COMPETITIVE CONDITIONS AND HOSPITAL STRATEGIES: A MEMPHIS CASE STUDY

We explore the strategies used by Memphis area hospitals to compete in a market dominated by a few large providers and examine how these strategies have been modified in reaction to changing competitive forces. The Memphis health care market includes most of Shelby County in Tennessee as well as portions of Desoto County in northern Mississippi and eastern Crittenden County in Arkansas. The mixture of public and private health care providers in this market serves an immediate population of 807,000 and patients who live in a 5-state area. Relative to population centers of comparable size, Memphis has a large number of health care providers: 17 community hospitals, 30 nursing homes, 28 home health care agencies, two HMOs, 1976 physicians, and 590 dentists. In 1982, these entities generated about $2 billion in revenues and approximately one of every nine jobs in the area (Tuckman and Chang 1984). The Memphis health care market is oligopolistic. The four largest hospitals (Baptist, Methodist, St. Francis, and The Med) have served about 78% of the area patients who have received treatment, but this share has declined slightly over time.

STRATEGIES FOR COMPETITION

Economists make three observations about oligopolistic (concentrated) markets that apply to Memphis: (1) prices are administered, (2) products are differentiated, and (3) behavior is rivalrous (Lipsey, Steiner, and Purvis 1984). In the past, Memphis hospitals employed several focus and differentiation strategies to cope with a rivalrous market. Each hospital chose a strategy mix based on its specific attributes, estimate of the gains achievable from adopting each strategy, and perception of how competitors would respond. Though several hospitals monitored their costs and at least one (Baptist) claimed to be a leader, none directly used cost leadership along the lines suggested by Porter (1980).

From extensive conversations, review of competitor actions, and an evaluation of available data, we have identified the following key strategies that define the basis for competition in the Memphis, Tennessee, marketplace.
• Horizontal integration
• Product diversification
• Product specialization
• Resource-based quality improvement
• Institutional differentiation
• Public relations and physician-centered marketing

Horizontal Integration

Horizontal integration strategies involve the acquisition of hospitals providing services similar to those of the acquiring unit—commonly emergency and acute care services. Usually, the primary goal is to serve untapped geographic market segments. In recent years this strategy has been used by the major competitors, mainly to preempt entry by new competitors. Through inquiry, two types were identified: citywide and regional horizontal integration.

Citywide Horizontal Integration. The goals of this type of integration are to (1) serve a shifting population base, (2) position hospitals nearer to high income patients, (3) keep the ratio of indigent patients within bounds, and (4) preempt competitors from gaining market share. In Memphis, three of the four largest competitors (Baptist, Methodist, and St. Francis) built new hospitals in the northern, southern, and eastern parts of town. The fourth, The Med, expanded its downtown facility. The satellite facilities of Methodist and Baptist provided general acute services but referred patients requiring more specialized treatment to their parent (downtown) facilities. St. Francis lodged its entire operation in the affluent eastern sector.

Regional Horizontal Integration. The goal of this strategy is to create and maintain rural referral channels that filter patients needing specialized treatment into centralized parent facilities. Methodist was the first Memphis hospital to employ this strategy. Shortly thereafter, Baptist determined that over 60% of its patients lived outside Shelby County and decided to follow its competitor (Mid-South Medical Center Council 1980). Both hospital systems adopted an acquisition strategy designed to (1) establish a "presence" in contiguous rural areas, (2) ensure referrals from rural community hospitals to the parent facility, (3) keep "outsider," for-profit hospital chains from stealing patients, and (4) acquire rural hospitals that, through improved management, would add to system profitability.

Between 1980 and 1985, Baptist added eight rural community hospitals to its system. Likewise, Methodist acquired a series of community hospitals, some on a lease with an option to purchase and others under a management contract. The two other major competitors—St. Francis and The Med—chose not to use this strategy. Because most of the rural hospitals were in communities barely able to sustain a single hospital, Baptist and Methodist did not compete in the same towns but rather on a regional basis (primarily in east Arkansas, west Tennessee, and north Mississippi). The acquired rural hospitals were not as profitable as first projected, in part because of a lack of economies of scale and other management problems. Initially, these providers offered a range of basic acute care services and referred patients to Memphis for specialized treatment. The competitors soon found that to improve the financial health of rural hospitals it was necessary to hire physicians with certain specialties (e.g., urology). This defeated the goal of ensuring referrals to Memphis, but it kept out rivals such as Hospital Corporation of America (HCA) and preempted referrals to Nashville from areas such as Union City, Tennessee, and Jonesboro, Arkansas.

To date, the two rivals have retained most of the acquired properties, but acquisitions have stopped since the profitable properties have been acquired. A comparison of preadmission and postadmission data suggests that the relative proportion of rural patients served by the two competitors has not changed dramatically as a result of this strategy. However, it is difficult to project what would have happened if outside competitors had successfully acquired the rural hospitals.

Product Diversification

Product diversification occurs when a hospital adds new products or services (hereafter called "products"). The strategy is used to (1) attract new patients, (2) augment image, (3) attract additional physicians, (4) raise profits, and/or (5) reduce the risks from offering limited product lines. New products normally are adopted when technology creates new acute care specialties (e.g., CT scans), new programs are funded that provide an incentive for hospitals to treat specific illnesses (e.g., Medicaid payments to adolescents with psychiatric problems), and/or the number of pay patients requiring a particular treatment increases to the point at which such treatment is profitable to provide (e.g., stroke rehabilitation). A hospital may also offer a new product if one or more of the physicians has a strong
interest in fostering product development. In the Memphis market at least nine hospitals (including satellites) and the University of Tennessee Center for the Health Sciences (UTCHS) added CT scan equipment, three of the four major competitors sought permission to purchase magnetic resonance imaging equipment, programs for disturbed adolescents under age 21 were created in at least four area hospitals, alcohol and drug abuse programs were developed at three of the top four hospitals, and three of the four top competitors introduced stroke and heart attack rehabilitation programs.

Product Specialization

Strategies designed to create a competitive advantage through the offering of specialized products can be found in both specialized and general hospitals. Le Bonheur Children's Hospital, Memphis Mental Health Institute, St. Jude, UTCHS, and the Veterans Administration Hospital have market segments largely free of extensive rivalry because their "products" have one or more of the following characteristics: very high-cost production, scarcity of physicians or technicians with the requisite expertise, and/or limited demand. St. Jude, for example, specializes in the treatment of costly (and sometimes unrecompensed) solid tumors in children as well as childhood leukemia; Le Bonheur offers alimentation and liver transplant treatments for children. The availability of adequate financing to facilitate treatment also can be important. For example, Memphis Mental Health Institute provides psychiatric services for patients that other hospitals do not want (e.g., the seriously ill, the poor). The major competitors chose not to compete in these areas and instead found profitable niches. For example, Baptist offers short-term acute adult psychiatric care and a sleep disorders center. Competition is limited in niches deemed "unattractive."

Some specialized products are both lucrative and relatively easy to supply. Lakeside Hospital specializes in alcohol and drug abuse and the small Mid-South Hospital has evolved from a general hospital to one specializing in the treatment of emotionally disturbed adolescents. Alcohol and drug abuse programs can be found both in the general hospitals and in specialty facilities such as Lakeside. Programs for emotionally disturbed children abound. Because these are potentially profitable areas with relatively large markets and a ready supply of trained personnel, greater competition ensues. More intense competition also faces hospitals with stroke and heart attack rehabilitation units. Given the willingness of insurance companies to pay, the large market for rehabilitative services, and the availability of speech and occupational therapists, competition is intense among hospitals providing these services. In contrast, none of them provides a residential program for head trauma victims—despite a need—because funds are not available to support such a program and the demand is perceived to be limited.

Resource-Based Quality Improvement

This strategy is intended to improve both the quality of the product and the image of the hospital. In the hospital industry, quality of service traditionally is defined in terms of physician rather than patient need. Hence, implementation of this strategy involves (1) construction of physicians' office buildings adjacent to hospitals, (2) investment in the latest high-tech supplies and equipment, (3) intensive nurse and technician staffing, (4) provision of adequate beds to ensure affiliated physicians immediate access, and (5) maintenance of high-tech, in-house labs with short turnaround times.

Institutional Differentiation

Differentiation is used to increase profits and attract physicians and patients. It is accomplished by (1) affiliating prestigious doctors with specialty practices, (2) providing unique product lines and ancillary procedures, (3) advertising the latest devices, medical procedures, and equipment, (4) adding imposing specialty, diagnostic, and office buildings, and (5) constructing facilities at attractive locations. The two top competitors—Baptist and Methodist—employed all five approaches, whereas St. Francis focused on items 4 and 5. The Med emphasized items 2 and 4, and Mid-South, Lakeside, and St. Joseph emphasized item 2.

Public Relations and Physician-Centered Marketing

Strategies of this type are used to increase market share through promotion of the hospital. Because the doctor is seen as the prime source of new patients, promotion takes the form of (1) providing doctors marketing and practice-based management services, (2) visiting doctors' offices to promote familiarity with the hospital and its offerings, (3) offering financial inducements and proximity to the hospital via space in an on-site building, and (4) promoting involvement with hospital boards and other decision-making bodies. Public relations strategies take the form of (1) hospital involvement in civic functions, (2)
linkage of the hospital with health-related activities such as free blood tests, and (3) limited promotion of the hospital name and image through advertising.

Pricing strategies, until recently, were not utilized by any of the providers even in specialties where competition was fierce. The concentrated marketplace enabled competitors to administer prices, and third-party payors accepted their billings largely without challenge. Physicians recommended hospitals to their patients on the basis of where they had staff privileges rather than price. Most patients accepted the prevailing prices because most were either covered by insurance or eligible for third-party subsidy. In a few rare cases, hospitals supplied services at cost.

CHANGING COMPETITIVE FORCES

Beginning in the early 1980s, Memphis hospitals (like those elsewhere in the nation) encountered changes in the forces that were the basis for industry competition. These changes include deregulation and reregulation, new federal and insurance company reimbursement rules, deflation, discovery of new technologies, changing supplier markets, and the growth of new competition. The following major developments occurred.

1. Most Memphis acute care providers serving Medicare patients were phased in under diagnosis related groups (DRGs). As a consequence, they were increasingly reimbursed a predetermined fee rather than by a cost-based formula.
2. In 1984, admissions at all types of hospitals began to drop nationally, raising vacancy rates and cutting revenues. The drop in admissions occurring in Memphis hospitals since the late 1970s accelerated after 1983, though gross revenues rose.
3. National occupancy rates of 66% in the spring of 1985 were the lowest in two decades. Memphis hospital occupancy rates averaged lower (about 60%) than those for the U.S. as a whole.
4. Nationally, medical service prices continued to increase faster than overall prices. In Memphis, government and employer concerns about rising health care costs increased.
5. Federal and state legislation encouraged competition from free-standing clinics, health maintenance organizations (HMOs), and preferred provider organizations (PPOs). All three provider types entered the Memphis market.
6. Nationally, employer-provided health care, self-insurance, and coalitions to increase consumer bargaining power increased, bringing new health care options to consumers. In Memphis, a local coalition of employers formed to monitor costs.
7. Growth in the number and size of medical schools and an influx of foreign-trained physicians created a national surplus of doctors. In Memphis, some practices reported level or reduced patient loads and new physicians had difficulty in getting started.
8. In specialties such as eye surgery, new technologies altered the relationship between physicians and the hospitals, creating an incentive for them to compete. In Memphis, new outpatient centers financed by independent physicians opened.

It is useful to consider the changes in the context of the full spectrum of health care delivery. Figure 1 illustrates this spectrum, beginning with services provided at birth and progressing to services for the aged. The lower part of Figure 1 shows the services of medical providers, whereas the top part shows nonmedical services that are substitutes for and thus competitors to medical services. For example, substance abuse control services are offered by hospitals and primary care providers. Neighborhood organizations, Alcoholics Anonymous, and church groups provide "competitive" services. Local sitter services are partial competitors with home health agencies, and retirement communities compete with nursing homes. Note that services toward the edges of the spectrum have greater competition than those in the middle. Prior to the change in competitive forces, Memphis hospitals employed strategies aimed mainly at preserving their share of the acute care market segment. This was rational for several reasons: (1) patient load and profits consistently increased in this segment and both were projected to grow, (2) the segment had virtually no competition from nonmedical providers, (3) the oligopolistic structure of the segment kept hospital administrators concerned with preemptive actions to protect their market share because competitor action focused on acute care, and (4) moving into adjacent segments required learning new businesses.

Changing competitive forces altered the pre-
mises and incentives on which earlier strategies had been based. First, demand began to decrease in the acute care segment, forcing hospitals to look to other segments to retain patient base. Increasingly, industry observers came to realize that the change in demand could be permanent. Second, the DRG-related changes, which encouraged shorter hospital patient stays, created a pool of post-hospital patients who could be served by others. The hospitals saw this pool as a potential source of increased revenue and providers in these segments as potential competitors. Third, the growth of HMOs and outpatient surgery centers blurred the line between primary care (once the province of physicians and hospital emergency rooms) and acute care (once the province of hospitals). Hospitals realized that physician-financed competitors could erode demand for their products and cause their revenue base to shrink unless they entered the newly defined segment. In deciding to undertake entry, they both took on new competitors and engaged in preemptive strategies against current competitors (e.g., other hospitals). Finally, a growing realization spread through the Memphis medical community that competition was increasing and that affiliation was important as a survival strategy. Physicians became more willing to accept new competitive arrangements such as PPOs. Certain physician-hospital ties were strengthened.

THE EVOLUTION OF MODIFIED STRATEGIES

The consequence of the above-mentioned changes was that strategies widened in scope and began to encompass a larger number of marketing tools. Thus, marketing was elevated in importance and strategic planning was taken more seriously. The list of strategies was modified to include

- mixed diversification/integration strategies,
- provision of more focused products,
- more consumer-oriented strategies,
- formulation of cost-reduction strategies,
- product line management, and
- increased reliance on price discounting.

**Mixed Diversification/Integration Strategies**

Economists normally use the term “diversification” in reference to acquisitions in new fields and the term “vertical integration” in reference to purchases made by suppliers of inputs to a process (e.g., medical companies) or of entities closer to the consumer (e.g., channels of distribution). The blurring of the lines between adjacent market segments and the redefinition of how services are provided...

![Diagram of Health Care Delivery Spectrum](image-url)
challenge these definitions. Hence, the term "mixed diversification/integration strategies" is used to refer to new strategies involving movements across segments.

**Continued Horizontal Integration.** Recently, Baptist East expanded its facility and requested additional ones. Methodist, in a joint venture with Mid-South, started construction of Germantown Community Hospital in the eastern suburb of Memphis. St. Francis added new facilities, Le Bonheur opened a clinic, and Shea Clinic moved east, along with a number of other clinics and hospital-related physicians' practices. This action created increased competition for St. Francis and other facilities that draw advantage from their eastern location. Similar expansions occurred with other hospitals. For example, Lakeside has proposed a $2.5 million child psychiatric hospital adjacent to its main facility.

**Acute Care Provision to New Primary Care Providers.** Memphis hospitals have (1) created or affiliated with other PPOs, (2) signed contracts with HMOs to provide specified acute care services, and (3) built or purchased minor emergency clinics. The goals of this strategy are to preserve and/or expand patient load in the acute care segment by preempting competition from new providers who have the potential to draw away acute care patients.

Baptist and Methodist hospitals concluded PPO agreements with their own employees and a number of employers. St. Francis and The Med have yet to follow these hospitals' example, but St. Joseph has developed a competing PPO plan. Eastwood, Crittenden (in West Memphis, Arkansas), and Mid-South are exploring potential plans and Le Bonheur has contractual arrangements with both Baptist and Methodist for the provision of children's hospital services. The initial HMO—Prucare—has now expanded to three locations and, since 1983, has been joined by another HMO. HMOs currently have less than a 10% market share, but it is expected to increase within five years.

Free-standing minor emergency clinics are direct competitors of both hospital emergency rooms and solo practice physicians. These clinics usually offer lower priced care than hospital emergency rooms (e.g., in Memphis, some charge less than physicians). They also try to locate closer to patients. To preempt an erosion of their emergency room patient load, major hospitals have entered this market. For example, Baptist signed a management agreement with a minor emergency chain of clinics and Le Bonheur constructed a clinic in East Memphis. Le Bonheur has taken advantage of its reputation to draw after-hours child patients away from doctors' offices and emergency rooms. To date, neither Methodist nor St. Francis has entered this segment, which is likely to be intensely competitive as the line between physician and clinical emergency care continues to blur.

**Movement into Adjacent Quasi-Acute Care Segments.** Strategies designed to position hospitals in the quasi-acute care segments are based on the spinoff of products. To date, these include (1) construction of free-standing diagnostic units and (2) opening free-standing ambulatory surgery centers. Participation in the newly developing free-standing diagnostic market is attractive to hospitals as it enables them to preempt competition from other hospitals and physicians, price services without including expensive overhead, and locate in convenient places. Patients choose such facilities because they can receive diagnostic testing without an overnight hospital stay. Physicians invest in these facilities because they are profitable, affordable, and also present a chance to compete with hospitals. Not surprisingly, the market is a fertile one and promises to become competitive. For example, a $3.8 million independent facility recently was approved for a group of 60 solo practice physicians, along with a $1 million diagnostic center for the Le Bonheur East clinic. Both Baptist and Methodist hospitals (the latter in joint venture with Germantown Community Hospital) have sought approval for such centers, and it is likely they will be competing in these markets.

Free-standing surgical clinics also bring quasi-acute care products closer to the targeted population, allow pricing of products without including the overhead of the downtown parent and, under some circumstances, lessen regulation. Surgeons recognize these advantages and, when their practice is large enough, find it worthwhile to disaffiliate from hospitals to start a clinic. With sufficient volume, they can charge hospital rates that enable them to earn large profits (price competition has yet to enter this market). To date, two physician groups—Surgical Care Affiliates and Memphis Eye and Cataract Ambulatory Surgery Center—have received approval to construct new facilities. The major hospitals have shown interest in this segment but have yet to seek regulatory approval for entry. Their participation is most likely to take the form of a joint venture.
Movement into More Distant Medical Segments. This strategy involves entry into medical health care segments providing nonacute care products such as (1) sports and wellness centers, (2) home health or lifeline care, (3) nursing home care, (4) medical sitter care, and (5) hospice care. The sports and wellness market segment encompasses medical providers of both primary and rehabilitative services, as well as nonmedical providers such as country clubs and gymnasiums. Thus, this segment cuts across traditional market lines and potential competitors range from libraries to health food stores. Baptist has an extensive "Healthplex" complex offering sports medicine, cardiac prevention and rehabilitation, wellness and fitness programs, and nutritional advice in a separate facility across from its downtown center. Methodist has a similar program with tennis, swimming, and sports in a clublike setting. Its extensive offerings compete favorably with local spas and recreational clubs in the city. The other hospitals have not entered this segment.

Home health services are potentially profitable if demand is great because they bring in high fees with relatively low overhead. However, the potential for high accounts receivable and the refusal of third parties to pay introduce risk into these enterprises. Between 1983 and 1985, increases in new home health care providers brought the total to 35 in the Memphis area. Each hospital either offered direct services or provided them through contractual arrangement with a private company. The competitors in this market segment are drug companies, national home health chains, local consortiums of nurses, and hospitals.

Lifeline services are offered by the B’nai B’rith Home and Hospital for the Aged, Baptist, and Methodist. Lifeline is profitable and it provides hospitals with an additional referral channel. Its primary advantage is being a marketing tool that shows the hospital’s concern for a particularly needy market segment.

The nursing home segment has the potential for major competition and it is not clear that hospitals have an advantage in entering this area. To date, the segment has been appealing to hospitals because it (1) provides a use for empty beds, (2) involves delivery of medical services and hence is not unfamiliar to administrators, (3) enables hospitals to monitor patients released early because of DRG incentives, and (4) enables hospitals to take advantage of their referral net-work. Whether these points are sufficient to warrant hospital entry into the nursing home area remains to be seen. However, certain differences are worth noting: (1) regulators make entry difficult in some areas, (2) the prevalence of for-profits in Tennessee has affected the cost structure of the industry, and (3) economies of scale are limited in Tennessee nursing homes; hence, small competitors can do as well as large ones. In the absence of restrictions on demand, one would expect this segment to be occupied by many small competitors with little advantage accruing to the hospitals. To date, Baptist, Methodist, and St. Francis have opened free-standing facilities.

Hospital competition is lacking in the medical sitter segment. At present, Le Bonheur offers an at-home baby sitting service for sick children, as well as an inpatient facility for the sick children of its employees. The other hospitals have not chosen to compete in this area, preferring instead to lump children’s services with other home health needs. Whether this proves to be a viable market segment remains to be seen. Finally, none of the hospitals have entered the hospice market and none compete directly with old age homes. These segments may become targets for hospital diversification as the baby boom generation ages.

Movement into Supplier Markets. Entry into supplier markets involves either acquisition of, or collaborative agreements with, businesses that provide services, equipment, or supplies to hospitals. This strategy is desirable to (1) hedge against a downturn in hospital admissions, (2) ensure greater quality control over inputs, (3) ensure certainty of supply, (4) secure lower cost inputs, (5) create profits that can be used to subsidize nonprofit operations, and (6) preempt a competitor advantage. Memphis hospitals have explored these types of acquisitions, and several have contractual arrangements that facilitate involvement in supplier markets. For example, Baptist and Methodist both own supply companies. Le Bonheur is part of a venture that supplies alimentation equipment to children’s hospitals nationwide. It has also affiliated with Baptist, Methodist, and St. Joseph in a joint venture called Med-Express to conduct lab tests for hospitals in other cities. Essentially, this service uses Federal Express and high speed data transmission to provide rapid turnaround of results. These types of acquisitions are likely to continue if hospitals continue to perceive that they can develop a competitive advantage.
Provision of More Focused Products.

Strategies of this type differentiate a hospital by positioning it to offer focused services and capture the high returns attainable in unique market segments. If competitors decide to offer the same specialties, the uniqueness of a hospital's offerings is lost. The Med gained a large market share mainly by treating Medicaid and indigent patients. Recognizing the need for flexibility, the city-owned facility changed its legal status from public trust to nonprofit corporation. To become more profitable, differentiate itself, and create a better image, it then created focused programs based on what it perceived as its competitive advantages: the Elvis Presley Trauma Center, a newborn center, a birthing center, and a burn center. Baptist added new specialties in sudden infant death syndrome and sleep disorders, units for diabetics, gerontology and geropsychiatrics, and an epicenter designed to treat epilepsy. Le Bonheur added alimentation and liver transplants for children, making it unique in the Midsouth in the provision of these services. The University of Tennessee began a heart transplant program. These types of focused programs are an important source of differentiation.

Focus also can help hospitals “stuck in the middle” (Porter 1980). Both Eastwood and Crittenden lacked an image and both made the decision to focus on emergency room services, publicizing their hospitality and concern for the patient. Each sought to connect its image with quality emergency care. In contrast, Mid-South (another largely “stuck” hospital) began quietly to emphasize child and youth services and treatment of patients with detached retinas. Though the hospital focused its services, it did not engage in extensive advertising and, perhaps as a consequence, we could not determine that the hospital’s image was fixed in the public’s mind.

More Consumer-Oriented Strategies

These strategies are designed to increase public interest in the hospital and to encourage consumers to choose a hospital rather than relying entirely on their physicians. They include (1) increased media advertising, (2) physician locator services, (3) greater use of public-oriented promotional campaigns, (4) increased direct mailings to consumers, (5) improved service offerings for valued patients, and (6) increased direct marketing to employers.

Increased Media Advertising. The goals of this strategy are to improve or differentiate the image of the hospital, reach and attract potential patients, and attract employer business. Virtually all the major competitors, and most minor ones, advertised more in 1985 and 1986 than in the early 1980s. In addition, the emphasis has shifted away from high-tech medicine toward quality of attention to the consumer’s need. For example, Baptist now emphasizes the physician’s concern with the patient, Eastwood represents itself as a hospital that provides immediate service, and Le Bonheur emphasizes service tailored to children. Advertising also is used to compete in adjacent segments. For example, St. Francis attempts to differentiate its image in substance abuse treatment by emphasizing holistic care in a hospital setting. Focus on consumer need and the comparative advantages of in-hospital treatment represents a redirection of advertising effort.

Physician Locator Services. This strategy enables hospitals to shape the process by which they receive referrals. Prior to its development, the consumer would normally choose a physician who would then recommend a hospital. This service enables the consumer to select a hospital and have it recommend a primary care physician, and thus assists the hospital in advertising directly to the consumer. It also helps to secure physician loyalty by demonstrating that the hospital can channel new business to affiliated physicians.

Greater Use of Public-Oriented Promotional Campaigns. The goal of this strategy is to attract new patients. In Memphis, most public-oriented campaigns have taken the form of free cancer screening, breast examinations, child fingerprinting, and/or rectal exams. They provide a valuable service to the consumer and an opportunity for the hospital to project an image of competence and caring. The number of such programs has increased in the last few years, and at least three of the four major competitors now participate in them.

Increased Direct Mailings to Consumers. To date, none of the hospitals have engaged in direct mailing promotions of their main facilities, though some have used such mailings for informational purposes. For example, Le Bonheur used a mailing to announce the opening of its new clinic. Such mailings also have been used by local free-standing clinics.

Improved Service Offerings for Valued Customers. The major hospitals maintain VIP suites for
favored customers, though they do not provide well-publicized gourmet meals or five-star services. VIP services are downplayed and most of the local populace is unaware of their existence.

**Increased Direct Marketing to Employers.** All the hospitals now recognize the importance of maintaining relationships with area employers. The growth of HMOs and PPOs, and the formation of an employer coalition, have forced area hospitals to market directly to employers. Hence, the role for hospital marketing departments has expanded.

**Formulation of Cost-Reduction Strategies**

The goals of cost-reduction strategies are (1) to enable hospitals to earn profits, minimize losses, or maintain desired product levels even if admissions are falling, (2) to enable hospitals to compete more efficiently in the acute care segment, and (3) to permit a lowering of prices should the need arise. Every area hospital engaged in cost cutting in the post-1983 period, largely in response to falling admissions and DRGs. The major strategies employed were (1) reductions in nursing and other staffs, (2) increased use of part-time employees, (3) contracting of services provided more efficiently by private business and returning to services that the hospital can perform more efficiently, (4) education programs to acquaint physicians with DRG guidelines and with their performance in relation to those criteria, (5) increased computerization both to identify and to track cost generators, (6) preadmission testing, (7) careful monitoring of supply usage, (8) bulk purchasing, (9) strict utilization review programs designed to release patients in a timely manner, and (10) where possible, sale of hospital-based services to external parties to take advantage of economies of scale (Tuckman and Chang 1986). To date, these strategies have been used primarily to keep a competitive edge rather than to establish a cost leadership role. Currently that role is filled mainly by the HMOs.

**Product Line Management**

Product line management strategies are aimed at identifying profitable products, assigning responsibility for their management, and encouraging their growth. Products that are marginally or not profitable also are identified. In Memphis, the issue has arisen of whether hospitals should provide services regardless of their profitability or eliminate unprofitable product lines. At present, the number of lines terminated is limited. The main product line strategies are (1) the restructuring of hospital records to show actual treatment costs and to identify profits and losses from the treatment of each illness, (2) the assignment of product line managers and the evaluation of how well they perform, (3) the identification of products which, if adopted, will augment profits, and (4) the maintenance of a reasonable ratio of pay to nonpay patients. Area hospitals have shown varying degrees of sophistication in the implementation of these strategies. For example, Baptist, Le Bonheur, and Methodist have made an extensive commitment to product line management whereas Mid-South and the Memphis Mental Health Institute make limited use of the concept. Likewise, area hospitals vary greatly in their ability to assign accurate revenues and costs to individual illnesses and to generate aggregate statistics on product lines.

**Price Discounting**

The goal of price discounting is to increase patient load by becoming a lower price supplier of acute care services. Some hospital administrators have been reluctant to use this strategy for fear of cultivating an image of low quality. However, the increase in competition has caused the following strategies to emerge: (1) PPO arrangements that provide primary care services through hospital plans at less than market rates, (2) hospital-paid waivers of deductibles that discount the full cost of a hospital stay for consumers, and (3) the pricing of specific procedures or treatments at levels that do not cover all overhead costs. These relatively low-key strategies enable consumers to obtain services at less than prevailing rates without perceiving that hospitals are directly cutting prices.

**CONCLUSIONS**

What can be concluded from this study of the Memphis health care market? First, hospitals are competing in more health care market segments with more products than they were a few years ago. The time when hospitals could afford to focus on just the acute care segment has passed. Second, increased competition has not forced any hospital out of business, but it has caused all of them to rethink their competitive strategies. One consequence is a broadening and a deepening of the strategies in the marketplace. The largest number of new strategies is observed in the diversification/integration area as hospitals move beyond the acute care segment into new areas of product provision. Altered management strategies also are observed in the form of product line management and cost reduction. Virtually every hospital has...
used outside consultants to streamline its organization and staff. Also noteworthy is the move from public relations and physician-based marketing to a broader range of consumer-oriented strategies designed to win acceptance from the general public, as well as the increase in focused products. Finally, an increase in the use of price discounting represents a departure from past practice.

Many additional changes are likely in the market. We have not seen an end to the evolving forms of specialties or to the forms of alternative delivery. Likewise, the much-heralded consolidation of the giants has yet to occur, though it may come in time.

There is little evidence of a major entry into the Memphis market from the for-profit chains. In the new marketplace, the consumer faces more health care choices than before. However, we find little evidence that this situation has been a source of concern or that it has had deleterious effects on health care delivery. Have the hospitals been hurt by the substantial increase in competition? Too little time has passed to offer a judgment. The answer will depend on the future direction of government policies (e.g., DRGs and certificate of need laws) and on how efficiently the hospitals continue to respond to changing market conditions. The process of strategy formulation is an unending one.

REFERENCES


