Using a Social Entrepreneurial Approach to Enhance the Financial and Social Value of Health Care Organizations

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In this study, a conceptual framework was developed to show that social entrepreneurial practices can be effectively translated to meet the social needs in health care. We used a theory-in-use case study approach that encompasses postulation of a working taxonomy from literature scanning and a deliberation of the taxonomy through triangulation of multilevel data of a case study conducted in a Taiwan-based hospital system. Specifically, we demonstrated that a nonprofit organization can adopt business principles that emphasize both financial and social value. We tested our model and found comprehensive accountability across departments throughout the case hospital system, and this led to sustainable and continual growth of the organization. Through social entrepreneurial practices, we established that both financial value creation and fulfilling the social mission for the case hospital system can be achieved.

Key words: social entrepreneurship, financial value, financial sustainability, social capital, enterprise value, social value

Introduction

The health care sector is in transition globally. Reforms in the United States and emerging economies in Asia and other nations around the world are calling for viable models to provide financially sustainable health services in the current turbulent and uncertain environment. There is growing awareness and concern regarding social demands and health care costs. For instance, there are ongoing discussions about hospitals’ attempts to fulfill their social mission while maintaining financial and operational sustainability. Many hospitals (mostly nonprofit) receive credit for services funded by the government. This political factor makes public subsidies sensitive to changes in federal revenues, and hence these nonprofit hospitals are challenged to find alternative revenue sources to avoid welfare dependency. Many hospital administrators have advocated the adoption of entrepreneurship in terms of patient-centered care, market responsiveness, and sustainability in the health sector, but barriers remain due to the health care structure, cultural influences, financing, and delivery of services. Social entrepreneurship, which is part of a broader
family of entrepreneurship, permits us to conceptualize systems and processes that are designed to achieve social change\textsuperscript{5} and to generate surplus to support activities that cannot generate revenue.\textsuperscript{6} That is, social entrepreneurship is critical for generating social impact and assuring financial sustainability. Entrepreneurial orientation with a social focus is a tool that allows the leadership team to proactively strategize to anticipate environmental changes and to lead the social movements that have policy implications.

In this research, the authors aim to develop a model by which the social entrepreneurial approach can be effectively translated to meet the social needs in health care. We use a theory-in-use case study approach that encompasses postulation of a working taxonomy from literature scanning and a deliberation of the taxonomy through triangulation of multilevel data of a case study conducted in a Taiwan-based hospital system that has an established reputation for effectively using business operating principles in managing hospitals.\textsuperscript{7} In this article, we first develop the conceptual taxonomy that is theoretically underpinned, with the plan that it will serve as a framework for case delineation and construct building for future research in health care.

**Conceptual Framework Development**

**Entrepreneurial Process with a Social Focus**

Entrepreneurship involves a process that proactively recognizes opportunities, takes risks, and provides for innovative new approaches for providing customer-centric solutions.\textsuperscript{8} “Social entrepreneurship” was a term used to refer more narrowly to an enterprise’s application of market-oriented principles in the nonprofit or public sector,\textsuperscript{9} but this definition has gradually been broadened to include all business practices of an enterprise that assumes financial, personal, and organizational reputation risks when stimulating social changes and progress.\textsuperscript{10} Even though businesses focus on economic returns, social enterprises emphasize the organization’s mission for generating social value and advancing social change\textsuperscript{11} so as to obtain their legitimacy and needed resources.\textsuperscript{12} As such, a conventional entrepreneurial orientation that encompasses only the entrepreneurial attributes of risk-taking, opportunity-recognition, and innovativeness falls short of addressing issues that contribute to sustaining socially relevant initiatives.

**Market Dynamism**

As shown in our conceptual model (Figure 1), a taxonomy for building social value is developed illustrating the process of social entrepreneurial practice. Specifically, market dynamism is the driving force of the environment coupled with the organization’s market orientation. Together, these can effectively impact entrepreneurship. For instance, when businesses compete in an especially volatile market, market intelligence is critical for those organizations to retain their financial stability and sustainability. Kohli and Jaworski (1990)\textsuperscript{13} identified market orientation as an on-going process of market information generation and dissemination. Market-oriented organizations tend to excel in their capabilities for seeking and using market information to best generate and deliver a superior customer value,\textsuperscript{14} and their market orientation has been found to drive entrepreneurship.\textsuperscript{15} In addition, environment changes also impact market dynamism. For example, global concerns of health disparity, social justice, economic
recession, and other social-economic environment changes have led to an increased awareness of the sustainable utilization of global resources. More government agencies are using contracts and vouchers to ensure measurable performance in the delivery of social services by both nonprofit and for-profit organizations. Because these organizations are competing in the same market segment, their fierce competition has compelled them to become more innovative and outcome-driven. Furthermore, environmental changes such as recent debates on health care reform in the United States and other emerging economies have created a stronger sense of uncertainty regarding the future of health care payer models and health care delivery systems that address the determinants of health. As a result, market dynamism is the first element affecting social entrepreneurship.

**Shared Social Visions of Top Management Teams**

In addition to market dynamism, the shared social vision of top management teams determines the organization’s entrepreneurial practice. In particular, the shared vision is socially driven. Moreover, social entrepreneurs are motivated by recognized market failures, but they view social value creation as an organization’s explicit and central mission. Hence, this determination influences their specific marketing strategies, actions that place a relatively higher priority on social value creation while, in the meantime, borrowing business principles from their commercial counterparts. During the social value creation process, risks are inevitable because any failure of the mission may impair the reputation and sustainability of the social enterprise or even the entrepreneur’s personal reputation. The buy-in from the top management team (TMT) and the operation team are pivotal, yet challenging for the organization to evolve into a social-entrepreneurial culture. Organizations without the shared social vision tend to have multiple and possibly divergent directions or views; thus, the shared social vision from top management teams is essential to successful entrepreneurial practice.

**Social and Financial Value Creation**

For-profit organizations measure their performance more obviously by means of their profit generation. For social entrepreneurs,
understanding and maximizing social value creation is the primary performance focus and is based on the organization’s social mission. Enterprise value is an important part of the model because social enterprises are considered change agents in society. They are able to create a sustainable social movement. Social enterprises can adopt an “earned income” strategy during the social value creating process to ensure their financial sustainability and self-sufficiency. Social value and economic value creation should not be dichotomous. As shown in Figure 1, social and economic (or financial) values are connected. For example, the Roberts Enterprise Development Fund (REDF) coined the term “social return on investment” (SROI) as an outcome of the entrepreneurial process. SROI quantifies the financial outcome and the social value that is generated, and it measures the sustainability of the enterprise. Kent and Anderson (2002) advocated that social entrepreneurs should be the “bridge builder(s)” working to create communities through which social value is to be generated. Social capital, which is broadly defined as an intangible asset embedded in relationships, can be leveraged to facilitate action and contribute to the organizations’ levels of performance by increasing communication efficiency, decreasing the cost of transactions, and leading to a synergistic enhancement of performance. Social capital should therefore enhance social and economic/financial value creation and result in policy change. As described above, Figure 1 depicts the proposed drivers for an organization’s social entrepreneurial practices and the resulting outputs. The case study systematically delineates individual constructs and discerns their relations using our conceptual framework.

**Methods**

The global health care industry is becoming increasingly more complex and challenging as world nations and economies grow ever more closely entangled. The task at hand is more than merely leadership development, cost containment, or technology adoption; rather, it demands a fundamental development of a viable business model that will allow hospitals to serve their target segments sustainably. We adopted a theory-in-use case study methodology that entails deducing a working taxonomy from literature based on scanning and using the taxonomy of an instrumental case study. In this epistemological process, the case plays a supportive role in facilitating the understanding of the concepts within the health care context. The transcripts of the interviews and the content of the publications and documents related to strategies, operation plan, and meeting minutes are reviewed, organized, and analyzed to determine core constructs, the contexts in which these constructs are translated into activities and actions, and the resulting consequences. Based on data analyses, core outcomes are measured in terms of the value generated in financial and social dimensions. Both forms of well-defined knowledge, namely constructivism and pragmatism, direct the strategies of inquiry and methods of data collection and analysis in this process. Patton (2002) stressed the importance of the study purpose in designing qualitative studies along the theory-action continuum. During the preliminary stage of developing a theoretical taxonomy for adopting a social entrepreneurial approach for sustainable social value creation, the theory-in-use case study methodology is both meaningful and appropriate for attaining insights and ideas that aim to increase familiarity with the
context and issues and to help generate testable hypotheses.\textsuperscript{35} The case hospital system in Taiwan is a private health care system that is renowned for its service innovation and efficiency.\textsuperscript{36} With the proposed taxonomy, we examined in-depth the relationships between the changes in the external environment, the entrepreneur’s market orientation, and the organizational development and outputs. Taiwan has modeled its health care practices on those of the United States after World War II. The majority of the key players in its health care sector were US trained. Due to its single-payer National Health Insurance system, which provides universal health coverage to its 23 million people, Taiwan has served as a pilot testing laboratory for a number of care models over the years. Hence, the lessons learned from Taiwan’s health care system have been widely discussed in various forums in the United States and the Asia-Pacific region, in particular, within China.\textsuperscript{37}

We collected data from focus group studies and one-on-one interviews with the instrument encompassing the following items:

1. Please elaborate on the environment and the impetus for the initial establishment of the case hospital system. What are the founder’s vision, expectation, strategic orientation, and his perspectives regarding social mission/responsibilities? What are the strategic directions/planning that you are aware of? How much has been accomplished so far, from your perspective?

2. What are the unique attributes of the case organization and its culture? What is the evolution of the case hospital system’s social mission, its organizational culture, and the services to the community?

3. Around the time of the promulgation of National Health Insurance, how was the case system in serving the target populations?

4. Based on the informant’s experience and understanding, what are the system’s contributions to and/or influences on the society and the health care sector?

5. How has the case hospital system been adapting to the societal and/or environmental changes?

6. What are the performance outcomes of the case hospital system?

A total of 13 informants were interviewed, including the former superintendent (equivalent to the position of hospital director in the US), chair of the steering committee, the current director of the administrative office, senior managers/administrators from administration, clinical departments, the emergency department, laboratory, and pharmacy, and frontline leaders from clinical departments. A particularly close scrutiny of personal writings from the founder and former director of the case hospital system’s Office of Administration provided for a critical understanding of the founding mission, vision, and operating principles. The informants’ experiences with the hospital ranged from 5 to 32 years. They personally witnessed the hospital’s establishment and evolution through their participation in the strategic development and implementation process. All interviews were audio-taped and transcribed to provide accurate data analyses.

The data analysis process was dynamically intertwined with theory and data, and this process involved (1) discerning recurring categories and emerging themes; and (2) employing the constant comparative method to ensure
the internal and external significance of each theme. The context for data analysis was defined within the historical context of the case hospital system and the evolution of its operations. The corresponding author has maintained close collaborations with the case hospital system, through which she has been able to continually update the required findings and correspond with informants with the purpose to best address any ongoing issues discovered in the process.

Findings

During the 1970s, the health care system in Taiwan was composed of small private clinics and large, primarily public general hospitals. The capacity of these large hospitals in terms of their medical service abilities and quality was determined to be insufficient for meeting the market demand. The ratio of the number of physicians per 1,000 people was merely 0.4, compared to 1.6 doctors per 1,000 people in 2010, and the emergency departments (ED) were primarily staffed with resident physicians. This insufficient and inappropriate provision of care at the ED victimized the father of a successful entrepreneur. In memory of his father, the entrepreneur founded the first privately owned general hospital on the island in 1976 with the clearly articulated mission of “promoting social welfare.” The founder managed to maintain that aspiration for the following three decades when serving as chair of the board of directors for the case hospital system.

Entrepreneur’s Market-Orientation

In response to the keen competition from its public hospital counterparts and the lack of support from government, the founder adopted the operating principles of his US$69 billion conglomerate, with an annual revenue that accounted for 17 percent of Taiwan’s GDP by 2008. During the formative phase of the case hospital, it specifically targeted blue-collar workers, operated with a lean process, and collected timely customer feedback. The founder also invested heavily in recruiting the best talents globally for the leadership team of the case hospital. Furthermore, he personally devoted his time and effort into learning the business from these experts and directly from patients and their families through the “Superintendent’s mailbox.” At the management level, a series of weekly meetings provided a platform for the departments’ business managers to disseminate information and to engage in formulating institutional responses to the information gathered. The case hospital system has prided itself on its research, continuing education and training of its medical staff, and ownership of the state-of-the-art technology, facility, and equipment.

Being the first privately owned large-scale general hospital with a broadened access to health care for all, the case hospital system grew rapidly and, as a result, invited more competition into the market place. According to an interviewee:

The government saw us as a strong rival and, to stay competitive, they were willing to approve the budget request(s) from other public hospitals for their upgrades and expansion in technology and infrastructure.

In addition, its growing economic value enticed other business conglomerates to enter into Taiwan’s health care sector to the extent that the government had to establish legislation to better monitor the financial performance of these foundation-owned private hospitals.
Shared Mission of the Top Management Team

The founder formed a leadership team that was composed of the superintendent, the vice superintendent, the chairman of the Medical Executive Committee, and directors of the Administrative Offices from both the case hospital system and his business enterprise. They conducted weekly dinner meetings on Friday nights to discuss and examine extensively the operational plans and the execution of such plans. These frequent face-to-face meetings of the management team were instrumental in both cultivating the organizational core value of “treating patients as our own family” and establishing a lean and tightly controlled operational infrastructure at the formative phase of the case hospital system.

The director from the business enterprise played a crucial role in building the systems and processes by translating business principles into the health care context. The “cost-down” concept became a major concern across the board from areas as divergent as cafeteria logistics to renal dialysis. The Friday night dinner meetings later evolved into a series of regular daily luncheons, and weekly, biweekly, or monthly meetings attended by various levels of the management teams. In 1985, a formal Medical Steering Committee was established to govern clinical care, teaching, and research programs. The vision of the TMT was clearly articulated, according to the informant, as one in which:

1. The case hospital system should provide quality care at an affordable price to the public;
2. All leaders should own the not-for-profit mindset and aim to generate social benefits instead of personal economic gains; and
3. the case hospital system should be devoted to advanced medical service and science through research and education.

Following the formative stage of the case hospital system, the founder had dedicated an ongoing 1 percent of the revenue from the daily operations to the system’s charity fund until he passed away in 2010. This fund was found to be particularly useful during the pre-National Health Insurance (NHI) era because the government had imposed stringent criteria for qualifying low-income families for public medical assistance. Some informants believed that this practice later instigated the government’s policy of requiring all the foundation-owned hospitals to allocate 10 percent of their surplus to a social service fund.

Entrepreneurial Practices Focusing on Financial and Social Values

During its formative phase, the case hospital system provided transportation to patients in rural areas to provide these individuals with access to proper health care. This system also was the first in Taiwan to deploy only attending physicians instead of residents or interns to the emergency department (ED) to ensure the proper treatment of patients in the ED where the founder’s father had lost his life as a result of delayed treatment. Moreover, the case hospital system developed a streamlined one-stop payment system to allow for outpatient and deposit-free inpatient registration processes.

Guided by their shared social mission, the case hospital system’s top management team strictly prohibited their physicians from “moon-lighting” or accepting “gift-money.” The gift-money (more commonly
referred to as the “red envelope”) was and is still a prevalent practice in some hospitals in Taiwan whereby doctors are incentivized to expedite the scheduling or preferentially treat the patients. Often times, it is given to surgeons before the operation in accordance with a “market price.” Sometimes such red-envelope fees can be correlated with a significant source of income for more well-known doctors within the nation. Therefore, to ensure effective implementation of these policies with doctor/patient satisfaction, the case hospital system initiated a performance-based physician fee (PF) payment system. The administration determined the PF rate based on the physician’s: (1) service volume, (2) seniority, and (3) overall contributions to the department in administration, clinical teaching, and profession. A ceiling was imposed, and surplus was pooled into a hospital fund for sponsoring activities such as travel expenses for attending work-related conferences under the auspices of the department of medical affairs.

The case hospital system emphasized cost-containment strategies to ensure its healthy financial outlook, and the system established a knowledge management infrastructure to better standardize its internal operations. The infrastructure integrated the hospital system’s centralized procurement and inventory control system with that of the founder’s conglomerate for procuring hospital supplies directly from the company. To manage these complex business systems and processes, the case hospital system staffed its Administration Center at the senior management level with “professional executives” who are responsible for formulating strategies, supervising hospital operations, and developing departmental leaders. These executives, functioning like the think tank of the hospital superintendent, routinely rotated across all departments in order to acquire a first-hand understanding of the frontline operation. At the operational front, “accountability managers” in turn led and managed a total of 3,783 (as of the Year 2011) “accountability centers” across all clinical departments and business offices, and monitored and audited their respective services against 140 existing service and quality indices, for example, wait time and number of visits. These key performance indices were determined by the Administration Center based on the management-by-objectives (MBO) process. During the monthly operation management meetings, individual clinical specialties were reviewed on a periodic basis. Any budgetary gap called for a closer scrutiny by the responsible accountability manager to determine a timely and appropriate course of action.

This unified information system has been instrumental in the case hospital system’s efforts in bundling patient care for those with chronic conditions. First, the hospital pharmacy launched an expedited dispensing service both to automatically package together the routine prescription refills for frequent users and to manually dispense new prescriptions. The case managers then coordinated the inter-specialty patient care, which engaged physicians across departments to share and evaluate patient information and treatment regimens and also had a greater focus on assisting in the development and monitoring of a comprehensive treatment plan for individual patients. When Taiwan’s NHI launched the integrated-care initiative for patients with multiple chronic conditions in December 2010 by offering a NT$1,000 (US$34) per case incentive to the participating hospitals,
the case hospital system was already prepared and readily joined the national initiative, which resulted in an additional revenue source for the organization.

**Multiple Dimensions of Outputs**

*Enterprise value.* The case hospital system’s entrepreneurial practice has resulted in the building of a significant enterprise value (Tables 1 and 2), which led to its sizable social and financial values (Table 2), thus becoming the largest health care system in Taiwan. The hospital system has expanded to maintain more than 10,000 beds in eight hospital complexes spreading across six different geographical regions; by 2010, it had a total of 342,336 admissions and 7,210,016 outpatient visits, which amounted to a total of 8 percent of the annual outpatient visits in Taiwan. Its annual revenue of US$1.561 billion in 2010 amounted to approximately 10 percent of the NHI total expenditures rendered to serving its insured. The business model borrowed from the founder’s conglomerate has allowed the case hospital system to provide patient-centered care with a healthy surplus margin even with the NHI’s stringent and tightly controlled global budget system since 2002.44

*Social capital.* During the 1970s and 1980s, when there were just a few teaching hospitals, the case hospital system opened its door and offered internships to medical students from other medical schools.45 Today, approximately one-fourth to one-third of all of the practicing physicians in Taiwan are derived from these programs. Many of the hospitals that were managed or led by these alumni have adopted a similar management system and the business philosophy. The established strategic alliances and the accumulated social capital evolved into a social force that has continually driven the transformation of Taiwan’s health care policies and systems. As one informant commented:

The health care sector in Taiwan went from 30 percent privately owned hospitals to close to 60 percent in the 1990s. The keener competition continued to drive the advancement in hardware (such as facilities and medical equipment) and software (the managerial and clinical skills training of the medical professionals), which allowed an earlier institution of National Health Insurance from 2000 to 1995. The availability of insurance helped particularly those who are under the poverty line and those who contract catastrophic ailments.

### Table 1. Annual Service Volume and Number of Staff in Case Hospital System, 2008–2010

<table>
<thead>
<tr>
<th>Year</th>
<th>Outpatient</th>
<th>Inpatient</th>
<th>Emergency</th>
<th>Staff (Excluding Physicians and Nurses)</th>
<th>Physicians</th>
<th>Nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>7,238,168</td>
<td>327,612</td>
<td>493,226</td>
<td>7,908</td>
<td>2,806</td>
<td>7,185</td>
</tr>
<tr>
<td>2009</td>
<td>7,332,406</td>
<td>326,342</td>
<td>513,723</td>
<td>8,438</td>
<td>2,906</td>
<td>7,408</td>
</tr>
<tr>
<td>2010</td>
<td>7,210,016</td>
<td>342,336</td>
<td>507,962</td>
<td>8,715</td>
<td>2,944</td>
<td>7,579</td>
</tr>
</tbody>
</table>
The case hospital system has been recognized as an important agent of change for the health care industry in Taiwan; many of those changes have essentially resulted in creating social value for patients at the national level and led to financial success for the organization. Recognizing the growing global economy, the case hospital system has begun to build its social capital by training about 160 to 190 interns from medical schools in the emerging economies during the years 2008 to 2010.

Social and economic/financial value with policy implications. With its founding principle of “serving the interests of patients first,” all caregivers were required to provide patient-centered services with respect and attentive-ness. Its Social Service Fund has, in recent years, disbursed approximately US$113 million of medicine to medically underserved patients for their medical assistance and required living expenses and assisted living expenses when needed. Furthermore, the case hospital system has sponsored specifically cochlear implants, stem cell transplantations, and other medical devices that improve the basic quality of life of its socially disadvantaged patients. The case hospital system also collaborated with NHI in offering free clinics to the indigent populations. Table 3 lists the investments of the case hospital system when generating these social and financial values for the underserved populations during the years 2008 to 2010.

Both the financial and social successes of the case hospital system have drawn more attention from the government and the existing establishments in the public sector.

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Revenue in US$</th>
<th>Total Revenue/Staff in US$ (Including Medical Staff)</th>
<th>Debt/Assets</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>1.486 billions</td>
<td>438,000</td>
<td>3.86%</td>
</tr>
<tr>
<td>2009</td>
<td>1.523 billions</td>
<td>423,000</td>
<td>2.77%</td>
</tr>
<tr>
<td>2010</td>
<td>1.561 billions</td>
<td>450,000</td>
<td>2.13%</td>
</tr>
</tbody>
</table>

*US$1 is roughly equivalent to NT$30 from 2008–2010.

<table>
<thead>
<tr>
<th>Year</th>
<th>Medical Assistance to the Socially Disadvantaged</th>
<th>Free Clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>US$ (M) Persons Served (M) US$ (K) Persons Served</td>
<td></td>
</tr>
<tr>
<td>2008</td>
<td>5.900 1.030 3.333 817</td>
<td></td>
</tr>
<tr>
<td>2009</td>
<td>10.364 1.590 8.000 2607</td>
<td></td>
</tr>
<tr>
<td>2010</td>
<td>18.209 4.020 31.333 10065</td>
<td></td>
</tr>
</tbody>
</table>

*US$1 is roughly equivalent to NT$30 from 2008–2010.
A multitude of foundation-owned hospitals fluxed into the market following the case system’s example in late 1970s to the 1980s. The government responded to this market force by establishing a new legal entity of hospitals in 1987 and allowing enterprises to establish nonprofit foundation-owned hospitals with endowment funds; these hospitals were later regulated under the jurisdiction of the Department of Health instead of the Ministry of Internal Affairs. This policy change quickly led to an even more significant increase in this segment, and the resulting keener competition compelled providers to use more advanced medical technology to attract patients. One informant stated: “We believed that health insurance for all the workers on the Island is essential and led the negotiations with the public insurance organization. Once the agreement was reached, other foundation- and faith-based hospitals followed suit.”

Figure 2 delineates the constructs that were discerned and evidenced in the case study. The socially focused entrepreneurial practices are instigated by the entrepreneur’s market-orientated response to the environmental challenges (such as providing care to underserved populations and implementing policies to ensure quality of care), and this is facilitated by the management’s shared social mission of generating social benefits and providing affordable quality of care. The multidimensional outputs of social capital and enterprise value further drive the creation of social and financial value.

Discussion

Health care as a social service has encountered major challenges globally in an environment with limited resources and widening social disparity. According to Tiku (2008), a market’s operational needs may sway the socially driven entrepreneurs toward becoming more market driven, whereas those who start with a more market-driven idea may develop more socially conscious practices as a result of the market demands. The findings of this case study show that the volatile environment must be coupled with market-oriented organizations to lead to entrepreneurial practices in the health care context. The positive financial output of such a business model then attracts the influx of competitors/providers. The continuously changing environment, policies (such as the tax status and regulations, insurance and payer systems) and the norm/philosophy of operations resulted in further expansions of privately owned general hospitals. Figure 3 illustrates both the steady growth of the health care sector and the provision of health care to the local population. During the period from 1960 to 2010, the number of hospital beds in the private sector grew from 30 percent to 66.04 percent, a sector in which foundation-owned hospital systems accounted for 69.14 percent of the whole. The provision of health care in terms of beds available improved from 0.7 beds per 1,000 people to 5.8 beds. This phenomenon illustrates the importance of the social entrepreneurs and their leadership teams as the driving force for fostering an “ethics-grounded” culture, one in which the social entrepreneurial processes resulted in outputs that encompass both financial and social outcomes as well as having a direct impact on policies. The case hospital system constantly operates in a fluctuating and uncertain context, and this presented a distinct opportunity for the organization to instigate a social movement that exerted strong influences on its public and political environments. Through its entrepreneurial practices of using social and enterprise
Figure 2. Key Components of the Social Entrepreneurial System of the Case Hospital System

**INPUTS**

**Market-Oriented Response to the Environment**
- Focusing on providing health care to underserved populations
- Initiating innovative forms of private general hospitals
- Implementing policies to ensure quality of health services
- Establishing systems for hearing the voices of the medical experts and the patients

**Shared Social Mission of the TMT**
- Provision of quality health care at affordable prices to the general public
- Emphasis of generating social benefits instead of personal economic gains
- Investment in education and advanced medical technologies

**PROCESS**

**Social Entrepreneurial Practice**
- Patient-centered care payment system
  - Deposit-free inpatient registration
  - Streamlined one-stop payment system for outpatient
  - Physician Fee system to incentivize physicians for providing fair and compassionate care to patients by avoiding “moonlighting” and receiving “gift money” from patients
- Management strategy
  - “Administration center” with job rotations at the management level
  - “Accountability centers” to manage by objectives, control cost, and monitor performance at the operational level
- Market-orientated knowledge management system
  - Standardization of processes with 140 performance indices
  - Centralization of procurement and patient care processes

**OUTPUTS**

**Social Capital Creation**
- Open residency training programs for interns from other medical schools
- Transplantation of management system and support of clinical services to member hospitals through strategic alliance

**Enterprise Value Creation**
- Cost containment and control over programs and activities
- Revenue streams from multiple customer-oriented service innovations

**Social and Economic/Financial Value Creation**
- Respectful and compassionate care for all
- Improved equitable access to quality care
  - Free transportation for the rural population
  - Social Service Fund for the medically underserved
- Financial Value/Viability
- Enhanced quality of medical care
  - More advanced medical technologies
capital, the result led to social value that benefits the general public and financial value that is advantageous for the organization itself. Furthermore, by building social capital, entrepreneurs are enabled to play a strong role in making an impact on the policy/public environment that eventually allows a much more powerful social value creation through fundamental social change.

The health care industry is in transition throughout the world. Health care reforms in the United States and other emerging economies, such as China, present an environment that is constantly changing and uncertain. The entrepreneurial orientation of the leaders of health care organizations and policy makers is shown to be an important drive for translating business principles into the development of more sustainable business models and processes in the health care context. For instance, bundled care models and accountability care organizations in the United States and privatization of hospitals in China are examples of entrepreneurial practices. Other scholars also recommend the formulation of networks to influence complementary or even competing organizations to mobilize their resources toward activities across organizational and sector boundaries to lead to maximal social impact.

To achieve these goals, hospital leaders should focus their efforts internally to attain support from their boards while continuing to engage in dialogues with external stakeholders as well as in advancing the social mission of their hospital. The innovative management system and business model of the case hospital system have shown to exert...
profound impacts on their counterparts in the public sector and within the health care market as a form of positive externality. Consequently, the government has actively responded to their evidence-based paradigm shifts in practice through on-going policies changes. Nonprofit health care organizations usually have a clear social mission, but they are often unable to fully appreciate the extent to which they may generate social values for the public at large. This case study provides an element of the initial evidence of real impact that such steps taken in the nonprofit health care market may hold. The financial viability of the case hospital system has motivated other health care institutions in Taiwan, China, and Asia at large to emulate its business model.

Conclusion

Socially driven entrepreneurial organizations are built to achieve change but most of them focus only on their social causes regardless of cost.51 However, in this study, we demonstrated that a nonprofit organization can adopt business principles that emphasize both financial and social value. Using a case hospital system in Taiwan, we tested our model and found comprehensive accountability across departments throughout the hospital system. This led to sustainable and continual growth of the organization. Consequently through social entrepreneurial practices, we have shown that both financial value creation and fulfilling the social mission for the case hospital system can be achieved. In future studies, we intend to test our model derived from the taxonomy presented in Figure 1 with the purposes of demonstrating that applying entrepreneurial practices to the health care industry can produce positive financial and social impacts as well as guide the direction of organizational and government policy changes.

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38. Lu and Chiang, *supra*, n.7.


40. Id.


42. Id.


