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Strategies Ontario Hospital Administrators Apply to Generate Non-Government Revenue to Remain Sustainable

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This is to certify that the doctoral study by

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Doctoral Study Submitted in Partial Fulfillment

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Abstract

Health care administrators in Ontario want to transform health care with a focus on improving efficiency and quality of care, yet they pay little attention to increasing revenue. The purpose of this qualitative case study was to explore strategies Ontario hospital administrators apply to generate nongovernment revenue to remain sustainable. The target study population consisted of 2 chief executive officers and 2 chief financial officers at Ontario academic research hospitals. The conceptual framework for this study included radical organizational change theory supported by complexity leadership theory, and grounded in an evidence-based approach. The researcher conducted open-ended semi-structured interviews and made efforts to collect relevant documents. The data analysis process included coding of the interviews followed by identifying themes and aggregate dimensions. Five themes emerged including working within the fiscal reality, the impact of the political environment, the focus on the mission, nongovernment revenue generation, and opportunities for the Ontario academic research hospital. The application of the findings from this study may contribute to social change by encouraging hospital executives to adopt a more coordinated and consistent approach to generating nongovernment revenue to support the mission of their hospitals.

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Dedication

I dedicate this dissertation to best friend and partner, Jackie Quigley Naus. Thank you for supporting me and for loving me as I pursued this dream. You are the best!

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I would like to thank my Chairperson, Dr. Carol-Anne Faint, for her guidance and encouragement throughout this process. I am also thankful for the support of my Committee member, Dr. Craig Martin, and URR member, Dr. Rocky Dwyer.

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Table of Contents

Section 1: Foundation of the Study

Health care in Ontario, Canada, involves providing care with limited resources. In Section 1, I presented the method, design, and conceptual framework of the study and provided a comprehensive literature review. I addressed the challenge of providing the best care possible for all citizens within a single-payer system. More specifically, I explored a system struggling and in need of new approaches.

Background of the Problem

Health care in Canada is considered a right, in contrast to the United States, where health care is considered a privilege (Bhatia & Orsini, 2014). Gettings et al. (2014) confirmed the negative perception toward commercial activity within the field of medicine in Canada. A number of researchers focused on how systems improvement can benefit patient care (Ouyang, Stephen, & Spohrer, 2013; Singh, Wheeler, & Roden, 2012). Other researchers developed theses predicated on changing the Canada Health Act (1985) to allow privatization of health care as a means to generate revenue (Sutherland, Crump, Repin, & Hellsten, 2013). French and Miller (2012) discussed the emergence of the entrepreneurial hospital but examined research conducted for commercial purposes within the hospital. Revenue from research is not general revenue but rather typically supports further research. Most promising was the literature related to innovation providing a means to explore opportunities within the existing system, but very little of this work focused on revenue generation (Marchildon, Verma, & Roos, 2013; Strumpf et al., 2012). Little research regarding sources of revenue within the Canadian health care

system was available, and when research was available, the results were generally negative (Duggal, 2008). This constitutes the gap in knowledge.

Problem Statement

Health care administrators in Ontario wanted to transform health care with a focus on improving efficiency and quality of care, yet they did not consider increasing revenue (Collier, 2011). Hospitals required Canada Health Act (1985) compliant, nongovernment sources of revenue due to health care consuming 42% of the total budget (Duncan, 2012). The general business problem was that hospital executives were uncertain how to increase revenue, yet financial constraints were forcing them to reduce costs or find new sources of revenue (Stabile & Thomson, 2014). The specific business problem was that some Ontario hospital administrators lack strategies to generate nongovernment revenue to remain sustainable.

Purpose Statement

The purpose of this qualitative case study was to explore strategies Ontario hospital administrators apply to generate nongovernment revenue to remain sustainable (Laxton & Yaya, 2013). The population for the study was Ontario's 24 academic research hospitals. I reviewed information from 2015 financial statements to identify existing nongovernment revenue generating activities, interviewed two chief executive officers (CEOs) and two chief financial officers (CFOs) at large (greater than $1 billion in revenue) and medium-sized ($500 million to $1 billion in revenue) Ontario academic research hospitals, and as part of the interaction with the executives, requested information on nongovernment revenue generating activities (brochures, flyers, websites,

etc.). Merriam (2014) argued for adjusting the size of the sample until reaching a point of saturation or redundancy. Interviewing four executives provided reasonable coverage given the phenomena studied and purpose of the study (Merriam, 2014). The interviewed individuals, representing senior leadership at these hospitals, provided guidance to other academic research hospitals; in fact, their guidance may apply to all Ontario hospitals struggling to address the challenge of providing care to the people of Ontario with limited resources.

Nature of the Study

Qualitative research required deep contextual knowledge of the subject matter and a combination of multiple disciplines (Cheng, Birkinshaw, Lessard, & Thomas, 2014). Answering my research question, what strategies might Ontario hospital administrators apply to generate nongovernment revenue to remain sustainable, required a qualitative approach because the academic literature, as well as the nonacademic literature, contained little information regarding strategies (either successful or unsuccessful) to increase sources of revenue. Quantitative research, used often to answer how much or how many, with the goal of predicting, controlling, describing, confirming, and testing hypotheses (Merriam, 2014), was not appropriate in the case of exploring nongovernment revenue generation in Ontario hospitals. Nongovernment revenue generation was relatively unknown, and the lack of theories meant that using the concept in a predictive fashion was not feasible. It was also too early in the evolution of knowledge regarding nongovernment revenue generation in Ontario hospitals to support a mixed methods approach. A mixed methods approach combines qualitative and quantitative methods,

often triangulating qualitative and quantitative data to develop a deeper understanding (Venkatesh, Brown, & Bala, 2013). Ontario hospitals do generate nongovernment revenue, but *how* was not publicly discussed. A public discussion starts with a case study describing what some of Ontario's hospital executives do and making the information widely available. Starting the discussion means beginning to create testable strategies, eventually leading to societally acceptable approaches. A qualitative study allowed for interpretation and the justification for the interpretation in a public forum, ideally leading to change and further research (Merriam, 2014).

I considered narrative, phenomenological, grounded theory, and ethnographic research, but the case study approach was ideal for exploration (Yin, 2014) and hence most appropriate for my research topic. A pragmatic approach allowed for the identification of effective strategies as well as the identification of the local cultural context enabling strategies to be successful. The purpose of the proposed research was to highlight successes and struggles, provide an appropriate context, and then develop a roadmap for use by all Ontario and Canadian academic research hospitals. Narrative researchers typically explore the life of an individual (Merriam, 2014), whereas I explored the boundaries and strategies employed by institutions. Phenomenological researchers describe the essence of a lived phenomenon (Merriam, 2014), whereas I described the mechanics and processes used by institutions to generate revenue. Grounded theory researchers focus on building theory from data (Merriam, 2014); whereas I explored what creates successful revenue generation. Ethnographic researchers describe and interpret group cultures (Merriam, 2014), whereas I analyzed the bounded

hospital system. None of the other methods provided the in-depth description and analysis of the case study as required in the exploration of nongovernment revenue strategies in Ontario academic research hospitals; therefore, I chose a qualitative case study as the format for my study.

Research Question

The central research question was: What strategies do some Ontario hospital administrators apply to generate nongovernment revenue to remain sustainable?

Interview Questions

The following were the interview questions used for my study:

1. What is your role within [name of institution]?
2. How would you describe the current financial situation at the hospital?
3. What nongovernment revenue does your hospital generate?
4. Why did you choose to pursue these opportunities as opposed to others?
5. Describe any nongovernment sources of revenue that you no longer pursue?
6. What factors determine whether your hospital is fully realizing its nongovernment revenue-generating potential?
7. What, if any, are the negative consequences of revenue-generating activities?

8. What plans, if any, do you have to generate additional nongovernment revenue?
9. What, if anything, needs to change to facilitate generating nongovernment revenue?
10. What additional information can you provide to assist my understanding of nongovernment revenue generation (brochures, flyers, websites, etc.)?

Conceptual Framework

Constructing the conceptual framework for my study required a careful understanding of the issues affecting the existing state of Ontario's academic research hospitals. A number of theoretical constructs were critical to understanding the hospital and the health care system, including organizational transformation, leadership, and the history of evidence-based change. More specifically, implementing change in these systems involved entities employing thousands of individuals, including some of the most highly educated members of society, and operating across decades if not centuries. Within the complex system, leaders must find ways to motivate and create the environment for change. The conceptual framework guiding my study was radical organizational change theory (Lee, Weiner, Harrison, & Belden, 2013), supported by complexity leadership theory (Weberg, 2012), and grounded in an evidence-based approach (Eddy et al., 2011; Smith & Rennie, 2014).

The modern hospital in Ontario was a complex organization requiring sophisticated organizational approaches to systems change. Lee et al. (2013) described

radical organizational change that occurs when the external conditions and internal dynamics of an organization interact under the influence of changing market conditions, changing institutional conditions, and declining organizational performance (leading to friction between stakeholders). The complex interplay of factors described by Lee et al. (2013) directly applied to the situation facing Ontario academic research hospitals, and therefore provided a solid conceptual framework for my research study.

Furthermore, I acknowledged the impact of leadership on the Ontario academic research hospital and the ability of both to evolve. Complexity leadership theory (Weberg, 2012) best described leadership in a complex health care organization with minimal control and structure. Understanding effective leadership within the hospital required a shift away from leader-centric thinking and a move toward collaboration, problem solving, innovation, and other outcomes leading to successful adaptation (Weberg, 2012).

Administrators, staff, and, to some extent, the general public, in Canada framed change within the public health care system through the lens of an evidence-based approach. The concepts pioneered by Eddy et al. (2011) and the Evidence-Based Medicine Working Group (Smith & Rennie, 2014) were firmly ingrained in Canadian medical and hospital culture to the point where changes proposed without supporting evidence rarely succeed. The conceptual framework of using evidence to guide practice provided the foundation for the approach to the study of nongovernment revenue generation in the Ontario hospital. The process of creating evidence involved analyzing research and developing guidelines. Groups sponsored by an organization, using an

explicit, rigorous process, developed a generic approach (applies to a class or group) that becomes a guideline. The ultimate effects of these guidelines were indirect (Eddy et al., 2011). The evidence-based approach, when applied to revenue generation, facilitated the acceptance of the new concepts within the hospital community.

Radical organizational change theory, complexity leadership, and evidence-based medicine were foundational concepts for my study. Positively impacting the financial performance of Ontario's academic research hospitals required understanding the system through the three constructs. Changes placed appropriately within the concept of radical organizational change theory, carefully led by both medical and administrative hospital leaders, and supported by evidence, were critical in strengthening Ontario hospitals in a challenging fiscal environment.

Operational Definitions

The key definitions and concepts in my study related to the Canadian health care system and more specifically to health care in the province of Ontario.

Canada Health Act: The Canada Health Act is a federal act defining the standards to which the provinces must adhere to receive funding from the federal government (Lewis, 2015).

Nongovernment revenue generation: Nongovernment revenue generation refers to the funds generated by hospitals in the province of Ontario that are not from the provincial government (as defined by the researcher: Naus, 2015).

Ontario Health Insurance Plan (OHIP): The Ontario Health Insurance Plan (OHIP) is a universal health insurance plan for all residents of Ontario. Every participant

in Ontario's provincial health insurance plan receives a unique 10-digit number enabling access to health care (Hwang et al., 2013).

Single-payer system: The single-payer system refers to the system in Canada whereby the provincial government, reimbursed by the federal government, pays the expenses of the hospital through a global operating budget and provides separate grants for capital projects (Himmelstein et al., 2014). In other words, the provincial government, funded through tax revenues, pays an individual's primary health care costs.

Assumptions, Limitations, and Delimitations

In my research I used a case approach to examine the perspective on revenue generation of a limited number of senior executives. The approach and the small sample size affected the generalizability of the results. Below I detailed my assumptions and the limitations and delimitations of the study.

Assumptions

Assumptions are unverified facts that were outside my control but provided relevance to my study (Simon, 2011). Assumptions represented my beliefs and biases (Bloomberg & Volpe, 2012). I made three assumptions in my study. First, I assumed that the participants were candid and honest in their responses. Second, I assumed that the individuals had a sound understanding of hospital operations and the revenue-generating activities occurring within them. Third, I assumed that all leaders interviewed had the best interests of the institution and the health care system in general in mind when answering the questions. As I interviewed senior executives at medium-sized and large

hospitals, I used a unique or atypical sample (Merriam, 2014) to ensure that the executives interviewed were experts in health care.

Limitations

Limitations are potential weaknesses that were outside my control (Simon, 2011) or external conditions that impact the study scope (Bloomberg & Volpe, 2012). There were three potential limitations in this study. First, as a case study, the results were particularistic and focused on the specific phenomena being studied (Merriam, 2014). The results of my study applied to the specific hospitals whose executives I interviewed as part of my project. Generalizing to other hospitals in Ontario, let alone nationally or internationally, is problematic and requires extreme caution. The successful strategies uncovered as part of my research exist within a specific context, and identifying and describing the context accurately in my research were part of the challenge. A second limitation arose from the potential to create an overly descriptive study (Merriam, 2014). Using the case study approach, I attempted to strike a balance between an accurate and complete description of the subject matter and the interpretation of the information to inform strategic direction and further research. The third limitation was the potential bias introduced by the integrity, or lack thereof, of the researcher, affecting the research project (Merriam, 2014). Caution was required to ensure that the preconceived notions of the researcher minimally affect the study (Merriam, 2014).

Delimitations

Delimitations defined the boundaries of a study and identified the scope limitations (Simon, 2012). Delimitations were also conditions imposed by the researcher

to constrain the scope of the study (Bloomberg & Volpe, 2012). The delimitations of my research project, with its focus on strategies employed, had limited focus on the quantity of the impact. In other words, I did not explicitly explore the actual dollar contribution of nongovernment revenue on hospital operations. I was more interested in the changing cultural norms enabling the strategies to exist within a single-payer system. Merriam (2014) argued that delimitations are the single most defining characteristic of the case study.

Significance of the Study

The survival of Canada's health care system relied on the ability to control costs and generate revenue. Historically, Ontario academic hospitals generated revenue as an afterthought. The proposed study was a starting point for making revenue generation a focus for the hospital to ensure its long-term sustainability.

Contribution to Business Practice

I contributed to business practice by exploring how Ontario academic research hospitals generated revenue outside of delivering care. Webster (2012) described the shift occurring in Canada as cost control measures, a diversion of resources away from hospitals and toward patients living at home with chronic diseases, and changed health care delivery, and furthermore noted that Canadian health care is disorganized, archaic, and expensive. Hospitals needed to find innovative ways to deliver care and demonstrate efficient, creative, and effective use of resources. I believed the appropriate use of resources is dependent on fully exploring revenue-generating opportunities to achieve

maximal efficiency while staying true to the commitments of the Canada Health Act (1985).

Implications for Social Change

I contributed to social change by highlighting how socialized medicine in Canada was at a crossroads (Duncan, 2012). Cost-cutting approaches and government bailouts were at an end (Marchildon, 2013). In maintaining the vibrancy and effectiveness of Medicare, hospital executives must find new sources of revenue (Collier, 2011). Through my research, I provided a roadmap to adding socially acceptable approaches to identifying and capitalizing on new revenue sources.

A Review of the Professional and Academic Literature

The specific business problem was some Ontario hospital administrators lack strategies to generate nongovernment revenue to remain sustainable. In the province of Ontario, most discussions regarding the transformation of health care focused on improving efficiency and quality of care. Unfortunately, the discussions paid little attention to increasing revenue (Collier, 2011). Hospitals required Canada Health Act (1985) compliant, nongovernment sources of revenue to help them balance their budget. Help from the provincial government was unlikely as health care consumed 42% of the total provincial budget (Duncan, 2012). Hospital leaders were uncertain how to increase revenue, yet financial constraints were forcing them to reduce costs or find new sources of revenue (Stabile & Thomson, 2014).

My literature search began with my first course at Walden University in September of 2013. I knew that my area of interest was generating revenue for hospitals

within the Ontario health care system—revenue not from the provincial health care budget. I added seminal works and up-to-date research as I progressed through required courses. I utilized Google Scholar and the search terms *health care*, *Ontario, hospital*, and *nongovernment revenue*. I then broadened my search with revenue generation in hospitals as a secondary topic and primary topics, including *current state, universal health care, controlling cost, experience in other industries, sustainability, physician impact, attitudes toward business, evidence-based medicine, international perspectives, patient perspectives, leadership, entrepreneurship, organizational design, business models, new approaches, disruptive innovation*, and *new revenue streams*. As I completed my last 8100 course, I began updating my references to ensure that 85% or more were after 2012. I included a total of 108 articles (and 26 other sources), 93 of these are peer reviewed and published within the past 5 years. My process consisted of identifying the essential seminal works as I could not eliminate these works and then, for nonseminal work, conducting Google Scholar searches using the authors/researchers whose work I was attempting to update.

My literature review contained reports prepared by nongovernment organizations (such as the C.D. Howe Institute). I included only a fraction of the reports available as the reports are not peer reviewed, indicating that the topic of nongovernment revenue generation in Ontario academic research hospitals has not been the subject of academic study. At best, these organizations addressed the topic from a political perspective.

Health care in Canada, with *health care* defined as medically necessary hospital and physician services, ranked higher than in other Organization of Economic

Cooperation and Development (OECD) countries (Marchildon, 2013). However, as the cost drivers of health care continued to put pressure on the system (through increasing salaries and escalating utilization of prescription drugs), and as government budgets continued to shrink, there were increasing pressures on health care organizations to find cost reductions or nongovernment sources of revenue (Duncan, 2012; Marchildon, 2013). The focus of the proposed study was nongovernment sources of revenue in Ontario academic research hospitals. I explored the issue by reviewing the existing state of revenue generation in academic hospitals in Canada and in Ontario. I then explored the topic of universal health care to provide additional context and discussed the efforts to date to control costs in the system. Because health care is complex, I examined the potential lessons from other industries applicable to Ontario health care, followed by an examination of the sustainability of the health care system and threats to that sustainability. Health care, unlike a purely business-focused organization, had an element of social responsibility important in the Canadian context. Physicians, partially because of their fee-for-service reimbursement in Canada, played a unique role in health care and any changes contemplated. Complicating any proposed changes to the system was the attitude toward business and a culture of using evidence to guide decision-making. I explored the international experience in applying business principles to hospitals and discussed the patient perspective and social responsibility. Because hospitals are large, complex organizations, I explored the role of leadership and its impact. Health care entrepreneurs offered a unique perspective applicable to hospitals, as did the researchers exploring the role of organizational change. I also discussed business models and new

approaches to providing and funding care while considering the impact of not changing and clearly articulating the need for new revenue streams. Government-funded health systems were facing significant challenges (Webster, 2012), and only through innovation can management address the issues.

The Theory

To understand the academic research hospital in Ontario, and how changes occurred or were possible within the hospital, management must first recognize the link between organizational context and intra-organizational dynamics (Greenwood & Hinings, 1996). Hospitals in Ontario were complex, and large organizations, structurally resistant to change because of their size and long history. Lee et al. (2013), through their radical organizational change theory, provided the best explanation of radical changes and the extent to which the changes occur through evolutionary or revolutionary processes. In the following paragraphs, I provided an explanation of radical organizational change theory, the roots of the theory, its significance, and when the theory is relevant. As stated earlier, the conceptual framework guiding my study was radical organizational change theory (Lee et al., 2013) supported by complexity leadership theory (Weberg, 2012) and grounded in an evidence-based approach (Eddy et al., 2011; Smith & Rennie, 2014).

Radical organizational change theory, as described by Lee et al. (2013), was rooted in Greenwood and Hinings' (1996) work. Greenwood and Hinings suggested that radical change (often called transformational change) resulted from the interaction between external conditions and internal organizational dynamics (Lee et al., 2013).

Potential external conditions included changing market conditions, institutional conditions, and declining organizational performance, all leading to, or exacerbating, dissatisfaction among stakeholders (Lee et al., 2013). The stakeholders created pressure for change as dissatisfaction increased when the organization's mix of strategic orientation, resource allocation, power distribution, and underlying values threatened these same stakeholders (Lee et al., 2013). As Lee et al. (2013) pointed out; the dissatisfaction leads to change only when stakeholders also developed value commitments pointing to replacing accepted structures, systems, and values. In the Ontario academic research hospital context, the province's single-payer system placed clear financial pressures on the organization, and its' essentially frozen budget was forcing an organizational response.

Greenwood and Hinings (1996) focused on three themes to explain the incidence of radical change and the extent to which the pace of change was evolutionary or revolutionary. The first theme related to resistance. The authors argued that the normative embeddedness (within its institutional context) of an organization affects the extent to which the organization resists or accepts change. The second theme related to the incidence and pace of change across institutional sectors. The more tightly institutional sectors were coupled (structurally) affects how insulated the sectors were to change occurring in other sectors, and the variance in coupling affects both the incidence and the pace of change (Greenwood & Hinings, 1996). The third theme related to variance within sectors. The authors argued that incidence and pace further affected the variance in

internal organizational dynamics (Greenwood & Hinings, 1996). The three themes led to Lee et al.'s (2013) model including antecedents, processes, and consequences of change.

Greenwood and Hinings (1996) also discussed the significance of value commitment. The authors identified four generic patterns: status quo commitment (all groups committed to the existing organizational structure), indifferent commitment (groups are neither opposed nor committed), competitive commitment (some groups support one structure, others support a competing structure), and reformative commitment (all groups oppose the existing structure and seek to replace it) (Greenwood & Hinings, 1996). Furthermore, Greenwood and Hinings identified two additional factors contributing to transformational change: intra-organizational power dependencies (enables promotion of organizational change by dissatisfied groups) and capacity for action (includes understanding the desired outcome and having the knowledge, skills, and resources to manage the transition to the new system and operate within it). Lee et al. (2013) noted that Greenwood and Hinings described the conditions for change; however, the authors did not describe the process of radical change or the outcomes of such change.

Lee et al. (2013) further developed the theory first proposed by Greenwood and Hinings (1996) by presenting the accumulated evidence supporting the theory and by explaining the theory more fully. Lee et al. (2013) identified 55 articles examining intended organizational change. The authors identified antecedents of transformational or radical change, including changing institutional conditions, changing market conditions, performance crises, interest dissatisfaction, value commitment, power dependence,

leadership, capacity for action, and other factors (organization size, change in governance structure, and command-and-control culture) (Lee et al., 2013). In the health care sector, their research supported the idea of radical change occurring when institutional and market conditions were in flux, as was the case in Ontario's academic research hospitals, where hospital structures were evolving by adopting a more business-oriented approach (institutional) and government was limiting budget growth (market) (Lee et al., 2013). Executive leadership was critical in enabling transformational change (Lee et al., 2013), and the focus of hospital leaders in Ontario facilitated the transformation.

The process and consequence of organizational change remained relatively undocumented. Lee et al. (2013) suggested that transformational change efforts tended to follow a plan, but not in a linear fashion. The length of the change was unreported (Lee et al., 2013). The results of radical change were mostly positive and often dependent on organizational and environmental contexts (Lee et al., 2013). In the health care industry, research on change noted institutional forces as contextual factors for change, a heightened awareness of the role of value commitments, a tendency to follow a plan for change, and change initiated at the top of the organization (Lee et al., 2013). Effective and positive change in the health care sector remained understudied.

Radical organizational change theory provided the link between organizational context and intra-organizational dynamics (Greenwood & Hinings, 1996). The theory, although based on literature biased toward studies of successful transformations and studies with short time frames, highlighted several important themes: executive leadership, capacity for transformation, and precipitating factors, both internal and

external, supporting radical change (Lee et al., 2013). Although transformational or radical change rarely went according to plan (Lee et al., 2013), the need for change was driving Ontario academic research hospitals to adopt new approaches, taking them outside their traditional sources of revenue.

The State of Health Care in Ontario

Canadians have the advantage of universal Medicare, but the meaning of this utilization has not been thoroughly explored. There are three recognized dimensions of universal Medicare: the population covered, the costs covered, and the health services covered. Marchildon (2014) noted that for Canadians, universal coverage was complete with respect to the population and expenses covered but limited in terms of what health services were covered (for example, acute care is covered, but home care and prescription drugs were not covered). Delivering value in Medicare meant optimizing quality, service, and cost (Makadon, Bharucha, Gavin, Oliviera, & Wietecha, 2010). Webster (2012) argued that the Canadian health care system was disorganized and expensive, as well as substandard and archaic. Webster (2012) noted that a reluctance to reform the system existed, resulting in little evolution since the 1970s. Although Canadians believed that Canada's health care system protects them, Canadians experiencing financial difficulty still faced unaffordable out-of-pocket costs (Himmelstein, Woolhandler, Sarra, & Guyatt, 2014). Canadians had a bureaucratic system that was difficult to navigate, static, and impervious to meaningful change. Perhaps focusing on factors that management can affect positively, such as revenue generation, provided an opportunity to initiate a larger program of change.

The Canadian health care system faced additional pressures, both systemic and external. Many hospitals have enjoyed the financial benefits of conducting trials on behalf of the pharmaceutical industry, but the revenues were at risk as companies faced losing patents on many blockbuster drugs (DeRuiter & Holston, 2012). Strumpf et al. (2012) argued that Canada faces a period of potentially transformative change in primary care with the implementation of specific and well-defined delivery models to broad, system-wide quality improvement initiatives (aimed at altering physician behavior) to creating practice networks. The authors indicated that Canada could achieve primary health care transformation through voluntary participation (Strumpf et al., 2012), but the changes were more difficult to achieve in the hospital sector. Health care reform in the hospital environment was extremely difficult. MacKinnon (2013) discussed three structural problems: fee-for-service physicians and a focus on hospitals, a funding model with no relationship between system users and cost, and a tension-filled federal-provincial structure making change difficult. Changing the environment, one supported by taxpayer dollars, was an extremely long process, reinforcing the argument for the consideration of alternative approaches.

The alternative approaches considered by health care leaders must occur within the context of universal health care. Canadians considered health care a right (Bhatia & Orsini, 2014), and many countries, with the notable exception of the United States, embrace universal care or are moving in the direction of universality. Allotey et al. (2012) discussed the challenges governments faced in determining the appropriate mix of regulatory and financing mechanisms resulting in the health care services appropriate for

their country. The authors argued for considering universal health care from the perspectives of equity and vulnerability, insurance and financing, coverage and satisfaction, and implementation (Allotey et al., 2012). Furthermore, Allotey et al. acknowledged that the social responsibility aspects of universal care were government responsibilities, and success required significant participation from the private sector. Similarly, Borgonovi and Compagni (2013) focused on social and political sustainability of universal health care but emphasized the factors affecting economic sustainability in health care, including prioritizing allocation of resources and ensuring optimized resourcing for health care. There were external factors affecting what universal health care looked like because universal health care had political, social, and economic dimensions.

Global financial crises impact health care and health equity. Ruckert and Labonté (2012) examined health equity and the impact of the 2008 global financial crisis and found lasting effects on the health of populations. These effects resulted from economic decline and health budget cuts, rising unemployment, qualitative transformations of health systems, reductions in welfare spending and programs, changes to aid flows, and labor market transformation (Ruckert & Labonté, 2012). Most governments responded initially with expansionary economic policies, but over time, the focus changed to closing budget deficits, with the effect felt most acutely by the more vulnerable members of society (Ruckert & Labonté, 2012). In Canada, with its robust health care system, austerity budgets and program cutbacks following 2008 further exacerbated the distribution of the social determinants of health and potentially led to health care inequity

(Ruckert & Labonté, 2014). The universal health care system, framed within an economic context, required choices, particularly during times of economic challenge, choices most often focused on cost containment.

Controlling Cost

Pushing against cost containment in universal health care were efforts at expanding the base of health care and concerns regarding the quality of care. Sutherland et al. (2013) discussed the potential role of financial incentives for funding public health care, including activity-based funding. The authors acknowledged that budget pressures were focusing policymakers on funding models that emphasize quality and outcomes at the lowest possible cost. Another concern regarding universal care was the quality of care. Brzezinski (2009) compared the U.S. and British health care systems and found no studies providing a direct comparison of the systems—systems with both triumphs and flaws. Nevertheless, the author noted a global trend in favor of universal health care (Brzezinski, 2009). Perhaps the focus for Canada's health care system should be on providing the best value for its citizens (Blomqvist & Busby, 2012a). Part of providing value involved controlling costs.

The first response to financial stress in the health care system was an attempt to control costs. Controlling costs (Detsky, 2012; Eddy et al., 2011; Emanuel et al., 2012) and aligning incentives (Dhalla & Detsky, 2011) required complex systemic changes. Detsky (2012) discussed three ways to control costs: getting rid of health insurance (resulting in individuals facing the full cost of care), simulating market forces (to induce consumer discipline), and implementing global budgets (applying top-down expenditure

constrains). Clearly, none of the three approaches was implementable. Emanuel et al. (2012) argued that the only sustainable solution to the health care dilemma was to control costs. To control costs effectively required controlling both the level of cost and the growth in costs (Emanuel et al., 2012). The authors argued for a coordinated strategy, including promoting payment rates within global targets, increasing the use of alternatives to fee-for-service payments, using competitive bidding for all commodities, and requiring exchanges to offer tiered products. Emanuel et al. further argued for requiring all exchanges to be active purchases, simplifying administrative systems, requiring full transparency of prices, making better use of non-physician providers, expanding the ban on physician self-referrals, leveraging federal employee programs, and reducing the costs of defensive medicine. Clearly, the controlling costs approach required phenomenal coordinated effort, which was not achievable by a single institution or network.

Perhaps more realistic were approaches that required leaders to focus on controlling costs using guidelines or aligning incentives. Eddy et al. (2011) used individualized guidelines to increase quality and reduce care costs. By using population-based guidelines to rank patients in order of expected benefit, a process conceptually similar to personalized medicine but using genetic information instead of clinical information, the authors demonstrated a clear benefit (Eddy et al., 2011). Dhalla and Detsky (2011) realized that for academic physicians, no incentive exists to improve health care quality. The authors argued that achieving academic notoriety meant a focus on achieving global renown, not improving health outcomes (Dhalla & Detsky, 2011).

Unless incentives aligned and cost control measures were realistic and implementable, the incentives and control measures had no value. Many of the cost control measures proposed were not realistic and perceived to have little value, and as a result, few succeeded in improving the system. This robust focus on controlling costs was a stark contrast to the relatively modest efforts at increasing revenue to create alternative sources available to improve and enhance health care.

Lessons from Other Industries

Health care systems were large and complicated, and although systems solutions are often complex, they contained valuable lessons. First, it was important to distinguish between systems thinking (thinking about social systems assumed to exist) and systemic thinking (which supposes a systemic social construction of the world). Understanding systemic thinking provided a base for action research (Harkins, 2011). Action research expanded knowledge and provided practical solutions (Rogers et al., 2013). Van der Lugt, Dooms, and Parola (2013) provided an example of action research in their study of hybrid organizations, in particular the port authority. The authors discussed critical factors leading to effective interaction between public entities (port authorities) and private companies leading to a number of strategic challenges: including reform, improving efficiency and effectiveness, guaranteeing long-term development, and developing the port network (Van der Lugt et al.). The lessons from action research applied directly to health care systems.

Engineering provided additional examples. Cure, Zayas-Castro, and Fabri (2014) examined the analysis of risk in health care and the requirement to integrate data from

disparate sources. The authors discussed human factors engineering and highlighted data from aviation and how leaders in the aviation sector used data to improve safety standards—processes that potentially apply to health care. The authors concluded that improving safety in medicine required equipping health care risk managers and health care providers with tools to proactively identify and address risk (Cure et al., 2014). Wong, Morra, Wu, Caesar, & Abrams (2012) used system dynamic principles to model emergency department activities. The authors concluded that their model provided a useful framework but acknowledged the challenge of incorporating multiple stakeholder perspectives across the continuum of care (Wong et al., 2012). Evident in the preceding examples was the complexity of working with whole systems. Understanding the systems was a significant challenge, but applying innovation within a systems framework adds an additional layer of complexity.

Innovation, although a foundational principle of medicine, was an understudied resource in health care (Dhar, Griffin, Hollin, & Kachnowski, 2012). Dhar et al. examined strategies for innovation in various industries to determine whether the strategies applied to health care. The authors identified freedom to be creative along with the structured management of ideas as key concepts and developed six categories of innovation strategies: dedicated time, formal teams, external ideas, idea-sharing platforms, company/job goals, and incentives (Dhar et al., 2012). Dhar et al. concluded that allocating employee time to innovation, creating separate innovation teams (to review and advise), and using outside collaboration created potential benefit for health care practice. Implementing the concepts in health care lead to long-term, sustainable

success as the implementation created the potential for innovative adaption. Mahsud, Yukl, and Prussia (2011) demonstrated that the key to effective organizations came from achieving ambidexterity in balancing efficiency (structured management) with innovation. Through combining ambidexterity and balance, organizations achieved sustainability.

Sustainability

Sustainability in an environment where ongoing government support was flat or shrinking was the challenge Ontario hospitals faced. Gamble (2012) highlighted eight issues hospital administrators must consider including were physicians aligned with the hospital's strategy, did the hospital deliver high-quality care, did the hospital have a strong leadership team, and was there a clear operating plan? Gamble also considered the following ideas: was there a compelling reason for the hospital to exist, was the hospital known for something, what was the payer mix (applicable to U.S. hospitals), and was the hospital large enough to withstand the risk of opportune investments? Similar questions regarding the financial sustainability of universal care in Canada were important. Laxton and Yaya (2013) estimated that, by 2030, Ontario's health care costs will represent 80% of the provincial budget and argued for alternative funding strategies. Sustainability required innovative and diverse strategies. Strumpf et al. (2012) noted Canada's focus on improving targeted organizational infrastructure, provider payment structures, the health care workforce, and quality and safety initiatives as drivers of positive change. The reforms were voluntary, incremental, and diverse and encouraged engagement and

participation by multiple stakeholders. The reforms highlighted the focus on sustainability in health care.

Another challenge to the health care system was sustaining initiatives shown to create positive results. Programs involving the elderly were a key example (SteelFisher, Martin, Dowal, & Inouye, 2013; Yue, Hshieh, & Inouye, 2015). Yue et al. demonstrated an estimated return of $1,200 to $2,700 per person per hospitalization and $13,000 per person in the year following discharge, whereas SteelFisher et al. (2013) studied 19 sites demonstrated the importance of communicating both the clinical and the cost effectiveness of programs. The leaders of both initiatives recognized the importance of communicating results in a manner meaningful to multiple groups, including hospital administrators.

The C.D. Howe Institute, a privately funded institute, produced a significant amount of research focused on Canadian health care sustainability. Topics examined included the use of capitation payments in Ontario (Blomqvist, Kralj, & Kantarevic, 2013), having fee-for-service physicians operating inside hospitals (Blomqvist & Busby, 2013), and paying family physicians (Blomqvist & Busby, 2012b). The center right think tank supported significant changes to Canada's health care system with a focus on the impact of the physician.

Physician Impact

Physicians played a central role in Canada's health care system. Some argued that a unique role based on a fee-for-service model was the primary driver of cost (MacKinnon, 2013). The pressure to remain relevant as physicians in an evolving system

was apparent (Lyons, 2010), and the perceptions of physicians as an expensive part of the system was also clear (Petch et al., 2012). Engaging physicians in the needed system transformation required an understanding of how to communicate effectively with them and avoiding common mistakes. Pratt, Fiol, O'Connor, and Panico (2012) discussed the need to improve the quality of intergroup physician-administrator relationships. Specifically, the authors discussed the intractable identity conflict wherein physicians and administrators do not identify themselves as members of the other group and each group has a negative opinion about the other; physicians were viewed by administrators as egotistical, narcissistic, and financially self-interested, whereas administrators were viewed by physicians as financially motivated, profit-oriented, nonclinical experts (Pratt et al., 2012). Furthermore, the authors argued that for micro-level work to occur, the relationships between the two groups must improve before attempting to implement broad structural changes (Pratt et al., 2012). Harkins (2011) discussed critical mistakes made in physician relations programs. The author's comments were particularly notable and representative of the perspective of a hospital management team selling services, a concept not common in the Canadian context. Harkins focused on the physician as a referral source to the hospital and treated the interaction between the hospital's sales and marketing people and referring physicians as a salesperson/customer relationship. Harkins' approach required engaging physicians in a collaborative fashion, leading to lasting professional relationships—an approach appropriate in today's budget-restrained Canadian hospital environment. The key to implementing systemic changes in health care required the development of partner relationships with key groups such as physicians.

Physicians were clear examples of knowledge workers. Zismer (2011) noted that physicians work best in a self-directed, self-managed environment, allowing them to maximize their professional judgment. Peckham and Hutchison (2012) supported the notion of the knowledge worker when examining the U.K. health care experience. The authors noted that although a large-scale, centrally driven primary care network may achieve economies of scale, locally driven networks offered the benefit of greater adaptability and argued for a judicious balance between the two (Peckham & Hutchison, 2012). How, then, did hospital management engage knowledge workers in transformative changes, or even iterative changes, moving the Canadian hospital in the direction of an entrepreneurial organization?

Attitude Toward Industry

The attitude toward a business approach in the academic research hospital was negative (Cutler, 2011). The problems plaguing businesses in general applied to hospitals, and the mistrust of corporations was evident in academic research settings (Brownlee, 2015). Kouchaki, Smith-Crowe, Brief, and Sousa (2013) demonstrated that mere exposure to money had a corrupting effect. The authors found that presenting money cues within a business decision framework increased the probability of unethical intentions and behavior (Kouchaki et al., 2013). Further exacerbating the problem was wide-ranging evidence supporting the negative perception, which included research examining the content of industry-supported medical school lectures (Persaud, 2014), bias found in high-impact versus low-impact journals (Bala et al., 2013), and differences in the volume of pharmaceutical advertising in medical journals (Gettings et al., 2014).

Additional evidence supporting the perception included patients as sources of revenue (Duggal, 2008) and the challenge of using unbiased experts when developing clinical practice guidelines (Neumann, Karl, Rajpal, Akl, & Guyatt, 2013). The relationship between private sector and public sector (hospital) institutions required careful and active management.

The fiscal reality facing many Ontario academic research hospitals meant that leaders needed to find new ways to conduct business, although they may need to avoid using the word *business*. In an editorial, Pope et al. (2015) described the demise of industry-sponsored arthritis clinical trials in Canada, with its corresponding impact on many research sites. Other sites explored public-private partnerships as a means to improve and sustain care. Barrows, MacDonald, Supapol, Dalton-Jez, and Harvey-Rioux (2012) reported on the Brampton Civic Hospitals' (Brampton, Ontario) use of partnerships to successfully improve care in both qualitative and quantitative ways. The work presented by Barrows et al. created transparency, which hopefully lead to more public-private partnerships and reduced the stigma associated with a business approach.

Significance of Evidence-Based Decision Making

The use of evidence-based decisions was pervasive in medicine. Evidence-based decisions did not exist in the 1970s (Eddy et al., 2011), but evidence-based medicine was practiced globally and combined the concepts of evidence-based decisions with evidence-based guidelines (Eddy et al., 2011). Nevertheless, the application of evidence-based knowledge was not straightforward; the application was, in fact, both an art and a science (Marchildon et al., 2013). Even reading systemic reviews and meta-analyses and applying

the findings were challenging (Murad et al., 2014), but in the application of evidence, medicine eliminated many unnecessary or inappropriate practices (Makic, Rauen, Jones, & Fisk, 2015). Using evidence-based approaches required continuous monitoring to ensure the identification of unexpected and unforeseen consequences as quickly as possible. For example, Palmer et al. (2014) identified potential increases in post–acute care admissions and uncertainty regarding the impact on other critical outcomes as the result of the implementation of activity-based funding. Palmer et al. demonstrated the need, in the hospital environment in particular, for providing evidence demonstrating the benefit of new approaches and monitoring the results carefully.

International Perspective

Understanding health systems and approaches in other countries was instructive. Ellis, Chen, and Luscombe (2014) discussed the variance between developed countries with respect to revenue generation for health care. Their comparison of Canada, the United States, Germany, Japan, and Singapore led them to conclude that each system had its strengths and weaknesses and that the five systems examined were representative of most countries' systems (Eliss et al., 2014). The work of Himmelstein, Jun, et al. (2014) focused on international medical costs and determined that much of the cost differential between countries such as Canada and the United States was due to significantly higher administrative costs, with the U.S. proportion of costs devoted to administration being the highest at 25.3% (Canada's proportion is 12.4%). Fuchs (2013a) indicated that the difference between the U.S. and other systems stemmed from Americans being more distrustful of government, a dislike in the United States of using redistributive public

policy to achieve equitable outcomes, and a political system different from that of most OECD countries. The challenge in many of the systems was in trying to make changes once the system became established.

Several countries, when faced with economic challenges, implemented significant changes. For example, Greece experienced the 2009 economic crisis acutely, and reduced public health expenditures and altered health care services and the pharmaceutical market (Simou & Koutsogeorgou, 2014). Researchers noted a post-crisis deterioration in public health, as demonstrated by rising rates of mental health issues, suicides, epidemics, and deterioration of self-rated health (Simou & Koutsogeorgou, 2014). Furthermore, Simou and Koutsogeorgou expressed concern about the focus on short-term reductions on expenditure that may have had dubious long-term societal consequences. The Netherlands came to similar realizations, and the comparison of changes to the Dutch system relative to England's system again highlighted the disruptive impact of economic pressures. England experienced a workforce redesign in health care in 2000 due to a mismatch between the demand and the supply of health care services (Bohmer & Imison, 2013). The results reported highlighted the difficulty in changing a complex system (Bohmer & Imison, 2013). Responding to economic pressures revealed a great deal about a nation.

The struggles and challenges from south of the Canadian border demonstrated how even the wealthiest nation is grappling with health care. Porter and Lee (2013) discussed the need to maximize value for patients and suggested a value-based reimbursement approach as a solution to the escalating cost of care. Emanuel et al. (2012)

argued for targeting cost drivers (both level and growth in costs), a reduction in costs for both private and public payers, and the need to target unnecessary administrative costs. Song et al. (2012) described the global health care payment system implemented in Massachusetts and noted that even with significant financial incentives utilization did not change rapidly. All of the examples suggested that changing the system as a whole, was extremely difficult. Despite significant economic pressure, historically, change happened in extremely small increments, if at all.

Patient Perspective and Social Responsibility

An important consideration when implementing change in the health care system was the perspective of the patient and the concept of social responsibility. Detsky (2012) listed nine high (important) level priorities, including restoring health when ill, timeliness, kindness, hope and certainty, continuity/choice/coordination, private rooms, no out-of-pocket expenses, the *best* medicine, and medications and surgeries. The second-level priorities included efficiency, aggregate-level statistics, equity, and conflicts of interest (Detsky). The lowest priority items identified included the real cost and percentage of gross national product (GNP) devoted to health care (Detsky). Essentially, sick people wanted to feel better and were not concerned how long the process took as long as they were not paying directly for it. Detsky contrasted the desire of patients with how the media portrays health care. Other than curing patients in a comfortable and comforting setting, the public and patients wanted hospitals to strike a balance between growing to provide more and better services and being responsible to and adding value to society (Takahashi, Ellen, & Brown, 2013). The concept of corporate social

responsibility (CSR) resonated strongly in the hospital sector, and the frame for CSR was within the context of business responsibilities, including economic, legal, ethical, and philanthropic elements (Takahashi et al., 2013). The implication for my research was that any business activities generating revenue must occur within the context of patient priorities and CSR—a unique framework for an organization trying to make money.

Leadership

A critical factor in implementing system changes enabling revenue generation was leadership. Current thinking on business leadership ranged from ethical leadership, where leaders cultivated ethical behavior in organizations (Abrhiem, 2012), to radical authentic leadership, a theory acknowledging the tensions between being authentic (which includes acknowledging goal divergence within an organization) and power, purpose, and time (Algera & Lips-Wiersma, 2012). The knowledge organization, however, required a move away from a focus on leader-centered thinking toward leadership thinking, with a focus on harnessing an organization's adaptive capacity (Weberg, 2012). Complexity leadership theorists suggested that for health care organization leaders, a need existed to develop competencies influenced by complexity, leading to collaboration, innovation, and organizational learning (Weberg, 2012). Health care organizations were exceedingly complex and difficult to manage, and leaders needed to create organizations with minimal control and structure (balancing administrative demands and operational needs), a culture of collectiveness, change, and the ability to adapt. Also important was the ability to thrive in ambiguous and unpredictable conditions, the ability to understand the interrelatedness of process and structures adapted

to facilitate exploration, and the capitalization on unforeseen opportunities (Weberg, 2012). With the above-mentioned approach, concepts including generating nongovernment revenue flourished and potentially strengthened the organization.

Facilitating the acceptance, or at least openness, to new ideas was a key function of leadership. We required leadership competency at all levels of the hospital organization. Senior-level roles must be organizationally aware and foster positive change; mid-level roles focus on performance improvement, communication, and self-management; and roles at all levels must maintain professional standards and values (Chan & Rubino, 2013). Ideally, leaders created and influenced culture, resulting in a happy and healthy work environment (Azanza, Moriano, & Molero, 2013), but the culture described may be unique to health care.

Entrepreneurship

Revenue generation required an exchange that included both a buyer and seller. Projects such as the one I proposed potentially support a greater emphasis on business concepts than the traditional public sector worker currently experiences. The emphasis was not without risk. Vogel and Masal (2012) examined the difference in leadership styles between the public sector and the private sector and found impactful differences. The authors recognized that concepts developed in the private domain (including a directive leadership style) had a potentially negative effect in the public sector, which valued a participative leadership style (Vogel & Masal, 2012). The authors argued for a careful combination of directive and participative elements to maintain public (intrinsic) service motivation (Vogel & Masal, 2012). Furthermore, research in public leadership

identified four distinct interrelated approaches, from functionalist to behaviorist and from biographical to political, arguing for further caution when introducing business concepts into the hospital (Vogel & Masal, 2014). Despite the caution, entrepreneurial management led to fiscal and performance improvements in the hospital (Zaugg, Gattiker, Moneta, & Reay, 2012). The motivation of hospital employees, however, was critical to the successful implementation of any proposed solutions.

Creating a culture including a business or entrepreneurial focus, despite the challenges, transforms health care. Critics in the United States pointed to negative productivity growth, inefficient medical care, poor coordination of care, significant waste of resources, and a lack of health care entrepreneurs (Cutler, 2011). Health care entrepreneurship may hold the key to addressing market imperfections and create organizational innovation (Cutler, 2011). Unless health care addresses the issues of waste and efficiency, phenomena such as medical tourism will continue to grow (Kumar, Breuing, & Chahal, 2012). Klein, Mahoney, McGahan, and Pitelis (2013) explored entrepreneurship in public organizations and recognized the need to extend entrepreneurship theory to non-market settings, where public institutions attempt to create and capture value. The authors recognized that public and private sector entrepreneurs acted in a similar fashion and may co-evolve in important ways (Klein et al.). Hospital leadership must create, influence, or be aware of the culture existing within their institutions to ensure that management creates an optimal environment for providing the best care possible in a sustainable fashion.

Organizational Change

Organizations such as the academic research hospital, particularly ones with a long history, may experience change fatigue. Beck, Brüderl, and Woyworde (2008) challenged the notion that change is a self-reinforcing process. The authors found that change inhibits further change and ultimately created stable organizational features (Beck et al.). The stable organizational features may explain why altering health care did not happen from within the organization; altering health care happened through external shocks. Beck et al.'s research highlighted the difficulty of stimulating transformational change. Lee et al. (2013) further found that health care transformations were complex and dynamic and rarely developed according to plan. Lee et al. found that most of the literature was published after 1990, despite the theories being developed in 1960, a bias in the research literature toward successful transformations, and short time-frames (insufficient to determine long-term success), as well as evidence of undue optimism and enthusiasm for transformative change. Chowdhury, Zelenyuk, Laporte, and Wodchis (2014) demonstrated the complexity of identifying models of efficiency and productivity in the hospital sector, and by applying the Malmquist Productivity Index, they demonstrated that in several models, the interplay between efficiency and productivity changes balanced, resulting in no improvement. The current fiscal environment in Ontario was forcing change as the government imposed budget pressures, but the difference between external pressures to change and internal pressures to maintain the status quo results in an unpredictable and unstable situation.

Business Models

Based on the questionable success rate for process improvements and the challenges in applying business concepts to the hospital environment, careful planning including the challenges was critical. Boons and Lüdeke-Freund (2013) argued that the essence of the business model is creating and delivering customer value. The same principles applied to the entrepreneurial hospital. Nongovernment revenue generation required a solid understanding of the customer and the context or environment within which the hospital operated. Teece (2012) discussed the need for entrepreneurial (managerial) capitalism to establish and sustain abnormal positive returns. Applying the concept to the hospital suggested a need to support capitalism at various levels within the organization, resulting in revenue along with a changing culture.

New Approaches

Changes in health care were an inevitable consequence of the fiscal realities faced by health care organizations regardless of whether the system was single payer or multi-payer. Stabile and Thomson (2014) examined the changing role of government in financing health care, and although the authors examined generating revenue, the focus of the examination was on collection of payment for services as opposed to identifying complementary sources of revenue. Others examined process improvement strategies and effects on health care (Robbins, Garman, Song, & McAlearney, 2012) and innovation centers (Ouyang et al., 2014). Still others examined the effect of learning organizations and customer orientations (Tsai, 2013, 2014) and the results of social health care (business) enterprises in the developing world (Kapoor & Goyal, 2013). However, none

focused on driving revenue through complementary revenue-generating opportunities. Although the examples provided represent real changes in the system, the consequences of the changes remain unclear.

There were a few examples of research suggesting opportunities for substantive changes with a potentially beneficial impact. French and Miller (2012) recognized that patients are a potential revenue-generating resource for the emerging entrepreneurial hospital. Burau, Blank, and Pavolini (2015) discussed the emergence of hybrid systems in response to problem pressures (including financial stress) and a divergence occurring as systems integrated by incorporating what worked in other systems. Wong and Morra (2011) identified how the office-hours system of running hospitals resulted in an organization working effectively one-third of the time despite infrastructure being available 24 hours a day, 7 days a week. Porter, Pabo, and Lee (2013) argued for a redesign of health care to improve value by organizing around the needs of the patient; I argued that the needs include more than medical care. The stakeholders (Harrison & Wicks, 2013) in care, particularly in the hospital setting, included patients and their families and friends, staff, and many others. To create maximal value for all stakeholders, management must consider opportunities beyond care, including opportunities leading to revenue generation.

Failures

When considering the concept of revenue generation, managers must consider the failure of systems to change. Examples of the failures included challenges with e-prescription systems, where organizations experienced lower utilization rates than

expected, likely due to an inadequate systems view (Kierkegaard, 2013). The recent attempts at implementing electronic health record schemes (Gellert, Ramirez, & Webster, 2014) were another example. Systems also have difficulty adapting to change, as was the case with the disruption caused by smartphones (Redelmeier & Detsky, 2013). Perhaps the reality faced by health care organizations was that the disruptive innovations experienced to date have not been disruptive enough (Terry, 2013). Terry indicated that eventually patient insistence drives the move, forcing hospitals into becoming a network as opposed to a bricks-and-mortar operation. Within the patient-centered approach, opportunities to create revenue existed.

Summary

Recognizing that structural changes continued to occur in health care, Collier (2011) recognized that the system needed new revenue streams. My review of the literature demonstrated that a desire to improve the system exists, as well as recognizing the need for comprehensive systemic changes. However, my review of the literature also demonstrated that few authors focused on how institutions generate revenue in support of their operations. Most of the focus appeared to be on controlling costs within Ontario's complex academic research hospitals and within the health care system more generally. The systems approach required complex systemic and political changes. However, the question remains as to what hospitals should do while waiting for changes to occur. The answer lay in generating revenue in a complementary fashion. My case study represented the starting point and a potential guide to other Ontario hospitals to the challenges and opportunities in pursuing revenue.

Transition

Health care practitioners, including physicians, administrators, and all the other professionals who care for patients in Ontario, provided care with limited resources. In this section, I presented the method, design, and conceptual framework of the study and provided a comprehensive literature review. I described the challenge of providing the best care possible for all citizens within a single-payer system. More specifically, I explored a system struggling and in need of new approaches. The following section contained the details of my project.

Section 2: The Project

Remaining sustainable was a key objective for administrators and managers in Ontario's academic research hospitals. My purpose was to explore strategies used by hospital administrators to secure nongovernment sources of revenue. In this section, I described the purpose of the project, the role of the researcher, the participants, and the research methods and design. Part of the rationale for describing in detail the various parts of my research project was to ensure that if other researchers repeat my methodology (all things being equal) they reach the same conclusions. Without these details, other researchers may be unable to replicate my methods and my results.

I also described in detail several additional aspects of my research project. I carefully documented the chosen study population and the sampling method, along with the ethical requirements adhered to, as well as the data collection instruments, the data collection techniques, the data organization technique, and the data analysis approach. Section 2 ended with a discussion of reliability and validity and how these concepts related to the research project.

Purpose Statement

The purpose of my qualitative case study was to explore strategies Ontario hospital administrators apply to generate nongovernment revenue to remain sustainable. The population for the study was the 24 academic research hospitals in Ontario. I interviewed two CEOs and two CFOs at large (greater than $1 billion in revenue) and medium-sized ($500 million to $1 billion in revenue) Ontario academic research hospitals. The interviewed individuals, representing senior leadership at these hospitals,

provided guidance to other academic research hospitals. Their guidance applied to all Ontario hospitals struggling to address the challenge of providing care to the people of Ontario with limited resources.

Role of the Researcher

Using a case study approach, I balanced adaptability (the ability to adapt to unanticipated events) with rigor and an ability to find meaning in information received from multiple modalities (Yin, 2014). My experience, gained outside the hospital system (in the pharmaceutical industry and in contract clinical research), strengthened an external perspective, offering additional insight into a system in need of new ideas and support. My experience was atypical for most hospital administrators and further enhanced interest in the research project. Over the past three years, I built relationships with senior hospital management, particularly at the CEO level, to secure access to senior administrators at Ontario academic research hospitals. Through my committee work and my work in the area of liability insurance, I came in contact with administrators from many of the hospitals that supported and participated in my research. I believed that I could get past the gatekeepers, primarily by demonstrating that I had something to offer that was unique and useful and supports their enterprise once completed. However, I was mindful of the bias I brought to my research. Yin (2014) identified five skills and values needed to conduct solid case study research: ask good questions, be a good listener (not affected by preexisting ideologies or preconceptions), stay adaptive (willing and able to see opportunities), understand the issues studied, and avoid bias (including being sensitive to contrary evidence). The researcher must also be mindful of the boundaries

between practice and research, basic ethical principles (respect for persons, beneficence, and justice), and the application of general principles for conducting research (informed consent, assessment of risks and benefits, and selection of subjects), as outlined in *The Belmont Report* (National Institutes of Health, 2014). Applying ethics-based principles and the five skills and values identified by Yin (2014) strengthened my research.

The interview protocol, data collection questions, or case study instrument was critical to the integrity of my research. Yin (2014) discussed two characteristics: the general orientation of the questions (the questions in the protocol) and the five levels of questions. The five levels consisted of questions asked of interviewees, questions asked of the case, questions asked regarding pattern finding, questions asked of the entire study, and normative questions of policy beyond the scope of the case study (Yin, 2014). As Yin pointed out, researchers can confuse the difference between verbal and mental lines of inquiry. Beyond the interview, determining which executives to interview required an analysis of hospital financial statement similar to those of Hamilton Health Sciences Corporation (2014). As well, the researcher reviewed documents and online sources describing nongovernment revenue generating activities provided by the participants as well as those found through the hospitals' web presence and publications (Merriam, 2014). The interview, the financial statements, and the documents and website information, combined with member checking (Houghton, Casey, Shaw, & Murphy, 2013) resulted in the triangulation (Elo et al., 2014) required for reliable and valid research. Nevertheless, it was primarily the interview that provided an opportunity to gain

deeper understanding of nongovernment revenue generation in Ontario academic hospitals, leading to theory development.

Participants

The population I studied was Canadian academic research hospitals that play a central role in delivering care (Sutherland et al., 2013). Unfortunately, funding for hospitals was a provincial responsibility (Canada Health Act), so a more realistic population for the study was the 24 Ontario academic research hospitals. The criteria used to recruit participants were (a) senior leaders (CEOs and CFOs) and (b) working within an Ontario academic research hospital. My participant sample consisted of two CEOs and two CFOs of the larger Ontario academic research hospitals, with larger hospitals defined as those with revenues in excess of $500 million CAD. As necessary, I was prepared to add participants until subsequent interviews yielded no new themes/data saturation (Ando, Cousins, & Young, 2014). In my role as vice president of research at one of the larger academic research hospitals (Hamilton Health Sciences Corporation), I participated actively in the Council of Academic Hospitals of Ontario (CAHO). My active participation, an endorsement from the Hamilton Health Sciences Corporation CEO, and discussions with CEOs from hospitals across Ontario established interest in my research project and confirmed a willingness to participate. I had a working relationship with the potential CEO candidates and through those relationships accessed the hospital CFOs. The CEO and CFO of a hospital were in the best positions to determine the effectiveness of nongovernment revenue–generating activities in the institutions they lead and are among the population most interested in the results of this study.

Research Method and Design

The goal of the researcher was to design a good case study that allowed the researcher to collect, analyze, and present data fairly (Yin, 2014). Exploring nongovernment revenue strategies in Ontario academic research hospitals required a qualitative study allowing for the interpretation and the justification in a public forum, ideally leading to change and further research (Merriam, 2014). The qualitative case study provided the in-depth description and analysis required in the exploration of nongovernment revenue strategies.

Research Method

Qualitative research required deep contextual knowledge of the subject matter and a combination of multiple disciplines (Cheng et al., 2014). Answering my research question (What strategies might Ontario hospital administrators apply to generate nongovernment revenue to remain sustainable?) required a qualitative approach because the academic literature, as well as the non-academic literature, contained little information regarding strategies (either successful or unsuccessful) to increase sources of revenue. Quantitative research, used often to answer how much or how many, with the goal of predicting, controlling, describing, confirming, and testing hypotheses (Merriam, 2014), was not appropriate in the case of exploring nongovernment revenue generation in Ontario hospitals. Nongovernment revenue generation was relatively unknown, and the lack of developed theories meant that using the concept in a predictive fashion was not feasible. It was also too early in the evolution of knowledge regarding nongovernment revenue generation in Ontario hospitals to support a mixed methods approach. A mixed

methods approach combines qualitative and quantitative methods, often triangulating qualitative and quantitative data to develop deeper understanding (Venkatesh et al., 2013). Ontario hospitals do generate nongovernment revenue, but how was not publicly discussed. A public discussion starts with a case study describing what some of Ontario's hospitals do and making the information widely available. Starting the discussion meant beginning to create testable strategies, eventually leading to societally acceptable approaches. A qualitative study allowed for interpretation and the justification for the interpretation in a public forum, ideally leading to change and further research (Merriam, 2014).

Research Design

I considered narrative, phenomenological, grounded theory, and ethnographic research, but the case study approach was ideal for exploration (Yin, 2014) and hence most appropriate for my research topic. A pragmatic approach allows for the identification of effective strategies as well as identification of the local cultural context enabling strategies to be successful. The purpose of the proposed research was to highlight successes and struggles, provide appropriate context, and then develop a roadmap for use by all Ontario and Canadian academic research hospitals. Narrative researchers typically explore the life of an individual (people stories) (Merriam, 2014), whereas I explored the boundaries and strategies employed by institutions. Phenomenological researchers describe the essence of a lived phenomenon (Merriam, 2014), whereas I described the mechanics and processes used by institutions to generate revenue. Grounded theory researchers focus on building theory from data (Merriam,

2014); whereas I explored what creates successful revenue generation. Ethnographic researchers describe and interpret group cultures (Merriam, 2014), whereas I analyzed the bounded hospital system. None of the other methods provided the in-depth description and analysis of the case study as required in the exploration of nongovernment revenue strategies in Ontario academic research hospitals; therefore, I chose a qualitative case study as the format for the proposed study.

Population and Sampling

The population studied was Ontario's 24 academic research hospitals. I interviewed two CEOs and two CFOs at large (greater than $1 billion in revenue) and medium-sized ($500 million to $1 billion in revenue) Ontario academic research hospitals (ResearchInfosource, 2015). Merriam (2014) argued for adjusting the size of the sample until reaching a point of saturation or redundancy. Starting with four executives to interview appeared to provide reasonable coverage given the phenomena studied and purpose of the study (Merriam, 2014). I identified the participating executives randomly by ranking the hospitals from highest to lowest based on revenue and separating them into large or medium hospitals (over $1 billion or between $500 million and $1 billion) and then using a random number generator identified the order in which I approached potential study participants. I contacted the randomly selected medium and large hospital executives and requested their participation in my research project. If they declined, I approached the next randomly selected organization until a CEO and a CFO from a medium and a large hospital agreed to participate. I interviewed the participants in their office, creating an opportunity to observe the work setting (Bloomberg & Volpe, 2012).

Prior to conducting the interviews, I analyzed the most up-to-date annual Financial Statement of the institute in an effort to identify any nongovernment revenue-generating activities. The information from the financial statements provided relevant background detail and formed part of the triangulation. The participants, representing senior leadership at the hospitals, may provide guidance to other academic research hospitals; in fact, their guidance may apply to all Ontario hospitals struggling to address the challenge of providing care to the people of Ontario with limited resources.

Ethical Research

The impact of a research project often extends beyond the participants in the study. Consequently, I took great care to ensure that I conducted my research mindful of the potential impact on my participants. Pozgar (2013) indicated the term *ethics* was used in three ways: in a philosophical sense, as a general pattern (or *way of life*), and as a set of rules. In the context of my research, *ethics* referred to the set of rules I followed in the conduct of my research. The research I conducted received approval from the Walden University Institutional Review Board (IRB) (Walden University approval 04-27-16-0048283) and from the Hamilton Integrated Research Ethics Board (HiREB) (HiREB Project #1718) (see Appendix A for IRB/REB approvals). Once I received ethics approval for my research, I requested interviews with four senior hospital executives. All activities followed Code of Federal Regulation (CFR) 45 (Protection of Human Subjects, 2015) to ensure the ethical treatment of human subjects and that I followed appropriate consent procedures.

All participants were volunteers. Any participant could withdraw from the project at any time without experiencing any negative consequences (Mandava, Pace, Campbell, Emanuel, & Grady, 2012). There were no incentives for participation (John, Loewenstein, & Prelec, 2012), with the exception of access to the final report/thesis. I acknowledged that I am an executive at one of Ontario's academic research hospitals and potentially perceived as having undue influence over my subjects (DuBois et al., 2012). My employer did not participate in this research project, and the executives approached were at my level or higher within their organizations. The identity of all participants remains confidential.

All participants received the consent form containing information on the study background, study methodology, the voluntary nature of the study, risks and benefits, payment, and privacy and a declaration of consent. The initial approach for participation occurred via email, by phone, or in person. I followed up this initial approach with written information regarding the project and complete study information. The interviews occurred in the private office of the four participants. I recorded the interviews but no personal information. The participants received detailed information regarding the observation and recording process, and I told all participants that they could withdraw consent at any time. The participants also received a copy of the consent form.

To further protect the privacy of the participants (Fiske & Hauser, 2014); the data collected in this study were stored in a de-identified format. The key enabling identification of participants, should follow-up be required, was stored separately from the data. Hard copies of the data were stored in locked files in the office of the researcher.

Electronic forms of the data were stored on the Hamilton Health Sciences Corporation computer within a password-protected environment. I maintained data for 5 years, after which I will destroy them. Walden University received a copy of the study results.

Data Collection Instruments

The data collection instrument in the open-ended semi-structured interview was the researcher (Pezalla, Pettigrew, & Miller-Day, 2012; Xu & Storr, 2012). Throughout the interview process, the researcher must follow her/his own line of thinking and ask questions in an unbiased fashion (Yin, 2014). The researcher in this study was the primary data collection instrument. The semi-structured interview process with an open-ended format allowed participants to explore the study topic freely (Rabionet, 2011; Schatz, 2012). The data collection process involved analyzing the 24 Ontario academic research hospitals and categorizing each hospital into one of three categories, small (revenue less than $500 million), medium (revenue between $500 million and $1 billion), or large (revenue greater than $1 billion), using data from Research Infosource Inc. (2015). I ranked Hamilton Health Sciences Corporation (my employer) for information purposes only. The ranking created an ordered list from highest to lowest revenue in each category. The ranked list for the medium and large hospitals and a random number generator provided the order in which I approached potential study participants. I contacted the randomly selected medium and large hospital executives and requested their participation in my research project. If they declined, I approached the next randomly selected organization until a CEO and a CFO from a medium and a large

hospital agreed to participate. The executive scheduled their interview within 2 months of contact, or I approached the next executive on the list.

The data collection process included a thorough literature review and a review of hospital Financial Statements, followed by in-depth interviews. The interviews consisted of ten open-ended questions (see Appendix B). Keeping in mind that reality is socially constructed as opposed to objectively determined, according to the interpretivists (Chowdhury, 2014); I enhanced reliability by starting with broad questions aimed at encouraging study participants to fully describe their experience. Using the same questions for all subjects further enhanced the stability and consistency of the data. The four interviewed subjects offered their personal perspective on the research topic, providing an opportunity for the researcher to triangulate. As well, I asked each participant if she/he had any materials that described their nongovernment revenue-generating activity. The goal was to find multiple sources of evidence that converged to support my findings (Yin, 2014). Validation resulted from strong descriptive data, recorded verbatim and transcribed accurately through multiple reviews. I provided all participants with a copy of the interview (transcript) and a written request asking them to indicate whether any responses need clarification. Providing opportunity to participants to clarify their responses is a process known as member checking (Houghton et al., 2013). The researcher then understood the meaning and experience under study more fully (Chowdhury, 2014).

Data Collection Technique

For my research, I interviewed four senior executives in their office recording each interview, which was approximately 45 minutes in length. I recorded observations regarding the environment in the study logbook. The data sources for my study included the interview responses, field observations, materials provided by the interviewees, and data from the public financial statements of Ontario academic research hospitals. I carefully observed the critical elements of physical setting, participants, activities and interactions, conversation, subtle factors, and my behavior (Merriam, 2014). I described the locations of the interviews in Appendix C. The ten interview questions were open-ended and intended to create frank, candid discussions. The process for the interview was a short period for equipment set-up and check, a brief introduction, and then the interview. The interview consisted of the ten questions and any follow-up questions. I recorded the interview using iTunes® SpeakEasy Voice Recorder and provide audio recordings of the entire discussion, allowing me to confirm accuracy through member checking (Houghton et al., 2013).

My data collection technique consisted of face-to-face interviews in the executive's office. I recorded the interviews using the digital recording device, and a third party transcribed the interviews. The semi-structured interview provided results that were precise and reliable (Rowley, 2012). I emailed the interview questions, along with the consent form, to each participant when he/she agreed to take part in the study. This process alleviated participant concerns regarding interview preparation (Rowley, 2012). Prior to the interview, I provided the participants with written copies of the purpose of the

study and a summary of the informed consent process and asked them to complete the consent form. Because I did not complete a pilot study, I encouraged all participants to request clarification of any questions they felt were unclear. The semi-structured interview format does not require pilot testing as I used the format to respond to the situation that evolved during each interview (Merriam, 2014). I also informed all participants of their right to answer all, some, or none of the questions. During the interview, I restated or summarized information provided by the participant to clarify any unclear responses and as a form of member checking. I maintained the transcriptions on a password-protected flash drive. Appendix D contained the semistructured interview protocol.

Qualitative research interviews have received criticism as a research methodology. The criticisms, representing the disadvantages of the interview as a data collection technique, included problems of representations, issues of language, the difficulty separating the researcher and knowledge, and the difficulty of writing to accurately present ideas (Qu & Dumay, 2011). The neopositivists believed that researchers uncover context-free truths about objective reality, whereas romanticists believed that researchers establish rapport, trust, and commitment, uncovering authentic experiences (Qu & Dumay, 2011). As a localist, I believed that the interview was an empirical phenomenon and recognized the social context of the interview (Qu & Dumay, 2011). The semistructured interview, with a basis in human conversation, helps the researcher develop an understanding of the research topic through the interviewees' perspective; was flexible, accessible, intelligible; and encouraged participants to disclose

important information (Qu & Dumay, 2011). Despite the limitations, I believed that important information, relevant to the business problem of increasing revenue in Ontario academic research hospitals, resulted from the semi-structured interview.

During the interview, I recorded relevant observations as determined by the researcher. The observations were casual in nature and involved looking for evidence of the culture of the organization based on the immediate environment (Yin, 2014). My focus was on recording revenue-generating practices that appeared to be significant to the participant. As well, I documented revenue-generating practices that the participant felt had potential, as well as those implemented by the institution.

Data Organization Technique

All information regarding my work was contained in paper notebooks, despite the limitations (Machina & Wild, 2013). These notebooks contained my field notes (Yin, 2014) and comments regarding all courses taken during the completion of my doctorate as well as my thesis work. These notes and the transcripts of the executive interviews form the raw data of my doctorate, which were concrete and contextual (Merriam, 2014). I maintained all hard-copy raw data in locked storage for a minimum of five years and I summarized the transcripts and the field notes and then examined them for themes.

Data Analysis

Yin (2014) discussed four principles of data collection: using multiple sources of evidence, creating a case study database, maintaining a chain of evidence, and using care when relying on data from electronic sources. The primary data source for my thesis were the executive interview, supported by the categorization of hospitals based on revenue as

indicated in Financial Statements and material provided by the interviewees. Each interviewee represented a potentially different perspective on revenue generation in Ontario academic research hospitals. As such, data triangulation from these multiple sources formed the basis for my data analysis.

The data analysis process consisted of interview coding, document coding, and observation coding. I reviewed interviews fully prior to coding. The coding process occurred following this first-pass review. When reviewing the transcript, I assigned codes to the themes observed. The first coding pass resulted in a preliminary code list. The steps for identifying themes and aggregate dimensions (Gioia, Corley, & Hamilton, 2012) were as follows:

1. Read through the transcript completely.
2. Read through and highlight points made by the subjects that appeared to be important or significant (first-order concepts)—essentially anything the researcher determines as potentially revealing.
3. Read focusing on the highlighted sections and assigning a word or phrase to move toward a theme. The code list identifies earlier notes with assigned words or phrases.
4. Review the codes identified and compress the codes into preliminary themes (second-order themes). This process results in various combinations or groupings.
5. Review the preliminary groupings or themes and develop aggregate dimensions.

6. Complete a final review revealing aggregate dimensions.

I followed the six-step process outlined above in combination with time, time to reflect and ensure that I grounded the theory accurately in data (Gioia et al., 2012). I used traditional text analysis, which did not require specialized software and resulted in a human interpretation of the data (Bloomberg & Volpe, 2012). I applied this same process to analyze the Financial Statements and the materials provided by the interviewees. I was aware that the traditional approach had limitations, including a tendency for incorrect data interpretation by coders, the time required to code data, and a tendency to overuse the *miscellaneous* category (Bloomberg & Volpe, 2012).

Once I coded each interview, I examined the four interviews to identify common themes, as well as themes unique to the participating executives. Aligning themes across participants revealed what themes were universal and what themes were institution- or executive-specific. I further explored the common themes and unique themes in the discussion.

Reliability and Validity

Another goal of the researcher was to design a good case study rooted in logic with minimal errors and bias (Yin, 2014). Reliable and valid research is research rooted in logic (Yin 2014). In the following sections, I described the reliability and validity of my research.

Reliability

The focus of qualitative data analysis must be to create trustworthy data (Elo et al., 2014). A part of creating trustworthy data involved creating reliable data, or data that,

by following the procedures described herein, achieve identical results (Yin, 2014). In my research, the recording of trustworthy data referred to recording dependable, credible, transferable, and confirmable data (Merriam, 2014). Researchers record dependable data by accurately documenting processes leading to the creation of the data and supporting the results with a clear description or audit trail of the data collection process (Houghton et al., 2013). I carefully described the methods to ensure that my data were dependable and employed member checking to enhance data accuracy. Supporting the credibility of the data required selecting the most appropriate data collection method (Elo et al., 2014) and then using data triangulation (data from multiple sources; the interview, Financial Statements, materials provided by the interviewees, etc.) to lead to appropriate conclusions (Fielding, 2012; Houghton et al., 2012). My review of the literature describing the state of the Ontario academic hospital supported the use of a case study. One of the goals of my research was that it be transferable, which meant that I could extrapolate the results to similar situations (Elo et al., 2014). Conformability referred to the extent to which the data are objective or the extent to which the data, if collected by independent researchers, agree (Elo et al., 2014). Again, through a careful review of the literature, careful selection of participants, and careful recording and analysis of results, I was confident that my data were conformable.

A final consideration relating to reliability is the idea of saturation. Saturation related to the point at which the data fully explain the variability between categories and the relationships between variables, allowing testing and validating of the relationships

and enabling the emergence of new theories (O'Reilly & Parker, 2012). The process I described lead to trustworthy, reliable data.

Validity

I addressed the concept of reliability in the previous section. Also important is validity. Yin (2014) described three types of validity: construct, internal, and external. Construct validity related to whether my approach identified the correct operational measures to answer my research question, whereas external validity related to the extent to which the results generated were generalizable beyond the study population (Yin, 2014). Rabionet (2011) argued that qualitative interviewing captured how people ascribe meaning to their lived experiences, whereas Elo et al. (2014) argued that trustworthiness was a term that encompasses credibility, dependability, conformability, transferability, and authenticity. Internal validity, or the identification of causal relationships (Yin, 2014), was not applicable to my research. The research I conducted was valid and rigorous in a fairly narrow and specific context, Ontario academic research hospitals. The potential remained that the results applied to other hospitals in a single-payer environment.

Transition and Summary

My focus was on how senior leaders in Ontario academic research hospitals achieved sustainability for their institutions through nongovernment sources of revenue. To achieve this, I interviewed four senior leaders and recognized the significant role that I, as a researcher, played in this project. I described the research methods and the research design of the project in this section. I described in detail the chosen study population, the sampling method, and the ethical requirements. I described the data collection instruments, the data collection techniques, the data organization technique, and the data analysis approach, and concluded with a discussion of reliability and validity. In Section 3, I presented the findings of my study and the application to professional practice. I also described the implications for social change and provided recommendations for action and further research. Finally, I provided reflections on my experience, a summary of my research, and my study conclusions.

Section 3: Application to Professional Practice and Implications for Change

Introduction

The purpose of this qualitative case study was to explore strategies Ontario hospital administrators applied to generate nongovernment revenue to remain sustainable (Laxton & Yaya, 2013). In the following sections, I presented my findings and discussed the themes identified. I also discussed potential applications to professional practice, discussed implications for social change, made recommendations for action, made recommendations for further research, provided personal reflections, and provided my conclusions.

I believe hospital executives must actively pursue revenue generation as part of a strategy to sustain their hospital. My research revealed five themes, (a) working within the fiscal reality, (b) the impact of the political environment, (c) the focus on the mission, (d) nongovernment revenue generation, and (e) opportunities for the Ontario academic research hospital, which leaders must consider in developing sustainable solutions. More specifically leaders must embrace nongovernment revenue as an important strategy, must actively promote the strategy both individually and collectively, and must capitalize on unused capacity within the health care system. Only by focusing on sustainable solutions will we maintain health care as a right (Bhatia & Orsini, 2014), change public perception regarding commercial activity in health care (Gettings et al., 2014), strengthen the Canada Health Act through changes enabling revenue generation (Sutherland et al., 2013), and address the lack of research on revenue generating activities occurring within the system.

Presentation of the Findings

The central research question was what strategies do some Ontario hospital administrators apply to generate nongovernment revenue to remain sustainable? Through interviews with Ontario academic research hospital CEOs and CFOs I identified five themes and present them in the following paragraphs. I presented the themes within the context of the conceptual framework used to guide the research. This framework included radical organizational change theory (Lee et al., 2013), complexity leadership theory (Weberg, 2012), and is grounded in an evidence based approach (Eddy et al., 2011; Smith & Rennie, 2014). I also described how the findings confirmed, disconfirmed, or extended knowledge and tied the findings to the conceptual framework applied in this study. Note, I asked all participants to provide relevant material (website, print, etc.) regarding nongovernment revenue generation and each declined citing the unfortunate need to draw as little attention as possible to these activities. One even went so far as to say that if I wanted this information I would have to file a Freedom of Information (FOI) request with the provincial government (the executive would not provide the information voluntarily). My review of published hospital financial statements yielded little information regarding nongovernment revenue generation other than activities that are standard at all hospitals (food services, parking, etc.).

The five themes were (a) working within the fiscal reality, (b) the impact of the political environment, (c) the focus on the mission, (d) nongovernment revenue generation, and (e) opportunities for the Ontario academic research hospital. During the interviews, each of the four senior leaders interviewed discussed all five of the identified

themes. The consistencies of answers with respect to the five themes suggested the conceptual framework and the interview questions enabled the effective identification of the relevant themes during the interview process.

Theme: Working Within the Fiscal Reality

Leaders of Ontario academic research hospitals faced a difficult fiscal reality. Sutherland et al. (2013) acknowledged that budget pressures are focusing policymakers on funding models that emphasize quality and outcomes at the lowest possible cost. The pressure to achieve quality and outcomes at the lowest possible cost was evident in the responses of all four leaders interviewed. All four participants discussed the mandate of the Ontario academic research hospital, the mandate to provide care, education, and research. At the same time, all four of the participants emphasized the pressure from government to reduce cost and a simultaneous pressure from the communities served by the hospital to provide full service. The challenge to achieve full service in care, education, and research, while reducing cost, all within the context of a large, complex organization was daunting.

All four of the participants spoke at length about the financial pressures and constraints within which they operate. The lack of funding/underfunding was a universal complaint. The challenges executives faced include human resource and physical space challenges accompanied by an efficiency expectation. All four of the executives interviewed believed that they had exhausted the capacity to find efficiencies within the system without cutting services. All four of the leaders expressed an interest in exploring new evidence-based opportunities. One also noted that initiating new activity was a

significant decision because once initiated, activities were difficult to discontinue without leaving the perception of a reduction in service.

All four of the leaders commented on the disconnections within the funding model for the Ontario academic research hospital. In particular, three of the leaders commented on the lack of a connection between the demand for health services and the supply of services they were able to provide. Within the single-payer system it was difficult for institutions to respond to an increase in demand with a corresponding increase in supply; the Ministry of Health dictates supply centrally through budgets, as do other Ministries within the provincial and federal government. Similarly, shifting resources in an effort to address a reduction in demand was problematic. Three of the leaders also highlighted the disconnection between capital budgets and operating budgets. This disconnection regularly resulted in a short-term focus on operating budgets where the care needs are typically acute and less focus on capital budgets where problems are often more complicated and, as a result, more difficult to deal with. The net impact of this for the hospital executives participating was a need to run a budget surplus on their operating budget to support sustainable infrastructure programs that kept the capital infrastructure (equipment, buildings, IT systems, etc.) operational.

The theme of a difficult fiscal reality was also evident in the lack of control experienced by Hospital executives. All four of the leaders commented on the difficulty of controlling cost drivers impacting their budgets. Leaders also commented on the challenge of mismatched resources (comments from 3 leaders), space constraints within their hospitals (3), the lack of a real (inflation adjusted) increase in budget for several

years (3), among others. The idea of a lack of control leads directly into the discussion of the political environment faced by the hospital leader.

The fiscal reality described by hospital executives required radical organizational change (Lee et al., 2013) supported by competent leaders applying complexity leadership theory (Weberg, 2012), and supported by evidence (Eddy et al., 2011; Smith & Rennie, 2014). The leaders all described a system in which they had cut costs as much as possible. Subsequent substantive change required new thinking and new approaches, as traditional approaches were exhausted and no longer effective. The fiscal reality executives faced required collaborative, problem-solving approaches to the fiscal reality of the academic research hospital (Weberg, 2012) and a move beyond theory to active lobbying of government for budget relief and real systemic change, conducted through a consolidated effort by all hospital executives. Executives must take care to frame solutions within the context of an evidence base, lest they fall into the same trap as politicians proposing changes that were merely politically attractive.

Theme: The Impact of the Political Environment

The political environment in the single-payer system that funds the Ontario academic research hospital affected it directly. For the purpose of this thesis, the political environment included public perception, as described by the study participants, and its impact on the hospital. All four of the leaders indicated that public perception and the political environment played a significant role in what issues they were willing to address. This reality created a layer of complexity to which business leaders can be less sensitive. All four of the hospital executives expressed that there are strategies that were

potentially beneficial to the Hospital in which they cannot engage. For example, there were tremendous sensitivities in caring for non-Canadian residents (4); the public perceived any hint of 'queue-jumping' (where treatment was provided to certain individuals, typically those with money, preferentially) negatively (4); the public was intolerant of displacing 'local' patients (4); and for one of the Hospital executives, there was public concern expressed regarding the hospital competing with the private sector.

The leaders described a number of systemic issues in the political environment affecting their ability to run their operation effectively. A number (3) expressed clearly that the system did not reward nongovernment revenue in fact, there was a disincentive to generate nongovernment revenue through care (i.e. what the hospital does best). The Base Funding Enhancement (BFE) calculation meant that if a hospital cared for an international patient (non-Ontario, non-Canadian) the Ministry applied the cost recovered for that patient directly to the base funding for the hospital and reduced the hospital's base funding by this amount. The leaders interviewed talked about a disincentive to generate revenue (3), a political cost to generating revenue (4), the existence of roadblocks and a negative government impact on their ability to use revenue generated from care as a way to improve hospital operations.

Two of the four executives interviewed expressed a desire to enable choice for patients. The reality of multiple streams of care was felt by two to have the potential to benefit both those that could afford to pay more and those that could not, as their wait-time was reduced by the existence of a second queue. The reality faced by executives was that of significant government influence in running a hospital (noted by all four). Another

reality was an environment within the academic hospital of a tradition of not monetizing new discoveries and sharing information freely (noted by two). A final reality was the unfortunate situation described by all of unfunded capacity within the system. Hospitals could offer more service because the infrastructure exists, but they do not have the operating funds to provide the additional services.

The political environment was such that hospitals generally did not publicize generating nongovernment revenue. Each executive, when asked to provide materials describing their nongovernment revenue-generating activities indicated they could not (although one indicated they would check for the information and then did not respond). One indicated that I may be able to find information on-line or if I filed a Freedom of Information (FOI) request (through legal channels), but three indicated explicitly that making their revenue generating activities public had negative consequences.

The political reality described by hospital executives required the active application of radical organizational change (Lee et al., 2013) that extended beyond the hospital and into the political realm. Leaders must engage in the political process and through lobbying and other efforts, effect change and address some of the issues described previously including under-utilized capacity. Applying complexity leadership theory (Weberg, 2012) along with an evidence-based approach (Eddy et al., 2011; Smith & Rennie, 2014) allowed executives to engage fully in processes that potentially lead to solutions to the crises facing Ontario academic research hospitals. Only by facing political reality can hospital leaders create the disruptive changes required to address the problems they faced.

Theme: Mission

A third theme consistently referred to by the participants was the focus on the mission of the hospital. Ontario academic research hospitals all have similar foci; the dedication to care typically comes first, followed closely by research and teaching. By definition, the academic research hospital provides care that is (hopefully) evidence-based and supports the generation (research) and dissemination (teaching) of evidence.

All four of the leaders referred to the need for the hospital to be true to its mission in all of its activities and to reinvest excess funds back into the hospital to support that mission. All four of the leaders talked about using external resources to achieve the mission of the hospital, two discussed reinvesting ‘profits’, one discussed using ‘profits’ to support patient activity or care, one discussed ensuring activities were ‘core’ to the mission, and one highlighted not competing with ‘for-profit’ entities. It was clear from the interviews that none of the leaders focused on ‘profits’ or nongovernment revenue as anything other than an opportunity to support better care. The idea of the hospital as a business as opposed to as a public facility was not acceptable to the leaders interviewed.

The mission of the academic research hospital imposed restrictions that affect leaders’ ability to generate nongovernment revenue. Executives must apply radical organizational change (Lee et al., 2013), complexity leadership theory (Weberg, 2012), and evidence-based approaches (Eddy et al., 2011; Smith & Rennie, 2014) to change, within the context of the academic research hospital mission. The mission and its impact on nongovernment revenue as described by leaders restricted the ability of leaders to be flexible. At worst, the mission limited options for change or revenue generation and at

best, it provided a framework for what was a reasonable change or revenue generating activity.

Theme: Nongovernment Revenue Generation

The fourth theme identified was nongovernment revenue generation in the hospital. All executives interviewed described nongovernment revenue generating activities occurring at their hospitals. Clearly, all executives saw the generation of nongovernment revenue as an important component of their mandate and the ability to generate revenue was critical to the hospital balance sheet.

One of the four leaders talked about the need to capitalize on the expertise and assets and it would appear that the Ontario hospital attempted to generate nongovernment revenue but as one noted, none had any 'home runs'. One leader distinguished between research revenue, which although nongovernment revenue in some cases (i.e. conducting industry trials), and nongovernment revenue. This executive acknowledged that they applied research residuals to support the research mission of the hospital. Two leaders commented on the limited resources available to them to support nongovernment revenue, and one leader noted nongovernment revenue generation was a 'side of the desk' activity. Capitalizing fully on the nongovernment revenue potential of the hospital required a dedicated focus seemingly unavailable to the Ontario academic hospital.

The list of nongovernment revenue generating activities identified by the leaders was extensive. The list included retail pharmacy (2), laboratory services (1), radiology services (1), Workplace Safety and Insurance Board (WSIB) services (1), Information Technology (IT) services (2), parking (2), retail (3) (gift shop, food services both catering

and on-site, etc.), real estate (2)/rental income (1), private room revenue (1), in-room phone/television revenue (1), and cleaning revenue (1). In general, these revenues appeared as extensions of the core services required at the hospital. In other words, hospital staff were providing services internally and over time began providing these same services externally (i.e. pharmacy). In some cases, the administration outsourced the services to external vendors who provided the service within the walls of the hospital (i.e. food court restaurants). Based on the interviews it appeared that the above-mentioned activities required careful thought and occupied significant management energy. For example, the choice of food vendors within the hospital food court (i.e. a fast-food outlet) was an issue that hospital executives dealt with regularly. My impression of these discussions was that the executives were uncomfortable with the responsibility related to generating nongovernment revenue as it required expertise for which their work experience and education did not prepare them.

The Ontario academic research hospital was typically an institution of some historic significance. Many of them had 100-year histories and as such have strong roots in their communities. These roots lead to community outreach through foundations that sought to solicit funds from citizens to support the activities and infrastructure of the hospital. One leader discussed the support they received from their foundation and how invaluable this support was. Two leaders also noted that their funds (foundation and otherwise) were professionally invested leading to additional revenue that can was then used to support the mission of the hospital.

There were four areas that the Ontario academic research hospital executives believed had potential to generate more nongovernment revenue within the mandate of their respective missions. The four included royalty/licensing (1), interprovincial revenue (1), international patients (4), and consulting (3). Royalty/licensing generated revenue from discoveries made within the hospital, by hospital/university staff/faculty (most of whom are both) that was monetized by an external company. Interprovincial revenue was revenue generated by treating patients from another Canadian province. This revenue was different (and less contentious) than international patients. All four of the executives interviewed indicated that, because of the roadblocks established by the provincial government they had all but abandoned international patients as a source of revenue because it was, as one indicated 'not worth the hassle'. This, despite the fact that international patients could occupy unfunded capacity and profits generated from their care could support local patient care. The consulting activities of two of the hospitals had been extensive and lead to significant revenue generation. All four of the leaders commented however that a significant amount of effort and staff time was required to ensure success. Consulting was not a core activity of the hospital and as a result, executives were only willing to dedicate a finite amount of resources. Based on the interview responses of the leaders, the four sources of revenue (royalty licensing, interprovincial revenue, international revenue, and consulting) described had the most potential to generate significant nongovernment revenue. However, because of political and other pressures, all four of the executives felt that fully pursuing these activities presented difficult challenges.

All four of the executives suggested that the generation of nongovernment revenue was an important part of their mandate and their ability to run their hospital effectively. The challenge was how to maximize this revenue. Leaders must apply radical organizational change (Lee et al., 2013) to ensure that stakeholders understand and accept nongovernment revenue as a way to enhance the hospital as opposed to as a threat with the potential to disrupt the system. Using the attributes identified in complexity leadership theory (Lee et al., 2013) and bolstered by evidence-based arguments (Eddy et al., 2011; Smith & Rennie, 2014) executives must maximize returns from activities they believed fulfill their mandate as leaders of academic research hospitals.

Theme: Opportunities for the Ontario Academic Research Hospital

The fifth theme identified in the interviews was that of opportunities for the Ontario academic research hospital. The leaders all recognized the importance of the limited nongovernment revenue generating activities in which their institutions participated and that the scope of these activities needed to increase to meet the demands of the hospital. Hospital executives must apply business principles to maximize revenue, within the mandate of their mission.

One of the four leaders discussed the value that existed within the brand that was their hospital. Leveraging the brand had the potential to lead to revenue generating opportunities. The leaders believed that with the fiscal challenges facing health care in Ontario, the hospital must learn how to charge appropriately for their services (1) (when not covered by OHIP), how to license effectively to generate optimal revenue (1), and how to capitalize on unused capacity that existed in the Ontario academic research

hospital (2). Finally, the leaders recognized the need to diversify (2), to explore (1), to collaborate (1), and to be creative (1) when it came to generating nongovernment revenue. Executives must conduct all of the noted activities to maximize stakeholder value.

Three of the four leaders interviewed recognized that new revenue streams, as described by Collier (2011), were critical for the Ontario academic research hospital. The executives each expressed a desire to improve the system and the functioning of their hospital, but as MacKinnon (2013) noted, changing or reforming the health care system is difficult. Balancing social and political sustainability (Borgonovit & Compagni, 2013) amidst continuing cutbacks (Ruckert & Labonté, 2014) created difficult challenges for the hospital executive. The discussions with all four of the leaders confirmed the findings in the literature with respect to controlling costs, the need for sustainable solutions, attitudes towards industry and the private/for-profit sector, and the awareness executives had regarding how hospitals generate revenue internationally. The perspective of the patient and the significant pull of social and corporate responsibility (Takahashi, 2013) were also important for hospital leaders. All four leaders universally expressed frustration at not being able to do more to generate nongovernment revenue to further the mission of the hospital.

The findings in this case study were consistent with the conceptual framework presented in Chapter 1 of this thesis. The modern Ontario hospital was a complex organization. All four of the executives confirmed the need for sophisticated organizational approaches to systems change. In particular, the leaders recognized the

external conditions (political context, financial constraints) and internal dynamics (inability to find more budget areas to cut, complex interplay between management, board, physicians, and staff) during a time of changing market conditions, institutional conditions, and organizational performance. Furthermore, two of the leaders recognized the need to better use their organizational resources frustrated by a politically managed health care system.

From the discussions with leaders, the impact they had on their organization was through minimal control and structure (Weberg, 2012). The Ontario academic research hospital is large and often multisite. The only way to affect change and enable the evolution of the hospital, particularly with respect to revenue generation, was through effective leadership. The move away from leader-centric thinking and toward collaboration and problem solving, innovation, and other outcomes leading to successful adaptation was evident in all four leaders' focus on learning from others, collaboration, and creativity. All the leaders of the hospitals indicated they were ready, what needed to change now was the political environment.

The final conceptual framework identified was the evidence-based approach to change. One leader discussed the need to be very careful about new opportunities to generate nongovernment revenue because once initiated it was next to impossible to discontinue the activity. The leader described how they immediately incorporated profits from these activities into the operating budget of the hospital. The responsible executive used evidence as described by Eddy et al. (2011) and the Evidence-Based Working Group (Smith & Rennie, 2014) to ensure decisions were effective in the long term.

What strategies do Ontario hospital administrators apply to generate nongovernment revenue to remain sustainable? Through the analysis of the interviews described in this results section, I identified five themes and presented them within the context of the conceptual framework used to guide the research. This framework included radical organizational change theory (Lee, Weiner, Harrison, & Belden, 2013), complexity leadership theory (Weberg, 2012), and was grounded in an evidence based approach (Eddy et al., 2011; Smith & Rennie, 2014). The results supported the conceptual framework applied in this study and provided guidance for strategies Ontario hospital administrators apply to generate nongovernment revenue and remain sustainable.

Applications to Professional Practice

Successfully running a large academic research hospital was difficult, particularly with a multitude of stakeholders. Webster (2012) noted that Canadian health care was disorganized, archaic, and expensive, and described the shift occurring in Canada as cost control measures, a diversion of resources away from hospitals and toward patients living at home with chronic diseases, and changed health care delivery. The data collected from the executive interviews suggested that significant issues existed with respect to money, politics, mission, business, and executing on opportunities. Hospital executives needed to address the issues identified in the interviews to support the hospital fully and to generate much needed revenue at a reasonable resource cost.

Executives needed the flexibility to think about generating nongovernment revenue within their organization. Leaders have focused almost exclusively on cost control (Webster, 2012) and they all recognized that the opportunities to significantly

lower costs without cutting programs are minimal (Duncan, 2012; Marchildon, 2013). They all recognized that opportunities existed to generate revenue and because the funding model was recognized as being disconnected (demand and supply do not move in an unrestricted fashion), they all understood the benefit achievable through generating nongovernment revenue (money) to support hospital operations. Government, however, needed to get out of the way.

Hospitals in Ontario were, unfortunately, political institutions (Smith, et al., 2013) and often politicians made decisions that were best for re-election, not for the institution. Appropriate framing of the 'international patient' and the fact that they occupied unusable capacity and therefore had no impact on wait times and care for the Ontario population and led to revenue that supported better care for Ontario residents. We should not penalize hospital executives and their budgets for making business decisions that improved their financial picture and improved care. Generating nongovernment revenue should be part of the hospital mission.

The leaders of Ontario academic research hospitals had a mission to provide care, teach, and conduct research. Leaders must achieve their mission in a sustainable fashion (Laxton & Yaya, 2013). Using 'profits' from nongovernment revenue generation supported the core activities of the hospital and had the potential to improve or enhance the mission and do so in a sustainable fashion. The alternative was to fund the hospital, both to operate and to make capital improvements, appropriately.

It is time to stop pretending that hospitals were not business ventures. Executives recognized the social responsibility inherent in the institution that is the hospital, but

leaders needed to generate revenue to cover their costs, or they must close. The bulk of this revenue comes from taxes, but residents cannot accept tax increases (Smith, 2016), particularly when alternatives like revenue generation existed. The opportunity for executives to, appropriately and in a socially responsible manner, generate revenue existed.

The executives interviewed discussed the revenue potential from royalty/licensing, from international patients, from consulting, and interprovincial revenue. The first three were certainly opportunities that existed for all Ontario academic research hospitals, if only the political framework allowed. Canada cannot continue to lose revenue from patients travelling to the United States to receive treatment that could be provided by utilizing Ontario's excess capacity. All that was needed was the political will. The Canadian public was ready as long as the message was clear; excess capacity was being used.

Hospital executives could greatly improve the business practices of the Ontario academic research hospital through the utilization of nongovernment sources of revenue while staying true to the commitments of the Canada Health Act (1985). The infrastructure was in place, the population understood the need to generate revenue and was clearly unprepared to pay more taxes, and finally political will was necessary. By starting modestly and perhaps as a group (i.e. involving all 24 academic research hospitals), small steps could be introduced to become less reliant on government funding.

Implications for Social Change

Socialized medicine in Canada was at a crossroads (Duncan, 2012) as was evident in the executive interviews and conceptual framework. Cost-cutting approaches and government bailouts were no longer among the options available to hospital leaders (Marchildon, 2013). The participants all acknowledged the need and potential to find new sources of revenue (Collier, 2011). When government stops interfering with the delivery of care and using it as a political instrument, when hospitals work together to enable consistent approaches to revenue generation across the province, and when care is taken to protect access for the citizens of Ontario, sustainable change leading to revenue to support the mission of the academic research hospital was possible.

Ontario academic research hospital executives must maximize revenue-generating potential while staying true to their core mission and being mindful of their stakeholders. This means actively pursuing revenue generation as well as cost control measures, it means creating an environment within the hospital infrastructure that allowed for entrepreneurship, and it meant that hospital executives must work together to develop province wide strategies for nongovernment revenue generation. Leaders also needed to recognize and adapt to the changes occurring as the focus of health system funders changes from acute care to prevention. Ontario academic research hospital leaders, if they work together were optimally situated to lead the transition away from a focus on acute care as long as they were prepared to be bold and focus on systemic transformation and not on protecting existing systems.

Recommendations for Action

The leaders interviewed provided a wealth of information regarding the Ontario academic research hospital and the challenges they, as leaders faced. A number of recommendations flow logically from the conversations. I focus on ten.

My recommendations were as follows:

1. Executives must embrace nongovernment revenue generation as a viable and significant strategy to support hospital operations
2. Executives must encourage government not to create roadblocks and interfere with the functioning of the hospital for political purposes
3. Executives must create flexibility within their organizations to take advantage of nongovernment revenue generating opportunities
4. Executives must recognize that politics are part of our health care system and must participate actively in the process to lobby on behalf of hospitals at provincial and national levels
5. Executives must work to eliminate disincentives for revenue generation including actively demonstrating how these activities positively affect care
6. Executives must communicate to government that government must encourage appropriate nongovernment revenue generating activities as part of responsible stewardship of the hospital
7. Executives must understand and communicate that the hospital mission is always paramount, but includes sustainability

8. Executives must strengthen and build on their existing nongovernment revenue generating capabilities
9. Executives must build and strengthen their hospital's brand within their communities (local, provincial, national, and international) and capitalize on that brand
10. Executives must capitalize on unused capacity within their institutions.

I aimed my recommendations at Ontario academic research hospital executives, but believe they applied to all Canadian hospital executives. Furthermore, provincial and federal politicians and government officials benefited from the recommendations, as do all stakeholders in the Canadian health care system. I intended to publish my findings in a Canadian health care journal, perhaps the Canadian Medical Association Journal, the Canadian Journal of Public Health, or the Canadian Health Policy Journal. I intend to disseminate my findings through HealthCareCAN, the Council of Academic Hospitals of Ontario, and the Ontario Hospital Association and present at the National Health Leadership Conference hosted by the Canadian College of Health Leadership.

Recommendations for Further Research

I recognized the limitations inherent in my study. As a case study, the results were particularistic and focused on the specific phenomena being studied (Merriam, 2014). The results applied to the specific hospitals whose executives I interviewed and generalizing to other hospitals in Ontario, let alone nationally or internationally, was problematic. A second limitation arose from the potential to create an overly descriptive study (Merriam, 2014). Using the case study approach, I attempted to strike a balance

between an accurate and complete description of the subject matter and the interpretation of the information to inform strategic direction and further research. The third limitation was the potential bias introduced by the integrity, or lack thereof, of the researcher affecting the research project (Merriam, 2014). Caution was required to ensure that the preconceived notions of the researcher minimally affected the study (Merriam, 2014). Nevertheless, I believed that by recognizing the limitations I collected information on real phenomena and believed the interpretation of this information suggested further research.

I explored nongovernment revenue generation in Ontario academic research hospitals. Subsequent research should extend beyond the academic research hospital in Ontario, and extend to all academic research hospitals in Canada and further work could include all Canadian hospitals (including community hospitals). Clearly all hospitals benefit from additional revenue, reducing their reliance on government, and examining a broader base provided insight into improving the entire system. I also suggested that quantitative research examining nongovernment revenue generation could provide important data on the magnitude of the contribution to hospital revenue possible. Unless we quantified the potential contribution, relative to the cost (both financial and human resource), it was difficult to determine whether these activities were worth pursuing. Additional research will help build the case for establishing a provincial or national entity to support these activities. I believe this is necessary because hospital executives were experts at running a hospital; they were not experts at generating revenue. Finally, I believed additional research regarding for-profit medical care delivered outside the nine

to five framework of the hospital, but using the underutilized capacity that exists in the system was also necessary. The sustainability of the Ontario academic research hospital required both research and action.

Reflections

I started down the path of completing my doctorate feeling ambivalent about what I would learn. I completed an undergraduate degree in science and master degrees in both science and business. All of these I completed at traditional institutions with lengthy in-class requirements. I was unsure of what to expect from an on-line program. I can now say with confidence that the learning experience, both for the on-line courses and for the doctoral thesis work, is exceptional. The volume of work is real. There is no way to 'fake' it, yet I was able to manage the workload, partially because the material was well organized, logically presented, and meaningful. The courses built logically toward my final thesis. Furthermore, I did not see the familiar 'see information, digest information, regurgitate information' pattern and as a result the courses and the work required had meaning.

I began my doctoral work shortly after starting my job in an Ontario academic research hospital. All my prior experience was in industry (pharmaceutical, clinical research, and consulting), in particular the for-profit sector. I found myself, for the first time, in the not-for-profit, government sector, and the doctoral process allowed me to recognize how my 'for-profit' bias affected me. The recognition that hospitals, while in many contexts can run like a business, have a mission critical to their ability to serve effectively their community. I underestimated the difficulty of running a hospital business

while providing care and doing this within a very large, multi-site organization. As much as I want nongovernment revenue generation to support the hospital budget, it must also support the hospital mission.

Conclusions

Historically, health care administrators in Ontario attempted to transform health care with a focus on improving efficiency and quality of care, with little attention paid to increasing revenue (Collier, 2011). Sustaining a hospital required Canada Health Act compliant, nongovernment sources of revenue. Unfortunately, hospital executives were uncertain how to increase revenue while financial constraints forced them to reduce costs (Stabile & Thomson, 2014). Some Ontario hospital administrators lacked strategies to generate nongovernment revenue to remain sustainable (Laxton & Yaya, 2013) which my research now provided.

Hospital executives must actively pursue revenue generation as part of a strategy to sustain their hospital. My research revealed five themes, (a) working within the fiscal reality, (b) the impact of the political environment, (c) the focus on mission, (d) nongovernment revenue generation, and (e) opportunities for the Ontario academic research hospital, which leaders must consider in developing sustainable solutions. More specifically leaders must embrace nongovernment revenue as an important strategy, must actively promote the strategy both individually and collectively, and must capitalize on unused capacity within the health care system. Only by focusing on sustainable solutions will we maintain health care as a right (Bhatia & Orsini, 2014), change public perception regarding commercial activity in health care (Gettings et al., 2014), strengthen the

Canada Health Act through changes enabling revenue generation (Sutherland et al., 2013), and address the lack of research on revenue generating activities occurring within the system.

Ontario hospital executives could greatly improve the fiscal reality facing academic research hospital through the utilization of nongovernment sources of revenue while staying true to the commitments of the Canada Health Act (1985). The infrastructure was in place, the population understood the need to generate revenue and was clearly unprepared to pay more taxes, and now we needed the political will.

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Appendix A: Ethics Approval

The plan for this study was reviewed for its adherence to ethical guidelines and approved by the Institutional Review Board at Walden University. For questions regarding participant rights and ethical conduct of research, contact the Dr. Leilani Endicott the Walden University representative at 612-312-1210.

Walden University approval 04-27-16-0048283

The plan for this study was reviewed by the Hamilton Integrated Research Ethics Board at their meeting on May 4th, 2015.

HiREB Project #1718

Appendix B: Interview Questions

1. What is your role within [name of institution]?
2. How would you describe the current financial situation at the hospital?
3. What nongovernment revenue does your hospital generate?
4. Why did you choose to pursue these opportunities as opposed to others?
5. Describe any nongovernment sources of revenue that you no longer pursue?
6. What factors determine whether your hospital is fully realizing its nongovernment revenue-generating potential?
7. What, if any, are the negative consequences of revenue-generating activities?
8. What plans, if any, do you have to generate additional nongovernment revenue?
9. What, if anything, needs to change to facilitate generating nongovernment revenue?
10. What additional information can you provide to assist my understanding of nongovernment revenue generation (brochures, flyers, websites, etc.)?

Appendix C: Interview Locations

All interviews occurred in the private office of the chief executive officer or chief financial officer.

Appendix D: Interview Protocol

Interview: Strategies Ontario Hospital Administrators Apply to Generate Nongovernment Revenue to Remain Sustainable

A. The face-to-face interview begins with introductions and an overview of the research topic.
B. I advise the participant I am sensitive of their time and thank them for agreeing to participate in the study.
C. I remind the participant of the recording of the interview and that the conversation we have will remain strictly confidential.
D. I turn on the recorder, participants identifying code, and the date and time of the interview.
E. The interview lasts approximately 45 minutes with responses to ten interview questions and follow-up questions.
F. I explain the concept of member-checking, ensure each question is thoroughly explained, and confirm the answer provided by the participant is recorded as intended by contacting the participants via e-mail with transcribed data, and request verification of the accuracy of collected information within five business days.
G. After confirming answers recorded to the satisfaction of the participant, I conclude the interview and sincerely thank the executive for participating.