

The Health Care Market: Can hospitals survive?

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In an increasingly competitive and resource-regulated market, hospital managers must develop alternative and less costly health care methods.

Does it sound familiar? Resources are scarce, competition is tough, and government regulations and a balanced budget are increasingly hard to meet at the same time. This is not the automobile or oil industry but the health care industry, and hospital managers are facing the same problems. And, maintains the author of this article, they must borrow some proven marketing techniques from business to survive in the new health care market. He first describes the features of the new market (the increasing economic power of physicians, new forms of health care delivery, prepaid health plans, and the changing regulatory environment) and then the possible marketing strategies for dealing with them (competing hard for physicians who control the patient flow and diversifying and promoting the mix of services). He also describes various planning solutions that make the most of a community's hospital facilities and affiliations.

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The illustrations on pages 106 and 107 are adapted from a spirogram, a pulmonary function test.

The hospital industry in the United States is big business. During 1978, more than 7,000 U.S. hospitals employed 3.2 million workers and expend over \$71 billion. Because the costs of hospital care have risen far more rapidly than the rate of inflation during the past 15 years (see the *Exhibit*), local, state, and federal governments have escalated regulatory efforts to contain them. These efforts have heightened competition among hospitals for increased use of their facilities. At the same time, new health care forms have presented hospitals with significant external competition. For these reasons, marketing is now a major management concern in health care field.

Conventional wisdom about the health care industry says that competition is minimal among health care providers. This is certainly true of price competition for inpatient hospital services. Because health insurance has anesthetized the consumer against rising hospital costs, those costs have creased in a hyperinflationary way.¹ Hospitals compete intensely, however, for physicians and patients, and new forms of delivering health care may compete with hospitals for health care business based on both increased convenience to the consumer and lower costs. And the more rapid hospital costs escalate, the more rapidly these alternative methods of delivering care will grow. that do not respond to these changes by b their mix of services and by developing more flexible distribution systems to bring in patients are like to experience difficulties competing in this new environment.

Before examining some of the marketing tools hospital managers are bringing to bear on their competitive problems, it might be helpful to look at some of the changes taking place in the health care field that are making these strategies so important.

Changing health care environment

The hospital is the core institutional provider of health care. Yet, for the reasons that follow, as their costs increase, hospitals will be in an increasingly vulnerable position within the health care

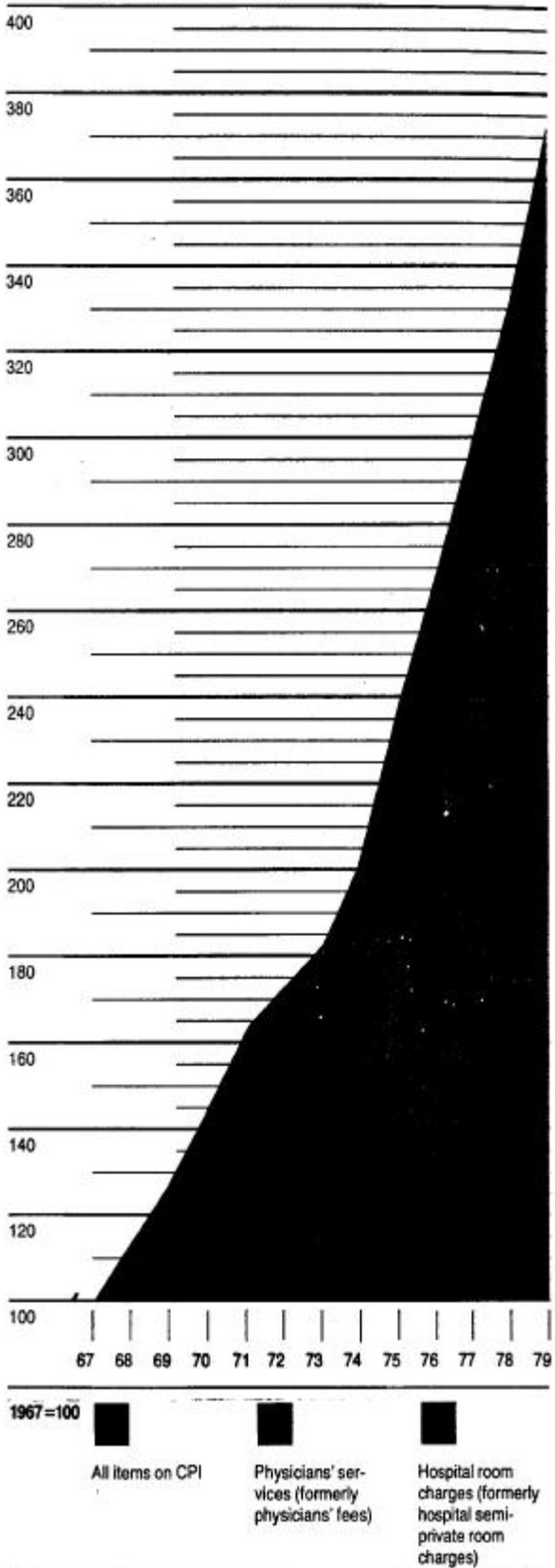
market. Much like the urban department store, which faces major competition from alternative outlets (drugstore chains, discount houses, direct mail, boutiques and specialty shops, and so forth), hospitals face threats from emerging alternative forms of health care.

Increasing economic power of physicians

Hospital managers labor under some unique managerial constraints in mobilizing their resources. They have almost no ability to control the use of hospital services directly. And physicians, who determine how and how much the hospital is used, exert enormous power in allocating resources-but the physicians, too, are often beyond managers' control.

Existing health insurance plans, including Medicare, pay many physicians' fees regardless of where they hospitalize their patients. Thus in most cases the hospital manager has no control over physician income. Recruitment, retention, and management of physicians-who, like a "sales force," bring in patients-are the key marketing issues for hospital managers. Physicians also have the financial resources to compete in their own offices with many hospital services. Since the overhead in an office setting is much lower than in a hospital, they can frequently undersell hospitals for the same services and will do so increasingly in the future.

Exhibit
**Selected components of the consumer price index,
 1967-1979 (All urban consumers)**



Source: For 1967-1977 data, *Handbook of Labor Statistics 1978* (Washington, D.C.: Bureau of Labor Statistics, U.S. Department of Labor). For 1978 and 1979 data, telephone conversation with Bureau of Labor Statistics, July 1, 1980.

New forms of health care delivery

Because of advances in drug therapy (for many mental disorders, for example) and in technology (in kidney dialysis, for instance), many patients can now receive health care without being hospitalized on a long-term basis. Standards of medical practice are changing as well. Many types of emergency (short of massive trauma) can now be managed outside the hospital. Also, many types of surgery can now be performed on an outpatient basis.

All the new forms of care have in common the substitution of outpatient for inpatient care, with both lowered costs and increased convenience for patients. As such, they threaten to reduce use of the hospital's key inpatient services. The extent of the shift to alternative forms of health care was revealed by a recent Blue Cross study that showed an 18.6% decline in inpatient days of care and a 137.6% increase in outpatient visits among Blue Cross subscribers between 1968 and 1978².

Prepaid health plans

More than 6.3 million Americans are now enrolled in health maintenance organization (HMO) plans. Patterned after the successful corporate health plan sponsored by Kaiser Industries, HMOs provide all their members' health care for a fixed, predetermined fee. Because HMOs can effectively reduce hospitalization rates for their members below the level of the general U.S. population, they present a competitive problem for hospitals³.

Changing regulatory environment

As public concern over the high costs of health care mounts, the hospital industry is rapidly emerging as one of the country's most heavily regulated: in 1976, New York hospitals alone spent more than \$1 billion coping with government regulation⁴. While much of this regulation has had little or no impact in reducing health care costs, some regulatory policies have enormously complicated the life of the hospital manager⁵.

1. Certificate of need

Since 1964, 46 states have enacted certificate of need laws that require health facilities to obtain approval from state health departments before proceeding with building programs. With the enactment of the National Health Planning and Resource Development Act of 1974, the federal government threw its weight behind these state laws and devoted itself to restricting further growth in hospitals and reducing excess bed capacity (estimated at between 68,000 and 83,000 beds)⁶.

In late May, the Carter administration accelerated these efforts by proposing that no federal funding, whether direct (through grants) or indirect (through tax exemptions for hospital beds), be provided for projects in "overbedded" areas.

These restrictions have created incentives for hospital managers to compete more aggressively with neighboring facilities. The 1977 National Guidelines for Health Planning set a target occupancy rate of 80% for all nonfederal, acute care hospitals in the United States (though many states a target of 85% or 90%). Under continued cost pressures, states may deny hospitals permission to renovate, replace, or equip themselves unless they meet occupancy standards. Hospitals that do not meet occupancy standards would then have difficulty keeping up with changes in medical technology, altering their mix of services, and recruiting and obtaining medical staffs.

2. Health manpower policy During the 1960s, Congress instituted loan programs for students pursuing health careers and grant programs for medical, dental, and other health profession schools to increase student enrollment. But federal policymakers in the Department of Health and Human Services (HHS)-formerly Health, Education, and Welfare (HEW) and the Office of Management and Budget are now convinced that the demand for physician services is virtually limitless and increases proportionately to the supply of physicians⁷. Accordingly, they believe that there are too many physicians and that they are maldistributed by specialty and geographic area. Based largely on this thinking, the Carter administration proposed in its fiscal year 1980 budget to discontinue capitation grants to medical, dental, and other health profession schools.

Also, in the Health Professions Educational Assistance Act of 1976, Congress restricted sharply the further entry into the United States of foreign trained physicians who come for residency training and who, as a rule, remain to practice here.

Reductions in the total number of new physicians will present managers of hospitals in the rural west, West, and South and some inner-city areas -- which have very low ratios of physicians to population with problems in attracting staff if their share of the physician market remains constant. Efforts of these institutions to substitute nurses and other allied health professionals for the lost foreign-trained physicians are likely to founder in an increasingly tight nursing and paraprofessional marketplace.

3. Federal Trade Commission While Congress and HHS want to cap the growth in physician supply, the FTC has conducted an investigation to determine whether the medical profession's control over medical school accreditation constitutes a "conspiracy in restraint of trade," apparently believing that *more* physicians would mean *lower* health care costs.

Under the theory that increased advertising would encourage price competition among physicians and reduce those costs, the FTC also acted in October to lift medical society restrictions on physician advertising. This explicitly countered HHS's prohibition against institutional providers-such as hospitals, nursing homes, and home health care agencies under the Medicare program-engaging in advertising and other marketing practices that might artificially stimulate use of their services.

4. Cost containment

The Carter administration's frontal attack on rising hospital costs was blunted last fall by a decisive defeat in the House of Representatives. If passed, the Carter bill would have regulated hospital revenue increases *per admission* without simultaneously capping hospital admissions. This regulation could create heightened competition for patients who would not have entered the health care system otherwise, unintentionally *increasing* overall health outlays.

In a regulatory environment as confused as the present health policy arena appears to be, the consequences of regulatory strategies often have an effect exactly opposite to that intended.

Regulatory approaches to hospital cost containment have, perhaps unwittingly, focused too much managerial attention on increasing or maintaining levels of hospital use and market share. By making certificate of need and rate review decisions contingent on those levels, overall health outlays may actually increase. Regulatory pressures have intensified to the point where some health care executives argue that takeover of the industry by large health corporations is inevitable.⁸ Ultimately, the problem of hospital costs may be solved by substitution rather than by capping or other direct regulatory action.

The message to hospital managers is unambiguous: analyze and adapt to the changing health care markets or face financial difficulties or absorption. Now let us look at some strategies for dealing with the changes.

Strategic response to the new environment

Many of the strategies hospital managers can use to confront the new environment are easily recognizable as those corporations use for protecting an enterprise's position in a maturing market. But these strategies represent a departure from conventional methods of hospital management. They include:

1. Compete aggressively for physicians.
2. Diversify out of acute inpatient care into a broader mix of medical services.
3. Develop captive distribution systems to control patient flow.
4. Promote the institution's services.

In what follows I discuss these strategies as well as some emerging new forms of organizational structure that may also represent creative responses to the new competitive environment.

Compete for physicians

Since the key to hospital use is an active, committed medical staff, recruiting and retaining physicians are the most important marketing issues facing hospital managers. Because it frequently involves commitments to program changes or acquisition of facilities or equipment, physician recruitment is expensive. Administrators may have to guarantee compensation regardless of direct productivity—for example, to physicians beginning their practices. In some academic health centers, the cost of a single recruitment (a department chairman or service chief) may exceed \$10 million. To attract physicians to more conventional hospital settings, administrators may have to purchase new equipment, hire nursing staff, construct or finance physicians' office buildings, provide parking facilities convenient to the hospital, pay for recreational facilities, or offer financial assistance in purchasing homes.

Hospitals are often affiliated with medical schools, many of which have special appointments and positions (e.g., clinical professorships) that are given to physicians in the community who are not full members of the medical school faculty but who may participate in teaching. Such affiliations give hospitals prestige in the community, a place to refer complex medical cases, and preferential access to the residents and medical students who may rotate through the hospitals as part of their training.

Many hospitals have developed medical education programs at the post-MD level to provide a captive market of potential recruits to the medical staff. By establishing residency programs, with or without medical school affiliation, hospitals secure licensed physicians who are training in a medical specialty. Major efforts are made to encourage those who are completing their training at the hospital to practice there later.

Some larger hospitals in Chicago and elsewhere now offer financial, legal, and other kinds of assistance in setting up medical practices to graduates of their residency programs who offer some assurance they will remain linked to the hospital. Because a stable patient population generates a predictable annual amount of fee income and hospital revenue, a medical practice is much like an annuity. Further, as patients grow older, their demand for health services obviously increases. Practices can actually be bought and sold by physicians who move into exclusively administrative activities or who retire or move away.

The federal government is increasingly interested in encouraging the growth of residency programs in primary-care specialties such as pediatrics, family practice, obstetrics, and gynecology. Because physicians trained in these specialties must depend heavily on consultation

from colleagues on the medical staff, they are doubly attractive to the hospital administrator. Patients requiring surgery or complex diagnostic procedures are referred to others on the medical staff—cardiologists, neurologists, neurosurgeons, and so forth—thus ensuring a flow of patients to these specialists.

Recruiting strategies for hospital-based physicians, such as pathologists, radiologists, and anesthesiologists, often focus on sharing profits on a volume basis from the medical diagnoses and tests they perform, which tend to be profitable for the hospital. Federal policymakers; have cited this practice as encouraging unnecessary tests or procedures, however, and Congress is considering outlawing it.

In an increasingly litigious environment, it is not surprising that some physicians themselves are beginning to view hospital privileges as a property right that cannot be abridged without due legal process. Accordingly, the ability of the administrator or chief of medical staff to terminate staff members who do not use the hospital actively or who do not meet ethical or other professional standards may be compromised, making it essential that recruitment efforts yield quality recruits.

The growth in aggregate supply of physicians predicted between now and 1990 may help tip the economic power balance back into the hands of hospital manager. However, even though many areas of the country -- including rural and inner-city -- will probably continue to have serious difficulties recruiting medical staff, local conditions of over supply will present hospital managers with another problem. Medical staffs may close ranks and refuse to grant privileges to young physicians moving into a community. This may create further litigation and affect a hospital's vitality and use of its service. In Illinois, the age (i.e., the youth) of the medical staff is a key variable in determining whether hospitals can finance long-term debt for capital projects and is considered an indicator of the overall health of the hospital.

Diversify into new services

Because inpatient hospitalization costs have escalated drastically, the search for substitute methods of rendering care will intensify. Inpatient care be increasingly rationed, whether through overt action by the insurance industry or the government in altering health care reimbursement policies through demands by consumers. Hospital managers can confront this problem by diversifying the vices they offer to patients.

Outpatient care Because much prehospital care is rendered in physicians' offices, most hospitals do not assume corporate responsibility for it. The hospital's "feeder" or retribution system includes all the office practices, physicians on the medical staff.

For many teaching hospitals, and for larger hospitals that have a mixture of volunteer and full-salaried medical staff, a portion of prehospital is rendered in captive outpatient facilities operated by the hospital, such as hospital-based clinics or emergency rooms. At the University of Chicago, which has a full-time salaried medical staff, hospitals and clinics deliver more than 220,000 outpatient and 80,000 emergency room visits annually. These two systems account for over 95% of hospital admissions.

Captive, hospital-based outpatient facilities, however, have significant problems. Because rent federal reimbursement regulations for Medical and Medicare authorize payment for whichever lower, cost or charges, and because full hospital overhead must be allocated to outpatient cost center if cost is used as the basis for reimbursement, the cost of outpatient care in hospitals has soared in tandem with that of inpatient care. Currently, many hospital-based outpatient clinics are increasingly unable to compete with office practices in urban areas. Because many health

insurance plans provide incomplete coverage for outpatient care or large deductibles, outpatient care tends to accumulate significant bad debt, and hospitals lose money on it.

The incentives to segregate outpatient activity in office buildings adjacent to the hospital are obvious. Medical services in these facilities are not only convenient to, the hospital but occur outside the hospital's cost base. Patient fees can compete with those of other providers of outpatient care. The hospital can also develop outpatient facilities that are linked to the hospital by common medical staff under a separate corporate umbrella.

Excellent examples of both strategies as part of an institution's master plan can be found at Rush-Presbyterian-St. Luke's Hospital and Medical Center in Chicago. Rush constructed offices that house more than 200 physicians adjacent to the hospital. Though Rush owns the building, it leases it to the group practices; the lease costs are part of the physicians' fees. The private practices of many of its voluntary staff are carried out in the building, which has its own ancillary laboratory and radiology facilities, as well as facilities for outpatient surgery.

Rush also developed a network of community-based outpatient facilities under separate incorporation from the parent hospital. The Mile Square Health Center, Inc., named for the mile square area of inner city around the hospital, delivers 12.5,000 visits of care annually. The center is affiliated with the Medical College at Rush, which provides academic appointments and teaching opportunities for the center's salaried medical staff.

Having put these two structures in place, Rush closed its hospital-based outpatient department, relying on these two captive but corporately independent distribution systems, its emergency room, and extensive referrals from physicians in the Chicago area to fill its hospital. One drawback to these strategies is that, under cost reimbursement, closing an outpatient department means inpatient overhead costs cannot be spread over as many cost centers, and they inflate artificially.

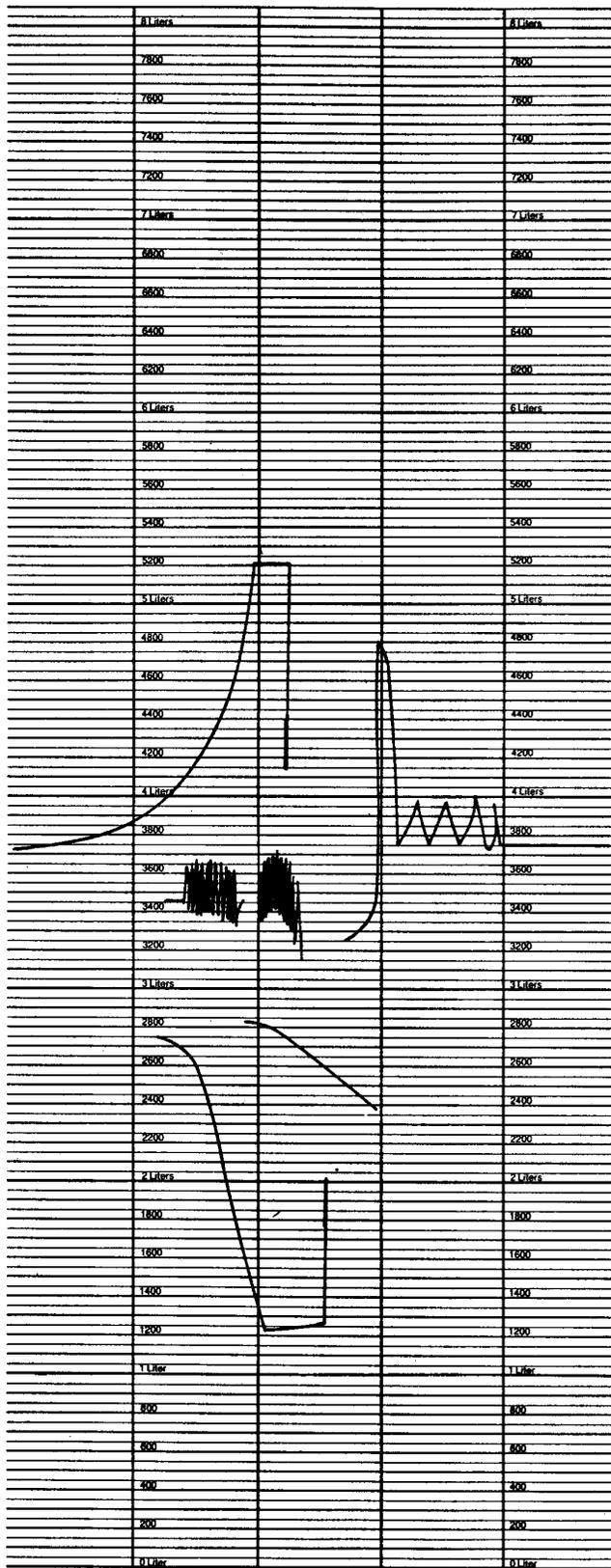
Outpatient surgery

Another major development in outpatient care is the growing acceptance of outpatient, or day, surgery. As many as 20% to 40% of all surgical procedures can be performed this way, saving one to three days of high-cost hospitalization.⁹ And many patients prefer day surgery because it minimizes time away from work and is more convenient than a longer hospital stay.

Both hospitals and private physicians have established day surgery programs that provide all the logistical support for surgery. Patients are prepared in their physicians' offices in advance of the visit. They come in the morning for surgery, spend the day recuperating in the facility-frequently with friends or family present-and go home in the evening.

Shifts within the hospital to day surgery programs may radically reduce a hospital's inpatient use. Hospitals with less than peak surgical bed occupancy or without a waiting line for elective surgical procedures should proceed with extreme caution in developing such programs. In some cases, however, the institution may not have a choice. For example, the creation of an outpatient surgical program in a physician's office across the street from the Good Samaritan Hospital of Phoenix forced the hospital to develop a similar program.

It is likely that regulators and insurers will accelerate the rapid development of such programs by refusing to reimburse hospitals for inpatient costs for surgical procedures that could be performed on an outpatient basis. Ultimately, hospitals may have no choice but to create their own day surgery programs to preserve their shares of the surgical market.



Freestanding emergency rooms

Yet another significant innovation in health care delivery could threaten a key feeder system for many hospitals—the hospital emergency room, which typically provides from 15% to 30% of hospital admissions. Many patients who are not acutely ill but who have no physician or other means of getting care use emergency rooms. In many under-served areas, as many as two-thirds of the visits may be non-emergency cases. Emergency rooms are the health system's current answer to the need for episodic health care.

For reasons of both high cost and potential substitution, hospital emergency rooms are vulnerable to replacement by innovative alternative methods such as the freestanding emergency room. According to a study conducted for the Robert Wood Johnson Foundation, 55 such facilities existed in the United States in late 1978.¹⁰ They can provide most of the services of a hospital-based emergency room except for full-scale surgery that requires general anesthesia. Most of them have their own laboratory and radiology facilities, though some contract with others for these services if rapid turnaround on tests is available nearby. They bill as if the either emergency rooms (if corporately linked hospital) or doctors' offices, usually at half or of the prevailing emergency room visit charge.

In the Chicago area, a fresh entry into this mark is the brainchild of a former partner of Arthur Young & Company, Dr. Bruce Flashner. Its name, the Doctor's Emergency Officenter, expresses cogently its hybrid private physician/emergency room nature. It is, however, reimbursed by Blue Shield as a doctor's office. (Ironically, Blue Shield refuses to reimburse the facility for itemized charges for patient care, despite the fact that the total charges per patient are lower than a typical physician's fee for the same type of care, which it does reimburse. But reimburses all lump-sum expenses as long as the are called "professional fees.")

The Officenter operates on a no-appointment basis and, six months after opening, receives an average of 50 visits a day. Dr. Flashner encountered difficulties with anxious physicians in the Arlington Heights community, where the facility is located, until it became clear that he did not intend to buy a practice through the center. Instead, its physicians return patients to their family doctors for continued care or refer them to specialists for complex conditions. In addition to a single doctor per shift, the center has two paraprofessionals who are trained handle billing, laboratory and radiology work, and other matters. The Officenter required almost no initial capital outlay; facility and equipment were leased, and the capital cost of the leases was less than \$100,000.

Bridging the gap between the expensive, frequently impersonal hospital emergency room and the private physician's office, facilities like this represent a competitive threat to both. Hospitals that are competing for patients will offer preferential admitting privileges for patients coming from there. It may actually be easier to be admitted through a freestanding facility than through the hospital's own emergency room.

In Phoenix, the Samaritan Health Service, one the nation's most successful voluntary multi-hospital systems, established a captive freestand emergency facility in the far eastern suburbs. The facility feeds the easternmost satellite hospital the Samaritan group with emergency cases requiring hospitalization. It was established in a developed area to provide Samaritan with a medical presence that could form the nucleus of a hospital if population growth were to continue at the current rate. Captive facilities give the hospital control, over geographic origins of patients coming into its facility and a low-cost method of entering new or developing markets.

Health maintenance organizations

Freestanding emergency rooms occupy one end of a continuum of medical treatment that runs from „cute episodic care to continuing primary care. The HMO-of which there are approximately 165 in the United States-occupies the other end¹¹. HMOs provide complete health care to a stable population of enrolled patients for a fixed arrival fee. They are integrated vertically, offering preventive and acute care, outpatient and inpatient care.

Paul M. Ellwood, Jr., the executive director of Interstudy of Minneapolis and one of the main figures in the development of HMOs, and Michael E. Herbert described, HMOs' underlying principles as risk sharing and enrollment of consumers¹². The risksharing feature means that to the HMO sickness is a cost. Since HMOs assume the cost of treating illness, they and their patients share an economic incentive to minimize it. The enrollment procedure ensures that the organization, not consumers or doctors, will control the resource allocation process required to meet the health care needs of its members.

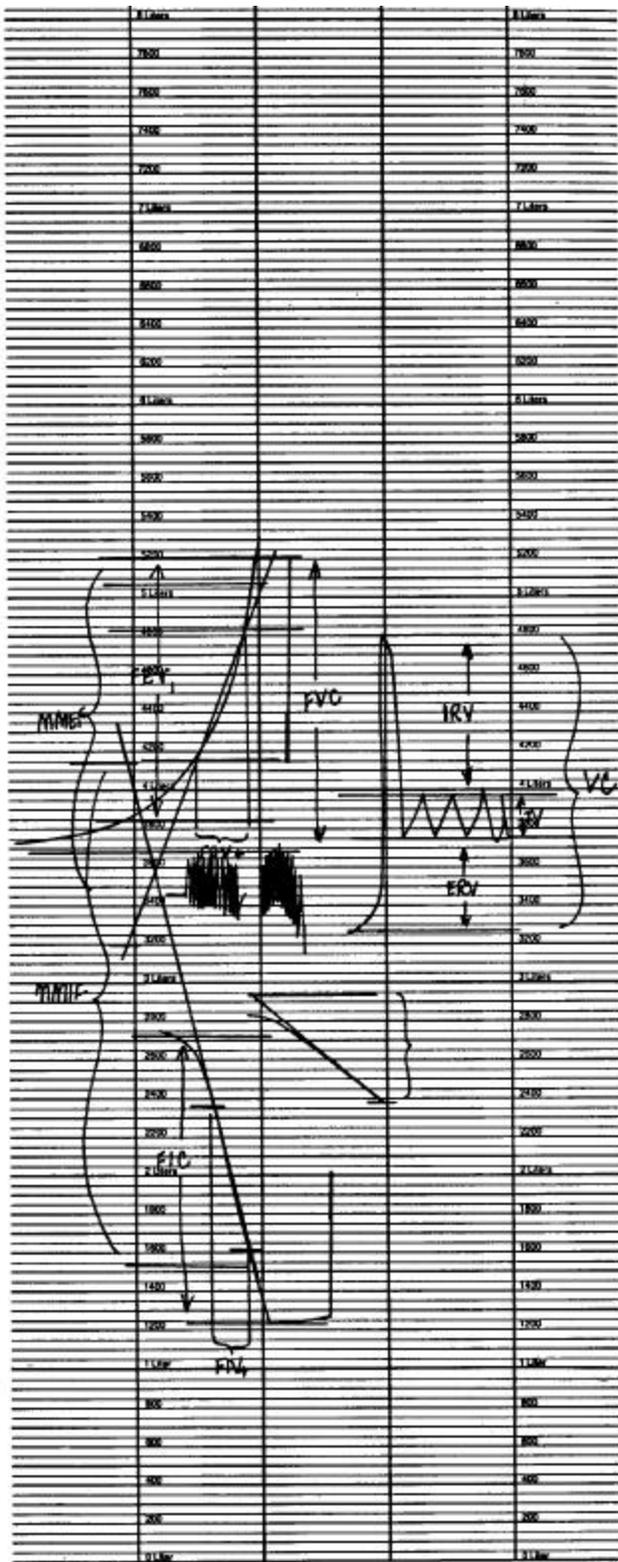
The HMOs embody a mechanism and incentives to ration expensive services such as inpatient care. This rationing can reduce levels of use of hospital services from 10% to 40% below those of traditional fee-for-service treatment.

Health maintenance organizations reduce health costs through programs, including an initial screening and periodic physical examinations, to prevent or avoid illness. just as the HMO is a competitive threat to conventional office practice, it is a threat to the hospital, since its interests run directly counter to the hospital manager's imperative to maintain his or her level of use.

A few progressive larger hospitals, such as Rush-Presbyterian-St. Luke's Hospital and Medical Center and Michael Reese Hospital and Medical Center in Chicago, have established HMOs based at their institutions. The Reese HMO grew out of demands by hospital labor unions for a more progressive health care system. While the HMO (which has almost 15,000 members) uses Reese for its hospitalization, the relatively expensive 1,000-bed teaching hospital setting has created major economic incentives for the HMO to hospitalize patients for routine illness in less expensive community-based institutions.

If a captive HMO is to successfully meet its economic objectives and minimize its fee levels, powerful incentives to lessen reliance on the parent hospital are created. The inherent conflict of interest for the hospital has caused HHS to discourage captive HMOs through its regulations governing federal subsidies. The development of an HMO is a risky undertaking that places a premium on accurate estimates of the market and on rates of enrollment. Achieving federal accreditation is a major bureaucratic hurdle. But certification opens up access to federal funding and market opportunities (e.g., federal requirements that qualified HMOs be listed as employee-benefit alternatives).

While the HMO holds tremendous promise for reducing health care costs in an open market, it is a questionable' growth strategy for the hospital manager, Ellwood and Herbert's estimate-that an HMO must enroll 100,000 people before it can generate a high enough level of use to support a 200-bed hospital-is still reasonable. The size of the necessary enrollment base suggests that HMOs may not be an effective way to increase or sustain levels of hospital use.¹³



Screening programs

Many hospitals now offer screening programs through schools and employers or to the general community for a variety of illnesses—such as diabetes, cancer, glaucoma, hypertension, and vision and hearing deficiencies—that may introduce new patients to their systems. These programs, staffed by physicians or by a combination of physicians and nurses, can be located in schools, shopping centers, or in the hospitals, themselves. The latter approach is useful for exposing the

public to new facilities or programs. Sponsorship of screening programs also gives hospitals access to public service announcements-in effect, free advertising of their services.

Develop distribution systems

Many hospitals have gone further than diversifying their mix of services to ensure a more effective distribution system and have developed transportation services to bring in patients. One of the most elaborate of these serves the University of Iowa Hospitals and Clinics, a 1,100-bed facility in Iowa City, a town of approximately 60,000 people. To survive, the hospital cannot rely on patients from Iowa City alone but must reach out to the entire state and region. The hospitals developed a fleet of Checker limousines that can be dispatched from Iowa City to any location in the state to bring patients to the hospital.

This service has made it more convenient for Iowa's physicians to use the tertiary facilities (open-heart surgery, cancer- therapy, kidney transplant, and so forth) at the University of Iowa, which is the tertiary medical center for the state. In addition, the hospitals own and operate an emergency service that is linked to the trauma center, and can dispatch a helicopter and put personnel into remote accident sites with minutes.

Another institution that has made a considerable investment in transportation systems is the Samaritan Health Service of Phoenix. Samaritan operates a fixed-wing air ambulance that brings patients from the isolated regions of northern Arizona and New Mexico. The plane is equipped with life support equipment and carries a critical care nurse radio contact with the hospital so he or she consult about and monitor the patient' s condition. In addition, Samaritan operates several mobile intensive care vans that transport patients requiring sophisticated diagnostic procedures from the service community-based facilities to Good Samaritan Hospital in central Phoenix. Patients are then sent back to their own hospitals with the test results. This system has increased the use of Good Samaritan's CAT (computerized axial tomographic) scanner as well as other complex diagnostic equipment. Though the mobile vans are operated at a small net subsidy by the hospital, the charges from the increased use of the ancillary hospital services more than cover the of operation.

Hospitals contemplating development of transportation services may expose themselves, to common carrier regulation and require special license from city agencies. They may also face some political problems from taxi and ambulance companies which have considerable leeway in where they a critically ill patient and may retaliate. For these reasons, Samaritan explicitly links its mobile vans to its network of facilities and does not pick up patients at other hospitals or at their homes. Nevertheless, diversification into transportation services is an imaginative approach to escaping geographic constraints of a physical plant and hold much promise.

Promotion of services

In August 1977, when the American Hospital Association issued standards for responsible use of advertising by hospitals, the hospital industry entered a new era. The guidelines state:

". . . Advertising may be looked upon as an investment that provides significant returns in community support of hospitals and knowledge of better health care opportunities. Advertising that has as its goal better informed public or improved patient care is always acceptable-if it is consistent with acceptable content as outlined in these guidelines."¹⁴

The guidelines themselves warn against political advertising, comparative references to other institutions, claims for performance, or promotion of individual physicians. While these guidelines discourage some of the more aggressive promotional strategies used in private industry, they do give hospitals considerable latitude in promoting their services.

Many of the larger institutions in the Chicago area have placed in the Sunday *Chicago Tribune* expensive, full-color supplements that stress the range and depth of their services. The supplements are supposed to either highlight new services and new facilities or enhance the institution's community image. To avoid difficulties with the federal government over the reimbursement of these costs under Medicare and Medicaid, hospital administrators financed their promotional efforts through voluntary contributions from affiliated charitable foundations.

Michael Reese Hospital and Medical Center pursued another, better-focused promotional strategy. Reese arranged with utility and insurance companies in Chicago to include health education brochures developed by the hospital in their billings and other mailings. The brochures were low-key, tasteful, and humorous and focused on such specific medical problems as stress, hypertension, smoking, and lack of physical fitness.

Sometimes including self-rating scales to interest readers, as well as suggestions about when it might be advisable to seek medical attention, the brochures usually referred to the appropriate clinical department one should visit at the hospital but stopped considerably short of directly soliciting business.

Both these promotional strategies are, nonetheless, indirect methods of increasing levels of hospital use. Though they may generate patient inquiries, promotional campaigns will never replace the physician as the principal pathway to the hospital's services. It is exceptionally difficult to measure the impact of broadly based promotions on levels of use, and such approaches may not be the most cost-effective way of reaching specific markets. However, the less tangible benefits of assisting in health education and community service should not be overlooked in a regulatory climate that is generally hostile to institutional providers.

A more focused promotional strategy has recently been employed by Northwestern Memorial Hospital in Chicago. It has developed a direct patient inquiry line staffed by a registered nurse who responds to patient complaints about medical problems and directs patients to medical specialists on Northwestern's staff. The inquirers are sent literature that promotes the specialty sections of the medical staff and lists the members of the section and their office telephone numbers. Although this direct marketing of tertiary services may bring in more patients to see specialty physicians, it does have the drawback of bypassing the family physician who generally mediates between the patient and specialists in complex medical matters.

To encourage physicians to refer patients to the specialty medical staff, a critical problem in teaching hospitals, the University of Chicago is developing an incoming WATS line that area physicians can use to contact the university's specialists. A detailed directory of the medical specialties represented on the medical staff and the disease categories where the staff is particularly strong will be distributed through university-organized, continuing medical education programs conducted in community hospitals. In all of these efforts, the promotional appeal is targeted to reach the decision makers who govern the flow of patients into the health care system.

A more controversial approach to advertising hospital services attracted national attention in 1977. Because neither patients nor physicians choose to use hospitals during weekends if they can avoid it, many hospitals have wide swings in their levels of use. In television, radio, and local newspaper advertising, Sunrise Hospital of Las Vegas offered a 5.25% cash rebate to patients who entered the hospital on Friday or Saturday. The program produced more than a 30% increase in admissions during the period. When insurance companies began deducting the 5.25% from their reimbursement of the hospital, however, Sunrise withdrew the rebate promotion and instead advertised a contest—a Mediterranean cruise for two—for weekend patients. This approach drew a sharp rebuke from the secretary of HEW as an example of profligate hospital spending.¹⁵

The growing use of commercial advertising by health care facilities has attracted the attention of the federal government. In the spring of 1979, the Health Care Financing Administration of HEW reinforced earlier rulings in a letter to its "fiscal intermediaries," the corporations that process Medicare claims and audit providers of Medicare services. The clear intention of the regulations is to avoid underwriting an expense "which seeks to increase patient utilization of the providers' facilities,"¹⁶ thereby increasing the costs of Medicare and Medicaid programs.¹⁶ The regulations are so rigorous they even forbid reimbursement for larger typeface listings in local telephone directories.

Hospitals are newcomers to the advertising world. Yet as competitive pressures intensify, managers are likely to use advertising ever more heavily as a marketing tool. Since most hospitals are small, it is unlikely that individual institutions will be able to support significant advertising expenses, and so they should concentrate on the most effective use of their limited funds. Promotional approaches that introduce new services or promote specific existing services are likely to prove the most fruitful. The national proprietary hospital chains will probably begin to advertise their hospitals nationally to establish product differentiation in the mass market.

Structural innovation

Seven years ago, Ellwood and Herbert characterized the health care industry as a poorly organized collection of 150,000 separate units of production that lacked both horizontal and vertical integration. Many of the approaches I have suggested advocate strategies of vertical integration through diversification into nonacute health care and of capturing and controlling more of the hospital's patient flow. At the same time, however, major changes are taking place in the hospital industry itself.

Horizontal integration is occurring at an explosive pace. The number of voluntary, not-for-profit hospitals in the United States has remained stable, while large proprietary hospital chains have acquired more isolated local institutions by direct ownership or through management contracts. Since 1975, the number of hospitals managed or owned by chains has increased from 469 to 765. The management and financial controls installed by the chains can, at least in the first few years, significantly reduce the rates of increase in those hospitals' costs, partly because the acquired institutions are generally smaller community-based hospitals and are relatively simple to manage. Because the financial and staffing controls in hospitals are often weak, they can be strengthened through systems imposed by the chain.

While the initial period of highly profitable growth of the proprietary chains has demonstrated that management of smaller institutions can be standardized and that tighter controls can reduce costs and improve net revenues, it remains to be seen how effectively the chains can cope with the competitive pressures I have discussed. There is no *national* market for health services. The chains are acquiring hospitals over a wide area, but they are not usually linked together clinically at the local level.

If they are to preserve their market shares in local communities, the chains will have to develop marketing expertise and performance standards to match their successes in financial management. The chains can minimize pressures (at the present time) by selling quickly unprofitable or troubled institutions, but this may change when they have saturated the market and must still generate profits from an enlarged base. If competing chains expand to the point saturating local or regional markets, they may have to diversify through direct ownership or franchises into ambulatory health services to protect their inpatient volume against competition from allied local hospitals.

Many of the emerging forms of health care delivery are eminently adaptable to the standardization of financial and management controls and of facilities employed in franchise arrangements. The parent company could dictate terms of patient referral or follow-up to ensure that any inpatients coming from the outpatient system flowed to hospitals it owned. Whether the chains will resources needed to take this next step be seen.

At the same time, new forms of organization are merging that are deeper and more complex structurally than the national chains; they can, if properly organized, exercise control over a regional health care market. Over a decade ago, under the leadership of Dr. James Campbell, a forceful, articulate health care entrepreneur Rush-Presbyterian-St. Luke's Hospital and Medical Center embarked on an ambitious organization strategy like that of a multidivisional corporation. Located in an inner-city area on the West Side of Chicago adjacent to the University of Illinois Medical Center and Cook County Hospital, the core hospital contains approximately 840 beds.

The Campbell strategy stratifies the health care system where primary- and secondary-level resources are organized around the tertiary-care teaching hospitals in a metropolitan area. Dr. Campbell felt that through multi-institutional agreements, Rush should own, control, or link up with sufficient health resources to meet the needs of 1.5 million people. The organization strategy contains the following elements:

1. Backward integration into supply of health manpower -- In 1969, Dr. Campbell reactivated the long dormant Rush Medical College, formerly linked to the University of Chicago. Using state and federal aid to health education programs as building blocks, he built the medical school into a university for the health sciences with three divisions—medicine, nursing, and allied health. By 1979, the medical school had an enrollment of 497 students. In addition, at the post-MD level, 341 MDs are engaged in medical education. Of this group, approximately 40% are retained within the Rush system when their training ends.

The students in the nursing and the allied health profession programs also form a substantial captive market of potential recruits into the Rush system. The prestige of academic programs,

including substantial research activities, has helped Rush attract and retain a first-rate clinical faculty and recruit top-quality residents to its specialty training programs. The ability to grant academic appointments made it easier for Rush to affiliate with community-based institutions.

2. Vertical integration with community hospitals using the medical school as its base, Rush affiliated or associated with a network of 11 community-based hospitals in the Chicago area. The medical staffs of these institutions received faculty appointments in the Rush Medical College. The medical staff at these affiliated institutions have been encouraged to use the expensive tertiary services available at Rush and to refer patients requiring subspecialty consultation or care to the central Presbyterian-St. Luke's Hospital. As a result, Rush has a medical/surgical occupancy rate of 91% and a waiting list for elective surgery.

3. Diversification into ambulatory and chronic care during the late 1960s, under separate incorporation, Rush launched two health care systems, the Mile Square Health Center (discussed earlier) and the Anchor Health Plan (an HMO). With a current enrollment of more than 32,000, the Anchor Health Plan uses the facilities of affiliated institutions as well as the central hospital to keep its costs down. Patients from the center may be hospitalized either at community-based facilities or at Rush. In 1976, Rush opened the 176-bed Johnston R. Bowman Geriatric Facility for Chronic Disease on its own campus. Although it was intended to care for older individuals who are undergoing lengthy recuperation from illness, it can also serve as a skilled nursing facility.

The resulting structure has effectively achieved Dr. Campbell's ambitious objective of providing health resources for the large population and a solvent, successful core hospital. As federal funds for medical education begin to level off, the clinical operations of the Rush system will be sufficiently strong to absorb an increasing share of the burden of financing health education. The system is not without problems-relationships with neighboring and affiliated institutions have not always gone smoothly, and some of its operations have lost money-but the overall system is healthy. The Rush system represents a model of cooperative multi-institutional relationships that link health resources to ensure the survival of all the various parts. Because it does not own all the elements but rather works with them through cooperative planning, Rush is protected financially from major shifts in the market or from vulnerability of individual elements of the system.

What is a hospital?

More than 20 years ago, in "Marketing Myopia," Theodore Levitt argued that the price of a static definition of an organization's business may be its extinction¹⁷. This is nowhere more true than in the hospital industry today. After a postwar period of explosive growth in activity, aggregate employment, and economic power, it is confronting major changes that threaten its key inpatient services. Hospital costs have risen to the point where they are a national political issue, and regulatory and planning bodies have proliferated in an effort, as yet unsuccessful, to control them.

The challenge to hospital managers is to deliver new forms of health care. By diversifying beyond acute inpatient care into a broader mix of medical services, managers accomplish two things. First, if the activities take place under the same corporate umbrella, they generate revenue that does not depend directly on inpatient use of their facilities. And second, they build pathways that can ultimately bring in additional inpatients and open facilities to new patients.

Hospitals augment their principal source of patients—the network of office practices of their medical staffs—through their emergency rooms and through organized, hospital-based outpatient services. The expansion and diversification of outpatient services hold the key to a hospital's future financial solvency. In many cases, peculiarities of the hospital reimbursement system will dictate corporate separation of some outpatient services from the hospital proper. However, as long as there is central organization and direction, through administration or medical staff loyal to the hospital, the separate corporate entities can serve the same objectives.

The effort to capture some of the new forms of health care delivery is not free of risk. High overhead problems of estimating patient volume and start-up head, start-up costs and phasing, potential damage to existing hospital programs, and additional hiring of scarce physicians and managers all suggest that, at least initially, diversifying away from acute inpatient care will involve financial commitments and careful planning. It should be obvious, however, that the alternative to hospital control of these new health care forms is the net loss of patient volume, both outpatient and inpatient. The higher inpatient hospital costs rise, the riskier it is to keep the definition of a hospital's business as acute inpatient care.

Both vertical integration and horizontal combination are taking place in the structure of the health care system. It is possible that in 15 or 20 years, most hospital care in the United States will be controlled, directly or through multi-institutional planning, by a few dozen organizations. The not-for-profit, voluntary hospital will be significantly challenged by proprietary institutions that have demonstrated in their initial forays into the market that they can generate significant profits at reduced rates of cost escalation. Structural changes will eliminate duplication of services in many areas and result in multi-institutional planning where government regulation may not succeed. The consumer, who will find the hospital and other health care providers increasingly concerned with meeting consumer needs, will ultimately benefit the most.

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