

Evaluation of Researches on Strategy Content in Healthcare Organizations

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<Abstract>

The purpose of this paper is to provide the comprehensive review of empirical investigations in strategy content in healthcare organizations. Given the absence of relevant reviews in assessing an external validity of strategy content research in the healthcare industry, the paper, by taking convergent view, discern two main streams of research in the school of content: (1) the strategy-structure-performance (SSP) contingent, and (2) competitive strategies which test the propositions that business strategy, industry structure (IO economics). Finally, the paper suggests some future direction for research in this area.

Key Words : Strategy Content, Corporate Strategy, Competitive Strategy

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I . Introduction

Research in strategy has fallen loosely into two domains: process and content (Fahey & Christensen, 1986; Ketchen et al., 1996; Macintosh & Maclean, 1999; Schendel, 1992). Process pursues essentially descriptive studies of how strategies are formed and implemented (Fahey & Christensen, 1986; Rumelt et al., 1994), while content focuses on the specifics of what was decided, seeks to understand the relationship between strategic choice and performance, and is strongly influenced by concepts developed in the field of economics (Macintosh & Maclean, 1999; Montgomery, 1988; Rumelt et al., 1994). Starting from a very small base about 40 years ago, research in strategy content is now offering numerous studies that address the implication of this area across the variable industrial settings.

The purpose of this paper is to provide the comprehensive review of empirical investigations in strategy content in the healthcare organizations. Since the healthcare industry is believed to have unique characteristics, researchers have been questioned the straightforward application of research framework developed in the broader strategic management literatures to the healthcare industry (Fottler, 1987; Luke et al., 1989). There have been no reviews to figure out an issue of external validity of the strategy research in the healthcare organizations (Blair & Boal, 1991; Lee & Alexander, 1999a; Shortell et al., 1985; Topping & Hernandez, 1991).

II. Research Framework

Blair and Hunt (1986) distinguish two types of research approach; (a) context-free and (b) context-specific. The former is oriented to the variables of studies (e.g. leadership, decision-making, or strategic management) so that findings can be free of any organizational contexts, while the latter is focused on specific organizational contexts (public, military, or healthcare organizations). Therefore, the results of study are only applicable for the designated contexts. Given the absence of relevant reviews in assessing an external validity of strategy content in

the healthcare organizations, adopting the terminology developed by Blair and Hunt (1986), this paper first provides the domain of strategy content research identified through the context-free approach, and distinguishes the lines of inquiry within the domain of each research stream both in the context-free and in the context specific world. Next, by comparing the empirical investigations between studies adopting different research approaches(e.g. the context-free and the context-specific), the paper assesses the external validity of the theoretical research framework developed in the broader strategic management to the healthcare organizations. Finally, the paper suggests some future direction for research in this area.

This review covers the empirical works appeared on both context-free and context-specific journals from 1980 to 2007, but studies focused on healthcare organizations were only included. The complete list of reviewed journals is shown in Table 1.

III. Domains of Research in Strategy Content

Many researchers have tried to identify the domains of research in strategy content. For instance, Fahey and Christensen (1986) identified three domains of research in strategy content based on decisions managers need to make: the goals, scope, and competitive strategies employed. Montgomery (1988) and Macintosh & Maclean (1999), drawing on implication of strategies for performance difference, identified three domains: corporate strategy, industrial organization (IO) economics, and resource-based view (RBV). Rumelt et al.(1994) also provided framework similar to that of Montgomery (1988) and Macintosh & Maclean (1999), however, Rumelt and his colleagues (1994) placed business strategy instead of a resource-based view on their classification scheme.

This study attempts to identify the domains of research in strategy content by converging the domains previously identified. Taking a convergent view, one can discern two main streams of research in the school of content: (1) the strategy-structure-performance (SSP) contingent, which is mainly concerned with the scale, scope, and form of corporations

<Table 1> Context-Free and Context-Specific Journals Reviewed

Journal	
Context-Free Journals	Academy of Management Journal
	Academy of Management Review
	Academy of Management Executive
	Administrative Science Quarterly
	Journal of Management
	Journal of Management Studies
	California Management Review
	Harvard Business Review
	Strategic Management Review
	Journal of Business Venturing
	Journal of Small Business Management
	Managerial and Decision Economics
	Organization Science
	Journal of Industrial Economics
	International Journal of the Economics of Business
Context-Specific Journals	American Journal of Preventive Medicine
	Health Affairs
	Health Care Management Review
	Health Care Financial Management
	Health Services Research
	Health Services Management Research
	Health Economics & Health Services Research Inquiry
	Journal of Health Economics
	Journal of Health and Social Behavior
	Medical Care
	Medical Care Review
	Medical Care Research and Review
	Hospital and Health Services Administration
	Topics in Healthcare Financing
	Modern Healthcare

(Chandler, 1962; Rumelt, 1982), and (2) competitive strategies which test the propositions that business strategy, industry structure (IO economics), and a firm's superior resources (RBV) are associated with performance difference between the firms (Hatten et al., 1977, 1978; Porter, 1981; Wernerfelt, 1995)(See Figure 1).

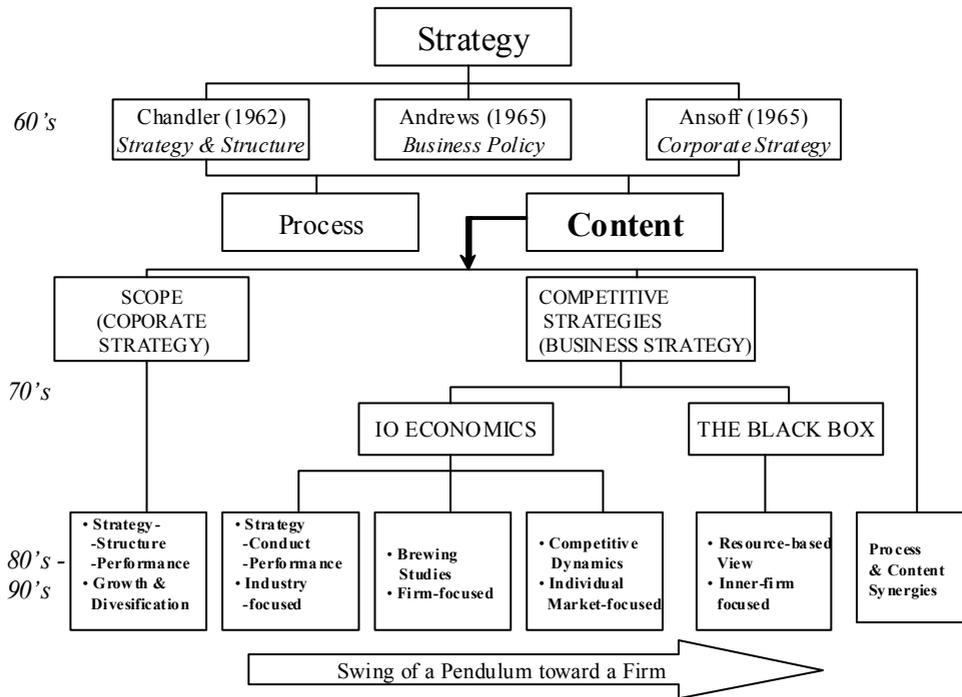


Figure 1. Chronology of Strategy Content

The SSP contingent deals with corporate strategy and usually tests propositions about the relationship between corporate growth strategies and performance. It has three sub-streams: (1) corporate strategy-performance, including diversification, vertical integration, and globalization, (2) means for implementing corporate strategy, including mergers and acquisitions, joint ventures, and strategic alliance, and (3) diversification measures.

Competitive strategies are dealt with factors, behaviors, and internal resources of a firm that give a firm a competitive advantage over its competitors. This line of research can be further categorized into four sub-streams: (1) Strategy-Conduct-Performance (SCP), which deals with

the influence of industry structure on performance difference between firms (industry-focused); (2) Business strategy, including strategic groups and generic strategies (a firm-focused); (3) Competitive dynamics, including multi-point competition and competitor action-reaction (individual market level-focused); and (4) RBV which deals with internal resources of the firm (inner-firm focused). The first three sub-streams are rooted in IO economics, whereas the RBV is rooted in a historical theory of strategic management, the black box of the firm (Hoskisson et al., 1999).

Based on the research domains identified here, taking the comparative perspective, the rest of paper provides literature reviews on the studies of strategy content in the healthcare organizations.

IV. Corporate Strategy

Corporate strategy deals with the ways in which a corporation manages a set of business together, and it is the area in which empirical research in strategy content began (Fahey & Christensen, 1986; Grant, 1995). Most studies in this line of research have attempted to empirically demonstrate the relationship among growth strategy (Strategy), organization form (Structure), and the expected performance of the corporations (Performance) (Capon et al., 1988; Nguyen et al., 1990; Palich et al., 2000).

1. Diversification: Growth Strategy

Although all corporate strategies are somewhat unique, there are four broad categories or types of diversification strategies which have been popular in the research of strategy content: (1) related or concentric diversification, (2) unrelated or conglomerate strategies, (3) vertical integration, and (4) globalization (Bourgeois et al., 1999). Among them, most works have focused specifically on performance differences between related and unrelated diversifiers (Bettis, 1981; Christensen & Montgomery, 1981; Markides & Williams, 1994).

1) Related vs. Unrelated Diversification

The results identified in the context-free literatures have shown three types of relationship between related and unrelated diversification in terms of performance: (1) The linear model, (2) The inverted-U model, and (3) The intermediate model (Palich et al., 2000) (see Figure 2). Based on the research results presented, although questions regarding the diversification-performance linkage still persist, the majority of work supports the inverted-U pattern. For example, Palich and his colleagues (2000) found strong evidence for this type of curvilinear relationship (Palich et al., 2000). That is, the diversified organizations will yield the higher financial performance than freestanding organizations, and, among diversification, related diversification will yield the higher financial performance than unrelated diversification.

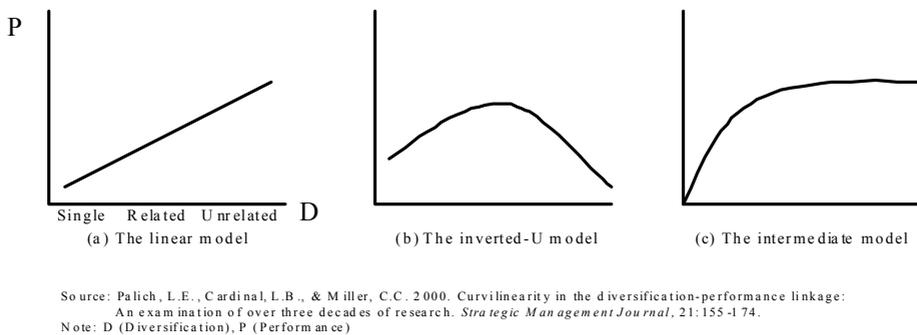


Figure 2. Diversification and Performance

Diversification in the healthcare organizations usually termed as ‘service diversification’(Lee & Alexander, 1999a: 255), a expansion of line of services from traditional acute care to non-acute care services to realize the basic motives of diversification (e.g., cost and risk reduction, and profit increases) (Ginter et al., 1998). Studies in the hospital settings also showed the predominance of inverted-U pattern of relationship between diversification and performance, similar to the studies in the context-free applications.

Earlier study by Eastaugh (1984) showed that diversified hospitals yield significantly better financial performance compared to freestanding hospitals. Later, one study examined the difference of financial performance between related and unrelated diversification (Clement et

al., 1993). Results indicated that hospitals with acute care-related diversification yield significantly higher financial performance compared to hospitals with unrelated diversification. In contrast, two other studies were identified providing negative impact of diversification. Clement (1987) found no significant difference of financial performance between related and unrelated diversification, and Eastaugh (1992) found that hospitals with less diversified experienced less decline in profitability while excess diversification of hospitals led to more declines in profitability.

Some studies examined the motives for diversification. Since the healthcare industry has experienced the dramatic environmental changes, the closure of hospitals has been the issue in the industry (Lee & Alexander, 1999a). It is believed that diversification would increase the survival rate of hospitals. A couple of studies were examined the diversification effect on hospital closure (Lee and Alexander, 1999b; Mullner, 1990). However, their studies showed that even related diversification significantly increased the risk of hospital closure (Mullner, 1990), or has no impact on it (Lee and Alexander, 1999b).

Finally, one study in this category examined the financial and organizational determinants of hospital's service diversification (Wheeler et al., 1999). They found that sub-acute diversification was a response to declining financial performance for investor-owned (IO) hospitals, but not for not-for-profit (NFP) hospitals. In addition, they found that higher resource availability was positively related to hospital's expansion into sub-acute care regardless of hospital's ownership type.

2) Vertical Integration

Vertical integration (VI) is a strategic decision 'to grow along the channel of distribution of the core operations'(Ginter et al., 1998: 178), and it has an isomorphic structure with related diversification. Whether a strategic alternative is viewed as vertical integration or related diversification may depend on the intent of the alternative (Ginter et al., 1998). For example, if organization's goal is to control the flow of patients to various units, the organization may decide to vertically integrate. If the intent of organization is to grow in new market, in contrast, the strategy adopted by the organization may be called "diversification."

In relation to vertical integration (VI), studies in the context-free world have attempted to

identify environmental effects on VI (Balakrishnan & Wernerfelt, 1986; Harrigan, 1986; Sutcliffe & Zaheer, 1998), the role of firm in VI decision (Argyres, 1996), type of VI (Barreyre, 1988; Carney & Gedajlovic, 1991; Mahoney, 1992), and post VI effects (Norton, 1988).

Vertical integration in the healthcare organizations has received considerable attention as a strategic response to dynamic environmental changes (Coddington & Moore, 1987). Specifically, studies argued that hospitals are vertically integrated to reduce transaction costs (Conrad et al., 1988; Mick & Conrad, 1988); and to increase market share (Brown & McCool, 1986). However, no empirical study has been performed wholly designated to the topic of vertical integration. Rather, studies in the hospital field seem to use diversification and vertical integration reciprocally. For example, one empirical study is titled with 'vertical integration', but the content of her study was not clear that she really focused on the issue of vertical integration of sample hospitals (Cody, 1996).

With the absence of empirical studies of vertical integration in the hospital field, Arndt (1992) argued that the discussion of vertical integration in hospitals is incomplete. He further suggested the adoption of more diverse theoretical background for the discussion of vertical integration in the healthcare organizations. Most studies in the healthcare organizations, according to his argument, explained the motive of vertical integration based on economic theories (e.g., transaction costs, market power), which are problematic to explain the motives of late adopters of vertical integration.

2. Diversity Measurement

Considerable attention has been devoted to measurement issues in the context-free literatures (Fahey & Christensen, 1986; Pitts & Hopkins, 1982). Attempts to measure the extent and type of firm diversity have followed two main avenues: (1) continuous measures developed from Standard Industrial Classification (SIC) codes, and (2) categorical measures (Hall & St. John, 1994).

In measuring firm diversity, studies adopting the continuous measures simply count the number of different products or businesses a firm has in or weight the products or

businesses by relative size of sales and assets (Gorecki, 1980; Montgomery, 1982). In contrast, the categorical measures are based on the premise that the type of diversity - related or unrelated - influences the performance of the firm (Rumelt, 1974). Montgomery(1982) found that the categorical measure was superior to continuous measures for describing differences in performance among firms.

In measuring diversity, the healthcare organizations seems to follow the SIC guideline, but there is no standardized criteria that can be applied in the study of hospital service diversification. For example, Wheeler and his colleagues (1999) measured diversification by "the total number of subacute beds operated by a hospital in a given year (69)" while Clement (1987) measured it by "the percent of total gross revenues derived from diversifying services (991)." Therefore, the standardized criteria measuring diversification is urgently needed to enhance the reliability and validity of the study in the healthcare organizations.

3. Divestiture: Contraction Strategy

In contrast to diversification, contraction strategies decrease the size and scope of operations (Ginter et al., 1998). Divestiture has been an issue in strategy research because it is closely related to unrelated diversification through acquisition (Bergh, 1997).

Studies in the context-free world showed that many unrelated businesses are divested because they do not meet performance expectations (Capon, 1999; Duhaime & Grant, 1984). It was an attempt that companies want to improve internal control and efficiency (Hoskisson & Johnson, 1992; Hoskisson et al, 1994; Hoskisson & Turk, 1990), but most studies showed that divestment strategy is negatively associated with corporate value (Woo et al., 1992; Wright & Ferris, 1997).

Since the introduction of the prospective payment system (PPS) in the healthcare industry, the reduction of excess capacity (reducing hospital beds) or eliminating unprofitable services have been an issue in the healthcare organizations (Cerne & Montague, 1994). Despite its frequency and necessity, literatures analyzed the operational reduction empirically are absent while prescriptive discussions are abound (Lee & Alexander, 1999a). Only three empirical studies were available in assessing the effect of operational reduction, and their results were

even inconsistent (Lee & Alexander, 1999b; Mick & Wise, 1996; Woodward et al., 1999). One study found the improved financial performance of a medical center after the reduction of services, but the results are limited because they assessed only one hospital (Woodward et al., 1999). In contrast, Mick and Wise (1996) used a national sample of 797 rural community hospitals, and they found no significant relationship between hospital downsizing and financial performance. Finally, Lee and Alexander (1999b) analyzed the downsizing effect in community benefit. They found that downsizing would provide the higher risk of hospital closure.

4. Means for Implementing Corporate Strategy

After organization decides the types of corporate strategy they pursue (i.e. expansion, contraction, or status of quo), the manager's next decision is which of the means for implementing corporate strategy should be chosen. The branches of research in this area categorized three means for implementing corporate strategy: (1) mergers and acquisitions, (2) joint ventures, and (3) strategic alliances (Macintosh & Maclean, 1999; Montgomery 1988).

1) Mergers and Acquisitions

Most studies on mergers and acquisitions have been performed in the 1990s because of its popularity in the 1980s, (O'Shaughnessy & Flanagan, 1998; Ginter et al., 1998). Studies of mergers and acquisitions in the context-free world investigated (1) the acquisitions of unrelated business or organizations (Bergh, 1997); (2) motives for mergers and acquisitions (Trautwein, 1990; Walter & Barney, 1990); (3) the likelihood of a layoff and turnover of employees in target firms after an acquisition or merger (O'Shaughnessy & Flanagan, 1998; Walsh, 1988, 1989; Walsh & Ellwood, 1991); and (4) the effect of mergers and acquisitions on firm performance (Brush, 1996; Lubatkin & O'Neill, 1987).

Most empirical studies in the healthcare organizations heavily focused on the outcomes of mergers and acquisitions. They have two veins of empirical research based on the level of outcome variables: (1) organization-focused, and (2) community-focused outcome variables. The former analyzed the effect of mergers and acquisitions on the financial performance of healthcare organizations (e.g. net revenue, or operating expense) (Greene,

1990; Mullner & Anderson, 1987). In contrast, rooted in economic theories, the latter assumes that the final beneficiary of mergers and acquisitions is community (e.g. patients), therefore, it assessed how mergers and acquisitions would affect the community benefit. In this vein, the studies adopt the price or cost of hospitals, or the level of competition as outcome variables (Connor et al., 1997; Lynk, 1995).

Hospitals involved in mergers and acquisitions showed improved profitability compared to non-merging hospitals (Wooley, 1989) or to the industry average (Mullner & Anderson, 1987). In addition, merged hospitals also showed enhanced operational efficiency such as reduced operating expense (Greene, 1990), strong capital structure (Briggs et al., 1981), and high occupancy rate (Alexander et al., 1996).

Studies measuring community benefit, however, showed somewhat inconsistent results. Lynk (1995) found no evidence on systematic price increases by private not-for-profit hospitals. However, by using same sample data, the following two studies found price increases in private not-for-profit hospitals (Dranove & Ludwick, 1999; Simpson & Shin, 1997). In addition, one study showed that, regardless of their ownership type, hospitals raised their price in response to merger (Keeler et al., 1999).

The inconsistent results led to the discussion of possible contingent effect of market condition in the study. Studies found that improved community benefit is particularly salient in market with higher HMO penetration and strong competition (Connor et al., 1998; Guo & Bazzoli, 1998). In addition, Alexander and his colleagues (1996) found that mergers occurred in era of prospective payment system (PPS) displayed greater improvement in operating characteristics than mergers in the pre-PPS era.

2) Joint Ventures

A Joint Venture is "a combination of the resources of two or more separate organizations to accomplished designated task (Ginter et al., 1998: 194)." Hennart and Reddy (1997) argued that joint ventures are preferred over mergers and acquisitions when a firm has little experience in the market, and when a firm has the same line of product as possible partner. Studies in joint ventures have analyzed the motives of joint ventures (Berg & Friedman, 1980; Kent, 1991), and environmental determinants of joint ventures (Oliver, 1990).

Studies in the healthcare organizations also showed similar trend of research. Throughout the 1990s, the most popular type of joint ventures has been the hospital/physician joint ventures (Lee & Alexander, 1999a). Because of its popularity in late 1990s, studies of joint ventures in the healthcare organizations has yet to be widely investigated.

Earlier study by Jacobson (1989), by analyzing the three cases of hospital/physician joint ventures, identified that hospitals and physicians decided to form the joint ventures to purchase expensive equipment, and to organize a clinical program. Also, one study showed that hospitals with lower margins and higher costs were more likely to form joint ventures with physicians (Mark et al., 1998).

Couple of studies have attempted to analyze the behavior of physicians in hospital/physician joint ventures. Kocher (1998) found that joint ventures generated greater physician involvement in decision-making and result in lower physician-hospital conflict. The other study showed that hospitals aiming at forming joint ventures were more likely to have strategies to modify physician behaviors and to integrate physicians, and the number of strategies implemented in relation to physician behaviors was positively associated with financial performance (Mark et al., 1998).

Only one study investigated the environmental determinants of joint ventures (Burns et al., 2000). Specifically, the study investigated the impact of HMO market structure on the formation of hospital/physician joint ventures, and found that the formation of joint ventures is affected by the number of HMOs in the market rather than by HMO penetration.

3) Strategic Alliance

Strategic alliance, a loosely coupled arrangement, is designed to achieve some long-term strategic purpose not possible by any single organization (Ginter et al., 1998). Studies in strategic alliance have shown that organizations strategically allied to reduce the cost and share the resources (Glaister & Buckley, 1996; Sakakibara, 1997). A firm's current state of strategic position (Eisenhardt & Schoonhoven, 1996), the role of leaders (Ellis, 1996), and awareness of partners' intent (Hitt et al., 1995; Serapio & Cascio, 1996) are found to be associated with success or failure of strategic alliance.

Most studies of strategic alliance in the context-free world have investigated the

post-alliance effect. The results of studies have shown that announcement of alliance enjoyed greater returns in the stock market (Das et al., 1998), greater chance to develop new products (Deeds & Hill, 1996), greater opportunity for innovation (Shan et al., 1994), and greater reputation (Dollinger et al, 1997).

Since strategic alliance in the healthcare organizations has emerged recently, the impact of this inter-organizational form has yet to be widely investigated (Lee & Laexander, 1999b). Five empirical studies in analyzing strategic alliance of hospitals were found. Couple of studies has investigated the determinants of success on strategic alliance. They found that a shared vision between potential collaborators built a strong foundation for a successful strategic alliance (Nelson et al., 1999), and hospitals with greater resources and more payer mix were more likely to join alliance (Zinn et al., 1997).

The other two studies were assessed the benefit of strategic alliance to hospitals. One study found that membership in a strategic alliance was positively associated with net patient revenue, but had no significant relationship with cash flow or expenses (Clement et al., 1997). A study by Chan and his colleagues (1999) found an inverted-U pattern of relationship between size and operational efficiency of the consortium. In other words, operational efficiency was improved as the size of the consortium is increased, but was decreased as the consortium became too large (Chan et al., 1999).

Remaining one study is worth to mention separately (Kaluzny et al., 1993). In evaluating the performance of strategic alliance between community clinical oncology program (CCOP) and National Cancer Institute (NCI), the study adopted quality-based measure, accrual credits earned by patient in each NIC-approved protocols. The study found that policy environment and operational structure of alliance were key contributors to explain the performance of CCOP.

V. Competitive Strategies

As previously described, competitive strategies has four sub-streams of research: (1) Strategy-Conduct-Performance (SCP) (industry-focused), (2) Business strategy, including

strategic groups and generic strategies(firm-focused), (3) Competitive dynamics, including multi-point competition and competitor action-reaction (individual market level-focused), and (4) RBV (Resource-Based View), which deals with internal resources of firms (inner-firm focused). However, empirical studies focused on the hospitals industry were rare across the four sub-streams of competitive strategies. Only few studies were available under the category of business strategy.

1. Strategic Groups

The concept of 'strategic groups' is introduced by Hunt (1972) to describe intra-industry structure, a level of analysis between the individual firm and the entire industry (Nath & Grucia, 1997). Although no formal definition is universally accepted, researchers have continuously adopted Porter's (1981) version: "a group of firms within the same industry making similar decisions in key areas." While the existence of strategic groups has been sufficiently documented, a growing number of empirical studies have shown that group membership has performed poorly as a predictor of firm profitability, and, therefore, have not found performance differences among groups in general (Cool & Dierickx, 1993; Fiegenbaum & Thomas, 1995; Lawless et al., 1989).

In contrast, studies in the healthcare organizations showed that strategic group membership has impact on overall performance. Three empirical studies were available in the hospital settings. Two studies examined the effect of strategic group membership on nursing home performance (Marlin et al., 1999; Zinn et al., 1994). Both identified seven strategic groups in the nursing home industry, and found that group membership has performed as a predictor of profitability. They also found that strategic groups providing a continuum of care (Zinn et al., 1994), and with high private and Medicare utilization (Marlin et al., 1999) had the best patient outcomes.

One remaining study in this category examined the strategic groups in acute care hospitals in the state of Maryland (Rosenstein, 1995). The author identified four distinct strategic groups of acute care hospitals based on the structure of post-acute care the hospitals provided, and all four groups were significantly differ from one another in terms of patient outcomes (e.g. the

number of discharges, the severity of illness, and the number of complications experienced by patients).

Different results of empirical studies between two different contexts may be rooted in the adoption of different outcome variables. Studies in the context-free world usually adopted the variables of financial performance while studies in the healthcare organizations adopted the overall performance variables including financial performance and patient outcomes.

2. Strategic Types (Generic Strategies)

While researches on strategic group focus on within one industry, studies on generic strategies do not limit themselves to one industry. There are two widely accepted and applied typologies of generic strategies: (1) The Miles-Snow typology (Miles & Snow, 1978), and (2) The Porter typology (Porter, 1981). While Porter's product has been popular in real world, most research works adopt the typology of the Miles-Snow. They classified the strategic types based on adaptive decision patterns; prospector, analyzers, defenders, and reactors (Miles & Snow, 1978).

Research in this area has four goals: (1) identification and nature of strategic types (scope and breadth), (2) validity of models in strategic types, (3) the link between generic strategies and environment, and (4) the differential performance implications of generic strategies (Fahey & Christensen, 1986; Zahra, 1989). Except the study of scope and breadth in generic strategies, although only four empirical studies were available, remaining three research streams can be identified through the healthcare organizations.

First, one study examined the model validity of strategic types using data from over 400 organizations in the healthcare organizations (Shortell & Zajac, 1990). The authors point out the inherent deficiency of the scales used to classify the hospitals based on the Miles-Snow typology. Following studies attempted to expand upon the convergent validity investigations of Shortell and Zajac (1990) (Buchko, 1994; James & Hatten, 1995).

Second, two studies were devoted to identifying the link between generic strategies and environment in the healthcare organizations. One study found that environmental factors did not have impact on hospital strategies while organizational characteristics showed significant

impact on hospital strategies. Specifically, size, membership, ownership, and severe case mix of hospitals were more likely to be related in pursuing proactive strategies (Ginn & Young, 1992). However, Zajac and Shortell (1989) found that hospitals change the type of their strategy in response to environmental change. They also found that the existence of prior strategy in hospitals was a precursor of strategic change. In the contest-free world, these kinds of inconsistency were also identified (Dvir et al., 1993; Jennings & Lumpkin, 1992).

Finally, this area of research has put a fair amount of effort into identifying the link between generic strategies and performance. Based on the Miles-Snow typology, most studies in the context-free world showed that defenders, prospectors, and analyzers performed equally well and were superior to reactors (Conant et al., 1990; Smith et al., 1989). Two relevant empirical studies were identified in the healthcare organizations. One study, using the Porter's typology, found that hospitals that follow a focused cost leadership strategy had superior performance while hospitals that use a combination of cost leadership and differentiation performed the poorest (Kumar et al., 1997). The other study, adopting the Miles and Snow's typology, found that defenders were significantly less profitable than the other generic strategies (Zajac & Shortell, 1989).

VI. Concluding Remarks and Future Suggestions

Looking back at the past four decades of empirical research evidence, I tried to assess an external validity of the theoretical framework developed in the context-free world to the healthcare organizations, the context-specific world. However, most lines of inquiry were not able to assess an external validity because of the absence of empirical findings in the healthcare organizations. Acknowledging the necessity of empirical investigation of strategy content in the healthcare organizations, it is possible to draw at least three future directions in this area, and they are all related to issues of measurement development.

First, research on strategy content in the context-free literatures showed that researchers are tracing back to examine fundamental questions such as whether strategic groups exist (Barney

& Hoskisson, 1990) or whether corporate strategy matters (Bowman & Helfat, 2001). One study argued that the backward trend of research in strategic types is rooted in inconclusive results of past studies, due to inadequate model specification (Reger & Huff, 1993).

Such inconsistency were also existed in the study of healthcare organizations. In addition to inadequate model specification, the absence of valid measurement also plays a pivotal role in generating unreliable research results. As previously described, for example, there is no standardized criterion available to measure the level of diversity in the healthcare organizations, and studies in hospital service diversification operationalized in different ways. (Clement, 1987; Wheeler et al., 1999). Thus, future studies should continue to put efforts into examining basic questions by calling for exploration of sophisticated measurements.

Second, the study shows the absence of comparative studies among different strategic decisions made by hospitals. For example, it is possible to analyze the firms' choice between mergers and joint ventures as the means for implementing corporate strategy. One study performed in the context-free world found that joint ventures are preferred over mergers and acquisitions contingent upon environmental factors (Hennart and Reddy, 1997).

The comparative study allows managers of hospitals to decide which strategy is more appropriate in given situation. Because of the fundamental shift in the institutional environment (e.g. increased competition and uncertainty), the closure of hospitals has been an issue in the healthcare industry. Therefore, choosing a right strategy for hospitals would help hospitals to survive in a highly competitive environment. In addition, from a researcher's perspective, the comparative study would lead researchers to develop comprehensive analytical tools (Lee & Alexander, 1999a).

Finally, the efforts of research should focus on combining process and content areas in research of strategic management. The rationale for this trend is a 'synergy effect' that results from merging these two areas. That is, weaknesses of one area will be compensated by strengths of the other area. Several studies in the context-free world attempted to assess possible synergy effect by combining these two areas (Huff & Reger, 1987; Ketchen, Jr. et al., 1996; Miller et al., 1988; Olson & Bokor, 1995). These studies argued that process and content interaction significantly enhanced explanation of performance. Therefore, the adoption

of this type of research in the healthcare organizations would expect to generate the same positive effect that already appeared in the context-free world.

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