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Marketing issues for the hospital industry

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Abstract
The controls on payments by insurance companies and governmental agencies (Medicare, Medicaid, Title 19) to hospitals have led to restricted hospital services for patients. This situation has caused overcapacity in hospitals. Also, there is a surplus of both hospital capacity and doctors. However, there are frequent shortages of nurses and many other trained technical personnel. This situation has behavioral implications which are discussed in this paper.

Introduction

The hospital industry has undergone radical changes in the past decades (Dawley *et al.*, 1999; Egger, 1999a; Sheldon and Windham, 1984; Steiber *et al.*, 1985). These changes include overcapacity and economic difficulties. The result has been that free standing hospitals, which relied mainly on for-fee revenues, could not generate enough patient revenues (Egger, 1999b; Steiber *et al.*, 1985). These hospitals had to undergo restructuring: get merged, be acquired, divest many of their facilities and services or departments and other survival oriented approaches.

Hejase *et al.* (2000) and Baird and Meshoulam (1988) summarize various approaches for improving institutional internal fit and external fit. They discuss approaches to deal with the different organizational stages such as: initiation, functional growth, controlled growth, functional integration, and strategic integration. Each hospital should analyze its desirable fit in the context of its particular internal and external environments, and the particular stage of the organization.

Background factors

Many smaller and medium sized hospitals had not been pursuing written, systematic strategic planning in the past many years (Bulcke *et al.*, 2000; Egger, 1999a; Kropt and Goldsmith, 1983). This had led to many inefficient units scrambling in search of panic, survival strategies.

Large hospital chains have been gaining ground on acquiring more and more individual marginal hospital units. These acquired hospital units are drastically restructured and managed strictly on an economic basis. Unprofitable services and departments are removed and profitable ones are expanded. Changes in an existing focal activity, cost cutting and restructuring, and change in leadership were found to be associated with closure of existing units.

The particular structures that a hospital has utilized is an important factor in determining its readiness, flexibility and propensity to fully respond to demands placed upon it by the dynamic external environments. It is suggested that organizations' selective use of "configurational" and "coactivational" prescriptions may lead to better internal organizational resource responses to external challenges (Dow, 1988). These structurally related analyses are important to correct and modify the responses and performances of hospitals as they re-relate to changing environments.

Large hospital chains continue to grow and try to adjust to economic pressures. Experts indicate that there is a likelihood that the 25 biggest chains would own or control an estimated 20 per cent of all US hospitals. Concentration of ownership or control of hospitals appears inevitable by the start of the twenty first century.

A significant number (about 40 per cent) of hospitals currently belong to chains (Steiber *et al.*, 1985). Among the over 4,700 (approximately) hospitals which are members of the American Hospital Association, some 255 are headquarters of hospital chains. The chains are owned or managed by city and county governments, voluntary (non-profit) hospitals, for profit hospitals, and teaching or university hospitals (Health Care Strategic Management, 2000a,b). The relationship between the headquarters of hospital chains and their individual units is that of the headquarters providing a general direction and requiring rates of returns (profitability requirements), while the individual units operate on a fairly autonomous basis.

Hospital inpatient stay has decreased from 78 per cent to 62 per cent during a period of eight years. This has caused considerable decline in patient revenues. Hospitals must now cope with decreased revenues and third party (e.g. insurance companies) controls over payments to hospitals, doctors and laboratories.

Medical insurance companies have schedules of payments for different illnesses, essentially following the payment trends of the US Government. The diagnostic related groups have been the basis of approving

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payments to hospitals, laboratories and doctors. This control, hitherto unknown to hospitals, has injected new elements in hospital administration, that is cost control and better marketing to seek greater patient revenues (Glaser *et al.*, 2000; Katz *et al.*, 1983).

The medical insurance companies and governmental agencies (providing Medicare, Medicaid, and Title 19) in an attempt to contain run away hospitalization costs have set up strict third party payment schedules through the use of set amounts for specific medical ailments. It is up to the hospitals to make or not make a profit for each inpatient case. Hospitals and doctors have been more strict with patients for the length of their stay because they fear that health maintenance organizations (HMOs), other medical insurances, and governmental departments may not fully reimburse the patient's medical expenses.

HMOs have been found to be an effective way of controlling medical premiums for their subscribers. But they restrict the list of doctors and hospitals to which subscribing patients can receive medical attention. This has caused hospitals, doctors in solo and group practice, teaching hospitals, larger clinics, smaller walk-in clinics, laboratories and pharmacies to join in the network of different HMOs in order to widen their market base and generate greater revenues. These changes in market structures have led to patients seeking more efficient providers (Egger, 1999b; Falkson and Leavitt, 1982).

The supply of doctors is in excess of demand in the marketplace. This has led many newly entering doctors to seek more readily available and more productive practices through such approaches as joining with nation-wide companies which place doctors or which contract jobs to doctors. Examples of such companies are National Emergency Services (the largest company of its kind), Spectrum and IPR. These companies contract with hospitals and clinics in rural and urban areas to provide specific doctors' services (e.g. emergency room doctors) on weekdays or weekends or both. This concept of contracting companies, as in the case of doctors enrolling themselves with HMOs, often results in improved sorting process in the marketplace. It is hoped that through this doctors would get better revenues, hospitals would get doctors and patients would get better services.

The emergence of senior citizens as a large distinct group with increasing life expectancy has led the providers to pay greater attention to medical problems of the aged: heart disease, cancer, pulmonary, kidney and urinary tract problems. Nursing homes and geriatric care has assumed increased relevance. As a contrast to low average inpatient stays in hospitals of some 62 per cent, that of nursing homes has increased to a healthy 92 per cent. Nursing homes' patient related cost is less than that of hospitals, and, aged patients are often released to nursing homes rather than be allowed a prolonged hospital stay.

Marketing strategies

Figure 1 (which is self explanatory) provides an integrative framework for this paper: how various parts of the paper are to be viewed together. Good strategic analysis is vital for the sound formulation of viable marketing strategies (Godiwalla, 1983) and many of the components of Figure 1 are based upon this observation.

Survival (or defensive) strategies

Significant internal restructuring and cost control are pursued along with collaboration or even merger with other similar size nearby hospitals (Peters and Tseng, 1984). Each hospital evaluates the cost/benefits of each service and they determine the service that one would give up so that the other hospital could retain and receive the patients from the first hospital. Services which require expensive equipment and staff but which have fewer patients are disbanded in favor of those services which require less expensive equipment and staff but which enjoy more patients, thereby enabling the service not only to break even but also provide contribution to hospitals' overhead and profits. Such rational and economic analyses between two or more cooperating hospitals in larger cities have led to better survival. Another approach for the hospitals is the enrollment with the better HMOs whose large list of subscribing patients provide a better flow of patients to the hospitals. The elimination of duplicate and unprofitable services within a group of affiliated hospitals has resulted in more efficient use of resources among the group of hospitals. Elimination of duplicate and unprofitable services immediately reduces the unnecessary economic burden upon the hospitals. A thorough analysis of organizational internal and external environments is essential for formulating organizational objectives, strategies and tactics (Godiwalla, 1983).

Concentration strategy

Focus upon one, few or some market niches, or "condition groups", or "patient oriented classification of demands placed on hospital consisting of one or more related conditions" (Thompson, 1982). For example, Shouldice Hospital, a privately owned hospital outside Toronto, specializes in only one specific condition group, inguinal hernia. It performs

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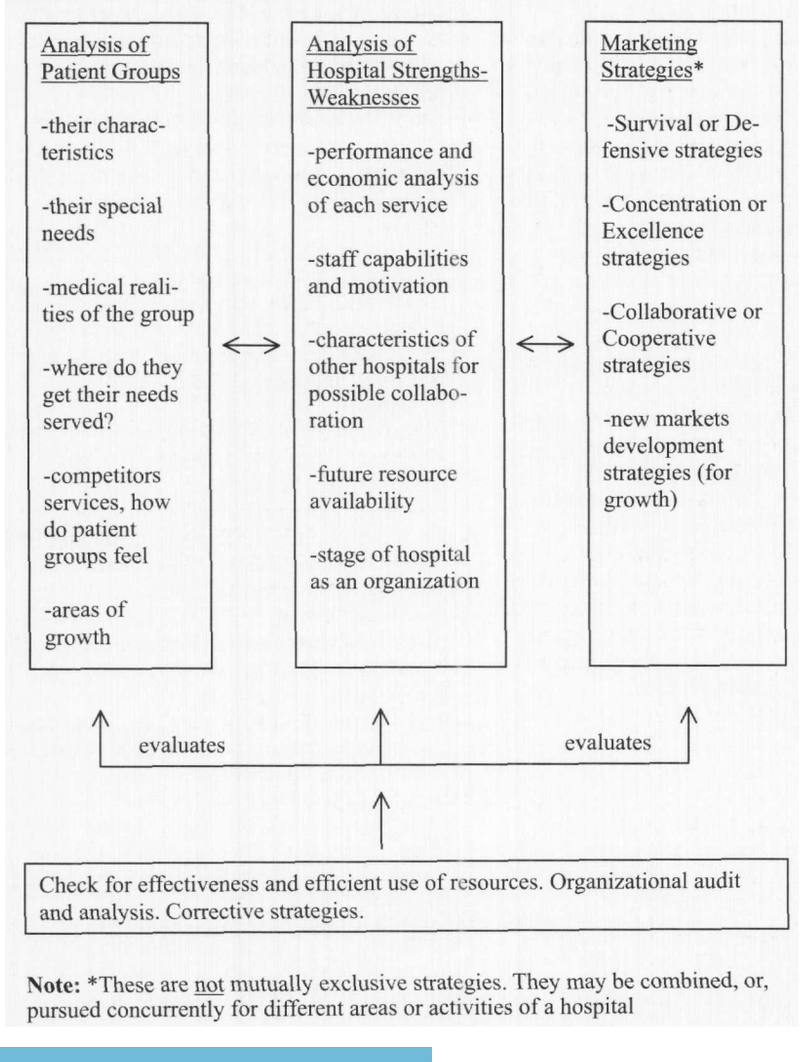
some 7,000 operations a year. Patients are so satisfied that they travel from distant places for annual reunions. Doctors at Shouldice are ten times more effective than others elsewhere. The administration focuses upon the most primary services. The hospital is famous for its "Shouldice method" by which local anesthetics and special suturing ensures rapid recovery. Shouldice's post operative care is vital. It focuses upon a series of exercises that enables patients to recover twice as fast. For Shouldice Hospital it is the positioning of itself in the marketplace, leveraging of value over cost, and integration of strategy and systems that enable it to be so successful. Staff costs are lowered by involving patients in their recovery. They know about their own recovery beforehand from other patients. They help other patients in their recovery.

While the example of Shouldice Hospital is rare (in the sense that very few hospitals can afford to focus only on one type of operation), however, hospitals need to identify a manageable number of services which are simultaneously in great demand, and can be delivered effectively and profitably.

The sequence of questions for formulation process, as outlined in Figure 1, is:

1 Analysis of target market segments.
2 How does each segment define "good service"?
3 What activities and resources are needed to deliver "good service"? What are different characteristics, elements and activities of "good service"? How do the employees perceive the good service and the prospective methods to deliver them? Define "good service" as evaluated by different segments.
4 Can the "good service" be delivered in a cost efficient manner? Through mass standardization (versus tailor-made to needs of segments), quality control, controlling supply or demand (or both), farming out certain unimportant services.
5 How can the hospital people's professional pride, dignity and development be enhanced? Through what rewards, recognition, job enrichment or enlargement, promotion, rotation can the intrinsic motivation of the work itself be enhanced? What extrinsic rewards are valued most by the hospital staff?
6 Can structural reorganization enhance better match between hospital units or departments and their respective patient groups or market segments? Are the characteristics of the market segments (or patient groups) properly analyzed and adequately used in the formulation of strategies?
7 Are all the strategies and activities properly synthesized or integrated?
8 Do the hospital staff and supervisors communicate adequately with each other in the development of integrative methods so that the patients receive good services and the early identification of latent problems so that they are averted?
9 What are the long term competitive strategies of the hospital? What are the significant activities of the hospital as judged by the patient groups and as evaluated for technical sophistication and effectiveness by peer hospitals?
10 The current and desired areas of excellence must be first evaluated to see if there is a growing market for them. If there is anticipated growth in certain market segments the hospital may then pursue expansion of services in those areas.

Figure 1
Hospital strategic process for marketing strategies



Note: *These are not mutually exclusive strategies. They may be combined, or, pursued concurrently for different areas or activities of a hospital

Collaborative or cooperative strategies

These strategies are aimed at combining the resources and services of two or more cooperating hospitals. In these days of

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dwindling patient revenues, individual institutions are not able to pursue services very effectively individually for a variety of reasons, most notably economic reasons. Although these services would not be uneconomical if only one hospital pursued it, however, it is competitively more advantageous for two hospitals to combine their resources. For example, Mount Sinai and St Lukes hospitals in Milwaukee have collaborated or cooperated together to further strengthen their specific services. Such examples have become more common in the past many years. These collaborative or cooperated moves are for both purposes: survival, or, competitive enhancement of the hospitals' services. Multiple hospital chains can pursue this strategy if they are nearby (in closeby cities). These strategies are similar to survival or defensive strategies except that these are agressive, not defensive in nature.

Conclusion

In conclusion, the growth areas of the hospital are the areas upon which the hospital must concentrate and expand. It should prune its marginal or unprofitable services. If several of these are necessary it may either pursue collaboration with nearby hospitals, or, if that is not possible, then it should pursue cost cutting. Market segments (or patient groups) must be analyzed for the development of marketing strategies: survival (or defensive) strategies; concentration strategies (as in the case of Shouldice Hospital); and collaborative or cooperative strategies (as in the case of Mount Sinai and St Lukes hospitals). These strategies may be pursued concurrently. The promotion of new or modified services need to be pursued on an ongoing basis through a planned effort, e.g. the development of services may be first discussed with groups of patients, insurance companies, other hospitals, civic bodies, consulting doctors, people of staff support services of the hospital such as nurses, technicians, and the research or teaching institutions. Prior consultations would ensure the soundness of formulation and development of services (their characteristics, the content of the strategies, etc.).

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