

Key Indicators of Hospital Quality Used in A Partly Competitive Environment



Management

KEYWORDS :

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Introduction:

This study investigates the relevant planning & control components for Hospital management while the healthcare sector is in the transition from not - for -profit (regulated) market competition. The key indicator of Hospital quality used in the Health economics literature is the Mortality rates. Productivity is difficult to measure in hospitals, so regulators & researchers typically use a wide range of measures. We find that higher competition (as indicated by a greater number of neighbouring hospitals) is positively correlated with increased management quality, and this relationship strengthens when we instrument with local political competition.

Creating Competitive Advantage:

To remain financially viable, a freestanding 200-bed hospital must secure and maintain a sustainable competitive advantage within its service area. Based on Kurt Salmon's consulting experience, the following six competitive factors are strongly correlated with the ability of small, independent hospitals to achieve long-term financial success:

- > Effective geographic barriers
- > Favourable pay or mix
- > Strong physician alignment
- > Significant high-quality asset base
- > Low-cost structure
- > High-quality care

The most successful hospitals achieve competitive advantage by exploiting at least one, if not more, of these six factors. The most desirable positioning is to compete on factors that are both within the organization's ability to control and that create effective barriers to entry against competitors.

Strategic Framework

This following framework illustrates the areas where hospital executives can exercise control and influence over a variety of strategic and operational factors. To obtain a superior market position, hospitals must achieve a competitive advantage on one or more competitive factors. The ability to exert control over the factors or use the factors as a barrier to competitor entry, however, varies widely.

Not all competitive factors are created equal. While some factors are difficult to control and don't deter competitors (e.g., pay or mix), others can be leveraged to significantly enhance or transform a hospital's strategic position for the better.

Kurt Salmon has organized the six competitive factors into quadrants (as shown in Exhibit 1). The following sections describe each quadrant by order of its strategic influence on a hospital's competitive position.

Quadrant A:

High competitive barrier with high ability to control Competitive factors associated with high barriers to entry that are within a hospital's control describe Quadrant A. Strong alignment with physicians is the primary competitive advantage in this quadrant and can allow a hospital to overcome strategic deficits in geography and/or pay or mix (Quadrants C and D).

By ensuring a future stream of patient admissions, well-aligned medical staffs create a significant competitive advantage for standalone hospitals. Strong alignment between a hospital and its medical staff can serve as an effective barrier against a competitor, who may be seeking to poach financially attractive pa-

tients. Recently passed health care reform legislation increases the potential value of close physician-hospital alignment, as it will better position hospitals to demonstrate quality and value, with a direct impact on reimbursement. Hospitals in Quadrant A are well-positioned to pursue competitive factors in Quadrants B, C and D. Exhibit 1: Successful positioning focuses on factors that a hospital can control and that deter competitors

Quadrant B:

Low competitive barrier with high ability to control Competitive factors that do not create a barrier to entry yet are fully within the control of the hospital describe Quadrant B. The factors associated with this quadrant relate to the hospital cost structure, clinical quality and the capital asset base—internal, operationally focused initiatives that are central to the viability of the hospital enterprise. These are factors that all hospitals must continuously work to improve.

Quadrants A, C and D describe strategic factors that are focused on improving a hospital's position in the external environment. However, operational and management performance factors in Quadrant B can hurt, or enhance, a hospital's strategic position. Examples of poor performance in Quadrant B factors include a high-cost structure, below-average clinical quality or facilities in need of significant improvement. Hospitals in Quadrant B will be well-served to focus on creating strategic competitive advantages in Quadrants A, C and D.

Quadrant C:

Low competitive barrier with low ability to control Competitive factors that do not create a barrier to entry and are difficult for a hospital to control describe Quadrant C. A favourable pay or mix is the primary competitive advantage for this quadrant. A favourable pay or mix drives increased profitability and excess cash flow. This, in turn, provides the possibility of reinvestment in clinical programs and facilities, enhancing a hospital's competitive position.

A favourable pay or mix does not provide a barrier to competitive entry, and may, in fact, provide an incentive for entry for Hospitals seeking better-insured patients. While hospital leaders can design strategies to attract commercially insured patients, the underlying socioeconomic status of the hospital's geographic area largely determines its pay or mix. Hospitals in Quadrant C must implement strategies to defend their well-insured-patient base.

Quadrant D:

High competitive barrier with low ability to control Competitive factors that exhibit high barriers to entry with limited ability to control describe Quadrant D. Geography is the most relevant competitive advantage in this quadrant. Barriers limiting patient migration can include natural bodies of water and dispersed populations with limited road access. Geographic barriers make it difficult for patients to migrate and switch organizations and lead to dominant market positions for those hospitals that reap these geographic benefits. In extreme cases, geography prohibits competitor entry, making that hospital the area's sole provider, which enables increased reimbursement rates. Hospitals have minimal ability to change their geography, and those without advantageous geography must create alternative competitive advantages.

HOSPITAL CASE EXAMPLES

Kurt Salmon assessed three independent (non-system) community hospitals ranging between 150 and 235 beds. Each is fi-

nancially successful but derives its competitive advantage from different factors. These cases illustrate how these factors can be translated into above-average financial performance.

Key Hospital Performance Statistics

- > Among strongest financial performers in the state
- > Unaligned medical staff has become strategic concern
- > Challenging pay or mix: 25% commercial, 55% Medicare, 15% Medicaid, 5% other
- > Continual focus on creating low-cost structure

Hospital A is located across a river from the major competing hospitals. The river provides a natural barrier between Hospital A and its nearest competitors, as the driving distance is long due to limited bridge access across the river. Primarily as a result of its challenging pay or mix, Hospital A is always working to reduce its cost structure.

The medical staff is an independent model comprised of more than 100 physicians, generally in solo and small, independent practices, and one large multispecialty group practice comprised of more than 40 primary care and specialty physicians. Hospital A and the large multispecialty practice are not affiliated.

Though geography has traditionally helped insulate Hospital A from hospital competition, these competitors are attempting to leverage physician alignment to overcome geographic disparities. Hospital A's nearest competitor across the river is attempting to align with the multispecialty practice to attract high-acuity and well-insured patients from Hospital A. While it is unlikely that substantial patient volume will migrate across the river, the erosion of this small but very profitable patient population may negatively impact Hospital A's financial position. Hospital A must develop a robust physician alignment strategy to reduce the impact of the diminishing effectiveness of its geographical advantage.

HOSPITAL B Strong physician alignment through an employment model has created a competitive advantage

Key Hospital Performance Statistics

- > Employed medical staff of 150 physicians
- > Current focus on reducing cost structure and improving care quality
- > Challenging payor mix: 25% commercial, 50% Medicare, 20% Medicaid, 5% other
- > Recent \$100 million facility investment including beds, ORs and ED

Hospital B is located next to a river that also serves as the state border. Across the river is a competing hospital with twice as many beds. Hospital B began employing physicians nearly a decade ago as a strategic move against its competitor across the river to secure future patient volumes. Today it employs more than 150 physicians in both primary and specialty care. Its competitor does not employ physicians.

Hospital B has taken steps to solidify linkages between the medical staff and the facility. The hospital implemented an electronic health record. This has fostered an integrated medical culture.

With a physician alignment strategy in place, Hospital B can focus on positioning itself for the anticipated requirements of health care reform and development of a more favourable pay or mix strategy.

Key Hospital Performance Statistics

- > Historically profitable
- > Unaligned medical staff with current focuses on creating alignment
- > 40% commercial, 45% Medicare, 10% Medicaid, 5% other
- > Limited focus on Quadrant B competitive factors

Located outside of a large city, Hospital C is a public district hospital that serves a predominantly suburban county. The hospital

benefits from advantageous geography due to its location on a peninsula with limited highway access. Major access points require traversing a bridge, which limits patient migration. The hospital's geographic and pays or mix advantages have enabled it to minimize its focus on the operational advantages of cost structure and new capital assets.

Though Hospital C has a traditional medical staff model comprised of small, independent-practice physicians, competing hospitals have aligned with physicians, compelling the hospital to develop a comprehensive alignment strategy. There is concern that independent physicians admitting to Hospital C may eventually join the established networks as they face increasing pressure on maintaining a viable independent practice. In nearby communities, physicians have become increasingly aligned with a handful of networks, including a staff-model HMO, a large IPA and several large-group practices directly affiliated with hospitals. Instituting a physician alignment strategy will define the hospital's future position, particularly in light of future health care reform requirements.

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 non pay 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 where as 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.

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 inflow 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 centres financed by independent physicians opened. It is useful to consider the changes in the context of the full spectrum of health care delivery. 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. Neighbourhood 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 pre-emptive actions to protect their market share because competitor action focused on acute care, and (4) craving into adjacent segments required teaming new businesses.

CONCLUSION

Yes, it is possible for an independent 200-bed community hospital to remain viable over the long term. However, to do so requires the development of at least one sustainable competitive advantage. Hospital executives must clearly understand the competitive advantages that are currently and potentially available to them and their associated strategic trade-offs.

Hospitals that fail to develop a single sustainable competitive advantage cannot remain financially viable. Eventually these organizations will be forced to seek out affiliation opportunities with stronger hospitals or systems, or worse yet, consider closing their doors.

Creating alignment among the medical staff is the most impactful competitive advantage available to most hospitals. Alignment of the medical staff can potentially mitigate geographic and pay or mix disadvantages, while helping to support quality and cost-structure initiatives. Kurt Salmon believes that over the next several years, creating strong physician alignment must be a strategic priority for independent 200-bed hospitals.

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.

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.

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