments and companies within hospitals, this study proposes that hospitals and privately funded departments/companies represent discrete and separate organizational forms. This is justified by the clear boundaries that exist between hospitals and privately funded rehabilitation departments/companies in terms of the patient populations that they service, the funding with which they operate, and their purposes or missions. Furthermore, using the Madore and Tiedemann (2005) explanatory structure of funding and delivery of health care services, the three relationship partners (hospitals, privately funded companies, and departments) differ in the ways that they are funded and in the manner in which surplus revenues are used. For example, hospitals are publicly funded NFP organizations, the departments within the hospitals are privately funded NFP entities, and the rehabilitation companies that are contracted by hospitals are usually privately funded FP organizations.

3.3.2 Organizational Behaviour Theories

A number of organizational behaviour theories are useful for explaining the motivations for entering into organizational relationships, including resource dependence theory (Pfeffer & Salancik, 2003) and neo-institutional theory (DiMaggio & Powell, 1983). These theories can
explain why relationship partners enter into relationships and what they aim to achieve as a result (Parmigiani & Rivera-Santos, 2011). “From an organization theory perspective, organizations partner with others to more effectively accomplish tasks and to reinforce inter-organizational and interpersonal relationships” (Parmigiani & Rivera-Santos, 2011, p. 1114). The motivation to enter into relationships involves the need to obtain resources and satisfy organizational requirements related to necessity, asymmetry, reciprocity, efficiency, stability, and legitimacy (Oliver, 2001). Consequently, theories that best explain the motivation for organizational relationships adopt the resource-based perspective. Institutional and stakeholder theories provide an explanatory framework for the type of partners that organizations choose.

3.3.2.1 Motivation and Choice of Partners for Organizational Relationships

Resource dependence theory is the most central and prominent explanatory theory in the study of organizational relationships (Oliver & Ebers, 1998; Parmigiani & Rivera-Santos, 2011). According to the resource dependence perspective, organizations enter into relationships in their efforts to secure resources vital to their operations. A general assumption of resource dependence theory is that the key to organizational survival is the ability to acquire and maintain resources. Within the resource dependence framework, organizations and leaders aim to obtain critical resources; in doing so, they may strike favourable bargains with exchange partners on the one hand, but on the other hand, they may attempt to avoid costly entanglements with them (Astley & Van de Ven, 1983). Generally, there is an asymmetry between organizations exchanging resources, as one organization has what the other needs. Examples of vital resources include capital; skilled personnel; trade contacts; physical artifacts, such as machinery; knowledge of efficient processes; and social legitimacy (Barney, 1992; Barney, 2001). Organizations, and leaders within them, are seen to be proactive and adaptive in their responses.
to resource constraints imposed by environments. In this way, organizations adapt themselves to endure environmental constraints by shedding, acquiring, sharing, or creating resources to offset environmental impact. Furthermore, organizational characteristics, such as size, mediate the organization’s ability to respond to environmental stress; the greater the size and scope of the organization, the better it will be able to withstand and influence environmental pressure (Banaszak-Holl, Zinn, & Mor, 1996; Lewin, Carmen, & Emery, 2004).

A complementary theory, which addresses the external constraints that may limit the organization’s ability to enter into specific relationships, is neo-institutional theory (DiMaggio & Powell, 1983). Neo-institutional theory focuses on how organizations strive to achieve legitimacy by conforming structures and processes to the demands of the institutional environment, which is composed of externally set norms, rules, and regulations (Shortell & Kaluzny, 2003). “Conformity confers legitimacy and stability, along with the support and resources necessary for survival” (Proenca, Rosko, & Zinn, 2000, p. 1015). Oliver (1991) extends neo-institutional theory to suggest that organizations, instead of passively conforming to institutional pressures, can in fact respond strategically and purposefully. Thus, it follows that organizations are strategic in choosing their relationship partners so as to not negatively influence the organization’s legitimacy or standing in the social environment. Organizations choosing to enter into relationships may use coercive, normative, and mimetic pressures (Daft & Armstrong, 2009; DiMaggio & Powell, 1983) to ensure that relationship partners conform to the institutional patterns of the lead organization and not compromise the reputation of the lead organization. An alternative strategic response by some organizations may be to partner with other successful organizations whose practices they can mimic and adopt (DiMaggio & Powell, 1983). The framework of neo-institutional theory can be used as a lens to understand how
hospitals choose their relationship partners; how they negotiate the different mores, social, and cultural structures that are inherent in relationships between publicly and privately funded organizations; and ways to uphold legitimacy as hospitals enter into relationships with privately funded rehabilitation companies.

Because organizations seek legitimacy from stakeholders (customers, associations, government, and collaborating organizations), the stakeholder perspective (Freeman, 1984) can further inform the reasons organizations choose some organizational relationship partners over others. Stakeholders can have varied and interdependent demands, and thus can create tensions for organizations if the organizations attempt to simultaneously respond to the multiple needs of stakeholders (Rowley, 1997). Mitchell et al. (1997) created a typology of stakeholders based on the degree of power that they wielded to change the behaviour of organizations, the level of legitimacy (social, moral, and legal pressure that stakeholders can exert on an organization); and the urgency of their requests (the criticality of stakeholders’ claims) (Mitchell, Agle, & Wood, 1997). Stakeholders’ perspectives can influence organizations’ legitimacy and reputation, and thus stakeholders’ approval, or lack of it, can influence the partnerships that organizations enter (Daft & Armstrong, 2009). The requirements of external stakeholders can affect organizations’ willingness to partner with other organizations, deter as well as approve negotiated partnerships, and affect partnership success (Selsky & Parker, 2005). Furthermore, the divergent interests of multiple stakeholders can dilute organizational priorities and alienate some stakeholders when the opinions of some, but not all, are implemented by the organization (Tregunno, Baker, Barnsley, & Murray, 2004).
3.3.2.2 Structure of Partnerships

The resource-based view (RBV) (Barney, 2001) and agency theory (Fama & Jensen, 1983) are relevant to understanding the formation of relationship structures (Parmigiani & Rivera-Santos, 2011). According to the RBV, potential partners enter into relationships to access rare and valuable resources (Barney, 1991; Barney, 1992). These resources are obtained by exchanging or sharing existing resources, or by developing new resources. According to theories that espouse the RBV, organizations choose to enter organizational relationships because they are means by which to obtain quicker and cheaper access to resources (Parmigiani & Rivera-Santos, 2011). From this perspective, organizations form partnerships because the creation of resources in a partnership is financially and logistically easier than creating them individually. The RBV can serve as a potential explanatory model for why hospitals choose to partner with privately funded companies. Specifically, hospitals may enter into such partnerships to create resources such as revenue and rehabilitation services that would be otherwise unavailable to their patients. Privately funded companies, in addition to the revenue, may gain competitive advantage through the legitimacy that may be afforded from their associations with hospitals.

Agency theory (Fama & Jensen, 1983) may also explain the structure of organizational relationships. In this perspective, the relationship is composed of a primary partner (the principal) that is in a business arrangement with a secondary, less powerful partner (the agent), where the principal creates mechanisms to align the agent’s actions with the principal’s needs (Parmigiani & Rivera-Santos, 2011). Agency theory is usually used in vertical relationship structures where there is an asymmetry of power between the principal (having more) and the agent (having less). The principal can impose mechanisms on the agent to conform with norms, rules, and interests of the principal (Eisenhardt, 1989). Agency theory has been used to
understand relationships between: companies/franchisees; shareholders/top executives; and suppliers/buyers (Eisenhardt, 1989; Hudson, Hardy, Henwood, & Wistow, 1999; Logan, 2000). This perspective can also inform the relationships between hospitals and privately funded rehabilitation departments/companies. Specifically, hospitals may want to closely align the privately funded departments/companies to the hospitals’ policies and procedures in order to ensure that the privately funded entities uphold the hospitals reputation and legitimacy in society.

3.3.3 Levels of Analysis in the Study of Relationships

Organizations are multilevel phenomena (Lewin et al., 2004). Organizational relationships can be studied at different levels of analyses: at the organizational level (inter-organizational relationships); between groups within an organization (intra-organizational or inter-unit relationships); and at the individual level of analysis (inter-personal relationships) (Brass et al., 2004; Daft & Armstrong, 2009). This research focuses on the organizational level of analysis, and examines relationships that hospitals have with privately funded rehabilitation departments (intra-organizational relationships) and companies (inter-organizational relationships).

Inter-organizational relationships are generally formed between two individually separate organizations and can be configured through horizontal linkages (alliances, joint ventures, and co-branding), vertical linkages (supply agreements and franchising), or multiple linkages (cross sector partnerships and networks) (Oliver & Ebers, 1998; Oliver, 2001; Parmigiani & Rivera-Santos, 2011). From an inter-organizational perspective, two specific configurations – alliances and franchises – are relevant to the understanding of partnerships between hospitals and privately funded departments and companies.
Using organizational parlance, “alliance partners” is a term that closely describes the relationship between hospitals and privately funded rehabilitation companies. Alliance partners have a need to achieve a task that can only be accomplished with the use of each of the partners’ resources (Daft & Armstrong, 2009; Parmigiani & Rivera-Santos, 2011). An example of an alliance partner comes from the work of Landry et al. (2009), where hospitals and privately funded rehabilitation companies enter into profit-sharing arrangements that benefit both partners.

Franchising is an organizational term that most closely describes the relationship between a hospital and its privately funded department. Following principal (hospital) and agent (privately funded department) logic, the two parties have a symbiotic relationship wherein the franchisor provides the brand name and the franchisee provides funds back to the principal, allowing the principal to grow.

At the intra-organizational (inter-unit) level of analysis, two general relationship forms exist: vertical linkages between the central organizations and its departments, and horizontal linkages between units of an organization (Pointer, Begun, & Luke, 1988). Inter-unit networks are identified as groups, divisions, business units, and subsidiaries (Brass et al., 2004). Functional ties are formed between two units based on the need of one unit to interact with another. Resource dependence theory predicts that a unit is likely to form an intra-organizational tie with another unit that has strategically related or needed resources (Brass et al., 2004).

Most research on intra-organizational relationships focuses on the ties between units (Argote, 1999; Brass et al., 2004; Tsai, 2000, 2002), and how organizational processes and administrative control either advance or hinder inter-unit collaboration and/or learning. Organizational processes influence the opportunities for the units to interact with one another,
and organizational control can have a negative impact on the formation of cooperation between the units, specifically when organizations have a highly centralized control mechanism that prevents units from interacting in ways that encourage inter-unit ties (Tsai, 2002).

The level of analysis is important in the understanding of relationships between hospitals and privately funded departments/companies because, as described in chapter 1, these relationships appear to defy the conventional geographic and organizational configurations that are typically depicted in the studies of intra- and inter-organizational relationships.

### 3.3.4 Overarching Principles of Organizational Relationships

Despite the possible variations for motivation, form, or level of analysis, organizational relationships have overarching principles that make them more alike than not. The similarities between all organizational relationships are, “1. They transfer information that gives rise to attitude similarity, imitation, and generation of innovations; and 2. They mediate transactions among organizations and cooperation among persons; they give differential access to resources and power” (Brass et al., 2004, p. 802).

Inter-organizational partners form relationships to seek resources from outside markets and intra-organizational relationships are generally formed to seek resources in the organization’s internal market (Coff, 1999; Di Gregorio, 2013). In intra-organizational relationships, “resource exchange is an attractive alternative to market exchange because different units of an organization usually share similar values and common corporate language that can facilitate communication in the exchange process” (Tsai, 2000, p. 926). Both inter- and intra-organizational relationships facilitate the exchange of tangible and intangible resources. For organizational units, the tangible resources are usually specific products and material goods.
while the intangible resources can be technical skills and “know-how” (Argote, 1999; Brass et al., 2004). Similarly, the resources that are exchanged between inter-organizational partners are also tangible (revenue, technology, and facilities) and intangible (knowledge, positional power, and legitimacy) (Brass et al., 2004; Oliver & Ebers, 1998; Oliver, 2001).

Ultimately, it is the motivation of the partners entering into the relationship that matters most in the analysis of organizational relationships. A meta-review of relationship forms and theories concluded that there are two pure forms of organizational relationships: co-exploration and co-exploitation (Parmigiani & Rivera-Santos, 2011). Exploration involves the “pursuit of new knowledge” and exploitation is the “use and development of things already known” (Levinthal & March, 1993; March, 1991). Parmigiani and Rivera-Santos (2011) expanded on the work of Levinthal and March (1993) to define and apply the concepts of exploration and exploitation to organizational relationships. According to the authors, the impetus for any organizational relationships is to allow for co-exploration and/or co-exploitation. Co-exploration in organizational relationships is defined as “the creation of new knowledge, tasks, functions, and activities,” whereas co-exploitation is defined as the execution of “existing knowledge, with expansion as the main activity” (Parmigiani & Rivera-Santos, 2011, p. 1122). Since there are at least two different partners in each relationship, each partner may have different intentions or aims for the relationship and this may cause tensions given the goals of each relationship partner. The authors suggest that co-exploration and co-exploitation are dynamic activities in organizational relationships and that there are likely constant tensions inherent in meeting each partner’s needs. Co-exploration and co-exploitation may occur simultaneously, separately, or one may precede the other in both time and space.
3.3.5 Knowledge Exchange and Entrepreneurial Orientation in Relationships

Organizational partners in a relationship can contribute to the evolution of current products/knowledge (exploitation) as well as attain resources/knowledge previously not available to the organizations (exploration). Organizations balance their exploration and exploitation endeavours based on the nature of their alliances (Lavie & Rosenkopf, 2006). In fact, bringing new knowledge related to entrepreneurial ideas from alliance partners into the parent firm is one of the most effective ways of creating entrepreneurial behaviour (Hoskisson et al., 2011). One way in which public NFP organizations are applying knowledge from relationships with private organizations is by becoming more entrepreneurially oriented in their actions, structures, and philosophies in order to sustain or acquire needed resources (Eikenberry & Drapal Kluver, 2004). While entrepreneurial orientation is generally studied in FP companies, more recently focus has been given to the entrepreneurial orientation of NFP organizations (Coombes, Morris, Allen, & Webb, 2011; Kearney, Hisrich, & Roche, 2009; Klein, Mahoney, McGahan, & Pitelis, 2010; Morris, Coombes, & Schindehutte, 2007; Morris & Joyce, 1998).

FP entrepreneurial orientation has defined objectives, such as economic profit, overcoming competitive environmental forces, and increasing shareholder wealth (Klein et al., 2010). These organizational purposes are more likely to lead FP organizations to innovation and risk taking (Morris et al., 2007). NFP organizations, however, may have more complicated social and political objectives and goals that are not necessarily related to economic profit, such as concern for public welfare and the development of new and existing services (Kearney et al., 2009). Entrepreneurial orientation of NFP organizations has been noted as an important factor in organizational survival in the contemporary environment (Coombes et al., 2011). NFP entrepreneurial outcomes can be related to new development (new strategies, ventures, business
models, markets, products/services, and/or internal processes) or better productivity (introduction of new processes/procedures, new policies, goal setting, and new financing methods) (Kearney et al., 2009; Klein et al., 2010; Morris, Vuvren, & Cornwall, 2009).

Knowledge exchange as a result of organizational relationships can create new patterns of activity. This allows organizations to be more efficient, to open up to new service opportunities, and to participate in innovative initiatives that organizations may not have been involved in if not for the partnership (Kanter, 1999; Pointer et al., 1988). For example, Kanter (1999) documented case studies of large FP organizations that, through their work with the NFP sector, stimulated their own business development, created legitimacy for their company, and developed new products. Additionally, NFP organizations are influenced by their association with funders. For example, NFP organizations that are funded by governments tend to exhibit government-driven bureaucracy (Froelich, 1999), whereas NFP organizations that entered into commercial activities demonstrated more entrepreneurial behaviours, such as a focus on revenues and changes in the type of members who represented on NFPs’ boards of directors. Furthermore, NFP organizations that received contributions from individuals or corporations may have their goals displaced by the requests of the donors (Froelich, 1999). Similar findings were underscored in a study within the pharmaceutical industry (Ernst, Lichtenthaler, & Vogt, 2011). The authors found that as a consequence of the relationship between privately funded and publicly funded pharmacies, the publicly funded pharmacies developed more entrepreneurial practices. Using a cross-sectional sample of NFPs, Macedo and Pinho (2006) found that, over time, NFP organizations tended to acquire the attributes of the organizations upon which they are financially dependent. Specifically, the authors concluded that NFP organizations that tended to receive more donations from private funders were more market-oriented than NFP organizations.
that received donations from public funding agencies (Macedo & Pinho, 2006). In a related theoretical paper, Hirth (1997) proposed that competition between NFP and FP hospitals in the US had spillover effects on both types of hospitals. For example, competition between NFPs and FPs had positive social effects on the performance of FP hospitals; specifically, in order to compete in the same market, FP hospitals adopted NFP practices to increase quality of care, health promotion, research, and education. Conversely, NFP hospitals, in the same market as their FP counterparts, tended to shift their focus from sole community benefit to include financial goals in their organizational mandates (Hirth, 1997).

An area that warrants further research is the impact of relationships on partners’ subsequent strategic and organizational practices (Inkpen & Tsang, 2008) –two important components related to the measurement of an entrepreneurial orientation (Peterson & Johnson, 2004). Indeed, entrepreneurial behaviour in NFP organizations is generally under-researched and not well understood (Kearney et al., 2009; Klein et al., 2010; Macedo & Pinho, 2006). Consequently, one of the aims of this research study is to examine the intended and unintended consequences of privately funded rehabilitation companies/departments on the behaviour and entrepreneurial orientation of hospitals with which they partner.

3.3.6 Relationship Effectiveness

With regard to the evaluation of organizational relationship effectiveness, there is agreement that this should be measured in comparison to set goals (Van de Ven, 1976). The World Health Organization (WHO) suggested that relationship effectiveness between privately and publicly funded health care organizations needs to be measured based on congruity of common goals, the establishment of metrics to evaluate relationship success, and agreed-upon
roles in relationships between privately and publicly funded organizations (Buse & Walt, 2000). Relationship effectiveness of private-public relationships is usually documented in common policy, legal contracts, and scorecards (Hodge & Greve, 2007). Partnership scorecards that take into consideration objectives related to strategy, finances, operations, and resources can aid in the evaluation of partnership effectiveness (Barr, 2007). However, the evaluation of effectiveness can deliver contradictory evidence due to lack of independent evaluators, poor evaluation rigour, and undeveloped definitions for relationship effectiveness (Hodge & Greve, 2007).

When evaluating organizational relationship effectiveness, it is important to understand the perspectives of various stakeholders (Freeman, 1984). Publicly funded health care organizations, such as hospitals, have various community and organizational stakeholders with multiple competing goals and agendas (McNulty & Ferlie, 2002). Thus, when publicly funded organizations form relationships, the expectation for relationship effectiveness comes from the communities that they serve (community interests, advocacy groups, providers of financial resources), networks (individuals and services connected with the organization), and the organizations and managers involved (Babiak, 2009; Weech-Maldonado, Benson, & Gamm, 2003). According to the literature, the factors that positively influence relationship effectiveness for NFP organizations in relationships with FP organizations are the perception of equitable exchange of resources (Babiak, 2009; Burke, 2006; Casey, 2008; Mizrahi & Rosenthal, 2001; Motiwala et al., 2008; Njau, Mosha, & De Savigny, 2009), achieving the goals of the relationship (Babiak, 2009; Day et al., 2010; Hahn, 2010; Marshall, 2000; Mizrahi & Rosenthal, 2001; Weech-Maldonado et al., 2003), legitimacy in the community (Babiak, 2009; Barrows, MacDonald, Supapol, Dalton-Jez, & Harvey-Rioux, 2012; Weech-Maldonado et al., 2003), knowledge exchange (Mizrahi & Rosenthal, 2001; Motiwala et al., 2008; Weech-Maldonado et
al., 2003), supportive leadership (Casey, 2008; Hahn, 2010; Lofstrom, 2010; Marshall, 2000; Motiwalla et al., 2008; Njau et al., 2009), and frequent, open communication between partners (Casey, 2008; Day et al., 2010; Hahn, 2010; Kinnaman & Bleich, 2004; Marshall, 2000). The awareness of factors that influence relationship effectiveness is useful to managers and leaders who may want to focus on specific issues in order to ensure relationship success. A literature gap that this study will address is the relative importance of the factors that influence organizational relationships. Knowing what specific factors are most likely to facilitate relationship effectiveness can assist managers in focusing their efforts on those that provide the most impact.

3.4 Chapter Summary

This literature review provided the context for understanding relationships between publicly funded hospitals and privately funded rehabilitation departments/companies. Using theoretical perspectives, this review summarized the potential motivations for relationships and explained the rationale between some relationship structures. The opportunity to explore and exploit resources appeared to be the dominant motivation for entering into organizational relationships. Relationship partners influenced each other, intentionally and unintentionally, through knowledge exchange. Of prominence was the exchange of entrepreneurial practices between public and private partners. Partners entered a relationship to accomplish specific goals, and literature indicated that the achievement of these goals implied relationship effectiveness.

This study investigates relationships formed between publicly funded hospitals and privately funded companies/departments. These relationships occur under the organizational umbrella of the hospital and provide an opportunity to investigate how parallel funding systems
for health care services can co-exist within Ontario hospitals. Understanding such relationships may contribute to the development of best practice principals that can be used in other publicly funded organizations that may wish to enter into such relationships.
Chapter 4
Research Methods

4.0 Introduction

This chapter outlines the methodology and methods used for data collection and analyses. This study used a mixed methods approach (semi-structured interviews and surveys) within multiple case studies to understand the relationships between publicly funded hospitals and privately funded rehabilitation departments/companies. Within and between case analyses were conducted.

This study was guided by two groups of research questions. The first set of questions describes the relationships and their perceived effectiveness, and the factors that influence the perceived effectiveness of these relationships. The specific research questions, as stated previously, are restated here:

#1.a. How are these organizational relationships structured?

#1.b. How is relationship effectiveness defined between publicly funded hospitals and privately funded rehabilitation departments/companies?

#1.c. Are these relationships perceived as effective by relationship partners?

#1.d. What are the factors and/or conditions that impact the perceived effectiveness of these organizational relationships?

Semi-structured interviews were used to investigate research questions #1.a., b., c., and d. (please refer to Appendices C, C1). In addition, surveys were used to investigate research question #1.d. (Please refer to Appendices D and D1).
The second group of questions focuses on: the description of the entrepreneurial orientation of the hospitals in this study; the impact that this relationship had on the entrepreneurial orientation of the hospitals; and any other intended or unintended consequences on the hospitals. The research questions that elaborate on the aforementioned inquiries, as stated previously and repeated here, are:

#2.a. How do hospital leaders describe the entrepreneurial orientation of their hospitals?

#2.b. What are the intended and unintended consequences of these relationships on the entrepreneurial behaviour of publicly funded hospitals?

#2.c. What are, if any, the other intended and unintended consequences of these relationships on publicly funded hospitals?

Semi-structured interviews were used to investigate research questions #2.b. and c. (Please refer to Appendix C). In addition, surveys were used to investigate research question #2.a. (Please refer to Appendix E). A more robust description of methods used to investigate each research question can be found in section 4.3.2 of this chapter.

4.1 Study Methods

Because research strategies are tools used to understand phenomena, the objectives and research questions guide the methods employed in conducting research (Morse, Barrett, Mayan, & Spiers, 2002). Mixed methods research facilitates studying research questions from qualitative and quantitative perspectives offer the opportunity to enhance the research strategy (Creswell & Plano-Clark, 2007). One research approach that is conducive to the mixed-methods tradition of inquiry is case study research. Case studies are used to explore current phenomena
through detailed, in-depth data collection involving multiple sources of information (Creswell, 1998). In this study, the “case” was considered the object of, or the unit of, analysis (Stake, 1995), and reflected the organizational relationship between a publicly funded hospital and a privately funded rehabilitation department/company. The present research used a multiple case design as a method (Stake, 2006; Yin, 2009). According to Yin (2009), multiple case designs are preferable to single cases because they can strengthen study conclusions by allowing replication and confirmation of study findings.

4.2 Sampling

4.2.1 Study Cases

The purpose of the sampling method was to identify cases that had experienced/demonstrated a particular phenomenon that was relevant to the topic of study. For this study, a heterogeneous and purposeful sampling approach was appropriate, as the aim of purposeful sampling was not to identify a sample representative of a general population of cases, but rather to identify a sample of cases that had particular experiences relevant to the study (Mays & Pope, 1995). Furthermore, a heterogeneous sample was favoured because it increased the scope/range of data as well as the likelihood that the full array of multiple situations would be uncovered (Denzin & Lincoln, 1998). In a multiple case design, using four to six cases is recommended for replication purposes and to ensure a degree of certainty if the differences in expected results are subtle (Stake, 2006; Yin, 2009).

The initial sampling strategy for this research focused on six publicly funded academic hospitals with privately funded WSIB rehabilitation departments. In this original sample, the cases to be studied were: two hospitals with newly formed WSIB rehabilitation departments; two hospitals with existing WSIB-funded rehabilitation departments; and two hospitals with publicly
funded rehabilitation departments. However, following the pilot and initial respondent interviews in academic hospitals, two changes to the sampling strategy were suggested by respondents. First, respondents suggested that the exclusive focus on academic hospitals would limit the understanding of public and private relationships in hospitals; thus, they suggested that non-academic community hospitals also be included in the study. Second, respondents noted that the focus on publicly funded hospitals with WSIB rehabilitation departments was too narrow given the diverse relationships that hospitals have with a variety of privately funded rehabilitation clinics. In response to these suggestions, and in consultation with this researcher’s PhD supervisor, the sample of cases for this study was expanded from six to ten, in order to include community hospitals and various intra-organizational and inter-organizational relationships with privately funded rehabilitation departments/companies. It should be noted that, in qualitative research, sampling choices frequently evolve through the successive waves of data collection (Denzin & Lincoln, 1998); thus, revising the sampling strategy, based on initial respondent interviews, is an accepted practice.

Purposeful sampling was used to identify cases of publicly funded Ontario hospitals that had relationships with privately funded rehabilitation departments/companies. Initially, such hospitals were identified using the WSIB website (http://www.wsib.on.ca/en/community/WSIB/230/ArticleDetail/24338?vgnextoid=84137a9a4ae4e210VgnVCM100000469c710aRCRD&vgnextchannel, accessed December 2013), which listed academic hospitals with WSIB specialty clinics. Snowball sampling was used where key informants and, later, study respondents identified additional community and academic hospitals that had relationships with privately funded rehabilitation departments/companies. Overall, this study sample included five academic hospitals (cases 1-5, please refer to Table 4.1) and five
community (non-academic) hospitals (cases 6-10, please refer to Table 4.1). With respect to hospital size, hospitals in this study had the maximum capacity to service between 265 to 1,150 patient beds, with an average capacity of 586 beds (academic hospitals had an average of 433 beds; community hospitals had an average of 497).

In order to display the diverse perspectives related to the organizational relationships between publicly funded hospitals and privately funded rehabilitation departments/companies, this study sought to achieve “maximum variation” (Miles & Huberman, 1994). Therefore, cases were chosen with relationships of varying length (less than 1 and up to 10 years), with privately funded rehabilitation departments and privately funded companies, with partners being located within the same facility or in geographically separate locations, and those that were ongoing as well as those that were terminated. All hospitals within this study provided inpatient rehabilitation services. To contrast the relationships that hospitals had with privately funded rehabilitation companies/departments, this study probed three relationships between publicly funded hospitals and their own publicly funded rehabilitation departments. Table 4.1 summarizes the cases that were used in order to study the relationships between publicly funded hospitals and the privately funded rehabilitation departments/companies.
Table 4.1

Description of Cases

Relationships between Publicly Funded Hospitals and Privately Funded Departments/Companies

<table>
<thead>
<tr>
<th>Case #</th>
<th>Hospital Type</th>
<th>Length of Reln. (years)</th>
<th>Hospital Relationship with Privately Funded</th>
<th>Location of Privately Funded Department/Company</th>
<th>Other Private Partnerships</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Academic</td>
<td>10</td>
<td>Rehabilitation department</td>
<td>Internal/external to hospital</td>
<td>Local, International</td>
</tr>
<tr>
<td>2</td>
<td>Academic</td>
<td>3</td>
<td>Rehabilitation company</td>
<td>Internal to hospital</td>
<td>Local</td>
</tr>
<tr>
<td>3</td>
<td>Academic</td>
<td>&lt;1</td>
<td>Rehabilitation department</td>
<td>External to hospital</td>
<td>International, National, Local</td>
</tr>
<tr>
<td>4</td>
<td>Academic</td>
<td>10</td>
<td>Rehabilitation department</td>
<td>External to hospital</td>
<td>International, National, Local</td>
</tr>
<tr>
<td>5</td>
<td>Academic</td>
<td>5</td>
<td>Rehabilitation company</td>
<td>Internal to hospital</td>
<td>International, Local</td>
</tr>
<tr>
<td>6</td>
<td>Community</td>
<td>5</td>
<td>Rehabilitation department</td>
<td>Internal to hospital</td>
<td>Local</td>
</tr>
<tr>
<td>7</td>
<td>Community</td>
<td>3</td>
<td>Rehabilitation company</td>
<td>External to hospital</td>
<td>Local</td>
</tr>
<tr>
<td>8</td>
<td>Community</td>
<td>5</td>
<td>Rehabilitation company</td>
<td>Internal to hospital</td>
<td>Local</td>
</tr>
<tr>
<td>9</td>
<td>Community</td>
<td>2</td>
<td>Rehabilitation company</td>
<td>External to hospital</td>
<td>Local</td>
</tr>
<tr>
<td>10</td>
<td>Community</td>
<td>10</td>
<td>Rehabilitation department</td>
<td>External to hospital</td>
<td>Local</td>
</tr>
</tbody>
</table>
4.2.2 Study Participants

The choice to engage in relationships with privately funded rehabilitation companies, or to create privately funded rehabilitation departments, reflects strategic decision making by senior leaders and upper management. Therefore, data was collected from senior leaders (CEOs, VPs, CFOs, and directors) of hospitals, privately funded rehabilitation departments/companies, and publicly funded rehabilitation departments within these hospitals. The designation of “participant” or “respondent” refers to senior leaders who participated in interviews for this study.

The CEOs of each of the ten hospitals chosen for this study participated in initial interviews, and assisted with the recruitment of other decision makers within their facilities who could provide information regarding the hospitals’ relationships with privately funded departments/companies. Identifying and accessing case study sites and other study participants through “gate keepers” to make first contact and to lead the researcher to other respondents is a recommended technique for case study researchers (Creswell, 1998). The CEOs recommended and made introductions to hospital vice presidents, directors of rehabilitation departments, directors of privately funded rehabilitation companies, and business development directors. Interviews with business development directors were not initially intended as part of the original proposal for this study; however, hospital CEOs stressed the importance of these introductions, and subsequent interviews with business development directors were conducted. Interviews with business development leaders provided a more global context to the various relationships (local, national, and international) that the hospitals held with privately funded companies and the factors that hindered and facilitated these relationships. This additional information was a product of the interview process and the recurring theme suggested that it is an important issue in
the understanding of relationships between publicly funded hospitals and privately funded companies. Uncovering new information is in line with the tradition of qualitative research, in that the researcher works inductively and unrestrictedly with respect to any new information that emerges from respondent interviews (Creswell, 1998). Overall, a consistent criterion for selection was used across all interviews: participants had to have knowledge of relationships between publicly funded hospitals and privately funded rehabilitation departments/companies (and/or publicly funded rehabilitation departments, when, for reasons of comparison, representatives of publicly funded departments were interviewed).

Three key informants piloted and provided input into the study surveys and interview questionnaires. Data from two out of three key informants was used for this study. In cases where pilot interviews were used for study data, three additional participants were sought from each of the facilities where the key informants were employed, in order to substantiate pilot data. Whenever possible, multiple respondents in each facility were interviewed to increase data dependability. Recruitment continued until themes reached saturation and no new concepts emerged from the interviews. Overall, interview and survey data from twenty-five respondents was used. A matrix of study participants is included in Table 4.2.

Potential respondents were contacted via an introductory e-mail (Appendix A). A more detailed participant information sheet was sent to interested potential participants and an interview time was set (Appendix B). Interviews were conducted between May and September, 2013. Respondents took part in semi-structured interviews and surveys, which followed the interview guides (Appendices C, C1, D, D1, and E) at the respondents’ places of work. Two interviews, with respondents in community hospitals, were conducted via the telephone to accommodate remote work locations. All respondents were provided with consent forms, which
were signed by all respondents prior to the interviews (Appendix F). For the purpose of anonymity and to limit possible reservations by the respondents during interviews, no personal or organizational identifiers were used in the write up of study results. Instead, organizational codes were assigned by the researcher to each hospital and respondent to enable data analysis within and between organizations. If any details in the participants’ responses made them or their organizations identifiable to others, those specific pieces of data were masked, without altering the meaning of the text. Any quotations used in this study that had identifying information were changed to “XX hospital” or “(name of clinic/hospital deleted to ensure anonymity).” This technique is used and recommended by Kaiser (2009) to ensure that anonymity is protected when reporting and publishing qualitative research.

According to Miles and Huberman (1994), sampling in qualitative research should begin and end with two objectives: (1) setting boundaries to define the properties of the sample that connect the sample to the research questions, and (2) setting the “frame” to the sample, the point at which the sample allows the researcher to uncover and confirm the constructs related to the study. Consequently, for this study, sampling continued until two criteria were reached: (1) sufficient interviews were completed to satisfy the purposeful and maximum variation sampling strategy, and (2) theoretical saturation of data was achieved to-the point at which no new categories or themes emerged from the data.
Table 4.2
Study Participants

<table>
<thead>
<tr>
<th>Role</th>
<th>Academic Hospital</th>
<th>Community Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Senior Leader (Hospitals)</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>Senior Leader (Business Development)</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>Senior Leader (Privately Funded Departments)</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Senior Leader (Publicly Funded Departments)</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>18</strong></td>
<td><strong>7</strong></td>
</tr>
<tr>
<td><strong>TOTAL PARTICIPANTS</strong></td>
<td><strong>25</strong></td>
<td></td>
</tr>
</tbody>
</table>

4.3 Methods

4.3.1 Research Questions

Interview questions and surveys were used to elucidate information regarding the nature of the relationships between publicly funded hospitals and the privately funded rehabilitation departments/companies. The interviews were semi-structured, thus respondents were able to add and elaborate on the information that was solicited.

4.3.1.1 Modifications to the Interview Guide

In all interviews conducted with hospital CEOs (entry interviews into all hospitals), and later during interviews with business development leaders, information emerged about additional
partnerships between hospitals and privately funded health care companies (regional, national, and international). As noted earlier, this additional information was a product of the interview process, and the recurring theme suggested that it is an important issue in understanding relationships between publicly funded hospitals and other privately funded health care companies. Thus, the interview guide evolved to include questions about hospitals’ relationships with privately funded rehabilitation departments/companies and other privately funded health care companies. In turn, this was reflected in slight, but important, modifications to the original research questions, with regards to the examination of the relationships between the publicly funded hospitals and other privately funded health care companies. The modification to the questions can be found below in sections 4.3.2 - 4.3.4. The methods for obtaining data relevant to each research question, original and modified, were not altered.

4.3.2 Forms of Data

The most prominent form of data in this study was respondent interviews. Interviews provided an in-depth exploration of respondents’ opinions related to their relationships and the hospitals’ with privately funded rehabilitation departments/companies. In fact, as described earlier, it is notable that all interviews conducted with hospital CEOs (entry interviews into all hospitals) elicited information about additional privately funded partnerships (regional, national, and international) even though the focus of this research was on relationships with privately funded rehabilitation companies/departments. As also noted previously, this additional information was a recurring theme; thus, the interview guide evolved to examine the multiple relationships with privately funded companies with which hospitals are involved. Strategic hospital documents were used to understand the goals of hospitals as these related to the hospitals’ entrepreneurship, financial diversification, private partnerships, and business
development. Data obtained from surveys (Appendices D, D1, E) was used to add rigour, as another source of evidence, and to provide an additional dimension to interview data (Yin, 2009). Table 4.3 outlines the forms of data and the data collection plan.

Table 4.3

<table>
<thead>
<tr>
<th>Research Questions</th>
<th>Interviews</th>
<th>Surveys</th>
<th>Documents</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. a. How are these organizational relationships structured?</td>
<td>Appendices C or C1</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>1. b. How is relationship effectiveness defined between publicly funded hospitals and a privately funded rehabilitation departments/companies?</td>
<td>Appendices C or C1</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>1. c. Are these relationships perceived as effective by relationship partners?</td>
<td>Appendices C or C1</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>1. d. What are the factors and/or conditions that impact the perceived effectiveness of these relationships?</td>
<td>Appendices C or C1</td>
<td>Yes (Appendices D or D1)</td>
<td>No</td>
</tr>
<tr>
<td>2. a. How do hospital leaders describe the entrepreneurial orientation of their hospitals?</td>
<td>Appendix E</td>
<td>Yes (Appendix E)</td>
<td>Hospital Strategic Documents</td>
</tr>
<tr>
<td>2. b. What are the intended and unintended consequences of these relationships on the entrepreneurial behaviour of publicly funded hospitals?</td>
<td>Appendix C</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>2. c. What are, if any, the other intended and unintended consequences of these relationships on publicly funded hospitals?</td>
<td>Appendix C</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>
The following section presents the methods used for each research question.

4.3.3 Methods for Research Questions

4.3.3.1 Methods for Research Questions #1.a., 1.b., 1.c., 1.d.

Semi structured one-on-one interviews were used to answer the following set of research questions: #1.a. “How are these organizational relationships structured?”; #1.b. “How is relationship effectiveness defined between publicly funded hospitals and a privately funded rehabilitation departments/companies?”; #1.c. “Are these relationships perceived as effective by relationship partners?” (Please refer to Appendix C for the complete interview guide). Given that the choice to have privately funded rehabilitation services within hospitals is a strategic decision, data was collected from leaders and decision makers (CEOs and directors) for the hospitals and from the leaders of privately funded rehabilitation departments/companies. As noted earlier, additional questions to elicit information regarding publicly funded hospitals and other privately funded companies were added to the study. Any modifications to the interview guide in Appendix C, which is intended to elicit information about relationships with other privately funded health care companies, are indicated by “**”.

For the purpose of comparison, a modified version of the questionnaire was created in order to understand the intra-organizational relationship between a publicly funded hospital and its publicly funded rehabilitation department. (Please refer to Appendix C1). This modified questionnaire was administered to the decision makers of three publicly funded hospitals, and the decision makers of the publicly funded rehabilitation departments within those hospitals.
The interview questions and survey for research question #1.d. (“What are the factors and/or conditions that impact the perceived effectiveness of these organizational relationships?”) are found in Appendices D and D1. As noted earlier, additional questions were added to elicit information regarding the publicly funded hospital and other privately funded companies. Any modifications to the interview guide in Appendices D and D1, which is intended to elicit information about relationships with other privately funded health care companies, are indicated by “**”.

Once participants had described factors that impacted relationship effectiveness, they were asked to rank, via a survey in Appendices D and D1, the relative importance of each factor using social judgment analysis (SJA) (Cameron & Whetten, 1981). To this end, methods related to research question #1.d. were both qualitative (interview data) and quantitative (descriptive) in nature.

Techniques from SJA were used to list and rank the relative importance of the responses provided. SJA is a quantitative method through which judgments about effectiveness can be measured and ranked. This method allows for quantitative descriptions of judgment evaluations and comparisons of two or more judgments (Brehmer & Joyce, 1988). Social judgment theory is the theoretical foundation for SJA, otherwise known as judgment analysis (JA). “The goal of JA is to describe, quantify, the relations between someone’s judgment and the information, or ‘cues’, used to make that judgment” (Brehmer & Joyce, 1988, p. 41). Because the technique is used in situations where individuals are likely to differ in their judgments (Hartman, Lundberg, White, & Barnett, 1995), it is appropriate to use such a technique to understand the possibly different evaluations/multiple variations that study participants may provide regarding factors
that contribute to the effectiveness of relationships between hospitals and privately funded departments/companies. Quinn and Rohrbaugh (1983) used SJA techniques as a way to mediate competing values related to the evaluation of organizational effectiveness. Their technique has been adopted here, whereby a two-step protocol is used to identify and rank the salience of factors related to relationship effectiveness. SJA is employed in this study in order to provide parsimony to the possibly different and diverse responses that study participants may provide in their identification of factors that contribute to/detract from relationship effectiveness. In this study, participants were asked to list/describe factors that facilitate as well as hinder the relationships between the publicly funded hospitals and privately funded (or publicly funded) rehabilitation departments, privately funded rehabilitation companies, and other privately funded health care companies with which the hospitals partner. They were then asked to rank the factors that contributed to/or detracted from relationship effectiveness in order to underscore the most salient factors that managers/decision makers can use to make such relationships more effective. A more detailed procedure for SJA, as it applies to this study, is described in Appendix G.

4.3.3.2 Methods for Research Questions #2.a., 2.b., 2.c.

To investigate the entrepreneurial orientation of hospitals and answer research question #2.a. (“How do hospital leaders describe the entrepreneurial orientation of their hospitals?”), data was collected from participant interviews, strategic documents, and an entrepreneurial survey (Appendix E). For the purposes of this study, a 17-item instrument developed to assess the level of entrepreneurial orientation in NFP organizations was used (please refer to Appendix E) (Morris & Joyce, 1998). The original scale was based on the earlier work of Miller and Friesen (1982), who used 15 items to assess entrepreneurial orientation by examining proactiveness, innovation, and risk taking (Miller, 1983; Miller & Friesen, 1982). This scale was then adapted
for the NFP environment by Morris and Joyce (1998), who applied the scale to 19 different NFP blood banks. The authors noted that an aggregate entrepreneurial score was not appropriate for comparison purposes between different and even alike organizations, as each organizational type has distinctive features that enhance and/or impede its entrepreneurial activity. This scale was again used in a 2007 study to validate a model for entrepreneurial and market orientation in NFP organizations (Morris et al., 2007). From a methodological point of view, the authors recommended that the instrument be administered to multiple staff members, and that the responses then be averaged across participants to get an entrepreneurial score for the organization. For this study, documents, in the form of strategic plans and balanced scorecards accessed from hospitals’ websites from the period of January 2014 to April 2014, were reviewed to complement the survey and interview data.

Because there may be other intended and/or unintended consequences of these relationships, semi-structured interviews were used to answer research questions # 2. b. and #2.c. (“What are the intended and unintended consequences on the entrepreneurial behaviour of these relationships on publicly funded hospitals?” and “What are, if any, the other intended or unintended consequences of these relationships on publicly funded hospitals?”). Please refer to Appendices C and C1 for the interview questions. Any additions intended to elicit information about relationships with other privately funded companies are indicated by “**”.


4.4 Data Analyses

4.4.1 Interview Data

Interview data analysis relied on methods outlined by Miles and Huberman (1994) and Stake (2006). As per Miles and Huberman, initial within-case data analysis began with multiple readings of the interviews, at which time this researcher underlined key words and passages. A coding key was created and the importance of the chosen codes was cross-checked with this researcher’s supervisor, who co-coded the interviews until an acceptable level of inter-coder reliability was achieved (Miles & Huberman, 1994). Next, this researcher created interim case summaries for each hospital. This technique is similar to that which is used by Stake (2006), who recommended categorical aggregation to identify recurring themes within each case. Thereafter, this researcher built a logical chain of events for each case as these related to each research question. In this second stage, Stake (2006) advised direct interpretation where the researcher looks for patterns, and for explanations for the patterns. The last phase is naturalistic generalization, or the development of “lessons learned,” so that others can benefit from applying information gained from case studies. In this phase of analysis, this researcher drafted explanatory notes for each facility related to each research question. Given that this study used multiple cases, additional procedures, such as cross-case analyses, were implemented to understand patterns across cases. For cross-case analyses, Stake (2006) recommended elevating the themes from each case to an aggregate “quintain” (a group of cases), while noting the similarities and differences of each case that make up the “quintain.” At this stage, this researcher examined patterns and variations as they related to types or “families” of hospitals (i.e., academic vs. community; hospitals with publicly funded rehabilitation departments vs. hospitals in relationships with privately funded rehabilitation departments). Next, as per Stake
(2006) and Miles and Huberman (1994), this researcher merged the case findings into clusters of information that speak to the similarities and differences related to the groups of cases.

### 4.4.2 Surveys

Surveys, as noted earlier, were used to provide rigour to the study and to enrich information obtained from qualitative interviews. Two adapted surveys were used for this study:

1. To determine the relative importance of factors that facilitated or hindered relationship effectiveness between publicly funded hospitals and privately funded rehabilitation departments/companies, a survey based on the technique of SJA was developed (Quinn & Rohrbaugh, 1983); and
2. The adapted Entrepreneurial Scale of NFP organizations (Morris & Joyce, 1998; Peterson & Johnson, 2004) was used to ascertain the entrepreneurial orientation of publicly funded hospitals. Methods used for survey analyses in research questions #1.d. and #2.a. are described below.

#### 4.4.2.1 Survey Analysis for Research Question #1.d.

In this survey, participants identified factors that, in their opinions, contributed and detracted from an effective relationship (Phase 1 of Appendix D and D1). Next, study participants were asked to rate the degree that each factor influenced the effectiveness of the organizational relationship between privately funded departments/companies and publicly funded hospitals (Phase 2 of Appendix D and D1). A distribution, or range of values, was assigned to the factors. In this study, the importance of factors ranged on 5-point scale with “1” indicating “not an influencing factor”, “3” indicating a “likely factor, and “5” being a “definitely contributing factor.” A frequency count and an average (mean) calculation were applied to the ratings assigned by respondents to factors that influenced relationship effectiveness. Overall, a
total of 117 factors were identified by the participants. To ensure parsimony, 12 codes were assigned to the 117 factors. The codes were assigned in a similar manner by which the interview text was coded (Miles & Huberman, 1994). Coding began with multiple readings of the interviews and the surveys in which the participants identified factors that influenced relationship effectiveness. This researcher underlined key words and passages in the text associated with the factors identified in the survey. Factors that were described as facilitating to relationship effectiveness were identified with a “+” sign and factors that were described as hindering relationship effectiveness were identified with a “−” sign. A coding key was created and the importance of the chosen codes was cross-checked with this researcher’s supervisor. Codes were added and revised with the continued re-reading of the interviews. Please refer to Appendix H for factors identified by the participants and the corresponding codes assigned by this researcher. The list of factors, as well as their relative importance, is intended for use by decision makers who may want to enter into similar types of relationships.

4.4.2.2 Survey Analysis for Research Question #2.a.

NFP entrepreneurial outcomes can be related to development (new strategies; ventures; business models; markets; products/services; and/or internal processes) or better productivity (new processes/procedures, new policies, goal setting, and new financing methods) (Kearney et al., 2009; Klein et al., 2010; Morris et al., 2009). These entrepreneurial principles for NFP organizations are reflected in the entrepreneurial survey found in Appendix E. This survey was administered to obtain a numerical score for the entrepreneurial behaviour of the publicly funded hospitals in this sample. The responses to the questions in the survey were added and averaged to gain the respondents’ overall entrepreneurial score for the hospital. Scores for all members of one hospital were added and averaged to gain an entrepreneurial score for each hospital (within
case analyses). Entrepreneurial scores were also averaged and compared for each family type of hospital (between case analyses).

### 4.4.3 Strategic Documents

The strategic plans and balanced scorecards of the ten hospitals involved in this study were accessed from the hospitals’ websites between January and April 2014. The presence and the frequency of the following concepts were noted to reflect the entrepreneurial behaviour by hospitals in this study sample: “business development”, “developing revenue from sources other than the Ministry of Health and Long-Term Care” and “strategic partnerships.” The presence and frequency of these terms are quantified in chapter 6 and are used to support the participants’ descriptions and subsequent ranking of the entrepreneurial orientation of hospitals.

### 4.5 Study Rigour

Hannes (2011) suggests techniques that can be used for critical appraisal of qualitative research to ensure data rigour. These techniques were applied to this study to ensure credibility, transferability, dependability, and neutrality of research. Table 4.4 details each qualitative criterion and the techniques used by this study to ensure rigour.
Table 4.4

Measures of Research Rigour

<table>
<thead>
<tr>
<th>Qualitative Criterion</th>
<th>Techniques used by proposed study to ensure sound qualitative research practices</th>
</tr>
</thead>
</table>
| Credibility           | • To ensure inter-rater reliability this researcher and supervisor co-coded the transcripts to review coding and emerging themes. Any discrepancy in coding was reconciled between the researcher and supervisor.  
• Attention was given to negative cases that provided rival/alternate explanations. For example, academic and community hospitals were used in the sample; information was gathered from representatives of privately funded as well as publicly funded rehabilitation departments/companies; information regarding relationship effectiveness was gathered about privately funded rehabilitation departments and privately funded companies; interviews from sought from respondents who reported partnership success and as well as respondents who reported stained partnerships.  
• Documentation and inclusion of verbatim quotes, used in this study, are meant to allow the reader to substantiate conclusions drawn by the researcher. |
| Transferability       | • Detailed descriptions about study participants and hospitals are included in the study to allow possible replication in other studies.  
• Replication through a multiple case design (n=10) in this study augments theoretical generalizability. |
| Dependability         | • Data triangulation through the use of multiple data sources (interviews, surveys, and hospital strategic documents) augments study dependability.  
• Review by and debriefing with committee members and audit trails of discussions ensure study quality.  
• The collection of data was consistent for all interviews (person conducting interviews and the interview questions).  
• The guarantee of anonymity was intended to increase reliability as the participants were more likely to feel secure to provide open and honest answers. |
| Neutrality            | • A description of the researcher’s professional background and possible bias that may affect the study findings are included below in section 4.5.1. |

(adapted from Hannes, 2011)
4.5.1 Researcher Neutrality

While it is impossible to completely eliminate all personal bias that I bring to this study as a researcher, I can significantly reduce any partiality by acknowledging my occupational history and perceptions that may influence the objectivity of this study. As Pamphilon (1999) writes, “The writer/interpreter cannot be truly objective in the analysis of narrative. Almost certainly, our feelings, emotions, past experiences, and life schemas will invariably influence analysis” (Pamphilon, 1999, p. 406). Thus, I reflect on my own stance as a researcher and person in this study. My interest in the subject matter evolved through my work history. I was employed in leadership positions in publicly funded rehabilitation departments and later in leadership positions in the privately funded rehabilitation department of a publicly funded hospital. Through this experience, I was able to note the different expectations and relationships that the publicly funded hospital had with its privately funded and publicly funded rehabilitation departments. While this knowledge may influence the analyses of the data, I have taken steps to ensure objectivity and eliminate as much bias as possible. First, this research is grounded in independent data sources, literature and theory. Second, direct quotations from study participants are provided to substantiate this researcher’s interpretations. Third, data coding and analyses were overseen by this researcher’s supervisor. And lastly, I voluntarily ended my employment at one of the sample site hospitals, in order to minimize bias, three years prior to collecting and analyzing the data for this study.
4.6 Study Ethics

The proposal for this study was reviewed by the University of Toronto Ethics Review Office and approval to proceed with this study was granted in February 2013.

4.6.1 Informed Consent

“Gate keeper” respondents (i.e., hospital CEOs) who were initially approached to participate in this research had an opportunity to voluntarily indicate an interest to participate in the study by responding to an introductory e-mail (please refer to Appendix A). Respondents who were introduced to this study by the “gate-keepers” were also sent an introductory e-mail and had an opportunity to participate or decline participation in the study. A more detailed information sheet (please refer to Appendix B) was sent to interested potential participants and an interview time and place were arranged. At the interview, this researcher explained the consent process and confidentiality of data, and participants were asked to sign a consent form (Appendix F). In addition, prior to the interview participants were advised by this researcher that they may withdraw from the study at any time during the interview process, as well as at any time after the interview, by contacting the researcher through e-mail. While no participants withdrew their consent to participate in the study, in the event of participant withdrawal all interview data would have been permanently deleted from any written notes, recordings, and/or transcripts. Participants were asked permission to audiotape the interviews. In the event that a participant felt uncomfortable with audiotaping, this researcher was prepared to take handwritten notes. None of the participants declined to participate in the study or to be audiotaped.

4.6.2 Confidentiality

For the purpose of anonymity and to limit possible respondent reservations, no personal or organizational identifiers were used during the interview process or in field notes. Instead,
organizational identifiers were assigned by this researcher to each hospital (A-for academic hospitals, C-for community hospitals, and P-for private company) and respondents were provided a numerical code under the hospital identifier; for example, “C-BCR1” refers to a respondent in a community hospital and “C-BCR2” refers to a second respondent in the same hospital. When quotations to illustrate a point are used, any details in the participants’ responses that may make them or their organizations identifiable to others were masked by this researcher, without altering the meaning of the text. This technique was used and recommended by Kaiser (2009) to ensure that anonymity is protected when reporting and publishing qualitative research.

4.6.3 Data Storage

All audiotaped data were personally conveyed by this researcher through a password-protected portal to a transcriptionist. The files once uploaded were visible to both the transcriptionist and this researcher. This researcher deleted the files from the uploaded portal once the data was transcribed. The transcriptionist was provided guidelines regarding personal and organizational anonymity so that transcribed transcripts were devoid of identifying information. If there were instances where the person or organization could be identified, this researcher further anonymized the data. The transcripts were only shared with this researcher’s primary supervisor for the purposes of co-coding. Transcribed interviews will be stored on this researcher’s personal computer hard drive and deleted one year post-thesis dissertation.
Chapter 5

Results

Relationship Effectiveness between Publicly Funded Hospitals and Privately Funded Rehabilitation Departments/Companies

“In real estate, it’s location. In health care, it’s relationships – relationships with patients, relationships between clinicians, the relationships of physicians to their organizations, inter-organizational relationships – that really make it tick and make it happen”

- Quote from study participant

5.0 Introduction

The purpose of this chapter is to investigate relationships between publicly funded hospitals and privately funded rehabilitation departments/companies. This chapter addresses four specific research questions:

#1.a. “How are these organizational relationships structured?”

#1.b. “How is relationship effectiveness defined between publicly funded hospitals and privately funded rehabilitation departments/companies?”

#1.c. “Are these relationships perceived as effective by relationship partners?”

#1.d. “What are the factors and/or conditions that impact the perceived effectiveness of these relationships?”
5.1 Summary of Responses

Table 5.1 summarizes the responses provided by study participants.

<table>
<thead>
<tr>
<th>Focus of Research Question</th>
<th>Description</th>
<th>Results from Data Analysis</th>
<th>Number of **Respondents/*Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.a. Structure of relationships</td>
<td>Ownership, geographic proximity, and inter-vs. intra organizational ties</td>
<td>No specific pattern to the structure of relationships. Respondents reported a variety of arrangements.</td>
<td>25**</td>
</tr>
<tr>
<td>1.b. Perception of relationship effectiveness</td>
<td>Present relationships were described as effective or strained</td>
<td>Effective Strained</td>
<td>8* 2*</td>
</tr>
<tr>
<td>1.c. Definition of relationship effectiveness</td>
<td>Responses that participants provided in relation to the definition of relationship effectiveness</td>
<td>The measurable achievement of intended goals for all direct relationship participants. The intended goals are: Profitability/productivity Quality of service</td>
<td>25** 23** 20**</td>
</tr>
<tr>
<td>1.d. Factors that impact relationship effectiveness</td>
<td>Factors that negatively/positively impact relationship effectiveness</td>
<td>Factors chosen and ranked by respondents</td>
<td>See Table 5.4</td>
</tr>
</tbody>
</table>

*Number of Cases (n=10)

**Number of Respondents (n=25)
5.2 Findings

The following section presents data related to Research Questions #1.a., b., c., and d.

The data is organized in the order presented in Table 5.1.

5.2.1 The Structure of Organizational Relationships between Publicly Funded Hospitals and Privately Funded Rehabilitation Departments/Companies

For the purposes of this study the structure of the relationships refers to the following concepts: ownership/management, geographic proximity, and inter- versus intra-organizational ties. In this study, hospitals created their own outpatient rehabilitation departments or contracted rehabilitation services from privately funded rehabilitation companies.

5.2.1.1 Structure of Relationships between Hospitals and Privately Funded Departments

When hospitals created their own rehabilitation departments, these departments were owned and operated by the hospitals. For the purpose of contrast between hospitals’ relationships with privately funded companies, this type of an arrangement is referred to as an intra-organizational relationship. All of the profits made by the privately funded rehabilitation departments were directed back to the hospitals’ operating budgets. There was a hierarchical arrangement in the sense that the hospital governed their privately funded departments. A leader of a privately funded rehabilitation department owned by the hospital described this arrangement.

So it truly is like a private business, where ultimately the goal is to contribute back or to have a profit or shareholder value, so in a way, the hospital is the shareholder. (A-UV1)

There was strategy involved in allowing these departments to be under the organizational umbrella of the hospital, even when geographically removed; because the invocation of the
hospital’s name afforded the newly formed department’s legitimacy by association. This was described eloquently by one leader of a privately funded department.

So, we thought we did quite a bit of analysis in the community and interviewing consumers, physicians, market surveys, market analysis. And essentially, what it showed is that there’s a great demand and a great interest, and that being associated with (hospital name to protect anonymity) would be a very positive thing because of the brand association. (A-ST3)

At the same time, hospitals allowed these departments to operate under organizational policies that encouraged entrepreneurship and revenue generation. For example, one leader of an academic hospital with a privately funded department discussed the variation in policies that were afforded to the privately funded rehabilitation department.

One of the things we had to do was to enable (department clinic name deleted to protect anonymity) to have HR policies to be more aligned with the private setting so we approved that. We tried to allow them to be mimicking the private world as much as possible by having different policy so the staff there gets bonuses. (A-UV4)

A senior leader of a privately funded rehabilitation program created by the hospital noted the primary financial motivation behind creating the privately funded department and the hands off approach by the hospital.

Well, it was clear when I spoke to the President that they are looking for alternative sources of funding. He’s focused on generating an alternative source of revenue. He hasn’t asked us a question about how the program is running. Once it got up and running, he was happy with that. (A-MN2)

Hospital leaders used a variety of terms to refer to the privately funded departments, including subsidiaries, clinics, corporations, and privately funded units. Three out of five academic hospitals and two out of five community hospitals in this study sample created their own privately funded departments. In terms of geography, out of the three academic hospitals that owned their own rehabilitation departments, one was geographically located inside the
hospital and two were geographically located outside the hospital. The hospital with an internally located, privately funded rehabilitation department also had multiple other privately funded rehabilitation departments, which were located outside the hospital. With respect to community hospitals, one of the two hospitals had a privately funded rehabilitation department that was located within the hospital and the second hospital had a privately funded rehabilitation department that was geographically located outside the hospital.

5.2.1.2 Structure of Relationships between Hospitals and Privately Funded Rehabilitation Companies

Two of the five academic hospitals and three of the community hospitals in this sample had contractual arrangements with privately funded rehabilitation companies in the form of interorganizational relationships. The precise contractual arrangements between the rehabilitation companies and the hospitals were confidential and not available for this researcher’s review. However, based on participants’ responses, when hospitals contracted out outpatient rehabilitation services, the privately funded rehabilitation company delivered rehabilitation services, rented space from a hospital to deliver rehabilitation services, and/or managed the operations of the hospital’s rehabilitation department (e.g., human resource management and invoicing), all with the intent to profit share with the hospital. One leader of a community hospital described the contractual arrangement that was made with a privately funded company when the hospital decided to divest its publicly funded rehabilitation department.

And we decided to go out to the marketplace, the private sector, and see if we could enlist some support in getting this thing up and running in integrating the globally funded and fee-for-service, in improving productivity, in improving access – in other words, higher volume – and ensuring that we were well-positioned to have profitable, sustainable outpatient offerings. (C-VW1)
The strategic choice to engage with privately funded rehabilitation companies was impacted by costs. For example, one leader of an academic hospital discussed the decision process regarding the most effective delivery solution for rehabilitation services to patients.

Right now, even as we’re looking at having the funds come to us, we’re having to make some decisions. And the decision is, do we keep, this will be a critical period. Do we actually, we have the funds to use our internal in-house resources or use the external resources. Which ones do you use? To be frank, one of the big issues is the unionized rates and the benefits are probably the biggest negative impact of actually going in-house. Do we have good physiotherapists that work at (hospital name deleted to protect anonymity), yes? But they’re more expensive than (company name deleted to protect anonymity), so we’ll get less volume than we would if we actually used an outside provider. (A-BC3)

Unlike hospitals that created their own rehabilitation departments, hospitals that were in relationships with privately funded rehabilitation companies were less likely to be able to align the practices of those companies with the hospitals’. A leader of a community hospital discussed the adjustments and the lack of control that the hospital had experienced when working with a privately funded rehabilitation company.

And again, it was a relationship that we developed with them where they have a slightly different business model than we do. We went to them in terms of doing some of the service of referring some of our patients to them, but there’s issues with respect to control in terms of how many patients or if the doctors even refer patients to rehab clinics. (C-GH1)

With respect to location, two out of the five academic hospitals that contracted with privately funded rehabilitation companies had the staff of these companies share office space with the publicly funded staff members. The three out of five community hospitals that contracted rehabilitation services from companies chose not to have the companies within the hospital building. There did not appear to be a consistent pattern with respect to the physical location of the privately funded entity and the structure of the relationships; some hospital
leaders tried different relationship arrangements with privately funded companies and shifted the geographic location of privately funded partners from inside to outside the hospital. For example, three community hospitals used to have privately funded rehabilitation companies operating within the hospital; however, because of dissatisfaction with the relationships and/or negative perceptions of stakeholders (members of the community), these hospitals chose to terminate these relationships, renegotiated the contracts so that the same companies were no longer within hospitals, or contracted with entirely new rehabilitation companies. Chapter 7 elaborates on the reasons that hospital leaders chose geographic separation from privately funded departments/companies.

Figure 5.1 demonstrates the variations of relationship structures. These included relationships between publicly funded hospitals and privately rehabilitation departments (dotted line connotes intra-organizational relationship) located geographically within or outside the hospitals; as well as cases of relationships between publicly funded hospitals and privately funded rehabilitation companies (solid line connotes inter-organizational relationship) that were likewise geographically located within or outside the hospitals.
Figure 5.1

Partnership Arrangements between Publicly Funded Hospitals and Privately Funded Rehabilitation Departments/Companies Examined for this Study

Table 5.2 demonstrates the similarities and differences between the privately funded rehabilitation companies and the privately funded rehabilitation departments. There are a number of similarities: comparable funding sources for the privately funded rehabilitation companies and the privately funded rehabilitation departments, the type of services they provided, the health care professionals that delivered the care, and the patient populations they served. The chief difference related to the ownership and thus the appropriation of any monetary surplus. Specifically, the privately funded companies were owned by private owners/shareholders and any net surplus profit was distributed to the owners/shareholders and to the hospitals. The privately funded rehabilitation departments were created and owned by the hospitals through a variety of partnership arrangements and any net surplus of profit was directed back toward hospital operations as per BOND.
Table 5.2  
Comparison of Privately Funded Rehabilitation Companies and Privately Funded Rehabilitation Departments

<table>
<thead>
<tr>
<th></th>
<th>Privately Funded Company</th>
<th>Privately Funded Hospital Department</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Funding</strong></td>
<td>Extended private insurance, WSIB, MVA, out of pocket</td>
<td>Extended private insurance, WSIB, MVA, out of pocket</td>
</tr>
<tr>
<td><strong>Ownership</strong></td>
<td>Private owners/shareholders</td>
<td>Hospital</td>
</tr>
<tr>
<td><strong>Type of care</strong></td>
<td>Outpatient Rehabilitation</td>
<td>Outpatient Rehabilitation</td>
</tr>
<tr>
<td><strong>Delivery of care</strong></td>
<td>Multidisciplinary team funded through private payment</td>
<td>Multidisciplinary team funded through private payment</td>
</tr>
<tr>
<td><strong>Patients</strong></td>
<td>Individuals injured on the job, as a result of motor vehicle accident, or others requiring rehabilitation</td>
<td>Individuals injured on the job, as a result of motor vehicle accident, or others requiring rehabilitation</td>
</tr>
<tr>
<td><strong>Surplus/profit</strong></td>
<td>Owners/shareholders/hospitals</td>
<td>Hospitals</td>
</tr>
<tr>
<td><strong>Geographic location</strong></td>
<td>In or outside hospitals</td>
<td>In or outside hospitals</td>
</tr>
</tbody>
</table>

5.2.2 Perception of Relationship Effectiveness

Perception of relationship effectiveness, from the perspective of hospital leaders, stemmed from the ability of the privately funded rehabilitation departments/companies to accomplish agreed-upon goals. Relationships were deemed to be strained if the set goals were not achieved within the context of the relationship.

For example, one senior leader of a community hospital that used a privately funded rehabilitation company spoke of how poor management of contracts led to questionable deliverables. The relationship between the hospital and the company has since been dissolved.
And over the years as I had said we trusted and put a lot of focus on that trust and I guess we let our guard down over what was happening outside of us because we thought what they were doing was great and we paid them and then they delivered. And I think the way it worked was we paid them three months in advance. Well how do you know three months in advance what you are going to be doing? And really keeping your pulse on contracts and I think organizations, especially health care organizations, have learned that and that emphasis has been out there more and more in the last three years. (C-BRC2)

Achieving goals required the setting of clear goals at the onset of the relationship. A senior leader of a hospital with a ten-year-old privately funded department described her frustration with the lack of clear goals for the department. Specifically, the leader described the difficulty in managing the department’s staff and using the extra funds from the department for the benefit of the hospital. When this researcher asked if goals had been established to evaluate the effectiveness of the department and its contribution to the hospital, the leader replied that they had not. Below is a small portion of the transcript from the interview.

Researcher: One of my questions is, have the goals been documented at the onset of the relationship.
Respondent: No, they weren’t.
Researcher: So, you’re looking to formalize them now.
Respondent: That’s right. (A-CD1)

This same leader noted the difficulty in re-appropriating revenues generated by the hospital department as a result of not setting clear contractual goals. The leader explained that the hospital had no guidelines that directed revenues from the privately funded rehabilitation department. Traditionally the revenues that were generated by this department were used to reinvest in that same department; however, the senior leader would have liked to funnel some surplus revenues into the hospital in order to cover the operations of the privately funded department and increase business development efforts by the hospital. According to this leader, she met resistance from leaders of the revenue generating department.
But that’s the tension right now, that the people that started it [revenue generating department] feel an intense ownership to it and believe they did all the work and put it all in, forget about rent and light and cleaning, the laundry, et cetera. And all those things that we need to come to terms with, that the level of the infrastructure we’re willing to invest in and the opportunities for future business. (A-CD1)

The importance of goals was likewise underscored for publicly funded rehabilitation departments within publicly funded hospitals. One senior leader of a publicly funded rehabilitation department noted that the department was often overlooked and the impact of rehabilitation on patient outcomes was not appreciated as much as this senior leader would have liked. When asked if the publicly funded department had clear indicators of relationship success, the respondent replied,

I don’t think so. But that’s something we’re struggling with a little bit as well. You know, we’ve not clearly defined what they are. Very interesting that we have a student who’s just completed her project now, looking at what some of the indicators are for this type of facility. We’re very good at looking at outcome measures and the purely clinical type of measurement tools. But looking at indicators of success, we’ve not been as good about getting our head around. So I think that’s just something we’re on the forefront of as well. (A-ST4)

5.2.3 Definition of Relationship Effectiveness

According to all participants’ responses, the definition of relationship effectiveness was centred on reciprocally achieving the relationship’s intended goals, where the goals were profitability and quality of service. The focus of this definition was on the relationships between hospitals and privately funded departments/companies; however, based on respondent interviews, it appeared that this proposed definition for relationship effectiveness applied to all relationship pairs in the study: relationships between publicly funded hospitals and privately funded rehabilitation departments/companies; relationships between publicly funded hospitals and other local, national, and international companies; and relationships between publicly funded
hospitals and publicly funded rehabilitation departments, where the term “profitability” was exchanged for “productivity” by study participants. Participants referred to productivity as the number of patients seen by therapists per day. Different targets were identified at various hospitals and these targets were usually based on the diagnoses and age of the patient. Table 5.3 provides a representation of responses by all study participants. For this study, a working definition of relationship effectiveness is proposed to be the achievement of reciprocally beneficial goals for all direct relationship participants. Sections 5.2.3.1 - 2 provide quotations from study participants regarding the relationships between hospitals and privately funded rehabilitation departments/companies. Data from participants in relationships between hospitals and publicly funded rehabilitation department was used to contrast and support the conditions that influence this definition.
Table 5.3
Concepts Used to Define Relationship Effectiveness

<table>
<thead>
<tr>
<th>Definition of Relationship Effectiveness</th>
<th>Participants</th>
<th># of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Achieving reciprocally beneficial goals</td>
<td>All</td>
<td>25</td>
</tr>
<tr>
<td>Goals that must be demonstratively achieved</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Profitability</td>
<td>Senior leaders (hospitals)</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>Senior leaders (business development)</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Senior leaders (privately funded department/company)</td>
<td>5</td>
</tr>
<tr>
<td>Productivity</td>
<td>Senior leaders (publicly funded departments)</td>
<td>2</td>
</tr>
<tr>
<td>Quality of service</td>
<td>Senior leaders (hospitals)</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>Senior leaders (business development)</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Senior leaders (privately funded department/company)</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Senior leaders (publicly funded departments)</td>
<td>3</td>
</tr>
</tbody>
</table>

TOTAL PARTICIPANTS 25
5.2.3.1 Achieving Reciprocally Beneficial Goals

All of respondents noted that relationship effectiveness depended on relationship partners achieving reciprocally beneficial goals. When respondents described effective relationships, they spoke of “win-win” and “mutually reinforcing” interests that were met as part of the relationship. For example, one senior leader of a community hospital spoke of reciprocity and the interdependence that both relationship partners had on each other in order to achieve organizational goals.

So, our self-interests are mutually reinforcing. And, so that makes for a partnership that people want to have work. The interdependency is real and it’s just a transactional convenience, so it’s got all the profiles of a good partnership. (C-GH1)

Another leader of a community hospital reiterated that most effective relationships tended to be those where both parties have an investment in achieving mutually and individually serving goals.

We have had highly effective partnerships, and we’ve had … they’ve been along a continuum, some less effective than others. Where they’ve been really effective … again, being clear on what we’re both trying to achieve, and that requires a mutual understanding of the fact that some of those goals and objectives can be divergent but there is often an mutuality to them that should be understood by both parties. (C-WX1)

A business development leader of an academic hospital discussed a relationship with a privately funded hospital department. He spoke to the reciprocal “win” for the hospital and the department.

The win for us is we want satisfied customers or patients, that is always our priority. At the same time we want it to have a cost benefit or for investing in something with a company that also wants something in return. (A-MN1)

A hospital leader of a community hospital used the “win” analogy when discussing an effective partnership, “Obviously there has got to be a win for both parties.” (C-BRC1)
A leader of business development in an academic hospital spoke to the mutual benefits afforded through the relationship between a hospital and a privately funded company. The leader noted that the hospital benefited from expertise to further business development and the privately funded company is also looking to realize its goals in this exchange.

And from the private side, if they’re investing all this money in terms of business development, they’ll at some point, want to make that money back in some way whether it’s through further opportunities. (A-UV3)

A leader of an academic hospital spoke to the reciprocal benefits enjoyed by the hospital and the privately funded rehabilitation company. The privately funded company was able to bill OHIP by servicing a large population of patients at the hospital; in turn, the hospital received high-quality rehabilitation services for free.

Because I think that, basically, there was not a cap for them. That it was to their benefit to offer a very high level of rehab services. We got free rehabilitation services; we got a lot of enhanced incentives, because they actually were able to build a quite substantial amount through physiotherapy. (A-BC3)

A leader of a community hospital gave an example of how expanding a clinical program benefited both to the hospital and the privately funded company.

Expanding the scope of service offerings has been an example of a goal and an objective that would work to the benefit of both the private sector partner and the public sector partner. (C-WX1)

Conversely, the perceived lack of reciprocity in the relationship negatively affected relationship success. In the case of one community hospital, the privately funded company that was in a relationship with the hospital was generating profits but hospital leaders did not feel that they were receiving the preferred level of service or interaction from the privately funded company. This perceived lack of benefit to the hospital contributed to the hospital ending the relationship with this particular rehabilitation company. This leader noted,
But as we looked at it, we felt that we weren’t getting the type of feedback we needed. The information coming back to us, in terms of the services and the quality measures and the output, we kind of felt that they were doing quite well often at the expense of our patients and our ability to really hold them accountable for what they were doing. (C-BRC1)

The next section focuses on specific goals that study participants described as being essential to relationship effectiveness.

5.2.3.2 Intended Goals

All relationship partners identified that relationship effectiveness was positively predicated on both partners meeting their individual and mutual goals. The next section identifies the intended goals of the partnership for the hospitals and their privately funded partners. Profit was a relationship goal for hospitals and privately funded departments/companies. Quality of service appeared to be an added goal for hospital leaders. From the perspective of study participants, assessment of relationship effectiveness was positive if these two goals were met.

5.2.3.2.1 Profitability

Achieving profitability was an important marker for the perception of relationship effectiveness for study participants. Respondents used different references (revenue, profit, surplus, and revenue positive) to reflect the surplus of revenues generated outside MOHLTC funding. According to one respondent, hospital leaders do not always have a true measure of profit and this may explain the different references to “profit” in participants’ responses. For example, one hospital leader who has worked in numerous hospitals spoke to the fact that most hospitals were not calculating true profit made from revenue-generating activities.
I’m using the word “revenues” because for some of the, I mean, really, I should be using the word “profits”, but we don’t know what the profits are. All you can see from the hospital’s financial statements are their revenues from non-Ministry of Health sources. … most hospitals don’t know how much it costs them to provide the service. But there’s about 30 hospitals in Ontario that have patient costing systems, you have to ask yourself the question, why isn’t it pretty well every hospital, at least any hospital of any significant size. Because if you’re going to try and … there’s no great value in generating revenue, if you’re losing money, it’s a drain on you. (A-TS1)

A senior leader of a hospital department listed components of profitability in a hospital setting, noting that these components assisted in the understanding of profit within a hospital setting: “…there is a relationship between productivity, quality, capacity utilization, space utilization, that will all contribute back to profitability”. (A-ST4)

With respect to generating profit, some hospital leaders were very direct in their responses related to profitability as a measure of relationship effectiveness. As one leader of a privately funded rehabilitation department noted, “If we did not turn a profit, we would not exist, let’s be clear.” (A-UV1) The same leader spoke to the need to generate a profit in order to ensure relationship effectiveness.

So for example the work that we are doing internationally, it puts (hospital name deleted to protect anonymity) on the map to that. But yet, I would have to say, if we were doing international work and just breaking even, nobody would be interested. (A-UV1)

When a senior leader of another hospital was asked how he would define relationship effectiveness between his hospital and the privately funded company he stated, “We take the money. Not much to evaluate aside from ‘cheque the right size’” (C-GH1). Another leader of a community hospital was more timid and requested a reinforcement of anonymity when describing profit that was gained from the partnership.

In that particular example, knowing that this is all confidential, there is a profit motive for both partners as well, and so to get back to the crux of what you’re most interested in, there is a monetary benefit for both ourselves and (name of privately funded company deleted to protect anonymity) in that arrangement. (C-WX1)
A leader of a privately funded rehabilitation company that provided services to hospitals noted that all participating partners (the privately funded company and the hospital) must realize profits in order to attain relationship effectiveness. She stated that in her experience hospitals perceived a greater degree of relationship effectiveness when they were able to realize large profits: “I also find they’re [relationships] more effective when the hospital has a profit share or a bigger interest in the partnership as opposed to just rent, that kind of thing.” (P-CI1)

Hospital leaders applied productivity expectations instead of profitability to the publicly funded rehabilitation departments. In the following quote, a senior hospital leader contrasted his productivity expectations for the privately funded rehabilitation and the publicly funded rehabilitation departments.

So, the main rehab department we expect the same quality of care and outcome, but in (privately funded clinic name deleted to protect anonymity) we’re much more focused on the productivity of the staff and we’re much more focused on what is the bottom line, whereas there is no bottom line in what we’re doing in the rehab department, so it is quite different. For example, as you know, our [publicly funded] rehab department is a big provider of educational services, whereas we don’t do that at (privately funded clinic name deleted to protect anonymity) I don’t think. If we are doing education at (privately funded clinic name deleted to protect anonymity), it’s a much more transactional product and we’re really interested in squeezing productivity out of the student as well as the staff that’s teaching, so we wouldn’t take the same approach to education in (privately funded clinic name deleted to protect anonymity) that we would in our standard rehab. (A-UV2)

A leader of another academic hospital similarly discussed the different productivity targets between the privately funded rehabilitation department and the publicly funded department in her hospital. She noted that the two rehabilitation departments had different volume targets and education mandates that influenced productivity. According to the leader, the productivity targets set for publicly funded rehabilitation staff were not rigorous, and as a result the hospital leader spoke of the benefit of using a privately funded rehabilitation company.
Even when there is that push, there may be volume targets but the volume targets are LHIN targets, work load targets, are not that rigorous. The benchmark is not so high, so I don’t think that we’re, that’s the huge focus on the contract either but when you stand back and you look at it, one is actually probably more efficient, more focused. The contribution, it’s more deliberate in terms of where people are focusing their energies. If you’ve got publicly-funded staff, you’re also putting energy into other things and in an academic hospital, you’re lucky if you’re going to get 70 percent productivity. You’re probably getting a higher productivity when you’re doing an outside company, where they’re not going to be so focused on teaching students or research or other things, going to meetings. There’s less of that, so you’re getting much more of the focus on that. So, that’s probably the bigger benefit. (A-BC3)

5.2.3.2.2 Quality of Service

In addition to profitability, respondents noted that relationship effectiveness hinged on the service providing company upholding the hospitals’ reputation by providing good quality of care for patients. Quality of service was described as being necessary in order to protect the hospitals’ reputation, offer no harm to patients receiving services, and ensure the repeat business of customers (usually insurance companies). In the quotes provided by participants, quality of service was mentioned along with profitability as two co-existing and mutually dependent markers of relationship effectiveness. From the responses, it appeared that the value created through profit would be devalued by reputational damage to the hospitals. For example, a business development leader in an academic hospital spoke to relationship effectiveness indicators between his hospital and the privately funded department. He identified them as profitability and quality of care. He cited that quality of care is important because its absence has the potential to cause reputational damage to the hospital.

Well, the primary indicator would have been profitability. Because yes, we are there to meet a need, others can meet it too. It was competitive a bit. And in that sense, we said we could do it better, cheaper and more effectively and efficiently and generate a net income. So that was very much the primary indicator. Obviously, the quality of care you provide, all of those things are important. You can’t be making money and then find that there are collateral damage happening to the organization, reputation or (name of insuring
company deleted to protect anonymity) is getting into difficulty and what have you. (A-CD2)

A leader of an academic hospital with a privately funded rehabilitation department discussed the importance of quality of care provided by the department. He also spoke to the importance of generating a profit, doing the “the right thing” by the patient, and ensuring that the paying customer, an important stakeholder, was also satisfied.

(Name of department deleted to protect anonymity) knows that developing a profit for the hospital is not the only reason we do (name of department deleted to protect anonymity) but it’s a necessary reason. So, it’s not sufficient but it’s necessary, whereas the rest of the organization the most important outcome is simply providing good care. Now, the client though is not necessarily the patient. So, in the case of (name of department deleted to protect anonymity), although we always do the right thing by the patient, the actual paying client, so we have to do right by the (payer name deleted to protect anonymity). (A-UV2)

The same leader further reconciled the possible conflict between making a profit and providing quality of care. He stated that providing good quality of care positively served the profit that is generated for the hospital.

Yeah, so the primary outcome that we’re looking for is improved patient health. But, the primary service we’re providing to the client is to the WSIB or to the third party insurers. And, insuring that our ethical standards are appropriate and that our quality of care is as high as it needs to be is something that is a special feature of how we manage (name of department deleted to protect anonymity), because we think that as a company that’s in the long-term best interests of (name of department deleted to protect anonymity) to do the best for our patient. So, while it may appear on the surface as if there’s a conflict in it, there’s not really, because in the long run providing excellent care that gets people back to work is what provides us with more business. (A-UV2)

A business leader of another academic hospital repeatedly stressed the importance of profitability and quality of care as the two conditions for relationship effectiveness. He spoke to these two indicators of relationship success in the following quote:
There's probably two. One is finance and volume driven, so are we hitting the volumes that we expected of referrals and ultimately is that leading to the revenue and bottom line numbers we're looking at? That's certainly a part of it, because it is a business. Second is, how do we deliver ... be a leader in terms of patient outcomes? So how do we drive this program on an ongoing basis versus any other clinics out there to be the best in terms of how many of these patients we can treat, help and get them back to work? (A-MN1)

In summary, participants reported that achieving the goals of profitability and quality of service were paramount to realizing an effective relationship between the hospitals and the privately funded rehabilitation departments/companies.

5.2.4 Factors that Influence Relationship Effectiveness

This section elaborates on and provides quotations to support the top seven factors that influenced relationship effectiveness between hospitals and privately funded rehabilitation departments/companies (the top seven factors were cited by at least 50% of study respondents involved in the relationships between hospitals and the departments/companies). Descriptions of the top seven factors that influenced relationship effectiveness are provided in Table 5.4. Table 5.5 provides the frequency of all factors cited. Please refer to Appendices H, I, J to view factors that influenced the relationship effectiveness for all study respondents, for respondents of academic hospitals, and for respondents of community hospitals, respectively.
Table 5.4

Top Seven Factors that Influenced Relationship Effectiveness - List of Codes and Working Definitions

<table>
<thead>
<tr>
<th>List of Codes</th>
<th>Working Definitions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organizational culture</td>
<td>Cultural beliefs, attitudes, and activities toward hospitals’ entrepreneurial activities and relationships with privately funded companies/departments.</td>
</tr>
<tr>
<td>Alignment</td>
<td>Cultural, organizational, and strategic compatibility between relationship partners.</td>
</tr>
<tr>
<td>Business development infrastructure</td>
<td>Roles, policies/practices, budgets, systems, strategy for business development.</td>
</tr>
<tr>
<td>Resource exchange</td>
<td>The exchange of non-monetary assets between partners.</td>
</tr>
<tr>
<td>Clear goals/expectations</td>
<td>Goals verbalized/documentated at the beginning of relationships and set for the purpose of reaching intended outcomes.</td>
</tr>
<tr>
<td>Terms of agreement met - quality of service</td>
<td>Meeting the intended expectations/performance set by relationship partners in relation to quality of service.</td>
</tr>
<tr>
<td>Terms of agreement met - profit</td>
<td>Meeting the intended expectations/performance set by relationship partners in relation to profit.</td>
</tr>
</tbody>
</table>

Table 5.5 lists the frequency with which each factor was cited. The average salience (on a scale of 0-5) provides a ranking of importance of each factor as identified by study participants.
Table 5.5

Factors that Impacted Relationship Effectiveness between Publicly Funded Hospitals and the Privately Funded Rehabilitation Departments/Companies (n=18)

<table>
<thead>
<tr>
<th>Factor</th>
<th>Frequency</th>
<th>Average Salience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organizational culture</td>
<td>15</td>
<td>3.8</td>
</tr>
<tr>
<td>Alignment</td>
<td>12</td>
<td>4.3</td>
</tr>
<tr>
<td>Business development infrastructure</td>
<td>11</td>
<td>3.5</td>
</tr>
<tr>
<td>Resource exchange</td>
<td>10</td>
<td>4.1</td>
</tr>
<tr>
<td>Clear goals/expectations</td>
<td>9</td>
<td>4.6</td>
</tr>
<tr>
<td>Terms of agreement met - quality of service</td>
<td>8</td>
<td>4.3</td>
</tr>
<tr>
<td>Terms of agreement met - profit</td>
<td>7</td>
<td>4.3</td>
</tr>
<tr>
<td>Interpersonal</td>
<td>4</td>
<td>4.0</td>
</tr>
<tr>
<td>Productivity</td>
<td>2</td>
<td>4.5</td>
</tr>
<tr>
<td>Stakeholders</td>
<td>2</td>
<td>3.5</td>
</tr>
<tr>
<td>Risk sharing</td>
<td>1</td>
<td>4.0</td>
</tr>
<tr>
<td>Brand integrity</td>
<td>1</td>
<td>5.0</td>
</tr>
</tbody>
</table>

5.2.4.1 Organizational Culture

According to interview and survey data, the organizational culture in hospitals both facilitated and hindered relationship effectiveness. Participants described different cultural attitudes, at different levels of the organization, toward relationships with privately funded departments/companies. For example, one hospital leader discussed the difference in the attitude toward privately funded services by front line staff and the senior leaders on the board of directors of the hospital.

Absolutely. The cultural orientations really were palpable at the clinical, the front-line clinical level, so much so that there was actually friction between front-line staff who were providing the fee-for-service and those who were in the globally funded. It’s interesting because I don’t think we even knew this about ourselves until we have this
experiment unfolding before our eyes. What’s also interesting is our board did not get it – didn’t get it, couldn’t understand why medical staff or clinicians would do anything but be totally supportive of making money. (C-WX1)

Another hospital leader reported the presence of cultural pockets when discussing the openness by hospital staff in relation to privately funded companies.

It’s the level of entrepreneurship between the executive senior leaders and the middle managers because there is a definite dynamic there, definitely. And if I were to do ratings, I would rate our executive senior team [as] much more entrepreneurial than the comfort level that exists with our middle managers. (C-BRC1)

A leader of a privately funded rehabilitation department that is located within a hospital described the cultural divide and limited engagement between the staff of publicly funded and privately funded rehabilitation departments.

We’re an entity at the end of the hall, and we’re certainly tolerated. We participate. If they come to us and say can we use your gym for this reason, sure we’re good neighbours so let’s do it. We’re in the hospital but not part of the mainstream. (A-MN2)

A leader of a privately funded company illustrated how personal attitudes at different levels of the organization facilitated or hindered relationship effectiveness.

Again, it’s who you’re dealing with. The hospitals may come and say yes, we want this, but whoever the person in charge is that they’re saying you deal with this person to get the partnership going, if they haven’t bought into this whole thing that can be very difficult. They have their own ways of putting stops to these things or finding barriers upon barriers. (P-CI1)
5.2.4.2 Alignment

Alignment was noted as an important factor that could positively or negatively influence relationship effectiveness between publicly funded hospitals and privately funded departments/companies. Respondents referred to alignment in terms of cultural, strategic, and organizational compatibility between the organizational relationship partners. Respondents spoke of alignment at the level of the organization and alignment at the group level, between staff.

At the organizational level, respondents cited the need for strategic alignment between the hospitals and rehabilitation departments/companies. For example, one leader of a community hospital described an effective relationship between the hospital and the privately funded partner as having a “common purpose” while upholding the separate goals of each organization.

I can say to date, touch wood, without exception, working together towards a common purpose but in a way that’s consistent with the values and expectations of each of the organizations separately. (C-WX1)

When hospitals owned their own privately funded rehabilitation departments they were able to strategically align the departments to their own policies and procedures. The leader of a privately funded rehabilitation department described the renovations that were requested by the hospital. The department had to comply in order to meet hospital regulations despite the fact that the department treated a population of patients with rehabilitation versus critical needs.

To give you an example, when we were revamping our satellite clinics to meet the hospital’s standards, they kept applying rules that were applicable to the hospital; for example, the possibility of flesh-eating disease, security concerns, hygiene concerns and so on. I pointed out to the whole group of people we had to meet with, and I said look, in all of the time this province has been doing this kind of work, a community-based clinic has never had a flesh-eating disease. It’s because you guys are dealing with really serious diseased patients, but we’re not. We have a select population. You can’t apply the same set of rules in your hospital as you can to a satellite clinic. It’s a different environment.
Oh no, no, no, we’re applying this set of rules so we had to renovate our clinics so that they fit the hospital’s rules. It was frustrating. We got through it eventually, but it delayed us by a good six to eight months while we renovated things and cost another X thousand dollars to meet their standards. There wasn’t a lot of flexibility on that. (A-MN2)

A leader of another privately funded department described the rigour with which the hospital ensured that the protocols outlining patient care met and even exceeded hospital standards.

While all our protocols were signed off on by (hospital name deleted to protect anonymity), (hospital name deleted to protect anonymity) themselves doesn’t have med protocols in place for all the services we had to provide. And, some of the physicians sat back and they thought it was even odd, so it was a difference between the allied healthcare professionals and the physicians that said, how on earth can they ask you to have protocols when they don’t have protocols? (A-ST3)

A senior leader in another hospital illustrated the hospital’s experience with two privately funded departments of the hospital. The first private department was at “arm’s length to the hospital.” According the senior leader, the relationship “got away from them” as the department was acting in an independent way that was putting the hospital’s reputation at risk and at the same time the relationship was hindering the entrepreneurial spirit of the private department. The relationship ended and the leader of the private department bought it from the hospital. The hospital retained significantly more control and oversight over the next privately funded department that the hospital created. This second hospital-owned department had to comply with hospital’s policies and procedures in a more stringent fashion. A senior leader described the relationship between the first and second departments in the following quote:

I think the main reason one worked and one didn’t work was the actual integration into the organization. So you have one that is still very much part of the organization and is not a separate corporate entity. So although it has its own advisory board, at the end of the day, the Chair of that advisory board is the CEO of the hospital so it’s not a separate
board of trustees, it’s not a separate company. And so it very much must follow (hospital name deleted to protect anonymity) policies, procedures, even financial reporting is subject to internal audits and is reported as part of (hospital name deleted to protect anonymity) whereas the other entity, as I understand it, was separately incorporated and sort of at arm’s length of the organization. (A-UV3)

In addition to alignment at the organizational level, alignment (or lack of it) at the group level, between staff in the publicly and privately funded streams either positively or negatively contributed to relationship effectiveness. One senior leader, whose hospital ended a relationship with a privately funded rehabilitation department, noted that lack of alignment between staff was detrimental to the relationship.

So there needs to be alignment of people and it basically felt like they were consultants but never really integrated into teams. Whose fault is that? Really that was the type of organization this was, not a lot of teams were working collaboratively together at the time. So I think that could have been an opportunity for closer partnering. (C-BRC2)

Another senior leader described the need for staff alignment in order to achieve an effective partnership.

I don’t know that we really do enough of an assessment of the alignment of the organizations. We all know we’re like families unto ourselves. We have our own little quirks and our ways of doing business and our expectations of how we should perform and where we fit in the system, etc. If there isn’t alignment on that front, it just sets a very different stage, I think, for the effectiveness of the partnership and therefore the outcomes that are achieved. (A-MN1)

One hospital that was working with a contracted rehabilitation company was having difficulty integrating the two clinical teams. As a consequence, the leaders assimilated the privately funded staff into the hospital in order to have a more seamless clinical service. The community hospital leader spoke to her experience.
We just weren’t achieving the goals we were trying to achieve, so that’s when we consolidated the two internally and then we recruited a manager to oversee them. (C-WX1)

5.2.4.3 Business Development Infrastructure

The presence of a business development infrastructure within publicly funded hospitals appeared to positively influence relationship effectiveness because it facilitated the link between hospitals and privately funded departments/companies as they engaged in entrepreneurial endeavours. A business development infrastructure within hospitals facilitated entrepreneurial behaviour of the privately funded departments/companies by allowing them to have policies and processes that were more aligned with commercial activities. A leader of a privately funded rehabilitation department described the benefit of recently instituting a business development role into the hospital because the person in this new role brought much needed market-oriented skills.

I thought that was a really critical position and that’s been transformational for us, for this program being able to execute the vision that we had five years ago. We simply could not do it, so that’s been helpful. The other thing about having that person is understanding the difference in roles. As a physician, I default towards focusing on quality of the service, excellence, outcomes (inaudible) based. I don’t intrinsically feel as comfortable about going for the heavy profits, doing the wheeling and dealing, I lose interest in some of the more laborious contractual or legal elements. So we’ve been able to really put a team together and find that balance between our clinical heads, that can really bring credibility to the program, but having that business operational support that will get all the work that has to be done, so that the monies can flow and be accounted for. I really found that helpful, in my experience. (A-CD3)

A leader of another hospital described the rationale for why he was recently hired into a business development role. He noted that an assessment of hospital expertise by a consulting company brought to his attention that the hospital had very little business “know-how”; thus, the business development role was created.
And, to their credit, one of their recommendations was, well, you have no business doing this as a hospital. You don’t have the skill set. You don’t have the knowledge base. You don’t have the capabilities in-house, which led then to put out a research for an individual that does have that background or those skill sets, and that’s where essentially I was hired. (A-ST3)

A business development infrastructure in a hospital generated policies and practices that, according to respondents, were more conducive to entrepreneurism. For example, a hospital leader with a well-established business development department noted that different rules have been applied to the privately funded hospital department in order to promote a more entrepreneurial environment: “Everyone is up for reward, which would be different from the publicly funded side.” (A-UV4)

Another leader within the same hospital reinforced the slightly different way in which the privately funded department functions.

So, (name of department deleted to protect anonymity) has this extra element on top of it of profitability, and that results in the management acting in a slightly different way in terms of evaluating individual productivity, in terms of having potential for incentivization of staff, which isn’t present in the rest of the hospital, and in terms of being more client-focused I think. (A-UV2)

Another leader of a privately funded department explained how the hospital adopted a “hands-off” approach to allow the department to generate revenue.

Basically, they let us do our own thing. They don’t interfere clinically. They set the financial targets. They do the accounting. We meet quarterly to review where we’re at and where we’re going. They have helped significantly with the marketing efforts. They have a good Marketing Department and a good Graphics Department. They’re quite effective. What they have not done is said do your work in such-and-such a way, which is great. That gives us freedom to do what we’re good at and produce the results. (A-MN2)
5.2.4.4 Resource Exchange

Resource exchange was described as a factor that positively influenced relationship effectiveness. Resource exchange referred to each partner benefiting from the non-monetary assets of the other. For hospital leaders, resource exchange of non-monetary assets occurred after the profit goals had been achieved. For example, one leader of an academic hospital discussed the exchange of resources, such as further business opportunities and possibilities for innovation, between the hospital and the privately funded company. According to this leader, resource exchange occurred after the partners achieved the originally intended business goals.

In every one of the partnerships that we’ve entered into – partnerships as opposed to contractual arrangements, I’m differentiating those – but in the partnerships there is risk and benefit sharing in each and every one of them, including this one. So, I think that that keeps both partners’ minds focused. We both have skin in the game, so to speak, and as I say, in a really strong partnership that business aspect of the skin in the game, once it’s in place and moving along, then you focus less on that. It becomes a monitoring function. Where you’re focusing your attention and energy is really on all of that good stuff, the strategic stuff, the opportunities, the innovation, that kind of thing. (C-WX1)

When business goals, such as profit, were not realized, the ability for further resource exchange was negatively affected. For example, a leader in an academic hospital spoke of the strain on the partnership when financial targets were not met. He spoke about working hard to ensure that poor financial outcomes did not erode the business relationship or cause the partners to attribute dishonest intentions to each other. In addition, the ability to explore further business opportunities with the partner were halted as a result of the strain related to not meeting the intended revenue targets.

If we were making money, it would have been easy to overcome that, but if you’re not making money, it becomes harder. I’m explaining to my board every month why are we losing money on that thing. I’m sure my counterpart is looking at the same thing, when are we going to start making money on this thing. And when that happens then people begin to impute motive to each other, they’re stealing our business, or we were doing something that we weren’t supposed to do. The leaders have to work hard at not letting
that thing eat away it. So I think we’ve done that successfully in that sense. But clearly, having a relationship with a large entity, where we are specialized and the large entity has far more reach than us, that could we create a partnership which could then be leveraged into a much bigger business, that has not been very successful. (A-CD2)

For leaders of privately funded departments/companies, the resource exchange stemmed from being under the “halo” of the hospital brand. Leaders of privately funded departments/companies noted the reputational benefit that they received from partnering with hospitals. For example, one leader of a privately funded hospital department noted that he was able to hire a better calibre of clinicians because the department was a part of the hospital brand.

It’s easier to hire employees. I’ve noticed that. People are much more willing to work for a hospital than they are a private enterprise. I think there’s a certain credibility that comes. (A-MN2)

The same leader further stated that he was able to grow his other rehabilitation clinics, outside the hospital setting, because he was able to invoke the hospital’s brand to potential customers.

When I call an insurance company and I say I’m calling from (hospital name deleted to protect anonymity) wow, what a difference between that and calling from the (clinic name deleted to protect anonymity). The rehab industry in Ontario has come under a lot of criticism around fraud and whatever, but the hospital is seen with a real halo effect so that’s one thing. (A-MN2)

Another leader of a privately funded department spoke about the fact that when the department was associated with a hospital there was a marketing advantage for the department.

Yes but the real sell, the real selling point for me is coming back to the research and coming back to the fact that what you are buying is not just today’s product that was created in a business office, you are buying something that was tested with research funding which is not something you can replicate. You can’t create a company tomorrow
in New York that says, we are a hospital management company and we are going to set up a research institute. You just can’t; research is expensive. (A-BC4)

5.2.4.5 Clearly Defined Goals

Clearly defined goals were important for relationship success particularly when they were identified at the onset of relationships. The absence of clear goals created a conflict about what needed to be achieved in the relationships, and negatively influenced the perception of relationship effectiveness. According to a leader of a community hospital, relationship effectiveness was predicated on setting clear goals because they acted as indicators against which to measure the achievement of desired relationship outcomes.

I think, in our case at least, the effectiveness of the partner relationship has been dependent on shared objectives and clarity around the goals. (C-WX1)

A leader of a community hospital described an effective relationship with a privately funded company. He stated that the relationship began with clear goals because knowing what each partner aimed to achieve informed how relationship success would be measured. He stated that this was how each partner had entered the relationship: “We had clear requirements at the front. They had clear requirements at the front”. (C-GH1)

According to respondents, clear goals were best defined in legal agreements. A senior leader of an academic hospital discussed the importance of formally documenting relationship goals.

I think you do definitely need to have some sort of a legal agreement that spells out the parameters of the relationships and we’ve done that in a number of cases, you get that memorandum of understanding. (A-UV1)
Another community senior leader discussed the development of clearly articulated performance expectations in contracts and the mutual penalties that occurred when the outcomes of the agreed-upon goals were not met. He used an example of the relationship between his hospital and a privately funded rehabilitation company.

What we’re seeing in contracts is that we’re developing a stronger matrix around performance and expectations on both sides. A particular organization, we are driving a lot more in terms of those matrixes and what we expect the service provider to do. It’s very clear if they do it, there are incentives for them in some cases. If they don’t do it, there are penalties in certain cases. So that very clear language in the contract is very helpful for both sides. (C-HI1)

5.2.4.6 Terms of Agreement Met

Relationship effectiveness was influenced by the ability of the partners to demonstrate that the goals established at the onset of the relationship were met. This in turn demonstrated the value created through the relationship, and positively influenced the perception of relationship success. Conversely, perceived failure to meet the intended goals negatively influenced the perception of relationship effectiveness. Relationship partners evaluated the achievement of two specific goals that were set at the beginning of the relationship: profitability and quality of service.

5.2.4.6.1 Terms of Agreement Met – Quality of Service

Quality of service was an influencing factor in relationship effectiveness. Particularly, hospital leaders wanted to make sure that the care that was provided by the privately funded rehabilitation departments/companies did not harm the reputation of the hospitals. One leader of an academic hospital noted the importance that quality of patient care had on the reputation of the hospital.
I think it’s about quality patient care because that is at the heart of our reputation, the heart of our brand. We have to strengthen that. We can’t dilute it. We don’t want to be on the front page seemed to be not caring. That would kill us. (A-UV3)

Another leader in an academic hospital that used a privately funded rehabilitation company spoke of quality indicators in relation to the absence of harm to patients. She spoke of monitoring the quality of care that was provided by the privately funded rehabilitation company.

…but, the other thing you’re looking at are quality indicators. If our falls were increasing or the mobility was decreasing. So, any of those things, any of the quality indicators that we would be looking at anyway would be the most important thing. (A-BC3)

A leader of an academic hospital stated that in addition to creating profit for the hospital, the clinical care that was provided by the department had to be in line with the reputation of the hospital.

So, in the end as you look at what we do, we want to provide and drive revenue for the hospital by providing the best possible community care that’s reflective of the hospital (A-MN1)

A leader of another academic hospital with a privately funded department noted that the department must uphold the clinical standards of the hospital vis-à-vis its reputation, despite the geographic distance from the hospital.

I think there is a (hospital name deleted to protect anonymity) way, and that way could be how we advertise or our logo or how we use our name or brand. So, I think there is a responsibility back to (hospital name deleted to protect anonymity). As much as they are in (place deleted to protect the anonymity of the hospital), a considerable distance away. (A-ST4)

5.2.4.6.2 Terms of Contract Met – Profit

During the course of the partnership, relationship partners attempted to meet the profit targets set at the beginning of the partnership. A senior leader of a rehabilitation department in
an academic hospital spoke to the expectation by the hospital to ensure that the department brought revenues into the hospital.

We certainly projected certain financial targets. We have not met them. The numbers have been not as high as we had expected or even the (name deleted to protect anonymity) had expected, but they seem to be flexible around that issue. It’s growing. They can see every quarter as we look at it that it’s a growing operation. Their expectations are for profit which, of course, I’m very used to it. (A-MN2)

A senior leader within the same hospital reiterated the expectations for profit that the department must meet: “… there's a financial stake on both parts, but ours we need certain financial thresholds to be met in order to effectively run the clinic the way we need to run it.” (A-MN1)

A senior leader of another hospital that used a privately funded rehabilitation clinic to provide rehabilitation to patients spoke to the monitoring process of the agreed-upon deliverables: “So, it’s spelled out and the hospital contracts are very detailed. So, the volume, exactly what they are going to deliver, the cost…” (A-BC3)

5.3 Chapter Summary

This chapter focused on the structure, definition of relationship effectiveness, and factors that facilitated and hindered relationship effectiveness between publicly funded hospitals and privately funded rehabilitation departments/companies. Hospitals structured these relationships in multiple ways; privately funded companies and departments could be found inside and outside the hospitals. Based on interview data, it appeared that those hospitals that engaged in relationships with privately funded departments had more influence on the behaviour of privately funded departments than the hospitals that were in relationships with privately funded companies. According to respondent interviews, dissatisfaction with the relationships and the
possible negative perception of stakeholders (to be further discussed in chapter 7) influenced hospital leaders to locate the privately funded departments and companies outside the hospital setting. These relationships were perceived to be effective if partners were able to achieve the goals set at the onset of the relationship. If the goals were not met, or if the goals were not set at the onset of the relationships, then hospital leaders reported such relationships to be strained. Relationship effectiveness was defined as the achievement of reciprocally beneficial goals for all direct relationship participants. In the context of this study, the goals were related to profitability and quality of service. According to study participants, relationships were deemed effective if goals (profitability and quality of service) set at the onset of the relationship were met. The top six factors that contributed to relationship effectiveness were:

• organizational culture
• alignment
• business development infrastructure
• resource exchange
• clear goals/expectations
• meeting relationship goals related to profitability and quality of service

The next chapter describes the recent increase in entrepreneurial activities by hospitals.
Chapter 6

Results

Entrepreneurial Behaviour of Hospitals

“...entrepreneurism is willingness and a high level of risk appetite in the hopes of high return, risk/reward”

- Quote from study participant

6.0 Introduction

This chapter reports on the theme of hospital entrepreneurism and addresses research question #2.a.: “How do hospital leaders describe the entrepreneurial orientation of their hospitals?” Hospital entrepreneurship was a recurrent theme in all interviews and became the backdrop to understanding partnerships between publicly funded hospitals and privately funded rehabilitation departments/companies.

This chapter describes the recent focus on entrepreneurial activities by the Ontario hospitals in this study sample. Entrepreneurial orientation for the NFP sector is defined as “the process of creating value for citizens by bringing together unique combinations of public and/or private resources to exploit social opportunities” (Morris & Jones, 1999). Innovativeness, risk taking, and proactiveness in the face of environmental challenges also demonstrated entrepreneurial orientation (Miller, 1983). Analyses of respondent interviews revealed that changes in funding by the MOHLTC led academic and community hospitals to become more entrepreneurial. Hospitals in this study had aspirations to use non-Ministry funds for patient care, to cover infrastructure costs, to augment the global budget, to stimulate innovation, and to further business development. Analyses of the interview data revealed that hospitals, and leaders within them, used three main strategies to augment the funding that was provided by the MOHLTC: (1) increasing their entrepreneurial focus and managing the hospital as a “business”;
(2) employing efficiency strategies, such as divesting of programs that are not cost effective and using business processes, to best utilize funding provided by the MOHLTC; and (3). revenue generating through commercializing intellectual expertise, creating new programs that generate revenue, and entering into partnerships. In summary, this chapter describes the reasons offered by participants for increased hospital entrepreneurship and the strategies that hospitals employed to augment funding provided by the MOHLTC.

6.1 Data Analyses

6.1.1 Themes

The following table identifies the themes that originated through data analyses. The themes were ranked in order by those most frequently occurring. The number of respondents that spoke to each theme is also included in Table 6.1.
### Table 6.1
List of Themes and Descriptions

<table>
<thead>
<tr>
<th>Theme (by most frequently occurring)</th>
<th>Description</th>
<th>Number of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Motivation to augment current funding</strong></td>
<td>Description by respondents regarding instances and reasons behind decreasing reliance on MOHLTC funding</td>
<td>25**</td>
</tr>
<tr>
<td><strong>Subsidising hospital activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Patient Care</td>
<td>17**</td>
</tr>
<tr>
<td></td>
<td>• Infrastructure Costs</td>
<td>10**</td>
</tr>
<tr>
<td></td>
<td>• Global Budget</td>
<td>10**</td>
</tr>
<tr>
<td></td>
<td>• Global Impact</td>
<td>7**</td>
</tr>
<tr>
<td></td>
<td>• Innovation</td>
<td>7**</td>
</tr>
<tr>
<td></td>
<td>• Reinvestment into Business Development</td>
<td>4**</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Strategies to decrease reliance on MOHLTC funding</th>
<th>Number of all hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Increased focus on entrepreneurship</strong></td>
<td>Instances where there is a change in the hospitals’ reported focus in entrepreneurial activities; references to business terms such as: customers, portfolio, and brand</td>
</tr>
<tr>
<td><strong>2. Efficiency strategies</strong></td>
<td>Strategies undertaken by hospital to increase efficiencies:</td>
</tr>
<tr>
<td></td>
<td>• Evaluating and divesting of programs</td>
</tr>
<tr>
<td></td>
<td>• Finding new efficiencies</td>
</tr>
<tr>
<td><strong>3. Engagement in revenue-generating activities</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Partnerships</td>
</tr>
<tr>
<td></td>
<td>-Ancillary</td>
</tr>
<tr>
<td></td>
<td>-National/international</td>
</tr>
<tr>
<td></td>
<td>-Rehabilitation department/companies</td>
</tr>
<tr>
<td></td>
<td>• New programs</td>
</tr>
<tr>
<td></td>
<td>• Commercialization of intellectual expertise</td>
</tr>
</tbody>
</table>

*Number of Cases (n=10)

**Number of Respondents (n=25)
6.2 Findings

The following section presents data related to hospital entrepreneurism as relayed by study participants. Specifically, this section discusses the motivation for the hospitals to augment their current funding, and the strategies that the hospitals undertook to decrease their reliance on MOHLTC funding.

6.2.1 The Motivation to Augment Funding

All respondents noted that changes in Ontario MOHLTC funding have affected the need for hospitals to seek and increase alternative sources of revenue. According to respondents, the rate of funding is not keeping up with inflation, and the limited increases in funding do not cover costs related to aging infrastructure, increasing salary costs, or needed improvements to hospital systems, such as technology.

A senior leader described the gap between what the hospital wants to achieve versus what MOHLTC funding allows.

So the “why” is that the way we’re funded from the Ministry is barely enough to cover our operating budget and in some cases, the inflation is not enough to cover the actual inflation that we experience. So the Ministry of Health and Long-Term Care, due to its own budgetary constraints, can only fund 0 to 1% inflation. Our actual inflation is likely much higher. So the gap between what we’re funded [for] by the Ministry and what we actually need is constantly growing. (A-UV3)

One senior leader acknowledged the continued reliance on MOHLTC funding but noted the need to diversify revenue sources.

Our reliance is as great today – greater than it was in the past. What we’re really trying to do is augment that funding through alternate sources. (C-WX1)
A senior leader of a community hospital described the new, recently introduced funding formula and anticipated the impact that it would have on the hospital.

It follows the patient and it follows the volumes as opposed to we gave you a hundred billion dollars as a hospital and now we’re giving you a hundred million plus inflation every year. So for hospitals to start to look for other opportunities, they really need to be sensitive in terms of whether they can take those on and make money doing it. (C-HI1)

Respondents from both academic and community hospitals expressed their need to increase revenues from non-Ministry sources in order to reduce their dependence on a single funding source. One respondent, when speaking to the need to generate alternative funding, expressed caution regarding sole dependence on the MOHLTC: “I would say the basis of it is getting money. And the fear that relying on our major funder for 95-100 percent of our operating budget was fragile” (A-CD1). Another respondent was very direct about the need to diversify funding sources: “Our strategic plan, point #2, was go private, go big, get some money in here before the province just bleeds out” (C-GH1).

6.2.2 Supporting Hospital Activities

Senior hospital leaders cited numerous reasons for increasing revenues from alternative sources. The revenues from alternative sources were used to supplement the funding provided by the Ontario MOHLTC. Table 6.2 summarizes the findings. It is interesting to note that the top three reasons mentioned for augmenting revenue (patient care, infrastructure costs, and adding funds to the global hospital budget) were the same for representatives of community and academic hospitals. Global impact, innovation, and reinvestment into business development appeared to be additional motivations for academic hospitals. This researcher analyzed strategic plans for the hospitals in this study sample. This analysis focused on the goals that hospitals aimed to achieve in the next four years, which paralleled the references made by study
participants related to motivations to generate additional funds for advances in patient care, improvements in infrastructure, increasing revenue, making a global impact, investing in business development, and innovation. As is evident from Table 6.3, and similar to participant responses, the strategic goals of academic hospitals were more oriented toward making global impact, augmenting business development, and innovation. Given that these activities are not financed under the MOHLTC funding model, academic hospitals may have added reasons to generate alternative revenues.

**Table 6.2**

Reasons Cited for Increasing Alternative Revenues - Respondent Interviews

(highest to lowest)

<table>
<thead>
<tr>
<th>Motivation to Increase Alternative Revenues</th>
<th># Academic Hospital Respondents</th>
<th># Community Hospital Respondents</th>
<th>Total #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advances in patient care</td>
<td>11</td>
<td>6</td>
<td>17</td>
</tr>
<tr>
<td>Maintaining and developing infrastructure</td>
<td>6</td>
<td>4</td>
<td>10</td>
</tr>
<tr>
<td>Increasing revenues</td>
<td>7</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td>Making global impact</td>
<td>7</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>Innovation</td>
<td>6</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Reinvestment into business development</td>
<td>4</td>
<td>0</td>
<td>4</td>
</tr>
</tbody>
</table>
Interview data from respondent interviews was consistent with the data outlined in Tables 6.2 and 6.3. The following sections provide participants’ responses related to the type of activities that additional funding can subsidize within the hospital setting.

6.2.2.1 Patient Care

Enhancing resources in order to maintain excellence in clinical care was the most frequently cited reason for publicly funded hospitals to seek alternative revenue sources. One senior leader of an academic hospital noted that the third party stream of revenue was used to contribute to patient care within the hospital.

Expanding services or increasing access to care for people in the publicly-funded system, because it never seems to be enough. (A-CD1)
Another senior leader discussed the ways in which alternatively funded revenues can be used to augment services for patients.

I think just within the new funding model that has just started with HBAM and QBPs. Not that it wasn't realized before, the need to find alternate revenues and alternate funding sources is just so much higher on the radar than ever that I think the push to find how can we further leverage our expertise and our resources and infrastructure to generate additional sources of revenue in here. Especially in cases where they could also enhance patient care. There are certainly programs we could bring in which can drive revenue for the patients and visitors and staff. (A-MN1)

6.2.2.2 Global Budget and Maintenance/Development of Hospital Infrastructure

The second and third most important applications of alternative revenues, as reported by study respondents, were used to boost the hospitals’ global budget and off-set infrastructure costs. Participants spoke of enriching global funding to cover education, research, and compensation costs related to human resources. When participants spoke of infrastructure costs, these related to hospital systems such as IT (Information Technology) and aging facilities.

As one senior leader of an academic hospital observed during the interview:

We are a very aspirational organization, very aspirational in terms of research we want to do, in terms of education, changing public attitudes, in many ways having a global impact because there aren’t too many organizations in the world, who have the breadth of functions that (hospital name deleted for anonymity) has. So, that all requires money and our typical sources of funding from the province, they want to make sure exactly what you’re doing for the citizens of Ontario and sometimes there isn’t a perfect fit in terms of what our aspirations are and what the province wants to fund. And even for research, when we get any grants and funding, it typically doesn’t cover the full cost so we have to support it by significant additional funds. (A-CD2)
Another senior leader spoke of the increasing expenses related to existing clinical and organizational services.

I think the existing funding model isn’t working, particularly, that new funds are coming in and they’re not even keeping pace with the existing costs of things. It’s become very expensive to actually provide the services that we have. The government isn’t actually even funding the union settlement. So, there’s a need to actually look at new ways of doing things. I think that there are new markets that haven’t even been thought of. I think that there’s an interest in innovation that we never thought about previously. And none of those things are funded. Like, very, very concrete things are funded, a bed, a nurse, and some services. But anything above that, innovation. There isn’t actually funding from the hospital budget for IT [Information Technology]. (A-BC3)

A business development director of an academic hospital also noted human resource costs and infrastructure costs as two reasons to generate revenues beyond MOHLTC funding. He stated, “And so those infrastructure costs plus the cost of talent, those are the two, I think, biggest costs for us. And so our goal with bringing the revenue in is to support that.” (A-BC4)

A leader of an academic hospital discussed the importance of additional revenues to support the global budget and hospital infrastructure.

So the opportunity for revenue generation is one to offset budget deficits in the operating part of the organization but also, it allows us to invest in innovation and research and things like capital redevelopment. So again, we could be in queue with the Ministry to redevelop a building which may take 10 to 15 years or, we can fund projects ourselves and get them done much quicker. (A-UV3)

6.2.2.3 Global Impact and Innovation

Global impact and innovation were of particular importance to academic hospitals.

Senior leaders expressed frustration that hospitals’ goals such as “global impact” and “innovation” were not financed as part of the new MOHLTC funding formula. One senior leader of an academic hospital noted:
People didn’t think probably because there was more expectation of regular increases in revenues from the Ministry of Health. Now we can see where the Ministry’s Revenue expectations are to 2017 when the Province notionally balances its budget, and I think it will. So, you can see for hospitals 1% increases every year toward 2017. Well, if 1% doesn’t cover the cost of compensation inflation. So, we recognize we’re going to have to generate more revenues if we’re going to be a place that creates global impact. (A-UV2)

Another senior leader within the same hospital pointed to the restrictions the MOHLTC funding model will place on the hospital’s ability to compete on a global scale with other renowned health care institutions. He stated,

I don’t think you can be a leading academic health centre and have global impact and be on the same stage as a Johns Hopkins or a Mayo Clinic if you don’t have that funding beyond just bricks and mortar operational funding. You need that additional funding to innovate. (A-UV3)

Yet another leader in an academic hospital discussed the ambitions of the hospital and the restrictions that the current funding model placed on innovation and global impact.

And in order to make investments, to grow services, to innovate, to support an academic mandate, all of those things that we should be doing, would like to be doing, and would be consistent with the strategic objectives of the organization and the vision of the organization, they’re not really funded necessarily by government. (A-MN1)

A leader from an academic hospital spoke of the big “wish list” that alternative funding can provide the hospital, giving a number of examples: “But also, to be able to do innovative things, to build new buildings, to create new programs, to try out new models of care, et cetera”. (A-CD1)

Another senior leader of a community hospital expressed an impending need, in light of the new funding model, to expand revenue sources in order to fund innovation.

And as dollars constrict more and more, we’re going to be looking for more and more opportunities to get some revenues that are non-traditional. We’re going down to 30%
global funding, which means 70% of our funding is going to be based on set programs and set deliverables and we’re not going to have any flexibility really. And so the idea of access to some revenues or supports to do some creative things that you want to do in your area is going to be more and more difficult. (C-BR1)

6.2.2.4 Reinvestment into Business Development

Similar to innovation and global impact, the creation of alternative funds to further business development appeared to be an aim of academic, but not community, hospitals. In this study, reinvestment into business development referred to hospitals using revenues generated outside of MOHLTC funding to further augment revenue generation from alternative sources. One business development leader of a hospital that was working with international companies spoke to the limited funding that was available to further reinvest into business development because any surplus generated had to flow back into hospital operations.

So especially in the international, if I just use international as an example, I cannot use a penny of Ontario dollars to invest in business development so I have to look at other sources of revenue. So I look at any surplus from other international activity that I can reinvest in business development, that’s what I look to do but that’s not a lot of dollars because we’re trying to maximize the return to the Ontario taxpayer, trying to maximize the return to patient care. (A-UV3)

Another leader discussed an innovative business development model that was created within the hospital.

We have done that in a variety of ways, the most important of which – and it was a real milestone in the history of this organization – was to create a structure, an internal structure, that focused on enterprise development, so business development, and in particular focused on two existing services that were being provided at the centre and a third which barely existed, I think was on its final legs, and where we saw huge strategic opportunity for us to actually grow a business. (A-MN1)

A leader of an academic hospital that had recently decided to venture into business development described some trepidation the investment into this endeavour was causing.
But, it’s definitely to the point where we have to make a decision to invest or not. We’ve made the decision to invest in a business development office. So, we’ll go down that line and we’ll make it work. It’s tricky. (A-CD1)

In conclusion, the motivation to generate extra revenues is multidimensional, based on the hospitals’ strategic mandates and varying between community and academic hospitals. It is noteworthy that the top three reasons for revenue generation, for both academic and community hospitals, related to addressing the perceived inadequacy of MOHLTC funding. The next section describes the emergence of strategies to address the perceived funding shortfall between what is funded by the MOHLTC and the revenue that hospital leaders identified as necessary in order to accomplish hospitals’ strategic objectives.

6.2.3 Strategies to Decrease Reliance on MOHLTC Funding

This section elaborates on the strategies that hospitals, and leaders within them, used in order to augment funding from sources other than the MOHLTC. These strategies included: focusing on entrepreneurship, increasing efficiency by divesting of clinical programs and increasing operating efficiency, and generating alternative revenues by engaging in partnerships and commercializing intellectual expertise. Table 6.4 demonstrates the use of these strategies by academic and community hospitals.
Table 6.4
Strategies Used by Hospitals to Increase Efficiency and Generate Alternative Revenues

<table>
<thead>
<tr>
<th>Strategy</th>
<th># of Academic Hospitals</th>
<th># of Community Hospitals</th>
<th># of all Hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0 Focus on entrepreneurship</td>
<td>5</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>2.0 Increase efficiency</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.1 Evaluating and divesting</td>
<td>5</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>of clinical programs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.2 Increasing operating efficiency</td>
<td>5</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>3.0 Grow revenue</td>
<td>5</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>3.1 Commercializing intellectual expertise</td>
<td>4</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>3.2 Creating new programs</td>
<td>5</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>3.3 Engaging in partnerships</td>
<td>5</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>-Local/National</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-International</td>
<td>4</td>
<td>0</td>
<td>4</td>
</tr>
</tbody>
</table>

6.2.3.1 Focus on Entrepreneurship

Focusing on entrepreneurship was one of the strategies that hospitals used to address the described gap between what was funded by the MOHLTC and the funding that hospitals required to meet their strategic objectives. This section describes the hospitals’ focus on entrepreneurship.

6.2.3.1.1 Hospital Entrepreneurship on the Rise

The trend for hospital entrepreneurship in Ontario is relatively new, as described by senior leaders. Individuals who hold senior roles in both community and academic hospitals noted the recent increase in hospitals’ entrepreneurial activities. A senior leader of an academic
hospital noted the current emphasis on entrepreneurism within the hospital, saying that “The hospital has tried over the last two years to figure how it’s going to become more entrepreneurial. How are we going to start bringing incremental revenue into the hospital?” (A-ST1) A senior business development leader in the same academic hospital noted:

I think there’s undoubtedly a significant change in the entrepreneurial environment of the hospital, I would say within certainly the last ten years. I think it’s exponentially kind of growing and changing. Within the last couple of years, itself, I have seen a significant change, the creation or the addition of an international projects program or division – I have to be careful in terms of their title – has significantly changed the environment and culture of how we look at funding different aspects of care. (A-ST4)

As part of the interviews, senior leaders were verbally asked how they would describe the change in the entrepreneurial orientation of their hospitals in the last 5 years using a 10-point scale. The change, over the years, in the entrepreneurial rating supported the increased focus on hospital entrepreneurism observed in qualitative interviews. Hospitals’ entrepreneurism through the 5 years was rated on a scale between 0 and 10, where “0” connoted no entrepreneurial activity and with “10” being the highest entrepreneurial rating that a hospital could achieve (please refer to Appendix E). One senior leader of a community hospital spoke to the trend of intensifying entrepreneurism. When asked about the change in the entrepreneurial orientation of the hospital she stated:

I would say when I first started [5 years ago] it was probably a “3” and we are at a “6” now. But I would say even in January (2013) we were probably only at about a 5 so we have made some baby steps in progress and we would still do better. (C-BRC2)

Another leader of a community hospital discussed the vast entrepreneurial evolution of the hospital.
We have probably gone, I’d say, from a 2 to … I’d like to say a 10, but we’re not where we want to be. We’ve probably gone from a 2 to an 8. Huge. In the last decade. Our most successful business was built from literally nothing, from a business in name only that was basically accommodated in virtually a closet, I’d hardly even call it an office, with a desk and an exam table, to an operation now that’s about eight or nine million. (C-WV1)

The trend in increased entrepreneurism was similarly marked in academic hospitals. One senior leader in an academic hospital described her effort to increase entrepreneurism in the hospital. She described the current state of entrepreneurism and her desired future state.

Now I would say that we’re, if I put a number out, I’d say we’re pushing 3½. I think we should easily be able to get to 7, 7 to 8. That would look like we have completely disposed of any restrictive policies or bylaws that are misguided, that we will understand that concept of private delivery of publicly-funded services and that we should have an opportunity to benefit from that. Our patients, I should say, should have an opportunity to benefit from that. (A-CD1)

A leader of an academic hospital’s privately funded rehabilitation department spoke to the change in entrepreneurship during his employment. He discussed the strategies and the encouraging approach by the hospital leaders to allow the hospital to expand its business development efforts.

It probably was about a 7 and it’s probably an 8 or 8.5 now. There was a vision, otherwise I wouldn’t be here so they brought me up for this. They created a separate entity, they spent a lot of time and money in the legal separation between us and protecting and making sure that everything and all the regulations were abided by. And I would rank it slightly higher because I think over that period I have seen more commitment in the sense that they have given me the reins honestly, they have said you figure it out. And so most of the last year-and-a-half has been exploring the preliminary questions that I asked, where we sell, who do we sell to, what do we sell, et cetera. And they haven’t interfered in that at all. (A-BC4)

A business development director of an academic hospital spoke to the recent inception of a privately funded rehabilitation clinic and the advancement toward hospital entrepreneurism.
Five years ago would we have been able to do (name of clinic)? No, I don’t think so. I don’t think the acceptance would have been there. But, there’s a greater group that accepts what we’re doing now than what would have been in five years. (A-ST2)

Both academic and community hospitals recognized the entrepreneurial spirit that was permeating the hospital environment. As part of this study, all respondents in hospital senior leadership positions were asked to fill out a survey that rated the entrepreneurial orientation of their hospitals on a 5-point Likert scale (please refer to Appendix E). Results from the data indicated that representatives of academic hospitals rated their hospitals’ entrepreneurial behaviour as being on average 3.5 out of 5 (with a range of scores 2.7 - 4.5). Representatives of community hospital rated their hospitals’ entrepreneurial behaviour on average as 3.7 out of 5 (with a range of scores 3.2 - 4.0).

6.2.3.1.2 Focus on Business Development

The strategic documents (strategic plans and balanced scorecards) of hospitals in this study suggested a focus on business development. The documents were analyzed for the presence and frequency of the following concepts: business development, developing revenue from sources other than the MOHLTC, and strategic partnerships. Four out of five academic hospitals and two out of five community hospitals included references to business development, developing revenue from sources other than the MOHLTC, and strategic partnerships. The frequencies of these references are provided in Table 6.5.
Table 6.5

Frequency of Terms Related to Entrepreneurship in Strategic Documents

<table>
<thead>
<tr>
<th>Type of Hospital</th>
<th>Business Development</th>
<th>Augment MOHLTC Funding</th>
<th>Strategic Partnerships</th>
</tr>
</thead>
<tbody>
<tr>
<td>Academic hospitals (n=4)*</td>
<td>4</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Community hospitals (n=2)**</td>
<td>3</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

*1/5 academic hospitals did not have references to above terms

**3/5 community hospitals did not have references to above terms

To achieve the strategic imperatives for business development, hospitals invested in business development personnel. For example, in the last three years all hospitals in this sample reported hiring business development leaders or changing senior leaders’ portfolios to include business development. All academic hospitals in this study sample hired and instituted formal roles for business development. All community hospitals in this study sample augmented the senior leaders’ portfolios, usually at the vice president level, to include business development. The focus of such positions was to increase revenues from sources other than the MOHLTC.

One business development leader in an academic hospital, who was hired three years ago into a new role, described his job in the below quote:

… as head of business development, it was to find new revenue models for the hospital outside of Ministry funding and donations through the foundation. That's my role. (A-MN1)

Another business development director in an academic hospital who was also hired into a new role spoke about the expectations of his job.
I think the core responsibility of my role is basically establishing a sales and marketing program for the hospital, and I view those as two separate entities. The marketing side is looking at what markets should we be in, how do we approach them, communication, tools, mastering all that kind of bundled together. (A-ST2)

A senior leader of an academic hospital hired two business development directors in the last year in order to find alternatives to MOHLTC funding.

We have now created a position of director business development, from a person who worked in the private sector, has done a lot of business development. We’ve hired a manager of business development and in fact, we’re hiring two of them. (A-CD2)

A senior leader of a community hospital discussed the role of a new vice president, who has been charged with bringing in non-MOHLTC revenues.

We brought in a VP a couple of years ago to drive private sector revenue. And, basically the VP has been given the mandate for a set increment of net new revenue. I don’t really care where it comes from. We have ethical standards. But, aside from that, just go get the money. (C-GH1)

**6.2.3.1.3 The Hospital “Business”**

The increased focus on hospital entrepreneurship prompted hospital leaders to handle the hospital as a “business.” The reference to a hospital as a “business” came up in almost all respondent interviews. Respondents spoke of the hospital as having a “brand,” managing customers (versus patients), and reviewing the hospital “portfolio.” With respect to the new conceptualization of the hospital as “business,” one senior leader in an academic hospital stated, “People have typically not had to think of hospitals as businesses. And so, because of that, they’ve not been populated with individuals who have that background.” (A-ST1)

A CEO of an academic hospital likened the CEO role to a business executive and referred to protecting the hospital “brand” and “products” during budget constraints.
I may have to operate less beds over time, but the beds I operate will deliver a quality product, and that’s the philosophy. So as a hospital CEO in this kind of environment, as any business executive, when times get tough, you do whatever it takes to maintain the integrity of the brand, doesn’t make a difference what business you’re in. (A-BC1)

A senior leader of another hospital described the hospital as having a portfolio that needed to be managed: “I think we are finding a way to protect ourselves against that one funder thing so we’re diversifying our portfolio like any good business manager would.” (A-UV3)

Another senior leader in an academic hospital spoke of building the hospital “business” through new programs and paying customers.

And, then the sales aspect is going to be something which is going to be brand, brand, brand new for the hospital, is physically having people going out and making connections and building business. (A-ST3)

A leader in the same hospital described a “customer” focus towards patients and users of the hospital.

I will say that, over the last number of years because of my experience and some folks that I’ve hired as well, who’ve brought that entrepreneurial approach and that approach to customer service, service excellence, efficiencies, those types of indicators, those are things that were very important to me in my previous role. (A-ST2)

A customer focus was also prevalent in community hospitals. As one leader described the model of health delivery in his hospital, “It’s much more consumer driven, hospital focused, [and] efficiency driven so that’s the model that’s out there”. (C-HI1)

6.2.3.2 Increase Efficiency

This section describes the efficiency strategies that hospital leaders used, given the described financial constraints. In order to increase efficiency, hospitals divested themselves of non-essential and revenue draining programs and used new tactics to further drive their operating
efficiencies. There were two specific efficiency strategies mentioned in interviews: evaluating and divesting clinical programs, and increasing their operating efficiency.

6.2.3.2.1 Establishing and Divesting Clinical Programs

This section describes how hospital leaders actively sought to establish clinical programs that were more likely to bring in revenues, or to divest programs that were revenue draining for the hospital. According to one senior leader of an academic hospital,

It is a government funded health system, the rate of inflation and cost of programs continues to rise at a rate that is not matched by the funding. So the funding tends to stay static, or go down, or maybe increases by a very small percentage while inflation and other costs continue to go up. So naturally over time any institution will either have to cut programs or downsize them, it’s just simple math more than anything. (A-BC4)

Another senior leader, who worked as CEO in multiple hospitals, made a comparison between hospitals and private companies. This senior leader noted that until recently hospitals have not been able to remove programs because hospitals, as not-for-profit humanitarian organizations, have been funded by the government to maintain health care programs that benefit the diverse needs of patients. More recently hospital leaders have begun to evaluate the “business” they are in and remove programs that are not liberally financed under the new MOHLTC funding model. This senior leader stated,

Well, private sector, it’s all about getting out of product lines that you don’t make money on, and trying to expand ones where you do make money. In health care, in hospitals, it’s generally been trying to … because government, historically, has been reluctant to allow you to get out of certain things, although now, they seem to be a little bit more willing, (inaudible) say, oh, it’s being done in the community. (A-TS1)

Specifically, this leader cited general rehabilitation as programs that were no longer offered in hospitals.
So they say, the only rehab we want to do here is rehab that ties in to getting you out of the hospital, we don’t want to have general rehab clinics where people can come in and get rehab, that’s not the business that we’re in. So the only things that are important are the things that generate profits, and the things that are really aligned tightly with the program, are the organizations. (A-TS1)

Many of the programs discontinued by hospitals appeared to be outpatient rehabilitation programs. While rehabilitation is offered to hospital inpatients as a way to expedite discharge following hospital procedures, many leaders discussed eliminating general rehabilitation programs that serviced discharged hospital patients. A respondent from a hospital that recently removed the outpatient rehabilitation program from its hospital stated, “And, health care institutions are also divesting things such as physiotherapy because they are cost centres for the hospital. They’re not revenue drivers for the hospital.” (A-ST2)

A senior leader in another academic hospital that offered rehabilitation services was evaluating whether to continue this program. His decision appeared to be based on funding.

I think we’re going to see to what extent the Ministry is going to be able to revise the funding formula so that rehab is a doable proposition in this kind of context. If it’s not, then we are going to have to explore, first of all strategically, whether we’re going to stay in the rehabilitation business, which I suspect we will, and if we will, then we’re going to have to find the right vehicle for service delivery. (A-BC1)

Another leader of a community hospital took an organization-wide approach to evaluate which clinical programs would be offered by the hospital and which programs could be offered by community agencies. The evaluation by this leader, of what “stays” and what “goes” appeared to be based on the financial costs associated with running programs.

And, so for us what that means is looking within our community and looking at those services that don’t necessarily have to be delivered in hospital. You don’t have to be in an acute care centre to actually get that service or that program. So, we’re looking at, for instance, all of the areas in our ambulatory care centre around clinics. Do clinics have to be in hospital? No, they don’t. You could probably come up with a partnership model
around some of the follow-up clinics that happen either in certain post-surgery or some of the cases that come to Emerg, where you could have them resident somewhere in the community. It’s a lot cheaper. (C-TQ1)

A financial evaluation of programs was a recurring theme for all hospital leaders. A hospital leader spoke of how he told the hospital staff that a clinical program would be discontinued because of its limited financial viability.

And, people understand that that decision happened because people could link the numbers, which were sort of abstract, to what we actually do. And, so the idea that we were running a business and a business service rather than running a service that’s underfunded. And, the idea of if you can’t do something and make positive margin on it, then we’re not doing it. And, in a public sector, that’s a really bizarre thing. But, the reference to need is always through the filter of need plus because if you can’t do it at a margin, then get out of it. So, at the governance level, an example of that, we have an interim long-term care ward, and you get penalized if you can’t hit census, which is okay stupid then. So, we can’t hit census because the ALC issue is slowly being solved, so we’re not going to subsidize it, we’re pulling the plug. And, although it was a bit of a challenging conversation for the board in that this is a service where we’re moving in the community. The fact that it’s not making money, it’s dead, was a non-issue. (C-GH1)

6.2.3.2 Increasing Operating Efficiencies

One way by which hospitals were expanding the use of funding that was provided by the MOHLTC was to find further operational efficiencies. Academic and community hospitals were using consulting companies to assist with new tactics and lean processes to ensure maximum efficiency of their operations. A vice president of an academic hospital described the recent efficiency processes undertaken by the hospital.

I think we’ve been able to bring a variety of strategies around flow processes, for example, from the Emergency Department to the inpatient areas. We’ve seen dramatic improvement in our flow through the organization. We have put in place, since January, essentially a strategy to – what’s the word we’re looking at – revision our clinics. (A-ST1)
A different hospital leader noted that it is easier to realize efficiencies rather than increase revenues.

So hospitals have been very focused on trying to reduce their expenditures, rather than trying to increase their revenues because after 30 years, since [Name-X] came up with BOND, how much more can a hospital really do? (A-TS1)

A CEO of a community hospital used strict performance targets to ensure that staff was working to set standards, commenting, “So, if you can’t hit your number, you’re not working here. And, people get that, they get that.” (C-GH1)

A new approach to service delivery was another tactic toward efficiency for one community hospital.

Well, I think it’s in the context of, up until this point hospitals were able to count on I think it’s 6%. I can’t remember what the percent is. There was increased funding year over year, and that’s the money they got. And, now it is an era of zero based increases and having to look at new and different ways to deliver services. (C-TQ1)

6.2.3.3 Growing Alternative Revenues

Hospitals involved in this study employed numerous strategies to augment MOHLTC funding by growing revenues through new sources. These included commercializing their intellectual expertise, developing new programs, and entering into partnerships. These strategies will be described in this section.

6.2.3.3.1 Commercializing Intellectual Expertise: “Selling Know-How”

Academic hospitals that had areas of clinical specializations/niches, such as cancer or geriatric care (note: these specializations are used as illustrative examples and are not necessarily related to the hospitals represented in the study sample), were able to package and market their
practice protocols, and consult regarding implementation of their protocols to other national and international health care organizations. This was a new development for academic hospitals, which until recently published their work gratis. One leader spoke to commercializing this knowledge.

…the idea that we would actually sell what we have, as opposed to give it away, is still a new concept. I think we wrestle with that in the academic health sciences centres. As teaching and research institutions, we’re used to sharing knowledge and not expecting anything in return, other than accolades, but we really can’t afford to do that anymore. So I think it’s no coincidence that we’re going to see more hospitals that feel that they have the capacity to try to sell their know-how. (A-BC1)

Another respondent in an academic institution noted, “It’s really important now in our research enterprise, the idea of commercialization of intellectual property. It’s far more important in a discussion in our research enterprise than it was five years ago.” (A-UV2)

A business development director in an academic hospital discussed the type of hospital services that will be available for “sale” by their institution.

So, what we’re in the process of launching is a business development group for clinical services. And, what that essentially means is anything medical within this hospital that we can take and sell to other people. Now medical can be things like lab tests, they can be different clinical programs, education, that kind of thing. So, it’s basically anything here at the hospital. When I talk about people that we’re going to sell to outside, those people can be other provinces, they can be other countries, they can be private industry, which I’m sure you want to talk about, and in some cases individuals, and selling services directly to the public. (A-ST3)

While commercializing intellectual expertise was a new and viable way to generate additional funding, all academic leaders that were involved with this opportunity described difficulty in “packaging their products.” Health care protocols have been tacitly stored by health care professionals and customers that were buying the “product” of health care needed to
experience its exactness. One business development leader who was in charge of “selling” intellectual expertise noted,

And products and services were not described, they were in peoples’ heads. So in addition to the protocols and practices not being on paper the actual product was just, well we have a department and they know how to do what they do and people come into that department every day because people know (organization name) is here and they get paid, the government pays us and so people walk in the door. And so these areas are, for most businesses outside of healthcare and particularly outside of Canada, these are essentials. (A-BC3)

A business leader of another hospital described a similar experience when attempting to sell intellectual expertise.

Or, they have protocols in their heads or their minds of how they do work, and they’ll train one another. So, if someone else new comes in, that’s the protocol they follow. It’s never been explicitly documented, but they do have a protocol that they follow. (A-UV3)

6.2.3.3.2 Development of New Programs

Academic and community hospitals in this study sample created new programs in order to generate additional funding. These clinical programs were housed in the hospitals and were geared toward patients for either delisted programs, such as rehabilitation; programs that were not covered under the CHA; or programs that were covered under the CHA but were newly introduced into the hospital because of the program’s potential to bring in additional funding from the MOHLTC. A community hospital leader described a new auto insurance program that was recently opened in the hospital.

…which is the third-party auto insurance assessment. Over the course of several years, we grew that business to the extent that it was actually supporting the centre’s operations, so hospital operations, quite significantly – to the tune of about 6% of ministry funding, so very significant for this organization. That was, as I say, in recognition of the fact that if we wanted to continue to invest in clinical services and the things that government doesn’t fund like research, like teaching activity, and so on, we were going to have to find a way to produce alternate sources of revenue. (C-WX1)
A CEO of an academic hospital discussed three new clinics (names have been deleted to protect the identity of the hospital) that have been created to generate additional funding for the hospital.

We also have ideas that extend way beyond the therapies. Because I think there’s a market for many other things that might have the (hospital name deleted for anonymity) brand and label on it. The other thing I might mention to you is, that there are also many opportunities internally for (hospital name) to market services that are not OHIP-covered. We’ve recently opened up a (first name of clinic deleted to protect anonymity), for example. We are looking at opening up, I know this doesn’t sound right but a (second name of clinic deleted to protect anonymity). It’s a big problem, apparently, in Toronto. There’s a big need in Toronto, believe it or not, for an (third name of clinic deleted to protect anonymity). And these are not OHIP-covered services, and there’s a demand for it. (A-ST1)

One strategy referred to by a business development leader in an academic hospital was to create programs that incentivized patients to make purchases inside the hospital rather than elsewhere. He described this program, “A pharma program at (hospital name deleted to protect anonymity) to drive patients to use the hospital pharmacy, rather than their neighbourhood pharmacy.” (A-MN1)

Another academic hospital leader similarly spoke of recapturing funds from patients and the MOHLTC that would otherwise be spent elsewhere.

And that we actually start new services that we actually have good argument for recapturing funding that’s either going to general hospitals or to out of province, out of country, to repatriate dollars that would allow us to provide services that are not currently in our budget. (A-CD1)

A senior leader of a community hospital was considering offering hip and knee surgery, even though this was not a current or core specialty for the hospital, because these surgeries and the follow-up care following the surgeries were eligible for additional financing under the new MOHLTC funding model.
I think you are aware that the health service funding reform in Ontario has different pots of money on how they fund hospitals now. And hips and knees are quality-based procedures as well so if they are coming back and I would say that part of their continuum of care is supported, but do we need to be the provider that supports it here at the hospital? And that is what we are looking at. (C-BR2)

A CEO of a community hospital described the decision to enter a “new clinical business.”

The quotation below describes a pragmatic and computational approach to the decision-making process regarding creating a new program within the hospital.

And, what we did is when we went into the orthopaedic business, we saw with the wait times that orthopaedics was being over funded and badly managed, and that they also have a long-term probability of staying in hospitals…. So, we picked a specialization that was expensive to get into, so barriers to access, barriers to entry, we were reasonably high, certainly for smaller providers, and had good long-term potential. And, then we put together a business unit, so both the op side and the clinical side, and we went with a price based costing rather than a cost based pricing, and we said, well, we know where the market is. We’d have to be 35% or better below market and margin. What does the service look like? And, we designed to price. (C-CG1)

Another respondent discussed why hospitals maintained privately funded rehabilitation programs even though these programs were not part the hospitals’ core mandate.

But profitability because it was a business, and organizations were getting into it because in these organizations, it wasn’t necessarily their mainstream. Like, at (hospital names deleted to protect anonymity), rehab is not a big focus of Hospital X, rehab is not a big focus of Hospital Y, but both of those organizations have big programs in this area. So if they weren’t making money, they might ask themselves the question, why are we doing this, it doesn’t align with our strategic directions or our priority programs. (A-TS1)

In summary, this section described new programs that hospitals developed in order to generate additional funds. The described new programs were OHIP-covered clinical programs, programs aimed at third-party insurance payers and the general public. The next section describes partnerships that hospitals participated in to offset hospital expenses and bring extra funds into hospitals.
6.2.3.3.3 Partnerships

All community and academic hospitals in this study had partnerships of one kind or another with privately funded companies. More common and established partnerships were with service-providing companies to which hospitals have outsourced services, such as laundry, food, and in some cases, laboratories. As noted earlier, most hospitals have divested themselves of general rehabilitation departments, and have partnered with privately funded rehabilitation companies or created their own privately funded rehabilitation departments. Academic hospitals with clinical specializations/niches more frequently partnered with national and/or international private companies to develop new products, programs, and/or to commercialize their clinical expertise. The following interview data elaborates on these partnerships.

One community hospital leader discussed the impetus and the advantages of partnerships with privately funded companies.

It’s a challenge for hospitals to raise revenue. Most of the revenue has been through partnerships as you mentioned earlier with service providers in terms of food or retail types of operations. I think you’re probably seeing a little bit more of a focus on tapping into alternative sources of revenue because of the challenges with the government and the government funding model and how they’re trying to drive efficiency and reduce funding allocated to health care so that’s probably the theme that’s driving it. (C-HI1)

A different community hospital leader discussed the various types of partnerships and different arrangements that the community hospital engaged in to generate additional revenues for the hospital.

Well, certainly bringing in private practices, providing space, in some cases, in off-hours. Access to clinic space with the family health team is something. Lab services, bringing in some of the lab collection of services that exist out there privately and finding space for them and, in turn, generating revenue for those folks having access to some prime real estate. I’ve mentioned the family health team. Some rehab services. (C-BR1)
Historically, and in the current budget, the MOHLTC has placed a lower expectation on small community hospitals to generate alternative funds in order to subsidize Ministry financing. According to respondents, there were limited opportunities to augment funding by community hospitals and thus MOHLTC funded a larger portion of community hospitals’ budgets. One respondent in an academic hospital elaborated on these circumstances.

The problem is that different hospitals have different abilities to generate revenue, it varies anywhere from, I expect there are hospitals that only about 5% of their revenues come from non-Ministry of Health sources. There are hospitals … well, I’m leaving research out of it because research really distorts it. But leaving research, we’re just talking about operations, there are hospitals that would probably have close to 18% of their revenues come from non-Ministry of Health resources. If I remember correctly, the average is, let’s say, 11% coming from non-Ministry of Health sources. So what are the main usual sources of those revenues? Well, parking, which you can charge a lot for in Toronto, but you can’t charge much for in Cochrane, otherwise people just park on the street. (A-TS1)

One community hospital leader discussed how the hospital was trying to catch up to the opportunities to partner with privately funded companies.

There are a lot of businesses out there that have perfected work processes or care processes so there are lots of opportunities to partner. And at this point, I don’t believe anyone really has an option anymore, that’s just my sense. Is it a good thing? I totally believe it’s a good thing. I have worked in organizations that were starting to partner and now I know a few more partnerships I would like to see us a little further ahead soon too. (C-BRC2)

Every hospital in this sample embraced opportunities afforded through partnerships. Some hospitals entered into such partnerships by creating subsidiaries or trusts that separated the hospital from entrepreneurial endeavours. A business development leader of an academic hospital discussed the role of the hospital’s private department.

We are a subsidiary of the parent company, the hospital. So we are essentially set up to develop commercial ventures to license our intellectual property, to sell our services to
various markets, both in Canada and overseas. And the ultimate objective is being able to generate revenue and so we were specifically set up for that purpose, it wasn’t a by-product of what we were doing. (A-BC4)

A different senior leader within the same hospital described more globally the entrepreneurial activities of the hospital in the last two years.

So I think that we’ve spun off two for-profit companies since I’ve been here, and these companies, by their nature, are seeking strategic business partnerships. So one company is very much focused on commercialising the intellectual property, M&A kind of research, and so we will seek out, depending on the nature of the intellectual property, we’ll seek out commercial partners to then pursue the development of that technology or of that idea. Then we’ve developed, internal to (hospital name deleted to protect identity of organization) an innovation technology and design laboratory. We have a global company that we’ve launched, hired executives from (name deleted to provide anonymity) to run it. (A-BC1)

While a more novel approach within this study sample, some community hospitals also focused on wider-ranging business opportunities. For example, a leader of a community hospital spoke to the development of a privately funded health care company that was created in order to funnel profits back into the publicly funded hospital.

So, again, the hospital doesn’t own it or operate it. But, we created a private company, lent it the money, and then the shares of the private company are owned by a removed trust, and then the trust pays money to a foundation that finds its way back to the hospital. And, part of that was survivability, so that if the hospital gets closed, merged or whatever, this thing is independent. (C-CG1)

6.3 Chapter Summary

This chapter described the recent focus of hospitals to augment revenue sources in response to the changes in hospital funding by the MOHLTC. Respondents in this study noted that revenues raised in addition to MOHLTC funding were used by hospitals to advance patient care programs, maintain and develop new infrastructure, and augment the hospital budget. In
addition to the aforementioned, academic hospitals used the additional funding to fulfill strategic initiatives, such as making global impact, innovation, and reinvesting to further business development. According to respondents, three main strategies were used to augment the revenues provided by the MOHLTC. These included (1) increasing focus on entrepreneurship, (2) using efficiency strategies, such as divesting themselves of revenue-draining programs and using business tactics (e.g., lean methodology and better process flows), and (3) growing alternative revenue through commercializing intellectual expertise, creating new clinical programs, and engaging in partnerships. In this study, academic hospitals with clinical specializations/niches more frequently commercialized their intellectual expertise, hired dedicated personnel for business development, and participated in more national and international partnerships than their community hospital counterparts. The next chapter focuses on the intended and unintended consequences on hospitals as a result of their relationships with privately funded rehabilitation companies/departments.
Chapter 7

Results

Intended and Unintended Consequences on the Hospitals as a Result of their Relationships with the Privately Funded Rehabilitation Departments/Companies

“Absolutely. 100%. This program [alternatively funded hospital department] has influenced a lot of the other processes within the hospital. It’s been used as a flagship”

- Quote from study participant

7.0 Introduction

The purpose of this chapter is to describe the intended and unintended consequences on publicly funded hospitals as a result of their relationships with the privately funded rehabilitation departments/companies. Specifically, this chapter addresses two research questions:

#2.b. What are the intended and unintended consequences of these relationships on the entrepreneurial behaviour of publicly funded hospitals? #2.c. What are, if any, the other intended and unintended consequences of these relationships on publicly funded hospitals?

Intended consequences are defined as those outcomes that hospitals and respondents sought in their relationships with the privately funded rehabilitation companies/departments. Unintended consequences are those outcomes that were not purposefully pursued in the context of these relationships.

This chapter focuses on the entrepreneurial and any “other “consequences experienced by hospitals as a result of their relationships with the rehabilitation departments/companies. Three main themes emerged from the data: (1) the adoption of new organizational practices by the hospital with respect to organizational efficiencies, clinical effectiveness, and increased
entrepreneurism (2) the need for the hospital to manage stakeholder perception, and (3) diminished morale of publicly funded rehabilitation staff in the presence of the privately funded department/company.

The first theme refers to the adoption of new organizational practices related to organizational efficiencies, clinical effectiveness, and increased entrepreneurial pursuits on the part of the hospitals. Specifically, hospital leaders aimed to adopt new efficiency practices (the intended consequence on the hospitals’ entrepreneurial behaviour) through their interactions with privately funded departments/companies. These efficiencies were related to better work practices and hospital processes. In addition, hospitals, as a result of said relationships, benefited from increased effectiveness in patient care. In particular, hospitals augmented clinical knowledge and expertise (intended “other” consequence), and adopted novel clinical practices (unintended “other” consequence) as a result of their relationships with the privately funded rehabilitation departments/companies.

The second theme focuses on the hospital leaders’ attempts to manage the perceptions of multiple hospital stakeholders (an unintended consequence of the hospitals’ entrepreneurial behaviour as a result of relationships with privately funded departments/companies). Specifically, hospital leaders had to mitigate the adverse perception of stakeholders (e.g., the MOHLTC, future donors, and staff) toward relationships between hospitals and privately funded rehabilitation departments/companies. To circumvent negative perceptions by hospital stakeholders, hospital leaders considered the possibility of reputational risk before entering into such relationships, and created geographic and administrative boundaries between hospitals and privately funded departments/companies.
The third theme, and an “other” unintended consequence, was that of diminished morale of the publicly funded rehabilitation staff. According to respondent interviews, publicly funded rehabilitation staff felt devalued in comparison to their privately funded counterparts. Table 7.1 demonstrates the positive and negative “intended” and “unintended” consequences on hospitals as a result of their relationships with the privately funded rehabilitation departments/companies.

**Table 7.1**

| Intended and Unintended Entrepreneurial and “Other” Consequences on Hospitals as a Result of their Relationships with the Privately Funded Rehabilitation Departments/Companies |
|---|---|
| **Intended Consequences** | **Unintended Consequences** |
| **Entrepreneurial behaviour of the hospital** | Adoption of new organizational practices: New efficiency strategies (positive consequence) | Managing stakeholder perception (negative consequence) |
| | Increased entrepreneurial pursuits (positive consequence) | |
| **“Other” consequences** | Adoption of new organizational practices: Increased effectiveness in patient care by augmenting clinical knowledge and expertise (positive consequence) | 1. Adoption of new organizational practices: Increased effectiveness in patient care by adopting novel clinical practices (positive consequence) |
| | 2. Diminished staff morale (negative consequence) | |
7.1 Data Analyses

7.1.1 Themes

The following is a table of themes that originated during data analyses. The themes are ranked in order by those most to the least frequently occurring. The number of respondents that spoke to each theme is also included in Table 7.2.

Table 7.2

List of Themes and Descriptions

<table>
<thead>
<tr>
<th>Themes (by most frequently occurring)</th>
<th>Description</th>
<th>Number of Respondents (n=25)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adoption of new organizational practices</td>
<td>Instances of intended and unintended knowledge transfer as a result of hospitals’ involvement in the relationships with the privately funded departments/companies. Knowledge transfer related to the hospitals adopting efficiencies, using strategies to increase effectiveness in patient care, and increasing entrepreneurial pursuits.</td>
<td>22</td>
</tr>
<tr>
<td>Management of stakeholders’ perceptions</td>
<td>This theme describes how hospital leaders managed the adverse perceptions of hospitals’ stakeholders toward the relationships that hospitals had with privately funded rehabilitation departments/companies.</td>
<td>20</td>
</tr>
<tr>
<td>Diminished morale</td>
<td>Perceptions by the staff of publicly funded rehabilitation departments.</td>
<td>15</td>
</tr>
</tbody>
</table>
7.2 Chapter Findings

This section reports on the intended and unintended consequences on the entrepreneurial orientation of hospitals as a result of their relationships with the privately funded rehabilitation departments/companies. In addition, “other” intended and unintended consequences of these relationships on hospitals are described.

7.2.1 Adoption of New Organizational Practices

Adoption of new organizational practices was the most dominant theme in respondents’ interviews regarding intended and unintended consequence on the entrepreneurial orientation of the hospital, and on any “other” consequence on the hospital as a result of its relationship with the privately funded rehabilitation department/company. The following subsections detail the influences of these relationships on hospitals.

7.2.1.1 Intended Consequence on the Entrepreneurial Behaviour of Hospitals: New Efficiency Practices

The following describes the respondents’ intent to implement new efficiency strategies for hospitals as part of their relationships with the privately funded rehabilitation departments/companies. In this section, respondents described efficiency practices that hospitals were lacking and opportunities for knowledge transfer from privately funded departments/companies to the hospitals, the hospitals’ staff, and its processes and systems.

7.2.1.1.1 Filling a Perceived Gap

This section focuses on the perceived gap, described by study respondents, related to organizational efficiencies. Respondents believed that further organizational efficiencies could be gained through the hospitals’ interactions with the privately funded rehabilitation departments/companies. One senior leader, who has acted as a CEO in multiple hospitals with
privately funded departments, spoke to the entrepreneurial focus of these departments. He believed that hospitals lacked these entrepreneurial practices, and that they would benefit from integrating them.

The (name of the department deleted to protect anonymity) has it right. I think the rest of the health care system is catching up to better management practices and better accountability around pay for performance. So in a sense, eventually it should all even out, but I think the public system is behind at the moment. (A-TS1)

A senior leader of a community hospital that worked with a privately funded rehabilitation and other service providing companies spoke to his belief that hospitals could learn from entrepreneurial orientation of privately funded companies.

You’ll find, I think, that in many respects private industry are more on a cutting edge. They have to be innovative and outward looking, to either distinguish themselves in the marketplace and to stay competitive themselves. Unfortunately, hospitals haven’t necessarily always been that entrepreneurial or that able to provide the time, the funds, for learning and innovation. So you tend to rely on people who already have it. And when you have these partners with that expertise, and if you have that type of relationship, your people learn from these people and from interacting with them. There is sort of, I don’t know the right word, you know, bleeding into the organization. (C-BRC1)

A senior leader of a privately funded rehabilitation company commented on the services that the company provided in order to integrate efficiency strategies that she believed were lacking within hospitals.

If it’s because of looking for cost savings or efficiencies, a lot of times hospitals have people that have worked there for a long time, it’s the status quo usually, so they usually have someone come in and be the bad guy and look at efficiencies and see what changes could be made. Again, it’s trying to understand what the industry benchmarks are and define certain processes and systems to what they’re already going to help them be more efficient. (P-CI1)

A senior leader of an academic hospital spoke to the learning opportunities related to efficiency practices that hospitals could gain from their interactions with privately funded departments.
But, what we do think is appropriate is to capitalize on the culture of entrepreneurship in the private sector to actually become more efficient ourselves, to watch them, but also to contract to them. (A-CD1)

7.2.1.2 Intentionally Seeking: Transfer of Efficiency Practices into the Hospital

The following section focuses on how respondents actively sought to transfer practices related to efficiency from the privately funded departments/companies into the hospital setting. For example, a business leader of an academic hospital spoke to the organizational knowledge transferred from the privately funded department into the hospital.

Learnings, quite a few; one of the very classic examples is, I have said the organization needs to learn from (name of department deleted to protect anonymity), in terms of how we need to organize if we want to be truly successful which means a clear mandate, resources, ability to give flexibility in terms of policies, incentives and those kinds of things. So certainly, that kind of learning is there. (A-CD2)

A business leader from yet another academic hospital described the impact that their privately funded department made on the hospital. He referred to the changes that the hospital was making in order to enable the department to be able to market the hospitals’ clinical protocols to other national and international health care organizations.

We will, no doubt, have an impact on the parent company and the way it does business and the way it operates. It is not our mandate, but I think in order for us to be successful selling we have to have changes internally. (A-BC4)

7.2.1.3 Intentionally Seeking: Transfer of Efficiency Practices to the Staff

In this section, hospital leaders described the intended changes on the entrepreneurial behaviour of the staff as a result of the relationships with the privately funded rehabilitation departments/companies. A senior leader of an academic hospital spoke to the desired behavioural changes.

But the ultimate to me is that it’s an opportunity to enhance the performance of your staff. Because they have a much more rigorous measure of your output in your
performance. So, you have that opportunity to lift up the rest of the organization from a professional point of view. (A-CD1)

A senior leader of a community hospital described the transfer of learning between the hospital staff and the staff of the privately funded rehabilitation company.

So we sought out our partner and we have had some staff who have gone through the same training that their staff go through, their leaders go through I should say. Their team leaders, group leaders, because we use the same language now as industry does in our setting and they help support training some of our staff. And in turn, we have had their staff come through and spend time here and assist us with some of our opportunities as well. So I think there is value in some of these even more informal partnerships around learning from each other. (C-BRC2)

Another leader of a community hospital referred to the positive cultural change in the hospital as a result of partnering with privately funded companies.

I think it’s going to be necessary, and I think bringing in more private changes the dynamics, the culture, the work ethic even, the focus on outcomes. And it certainly changes the dynamics of how you do business. And I think if we’re going to make some meaningful transformative change in health care, we have to involve some private folks. (C-WX1)

7.2.1.4 Intentionally Seeking: Transfer of Efficiency Practices into Hospitals’ Processes and Systems

Hospital leaders also spoke of the entrepreneurial influence by the privately funded rehabilitation departments/companies on the hospitals’ processes and systems. A senior leader of a hospital’s privately funded department described the beneficial effect of the department on hospitals’ administrative processes.

One example was managing bookings, the administrative processes. A typical public program has wait-times, they always talk about wait-times, but we’ve been able to say, because our contract requires us to keep very tight wait-times, of like two to four weeks. Then we say, well, how do we run the administration? A lot of these are administrative, how they identify bookings, the follow-up to sure people, cutting down on no-show rates, cancellations, how we book in people’s calendars so they’re all their time is accounted for. Some of those really tight measures that would make a difference on the bottom-line when we rolled it out to another program. I took over another program, this was a couple
of years ago, it had a really, like over a year wait-time and we rolled in some of the processes. We were able to get it down to like four to six weeks. (A-CD3)

A leader of another privately funded department noted that while the senior leaders appreciated and implemented his suggestions, these were not always welcomed by hospital staff.

In particular, this leader described his input into the financial practices of the hospital.

But there will be an impact and I’m not setting out to do that, I don’t have an operational role and I don’t have an administrative role in the parent company and I don’t want it. But as I discover these things and then I go, for instance, and talk to finance, yeah they roll their eyes and say, people don’t do this and they don’t tell us this. (A-BC4)

A senior leader of a rehabilitation company that was hired by hospital leaders to assist with business development described the role of her company within the hospital. This leader conveyed the reasons why senior hospital leaders hired the rehabilitation company.

They’re not in the business of making money. Even with their finance departments, they often lose tons of dollars with collections because they don’t know how to do that or it gets lost in the shuffle. So, a big part of the revenue-generating piece is because they need someone’s business expertise to help them start up that business and run it. They don’t often have the proper billing and scheduling systems. (P-CI1)

7.2.1.2 “Other” Intended Consequence: Increased Effectiveness in Clinical Care through the Transfer of Clinical Knowledge and Expertise into the Hospital Setting

Hospital leaders spoke of leveraging the hospitals’ relationships with the privately funded departments/companies in order to augment current clinical knowledge and expertise. The leaders discussed how these relationships allowed hospitals to benefit by exploiting the knowledge and expertise developed by the privately funded rehabilitation departments/companies. For example, a leader of a community hospital discussed how she sourced the expertise of a rehabilitation company in order to advance care for hospital patients. The leader noted that when the hospital was found to be lacking expertise related to a new
strategic patient care initiative, the hospital sought and found the required expertise in a privately funded rehabilitation company.

I guess the last point that I raised here was really the ability to leverage the knowledge and expertise of both partners…. And at the same time, we recognized that that was an aspect of clinical programming that we had no experience with, no expertise in, and that was highly regulated by government, so a totally new ball game. We looked at that and we said in order to manage that operation efficiently, we need long-term care expertise. So, we went out through an RFP [Request for Proposal] process and found that expertise. As the years have evolved, going back to the point of really an effective partnership will leverage the knowledge and experience of both, we sought out a partner because we needed to bring on that expertise to accomplish a strategic goal. (C-WX1)

Another leader of a privately funded department described how the hospital applied the expertise developed by its privately funded department in order to plan new hospital programs.

As the hospital wanted to embark on the same thing, they were looking at the ambulatory program which encompasses a whole bunch of different clinics. How would they go on to do a little bit of a patient experience project? Essentially what happened is they just leveraged a whole lot of our insights. They did some further data collection for their purposes and to get people involved, so they’re kind of hearing it from the horse’s mouth, but a lot of the insights and some of the recommendations were lifted from the work that we were doing here. (A-ST2)

In addition to directly exploiting knowledge developed by rehabilitation departments/companies for the benefit of the hospital, there appeared to be cross-departmental knowledge exchange where both parties, the hospital program and the privately funded department, benefited. In the following quote, a leader of a privately funded department discussed how rehabilitation teams in publicly and privately funded streams met to exchange information and, when clinically appropriate, made cross-department referrals. According to this leader, the practice of sharing knowledge increased effectiveness in clinical care.

Exactly, there's a very close relationship, we do rounds, we're invited to their rounds, they're invited to ours. When we have interesting cases or things we share it with them, both within the hospital and within the broad clinic network and similar with them. There's a very close relationship in terms of learning. Not only referral of patients where
appropriate between them when it makes sense form a clinical point of view, but also from a learning perspective. (A-MN1)

7.2.1.3 Unintended Consequence on the Entrepreneurial Behaviour of Hospitals: Increased Entrepreneurial Pursuits

Interview data indicated that hospitals, as a result of their relationships with the privately funded rehabilitation departments/companies, were able to engage in additional entrepreneurial partnerships. According to study respondents, hospitals leveraged their relationships with the rehabilitation departments/companies to expand their entrepreneurial focus beyond just the relationships with said departments. For example, one senior leader of an academic hospital noted that the hospital-owned, privately funded department afforded the hospital opportunities and infrastructure to obtain other business opportunities.

It was more that the (name of department removed to protect anonymity) was the impetus to launch this, and once we had the infrastructure and the program running smoothly opening it up to other referrers whether it be motor-vehicle or long-term disability and so on. (A-MN1)

Another leader of an academic hospital with a privately funded department further reiterated the point of using the department to launch additional profit-generating business.

There were talks of selling us off and that kind of thing, and not really realising the longer-term potential, initially. It took many years for them to realise what our potential is in not only working with third-party pairs such as (company name deleted to protect anonymity), but also branching outside of that, so some of the international work that we’re doing. So now we’re in a place, we’re big enough, we’re in a place now where I think we make a big enough dent into their, with our contribution back to them, that they have recognised us as a strong business entity. (A-UV1)

A leader of a community hospital described how the relationship with a privately funded rehabilitation company grew into additional business opportunities.

What’s also interesting about that – and again, this is strictly confidential, of course – what has resulted from that is an interest on the part of the partner to pursue other business opportunities with us. (C-VW1)
7.2.1.4 “Other” Unintended Consequence: Increased Effectiveness in Patient Care – Adoption of Novel Clinical Practices

Some patient care initiatives developed by hospitals were an unintended positive consequence of the relationships. That is, the hospitals eventually implemented novel clinical initiatives that were first developed by the privately funded rehabilitation departments/companies. The hospitals did not originally seek to implement these initiatives, but saw value in the practices developed by the privately funded departments/companies. This section describes the transfer of knowledge related to increased effectiveness in patient care within the hospital as a consequence of the hospitals’ interactions with the private departments/companies.

Respondents described knowledge transfer in two specific areas: clinical practice and increased cultural sensitivity. For example, a senior leader of a privately funded department discussed how the department developed new clinical practices for its patients which were, after some time, applied to hospital patients. According to the respondent, the hospital would not have been able to initiate these strategies because of the costs and the experimentation involved.

Yeah, certainly in the pain management area, what you were talking about, had to do with pain medication and being able to discharge people, keeping people in the hospital at a high cost, discharging them home with their medications in a pump that was really important. There really wasn’t the opportunity to try that in the non-funded side because of the costs involved, and they had to demonstrate that it could actually work. I would think through our surgical program, we’ve demonstrated certain efficiencies that were not there to begin with. In how Operating Rooms should be running, the two-room model where the surgeon moves from one room to the next very quickly, and staff just had to be brought on board with that, to work efficiently so that that would work. (A-UV1)

With respect to cultural sensitivity, a leader of another academic hospital that commercialized their intellectual expertise through their privately funded department described how cultural learning, made possible as a result of working in different countries, created a more culturally sensitive environment for publicly funded hospital patients.
But I can give you an example in a slightly different context because this development is very big. I can give you the other examples, where we now are working in I think 14 countries, in South America, Asia and Europe, to help build capacity. But by living there and going there we learn about those cultures. And frequently these are the cultures where they’re either war torn or have significant upheavals going on and they all have significant populations in Toronto. So we bring back the knowledge. When we went to Sri Lanka, when they had the tsunami, we were there for two or three years, there’s a huge Sri Lanka population here with all kinds of mental health issues. We bring back that expertise. (A-CD2)

The beneficial unintended consequence of working in far removed countries is similarly described by another leader of an academic hospital. This leader spoke to how clinicians established better professional relationships when they travelled to and worked in other countries as members of the privately funded department. As a result, publicly funded hospital patients received the benefit of the staff members’ professional collaboration and cultural sensitivity.

And in those environments, it’s informal and they actually work better when they come back home. And so we’re a large organization and to bring teams together and then to isolate them for two weeks in a different part of the world, they just have a totally different appreciation for each other’s profession, there’s a new respect there. So I think just bringing that back home has really helped our teams. And we’ve heard that from them when we send out surveys. That’s the type of feedback we receive. Also, we’ve learned a lot about the Arabic culture and the Middle Eastern culture and especially patients coming here, what are we not doing well for Ontario patients? (A-UV3)

7.2.1.4.1 “Other” Unintended Consequence: Variation in the Treatment of Publicly and Privately Funded Patients

While the study data suggested that the presence of privately funded departments/companies appeared to positively influence the treatment of publicly funded patients, participants also offered cause to consider that privately funded patients were receiving more privileged status within the hospitals. For example, one hospital leader described the possible bias that hospitals had while servicing patients who generated additional revenues for the hospital.

I’m sure it happens in organizations, knowingly or unknowingly. But I don’t remember ever discussing, at the management team of (hospital name deleted to protect anonymity)
or (hospital name deleted to protect anonymity), let’s make sure we give (funder name deleted to protect anonymity) priority. But it may have just been how we resourced things, how easy … and because they’re trying to generate a profit, how much attention they place on improving processes and systems to make sure that the people who come through, get good access to service. (A-TS1)

Another leader of an academic hospital described how patients that came through the alternatively funded department brought to light imperfections found in the publicly funded system. According to this respondent, the correction of these shortcomings ultimately benefited publicly funded patients.

And it really gets highlighted with international patients because not only are they being exposed to a foreign system; they’re being exposed to a foreign environment so they have a lot more questions. And when things go wrong or they’re lost or whatever, you hear about it quicker so there are a lot of things we found out just from the international population that wow, you know what, how do Ontario patients even navigate this place it’s so complicated? And so it just exposes the imperfections in our system, so it allows you to say okay, you know we say we’re patient-centred, we say we’re this wonderful place but really, we’re not doing a good job and this just exposes it. Because these people are paying a lot of money so it definitely gets to Patient Relations quicker, we hear about it, et cetera. So you really get to uncover a lot of things that you may not have been able to uncover if it was the Ontario population so I think that’s only going to improve patient care at the end of the day. (A-UV3)

In the face of the described disparities, one leader of a privately funded rehabilitation company illustrated the benefit of having patients whose treatments were funded by alternate sources. She cited an example of how her company assisted hospitals in reviewing rehabilitation waitlists to remove privately funded patients from publicly funded waitlists. Through this process the company taught hospitals how to create two different waitlists for publicly and privately funded patients, the benefit being that publicly funded patients received quicker access to services.

These hospitals, remember, we come in and they’ve got six-month, nine-month waiting lists, so what we do is we come in and we say there’s a bunch of patients that don’t need to be on this wait list because there’s Mrs. Jones that has a knee replacement and has no extended health benefits, it wasn’t a motor vehicle accident, that kind of stuff, whereas Ms. Smith had a motor vehicle accident, so she’s ahead of Mrs. Jones on the wait list.
When we put in the private clinics, this is what we see: there’s a good portion, at least 25%, of the waiting list that gets moved over to the private side automatically because they are WSIB patients, a motor vehicle patient, or they have extended health. No one’s forced. If they have extended health no one’s forcing this, but most of the time they do. Then what happens is that you see that wait list turn into … in all the places where we have private clinics, we don’t really have wait lists on the globally funded side anymore. That six months is now down to a week or two weeks or whatever. Now, going into the private side, usually by a couple of day it may be faster, only because there’s less volume going through there, so you may get that. That’s why I was saying that piece where I said you’ve got a group of patients that you need to service. People come in through outpatient departments, there’s a cohort of patients. Each patient should be seen with high-quality care with good access. How it’s paid for is immaterial to the patient and to the community. If the hospital from the administrative, not even from the therapist … it’s the administrative responsibility to pay for that patient. No one gets better service because they’re on the private side. The service is the same. You get a knee replacement on the globally funded side versus the private side, it’s the same service. Obviously, there’s different programming for motor vehicle accidents, a little bit for WSIB as well, so they’re going to get a different service than the B patient but that’s only because it’s necessary for treatment. No one really gets in faster, per se. That’s the piece that people need to understand is that you have a cohort of patients and how they’re paid for is immaterial. You take funding from all different sources and then everybody gets high-quality, fast, and equal service. (P-CI1)

7.2.2 “Other” Unintended Consequence: Management of Stakeholder’s Negative Perceptions

This section describes how hospitals’ leaders managed the perceptions of hospital stakeholders (MOHLTC, potential donors, and hospital staff) toward the hospitals’ relationships with privately funded rehabilitation departments/companies. According to the respondents, stakeholders had negative perceptions toward these relationships because of the philosophical differences that stemmed from mixing publicly and privately funded health care in a hospital setting. Negative perceptions by the MOHLTC and potential donors could have, according to study participants, funding implications for the hospitals, whereas negative perceptions by staff perpetuated behaviours that limited referral patterns to the privately funded departments/companies.
7.2.2.1 Unintended “Other” Consequence: Managing the Perceptions of the MOHLTC

Senior hospital leaders noted the caution with which they approached their hospitals’ relationships with privately funded departments/companies. One leader in an academic hospital with a privately funded department explained the attentiveness that was required to manage the perceptions of the hospital’s main stakeholder and funder, the MOHLTC.

I think the issue that’s most important is to figure out how to foster it, so to be permissive enough that people can follow leads, think through how they’re going to create revenues without blowing the place up, because let’s face it, we get $1 billion from the government every year….. It’s important to look for an incremental $100 million in entrepreneurial revenues, but if you piss off, pardon me, the primary customer, they’re going to make you have an overall loss, so that’s important….. so, they should all run off the CEOs desk until they’re established. Yeah, they really need to be because they’re a big risk. (A-UV2)

A senior leader of a different hospital with a rehabilitation department likewise commented on the potential for risk when engaging in revenue generation activities via the privately funded department.

The initial conflict immediately was wait a minute, if we start developing revenues by providing any of these services within the province of Ontario, would that be deemed as a conflict with our primary mandate whereby we are already funded to do some of those things. You have to get past that hurdle and that’s not an easy hurdle because there are frequently organizations that get on the wrong side of the law or bad publicity in the media and the governments typically come down very hard on them. (A-CD2)

A business leader of an academic hospital summarized the deliberation with which potential business opportunities with the privately funded department were evaluated to ensure there was no harm to the hospital’s reputation.

So, there were four kind of main criteria, being liability for the hospital, affecting the tax status of the hospital, contribution back to the hospital, minimizing any taxes that we would have to pay as an entity, and the last one being adherence to the Health Act. (A-ST3)
7.2.2.2 Unintended “Other” Consequence: Managing the Perceptions of the General Public and Potential Donors

The perceptions of the general public and particularly potential donors, regarding the relationships between hospitals and the privately funded rehabilitation departments/companies were of importance to study respondents. According to respondents, hospitals relied on philanthropic donations and any negative perception by potential donors regarding the entrepreneurial orientation of hospitals with a privately funded health care providing partner could negatively influence philanthropy. A leader of a privately funded hospital department discussed the significance of donors to the hospital and noted that he had to be acclimatized to the importance of donors since joining the hospital.

One of the things they really focus on is donors. It’s kind of odd. I never even thought of it before I joined the hospital. It wasn’t even in my line of sight, but when you talk about somebody on the outside, their immediate concern is could this person be a donor? (A-MN2)

A leader of a community hospital described the sensitivity that potential donors may have to the hospital’s involvement with privately funded organizations. He described his concerns regarding partnering with a privately funded rehabilitation company and the negative effect this may have on philanthropy.

And to bring in private for profit organizations could have a very, very serious impact on how the hospital is perceived by the community, in terms of funding, in terms of how the foundation is subsequently supported. And yet if we’re having these types of relationships with for profit, it’s going to take away the kind of charitable aura that exists. (C-BRC1)

7.2.2.3 Unintended “Other” Consequence: Managing the Perceptions of Hospital Staff

The negative perception of staff, particularly physicians, toward the privately funded departments/companies could undermine the hospitals’ revenues. For example, one hospital
leader described how physicians would not make referrals to the privately funded department within the hospital.

So, our own culture was not really that conducive to making it a hugely successful business very quickly, so we had to do a lot of work in the early years with the medical staff who we relied on referrals from and clinical staff, the majority of whom, both physicians and staff, felt that outpatient rehab services should be funded by the government. (C-WX1)

Another leader of a community hospital described how the hospital’s physicians challenged the hospital’s efforts to work with a privately funded rehabilitation company by refusing to refer patients to the clinic, despite the physical proximity and the convenience of the clinic for the patients.

We went to them in terms of doing some of the service of referring some of our patients to them, but there’s issues with respect to control in terms of how many patients or if the doctors even refer patients to rehab clinics. Although their model is more cost effective because of the structure of their environment and the quality of their service is good, the challenge then is to get patients to go there and that isn’t something the hospital directs, it’s what the physician directs. (C-HI1)

In another hospital it was the hospital administration that was limiting physicians’ opportunities to work within the privately funded department. Despite the fact that the department’s profits benefited the hospital, hospital leaders restricted the physicians’ capacity to work within the department. The leader of this department described the situation.

I think that part is the issue around physicians doing non-OHIP, non-publicly funded work themselves, how people view that within this hospital environment. That issue hasn’t been fully resolved. I still get conflicting messages around… I say, hey guys, I’ve got a ton of work I can bring in, and I can grow this. They’re like, no, your docs are working too much time here, they’re cherry picking, or, they need to contribute to other parts of the hospital as well. I guess its competing resources. It’s still seen as, physicians in general, a competing resource for the core functions of the hospital, it’s a conflict. (A-CD3)
A leader of another privately funded hospital department described the barriers that he experienced when hospital academics and physicians constrained the opportunities to generate revenues for the hospital.

And therefore the experts are right here and we have to rely on them. And if they give us trouble for whatever reason, if they say, well we don’t think we should sell us, or, we don’t have time to do this, or whatever and you don’t have that high level commitment everything else falls. I think that feeds into everything else because with communication you have to be able to say, here we are, here is what we are doing and we are going to be coming to you, and so forth. (A-BC4)

7.2.2.4 Managing Stakeholders Perceptions: Philosophical and Geographic Separation between Hospitals and the Privately Funded Departments/Companies

Respondents reported the need to manage the possibly adverse perceptions of stakeholders toward the hospitals’ relationships with privately funded department/companies. Specifically, hospital leaders described two ways of separating the privately funded department from the publicly funded hospital: (1) administratively, and (2) geographically. A leader of a hospital’s privately funded department spoke to the importance of philosophically separating the department from the main hospital in order to ensure that there was no negative fall-out from the hospital’s entrepreneurial activities on donors’ philanthropy.

A very strong donor community, a very strong sense of who we are so I see that here. Because when I came in that is the first thing you notice, it’s an older place but it is fantastic programming, it’s a sticky client base, if you will, so you have got to maintain that but you can still be entrepreneurial. In other words, entrepreneurial in a large organization doesn’t mean the entire organization collectively is taking the risk. (A-BC4)

A leader of another hospital described the reasoning behind geographically separating the privately funded department from the hospital, which was to ensure that there were no negative perceptions from families that will be paying out of pocket for private rehabilitation services.

But we also felt that the separate identity would be better served by being physically separate from (hospital name deleted to maintain anonymity). Because then, if you have
it adjacent to one department, well how come we’re paying but those guys are not paying. It could be a very confusing model for families. (A-ST1)

A leader of a community hospital who noted that the employees were impeding referrals into the privately funded department stated that the privately funded department has become more productive since being geographically separated from the main hospital. In the quote below, he noted the benefit to the physical separation between the hospital and the privately funded department.

They are physically located separately. Many of the roistered clinicians, some do clinical work at the centre, many of them do not do clinical work at the centre. It’s more successful. (C-WV1)

7.2.3 Unintended “Other” Consequence: Diminished Staff Morale

An unintended consequence of the relationships between hospitals and the privately funded rehabilitation departments/companies was the impact on publicly funded rehabilitation staff. Specifically, the existence of privately funded rehabilitation departments/companies within publicly funded hospitals negatively influenced the morale of the staff funded by the publicly funded stream. A senior leader of a privately funded company that worked with multiple publicly funded hospitals discussed how publicly funded rehabilitation staff reacted when the privately funded company was situated in the hospital.

Usually, staff are afraid. They think that the result of this is that there’s going to be jobs cut and things like that. Usually, it takes a while for us to help them to understand that if the hospital has taken an interest in doing this it’s a good thing as opposed to the hospital just cutting services totally because some have. There’s always a little bit of worry, and people don’t like change. You’re going to change my practice – what does that mean for me? (P-CI1)

A senior leader of a privately funded rehabilitation department similarly observed the division between the publicly funded and alternatively funded rehabilitation therapists.
They definitely notice us, but I wonder sometimes whether they might notice us in maybe a negative light, too because here we are, we could be seen as being a bit of a favoured program because we generate revenue. Then also, sometimes the generating revenue or profit perspective in health care is seen by people negatively as well. When we do go to different areas to try to link in, get services, get things going, we have a very business mind, and we want things done efficiently and effectively, and I think that ruffles some feathers at times, for sure. (A-UV1)

A hospital leader who has overseen multiple hospitals with privately funded departments explained the possible reason why publicly funded staff may have felt resentful of their alternatively funded counterparts. He described the conflict at the senior management level related to disputes between the senior leaders of publicly funded and privately funded programs. The revenues generated from privately funded rehabilitation were seen as a desirable surplus and leaders competed to redirect funding into their own hospital programs.

I know the way we organized when I was there, is particularly to give (name deleted to protect anonymity) incentive to grow the business, is any increased profits, were kept within the (program of the hospital), they didn’t go to some central pot within (the hospital). Some of the other VPs thought that wasn’t particularly fair because, getting back to your point, because I had organized the place into (main program names). So Name-X at the (program name), or Name-X at (program name), might say well, I don’t have a (revenue generating department name) where I can make profit, so how is that fair when I go to balance my budget. So there was that kind of relationship issue, but also there was the rehab staff. (A-TS1)

This same leader described the conflict that transpired at the clinical staff level. He stated that the publicly funded staff, while providing as similar rehabilitation service, were not seeing the monetary reinvestment into their publicly funded departments, a regular occurrence in the hospitals’ privately funded rehabilitation department.

I would say it could be viewed the same way, that the therapy staff, the ones who are maybe doing outpatient therapy associated with trying to move people out of the hospital, might feel they’re not getting the same priority as the people who are in this revenue generator because the revenue generator can reinvest the money back into its own program. (A-TS1)
Despite the noted challenges, one senior leader described how the department offered employment to publicly funded rehabilitation staff when the hospital’s outpatient rehabilitation department permanently closed.

One of the big things and one of the really exciting things about that enterprise was that, in an era when we had, when we were shrinking and shrinking our Allied Health, for example, physio, OT and even psychology was a bad one, in the general hospitals. It’s just wiped out, the whole department was just closed down in general hospitals. So, one of the things that was really nice about (clinic name deleted to protect anonymity) was that it opened up education opportunities for Allied Health professionals. Then it becomes a really attractive place to train. You have a pool of experts in these specific areas that can build the capacity in the system. (CD1)

7.3 Chapter Summary

This chapter described the intended and unintended consequences on the entrepreneurial behaviour of hospitals as a result of their relationships with privately funded rehabilitation departments/companies. In addition, this chapter detailed “other” possible consequences on hospitals as a result of these relationships. Adoption of new organizational practices by the hospital was the dominant theme when analysing interview data with respect to intended and unintended consequences on hospitals as a result of these relationships. One intended positive consequence on entrepreneurial behaviour was the adoption, on the part of hospitals, of new efficiency strategies aimed at improving organizational processes and systems. In relation to “other” intended positive consequences, hospital leaders endeavoured to augment the clinical knowledge and expertise found in hospitals with that of their privately funded partners. In addition, transfer of knowledge with respect to novel clinical practices was an unintended positive consequence. The analysis suggests that privately funded departments/companies were able to develop novel clinical practices more readily than the hospitals with which they worked, and their adoption occurred after the practices had been tested and established by the privately
funded departments/companies. In addition, some hospitals, through their privately funded departments, provided services in far-removed countries; when staff returned they brought with them new knowledge that was shared and used for the benefit of publicly funded hospitals and patients.

With respect to unintended consequences, respondents reported one unintended negative consequence on the entrepreneurial orientation of hospitals as a result of their relationships with the privately funded rehabilitation departments/companies. Specifically, respondents noted that they needed to guard against and manage the negative perceptions of stakeholders (MOHLTC, potential donors, and hospital staff) regarding the described relationships. Negative perceptions by the MOHLTC and potential donors could potentially have adverse funding implications for the hospital. Negative perceptions by staff perpetuated behaviours that sabotaged referral patterns and revenue-generating abilities of the privately funded departments/companies. Hospital leaders described the strategies with which they managed against negative perceptions to ensure that the relationships between hospitals and privately funded departments/companies were successful. The opportunity to increase hospitals’ entrepreneurial pursuits was an unintended positive consequence as a result of hospitals’ relationships with the privately funded rehabilitation companies/departments. Hospitals, through their experiences with the privately funded companies/departments, were able to leverage the newly created products/programs into new business opportunities.

An unintended “other” negative consequence involved diminished morale of the publicly funded rehabilitation staff; a possible reason, as relayed by study participants, was the organizational reward systems connected to recognition and perceived favouritism of privately funded staff.
Chapter 8  
Discussion and Conclusion

8.0 Introduction

This study investigated relationships between publicly funded Ontario hospitals and privately funded rehabilitation departments and companies. These relationships served as a vehicle from which to observe and document the evolution of hospital entrepreneurship in Ontario. Seven research questions served to describe and characterize the structure of these relationships, define the perceived relationship effectiveness and the factors that facilitated and/or hindered such relationships, and understand the unintended and intended consequences overall and on the entrepreneurial orientation of hospitals as a result of these relationships.

Data from this study indicated that publicly funded hospitals and their leaders have strategically adapted to perceived resource scarcity by becoming more “business”-like in their behaviours. The study also demonstrated the continuous evolution of entrepreneurial behaviours within publicly funded hospitals. While hospitals have demonstrated entrepreneurial activity since the introduction of BOND, this study exposed more recent entrepreneurial activity, including the commercializing of intellectual expertise by selling clinical protocols to other national and international health care organizations, sending clinical teams to international countries to participate in paid teaching and treatment of patients, participating in international health care tourism by treating international privately paying patients, and hiring business development directors. The entrepreneurial response by hospitals was subjected to multiple forces exerted on hospitals by internal (staff/boards of directors) and external (MOHLTC, public,
donors) stakeholders to conform to normative patterns of behaviour consistent with NFPs in Canada.

The main findings of this study were:

1. In light of perceived funding gaps, hospital leaders were increasing the hospitals’ entrepreneurial orientation by using strategies to more efficiently utilize the funds provided by the MOHLTC as well as to generate revenues in addition to MOHLTC funding. Hospital niche (generalist vs. specialist) influenced the strategies that hospitals had at their disposal to generate additional revenues.

2. One strategy to procure additional funding involved creating privately funded rehabilitation departments or partnering with privately funded rehabilitation companies. The structure of these relationships varied with respect to organizational and geographic boundaries.

3. Perceived relationship effectiveness between hospitals and the privately funded rehabilitation departments/companies hinged on the achievement of mutually beneficial goals. From the perspective of hospital leaders, relationship effectiveness was realized if relationships with privately funded departments/companies offered hospitals the opportunity to create profit while not compromising the hospitals’ reputations.

4. Relationship effectiveness was facilitated or hindered by a number of factors. Three subsets of factors were most frequently cited and ranked as most important to relationship effectiveness: (1) factors that were internal to the hospital (organizational culture and business development infrastructure), (2) factors that acted as a link between the two relationship partners (alignment and resource exchange), and (3) factors that were related
to the attainment of the goals of the relationship (clear goals and agreements met). While these relationships for outpatient rehabilitation services were acceptable under the CHA, the presence of two parallel funding streams for health care services was out of the general norm for Ontario hospitals. Consequently, hospitals and leaders within them managed tensions associated with the negative perceptions of hospital stakeholders toward such relationships.

This chapter is structured in the following way: first, the main findings of this study are discussed in relation to the relevant organization science literature; second, study findings will be discussed in connection to theoretical and practical implications; lastly, study limitations and future directions for research will be proposed.

8.1 Reflection on the Literature

8.1.1 Entrepreneurial Orientation of Hospitals

8.1.1.1 Strategic Responses to Funding Changes

Although entrepreneurial orientation has been noted as an important factor in organizational survival, entrepreneurial orientation has only been recently researched in NFP organizations (Coombes et al., 2011; Kearney et al., 2009; Klein et al., 2010; Morris et al., 2007; Morris & Joyce, 1998). Furthermore, entrepreneurial orientation in NFPs can be complicated by their focus on social and political objectives (Kearney et al., 2009). This study demonstrated the recent strategic focus on entrepreneurial activities in Ontario hospitals, which has been manifested in an increased emphasis on efficiencies and revenue generation, and has stemmed from the perceived gap between the funds provided by the MOHLTC and the resources necessary to support the strategic goals of hospitals.
In this study, hospitals demonstrated strategic entrepreneurial actions, such as commercializing clinical expertise, hiring business development directors, providing treatment to international patients, and entering into partnerships with privately funded companies to offset funding constraints. According to the data in this study, the presence of clinical specialization facilitated hospitals’ opportunities to use some of these strategies related to revenue generation; however, the absence of clinical specialization in some hospitals limited these opportunities.

Applying the Miles and Snow (1978) framework to the current study, hospitals used a variety of “prospector” strategies by engaging in local, national, and international partnerships for non-health care and health care services. Hospitals also invested in business development roles either by hiring business development professionals (academic hospitals) or expanding the portfolios of existing senior leaders (community hospitals). Business development leaders assisted hospitals to create environments that were conducive for business development and also were instrumental in commercializing the intellectual expertise of hospitals into tangible products. Hospitals also demonstrated “defender” type strategies by focusing on better use of current resources through efficiencies. Specifically, hospital leaders used “lean” strategies and better work flows, and adopted organizational practices used by the privately funded health care companies with which hospitals partnered. Hospital leaders also implemented “analyzer” types of strategies. Particularly, hospital leaders evaluated the “business” of the hospital and accordingly further invested in or created programs that would garner the most government funding. At the same time, these hospitals divested themselves of programs that did not support the “business” strategy, either because clinical programs did not support themselves financially given the funding model or, as in the case of outpatient rehabilitation, they could be offered at a profit through privately funded means. It is interesting to note that hospitals in this study sample
did not display any “reactor” characteristics likely because – as a consequence of the multiple funding changes over the last twenty years (Flood et al., 2006; Ministry of Health and Long Term Care, 2014; Ontario Hospital Association, 2010) – hospitals are continually looking for strategic opportunities to augment funding and to better use the funding provided by the MOHLTC.

8.1.1.2 The Effect of Funding on Service Delivery

Various funding models predispose hospitals and leaders toward strategies intended to moderate the effects of funding changes (Deber et al., 2008; Sutherland, 2011). Deber, Hollander, and Jacobs (2008) provided a model that linked payment approaches to incentives, which in turn influenced service delivery in the health care sector. A change in government philosophy, and subsequent policy, can change the levers that drive the quantity and quality of health care provided by organizations or single health care providers. This examination of hospital behaviour as a result of funding changes is particularly relevant in the context of the recent shift from global funding to a more diverse funding method: a combination of global, HBAM, and QBP. HBAM and QBP are comparable to the Activity-Based Funding model (ABF) described earlier. Critics of the model warn that ABF brings uncertainty to hospitals with respect to their yearly expected revenues and may incent behaviours that benefit the financial health of the hospital and disadvantage patient care. For example, ABF may provide incentives to hospitals to increase the volume of patient groups that are most “profitable” to the hospital and reduce equitable access to care for all patients. This may result in hospitals focusing only on procedures and patient groups that are better funded, discharging sick patients into the community before they are ready, and increasing the overall costs to the system without a funding cap afforded by global budgets (Palmer et al., 2013; Sutherland, 2011; Sutherland,
While these specific effects were not observed in this study, the impact of newly implemented ABF was described by some participants in the study. For example, leaders described a deliberate review of core and non-core programs that the hospitals would continue to offer, stop offering, or get into the “business” of offering through partnerships or by commercializing their intellectual expertise. According to participants’ responses, government funding, or lack of it, was driving the change in program offerings. Participants discussed divesting and downsizing programs, and using statistics/margins to understand what programs would provide hospitals a budget surplus when considering the clinical programs that hospitals would offer. Conversely, participants discussed the creation of new programs for the sole purpose of obtaining additional government funding from procedures financed through QBP.

8.1.1.3 Organizational Characteristics and Entrepreneurial Behaviour

In this study, the extent of entrepreneurial behaviour and the strategies available to hospitals were influenced by the hospitals’ clinical specializations/niches (generalist vs. specialist). First, specialist hospitals displayed more entrepreneurial behaviour because they had specific content/process knowledge that could be commercialized. The content/process knowledge related to specific populations and/or diseases allowed specialist hospitals to capitalize on their “brand” and to commercialize their intellectual expertise to national and international markets. Second, academic hospitals, through their niche specializations, attracted privately paying customers (WSIB, national and international health care organizations, and international patients) who requested the development and/or provision of specialized services.
Third, academic hospitals, as a result of business development opportunities, reinvested resources to hire professional business development personnel, who further created new opportunities and supported business development through policies and practices that ensured entrepreneurship could flourish in publicly funded hospitals. By contrast, community hospitals in this study did not have the same opportunities for commercializing their intellectual expertise nor were they sought out for partnerships to deliver privately funded health care. This limited the amount of discretionary funds that community hospitals could invest to expand business development and restricted hospitals’ opportunities to generate additional revenues for activities not financed under the MOHLTC funding model.

The characteristics of health care organizations have been linked to their capacity to respond to environmental changes through entrepreneurial activities (Banaszak-Holl et al., 1996; Hanlon, 2001; Rosner, 1968; Westphal, Gulati, & Shortell, 1997). Generally, larger health care organizations, with more patient beds, have more resources available to them and thus may have greater organizational capacity to respond to environmental threats. The greater the size of health care organizations, the greater access to resources, and the greater likelihood that niche specialty programs can be created (Banaszak-Holl et al., 1996). Here, hospital size did not appear to influence the ability of hospitals to develop a niche, as the hospitals in this study were relatively evenly distributed with regard to size.

In this study, the opportunity to develop a clinical niche appeared to be linked to the proximity to other hospitals. Community hospitals in rural areas with few or no other nearby hospitals had to offer a wide range of services that met the recurrent and customary health care needs of their patients. These hospitals provided emergency, diagnostic, family, and ambulatory services not aimed at any specific disease or patient population, thus reducing the opportunity to
concentrate on a diagnostic specialty or specific patient population. Such hospitals in this study
did not develop specialized services that could be commercialized. This finding is supported by
Hanlon (2001), who found that larger hospitals in close proximity to other hospitals tended to
specialize their health care programming. According to Hanlon (2001), larger hospitals in the
vicinity of other hospitals identified programs that could be abandoned because they duplicated
programs that other hospitals offered. Consequently, hospitals in regions densely populated with
other hospitals were able to focus their clinical specialties. Conversely, smaller community
hospitals not in the vicinity of other hospitals, offered a more general range of services that could
not be shed (Hanlon, 2001).

8.1.2 Relationships between Hospitals and Privately Funded Rehabilitation
Departments/Companies

8.1.2.1 Relationship Structure

One strategy used by hospitals in this study to augment MOHLTC funding involved the
provision of privately funded rehabilitation by creating their own privately funded departments
or partnering with privately funded companies. In terms of relationship structure, the term
alliance partners (a form of an inter-organizational relationship) best described the relationships
between hospitals and privately funded rehabilitation companies observed in this study, whereas
franchising is an organizational relationship form that most closely described the intra-
organizational relationships observed between the hospital and its privately funded rehabilitation
department. However, unlike the relationship partners described by Parmigiani and Rivera-
Santos (2011), the organizational boundaries between hospitals and the privately funded
rehabilitation departments and companies studied here were variable and, in some cases,
indistinct. For example, in some instances the staff of the privately funded companies that
worked for multiple years in publicly funded hospitals were managed by publicly funded senior leaders within hospitals, followed hospital policies, shared office space with publicly funded rehabilitation staff, and attended staff meetings with publicly funded rehabilitation staff. Furthermore, and despite the fact that hospitals and privately funded companies were distinct organizations, hospitals were able to influence the physical layout and organizational procedures of privately funded rehabilitation companies even when these companies were geographically located outside of hospitals. Similarly, there was a great deal of variation with respect to geographic location of departments and companies in relation to hospitals. For example, some private companies had departments within hospitals, while some privately funded rehabilitation departments, created by hospitals, geographically resided within hospitals, outside of hospitals, and even, in instances of multiple departments, in different cities. Leaders referred to the privately funded rehabilitation departments and companies using a variety of terms, including subsidiaries, clinics, privately funded departments and units. No specific distinctions were made to identify the departments created by hospitals and the privately funded companies that provided services within hospitals.

Given the merging of relationship structures, vague geographic boundaries, and varied nomenclature, the terminology commonly used in the organization science literature to describe such relationships – franchises/intra-organizational relationships or alliance/inter-organizational relationships – does not adequately describe these organizational relationships. Therefore, an alternative term to describe the relationships that are formed between hospitals and privately funded rehabilitation companies/departments is proposed: enter-partnership. Entre-partnership reflects the entrepreneurial spirit and the organizational connection observed between hospitals and privately funded rehabilitation departments/companies in this study.
8.1.2.2 Relationship Effectiveness and Factors That Influence It

The definition of relationship effectiveness that emerged from this study is “the achievement of reciprocally beneficial goals for all direct relationship participants.” This proposed definition is validated in existing literature (Barr, 2007; Buse & Walt, 2000; Van de Ven, 1976). According to the organizational literature, relationships between public and private organizations should be measured by the achievement of specific, measurable, and intended goals that cannot be realized by relationship partners independently. In his classic work, Van de Ven (1976) used the concepts of perception, equity, and value in the definition of relationship effectiveness, stating that “The perceived effectiveness of an IR [inter-organizational relationship] refers to the extent to which the agencies subjectively believe that each party carries out its commitments and that the relationship is worthwhile, equitable, productive, and satisfying” (Van de Ven, 1976, p. 33). Comparable to the definition adopted in this study, the definition by Van de Ven was dependent on the perception of relationship partners as being able to achieve commitments (goals) in an equitable (mutual/reciprocal) fashion.

Chapter 5 of this thesis examined factors that hindered or facilitated relationship effectiveness between hospitals and privately funded rehabilitation departments/companies. The top six factors that facilitated or hindered relationship effectiveness (in the order of importance as ranked by study participants) were organizational culture, alignment, business development infrastructure, resource exchange, clear goals, and terms of agreement met. These factors can be separated into three subsets: factors that are internal to the hospital (organizational culture and business development infrastructure), factors that act as a link between the two organizations (alignment and resource exchange), and factors that influence the attainment of the goals of the relationship (clear goals and agreements met though actual measurement/assessment/evaluation).
Of the factors that are internal to organizations, culture was the most frequently cited and salient factor that influenced relationship effectiveness between hospitals and privately funded companies/departments. Organizational culture was defined as the language, behaviour, beliefs, values, assumptions, and symbols which created the characters and norms of organizations (Scott, Mannion, Davies, & Marshall, 2003). In health care organizations, culture may be difficult to change because staff may view change – for example, change that involves entrepreneurial activities – negatively, as they associate it with compromising basic values, missions, and services (Morris et al., 2007; Scott et al., 2003). In this study, a business development infrastructure allowed hospitals to have separate and focused resources, policies, and procedures that facilitated relationships between hospitals and privately funded companies/department. Furthermore, a business development infrastructure provided the opportunity for hospitals to develop new business opportunities and business relationships. Participants noted the benefit of designating individuals to assist with business development. It has been observed in other industries (Morris et al., 2009) that, as the entrepreneurial process evolves, organizations may require not just one business development specialist but teams of individuals who fill multiple roles. In the cases studied here, business development roles were recently instituted in specialty academic hospitals, and added to the existing portfolios of vice presidents in community hospitals. Particularly in specialist academic hospitals, business development leaders provided an organizational structure that facilitated entrepreneurism through unconventional performance and productivity expectations, as well as distinctive compensation incentives for the privately funded staff. This too was consistent with the work of Morris et al. (2009), who suggested that compensation and reward systems are required to promote innovative behaviours and entrepreneurial spirit.
The second set of factors that were cited by participants as facilitating or hindering relationship effectiveness were alignment between partnering organizations, and resource exchange. In this study, alignment between organizations was defined as cultural, organizational, and strategic similarity between relationship partners. “Domain similarity” between organizations most closely resembles the references made by study participants to “alignment,” and refers to “the extent to which organizations obtain their money from the same sources, have the same goals, have staff with the same professional skills, provide the same kind of services to the same clients or customers” (Van de Ven, 1976, p. 32). According to Van de Ven, domain similarity between partners is highly correlated to attaining the intended goals of the partnership. Tsai (2002) used the term “strategic relatedness” in reference to the similarities between units in an organization, defining it as the similarity of approach by organizational units toward customers and products (Tsai, 2002). From an institutional perspective, some hospitals in this study exerted coercive and normative forces in order to ensure better alignment between hospitals and privately funded rehabilitation departments/companies. In one case, for example, a hospital requested that a rehabilitation company structurally alter the physical space of their existing offices, outside of the hospital setting, in order to comply with the standards of the hospital. Some hospitals in this study also integrated the rehabilitation company’s staff into the hospital to ensure that all rehabilitation staff practiced under the same clinical guidelines. Furthermore, some hospitals in this study geographically moved the privately funded departments/companies out of the hospital setting if the provision of privately funded health care was misaligned with the hospital brand, or if stakeholders perceived the presence of privately funded departments negatively.
The organizational learning and knowledge management literature indicates that the transfer of knowledge from organizational relationships can create new patterns of activity that can make organizations more efficient, open up new opportunities, and facilitate innovations (Pointer et al., 1988; Teece, Pisano, & Shuen, 1997). Organizational relationships also increase the propensity toward entrepreneurial orientation. One of the most effective ways of creating entrepreneurial behaviour in NFPs is the transfer of knowledge from privately funded organizations (Hoskisson et al., 2011). In fact, one way in which NFP organizations, such as hospitals, are exploiting knowledge gained from relationships with private partners is by becoming more entrepreneurially oriented in their actions, structures, and philosophies in order to sustain or acquire needed resources (Eikenberry & Drapal Kluver, 2004). While these authors focused specifically on inter-firm alliances, similar patterns of exploration and exploitation were observed within organizational boundaries (Tsai, 2002; Brass et al. 2004). This study corroborated these findings. Specifically, hospital leaders sought opportunities to learn, implement, and adapt efficiency strategies from the privately funded companies and departments. Hospitals also experienced transfer of knowledge in the form of improved clinical effectiveness. In this study, hospitals, in the context of their partnerships, further developed and used available products/knowledge/practices (exploitation) as well as attained resources/knowledge that were previously not available to the hospital (exploration). The findings of this study support the resource-based perspective of the firm, in that organizational relationships allowed relationship partners (hospitals and privately funded rehabilitation companies/departments) to exploit existing practices and explore new practices through knowledge transfer (Levinthal & March, 1993; Parmigiani & Rivera-Santos, 2011).
Of note, the relationship partners in this study did not participate in co-exploration and co-exploitation (Parmigiani and Rivera-Santos, 2011). Rather, the hospitals and the privately funded rehabilitation companies/departments explored and exploited resources gained through relationships independently. Thus, while cooperation was required between partners in order to achieve the desired resources (mainly additional revenues for the hospitals and legitimacy by association for the privately funded companies/departments), relationship partners did not co-explore nor co-exploit resources. This suggests that while organizations may choose relationship partners to explore/exploit required resources, the type of relationship partners, and whether such partners gain stakeholder approval, may influence whether relationship partners will co-exploit and co-explore.

A third subset of factors that contributed to relationship effectiveness included clearly set goals at the onset of the relationships and the demonstration that the goals were met in the context of the relationships. In this study, the absence of clear goals limited the ability of relationship partners to demonstrate the achievement of the intended goals. In fact, definitions of relationship effectiveness by participants of this study and in organizational literature are predicated on achieving set relationship goals (Brass et al., 2004; Buse & Walt, 2000; Van de Ven, 1976). Value creation refers to the perception by relationship partners that relationship goals (products, profit, and projects) have been attained in the context of the relationship (Wagner, Eggert, & Lindemann, 2010). According to the authors, value creation and the closely related concept of value appropriation were strongly associated with perceived relationship satisfaction. Specifically, using concepts from equity theory (Huseman, Hatfield, & Miles, 1987), Wagner et al. (2010) argued that relationship satisfaction comes from perceived equality and justice in organizational relationships. That is, value creation (resources created as a result
of the organizational relationships) and the perceived fairness in value sharing (the equitable division of resources) were strongly correlated to perceived relationship satisfaction. The concepts of value creation and value appropriation resonated with the definition of relationship effectiveness that emerged in this study, specifically the ability of both relationship partners to achieve goals set in the context of the relationship. Participants were cognizant that relationship effectiveness rested on perceived satisfaction of the needs of both relationship partners. Some hospitals identified that they were not able to appropriate value from relationships either because the contracts between partners were not managed well or because clear goals regarding value appropriation were not set.

Hospitals had more influence and coercive power to appropriate the value (profit) created from their privately funded departments than from the privately funded companies. Hospitals were able to set specific profit/quality goals for their privately funded departments and modify circumstances that ensured value creation. For example, hospitals created specific policies and procedures that motivated productivity in privately funded staff of rehabilitation departments. Hospitals also varied salaries and bonuses to incent productivity/profit goals for the privately funded departments. With respect to value appropriation, hospitals appropriated all of the value (profit) created in the relationship with privately funded departments, whereas in relationships with privately funded rehabilitation companies the profits were distributed (equally or in a pre-agreed arrangement) between the hospital and the rehabilitation company.

8.1.3 Institutional Tensions Related to the Presence of Privately Funded Health Care in Hospitals

Every hospital experienced some tension related to its involvement with privately funded health care departments/companies. This analysis showed that the negative opinions by external
and internal stakeholders were related to the high regard and support of the predominantly publicly funded Canadian health care system.

Hospital leaders were concerned that negative perceptions would influence the funding provided by the MOHLTC and philanthropy from donors. The negative perception of internal stakeholders in turn negatively affected referral patterns to the privately funded rehabilitation departments and limited opportunities for health care professionals to work in the privately funded companies/ departments of some hospitals. To manage the undesirable perceptions of hospitals’ stakeholders toward the provision of privately funded health care, leaders used multiple strategies: they administratively and geographically separated the privately funded companies/departments from the hospital, hospital leaders strictly followed rules set under BOND, leaders carefully deliberated over entering into relationships with privately funded companies, leaders took extra precautions to ensure that the privately funded departments/companies provided quality patient care, and leaders ensured that privately funded departments/companies aligned with the clinical and administrative policies set up by hospitals. Leaders of hospitals in rural communities were much more aware of the perceptions of their constituents toward hospital entrepreneurship. The centrality of hospitals in small rural communities made the leaders of such hospitals more accountable to the constituents who were donors and volunteers of the hospitals. Thus, in order to manage any negative perceptions of hospital constituents, leaders in rural hospitals were very careful about investing funds and overtly participating in entrepreneurial activities and partnerships with privately funded companies.

From a theoretical perspective, stakeholder theory (Freeman, 1984) can be used to understand the complexity of having to manage the different needs of multiple stakeholders in
organizational relationships. The various expectations of numerous stakeholders can impose conflicting demands on hospitals. According to Morris et. al (2007), the recent market focus (a focus on customers, their current and future needs, and their satisfaction levels) of NFPs may be in conflict with the two other main stakeholders: clients (receiving services) and donors/funding sources. For example, “donors and funding organizations can become alienated when the non-profit attempts to engage in entrepreneurial actions, believing that their contributions should be directed toward the non-profits traditional needs, not toward new and potentially risky undertakings” (Morris et al., 2007, p. 15). Given the social and political ideology toward publicly funded health care present in Canada, organizations must match their entrepreneurial behaviour with the cognitive and emotional schemas of their stakeholders. “Entrepreneurship may be seen as legitimate in one context, whereas in another context it might be seen as opportunistic and self-seeking” (Adler & Kwon, 2002, p. 33). Thus, hospitals and their leaders balanced the activities they viewed as necessary for the financial health of the organization, while at the same time managing the perceptions of important stakeholders on whom they relied for funding (MOHLTC) and referrals (in the case of doctors), as well as potential donors’ philanthropic kindness and work engagement (in the case of employees).

8.2 Distinctive Contributions of the Study

This study aimed to make contributions to existing theory and management practice. Each one will be addressed in the following sections.

8.2.1 Theoretical Contributions

Strategic adaptation in the face of perceived resource scarcity is anticipated in two theories that adhere to the resource-based perspective: resource dependence theory (Pfeffer &
Salancik, 2003) and neo-institutional theory (DiMaggio & Powell, 1983). Resource dependence theory and neo-institutional theory are complementary (Oliver, 1991) and have been previously used to address the challenges inherent in competition, survival, and privatization of hospitals (Banaszak-Holl et al., 1996; Ehreth, 1993; Scott, 1993; Scott, Ruef, Mendel, & Caronna, 2000; Yarbrough & Powers, 2006). However, these studies took place in countries where the hospitals are privately funded or where a mix of private and public funding for hospitals is more usual. This study applied concepts of resource dependence theory and neo-institutional theory to understand how publicly funded hospitals operating in Ontario, and their leaders, strategically navigated political, social, and organizational tensions as they engaged in the provision of privately funded health care services for the purpose of revenue generation.

Resource dependence theory offered insight into why hospitals formed relationships with privately funded departments/companies, while neo-institutional theory was used to explain the multiple constraints imposed on hospitals related to engaging in such relationships. Overall, hospital leaders attempted to find equilibrium between institutional pressures to comply with long-held norms and the need to increase the financial viability of hospitals in the current dynamic and resource-scarce operating environments.

This study aspired to offer some nuances to the well-established perspectives of resource dependence theory and neo-institutional theory. First, this study demonstrated that, in addition to sought resources, organizations may obtain additional resources that were not originally sought. For example, in addition to revenues and transfer of knowledge related to organizational efficiencies (the intended/sought resources) hospitals also benefited from clinical effectiveness and additional business opportunities (not intended/sought resources) as a result of their relationships with privately funded companies/departments. The notion of obtaining and
benefiting from unintended resources in the quest for intended resources is not directly addressed by resource dependence theory.

Second, in the quest to reduce dependence and obtain resources, institutional forces cannot be ignored. The neo-institutional perspective posits that organizations survive and succeed by conforming to the rules/expectations/norms set by institutional environments. The organization’s external environment, composed of political pressures and social expectations, places coercive/normative demands on the organization through rules, regulations, and laws. Oliver (1991) demonstrated that organizations may vary their strategic responses and actively respond to externally imposed institutional pressures by using one of the following tactics: acquiescing, compromising, avoiding, defying, and manipulating. Neo-institutional theory highlights the strategic responses of organizations to external pressures exerted by the institutional environment. It also illustrates the power that organizations themselves have to shape their own structures and processes, and to influence other smaller organizations within their environments. However, the neo-institutional perspective does not emphasize the counter-pressure of the organizations’ internal environment. This study demonstrated that demands outside and inside of the organization influenced hospitals' strategic responses. Furthermore, hospitals exhibited multiple strategic responses simultaneously by acquiescing to rules set by the government, and by compromising the extent of entrepreneurial activity in an effort to balance the needs of multiple stakeholders.

The ability to obtain resources by hospitals through relationships with privately funded organizations was highly influenced by the normative pressures of stakeholders outside and the opposing influencing forces within the hospital environment. This was evident by the regulations that were set by the MOHLTC with regard to how hospitals could use alternatively
generated revenues and the opposition by hospital employees and physicians toward the presence of such departments/companies within hospitals. In order to comply with the regulations set by the MOHLTC, hospitals carefully complied with the BOND guidelines and also imposed coercive and normative pressures on the privately funded departments/companies to adapt to the hospitals’ rules and regulations. Furthermore, in this study some hospital employees and physicians challenged the hospitals’ intent to work with privately funded rehabilitation companies/departments and negatively influenced the referral patterns to, and the staffing of, the privately funded departments/companies. Consequently, in order to avert this conflict, hospital leaders were compelled to administratively and geographically separate the privately funded departments/companies from the hospitals. Thus, the study of organizational relationships can benefit from multi- (macro, meso, and micro) level and interactive systems perspectives; this maybe particularly relevant in the context of NFP organizations because of their public mandates and the diverse expectations of multiple stakeholders. The stakeholders, internal and external to hospitals, contributed to the maintenance and disruption of entrepreneurial activities by exerting normative and coercive pressures that compelled hospitals to simultaneously use a variety of strategies in order to manage demands placed by the multiple stakeholders.

**8.2.2 Contributions to Management Practice**

The study findings may be of value to organizational leaders who may wish to establish and maintain effective relationships between hospitals and privately funded companies. By understanding factors that hindered or facilitated relationship success, leaders can better anticipate and deal with potential issues. For example, the setting of clear goals and managing contracts to ensure that goals are realized were important but not managed well by all leaders. Conscious awareness of goals and the resources that are sought from these relationships will
assist with identifying the value (the pie) of such relationships and the fair value appropriation from the resources created from the relationships (the fair size of the slice of the pie). Second, stakeholders’ reservations towards hospital entrepreneurship need to be anticipated to ensure that hospitals, when strategically appropriate, are able to engage in private-public partnerships for health care services. Clear communication regarding the impact of privately funded health care on publicly funded hospitals needs to be addressed by hospital leaders to ensure that external and internal stakeholders make well-informed judgments. Finally, the presence of privately funded staff alongside publicly funded staff members can create feelings of inequity if they are providing similar services for different incentives. Thus, equitable treatment and the perceived fairness by all staff are important in preserving staff morale, productivity, and retention.

8.3 Study Strengths and Limitations

In terms of strengths, this study used a number of techniques to increase the credibility, transferability, and dependability of study results. First, multiple cases, including rival/alternate cases, were used to ensure replication of findings across variable relationship structures, relationship partners, and hospital types. The use of multiple respondents from each organization allowed for within and between case analysis for pattern matching and explanation building. Furthermore, mixed methods (qualitative and descriptive statistics) were used to analyze multiple data sources, such as interviews, surveys, and documents, in order to increase study rigour.

There are several limitations to this study. First, the purpose of the study effectively limited selection to hospitals that were involved in relationships with privately funded rehabilitation companies/departments. That is, hospitals were already focused on entrepreneurial
activities to proactively offset the perceived funding gap. This sampling bias may limit
generalizability, although certainly the findings are applicable in the development of research
involving other NFP organizations that wish to enter into partnerships with privately funded
companies or that may wish to increase their entrepreneurial focus.

Second, the unit of analysis was the relationship between hospitals and privately funded
companies/departments. Given that this study examined an emerging relationship, cases that
demonstrated maximum variability of such relationships were purposely sought. In future
research, a similar study might examine multiple similar, rather than varied, cases.

Third, the relationships between hospitals and privately funded rehabilitation
departments/companies were considered as analogous, given the similarity of the relationship
purpose, structure, and function as well as the domain similarity between privately funded
departments and companies. However, a more detailed study of the differences and similarities
between relationships of hospitals with privately funded companies versus relationships of
hospitals with privately funded rehabilitation departments may offer more nuanced data
regarding the factors that facilitate or hinder such relationships.

Fourth, this study predominantly examined these organizational relationships and their
impact on hospitals from the perspective of hospital leaders. While information was gathered
from other participants in the relationship (leaders of privately funded departments and
companies as well as leaders from publicly funded rehabilitation departments), this author
acknowledges that the perspectives of other stakeholders, such as the MOHLTC, members of
hospitals’ boards of directors, and privately and publicly funded rehabilitation staff, would offer
broader practical and theoretical perspectives on the studied relationships.
Finally, this study was limited to hospitals in Ontario. Given that each province defines for itself medically necessary services and likely has different rules of engagement for private and public partnerships, the findings may not be applicable to all provinces in Canada.

8.4 Future Research and Conclusion

The following recommendations are provided to invite future research in light of the findings. First, this study demonstrated that academic specialist hospitals had more opportunity to commercialize their expertise, had more resources and expertise available to them for business development, and were more sought after by privately funded customers. Therefore, further research would be helpful to elaborate on the differences in the current and potential entrepreneurial activities of large urban, small urban, and rural community hospitals with different resource levels, community needs/expectations, and propinquity of other hospitals. Such practical research may assist publicly funded hospitals to participate in strategies and activities that can help to generate revenues in addition to the funding provided by the MOHLTC.

Second, this study examined the entrepreneurial orientation of hospitals through an adapted entrepreneurial scale. Studies outlining the creation and use of the original scale (and the adapted version) do not offer a standard score that NFP organizations can use to rank their entrepreneurial orientation against other “like” organizations. Thus, future research might focus on administering the entrepreneurial orientation scale to a large sample of academic and/or community hospitals so that an aggregate baseline entrepreneurial score can be established. This baseline score may be used by hospitals wishing to gauge, increase, or decrease their entrepreneurial focus in comparison to similar hospitals.
Third, some respondents within this study indicated that privately funded patients may receive a more privileged status given the amount of extra revenues associated with their care. Consequently, from policy and organizational perspectives, it may be important to compare and contrast the treatment and experiences of publicly and privately funded patients from the perspectives of clinicians and the patients themselves. The findings of such future research may enhance the treatment of all patients receiving care in publicly funded hospitals.

Fourth, according to the data in this study, leaders in publicly funded hospitals found utility in the application of business practices learned from their privately funded partners. It will be important to identify, through future research, those organizational practices that are beneficial to adopt from the private sector and those that are not. Being aware and conscious of the effect of practices borne out of the private sector and how to most effectively employ them in the public sector can be of value for leaders.

Fifth, the presence of privately funded rehabilitation departments in publicly funded hospitals created feelings of inequity for some publicly funded rehabilitation staff and senior managers, particularly when providing similar services for different incentives. It will be important to study staff morale and its impact on patient care/service provision when parallel funding systems, different organizational practices and reinforcements exist for staff offering comparable services within the same organization.

Finally, hospital leaders appreciated the practices of privately funded departments and companies for their emphasis on productivity and efficiency. Accordingly, future research should examine productivity benchmarks for publicly funded hospital employees and update them if the current benchmarks do not meet the standards required by hospitals and their leaders.
Such research may offer leaders a more objective measure of the value created in the employment of publicly versus privately funded health care workers.

The findings of this study revealed the characteristics of relationships between hospitals and privately funded rehabilitation departments/companies, contributed to defining relationship effectiveness, and identified the factors that hindered and facilitated relationship effectiveness. Of significance to Ontario health policy decision makers, this study found evidence for increasing hospital entrepreneurship and related strategies, which were evolving in response to perceived funding restrictions from the hospitals’ main funder. Normative and coercive pressures from hospitals’ multiple stakeholders moderated hospitals’ entrepreneurial activities.
Appendix A
E-mail Invitation to Participants

Dear [Participant Name],

I am a PhD candidate investigating organizational relationships within the health care industry as part of my doctoral thesis research. I am contacting you because of my interest in conducting a short interview with you (1-1.5 hours). The interview will be conducted face to face at a time and place of convenience to you.

My research aims to bridge an existing knowledge gap in how certain hospitals operating in Ontario manage their relationships with privately funded or publicly funded care departments under the same organizational umbrella.

The planned participants in this study are individuals involved in an intra-organizational relationship between a publicly funded hospital and a privately funded rehabilitation department, or those involved in an intra-organizational relationship between a publicly funded hospital and a publicly funded rehabilitation department. You are a potential interview candidate for the FORMER OR LATTER group of participants.

The interview questions will be open-ended and relate to your perceptions on the aforementioned private-public (OR public-public depending on participant) relationship in terms of effectiveness, positive and negative aspects, and associated outcomes and consequences.

I have sought and received ethics approval from the University of Toronto to conduct this study. If you are interested in participating in this study I will, in addition, seek ethics approval from your hospital ethics department prior to conducting the study with you or any other member of your organization.

Please advise me by return e-mail of your interest and/or availability for a semi-structured interview.

If interested, I will provide a more detailed information sheet on the project (including details on privacy and confidentiality) and on the research questions that will form the basis of the interview. Additionally, a consent form will be provided requiring your signature prior to the interview.

With best regards,

Anna Ballon, PhD Candidate
Appendix B

Participant Information Sheet

Title of Study: Entrepreneurship in Publicly Funded Hospitals: A Multi-Case Study of Privately Funded Rehabilitation in Ontario Hospitals

Principal Investigators: Anna Ballon, PhD Candidate & Whitney Berta, PhD

Institute of Health Policy, Management & Evaluation

University of Toronto

Purpose: What is this study about?

This research aims to bridge an existing knowledge gap in how certain hospitals operating in Ontario manage their relationships with privately funded rehabilitation departments under the same organizational umbrella. There are two overall groups of participants in this study: one group of participants includes those involved in an intra-organizational relationship between a publicly funded hospital and a privately funded rehabilitation; the other group includes individuals involved in an intra-organizational relationship between a publicly funded hospital and a publicly funded rehabilitation department. As the TITLE of HOSPITAL X/Rehab Depart X you have been identified as a potential interviewee for the LATTER/FORMER group.

We are interested in answering the following broad questions and sub-questions: #1a. How are these relationships structured? #1b. How is relationship effectiveness defined between a publicly funded hospital and a privately funded rehabilitation department OR a publicly funded rehabilitation department (wording will depend on whom the information sheet is forwarded to)? #1c. Are these relationships perceived as effective? #1d. What are the factors and/or conditions that impact the perceived effectiveness of these intra-organizational relationships? and #2a. How do hospital leaders describe the entrepreneurial orientation of their hospitals? ; #2b. What are the intended and unintended consequences on the entrepreneurial behaviour of the publicly funded hospital as a result of its relationship with the privately funded rehabilitation department (or publicly funded rehabilitation department) and #2c. What are, if any, other intended and unintended consequences of this relationship on the publicly funded hospital?

We are interested in your views on these topics shared with us in a semi-structured interview. The information and perspectives that you will share will help A. Ballon generate data to complete a doctoral thesis and to make significant knowledge contributions to this field of research.
The interview will be conducted face to face at a time and place of convenience to you. It is anticipated that the interview will take 1-1.5 hours

**How is the research done?**

The Principal Investigator (A. Ballon) will conduct the interview based on a set of questions designed to elicit your perspectives and opinions. If you would like to get an idea of the specific questions that will be asked, feel free to contact us for this information. Beyond pursuing the questions, the interview will be conversational and open-ended. We will record the discussion in order to be able to effectively capture the information that you share. The content of the audiotape will later be transcribed to text using word processing software so that it can be analyzed using qualitative data analysis methods. The transcribed text will not include any identifying names, whether personal or organizational, and will be completely anonymized. The audiotape/digital files will subsequently be destroyed. The analysis will involve identifying common themes in the responses from all participants in order to identify important factors to consider and examine empirically for purposes of answering the research questions.

**Voluntary Participation:**

Your participation is entirely voluntary and you may withdraw from the interview at any time during and after the interview without consequence. If you choose to withdraw from the interview your input and data will be permanently deleted. You may choose not to answer any of the questions during the interview. Your participation or non-participation in this study will not affect you or your status at your organization or association in any way.

**Privacy and Confidentiality:**

The information you share during the interview will be held in confidence. Only A. Ballon and supervisor Whitney Berta will view the anonymized interview transcripts.

Audiotapes and/or digital files will be erased after they are transcribed into word processor software. Your name and the name of your organization or association will not appear in the word processor files.

All files will be destroyed upon completion of data analysis. In the interim, all data will be stored on a password protected computer in offices only accessible to the Principal Investigator at the University of Toronto, and situated within the Institute of Health Policy, Management and Evaluation.

Any results reported from this research will be presented such that information you share is not identifiable with you individually or your organization.

We ask each individual involved in the interviews to sign a Consent form.
Possible Risks:

There are no known risks to you in participating in this study. As noted above we will take every precaution to protect your confidentiality so that you can feel free to be open and candid in the interview.

Ethics Review:

This study and the data collection instruments we have designed to complete it have undergone ethics review with the Ethics Review Office at the University of Toronto. If you have any questions concerning the rights of participants in human subjects research contact, Mr. Daniel Gyewu, Ethics Review Officer, at ethics.review@utoronto.ca

Who can I talk to further about this research?

If you have questions or would like further information about this research, please contact:

Anna Ballon by telephone at 416-278-6700 or via e-mail at anna.ballon@utoronto.ca
Appendix C

Interview Guide for Research Questions: # 1.a.,b.,c.,d. and 2.b., c.

Guide for Participants involved in Intra Organizational Relationship between a publicly funded hospital and a privately funded rehabilitation department/company (**or other privately funded companies)

**Briefly describe project/Assure aggregation of data and individual confidentiality**

Date:

Place (Code Name):

Interviewer:

Interviewee (Code Name):

Organizational Position of Participant:

**Background questions:**

How long has the partnership existed? (Research Question# 1.a.)

How is it structured? (Research Question# 1.a.)

Who is involved in these relationships? (Research Question# 1.a.)

Why did the public partner enter into the relationship? Research Question # 1.c.)

What has been your role in the relationship between the hospital and the privately funded rehabilitation department (**privately funded company)? How long have you been in this role? (Research Question# 1.a.)

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Research Questions (adapted from Barr, 2007)

Do you consider the relationship between the hospital X and its privately funded rehabilitation department (**the privately funded company) to be effective? Why or Why not? (Research Question #1.b.)

How would you define if the relationship is effective between them? What are the indicators? (Research Question #1.c.)
What was the original purpose (goal) of the partnership? Have the goals been met? (Research Question #1.b and c)

Has that purpose changed over time? Were/are there any positive/negative intended or unintended consequences/effects on the entrepreneurial behaviour of the hospital/other? (Research Question #2.b and 2.c.)

Have the goals been documented at the onset of the relationship? As the relationship evolved? Can I have access to the documents? (Research Question #1.b and c)

**Additional Comments or Observations:** Do you have any additional comments or observations regarding the intra-organizational relationship between a public hospital and a privately funded department within it (**privately funded companies with which the hospital has partners**)?

**Other Key informants:** Is there anyone else that you think I may want to contact because of your knowledge of the hospital system and privately funded companies (**partnerships between a publicly funded hospital and the privately funded company**)?

**Thank the individual for participating in the interview. Ask willingness to participate if there is need to follow up with further questions related to this study.**
Appendix C1

Interview Guide for Research Questions #: 1.a.b.c.d. and 2.b., c.

Guide for Participants involved in Intra Organizational Relationship between a publicly funded hospital and a publicly funded rehabilitation department

**Briefly describe project/Assure aggregation of data and individual confidentiality**

Date:

Place (Code Name):

Interviewer:

Interviewee (Code Name):

Organizational Position of Participant:

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<thead>
<tr>
<th>Research Questions (adapted from Barr, 2007)</th>
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<tr>
<td>Do you consider the relationship between the hospital X and its rehabilitation department to be effective? Why or Why not? (Research Question #1.a)</td>
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<td>How would you define if the relationship is effective between them? What are the indicators? (Research Question #1.c)</td>
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<td>Are the goals of this relationship being met? (Research Question #1.b and c)</td>
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<td>Has the relationship/expectations changed over time? (Research Question #1.b)</td>
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Has the relationship evolved? Are there any documents that can demonstrate the relationship that you describe, such as balanced score cards, policies, etc.? Can I have access to the documents? (Research Question #1.b &c)

**Additional Comments or Observations:** Do you have any additional comments or observations regarding the intra-organizational relationship between a public hospital and the rehabilitation department?

**Other Key informants:** Is there anyone else that you think I may want to contact for more information?

**Thank the individual for participating in the interview. Ask willingness to participate if there is need to follow up with further questions related to this study**
Appendix D

Interview Guide and Survey for Research Question # 1.d.

Guide for Participants involved in an Organizational Relationship between a publicly funded hospital and a privately funded rehabilitation department/company.

Date:
Place (Code Name):
Interviewer:
Interviewee (Code Name):
Organizational Position of Participant:

As you know you have been asked to participate in a study that is examining the factors that positively or negatively contribute to the effectiveness of the relationship between the publicly funded hospital and a privately funded rehabilitation department/company. There are two phases to this question. In Phase 1, I will ask you to list any factors that you believe negatively or positively contribute to the effectiveness of this relationship. In Phase 2, I will ask you to rate the importance of this factor’s influence on the relationship.

Phase 1

Please list/tell me all positive and negative factors that contribute to this relationship:

1.
2.
3.
4.
5.
6.
Phase 2

Please rate on a numerical scale the importance of the factors that influence the organizational relationship between the publicly funded hospital and the privately funded rehabilitation department/company.

Date:

Participant (code):

Factors provided during the interview

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Appendix D1

Interview Guide and Survey for Research Question # 1.d.

Guide for Participants involved in an Organizational Relationship between a publicly funded hospital and a publicly funded rehabilitation department

Date:

Place (Code Name):

Interviewer:

Interviewee (Code Name):

Organizational Position of Participant:

As you know you have been asked to participate in a study that is examining the factors that positively or negatively contribute to the effectiveness of the relationship between the publicly funded hospital and a publicly funded rehabilitation department within it. There are two phases to this question. In Phase 1, I will ask you to list any factors that you believe negatively or positively contribute to the effectiveness of this relationship. In Phase 2, I will ask you to rate the importance of this factor’s influence on the relationship.

**Phase 1**

Please list/tell me all positive and negative factors that contribute to this relationship:

1.

2.

3.

4.

5.

6.

**Phase 2**

Please rate on a numerical scale the importance of the factors that influence the organizational relationship between the publicly hospital and the publicly funded rehabilitation department within it.

Date:

Participant:
Factors provided during the interview

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Appendix E

Survey for Research Question #2.a.

Scale to Assess the Entrepreneurial Orientation of the Publicly Funded Hospital

Hospital Code:

Date:

Background Questions:

1.a. How would you describe the entrepreneurial spirit/activities of your hospital?

1.b. Please rate your hospital’s overall entrepreneurial orientation on a scale of 0-10; with “0” being not at all entrepreneurial and “10” being the most entrepreneurial.

Please circle the number that best corresponds to your level of agreement with each of the following statements:

Our hospital is characterized by:

1. A high rate of new program and service development compared to other hospitals in our field or area
   1  2  3  4  5
   Strongly Disagree  Strongly agree

2. An emphasis on continuous improvement in methods of operation or service delivery
   1  2  3  4  5
   Strongly Disagree  Strongly agree
3. Risk taking by key managers or administration in seizing and exploiting new opportunities

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Strongly Disagree  
Strongly agree

4. A “live and let live” philosophy in dealing with other organizations that compete for the same resources we do

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Strongly Disagree  
Strongly agree

5. A seeking of unusual, novel solutions by senior managers to problems via the use of “idea people”, brainstorming, etc.

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Strongly Disagree  
Strongly agree

6. A management philosophy that emphasizes proven services, programs, and approaches

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Strongly Disagree  
Strongly agree

7. A management philosophy that emphasizes the avoidance of heavy expenditures on developing new programs

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Strongly Disagree  
Strongly agree
8. A charismatic leader at the top

1  2  3  4  5

Strongly Disagree  Strongly agree

At our organization, decision making is characterized by:

9. Cautious, programmatic, step-at-a-time adjustments to problems

1  2  3  4  5

Strongly Disagree  Strongly agree

10. Active searches for major new opportunities

1  2  3  4  5

Strongly Disagree  Strongly agree

11. Major social change as a dominant goal

1  2  3  4  5

Strongly Disagree  Strongly agree

12. Large, bold, decisions despite uncertainty

1  2  3  4  5

Strongly Disagree  Strongly agree

13. Compromises among the conflicting teams of the different publics we serve, including sources of funding, clients, employees, governments, board members, etc.

1  2  3  4  5

Strongly Disagree  Strongly agree
14. Adherence to status quo and stability as primary concerns

1 2 3 4 5

Strongly Disagree Strongly agree

15. Over the past two years how many new programs or services were introduced by your organization?

16. Over the past two years, how many major improvements were made to existing programs and services?

17. Over the past two years, how many major improvements did your hospital make its internal processes or methods of operations (e.g. new marketing approaches, new record keeping methods, new approaches to funding, new human resource management systems, etc.)?

Adapted from Peterson & Johnson (2004) and Morris & Joyce (1998).
Appendix F
Participant Consent Form

Title of Study: Entrepreneurship in Publicly Funded Hospitals: A Multi-Case Study of Privately Funded Rehabilitation in Ontario Hospitals

Principal Researchers: Anna Ballon, PhD Candidate, Supervised by Whitney Berta, PhD

Institute of Health Policy, Management & Evaluation, University of Toronto

I have read and understood the Participant Information Sheet attached to this Consent Form and agree to participate in the study.

I understand that my participation in this study is voluntary and that I may withdraw from participation at any time during the interview process and at any time after the interview by contacting the researcher at anna_ballon@rogers.com. I understand that I can refuse to answer any question in the interview without consequence to myself. My choice to participate or not to in the study has no consequence to me or the organization/department I represent. In the event that I choose to withdraw from the study my responses and all interview data will be deleted from any recordings, notes, and transcripts.

I have been told that the information from the taped interview will be handled in a way that protects my privacy. My comments will remain confidential. No information that identifies me will be disclosed. I will not be identified in any report or presentation that may arise from the study.

I understand, that in addition to my personal anonymity, and in order to ensure the privacy and reputation of my organization, any remarks, positive or negative, that I may potentially make to render my organization identifiable, will be altered by the researcher to protect my personal and my organization’s confidentiality.

Name: (please print) Facility Name:

Signature: Date:
Appendix G

Description of Social Judgment Analysis

Quinn and Rohrbaugh (1983) used techniques of Social Judgment Analysis as a way to mediate competing values related to the construct of organizational effectiveness. The authors used a two-step study where initially expert judges narrowed down constructs related to organizational effectiveness and later validated the constructs by a larger expert panel. From this analysis the authors proposed a model that organized concepts that are most central to the construct of organizational effectiveness, made clear the values in which the concepts are embedded, and created a framework for organizational effectiveness assessment (Quinn & Rohrbaugh, 1983). Judgment Analysis has been used in studies aimed at discovering in-group (Cirincione-Reagan, 1994; Dougan, 1999; Henry, Strickland, Yorges, & Ladd, 1996; Mohammed & Ringseis, 2001) and individual (Balzer, Rohrbaugh, & Murphy, 1983; Bobko & Roth, 2008; Cosier, 1978; Dhami & Olsson, 2008) decision making.

The following are the procedures involved in SJA (Cooksey, 1996; Stewart, 1988):

1. Identifying the cues
2. Defining the distribution of the cue values
3. Defining relations among cues

Below is the description of how these procedures were applied to the current study.

1. Identifying the cues- For the current study “cues” refer to indicators/factors that contribute or detract from relationship effectiveness. Study participants were asked to identify the positive and negative factors that facilitated/hindered the relationship effectiveness between hospitals and privately funded departments/companies. The respondents were asked to rank the degree to which a single factor influences the effectiveness of the intra organizational relationship between the privately funded health care department and the public hospital.

2. Defining the distribution of the cue values- Cue distribution refers to the range of values that are assigned to cues. The respondents were asked to rank the degree to which a single factor influences the effectiveness of the organizational relationship between the privately funded health care department/company and the public hospital. In this study the cues were on a range of numerical numbers.

3. Defining relations among cues- Participants ranked the importance of factors that facilitated or hindered the relationship between hospitals and privately funded rehabilitation departments/companies. Ratings were made on 5-point scale with 1 indicating “not an influencing factor”; 3 indicating a “likely factor; and 5 being a “definitely contributing factor”. The frequency and the ranking of each factor were reported in chapter 6.
### Appendix H

**Reported Effectiveness Factors and Assigned Codes**

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<th>Type of Reln.</th>
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<th>Codes</th>
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<th>Salience</th>
<th>Frequency</th>
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<td>hospital-clinic</td>
<td>Financial success</td>
<td>terms of agreement met-profit</td>
<td>+</td>
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<td>hospital-clinic</td>
<td>Patient referrals/quality of care</td>
<td>terms of agreement met-quality of service</td>
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<td>hospital-clinic</td>
<td>Knowledge transfer/sharing of resources</td>
<td>resource exchange</td>
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<td>1</td>
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<td>hospital-clinic</td>
<td>Space (sharing)/cost saving</td>
<td>resource exchange</td>
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Appendix I

Factors that Influence Relationship Effectiveness

Data for all Participants

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## Appendix J

**Factors that Influence Relationship Effectiveness**

**Academic Hospitals and All Privately Funded Partners**

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Appendix K

Factors that Influence Relationship Effectiveness

Community Hospitals and All Privately Funded Partners

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