Purpose

The healthcare organization (HCO) described in chapters 2 through 15 is complex, formal, long-lived, and dynamic. It is capable of identifying and meeting the health needs of its community with the latest technology and the most appropriate care. But it thrives only because it fulfills the changing needs of stakeholders, as the stakeholders perceive them. The most sophisticated functions of the organization are those that identify, evaluate, and respond to changes in stakeholder needs. Marketing—the deliberate effort to establish fruitful relationships with exchange partners and stakeholders—is one of these functions. Strategy—selection of the profile of stakeholder needs to be met—is the other. In successful HCOs, as in other industries, the two functions are intertwined, creating a seamless, continuous activity that sets the basic direction of the enterprise; modifies the direction as conditions change; and, in some cases, redirects the enterprise through sale, merger, or closure. This chapter describes how excellent HCOs identify a profile of stakeholder needs and position themselves in response. It begins with marketing, reflecting the centrality of the listening function.

The purpose of the marketing and strategic functions is to identify and support a sustainable set of activities that fulfill as many as possible of the stakeholders’ needs. In a free-market society, both customer and provider stakeholders “vote with their feet,” selecting organizations that meet their needs often without fully expressing what those needs are. An organization thrives because it attracts and retains stakeholders better than competing alternatives do.

Success is not strictly the sum of its parts; sustainable relationships tend to be mutually reinforcing. A successful strategy produces stronger relationships and supports further improvement. Ineffective strategies weaken
the organization and start a cycle that leads to collapse or reorganization. The issues quickly become complex. A successful strategy must meet several different criteria:

- The services offered use processes that are competitive on cost, amenities, and quality.
- Demand is adequate to cover the fixed costs and meet quality standards.
- The work environment attracts and retains associates who are committed to implementing the strategy.
- The services identify and capitalize on a competitive advantage, a reason customers select them over alternatives.
- The constellation of services is one that attracts and builds patient and associate loyalty, and one that includes what patients and associates can realistically expect.

Each of these criteria presents a risk of failure. Only the first criterion is attacked solely by improving the processes within the organization itself. All the rest require attention to the whole environment. The set of solutions is the organization’s strategy, sometimes called its “business model.”

Critical Issues in Marketing and Strategy

Marketing is a broad approach to building exchange relationships
- Not limited to patients, it applies to all relationships
- Not simply promotion, it includes all aspects of the organization’s interfaces to the world

Markets are “segmented”
- Segments are subgroups with similar needs
- Both strategy and marketing are usually targeted to specific segments

“Listening” is fundamental
- Goal is to understand the perspectives of customers, associates, and suppliers
- Both qualitative and quantitative approaches are used
- Approaches are often designed ad hoc

Strategies are framed using the tools of evidence-based management
- Integrating the results of listening and the environmental assessment
- Conducting extensive discussions to gain stakeholder understanding and agreement

Senior management and governance manage strategic discussion and implementation
- Commitment to long-term benefit for all, rather than expedient gains for a few, is central to success
- Large healthcare systems can strengthen both the commitment and the evidence-based tools

Marketing Functions

The term “marketing” has a professional definition that is substantially broader than the common use of the term. Here is one favored by Philip Kotler, a noted professor of marketing:

the analysis, planning, implementation, and control of carefully formulated programs designed to bring about voluntary exchanges of values with target markets for the purpose of achieving organizational objectives.¹

Others use a “Four Ps” mnemonic to capture the breadth of the concept:

Product: What exactly is the product or service offered in the exchange? (Includes benchmarks and competitive operational standards)
Place: Where and how does the exchange take place? (Includes hours of service, geographic locations, and relations between services)

Price: What is the total economic value of the exchange? (Not only the price paid the vendor but also collateral costs such as transportation and lost income)

Promotion: What activities are necessary to bring the opportunity to the attention of the stakeholders likely to accept it? (Includes publicity, advertising, incentives)

The order of the four Ps is important. The consequences of bad product design or placement cannot generally be overcome by low prices or extensive promotion. By either definition, marketing applies not just to customers but also to all exchanges, including those with competitors, employees, and other community agencies. Marketing is about relationships. Healthcare marketing must overcome several complexities that affect relationships:

- Intimate, life-shaping services about which people have strong and sometimes irrational feelings.
- Delivery mechanisms that have high fixed costs. This requires careful adjustment of supply and demand and opens the possibility of differential pricing.
- Providers who are divided into a large number of professions, who often compete between and within their specialties.
- Unpredictable customer expenses that fall disproportionately on a few people. These must be financed by health insurance, bringing a third party into the transaction. The insurance mechanism raises the need for agreement about what is appropriate.
- Health insurance that is financed largely through payroll taxes and deductions and employer contributions, bringing a fourth and a fifth party into the transaction.
- Differences of opinion among patients, buyers, providers, and society at-large about what is appropriate. Even with protocols, optimum treatment is only imprecisely known; evidence-based conclusions may not be satisfactory to customers; and there may be serious disagreements about what is necessary or even acceptable.

In such a complex environment it would be disastrous to think of marketing as a simple or limited activity. As shown in Figure 15.1 marketing addresses relationships with three main classes of people—patients and their families, associates, and buyers and fiscal intermediaries. Successful marketing efforts find the best possible balances between the conflicting needs of these groups.

A strategic approach to marketing includes seven major functions, as shown in Figure 15.2. The first three functions—identifying markets, listening, and branding—establish a platform for more specific relationships. The
fourth promotes the organization to patients. The next two address marketing to associates and to other organizations. The seventh establishes an ongoing assessment and continuous improvement.

**Identifying Markets of HCOs**

As Kotler implies, specific targets are the key to marketing. Market segmentation differentiates exchange partners into particular subgroups based on the groups’ exchange need and the message to which they will respond. It is closely analogous to the statistical process of specification, described in Chapter 10, and in fact often starts with the same taxonomies. Like listening and branding, it underlies the other marketing functions.

Market segmentation allows listening and promotion to be more efficient. People of different ages and genders have unique healthcare needs and may also carry certain insurance, want certain schedules and amenities, and listen to certain media. To attract a given demographic, the organization should work with that insurance plan, provide those schedules and amenities, and advertise in those media. Efforts that are not targeted are
inherently inefficient. The first marketing function is to understand the appropriate segmentation of the organization’s market. Segmentation usually goes well beyond demographics, into economic, cultural, and lifestyle issues as the organization attempts to build demand for specific services.

A relatively simple service—well-baby care—illustrates the issues and contribution of segmentation. The epidemiologic model begins with a specific market segment—newborns:

\[
(1) \quad \text{(Well-baby visits/Year)} = (\text{Births/Year}) \times (\text{Percent of mothers seeking visits}) \times (\text{Visits/Baby})
\]
(2) \((\text{Our well-baby visits}) = (\text{Well-baby visits/Year}) \times (\text{Our market share})\)

Our goals are to increase the total number of babies receiving appropriate care (Equation 1) and to increase our market share (Equation 2).

The initial estimate treats the well-baby market as homogeneous—that is, it assumes all babies and mothers are alike. This is a doubtful assumption; it is possible to identify a series of questions based on potential differences in the baby and mother market.

Segmentation by current source of care:

- **Segment A**: babies not now receiving well-baby care
- **Segment B**: babies now receiving care from our hospital and doctors
- **Segment C**: babies now receiving care from competitors

Segmentation by source of financing:

- **Segment A**: self-pay
- **Segment B**: private insurance
- **Segment C**: Medicaid

Each of these segments will introduce new questions for increasing well-baby care overall and improving market share. Out of the segmentation will come differentiated programs reflecting the needs of the segments, as shown in Figure 15.3. We might help doctors on our staff promote or improve their services and attract more patients. We might lure doctors from competing HCOs to join our organization. We might collaborate with several social agencies to serve babies with Medicaid financing.

As the opportunities are explored, the well-baby proposal may change shape several times. A community effort to reach babies now missed may emerge. Medicaid, local government public health and our competitors may join. Schools, daycare centers, and churches may be willing to advocate use of the well-baby service, providing low-cost promotion. To keep costs low, some care sites may emphasize nurse practitioner care. A successful program might lead to similar programs in other areas, such as prenatal care, women’s health, and domestic violence. Simultaneously, we may start programs to lure customers and doctors to our organization. The trend of events might stimulate discussion of merger with our competitors or of joint ventures in well-baby or other private markets. A thorough and differentiated analysis, combined with pursuit of the opportunities it identifies, can destabilize the entire healthcare market and lead to radical restructuring. That rarely happens, of course, but the best solution is often a step or two beyond the most obvious.

**Common Segmentation Taxonomies**

Market segmentation usually follows established taxonomies or ways of subdivide exchange partners. Figures 10.3, 14.3, and 14.4 show common taxonomies for market segmentation with patients, payer, and providers. As in the well-baby example, multiple segmentation approaches are used to identify the
precise segments and their associated conditions. Organized providers include both competitors and organizations providing unique services. The segmentation perspective explicitly includes exchange relationships with competitors such as joint ventures, mergers, or agreements to divide markets. These actions always raise antitrust considerations. Discussion of prices and division of paying customer markets are per se violations of the Sherman Act. Legal counsel is always advisable prior to conversations with direct competitors. However, federal policy supports collaboration where a clear case for the patients’ and community’s interest can be made.

**Listening**

Marketing requires “listening” activities to understand exchange partners’ perspectives. This understanding promotes dialog, identifies and prioritizes needs, suggests paths to improved relationships, and reveals opportunities

**FIGURE 15.3**

Possible Outcomes of the Well-Baby Analysis
for improved work processes. No organization can be all things to all people; listening also helps an organization successfully specify what they want to be to what people and how. HCOs listen through formal surveys, focus groups, monitors, and a wide variety of personal-contact devices involving dozens or hundreds of managers. Many of these yield qualitative rather than quantitative information. The marketing unit or department plays a critical role in assembling and interpreting these data.

The major listening approaches are summarized in Figure 15.4.

**Formal Surveys**

Surveys provide the most reliable quantitative information about relationships and attitudes and are widely used in marketing, journalism, and politics. Sampling techniques allow inference from a relatively small number of contacts, and samples can be stratified to reflect specific segments of a population. Hospitals now sample patients and associates on a continuous basis, providing regular reports on both summary attitudes toward the organization and its services and insight into perceptions about specific processes. CMS recently mandated Hospital Consumer Assessment of Healthcare Providers and Systems (CAHPS) or HCAHPS, a 27-item survey of inpatient attitudes “that encompass seven key topics: communication with doctors, communication with nurses, responsiveness of hospital staff, cleanliness and noise level of the physical environment, pain control, communication about medicines, and discharge information.” Individual hospital results are published on the CMS website, “Hospital Compare” (www.hospitalcompare.hhs.gov). A similar set, the ambulatory CAHPS (AHAHPS), covering outpatient care, is available from the Agency for Healthcare Research and Quality (AHRQ).

Associate satisfaction surveys are less formally standardized, but major vendors provide questions that permit **benchmarking** and trend analysis. Household surveys are also commonly used; they provide data on community attitudes and conditions as opposed to populations of people affiliated with the organization. They are most commonly used to identify market share and attitudes of important population segments.

Surveys have become highly sophisticated instruments. The questions, timing, method of contact, response rate, and specification of the population can all affect the results so that professional statistical analysis is almost always necessary. Surveys for patients and associates are now provided by commercial companies, which handle these statistical issues and also provide trends, comparative, and benchmarking data.

**Focus Groups**

Focus groups are small sets of stakeholders who are invited to meet face-to-face to discuss a topic of particular interest to them. The discussion is led by an experienced interviewer who usually follows a semistructured script but whose main task is to elicit candid comments from the participants. The
conversation is recorded, and the participant comments summarized. The sample is usually drawn to reflect a specific service or associate population. It is not random and is too small to permit statistical analysis, but it provides a depth of insights lacking from larger-scale surveys and has generally been found to be reliable. The findings can often be tested in larger-scale surveys to increase their reliability.

HCOs use a variety of reports from the workplace to identify important departures from expected performance. Most monitors are generated by the associates, patients, and family directly involved. Leading HCOs now use three main approaches—“incident reports” generated by associates, a variety of vehicles to capture specific patient or associate dissatisfaction, and cards to recognize exceptional effort by associates. The “trigger” in each of these is the subjective sense that a reportable event has occurred. Because this varies among people, and across time and place, in ways that cannot be independently assessed, monitors are inherently less reliable than surveys. Underreporting is a serious issue. It is obviously related to a culture of blame, but other cultural factors also affect reporting rates. Associates are trained to report service-recovery situations and clinical errors, including drug administration errors and patient falls, whenever they occur. Even these relatively clear-cut events are subject to reporting failures. Despite these problems, monitors make real contributions to understanding work processes and relationships. Individual incidents often provide clues to process improvements. Aggregate data on recurring problems, like drug administration errors and patient falls, can indicate trends and processes or units needing attention.

Statistical monitors are uniformly reported, but they are only available for a limited set of events. AHRQ’s patient safety indicators and Solucient’s Complications Index are examples of objectively determined failure rates. They are derived from the diagnostic codes mandated on Medicare hospitalization insurance claims and are required by most insurers. They cover a limited set of events, but one that is relatively free of reporting bias, and can be benchmarked and trended. Their most important use is to validate the subjective reporting processes.

Surveys, written and oral reports, and statistical monitors provide a rich base for understanding relationship needs. Leading hospitals supplement these by deliberate personal contact. They encourage senior management to be highly visible in the organization by rounds and on-call responses. They encourage performance improvement teams to observe and walk through the processes they are studying. They sometimes hire agents to observe and report on competitors’ processes. They assemble focus groups—small groups of actual or potential customers who are encouraged to discuss factors in product, placement, and price that are important to them. These personal-contact activities...
### FIGURE 15.4
Major Listening Activities

<table>
<thead>
<tr>
<th>Activity</th>
<th>Description</th>
<th>Applications</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Formal surveys</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient satisfaction</td>
<td>Telephone, web, or mail survey</td>
<td>Offered to inpatients and various categories of outpatient care; assesses satisfaction with both amenities and perceived quality of care; usually provided by a national survey firm, which supplies comparative data and evaluates reliability; forms the basis for the “loyal” patient estimates</td>
</tr>
<tr>
<td>Associate satisfaction</td>
<td>Telephone, web, or mail survey</td>
<td>Offered to various categories of associates; usually provided by a national survey firm, which supplies comparative data and evaluates reliability; forms the basis for the “loyal” patient estimates</td>
</tr>
<tr>
<td>Community</td>
<td>Telephone or mail survey</td>
<td>Estimates market share, prevalence of insurance, travel patterns, and other community characteristics not in the decennial census; can be used to update census data; can be focused on specific population segments</td>
</tr>
<tr>
<td><strong>Monitors</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Incident reports</td>
<td>Associate-generated written reports</td>
<td>Associates are encouraged to report any event that represents a serious failure, such as a fall, a clinical error, or an unacceptable delay; gifts to patients under service recovery programs require reports</td>
</tr>
<tr>
<td>Complaints</td>
<td>Written, oral, or electronic reports from patients or associates</td>
<td>Patients are offered “bounce-back” cards, and both patients and associates are encouraged to communicate directly with organizational authorities</td>
</tr>
<tr>
<td>Service recovery</td>
<td>Written reports of actions to correct failures</td>
<td>Associates are authorized to offer gifts or benefits in cases where processes have egregiously failed; the incident must be reported in writing</td>
</tr>
<tr>
<td>“Caught in the act”</td>
<td>Written reports of exceptional behavior by associates</td>
<td>Cards for “caught in the act” are publicly available; the events reported are judged by a panel, and prizes are awarded</td>
</tr>
<tr>
<td>Statistical monitors</td>
<td>Counts of untoward events documented in the patient record</td>
<td>The record can be surveyed for evidence such as specific drug orders, progress notes, or treatments; certain problems create diagnostic complications that must be reported; electronic reports are surveyed to count these events</td>
</tr>
</tbody>
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*continued*
yield only qualitative and highly subjective information, but they accomplish three important goals:

1. They show management’s commitment to continuous improvement and put a human face on policies and work requirements.
2. They improve managers’ empathy with the work environment.
3. They provide detailed information that is often valuable in solving specific situations.

Personal-contact programs have some important limitations. They cannot be effective in situations where the basic work processes are inadequate. Too much demand on management’s time or too frequent intervention to solve specific problems is evidence of failures that must be addressed systematically rather than episodically. The subjective character of the information can mislead managers, encouraging blame and “fixing” rather than process analysis and improvement. Personal contact works best when the organization has developed mostly competitive work processes and uses the processes to supplement measurement, process analysis, and goal setting. It can also

<table>
<thead>
<tr>
<th>Activity</th>
<th>Description</th>
<th>Applications</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Personal contact</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Focus groups</td>
<td>Small groups of current or potential customers meeting face-to-face</td>
<td>Focus groups are encouraged to speak candidly about existing services and explore what is important about proposed services; they provide insight to specific process opportunities that do not arise in surveys</td>
</tr>
<tr>
<td>“On-call” managers</td>
<td>24/7 designated contact official</td>
<td>A senior manager is always accessible to patients or associates for prompt attention to complaints or difficulties arising; allows direct intervention and service recovery in complex situations</td>
</tr>
<tr>
<td>Walking rounds</td>
<td>Regularly scheduled senior management visits</td>
<td>Personal contact and visits to actual work sites by front-office managers; visits encourage questions, explain positions, reward efforts, validate public pronouncements, and humanize</td>
</tr>
<tr>
<td>Shadowing and walk-throughs</td>
<td>Observation of a single patient through a complex process</td>
<td>Shadowing allows associates to understand both the process and its impact on patients; walk-throughs actually duplicate patient activity</td>
</tr>
<tr>
<td>Mystery shopping</td>
<td>Observation of a competitor's process</td>
<td>Mystery shoppers were initially used to discover competitors’ prices. In healthcare, they reveal competitors’ processes and competitive advantages</td>
</tr>
</tbody>
</table>
be used to stimulate interest in starting work on these fundamentals and to reassure and encourage in times of exceptional need.

**Branding the Organization**

One function of marketing is to maintain the overall reputation or **image** of the organization so that it remains attractive to most members of the community-at-large. Image building, or **branding**, usually begins as a communitywide communications effort to convey the mission and the competitive advantages of the organization. Branding activities include public and community relations, image advertising and promotion, and media relations. It relates indirectly to lobbying because grassroots support increases political influence.

A deliberate program of public and community relations includes descriptive information and personal appearances by management and caregivers. It also includes deliberate contacts with influential and opinion leaders and direct assistance to community groups.

Public information is one of several sources from which people derive a positive image of the organization. The organization often issues material such as newsletters, annual reports, web sites, news releases, and regular mailings that describe the organization in general terms and highlight specific events. Obviously, success begins with having a good story to tell. Some organizations have moved deliberately to release reliable information about finances, service, and quality to the public. A systematic program to prepare and disseminate annual reports of performance may increase stakeholder loyalty and support. National standards for the release and accuracy of information are missing, but buyer pressure is building for both. The organization should also have a plan in place for communicating when a healthcare crisis occurs. A crisis is anything that suddenly or unexpectedly has adverse effects on an HCO or its patients, associates, or community.

Image advertising and promotion includes purchased media exposure that is not related to a specific sales objective or that combines a specific and a general goal. It also includes association of the institution with various activities, such as athletic events or public services, and distribution of products bearing the name and logo of the organization. Most well-managed organizations try to establish their name, mission, and an image of warmth and supportiveness. Some also emphasize their technological proficiency or convenience. Often the image message is combined with a specific promotion. Advertising techniques easily support dual concepts like, “Bring your baby for care while he’s well to keep him well” and “Excalibur Health System cares about you and your family.”

Image promotion is far from a panacea. It takes a large number of exposures even to increase name recognition, and changing attractiveness
is harder. The implication is that an established reputation—being among the first two or three names people independently recall for healthcare—is a valuable asset, hard to replace, and well worth protecting.

Most organizations are acutely aware of what is said about them in the media, but the evidence suggests that the public at large is quite resistive to media statements. Nonetheless, the media can portray the organization favorably or unfavorably, and the result often depends on the quality of information supplied by the organization. There are two types of media communication. One is the planned release of information, where the organization wishes to have its story told by print or electronic media. Attractive, thorough releases; identification of visual elements for photos and television; access to knowledgeable, articulate spokespersons; and identification of newsworthy elements all assist in improving the coverage. A deliberate program of regular information releases and efforts to draw media attention to favorable events promote a positive image. The more information released, the greater the familiarity and attractiveness of the community is likely to be.

The second type of communication is response to media initiatives. These are often related to major news events, such as healthcare to prominent personages or general disasters. In the worst case, they come as a result of unfavorable events, such as lowered bond ratings, civil lawsuits, or criminal behavior. They can be quite hostile when journalists sense or assume something is wrong. Investigative journalism is an aggressive effort to dig out all the public might want to know, with emphasis on what the organization might want to hide. Effective handling of media initiatives is largely preventive. The organization should prevent events that will draw investigation. It should maintain a strong program of releasing newsworthy, positive information about itself. It should attempt to deal fully and candidly with issues, anticipating reporters’ questions and preparing detailed responses. It should establish its spokespersons and equip them to give thorough, convincing replies to questions. Training and experience are necessary to handle the functions of media relations well.

Community surveys allow the organization to monitor two dimensions of recognition of the institution—familiarity and attractiveness. Familiarity is usually measured by consumers’ ability to recall the name without prompting and by their ability to recognize the name in a list. Survey questions assess what people think of the organization, how they compare it to competitors, and which attributes they like most or least.

Branding is much more difficult than most people expect. Dozens or hundreds of exposures to the image are necessary to establish favorable independent recognition—the level that is felt to be necessary to attract and retain market share. Coordination of themes, logos, and printing styles is important.
A successful branding program identifies both goals and audiences and integrates branding messages with those for specific audiences. Outreach activities such as healthcare screening vans, helicopter services, and open houses are used to reach specific audiences. Special community-relations efforts may be directed to groups with special interests, such as people living in a local neighborhood or people who are influential in the organization’s target markets.16

**Communication to Patients**

HCOs are a respected source of information on health matters, and they communicate often with patients and others in their community. Leading organizations work hard to retain respect, tying their branding activities to specific communications about three principal goals:

1. To encourage wellness and disease prevention
2. To convince patients to select provider and services
3. To adjust patient expectations about care

Reaching the public effectively is challenging. Healthcare messages are often on topics people would rather avoid. Commercial retailers spend far larger sums than not-for-profit organizations are comfortable with. “Clutter”—the sheer volume of consumer messages—makes it difficult to register on the customers’ minds. Despite this, communications programs can both reinforce branding and build demand for effective healthcare.

Health systems join in the wellness promotion movement to encourage healthy lifestyles and cost-effective prevention behaviors. General promotional campaigns to well members of the population include websites, direct mail, broadcast and print public relations material, media advertising, and print and video material in schools and work sites. The healthcare experience often becomes a “teachable moment,” a window of increased receptivity, and messages from healthcare professionals are well received. Health promotion messages can be integrated with branding and can be joint messages with other groups, including employers, intermediaries, and competitors. Messages must overcome complex motivations to pursue the unhealthy behavior. Campaigns repeat the message over and over and use a variety of vehicles to convey and reinforce it. Wellness promotion becomes an ongoing activity, consuming a specific budget and constantly studied for opportunities to improve cost-effectiveness.17

The key to attracting and retaining patients is service more than promotion. “Loyal” or “delighted” patients—those who will return when necessary and refer others—are obtained by maintaining service and quality. The most effective way to manage patient satisfaction is to identify service weaknesses and meet them through continuous improvement. Service recovery can supplement but not replace continuous improvement. Beyond performance
and listening, there is a small role for explicit promotion activities. An HCO would explicitly promote a new or expanded service or a service where a portion of the market could realistically be shifted to or from a competitor. A campaign of promotion would include web sites, press releases, advertising, and monitoring of customer reactions.

One aspect of patient satisfaction relates to initial expectations about care. These can be unrealistic. Media reports frequently emphasize dramatic, curative medical intervention and may overstate the power and value of high-tech care. Drug companies overtly hype branded prescriptions of dubious worth. It is important to counter these and restore realistic expectations. In reality, self-treatment and family care are effective in many conditions. In the case of self-limiting disease and terminal disease, there is often nothing healthcare professionals can add. Similarly, the appropriate use of lower-skilled professionals, such as nurse practitioners in place of physicians or primary physicians in place of specialists, offers advantages in both cost and effectiveness. The marketing approach begins with attractive provision of the lower-cost service. Promotion helps build awareness of alternatives, provides reassurance to make people comfortable with it, and provides reassurance about the availability of technologically advanced care when needed.

HCOs promote the use of less skilled professionals, the use of walk-in clinics in place of emergency departments, ambulatory instead of inpatient care, generic instead of brand name drugs, substitutes for high-cost intervention, and improved management at the end of life. All of these can reduce the cost of care while sustaining or improving the quality.

Healthcare promotion has reached neither the level of funding nor the sophistication of approach of other consumer purchases. A number of factors have limited its development:

1. Overt promotion was considered unethical by physicians and inappropriate by not-for-profit hospitals until 1978 when a ruling of the U.S. Supreme Court held the proscription to be in violation of antitrust laws. Some ethical reluctance toward promotion remains because indiscriminate promotion of healthcare generates unnecessary demand for services. It is often difficult to distinguish promotion to attract competitors’ patients from promotion to expand unnecessary demand.

2. Perverse incentives in the payment system discourage wellness promotion and the promotion of lower-cost alternatives to care. HCOs and their physicians are paid to intervene in disease and not to prevent disease. A mission of wellness favors employer stakeholders but can mean reduced income for the hospital, its employees, and its specialist physicians.
3. Effective promotion is often expensive. Television advertising is the most expensive. In metropolitan areas, many print media are also expensive. Urban daily newspapers and television reach a population much larger than that served by a single hospital or physician group. Only the larger systems serving several counties can efficiently advertise in these media.

4. The need for communication is often greatest in the most disadvantaged sectors of the population. Special efforts are necessary to reach these groups. They need culturally and literacy sensitive communications, both in content and in media. Although improvement of the health of the poor is a major opportunity for cost savings, the return is slow, highly dispersed, and diluted by perverse incentives. The groups and their needs are easily overlooked by more prosperous citizens.

5. Promotion of palliative care raises complex ethical and financial issues. The cost of care at the end of life, estimated to be more than 25 percent of all Medicare expenses, can be reduced without substantial change in the outcome through the use of fewer heroic measures and formalized end-of-life services. However, the effective use of hospice and palliative care requires resolution of the ethical issues and acceptance of alternatives by patients, families, and caregivers.

Leading HCOs are developing a set of tools to deal with these issues. The complexities of the payment system remain the most challenging, but the growth of pay for performance and patient cost sharing both move the payment system away from the worst extremes. Employers and taxpayers have the most at stake in the question; their attention to it may be growing. Some leading organizations consider it their duty to press for reduced cost to the community, even though it may mean reduced hospital employment and federal funding. Three additional approaches help ensure effectiveness of marketing:

1. Development of careful advance plans for marketing campaigns that specify reach (the focal audience for the campaign), frequency (how often individuals in the focal audience are contacted), media, cost, and expected outcome. Quantifying the campaign in advance allows review of alternatives and establishes explicit goals.

2. Targeting messages to specific populations where change is desired. The logic used in prevention and diagnostic testing applies to promotion as well—funds spent communicating to populations who are not involved or are nonresponsive are wasted. While branding usually aims to reach a broad spectrum of the community, promotion should almost always be targeted to specific groups. Promotion can be targeted to social class and health attitudes.

Sophisticated multifactor targeting can focus directly on the expectations of specific patient groups. For example, advance description of elective surgical procedures can identify many common complications...
or variations in the recovery pattern and provide instructions or reassurance about them. It can prepare the patient to accept the usual outcomes and, in some cases, convince patients that the rewards of the procedure are not worth the pain, risks, and cost. Clinical problems associated with a high level of dissatisfaction can be identified and studied to devise more satisfactory treatment patterns. These may deliberately emphasize activities that are designed to provide symptomatic relief, such as the deliberate use of chiropractors in certain cases of low back pain.

3. Systematic use of community partnerships and coalitions. Building networks to address problems offers several advantages. The costs can be shared. Collaboration also builds on the respect these organizations have, bringing familiar faces to the target audiences. The use of sites and agencies other than healthcare allows more complete and candid discussion of the complex issues. For example, on issues of prevention and end-of-life care, churches, congregate-living centers, and senior recreational facilities can hold educational discussions. On other issues, schools and employers can strengthen communication. The collaboration has listening aspects as well. Specific needs can be identified and addressed. The hospital’s own associates can participate as partners. Promotion that reaches both patients and staff will improve staff understanding and acceptance as well.

**Communication to Associates**

Although much of the communication to associates is managed by the accountability structure and the human resources unit, many promotional activities also reach the associates. Web sites and signage are seen more by associates than customers. Publicity and advertising attract associate attention. The service excellence program (see Chapter 12) can be described in part as a program to work with associates to present a shared message to patients and families. The mission and vision are promoted aggressively among the associates. The annual report and periodic newsletters and press releases used by local media reach providers as well as customers. Consistency of message and style are important.

Periodic shortages of professional caregiver personnel occur, and institutions serving less attractive markets have chronic difficulty recruiting adequate numbers. As a result, most large HCOs promote themselves directly to clinical professionals in short supply. Programs to attract physicians seeking locations to practice primary care medicine are commonplace; considerable care and expense is justified in light of the importance of the decision on both sides. Many organizations advertise routinely in nursing, physical therapy, and pharmacy journals to attract new professionals.
Strategic affiliations to recruit personnel are also common. Affiliation with teaching programs increases the familiarity of graduating students. Programs to assist students with summer and part-time work affect not only the students directly involved but also their classmates who learn by word of mouth. Some institutions reach several years below graduation. Working with inner-city high schools to encourage young people to enter healing professions is popular. Like many promotional activities, it reaches two audiences—the students and the community-at-large. Current nonprofessional workers are also an important source. Scholarships and scheduling assistance to permit further degree education are common.

Managing External Relationships

One aspect of marketing is the deliberate management of relationships with other organizations. To understand the issues, it is useful to consider healthcare as a large set of component functions and services. These can be more or less finely specified, but the set used in Figure 2.3, reproduced in Figure 15.5, suggests the scope of an overall commitment to sustaining community health. A variety of different units are necessary to fulfill all these functions, and they can be organized in an almost infinite array of combinations. A “cottage” model of healthcare will have all of these operating as independent units, dealing directly with the patient. There will often be several vendors competing in each function. Starting from that point, more or less permanent ties can be made between the units, as shown in Figure 15.6.
An HCO operating in a specific city must consider its positions on the ownership and management dimensions— with whom does it collaborate, and how? And with whom does it compete, and on what terms? The optimum arrangement would be the one that provides the community with safe, efficient, patient-centered, timely, efficient, and equitable care, but finding that arrangement can be a substantial challenge.

The model called vertical integration will organize the services across the list in Figure 15.5. The horizontal integration model will organize similar services—one slice of Figure 15.5—from several geographic sites. Most of the consolidation that has occurred in the last decade has been horizontal, involving mergers of units with similar functions, often those who formerly competed in the same community. The large for-profit systems of hospitals and long-term care are horizontally integrated. Some of the larger and better-run systems, such as Kaiser-Permanente, Intermountain Health Care, and Catholic Health Initiatives, have also integrated vertically. Much of U.S. healthcare as of 2005 is simply cottage industry—individually owned and operated units providing one slice of the figure to one community.

A similar model can be constructed for technical support services, such as planning, information, human resources, marketing, and plant services. Again, each functional unit can provide its own—the cottage model—or receive it from its parent—the vertical model—or buy it from a national service company—the horizontal model. Information services companies and
housekeeping companies are horizontal examples. Several hundred companies sell accounting and business office services to doctors’ offices.

Substantial consolidation—movement to corporate models—occurred in the past decade, but overall, the degree of centralized management is limited. Almost two-thirds of acute hospitals are in multihospital systems, but the achievements of these organizations are challengeable. Hospital conversions—transfers of not-for-profit corporations to for-profit ones—attracted widespread attention in the 1990s. A combination of tax and inurement issues and financial difficulties of the leading for-profit companies led to an abrupt and probably permanent decline in conversions. Conversions may sacrifice important intangible assets that the community should protect.

Most primary and acute physician care is delivered by small group practices that are independent private corporations. Horizontally integrated companies in medical specialties, such as rehabilitation services, have only small market share. Efforts to horizontally integrate medical practices failed spectacularly in the 1990s.

Many collaborative possibilities lie between independence and corporatization. For example:

- Suppliers and intermediaries—long-term contracts specifying cost, quality, and other performance objectives—can reduce costs and improve service.
- Physician organizations—service line joint ventures support effective specialty care. Other acute care providers, home care, and long-term care organizations partnerships can reduce cost and increase market share on specific activities, even when these organizations are competitors.
- Organizations outside healthcare, such as schools, churches, and community organizations, coalitions can achieve prevention goals beyond the reach of the participants acting alone.

Offsetting the advantages are the transaction costs—loss of flexibility, increased communication requirements, and conflicting values among participants—that arise from more complicated relationships. At some point, the transaction costs exceed the benefit of collaboration; independence will be more successful.

The collaboration possibilities range from competition through several levels of contractual permanence to essentially irreversible mergers or acquisitions, as shown in Figure 15.6. Large organizations succeed because they invent collaborative mechanisms that are more effective than market forces. The nature of the collaboration—its length, cost and quality performance terms, agreements for sharing information, sharing of capital investment, and market exclusivity—places the relationship on the Figure 15.6.
The question about each of the existing relationships is, “Would this service be improved if it were (1) moved to a tighter ownership/management relationship? or (2) moved to a more independent relationship in direct exposure to market forces?

One implication is that any component of the existing organization can be sold to or merged with another organization or replaced by a contract relationship. Conceptually, an HCO could be a governing board managing a large set of relationships with independent companies just as easily as it could be a corporation owning the full array of services.

In reality, the management of relationships has become one of the major activities of the modern HCO. Most organizations now collaborate on several major services, of which insurance and physician organizations may be the most important. The networks they have created require constant relationship management. Figure 15.7 suggests several common levels of collaborative activity:

<table>
<thead>
<tr>
<th>Service or Function</th>
<th>Common Current Arrangement</th>
<th>Possible Alternative Structure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low-volume specialty care (e.g., inpatient mental, long-term acute care)</td>
<td>Not offered</td>
<td>Joint venture with competing provider; contract with horizontally integrated provider</td>
</tr>
<tr>
<td>Ambulatory services (e.g., oncology, specialty surgery off-site emergency)</td>
<td>Owned or joint venture with physicians</td>
<td>Joint venture with competing provider; contract with horizontally integrated provider</td>
</tr>
<tr>
<td>Primary care</td>
<td>Independent physician groups</td>
<td>Joint venture with physician owners; acquire and own practices</td>
</tr>
<tr>
<td>Long-term services (e.g., home, hospice, nursing home care)</td>
<td>Offered by independent companies</td>
<td>Preferred partnership with specialty provider; contract with horizontally integrated provider; owned</td>
</tr>
<tr>
<td>Technical support function (e.g., finance, information services, human resources)</td>
<td>Owned</td>
<td>Purchased from preferred partners; provided by multihospital HCOs</td>
</tr>
<tr>
<td>Integrated acute service (inpatient and outpatient care)</td>
<td>Owned</td>
<td>Contracted to a horizontally integrated management company; converted to for-profit ownership</td>
</tr>
</tbody>
</table>
• Short-term, market-driven contracts include patient referrals, purchases, temporary worker contracts, or consulting engagements. The need for repeat business is the principal force for performance. Standards are set by the market and are often implicit rather than explicit.

• **Preferred partnerships** include health insurance participation agreements, physician-hospital privileging, supplier contracts, or outsourcing contracts. The contract attempts to specify performance characteristics, including incentives, and is written for a year or more. The standards are explicit and are managed like internal organization expectations—that is, they are negotiated regularly. The standards improve over time, and the intent is to keep the partnership in place. The arrangement can be abrogated, however, if desired by either partner.

• Joint ventures involve capital investment by both partners, such as ambulatory treatment centers, or shared high-cost, low-volume equipment. Joint ventures usually have joint governance or management teams. The capital investment makes them more difficult to abrogate, and they are usually expected to be permanent.

• **Mergers** are where the capital, governance, and management of prior corporate entities are replaced by a new combined entity. Mergers are generally irreversible.

• **Acquisitions** are where one existing entity totally acquires another. The acquiring company owns the capital and continues governance and management. Acquisitions are generally irreversible.

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**Strategic Functions**

Strategy—the placement of the organization in its environment—can be said to pick up where marketing leaves off, but more accurately, the two are seamlessly connected. If marketing is about relationships, strategy is the selection and prioritization of relationships. The organization identifies its strategy through its governance processes (see Chapter 3) and implements it through its operations (see chapters 4 through 15). The strategic functions (shown in Figure 15.8) are the specific activities that help the organization maintain an effective strategy in a dynamic environment.

**Revising the Mission and Vision**

The mission, vision, and values set by the governing board (see Chapter 3) represent the most central desires of the owners and stakeholders and, as such, become the cornerstone for all subsequent planning decisions. To fulfill that function, they should be as permanent as possible, but even the most carefully set mission may lose its relevance in a dynamic environment. Changes in demography and technology make certain services essential and
Chapter Fifteen: Marketing and Strategy

others redundant. Acquisitions and divestitures may change the competitive environment. Changing stakeholder attitudes may force new priorities.

Even though major change is infrequent in the mission and even rarer in the vision, well-run organizations review the need for change annually. They contemplate mission revision far more often than they actually revise because it is wise to consider alternatives carefully. Periodically, the organization should undertake a broader-scale review sometimes called “visioning.” Given the mission’s central role, it is important to work carefully with possible changes. Actual revisions are developed by extensive listening and discussion among stakeholders. Several task forces are established to attract most of the organization’s leadership and stakeholders (a group often numbering in the hundreds) into debate about possible revisions. The review process not only develops consensus positions, but it also increases stakeholder understanding of respective viewpoints and the reasons for specific wording. Marketing or planning staff must manage these efforts, keep track of proposed changes, and arrange for the resolution of serious disagreements. The final changes require formal governing board adoption.

**Strategic Positioning**

The mission, vision, ownership, scope of services, location, and partners of the organization define its **strategic position**. Like visioning, strategic positioning not only defines the strategy but also establishes broad understanding of

<table>
<thead>
<tr>
<th>Activity</th>
<th>Definition</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revising the mission and vision</td>
<td>Stating the underlying purpose and values of the organization</td>
<td>Adding prevention and nonacute services to a traditional hospital mission</td>
</tr>
<tr>
<td>Strategic positioning</td>
<td>Identifying and evaluating alternative approaches to maximizing stakeholder value</td>
<td>Positioning an array of clinical services geographically to achieve higher market share</td>
</tr>
<tr>
<td>Implementing the strategic position</td>
<td>Committing to processes and resources that will achieve the strategic goals</td>
<td>Forming strategic partnerships; investing in information technology</td>
</tr>
<tr>
<td>Responding to external opportunities and threats</td>
<td>Evaluation of events that change the strategic risks or benefits</td>
<td>Acquiring a faltering competitor</td>
</tr>
</tbody>
</table>

**FIGURE 15.8**

Strategic Functions

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the strategy so that the organization can both implement it effectively and respond to external challenges and opportunities. Successful strategic positions are constructed by identifying alternatives (what-ifs), testing the alternatives extensively with simulations and pilots, and evaluating the tests in task forces or committees of the most knowledgeable associates.

Identifying Strategic Opportunities

Strategic alternatives are identified through an ongoing review, directed by the senior management team and presented to the governing board for discussion, amendment, and approval. The governing board reviews strategy whenever necessary, but always at the time of the annual environmental review.

The review begins by assessing performance on each of the four dimensions of the strategic balanced scorecard—financial, operational, customer, and learning (see Figure 3.4). Achievements are compared to the prior year’s expectations, competitor achievements, and benchmarks, and the changes are noted in the environmental assessment. Specific areas of each dimension are often categorized as “Strengths” or “Opportunities for Improvement”, creating a profile that tests both the organization’s goals and its performance. The resulting display is checked against the mission and vision and used to identify what the organization could be.

A key part of the review is the study of overall patterns and identification of the interrelationship between the performance dimensions. Study of high-performing organizations is helpful. Innovative thinking that transcends traditional boundaries helps identify truly creative opportunities. Porter’s framework for evaluating strategy is useful, both to improve the balanced scorecard measures and to identify important questions. The framework suggests that strategy must address questions from “five forces” or external domains:

1. **Buyers and customers.** What are buyers’, patients’, and community’s needs? What opportunities for measured improvement are revealed by benchmarking quality, cost, access, and amenities? What unique economic or epidemiologic characteristics should be incorporated into specific strategies?

2. **New technology and substitutes.** What are the implications of new diagnostic and treatment technology? What opportunities exist to reduce the cost of technology, such as by substituting less expensive protocols or changing processes to use less skilled personnel? What opportunities for improvement are presented by new operational technology, such as the electronic medical record and the Internet?

3. **Resource availability.** What funds are available for investment in expansion or renovation? What human resources are required, and how will they be acquired? What opportunities exist to improve retention and service excellence? What land is required? How effectively is the organization using its information resources?
4. **Competitor activity.** What actions are competitors taking, and what are the implications of those actions for our strategy? What opportunities exist to forward stakeholder goals by collaboration with competitors?

5. **Potential competitors.** What new models of healthcare delivery are being developed elsewhere? Which stakeholder groups might start competing organizations, and why? What regulatory protections does the existing organization have? What incentives are offered to encourage competitors? What actions might our organization take to forestall competition?

The opportunities identified by the review will be identified, and roughly prioritized. Various ways to improve the institution’s position, usually called **scenarios**, will be proposed and evaluated against the agenda of opportunities. Some will die quickly, as major flaws appear. Others will receive detailed and quantitative review, and models of their implications will be constructed. Models, also called business plans, consist of a narrative, describing the alternative as clearly as possible and identifying how it differs from current practice, and a quantitative simulation that forecasts the changes in key balanced scorecard performance measures.

The model and its results are evaluated by teams of associates and stakeholders. The quantitative profile is used to test the proposal for realism—contribution to mission, synergy with existing programs, risk of failure, fit with the environment, and fit with accessible resources. The best organizations share their strategic exercise broadly. The review helps a large number of members and customers understand that the organization’s profile of needs and achievements and the possible improvements. The result is that the strategic position is not secret. In the words of the Intermountain planner, Greg Poulsen, “It’s in our competitors’ portfolio tomorrow morning.” The Intermountain approach is to win not on secrecy but on sound implementation. Speed and thoroughness are both important.

Various devices can be used to stimulate discussion and understanding of alternatives. A matrix allowing consideration of two dimensions of desirability is sometimes useful. There are several alternatives for defining the axes. The versions by the Boston Consulting Group or General Electric are popular. Both lead to a display such as that illustrated in Figure 15.9, where the axes are market attractiveness (opportunities for growth or profit) and organizational advantage (internal resources, sometimes called “competencies”). It is generally easier to expand an existing competency than to develop new competencies, but ignoring the market is perilous. The display is useful to focus attention on these trade-offs. For example, a small rural hospital, noting both that there was a high demand for home care and respite care in its community and that it had the skills for such services (Situation A), would include them in its plans. Obstetrics, important to the customers
but expensive for the hospital (Situation B), would be retained. A high-tech service, only infrequently needed and requiring specialists who would be difficult to recruit (Situation C), would be avoided. But a service already in place, with specialists attracting market share from elsewhere (Situation D), would be retained or expanded. The resource barrier that exists in C has been met in D, and the investment gives the hospital an advantage.

Various approaches are used to build successful corporate strategy, but these do not transfer easily to the complexities of healthcare. Eastaugh\(^59\) has modified four corporate archetypes designed by Miles and Snow\(^60\)—“prospector, analyzer, reactor, and defender”—to fit hospitals. The differences between the archetypes are two dimensional, as shown in Figure 15.10. One dimension, willingness to seek innovation outside the traditional parameters, is external and tends to higher risk. The other, concentration on meeting quality and cost standards in the core business, is internal, analytic, and risk averse. The evidence suggests that prospectors and defenders do badly; too much risk and too
little action are both dangerous. Analyzers do better than defenders; carefully selected innovation is better than sticking too closely to established models.

Other strategic philosophies include Porter’s “cost leadership versus quality differentiation, ” and Miller and Friesen’s “adaptive, dominant, giant, conglomerate, and niche innovator.” Cost leadership has been severely blunted by the complexities of healthcare finance. Service excellence is a form of quality differentiation; it has been extremely successful as a strategy to differentiate a hospital from its competitors.

The Miller-Friesen “giant” and “conglomerate” categories have found limited application in healthcare, but niche strategies, deliberately seeking highly specialized services that can be delivered to a particular market segment, have important roles both in meeting specific needs and in illustrating innovative opportunities. The theoretical advantage of niche strategies is the ability to respond quickly and excellently within the limited service. Niches tend to emerge around new services and to sustain themselves when unique factors in the service are difficult for competitors to copy. Specialty hospitals serving children, the mentally ill, cancer patients, and the like are following niche strategies. Small, rural HCOs offering primary care and limited hospitalization are also niche strategists, and so are independent home care and hospice organizations. Herzlinger has advocated specialty hospitals for the major service lines of care, claiming that competition will be enhanced and responsiveness improved if “focused factories” are independent and for-profit, rather than linked under a not-for-profit umbrella. Porter and Teisberg have joined her cause, claiming that the existing structure stifles competition and therefore progress. The service line strategy of integrated systems is an attempt to gain advantages of niching while retaining those of the larger organization.
Niches often exploit transient advantages, and that may be the case with the specialty hospital movement. The niche concept in healthcare increases costs and difficulties of coordinating care. The technology may change, wiping out whatever advantage the niche had. The financing may change, leaving the niche company with insufficient funds to finance expansion. Customer judgments may change so that people who were willing to travel or pay extra for a specialized service decide not to. A new model, different from either of the existing models, may emerge. So far, niche-strategy institutions are a relatively small part of the total; integrated comprehensive strategies prevail. Specialty hospitals per se encountered political resistance beginning in 2003. In 2005, CMS announced a review of its procedures for enrolling specialty hospitals and “a series of steps to reform Medicare payments that may provide specialty hospitals with an unfair advantage.”

Implementing the Strategic Position
The consensus that emerges from the review of scenarios and is adopted by the governing board is the proposed strategic position. It is expressed in specific balanced scorecard goals that the organization expects to attain over the next several years. The final models become the road maps to meet these goals. The strategy will be implemented by assembling the resources indicated by the road maps. For most strategies, implementation raises fundamental questions about how the organization should partner to acquire the resources. Answering these questions and completing the actual assembly often takes several years, requiring documentation beyond the annual budget.

Managing Resources
Several possibilities exist for most healthcare resources. They can be “made” (assembling raw materials and training labor to provide the product or service) or “bought” (acquired at the finished stage from another organization). In many real situations, make or buy is not a dichotomy but a surprisingly large array. For example, the small hospital contemplating home and respite care in Figure 15.8 could face at least six different possibilities:

Make:
1. Start a home care program, hire an experienced manager, write protocols, buy vehicles and supplies, hire and train staff, and so on.
2. Partner with a competitor hospital to start a program as joint venture.

Buy:
3. Partner with another hospital that already has such a program.
4. Purchase a franchise from a regional home care company.
5. Purchase the service with a long-term contract specifying quality, quantity, and cost.
6. Merge the hospital with a healthcare system that has demonstrated capability in home and respite care.

Sound strategy calls for selecting the most promising of these possibilities and developing the relationships necessary to make it effective. In reality, all six involve relationships. Even the first will require an automobile dealer and a protocol source, for example. Also in reality, the hospital likely has working examples of several possibilities. Its imaging may be a joint venture; it probably buys plant services on a long-term contract; it may use a company to assist with its protocols in other services; or it might have a partnership with a referral center for specialty care.

The management of these relationships is a core concept of strategic organization. Each potential solution must be tested on its contribution to mission, compared to benchmark and competition. The appropriate relationships must be identified and established before the strategy is implemented, and after implementation they must be maintained. The evaluation of the make-or-buy profile and the relationships that implement it should not be limited to new or proposed services; any component of the organization that is failing to progress toward benchmark should be reviewed as well.

The make-or-buy profiles of hospitals have changed drastically in the last decades, and continued change is likely. Systems have centralized many management services effectively. Service lines often include new financial ventures with physicians. Imaging and emergency medicine have developed regional supply companies. Contracted plant services have grown, and vendors now offer management of a number of functional areas.

Many strategy elements take several years to implement. Implementation processes and new strategies must be coordinated with those in preparation as well as those in place. The decisions that result from the strategic analysis process are incorporated in a set of documents that are sometimes called the long-range or strategic plans. The documentation includes the following parts:

- **Environmental forecasts.** These are derived from the environmental assessment, cover about five years, and identify potential directions of change for a second five years. They are updated annually but serve as a central resource and database for the planning activities of all units.
- **Services plan.** This specifies the clinical services and other major activities in which the institution will engage, with annual forecasts of the expected volume and achievement of goals for cost, quality, worker satisfaction, and customer satisfaction.
- **Long-range financial plan.** This summarizes the expected financial impact on income statements, cash flow, long-term debt, and balance sheets (see Chapter 11).
• **Information services plan.** This describes the future capability and hardware array of information service, including plans for collection, standardization, communication, and archiving of data (see Chapter 10).

• **Human resources plan.** This shows the expected personnel needs, terminations, and recruitment requirements (see Chapter 12).

• **Medical staff plan.** This is a part of the human resources plan focusing on physician replacement and recruitment (see Chapter 6).

• **Facilities plan.** This details the construction and renovation activities (see Chapter 13).

Although the plans may be separate documents, the processes generating the decisions must be integrated. In general, mission and vision drive services and finances, and these, in turn, drive facilities, human resources, and information needs. Thus, the plans can be portrayed in a hierarchical relationship as shown in Figure 15.11.

The planning unit is responsible for maintaining and coordinating the strategic plans as a set and preparing the annual environmental assessment with its required forecasts. The other technical and logistic support services are responsible for their components.

**Responding to External Opportunities**

Many strategic opportunities arise from external events and must be evaluated on a timetable outside the organization’s control. They often involve long-term commitments, large sums of money, and several parts of the organization. They often threaten to disrupt the lives of many associates. They may also require secrecy because premature public knowledge would substantially change the nature of the transaction. Finally, they are often irreversible; the opportunity, once passed, will not soon return.

These high-risk decisions test the governance structure and the skills of its leaders as no other activity does. The uniqueness of each opportunity
makes rules impractical, but some characteristics are common to successful responses:

- The criterion for all opportunities is the maximization of stakeholder satisfaction. This criterion is broader than the mission and vision; some opportunities require revision of the mission and vision.

- Surveillance of market and political trends gives advance warning. Many opportunities can be predicted some years in advance. Surveillance of competitors’ activity can alert the organization to many partnership opportunities. Who is growing, failing, buying, selling, or approaching a critical organizational juncture can usually be detected in advance.

- The general opportunities can be debated in advance and broad positions established as part of the strategic position. A well-written mission statement, long-range plan, and fiscal plan, plus the history of discussion surrounding them, provide the criteria for evaluating most specific strategic opportunities.

- Well-run organizations can assemble a knowledgeable response team for each specific opportunity. The team membership emphasizes maturity in business decisions. The CEO is usually team leader, although a senior board officer occasionally assumes this role. Trusted senior physicians and other senior managers should also be included. Planning, marketing, and finance staff make up the workforce. Outside consultants may be useful.

- Response teams may be limited in size if necessary and be accountable only to senior governance officers until the project has undergone initial review. This arrangement preserves confidentiality where that is necessary. The usual result of the confidential review is a larger-scale, more public review.

In short, preparation allows the well-managed institution to make prudent evaluations of opportunities within externally imposed time frames.

**Improving Marketing Performance**

Marketing is generally an allocated overhead, although some specific campaigns can be transfer priced. Marketing should be accountable to the governing board and to the operating units on three criteria:

1. **Efficiency**—activities are carried out at the lowest cost consistent with effective performance.
2. **Effectiveness**—activities have specific goals and generally achieve them. Many of these goals are measurable through listening activities. Others, like the listening itself, must be subjectively evaluated.
3. **Responsiveness**—activities are addressed to the identified concerns of stakeholder constituencies.
Although the application of these criteria is subjective, marketing can and should prepare a budget and plan each year, study its own processes, identify opportunities, and document continuous improvement.

**Measures of Marketing and Strategic Performance**

**Measures of Marketing Activity**

Not all aspects of marketing can be quantified, and the more global measures of market performance, such as market share, clearly include multiple accountabilities. Branding and specific promotion to customers and associates usually have direct measures of resources consumed and productivity, and outcomes can often be assessed. The other functions—market identification, listening, external relationships, and market measures—can be evaluated by internal or external audits. The combined approaches support annual goals with continuous improvement.

Promotional campaigns should have pre- and postcampaign evaluations built in. Campaigns identify specific goals, such as market share or behavior change in population segments. Their costs can be estimated, expectations established about outcomes, and actual results compared to expectations. Expectations can be set about exposures (reach times frequency), response rates (demand), costs, costs per exposure and per response, process quality, timeliness, and changes in customer satisfaction and target market share. Surveys and statistical analysis of behaviors can evaluate the impact of the promotion. The campaigns are often reasonably free of interactions with the rest of the institution so that marketing can be directly accountable for the results. Many of these measures can be used for branding as well. For example, an organization might identify several strategies to expand market share, using several service lines; centers of excellence in certain referral specialties; and an expanded availability of primary care physicians. Each of these has specific measures that can be evaluated by surveying the community to gauge recognition of the promotional material and responses and by analyzing trends in new registrants for the various services. Expectations for improvement in these measures can be established and performance evaluated as shown in Figure 15.12. Campaigns may take several years, but interim progress can be evaluated annually.

Auditing can supplement these measures, both with increased understanding of accountabilities and evaluation of more subjective marketing activities. An audit performed by an outside consultant might review quantitative results, pointing out comparable values from other organizations. (True benchmarking is unlikely because other communities are not strictly comparable.) A consultant can conduct or validate surveys or analyses
showing results. A consultant can review practices, goals, and organization structures and can suggest opportunities for improvement. Even without a consultant, an internal 360-review process can accomplish many of the same objectives by systematically surveying associates in the unit and users of the service. Periodic supplementation by an independent outsider will improve the reliability of internal review.

<table>
<thead>
<tr>
<th>Campaign</th>
<th>Actions</th>
<th>Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centers of excellence in orthopedics,</td>
<td>Preparation of data on cost per case and quality of results</td>
<td>Increase in listings or contracts with intermediaries</td>
</tr>
<tr>
<td>cardiology</td>
<td>Publication of original research in peer-reviewed journals, distribution of reprints</td>
<td>Change in total demand, market share</td>
</tr>
<tr>
<td></td>
<td>Direct sales to managers of local HMOs, PPOs</td>
<td>Change in cost per case</td>
</tr>
<tr>
<td></td>
<td>Competitive bid for Medicare, Medicaid contracts</td>
<td>Change in profit per case</td>
</tr>
<tr>
<td></td>
<td>Presentations to primary care physicians</td>
<td>Cost of campaign per new case</td>
</tr>
<tr>
<td></td>
<td>Feature stories in local media</td>
<td>Number of public relations appearances, audience size</td>
</tr>
<tr>
<td></td>
<td>Media promotion</td>
<td>Number of exposures; exposures per target audience member; cost per exposure by medium</td>
</tr>
<tr>
<td>Increased primary care access</td>
<td>Direct mailing to physicians in primary care fellowships</td>
<td>Survey of awareness and attractiveness [1]</td>
</tr>
<tr>
<td></td>
<td>Coordination with presently affiliated physicians</td>
<td>Number of subscribers, percent of total market, cost per subscriber</td>
</tr>
<tr>
<td></td>
<td>Meetings with local physicians affiliated with competitors</td>
<td>Surveys of patient satisfaction</td>
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<tr>
<td></td>
<td>Program of practice acquisition, expansion</td>
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<tr>
<td></td>
<td>Introduction of nurse practitioners</td>
<td></td>
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<tr>
<td></td>
<td>Media advertising and public relations</td>
<td></td>
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<tr>
<td></td>
<td>Program of office support</td>
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</tbody>
</table>

Global Measures of Marketing and Strategy

The measures of contribution or value of marketing and strategic positioning are the four dimensions of the strategic balanced scorecard—financial, operational, customer, and innovation/learning—that measure the success of the enterprise (see Figure 3.4). Governance and the senior management team are accountable for the results, which are reviewed in the annual environmental assessment. The marketing and strategic activities can also be reviewed subjectively, as part of the board’s review of its own performance, and as part of senior management’s annual review.

Organization and Personnel

Seventy percent of hospitals were reported to have moderate to high marketing orientations in 1991. Larger hospitals reported an average of about 15 people in marketing, public relations, and planning activity, with seven devoted to marketing, five to public relations, and only three to planning. In a different survey, about a third of marketing expenditures were for advertising, and only one in four marketing people reported responsibility for planning. Most of the funds went for consumer marketing. Physician marketing received 20 percent of the funds, and employer marketing about 10 percent. A later survey suggests that marketing investments stabilized in the later 1990s, possibly as a result of cost-containment efforts and the increasing numbers of managed care enrollees, resulting in a shift in marketing to organizational buyers as important customers.

Marketing processes are increasingly sophisticated. A master’s degree in business or health administration is a useful beginning, but neither degree emphasizes the details of advertising or public relations. Experience with a commercial agency or a successful healthcare marketing team is highly desirable for the senior marketing team.

Consultants are available for most marketing functions. Advertising is purchased from agencies with experience in design, campaign development, and media contracts. Market studies and customer surveys are often contracted to consultants. The consultant should be able to achieve both better results and lower costs. The database that results from continuing study of a market is a valuable proprietary resource. Even if much of the data collection is delegated to consultants, the organization should make an effort to retain the data in their entirety. Consultants can assist in strategic marketing by providing data collection and undertaking sensitive inquiries. Negotiation is often retained as an activity of the CEO or senior staff, but consultants and trustees may be as effective as negotiators, intermediaries, or mediators.

Figure 15.13 suggests the formal marketing accountability hierarchy for a large organization. In smaller organizations, most of the specific
accountability centers disappear and consultants are used extensively. In multihospital systems, a central marketing unit can offer in-house consultant service, at least theoretically providing a competitive advantage. It is possible to establish transfer payments for marketing services, permitting better cost allocation between subsidiaries and promoting a professional relationship between the units.

Strategic support is a function of senior management. Planning and internal consulting units generally provide technical assistance, and outside consultants are frequently used. The cost of strategic positioning is an overhead item, not easily approached through transfer pricing. (The clients of strategic positioning are the stakeholders, not the units of the organization.)

The Managerial Role

Marketing and strategy are exceptionally sensitive to the efforts and effectiveness of senior leadership. Successful organizations succeed because they face strategic issues systematically. Success feeds on itself. Because it meets needs, it attracts support, and the support provides resources for further expansion. On the other hand, studies of failures of HCOs usually reveal that strategic errors were made several years before the ultimate crisis, and often repeatedly. Unfortunately, excellence is extremely rare. Hospitals and their associated physicians fall alarmingly short on safety, quality, effectiveness, patient satisfaction, and cost. Studies of trends in available

FIGURE 15.13
Formal Hierarchy for a Large Marketing Operation
national measures of performance suggest that the typical hospital is not strategically managed; it is simply drifting.\textsuperscript{82}

Successful strategic positioning depends on two factors—the ability to identify promising candidates quickly and accurately from a broad range of alternatives and the ability to implement the selected candidates effectively. Hamel and Prahalad point out that corporations that thrive in competitive markets have greater ambition and follow a rigorous program of focused, complementary innovation.\textsuperscript{83} In healthcare, provider logic, rather than customer logic, has traditionally driven innovation—that is, new products and services are often driven from the perspective of a technological challenge, rather than one of what the customer might want given a full understanding of the options. (Cesarean sections, circumcisions, prostatectomies, and executive physicals are among the more glaring examples.) Missing, so far, are creativity, role playing, and breakthrough innovation oriented around customer realities. There are methods and styles of delivering healthcare we have not dreamed of yet.

The hospitals that are now well managed speak of “a journey.”\textsuperscript{84} They have made a series of changes that over a period of a few years have moved them from drift to excellence. Governance and senior management commitment are essential to start the journey and to sustain it. Excellence requires breaking old habits, learning new skills, and building a new culture. Strategic issues require weighing core values; the rewards and penalties are deferred; the decisions are difficult and sometimes painful. Denial is always tempting, particularly when things are going at least tolerably well. Governance and senior management must support, encourage, teach, and reassure for the change to succeed. The journey is completed by building a strong technical foundation. What begins as commitment is translated to a way of life by tools that make it easy to address the issues and hard to deny them.

**Technical Foundation for Strategic Excellence**

The journey transforms the culture of the organization to one where evidence-based management and continuous improvement are unquestioned. It begins by measuring and benchmarking the most important dimensions of performance. It continues with a sturdy set of processes for performance improvement and a service excellence environment. As it progresses, it comes to include negotiating and partnering skills so that the organization can benefit from joint ventures, coalitions, mergers, and other collaborative activity.

In the twentieth century, medicine moved from the personal skills and judgment that made Sir William Osler and the Mayo brothers famous to the quantitative testing, imaging, electronic communication, and protocols that support twenty-first century doctors. A similar change must occur in management. Evidence-based management is quantitative. Numbers replace judgments, and
documented methods replace traditional ones. The strategic balanced scorecard (see Figure 3.4) must be in place and so should, at least, a starting set of the detailed operational measures that identify the opportunities for improvement in each accountability unit (see Figure 4.8). Enough benchmarks must be available to make the destination clear to all operating units. Effective listening, a demographic database, and skills to implement the epidemiologic planning model must be in place to drive the environmental assessment. The internal audit must be expanded and strengthened so that the measures are reliable. The trustees, physician leaders, and management associates must become comfortable using these measures and benchmarks.

The theory for continuous improvement is the Shewhart cycle comparing performance to benchmark, setting a goal, identifying a process improvement, and implementing it. (It appears repeatedly in the book in different forms, beginning with the Shewhart cycle in Figure 2.7.) It must be broadly understood and implemented through performance improvement teams. Excellent organizations have dozens of formal teams and can encourage informal teams to address local issues. For these teams to be successful and efficient, internal consultants must be available to interpret, analyze, and forecast the quantitative data. The organization must manage a number of recurring learning processes, including environmental assessments, operating and capital budget development processes, and processes to select and maintain clinical protocols.

The journey requires a culture that is supportive and respectful. The leading organizations have all built that culture around their mission, vision, and values, making sure that no opportunity is lost to reinforce those beliefs. Belief must be reinforced by actually meeting associates’ daily needs. This requires effective processes for physician and nurse credentialing, associate recruitment and orientation, and supervisory training. It also requires realistic listening to associates, appeals processes, and conflict-resolution processes.

It is clear from the experience of excellent organizations that the historic model of the local hospital, with its affiliated but independent medical staff, is no longer adequate. Patient needs are too complex. The range of skills is too extensive. The transaction costs of a cottage industry, both in direct dollars and in failed coordination, are too high.

The model that emerges from the leaders’ experience emphasizes both expanded formal accountability and more strategic partnering. The local hospital of the future will be accountable to a larger system and will be a partner in the community to meet comprehensive patient needs. The relationships it builds will routinely include employment, joint ventures, strategic partnerships, and contractual agreements. It is likely, for example,
to employ its nurses; have joint ventures with its specialists; contract with its emergency, imaging, and pathology physicians; form a strategic partnership with a physicians’ association in primary care; and build a community coalition on health promotion and disease prevention. Many of these structures already exist. What must change is the level of accountability. Each of these affiliates must document its performance on balanced scorecard dimensions and stand the tests of benchmarking and competition. The management of these relationships will be a critical skill. The competing agendas of various stakeholders must be understood and resolved.86

**Leadership Requirements for Strategic Excellence**

Senior management in the future will spend most of their time negotiating relationships. The evidence-based approach and the commitment to mission will provide the foundation for dialog. A sound tradition of consensus building will make the negotiations fruitful. The governing board will have a role in negotiations and will establish and control the general direction of the organization through its function of selecting the executive, the mission, the strategic position and the budget.

Evidence that the HCO contributes to the whole community is a powerful negotiating tool. Individuals seek their personal betterment, but evidence that the organization meets broader needs suggests both fairness and long-term stability, strengthening the case for a constructive relationship. It is not an accident that associates want to work at excellent organizations or that success feeds on itself. Excellent HCOs are rewards based rather than adversarial. The foundation of their posture toward associates, competitors, and the community-at-large is one of collaboration to achieve mutual goals. Potential associates and partners can approach the negotiations, recognizing that the organization fulfills healthcare, employment, and financial goals well and that strengthening the organization benefits the community and its citizens.

A strong consensus-building process must underpin the negotiations. The evidence from the leading organizations suggests that consensus building has three parts: (1) acceptance of the mission and the evidence-based approach, (2) careful and sensitive listening, and (3) due process. The first preselects; those who do not accept the validity of the mission and the evidence-based approach need not open discussions. The second, careful listening, provides flexibility and room for innovation. It promotes dialog to identify innovations and prevents disputes by promptly identifying potentially threatening issues. The third, due process, protects the rights of the parties, and shows respect. Appeal processes, rules to balance power asymmetries, and mediation and techniques for conflict resolution are available, although the evidence suggests they will not often be needed.
In leading HCOs, the trustees are focused on the core strategic decisions that determine the organization’s future. The board’s governance processes make it difficult to evade their responsibility. The strategic balanced scorecards and benchmarks help them understand objectively the needs of the organization and the community. Calendars, careful preparation of alternatives, prior work by task forces and committees, and consent agendas structure the decision processes. Guidance from more experienced colleagues helps new members learn responsibilities. The evidence-based approach helps them understand the choices they must make. The best boards now use both individual self-assessment and annual review of the board’s decisions and processes to improve their performance.

**Multihospital System Contribution to Excellence**

The technical and leadership requirements for strategic excellence suggest a powerful advantage for large, multisite healthcare systems. Catholic Health Initiatives, SSM Health Care, and Intermountain Health Care have exploited this possibility and can document their superiority on the strategic balanced scorecard. Effective healthcare systems can develop expertise in the tools and in fact promote learning across their member organizations.

A surprising array of tools can be centralized. Successful models exist for centralizing purchasing, planning, internal consulting, and finance and internal auditing. Much of marketing, accounting, and information services can be moved to benchmark by centralization. Many plant services are centralized through commercial companies. Clinical care can be centralized also. Telemedicine offers new possibilities for specialist/primary collaboration. Some pathology and imaging services can be centralized. The management of clinical services can be centralized. One can easily imagine a single cardiovascular service serving communities in several states. Nursing process protocols, staffing levels, and training materials can be centralized. They depend on patient needs, not geographic locations. Scheduling models that are effective enough to work in Des Moines will probably also work in Detroit.

In these models, what is centralized is managerial skill and specialized knowledge. The actual service remains at the patient’s side, as it must. The knowledge to provide that service in the most effective manner is centralized. It is redistributed by systematic teaching and sensitive consultation. Successful models are collaborative, rather than authoritarian.

The healthcare system makes four critical contributions to centralization. First is the shaping of mission, vision, and values to a comprehensive stakeholder perspective and the emphasis on those commitments in day-to-day decisions. The discipline to recognize that long-run success must be mutual success should be the first commitment of the central organization. Catholic Health Initiatives and SSM Health Care show clearly that the discipline can be effectively and productively enforced.
Second is the insistence that the performance of centralized processes be benchmarked. Moving from purely local healthcare to centralized models is progress only because the measured performance improves. Decisions to centralize are a variant of the make-or-buy decision; they should be made on objective criteria, and implementation should achieve the initial goals. The healthcare system can ensure that that happens.

Third is maintaining a listening and collaborative environment. Authoritarian behavior on the part of central managers will be profoundly destructive. Sensitive listening, using all the marketing tools to identify both patient and associate needs at the local sites and responding to those needs, makes centralization viable.

Fourth is maintaining a learning environment. Systems can and should orient managers and trustees. They can reduce the cost of training

Questions to Debate

- Why are the “Four Ps” important? Why are they ordered as follows: product, place, price, promotion? What sorts of questions would the four Ps prompt for implementing the new well-baby programs suggested in the Figure 15.3 analysis?

- How does “listening” affect performance improvement teams? Consider a team designing a major renovation or expansion of a service. Focus groups and surveys will cost nearly $100,000. What should senior management consider in deciding whether to spend the money? What is your backup plan if you think that’s too much money?

- Successful efforts in health promotion and palliative care could mean less income for the hospital and its doctors, and even reduced employment. How would you justify a hospital’s investment? Identify the stakeholder segments that must be sold on the concept, and propose the best arguments for each.

- The chapter suggests that good strategy results from a systematic process of information analysis and consensus-building discussion. “The Managerial Role” section in this chapter suggests that the functions described in the preceding chapters are important and that multihospital systems can help. Others argue for more independence—“focused factories.” Who is right?

- The first paragraph of “The Managerial Role” section is an indictment of American healthcare that concludes “the typical hospital is not strategically managed; it is simply drifting.” How could this be true? If it’s false, how do you prove that? If it’s true, what should be done about it?
with centralized learning tools. They can implement succession planning and management development, providing systematic learning and growth among the managers. They can, and many do, incorporate diversity goals into their management development. They can and do promote mentoring and peer learning across their organization.

The models for the twenty-first century are with us today. They are too little recognized, too seldom copied, and too often ignored in favor of short-term single stakeholder advantage.

Suggested Readings


Notes


